2025 Community Health Needs Assessment & Community Service Plan for Kings County (Brooklyn)

December 2025

The Brooklyn Hospital Center

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About The Brooklyn Hospital Center and the 2025 CHNA & CSP

The Brooklyn Hospital Center (TBHC) is the oldest hospital in Brooklyn and an independent community hospital. Since 1845, TBHC has provided outstanding health services, education, and research to our Brooklyn community. As Brooklyn's first hospital, TBHC is proud to be a part of an incredibly diverse borough and is committed to *Keeping Brooklyn Healthy*.

We take care of our community in our licensed 464-bed hospital and via our network of family health centers, medical practices, and other ambulatory care sites, located both on our main campus and throughout Brooklyn's neighborhoods. We are a clinical affiliate of The Mount Sinai Hospital and an academic affiliate of The Icahn School of Medicine at Mount Sinai.

TBHC is a community leader, partnering with many other Brooklyn institutions. The TBHC outreach team continues to strengthen relationships with the community through lectures, tabling, health education, and networking opportunities. These efforts expand awareness, provide direct services, and distribute healthy living literature, while building lasting partnerships. In 2024, TBHC participated in 140 community health events held at schools, colleges, senior centers, houses of worship, and community-based organizations. Topics included diabetes, heart disease, cancer, vaccinations, and more. More than 1,600 individuals received services such as blood pressure screenings, dental and foot check-ups, health education, counseling, appointment scheduling, and referrals for uninsured individuals to trusted community partners.

As a trusted local healthcare leader and partner, TBHC is dedicated to understanding and addressing the most pressing health and wellness concerns for our community. TBHC conducts a Community Health Needs Assessment (CHNA) every three years to help us better serve our community by measuring the health status of residents, gathering wide community input on health concerns, and identifying opportunities to collaborate with partners.

The CHNA informs the development of TBHC's Community Service Plan (CSP) to move from data to action to address identified priority health needs. The CSP serves as a guide for strategic planning and a tool by which to align community health investments with the highest needs in our community.

We invite our community partners to learn more about the CHNA and CSP and opportunities for collaboration to address identified health needs. Please visit our website or submit comments directly to Lenny Singletary at lsingletary@tbh.org.

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Executive Summary

2025 Community Health Needs Assessment

The goal of the CHNA was to gather data and community input to inform strategies to support a healthy and thriving Brooklyn and to foster a collaborative approach for community health improvement.

CHNA Study Objectives:

- Compile a comprehensive profile of the factors that impact health and wellbeing for residents
- Compare community health indicators with previous CHNAs to document trends and changes
- Demonstrate the impact of Social Drivers of Health; document disparities experienced by populations and communities
- Strengthen community member engagement and partnerships; engage residents in the study process
- Define three-year priority areas and develop action planning
- Develop a community resource to monitor the progress of community health initiatives

The results of the CHNA will help us identify priorities and strategies to improve health and wellbeing in Brooklyn and promote health for all residents. Responding to the study findings and sharing data with other community-based organizations, TBHC aims to ensure that all residents benefit from our local resources, robust social service network, and the high-quality healthcare available in our community to help residents live their healthiest lives.

Research Partner

TBHC contracted with *Build Community* to conduct the CHNA. *Build Community* is a woman-owned business that specializes in conducting stakeholder research to illuminate disparities and underlying inequities and transform data into practical and impactful strategies to advance health and social equity. An interdisciplinary team of researchers and planners, *Build Community* has worked with hundreds of healthcare and community-based organizations and their partners to reimagine policies and achieve measurable impact. Learn more about their work at buildcommunity.com.

2025 CHNA Leadership and Oversight

TBHC convened a steering committee of representatives from across the organization to collaborate on the CHNA, with guidance from its Community Advisory Board and Health Access Committee. This collaboration ensured a comprehensive study and helped foster collective impact to address the most pressing issues that affect health for residents.

2025 CHNA Steering Committee Members

The following individuals served on the CHNA steering committee as liaisons to TBHC and the communities they serve.

Sheila Anane, Vice President, Ambulatory Quality and Service

Yolanda Copeland-Romain, Physician Services Navigator, Physician Relations

Anuradha Iyer, Senior Director, Quality Management and Quality & Patient Safety

Lenny H Singletary III, Senior Vice President, External Affairs, Strategy & Marketing

Community Advisory Board

TBHC is dedicated to reaching beyond the hospital's walls to its neighbors and partners so that it can provide services directly to the community and, in turn, hear from them about their health needs. One of the ways that TBHC keeps connected to the community is through its Community Advisory Board (CAB). The CAB is a diverse group of individuals with strong ties to the community, and a keen understanding of how the hospital works.

TBHC's CAB members are committed to:

- Assist in assessing and identifying the health needs of the community.
- Offer guidance in identifying local strengths and opportunities for THBC.
- Cultivate and maintain relationships with community leaders, community-based organizations, and civic groups to strengthen the hospital's link to the community.
- Assist hospital administration in its community outreach efforts.
- Organize community forums of mutual interest to TBHC and the community.
- Monitor TBHC's patient satisfaction process to ensure that issues are addressed and resolved appropriately.
- Communicate how our community views TBHC.

Health Access Committee

Advancing access to care is a strategic initiative at TBHC. In 2025, TBHC established a Population Health Plan and accountability structures that include The Health Access Committee of the Board of Trustees and TBHC's The Health Access Committee. The Health Access Committee has a multidisciplinary membership, representing senior leadership, clinical and administrative leadership, and frontline staff at TBHC. The CHNA and CSP process engaged the Health Access Committee and aligned with the Population Health Plan to advance their collective work and further reduce disparities in health and wellbeing.

2025 CHNA Study Area

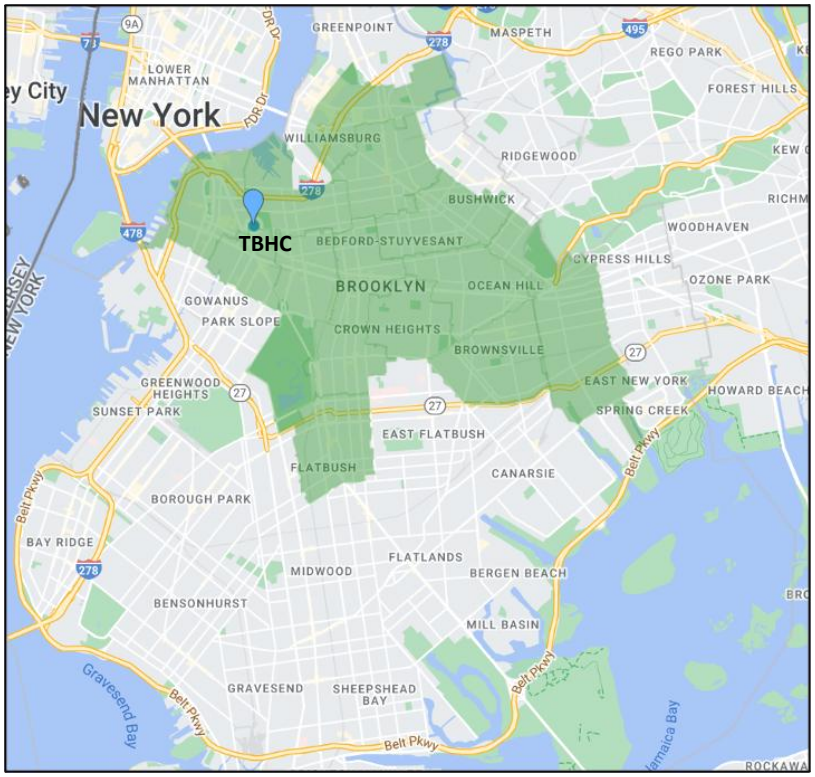
TBHC is located in the heart of downtown Brooklyn, one of the five boroughs comprising New York City (NYC). Brooklyn is the most populous borough in NYC with more than 2.4 million residents and was one of the fastest growing boroughs over the last decade.

Brooklyn is a uniquely diverse community, benefiting from a rich variety of residents and cultures. It is home to speakers of more than 200 languages, with nearly half of households speaking a language other than English at home. There are at least 70 officially recognized neighborhoods in Brooklyn, each with its own unique identity and history.

TBHC used the zip codes of residence for most patients seen at its hospital facility to define its primary service area. TBHC serves a diverse and expansive catchment area encompassing nearly one million residents, more than one in three people in Brooklyn. Over 80% of those residents live in North and Central Brooklyn. TBHC's primary and secondary service areas span neighborhoods including Fort Greene, Downtown Brooklyn, Williamsburg, Brownsville, Bushwick, Crown Heights, Bedford-Stuyvesant and East Flatbush.

For purposes of the CHNA, secondary data focus on the entire borough. Demographics and other available indicators for zip codes comprising the primary service area were analyzed to determine opportunities for prioritized interventions to address health and social disparities.

The Brooklyn Hospital Center Primary Service Area



Research Methodology

The CHNA was conducted from April to December 2025 and included primary and secondary research methods to determine health trends and disparities.

Primary Research and Community Engagement

Community engagement was an integral part of the CHNA. Collaborating with community-based organizations across the borough, input was solicited and received from a wide array of community stakeholders and residents, with a particular focus on diverse populations, under-resourced areas and communities that have been historically marginalized. Study participants provided perspectives on unmet health and social needs; community resources available to meet those needs; barriers to accessing services; service delivery gaps and recommendations to improve health and wellbeing.

Key Stakeholder Survey

We conducted an online survey with 40 individuals that serve diverse communities and populations across Brooklyn to collect input about local health needs, client experiences in receiving and accessing services, and opportunities for collective impact. A list of the represented community organizations and the participants' respective titles is included in Appendix B.

Community Conversations

We held meetings with community and hospital representatives to share CHNA data findings, gather feedback on priority health issues, and collectively define challenges and meaningful strategies for health improvement.

Secondary Data Analysis

Secondary data, including demographic, socioeconomic, and public health indicators, were analyzed to measure key data trends and priority health issues, and to assess emerging health needs. Data were compared to New York City, New York State, and/or national benchmarks and Healthy People 2030 (HP2030) goals, as available, to assess areas of strength and opportunity. Healthy People 2030 is a national initiative establishing 10-year goals for improving the health of all Americans.

Secondary Data Statistics

Secondary data are reported for all of Brooklyn and by zip code, as available, to demonstrate localized health needs. The most recently available data at the time of publication is used throughout the study. Due to the time required to collect and analyze data, it is typical for the data to reflect prior years rather than the current year. A comprehensive list of secondary data sources is included in Appendix A.

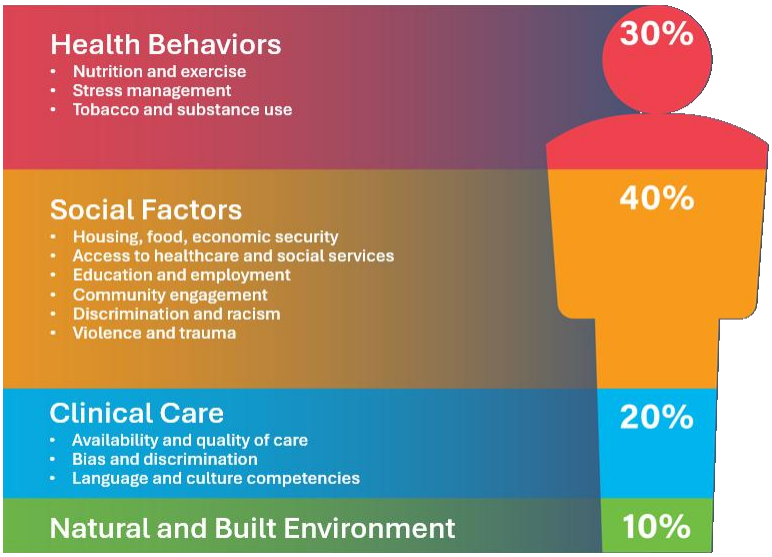
Social Drivers of Health

Where we live impacts choices available to us

The CHNA was conducted to provide deeper insights into the differences in health and wellbeing experienced between groups of people in Brooklyn. We used the Social Drivers of Health (SDoH) framework to study and document income and poverty; housing and food security; early learning and education; social factors; and the environment and built community. We analyzed data across these five domains of SDoH to identify strengths and challenges in our community that impact our health and wellbeing.

Graphic Credit: U.S. Department of Health and Human Services

Social Drivers of Health are the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.



50% of a person's health is determined by social factors and their environment.

Only 20% of health outcomes are attributed to clinical care.

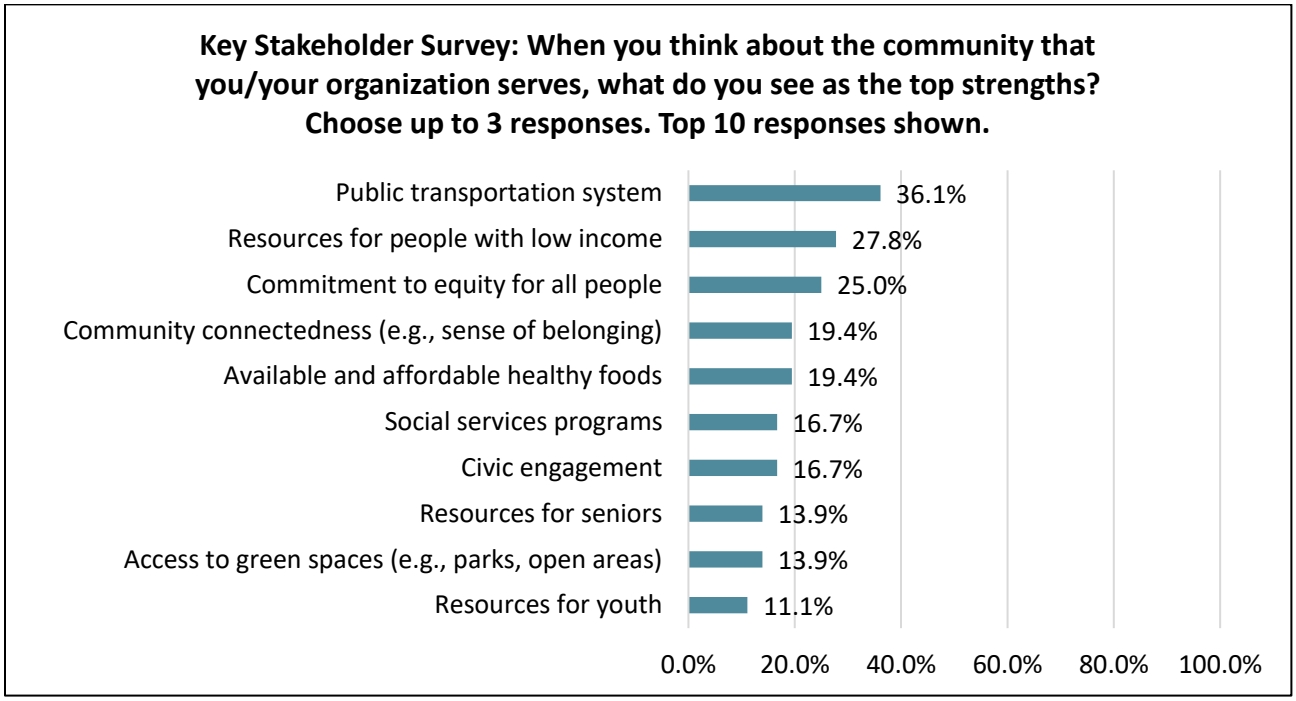
Examining data across SDoH domains helps us understand factors that influence differences in health status, access to healthcare, and outcomes between groups of people**.** These differences include higher prevalence of chronic diseases like diabetes, lack of health insurance, inability to afford essential medications, and shortened life expectancy. Advancing health for all residents means ensuring that all people in a community have the resources and care they need to achieve optimal health and wellbeing. To advance health for all, we need to look beyond the healthcare system to address "upstream" SDoH issues like education attainment, job opportunities, affordable housing, and safe environments.

Our Strengths and Opportunities

Brooklyn is a thriving borough with strong population growth, economic prosperity, and a booming housing market. The total population increased at a faster rate than NYC overall with estimated growth of 7.3% from 2010 to 2023. Median household income rose 70% and overall poverty levels declined 23% over the past decade. Since downtown Brooklyn was rezoned in 2004, over 26,000 new housing units have been added.

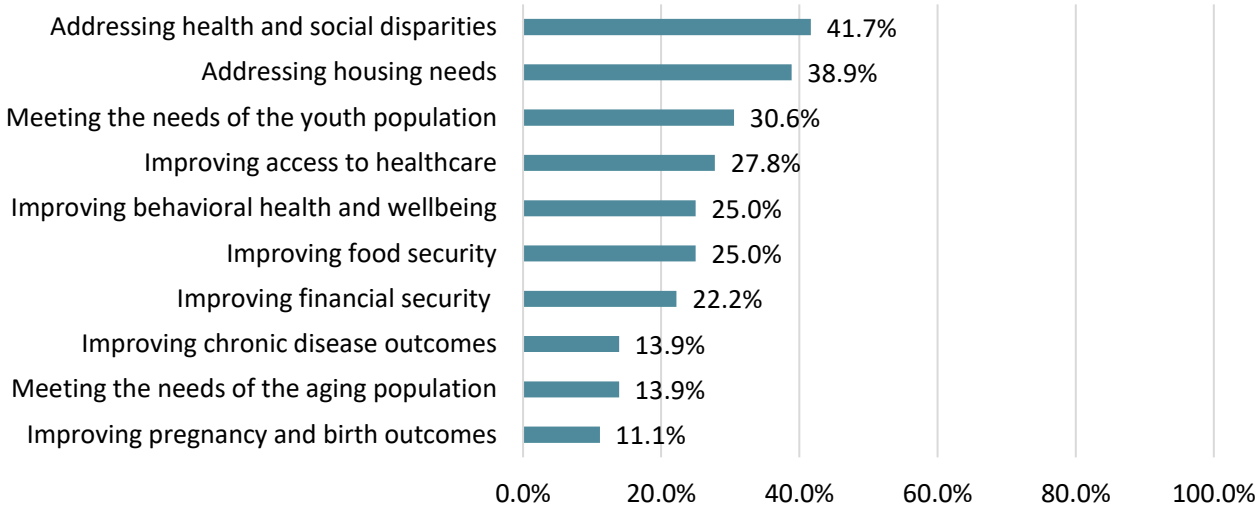
Brooklyn residents as a whole live longer and enjoy better health while they're alive. Average life expectancy for borough residents in 2022 was about 80.1 years, three years higher than the national average. More residents have health insurance and death rates due to common chronic conditions like diabetes and heart disease have declined. The borough features ample green spaces, opportunities for active transportation (Brooklyn is considered one of the most walkable cities in the world), and quality hospitals and other healthcare facilities.

When asked what they see as the top strengths for the community, participants of the Key Stakeholder Survey voiced a shared dedication to community and support for neighbors, including *commitment to equity for all people*, *community connectedness*, and *civic engagement*. Other top identified attributes included the *public transportation system*, *resources for people with low income*, *available and affordable healthy foods*, and *social service programs*.



Using these existing strengths and community assets, communities can work together to improve health. When asked to name the most pressing concerns for residents, Key Stakeholder Survey participants identified *addressing health and social disparities and housing needs* as top priorities, followed by *meeting the needs of the youth population* and *improving access to healthcare*.

Key Stakeholder Survey: Among these issues, what do you think are the most pressing concerns for our community to prioritize over the next few years? Please select up to 3 areas. Top 10 responses shown.



Brooklyn's prosperity is not shared equitably among all residents. There is a more than 10-year difference in life expectancy between Brooklyn neighborhoods with the highest and lowest averages. Residents of Brownsville in TBHC's primary service area have the lowest life expectancy of any neighborhood in NYC.

Historic and systemic issues of discrimination and racism have contributed to a four to eight-year deficit in average life expectancy for Black and/or African American Brooklynites compared to other racial and ethnic groups. Related to disparities in life expectancy is disproportionate infant and maternal death. Across NYC, the infant death rate for Black and/or African American infants is nearly three times higher than that for white infants. Across all of New York State, pregnancy-related deaths are five times higher for Black, non-Hispanic pregnant persons than white, non-Hispanic pregnant persons.

Income inequality is prevalent in Brooklyn. The borough has a similar median household income as the nation, but more experiences of poverty that affect 18.9% of residents and 25.7% of children. Food insecurity among Brooklynites has increased, affecting 17.1% of residents and 26.5% of children in 2023. The high demand for housing has put upward pressure on home values. Over the past decade, Brooklyn's median home value increased 59.7% and median rent increased 55.3%; 46% of homeowners and 51% of renters are housing cost burdened, spending at least 30% of their income on housing expenses alone.

TBHC is the health resource for historically underserved Brooklynites. More than 80% of TBHC patients are publicly insured by Medicaid or Medicare, the government health coverage available to eligible

people with low income and/or aged 65 or older. As many as one-quarter to one-third of people in TBHC's primary service area live in poverty.

KEY STAKEHOLDER SURVEY FEEDBACK:

"An emerging trend in our borough is the growing need for access to food and basic necessities, especially among low-income families. Rising costs have made it difficult for many to afford groceries, hygiene products, and other essentials. We're seeing increased demand for food pantries, donation programs, and community outreach to help meet these needs. Expanding access to these services—and ensuring they're accessible to underserved populations—is essential to supporting residents living in poverty."

Provider availability for primary, dental, and mental healthcare services is lower in Brooklyn than statewide or nationally. A significant portion of the borough is a Health Professional Shortage Area for these services for the Medicaid-eligible population, which comprises about 38% of insured residents. Key Stakeholder Survey participants shared concerns about the possible loss of funding for Medicaid and other government programs and community healthcare systems that help narrow the disparities gap.

Youth and older adult populations are increasingly placed at risk for health and social barriers. Across Brooklyn, 1 in 4 youth experience poverty and/or food insecurity. Approximately 8% of youth ages 16-19 are disconnected from their community, neither in school nor working. The number of older adults living in Brooklyn is growing and 10.8% live alone and 21.1% live in poverty. More than 70% of older adult Medicare beneficiaries manage three or more chronic conditions.

KEY STAKEHOLDER SURVEY FEEDBACK:

"Many youth in our community face isolation, academic pressure, and lack of structured, affordable after-school or mentorship programs. There is an increasing demand for safe community-based spaces where youth can connect, express themselves, and access mental health support without stigma."

"[We need] Partnering with local organizations to expand access to senior-focused healthcare, including mobile clinics and telehealth services."

Consistent with New York State overall, about 15% of Brooklyn adults have chronically poor mental health and/or diagnosed depression. Approximately 18% of Brooklyn adults report excessive alcohol use, an increase from prior years. Among youth, 35.5% of NYC high school students report experiencing frequent mental distress, an increase from prior years, and nearly 14% of high school students report an attempted suicide.

KEY STAKEHOLDER SURVEY FEEDBACK:

"We should make mental health services easier to access – more affordable, more available in different languages, and more trusted in the community. People need safe spaces where they feel comfortable asking for help."

Community Priorities and Community Service Plan

Determining Community Priorities

To improve community health, it is imperative to prioritize resources and activities toward the most pressing and cross-cutting health needs. In determining the issues on which to focus efforts over the next three-year cycle, TBHC collected feedback from community stakeholders and aligned its efforts with the New York State Prevention Agenda.

The Prevention Agenda is New York's State Health Improvement Plan. It is aimed at improving the health status of individuals in New York and reducing health disparities through a strong emphasis on prevention. The 2025-2030 Prevention Agenda outlines 24 key priorities to address health conditions, behaviors, and systemic issues such as poverty, education, housing, and access to quality healthcare.

TBHC's leaders applied the following criteria to define Prevention Agenda priorities for the hospital:

- Prevalence of health disparity and number of community members affected
- Prevalence of health disparity compared to city, state, and national benchmarks
- Existing programs, resources and expertise to address issues
- Input from community partners and representatives
- Alignment with concurrent public health and social service organization initiatives

Based on the CHNA, TBHC will focus on the following New York State Prevention Agenda priorities:

Nutrition Security

Preventive Services for Chronic Disease Prevention and Control

Prevention of Infant and Maternal Mortality

The identified priorities represent key disparities affecting Brooklyn residents and are aligned with TBHC's existing resources and initiatives to advance healthcare access. The following sections highlight evidence-based interventions, strategies, and activities being implemented by TBHC as part of its CSP to address the priority areas and associated health disparities.

Community Service Plan Summary of Activities

TBHC's CSP is aligned with its Population Health Plan to reduce disparities in health and healthcare. As part of the Population Health Plan, TBHC's Health Access Committee identified the following quality improvement projects:

1. Improve the collection of patient demographic data of race and ethnicity to better track and respond to health disparities
2. Improve the process for screening for social drivers of health (SDoH), and implement screening for emergency department treat and release patients and all primary care centers at TBHC
3. Engage with a social care network so that patients receive appropriate services when health related social needs are identified through SDoH screening
4. Reduce preventable readmission rates

Screening patients for SDoH and engaging with a social care network will position TBHC to holistically meet the needs of patients by better identifying and responding to unmet health-related social needs. These needs include, but are not limited to, nutrition security. In 2023, 17.1% of all Brooklyn residents and 26.5% of children were food insecure, and the percentage of affected people increased annually since 2021. This disparity reflects new financial stress experienced by residents due to rising costs of living, as well as growing income inequality.

