
The Brooklyn Hospital Center

*Keeping Brooklyn healthy.*

# Three Year Community Service Plan Update
# September 15, 2012

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## 2012 Community Service Plan Update

**1. Please give us your contact information**


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**2. Region hospital/system is part of: (choose all that apply)**

[X] MARO - NYC

**3. Which hospital or health system do you represent? The hospital systems are listed in italics. If the name of the hospital is not listed, or has changed, please select the "other" option at the end of the list, and write in the correct name. (Check all that apply)**

[X] The Brooklyn Hospital Center (TBHC)

**4. In which county is the hospital located? If submitting a joint CSP for hospitals in multiple counties, please select counties that are applicable**.

[X] Kings County

**5. If you selected New York City as an option, please indicate boroughs that are part of your service area.**

[X] Brooklyn

**6. What is your 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.

**7. Please describe the Hospital Service Area. Indicate any changes to the primary service area used in the community service planning. Indicate whether or not any changes have occurred since the submission of the 2011 report.**

The Brooklyn Hospital Center provides health care services to communities within the following zip codes:

*Primary*: 11201, 11205, 11206, 11207, 11208, 11211, 11213, 11216, 11217, 11220, 11221, 11225, 11226, 11233, and 11238

*Secondary*: 11203, 11204, 11209, 11210, 11219, 11222, 11223, 11228, 11232, 11236, and 11237

The service area has not changed since the submission of the last report. The following is a look at TBHC patient classification for insurance status, age, and race:

| **Patient Demographics--Percentage of total discharges** | **2011** | 2010 |
|---|---|---|
| Patient Financial Class | | |
| Medicaid (Including HMO) | 47.66% | 49.33% |
| Medicare (Including HMO | 32.62% | 31.09% |
| Commercial and HMO | 18.17% | 17.99% |
| Self-Pay | 1.56% | 1.59% |
| | 100.00% | 100.00% |
| **Patient Age** | | |
| 0-1 | 13.39% | 14.37% |
| 2-17 | 4.88% | 4.99% |
| 18-44 | 26.60% | 27.56% |
| 45-64 | 24.91% | 24.44% |
| 65-74 | 12.19% | 11.07% |
| 75 and older | 18.03% | 17.56% |
| | 100.00% | 100.00% |
| **Patient Race** | | |
| Black/Non Hispanic | 67.17% | 65.61% |
| Hispanic | 20.24% | 20.77% |
| White Non-Hispanic | 6.91% | 7.41% |
| Asian | 4.16% | 5.12% |
| Other | 1.51% | 1.09% |
| | 100% | 100.00% |

**8. Which partners have you worked with in planning, implementation and evaluation of your Community Service Plan?**

[X] Academia
[X] Community-based organizations
[X] Elected Officials
[X] Employees and business
[X] Faith organizations
[X] Governmental organizations
[X] Local health department
[X] Health care partners (primary care providers, insurers, hospitals, long-term care)
[X] Media
[ ] Philanthropists
[X] Schools
[ ] Other_____

**9. How do you work with your partners? (check all that apply)**

[X] Aware of services offered by partner
[X] Share data for planning purposes
[X] Plan programs together
[X] Evaluate programs together

[X] Coordinate outreach to the community
[X] Other: Develop systematic improvements for outpatient services through collaborations with other community based providers, including hospitals, social service and supportive service organizations and Federally Qualified Health Centers.

**10. What are the Prevention Agenda Priorities identified in the CSP?**

[X] Access to Quality Health Care
[X] Chronic Disease
[X] Infectious Disease

**11. How do these priorities compare to the priorities reported in the previous CSP?**

[X] Same

**12. Please check priorities added or deleted or write NA (not applicable) if no change was made.**

Priorities Added [NA]
Priorities Deleted [NA]

**13. Please identify discrete (quantitative) goals/objectives for the selected priority areas. For example a CSP reported that hospital x is working toward addressing obesity specified "To have 1,000 county overweight or obese residents loose an average of five pounds over three years, and in the first year the hospital reports that 181 participated and lost an average of 5.6 pounds." Another hospital 'y' working on reducing hypertension tracks "Hypertensive participants with BP < 140/90 mmHg". This hospital also tracks availability and sales of low-salt items in their cafeteria.**

*Access to Quality Health Care*

As part of its strategic plan, TBHC continued its multi-pronged approach to help members of its service communities to gain more access to health care. The following goals framed this effort:

Goal 1: Secure funding and embark on projects which expand access to primary care and facilitate easier navigation through hospital service areas.

Goal 2: Create community partnerships to support a collaborative approach to health care delivery in Brooklyn and create a platform to provide population management and care integration among all health care providers.

Goal 3: Promote health care services and programs through a robust community outreach program which targets those neighborhoods identified as experiencing unmet need and lacking in primary care services, provides free screenings and education, and fosters partnerships with key health service agencies

Goal 4: Increase awareness about programs for uninsured and underinsured persons in the community

*Chronic Disease*

Statistics from the New York State Department of Health and the New York City Department of Health and Mental Hygiene indicate that the population which The Brooklyn Hospital Center serves faces health disparities that surpass state and national averages in the areas of asthma, cancer, heart disease, and diabetes. Over the past year, TBHC focused on strengthening service in these areas to address existing disparities.

Asthma:

Goal 1: Expand provision of an asthma self-management plan to patients
Goal 2: Increase patient education about medication use and asthma triggers
Goal 3: Increase awareness in the community about asthma

Cancer:

Goal 1: Maintain partnership with the American Cancer Society to sustain cancer support groups
Goal 2: Increase education and information to underserved, uninsured and underinsured women about breast cancer prevention through the Breast Health Partnership
Goal 3: Increase information and free screenings — mammograms, pap smears — to women in underserved minority groups
Goal 4: Increase prostate cancer education and free screenings
Goal 5: Increase partnerships with local physicians and medical groups to increase pediatric cancer care

Heart Disease:

Goal 1: Improve the cardiovascular health of members of the community and patients by implementing through advances in care
Goal 2: Increase information and education on smoking, cholesterol, high blood pressure, and sedentary lifestyle physical inactivity to improve heart health of community residents
Goal 3: Support community education/outreach efforts aimed at reducing heart disease
Goal 4: Increase the variety of cardiac services to the community such as new approaches to peripheral vascular disorders, new cardiac imaging techniques including cardiac CT, MR and PET

