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1. **Identify county or service area covered in this assessment plan – Kings County**

The *Brookdale Hospital Medical Center* ("Brookdale") serves residents primarily from East and Central Brooklyn. Brookdale’s **primary service area** includes the underserved neighborhoods of Brownsville, East New York, Canarsie, and Flatlands, which are inside Community Districts (CD) 5, 16, and 18. In 2015, 73% of all hospital discharges came from four zip codes in these neighborhoods (11212, 11207, 11208, and 11236). Another 10 zip codes from neighboring CDs 3, 4, 8, 9 and 17 comprise Brookdale’s **secondary service area**. In 2015, 18% of all discharges came from these zip codes.

2. **Participating Local Health Department and contact information.**

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

Contacts:

(i) Anna Gallego – Director of Public Policy, Office of the First Deputy Commissioner, agallego1@health.nyc.gov; 347-496-4106

(ii) Asia Young – Hospital Community Benefits Coordinator, Office of the First Deputy Commissioner, ayoung6@health.nyc.gov; 347-496-4043

3. **Participating hospital/hospital system and contact information.**

Brookdale Hospital Medical Center, One Brookdale Plaza, Brooklyn, NY 11212

4. **Name of coalition/entity, if any, completing assessment and plan on behalf of participating counties/hospitals – N/A**
EXECUTIVE SUMMARY

1. What are the Prevention Agenda priorities and the disparity you are working on with your community partners, health department and hospitals for the 2016-2018 period?

The disparity that Brookdale will address is the disproportionately high rate of chronic diseases in its service areas. Brookdale will address the following two Priority Areas/Focus Areas for the three-year period 2016-2018, in alignment with the NYS Department of Health (NYS DOH) Prevention Agenda 2013-2018:

a) Priority Area: Prevent Chronic Diseases

Focus Area 1: Reduce Obesity in Children and Adults

b) Priority Area: Prevent Chronic Diseases

Focus Area 3: Increase access to High Quality Chronic Disease Prevention Care and Management in Both Clinical and Community Settings

2. What has changed, if anything, with regard to the priorities you selected since 2013, including any emerging issues identified or being watched?

Brookdale selected obesity and HIV/AIDS as the two disease priorities to be addressed during the 2013-2015 CSP period. Brookdale staff worked diligently on both priorities, making great progress in raising awareness, developing new partnerships and community collaborations, and overall, achieving many of the goals set forth. For the 2016-2018 CSP timeframe, Brookdale will continue to focus on reducing obesity in children and adults, but has replaced HIV/AIDS with the NYS DOH Prevention Agenda Focus Area, “Increase Access to High Quality...
**Chronic Disease Preventive Care and Management in Both Clinical and Community Settings.** This new focus is broad and encompasses the service delivery transformation work that is now underway at Brookdale, and impacting many diseases (including HIV/AIDS), and healthcare disparity.

3. **What data did you review to identify and confirm existing priorities or select new ones?**

Brookdale reviewed a variety of primary and secondary data to arrive at the two NYS Priority Area/Focus Areas selected, which included: Analyses of clinical diagnosis and treatment data for Brookdale patients; Data analysis from a survey administered to East Brooklyn residents at a healthcare forum, “Voice Your Vision East Brooklyn,” convened by the NYS DOH in 2016; “The Brooklyn Study: Reshaping the Future of Healthcare,” a feasibility study commissioned by the NYS Department of Health and conducted by Northwell Health in 2016; NYC DOH 2015 “Community Health Profiles,” and “TCNY Community Priorities and Related DOHMH Services in Brooklyn,” published in August 2016; “NYC Health Provider Partnership Brooklyn Community Needs Assessment” (CAN), published in October, 2014 by the New York Academy of Medicine.

4. **Which partners are you working with and what are their roles in the assessment and implementation processes?**

The partners for both focus areas selected include: Brookdale senior leadership; Brookdale clinicians and other front-line healthcare providers; community-based organizations (CBOs) and faith-based organizations (FBOs) that serve the East Brooklyn area; other healthcare service providers in the community; and elected officials that represent East Brooklyn.
5. How are you engaging the broad community in these efforts?

Brookdale has a robust community outreach and engagement agenda. The overall goal of
Brookdale’s community outreach is to develop real partnerships inside its service areas, to
work towards reducing health disparities and improving health outcomes for its patient
population. Brookdale’s Community Advisory Board is charged with ensuring that the voice of
the community is represented in Brookdale’s decision making process. Brookdale’s External
Affairs Department staff work with community leaders, CBOs, FBOs, and elected officials to
access the community and to ensure that all stakeholders remain engaged and contribute to
Brookdale’s role as a leading healthcare provider in East Brooklyn. Staff work with
departments across Brookdale to coordinate community meetings, health education fairs,
disease prevention and wellness events, youth initiatives, and a host of activities that are
designed to seek community input, disseminate health information about health issues and
initiatives at Brookdale, and inform the community about treatment and care options.

6. What specific evidence-based interventions/strategies/activities are being implemented to
address the specific priorities and the health disparity and how were they selected?

Focus Area 1: Reduce Obesity in Children and Adults

Brookdale is continuing to use the evidence-based clinical intervention and prevention program
“Live Light, Live Right,” (LLLR) as the linchpin of its anti-obesity efforts. LLLR was
launched 14 years ago to focus on childhood obesity. The program has expanded by
implementing a strong obesity prevention agenda in partnership with Brookdale clinicians, and
East Brooklyn CBOs. Brookdale’s Advanced Bariatric Care Center addresses high-risk adult
obesity.
Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Brookdale promotes evidence-based care and has launched several specialty clinics to prevent, treat and manage chronic diseases. Clinics increase screenings and treatment for various diseases (cardiovascular, diabetes, cervical cancer, breast cancer). Brookdale emphasizes and makes every effort to deliver healthcare to its diverse patient population in a culturally appropriate manner.

7. How are progress and improvement being tracked to evaluate impact? What process measures are being used?

Progress is measured by analyzing data from EPIC, Brookdale’s EMR system. Specific data points that EPIC now tracks include the number of kids enrolled in LLLR and other disease prevention programs, indicators for obesity such as Body Mass Index, and treatment outcomes. In addition, event-based surveys, and other tools will measure participation levels in LLLR prevention events for both adults and children at the hospital and the larger community.
REPORT

Introduction and Brookdale Background

The Brookdale Hospital Medical Center ("Brookdale") is a not-for-profit 501(c)(3) hospital provider that is licensed under Article 28 of the New York Public Health Law, and exempt from federal taxation under 501(c)(3) of the Internal Revenue Service Code. Brookdale is a critical part of the healthcare delivery system in the borough of Brooklyn. Brookdale was established in the East Brooklyn community of Brownsville in 1921. Today, Brookdale continues to serve as a safety-net hospital for hundreds of thousands of residents from communities with concentrated poverty.

