

member  
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**The Brooklyn Hospital Center**

*Keeping Brooklyn healthy.*

**2013 Community Service Plan  
November 15, 2013**

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# The Brooklyn Hospital Center 2013-2017 Community Service Plan

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# 1. 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.

# 2. Definition/Description of Community Served

## Definition of Community Service Area

The Brooklyn Hospital Center (TBHC) serves a population area of almost one million residents, with more than 80% residing in North and Central Brooklyn.

## Primary & Secondary Service Areas by Zip Code

11201, 11203, 11204, 11205, 11206, 11207, 11208, 11209, 11210, 11211, 11212, 11213, 11214, 11215, 11216, 11217, 11218, 11219, 11220, 11221, 11222, 11223, 11224, 11225, 11226, 11228, 11229, 11230, 11231, 11232, 11233, 11234, 11235, 11236, 11237, 11238, 11239 and 11249.

## Primary & Secondary Service Areas by Neighborhood

Fort Greene, Downtown Brooklyn, Brooklyn Heights, Vinegar Hill, Fulton Ferry, Bushwick, Williamsburg, Prospect Heights, Cypress Hills, Flatbush, East Flatbush, Crown Heights, Bedford Stuyvesant, Gowanus, Greenpoint, East New York, Brownsville, Borough Park, Sunset Park and Bensonhurst.

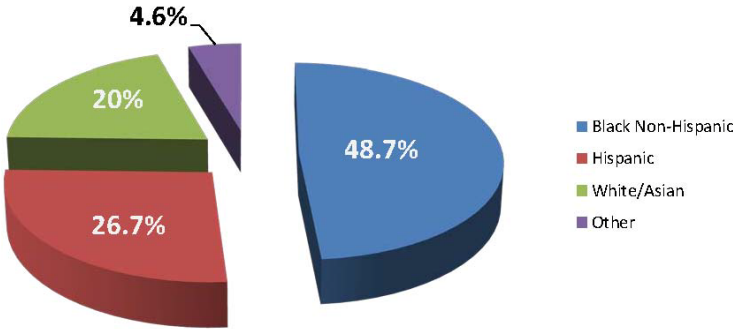
## Description of Community Served

The population served by TBHC is extremely diverse, both socioeconomically and culturally, including low-to-moderate income residents as well as individuals from racial and ethnic minority groups that reflect diverse cultural backgrounds. Most recent census figures from 2012 show that 48.7% of hospital-area residents are Black Non-Hispanic and 26.7% are Hispanic.

Within these groupings, there are many residents from Jamaica, the Dominican Republic, Haiti, Trinidad and Tobago, Mexico, and other Caribbean countries. Approximately 20% of all residents in the hospital’s primary service area are characterized as White or Asian.

Many of these residents have extremely low incomes. More than a third lives in households with incomes below the Federal Poverty Level, with almost 40% percent of households earning \$25,000 or less, and 65% earning \$50,000 or less. Overall, the average household income in the communities served by TBHC is less than that of New York City residents and other Kings County residents. The majority of residents rely on Medicaid or Medicare, with less than 20% enrolled in commercial insurance plans.

Community Demographics



## **The Brooklyn Hospital Center's Commitment to Help Meet the Financial Needs of Uninsured and Underinsured Individuals**

TBHC's commitment is to ensure that financial status does not prevent access to care. In May 2013, the hospital opened a new Patient Family Service Center (PFSC) and a discharge service in the Emergency Room to meet the needs of patients with financial challenges. The PFSC and the discharge service provide patients with a convenient, centralized location for financial counseling and support. Patients are guided by knowledgeable staff through the process of completing financial assistance materials or applying for a State or Federal government-sponsored program.

TBHC's financial assistance program, along with the Medicaid eligibility program, is a streamlined process with patients served in a timely manner. Services include Financial Assistance (self pay sliding scale), Charity Care, and assistance with the Medicaid application process.

## 3. Public Participation

### a. Participants

The Brooklyn Hospital Center recognizes that collaboration and coordination with an engaged Community Advisory Board (CAB), local community-based organizations (CBOs), government agencies, physicians, nurses and other health care providers is essential to the hospital's goal of identifying and meeting Brooklyn's health needs.

The hospital's collaborative relationships have expanded substantially in the past two years. TBHC established the Community Health Planning Workgroup (CHPW), a diverse collaborative group consisting of 15 community-based organizations. The 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.

The CHPW has achieved many successes, including the facilitation of a community health needs assessment. *The Need for Caring in North and Central Brooklyn Report* is the result of the assessment findings and provides a thorough review of the health needs, gaps and barriers to care in North and Central Brooklyn.