Diabetes:

Goal 1: Increase diabetes education and smoking cessation information to the community
Goal 2: Increase free glucose screenings at community health fairs and large scale events
Goal 3: Improve patient satisfaction through the implementation of a telephone overflow call system
Goal 4: Provide the highest level of diabetic care as outlined by the National Committee for Quality Assurance (NCQA)

*Infectious Disease*

The Brooklyn Health Center's PATH Center (Program for AIDS Treatment and Health) is an internationally acclaimed program offering a one-stop location with state-of-the-art HIV medical and psychosocial care for adults, children, teens and families. Over the past year, PATH focused on the following goals:

Goal1: Add 200 new PATH patients in 2012
Goal 2: Apply for Level 3 Medical Home Certification for the PATH Program
Goal 3: Increase follow-up and retention in care services
Goal 4: Build awareness about HIV/AIDS prevention through community outreach efforts

**14. What measures are you using to track progress in your selected priorities? Example of an outcome measures is "Number of BMI/pounds reduced per participant", and a process outcome is "percent of participants who completed the program" or "number of programs offered" If "Not Applicable" please explain why.**

*Access to Quality Health Care*

Measure 1: Grants awarded to expand primary care and facilitate easier navigation through hospital service areas.
Measure 2: Engage community based organizations through TBHC's Community Health Planning Workgroup (CHPW) to help the hospital identify and create plans for improving the health status of residents
Measure 3: Number of health fairs and community events; engagement with new community organizations
Measure 4: Information disseminated on Financial Assistance Program; partnerships with managed care organizations; information sharing at large-scale events

*Chronic Disease*

Asthma:
Measure 1: Number of patients who received an asthma self-management plan
Measure 2: Number of patients educated about medication use and asthma triggers
Measure 3: Distribute literature about asthma at 25 health fairs; provide asthma inhaler use/screening at TBHC's annual health fair

Cancer:
Measure 1: Continued American Cancer Society sponsorship of cancer support groups and the continuation of support groups serving patients with breast, prostate, and other forms of cancer
Measure 2: Number of underserved, uninsured and underinsured women who received information and services about breast cancer prevention through the Breast Health Partnership
Measure 3: Number of women over 40 in underserved minority groups who received free mammograms and pap smears
Measure 4: Number of men who received prostate cancer education and free PSAs
Measure 5: Physician networking event to introduce a specific community to the Pediatric Hematology/Oncology Department

Heart Disease:
Measure 1: Core measures in Congestive Heart Failure and Acute Myocardial Infarction; complications log with 100% capture on invasive and noninvasive procedures
Measure 2: Number of 'heart-healthy' events
Measure 3: Number of blood pressure screenings
Measure 4: Number of partnerships with community physicians and increased cardiology services to the community through participation in neighborhood health fairs

Diabetes:

Measure 1: Number of diabetes education and smoking cessation sessions; related literature distribution

Measure 2: Number of free glucose screenings offered at community health fairs and large-scale events

Measure 3: Number of monthly telephone overflow calls to ensure 24x7 access to patients; quarterly HEDIS quality metrics for diabetic patients

Measure 4: Achievement of NCQA Diabetes Recognition Program (DRP) designation for providing the highest level of care for diabetic patients

*Infectious Disease*

Measure 1: Number of new HIV patients added in 2012

Measure 2: Achievement of Level 3 Medical Home Certification

Measure 3: Increase show rate to 70% and increase retention rate to 85%

Measure 4: Number of community events

**15. Please provide an update on the Plan for Action. Provide a summary of the implementation status of your 3-year plan, including successes and barriers in the implementation process. If applicable, indicate how and why plans have been altered as a result of stated successes and barriers**.

The following is a summary of successes in the implementation status of TBHC's Plan for Action:

*Access to Quality Care*

Over the past year, The Brooklyn Hospital Center focused intensely on increasing access to health care for local residents through the following efforts:

HEAL 15 and 19 Grants: TBHC continued to develop projects associated with a 2011 award of $4 million in HEAL 15 grant funding and $8.5 million in HEAL 19 grant funding from the New York State Department of Health (NYS DOH). Both grants are based on a strategic realignment of the hospital's clinical services to best address the health care needs of the community and enhance ambulatory services. TBHC identified a location and negotiations are underway to secure the site so that an ambulatory services building can be developed. The site will house its outpatient clinical services expansion, including Dental and Oral Surgery; PATH (Program for AIDS Treatment and Health); and a new diagnostic imaging center. TBHC also plans to renovate and expand its Adult Medicine primary and specialty services and the Family Medicine Center.

HEAL 21 Grant: TBHC led the grant application process for the proposed integration of The Brooklyn Hospital Center, Interfaith Medical Center (IMC) and Wyckoff Heights Medical Center (WHMC) into a health care system. The three institutions currently provide ambulatory and inpatient services to an area in which over one million people reside. More than 50 percent of that population relies on Medicaid services. Easy access to high quality healthcare services is a challenge primarily because of an inadequately capitalized integrated delivery system that is unaligned with the needs of the community. The proposal to create the Brooklyn Healthcare System could have a transformative impact on improving access to health care for Brooklyn's residents. A two-phase grant project is proposed. TBHC was awarded $1 million in HEAL 21 grant funding to implement *Phase One*. The dollars were applied toward a Feasibility Study which is expected to be complete in fall 2012.

Award of CMS Transitional Care Grant: TBHC, in conjunction with Cobble Hill Health Center (CHHC), and Interfaith Medical Center (IMC), was awarded a grant from the Centers for Medicare and Medicaid Services (CMS) to participate in the Community-based Care Transition Program

(CCTP) regarding preventable readmissions. The award of this grant demonstrates CMS's acknowledgement of TBHC's commitment to improving preventable readmissions and quality of care. The partnership, entitled The Brooklyn Care Transition Coalition (BCTC), includes CHHC serving as the community-based organization (CBO) which coordinates an interdisciplinary team to provide care transition services to an estimated 1,508 Medicare fee-for-service (FFS) beneficiaries admitted to IMC and TBHC each year over the next five years. The intervention models incorporated in this partnership are anticipated to generate a projected total Medicare savings of $1,887,407 (net savings to Medicare of $1,100,520) per year and $5,502,598 net Medicare savings over five years. The three organizations began implementation of the interventions in 2011.