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

Brookdale works with its affiliates, and a broad network of public and non-profit partners, to bring a full complement of healthcare services to its patient population, including many specialty and subspecialty clinics/services, to address a wide range of diseases that impact its patient population.

Brookdale’s healthcare delivery model includes: inpatient care, ambulatory care, long-term care, senior living and emergency medicine. Core assets\(^1\) that support the delivery of care include:

- Approximately 50 surgical and subspecialty care clinics/services;
- 530 certified acute-care beds;
- An Emergency Department, which is a NYS-designated Level-1 Trauma Center, and one of the busiest in the region;
- A 448-bed skilled-nursing facility, and an 86-unit assisted-living and independent-living facility, which both operate at a 95% or higher occupancy rate;
- Six primary care facilities;

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\(^1\) These community assets are housed at either Brookdale Hospital or its affiliated entities, including: Brookdale Family Care Centers, Inc.; The Brookdale Residence Housing Development Fund Corporation (The Arlene and David Schlang Pavilion); The Schulman and Schachne Institute for Nursing and Rehabilitation, Inc.; and Urban Strategies/Brookdale Family Care Center, Inc.
✓ A comprehensive Adult Day Care Center;
✓ A Level-3 Perinatal Center;
✓ A Mental and Behavioral Health Center;
✓ A 16-chair dental suite that supports dental and oral services;
✓ An HIV Center; and
✓ An Urgent Care Center.

**NYS DOH Question #1: Provide a short description of the community being served and how the service area has been defined.**

**Definition of Brookdale Service Areas and Demographic Composition**

Brookdale serves residents primarily from east and central Brooklyn, which include the neighborhoods of Brownsville, East New York, Canarsie, and Flatlands. These neighborhoods, which are inside the geographic boundaries of NYC Community Districts 5, 16, and 18, comprise Brookdale’s primary service area. In 2015, 73% of all hospital discharges came from four zip codes in these neighborhoods (11212, 11207, 11208, and 11236). Another 10 zip codes, which fall within the areas of east and central Brooklyn (inside the geographic boundaries of Community Districts 3, 4, 8, 9 and 17), comprise Brookdale’s secondary service area. In 2015, 18% of all discharges came from these zip codes. Together, the two service areas account for 91% of Brookdale’s discharges.

Brookdale’s primary and secondary service areas have a population of approximately 370,000 and 662,000, respectively, a total of just over one million residents. The majority of residents from both service areas are Black/African American (approximately 71%). Both service areas have a large concentration of immigrants and a myriad of ethnicities – 37% of residents are foreign-born. A growing Hispanic immigrant population accounts for 18% of residents. The median age of residents in

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2 Zip codes: 11203, 11210, 11213, 11216, 11221, 11225, 11226, 11233, 11234, and 11239.

Brookdale’s primary service area is 32.5, with 31% under 19 years old. The median age in our secondary service area is slightly higher, at 35.1, with 27% under 19 years old.4

**Socio-economic Status of Brookdale Service Areas**

Brookdale serves as a “safety net” to a patient population in East Brooklyn that is predominantly low-income, with at least 50% receiving government income support (Temporary Assistance for Needy Families, Supplemental Security Income, and Medicaid). Most patients come from neighborhoods with a large concentration of poverty. Three of the four zip codes (11212, 11207, and 11208) in Brookdale’s primary service area have an average median household income of $32,000.5 Approximately 32% of residents live below the federal poverty level, compared to 22% for the borough of Brooklyn, and 19% for NYC overall. Five of 10 zip codes in the secondary service area have an average poverty rate of 28%. The health insurance coverage for Brookdale’s patient population is approximately: 53% Medicaid; 29% Medicare, 18% either “self-pay,” charitable care or privately insured. The percentage of residents with no health insurance coverage ranges from 10% in Canarsie/Flatlands, to 25% in Bushwick.

Most of the neighborhoods served by Brookdale have the HHS-designations of “Health Professional Shortage Area” (HPSA) and/or “Medically Underserved Area” (MUA).6 Some of the factors that result in poor health outcomes for the population served include: a high disease burden, lack of access to care, a shortage of primary care doctors, linguistic and cultural isolation, and low health literacy. Residents suffer disproportionately from chronic diseases like HIV/AIDS, heart disease, obesity, diabetes, cancer, and sickle cell anemia. According to the 2015 NYC DOH community health profile report, the two top causes of death in Brownsville were heart disease and cancer, both rates of death significantly higher than the NYC rates. The heart disease rate was 272.9 per 100,000 deaths, 35% higher than the NYC rate of 202.6, and the cancer rate was 205.8 per 100,000 deaths, 31% higher than the NYC rate of 156.7 deaths per 100,000. Maternal and newborn health indicators are also poor in Brookdale’s target area; several zip codes have low birth weight, premature birth, teen pregnancy, and infant mortality rates that are among the highest in Brooklyn. Brookdale’s service areas are plagued

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5 U.S. Census, 2010
6 U.S. Health and Human Services/Health Resources and Services Administration, [www.hpsafind.hrsa.gov](http://www.hpsafind.hrsa.gov)
by crime, especially gun-violence. Brookdale’s Emergency Room encounters one of the highest incidences of puncture wounds in the State, including a gunshot wound victim every 36 hours.

\textit{NYS DOH Question \#2: Provide a short summary of health and other data that was reviewed to identify health issues of concern to the community. This could involve Prevention Agenda Dashboard, County Health Ranks and/or other sources of data on demographics and health issues facing the community and the underlying conditions that contribute to their health.}

Brookdale reviewed the following quantitative and qualitative primary and secondary data sources to understand the health needs of its service areas:

i. Analyses of clinical diagnosis and treatment data for Brookdale’s patient population.

ii. \textit{“Voice Your Vision East Brooklyn,”} a survey of community residents administered at a community healthcare forum convened by the NYS DOH in 2016.

iii. \textit{“The Brooklyn Study: Reshaping the Future of Healthcare,”} an assessment of healthcare needs of the East Brooklyn community and the viability of area hospitals, including Brookdale, which was commissioned by NYS. The study was prepared by Northwell Health in 2016 and published in October 2016.


v. The \textit{“NYC Health Provider Partnership Brooklyn Community Needs Assessment” (CAN)}, conducted and published in 2014 by the New York Academy of Medicine (NYAM) as part of the application process for Delivery System Reform Incentive Program (DSRIP) funding. This was a comprehensive review of all health needs for the borough of Brooklyn.

