













Brooklyn Hospitals Safety Net Plan

2014 - 2017

Fred Hyde & Associates, Inc.

Brooklyn Hospitals
Safety Net Plan

Table of Contents

The report and support material including all exhibits may be found at www.brooklynhospitalplan.org.

Executive Summary, Implementation Plan

Public employee unions representing the workers of SUNY Downstate Medical Center presented a plan this past summer for the re-development of University Hospital of Brooklyn (UHB) and Long Island College Hospital (LICH). That plan involved the creation of decentralized emergency/urgent/primary care facilities and the re-training of inpatient hospital workers to staff those facilities; however, that plan was not accepted. In the interim, downsizing has continued at UHB, the agreement through which SUNY acquired LICH has been voided by the judge who approved that agreement, and the financial health of Brooklyn hospitals remains a focus of public concern.

At the beginning of the summer, staff representing legislative leaders requested a broader plan, one which would address the outstanding concerns of members of the Brooklyn Delegation, including: (1) how a stronger SUNY Downstate can contribute to the medical resources of Brooklyn; (2) how *all* of the hospitals caring for the un- and under-insured in Brooklyn might benefit from concerted legislative action; and (3) how the benefits to those hospitals would translate into the development of the most important missing resources in Brooklyn, namely an adequate number of physicians to treat Medicaid and uninsured patients.

Physician leaders on the faculty of SUNY Downstate have agreed to "sponsor" this project in communication with their colleagues responsible for emergency, urgent and ambulatory care in the 14 other Brooklyn hospitals. The result will be recommendations through a physician group for the consideration of the Brooklyn Delegation and the Executive. If supported, this plan would be Brooklyn's initiative in an attempt to secure Section 1115 Medicaid Waiver funds from the State of New York.

This plan is therefore intended for review by legislators, staff of the executive branch of the State of New York, and others interested in the financial health of Brooklyn hospitals. The title and the undertaking are, by their nature, presumptuous, and would have been impossible to address without the predecessor work of the Brooklyn Healthcare Improvement Project, the New York State Commission on Health Care Facilities in the 21st Century, and many others concerned about the adequacy of hospital care. Regrettably, these efforts, now seven years old, have yielded little in the way of action.

Summary of the Narrative

Diagnosis

(1) Brooklyn is not "over-bedded" with an inappropriately large number of hospital inpatient beds.

(2) There is no evidence to support a charge that Brooklyn hospitals are managed any more or less competently than those in the other boroughs of New York City. Indeed, Brooklyn hospitals are as likely to be led and staffed by dedicated men and women struggling with inadequate resources, growing needs and frequent criticism.

(3) Rather, Brooklyn hospitals are underpaid for their inpatient services, systematically. Underpayment of hospitals and doctors has been, since the Clinton Administration, a key strategy among the states for expanding Medicaid enrollment - - making the same dollars go farther for more beneficiaries, but at reduced reimbursement for the services delivered to those beneficiaries.

(4) The most important result is that safety net hospitals, including those in Brooklyn, have no capital with which to transform their failing business model, that is, to develop comprehensive emergent and urgent care medical facilities, thereby decanting overcrowded emergency rooms, re-deploying staff now dedicated to inpatient care and creating new and more meaningful opportunities for physician training in ambulatory care. Such capital as these hospitals have is entirely in the form of debt, further compromising their finances.

(5) The result has reached a breaking point, where the services, especially those provided by institutions most heavily involved with safety net care - - Medicaid, managed Medicaid, uninsured - - are most imperiled.

(6) The more poor people seen by safety net hospitals, the less stable the hospitals become financially, the more susceptible to reversal.

Treatment

(1) Primary Care: Expanding delivery of primary care through individual or small group practices is untenable in safety net areas under existing reimbursement rules. The State of New York is so far behind the other states (ranking last of the fifty, tied with Rhode Island) in reimbursement to physicians that "catching up" would be unaffordable. In addition, promises in the Patient Protection and Affordable Care Act (PPACA) that reimbursement for primary care would increase are modest, and, as yet, unfulfilled. Third, individual and small group practices face the same major impediment as primary care clinics, Federally Qualified Health Centers, and many hospital outpatient clinics, namely, they are open and available when it is convenient for their staff to be available, not necessarily when they are needed by patients. Finally, increased enrollment in insurance plans under PPACA will have only a minor impact in New York, if any.

(2) Across the economic spectrum, many patients (especially those younger or untethered to existing providers) favor institutional care. For example, Kangovi and others[1] have written that lower socioeconomic status patients prefer hospital care, perceiving it as less expensive (to them), more accessible and of higher quality than other ambulatory care. Some theories of primary care expansion are at variance with the reality facing patients requiring care in the safety net. Safety net patients can be expected to value care which is available (geographically and temporally - - that is, near them, and open when needed), with substantial band width (having specialists and diagnostic tools available, proximally, not remotely), and definitive ("Here is my diagnosis, Mrs. X, and here are the options for treatment," as opposed to "You'll have to see Dr. So-and-So, who is in on Thursday mornings at the address on the card they will give you when you leave.").

(3) Each of the hospitals (in Brooklyn and nationally) is required by federal law to produce a Community Health Needs Assessment, and to keep it up to date. PPACA requires that this plan be renewed regularly, with hospitals fined for failing to do so. The Community Health Needs Assessments currently on file are found on the website associated with this report; they are a mixed bag, some excellent, some wanting, some out of date. A key part of this proposal is that the hospitals in Brooklyn - - at least those concerned about safety net

[1] Kangovi, S., et al, "Understanding Why Patients Of Low Socioeconomic Status Prefer Hospitals Over Ambulatory Care," *Health Affairs*; Vol. 32, No. 7, 2013

patients - - amend their Community Health Needs Assessment plans, so as to provide specifics concerning people, space, money and equipment required for expansion of comprehensive ambulatory care.

(4) For University Hospital of Brooklyn (SUNY Downstate Medical Center) and other similarly situated hospitals, the prescription suggested is decentralized, freestanding, comprehensive ambulatory care centers staffed by retrained personnel from the inpatient services of the hospital, funded by equity grants (not debt) from the Section 1115 Waiver money, paid for through a negotiated Medicaid rate sufficient to cover ongoing services.

(5) Recapitalization of the safety net hospitals is necessary because (a) chronic underpayment has deprived these hospitals of any meaningful operating margin, (b) philanthropy and net from operations (the sources of equity for non-profit hospitals) is limited-to-non-existent for these hospitals, and (c) the State of New York has consistently offered/mandated debt as the form of capitalization, exposing the hospitals to higher risk in the future.

Debt is the form of nearly 100% of hospital capitalization in safety net hospitals. Reliance on debt means that the risk profile of the hospital is higher than would be the case with any equity investment (from the hospital or philanthropy or from outside grant.) This is a common issue in business, with these consequences: when chance reduces the volume of business activity (lower than expected inpatient admissions), the business (in this case the hospital) has no choice but to lower expenses, in the case of hospitals doing so by laying off trained and experienced personnel. Other alternatives (outsourcing key functions, entering into dicey arrangements with physicians to preferentially admit patients, etc.) contain moral hazard.

Offering debt through the Dormitory Authority of the State of New York, with credit enhancement through the FHA, may appear to be solving a problem for hospitals (in the short run), but it is creating a much larger set of problems (in the long run) as those hospitals continue to service debt whether or not their inpatient volume is stable and whether or not third parties (especially the State) pay what is required for services.

Therefore, it is imperative that any funds made available for recapitalization and reconfiguration (development of comprehensive ambulatory care, retraining of personnel) be done through grants of equity from funds made available by the State through the Section 1115 Waiver, not through a guarantee of additional indebtedness.

(6) With whatever specific opportunities are developed by the other hospitals, SUNY and those hospitals should work together for the orderly placement of as many SUNY resident physicians as possible, so as to orient those physicians to education in an ambulatory setting. The current disorganized and episodic approach to ambulatory care (nationally) guarantees that ambulatory settings will not be taken seriously as sites of education and training by resident physicians.

Summary:

This plan calls for:

- the return of funds taken from hospitals (those gathered in the "savings" associated with the "waiver" - - the waiver being in part from payment amounts which otherwise would have been paid to hospitals and doctors);
- the application of that money to the development of comprehensive ambulatory care centers, owned by sponsoring hospitals, staffed by hospital employees currently employed in inpatient care, and
- serving, to the extent possible, as educational sites for resident physicians, many of whom will go on to practice in Brooklyn and in New York State.

Theories and Proposals in the Plan, Especially the Role of Medicaid Payment to Hospitals

As of July 2013, there were 5.3 million enrollees in New York State's Medicaid program, 3.2 million of whom were in New York City, 2.1 million in the rest of the State. In managed care, there were 4 million of the 5.3 million enrolled statewide, 2.6 million of those in New York City.[2]

The introduction of managed care organizations into the Medicaid program in New York and nationally has adversely affected the financial integrity of safety net hospitals and physician groups. This is because the managed Medicaid contractors pay less for hospital and physician services than would have been paid under standard Medicaid rates. (For example, see GAO testimony 1-27-2013 on this issue, in references.)

States have therefore produced "savings" in their Medicaid programs. The list of activities and projects purported to have produced those savings is extensive. However, most of the "savings" have come from underpayment to doctors and hospitals.

The History of the Section 1115 Waiver

The New York State application for return of the Section 1115 Medicaid Waiver "savings" estimates the total amount of those savings at $10 billion. This is money New York State wants back from the federal government. What, you might ask, has produced this result - - what was New York "waiving" and how have these savings been produced?

Section 1115 was added to the Social Security Act in 1962, prior to the passage of Medicare and Medicaid. It was intended as a modest nod in the direction of states, innovating with then-new concepts of social insurance.

Section 1115 remained modest until the Clinton administration. The failure of Hillary-care induced federal and state officials alike to look for ways of increasing Medicaid enrollment, without proportionately increasing total cost. They did this by "waiving" some of the rules which would

[2] Gahan, Jr., John W., "Bureau of Vital Access Provider Reimbursement, New York State Medicaid Updates," September 2013, page nine

otherwise apply to the Medicaid program. What rules were "waived?" In general, the rules waived had to do with the reimbursement for services to hospitals and doctors who took care of Medicaid patients.

In 1965, when Medicaid was passed, it called for reimbursement to hospitals on the basis of "cost." Medicare, likewise, was to pay hospitals on a "cost" basis. States progressively chafed under the requirement to pay cost, as costs grew beyond multiples of original projections. In 1986, Senator David Boren sponsored legislation ("The Boren amendment") changing "cost-based" to "cost-related." Later, the Boren amendment was repealed. Some states - - notably California - - took the repeal as a sign that Medicaid (MediCal program in California) could slash rates to providers. However, the courts disagreed.

As a result, Section 1115 Waivers came about as a way of attempting to expand enrollment by introducing savings that did not directly slash payment to hospitals and doctors, but did so indirectly through managed care companies. Managed care management of government insurance programs is firmly entrenched in Medicare, covering approximately one-quarter of the Medicare population; not always noted by the beneficiaries, managed Medicare is subsidized, depending on the year, by 8 – 12%, in comparison to the cost of standard Medicare.

But managed Medicaid appealed to governors overwhelmed with school, jail and health costs. Comparison (see below) of hospital Medicaid fee-for-service vs. Medicaid managed care shows a $3,500 per discharge difference paid to hospitals in Brooklyn, that is, the managed care (HMO) Medicaid fee is that much less.

So the "waiver" involves, in part, "waiving" of the rules which would otherwise govern payment to hospitals. However, it also involves waiving the rules concerning payment to doctors. A graphic shown in Exhibit 4, originally from an Urban Institute study, turned into a graphic by journalist and commentator Avik Roy, shows the amount of payment by state Medicaid plans to doctors, as a percentage of payment to the same doctors in the same state for the same services, but for patients covered by commercial insurance. New York pays at 29% of the commercial rate, tied for lowest in the nation with Rhode Island. In other words, "waiving" some of rules for paying doctors has this result: a doctor in New York State who would earn a dollar taking care of a patient who had commercial health insurance would earn only $.29 cents (with considerable

additional difficulty in enrollment, management and collection) seeing the Medicaid patient. One direct result is that doctors increasingly do not see Medicaid patients.

A second result is that, to serve safety net populations, inner-city, un- and underinsured, in areas of high unemployment, is not feasible for individual physicians, groups of physicians or corporate entities dependent on physician reimbursement for their support.

The Medicaid waiver in a number of states has become a substantial part of the state's Medicaid program. However, in effect, what was a "fee-for-service" program (pay doctors and hospitals for taking care of the medically indigent) has turned into a grants and contracts program.

This proposal would, hopefully, reverse that trend: It would return money to the hospitals, but for directed purposes, and in ways intended to help them offset the operating deficits that result from Medicaid and especially from managed Medicaid.

Brooklyn's Share of the Waiver Money

How much of this money should go to Brooklyn?

Proposals could be made to take into account any or all of the following: The percentage of uninsured in a given hospital service area; bad debt reflected on the hospital's income statement as an expense (after December 2011 as deduction from revenue); calculations of the impact of fee-for-service and managed Medicaid; or any of a number of other formulae.

Boston University authority Dr. Alan Sager shows that complicated formulae, that is, those not readily understood by all participants, favor the well-connected, over those who are not.[3] In a report on the complexity of this matter, Sager took 168 pages to document this issue. Judy Wessler, then director of the Commission on the Public's Health System, summarized a major result of this examination in the introduction to Sager's

[3] Sager, Alan, "Paying New York State Hospitals More Fairly for Their Care of Uninsured Patients, A Report to the Commission on the Public's Health System," August 31, 2011

report, as follows: there is "little or no relationship between the actual dollars received by the hospital from the hospital Charity Care Pool and the amount of health care services they provided to the uninsured."

As a consequence, and to avoid complexity, opacity and the resulting impact of influence, this simple methodology is suggested: Take the percentage of the Brooklyn population (2.5 million, see Exhibit on population of boroughs), divided by the population of New York (approximately 19.5 million) or 13%. It is suggested for consideration by the reader and by leaders in the State that a minimum of 13% of the $10 billion waiver amount be returned to hospitals in Brooklyn, for the purposes noted in the next section.

What Would This Money Be Used For?

As challenged as Brooklyn hospitals are financially, all other service providers are more so. Hospitals, in other words, represent in Brooklyn what they do throughout the world and in modern history, namely, the place where the community puts its health resources.

The part of the resources devoted to the care of the "horizontal" patient, the inpatient bed, has been under attack since the passage of Medicare. At the time Medicare passed (1965), the nation had more than four beds per 1,000 population. Now that number (depending on who is measuring) varies from 3.1 to 3.5, or, if only beds that are actually staffed are counted, may be as low as 2.5. In New York City (see first Exhibit) the beds per 1,000 are slightly less than three, but with this extraordinary differential: in Manhattan, there are six beds per 1,000, while in Brooklyn, there are two.