Please visit [www.tbh.org/brooklynhealthcaresystem](http://www.tbh.org/brooklynhealthcaresystem) to download a copy.

CHPW published its completed community health needs assessment report in February 2013. The study's intent was to inform proposed changes to the health care delivery system and was funded by the New York State Department of Health, the I M Foundation, and The Brooklyn Hospital Center. Results were distributed to the funders, including a special presentation to the NYSDOH; key community stakeholders; elected officials and health care providers.

This study was undertaken to determine residents' perceptions of needs, barriers and gaps in access to health care services in 15 zip codes in North and Central Brooklyn. Over 800 Brooklyn residents responded to field questionnaire interviews and participated in focus group discussions. 644 surveys were conducted within the community.

The results of this research are summarized in Section 4 of this Community Service Plan: *Assessment Process of Agenda Priorities*.

Other collaborators that play an invaluable role in helping to assess community health need include the hospital's Board of Trustees, elected and appointed officials, and the Community Advisory Board (CAB), which is composed of concerned and engaged community members who assess and identify local health needs and offer guidance regarding the scope and quality of care that TBHC offers the community.

## **b. Dates and Outcomes of Public Input Process**

**Community Advisory Board** members meet formally once a month to receive updates about the hospital and to share information about the community with TBHC administrative leadership. The intent is to ensure members are well informed about the hospital so they can function as active representatives in the community, and exchange relevant information.

The Community Advisory Board met on the following dates in 2013: January 15; February 19; March 19; April 16; May 21; June 18; September 17; October 15; and November 12.

The **Community Health Planning Workgroup** members meet bi-weekly at the hospital. The CHPW members, along with TBHC representatives, presented to the New York State Department of Health in September 2012, and together have ongoing communications with NYSDOH leadership regarding the healthcare delivery system in Brooklyn.

### *Discovered Barriers to Care and Gaps in Service*

The community health needs assessment report, called *The Need for Caring in North and Central Brooklyn*, found a high number of residents who report living with preventable chronic illness. The following are select observations from the survey:

- 24.8% respondents reported high blood pressure/hypertension
- 19.9% respondents reported asthma
- 15.7% respondents reported diabetes

These findings do not include the many chronically ill individuals who have not yet been diagnosed with a chronic illness. This survey not only found a high percentage of individuals reporting chronic illness but also reporting corresponding social factors that lead to negative health outcomes such as low or no health insurance coverage and a lack of dependable, accessible primary care.

Other observations:

- 85% of the respondents said that it would be most convenient to receive care in their neighborhood, yet almost 20% of the sample (18.7%) received no local care.
- 50% of respondents reported using the emergency room in the past two years. Asthma and high blood pressure were the major reasons most cited for emergency visits. African Americans and Latinos had the highest ER utilization rate.
- 50% of respondents reported a limited ability to access health care services. Identified barriers included: waiting too long for an appointment (13.5%); lack of health insurance (12.2%) or problems with insurance (7.6%); the cost of care (9.1%). Quality of care,

culture and language differences, hours of service, and the attitude of providers were also concerns.

The following are recommendations from *The Need for Caring in North and Central Brooklyn* report. These identified needs are the foundation of this Community Service Plan.

- Facilitate access to health care facilities. Provide more accessible, user friendly and comfortable settings
- Improve screening of and outreach to diverse populations
- Improve patient centered care and customer-service training
- Provide evening-weekend hours for primary care
- Target services to focus on particular illnesses and communities
- Increase access to specialty health care services in the community

### **c. Comprehensive Study of the North and Central Brooklyn Health Care System**

Contemporaneously with the hospital's collaboration with the Community Health Planning Workgroup, The Brooklyn Hospital Center conducted a feasibility analysis of the state of health care in North and Central Brooklyn, and explored the possibility of a merger with other Brooklyn providers as proposed by the New York State Medicaid Redesign Team (MRT).

The feasibility report contains useful data that helps The Brooklyn Hospital Center and its community partners plan to provide better access to primary and preventive care and other ambulatory services, and more coordinated care to decrease redundancy and cost.

Perhaps most importantly, the feasibility study improved coordination between the hospital and community based organizations (CBOs). TBHC will continue working with CBOs and Federally Qualified Health Centers (FQHCs) to broaden and strengthen care coordination, post-acute care management and population health management programs. This high level of integration will assist the highest utilizers of care, helping to appropriately replace high-cost acute care with lower-cost preventive and primary care.

## **d. Public Notification**

### **Media**

The hospital's Marketing and Communications Department uses a number of platforms to keep the public informed of community health planning activities. TBHC uses press releases, direct mailings, social media, outreach events and hospital newsletters to make the public aware of—and invite participation in—all health planning-related activities.