These studies confirm the findings from a comprehensive survey of community residents conducted by Brookdale in 2013. Brookdale continues to use its 2013 health needs assessment
as a guide, since the health and other social disparities that impact residents in East Brooklyn have not changed much since 2013, and therefore, the results are still valid today – healthcare needs and the disease burden are still overwhelming, and the lack of resources in the area means that progress on both fronts will be slow. In addition, Brookdale staff is engaged in analysis of healthcare needs in East Brooklyn on an ongoing basis, as Brookdale works with the community, elected officials, NYC DOH and NYS DOH and other agencies to redesign its healthcare model to meet the needs of East Brooklyn residents.

Assessment of the data reviewed confirms that:

i. There are a number of major diseases and healthcare needs that disproportionately negatively impact the health outcomes for residents in Brookdale’s service areas, resulting in a significant chronic diseases disparity, when compared to the rest of Brooklyn and NYC.

ii. Obesity and several secondary diseases (cardiovascular, diabetes, hypertension, and cancer), are disproportionately prevalent; and

iii. There is an urgent need for chronic disease prevention care, to help reduce the disease burden in Brookdale’s service areas.

This assessment led Brookdale to the conclusion that the two NYS DOH Prevention Agenda focus areas, reducing obesity in children and adults and increasing access to chronic disease prevention care, should be central to Brookdale’s 2016-2018 CSP Implementation Strategy. Continuing to focus on obesity will allow Brookdale to build upon the progress made during the past few years. By incorporating a focus on chronic disease prevention, Brookdale will not only improve patient outcomes, but reduce the cost burden to Brookdale and the healthcare system.
NYS DOH Question #3: Identify the two Prevention Agenda priorities and the health disparity being addressed with community partners including LHDs and hospitals, and provide a description of the community engagement process that was used to select or confirm existing priorities.

The disparity that Brookdale will address is the disproportionately high rate of chronic diseases in its service areas. Brookdale will address the following two Priority Areas/Focus Areas for the three-year period 2016-2018, in alignment with the NYS Department of Health (NYS DOH) Prevention Agenda 2013-2018, that together, will help have an impact on this disparity:

i. **Priority Area:** Prevent Chronic Diseases
   
   Focus Area 1: Reduce Obesity in Children and Adults

ii. **Priority Area:** Prevent Chronic Diseases

   Focus Area 3: Increase access to High Quality Chronic Disease Prevention Care and Management in Both Clinical and Community Settings

The preparation of the CSP serves as a unique opportunity for Brookdale to work side by side with community residents, public health officials, elected officials, and other key community stakeholders, to focus on one of Brookdale’s central goals: To adapt and enhance Brookdale’s service delivery model, to continue to meet the healthcare needs of the communities it serves.

Brookdale’s ongoing objectives are:

i. To identify the healthcare needs of the East Brooklyn communities served by Brookdale.

ii. To identify the barriers to accessing healthcare in the communities served.

iii. To identify the gaps in healthcare delivery in the communities served.

iv. To identify the diseases that have the most devastating impact on residents.
v. To continually assess Brookdale’s capacity to work with the community, to meet the healthcare needs of residents, including addressing the two focus areas selected.

vi. To develop the three-year CSP action plan to address the two focus areas selected for 2016-2018, and synergize efforts with the New York State Prevention Agenda, as well as the New York City Department of Health and Mental Hygiene’s “Hospital Community Health Interventions.”

vii. To identify the resources and the community support systems needed to achieve the goals set for the two focus areas selected.

NYS DOH Question #4: For each of at least two Prevention Agenda priorities, identify the goals(s) and objective(s), the interventions, strategies and activities you are or will implement, and process measures with measurable and time-framed targets that will be used to track progress over the three-year period. Interventions should be evidence-based or promising practices. They can include activities currently underway and/or new strategies to be implemented. Process measures must be selected to track progress in implementing the strategies.

Describe the following:

a) Actions the hospital intends to take to address the health issue and the anticipated impact of these actions.

The three-year Implementation Strategy presented in this report is structured to tackle obesity in children and adults, and the lack of chronic disease preventive care in Brookdale’s service areas, within the constraints of Brookdale’s fiscal resources. Brookdale established goals and objectives for this CSP to optimize the use of successful prevention models that are now in place, community collaborations and
other relevant resources outside of Brookdale’s service areas. Brookdale anticipates that the actions proposed will improve awareness and treatment of obesity and other chronic diseases, which will lead to better outcomes and a reduction in the disease burden in East Brooklyn. During the past two years, Brookdale launched a Breast Health Center, and OB/GYN services that are all focused on increasing preventive care. For example, the Breast Health Center operates with more flexible hours to accommodate more mammography screenings. Brookdale expects that all of its specialty services will examine how services are provided, encourage more screenings for chronic diseases, and work with community partners to disseminate information about screening and treatment options available at Brookdale.

b) Resources the hospital will commit to address the health need.

Brookdale is still a financially distressed hospital that is working with NYS government elected officials, as well as NYS DOH and other key stakeholders to revamp its operations and service delivery model. As such, resources allocated to accomplishing the goals and objectives of the two focus areas selected are limited. Nonetheless, Brookdale is committed to being creative and innovative in the use of resources and leveraging resources outside the community, to promote its agenda. The current work that is now underway is all geared towards reducing health disparities in East Brooklyn and will be the framework within which goals and objectives presented in the three-year Implementation Strategy are accomplished. Brookdale’s senior leadership is ensuring that projects undertaken are in the best interest of the communities served. The focus on expanding specialty services for diseases like breast cancer, diabetes, and heart disease is part of Brookdale’s efforts to recruit, and redirect clinical and operations resources to areas where they are most needed.
c) Actions the LHD intends to take to address the health need and the anticipated impact of these actions.

Brookdale is committed to collaborating with the NYC DOHMH and the NYS DOH whenever and wherever possible, to achieve success with the two focus areas selected. Brookdale’s focus areas are aligned with NYC DOH’s Take Care NY priorities. NYC DOH has agreed to facilitate the sharing of best practices and resources among hospitals, to support hospital CSP efforts.

d) Resources the LHD will commit to address the health need.