Financial "attack" on inpatient utilization began in 1972 with pre-admission certification, mandatory list of procedures to be done on an outpatient basis, Professional Standards Review Organizations, all part of P.L. 92-603 in 1972. Congress sought to limit access to the most expensive part of the hospital, namely the inpatient admission.

This trend continued in 1982, with passage of legislation which changed (effective in 1983) what had been reimbursement on the basis of room and board and special services for inpatient expenses, to *prix fixe* basis, the Diagnosis-Related Group (DRG). Now, multiple new efforts are underway, especially under the Patient Protection and Affordable Care Act, to further limit utilization of the inpatient bed. Some of these involve loss to the institution, some involve unanticipated financial penalties for the Medicare patient (e.g., observation status). In any event, inpatient care is and has been for some years under attack. Growth in inpatient utilization per covered individual is not anticipated in any of the various scenarios projecting utilization for the future. (See Exhibit 7, comparison of decline in inpatient and growth in outpatient services.)
What has happened in the interim, however, is that outpatient services have grown, especially among hospitals having access to capital. A hallmark of the difficulty facing safety net hospitals in making a transition from in- to out-patient care is this: lack of access to capital. This difficulty is exacerbated by State officials who regard debt as the most appropriate form of capital. Safety net hospitals have, as a result, too much debt, producing an unfavorable risk profile. When projected utilization falls short (decline in inpatient census), safety net hospitals have few managerial tools, save laying off employees with experience and skills.

Many of the newer outpatient developments have therefore taken place beyond the walls of (and control of) the hospital, for example, in development of 5,000 free-standing ambulatory surgery centers, almost all of them newly established since the passage of Medicare and Medicaid.

The most notable example of hospital initiative in this area in New York City—a zenith of sorts in ambulatory care planning—will open in April of 2014. This facility will be a 164,000 square foot ambulatory care facility, open 24 hours a day, seven days a week, with more than 400 physicians and staff, planned for the West Village by the North Shore-LIJ system, in part as a replacement for the bankrupt St. Vincent's Catholic Medical Center. The North Shore enterprise promises an extremely limited number of beds for stabilizing patients, expedited transfer to its Manhattan affiliate, Lenox Hill Hospital, but, most importantly, genuinely comprehensive ambulatory care - - that is, the availability of the equipment, the specialists and the administrative structure to provide definitive care to the patient who comes with an emergent or urgent medical problem.

This proposal asks the fifteen hospitals of Brooklyn to consider whether comprehensive ambulatory care, decentralized and separate from the hospital, but controlled by and affiliated with each of them, is a model for service to the under- and uninsured in Brooklyn.
With approximately half a million residents underserved, uninsured or under-insured, each resulting hospital-owned enterprise should be sized in a manner sufficient to support the service and the educational programs, but not so large as to replicate the organizational problems of hospitals themselves.

The suggested formula:

- Minimum two shifts of operation, for an estimate capacity of 300 visits per day;
- 110,000 visits (300 x 365) available per year per center;
- Five to six visits per person per year needed by 500,000 people = 2.5 to 3 million visits needed per year;
- 2.5 to 3 million visits needed, divided by 110,000 visit capacity per center, calls for somewhere in the range of 23-27 centers, say two dozen ;
- In sum, approximately two dozen comprehensive ambulatory care centers would be sufficient to provide urgent and ongoing care for a half million Brooklyn residents.

This plan does not pretend to offer the detail necessary to conclude a particular number or configuration of centers. Rather, it suggests that the hospitals, in updating their Community Health Needs Assessments, in line with a request this past summer by NYS DoH Commissioner Shah, do so in a collective group, led by physicians who are knowledgeable about safety net medical care. With a deadline of December 31 for the updating, the physician group would be expected to develop programs consistent with the medical culture and available resources of each of the respective hospitals' service areas.

The Role of the SUNY Downstate Academic Medical Center

SUNY Downstate is the only medical school in Brooklyn. America's medical schools are (in general) the centerpiece of the nation's efforts to provide medical care in safety net communities. This is because first, teaching hospitals affiliated with medical schools receive enhanced

reimbursement under the federal government's Medicare program, and many of the state-federal Medicaid programs, for the expenses of graduate medical education. What are those expenses? They are primarily the employment of resident physicians in training, doctors who have graduated from medical school, who are licensed, who have current and in many cases advanced skills, and who, as part of their training, devote themselves to long and difficult postings in safety net hospitals and ambulatory care facilities.

In other words, the government pays hospitals incremental amounts above ordinary scale to employ resident physicians, in the hopes that these resident physicians will learn, give back service and become part of the nation's medical future.

Recently SUNY has suffered a degradation of its brand, the result of an improvident acquisition of the Long Island College Hospital, attempts to close that hospital, and periodic difficulty marshaling uniform support from public sponsors in Albany.

This plan, which proposes that physician leaders from SUNY Downstate work with their counterparts in *all* of Brooklyn's hospitals, has the potential to underline the public service mission of SUNY Downstate, and to provide, through its residency programs, support for the growth and development of comprehensive ambulatory care in Brooklyn.

SUNY Downstate should be a jewel, a means of focusing the attention of physicians in training and their educators on the needs of Brooklyn. It is hoped that, in a setting where physicians from SUNY are working with physicians from the other 14 hospitals in Brooklyn, some of the externalities will diminish, and focus on the needs of the patient will be paramount.

For SUNY Downstate Medical Center, University Hospital of Brooklyn, the suggested program includes four such comprehensive ambulatory care centers, as developed in a previous plan.

Total cost of each center can be expected to be in this range:

- 40,000 square feet per center (for 300 visits per day);
- $400 per net square foot construction, $16 million in capital cost per center, plus estimated $4 million for equipment; a total of $20 million in capital per center;
- Operating subsidies over three years equal to the capital start-up, or approximately $40 million combined capital and operating subsidy per center;
- $40 million x 24 = $960,000,000, or approximately $1 billion of the $1.3 billion of Brooklyn's share of the waiver money for such centers.

In sum, the proposal calls for the fifteen hospitals and, in particular, their emergency department directors, to work (as a group and also within their respective individual hospital settings) on modification of each hospital's Community Health Needs Assessment, so as to produce, by calendar year end, a detailed formula of people, space, money and equipment necessary to bolster ambulatory safety net services in Brooklyn.

How does this help the financial standing of hospitals? Most notably, by providing a source of capital (in the form of equity, a grant from the waiver money) to transform the hospital's "business" model from (largely) inpatient dependency to a better mix of in and outpatient care. In addition, staff (professional and support) now engaged in taking care of inpatients would have sufficient time, in a three-year subsidized start-up period, to assume new roles in outpatient service.

This three-year transition period would be accompanied by a serious (well led, organized, budgeted) retraining effort, paid for through waiver funds to the hospitals. The intended outcomes are (1) comprehensive ambulatory care for the underserved, (2) meaningful employment opportunities for staff who otherwise will be laid off from impoverished inpatient-centered institutions, (3) opportunities for transformation of inpatient to outpatient corporate culture, and (4) structured opportunities for educational advance in ambulatory care, especially for the resident physicians.

To maximize reimbursement (especially under the Medicare program) these centers must be owned and controlled by the hospitals. To be reimbursed for the cost of graduate medical education (the resident physicians, medical horsepower for the new centers) the enterprise claiming

graduate medical education payments must provide all or substantially all of non-hospital site training.[4] Moreover, the single hospital interpretation for reimbursement[5]would disallow cost-sharing between two or more hospitals of a joint residency training program at the same non-hospital site.

In English, this means that the special reimbursement for graduate medical education can be guaranteed only if it flows to a single hospital which bears all of the cost of providing the resident physician.

What Have Other States Done With Medicaid Waiver Money?

Other states have recognized this phenomenon. For example, both Texas and California in their Section 1115 Waiver applications indicate that they hope to restore financial integrity to hospitals and doctors compromised by managed Medicaid programs. Texas, for example, says the following in a presentation of its 1115 Waiver application: "Replaces funding lost when Medicaid Managed Care rolled out statewide."

The "savings" claimed in the Section 1115 Medicaid Waiver program should be used to restore financial integrity to hospitals.

Brooklyn suffers from well document shortages of medical care. SUNY Downstate is uniquely positioned to fill the gaps in central Brooklyn health care because of its medical college and large number of resident physicians. It is the only "engine" for the development of the next generation of medical professionals in Brooklyn. SUNY Downstate is in a position to shape and determine where and under what circumstances those professionals will acquire their skills, their outlook and their professional commitment.

The State, and especially SUNY Downstate, should work with all of the hospitals having safety net gaps, in development of decentralized, satellite urgent and emergency care centers, that is, services that forestall visits to hospital-based emergency rooms.

[4] 42USC, §§1395ww(d)(5)(B)(iv).
[5] 72 Federal Register, 26870 (May 11, 2007)

Exhibit Number One, New York City Hospitals

This exhibit shows that New York City (on average in the five boroughs) has fewer acute care hospital beds per 1,000 (2.97) than the national average. The numbers of beds shown in the exhibit are drawn from the "certified beds" listed on the New York State Department of Health website. This may be less than the number of licensed beds, or may be greater than the number of staffed beds, but, in any event, is the number used by the State to assess the adequacy of health services.

The point of discussions concerning "overbedding" as a reason for hospital financial dysfunction is this: the charge appears to have some logic (greater capacity, greater expense, resulting in inefficient use of available funds). In fact, hospitals rarely staff or operate beds in significant excess of the demand for hospitalization of patients.

At the beginning of the Medicare era (1965), the country had four beds per 1,000. Attempts (see text above) to "squeeze" the utilization of the inpatient beds resulted in "bulging" of other parts of the "demand balloon" - - a surfeit of entirely new ambulatory activities (freestanding ambulatory surgery centers), long-term acute care hospitals, and others, most of which did not exist prior to the passage of Medicare, and all of which have added to the extraordinary growth of expenditures in the institutional health care field.

The result of focus on "overbedding," whether inadvertent or planned, is to direct attention away from the primary problem that plagues New York City safety net hospitals, namely the underfunding of Medicaid (and now managed Medicaid) by the State of New York (see Exhibit Two).

Pages two through five of this exhibit show the results by borough, alphabetically.

Brooklyn hospitals (page three) have 2.46 certified beds per 1,000, 2.26 if the Long Island College Hospital is closed, and 2.15 if the Long Island College Hospital and Interfaith Medical Center are both closed. Except for Queens, Brooklyn has the fewest hospitals per 1,000 population. Manhattan, by contrast, has approximately 6 beds per 1,000 population.

Borough	Population	Acute Hospital Beds, per NYS DoH	Acute Beds per 1,000 Population	Number of Hospitals (DoH)	Hospitals/Million Residents
Bronx	1,408,473	3,898	2.77	11	7.81
Brooklyn	2,565,635	5,514	2.15	15	5.85
Manhattan	1,619,090	9,993	6.17	20	12.35
Queens	2,272,771	3,788	1.67	9	3.96
Staten Island	470,728	1,224	2.60	4	8.50
Total	8,336,697	24,417	2.93	59	7.08

Name of Hospital	Address	City, State, Zip	Phone Number	Website	Certified Beds, NYS DOH
Bronx Lebanon Hospital Center - Concourse Division	1650 Grand Concourse	Bronx, NY 10457	(718) 901-8800	www.bronx-leb.org	415
Bronx Lebanon Hospital Center - Fulton Division	1276 Fulton Avenue	Bronx, NY 10456	(718) 901-8800	www.bronx-leb.org	164
Calvary Hospital	1740-70 Eastchester Road	Bronx, NY 10461	(718) 863-6900	www.calvaryhospital.org	225
Jacobi Medical Center	1400 Pelham Parkway	Bronx, NY 10461	(718) 918-5000	www.nyc.gov/html/hhc/jacobi/home.html	457
Lincoln Medical & Mental Health Center	234 East 149th Street	Bronx, NY 10451	(718) 579-5000		347
Montefiore Medical Center - Weiler Hospital of Einstein College Division	1825 Eastchester Road	Bronx, NY 10461	(718) 904-2000	www.montefiore.org	403
Montefiore Medical Center - Moses Division	111 East 210th Street	Bronx, NY 10467	(718) 920-4321	www.montefiore.org	767
Montefiore Medical Center - North Division	600 East 233rd Street	Bronx, NY 10466	(718) 920-9000	www.montefiore.org	321
New York Westchester Square Medical Center	2475 St. Raymond Avenue	Bronx, NY 10461	(718) 430-7300	www.nywsmc.org	140
North Central Bronx Hospital	3424 Kossuth Avenue & 210th Street	Bronx, NY 10467	(718) 519-5000	www.nyc.gov/html/hhc/ncbh/home.html	213
St. Barnabas Hospital	4422 Third Avenue	Bronx, NY 10457	(718) 960-9000	www.stbarnabashospital.org	446
Totals					3,898
Population*					1,408,473
Beds/1,000 population					**2.77**
***Source: New York City Department of City Planning Census Estimates 2012**				Without Calvary:	2.61

Name of Hospital	Address	City, State, Zip	Phone Number	Website	Certified Beds, NYS DOH	Chief Executive	Ownership/Governance
Beth Israel Medical Center - Brooklyn (Kings Highway Division)	3201 Kings Highway	Brooklyn, NY 11234	718 245-3131	www.wehealnewyork.org	212	Harris Nagler, MD, President	Continuum, NFP
Brookdale University Hospital and Medical Center	2554 Linden Blvd	Brooklyn, NY 11208	718 240-5000	www.brookdalehospital.org	530	Mark E. Toney, President and CEO	MediSys, NFP
Brooklyn Hospital Center	121 Dekalb Ave	Brooklyn, NY 11217	718 250-8000	www.tbh.org	464	Richard B. Becker, MD, President and CEO	NYP, NFP
Coney Island Hospital	2601 Ocean Parkway	Brooklyn, NY 11235	718 616-3000	http://www.nyc.gov/html/hhc/coneyisland/html/home/home.shtml	371	Arthur Wagner, Executive Director	HHC
Interfaith Medical Center	1545 Atlantic Ave	Brooklyn, NY 11213	718 613-4000	www.interfaithmedical.com	287	Patrick Sullivan, Interim President & CEO	NFP
Kingsbrook Jewish Medical Center	585 Schenectady Ave	Brooklyn, NY 11203	718 604-5000	www.kingsbrook.org	318	Linda Brady, President & CEO	NFP
Kings County Hospital Center	451 Clarkson Ave	Brooklyn, NY 11203	718 245-3131	www.nyc.gov/html/hhc/html/kings.html	639	Ernest J. Baptiste, Executive Director	HHC
Long Island College Hospital (SUNY Downstate at LICH)	339 Hicks St	Brooklyn, NY 11201	718 780-1472	www.lich.org	506	John F. Williams, MD, President	SUNY, NYS
Lutheran Medical Center	150 55th St	Brooklyn, NY 11220	718 439-5440	www.lutheranmedicalcenter.com	450	Wendy Z. Goldstein, President and Chief Executive Officer	NFP
Maimonides Medical Center	4802 Tenth Ave	Brooklyn, NY 11219	718 283-6000	www.maimonidesmed.org	711	Pamela S. Brier, President	NFP
New York Community Hospital of Brooklyn, Inc.	2525 Kings Highway	Brooklyn, NY 11229	718 692-5300	www.nych.com	134	Lin H. Mo, President/CEO	NFP
New York Methodist Hospital	506 Sixth St	Brooklyn, NY 11215	718 768-3404	www.nym.org	591	Mark J. Mundy, President and Chief Executive Officer	NFP
University Hospital of Brooklyn (SUNY Downstate Medical Center)	445 Lenox Rd	Brooklyn, NY 11203	718 270-1662	www.uhb.org	376	John F. Williams, MD, President	SUNY, NYS
Woodhull Medical Center	760 Broadway	Brooklyn, NY 11206	718 963-8040	http://www.nyc.gov/html/hhc/woodhull/html/home/home.shtml	394	George Proctor, Executive Director	HHC
Wyckoff Heights Medical Center	374 Stockholm St	Brooklyn, NY 11237	718 963-7272	www.wyckoffhospital.org	324	Ramon J. Rodriguez, President & Chief Executive Officer	NFP
Totals (All as listed; without LICH; without LICH and Interfaith)					6,307	5,801	5,514
Population*					2,565,635		
Beds/1,000 population (All as listed; without LICH; without LICH and Interfaith)					**2.46**	**2.26**	**2.15**