Award of HealthFirst Member Satisfaction Grant: TBHC also received $250,000 in funding from HealthFirst to collaborate with The Center for Immigrant Health and Cancer Disparities (CIHCD) at Memorial Sloan-Kettering Cancer Center to improve the quality of care for HealthFirst Medicare patients and specifically increase the member satisfaction ratings related to the quality indicator of the patient experience with the provider. The strategy for the project, entitled *Optimizing the Member and Provider Experience (OMPE)* will do the following: Engage CIHCD to assess, train and educate 71 family medicine staff who practice in the organization's four Patient Centered Medical Homes – designated ambulatory health care centers. This includes the provision of training to 20 family medicine attending physicians, 21 family medicine residents and 30 support staff. The CIHCD team will provide language and culturally sensitive education and training as part of its *Enhancing Provider-Patient Communication Across Language and Cultural Barriers* program, with the intent of improving provider/patient communication, self management skills and health status awareness. This training and education will be provided at TBHC, and at its community family health centers--La Providencia Family Medicine Center, Manhattan Avenue Family Health Center, and the Williamsburg Family Health Center.

Brooklyn Health Information Exchange (BHIX) Membership: TBHC has entered into an agreement with the Brooklyn Health Information Exchange (BHIX) to be a member participant. BHIX is a not for profit RHIO (Regional Health Information Organization) devoted to developing, deploying and operating innovative uses of interoperable health information technology and analytics to facilitate patient-centric care and promote improved health care quality. BHIX is Brooklyn's RHIO and TBHC will now benefit from sharing patient care management information with other community based providers and hospitals, consistent with the Health Home model as well as the hospital's initiatives regarding preventable readmissions and other quality efforts underway. BHIX fosters improvements in community clinical connectivity and supports sharing of healthcare data among patients, doctors and other practitioners, hospitals, long term and home care services, community based organizations, government agencies and insurers.

The New York Community Trust's Preventable Hospital Readmission Initiative Grant: The Brooklyn Hospital Center was awarded grant funding from The New York Community Trust's Preventable Hospital Readmission Initiative (PHRI), Stage II Supplemental Proposal, to address the challenge of preventable hospital readmissions. The PHRI grant funding request of $50,000 will help TBHC to advance and continue its efforts to understand the underlying issues and tackle the problem of re-hospitalizations. TBHC is well underway in its efforts to improve its patterns of preventable readmissions. The hospital has previously been awarded a CMS CCTP grant in a joint collaboration with the Cobble Hill Health Center and Interfaith Medical Center. In addition, the hospital received $70,000 in funding from the United Hospital Fund regarding its preventable hospital readmissions initiative grant.

CMS Strong Start Preterm Grant: The Brooklyn Hospital Center collaboratively submitted a $3,605,198 grant application to CMS regarding their Strong Start funding initiative. The project – the Brooklyn Prenatal Health Initiative - presents a critical opportunity for health care and social service providers in Brooklyn to implement an innovative, community-based model of care and support to advance maternal and infant health outcomes for some of New York City's most vulnerable individuals. TBHC is a member in a collaborative of hospitals, federally qualified health

centers, community-based organizations and a district public health office who have collectively designed a patient-centered model of care and support service access, utilizing the Centering model of group prenatal care (Option #1) as a basis, aimed at reducing preterm birth and advancing the CMS three-part aim of better health care delivery, improved population health status, and reduced costs of care.

The diverse organizations listed below provide a safety net of care and support to North, Central and Southwest Brooklyn residents: The Consortium includes: Hospitals: The Brooklyn Hospital Center, Lutheran Medical Center and Maimonides Medical Center; Federally Qualified Health Center Networks: Lutheran Family Health Center Network (part of Lutheran Medical Center), Community Healthcare Network, and Brooklyn Plaza Medical Center; Community-Based Organizations: Brooklyn Perinatal Network (managing a coalition of community-based organizations); Local Health Department: Healthy Start Brooklyn (a unit within the Brooklyn District Public Health Office). Together, the Consortium anticipates serving 2,800 women over the three year service period of the grant. Overall, the Consortium's goals are to reduce preterm birth among Medicaid- and CHIP-enrolled women; improve health outcomes for newborns; avoid costly NICU admissions; and improve engagement in and satisfaction with prenatal care. The Consortium believes this health and social support model could be replicated in other urban communities around the country to improve maternal health outcomes and reduce health disparities.

TBHC's Community Health Planning Workgroup: The Community Health Planning Workgroup (CHPW) is a consortium of Brooklyn community-based organizations. Originally formed as a separate task force to the Governor's Medicaid Redesign Team's Brooklyn Workgroup, convened by Senator John Sampson and Brooklyn Borough President Marty Markowitz, this taskforce developed a supplemental, community-rooted perspective report to the Governor's MRT Brooklyn Workgroup entitled, Creating a Vision *for Brooklyn's Health Care System: A Report of the Brooklyn Healthcare Working Group*. Subsequent to the publication of this report in fall 2011, TBHC continued engaging these health care and social services providers and other stakeholders in the planning and assessment process.

The CHPW has emerged as a key group for collaborations on community health issues and it meets regularly at TBHC. There are 15 member organizations represented in the CHPW, with four hospital providers (TBHC, Lutheran Medical Center, Interfaith Medical Center and Kings County Hospital Center) and four Federally Qualified Health Centers (Community Healthcare Network, Brooklyn Plaza Medical Center, Bedford Stuyvesant Family Health Center, and Brownsville Multi-Service Family Health Center). Other community organizations include the Brooklyn Perinatal Network, New York Lawyers for the Public Interest, Commission on the Public's Health System and the Brooklyn NAACP. Representation is also provided from Senator Velmanette Montgomery's office and TBHC's Community Advisory Board. Representatives from Senator John Sampson's office, the Brooklyn Borough Presidents Office, the NYC Department of Health and Mental Hygiene, and Brooklyn's Community Board Two have attended meetings.