### **Online Presence**

The Brooklyn Hospital Center utilizes its own web site ([www.tbh.org/brooklynhealthcaresystem](http://www.tbh.org/brooklynhealthcaresystem)) and social media platforms such as Facebook and Twitter to invite public participation. TBHC's previous Community Service Plan (CSP) and CSP updates are available on [www.tbh.org/community-outreach/community-service-plan](http://www.tbh.org/community-outreach/community-service-plan), and the hospital will post this report and forthcoming updates on this page and point social media users to this page via hyperlink. TBHC also posts updates and outcomes of meetings of the Community Health Planning Workgroup mentioned above.



## 4. Assessment Process of Agenda Priorities

As described above, substantive meetings took place among the hospital and its Community Advisory Board, the Community Health Planning Workgroup, TBHC physicians and staff, and the hospital's Board of Trustees to help determine which Prevention Agenda priorities to focus on for this Community Service Plan.

Focus areas were determined based on several sources:

- NYSDOH Prevention Agenda 2013-2017
- NYCDOH Take Care New York Prevention and Wellness Priorities
- The CHPW's Community Health Needs Assessment (*The Need for Caring in North and Central Brooklyn*) ([www.tbh.org/brooklynhealthcaresystem](http://www.tbh.org/brooklynhealthcaresystem))
- Community Advisory Board
- Partnering with government agencies and community based organizations
- Patient discharge data and outpatient data
- The Brooklyn Hospital Center's service areas (including the main hospital and ambulatory care centers throughout North and Central Brooklyn)
- Current growth areas including expanded Patient Centered Medical Home (please see page 20) designations, the hospital's data-focused Center for Healthcare Innovation (please see page 23), and involvement with the Brooklyn Health Information Exchange (please see page 24).

With all of the above considerations in mind, The Brooklyn Hospital Center selected the following Prevention Agenda priorities:

1. Prevent Chronic Disease: Heart Disease
2. Prevent Chronic Disease: Cancer
3. Prevent Chronic Disease: Respiratory Disease
4. Prevent Chronic Disease: Diabetes
5. Reduce Childhood Obesity

As demonstrated in the next section, The Brooklyn Hospital Center has the ability to support the state and city's prevention goals as outlined in the 2013-2017 Prevention Agenda based on strong and continually improving collaborations with government agencies and community based organizations, the depth of TBHC's medical staff, and because of the hospital's expanding ability to capture health status data, interpret that data and act on it accordingly.

## Community Collaboration for Prevention

Collaboration with community-based organizations (CBOs) is central to the hospital's approach to prevention and community wellness. Like the hospital itself, CBOs are on the front lines of the community, interacting intimately with the residents who stand to benefit the most from preventive care. Here are just some of the examples of CBO partnerships in the past two years.

### Cardiac Care

The Division of Cardiology works frequently with the hospital's *Wellness for Life* Club. Managed by nutritionist Karen Congro, RN, CDN, this monthly community support group is focused on preventing illness and improving quality of life through exercise, awareness of current medical trends, and proper nutrition. It offers its members a wealth of resources and activities from aerobic exercise and healthy cooking tips to the latest news on potentially harmful drug interactions. A strong sense of community is at the center of the group's success, because it encourages group members to support one another between sessions. Members are not only educated but challenged in a friendly, caring environment to exercise, eat well, lose weight, and undergo regular blood pressure, cholesterol and blood sugar screenings.

### Cancer Care

The hospital was awarded a five-year New York State Department of Health grant in 2013 to house the Cancer Screening Program. The program offers free colorectal, breast, and cervical cancer screening to men and women with low or no health insurance, ages 50 and over, within the borough. The program was initiated with 14 community partners already established and engaged in the service.

From January 1, 2012 until June 30, 2013, as a participant of the Cancer Screening Program that was formally run under the auspices of the American Cancer Society, the hospital performed 304 cancer screenings.

In the third quarter of 2013, the hospital distributed educational materials about cancer screening services through a workshop conducted at the YWCA, The Brooklyn Hospital Annual Health Fair, and the hospital's annual Physician Open House, which included more than 60 multidisciplinary physicians practicing throughout the community.

From September 2012 into the first half of 2013, the hospital participated in events that included: the Atlantic Antic Street Festival; The 88<sup>th</sup> NYPD Precinct's National Night Out; the Brooklyn Borough President's Take Your Man to the Doctor Day; the Women Conquering Cancer Health Fair; the Cancer Survivor's Day Health Fair; the YWCA of Brooklyn's Women's Cancer Seminar; the Myrtle Avenue Revitalization Project's Food Conference; Community Board 4's Annual Community Parade in Bushwick; Hatzolah's Women's Event in Williamsburg; The Haitian Times' Kreyol Festival; Assemblyman Felix Ortiz Annual Health Fair in Sunset Park;

Assemblyman Cymbrowitz Steven's Annual Health Fair; and Assemblywoman's Annette Robinson's Men's Health Fair at Restoration Plaza in Bedford Stuyvesant.