The NYC DOH is committed to supporting the efforts of hospitals around NYC to combat many diseases, including obesity, and to seeking the resources to address the lack of chronic disease prevention programs. The Take Care NY initiative outlines the health priorities and agenda for NYC.

e) Role of other participants, stakeholders, other local government agencies, or other CBOs, business, academia, etc., in addressing the priority.

Brookdale will continue to leverage the expertise and input of a variety of partners, to accomplish the goals of the CSP. Specific roles and responsibilities are highlighted in the three-year Implementation Strategy.

f) Is action addressing a health disparity and how?

The disparity that Brookdale will address is the disproportionately high rate of chronic diseases in its service areas. Brookdale’s anti-obesity model, Live Light Live Right (LLLR), will not only reduce the rate of obesity in children and adults, but will also reduce diseases that are typically associated with obesity (diabetes, cancer, heart disease, and high blood pressure). Brookdale is utilizing a multi-pronged approach to reducing obesity, which includes: a clinical component, intervention measures such as healthy eating and physical activities, and education of
clinicians and other frontline staff, in the diagnosis and treatment of obesity. Other prevention models for diseases like Breast Cancer, Cardiovascular Disease, and Diabetes, all of which are a burden to the Brookdale service areas, will increase education, screening and treatment and disease management. It is expected that Brookdale’s comprehensive disease prevention agenda will contribute to a reduction in the rate of chronic diseases in East Brooklyn.

NYS DOH Question #5: Briefly describe the process that will be used to maintain engagement with local partners during the next three years, and the process that will be used to track progress and make mid-course corrections.

As Brookdale goes through the process of restructuring its healthcare delivery model to become more efficient and responsive to the needs in its service areas, securing a broad range of perspectives and feedback from the public is a high priority. The CSP implementation during the three-year period is an opportunity to seek the on-going involvement of a diverse group of stakeholders, to obtain honest feedback and recommendations directly from the community. Community engagement is an important component of the multi-faceted strategy that Brookdale plans to implement, to address the two focus areas successfully. As Brookdale progresses through the three-year plan, the expectation is that key partners will provide feedback and guidance on an ongoing basis, and will work closely with Brookdale to secure the buy-in of the larger community.

Brookdale currently has a robust community outreach and engagement agenda. Brookdale’s Community Advisory Board is charged with ensuring that the voice of the community is represented in Brookdale’s decision-making process. Brookdale’s External Affairs Department works with community leaders, CBOs, FBOs and elected officials, to access the community and ensure that all major stakeholders remain engaged and contribute to Brookdale’s role as a leading healthcare provider.
in East Brooklyn. The External Affairs staff work with departments across Brookdale to coordinate health education fairs, disease prevention and wellness events, youth initiatives, and a host of activities that are designed to disseminate health information, and inform the community about treatment and care options.

The overall goal is to reduce health disparities and improve health outcomes for Brookdale’s patient population. EMR data will be assessed periodically, to determine the impact of Brookdale anti-obesity and other chronic disease prevention efforts. The appropriate staff and patients will be surveyed to seek input on strategy, and effectiveness of models, on a department by department basis.

**NYS DOH Question #6: Briefly describe plans for dissemination of the Executive Summary to the public, how it will be made widely available, including providing the website where it can be located.**

The CSP will be disseminated through several distribution channels. First, the report will be placed on the Brookdale website ([www.brookdalehospital.org](http://www.brookdalehospital.org)) in an easily downloadable format, to facilitate access. Brookdale will ensure that the link to the report is readily available through major search engines. Second, the report will be made available through the Office of the CEO, Office of External Affairs, and all of Brookdale medical administration offices. Third, Brookdale will distribute hard copies to its Community Advisory Board, East Brooklyn CBOs and faith-based organizations, Community Board Offices, elected officials, and all other stakeholders that regularly provide input. These individuals and entities will be expected to utilize the report as an important resource, as they advocate and make policy decisions on behalf of East Brooklyn communities.
CONTACT INFORMATION

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APPENDICES

- Appendix 1 - 2016-2018 Three-year Implementation Strategy
- Appendix 2 - Brookdale Patient Demographic Composition Data Summary
- Appendix 3 – Area Maps
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<th>Outcome Objectives</th>
<th>Interventions/ Strategies/ Activities</th>
<th>Process Measure</th>
<th>Partner Role</th>
<th>Partner Resources</th>
<th>Date</th>
<th>Will Action Address Disparity?</th>
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<tr>
<td>GOAL 1: Prevent childhood obesity through early childcare and schools.</td>
<td>To create and implement a systems based practice for early identification and referral for infants and children at risk for obesity or with obesity; Conduct training of clinicians to support referral system at every Brookdale primary care site, as well as training for the pediatric residents; Dr. Dhuper and Live Light Live Right (LLLR) team will lead the training and work with ambulatory care team to implement.</td>
<td>Training; Screening questionnaire and referral form will be incorporated into EPIC, Brookdale EMR; Age appropriate nutrition handouts will be provided to all pediatricians and incorporated into EPIC; Patients considered “high risk” will be referred to LLLR through EPIC; LLLR program implementation.</td>
<td>Use Epic to track number of patient screenings and referrals.</td>
<td>Brookdale primary care sites; clinicians, including pediatricians and residents.</td>
<td>LLLR team and consultants will train physicians.</td>
<td>2017 Jan - Mar - Complete screening tools and incorporate in EPIC.</td>
<td>Yes</td>
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Screening high risk population for early prevention of obesity and providing age and culturally appropriate handouts with care coordination is a way to address disparities of poor preventative care, lack of resources and language barriers.
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<tr>
<td>GOAL 2: Expand the role of health care, health service providers and insurers in obesity prevention</td>
<td>Train pediatricians in early identification and referral of children with obesity; LLLR is an innovative health care model which provides Medical, Nutritional, behavior and exercise programs to overweight and obese children and works with community partners to provide services (livelight.org)</td>
<td>LLLR to continue to offer two clinics a week, with a comprehensive approach for childhood obesity, and provide medical, nutritional, behavior therapy, exercise programs and care coordination.</td>
<td>Screen for medical comorbidities; Measure and track outcomes BMI, BMI Z, waist, BP, Lipids, Insulin, Liver function, glucose and Hb A1c; Screen for sleep apnea</td>
<td>LLLR team</td>
<td>Robin Hood Foundation support</td>
<td>Ongoing and established program</td>
<td>Yes. Addresses obesity, Type 2 diabetes, Cardiovascular risk, Physical activity, Nutrition</td>
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<td>Goal</td>
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<td>GOAL 3: Create community environments that promote and support healthy food and beverage choices and physical Activity.</td>
<td>To work and expand local partnerships to support physical activity and nutrition</td>
<td>Collaborate with the Center for Health Equity (CHE) and Brooklyn DPHO; Continue to expand the Bike club for children in Brooklyn; Work with at least 2 schools to promote the Healthy Schools program; Serve as consultants to the schools and offer after school programs in schools interested; Adopt one Bodega close to Brookdale Hospital and collaborate with the Shop Healthy Program to promote healthy food items in that bodega, provide incentives such as Health bucks: Participate in 10 local health fairs, community events, provide cooking demos and workshops; LLLR and Brookdale to provide support and partner with Healthy Start programs to promote optimum nutrition to teens and pregnant women and promote breastfeeding and age appropriate feeding practices to prevent obesity.</td>
<td>Track and hold quarterly collaborative meetings and minute of meetings</td>
<td>DPHO team - Maggie Veatch Director of physical activity; Megan Galucia - Director of school wellness program;</td>
<td>DPHO has a large network of resources and funding to promote healthy environments, and will partner with LLLR to bring these services to our patients and communities; LLLR team of consultants, nutritionists, care coordinator and exercise trainers plus partners. See Livelight.org</td>
<td>2017</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Promote the bike club and other exercise programs  Work with 2 schools  Work with one bodega  