TBHC is also well positioned to address nutrition security as the largest provider of the Women, Infants and Children (WIC) Program in Brooklyn. TBHC operates seven WIC locations throughout the borough, providing nutrition education, breastfeeding support, benefits for nutritious food, and healthcare services to pregnant and breastfeeding people and children up to age 5. The WIC Farmers' Market Nutrition Program (WIC FMNP) provides coupons to eligible WIC participants to purchase fresh, local produce at participating farmers' markets, farm stands, and mobile markets in Brooklyn. Current average monthly enrollment in the TBHC WIC program is 27,500 people.

TBHC's Population Health Plan will improve the collection of patient demographic data for race and ethnicity to better track health disparities affecting communities of color. TBHC's efforts will seek to advance equitable outcomes for patients across its service lines, including key areas of chronic disease and maternal and infant health. Across all of NYC, Black and/or African American residents are more than twice as likely to die from diabetes and nearly 50% more likely to die from heart disease than white residents living in the same community. The death rate for Black and/or African American infants is nearly three times higher than that for white infants.

TBHC's CSP will also leverage its clinical expertise in chronic disease and maternal care. TBHC is a leader in providing chronic disease treatment, particularly for cancer, heart disease, and diabetes. New York Cancer & Blood Specialists, one of the leading cancer practices in the nation, has partnered with TBHC to create a new comprehensive cancer care program, The Brooklyn Cancer Center, which bridges the gap in cancer care for all Brooklyn residents. For cardiology and diabetes treatment, TBHC uses a multi-faceted and team-based approach that brings together specialists, primary care, and nutrition, among others, as well as key community partners like Healthfirst, to decrease readmissions, increase medication adherence, improve access to care and screenings, and improve disease control.

TBHC is also a leader in providing HIV and AIDS care. The PATH Center at TBHC is a cornerstone of HIV prevention, treatment, and support services for Brooklyn residents, particularly among Black, Indigenous, and People of Color (BIPOC) and LGBTQIA+ communities who are disproportionately impacted by HIV. Since its designation as a New York State Department of Health Designated AIDS Center in 1998, the PATH Center has built a strong reputation for delivering high-quality, trauma-informed, and non-judgmental care to individuals living with or at risk for HIV/AIDS. Through a comprehensive model of core medical services, medical case management, behavioral health, nutrition, and linkage to care, the Center supports patients in achieving positive health outcomes including viral suppression, retention in care, and prevention of new infections.

TBHC brings thousands of babies into the world each year, and offers comprehensive prenatal, labor, delivery, and postpartum care. Services are patient-centered with amenities and accommodations to

meet faith and culturally based needs, and options for people who are uninsured or underinsured. The Prenatal Care Services Program at TBHC offers health insurance to pregnant people in need of obstetrics care who are not covered or only partially covered by health insurance. Through this program, TBHC offers free comprehensive prenatal care from the pregnancy up to two months after delivery. TBHC's services are complemented by its WIC program to meet the nutritional needs of families.

TBHC also partners with community agencies to support doula services for patients. Doula services provide a holistic approach to healthcare that is critically important for Black and/or African American people. Community-based doulas, especially those who share racial and cultural identities with their clients, provide emotional support, navigation through the healthcare system, and advocacy for pregnant people who may face skepticism and mistreatment from providers.

In addition to offering clinical expertise in the identified priority areas, TBHC is a committed community partner and coordinates a robust program of activities throughout the year. Several health events, ranging from large-scale health fairs to free education presentations are conducted on an ongoing basis. Presented health topics include diabetes, heart disease, cancer, vaccinations, and more. In 2024 alone, more than 1,600 individuals received services such as blood pressure screenings, dental and foot check-ups, health education, counseling, appointment scheduling, and referrals for uninsured individuals.

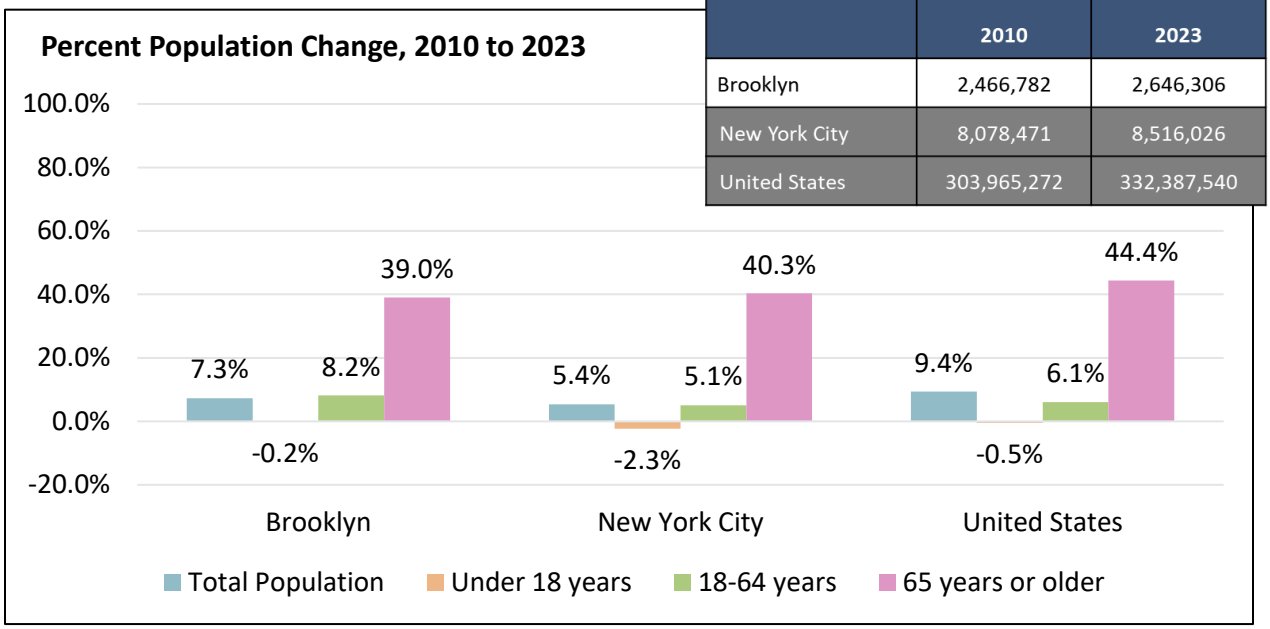
In this, and many other ways, TBHC cares for the Brooklyn community.

Our Community and Residents

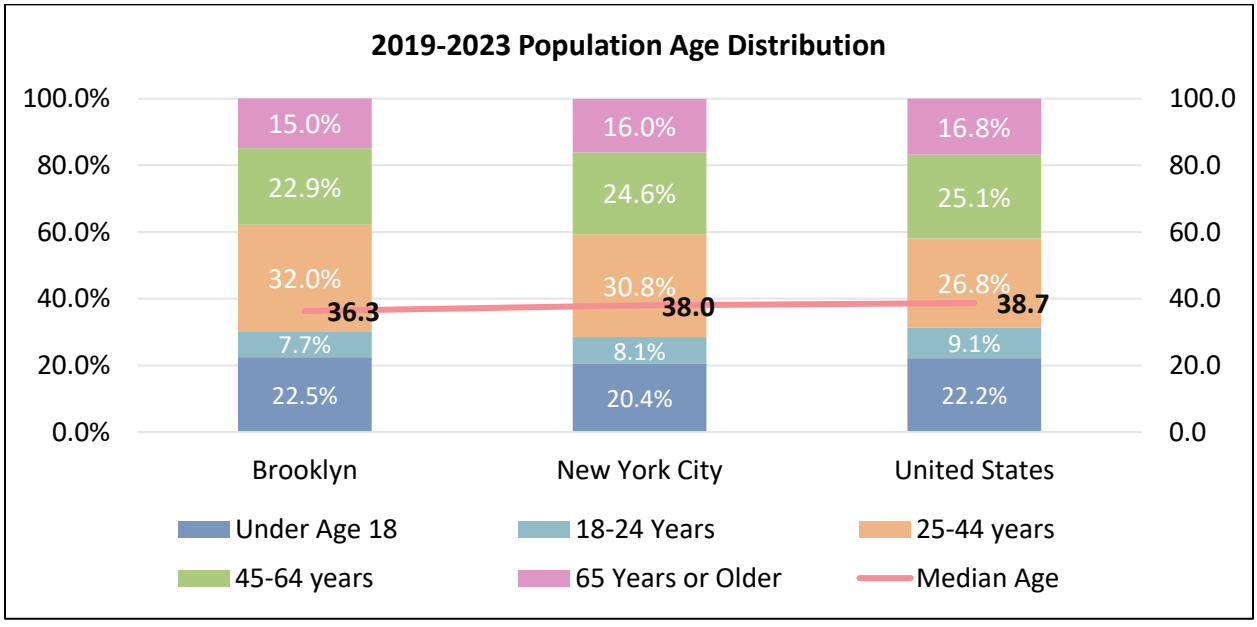
Brooklyn had a total population of 2,646,306 in 2023, a 7.3% increase since 2010. Population growth in Brooklyn was higher than NYC overall but slower than the national average. Consistent with national trends, Brooklyn saw a decline in the number of residents under the age of 18 and an approximately 40% increase in the number of residents aged 65 or older. Brooklyn is home to more working aged young adults, and nearly one-third of residents are aged 25 to 44 years.

Total Population by Year

	Total Population 2010	Total Population 2023
Brooklyn	2,466,782	2,646,306
New York City	8,078,471	8,516,026
United States	303,965,272	332,387,540



Source: US Census Bureau, American Community Survey



Source: US Census Bureau, American Community Survey

Disability is a physical or mental condition that limits a person's movements, senses, or activities. Across the US, 13% of the population and about 33% of older adults live with a disability. The total population of Brooklyn and NYC is less likely to experience disability than the national average, although experiences of disability are more prevalent among older adults.

2019-2023 Population with a Disability

	Brooklyn	New York City	United States
Total population	10.7%	11.7%	13.0%
Youth under 18 years	2.8%	3.9%	4.7%
Older adults 65+ years	36.2%	34.6%	32.9%

Source: US Census Bureau, American Community Survey

Consistent with citywide and national trends, population diversity is increasing in Brooklyn. People of color, particularly those that identify as multiracial, make up a larger portion of the population than in prior years.

2019-2023 Population by Race

	American Indian and/or Alaska Native	Asian	Black and/or African American	Native Hawaiian and/or Pacific Islander	White	Other Race*	Two or More Races
Brooklyn	0.6%	12.0%	29.0%	0.0%	39.3%	10.2%	8.8%
New York City	0.7%	14.6%	22.7%	0.1%	35.9%	15.5%	10.5%
United States	0.9%	5.8%	12.4%	0.2%	63.4%	6.6%	10.7%

Source: US Census Bureau, American Community Survey

*Other Race has historically captured ethno-racially mixed individuals, as well as Latinx individuals who do not consider ethnicity as separate or distinct from race.

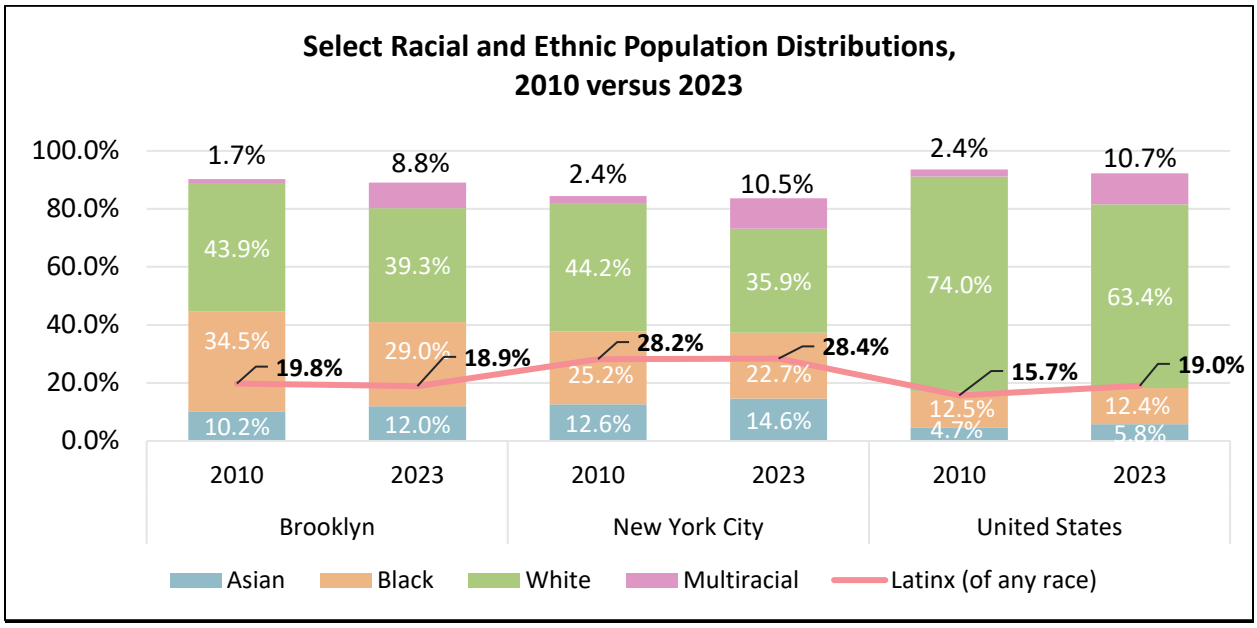
2019-2023 Population by Ethnicity

	Latinx origin (any race)
Brooklyn	18.9%
New York City	28.4%
United States	19.0%

Source: US Census Bureau, American Community Survey

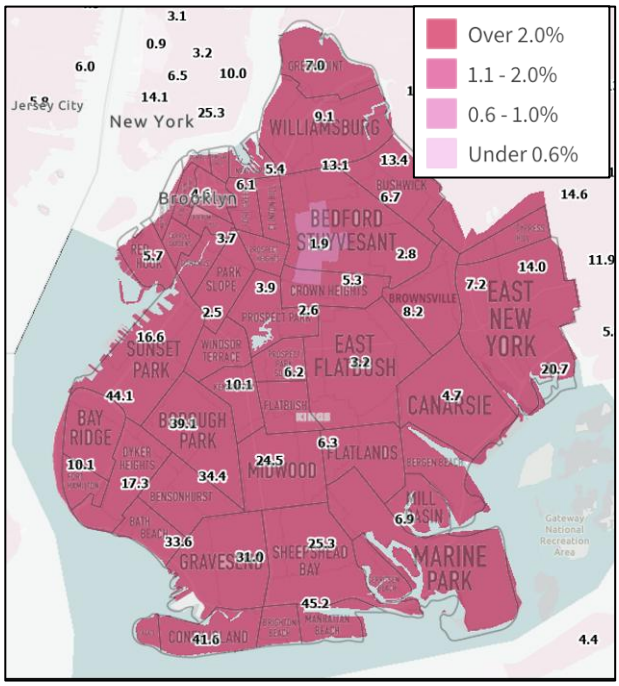
Brooklyn is a uniquely diverse community, benefiting from a rich variety of residents and cultures. It is home to speakers of more than 200 languages. Approximately 44.3% of Brooklyn residents speak a primary language other than English, double that of the national average (22%). Among residents that speak a language other than English, 40.7% speak an Indo-European language, 32.8% Spanish, 18.9% Asian and Pacific Island languages, and 7.6% another language.

In the southwest portion of Brooklyn, in 33% or more of households, no one aged 14 or older speaks English at least 'very well' and another language is often spoken in the home. These households are considered linguistically isolated, and the findings inform a heightened community need for multilingual and culturally appropriate resources and workforce efforts to ensure that providers and staff reflect the diversity of residents.



Source: US Census Bureau, American Community Survey

2019-2023 Linguistically Isolated Households by Zip Code



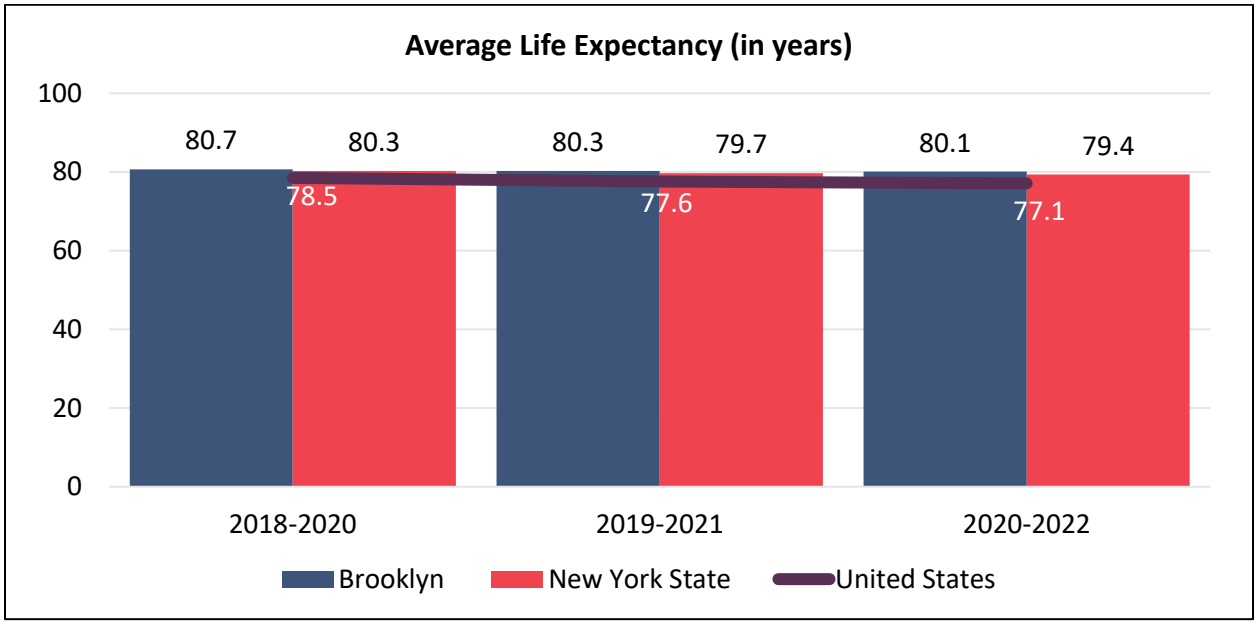
Source: US Census Bureau, American Community Survey

Measuring Health in Our Community

Life expectancy is a key measure of health and wellbeing within a community, often reflecting the underlying socioeconomic and environmental factors. The Social Drivers of Health framework shows that at least 50% of a person's health profile is influenced by the socioeconomic and environmental factors that they experience. Understanding the impacts and addressing the conditions in the places where people live is essential to improving health outcomes and advancing health equity.

Life expectancy measures how long people generally live within the defined geography and is the culmination of living conditions, health status, economic security, and the overall experience of residents within a community.

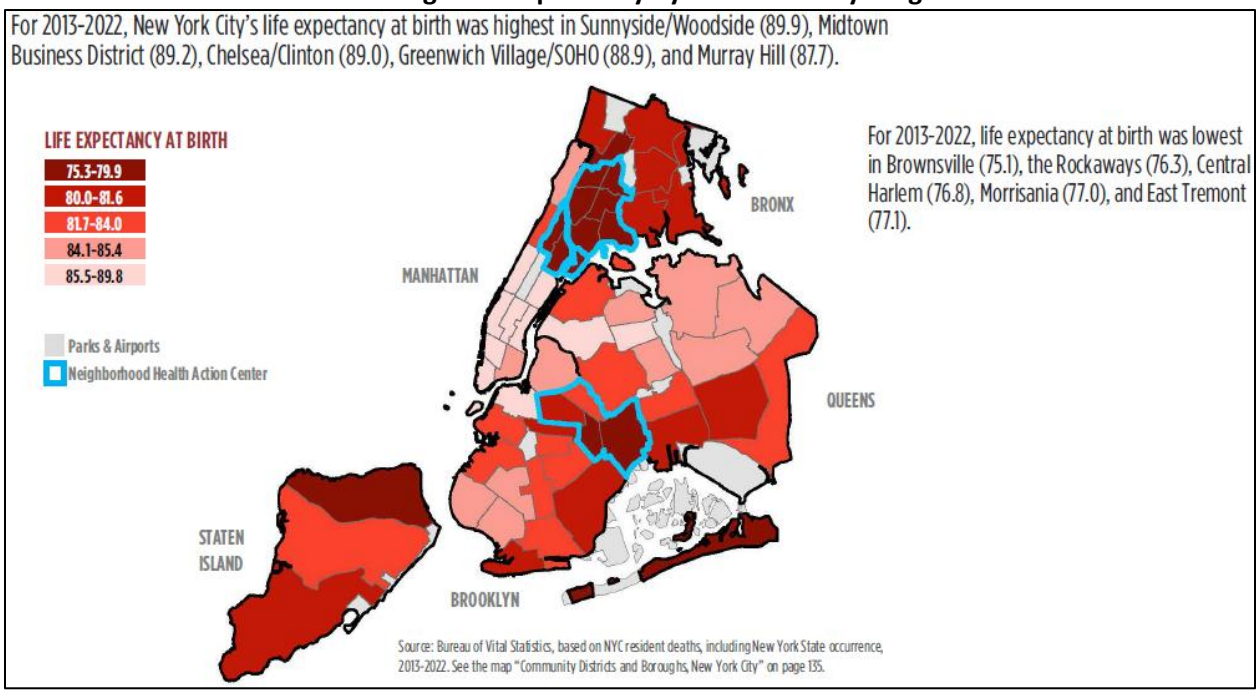
Brooklyn overall reports high average life expectancy that exceeds the national average by three years. Overall higher life expectancy in Brooklyn reflects strong SDoH factors, including a diverse economy, rich health and social services, public transportation options, and access to green spaces. Note: Average life expectancy declined nationally during the COVID-19 pandemic.



Source: Centers for Disease Control and Prevention

However, not all people across Brooklyn share these positive outcomes. Within Brooklyn, there is a 10-year difference in life expectancy between neighborhoods with the highest and lowest averages, reflecting the impact of SDoH and historical disparities. The Brownsville neighborhood in TBHC's primary service area has the lowest average life expectancy of any NYC neighborhood, estimated at 75.1 years.

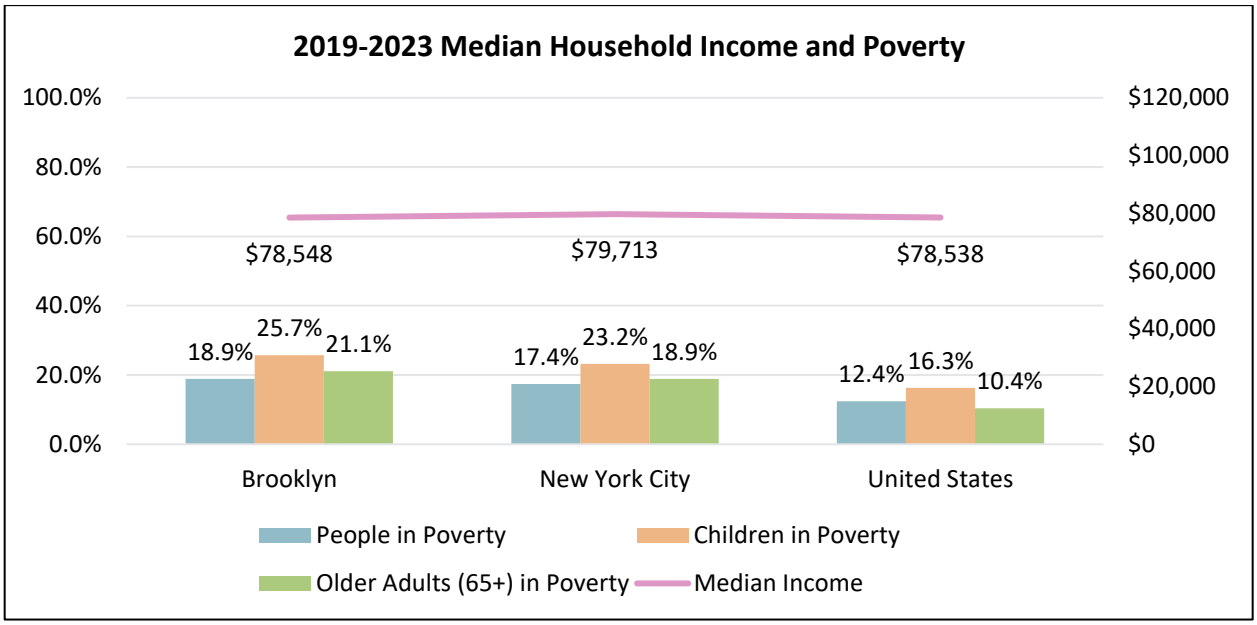
2013-2022 Average Life Expectancy by New York City Neighborhood



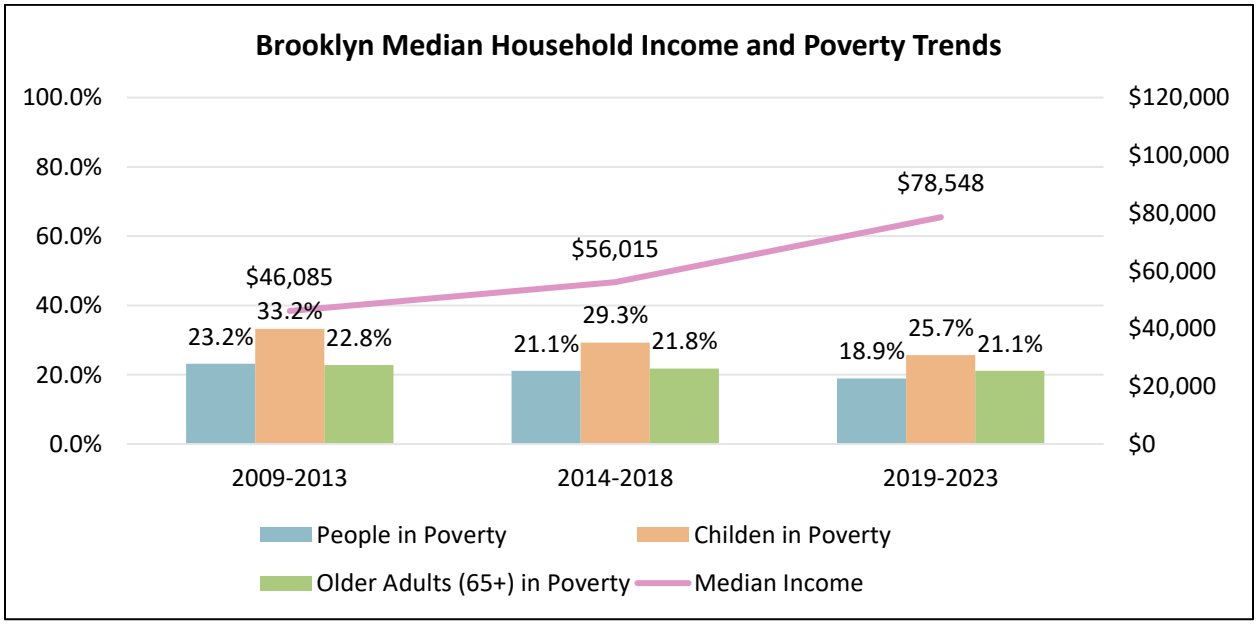
BROOKLYN	CD	Life Expectancy
Fort Greene, Brooklyn Heights	BK02	86.1
Borough Park	BK12	85.0
Bensonhurst	BK11	84.9
Bay Ridge	BK10	84.6
Williamsburg, Greenpoint	BK01	84.4
Sunset Park	BK07	84.0
Sheepshead Bay	BK15	84.0
Park Slope	BK06	83.5
Flatbush, Midwood	BK14	82.4
Crown Heights South	BK09	82.1
Bushwick	BK04	82.0
East Flatbush	BK17	82.0
Crown Heights North	BK08	81.5
Canarsie	BK18	81.5
Coney Island	BK13	80.4
Bedford Stuyvesant	BK03	80.0
East New York	BK05	78.2
Brownsville	BK16	75.1

Source: New York City Department of Health and Mental Hygiene

A key SDoH factor and indicator of health disparity is financial security and access to wealth. Brooklyn and NYC overall have similar median incomes as the nation, but higher overall poverty. This finding may reflect in part widening wealth disparities and income inequality among residents. Brooklyn's median household income rose 70% over the past decade, but overall poverty declined at a slower rate of 23%. Consistent with NYC overall, approximately 1 in 4 children and 1 in 5 older adults living in Brooklyn experience poverty. Looking more closely at neighborhoods and populations, clear disparities are present.