***Source: New York City Department of City Planning Census Estimates 2012**

Name of Hospital	Address	City, State, Zip	Phone Number	Website	Certified Beds, NYS DOH
Bellevue Hospital Center	462 First Avenue	New York, NY 10016	(212) 562-4141	www.nyc.gov/html/hhc/bellevue/home.html	912
Beth Israel Medical Center/Petrie Campus	First Avenue at 16th Street	New York, NY 10003	(212) 420-2000	www.wehealnewyork.org	856
Coler-Goldwater Specialty Hospital & Nursing Facility - Goldwater Hospital Site	1 Main Street, Roosevelt Island	New York, NY 10044	(212) 318-8000	nyc.gov/html/hhc/coler-goldwater/home.html	417
Coler-Goldwater Specialty Hospital & Nursing Facility - Coler Hospital Site	Roosevelt Island	New York, NY 10044	(212) 848-6000	nyc.gov/html/hhc/coler-goldwater/home.html	210
Harlem Hospital Center	506 Lenox Avenue	New York, NY 10037	(212) 939-1000		286
Hospital for Special Surgery	535 E. 70th Street	New York, NY 10021	(212) 606-1000	www.hss.edu	205
Lenox Hill Hospital	100 East 77th Street	New York, NY 10021	(212) 434-2000	www.lenoxhillhospital.org	652
Memorial (Sloan Kettering) Hospital for Cancer and Allied Diseases	1275 York Avenue	New York, NY 10021	(212) 639-2000	www.mskcc.org	514
Metropolitan Hospital Center	1901 First Avenue	New York, NY 10029	(212) 423-6262	www.nyc.gov/html/hhc/html/facilities/metropolitan.shtml	356
Mount Sinai Hospital	One Gustave L. Levy Place	New York, NY 10029	(212) 241-6500	www.mountsinai.org	1,171
New York Downtown Hospital	170 William Street	New York, NY 10038	(212) 312-5000	www.downtownhospital.org	180
New York Presbyterian Hospital - Allen Hospital	5141 Broadway	New York, NY 10034	(212) 932-4000	www.nyp.org/allenpavilion	201
New York Presbyterian Hospital - Columbia Presbyterian Center	622 West 168th Street	New York, NY 10032	(212) 305-2500	www.nyp.org	977
New York Presbyterian Hospital - New York Weill Cornell Center	525 East 68th Street	New York, NY 10021	(212) 746-5454	www.nyp.org	850
NY Eye and Ear Infirmary	310 East 14th Street	New York, NY 10003	(212) 979-4000	www.nyee.edu	69
New York Hospital for Joint Diseases	301 East 17th Street	New York, NY 10003	(212) 598-6000		190
NYU Hospitals Center	550 First Avenue	New York, NY 10016	(212) 263-7300	www.nyumc.org	879
Rockefeller University Hospital	1230 York Avenue	New York, NY 10021	(212) 327-7511		40
St. Lukes Roosevelt Hospital - St. Lukes Hospital Division	1111 Amsterdam Avenue	New York, NY 10025	(212) 523-4000	www.wehealnewyork.org	523
St. Lukes Roosevelt Hospital - Roosevelt Hospital Division	1000 Tenth Avenue	New York, NY 10019	(212) 523-4000	www.wehealnewyork.org	505
Totals					9,993
Population*					1,619,090
Beds/1,000 population					**6.17**

***Source: New York City Department of City Planning Census Estimates 2012**

Name of Hospital	Address	City, State, Zip	Phone Number	Website	Certified Beds, NYS DOH
Elmhurst Hospital Center	79-01 Broadway	Elmhurst, NY 11373	(718) 334-4000	nyc.gov/html/hhc/html/facilities/elmhurst.shtml	545
Flushing Hospital Center	45th Avenue & Parsons Blvd.	Flushing, NY 11355	(718) 670-5000	www.flushinghospital.org	293
Forest Hills Hospital	102-01 66th Road	Forest Hills, NY 11375	(718) 830-4000		312
Jamaica Hospital Medical Center	89th Avenue & Van Wyck Expressway	Jamaica, NY 11418	(718) 206-6000	www.jamaicahospital.org	384
Long Island Jewish Medical Center	270-05 76th Avenue	New Hyde Park, NY 11040	(718) 470-7000	www.northshorelij.com	983
Mount Sinai Hospital of Queens	25-10 30th Avenue	Long Island City, NY 11102	(718) 932-1000	www.mshq.org	235
New York Hospital Medical Center of Queens	56-45 Main Street	Flushing, NY 11355	(718) 670-1231	www.nyhq.org	535
Queens Hospital Center	82-68 164th Street	Jamaica, NY 11432	(718) 883-3000	www.ci.nyc.ny.us/html/hhc/html/queens.html	244
St. John's Episcopal Hospital South Shore	327 Beach 19th Street	Far Rockaway, NY 11691	(718) 869-7000	www.ehs.org	257
Totals					3,788
Population*					2,272,771
Beds/1,000 population					**1.67**

***Source: New York City Department of City Planning Census Estimates 2012**

Name of Hospital	Address	City, State, Zip	Phone Number	Website	Certified Beds, NYS DOH
Richmond University Medical Center	355 Bard Avenue	Staten Island, NY 10310	(718) 818-1234	www.rumcsi.org	448
RUMC-Bayley Seton	75 Vanderbilt Avenue	Staten Island, NY 10304	(718) 818-1234	www.rumcsi.org	62
Staten Island University Hospital - North	475 Seaview Avenue	Staten Island, NY 10305	(718) 226-9000	www.siuh.edu	508
Staten Island University Hospital - South	375 Seguine Avenue	Staten Island, NY 10309	(718) 226-2000	www.siuh.edu	206
Totals					1,224
Population*					470,728
Beds/1,000 population					**2.60**

***Source: New York City Department of City Planning**
Census Estimates 2012

Exhibit Number Two, Summary of Problems, Brooklyn Health Care Delivery System

This exhibit is a collection of information from groups that have spent considerable time assessing health care delivery system problems in Brooklyn. This group includes the Brooklyn MRT Health System Redesign Work Group, the Brooklyn Healthcare Improvement Project of SUNY Downstate Medical Center and the Community Health Needs Assessments done (per Medicare requirement) by hospitals in Brooklyn. (The numbers following each of the "key points" in this specific exhibit refer to the page number in the documents previously published by the named resource.) All of these documents will be found for reference on the web site associated with this report.

A summary of the problems chronicled in this document includes the following:

(1) The financial distress of Brooklyn hospitals stems directly from underpayment for inpatient services by Medicaid, as well as high long-term debt burdens and the lack of flexibility (no capital) for responding to the changing healthcare marketplace (inpatient to outpatient, episodic to continuous). This comprehensive list of problems also includes high utilization of emergency departments, a high prevalence of uninsured residents (15% on average in Brooklyn, as high as 25% in distressed areas), as well as a high rate of "under-insured."

(2) In addition, problems chronicled in this list include high incidence and prevalence of chronic disease, high measurements of factors associated with chronic disease (high blood pressure, diabetes), and chronic disease screening rates below city-wide and state-wide averages.

(3) Further, the problems include lack of a primary care provider for as many as a quarter of Brooklyn residents, and the absence of strong primary care and community-based specialty care networks. This leads to long wait times, limited access and episodic care, as well as the aforementioned high rates of emergency department utilization and hospitalization for preventable illness.

(4) Further limitation is that of public transportation, with travel in excess of thirty minutes to health care facilities common; lack of available specialists in neighborhoods leads to outmigration and additional travel time.

Brooklyn Healthcare Delivery System

Healthcare Problems, Summary

Resource	Primary Topic		Key Points	Category
Brooklyn MRT Health Systems Redesign Work Group	Brooklyn Hospital Future Viability	1	Several hospitals in Brooklyn are on the brink of shutting down because of payor mixes skewed towards public payors causing low operating margins, high long term debt burdens, and a lack of flexibility in responding to the changing marketplace of healthcare delivery. This makes the hospitals unable to effectively serve their communities over the long term.	Finance
		2	Hospital inpatients are less complex to treat and their discharges are declining. ED utilization has increased significantly particularly with the recent closure of hospitals in the community. This is leading to an overall decrease in revenue for hospitals.	Finance
		3	15% of residents are uninsured in Brooklyn with the rates as high as 25% in certain areas. Hospitals are also burdened by the high rate of underinsured. This is associated with above average unemployment and below median household income compared to the city and the state.	Insurance
		4	Residents of Brooklyn have higher rates of chronic diseases and smoking than the New York City average. In 2009, 26% of adults were obese, 11% of adults had diabetes, and 31% of adults had high blood pressure. Chronic disease screening rates are below the citywide and statewide rates in these same areas.	Health Indicators
Brookdale Hospital Community Service Plan 2009	Community Health Needs Assessment	5	There are ethnic disparities associated with chronic diseases particularly among African Americans.	Health Indicators
The Need for Caring in North and Central Brooklyn	Community Health Needs Assessment	6	There are high rates of unnecessary ED utilization and hospitalizations for preventable illnesses.	Utilization
Woodhull Medical Center CHNA 2013	Community Health Needs Assessment	7	Higher than statewide average inpatient psychiatric services are being utilized in the borough with many inpatient facilities closing and outpatient facilities still not restored after Hurricane Sandy.	Access to Care
Brooklyn MRT Health Systems Redesign Work Group	Brooklyn Hospital Future Viability	8	23% of Brooklyn residents lack a primary care provider. There are no strong primary care and community-based specialty care networks across communities which indicates a fragmentation of the healthcare delivery system.	Access to Care
Brooklyn Healthcare Improvement Project (B-HIP), SUNY Downstate	Healthcare in Northern and Central Brooklyn	9	Patients face long wait times and limited access to weekend/after-hours primary care -- which are only 16% of the clinic hours available in Brooklyn.	Access to Care
Brooklyn MRT Health Systems Redesign Work Group	Brooklyn Hospital Future Viability	10	Health Professional Shortage Areas are associated with the incidence of poverty in Brooklyn neighborhoods. This indicates an uneven distribution of primary care facilities and providers.	Access to Care
		11	Outmigration of patients from Brooklyn to hospitals in Manhattan has increased between 2006 and 2010. Individuals generally go outside of their neighborhoods for care because a specialist is not available in their neighborhood or were referred to a physician outside of their neighborhood.	Utilization

Brooklyn Healthcare Delivery System

Healthcare Problems, Summary

Resource	Primary Topic		Key Points	Category
The Need for Caring in North and Central Brooklyn	Community Health Needs Assessment	12	Using public transportation leads to traveling more than 30 minutes to access healthcare facilities.	Access to Care
Kings County Hospital CHNA 2013	Community Health Needs Assessment	13	Communication between patients and providers is difficult because of language barriers. A great deal of Brooklyn residents have limited English proficiency with those 5 years or older 25% claiming to speak English "less than well" according to the 2010 US Census.	Access to Care

Proposed Solutions

The Need for Caring in North and Central Brooklyn	2013 Community Health Needs Assessment	1	Increasing the number of primary care medical homes, urgent care centers, comprehensive ambulatory care centers, and mental health facilities within the community will improve access to appropriate levels of care and alleviate unnecessary utilization of EDs and hospitalizations for preventable conditions.	Access to Care
Maimonides Medical Center Community Service Plan 2011	Community Health Needs Assessment	2	Widespread adoption of the Brooklyn Health Information Exchange will allow for improved care coordination between hospitals and the entire range of healthcare providers in the community.	Collaborative Efforts
Brooklyn Healthcare Improvement Project (B-HIP), SUNY Downstate	Healthcare in Northern and Central Brooklyn	3	Hospitals should implement patient navigator programs and collaborate with community organizations to effectively engage (in a linguistically and culturally competent manner) and inform patients and residents with regard to access to health screenings, acquiring health insurance, accessing the appropriate levels of care to meet their health needs, and self-management of chronic health conditions.	Access to Care
New York Community Hospital Community Service Plan 2009	Community Health Needs Assessment	4	Advisory boards composed of community stakeholders should be organized to provide feedback and continuously improve services offered by hospitals and community-based facilities.	Collaborative Efforts