CHE exist to implement policy and local programs to address local health disparities noted from the NYC DOH Community Health profiles 2015.
### GOAL 1:
Prevent childhood obesity through early childcare and schools.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Outcome Objectives</th>
<th>Interventions/Strategies/Activities</th>
<th>Process Measure</th>
<th>Partner Role</th>
<th>Partner Resources</th>
<th>Date</th>
<th>Will Action Address Disparity?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To create and implement a systems based practice for early identification and referral for infants and children at risk for obesity or with obesity; Training for this program will be done at every BFCC site, as well as training for pediatric residents; Dr. Dhuper and LLLR team will lead the training and work with ambulatory care team to implemente.</td>
<td>Clinician training; Screening questionnaire and referral form will be incorporated into EPIC; Age appropriate nutrition handouts provided to all pediatricians and incorporated into EPIC; Patients considered high risk referred through EPIC to LLLR; LLLR care coordinator will contact the families and schedule a clinic visit or nutrition evaluation</td>
<td>Use EPIC to track numbers screened and referred; Track number of patients reached by the LLLR team and; Track number of patients seen at the LLLR clinic for evaluation and nutrition counseling</td>
<td>Brookdale Family care centers pediatricians and residents; Training and data collection by LLLR team; Epic Consultants, Brookdale hospital</td>
<td>LLLR team and consultants will train the physicians; Brownsville Early Childhood Collaborative team will work with LLLR to track process development and outcome.</td>
<td>2017 Jan-Mar: Complete screening tools and incorporate into EPIC; Jan-Jun: Train all the BFCC physicians and pediatric residents; Oct-Dec: Track outcome data for numbers screened.</td>
<td>Yes. Screening high risk population for early prevention of obesity and providing age and culturally appropriate handouts with care coordination is a way to address disparities of poor preventative care, lack of resources and language barriers.</td>
</tr>
</tbody>
</table>
### GOAL 2: Expand the role of health care, health service providers and insurers in obesity prevention

- **Goal**: Pediatricians to become trained in early identification and referral of children with obesity; LLLR is an innovative health care model which provides Medical, Nutritional, behavior and exercise programs to overweight and obese children and works with community partners to provide services (livelight.org)

- **Interventions/Strategies/Activities**: LLLR to continue to offer 2 clinics a week, with a comprehensive approach for childhood obesity and provide medical, nutritional, behavior therapy, exercise programs and care coordination.

- **Process Measure**: Screen for medical comorbidities; Measure and track outcomes BMI, BMI Z, waist, BP, Lipids, Insulin, Liver function, glucose and Hb A1c; Screen for sleep apnea

- **Partner Role**: LLLR team

- **Partner Resources**: Robin Hood Foundation support

- **Date**: Ongoing and established program

- **Will Action Address Disparity?**: Yes. Addresses obesity Type 2 diabetes, Cardiovascular risk, Physical activity, Nutrition. All risk factors more prevalent in low income neighborhoods.

---

**Priority Area: Prevent Chronic Diseases - YEAR 2**

**Focus Area 1: Reduce Obesity in Children and Adults**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Outcome Objectives</th>
<th>Interventions/Strategies/Activities</th>
<th>Process Measure</th>
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<th>Partner Resources</th>
<th>Date</th>
<th>Will Action Address Disparity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL 2: Expand the role of health care, health service providers and insurers in obesity prevention</td>
<td>Pediatricians to become trained in early identification and referral of children with obesity; LLLR is an innovative health care model which provides Medical, Nutritional, behavior and exercise programs to overweight and obese children and works with community partners to provide services (livelight.org)</td>
<td>LLLR to continue to offer 2 clinics a week, with a comprehensive approach for childhood obesity and provide medical, nutritional, behavior therapy, exercise programs and care coordination.</td>
<td>Screen for medical comorbidities; Measure and track outcomes BMI, BMI Z, waist, BP, Lipids, Insulin, Liver function, glucose and Hb A1c; Screen for sleep apnea</td>
<td>LLLR team</td>
<td>Robin Hood Foundation support</td>
<td>Ongoing and established program</td>
<td>Yes. Addresses obesity Type 2 diabetes, Cardiovascular risk, Physical activity, Nutrition. All risk factors more prevalent in low income neighborhoods.</td>
</tr>
</tbody>
</table>
## GOAL 3: Create community environments that promote and support healthy food and beverage choices and physical activity.

**Goal Outcome**

**Objectives**

To work and expand local partnerships to support physical activity and nutrition.

**Interventions/ Strategies/ Activities**

- Collaborate with the CHE and Brooklyn DPHO; Continue to expand Bike club for children; Work with at least 2 schools to promote the Healthy Schools program; Serve as consultants to the schools and offer after school programs; Adopt one Bodega close to Brookdale Hospital and collaborate with the Shop Healthy Program to promote healthy food items in that bodega, encourage parents to visit this bodega, provide incentives such as Health bucks; Participate in 10 local health fairs, community events, provide cooking demos and workshops; LLLR to provide support and partner with Healthy Start programs to promote optimum nutrition to teens and pregnant women and promote breastfeeding and age appropriate feeding practices to prevent obesity.