The CHPW has crafted the following purpose statement: *The purpose of the Community Health Planning Workgroup (CHPW) is to assess community health care needs and to consider the scope of health care resources within the community; develop a framework for a health system in Brooklyn which will provide the highest quality health care services; and ensure that funding for the community's health needs are secured and all stakeholders are kept informed about the status of HEAL 21 funding and allocations.*

Community Outreach: Over the past year, the thrust of the Community Outreach program was aimed at increasing access to the hospital's programs and services. TBHC focused on engaging and reintroducing the hospital to key community based organizations (CBOs); bringing health information and free screenings to underserved neighborhoods; and increasing hospital usage by members of the Arab/Muslim community. Additionally, TBHC continued to cultivate relationships with community boards and other local agencies in order to keep the community informed and maintain a connection with community leaders.

Over the past year community outreach emphasized access to health care by partnering with managed care organizations on some key events. The hospital conducted a lecture series for seniors in collaboration with HealthFirst and Councilwoman Letitia James. The lectures were held at three local senior centers. TBHC physicians focused on topics related to senior health, while information was provided about the hospital's Financial Assistance Program and other services and programs. Seniors who were interested also received information about free or low cost insurance programs. Several community partners such as HHS Connect, the Deputy Borough President's Office, and the New York City Department for the Aging provided information on entitlements and other programs for seniors.

The hospital participated in more than 55 health fairs and attended over 60 community meetings. These efforts included making new connections and partnerships with community groups as another path to increasing access to health care for various segments of the population.

The list below includes new events, organizations and community leaders that the hospital worked with over the past year.

| **Organization** | **Activity** |
|---|---|
| Antioch Baptist Church, 107-14 Pinegrove Street | Health Fair |
| Myanmar Medical Education Society (MAMES) | Health Fair for Burmese Immigrants |
| Salem Missionary Baptist Church, 305 E 21st | Blood Pressure Health Fair with the American Heart Association |
| Bishop Henry B. Hucles Episcopal Nursing Home<br>835 Herkimer Street | Information |
| United Men of Antioch – Antioch Baptist Church<br>828 Green Avenue | Men's Health Fair |
| Downtown Bangladeshi Business Association | Immunization Health Fair |
| Child Development Support Corp Head Start Program | Networking Meeting |
| Islamic Center of Bayridge, 68-02 5th Avenue | Blood Pressure Health Fair with the American Heart Association |
| Child Development Support Corp Head Start | Hearing Screenings |
| Clara Barton High School for Health Professions<br>901 Classon Avenue | Speaker: Dental Health |
| PS 20, 225 Adelphi Street | Health Fair |
| Ingersoll Community Center, 177 Myrtle Avenue | Community Health Fair |
| Walt Whitman Library, 93 Saint Edwards Street | Blood Pressure and Information Health Fair |
| Miracle Church of Christ, 1487 St. John's Place | Speaker and Blood Pressure Health Fair |
| NYC College of Technology, 300 Jay Street | Health Fair |
| St. Augustine Episcopal Church 4301 Avenue D | Information |
| Myrtle Avenue Brooklyn Partnership | Food Conference / Health Screenings / Partnership for *Wellness for Life* Program |
| Council Member Letitia James | Partner for Senior Lecture Series with HealthFirst |
| Senator Velmanette Montgomery | Partner for Women's Health Fair with YWCA |
| PS 274, Bushwick Avenue | Speaker – Asthma |

| | |
|---|---|
| PRIDE- LGBTG (PATH) | Annual Walk Prospect Park |
| PS 062, 51 St. Edwards Street | Speaker – Health |
| International African Arts Festival | Senior Resource Day |
| Council of People's Organization (COPO) | Health Fair / Proposed partnership with Rehabilitation |
| NYCHA/NFL Football Officiating Academy | Health Screenings |
| World Changers Church | Information |
| New Jerusalem United Methodist Church | Health Fair |
| Health Education Project | Collaboration on TBHC Annual Health Fair |
| Brooklyn Metropolis Lion's Club | Health Fair |
| Brooklyn Navy Yard | Health Fair |
| The Church of God Prophecy | Annual Health Fair with Neighborhood Health Plan |
| NYC Department for the Aging | Participation in senior lecture series |
| Old Navy – Atlantic Terminal Mall | Child Safety Day |
| Barclays Center | Basketball Clinic at LIU – Keeping Healthy theme |

The hospital's Community Advisory Board (CAB) played a key role in keeping TBHC abreast of community issues and strengthening relationships with legislators and the faith-based community.

The CAB held a successful Annual Meeting on April 17th. Following an overview of health care on the national, state, and local levels the CAB and guests heard from Deputy Borough President Sandra Chapman. Ms. Chapman built on her literacy platform to highlight health literacy and sensitivity to immigrant groups who have difficulty navigating the complicated health care landscape. She suggested the formation of a junior health literacy council to create awareness about this issue. CAB member, Dr. Natalie Langston-Davis has since been leading efforts to create the council. A panel of TBHC experts spoke on the topic *Health Care in Our Community: Access and Affordability*.

*Chronic Disease*

Asthma:
According to the NYC Department of Health and Mental Hygiene some areas in Brooklyn experience a higher prevalence of asthma in comparison to other New York City boroughs. This is particularly evident in the following TBHC service zip codes: 11201, 11205, 11215, 11217, 11231, and 11238. In order to address asthma as the serious health concern that it is TBHC's Adult Pulmonary Clinic provided an asthma action plan to all discharged patients, intensified patient education, and intentionally included asthma prevention in its outreach efforts.

TBHC sought to minimize the impact of asthma related symptoms and illness on patients and their families and reduce acute exacerbations of asthma, which would require hospitalization. Both objectives were realized through comprehensive disease management based protocols. Additionally, the Department of Pharmacy ensured the presence of certified asthma educators in the clinic, and medication training sessions were provided to most asthma patients.

Of the 360 patients seen in the Adult Pulmonary Clinic in 2011, more than half showed poor techniques in inhaler use. The asthma educators counseled these patients and approximately 40 percent of them showed a marked improvement resulting in better control of their asthma symptoms. When some of the patients forgot the techniques after one session, the educators provided reinforcement during subsequent clinic visits. Because of the seriousness of the condition, the educators remained committed to helping these patients improve their outcomes.