Brooklyn Healthcare Delivery System

Current Problems

Resource	Primary Topic		Key Points	Category
Brooklyn MRT Health Systems Redesign Work Group	Brooklyn Hospital Future Viability	1	While there are well-managed hospitals in the borough of Brooklyn, providing excellent healthcare services to meet the needs of the communities they service, there are many others that are on the brink of failure due to skewed payor mixes, poor management, and a lack of flexibility in responding to the changing marketplace of healthcare delivery all of which are constraining these hospitals' ability to effectively serve their communities over the long term (14).	General
		2	Critical socioeconomic indicators for Brooklyn: (1) Median household income for the entire borough was $42,143 in 2010 (2) 2010 unemployment rate for Brooklyn was 10.5%, higher than the 9.3% rate observed throughout New York State (3) Of those 25 and older, 12% of residents have less than a 9th grade education, 29% have attained a high school diploma or equivalent, and 29% have a Bachelor's or graduate degree (20).	Demographics
		3	The highest poverty rates in Brooklyn include: Greenpoint, Bushwick-Williamsburg, Central Brooklyn, and East New York-New Lots each with more than 30% of households living below the federal poverty level (20).	Demographics
		4	The highest rates of uninsured residents are located in Bushwick-Williamsburg and Sunset park, each with over 25% (21).	Health Indicators
		5	38% of Brooklyn residents are of foreign nationalities and 45% of these residents are not US citizens. These immigrants residing in the borough are mostly of Latin-American origin (52%), European (20%), and Asian (25%). This large foreign-born population means that a great deal of Brooklyn residents have limited English proficiency. Of those who are 5 years or older, 25% claim to speak English "less than well" (21).	Demographics
		6	Residents of Brooklyn have higher rates on health status indicators than the New York City average. In 2009, 26% of adults were obese, 11% of adults had diabetes, and 31% of adults had high blood pressure (21).	Health Indicators
		7	Rates of hospitalization and premature death are higher in Brooklyn when compared to the New York City average between 2007-2009. 47% of residents died prematurely compared to 45% citywide; premature death is defined by death before age 75 (21).	Health Indicators
		8	Brooklyn has higher rates of heart disease hospitalizations, heart disease deaths, diabetes hospitalizations, and diabetes deaths than the citywide average (22).	Health Indicators
		9	Health disparities within Brooklyn are significantly related to race and ethnicity. 62.3% of Black non-Hispanic residents died prematurely (before age 75) between 2007 and 2009 at a rate double that of White non-Hispanics. Black non-Hispanic residents have the highest rates of obesity (31.8%) and high blood pressure (35.0%) and second highest rate of diabetes (13.2%) as compared to other ethnicities in 2009. Black non-Hispanic children in Brooklyn were hospitalized for asthma at a rate of 70.0 per 10,000 compared to 7.6 per 10,000 for White non-Hispanic children. Hispanic Brooklyn residents have the highest percentage of death before age 75 (62.5%), highest prevalence of diabetes (15.5%) and asthma (11.0%), and the second highest rates of obesity (29.3%) and high blood pressure (31.3%) (22).	Health Indicators
		10	High rates of chronic disease are compounded by socioeconomic barriers to healthcare, such as lack of health insurance, limited English proficiency, and poverty. Large segments of the population in several neighborhoods live in extreme poverty, have low levels of educational attainment, and are linguistically isolate. 40% of Brooklyn residents are on Medicaid and 15% are uninsured (25-26).	Demographics
		11	The healthcare delivery system of Brooklyn is ill-equipped in some areas to address the complex health issues facing communities. It is dominated by hospitals that are dependent upon public funding and, in many cases, weakened by cuts in government programs, intense competition for admissions from within the borough and without, an unfavorable reimbursement environment, and rising costs (26).	Finance
		12	Too many hospitals have failed to create, and are not organized to partner with, strong primary care and community-based specialty care networks in their communities (26).	Collaborative Efforts
		13	Even the well-managed hospitals of Brooklyn lack the resources to make necessary investments in physical plant, staff, medical talent, information technology, or new models of care (26).	Finance

Brooklyn Healthcare Delivery System

Current Problems

Resource	Primary Topic		Key Points	Category
		14	The healthcare delivery system of Brooklyn fails to engage patients in care through primary care settings, resulting in preventable use of higher cost services and poor health outcomes (26).	Utilization
		15	Brooklyn hospitals' utilization data reveals a variety of trends and factors that undermine their financial stability including declining admissions in many facilities, a low case mix index, high lengths of stay, low occupancy rates, migration of lucrative cases to Manhattan facilities, and high rates of preventable admissions and emergency department visits (26).	Finance
		16	In 2010, there were approximately 297,000 inpatient discharges from Brooklyn hospitals, down from approximately 301,000 in 2009. These discharges were concentrated heavily in the medical service category: Medical (38%), Surgical (26%), Pediatric (5%), Obstetrical (12%), Healthy Newborn (9%), High Risk Neonate (1.5%), Psychiatric (5%), and Chemical Dependency (3%) (26-27).	Utilization
		17	Of the 2010 patient discharges in Brooklyn, the combined 8% of mental illness (psychiatric and chemical dependency) discharges resulted in more than 15% of the inpatient days -- the largest percentage of inpatient days of all the clinical categories (27).	Utilization
		18	The case mix index, or the measure of acuity of the patients served the complexity of the resources required for their treatments) for medical-surgical patients in 2010 was 1.41 for Brooklyn, lower than the average of 1.54 of New York City and the state. Because reimbursement is tied to case mix index, the lower average is associated with lower revenues (27).	Health Indicators
		19	Average length of stay (ALOS) in Brooklyn is 6.12 days overall with 6.03 for medical-surgical patients. This value is higher than the national average of 4.8 days and is higher than three of the four other boroughs of New York City. Manhattan is the exception and has a longer ALOS of 6.21 days (27).	Utilization
		20	Despite the longer average length of stay (ALOS), the Brooklyn hospitals are not fully occupied. In 2010, 71% of inpatient beds in Brooklyn were occupied daily (excluding healthy newborn admissions). This is below the planning standard of 85% occupancy. However, these rates vary widely between hospitals. Brookdale, Brooklyn Hospital, Interfaith, Long Island College Hospital, Wyckoff, and Kingsbrook Jewish each had occupancy rates of less than 66% in 2010. Long Island College Hospital, in particular, had an occupancy rate of 45.2% (27).	Utilization
		21	The inpatient payor mix of the borough is dominated by Medicaid, which paid 42% of discharges in 2010. Medicare covered 33% and commercial insurance covered 17%. The remaining 8% of patients are considered "self-pay" patients, who typically include uninsured and charity care patients. With high percentages of patients covered by Medicare and Medicaid (75% in 2010), Brooklyn hospitals are particularly vulnerable to the effects of the state and federal budgets (28).	Finance
		22	Inpatient discharges have declined by 2% between 2008 and 2010. Discharge trends vary widely by hospital. From 2006-2010, there was a 20% decline at Long Island College Hospital, declines of 8%-11% at Brookdale, Woodhull, and Wyckoff. During this same period, discharges increased by 5%-9% at University, Kings County, Methodist, and Beth Israel Brooklyn (formerly the "Kings Highway" division). Discharges increased between 11%-15% at Kingsbrook Jewish, New York Community, and Maimonides (29).	Finance
		23	Discharge trends vary by payor. Across the 15 Brooklyn hospitals from 2008-2010, discharges of Medicare patients declined by 1%, Medicaid patients declined by 7%, and commercially-insured patients declined by 7% as well. Three of the five sharpest declines were observed at the three HHC hospitals: Coney Island Hospital (-15%), Kings County Hospital (-15%), Woodhull Hospital (-30%). Declines of -18% and -21% were observed at Lutheran and LICH, respectively (29).	Finance
		24	Self-pay inpatients are a small percentage overall yet increased by 56% between 2008-2010 (29).	Finance

Brooklyn Healthcare Delivery System

Current Problems

Resource	Primary Topic		Key Points	Category
		25	With declining admissions at many hospitals and little growth overall, competition for patients among hospitals is fierce. Not one Brooklyn hospitals commands 40% of the inpatient discharges in the zip codes that provide 50% or more of its inpatients (their primary market). Only four hospitals attract more than 30% of the inpatient discharges from their core markets: Lutheran (37%), Maimonides (37%), Coney Island (32%), and Wyckoff (21%). More than 70% of the residents of the core market areas of the remaining 11 hospitals go to the other hospitals for care. Kingsbrook Jewish and NY Community command the smallest shares of their markets at 9% and 8%, respectively (30).	Service Area
		26	Competition for Brooklyn patients include the Manhattan hospitals (particularly for commercially-insured and surgical patients), Brooklyn hospitals are also competing with each other for patients (30).	Service Area
		27	Low growth in admissions is in part attributable to migration of patients from Brooklyn to other boroughs or counties for care. While more than 90% of Brooklyn hospital inpatients are Brooklyn residents, only 76% of Brooklyn residents who were admitted to a hospital in 2010 used a Brooklyn hospital. 18.4% went to Manhattan facilities, 2.7% to hospitals in Queens, 1.2% to Staten Island, .6% to the Bronx, and 1.4% elsewhere (30).	Service Area
		28	Migration to Manhattan for care has risen from 60,000 to over 65,000 from 2006-2010. The strongest magnets for Brooklyn patients in 2010 were Beth Israel Medical Center, NYU Langone Medical Center, NY Presbyterian-Weill Cornell Medical Center, and Mount Sinai Medical Center (31).	Service Area
		29	Brooklyn hospitals are not attracting patients from other boroughs and are losing a significant portion of their geographic market to Manhattan's academic medical centers. The number of commercially-insured Brooklyn patients going to Manhattan hospitals increased by 15% from 2006-2010. For 2010, 35% of commercially-insured patients migrated to Manhattan for care, whereas only 13.5% of Medicaid patients did so (31).	Service Area
		30	46% of all Emergency Department visits that do not result in a hospital admission in Brooklyn are either non-emergent or primary care treatable. These high rates of preventable emergency department or inpatient use are indicators of waste in a healthcare delivery system; the need for higher intensity and expensive healthcare services could be averted through the use of lower level, less costly care (31).	Utilization
		31	The rate of inpatient admissions that could be avoided with appropriate preventive care or disease management in the community, known as the PQI rate, is also 20% higher in Brooklyn hospitals than he statewide average hospital rate. For Brooklyn, 15.4% of adult medical-surgical admissions occur in this category compared to 13.1% citywide and 12.9% statewide (31).	Utilization
		32	Sub-optimal inpatient and emergency department use in Brooklyn varies by neighborhood and is associated with the health professional shortage area (HPSA) designations and with the incidence of poverty. In 2008, East New York-New Lots, Central Brooklyn, and Bushwick-Williamsburg had the highest rates of emergency department visits that did not result in a hospital admission (at 50, 52, and 57 per 100 residents, respectively). The highest rates of PQI inpatient discharges are found in these same neighborhoods as well as Northwest Brooklyn and Sunset Park. The highest PQI rates by hospital are found at Woodhull, Beth Israel Brooklyn, Brooklyn Hospital, Brookdale, Interfaith, and Kings County which are all above the state and city PQI rates (32).	Utilization
		33	High rates of primary care treatable ED use and PQI hospitalizations suggest that patients are not accessing appropriate or effective primary care necessary to keep them health and out of the hospital. Also, high rates of non-emergent ED use suggest that patients are not connected to a primary care provider who can see them when they are ill (33).	Utilization
		34	A significant portion of the effort and resources of Brooklyn's hospitals are directed towards accommodating the effects of a fragmented healthcare system that both lacks adequate primary and preventive care and encourages patients to rely inappropriately on ED and hospital-based services (33).	Utilization
		35	Brooklyn's hospitals do poorly on patient satisfaction surveys such as the HCAHPS survey conducted by CMS. Not a single Brooklyn hospital reached or exceeded the statewide average score with respect to the percentage of patients who would "definitely recommend" the facility (34).	Quality Improvement

Resource	Primary Topic		Key Points	Category
		36	Patient satisfaction with the communication is also less than ideal in Brooklyn hospitals. The percentage of patients who report that their doctor "sometimes or always communicates well" with them falls below the state and city averages of approximately 94% and 92%, respectively, in every single Brooklyn hospital, with the exception of Maimonides (34).	Quality Improvement
		37	23% of all Brooklyn residents, and nearly one-third of residents in five Brooklyn neighborhoods, indicate that they lack a primary care provider --Greenpoint, Central Brooklyn, Bushwick-Williamsburg, East New York-New Lots, and Sunset Park (35).	Health Indicators
		38	Since 40% of Brooklyn residents are on Medicaid and 15% are uninsured, medical practices that do not routinely serve Medicaid and uninsured patients cannot satisfy primary care needs in Brooklyn's economically-challenged communities. This is because, unlike FQHCs and hospital-sponsored clinics, private medical practices rarely offer substantial free care to low-income, uninsured patients (35).	Finance
		39	It is difficult to develop a complete picture of primary care capacity and utilization in Brooklyn due to gaps in data -- physician practices are not required to report visit data to the Department of Health. However, Medicaid beneficiaries had an average of 6.7 outpatient visits per member per year in Brooklyn compared to 5.3 citywide and 5.2 statewide. These rates vary widely by neighborhood and are the lowest in central and northeast Brooklyn (35).	Utilization
		40	The availability of primary care varies by neighborhood in Brooklyn. Although there are dozens of hospital outpatient clinics, diagnostic treatment centers, and 13 FQHCs with more than 80 sites, outpatient facilities are unevenly distributed among Brooklyn neighborhoods (35-36).	Service Area
		41	There are 9 federally-designated primary care health professional shortage areas (HPSAs) in Brooklyn: Bedford-Stuyvesant, Bushwick, Coney Island, Crown Heights, East New York, Midwood, Red Hook, Sunset Park, and Williamsburg (36).	Service Area
		42	There are 85 FTE primary care physicians per 100,000 residents across Brooklyn, which is higher than the statewide average of 82 FTE physicians per 100,000 residents. However, in Canarsie-Flatlands, Central Brooklyn, Greenpoint, and East New York-New Lots, the rate is less than 60 FTEs per 100,000. In Sunset Park, the rate is 93 per 100,000 and in Northwest, Southwest, and Southern Brooklyn, the rate is more than 115 FTE primary care physicians per 100,000 residents (36).	Service Area
		43	Brooklyn residents use inpatient psychiatric services at a higher rate than the statewide average (5.8 per 10,000 compared to 5.0 per 10,000). The NYS Office of Alcohol and Substance Abuse Services' 2011 Service Need Profile reports that over 206,000 Brooklyn residents age 12 and over have a substance use disorder. All together, 50% of mental health clients report a chronic medical condition in Brooklyn compared to 44% statewide (37).	Utilization
		44	Brooklyn hospitals are seeing high levels of utilization among people with behavioral health diagnoses. Of all inpatient discharges in the area, 27% involve behavioral health as a primary or comorbid diagnosis. For 11 Brooklyn hospitals, 30-day readmission rates to a psychiatric inpatient setting from inpatient psychiatric care in Brooklyn are higher than the statewide average (37).	Quality Improvement
		45	Outpatient behavioral health services are unevenly distributed among Brooklyn neighborhoods. The 69 mental health clinics and 44 chemical dependence treatment outpatient programs are concentrated in Central and Northwest Brooklyn neighborhoods even though Southern Brooklyn and Bushwick-Williamsburg have higher numbers of residents discharged from hospitals with a behavioral health diagnosis (38).	Service Area
		46	Overall, in regards to behavioral healthcare services, there is a heavy reliance on inpatient and emergency department care, segregation of medical and behavioral healthcare, lack of coordination along the continuum of care, insufficient early intervention, and lack of resources for functional supports such as housing, employment, and education. Reimbursement methodologies are unrelated to individual outcomes (38).	Collaborative Efforts
		47	Residents of the communities served by these hospitals are voting with their feet and choosing to use hospitals outside of their immediate neighborhoods and outside of Brooklyn (42).	Service Area