**Process Measure**

- Track and hold quarterly collaborative meetings and minute of meetings; Track number of participants attending exercise and bike program; Track attendance at Health fairs; Report on school interventions.

**Partner Role**

- DPHO team - M. Veatch, Director of physical activity, M. Galucia Director of school wellness program, V. Gardner Creating Healthy Schools and Communities Community Coordinator; Dr. Dhuper and DPHO team will give local talks and grand rounds to create awareness of resources available to community.

**Partner Resources**

- DPHO has a large network of resources and funding to promote healthy environments. They are partnering with LLLR to bring these services to patients and communities. LLLR team of consultants, nutritionists, care coordinator and exercise trainers plus partners. See Livelight.org

**Date**

- 2017

**Will Action Address Disparity?**

- Yes.

CHE created to implement policy and local programs to address local health disparities noted from the NYC DOH Community Health Profiles 2015.
<table>
<thead>
<tr>
<th>Goal</th>
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<th>Partner Resources</th>
<th>Date</th>
<th>Will Action Address Disparity?</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL 1: Prevent childhood obesity through early childcare and schools.</td>
<td>To create and implement a systems based practice for early identification and referral for infants and children at risk for obesity or with obesity Training for this program will be completed at every BFCC site as well as training for the pediatric residents.</td>
<td>Training will be completed; Screening questionnaire and referral form will incorporated into EPIC EMR; Age appropriate Nutrition handouts will be provided to all pediatricians and incorporated into EPIC; The patients considered as high risk will be referred through the EPIC system to LLLR; LLLR care coordinator will contact the families and schedule a clinic visit or nutrition evaluation</td>
<td>Use EMR Epic to track numbers screened and referred; Track number of patients reached by the LLLR team; Track number of patients seen at the LLLR clinic for evaluation and nutrition counseling</td>
<td>Brookdale Family care centers pediatricians and residents; Training and data collection by LLLR team; Epic Consultants, Brookdale hospital</td>
<td>Live Light Live Right team and consultants will train the physicians; Brownsville Early Childhood Collaborative team will work with LLLR to track process development and outcome</td>
<td>Track outcome data for numbers screened and referred to LLLR; Track number of patients seen by a nutritionist; Track Referral to the exercise program</td>
<td>Yes Screening high risk population for early prevention of obesity and providing age and culturally appropriate handouts with care coordination is a way to address disparities of poor preventative care, lack of resources and language barriers.</td>
</tr>
</tbody>
</table>
### GOAL 2: Expand the role of health care, health service providers and insurers in obesity prevention

**Pediatricians to become trained in early identification and referral of children with obesity;**

**LLLR to extend its capacity as an innovative health care model which provides medical, nutritional, behavior and exercise programs to overweight and obese children, and increase collaboration with community partners to provide services.**

( livelight.org)

**LLLR to continue to offer 2 clinics a week, with a comprehensive approach for childhood obesity, and provide medical, nutritional, behavior therapy, exercise programs and care coordination.**

**Screen for medical comorbidities; Measure and track outcomes BMI, BMI Z, waist, BP, Lipids, Insulin, Liver function, glucose and Hb A1c; Screen for sleep apnea.**

**Will Action Address Disparity?**

Yes.

Addresses obesity, Type 2 diabetes, Cardiovascular risk, Physical activity, Nutrition.

All risk factors more prevalent in low income neighborhoods
<table>
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</tr>
</thead>
<tbody>
<tr>
<td>GOAL 3: Create community environments that promote and support healthy food and beverage choices and physical Activity.</td>
<td>To work and expand local partnerships to support physical activity and nutrition</td>
<td>Collaborate with the CHE and Brooklyn DPHO; Continue to expand Bike club for kids; Work with 2 additional schools to reach a total of 4, to promote Healthy Schools program; Serve as consultants to schools and offer afterschool programs; Adopt two Bodegas close to Brookdale; Work with 2 farmers markets to promote the Shop Healthy Program to encourage healthy foods and eating; Participate in 10 health fairs, community events; provide cooking demos and workshops; LLLR will work with an additional partner in Brooklyn to promote healthy eating; Work with Heath First or other insurance company to support part of the services provided; Work with Healthy Start programs to promote optimum nutrition for teens and pregnant women, and promote breastfeeding and age appropriate feeding practices.</td>
<td>Track and hold quarterly collaborative meetings and minute of meetings; Track number of participants attending exercise programs, and bike program; Track attendance at Health fairs; Report on school interventions</td>
<td>DPHO team- Maggie Veatch Director of physical activity; Megan Galucia Director of school wellness program; Victoria Gardner - Creating Healthy Schools and Communities Coordinator; Dr. Dhuper and DPHO team will give local talks and grand rounds to create awareness of resources available to the community</td>
<td>DPHO has a large network of resources and funding to promote healthy environments, and will partner with LLLR to bring these services to patients and communities; LLLR team of consultants, nutritionists, care coordinator and exercise trainers plus partners. See Livelight.org</td>
<td>2018</td>
<td>Yes. Providing preventive services and building local partnership to address local health Disparities reported in noted The NYC DOH Community Health profiles 2015.</td>
</tr>
</tbody>
</table>
**GOAL 1:** Increase screening rates for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.