TBHC also addressed the prevalence of asthma through the management of its patients. All patients were provided with a Peak Flow Meter and an Asthma Action Plan. Patients were educated on how to monitor their peak flow and were taught how to modify medication regiments through individual interventions with their Prescribers (when indicated). The asthma action plan (also called a management plan) is a written protocol developed by patients with their doctor. The plan outlines daily treatment, such as what kind of medicines to take and when to take them, and describes how to control asthma long term and handle worsening asthma symptoms or attacks. The plan also explains when to call the doctor and when to go to the emergency room. All admitted patients were also provided with a copy of an asthma action plan before discharge. Follow-up appointments were provided to reinforce the education and monitor progress.

TBHC included asthma education in many of its community outreach efforts, distributing information about asthma care at more than 40 health fairs. During its annual community health fair on June 9, 2012, Long Island University's Brenda Pillars Asthma Education Program partnered with TBHC's Department of Pulmonary Medicine to provide screenings and education on inhaler usage. The Brenda Pillars program promotes self-management to avoid asthma symptoms, helps improve cultural sensitivity for health care providers who serve Brooklyn's diverse communities and seeks to advance common-sense public policy. TBHC's approach to asthma treatment is in concert with these ideals.

Cancer:

TBHC's Cancer Resource Center continued to assist cancer patients and their loved ones over the past year. The center, the only one of its kind in New York City, remained open to the public, cancer patients, their family members, friends and caregivers. Specially trained volunteer cancer survivors provided individualized guidance about cancer treatments, clinical trials, early detection guidelines and other pertinent issues. TBHC also maintained its partnership with the American Cancer Society to offer the following support groups:

- *Look Good/Feel Better* offered beauty techniques and make-up application to female cancer patients who were in active treatment. This helped the patients to improve their appearance-related side effects of cancer treatment.
- *Man To Man*, a monthly meeting provided cancer education and support to men with prostate cancer.
- *The Coping Club*, a monthly program, offered education, recreation, and support to cancer patients. As a prerequisite, participants attended a day-long seminar during which a panel of experts provided information and answers to questions for newly diagnosed cancer patients.

TBHC also served the community through its Brooklyn Breast and Cervical Health Partnership. This program offered low-cost or free mammograms, pap smears, pelvic exams and clinical breast exams to eligible uninsured or underinsured women. Funded by the New York State Department of Health and the Centers for Disease Control and Prevention, the program usually supported examinations for about 30 women each month. Over the past year allocations covered costs for only nine women during some months. The loss of funding for community outreach, breast cancer education, screenings and treatment projects from the Susan G. Komen Foundation also made TBHC's efforts to address breast cancer a challenge. In spite of the roadblocks, the hospital's Cancer Communications Department offered information at more than 50 events over the past year. In addition to African-American groups, medically underserved women from the Arab/Muslim community and Hispanic neighborhoods were provided with information. Funding shortages from both sources presented a huge barrier in offering free cancer screening services to poor women in the inner city. Many of these eligible women and others who lost their insurance coverage as a result of the economic recession experienced long wait times or referred to other programs farther away from their neighborhood.

Funding shortages also stymied the organization of the Annual National Cancer Survivors Program in June. Designed to "show the world that life after a cancer diagnosis can be meaningful and

productive," in past years the program brought together hundreds of survivors – children, men, women and seniors. Local legislators and providers also attended to celebrate with those who had overcome a cancer diagnosis, illness and treatment. Plans are underway to reinstate the program in 2013.

TBHC also focused on providing free PSA tests to men, at health fairs dedicated to that purpose and at routine events. Between September 2011 and September 2012 nearly 80 men received free PSAs. The test results were sent to the men in mail and those who had abnormal results were referred for further testing. Although the PSA screening was available at large scale community events such as the Brooklyn Borough President's *Take Your Man to the Doctor Day* on October 6 and the 37th Annual Atlantic Street Festival on October 2, which attracted over one million people, TBHC faced the challenge of having men in these underserved communities take advantage of the test. This indicates that there may be room for much more education and outreach to that group.

Another key endeavor was Physician Networking Breakfast in the Arab/Muslim community to introduce the hospital's Pediatric Hematology/Oncology service. Doctors attending the meeting were grateful to TBHC for providing information and for being of service to a growing community which is in need of culturally sensitive medical services. Plans are underway to partner with a community organization for a cancer information seminar during Cancer Awareness month in October. Despite a number of challenges, TBHC remains committed to providing the most technologically advanced and compassionate cancer care available.

Heart Disease:

Core measures were developed by The Joint Commission and endorsed by the National Quality Forum as minimum process of care standards. They are widely accepted methods for measuring patient care quality that includes specific guidelines for heart attack, heart failure, pneumonia, pregnancy and related conditions, and surgical infection prevention." Over the past year, the Cardiology Department has realized improvement and sustained quality practices in core measures scores. All complications are captured on invasive and noninvasive procedures. All major complications are reviewed in the division and cardiologists continue to assess cases based on additional quality indicators:

- Provision of quality health care in the area of cardiovascular disease
  - Core measures attain 100% compliance in the majority of measures
  - No significant complications in invasive cardiac procedures
- Facilitated communication between physicians
  - Hospital EMR allows office-based physicians to be updated on patients in the hospital
  - EMR also allows patient education materials to be distributed prior to discharge

Over the past year, The Brooklyn Hospital Center increased the number of voluntary and salaried physicians in Cardiology. Some of these new physicians completed their training in Cardiology at Brooklyn Hospital; so they are acquainted with the unique medical and social needs of the community. A number of these physicians bring unique expertise and provide additional services planned for the division, such as cardiac CT angiography. Many of the physicians have been trained in non-surgical approaches to peripheral artery disease, including percutaneous vascular intervention. The division plans to expand this service soon to address the prevalence of heart disease in the areas TBHC serves.

TBHC also increased its emphasis on heart health at community events. In partnership with TBHC the American Heart Association, TBHC trained members of select communities to conduct blood pressure screenings. The trainings were held for a group of African-American women and for

another group of Arab-Muslim women. Both groups are disproportionately affected with hypertension. These sessions also included blood pressure screenings and education on how high blood pressure affects one's heart health. TBHC also increased its blood pressure screenings for men and college students. Additionally, TBHC cardiologists commemorated February as Heart Month with a series of Medical Grand Round lectures and participation in the hospital's Wellness for Life program.