Brooklyn Healthcare Delivery System

Current Problems

Resource	Primary Topic		Key Points	Category
		48	Six hospitals (Brookdale Hospital Medical Center, Brooklyn Hospital Center, Interfaith Medical Center, Kingsbrook Medical Center, Long Island College Hospital, Wyckoff Heights Medical Center) lack a business model that will allow them to survive in the long term (and even the short term). They all lack favorable positions in key indicators of financial stability: operating margin, current ratio, debt-to-bed ratio, and net assets (42).	Finance
		49	Brookdale, Wyckoff, Interfaith, and LICH have a negative operating margin with Kingsbrook Jewish and Brooklyn Hospital having slightly positive operating margins (42).	Finance
		50	Brookdale Hospital Medical Center, Interfaith Medical Center, Kingsbrook Medical Center, Long Island College Hospital, and Wyckoff Heights Medical Center each have current ratios of less than 1.0 -- each hospital lacks revenues sufficient to support day-to-day operations. This forces facilities to consider reliance on managing cash flow or borrowing to help cover expenses (43).	Finance
		51	Brookdale Hospital Medical Center, Brooklyn Hospital Center, Interfaith Medical Center, Kingsbrook Medical Center, Long Island College Hospital, and Wyckoff Heights Medical Center each have high levels of long-term debt. Each of these six hospitals have long-term debt to bed ratios above the state median of $141,000 per bed with Interfaith reaching an extreme of $517,000 per bed -- more than double the median of Brooklyn (44).	Finance
		52	Low operating margins, combined with high levels of long-term debt and low current ratios, preclude the six hospitals of interest from capital investment in physical plant and depreciable medical/nonmedical equipment. With capital spending ratios below 100%, these hospitals are disinvesting or spending less in new capital than what is being incurred in depreciation of old capital. This will make it difficult for these facilities to maintain quality of care and keep abreast of advances in the organization and delivery of inpatient and outpatient services (44).	Finance
		53	The net asset positions of Brookdale, Long Island College, Interfaith, and Wyckoff Heights ranged from -$78 to -$285 million in 2010. This makes it difficult for these hospitals to initiate restructuring of services and physical plant that would be necessary for any significant improvement in efficiency or increases in revenues necessary for their longer term viability and for the delivery of quality care appropriate to the identified health care needs of their communities (45).	Finance
		54	Federal Medicare disproportionate share (DSH) payments will be cut substantially beginning in 2014, which will have a particularly significant impact on hospitals, like those in Brooklyn, that serve large numbers of low-income Medicare and Medicaid beneficiaries (46).	Finance
		55	Through the work of the Medicaid Redesign Team (MRT), the state is shifting all Medicaid beneficiaries, including individuals with disabilities, mental illness, and long-term care needs, into managed care plans. This will virtually eliminate Medicaid fee-for-service payments for hospitals, and require them to rely primarily on their ability to leverage adequate reimbursement from managed care plans and to manage their costs (46).	Finance
Crain's Health Pulse, 11-16-2011	Emergency Department Use	1	Residents of central and northeast Brooklyn have both the highest number of ED visit rates (per 100 residents) and subsequent hospital admission rates (per 100 residents). The rates of these neighborhoods are much higher than the New York City average. The specific neighborhoods include Flatbush, East New York & New Lots, Central Brooklyn, Bushwick, and Williamsburg (1).	Utilization
The Need for Caring in North and Central Brooklyn	Community Health Needs Assessment	1	The major reasons for not going to a doctor according to the patients surveyed include not being sick, not having insurance, the cost of care, insurance difficulties, time issues, and a belief in natural healing (55).	Utilization
		2	Patients surveyed indicated that high blood pressure, asthma, diabetes, hearing/vision problems, dental problems, bone/joint/muscle problems, obesity, depression, and health/vascular issues were the most predominate health concerns in their household -- in descending frequency (50-51).	Health Indicators
		3	Survey respondents indicated that they (52.4%) and their household members (46.7%) generally had income-eligible public health insurance -- Medicaid, Child Health Plus, and Family Health Plus (49).	Finance
		4	When asked if they and those living in their household had health insurance, including Medicaid, 72.6% of survey participants answered that all members of the household have health insurance, 12.0% said that some have insurance, 11.9% said that no one in the household has health insurance, and 3.4% were not sure (47).	Finance

Resource	Primary Topic		Key Points	Category
		5	When asked about their location of birth, 39.5% of survey respondents indicated they were foreign born while 60.5% indicated they were born in the US (42-43).	Demographics
		6	Of the 577 respondents who indicated their race in the survey, 42.5% self-identified as African-American, 23.4% self-identified as Caribbean/West Indian, 15.3% self-identified as Mixed race/ethnicity, 12.8% self-identified as White, 4.2% self-identified as Arab/Middle Eastern, .9% self-identified as African, .9% self-identified as Asian/Pacific Islander, and .2% self-identified as Native American (39-40).	Demographics
		7	In response to the question "Have you and your household members been able to get regular check-ups when you are healthy?" 86% of respondents said yes, 14% said no (56).	Utilization
		8	In response to the question "In the last two years, have you and your household members' visits to a doctor or nurse been in your neighborhood?", almost 20% of all respondents made all visits outside their neighborhood. Slightly less than 40% of respondents had all visits in their neighborhood and 32% of respondents' visits were, in part, in their neighborhood. This question was included in the survey because there have been concerns raised about a lack of services in many of the North and Central Brooklyn communities (57).	Utilization
		9	The zip code with the highest percent of respondents not using services in their neighborhood are: 11201 (Downtown Brooklyn, 50.0%), 11217 (Gowanus, 46.2%), 11233 (Bedford-Stuyvesant, 37.0%), 11238 (Prospect Heights, 29.6%), and 11207 (East New York, 26.5%). This was data gathered from the 118 respondents of the survey who indicated that none of their visits had been to a provider in their neighborhood for the last two years (58).	Utilization
		10	The type of facility in the community where respondents sought care most frequently include a doctors or nurses office (37.4%), hospital clinic (26.6%), community health center (23.8%), emergency room (12.0%), traditional healer (.8%), another kind of place (.5%), and don't know (.9%). Not all of the named facilities cited were located in the area of study (59).	Utilization
		11	The length of travel time to access care in the community was most frequently 10 to 30 minutes (52.8%), followed by less than 10 minutes (30.0%), 30 to 60 minutes (11.9%), over an hour (2.2%), and do not know/not sure (3.0%) (60).	Service Area
		12	The modes of travel to access care in the community were walking (35.2%), riding a bus (27.6%), taking the subway (11.3%), hailing a cab (9.7%), driving (9.4%), other (3.4%), and using car service (3.3%) (61).	Service Area
		13	When asked where would be the most convenient place for them and members of their household to obtain care, 89.4% of survey respondents preferred to receive care near where they lived, 6.5% wanted care near where they worked, and 4.1% did not know or were not sure (62).	Utilization
		14	The most frequently cited reasons for going outside of the neighborhood to seek care: specialist outside of the neighborhood (25.7%) which indicates a choice, and referred or assigned doctor in another neighborhood (14.7%) which suggests there was no choice (63). The most often-cited specialists are: obstetricians/gynecologists, dentists, general doctors, and cardiologists (65).	Utilization
		15	When survey respondents were asked if they or members of their household had been to an Emergency Room within the last two years, half of the respondents (49.7%) indicated yes (69). African-Americans had the percent of persons using the Emergency Room in the last two years at 56.5% (69-70).	Utilization
		16	Survey respondents were asked in the last two years, if they or any of your family ever had difficulty getting access to health care providers in their neighborhood. 43.1% indicated that they had no difficulty getting access to providers in their neighborhood. The providers most often cited for access problems in the responses were dentists, doctors for basic care, prenatal care from a mid-wife/OB/GYN, pediatricians, and mental health providers (72).	Health Indicators

Brooklyn Healthcare Delivery System

Current Problems

Resource	Primary Topic		Key Points	Category
		17	Issues that limited the ability of individuals to access healthcare included waiting too long to get an appointment (13.5%), lack of health insurance (12.2%), waiting too long at the appointment (9.6%), not being able to afford the bill (9.1%), insurance not paying for what was needed (7.6%), a health plan problem (6.2%), and not being able to find a doctor that took one's insurance (5.3%). There survey responses captured 16 other limits to accessing healthcare (74-75).	Health Indicators
		18	83% of survey responders indicated they had access to medication while 14% claimed they did not. 4% did not know or were unsure (77).	Health Indicators
		19	In this study, of the 301 respondents who indicated they had used the ER in the last two years, the highest percentage usage of ER visits by insurance coverage was: Medicaid (49.5% for self, 37.9% household), insurance by employer (13.6% self; 9.6% household), Medicare (9.6% self, 4.0% household), and no health insurance/self-pay (7.3% self, 3.7% household) (87).	Finance
		20	Lack of transportation to hospitals was indicated as a problem in focus groups. Stairs on the subway and walking long distances are difficult for those patients with disabilities who need transportation and do not get it (96).	Service Area
		21	Many focus group participants indicated a need for community education about medications because of the difficulty in understanding the paperwork that comes with prescriptions, especially when it is only in English (96).	Collaborative Efforts
		22	Need for more qualified interpreters or medical professionals that speak their language so that there is better communication and provide culturally competent and linguistically competent care (99).	Collaborative Efforts
		23	Many focus group participants indicated a differential treatment by insurance type (95).	Quality Improvement
		24	Many focus groups indicated lack of information about their health insurance plans which is seen as a barrier to care (109,111, 121).	Quality Improvement
		25	A focus group of pregnant mothers emphasized that long waiting times a problem particularly because of limits on food and beverage consumption in waiting areas (115).	Quality Improvement
		26	A focus group for LGBTQ patients indicated a lack of awareness and knowledge among health care providers about LGBTQ issues which not only hampers communication and good relationships with providers but also compliance. Brooklyn is not seen as a good place to seek care (121).	Patient Outreach
Brooklyn Healthcare Improvement Project (B-HIP)	Healthcare in Northern and Central Brooklyn	1	Northern and Central Brooklyn have the greatest need for improvement, as evidenced by poor health indicators (high prevalence of chronic diseases and rates of infant mortality) combined with acknowledged delivery system problems such as a shortage of accessible primary care providers as reported by HRSA. High rates of potentially preventable ED use and avoidable hospital admissions have also been observed (12).	General
		2	The majority of study area residents are enrolled in public insurance or are uninsured. An additional, unknown number are undocumented immigrants who are ineligible for public health insurance, but receive medical care in local emergency departments regardless of their ability to pay (12).	Finance
		3	Challenges to care coordination are present in a population that speaks over 35 languages, not including dialects, with more than two-thirds of residents speaking a language other than English at home (14).	Demographics
		4	In the study area, approximately 25% of the population is below the age of 18 -- 13% higher than the state average. 23% of the study area population over 25 years of age has not graduated from high school -- 44% higher than the state average (14).	Demographics

Resource	Primary Topic		Key Points	Category
		5	Health information is complex, so younger, linguistically isolated, less educated individuals are at a higher risk for conditions that should be treated in close coordination with primary care providers to avoid unnecessary ED usage and hospital admissions. Inefficient utilization imposes high cost in the long term on patients, their communities, and the healthcare delivery system (14).	Utilization
		6	Out of pocket healthcare costs are rising faster than income over time, placing a stress on lower income individuals who have been shown to ration care in response to budgetary constraints. This will be exacerbated as New York State completes its transition of all Medicaid fee-for-service beneficiaries into managed care -- a program that requires more cost sharing (15).	Finance
		7	22% of the study area has received food stamps/SNAP benefits in the past 12 months (15).	Demographics
		8	The study area contains several Health Professional Shortage Areas (HPSAs) and Medical Underserved Areas (MUAs) designated by the US Health Resources and Services Administration. 699 FTE primary care physicians serve a population of 1 million individuals, a ratio of one PCP per 1,502 lives (25).	Service Area
		9	There has been a 15% growth rate of the above 65 population in the study area. These individuals require more frequent PCP visits (25).	Demographics
		10	There are glaring disparities in healthcare utilization among the neighborhoods in Brooklyn. There is evidence that would suggest that fewer PCPs and higher ED usage within certain zip codes means that there may not be sufficient availability of PCPs in some areas and residents have chosen to use emergency departments as a primary care resource. For example, zip code 11217 (of Gowanus/Park Slope) is a relatively well off neighborhood with 1 PCP per 1,287 residents, 258 ED visits per 1,000 residents, and 46 discharges per 1,000 residents between 2007-2009. By comparison during the same period, in zip code 11212 (Brownsville), a mostly underserved population with 1 PCP per 2,203 residents, there were 478 ED visits per 1,000 residents and 210 discharges per 1,000 residents. Underlying health of the populations was not controlled for (26).	Utilization
		11	Out of the 11,623 total weekly operating hours for primary care locations in the study area, only 16% (1,892 hours) are on weekends or after 5:30pm during the week (27).	Service Area
		12	Expansion of evening hours would result in additional expenses related to security/safety measures and more staff compensation during more dangerous hours. Given a public payor mix skew in the area, reimbursement rates are not adequate to support such extra costs (28).	Finance
		13	Informal discussions between the coalition directing the study along with community groups point out that residents in the study area may not be fully utilizing the primary care that is available in the community (28).	Utilization
		14	Of the 11,008 respondents to the B-HIP survey, 43% (4,680 patients) came to the ED for reasons other than what they themselves considered to be an emergency (30). The percentage of uninsured patients who came to the ED for reasons other than what they themselves considered to be an emergency was actually higher -- 48% of the 1,990 uninsured patients (31).	Utilization
		15	Overall results of the survey indicate that patients in the survey area use the ED as a supplement to their primary care situationally regardless of whether they have commercial or public insurance coverage (31).	Utilization
		16	33% of all B-HIP survey respondents say they do not have a PCP and 5% do not know if they have a PCP. This is observed despite the fact that Medicaid managed care enrollees had to have chosen a PCP or have had one auto-assigned (32).	Utilization
		17	Patients presenting with non-emergent needs were asked where else they would go for care as an alternative to the ED they were currently in while filling out the survey. 65% of these patients explained that they would go to another ED and only 15% would go to their PCP (32).	Utilization