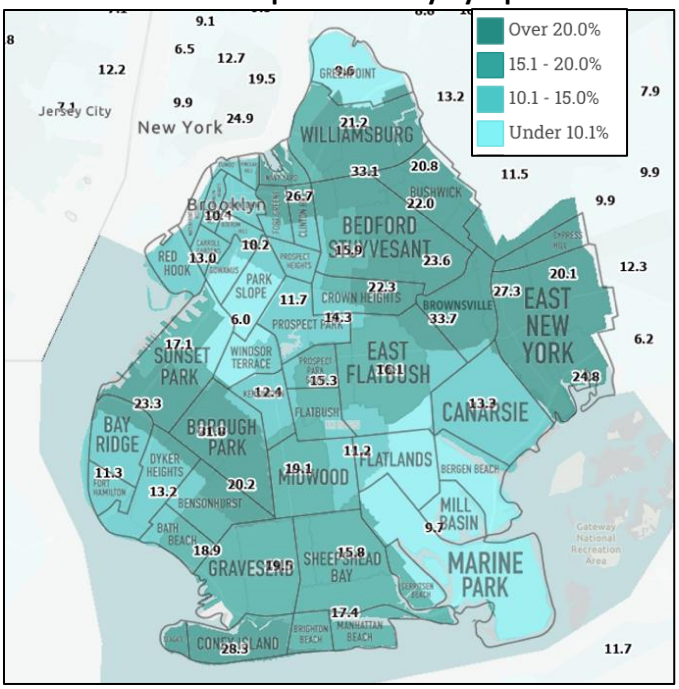
Source: US Census Bureau, American Community Survey



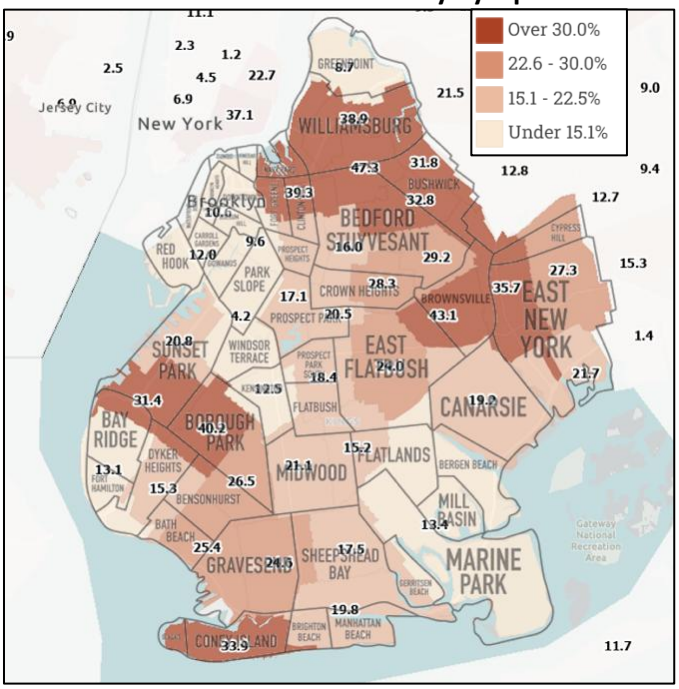
Source: US Census Bureau, American Community Survey

Experiences of financial hardship and poverty do not affect all people equally. Residents in the north and northeastern regions of the borough disproportionately live in poverty. Residents of the eastern portion of TBHC's primary service area are nearly two times more likely to live in poverty than residents of neighboring communities.

2019-2023 People in Poverty by Zip Code



2019-2023 Children in Poverty by Zip Code



Source: US Census Bureau, American Community Survey

The Health Resources and Services Administration Unmet Need Score (UNS) helps in allocation of resources—including primary and preventive healthcare services—across communities with higher unmet need based on social, economic, and health status. The UNS evaluates zip codes using a weighted sum of 28 health and social measures with values ranging from 0 (least need) to 100 (greatest need).

In TBHC's primary service area, there is a 52-point difference between zip codes with the highest and lowest UNS value, demonstrating community-level disparities. Consistent with average life expectancy trends, zip code 11212 (Brownsville) has the highest UNS value in TBHC's primary service area.

The Brooklyn Hospital Center Primary Service Area Zip Codes by Unmet Need Score and Select Social Drivers of Health Indicators (Years 2019-2023)^

Zip Code	Total Population in Poverty	Children in Poverty	No High School Diploma	No Health Insurance	2025 Unmet Need Score
11212	33.7%*	43.1%*	22.2%	6.5%	75.18
11207	27.3%	35.7%	19.3%	5.0%	66.88
11233	23.6%	29.2%	14.1%	6.8%	63.24
11213	22.3%*	28.3%*	16.0%	6.7%	60.65
11206	33.1%	47.3%	23.2%	6.2%	60.64
11221	21.9%	32.8%	15.6%	8.3%	59.77
11226	15.3%	18.4%	14.0%	7.9%	54.14
11225	14.2%	20.5%	11.4%	5.9%	43.71
11211	21.2%	38.9%	14.4%	4.8%	43.53
11205	26.7%	39.3%	14.5%	3.4%	43.00
11216	15.9%*	16.0%	9.0%	6.1%	38.26
11238	11.7%*	17.1%*	7.0%	3.2%	28.60
11217	10.1%	9.6%	7.1%	3.8%	27.85
11201	10.4%	10.6%	4.3%	2.8%	23.27
New York City	17.4%	23.2%	16.3%	6/4%	NA

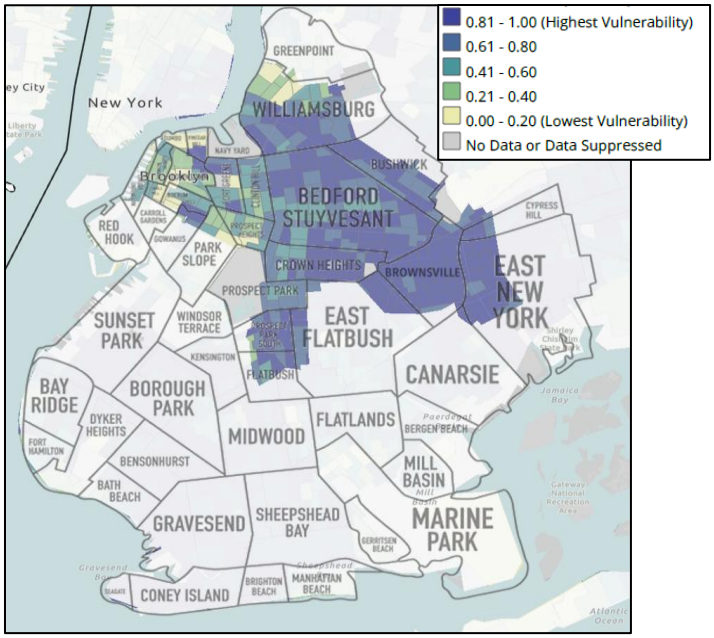
Source: Health Resources & Services Administration & US Census Bureau, American Community Survey
^Select SDoH indicators are presented to illustrate measures that influence the calculation of the Unmet Need Score.
*Denotes areas where poverty levels increased from 2022 CHNA reporting. Poverty levels declined for all other zip codes.

The Social Vulnerability Index (SVI) goes a level deeper than the UNS to demonstrate vulnerability to health disparities at a census tract-level. The SVI scores census tracts on a scale from 0.0 (lowest) to 1.0 (highest) vulnerability based on factors like poverty, lack of transportation, and overcrowded housing.

Census tracts are small geographic regions defined for the purpose of taking a census, designed to be relatively homogeneous in terms of population characteristics, economic status, and living conditions. Census tracts typically contain between 1,500 and 8,000 people.

The SVI findings reinforce historical disparities in average life expectancy in Brownsville, East New York, and Bedford Stuyvesant neighborhoods. Most communities within these neighborhoods have SVI values of 0.9 or higher, and many communities have SVI values of 0.98 or higher out of a maximum score of 1.0. These findings suggest more negative social risk factors.

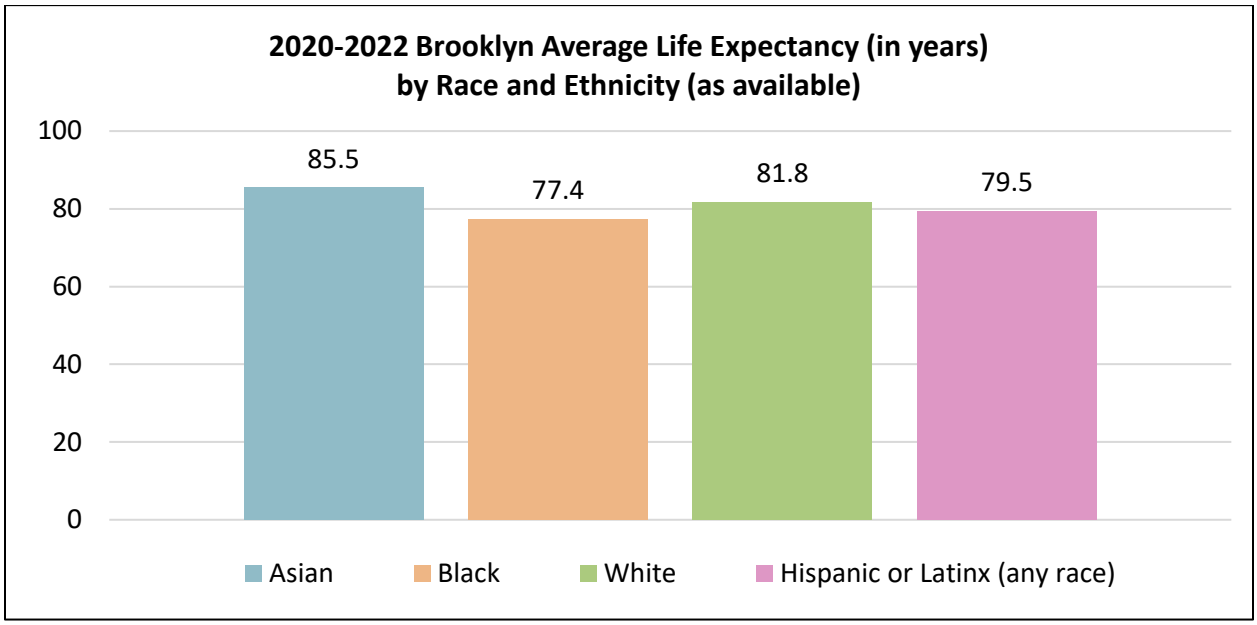
2022 Social Vulnerability Index by Census Tract within TBHC Primary Service Area



Source: Centers for Disease Control and Prevention

Social drivers of health barriers do not affect all people equally, differing substantially by race and ethnicity due to persistent and systemic racism, discrimination, and geographic barriers that limit many families' access to resources and opportunities for financial stability.

These longstanding disparities have contributed to significant differences in health and wellbeing for people of color. Across Brooklyn, Black and/or African American residents have a lower average life expectancy of four to eight years than other population groups living in the same community.



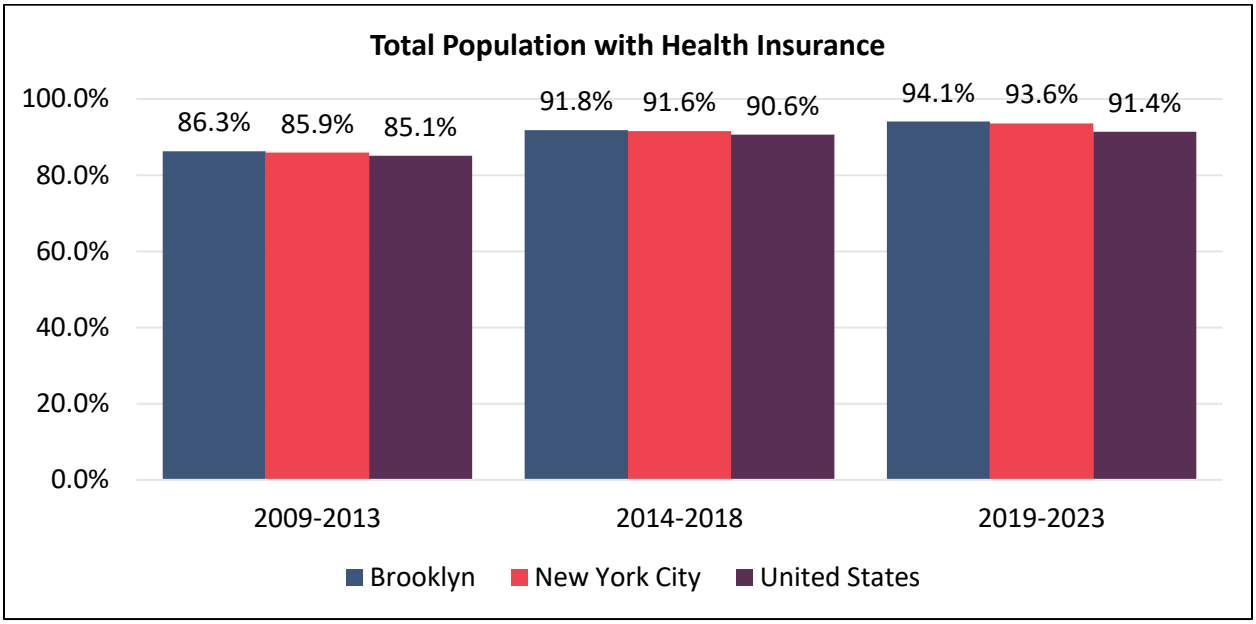
Source: Centers for Disease Control and Prevention

Community Health Needs

The CHNA was a comprehensive study of health and socioeconomic indicators for Brooklyn residents. The following section highlights key health and wellbeing needs as determined by secondary data statistics and community stakeholder feedback.

Access to Care and Services

The proportion of Brooklyn residents with health insurance increased over the past decade, and 94% of residents had health insurance in 2023 compared to 91% of residents nationwide. Access to routine primary care is better than the national average with approximately 77.5% of adults receiving an annual checkup in 2022 compared to 74.2% of adults nationwide.



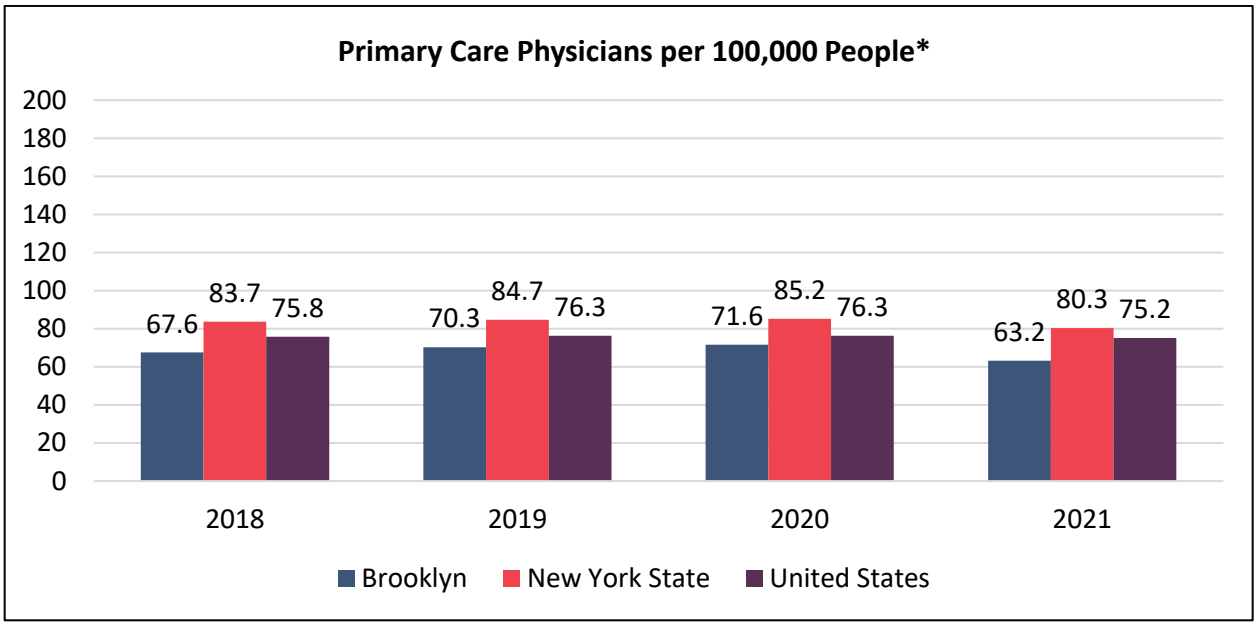
Source: US Census Bureau, American Community Survey

Despite these positive findings, access to healthcare services is challenged by provider availability and economic barriers. Availability of primary care physicians per 100,000 people in Brooklyn has been consistently below state and national levels and declined in recent years. A significant portion of Brooklyn is a primary care Health Professional Shortage Area (HPSA) for Medicaid-eligible residents. Medicaid is the government health coverage available to eligible people with low income.

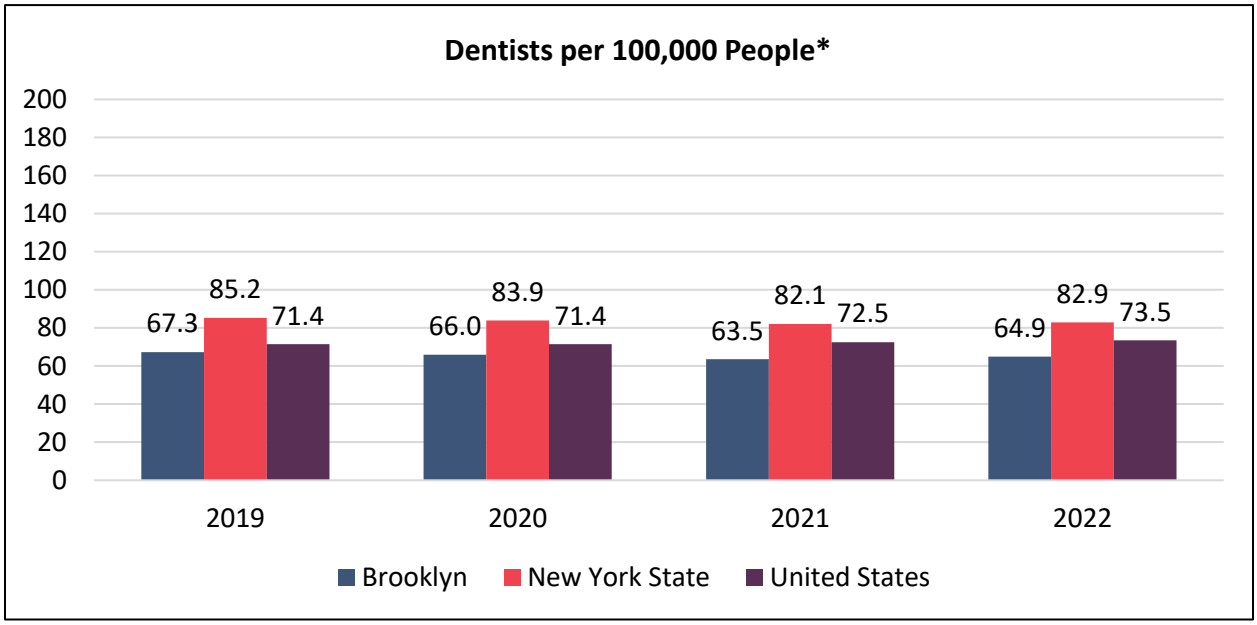
Since the 2022 CHNA, the proportion of Brooklynites with Medicaid increased from 36.5% to 38.2%. The proportion of Brooklynites with Medicare, government health coverage for people aged 65 or older, also increased from 14.5% to 15.4%. Currently, more than 80% of TBHC patients are publicly insured by Medicaid and/or Medicare. Medicaid and Medicare reimburse about 70% of the total cost of care, contributing to financial challenges for healthcare institutions.

Access to dental care is also limited in Brooklyn. The rate of dentists per 100,000 residents is below state and national levels and declined in recent years. A significant portion of Brooklyn is a dental HPSA for

Medicaid-eligible residents. Fewer than 60% of Brooklyln adults receive routine dental care compared to 63%-64% of adults statewide and nationlly.

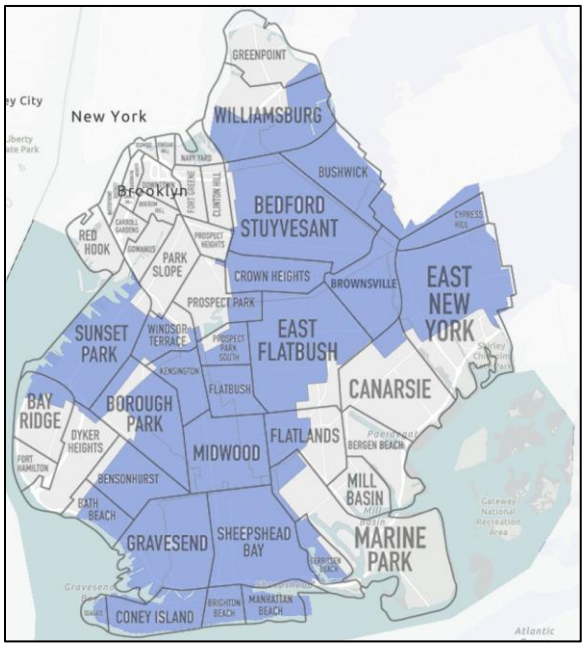


Source: Health Resources and Services Administration and Centers for Medicare & Medicaid Services
*New York State benchmark provided in lieu of New York City benchmark based on data reporting.

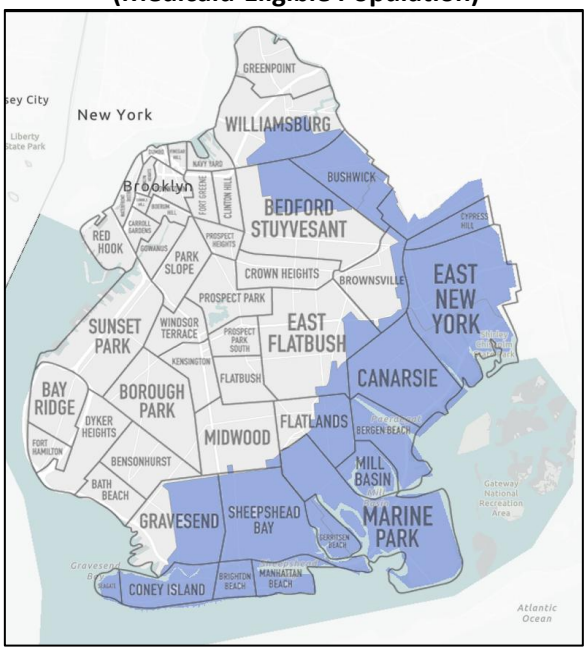


Source: Health Resources & Services Administration and Centers for Medicare & Medicaid Services
*New York State benchmark provided in lieu of New York City benchmark based on data reporting.