TBHC continued its affiliation with the Lafayette Medical Center, a medical practice in the community. Through this association, the hospital remained focused on its goal of meeting the need for cardiology services in an underserved community.

Diabetes

The New York State Health Foundation reports that diabetes rates are at epidemic proportions in New York City. Diabetes is currently the fourth-leading cause of death in New York City; more than 700,000 city residents-double the number 15 years ago-have the disease. Brooklyn is included in that dismal picture with more than 164,000 residents currently suffering from the disease. Nearly 7,000 people in Brooklyn are hospitalized for diabetes every year. Over the past year, The Brooklyn Hospital Center remained committed to providing education, free screenings, and the best treatment available to people in its patient population who are affected by the disease.

As part of its community outreach efforts, glucose screenings were offered at more than 30 community health fairs. More than 1,106 persons received glucose screens. TBHC's health fairs were tailored to target specific audiences-school children and parents, college students, men and seniors. TBHC also held events specifically to educate and screen members of the ethnic groups included in its patient population: Arabs/Muslims, Chinese, Polish, Hispanic, and African-American. At each event, a registered nurse or physician was available to provide counsel regarding the test result and the necessary steps for a healthier lifestyle.

The overall quality of care among diabetes patients has improved significantly in 2011. Diabetic outcome measures such as hemoglobin A1c level, lipid control, blood pressure control have enhanced the overall coordination of diabetic care. With the help of its multi-disciplinary care team, TBHC has also improved diabetic treatment by implementing patient-centered, medical home standards.

*Infectious Disease*

Over the past year, the PATH Center continued addressing the healthcare needs of the growing number of people infected and affected with HIV/AIDS. In 1997, the first year of operation, PATH saw 216 HIV+ patients. PATH continues to exceed previous years in terms of reaching new and continuing patients. During 2011, 397 new patients were seen, for a total of 1,472 patients seen during the year. With the increase in patients and patient satisfaction, PATH's visit volume increased by more than 15 percent in 2011, as it had in 2010.

In 2011, The PATH Center received funding to expand adolescent and young adult services, through the development of a Specialized Care Center serving HIV+ people ages 13-24. The PATH Center also expanded its efforts for outreach, HIV testing, retention and re-engagement. Funding was received from Health Resources and Services Administration Special Projects of National Significance through Boston University School of Public Health for the Minority AIDS Initiative's Retention and Re-engagement Project for evaluating effective engagement and retention services. This is part of a three-site study, including Puerto Rico and Miami. In addition, the Elton John AIDS Foundation provided funds for hiring additional peers to provide outreach and HIV testing to bring more people into care earlier in their disease process.

Through all of these initiatives, PATH plans to increase its visibility so that community members are aware of where they can go for HIV testing, treatment and care. In 2012, Ryan White Part C provided supplemental funding to hire an additional outreach worker to help identify and bring into care young men of color who have sex with men – one of the current populations with increasing rates of HIV infection. This funding source enabled PATH to expand its staff by eight outreach staff, and three additional staff to support the adolescent initiative. PATH outreach staff also participates in the hospital's community events as a means of building awareness, promoting safe sex, and emphasizing prevention. The increased visibility and outreach are especially important as the HIV "at-home" test just became approved, and TBHC wants to ensure that members of the community have access to the care which is available at the PATH Center.

**16. Explain any impact or changes that have been realized to date as a result of your collaborative plan. If "Not Applicable", please explain why.**

*Access to Care*

TBHC, on behalf of its CHPW, submitted a proposal in May to the NYSDOH for funds to conduct a community health needs assessment for residents of North and Central Brooklyn. The results of this assessment will help inform and contribute to an overall feasibility study that is underway with Navigant, the global healthcare redesigning consulting firm retained by TBHC.

In June, NYSDOH awarded $125,000 to the CHPW to fund the assessment. TBHC and Interfaith Medical Center's Foundation each contributed $40,000 towards the project, for a total budget of $205,000. To date, the CHPW has conducted several focus groups and distributed over 600 surveys for the assessment.

Navigant began the feasibility study related to establishing a health care system for the region as outlined in the HEAL 21 grant application. TBHC intends to pursue continued, detailed, exploration regarding how to help reconfigure the health care delivery system in Brooklyn and improve patient access to high quality, economically sustainable care. The goals of the integration remain:

- Streamline inpatient and tertiary care in a manner that is both sustainable and aligned with the community's health needs
- Restructure existing liabilities supported by enhanced operating margin projections
- Reinvest in programs and infrastructure
- Increase access to high quality primary care (with development of an integrated PCP network or PCP partnership)
- Provide greater access to outpatient services

Hospital Medical Home Demonstration Project Grant Submission: On July 2nd, TBHC submitted an application to NYSDOH regarding its H-MH Demonstration Project, which will provide $250M over the next 3 years for teaching hospitals to transition their outpatient training sites to patient-centered medical homes. Funding for this project is provided by CMS under NY's Medicaid managed care waiver. Funding will be distributed on a formula with 80% allocated based on Medicaid clinic volume and 20% based on the number of primary care residents trained. GNYHA has provided TBHC with a preliminary estimate of the potential for $1.7M in first year value. Award notifications are expected in August.

TBHC's submission includes six outpatient facilities: OPD 2 Internal Medicine service; the PATH Program (two locations: downtown campus and Church Avenue services); The Children's Center; La Providencia Family Health Center and the Family Medicine Center. La Providencia and the Family Medicine Center have already attained Level 3 NCQA PCMH recognition based on the 2008

standard. With this grant request, they aim to receive Level 3 recognition based on the latest 2011 standard.

Asthma

Of the 360 patients seen in the Adult Pulmonary Clinic in 2011, more than half showed poor techniques in inhaler use. The asthma educators counseled these patients and approximately 40 percent of them showed a marked improvement resulting in better control of their asthma symptoms. When some of the patients forgot the techniques after one session, the educators provided reinforcement during subsequent clinic visits. Because of the seriousness of the condition, the educators remained committed to helping these patients improve their outcomes.