### **Asthma and Diabetes**

Free glucose screenings and asthma education were offered at over 80 community health fairs and community education events throughout the hospital's Brooklyn catchment area. More than 1,106 persons received glucose screens, and asthma educational materials were passed out to hundreds of interested persons. 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.

The health fairs—most of which were co-sponsored by local faith and community based organizations—were tailored to the broadest demographic with respect to age, gender ethnicity and race. At each event a TBHC-affiliated physician, a registered nurse or nurse practitioner was available to provide counsel regarding the test result.

TBHC and its Department of Family Medicine established a weekly Diabetes Club, which meets on the last Friday of each month to teach participants about nutrition, exercise, and diabetes self management skills. The Family Medicine Center's Medical Director, a certified diabetic educator, leads this program. TBHC Family Medicine physicians are recognized for 2010-2013 by the National Committee for Quality Assurance's Diabetic Physician Recognition Program (DPRP) for providing quality care to diabetic patients.

### **Adult and Childhood Obesity**

TBHC offers weight loss care to young people through its Children's Health Center. Adult weight loss care is provided through the multidisciplinary Weight Loss Center, which currently serves 600-700 patients annually. The Weight Loss Center offers obesity education, nutritional counseling, pre-operative and post operative care and social support services. A variety of information session and support groups are conducted by the Weight Loss Center, and expert personnel provide information on a TBHC Facebook group called *Brooklyn Loses Weight*, designed for persons interested in losing or maintaining a healthy weight. This online forum ([www.facebook.com/groups/brooklynlosesweight](http://www.facebook.com/groups/brooklynlosesweight)) provides support and tips to help Brooklyn residents through their weight loss journey, as well as a forum for conversation on weight loss.

To support juvenile obesity prevention on a community level, monthly health education nights are held at The Brooklyn Hospital Center. Called the "Healthy Family, Healthy Child" series, the series was co-developed and is conducted in collaboration with Project Sunshine, a New York-based not-for-profit organization that provides free educational, recreational, and social programs to children and families living with medical challenges.

With different lesson plans each month, each session is co-conducted by a pediatrician and nutritionist. Each lesson includes an educational component for the parents, an interactive activity, a cooking demo on healthy cooking and food sampling.

## 5. Three Year Plan of Action

### TBHC Priority 1: Prevent Chronic Disease – Heart Disease

TBHC was one of only four hospitals in Brooklyn recognized as a *Top Performer on Key Quality Measures*® for 2012 by The Joint Commission. This recognition is given to hospitals that meet or exceed target rates of quality performance for 2012. TBHC was recognized for care of heart attack and heart failure patients among other quality areas.

Over the past year, TBHC, including the Division of Cardiology, has advanced and sustained quality practices in core measures scores developed by The Joint Commission and endorsed by the National Quality Forum.

Facilitated health care communication technology also improved in the past year. The hospital's Allscripts electronic health record allowed office-based physicians to be informed regarding patient status and care. Within the division, echocardiographic reports and images are now part of the electronic system. Future goals include incorporating all cardiovascular tests and results into the database. The electronic health record also allows patient education materials to be distributed prior to discharge.

#### 2014-2016 Goals and Success Measures

**Goal 1: Attain 100% compliance in meeting Core Measures to reduce mortality in heart attack in at least 3 of 4 quarters for a 12-month period. 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.**

- Attain  $\geq 90\%$  compliance in at least 3 of 4 quarters in 2014
- Attain  $\geq 95\%$  compliance in at least 3 of 4 quarters in 2015
- Attain 100% compliance in at least 3 of 4 quarters in 2016

**Measure:** All patients admitted with a heart attack and discharged with a prescription for aspirin, ACE inhibitors or ARBs, and statins or documented contraindications if no prescription given

**Goal 2: Attain 100% compliance in meeting Core Measures to reduce mortality in heart failure. Attain  $\geq 90\%$  compliance in at least 3 of 4 quarters in 2014.**

- Attain  $\geq 95\%$  compliance in at least 3 of 4 quarters in 2015
- Attain 100% compliance in at least 3 of 4 quarters in 2016

**Measure:** All patients admitted with heart failure and discharged who have a recent test of cardiac function and a prescription for ACE inhibitors or ARBs or documented contraindications if no prescription given.