Resource	Primary Topic		Key Points	Category
		18	17% of patients in the B-HIP survey stated that the ED is the place they always go to get their care (33).	Utilization
		19	Almost 50% of ED staff surveyed by B-HIP responded that 25% or less of the case they see in the ED are truly emergent (34).	Utilization
		20	The main concern for providing care to ED patients as identified by the majority of the ED staff survey responders seems to be related to the inadequate staffing of the ED with transporters, nurses, and technicians.	Human Resources
		21	Patients' perception of their own ED usage suggests that a large proportion of the population could be seen in a more appropriate venue but that available options are inadequate to address patient needs (35).	Utilization
		22	Regardless of insurance type, the majority of insured ED visitors for medical diagnoses (excluding injury, behavioral health, and substance abuse) have not seen their PCP within weeks to months prior to presenting in the ED. These patients have seen a PCP within the previous year but do not keep up with their follow-up appointments (36).	Utilization
		23	While the uninsured have been long been believed to be frequent users of the ED, both administrative and survey data reveal that the uninsured are not actually responsible for the majority of primary care-treatable of potentially preventable visits in the B-HIP area emergency departments surveyed. Rather, it is the Medicaid population that made up the majority of these types of visits (36).	Utilization
		24	Mapping of all discharges by hospital for B-HIP and non-B-HIP Brooklyn residents reveals that B-HIP patients are more likely to seek care at nearby hospitals to a greater degree than non-B-HIP area patients -- 79% versus 73%, respectively (38).	Utilization
		25	Females are less likely than males to be admitted as an inpatient for an ACS condition (ED visits without admissions). Black/African-American and Latinos/Hispanics have higher odds than white of admissions for an ACS condition. Accounting for poor English language skills did not influence these results (39).	Health Indicators
		26	Three B-HIP "hotspots" are located in communities with healthcare problems (and other challenges that are already well-known to local residents and in Brooklyn: Brownsville/East New York, Crown Heights/Bedford Stuyvesant, and Bushwick/Stuyvesant Heights. Together, these three hotspots represent 9% of all potentially preventable ED visits, 6% of all discharges, and 8% of all ACS condition discharges in Brooklyn -- with only 4% of the borough's population (41).	Utilization
		27	The rate of ED visits without admissions or (ACS condition) of 463 per 1,000 in Brownsville/East New York is more than double the Brooklyn-wide rate and more than triple the non-B-HIP study area rate (41).	Utilization
		28	ACS admissions in Brownsville/East New York, Crown Heights/Bedford Stuyvesant, and Bushwick/Stuyvesant Heights alone take a heavy financial toll on the health system. The average cost of the top 20 ACS admission types is $9,833 per case at a cost of $31 million annually.	Finance
		29	Currently there may not be adequate Health Home capacity to handle the B-HIP study area, where a large number of medically and behaviorally complex patients reside (49).	Service Area
		30	Out of pocket costs such as drug co-pays can discourage lower income patients from filling their prescriptions and reduce patients' willingness to start treatment for newly diagnosed chronic illnesses. These sicker patients utilize more costly and expensive treatments down the line (49).	Finance
		32	The B-HIP zip codes, like many other low income, urban areas, have some of the highest rates of diabetes in the nation. Yet to date, few institutions in New York City have been able to create self-supporting diabetes care centers (50).	Service Area

Brooklyn Healthcare Delivery System

Current Problems

Resource	Primary Topic		Key Points	Category
Brookdale Hospital Community Service Plan 2009	Community Health Needs Assessment	1	In the hospital's service area, smoking rates for adults range from 13% to 22%, depending on the neighborhood. East New York (21%) and Central Brooklyn (22%) had smoking rates higher than the New York City (18%) and Brooklyn averages (19%) (4).	Health Indicators
		2	The percentage of East New York (62%) and Flatbush (62%) adults who attempted to quit smoking are lower than the New York City (66%) and Brooklyn (65%) averages (5).	Health Indicators
		3	Colon cancer screening rates in Flatbush (42%), East New York (40%), and Central Brooklyn (36%) were below the citywide (47%) and Brooklyn (43%) rates (5).	Health Indicators
		4	Colorectal death rates in men are higher in Central Brooklyn (38 per 100,000), East New York (31 per 100,000), and Canarsie/Flatlands (27 per 100,000) than the New York City average (23 per 100,000) (6).	Health Indicators
		5	Colorectal death rates in women are higher in Central Brooklyn (21 per 100,000) and Canarsie/Flatlands (20 per 100,000) than the New York City average (17 per 100,000) (6).	Health Indicators
		6	Admissions for diabetes, hypertension, congestive heart failure, angina, chronic obstructive pulmonary disease, asthma, dehydration, pneumonia, and urinary tract infection (avoidable hospitalizations) are disproportionately higher in African Americans (7).	Utilization
		7	Closures of neighboring hospitals in 2009 -- Mary Immaculate and St. John's Queens Hospitals -- have increased crowding in emergency rooms and inpatient beds (11).	Utilization
The Brooklyn Hospital Center Community Service Plan 2012	Community Health Needs Assessment	1	The hospital needs to secure funding to embark on projects which expand access to primary care and facilitate easier navigation through hospital service areas (4).	Finance
		2	Community partnerships need to be established to support a collaborative approach healthcare delivery in Brooklyn in order to create a platform to provide population management and care integration among all healthcare providers (4).	Collaborative Efforts
		3	Community outreach programs targeting those neighborhoods identified as experiencing unmet need and lacking in primary care services are not established yet. These will provide free screenings, education, and foster partnerships with key health service agencies (4).	Collaborative Efforts
		4	Awareness of programs for uninsured and underinsured persons in the community is not high enough (5).	Patient Outreach
		5	Statistics from the NYSDOH and NYCDOH indicate that the population which the Brooklyn Hospital Center serves faces health disparities that surpass state and national averages in the areas of asthma, cancer, heart disease, and diabetes (5).	Health Indicators
Coney Island Hospital CHNA 2013	Community Health Needs Assessment	1	HHC hospitals provided a far higher proportion of care to self-pay (or uninsured) patients than any other single healthcare provider in New York City. In 2010, HHC acute care hospitals were the source of 37% of all uninsured inpatient discharges, 43% of uninsured ED visits, and 67% of uninsured clinic visits among all New York City hospitals. This volume of uninsured care translates out to approximately $698 million in uncompensated care annually at HHC (3).	Finance
		2	In the Primary Service Area, the percentage of persons 65 and older is now 18%, significantly higher than the 11.4% for Brooklyn and 12% for all of New York City. The hospital serves the oldest population within HHC (5).	Demographics

Resource	Primary Topic		Key Points	Category
		3	Navigating healthcare services is complicated by the fact that English is not the primary language of most patients treated by the hospital. These patients come from the former Soviet Union, South Asia, and China as well as Spanish-speaking countries. They tend to often have limited to no English skills and lack familiarity with the American healthcare system -- which can be very complex. Significant challenges are posted during care coordination when language barriers exist. This is critical concern for establishing treatment compliance for chronic diseases which require patients and providers to communicate effectively regarding the entire range of their care (6).	Demographics
		4	The burden of poverty within the service area is revealed by the population in the service area that receives income support. In 2011, the populations of the community districts that compose the service area (11, 13, 15) received income support at a rate between 35% and 47.4% (6).	Demographics
		5	The safety net burden for discharges, ED visits, and clinic visits is significantly higher than that of the average city voluntary hospitals or HHC hospitals. 48% of inpatient discharges, 41% of total ED visits, and 43% of outpatient clinic visits are reimbursed by Medicaid. Similarly, 32% of ED visits and 31% of clinic visits are classified as uninsured/self-pay which is much higher than the rates observed in non-HHC New York City hospitals -- 16% for Emergency Department visits and 11% for outpatient clinic visits(7).	Finance
		6	The primary and secondary service areas show elevated rates of Diabetes, Obesity, High Cholesterol, Hypertension, Asthma, and Adult Smoking compared to the New York City average (7).	Health Indicators
		7	Community Districts 13 and 15 show significantly higher death rates due to heart disease, malignant neoplasms, flu/pneumonia, CVA, chronic lower respiratory illness, diabetes, and suicide (7-8).	Health Indicators
Kings County Hospital CHNA 2013	Community Health Needs Assessment	1	There are two areas of clinical over-utilization: inpatient medicine with an occupancy rate of 101.64% and inpatient surgery with a 105.53% occupancy during FY 2012 (3).	Utilization
		2	HHC's commitment to caring for patients regardless of their ability to pay, ultimately gives it the highest "market share" of low-income, uninsured patients across New York City (3-4).	Finance
		3	HHC hospitals provided a far higher proportion of care to self-pay (or uninsured) patients than any other single healthcare provider in New York City. In 2010, HHC acute care hospitals were the source of 37% of all uninsured inpatient discharges, 43% of uninsured ED visits, and 67% of uninsured clinic visits among all New York City hospitals. This volume of uninsured care translates out to approximately $698 million in uncompensated care annually at HHC (4).	Finance
		4	New York City Planning 2010 Population Data indicate that 26% of the primary service area residents of the hospital and 32% of the secondary service area residents speak a language other than English (5).	Demographics
		5	Fewer residents aged 25 and older have completed at least some college education compared to 42% in Brooklyn and 47% in New York City overall. For Central Brooklyn this rate is 38%, for East New York this rate is 28%, and for Flatbush this rate is 42% (5).	Demographics
		6	The percent of residents living below the poverty level is generally the same or higher than the Brooklyn and New York City averages of 25% and 21%, respectively. For Central Brooklyn the percent living below the poverty level is 31% and for East New York it is 34%. In Flatbush, the percent of residents living below the poverty level is the same as the New York City percentage but is lower than the Brooklyn percentage (5).	Demographics
		7	In Flatbush, residents were born outside of the United States at a rate (51%) higher than in Brooklyn and New York City -- 38% and 36%, respectively (5).	Demographics
		8	Significant health disparities are associated with race and ethnicity. Specifically, Black and Hispanic residents tend to exhibit disproportionately high rates of chronic diseases and negative health outcomes (5).	Health Indicators

Brooklyn Healthcare Delivery System

Current Problems

Resource	Primary Topic		Key Points	Category
		9	Central Brooklyn patients are more likely to seek medical care at the hospital emergency department, at a rate of 13%, when compared to the overall rate of 8% for the city (5).	Utilization
		10	Lack of insurance contributes to non-compliance with prescription medications (5).	Demographics
		11	Socioeconomic factors create barriers to healthcare, and ultimately result in patients having less access to primary and preventive care services. When patients do seek care in the emergency department, the disease/condition has progressed to an advanced stage (5).	Utilization
		12	Central Brooklyn residents experience more barriers to healthcare access than city residents generally, with nearly 3 in 10 without a regular doctor (6).	Health Indicators
		13	Residents in Central Brooklyn have had a higher mental illness hospitalization rate over the past 10 years than in Brooklyn and in New York City overall (6).	Health Indicators
		14	Residents in Central Brooklyn observe a death rate due to HIV disease that remains twice as high as the city's HIV-related death rate -- even though the overall HIV disease death rate has decreased over the past decade (6).	Health Indicators
		15	More than 25% of adults in Flatbush are obese with more than half of adults reporting that they do no physical activity at all (6).	Health Indicators
		16	Mothers in Flatbush are less likely to get timely prenatal care resulting in babies more likely to be born with low birth weight than in New York City overall (6).	Health Indicators
		17	East New York adults have increased risk of developing heart disease, obesity, and diabetes. Heart disease hospitalizations are well above the citywide average, nearly one-third of adults are obese, and 16% have diabetes (6).	Health Indicators
		18	Infant mortality rates in the hospital service area are much higher than both Brooklyn and New York City overall. Brownsville (11.3 per 1000), East New York (9.5 per 1000), and Bedford Stuyvesant (8.7 per 1000) each observe greater infant morality rates per 1,000 live births from 2007-2009 than Brooklyn and New York City -- 5.2 and 5.4 per 1000, respectively (6).	Health Indicators
		19	The communities served by the hospital experience extremely high rates of mortality due to violence, with crude death rates several times higher than rates of New York City and Brooklyn. In 2009, these were 5.9 and 7.9 for New York City and Brooklyn -- respectively -- compared to 22.3, 19.3, and 18.0 for Brownsville, East New York, and Bedford Stuyvesant, respectively (6).	Demographics
		20	Bedford Stuyvesant and East New York, part of the hospital's primary and secondary service areas, have received health professional shortage area (HPSA) designations for their lack of primary care services (6).	Service Area
Kingsbrook Jewish Medical Center Community Service Plan 2011	Community Health Needs Assessment	1	Residents in the service region of the hospital face health disparities that surpass state and national averages for diabetes, stroke, hypertension, and asthma (1).	Health Indicators
		2	There is a need to advance prevention and avoidance of behaviors that expose individuals to HIV (2).	Health Indicators
		3	Access to screenings for chronic diseases needs to be enhanced (3).	Health Indicators

Brooklyn Healthcare Delivery System

Current Problems

Resource	Primary Topic		Key Points	Category
		4	Local provider and community awareness about the benefits of palliative care needs to be improved (6).	Patient Outreach
Lutheran HealthCare Community Service Plan 2012	Community Health Needs Assessment	1	The hospital must expand primary care capacity to limit the barriers to primary care to assist in lowering emergency room visits and wait times (2-3).	Utilization
		2	The hospital must establish a school-based oral health program because of limited access observed in the community (3).	Collaborative Efforts
		3	The hospital must cater to the needs of its residents in a culturally sensitive manner (3).	Patient Outreach
		4	Hospitals must limit barriers particularly when it comes to insurance enrollment (4).	Finance
		5	The hospital cannot increase access to screening services without collaborating with community organizations to increase their utilization (4).	Collaborative Efforts
		6	There are numerous barriers to colonoscopy screening for Lutheran's patient population, particularly men. Only 20% of LHC's male patients receive colonoscopy screenings (5).	Health Indicators
		7	The hospital must foster more effective communication between patient and the clinical care team (6).	Patient Outreach
		8	Lutheran must improve the patients' health outcomes -- particularly for chronic diseases and conditions such as diabetes and high blood pressure (6).	Health Indicators
		9	Expanding insurance enrollment outreach efforts into the Emergency Room -- episodic users of healthcare services -- is traditionally very difficult to address (14).	Finance
		10	Sunset Park, a neighborhood in the service area of Lutheran, has the third highest teen birth rate (108 per 1,000 in 11232 and 96 per 1,000 in 11220) and second highest adolescent abortion rate in Brooklyn (8).	Health Indicators
		11	Measurement is needed to accurately gauge performance of sites and the organization as a whole (10).	Institutional Governance
Maimonides Medical Center Community Service Plan 2011	Community Health Needs Assessment	1	The hospital needs to actively engage medical staff, community leaders, community organizations, and health service delivery partners in discussions on improving coordination and access to services (1).	Collaborative Efforts
		2	Regular discussion of community health needs are necessary to properly serve the community (2).	Collaborative Efforts
		3	Appropriate utilization of emergency services is a community health need (2).	Utilization