Cancer

A key achievement in oncology services over the past year was the hiring of a Patient Navigator. The navigator, a registered nurse, ensured that cancer patients, their families and caregivers received personalized attention to help lessen or remove any obstacles pertaining to care. The navigator also educated patients on resources such as treatment options, support groups, child care, transportation, and other social services.

Heart Disease

All complications are captured on invasive and noninvasive procedures and all major complications are reviewed in the division and cardiologists continue to assess cases based on additional quality indicators:

- Provision of quality health care in the area of cardiovascular disease
  - Core measures attain 100% compliance in the majority of measures
  - No significant complications in invasive cardiac procedures
- Facilitated communication between physicians
  - Hospital EMR allows office-based physicians to be updated on patients in the hospital
  - EMR also allows patient education materials to be distributed prior to discharge

Diabetes:

Over the past year, TBHC addressed issues which were creating roadblocks to follow-up care. A telephone overflow call system was introduced to contact patients to check their status, provide instructions, and remind them of appointments. Since then, overall patient satisfaction in the ambulatory care center has increased from 3.9 to 4.2.

The enhancements resulted in the following:

- Overall improvement in Healthcare Effectiveness Data and Information Set (HEDIS) measures (HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service)
- Significant Improvement in the HCAPHS Patient Satisfaction (HCAHPS survey items complement the data hospitals currently collect to support improvements in internal customer services and quality related activities)
- Improved telephone access to patients
- EMR (Electronic Medical Record) real time alerts to give evidence based guidelines for diabetes management

*Infectious Disease*

The focus on “test and treat” as both prevention and care, has supported increased testing throughout NYC, including the “Knows” campaign in every borough. We are an active member of “Brooklyn Knows” with the goal that everyone know their HIV status. Agencies working together to provide an infrastructure for testing and linkages to care is an important component of a

community's response. However, on the negative end, funding for prevention programs has been reduced -- the very avenue that usually supports community education, testing and prevention.

The "at home" HIV test just received FDA approval. Although this seems positive, a great concern is the linkage to care, especially with the great stigma and fear that still exists in many communities, especially the Black community. It is even more essential for us to ensure that people know where they can go for care and services if they test positive, and to learn that they may be at risk thus spurring them to be tested (whether at home or at an agency).

As HIV disease transitions to becoming part of the standard of care, many think that the need for supportive services should be minimized. With the pharmacological advancements in HIV medicine, the fear of becoming positive has, for some, gone away. This, unfortunately, increases the need for HIV health education and community awareness. Some no longer fear becoming HIV+ thinking it is an easily treatable disease. Others who find out they are positive, still will not come in for care due to ongoing stigma and fear.

Young adults and teens between 13 and 29 represent 34% of new HIV infections, the largest share of any age group. Black teens are disproportionately affected, representing 68% of reported AIDS cases among 13 to 19 year olds in 2007. These numbers show that an increase in educational initiatives needs to be implemented to combat the silence and stigma that is still associated with HIV.

During the first part of 2012 there was uncertainty about the direction of health care reform and Medicaid reform. That has been clarified and New York is now poised to encourage people to engage in care. Larger issues loom, however, due to Medicaid reform. Brooklyn's landscape is changing as NYS' Medicaid Reform Team encourages re-structuring among the Brooklyn hospitals. In addition, the Health Home initiatives are changing the support structures that we have come to rely on to engage and retain our hard to reach clients. The idea of care coordination for the chronically ill is positive, however, developing the infrastructure for this initiative has proven difficult and we have concerns about the actual impact on our patients.

**17. Since completing your CSP in 2011, have you conducted any new surveys?**

[X] Yes.

The hospital's Community Health Planning Workgroup (CHPW) has embarked on a community health needs assessment as a precursor to the organization of the proposed Brooklyn health provider integration. The survey seeks to review the health status of the community and identify unmet needs. Focus groups were also conducted to understand consumer preferences and needs for primary and outpatient care services in downtown Brooklyn.

**18. Please list other non-prevention agenda priorities or issues on which the hospital is working? If none, please write NA (not applicable).**

The Brooklyn Hospital Center selected *Obesity*, *Child Safety*, and *Stroke* as its non-prevention agenda items:

*Obesity*

Wellness for Life: Statistics from the New York City Department of Health and Mental Hygiene (NYCDOHM) indicate that the population in TBHC's service area is less healthy than persons within the city population. That population is also at alarmingly higher risk for hospitalization for heart disease, diabetes, and cancer, and for mortality associated with these conditions. Factors such as race, culture, and socioeconomic status also feed into unprecedented health disparities which disproportionately affect the morbidity and mortality of the aforementioned diseases,

TBHC's service area has also been identified as a food desert – a low income area where healthy and affordable produce is not readily available. The *Wellness for Life* program recognizes these challenges and has tailored its nutritional program to address and combat these issues.

Now in its seventeenth year, *Wellness for Life* provides support for seniors, HIV infected persons, and patients who are part of out-patient medical nutrition therapy programs. Each session begins with one standing exercise and a seated body workout so that those who are wheelchair bound can participate. A calorie-controlled diet plan is offered for those with weight-loss goals. The monthly weigh-in allows participants to record their progress and strive for a coveted prize. One of the favorite features of the program is a healthy-foods tasting session. Popular recipes and ethnic cuisine are prepared with wholesome ingredients and using healthy techniques. Samples of these dishes are served to participants. They also receive recipes, menus, shopping lists, and nutritional guides. Over the past year, the Brooklyn Hospital Foundation awarded *Wellness for Life* a grant to underwrite the food tasting part of its program.