Primary Care Health Professional Shortage Areas (Medicaid-Eligible Population)



Dental Health Professional Shortage Areas (Medicaid-Eligible Population)



Source: Health Resources & Services Administration

Community stakeholders identified the ability to pay for out-of-pocket costs, workforce shortages, and the need for care and outreach to underserved communities as other key limiting factors for accessing care. To address these concerns, stakeholders recommended more affordable and free care options (e.g., sliding scale, free clinic days), mobile health services that reach underserved communities, and more intentional efforts to center the voices of residents and create trusted healthcare spaces. They also recommended enhanced healthcare and social service partnerships to foster shared data and funding, advocacy for policy change, and co-designed solutions that address systemic barriers to health and wellbeing.

KEY STAKEHOLDER SURVEY FEEDBACK:

"At a time when undocumented people are feeling unsafe engaging in services, we need to make sure that they still have access to free/affordable healthcare services."

"There's also an emphasis on caring for the aging population and managing chronic diseases, while ensuring healthcare providers are culturally competent to serve diverse communities."

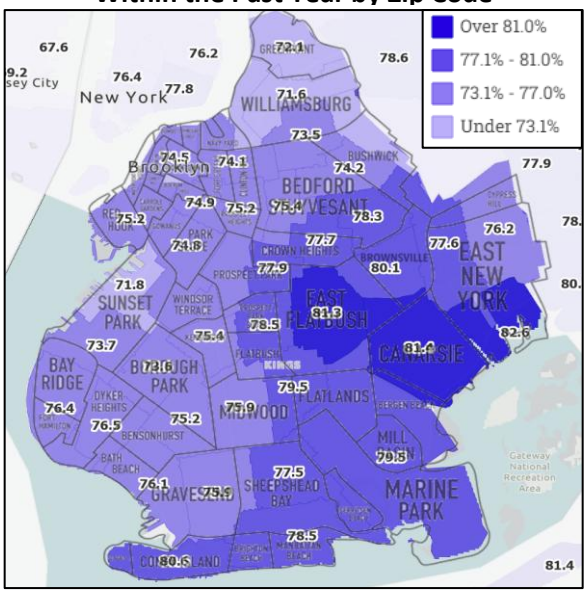
"Collaborate on funding and policy advocacy: Pursue joint funding opportunities and advocate for systemic changes—like expanded supportive housing and mental health services—that reflect shared goals."

"Center Community and Lived Experience: Involve people with lived experience of homelessness in planning and evaluation to ensure services truly meet their needs."

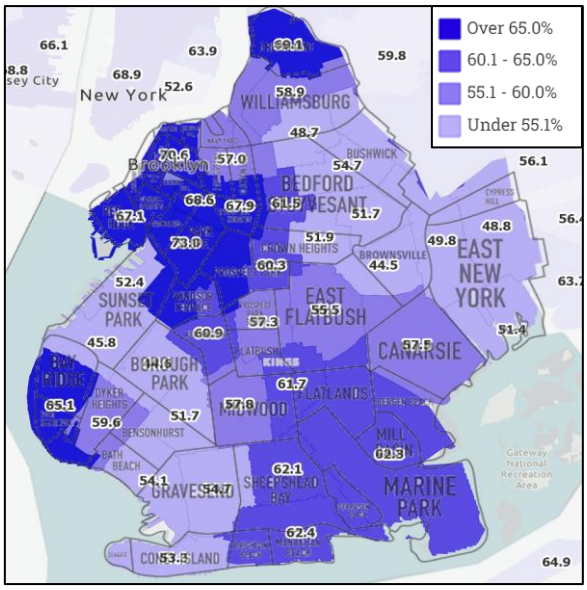
"Supporting workforce development through training programs and using data to guide targeted outreach would further enhance healthcare access."

When viewed by zip code, disparities in healthcare access are evident across the borough. Disparities in dental care access strongly align with socioeconomic barriers (e.g., poverty) for neighborhoods.

2022 Adults with a Primary Care Visit Within the Past Year by Zip Code



2022 Adults with a Dental Care Visit Within the Past Year by Zip Code



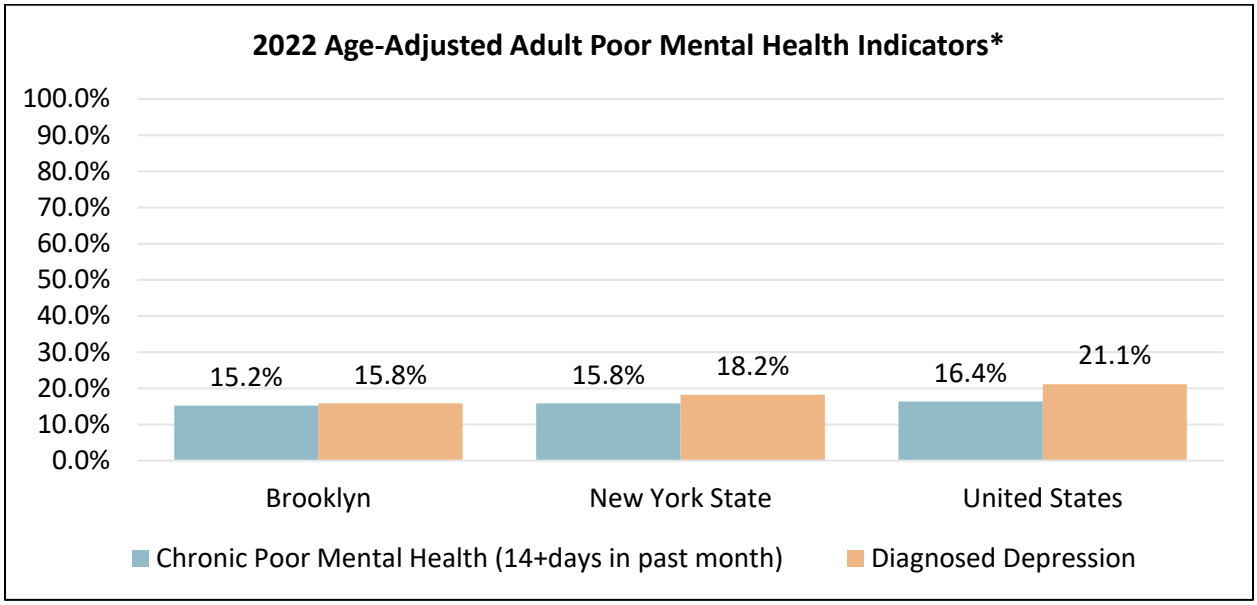
Source: Centers for Disease Control and Prevention

Community Recommendations to Improve Access to Care and Services

- Address healthcare and social service delivery gaps for the growing older adult population
- Ensure culturally and linguistically appropriate health information and education material; improve outreach to underserved communities
- Expand mobile health clinics and telehealth hubs to underserved areas
- Develop secure systems for cross-agency data sharing to identify common gaps, prioritize efforts, and co-design solutions
- Involve residents and people with lived experience in planning, evaluation, and decision-making to ensure culturally responsive solutions
- Leverage new data and artificial intelligence capabilities to track and respond to patient disparities
- Provide affordable and free care options such as screenings, clinic days, and wellness programs
- Strengthen partnerships between healthcare and social services to address underlying SDoH barriers and holistically address the needs of patients
- Unite local agencies and community-based organizations to collectively advocate for policy change and pursue collective funding opportunities to address systemic barriers

Behavioral Health

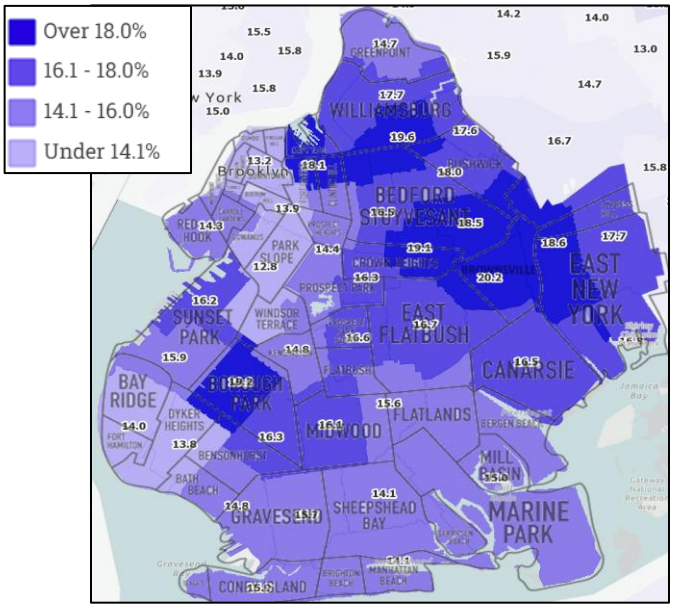
In 2022, 15.2% of Brooklyn adults reported chronic poor mental health (14 or more days of poor mental health in past month) and 15.8% reported a diagnosed depression disorder. The prevalence of poor mental health among Brooklyn adults has been relatively stable in recent years, contrary to state and national increases, and overall, fewer Brooklyn adults report poor mental health compared to state and national averages. However, when viewed by neighborhood, clear disparities are present and generally aligned with areas placed at risk for socioeconomic barriers.



Source: Centers for Disease Control and Prevention

*New York State benchmark provided in lieu of New York City benchmark based on data reporting.

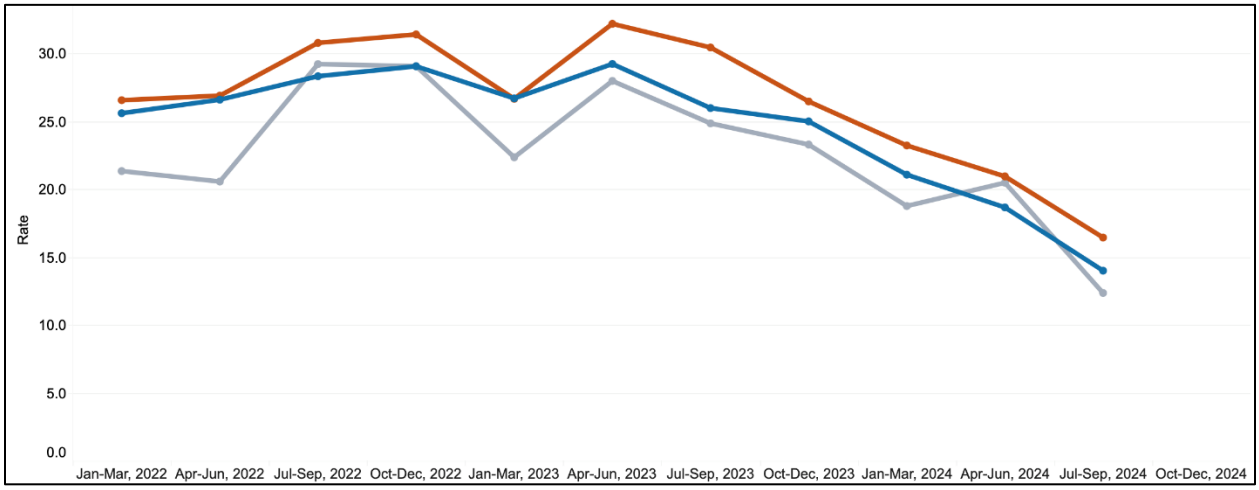
2022 Adults with Chronic Poor Mental Health by Zip Code



Source: Centers for Disease Control and Prevention

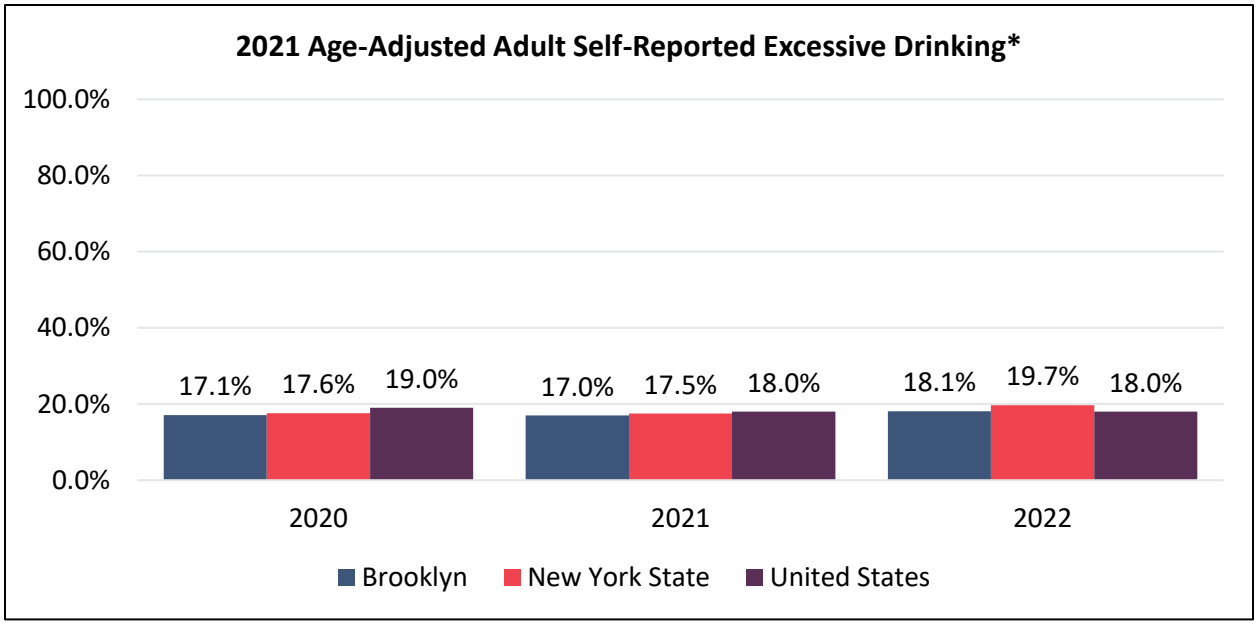
Mental health and substance use disorders are often co-occurring conditions. Consistent with citywide and statewide trends, fatal drug-related overdoses in Brooklyn have been declining since the second quarter of 2023. As of the third quarter of 2024, Brooklyn had fewer overdose deaths (12.3 per 100,000 people) than the city (16.4) and state (14.0).

Drug Overdose Deaths by Quarter, 2022-2024, Crude Rate per 100,000



Source: New York State Department of Health

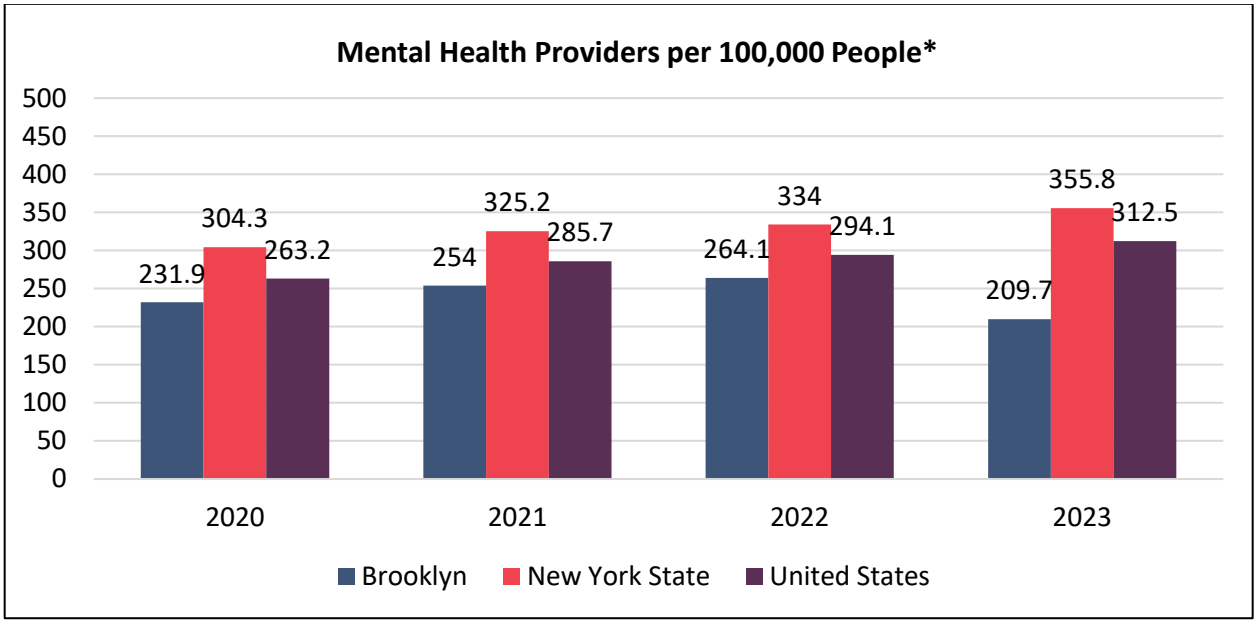
Alcohol is the most prevalent addictive substance used among adults. Excessive alcohol use, such as binge drinking or heavy drinking, increased in Brooklyn in 2022, although prevalence remained below the statewide average.



Source: Centers for Disease Control and Prevention

*New York State benchmark provided in lieu of New York City benchmark based on data reporting.

Contrary to state and national trends, availability of mental health providers in Brooklyn declined in 2023. Brooklyn has consistently had fewer mental health providers than New York State and the nation. Nearly half of the borough is a mental healthcare HPSA for Medicaid-eligible residents. Note: Mental health providers include those specializing in psychiatry, psychology, mental health, addiction or substance use disorders, or counselling.



Source: Centers for Medicare and Medicaid Services

*New York State benchmark provided in lieu of New York City benchmark based on data reporting.

Mental Health Professional Shortage Areas (Medicaid-Eligible Population)

Source: Health Resources & Services Administration

Community stakeholders identified the ability to pay for care, the need for care and outreach to underserved communities, and stigma as other key limiting factors for accessing behavioral healthcare. Stakeholders recommended both upstream preventive efforts to build community resilience (e.g., family-friendly events, mindfulness and relaxation techniques, teen-led support groups) and downstream clinical efforts to increase funding and hiring for behavioral health providers.

KEY STAKEHOLDER SURVEY FEEDBACK:

"We should make mental health services easier to access – more affordable, more available in different languages, and more trusted in the community. People need safe spaces where they feel comfortable asking for help."

Youth were perceived by community stakeholders as one of the most at-risk populations for behavioral health concerns, largely due to COVID-19 impacts (e.g., isolation, developmental delays), perceived lack of structured recreational and mentorship programs, and academic success pressures.

KEY STAKEHOLDER SURVEY FEEDBACK:

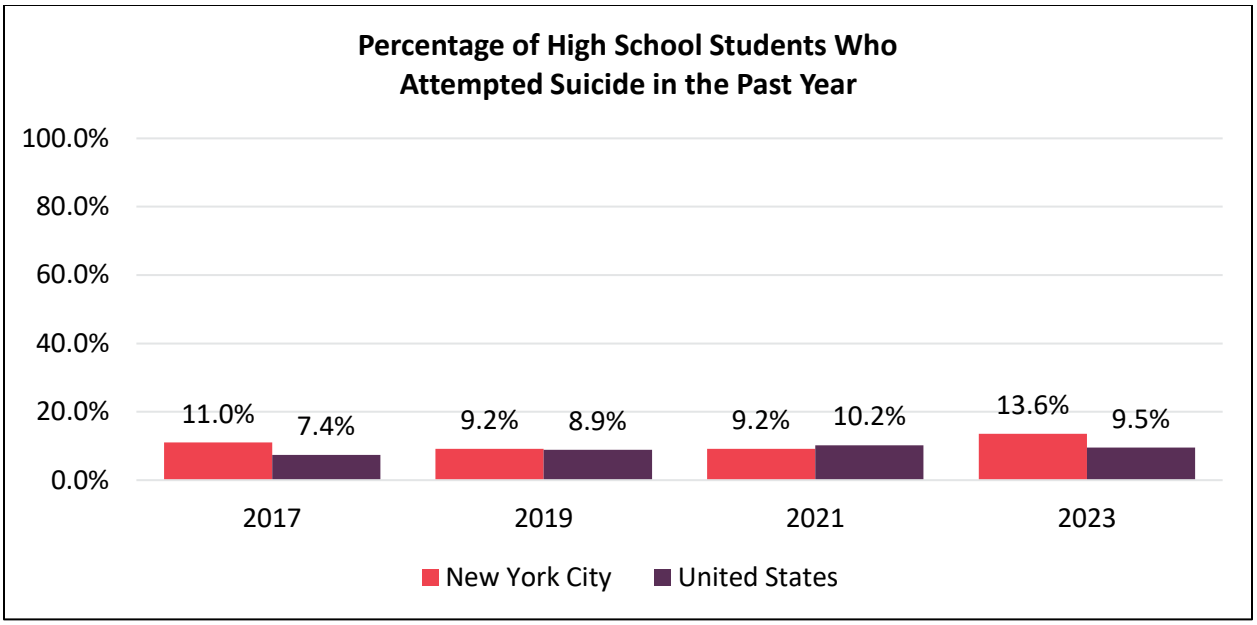
"[We need] Mentorship and mental wellbeing creating Education-Minded, Career Focused Youth. Invest in our youth through education, healthcare and employment. Improve productivity and increase social mobility."

"Invest in our youth. Opportunity leads to positive outcomes."

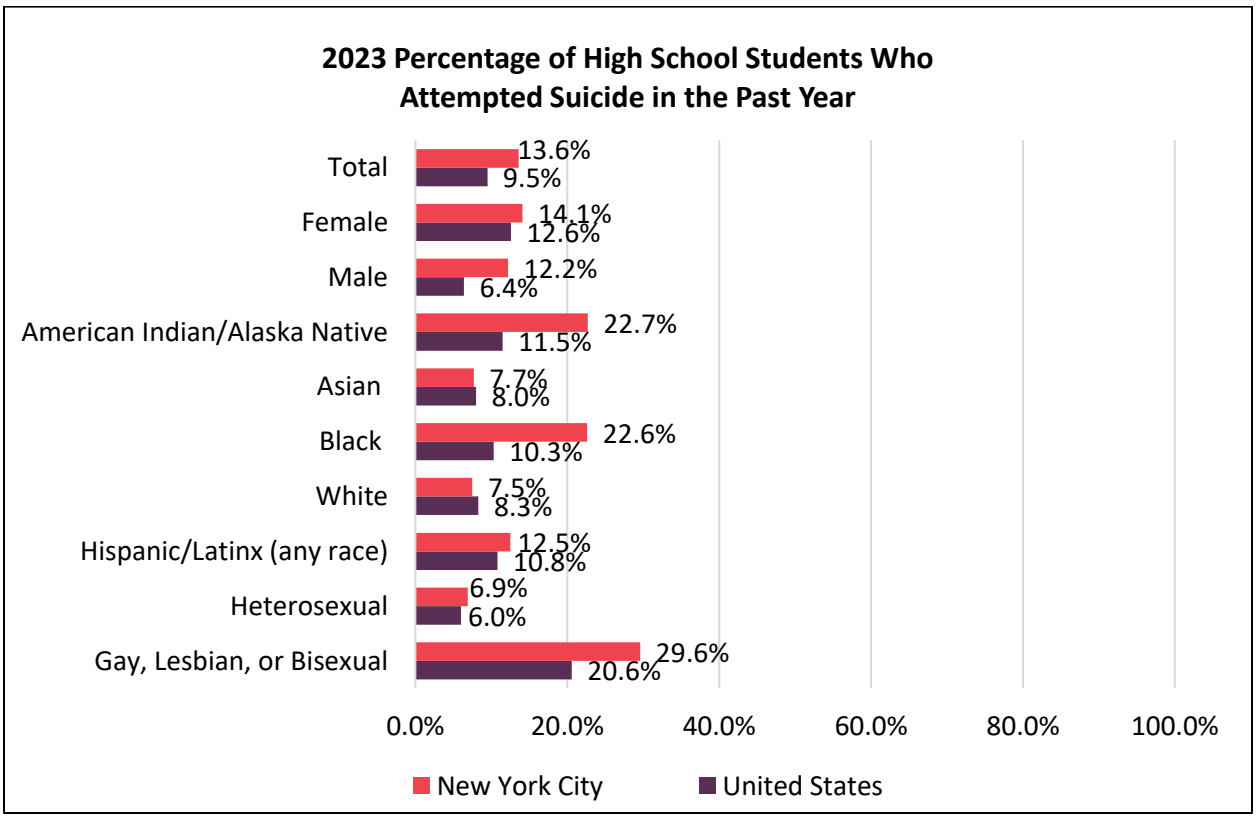
"[We need] Free afterschool activities besides basketball."

In 2023, 35.5% of all NYC high school students reported feeling consistently sad or depressed, a slightly lower proportion than the nation overall (39.7%). The proportion of NYC high school students who reported an attempted suicide increased from 9.2% in 2021 to 13.6% in 2023, exceeding the national average. This trend should continue to be assessed and monitored.

Experiences of mental distress disproportionately affect students historically placed at risk, including students of color and those who identify as LGBTQIA+. Notably, when compared to their heterosexual peers, students who identify as LGBTQIA+ are nearly four times more likely to report a suicide attempt.