<table>
<thead>
<tr>
<th>Goal</th>
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<tbody>
<tr>
<td></td>
<td>Assess current screening and disease management practices at Brookdale clinics and points of service, to determine capacity to incorporate and/or expand screenings, disease management, and patient education for East Brooklyn; Assess EPIC (Brookdale's EMR) support needed to accomplish goal.</td>
<td>Conduct clinical process assessments; Establish personal &quot;Plan of Care&quot; protocol for chronic disease patients; Incorporate patient followup care and compliance tracking; Work with External Affairs Dept. to develop strategy around East Brooklyn community outreach and education.</td>
<td>Assessment of clinics and service delivery points of service complete; strategic planning sessions for community outreach and education conducted; EPIC capacity enhancements needed to support increase in screenings and disease management identified.</td>
<td>CMO and administrators take lead on assessment of clinics; clinicians - participate in assessments; External Affairs Dept - community outreach; NYC DOH - facilitate best practice sharing; Brookdale technology staff - EMR review.</td>
<td>Brookdale staff; NYC DOH staff support</td>
<td>2016-2017</td>
<td>Yes</td>
</tr>
<tr>
<td>Goal</td>
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<tr>
<td><strong>GOAL 2:</strong> Promote evidence-based care to manage chronic diseases.</td>
<td>Assess Brookdale’s capacity to educate Brookdale clinicians on the importance of promoting disease management (using the anti-obesity program “Live Light Live Right” (LLLR) as a model) and to promote chronic disease management in East Brooklyn; Review Brookdale’s ability to accommodate all patient insurance options, to serve more patients.</td>
<td>Work with Dept. Chairs, clinic administrators to conduct assessments; Seek out funding and in-kind resources to support this goal; work with community partners to determine infrastructure that is now in place to support evidence-based disease management and promotion.</td>
<td>Assessment of Brookdale’s clinical and operational capacity to promote evidence-based care programs completed; strategic planning sessions for community outreach to promote disease management at Brookdale.</td>
<td>CMO and administrators take lead on initiating assessments; clinicians participate in assessments; External Affairs Dept. - community outreach; NYC DOH - facilitate best practice sharing.</td>
<td>Brookdale staff; NYC DOH staff support</td>
<td>2016-2017</td>
<td>Yes</td>
</tr>
<tr>
<td>Goal</td>
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<tr>
<td><strong>GOAL 3:</strong> Promote culturally-relevant chronic disease management education.</td>
<td>Evaluate Brookdale's current chronic disease management efforts, to determine deficiencies in cultural relevance.</td>
<td>Work with Brookdale Dept. Chairs, clinic administrators, other staff to conduct assessments. Work with External Affairs Dept. staff to assess community cultural outreach needs and strategies.</td>
<td>In-house assessments complete; Community feedback received.</td>
<td>CMO and administrators - initiate and take the lead on assessments; clinicians - participate in assessments; External Affairs Dept - community outreach; NYC DOH and GNYHA - facilitate best practice sharing.</td>
<td>Brookdale staff; NYC DOH staff support</td>
<td>2016-2017</td>
<td>Yes</td>
</tr>
</tbody>
</table>
## GOAL 1: Increase screening rates for cardiovascular diseases, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.

<table>
<thead>
<tr>
<th>Goal</th>
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</tr>
</thead>
<tbody>
<tr>
<td>GOAL 1: Increase screening rates for cardiovascular diseases, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.</td>
<td>Based on Brookdale capacity and availability of financial resources, Brookdale will increase screenings for diseases like breast, cervical, and colorectal cancer; obesity, cardiovascular disease; and diabetes in East Brooklyn, and enhance EPIC's capacity to support patient Plan of Care and tracking.</td>
<td>Dept. Chairs, and clinic administrators promote more screenings, routinize development of patient &quot;Plan of Care&quot; and treatment compliance followup; External Affairs Dept. staff promote more screenings in East Brooklyn.</td>
<td>Number of clinics that incorporate Plan of Care, treatment compliance followup, and education into treatment model. Number of patients screened and referred to treatment programs, as reported in EPIC.</td>
<td>CMO and administrators - promote screenings at points of service; External Affairs Dept - community outreach; NYC DOH - facilitate best practice sharing.</td>
<td>Brookdale staff; NYC DOH staff support</td>
<td>2017</td>
<td>Yes</td>
</tr>
</tbody>
</table>
**GOAL 2: Promote evidence-based care to manage chronic diseases.**

- **Increase the number of patients enrolled in evidence-based care and disease management programs at Brookdale:**
  - Increase the number of patients enrolled in chronic disease management clinics and primary care sites.
  - Increase community outreach events to raise awareness of chronic disease management programs at Brookdale.

- **Brookdale's chronic disease management clinics and primary care sites are making an effort to reach more patients with chronic diseases, enrolling them in education and disease management, and tracking their progress through EMR:**
  - Clinicians are aware of the importance of disease management, and actively screening and referring patients to disease management.
  - Efforts continue to focus on developing a strong community network to support chronic disease education in East Brooklyn.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>GOAL 2</strong></td>
<td>Increase the number of patients enrolled in evidence-based care and disease management programs at Brookdale; Increase the number of community outreach events to raise awareness of chronic disease management programs at Brookdale.</td>
<td>Brookdale's chronic disease management clinics and primary care sites are making an effort to reach more patients with chronic diseases, enrolling them in education and disease management, and tracking their progress through EMR; Clinicians are aware of the importance of disease management, and actively screening and referring patients to disease management; Efforts continue to focus on developing a strong community network to support chronic disease education in East Brooklyn.</td>
<td>Number of patients utilizing clinics; Number of patients following Plan of Care; participation rates in community education efforts; Number of clinicians who utilize EPIC to promote screenings and chronic disease management by referring patients; Number of community education events held.</td>
<td>CMO and administrators - promote screenings and disease management at points of service; External Affairs Dept - community outreach; NYC DOH - facilitate best practice sharing.</td>
<td>Brookdale staff; NYC DOH staff support</td>
<td>2017</td>
<td>Yes</td>
</tr>
</tbody>
</table>
**GOAL 3:** Promote culturally-relevant chronic disease management education.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>Ensure that all clinics and primary care sites are providing care in a culturally-relevant manner.</td>
<td>Ensure that physicians and staff enroll in cultural-sensitivity training; Ensure that all clinics and points of service care delivery are culturally sensitive; Ensure staff diversity; Ensure that patients and larger community are aware of language bank services.</td>
<td>Disease management delivery and education materials are culturally appropriate; Brookdale staff is diverse.</td>
<td>CMO and administrators ensure that learning and care environment are culturally-sensitive and appropriate; External Affairs Dept - ongoing community outreach; NYC DOH - facilitate best practice sharing.</td>
<td>Brookdale Hospital staff - Implementation; NYC DOH, GNYHA and HANYS - cultural sensitivity trainings and resources</td>
<td>2017</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Priority Area: Prevent Chronic Diseases - YEAR 3

#### Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>GOAL 1:</strong> Increase screening rates for cardiovascular diseases, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.</td>
<td>Based on Brookdale capacity and availability of resources, increase screenings for diseases like breast, cervical, and colorectal cancer; obesity, cardiovascular disease; and diabetes in East Brooklyn.</td>
<td>Dept. Chairs, and clinic administrators promote more screenings, routinize development of patient &quot;Plan of Care&quot; and treatment compliance followup; External Affairs Dept. staff promote more screenings in East Brooklyn.</td>
<td>Number of patients screened and referred to treatment programs and following Plan of Care, as reported in EPIC.</td>
<td>CMO and administrators - promote screenings at points of service; External Affairs Dept - community outreach; NYC DOH - facilitate best practice sharing.</td>
<td></td>
<td></td>
<td>2018</td>
</tr>
</tbody>
</table>

12/23/2016

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**GOAL 2:** Promote evidence-based care to manage chronic diseases.