A recent survey of participants and anecdotal information indicate that *Wellness for Life* is immensely successful. Ninety-five percent of those surveyed indicated that *Wellness for Life* was "very helpful" in their efforts to improve nutrition and promote healthy lifestyle. The participants pointed to a number of benefits including, lower cholesterol, improved eating habits, weight loss, lower blood pressure, and the motivation to make healthy food choices. They indicated that the "Picture of Health" award, given for the most weight loss, also provided inspiration to strive for their goal weight. Physicians who refer their patients to the program also reported satisfaction with the results patients obtain. Over 100 persons attend *Wellness for Life* each month and the numbers are growing

WIC Program: TBHC's WIC Program provided nutrition education, assessment and checks for nutritious foods to 22,000 women, infants and children monthly. WIC's individualized targeted nutrition intervention included physical activity and healthy lifestyle changes. The TBHC–WIC Program collaborated with the Bedford-Stuyvesant Early Childhood Program and provided nutrition education classes to the parents and their families on a monthly basis at 10 different sites. The program was selected as one of five WIC Programs in the USA to participate in a USDA pilot project to increase breastfeeding initiation and duration rates using WIC Peer Counselors. Research has shown that breastfeeding plays a vital role in prevention of obesity and other chronic diseases. WIC is applying for funding from the Office of Women's Health to hold a series of one day conferences for WIC staff, Nurses and physicians on evidence based practices that will help increase breastfeeding rates among medically underserved communities and TBHC's patient population.

*Pediatric Safety*

Infant CPR: In the one year period, Pediatrics trained over 250 community persons in infant CPR. Questions about pediatric safety were also answered during the sessions. These sessions took place in the evening (between one and four sessions per month) and were taught by hospitalists who staff TBHC's Pediatric Emergency Room and by critical care physicians who work in the Pediatric Intensive Care Unit (PICU). The critical care physicians have begun an additional IRB approved study on the effectiveness of this training. Those who have taken the course are being evaluated voluntarily for their CPR skills using TBHC's simulation facility. The study will ascertain the effectiveness of the instructions. While the outcome measure of lives saved is too difficult to evaluate; this study may give us some insight.

Women Infant and Children (WIC) Program: WIC provided education on how to prevent sudden infant syndrome (SIDS) to all its participants. The classes also included instructions on appropriate use of bicycle helmets; how to use car seats for infants and children; and the appropriate age for introducing different foods to infants and children so as to avoid choking.

Hearing Screenings: TBHC's Audiology Department provided free hearing screenings for over 120 preschool age children in "head start" programs in underserved neighborhoods in downtown Brooklyn. TBHC has established relationships with the Child Development Support Corp Head Start Program and the Brooklyn Kindergarten Society. As a result of its community outreach efforts, TBHC also considered a partnership agreement with the CDI Head Start Children's Center. Plans are underway to arrange for the Audiology Department to offer this service to its student body. Students who do not pass the hearing screenings are referred to TBHC. TBHC also provides care to students who are uninsured by assisting them with securing free or reduced cost services.

*Stroke*

TBHC's Stroke Center received an American Heart Association/American Stroke Association *Get With The Guidelines®-Stroke Gold Plus Performance Achievement Award* in 2012. A *Get With The Guidelines (GWTG) Achievement Award* demonstrates the hospital's commitment to quality and ability to work as a team that is dedicated to providing its patients with care that is appropriate and based on the latest clinical guidelines. Specifically, the hospital has achieved 'Gold' by sustaining 85% or higher adherence to specific evidence based guidelines, over a 24-month consecutive period as measured in the *Get With The Guidelines* program. In addition to its stellar inpatient and emergency care, TBHC's Stroke Center is also involved in community education efforts. The coordinator of the Stroke Center disseminates regular e-mail blasts on stroke prevention; staff participated in community events; and the center conducted a week-long information booth in the hospital's lobby to highlight National Stroke Awareness Month.

**19. Describe the hospital's successes and challenges regarding the provision of financial aid, in accordance with Public Health Law 2807(k)(9-a), and any changes envisioned for this year. Also, include a general overview of accomplishments, process improvements and/or best practices related to the hospital's financial aid program. The hospital's policy or financial data is not required.**

Some of the hospital's successes regarding the provision of financial aid can be related to the ability to ensure that the qualifying self-pay population receives rates that are affordable when they are not insured. A portion of the financial aid program recipients are consumers who are recently unemployed and are in the process of applying for insurance. TBHC allows them to receive treatment and services at an affordable rate. This fosters increased access to care, helps to maintain a relationship with TBHC and its physicians, and creates a connection for continued use all hospital services.

TBHC's greatest challenge is retaining the consumers who are advised of the program. During an emergent and/or clinic visit, most people do not walk with the documents necessary to qualify them for the Financial Assistance Program. It can be a timely process for a consumer to provide information or complete documentation after they are treated. Some consumers, once treated, disregard the need for payment of services rendered.

One of the best practices occurs at the point of registration. When it is realized that a patient is "self-pay", the patient is informed of the Financial Assistance Program, is given a brochure, and is referred to a financial counselor. All billing statements now include information regarding TBHC's financial assistance program and online access to applications. Once patients are qualified, they now have the ability to make payments online as well as at various points of service via e-Cashiering.

**20. Is your hospital/health systems' Community Service Plan posted on the website?**

[X] Yes

**21. What is url address of the CSP posted on the hospital website?**

The CSP is posted on TBHC's website: **http://www.tbh.org/community-outreach/community-service-plan**

**22. What are some other ways that the CSP is disseminated to the public?**

Over the past year, The Brooklyn Hospital Center distributed copies of its Community Service Plan to several key external groups:

- Community Leaders who attended the Community Advisory Board Annual Meeting
- Community Board Two
- TBHC Community Advisory Board Members

**23. Are there any additional comments that you would like to share about your hospital's CSP? If you have attachments, please list the attachment title, and email the attachment to Charles Bonsu cxb06@health.state.ny.us**

The Brooklyn Hospital Center's CSP was thoughtfully developed to ensure that we meet the underlying current clinical conditions, health education and access to care of our ever-changing community, including projected changes in demographics and anticipated regulatory reform.

**24. This question confirms whether you have completed the Community Service Plan. If you are not sure, please exit the survey, and do not press the 'Done" button. If you are done with the survey, please respond with "I confirm that the CSP is completed", and press the "Done" button. If you need a copy of the completed survey, please send a request to Charles Bonsu, cxb06@health.state.ny.us**

Sources:

New York State Health Foundation, April 8, 2011. Retrieved from: http://nyshealthfoundation.org/news-events/news/with-164000-brooklyn-residents-suffering-from-diabetes-new-york-state-health

The New York Department of Health and Mental Hygiene (NYC DOHMH)

Center for the Study of Brooklyn

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