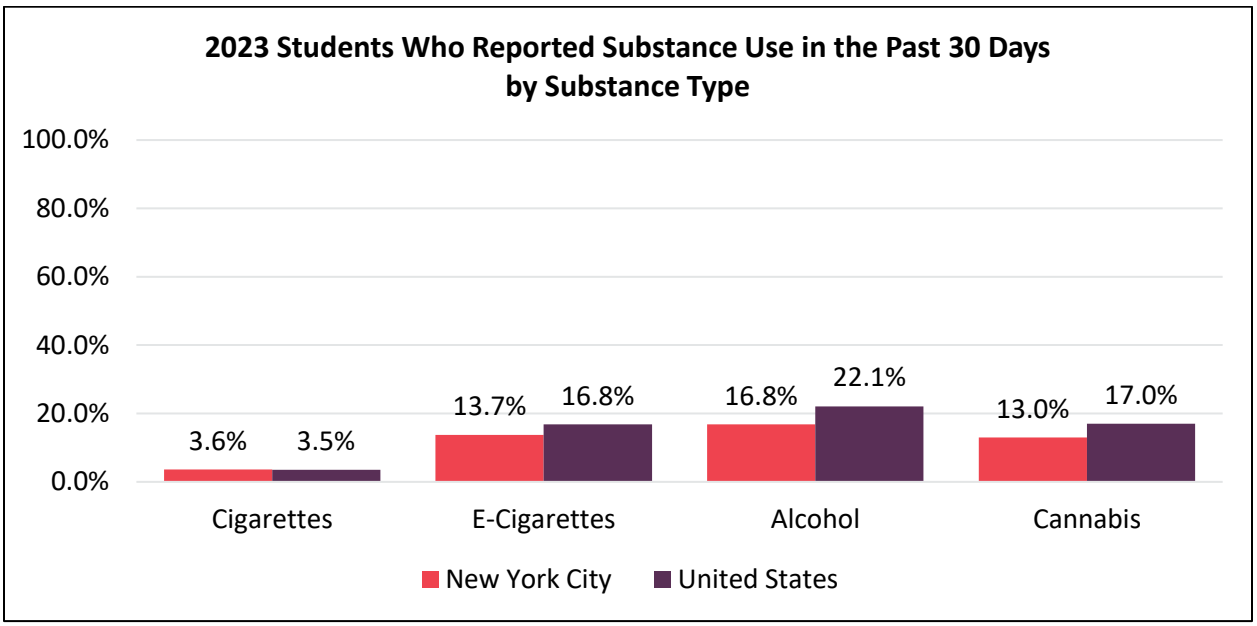


Source: New York City Department of Health and Mental Hygiene & Centers for Disease Control and Prevention



Source: New York City Department of Health and Mental Hygiene & Centers for Disease Control and Prevention

New York City high school students are less likely to use substances like cigarettes, e-cigarettes, alcohol, and cannabis when compared to their peers nationwide. Slightly more than 1 in 10 students reported using these substances in 2023. Substance use among students generally declined in 2021, likely due in part to social isolation caused by the pandemic but increased for all substances in 2023.



Source: New York City Department of Health and Mental Hygiene & Centers for Disease Control and Prevention

Community Recommendations to Improve Behavioral Health

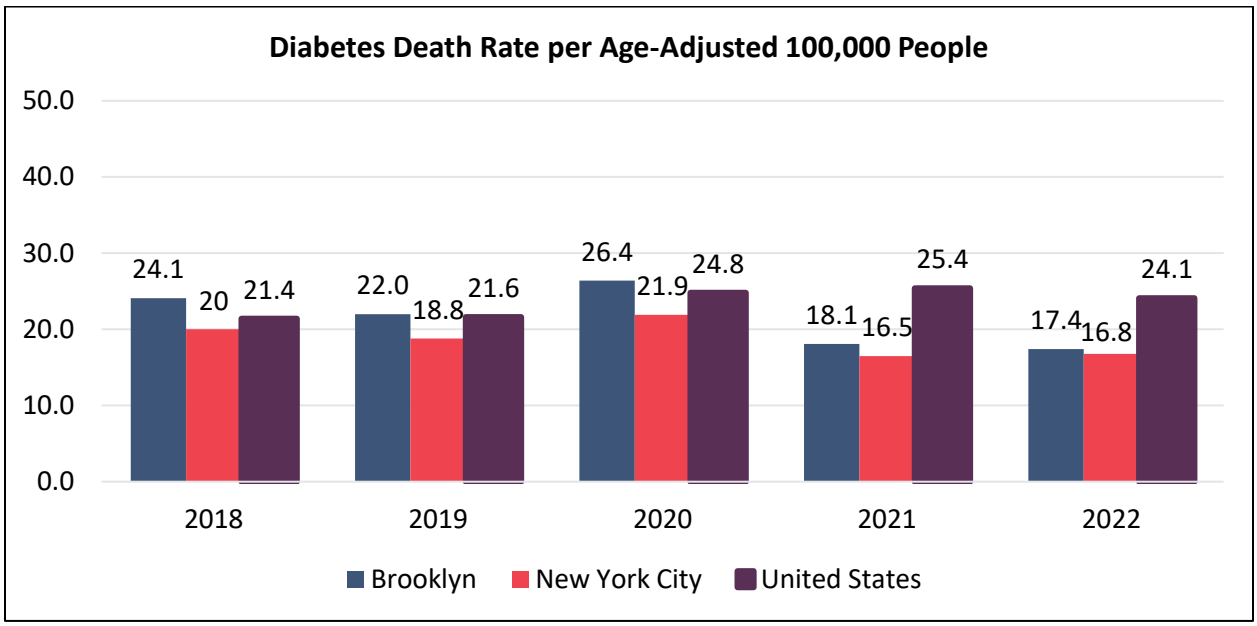
- Assess funding and capacity for behavioral health services offered by TBHC
- Host family-friendly community events with a focus on family mental health
- Partner with trusted community spaces to provide mental health resources that are culturally and linguistically relevant and that address stigma
- Prioritize youth mental wellness, resiliency programming, mentorship, and social mobility opportunities
- Promote holistic wellness practices and education on mindfulness, relaxation, and stress management techniques
- Provide integrated primary and mental healthcare services

Chronic Disease Prevention and Management

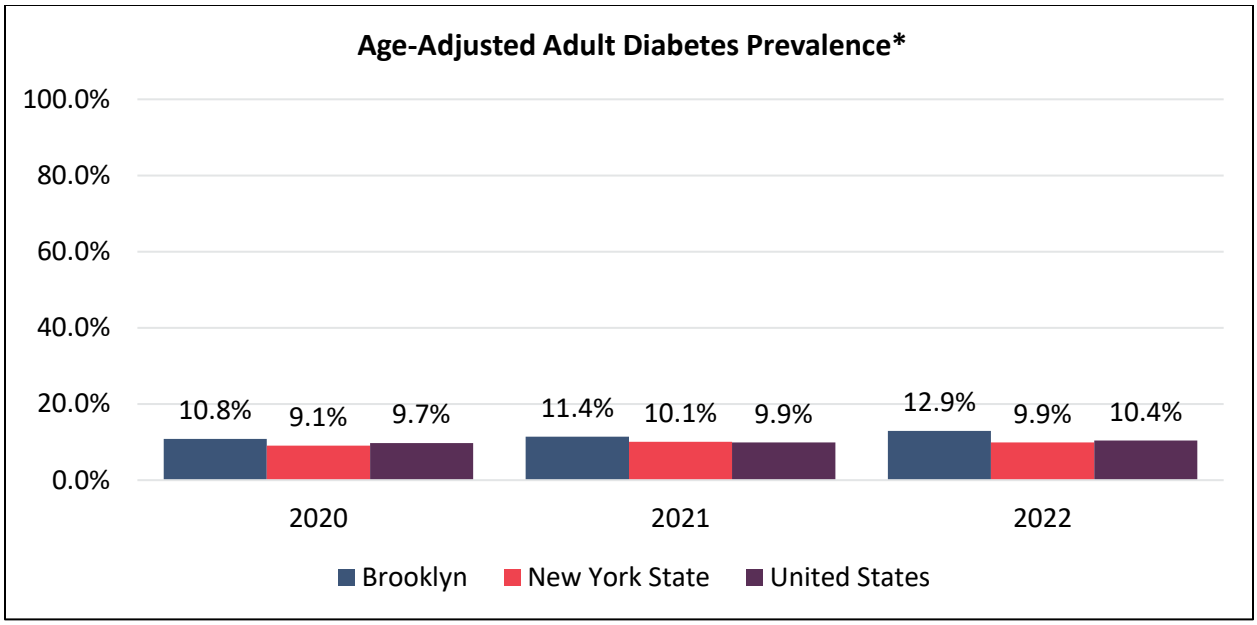
Brooklyn residents saw a decline in deaths due to chronic diseases like diabetes and heart disease, despite having a higher and/or increasing prevalence of disease. This finding may indicate better screening for early detection and treatment and better care management. It should be explored for successful intervention efforts.

The diabetes death rate in Brooklyn declined 52% from 2020 to 2022, falling below the national rate of death and in line with citywide trends. Additional preventive efforts are needed to address the high and increasing prevalence of diabetes among adults. In 2022, nearly 13% of Brooklyn adults had been diagnosed with diabetes compared to 10% of adults citywide.

When viewed by zip code, there is a higher prevalence of diabetes in the eastern portion of the borough, affecting approximately 1 in 7 adults.



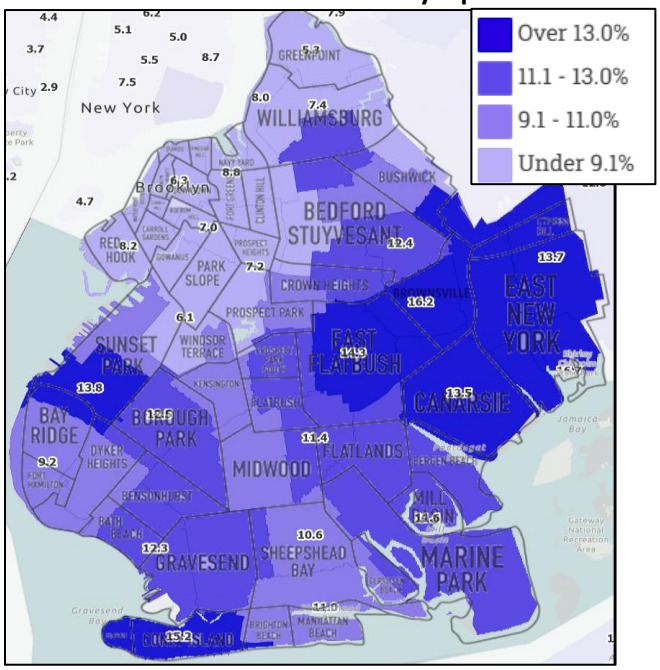
Source: Centers for Disease Control and Prevention & New York State Department of Health



Source: Centers for Disease Control and Prevention

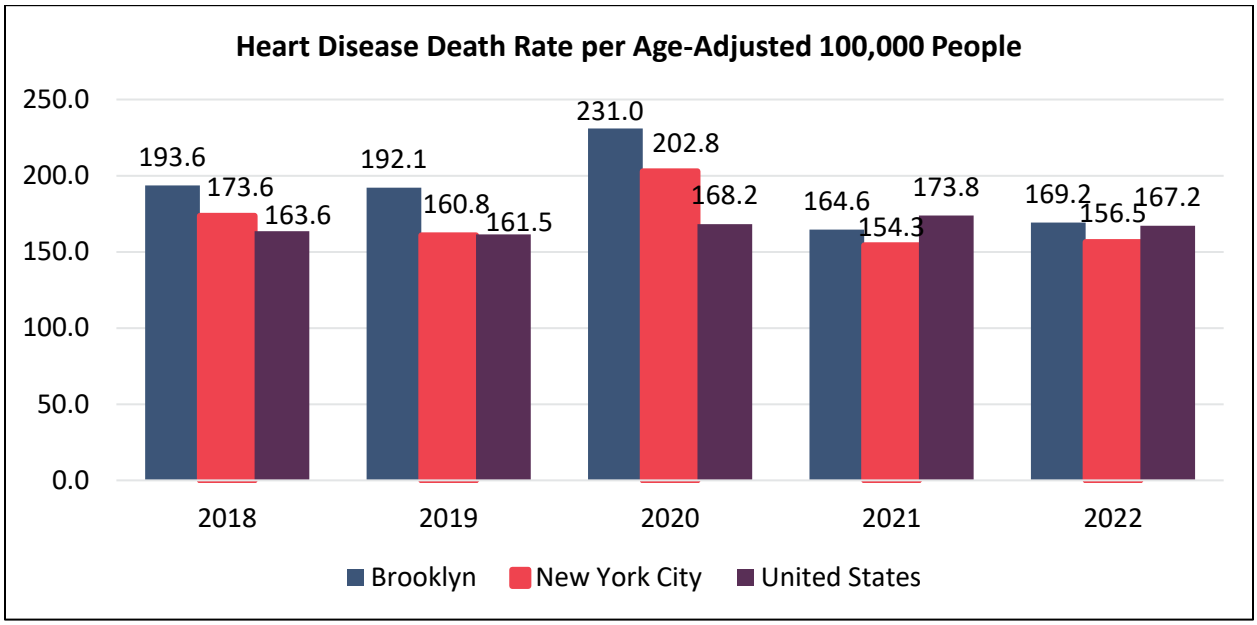
*New York State benchmark provided in lieu of New York City benchmark based on data reporting.

2022 Adults with Diabetes by Zip Code

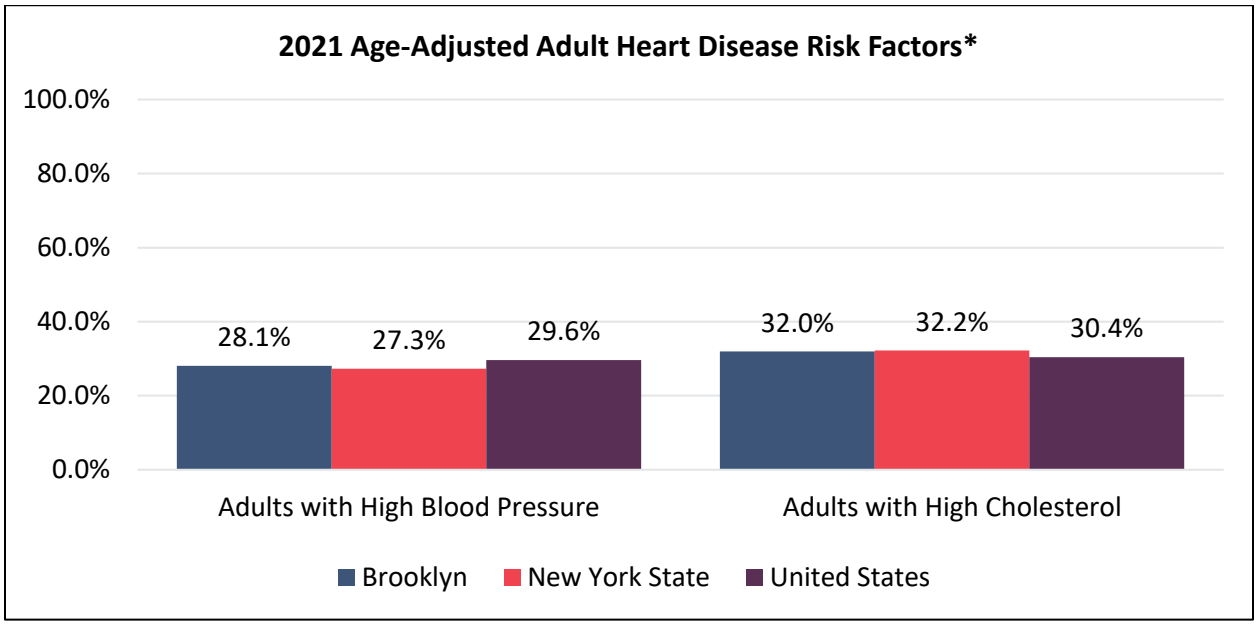


Source: Centers for Disease Control and Prevention

Brooklyn also saw a decline in heart disease related deaths. The heart disease death rate in Brooklyn declined 36.5% from 2020 to 2022, generally falling in line with citywide and national trends. About 30% of Brooklyn adults have been diagnosed with heart disease risk factors such as high blood pressure and/or high cholesterol.



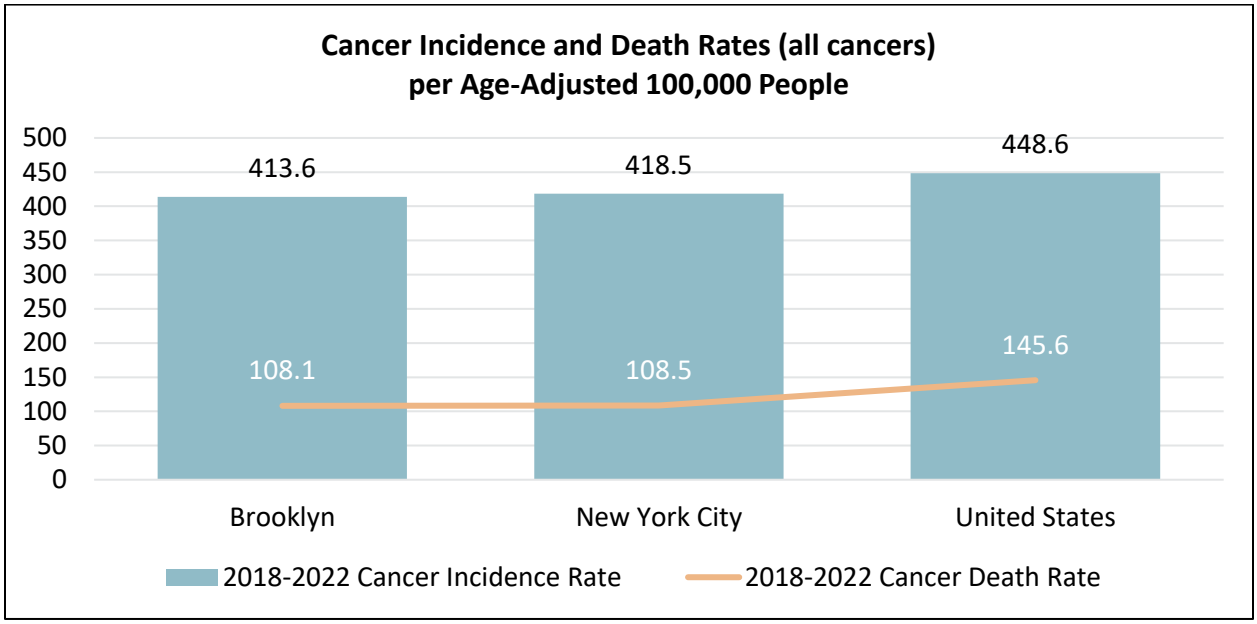
Source: Centers for Disease Control and Prevention & New York State Department of Health



Source: Centers for Disease Control and Prevention

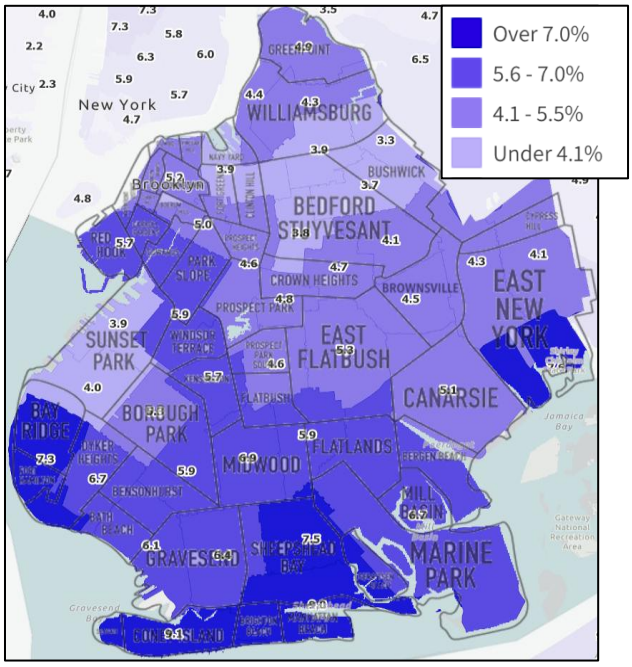
*New York State benchmark provided in lieu of New York City benchmark based on data reporting.

Brooklyn and NYC have lower cancer incidence and death rates than the nation. Within Brooklyn, approximately 3%-9% of adults report a cancer diagnosis. Higher cancer prevalence in the southern portion of the borough generally aligns with an older demographic.



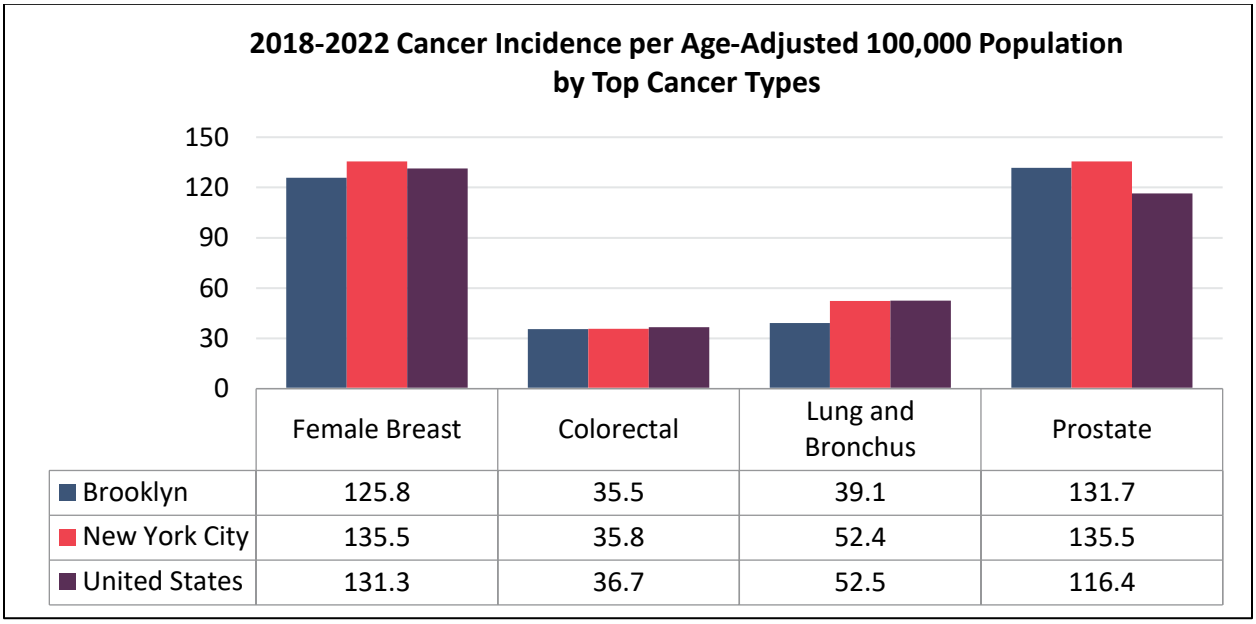
Source: Centers for Disease Control and Prevention & New York State Department of Health

2022 Adults with Cancer (non-skin) or Melanoma, by Zip Code



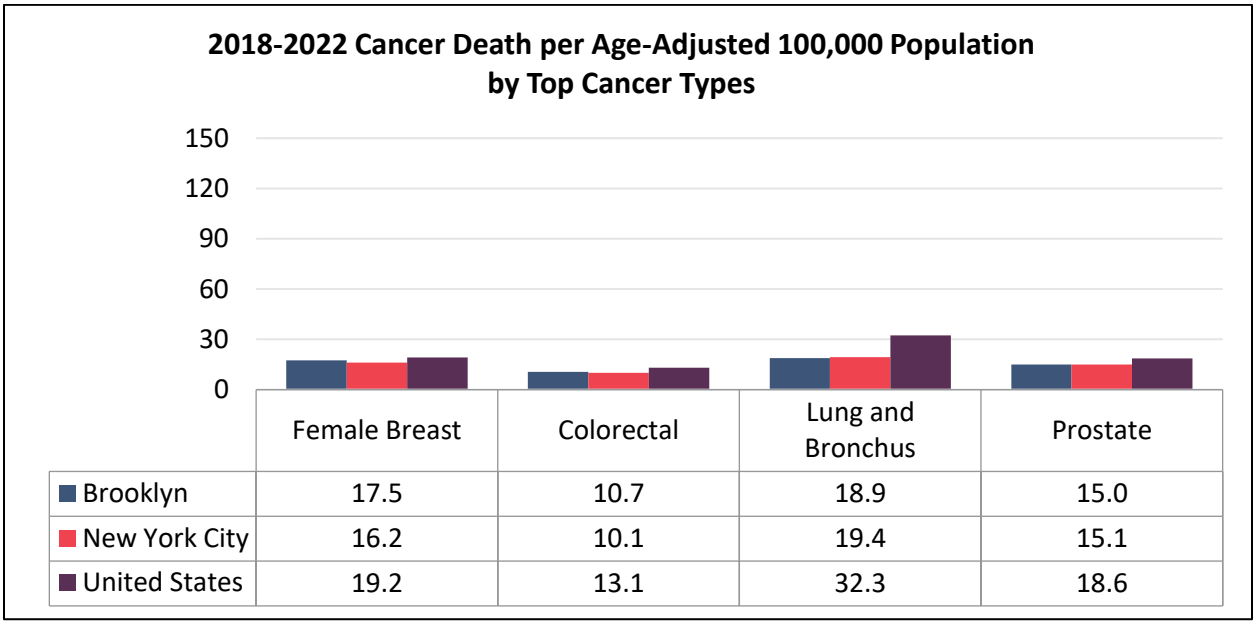
Source: Centers for Disease Control and Prevention

The following graphs show incidence and death rates for the top four most common types of cancer: female breast, colorectal, lung, and prostate cancers. Consistent with NYC overall, Brooklyn has lower death rates than the nation for all four cancer types. It is worth noting that Brooklyn and NYC report higher incidence of prostate cancer than the nation, but lower prostate cancer death rates. This finding may reflect better screening practices for early detection and treatment.