**Goal 3: Controlling blood pressure in patients in the ambulatory care clinic with diabetes mellitus to a level of 140/90 mm Hg or below**

- Attain  $\geq$ 40% control in 2014
- Attain  $\geq$ 50% control in 2015
- Attain  $\geq$ 60% control in 2016

**Measure:** Percentage of ambulatory care patients meeting goal

**Goal 4: Attain 66% compliance in reducing the LDL-C among adults in the ambulatory clinic with diabetes mellitus to below 100 mg/dL**

- Attain  $\geq$ 40% control in 2014
- Attain  $\geq$ 50% control in 2015
- Attain  $\geq$ 60% control in 2016

**Measure:** Percentage of ambulatory care patients meeting goal

**Goal 5: Increase heart disease awareness in the community by various platforms including literature distribution and screening sessions at health fairs**

- Educating and/or screening 100 visitors in 2014
- Educating and/or screening 150 visitors in 2015
- Educating and/or screening 200 visitors in 2016

**Measure:** Quantity of literature distributed and number of patients screened at health fairs, including TBHC's Annual Health Fair

## **TBHC Priority 2: Early Detection of Colorectal, Breast & Cervical Cancer**

Screenings and education are essential tools to prevent incidence and mortality from cancer. In Brooklyn, screening rates are unacceptably low for colon, breast and cervical cancer. To address this, the hospital participates in a variety of community events to encourage awareness and engage residents to be screened appropriately. The hospital provides cancer education, smoking cessation counseling, cancer screenings, and screenings for other conditions such as obesity and high blood pressure. Please see the above section, *Community Collaboration for Prevention*, for more detailed outreach information.

### **2014-2016 Goals and Success Measures**

#### **Goal 1: Increase awareness of the importance of colorectal, breast, and cervical cancer screening in the Brooklyn community by participating in health fairs and presenting workshops at local organization sites**

- Participate in at least five community health fairs and workshops in 2014
- Participate in at least eight community health fairs and workshops in 2015
- Participate in at least ten community health fairs and workshops in 2016

**Measure:** Number of health fairs and workshops conducted annually

#### **Goal 2: Increase number of community partners for both education and screening, including screening providers and community-based organizations**

- Increase number of community partners from 14 to 18 by the end of 2014
- Increase number of community partners from 18 to 22 by the end of 2015
- Increase number of community partners from 22 to 26 by the end of 2016

**Measure:** Number of collaborations with community partners for both education and screening

#### **Goal 3: Achieve maximum number of annual screenings based on NYS budget allocations**

- Conduct 3,250 cancer screenings within the borough through both The Brooklyn Hospital Center and its community partners annually in 2014
- Conduct 3,300 cancer screenings within the borough through both The Brooklyn Hospital Center and its community partners annually, pending funding from NYS and the number of participating providers, in 2015
- Conduct 3,350 cancer screenings within the borough through both The Brooklyn Hospital Center and its community partners annually, pending funding from NYS and the number of participating providers, in 2016

**Measure:** Number of screenings conducted each year

**Goal 4: Increase awareness of cancer prevention in the community through speaking engagements/workshops including physicians and other clinicians**

- Conduct at least four workshops/speaking engagements on cancer prevention at health fairs and in other forums at least quarterly in 2014
- Conduct at least five workshops/speaking engagements on cancer prevention at health fairs and in other forums in 2015
- Conduct at least six workshops/speaking engagements on cancer prevention at health fairs and in other forums in 2016

**Measure:** Number of workshops and speaking engagements conducted each year



### **TBHC Priority 3: Prevent Chronic Disease—Respiratory Disease**

The neighborhoods surrounding The Brooklyn Hospital Center have a high prevalence of bronchial asthma. Poor living conditions and lack of asthma education contribute to significant morbidity and functional impairment. Of the 385 patients with asthma who were seen in the hospital's Adult Pulmonary service in 2012, 122 patients (31%) showed poor techniques of inhaler use. Certified asthma educators from the Pharmacy Department were actively involved in educating the patients about proper techniques of inhaler use. Following intense education, 62 of the 122 patients showed marked improvement, resulting in better control of their asthma symptoms. Several patients needed further re-enforcement during follow-up regarding the proper technique of inhaler use. Patients are also educated about avoidance of indoor and environmental triggers of asthma.

#### **2014-2016 Goals and Success Measures**

##### **Goal 1: Attain 100% improvement in asthma control**

- Attain  $\geq 90\%$  improvement in asthma control in at least 3 of 4 quarters in 2014
- Attain  $\geq 95\%$  improvement in asthma control at least 3 of 4 quarters in 2015
- Attain 100% improvement in asthma control in at least 3 of 4 quarters in 2016

**Measure:** Self-reported asthma control questionnaire score and Peak Expiratory Flow Rate (PEFR) trend. Questionnaires will be administered during each session visit for comparative monitoring.