Brooklyn Healthcare Delivery System

Current Problems

Resource	Primary Topic		Key Points	Category
		4	Patients and families pose a challenge to staff administering financial aid policies to establish eligibility (5).	Finance
New York Community Hospital Community Service Plan 2009	Community Health Needs Assessment	1	The hospital needs to find ways to better serve patients and foster a dialogue with the community (12).	Collaborative Efforts
		2	The hospital has observed that the website needs to be re-designed because it is not easy for the community to use it as a resource and feedback tool (13).	Patient Outreach
		3	Tobacco use is widely prevalent among all age groups in the community, and is a deeply entrenched, culturally accepted practice among new immigrant groups. This leads to preventable morbidity and mortality (15).	Health Indicators
		4	Diabetes and other chronic diseases are highly prevalent in the elderly population served by the hospital -- particularly diabetes, coronary artery disease, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD) (16).	Health Indicators
		5	Patients do not appreciate the nature of their illness and the importance of compliance with medication and dietary instructions -- in the case of diabetes.	Patient Outreach
		6	The hospital needs to improve its readiness for public health crises including natural disasters, infectious diseases, or man-made disasters that would affect a large number of individuals. Does the institution understand all the hazards it must plan for and can it maintain operations to provide essential services that community needs? (17)	Collaborative Efforts
		7	The hospital needs to create linkages for youths in the community (22).	Collaborative Efforts
New York Methodist Hospital Community Service Plan 2012	Community Health Needs Assessment	1	The hospital was not doing enough to educate and council patients at risk or diagnosed with diabetes (3).	Patient Outreach
		2	The hospital was not doing enough to educate mothers about breast feeding and motivating them to breastfeed at least some of the time (3).	Patient Outreach
		3	30-day readmission rates for the hospital's CHF patients were observed to be at a high of approximately 30% several years ago (3).	Care Management
		4	The hospital's public website was not optimized to serve the community (3).	Patient Outreach
		5	The hospital was not emphasizing social media to engage the community (3).	Patient Outreach
		6	Patients struggle to access healthcare in the community (8).	General
		7	The hospital needs to improve health education for patients and community residents (2).	Collaborative Efforts

Brooklyn Healthcare Delivery System

Current Problems

Resource	Primary Topic		Key Points	Category
		8	The hospital has observed an increased number of appeals for financial aid because patients are opting for higher deductible/co-payment insurance plans (9).	Finance
Woodhull Medical Center CHNA 2013	Community Health Needs Assessment	1	Hospital is located in a federally designated primary care Health Professional Shortage Area (3).	Service Area
		2	A significant portion of households surrounding Woodhull Medical Center continue to suffer from poverty, low levels of education, and poor health status (5).	Demographics
		3	66% of discharges, 51% of ED visits, and 48% of outpatient primary care visits are reimbursed by Medicaid. 9% of discharges, 33% of ED visits, and 35% of outpatient primary care visits are reimbursed by Medicaid. These rates are much higher than the citywide average (3, 5).	Finance
		4	Many adults in the hospital's service area have not attained high levels of education. 33% of primary service area adults and 24% service area adults have not completed high school (6).	Demographics
		5	Service area residents have higher rates of diabetes, obesity, hypertension, asthma, and tobacco use than NYC as a whole (6).	Health Indicators
		6	English is not the primary language for a large number of hospital service area residents. This poses significant challenges to coordinating care and services (7).	Demographics
		7	Communities served by the hospital are impoverished with over 26% of all families and over 35% of families with children living below Federal poverty guidelines (7).	Demographics
		8	There are four hospital in or near the hospital's service area (Wyckoff, Interfaith, Brooklyn Hospital, and Brookdale) each with financial troubles. If either were to close services or close completely, Woodhull would face increased demand for all of its services (9).	Finance
		9	699 FTE primary care physicians are in the service area of the hospital. While a large number, these physicians -- as a group -- do not sufficiently support the population's need for primary care services (10).	Service Area
		10	The obesity rate in the hospital's primary service area is 28.6% which is higher than 23.7% citywide. Some neighborhoods in the service area have obesity rates as high as 36.6% (15).	Health Indicators
		11	Rate of psychiatric discharges per 1,000 patients is higher in the service area than in Brooklyn and NYC (16).	Health Indicators
		12	The rate of diabetes in the Woodhull Medical Center service area is 11.1% compared to 10.5% in NYC (17).	Health Indicators
Wyckoff Heights Medical Center Community Service Plan 2011	Community Health Needs Assessment	1	Many hospitals are experiencing significant reductions in resources and services (11).	General
		2	High incidence of wounds due to type 2 diabetes in the community the hospital serves (11).	Health Indicators

Brooklyn Healthcare Delivery System

Current Problems

Resource	Primary Topic		Key Points	Category
		3	High prevalence of cardiovascular disease in service area and severity of coronary artery disease is much higher than other areas (12).	Health Indicators
		4	Low patient satisfaction scores in the Emergency Department (18).	Quality Improvement
		5	Elderly patients mostly suffer from multiple illnesses and functional decline, leaving them unable to access appropriate healthcare because they are homebound (21).	Health Indicators
		6	High rate of low birth weight and poor health outcomes for babies in the community(32).	Health Indicators
		7	High prevalence of obesity in WIC population of the community (34).	Health Indicators
		8	A large portion of the patients Wyckoff serves are indigent and some 10% of patients are completely uninsured (40).	Finance

Exhibit Number Three, Proposed Solutions from Past Studies

The proposed solutions to the multiple and complex health care delivery system problems in Brooklyn are chronicled in this exhibit, drawn from many of the same sources (Brooklyn MRT Health System Redesign Work Group, Brooklyn Healthcare Improvement Project, Community Health Needs Assessments developed by individual hospitals).

The proposed solutions from this history include increasing the number of primary care medical homes, urgent care centers, comprehensive ambulatory care centers and mental health facilities, to provide a more appropriate level of care and to alleviate unnecessary utilization of emergency departments and hospitalizations for preventable conditions.

In addition, proposals include access to specially developed care services to limit travel for patients. Other suggestions include hospital organization and governance (more advisory boards), more patient navigators, more collaboration between community organizations, greater investment in linguistic and culturally competent hospital personnel.

Notably, New York State has apparently come up short in the specificity of the solutions offered as part of its submission for a "Waiver" of Medicaid reimbursement, based on state claimed savings of $10 billion. A coalition of community activists, led by Ms. Judy Wessler of the Save Our Safety Net Campaign, indicated that the director of the Center for Medicaid and CHIP Services at CMS and other CMS representatives found that the "state has failed to respond to CMS' request for 'specific information about how the funds will be used, and what the outcomes of the program will be.'" (*Crain's Health Pulse*, August 8, 2013).

The task outlined here is the development of specific detail, involving people, space, money and equipment, especially aimed at the "appropriate levels of care" necessary in urgent and comprehensive ambulatory care.

Brooklyn Healthcare Delivery System

Proposed Solutions

Resource	Primary Topic		Key Points	Category
Brooklyn MRT Health Systems Redesign Work Group	Brooklyn Hospital Future Viability	1	Additional analysis of health status, healthcare needs, and existing capacity by neighborhood is needed to align health care resources with community health needs in Brooklyn and to identify hot spots for disease and sub-optimal utilization. With that information, providers and their communities can respond by developing appropriate health care resources and interventions (23).	General
		2	The Brooklyn Health Improvement Project (BHIP), a HEAL-funded project created in 2009 and led by SUNY Downstate, is a multi-stakeholder collaborative engaged in developing a community health planning process. It is governed by a broad-based coalition including representatives from community-based organizations, hospitals, FQHCs, health plans, businesses, and civic leaders. Their health planning work is data-driven and is engaged in data development and analysis activities concerning primary care and emergency department utilization. It is also developing community engagement and primary care access strategies to improve community health (23-24).	Collaborative Efforts
		3	The Brooklyn Health Information Exchange (BHIX) is a not-for-profit regional health information organization (RHIO) devoted to improving health care through the collection, exchange of, and analysis of health information. Its members include 7 hospitals, 10 community health centers, 3 physician practices, 7 community-based and government-sponsored behavioral health providers, 7 nursing homes, 5 home care agencies, and 6 payers. BHIX works in tandem with statewide initiatives to develop common policies, technical standard, and protocols for health information technology and exchange. Its information technology architecture enables interoperability through which providers are linked together within BHIX and, in turn, across the Statewide Health Information Network of New York (SHIN-NY). Using advanced decision support systems and patient notification, BHIX will play an active role in improving quality of care and reducing medical errors and oversight. BHIX has funding for various activities under the state's HEAL grant program, including two multi-stakeholder medical home initiatives (24).	Collaborative Efforts
		4	A third initiative funded by a HEAL grant and led by Sunset Park Family Health Center, has enabled the adoption of interoperable electronic health records in 9 diagnostic and treatment centers, including 7 federally qualified health centers (FQHCs). The centers created a Community Health Information Technology Adoption Collaborative ("CHITA") to implement a community-wide electronic health record system, enable the creation of patient-centered medical homes, and support care coordination in Brooklyn. In addition, the CHITA has enabled the exchange of clinical data for quality improvement activities (24).	Collaborative Efforts
		5	Modest reductions in PQI discharges and ALOS would yield further reductions in bed need in Brooklyn. If ALOS were reduced by only one day, Brooklyn could reduce its inpatient beds by an additional 869 beds (34).	Quality Improvement
		6	Utilizing managed care techniques and Medicaid claims data to track individuals' patterns of service use, unexpected interruptions in services are identified, and providers of services can then work to re-engage high-need individuals with mental illness to ensure that they remain engaged in care. This is a model being used by the Brooklyn Care Monitoring Initiative (38).	Care Management
		7	The state is overseeing the creation of "health homes" for Medicaid beneficiaries with multiple chronic conditions. These multi-disciplinary collaborations of community-based services will link individuals with complex health care needs -- including mental health and substance use disorders -- with health care providers and community and social supports. Value and risk-based payment reforms, health plans, behavioral health organizations and providers will be held accountable for optimizing the beneficiaries' physical and mental health (38-39).	Quality Improvement
		8	Providers along the continuum of care must integrate or collaborate with each other to improve the health of Medicare and/or Medicaid beneficiaries and accept payment arrangements that reward positive outcomes and efficiency and/or penalize negative outcomes and inefficiency (46).	Collaborative Efforts
		9	The new models of coordinated care and performance-based reimbursement demand a fundamental reconfiguration of Brooklyn's healthcare delivery system from a strategic, organizational, physical, and financial perspective (46).	General

Brooklyn Healthcare Delivery System

Proposed Solutions

Resource	Primary Topic		Key Points	Category
		10	In order to improve the health status of Brooklyn residents and to succeed under emerging payment methodologies, health care providers must create integrated systems of care and service delivery models, comprised of hospitals, physicians, federally qualified health centers, nursing homes, home care agencies, behavioral health providers, and hospice programs. This will reduce the fragmentation of the delivery system, eliminate waste, support coordination, and reduce inappropriate utilization of service, while building access to efficient and effective community-based systems of care (47).	Collaborative Efforts
		11	Providers may or may not necessarily unite under the auspice of a single entity, but they must be comprised of providers linked by formal relationships (operational and even financial) so that they are able to coordinate patient care, transmit patient information electronically, and jointly engage in quality, performance, and population health improvement activities (47-48).	Collaborative Efforts
		12	Hospital services should be rationalized within integrated systems to create regional centers of excellence and to respond to community needs. Some hospitals need to be replaced by more compact inpatient hubs surrounded by primary care, urgent care, and other ambulatory care sites (48).	Collaborative Efforts
		13	Patient-centered primary care services, strategically-located and linked to acute and long-term care providers, must be developed. Primary care and urgent care facilities should be established with hours and availability that match emergency departments with walk-in capacity. These facilities should be strategically planned based on health status, utilization, and demographic data. New capacity development must be based on intimate knowledge of cultural, language, transportation, education and lifestyle issues that affect healthcare access and utilization (48).	Primary Care Facilities
		14	Hospitals should affiliate with FQHCs and/or networks of physicians in order to assure that effective primary care capacity is developed and integrated with other hospital services. Hospital management should be reconfigured to include senior executives who can directly oversee outpatient development and partnerships with community-based physicians and facilities. The focus of these activities must be clinical integration, prevention, and care coordination -- not maximizing inpatient market share (48).	Collaborative Efforts
		15	Restructuring must reduce waste and improve the quality of care, the settings for care, the engagement of patients in care, the way clinicians deliver care, and ultimately community health. This requires the model of care to promote prevention, patient engagement, and self-management. Providers must be more responsive to patient needs to that sub-optimal ED and inpatient use is reduced. Waste in the form of excessive lengths of stay, failure in care processes that cause delays and complications for patients, and ineffective care coordination during transitions, and administrative excesses must be minimized (48).	Quality Improvement
		16	Community-based organizations, the local health department, faith-based organizations, and local businesses must all be directly partnered with to encourage more optimal patient engagement and to improve community health (48-49).	Collaborative Efforts
		17	Strong institutional governance and experienced leadership are needed to stabilize Brooklyn's most troubled hospitals and to steer them into new integrated healthcare systems. Boards must be composed of dedicated and objective members with skills and expertise to govern effectively. Boards must also be representative of, responsive to, and responsible for, the health needs of the community served by the hospital. Key indicators of financial and clinical performance must be monitored; management's plans to address these indicators must be evaluated as well. It is also the boards' responsibility to actively foster collaborations (mergers or affiliations) with other institutions to serve the best interests of the community (49).	Oversight
		18	Academic medical centers from outside Brooklyn that seek to establish affiliations or ambulatory care facilities in the borough must partner with local hospitals and other providers and strive to serve Brooklyn residents in Brooklyn (49).	Collaborative Efforts
		19	Entrance of new providers to Brooklyn should involve applying for a Certificate of Need, subject to state approval, that demonstrates a commitment to: providing primary care to the community, offering comprehensive care, integrated delivery, minimizing patient referrals to facilities outside of Brooklyn, implementing evidence-based practices and clinical protocols, implementing an EHR system that facilitates sharing of information in a seamless manner with providers throughout the borough, and partnerships to develop new lines of services offering new revenue sources to strengthen Brooklyn hospitals and providers (49-50).	Oversight