**Increase the number of patients enrolled in evidence-based care and disease management programs at Brookdale; Increase the number of community outreach events to raise awareness of chronic disease management programs at Brookdale.**

Brookdale’s clinics and primary care sites are making an effort to reach more patients with chronic diseases, establishing Plan of Care for them, and enrolling them in education and disease management, and tracking their progress through EMR; an increase in the number of clinicians who are aware of the importance of disease management, and are actively screening, and referring patients for disease management; Brookdale is developing a strong community network that is supporting chronic disease education in East Brooklyn.

- **Patient use of clinics, enrollment in disease management, and compliance level; Participation in community education efforts; Number of clinicians who use EPIC to promote chronic disease management by referring patients; Number of community events held.**

- **CMO and Administrators - promote screenings and disease management at points of service; External Affairs Dept - community outreach; NYC DOH facilitate best practice sharing.**

- **Brookdale staff; NYC DOH staff support.**

- **2018**

- **Yes**
### GOAL 3: Promote culturally-relevant chronic disease management education.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Ensure that clinics and primary care sites are providing care in a culturally-relevant manner.</td>
<td>Ensure that clinicians and other staff enroll in cultural-sensitivity training; Ensure that all clinics and points of service care delivery is done in a culturally sensitive manner; Ensure staff diversity; Ensure that patients and larger community are aware of language bank services.</td>
<td>Disease management delivery and education materials are culturally appropriate; Brookdale staff is diverse.</td>
<td>CMO and administrators ensure that learning and medical care environments are culturally-sensitive and appropriate; External Affairs Dept - ongoing community outreach; NYC DOH - facilitate best practice sharing.</td>
<td>Brookdale Hospital staff - implementation; NYC DOH, GNYHA and HANYS - cultural sensitivity trainings and resources</td>
<td>2018</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Primary Service Area</td>
<td>2015</td>
<td>2014</td>
<td>2012</td>
<td>Total Residents</td>
<td>Black / African American %</td>
<td>Foreign Born %</td>
<td>Not a US Citizen %</td>
</tr>
<tr>
<td>---------------------------------------------</td>
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</tr>
<tr>
<td>11212 Central Brooklyn</td>
<td>26%</td>
<td>27%</td>
<td>26%</td>
<td>84,500</td>
<td>71,964 (85%)</td>
<td>27,088 (32%)</td>
<td>11,832 (14%)</td>
</tr>
<tr>
<td>11207 East New York and New Lots</td>
<td>19%</td>
<td>19%</td>
<td>18%</td>
<td>93,386</td>
<td>62,417 (67%)</td>
<td>28,001 (30%)</td>
<td>12,933 (14%)</td>
</tr>
<tr>
<td>11208 East New York and New Lots</td>
<td>14%</td>
<td>15%</td>
<td>14%</td>
<td>94,469</td>
<td>45,147 (48%)</td>
<td>34,443 (36%)</td>
<td>14,681 (16%)</td>
</tr>
<tr>
<td>11236 Canarsie and Flatlands</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
<td>93,877</td>
<td>79,835 (85%)</td>
<td>44,670 (48%)</td>
<td>15,372 (16%)</td>
</tr>
<tr>
<td>Sub-Total</td>
<td>73%</td>
<td>72%</td>
<td>72%</td>
<td>366,232</td>
<td>259,363 (71%)</td>
<td>134,202 (37%)</td>
<td>54,818 (15%)</td>
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<tr>
<td>Secondary Service Area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11233 Central Brooklyn</td>
<td>5%</td>
<td>5%</td>
<td>5%</td>
<td>67,053</td>
<td>56,838 (85%)</td>
<td>15,102 (23%)</td>
<td>7,246 (11%)</td>
</tr>
<tr>
<td>11239 Canarsie and Flatlands</td>
<td>3%</td>
<td>3%</td>
<td>3%</td>
<td>13,393</td>
<td>7,644 (57%)</td>
<td>3,800 (28%)</td>
<td>543 (4%)</td>
</tr>
<tr>
<td>11203 Flatbush</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>76,174</td>
<td>69,433 (91%)</td>
<td>41,079 (54%)</td>
<td>14,073 (18%)</td>
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<tr>
<td>11234 Canarsie and Flatlands</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>87,757</td>
<td>37,024 (42%)</td>
<td>33,200 (38%)</td>
<td>9,222 (11%)</td>
</tr>
<tr>
<td>11213 Central Brooklyn</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>63,767</td>
<td>46,454 (73%)</td>
<td>22,496 (35%)</td>
<td>10,929 (17%)</td>
</tr>
<tr>
<td>11226 Flatbush</td>
<td>2%</td>
<td>2%</td>
<td>2%</td>
<td>101,572</td>
<td>76,853 (76%)</td>
<td>51,183 (50%)</td>
<td>25,738 (23%)</td>
</tr>
<tr>
<td>11221 Bushwich and Williamsburg</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>78,895</td>
<td>44,774 (57%)</td>
<td>21,304 (27%)</td>
<td>12,621 (16%)</td>
</tr>
<tr>
<td>11216 Central Brooklyn</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>54,316</td>
<td>41,543 (76%)</td>
<td>14,642 (27%)</td>
<td>7,111 (13%)</td>
</tr>
<tr>
<td>11225 Flatbush</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>56,829</td>
<td>42,766 (75%)</td>
<td>26,416 (46%)</td>
<td>12,453 (22%)</td>
</tr>
<tr>
<td>11210 Flatbush</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>62,008</td>
<td>35,821 (58%)</td>
<td>24,861 (40%)</td>
<td>9,210 (15%)</td>
</tr>
<tr>
<td>Sub-Total</td>
<td>18%</td>
<td>19%</td>
<td>18%</td>
<td>661,764</td>
<td>459,152 (69%)</td>
<td>254,103 (38%)</td>
<td>109,146 (16%)</td>
</tr>
<tr>
<td>Total 3 Mile Radius</td>
<td>90%</td>
<td>91%</td>
<td>90%</td>
<td>1,027,996</td>
<td>718,515 (70%)</td>
<td>388,305 (38%)</td>
<td>163,964 (16%)</td>
</tr>
</tbody>
</table>

| Brooklyn Total                             | 2,504,700 | 860,083 | 926,511 | 413,421 | $44,593 | 22.1% |
| United States                              | 306,603,772 | 38,395,857 | 39,268,838 | 22,118,154 | $52,762 | 14.3% |