##### **Goal 2: Attain 100% compliance with asthma self-management action plan**

- Attain  $\geq 90\%$  compliance in at least 3 of 4 quarters in 2014
- Attain  $\geq 95\%$  compliance in at least 3 of 4 quarters in 2015
- Attain 100% compliance in at least 3 of 4 quarters in 2016

**Measure:** Percentage of compliance with written asthma action plan

##### **Goal 3: Attain 100% compliance with effective use of medications (controllers and relievers)**

Attain  $\geq 90\%$  compliance in at least 3 of 4 quarters in 2014

- Attain  $\geq 95\%$  compliance in at least 3 of 4 quarters in 2015
- Attain 100% compliance in at least 3 of 4 quarters in 2016

**Measure:** Percentage of compliance with controller and reliever medications

##### **Goal 4: Attain 100% proficiency in correct use of HFA/nebulized medications**

- Attain  $\geq 90\%$  proficiency in at least 3 of 4 quarters in 2014
- Attain  $\geq 95\%$  proficiency in at least 3 of 4 quarters in 2015
- Attain 100% proficiency in at least 3 of 4 quarters in 2016

**Measure:** Percentage of patient proficiency in correct technique of inhaler use determined through patient demonstration of inhaler use

**Goal 5: Increase overall awareness regarding Asthma in the community by distributing literature at health fairs and providing asthma inhaler use/screening sessions at TBHC's Annual Health Fair**

- Reach or screen 100 visitors in 2014
- Reach or screen 150 visitors in 2015
- Reach or screen 200 visitors in 2016

**Measure:** Amount of literature distributed at health fairs. Number of asthma inhaler use/screening sessions conducted at TBHC's Annual Health Fair.

**Goal 6: Attain 100% control in asthma exacerbations**

- Attain  $\geq 90\%$  control in asthma exacerbation in at least 3 of 4 quarters in 2014
- Attain  $\geq 95\%$  control in asthma exacerbation in at least 3 of 4 quarters in 2015
- Attain 100% control in asthma exacerbation in at least 3 of 4 quarters in 2016

**Measure:** Work absenteeism (number of days absent from work due to asthma exacerbations). Number of ED visits and hospitalizations due to asthma attacks

**Goal 7: Attain 100% reduction in exposure to indoor allergens**

- Attain  $\geq 90\%$  reduction in exposure to indoor allergens in at least 3 of 4 quarters in 2014
- Attain  $\geq 95\%$  reduction in exposure to indoor allergens in at least 3 of 4 quarters in 2015
- Attain 100% reduction in exposure to indoor allergens in at least 3 of 4 quarters in 2016

**Measure:** Percentage reduction in exposure to home allergens (e.g. carpets, rodents, roaches, molds, pets)

## TBHC Priority 4: Prevent Chronic Disease—Diabetes

Glucose screenings were offered at more than 80 community health fairs in 2013. 1,106 persons received glucose screens. TBHC staff members participating in the fairs tailored their interventions to 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 encourage self-management techniques. The HEDIS core measures and compliance rates, obtained from audits of charts over the past year, are given below.

1. HbA1C testing	34/36 (94% compliant)
2. HbA1C result >9.0=poor control	11/36 (31% compliant)
3. HbA1C <7.0=good control	21/37 (57% compliant)
4. LDL-C testing	35/38 (92% compliant)
5. LDL-C result <100	25/39 (64% compliant)
6. Retinal Eye Exam	33/37 (89% compliant)
7. Nephropathy screening test or evidence of nephropathy	25/37 (68% compliant)
8. Blood Pressure collected as 2 measures	
a. <140/90	32/39 (82% compliant)
b. < 130/80	29/39 (74% compliant)

### 2014-2016 Goals and Success Measures

#### **Goal 1: Administer four screening tests to all diabetic patients: (1) HbA1C, (2) lipid profile, (3) eye exam, and (4) urine for albumin (protein)**

- Administer all four tests to 30% of patients in 2014
- Administer all four tests to 40% of patients in 2015
- Administer all four tests to 50% of patients in 2016

**Measure:** Percentage of patients who complete all four screening tests

#### **Goal 2: Reduce the rate of hospitalization resulting from short-term complications**

- Reduce the rate of hospitalization from short-term complications by 5% in 2014
- Reduce the rate of hospitalization from short-term complications by 10% in 2015
- Reduce the rate of hospitalization from short-term complications by 15% in 2016

**Measure:** Percentage decrease in rate of hospitalization from short-term complications

#### **Goal 3: Improve percentage of total patients with HbA1C of less than 8**

- Achieve HbA1C of less than 8 for 30% of total patients in 2014
- Achieve HbA1C of less than 8 for 40% of total patients in 2015
- Achieve HbA1C of less than 8 for 50% of total patients in 2016

**Measure:** Percentage of total patients with HbA1C of less than 8

## **TBHC Priority 5: Improving Child Health (Reducing Childhood Obesity)**

The Brooklyn Hospital Center monitors patient obesity rates closely through the Patient-Centered Medical Home project (please see p. 22). The goal is to identify those patients at greatest risk for co-morbidities of obesity, and work with patients and family members to achieve healthy weight loss.