	Female Breast	Colorectal	Lung and Bronchus	Prostate
Brooklyn	125.8	35.5	39.1	131.7
New York City	135.5	35.8	52.4	135.5
United States	131.3	36.7	52.5	116.4

Source: New York State Department of Health & Centers for Disease Control and Prevention

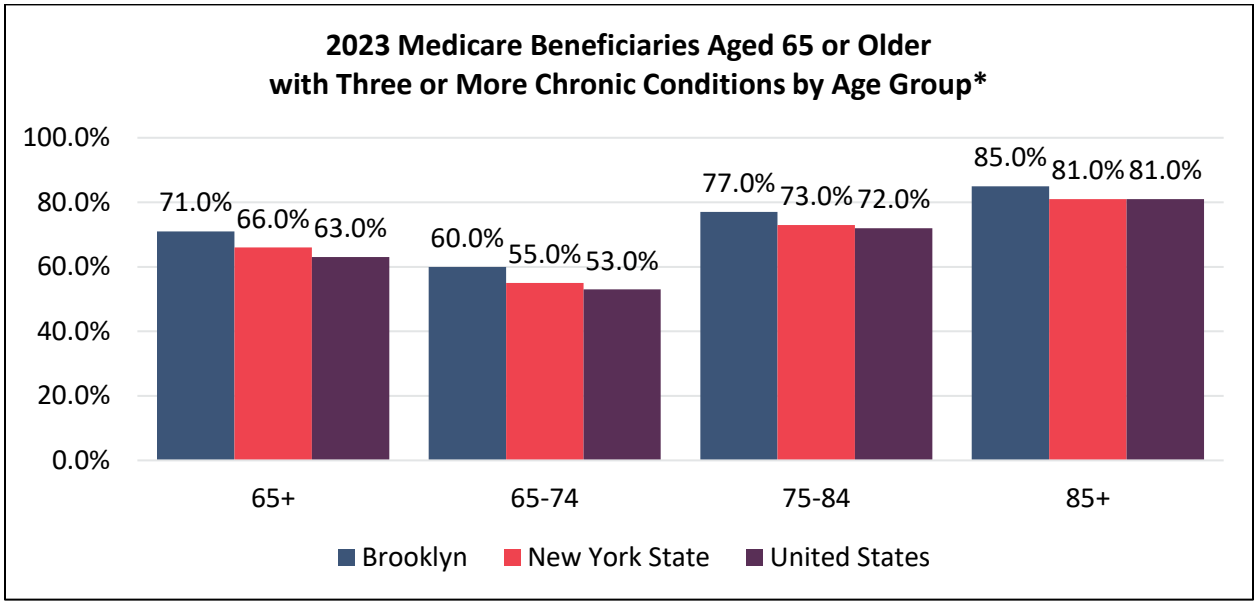


	Female Breast	Colorectal	Lung and Bronchus	Prostate
Brooklyn	17.5	10.7	18.9	15.0
New York City	16.2	10.1	19.4	15.1
United States	19.2	13.1	32.3	18.6

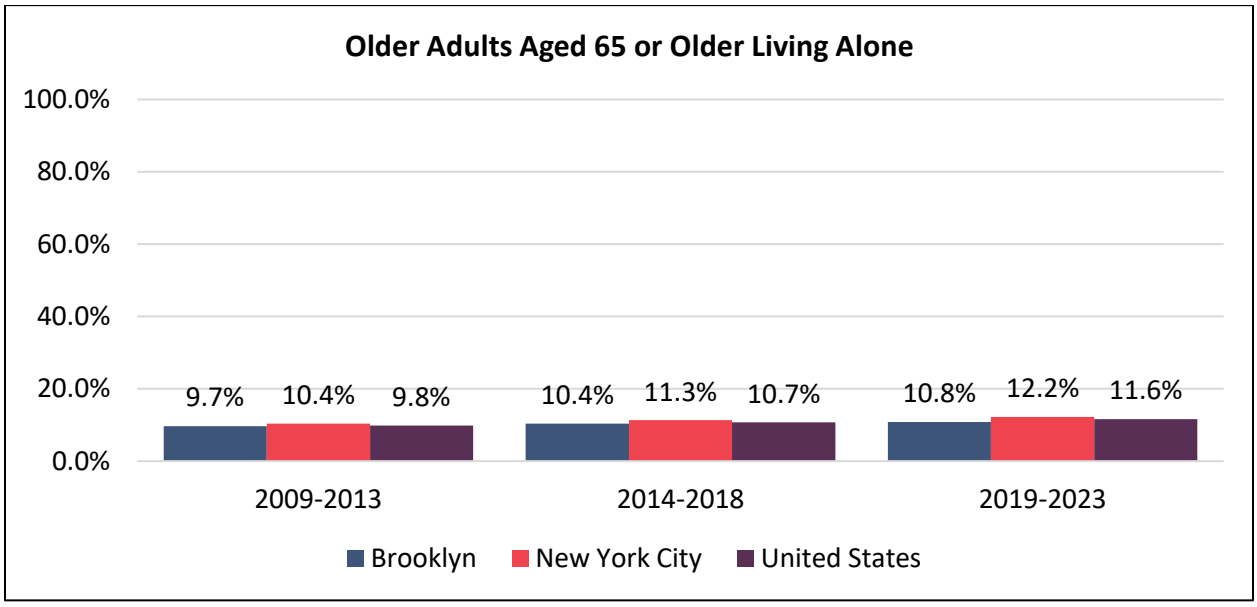
Source: New York State Department of Health & Centers for Disease Control and Prevention

While Brooklyn represents a younger population, it is aging. The number of Brooklyn adults aged 65 years or older grew 39% over the last decade. Older adults are more at risk for chronic disease, as well as factors that impede disease management, including economic insecurity, social isolation, and access barriers (e.g., transportation, digital literacy).

Approximately 71% of Brooklyn older adult Medicare beneficiaries manage three or more chronic conditions, a higher proportion than the state and nation overall. Similar to state and national trends, disease prevalence increases significantly with age. Approximately 11% of Brooklyn older adults live alone, an indicator of social isolation. Approximately 21% of older adults live in poverty.



Source: Centers for Medicare & Medicaid Services
*New York State benchmark provided in lieu of New York City benchmark based on data reporting.



Source: US Census Bureau, American Community Survey

Community stakeholders identified the need for better access to older adult-focused healthcare in Brooklyn. Recommendations included hospital-community partnerships to enhance care coordination, mobile clinics and use of telehealth services, and preventive efforts to reduce isolation and promote healthy aging.

KEY STAKEHOLDER SURVEY FEEDBACK:

"Partnering with local organizations to expand access to senior-focused healthcare, including mobile clinics and telehealth services."

"By leveraging its clinical expertise and community reach, the hospital can play a key role in coordinating care, reducing isolation, and promoting healthy aging across the borough."

"There's also an emphasis on caring for the aging population and managing chronic diseases, while ensuring healthcare providers are culturally competent to serve diverse communities."

Community Recommendations to Improve Chronic Disease Prevention and Management

- Address issues of discrimination and racism within healthcare that contribute to health disparities for people of color
- Expand access to older adult-focused healthcare and strengthen partnerships with other healthcare and social service agencies to improve care coordination and address underlying SDoH barriers
- Provide healthy aging programming, including opportunities that reduce social isolation
- Prioritize addressing upstream SDoH barriers (e.g., poverty, housing, food insecurity); strengthen partnerships between healthcare and social services to holistically address the needs of patients

Economic Stability

At the root of health disparities for Brooklynites are socioeconomic experiences or social drivers of health. The recent rise in costs of living has further deepened these experiences and challenged people to meet their basic needs and maintain their health.

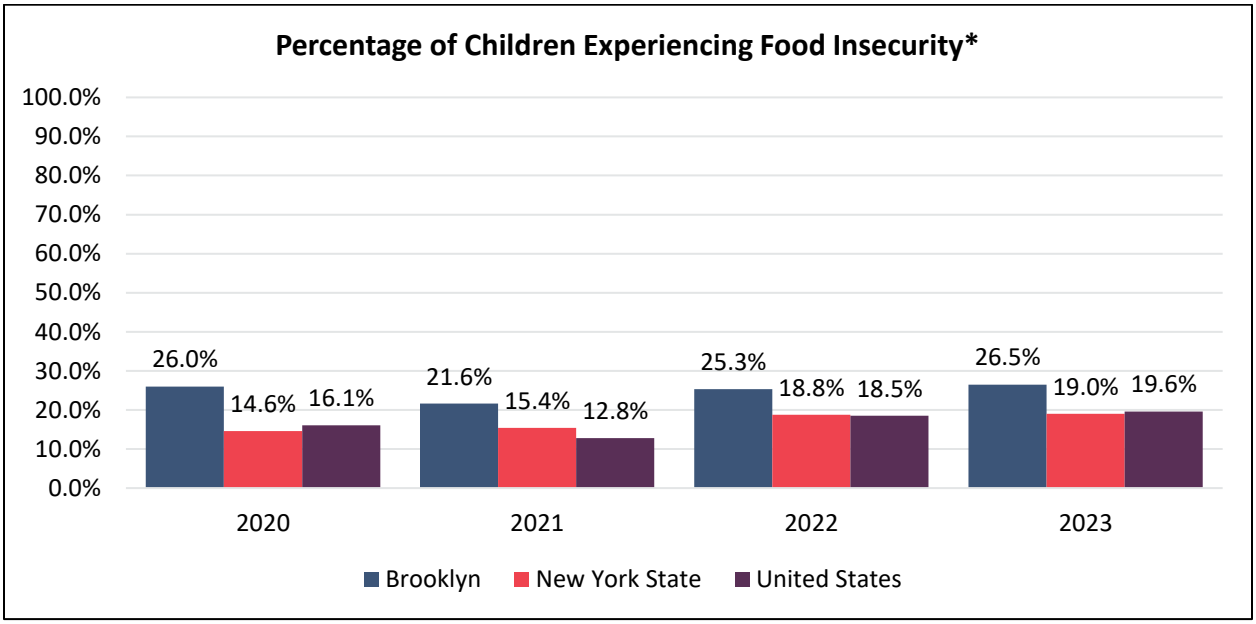
Experiences of food insecurity across Brooklyn and the nation increased since 2021. Brooklyn has historically had higher food insecurity rates, and as of 2023, 17.1% of all residents and 26.5% of children were affected. Other indicators of economic stability also declined. In 2023, the cost of childcare for a household with two children, measured as a percentage of median household income, was approximately 40% in Brooklyn compared to 27% nationally. Over the past decade, median home value increased 59.7% and median rent increased 55.3%.

KEY STAKEHOLDER SURVEY FEEDBACK:

"Our church is witnessing increasing food insecurity across the borough, affecting families, seniors, and working individuals. Rising costs and limited access to nutritious food make ongoing support essential."

"There's a growing need for sustainable food programs, easier access to benefits, and community-based solutions like food pantries and meal delivery for families with young children."

"As a clothing store owner who collects donations for the community, I'm seeing a growing need for programs that help people improve their financial security—like job training in high-demand fields, support for small businesses, and access to affordable financial tools. Many in our community are also looking for help building credit, managing debt, and saving for the future."



Source: Feeding America

*New York State benchmark provided in lieu of New York City benchmark based on data reporting.

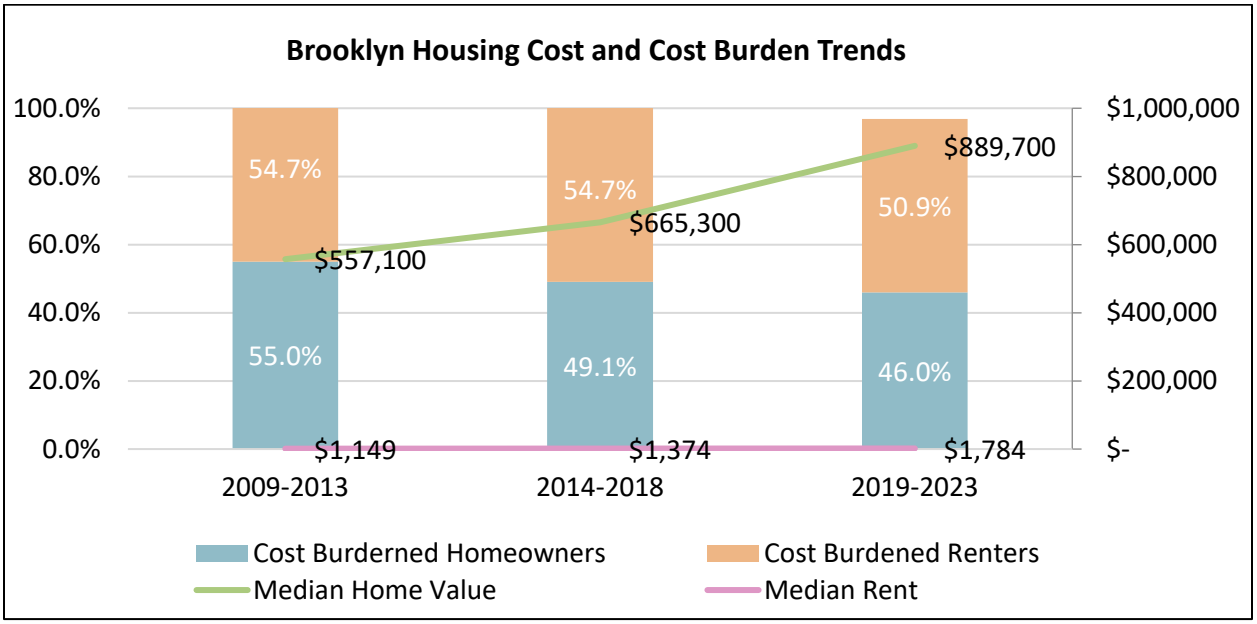
Childcare Availability and Affordability*

	Number of childcare centers per 1,000 population under 5 years old	Childcare costs for a household with two children as a percent of median household income
Brooklyn	8.0	40.0%
New York State	6.1	37.7%
United States	7.0	27.0%

Source: Homeland Infrastructure Foundation-Level Data, 2010-2022 & The Living Wage Calculator, Small Area Income and Poverty Estimates, 2023 & 2022

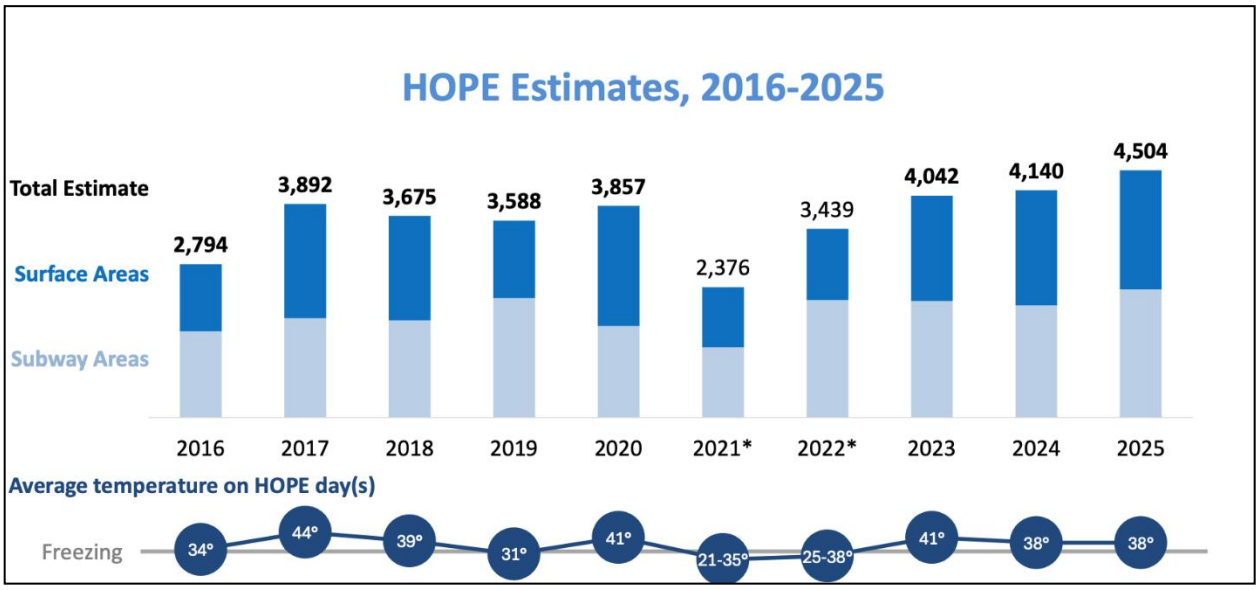
*New York State benchmark provided in lieu of New York City benchmark based on data reporting.

Brooklyn housing is expensive. Brooklyn's median home value was nearly $900,000 in 2023, nearly three times higher than the national median. Approximately 46% of Brooklyn homeowners are cost-burdened by their home. Housing cost burden reflects the proportion of households that spend more than 30% of their combined income on rent or mortgage expenses and therefore have few resources to spend on their basic needs, such as food and utilities. Renters, who make up 70% of households, are more likely to be cost-burdened compared to homeowners with 51% facing financial strain due to rent costs.



Source: US Census Bureau, American Community Survey

Brooklyn's expensive housing costs are reflected in the number of people experiencing homelessness. Every January, thousands of volunteers across the five NYC boroughs participate in an annual Homeless Outreach Population Estimate (HOPE) to identify individuals living unsheltered. The HOPE survey, conducted on January 28, 2025, identified an estimated 4,504 unsheltered individuals across NYC, a 9% increase compared to January 2024. Homelessness estimates on surface areas (not including subway areas) increased by 12% in Brooklyn from 249 people in 2024 to 280 people in 2025.



Source: New York City Department of Homeless Services

Brooklyn housing is also older, posing more health risks such as lead exposure and asthma triggers. Approximately 80% of Brooklyn and NYC housing units were built before 1980. Historically, about 8% of Brooklyn children that were tested had high blood lead levels, compared to a NYC average of about 7%. Asthma is the most common chronic condition among children and a leading cause of hospitalization and school absenteeism. From 2020 to 2022, Brooklyn reported 2,634 child ED visits due to asthma.

Hospitalizations among Children (0-17) for Primary Asthma Diagnosis 2020-2022

	ED Visits	Rate per 1,000 Children
Brooklyn	2,634	15.0
New York City	--	20.1
New York State excluding New York City	--	8.5

Source: New York State Department of Health

When asked to identify the top community health and wellbeing concerns for Brooklynites, nearly 40% of Key Stakeholder Survey participants chose housing needs. Participants identified a lack of affordable and safe housing due to increasing rents and home prices. More people are being displaced from their home or living in overcrowded units to share costs. There is a need for policies that protect tenants and prevent eviction, services for families with housing insecurity, and new approaches to housing development that preserve and expand affordable units. Improving the built environment through safe, clean, and accessible public spaces is also important to combat dense housing conditions.

KEY STAKEHOLDER SURVEY FEEDBACK:

"The Brooklyn Hospital Center can lead efforts by connecting healthcare with social support services. By screening patients for food insecurity and referring them to trusted community resources, TBHC can help bridge critical gaps. Our partnership with TBHC WIC at Williamsburg already supports families with nutrition education and essential services. TBHC can further its impact by hosting resource events, offering space for distributions, and advocating for policies that address basic needs and poverty."

"Host housing navigators or legal aid clinics at the hospital to assist patients in accessing emergency housing, rental assistance, or eviction prevention."

"Use the hospital's trusted voice to advocate for policies that expand affordable housing and protect vulnerable populations in the borough."

"Explore workforce housing partnerships or subsidies to help hospital employees, especially lower-wage staff, afford to live in the community they serve."

Community Recommendations to Improve Economic Stability

- Advocate for affordable housing policies, including preservation and expansion of units, and protections for populations placed at risk
- Expand and maintain safe, clean, and accessible public spaces to relieve overcrowded living conditions, foster community connections, and support health
- Explore alternative housing models, such as accessory dwelling units and community land trusts
- Host and support food distribution efforts across the borough
- Integrate housing and food security services within healthcare settings, including screening for support needs, case managers, and a referral network for resources
- Partner with local institutions to create job training opportunities, internships, and mentorship programs within the hospital
- Provide financial planning services for residents, including debt management, building credit, literacy, and saving practices

Maternal and Infant Health

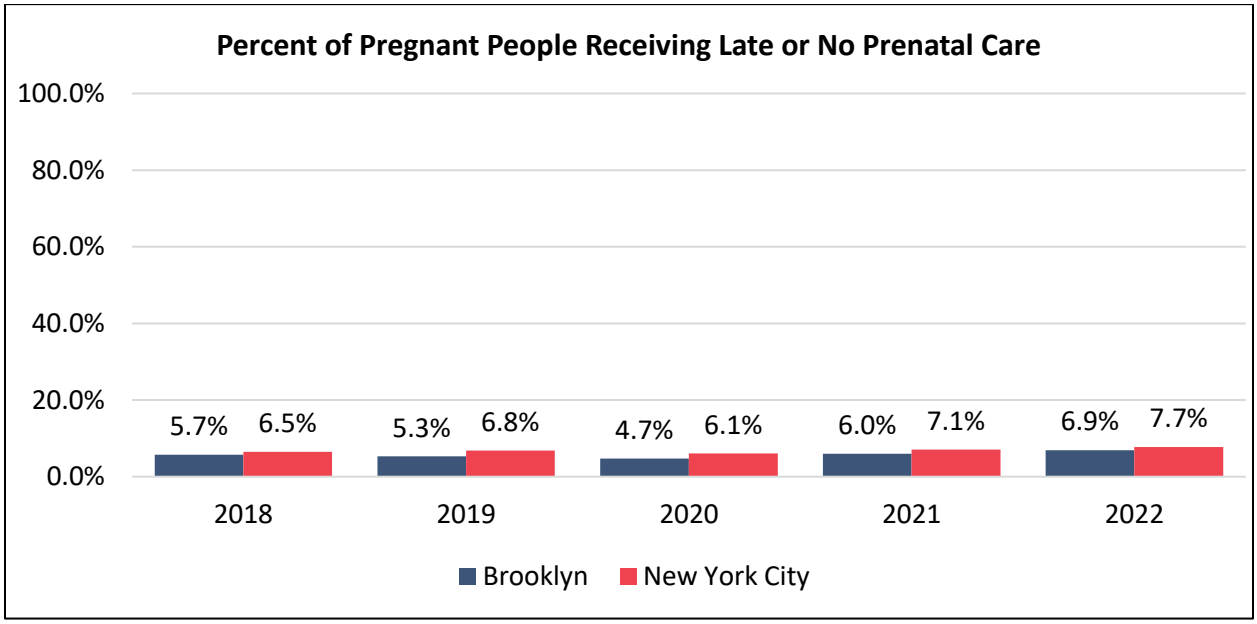
Brooklyn has a slightly higher birth rate than NYC and the nation, although it has declined consistently with national trends. The birth rate per 1,000 Brooklynites decreased from 14.3 in 2019 to 12.7 in 2022.

2022 All Births and Birth Rate per 1,000 Population

	Birth Count	Birth Rate per 1,000
Brooklyn	32,804	12.7
New York City	99,459	11.9
United States	3,667,758	11.0

Source: New York City Department of Health and Mental Hygiene & Centers for Disease Control and Prevention

Access to adequate prenatal care can have significant positive impact on maternal and infant health outcomes. In 2022, approximately 93% of pregnant people in Brooklyn received first trimester prenatal care, a similar proportion to NYC and the nation overall. However, access to prenatal care has declined and an increasing proportion of pregnant people receive late or no prenatal care.



Source: New York City Department of Health and Mental Hygiene

Despite declines in prenatal care access, pregnant people and babies in Brooklyn generally experience better birth outcomes than their peers citywide and nationally. Brooklyn saw a decline in births to teenagers, and the borough continued to meet the Healthy People 2030 goal for preterm births. The proportion of babies born with low birth weight is lower than NYC and national averages.

Positive prenatal and birthing outcomes are not shared by all residents and disparities exist between population groups. Populations of color continue to receive less prenatal care and experience a higher proportion of negative birth outcomes. Black and/or African American birthing people and babies continue to be placed at risk for many of these factors.

2022 Maternal and Infant Health Indicators

	Teen (15-19) Birth Rate per 1,000	Late or No Prenatal Care	Preterm Births	Low Birth Weight Births	Exclusive Breast Feeding*
Brooklyn	9.3	6.9%	8.4%	7.9%	38.9%
New York City	9.1	7.7%	9.6%	9.2%	40.4%
Asian, non-Hispanic	1.8	3.1%	9.3%	10.7%	--
Black and/or African American, non-Hispanic	9.2	7.7%	13.7%	14.2%	--
White, non-Hispanic	4.4	2.0%	7.3%	6.4%	--
Hispanic or Latinx (any race)	15.5	5.9%	10.9%	9.5%	--
United States	13.6	6.8%	10.4%	8.6%	NA
HP2030 Goal	NA	NA	9.4%	NA	NA

Source: New York City Department of Health and Mental Hygiene & Centers for Disease Control and Prevention
*During the first five days of life.

The infant death rate is widely used as a key indicator of community health because it reflects not only the health of infants but also the overall health and wellbeing of a population. It serves as an indication of factors like access to healthcare, socioeconomic conditions, and the quality of the environment.