### **2014-2016 Goals and Success Measures**

#### **Goal 1: Identify >75% of those patients with BMI>95<sup>th</sup> percentile (obese) during well child care visits and document accordingly**

- By end of 2014, 50% of patients with obesity identified
- By end of 2015, 60% of patients with obesity identified
- By end of 2016, 75% of patients with obesity identified

**Measure:** Make a record of those patients with BMI>95<sup>th</sup> percentile, which would be classified as obese. By the end of 3 years, those patients would be identified who need routine follow-up to address weight issues.

#### **Goal 2: Ensure that at least 75% of those patients identified as obese in the BMI>95<sup>th</sup> percentile have an initial evaluation with history, counseling and plan done by PMD using the obesity template within the electronic medical record**

- By end of 2014, 50% of patients with obesity identified should have the full evaluation completed
- By end of 2015, 60% of patients with obesity identified should have the full evaluation completed
- By end of 2016, 75% of patients with obesity identified should have the full evaluation completed

**Measure:** Generate a list from the electronic medical record, Office Practicum, quarterly or as needed, of those patients with BMI>95<sup>th</sup> percentile to enable chart audit to ensure that these patients received the obesity evaluation with history taking, counseling and plan. By the end of 3 years, those patients identified as being obese should have had the obesity evaluation done at either a well-child visit or a follow-up visit dedicated to obesity as the main issue.

#### **Goal 3: Ensure that at least 75% of those patients identified as obese within the BMI>95<sup>th</sup> percentile have been referred to the nutritionist for further evaluation and support in healthy lifestyle changes**

- By end of 2014, 50% of patients with obesity identified referred to the nutritionist
- By end of 2015, 60% of patients with obesity identified referred to the nutritionist
- By end of 2016, 75% of patients with obesity identified referred to the nutritionist

**Measure:** Generate a list from the electronic medical record, Office Practicum, quarterly or as needed of those patients with BMI>95<sup>th</sup> percentile to enable chart audit to ensure that these patients were referred to the nutritionist. By the end of 3 years, those patients identified as being obese should have had a referral made to the nutritionist at either a well-child visit or a follow-up visit dedicated to obesity as the main issue.

## **6. Dissemination of the Plan to the Public**

The Brooklyn Hospital Center will make its Community Service Plan available to the public on <http://www.tbh.org/community-outreach/community-service-plan>. As in previous years, the plan will be uploaded in its full-length version, and prepared in a summary brochure format for easier viewing by the public.

The hospital will also provide hard copies and distribute to the hospital's Community Advisory Board, the Community Health Planning Workgroup, local Community Board meetings, local legislators, CBO leaders, the hospital's staff and community leaders. Additionally, the hospital will announce the publication on various social media outlets including Facebook and Twitter.

## **7. Engaging with Local Partners**

TBHC will utilize several channels for engaging with local partners over the three years of the Community Service Plan, and track progress of the plan.

The hospital will continue meeting regularly with the Community Health Planning Workgroup, and with the hospital's Community Advisory Board (CAB), with updates at each meeting and a written quarterly report submitted to the Board and reviewed at the meeting. TBHC clinical leaders and community outreach specialists will report to CAB members at these meetings, which also include leaders from Community Based Organizations. These clinical leaders will represent the multiple service lines discussed in this report—Pediatrics, Women's Health, Family Medicine, Internal Medicine—and will be able to make adjustments in their planning as needed.

The hospital will also continually expand and collaborate with the CAB and CHPW so that more representatives from community based organizations are present to collaborate on the hospital's goals. TBHC will reach out on a quarterly basis to the CAB by email, conference calls and a dedicated section of [www.tbh.org](http://www.tbh.org) to maintain engagement with local partners over 3 years of the Community Service Plan.

## **Appendix 1: Wellness and Quality Initiatives**

### **Hospital-Medical Home**

In October 2013, TBHC was awarded \$3.2 million from NYSDOH to implement the Hospital-Medical Home Demonstration Project, which provides \$250 million over the next three years for teaching hospitals to transition their outpatient training sites to patient-centered medical homes.

TBHC's grant award includes the transformation of four TBHC outpatient facilities into 2011-level NCQA Patient Centered Medical Homes. The four sites are: the Adult Ambulatory Care Center; The Children's Center; La Providencia Family Health Center and the Family Medicine Center. La Providencia has 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. In October 2013 the Family Medicine Center achieved this goal. Regular monthly planning meetings occur to ensure TBHC meets the deadline of attaining recognition for the remaining sites by July 1, 2014.

### **Preventable Hospital Readmission Initiative**

The Brooklyn Hospital Center received grant funding from The New York Community Trust's Preventable Hospital Readmission Initiative (PHRI) Stage II Supplemental Proposal, addressing the challenge of preventable hospital readmissions. The Preventable Hospital Readmission Initiative (PHRI) grant funding request of \$50,000 will help TBHC 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 was previously 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 Submission**

The Brooklyn Hospital Center collaboratively submitted a 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, New York, 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 collectively designed a patient-centered model of care and support service access, utilizing the Centering Model of group prenatal care aimed at reducing preterm birth.

**Medicaid Health Home**

TBHC participates in three Brooklyn-based Medicaid Health Homes. Community provider networks like these ensure that coordinated care across continuum of medical, mental health, rehabilitative care, substance abuse and social services is provided to patients with complex needs.

**CMS Innovation Center**

On August 15, 2013, TBHC submitted an application for a CMS Innovation Center grant based on a project called the Patient Recovery Program, utilizing information technology to enhance communication and interaction between providers and patients, families and caregivers. This project is a collaborative relationship between Cobble Hill Health Span, Sunrise Medical Group, Glen Ridge Physicians, Aetna, HealthFirst, and other TBHC-affiliated physicians regarding managing patients with a variety of complex illnesses.

**HealthFirst Quality Incentive Program**

TBHC was awarded grant funding from HealthFirst, under the HQIP program. This grant is available to hospitals participating in the 2013 HealthFirst quality incentive program and is aimed at improving quality through enhancements to the electronic medical record and IT. TBHC was awarded on the projects of utilizing IT to enhance medication reconciliation and HEDIS indicators for care of older adults.



## Appendix 2: Prevention Initiatives

### Center for Healthcare Innovation

TBHC embarked in 2013 on the formation of a Health Situation Room (HSR), a critical first step towards the establishment of a Center for Healthcare Innovation in Brooklyn. The HSR is an analytic unit that pulls data on selected preventive health topics from the hospital's Electronic Medical Record, and superimposes community level data in order to better understand how the social environment influences health care outcomes for patients, and to develop targeted interventions.

A major activity of the HSR will be to develop epidemiologic profiles for specific diseases and conditions, as well as population subgroups (e.g., the TBHC diabetic population), and to implement interventions that improve care, reduce costs, and reduce health care disparities.

Consistent with the New York State 2013-2017 Prevention Agenda, TBHC has identified asthma, diabetes and cancer (breast, cervix and colorectal) as high-prevalence conditions that can be addressed through the HSR. TBHC's Prevention Steering Committee will play a critical role in defining meaningful clinical process and outcome variables that should be captured within the datasets to be analyzed within the HSR.

### Prevention Steering Committee

The Brooklyn Hospital Center formed a Prevention Steering Committee (PSC) in October 2013 under the direction of TBHC's Chair of Medicine—an acknowledged expert in preventive medicine, health disparities and population health management. The goal of the PSC is to advance population health management in Brooklyn, and to recommend key indicators (e.g. ED visits, HbA1C level) for in depth analysis.

The PSC identifies priority areas for monitoring, and defines novel areas for performance measurement and exploration, beyond regulatory requirements, for specific subgroups of TBHC patients.

The indicators identified by the PSC are subjected to rigorous epidemiologic analysis by the above mentioned Health Situation Room (HSR) in order to identify opportunities for healthcare innovation.

### **Participation in the Brooklyn Health Information Exchange (BHIX)**

TBHC entered into an agreement with the Brooklyn Health Information Exchange (BHIX) as 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 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. BHIX houses data from over one million patients, representing encounters at dozens of health care facilities and insurers.

BHIX is allowing the hospital and its affiliated physicians the opportunity to electronically share valuable, health information in real time, thus improving quality of care and reducing miscommunication and reducing the need for repeating imaging and laboratory tests unnecessarily. BHIX has engineered interfaces to a broad variety of electronic health records and other clinical information systems, including interoperable integrations that support access to community-wide health information from within the EMR. To date, 16,000 TBHC patients have given consent for TBHC to view their medical care from other facilities. The patients that have given consent have been cared for in 34 facilities, from which the hospital can now access medical information.