Brooklyn has a lower infant death rate than NYC and the nation and meets the Healthy People 2030 goal. However, across NYC, the infant death rate for Black and/or African American infants is nearly three times higher than that for white infants born in the same community. Similar disparities are seen related to maternal deaths. Across all of New York State, pregnancy-related deaths are five times higher for Black, non-Hispanic pregnant persons than white, non-Hispanic pregnant persons. Structural racism and the associated social and environmental stresses experienced by people of color are at the root of these disparities, resulting in dramatically higher mortality rates for Black and/or African American people.

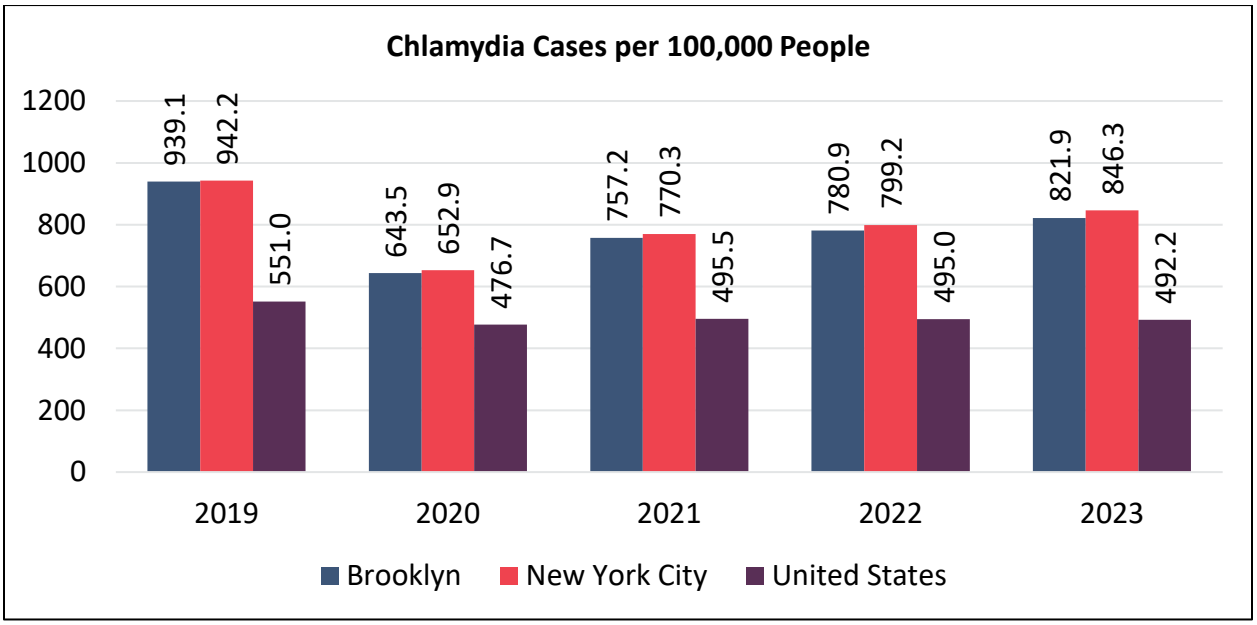
2022 Infant Deaths per 1,000 Live Births

	Infant Deaths per 1,000 Live Births
Brooklyn	3.3
New York City	4.3
Asian, non-Hispanic	1.9
Black/African American, non-Hispanic	7.6
White, non-Hispanic	2.7
Latinx (any origin)	4.9
United States	5.6
HP2030 Goal	5.0

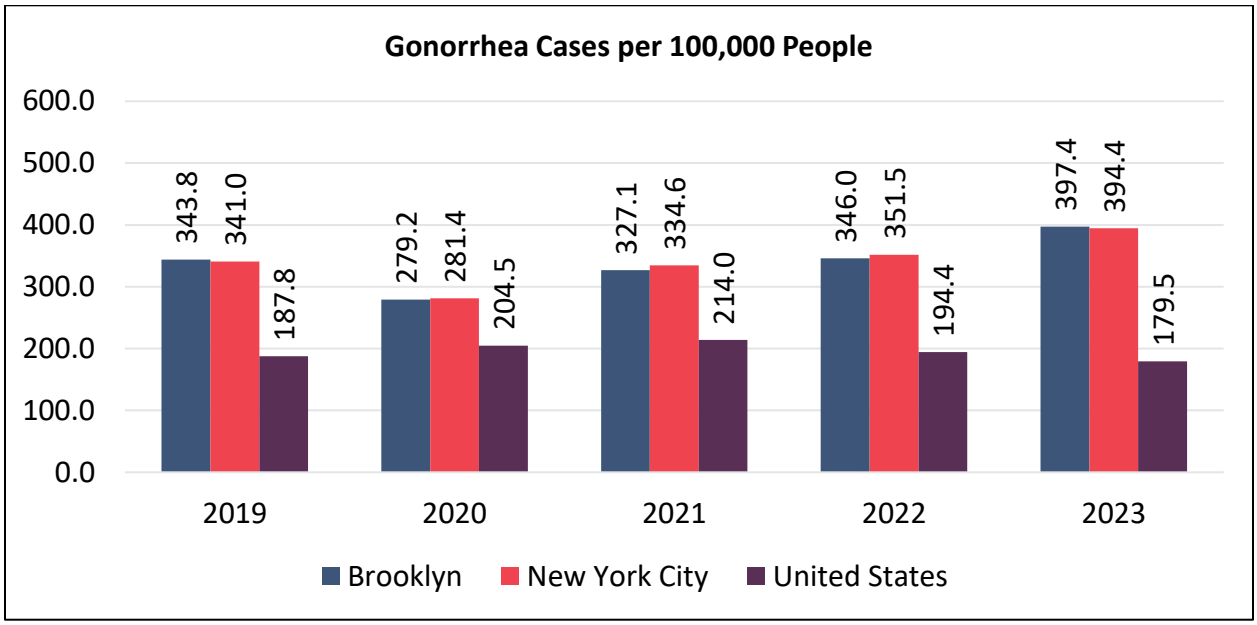
Source: New York City Department of Health and Mental Hygiene & Centers for Disease Control and Prevention

Sexually Transmitted Infections (STIs)

Brooklyn and NYC have consistently higher rates of chlamydia and gonorrhea than the nation. Chlamydia and gonorrhea infection rates fell in 2020, likely due in part to pandemic-related isolation, but they have been steadily rising in Brooklyn and citywide since then. The rate of chlamydia and gonorrhea cases per 100,000 Brooklynites is nearly twice the rate of the nation in 2023.



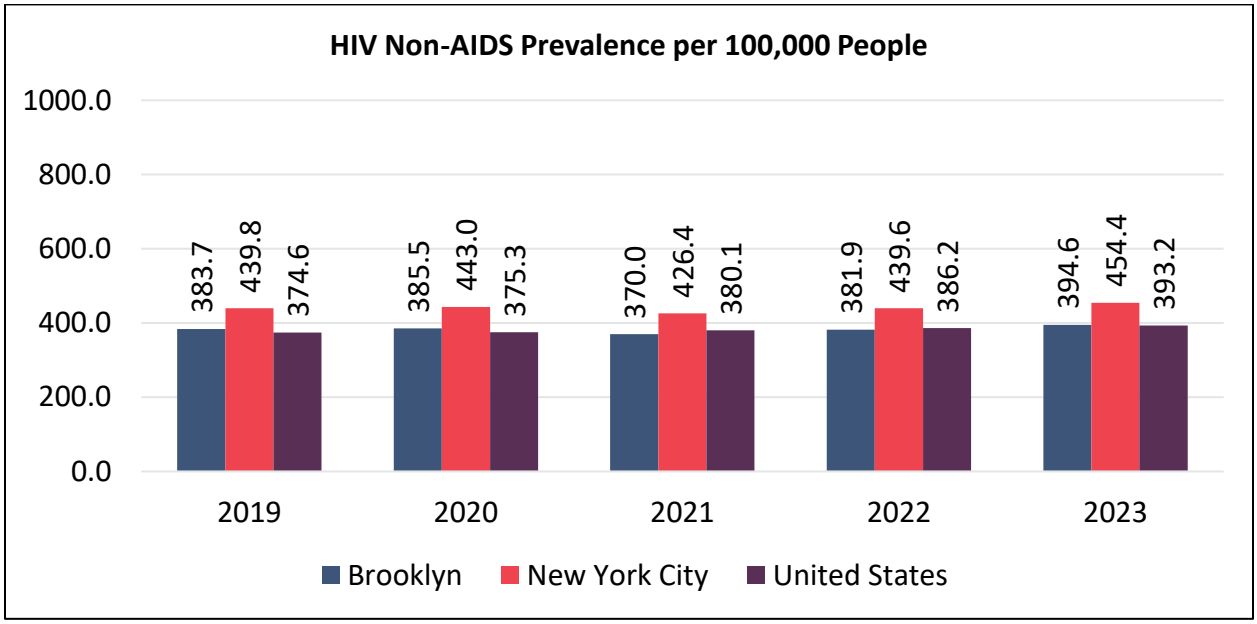
Source: Centers for Disease Control and Prevention and New York State Department of Health



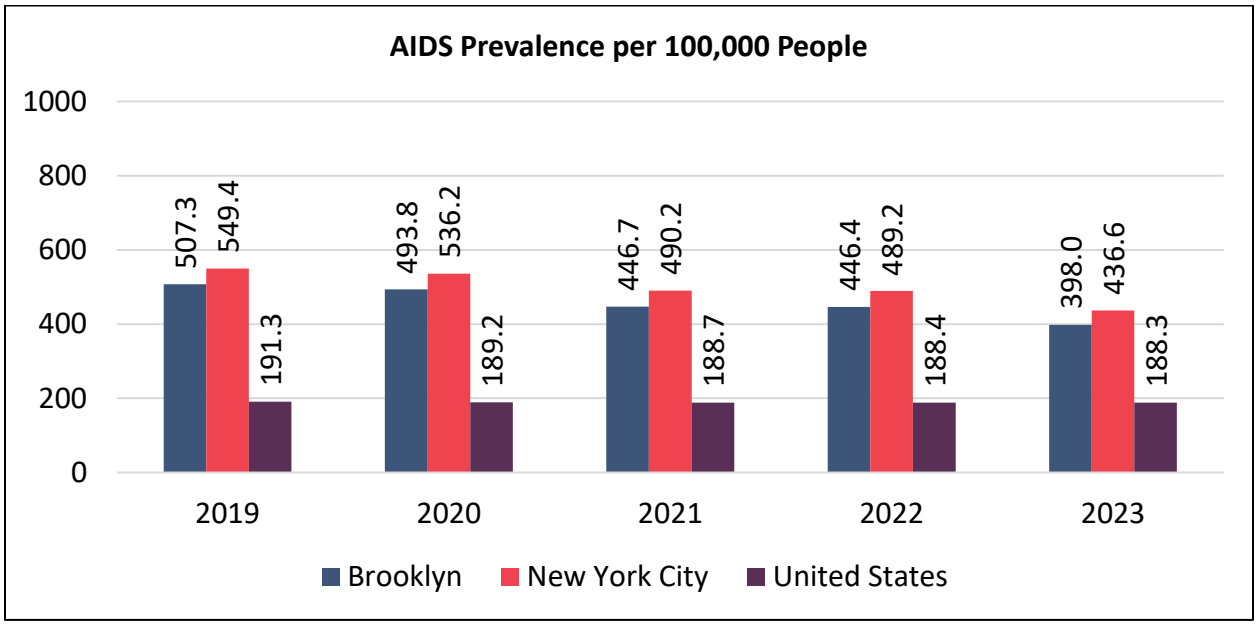
Source: Centers for Disease Control and Prevention and New York State Department of Health

Prevalence of human immunodeficiency virus (HIV) in Brooklyn is similar to the nation overall and lower than NYC averages. Recent increases in HIV prevalence in Brooklyn should continue to be monitored.

HIV is the virus that causes acquired immune deficiency syndrome (AIDS). AIDS prevalence in Brooklyn and NYC is more than double the prevalence nationally, although it has declined. AIDS is the most serious stage of HIV infection, at which point a person's immune system is severely weakened and vulnerable to opportunistic infections. Opportunistic infections are ones that someone with a healthy immune system could typically fight off but that cause serious illness in a person with AIDS. With proper and consistent treatment, HIV can be managed indefinitely, effectively preventing the progression to AIDS.



Source: Centers for Disease Control and Prevention and New York State Department of Health



Source: Centers for Disease Control and Prevention and New York State Department of Health

Community Assets to Address Identified Health Priorities

Community assets and resources, including organizations, people, policies, and physical spaces, elevate quality of life for residents. Identifying the assets that exist in Brooklyn is an important component of the CHNA, both to mobilize and employ resources to address identified health issues, as well as to address existing gaps in services.

The following section highlights available assets and resources at TBHC and within Brooklyn Community District 2. Brooklyn Community District 2 is one of 59 geographically exclusive, independent City agencies that serve as the most local form of representative government in NYC. Brooklyn Community District 2 covers most of TBHC's primary service area, including Downtown Brooklyn, Boerum Hill, Brooklyn Heights, Clinton Hill, DUMBO, Fort Greene, Fulton Ferry, Navy Yard, and Vinegar Hill.

The Brooklyn Hospital Center Clinical Services

The Brooklyn Hospital Center offers a full range of comprehensive primary and subspecialty medical care. The following select services are available to address the identified CHNA priority areas.

Priority Area: Nutrition Security

- Community Affairs Department (community information and referral)
- Women, Infants and Children (WIC) Program Centers

Priority: Prevent Preventive Services for Chronic Disease Prevention and Control

- Community Affairs Department (community information and referral)
- Department of Family Medicine
- Departments of Pediatrics
- Dialysis Services
- Division of Endocrinology
- Geriatrics Care Center
- Smoking Cessation
- The Brooklyn Cancer Center
- The Brooklyn Heart Center
- Vaccine Center

Priority: Prevention of Infant and Maternal Mortality

- Gynecological Care
- Obstetric Care
- Perinatal Care and Sonography
- The Prenatal Care Services Program (uninsured/underinsured coverage)
- Women, Infants and Children (WIC) Program Centers

Brooklyn Community District 2 Resources

Note: The list is not intended to be a comprehensive assessment of all services available to Brooklyn residents and may not capture the many critical programs offered by agencies across the borough.

Multi-Service Providers

Arab-American Family Support Center 150 Court Street, 3rd Floor, Brooklyn NY 11201 Phone: 718-643-8000 Email: info@aafscny.org	**HeartShare Human Services of New York** 12 Metrotech Center, 29th Floor, Brooklyn NY 11201 Phone: 718-422-4200 Email: info@heartshare.org
Brooklyn Community Services 151 Lawrence Street, Floor 4, Brooklyn NY 11201 Phone: 718-310-5600	**Helen Keller Services for the Blind** 180 Livingston Street, Brooklyn NY 11201 Phone: 718-522-2122 Email: info@helenkeller.org
Brownsville Neighborhood Health Action Center 259 Bristol Street, Brooklyn NY 11212	**ICL (formerly the Institute for Community Living)** 125 Broad Street, New York NY 10004 Phone: 844-425-4673 Email: iclhope@iclinc.org
Catholic Charities Brooklyn and Queens 191 Joralemon Street, Brooklyn NY 11201 Phone: 718-722-6000	**Partnership for the Homeless** 305 Seventh Avenue, 14th Floor, New York NY 10001 Phone: 212-645-3444 Email: info@thepartnershipnyc.org
Families United for Racial and Economic Equality 388 Atlantic Avenue, 2nd Floor, Brooklyn NY 11217 Phone: 718-852-2960 Email: info@furee.org	**Services for the Underserved** 463 7th Avenue, 17th Floor, New York NY 10018 Phone: 212-633-6900 Email: info@sus.org
Fifth Avenue Committee 621 DeGraw Street, Brooklyn NY 11217 Phone: 718-237-2017 Email: fac@fifthave.com	**VOCAL-NY** 300 Douglass Street, Brooklyn NY 11217 Phone: 718-802-9540 Email: info@vocal-ny.org

Early and Special Education

Alonzo A. Daughtry Memorial Day Care Center 565 Baltic Street, Brooklyn NY 11217 Phone: 718-596-1993 Email: info@daughtrydaycare.org	**Mary McDowell Friends School** 20 Bergen Street, Brooklyn NY 11201 Phone: 718-625-3939
Child Development Support Corp. 352-358 Classon Ave, Brooklyn NY 11238 Phone: 718-398-2050 Email: info@cdscnyc.org	**The Sterling School** 134 Atlantic Ave, Brooklyn NY 11201 Phone: 917-909-0942 Email: admin@sterlingschool.com
Brooklyn Autism Center 57 Willoughby Street, 3rd Floor, Brooklyn NY 11201 Phone: 718-554-1027 Email: info@brooklynautismcenter.org	**Young Minds Child Care Center** 972 Fulton Street, Brooklyn NY 11238 Phone: 718-622-8622
League Education & Treatment Center 483 Clermont Avenue, Brooklyn NY 11238 Phone: 718-643-5300 Email: info@leaguecenter.org	

Health

The Brooklyn Hospital Center 121 DeKalb Avenue, Brooklyn NY 11201 Phone: 718-250-8000 *Additional services listed below	**Lafayette Child Health Clinic** 434 DeKalb Avenue, Brooklyn NY 11205 Phone: 718-638-8258
Brooklyn Plaza Medical Center 650 Fulton St, Brooklyn, NY 11217 Phone: 718-596-9800	**START Treatment & Recovery Center** 937 Fulton Street, Brooklyn, NY 11238 Phone: 718-789-1212 Email: info@startny.org
Cumberland Diagnostic and Treatment Center 100 North Portland Avenue, Brooklyn NY 11205 Phone: 718-260-7835	

Senior Centers and Services

Cobble Hill Health Center 380 Henry Street, Brooklyn NY 11201 Phone: 718-855-6789 Email: info@cobblehill.org	**RAICES Times Plaza Neighborhood Senior Center** 460 Atlantic Avenue, Brooklyn NY 11217 Phone: 718-694-0895 Email: admin@raices.us
Farragut Senior Center 228 York Street, Brooklyn NY 11201 Phone: 718-422-1069	**St. Charles Jubilee Senior Center** 55 Pierrepont Street, Brooklyn NY 11201 Phone: 718-855-0326
Grace Agard-Harewood Senior Center 966 Fulton Street, Brooklyn NY 11238 Phone: 718-638-6910	**Willoughby Neighborhood Senior Center** 105 North Portland Avenue, Brooklyn NY 11205 Phone: 718-875-1011
Heights and Hill Community Council 81 Willoughby Street, Suite 302, Brooklyn NY 11201 Phone: 718-596-8789 Email: info@heightsandhills.org	**Wyckoff Garden Neighborhood Senior Center** 280 Wyckoff Street, Brooklyn NY 11217 Phone: 718-237-1802

Women and Families

Center for Anti-Violence Education 30 Third Ave, Suite 104, Brooklyn NY 11217 Phone: 718-788-1775 Email: caeinfo@caeny.org	**Safe Horizon** 50 Court Street, 9th Floor, Brooklyn NY 11201 Phone: 718-943-8631 Email: help@safehorizon.org
Brooklyn Family Justice Center 350 Jay Street, 16th Floor, Brooklyn NY 11201 Phone: 718-250-5111	**La Leche League Fort Greene + Clinton Hill** Phone: 718-643-9219
Planned Parenthood of New York City **Joan Malin Brooklyn Health Center** 44 Court Street, 6th Floor, Brooklyn NY 11201 Phone: 212-965-7000	**Brooklyn Perinatel Network** 259 Bristol Street, Suite 242, Brooklyn NY 11212 Phone: 718-643-8258 Email: info@bpnetwork.org

Youth Services

Children of Promise, NYC 54 MacDonough Street, Brooklyn NY 11216 Phone: 718-483-9290 Email: info@cpnyc.org	**Madison Square Boys & Girls Club** **Navy Yard Clubhouse** 240 Nassau Street, Brooklyn NY 11201 Phone: 718-625-4295

Our Response to The Community's Needs

In 2022, TBHC conducted a similar CHNA and developed a supporting three-year Community Service Plan (CSP) to address identified priority health areas. Based on the 2022 CHNA findings, TBHC leadership identified three priority areas:

- Prevent Chronic Diseases
- Prevent Communicable Diseases
- Promote Wellbeing and Prevent Mental and Substance Use Disorders

TBHC invested in population health management strategies and partnered with diverse community agencies across Brooklyn to fund programs and initiatives aimed at addressing the identified priority areas. The system measured contributions and impact from these investments, as outlined below.

Community Outreach and Engagement

The goal of the TBHC Community Affairs Department is to create community-based, community-focused, and community-driven programs that will be sustainable and impactful and will serve to improve the health of families. The department runs an active programming calendar working with places of worship, senior citizen centers, schools, elected officials, local police precincts, cultural and community institutions, community boards, and TBHC's Community Advisory Board, among others.

From January 2023 to November 2025, TBHC participated in more than 407 events and activities to improve the health and wellness of community members. Health promotion programs encompassed broad health topics, as outlined below, and often aligned with National Health Observances, i.e., American Heart Month (February), Colorectal Cancer Awareness Month (March), Men's Health Month (June), Breast Cancer Awareness Month (October), American Diabetes Month (November), and World AIDS Day (December).

Health Fairs and Screenings	Health Lectures/Education		Kids Health
• Ambulance services • Asthma • AIDS/HIV testing • Blood pressure • Cholesterol • Dental care • Hearing • Nutrition education • Podiatry • Senior health	• BMI and Obesity • Colon cancer • COVID-19 and vaccines • Death and grieving • Diabetes • Heart disease prevention • HIV prevention • Hospice care • Lung Cancer • Medication management • Men's health: prostate cancer	• Orthopedics/ Sports Medicine • Pain management • Sexual health/ contraceptives • Smoking cessation • Stress management • Stroke • Weight loss-bariatric surgery • Women health: OB/GYN, mammograms, breast health • Wound care • Vascular health	• Asthma • Breastfeeding • Dental care • General health • Mental health • Nutrition • Vaccines/Immunization • WIC participation

At health fairs, TBHC provided free blood pressure screenings and other services to community members. Some of the screenings have identified members at risk of a hypertensive emergency and resulted with members being linked to emergency, primary, and/or specialty care. Many of these programs were offered in collaboration with community groups and elected officials.

Community Partner Organizations:

- 20-K1 Leos YMCA
- Arab American Association
- Arab American Family Support Center
- Assemblyman
- Atlantic Terminal Family and Friends
- Beacon Community and Family Life Center
- Bed-Sty Alive
- Boys and Girls Club
- Brooklyn Adult Learning Center
- Brooklyn Borough President's Office
- Brooklyn Care Team
- Brooklyn Center for Independence of the Disabled
- Brooklyn Community Services
- Brooklyn Education Opportunity Center State University of NY
- Brooklyn Libraries
- Brooklyn Metropolis Lions Club
- Brooklyn Navy Yard
- Brooklyn Perinatal Network, Inc.
- Brooklyn STEAM Center
- CABS Health Network
- CAMBA
- Caribbean Women's Health Association
- Churches (Bedford Central Presbyterian, Emmanuel Baptist, NYC SDA Baptist, St. Nicholas Cathedral Church, First Calvary Baptist, St. Paul's)
- Colleges & Schools (Franklin D. Roosevelt High School, Medgar Ever College, Pratt College, St. Francis College, St. Joseph's College, United Family of Stars, NYC College of Technology CUNY)
- Community Boards 2, 3, 9, and 16
- Community Centers
- Community of People Organization (COPO)
- Council Of Peoples Organization
- Daycare Centers
- Department of Parks and Recreation
- Downtown Brooklyn Partnership
- Eagle Academy for Young Men
- Erasmus Hall High School
- Family Worship Center
- Federal Bureau of Investigation (FBI) – New York City
- Fire Department of New York (FDNY)
- First Atlantic Terminal Housing Corporation
- Fort Greene Children & Family Services Early Head Start
- Fort Greene Council, Inc Grace Agard Harewood NC-Senior Center
- Fort Greene Park Conservancy
- Gibran International Academy
- Graham's Brooklyn Back to School
- Harbor Senior Apartment Seniors
- K588 Middle School Crown Heights Beacon & P.S 138
- LIU
- Moroccan American House Association
- Mosques i.e. Masjid Al-Ihsan, Masjid Al- Taqwa
- Muslim Community Engagement Council
- Myrtle Avenue Brooklyn Partnership
- New Directions Alcoholism and Substance Abuse Treatment Program
- Northside Center for Child Development
- NYC Administration for Children's Services
- NYC Department of Education
- NYC Department of Health and Mental Hygiene
- NYC Employees Retirement System
- NYC Housing Authority (NYCHA) i.e. Ingersoll and Farragut Housing Developments
- NYC Mayor's Office
- NYC Police Department i.e. 88th Precinct, School Safety Division
- NYPD School Safety Division Autism
- Office of Faith-Based Initiatives at the NYC Department of Health and Mental Hygiene
- Oxford Nursing Home
- Police Athletic League
- Power of Hope
- Pratt Institute
- P.S. 156 Waverly School of the Arts
- Red Hook Older Adult Center
- Refugee and Immigrant Center for Education and Legal Services (RAICES)

Offices of Elected Officials Partners:

- Brooklyn Borough President, Antonio Reynoso
- New York City Council Members, Chris Banks, Crystal Hudson, and Mercedes Narcisse
- New York State Assembly Member, Phara Souffrant Forrest - Assembly District 57
- New York State Assembly Member, Jo Anne Simon – Assembly District 52
- U.S. House of Representatives
    - Congressman Hakeem Jeffries (NY-08)
    - Congresswoman Nydia M. Velázquez (NY-07)
    - Congresswoman Yvette D. Clarke (NY-09)

Health Equity & Addressing Health-Related Social Needs

TBHC adopted a Population Health Plan in 2025 to address disparities in health and healthcare for its patients. The Board of Trustees at TBHC and executive leadership are committed to this initiative and have established accountability structures that include The Health Access Committee of the Board of Trustees and TBHC's The Health Access Committee.

As part of the Population Health Plan, TBHC will implement the following quality improvement projects:

1. Improve the collection of patient demographic data of race and ethnicity to better track and respond to health disparities
2. Improve the process for screening for social drivers of health (SDoH), and implement screening for emergency department treat and release patients and all primary care centers at TBHC
3. Engage with a social care network so that patients receive appropriate services when health related social needs are identified through SDoH screening
4. Reduce preventable readmission rates

The Health Access Committee is charged with overall action planning to advance health equity among TBHC's patient populations. The Health Access Committee ensures that there is data collection on SDoH across all patient populations at TBHC; identifies existing internal programs and services and external community-based partnerships that are available to help address health-related social needs (HRSN); determines the demographic characteristics to be used during analysis of HRSN information; compares quality and safety data, including health outcomes when appropriate, for various demographic categories; identifies healthcare disparities in the hospital's patient population; and ensures that actions are taken to address healthcare disparities.

TBHC is in the process of engaging with a community resource or social care network to better coordinate the referrals of patients with HRSNs. At this time, emergency department or admitted patients who screen positive for any SDoH are referred to NADAP, a community service organization for underserved New Yorkers in and around the five boroughs that helps them enroll in healthcare, find work, receive community support, and access the resources they need to improve their mental, physical, emotional, and financial wellbeing. In addition, TBHC's primary care centers maintain a list of community-based organizations to refer patients with HRSNs.

TBHC is the largest provider of the Women, Infants and Children (WIC) Program in Brooklyn, operating seven WIC locations throughout the borough. WIC program centers provide nutrition education and counseling; breastfeeding education and peer support; monthly assistance for healthy food, baby food, formula and more; and healthcare services to pregnant and breastfeeding people and infants and children up to age 5. The WIC Farmers' Market Nutrition Program provides coupons to eligible participants to purchase fresh, local produce at participating farmers' markets, farm stands, and mobile markets in Brooklyn.

Current average monthly enrollment in the TBHC WIC program is 27,500 people, exceeding the state assigned caseload (20,700) by more than 130%. The WIC program demonstrated the following outcomes for participants in 2025:

- 95.3% of participants initiated breastfeeding
- 72.5% of participants were breastfeeding at 6 months post-birth
- 39.1% of participants were breastfeeding at 12 months post-birth
- 95.8% of participants received Farmers' Market Nutrition Program benefits
- 7.9% of infants were born with low birth weight
- 4.2% of infants were born with high birth weight
- 13.7% of children were diagnosed with anemia

Clinical Excellence

The Brooklyn Cancer Center (TBCC) was established through a partnership between New York Cancer & Blood Specialists (NYCBS), one of the leading oncology practices in the nation, and TBHC. Residents of Brooklyn no longer need to travel out of the borough for excellent cancer care. The Brooklyn Cancer Center provides cutting-edge oncology care, including access to clinical research trials, and culturally sensitive services for patients with all types of cancer and blood disorders.

As part of its commitment to quality cancer care, TBHC aimed to increase screening rates for cancers and facilitate early detection and treatment for conditions. TBHC conducted community outreach activities for breast, cervical, and colorectal cancer screenings, and provided these screenings for uninsured and underinsured people throughout Brooklyn. Cancer screening rates among eligible patients who received primary care at TBHC show the following outcomes:

Percentage of Eligible TBHC Primary Care Patients Screened for Cancer

Cancer Screening Type	2022	2023	2024
Breast	79%	76%	79%
Cervical	69%	65%	64%
Colon	61%	68%	63%

TBHC continues to be a leader in providing comprehensive cardiovascular care, including care for heart-attack events and congestive heart failure (CHF). With heart emergencies, time saved equals lives saved. Recent statistics show that TBHC patients save even more time because its “door-to-balloon”

performance is speedy. According to the American Heart Association and the American College of Cardiology, the recommended time from a first medical contact to cardiac intervention such as a balloon stent is 90 minutes or less. TBHC consistently does much better than that, regularly beating the New York State percentages.

The CHF program at TBHC is aligned with quality measures outlined by the American Heart Association and American College of Cardiology Foundation. The program aims to decrease readmissions, particularly for Medicaid patients. TBHC also continued percutaneous cardiac interventions (PCI) for local residents, allowing faster access and better outcomes delivered close to home.

Cardiac services have expanded at TBHC. TBHC added new services for the treatment of varicose veins and cardiopulmonary testing to assess heart and lung function, as well as a new bicycle for cardiac stress testing for patients with difficulty walking. TBHC aims to open a new cardiac rehabilitation center in 2026.

TBHC takes a multi-disciplinary team approach to diabetes care and management that includes experts in endocrinology, primary care, nutrition, pharmacy, and outreach support. The approach emphasizes patient goals, addressing barriers to goal attainment, and updated patient medication regimens to improve diabetes outcomes. TBHC received American Diabetes Association recognition for Diabetes Education. This recognition was achieved by demonstrating standards for Diabetes Self-Management Education and Support for patients.

Diabetes management for patients who received primary care at TBHC shows the following outcomes:

Diabetes Management Outcomes for Eligible TBHC Primary Care Patients

	2022	2023	2024
A1c less than 9 (good control)	84%	86%	85%
Received preventive eye exam	60%	59%	55%

In response to the community's growing mental health challenges and limited available community resources, TBHC added a psychiatric nurse practitioner in 2022 to support patients with anxiety and/or depression. The service was originally offered virtually for video or telephone consultation. In 2024, TBHC expanded telepsychiatry services to include additional providers, added in-person care, and began offering complete consultations for patients in the emergency department or admitted to the hospital. From January 2023 to October 2025, 3,312 psychiatry visits were completed.

The PATH Center continues to play a vital role in preventing communicable diseases and advancing health equity for Brooklyn residents living with or at risk for HIV. By combining evidence-based medical care with comprehensive support services and innovative treatment options like injectable Cabenuva, TBHC ensures patients achieve optimal health outcomes while addressing structural and social barriers that perpetuate disparities. Through ongoing quality improvement, interdisciplinary collaboration, and community-centered approaches, the PATH Center remains at the forefront of HIV prevention and care in New York City.

The PATH Center demonstrated the following outcomes for people living with or at-risk of HIV/AIDS:

- **Zero HIV-Positive Births:** TBHC has not recorded an HIV-positive birth in over two decades. The PATH Center convenes interdisciplinary case conferences involving obstetrics/gynecology, pediatrics, pharmacy, social work, and community partners to coordinate care for all pregnant HIV-positive patients. This team-based approach ensures appropriate treatment and follow-up to prevent mother-to-child transmission.
- **Comprehensive HIV Care**: The PATH Center provides HIV care and treatment to more than 1,100 patients annually. All patients receive mental health, substance use, SDoH, and nutrition screenings with timely referrals for services as indicated. Health education, adherence counseling, and risk reduction interventions are integrated into all clinical visits.
    - In 2024, 93% of patients achieved viral load suppression (<200 copies/mL). The goal for 2025 and beyond is 99%.
    - The PATH Center has exceeded its retention in care goal of 80%, achieving 92% of patients completing at least two medical visits per year.
- **HIV Testing and Early Linkage**: The PATH Center continues to offer free, rapid HIV testing to identify new infections, increase awareness among at-risk groups, and facilitate immediate linkage to care. The Center also collaborates with TBHC's emergency department to connect patients undergoing repeat HIV or STI testing with PrEP services through a warm handoff process.
- **Wraparound and Supportive Services:** The PATH Center maintains a diverse network of referral partners to address non-medical barriers to care. A key partner, Council on Adoptable Children (COAC), provides intensive care navigation to high-needs patients—offering appointment reminders, transportation coordination, directly observed therapy, and ongoing communication with PATH providers.
    - In 2023, PATH was awarded the Retention and Adherence Grant through the NYS AIDS Institute. This grant supports intensive case management for patients facing environmental and social barriers to care. Strategies include individualized service planning, appointment accompaniment, linkage to housing/financial resources, home visit reassessments, and coaching on communication device management.
- **Advancing HIV Prevention through Long-Acting Injectable Therapy:** The PATH Center remains a leader in implementing long-acting injectable HIV treatment options, notably Cabenuva (cabotegravir/rilpivirine). Currently, 125 HIV-positive and PrEP patients are enrolled in the bi-monthly injectable program, which has proven particularly effective for patients facing challenges with daily oral adherence and stigma related to medication use. The program includes individualized care planning, adherence monitoring, and integration with case management to maximize engagement and viral suppression outcomes.

2026-2028 Community Service Plan

Prioritization Process and Identified Priorities

To improve community health, it is imperative to prioritize resources and activities toward the most pressing and cross-cutting health needs. In determining the issues on which to focus efforts over the next three-year cycle, TBHC collected feedback from community stakeholders and aligned its efforts with the New York State Prevention Agenda. TBHC engaged in conversation with its Community Advisory Board to better align the CSP with existing and planned community initiatives and met with its clinical leaders to create alignment with system population health management strategies.

The Prevention Agenda is New York's State Health Improvement Plan. It is aimed at improving the health status of individuals in New York and reducing health disparities through a strong emphasis on prevention. The 2025-2030 Prevention Agenda outlines 24 key priorities to address health conditions, behaviors, and systemic issues such as poverty, education, housing, and access to quality healthcare.

TBHC's leaders applied the following criteria to define Prevention Agenda priorities for the hospital:

- Prevalence of health disparity and number of community members affected
- Prevalence of health disparity compared to city, state, and national benchmarks
- Existing programs, resources and expertise to address issues
- Input from community partners and representatives
- Alignment with concurrent public health and social service organization initiatives

Based on the CHNA, TBHC will focus on the following New York State Prevention Agenda priorities:

Nutrition Security

Preventive Services for Chronic Disease Prevention and Control

Prevention of Infant and Maternal Mortality

The identified priorities represent key disparities affecting Brooklyn residents and are aligned with TBHC's existing resources and initiatives to advance healthcare access. The following sections highlight evidence-based interventions, strategies, and activities being implemented by TBHC as part of its CSP to address the specific priorities and associated health disparities.

TBHC 2026-2028 Community Service Plan

The 2026-2028 CSP builds upon previous health improvement activities, while advancing new opportunities that recognize emerging health challenges and a focus on healthcare access. The following is a summary of TBHC's 2026-2028 CSP, outlining goals, objectives, strategies, and process measures for addressing the identified priority areas.

Priority Area: Nutrition Security

Goal: Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods.

Objectives: Screening for Social Drivers of Health (SDoH)

- Increase screening rate for SDoH for admitted patients from 30% in calendar year (CY) 2024 to 60% by end of CY 2025 and 80% by end of CY 2026.
- Implement a process for SDoH screening for emergency department (ED) treat and release patients and establish baseline screening rates.
- Increase referrals to appropriate community resources and support for patients that screen positive for health-related social needs (HRSNs).

Intervention	Population of Focus	Anticipated Impact
Conduct standardized screening of unmet HRSNs and provide referrals to state, local, and federal benefit programs and community-based providers to address unmet needs	TBHC Inpatient and ED Patients	• Percentage of admitted patients screened for SDoH • Percentage of ED treat and release patients screened for SDoH
Develop a robust referral process through a social care network so that patients receive appropriate services when HRSNs are identified	TBHC Inpatient and ED Patients	• Establishment of social care network and related referral process • Percentage of patients with identified HRSNs connected with appropriate services
Provide staff training to promote awareness of SDoH and their impact on patient health outcomes and effective screening practices	TBHC Staff	• Number of staff trained on SDoH and effective patient screening practices
Anticipated Resources:		
▪ Health Access Committee staffing, time, and training ▪ IT infrastructure ▪ Education funding		

Objectives: Women, Infants and Children (WIC) Program

- Maintain or increase WIC program enrollment, estimated at 27,500 per month.
- Maintain or increase participation in the WIC Farmers' Market Nutrition Program (WIC FMNP), estimated at 95%.

Intervention	Population of Focus	Anticipated Impact
Provide nutrition education and counseling; breastfeeding education and peer support; monthly assistance for healthy food, baby food, formula and more; and healthcare services to pregnant and breastfeeding people and infants and children up to age 5	WIC Program Participants	• Percentage of WIC participants initiating breastfeeding and maintaining at 6- and 12-months post-birth • Percentage of child participants with anemia • Percentage of infants with low birth weight
Provide the WIC FMNP, offering coupons to eligible participants to purchase fresh, local produce at participating farmers' markets, farm stands, and mobile markets in Brooklyn	WIC Program Participants	• Percentage of participants enrolled in WIC FMNP • Percentage of child participants with anemia • Percentage of infants with low birth weight
Anticipated Resources:		
▪ WIC staffing and location maintenance ▪ Community education and outreach funding		

Objective: Equitable Food Procurement

- Support policies and practices the promote equitable procurement of food services.

Intervention	Population of Focus	Anticipated Impact
Implement values-based food procurement practices, such as increasing food purchases from minority and women-owned businesses, to create a more equitable, accountable, and transparent food system	TBHC Procurement	• Food services and goods procured from minority and women-owned businesses
Anticipated Resources:		
▪ Staffing and education		

Priority Area: Preventive Services for Chronic Disease Prevention and Control

Goal: Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases.

Objectives: Prevention and Screening Practices

- Increase the percentage of eligible TBHC primary care patients who receive recommended breast, cervical, and colon cancer screenings from 2024 baselines of 79% (breast), 64% (cervical), and 63% (colon).
- Ensure timely and appropriate access to tests for high blood sugar or diabetes for TBHC primary care patients.
- Maintain high community engagement and robust community partnership to provide health education and access to preventive screenings and services.

Intervention	Population of Focus	Anticipated Impact
Implement policies and practices to routinely test adult patients for diabetes and risk for future diabetes	TBHC Primary Care Patients	• The percentage of eligible adults who had a test for high blood sugar or diabetes within the past year
Implement policies and practices to routinely screen adult patients for cancer based on recommended guidelines	TBHC Primary Care Patients	• The percentage of eligible adults who receive breast, cervical, and colon cancer screenings based on the most recent guidelines
Partner with community agencies to promote access to disease prevention and screening services	Community Residents, Populations Placed at Risk	• Number of community events, screenings, and participants • Number of community members identified with disease and referred to care services
Partner with community agencies to support community mental health education and mental wellness programs (e.g., walking programs, yoga, physical activity)	Community Residents, Populations Placed at Risk	• Number of community events, screenings, and participants
Anticipated Resources:		
▪ Community Affairs Department staffing and time ▪ Community investments in education and preventive services ▪ IT infrastructure		

Objectives: Addressing Disparities in Healthcare

- Improve the collection of patient demographic data of race and ethnicity to better track health disparities; reduce race "unknown" and ethnicity "other" as first step from 10% to 8% by end of CY 2025 and <6% by end of CY 2026.
- Improve patient outcomes by addressing identified health disparities within TBHC care processes.

Intervention	Population of Focus	Anticipated Impact
Implement training for registration staff and electronic medical record improvements to accurately collect patient demographic information at first point of contact	TBHC Inpatient and ED Patients	• Accurate and complete collection of patient race, ethnicity, age, and preferred language information
Conduct standardized screening for patients' unmet HRSNs	TBHC Inpatient and ED Patients	• Percentage of admitted patients screened for SDoH • Percentage of ED treat and release patients screened for SDoH
Work with the Health Access Committee to ensure patient data collection, review quality and safety data for various demographic categories, identify healthcare disparities, and ensure that actions are taken to address disparities	TBHC Patient Populations	• Accurate and robust analysis of patient HRSNs and quality outcomes • Reduction in healthcare disparities
Engage TBHC's Community Advisory Board to help identify and respond to community health needs and strengthen the hospital's link to the community	TBHC Community Advisory Board	• New and/or strengthened community partnerships
Anticipated Resources:		
▪ Health Access Committee staffing, time, and training ▪ IT infrastructure ▪ Training and education funds		

Objectives: Chronic Disease Control

- Maintain or increase the percentage of adult patients with diabetes whose most recent HbA1c level indicated good control from the 2024 baseline of 85%.
- Establish a clinical team to monitor and reduce 14-day potentially preventable readmission rates.
- Ensure timely and appropriate access for patients experiencing cardiac events.

Intervention	Population of Focus	Anticipated Impact
Promote a team-based approach (including endocrinology, primary care, nutrition, and pharmacy) for diabetes care and management	TBHC Diabetes Patients	• Percentage of patients receiving regular care and recommended screenings (e.g., eye care) • Number of patients with reported better control of their condition based on HbA1c levels
Provide evidence-based self-management interventions for individuals with diabetes and/or heart disease	TBHC Diabetes and Heart Disease Patients	• Percentage of patients with reported control of their condition
Provide multidisciplinary care addressing the health, social, and spiritual needs of older adults, including long-term planning and caregiver support	TBHC Older Adult Patients	• Hospital utilization (readmissions, ED visits) for patients • Patient perceived functional ability/independence
Anticipated Resources:		
▪ Clinical Staffing ▪ IT infrastructure ▪ Training and education funds		

Objectives: People Living with HIV or AIDS

- Increase the proportion of patients with diagnosed HIV who achieve viral load suppression to 99%, focusing on Medicaid, BIPOC, and LGBTQIA+ communities.
- Increase the proportion of patients with diagnosed HIV who complete at least two medical visits per year to 92%.
- Expand access to wraparound and supportive services for Medicaid members.
- Ensure 100% of pregnant HIV-positive patients receive prenatal HIV testing, treatment, and follow-up.

Intervention	Population of Focus	Anticipated Impact
Link and retain persons newly diagnosed with HIV and/or struggling with treatment adherence to care	TBHC PATH Center Patients	• Percentage of patients with ≥2 HIV medical visits per year • Percentage of patients achieving viral load suppression • Tracking outcomes by demographic factors
Facilitate supportive, wraparound services for Medicaid patients living with HIV	TBHC PATH Center Patients	• Number of patients receiving case management • Number screened for SDOH and referred • Percentage of patients achieving viral load suppression
Coordinate care for pregnant HIV-positive people to prevent perinatal transmission	TBHC PATH Center Patients	• Number receiving prenatal HIV testing and antiretroviral therapy • Number followed by PATH OB rounds • Maintain zero HIV-positive births
Facilitate access to PrEP for high-risk persons	TBHC Patient Populations	• Number assessed and prescribed PrEP • Number achieving continuity of PrEP care
Implement emergency department warm handoff program for PrEP services	TBHC Patient Populations	• Proportion of identified patients referred to PrEP • Number linked to services • Number of new HIV diagnoses linked to treatment
Partner with community agencies to promote prevention and education	Brooklyn Community	• Number of community events, screenings, and participants
Anticipated Resources:		
▪ Clinical Staffing ▪ IT infrastructure ▪ Community Affairs Department staffing and time ▪ Community investments in education and preventive services		

Priority Area: Prevention of Infant and Maternal Mortality

Goal: Improve health outcomes by lowering mortality and morbidity rates for infants and birthing persons.

Objectives:

- Increase the percentage of birthing people who receive first trimester prenatal care.
- Ensure data tracking and stratification to monitor mortality and morbidity rates for infants and birthing people and employ best practices when responding to disparities.

Intervention	Population of Focus	Anticipated Impact
Implement standardized data tracking for prenatal care services and outcomes for infants and birthing people	TBHC Maternal Care Patients	• Ongoing monitoring of prenatal care access trends and health disparities
Provide the Prenatal Care Services program, offering prenatal care to pregnant people who are uninsured or underinsured	TBHC Maternal Care Patients, Uninsured or Underinsured	• The percentage of maternal care patients who receive first trimester prenatal care • Improved maternal and infant health outcomes
Facilitate linkages to the WIC program for eligible patients	TBHC Maternal Care Patients	• Percentage of participants initiating breastfeeding and maintaining at 6- and 12-months post-birth • Percentage of participants enrolled in WIC FMNP • Percentage of infants with low birth weight
Conduct standardized screening for patients' unmet HRSNs	TBHC Maternal Care Patients	• Percentage of patients screened for SDoH and referred for unmet HRSNs
Implement policies and practices to support doula care and services	TBHC Maternal Care Patients	• Number of births involving doula care
Integrate hospital-based midwifery model of care	TBHC Maternal Care Patients	• Number of births involving midwife care
Provide lactation consultant and educational classes	TBHC Maternal Care Patients	• Number of patients receiving lactation services
Anticipated Resources:		
▪ Health Access Committee staffing, time, and training ▪ Clinical Staffing ▪ IT infrastructure ▪ Community investments in education and preventive services		

Health Needs Not Identified and/or Addressed by CSP

The CHNA consistently identified housing, access to healthcare, and meeting the needs of youth and aging populations as community health priorities. While not named priorities within the CHNA, TBHC is committed to addressing these areas either directly or in collaboration with community partners.

As part of its Population Health Plan, TBHC will improve its process for screening for SDoH, including housing, and will engage with a social care network to help connect patients with services when needed.

Improving access to care is central to TBHC's mission and a cross-cutting strategy for priority areas. TBHC is actively working to recruit and retain clinical providers that reflect the needs and diversity of the community, and to develop new care sites. TBHC is committed to providing services for residents regardless of their ability to pay, through financial assistance programs.

Youth health needs, particularly behavioral health needs, have increased across NYC. TBHC will continue to partner with community agencies providing behavioral health services to facilitate referrals and to advocate for needed services. TBHC will also look for opportunities through its Community Affairs Department to support structured recreational and mentorship programs for youth.

TBHC is considering the needs of older adults as part of its broader strategy to improve chronic disease outcomes and as part of its participation in programs like the New York State Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. The AHEAD Model is a Centers for Medicare & Medicaid Services initiative to improve population health and healthcare spending by improving financial stability for safety net hospitals, investing in primary care, and addressing HRSNs of patients.

Partner Engagement

TBHC is dedicated to reaching beyond the hospital's walls to its neighbors and community partners so that it can provide needed services directly to the community and, in turn, hear from them about their healthcare needs. TBHC is an active partner with places of worship, senior citizen centers, schools, elected officials, local police precincts, cultural and community institutions, and community boards, among others.

One of the ways that TBHC keeps connected to the community is through its Community Advisory Board (CAB). The CAB is a diverse group of individuals with strong ties to the community, and a keen understanding of how the hospital works. The TBHC CHNA Steering Committee, in partnership with the CAB, will meet regularly to review CSP process measures and maintain an active workplan, as provided by the New York State Department of Health. The workplan is submitted annually and describes the actions TBHC has taken to address the identified priority areas.

CHNA and CSP Communication Plan

TBHC made the CHNA and CSP available on its website. TBHC will maintain a printed copy of the CHNA and CSP at the hospital for public inspection upon request. An electronic copy of the CHNA and CSP was provided to the TBHC CAB, among other partners.

Board Approval and Next Steps

The Brooklyn Hospital Center would like to thank our community partners that provided guidance, expertise, and ongoing collaboration to inform the 2025 CHNA and CSP and help improve the health and well-being of the borough.

We are committed to advancing health initiatives and community collaboration to support key health needs identified in the CHNA. The 2025 CHNA and CSP report was presented to TBHC's Board of Trustees and approved in December 2025. Following the board's approval, the CHNA and CSP report was published and made accessible to the public via TBHC's website.

We invite our community partners to learn more about the CHNA and CSP and opportunities for collaboration to address identified health needs. Please visit our website or submit comments directly to Lenny Singletary at lsingletary@tbh.org.

Appendix A: Public Health Secondary Data References

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Appendix B: Key Stakeholder Survey Participants

Organization	Title/Role
Aldus Pharmacy WIC2U	Coordinator
All My Children Daycare and Nursery School	Program Manager
Amsterdam News	Reporter
Brooklyn Community District 2	District Manager
Coalition for the Homeless	Employee
Cypress Hills Local Development Corporation	Intake Specialist/Asylum Seeker Resource Coordinator
DOHMH	Mental Hygiene Division
Dornblaser Consulting	Principal
Eleven33 Manhattan	Community Engagement Director
Empire Kosher Supermarket	Manager
Expecting Relief	Director
Family Services Network of New York	Prevention Education and Outreach Coordinator
Farragut Resident Association	Secretary
Farragut Resident Association	President
Friends of Crowne Heights Educational Center INC	Assistant Director
Hunger Free America	WIC Benefits Specialist
Infant Formula Laboratory Service	Manager
Ingersoll Resident Association	President
Little essentials	Senior Development and Finance Consultant
North Brooklyn YMCA	Membership & Healthy Lifestyles Director
Northside Center for Child Development	Health Aide
Parachute	Owner
Parent-Child Relationship Association	Executive Director
Primary Care Doctor Office	Medical Assistant
RaisingHealth	Coordinator of Health Initiatives
Recess Art	Executive Director
Sheraton Brooklyn Hotel	Sr. Sales Manager
St. Francis College	Vice President
Sunshine Pharmacy of NY Inc.	MANAGER
The Brooklyn Hospital Center	Secretary of the TBHC Community Advisory Board
The Brooklyn Hospital Center	Trustee
The Brooklyn Hospital Center	Trustee
Trinity Human Services	Social Worker
Whitman Houses Resident Association	President
Women`s Safe Start II	Case Manager