Brooklyn Healthcare Delivery System

Proposed Solutions

Resource	Primary Topic		Key Points	Category
		20	Support offered by the state to troubled facilities must provided based upon a viable plan for long-term sustainability, subject to enforceable conditions and ongoing monitoring. In addition, the plan must demonstrate long-term savings and any support must be revenue neutral. The state cannot be a passive payer, allowing poorly managed institutions to slip into deeper levels of dysfunction. Restructuring plans should leverage the unique strengths of hospitals including: ties to community/faith-based organizations, businesses, consumers, workers, local providers, FQHCs, academic institutions, and ability to benefit from Medicaid and Medicare reforms (50).	Oversight
		21	The healthcare delivery crisis in Brooklyn reveals that there must be more collaboration during restructuring plan development and implementation. In addition to DOH financial and operational oversight, broad and structured input from communities is needed to ensure that community needs are addressed. Effective health planning tackles both the supply of, and demand for, healthcare services. Community input must occur on a neighborhood level (50).	Collaborative Efforts
		22	Innovative options for capital formation, including private investment, are needed to support capital and operational improvements in Brooklyn hospitals; but private investment must not be allowed to undermine a facility's commitment to the community or its accountability for the quality of care. Other healthcare industry actors may also be publically-traded. However, given the context of limited state and federal resources, opportunities to encourage private investment in Brooklyn's hospitals must be explored in a manner that assures accountability for quality, community involvement in governance, and an enforceable commitment to addressing community needs (51).	Finance
		23	The cost structure of healthcare facilities in Brooklyn must be rationalized. The largest cost center for all healthcare facilities is labor, including executive, physician compensation, and workforce costs. (51).	Finance
		24	Including care coordination with nursing homes along the "continuum of care" is essential to improving the health status of nursing home residents and avoiding costly hospitalizations. Hospital readmissions penalties and emerging risk-based payment mechanisms will directly impact nursing homes' bottom line; this demands stronger collaboration particularly between hospitals and nursing homes (51-52).	Collaborative Efforts
		25	Legislation should be enacted to give the State Health Commissioner the authority to appoint a temporary operator for healthcare facilities that present a danger to the health or safety of their patients, have failed in their obligations, or are jeopardizing the viability of essential healthcare capacity (52).	Oversight
		26	Legislation should be enacted to give the State Health Commissioner the authority to replace healthcare facility board members who are not fulfilling their duties to the organizations they are charged with governing (52).	Oversight
		27	A Brooklyn Healthcare Improvement Board should be appointed by the State Health Commissioner to advise the Commissioner and oversee the transformation of healthcare delivery in Brooklyn. It should be composed of DOH, DASNY, OMH, OASAS, MRT Work Group, community leaders, and other experts in order to evaluate applications for restructuring support, coordinate restructuring activities, assess healthcare facility and system governance and management, coordinate debt restructuring activities, review restructuring plans with stakeholders, and evaluate performance in restructuring efforts (52).	Oversight
		28	Legislation should be enacted to provide Brooklyn hospitals and others that qualify to access capital (including the issue of new debt if necessary) and other means of reducing existing debt burdens that substantially impair the hospital's ability to restructure (54).	Finance
		29	Payment reform measures should be accompanied by mechanisms that grant better access to capital for selected facilities and other essential providers. Sources could include private lending by commercial banks or other private interests and tax-exempt bonds issued by DASNY and other lenders. Restrictions on private investment in healthcare facilities should be reviewed and pilot/demonstration projects to relax such restrictions should also be considered. HEAL funds may be another source of capital because these funds may be viewed as a reinvestment of savings to be generated from reforms and downsizing in Brooklyn and elsewhere throughout the State of New York (54).	Finance

Brooklyn Healthcare Delivery System

Proposed Solutions

Resource	Primary Topic		Key Points	Category
		30	Brooklyn's hospitals serve significant numbers of uninsured and Medicaid patients and will be affected by pending changes in the distribution of federal Medicaid disproportionate share (DSH) funds. A new allocation method consistent with CMS guidelines should be developed to fairly and equitably approach the allocation of funds across hospitals with a greater proportion of funds allocated to those hospitals that provide services to uninsured and underinsured individuals (54-55).	Finance
		31	Development of physician practices in underserved areas as well as physician practices' involvement in integrated systems of care through EHR and payment arrangements must be pursued. While progress has been made through enhanced Medicaid payments with PCMH accreditation, Doctors Across New York practice support and loan repayment assistance grants, as well as the promotion of primary care for Medicaid beneficiaries -- more must be done to support physicians seeking to practice in under-served areas. This may include strategies to fund case managers and social workers to coordinate care and tax credits for charity care provided by physicians (55).	Finance
		32	In order to expand primary care in the communities most in need, the state should explore new programs that use public support to leverage outside investment in high quality primary care projects (55).	Finance
		33	Funding should be provided for a multi-stakeholder planning collaborative in Brooklyn to assure that restructured hospitals and new systems under development address community health needs through data-driven interventions with input and consensus of the community. This will improve care coordination, primary care utilization, and community health while curbing unnecessary healthcare spending on such things as medical technology (55).	Oversight
Crain's Health Pulse, 3-20-2013	Multi-Specialty Healthcare Facility in Brooklyn	1	Calko Medical Center, a $60 million, 100,000-square-foot, nine-story building in Bensonhurst, formally opened on March 20th, 2013. The facility houses an ambulatory surgery center, an urgent care center, and 30,000 square feet of private physician offices, including a large endoscopy practice, a pain management center, a fertility practice, and an orthopedics group. The center also has an imaging center and laboratory facilities. The project was conceived by Dr. Robert Kodsi, an attending gastroenterologist at Maimonides, and real estate developer Mark Caller as a way to use a parcel of land at 6010 Bay Parkway for one-stop medical services. Construction began in May 2011. Maimonides has no ownership in the building. But Genesis Fertility and the Borough Park Pain Management Center, both run by Maimonides physicians, are leading space there, as are several other doctors affiliated with Maimonides. The hospital is providing anesthesiology and laboratory services for the facility (1).	Multi-Specialty Facilities
Crain's Health Pulse, 4-19-2013	Primary Care Center Debuts in Brooklyn	1	With the help of $1.3 million in low-cost financing from the Primary Care Development Corp., Premium Health Inc. announced on April 18 that it is developing a health center to serve residents of the Borough Park, Kensington and Flatbush sections of Brooklyn. The 5,000-square-foot center, located at 620 Foster Ave., will offer care for children and adults, including reproductive health services. Premium Health chose its location because those Brooklyn neighborhoods are medically underserved. An estimated 10,000 residents have an unmet need for primary care. Premium Health is a nonprofit affiliated with Lutheran Family Health Centers. The center opened weeks ago, but is not yet up to full operational capacity. When it is, it expects to have a full-time staff of 15 serving 4,000 patients annually (1).	Primary Care Facilities
The Need for Caring in North and Central Brooklyn	2013 Community Health Needs Assessment	1	Conduct an air quality study to identify triggers in ambient air in Brownsville (11212), Cypress Hills (11208), Bushwick (11237) and Bedford Stuyvesant (11221), which showed the highest prevalence of asthma. Medical care alone cannot ameliorate this condition (133).	Quality Improvement
		2	Consider the basic nutritional needs of patients who are waiting long lengths of time for care. Certain health conditions (e.g. diabetes, pregnancy) may make it difficult for consumers to endure long waits at an appointment without food or beverages (133).	Quality Improvement
		3	Improve screening questions to be more inclusive of the needs of diverse populations, including people with disabilities and people who identify as LGBT, and target outreach to. This will provide for better accurate information gathering, hence improving more earnest consumer disclosures and sharing during medical visits (133).	Quality Improvement
		4	Increase the cultural and linguistic competency of health care providers, staff and administrators by providing ongoing staff development and training on communication skills, the needs of special populations and the importance of being sensitive to their unique needs and the importance of patient-centered care (133).	Quality Improvement

Brooklyn Healthcare Delivery System

Proposed Solutions

Resource	Primary Topic		Key Points	Category
		5	Implement customer service training for all levels of health care staff to improve interactions with clients. Many of the participants noted differential treatment by staff by demographic characteristics -- e.g. health insurance status, socio-economic status, immigration, race/ethnicity, language, and sexual identity (133).	Quality Improvement
		6	Improve the accessibility and readability of essential medical/health care information in written materials, including but not limited to materials that discuss how to choose a health care provider, what insurance covers or does not cover, and out of pocket costs versus covered costs (133).	Quality Improvement
		7	Collaborate with community or health plan enrollers to work with consumers regarding changes in health care coverage to ensure that consumers maintain coverage for their health care services (133).	Quality Improvement
		8	Provide funding to train and educate patient advocates to support consumers by helping them navigate health care facilities and educate them on service availability (133).	Quality Improvement
		9	Target physician increases of for the various types of primary care to meet the specific needs of neighborhoods. Bedford-Stuyvesant could benefit from an increased number of OB/GYN and pediatric providers while Prospect Heights could benefit from an increase in OB/GYN providers (133).	Primary Care Facilities
		10	Extend primary care hours to evenings and weekends to better accommodate the schedules of patients (133).	Capacity Expansion
		11	Increase awareness of and access to low cost health services and public health insurance (133).	Patient Outreach
		12	Financially support outreach and education efforts by grass roots community based organizations to promote community resources/services and provide education/assistance that will help facilitate appropriate referrals (134).	Patient Outreach
		13	Increase access to translation and interpretation services and work with consumers to develop delivery systems that will better meet consumer needs (134).	Quality Improvement
		14	Establish centralized referral services or information centers where consumers can obtain information on existing health care resources in their community. In addition, increase consumer awareness of grass roots community based organizations which can assist them with meeting their health care needs (134).	Collaborative Efforts
		15	Increase peer support groups for residents and make residents aware that such groups are available, particularly for special populations (134).	Care Management
		16	Develop a system of care among a coordinated network of health care and social service providers, residents and community based organizations to address various barriers such as; the lack of cultural and linguistic competent information and resources available to community residents; the need for provider resource sharing to address long waiting time for and at appointments; the need for extended office hours/days to also address gaps in care/services and emergency room overuse (134).	Collaborative Efforts
		17	Develop a process to engage community residents ("community advisory board") to work on some of the community level utilization barriers, such as over-use of emergency rooms. Residents can help in various ways such as the development of messaging at the community level that will encourage use of alternative services and conducting outreach to encourage residents to use primary care and other services. African Americans and persons insured by Medicaid need special focus as they had the highest rates of emergency room use. Communities to pay special attention to are: Bedford Stuyvesant (11221 and 11216), Brownsville/East Flatbush (11212). Funding resources will be needed to engage residents (134).	Collaborative Efforts

Resource	Primary Topic		Key Points	Category
		18	Explore improving or developing health care access and care coordination by linking community pharmaceutical services and hospital care electronic systems (134).	Collaborative Efforts
		19	Explore improving or developing better electronic systems between community pharmaceutical services and hospitals, which may improve medication compliance (134).	Collaborative Efforts
		20	Focus attention on particular illnesses and communities in order to target services where they are most needed. Our findings indicate that the following health conditions were prevalent and often the reason cited for emergency room visits: Asthma, diabetes, and hypertension. These illnesses were particularly prevalent in the following areas: Bushwick (11237) and Brownsville/East Flatbush (11212), Cypress Hills (11208) and Bedford Stuyvesant (11221). When comprehensive, continuous care is available these conditions can be treated on an outpatient basis (135).	Quality Improvement
		21	Increase the availability of quality dental care services in North and Central Brooklyn. Priority should be given to communities reporting greatest problems in accessing dental care; which are: Bedford Stuyvesant (11221), Bedford Stuyvesant/Ft. Greene (11205), Williamsburg (11206) and Cypress Hills (11208). Many residents travel outside of the borough for such services (135).	Multi-Specialty Facilities
		22	Increase access to specialty health care services in the community. Participants indicated that they had to travel outside of their community to see specialists (135).	Multi-Specialty Facilities
		23	Develop working relationship with Access-A-Ride to address consumer concerns with its transportation procedures, costs, and timeliness to increase utilization and access to appointments, particularly for senior citizens and people living with disabilities (135).	Collaborative Efforts
		24	Develop a coordinated campaign to outreach to and work with primary care practitioners, health clinics and managed care plans to encourage and increase the number of providers who accept public health insurance. While this coordinated campaign should cover North and Central Brooklyn, targeted focus should be on Bedford Stuyvesant (11216 and 11221) and Brownsville/East Flatbush (11212). Similar campaigns have been utilized in the past and can serve as a model - such as the measles epidemic campaign, borough-wide Child Health Plus promotion by facilitated enrollment agencies, and the borough-wide HIV outreach and referral case management campaign. With the introduction of the Affordable Care Act's increase in primary care reimbursement, receptivity to this campaign may be greater (135).	Finance
		25	Modify the design of health care facilities to make them more accessible, "user friendly" and comfortable. For example, improve wheelchair access, the level of lighting, the font of printed materials, and the comfort of seats in waiting rooms and clinics for pregnant women (135).	Quality Improvement
		26	Extend urgent care center hours in North and Central Brooklyn to offset emergency room use. According to our analysis, participants utilized emergency rooms for immediate problems and when health care offices were closed. Extending hours may have to address the issue of emergency room overuse (135).	Capacity Expansion
		27	Use evidence based strategies to help redesign systems for patient scheduling and patient flow to reduce waiting times for and at appointments. For example, technology can be used to help patients schedule their appointments using the internet (136).	Capacity Expansion
		28	Increase access to dental and mental health services. Participants indicated that this was a major gap in the current service delivery system in North and Central Brooklyn. One stop care models where these services are added to current facilities, renting space near current facilities, using mobile vans and referrals to training programs in dentistry and clinical and counseling psychology programs/clinics which offer services with reduced and sliding scale fees can be used to address these needs (136).	Multi-Specialty Facilities
		29	Provide funding to train and educate patient advocates to support consumers by helping them navigate health care facilities and educate them on service availability (136).	Care Management

Brooklyn Healthcare Delivery System

Proposed Solutions

Resource	Primary Topic		Key Points	Category
Brooklyn Healthcare Improvement Project (B-HIP)	Healthcare in Northern and Central Brooklyn	1	A system that engages patients in a culturally competent way and allows for strong bonds to be formed between patients and providers in a medical home-setting will be crucial to reducing the costly use of ED and inpatient care. Delivering high quality care and presenting information in a way that is easily understood, while ensuring courteous customer service will go far in altering ingrained healthcare utilization patterns and improving population health and wellness (16).	General
		2	Effective local health planning processes can only happen with the participation of key players. Insurance plans, drug companies, local businesses, along with local government, hospitals, local health providers, and community based organizations are needed in such efforts (16).	Oversight
		3	The tendency of Northern/Central Brooklyn residents to utilize (at least hospital care) relatively close to home should be taken into account in the design of future localized interventions and resource allocation decisions (38).	Primary Care Facilities
		4	Interventions to reduce ACS condition related ED visits and hospitalizations in the hot spots must be carefully tailored to the unique needs, resources, and preferences of the local communities (43).	Primary Care Facilities
		5	Potential savings can be realized if B-HIP study area residents' rates of ED visits without admission, hospital discharges, and ACSC discharges in the study area are reduced to Brooklyn-wide levels with an estimated $145.3 million per year (44).	Finance
		6	Potential savings can be realized if B-HIP study area residents' rates of ED visits without admission, hospital discharges, and ACSC discharges in the study area are reduced to non-B-HIP neighborhoods of Brooklyn levels with an estimated $465.1 million per year (44).	Finance
		7	Medicaid and other payor reimbursement for safety net providers for medically underserved areas/populations must be aligned with the true cost of providing care. These areas/populations face disproportionate socioeconomic hardship and prevalence of chronic illnesses when compared to more affluent neighborhoods. This requires more care coordination and social service assistance, yet Medicaid and other payor reimbursement is not sufficient to cover the costs of extra effort and resources expended by safety net providers (46).	Finance
		8	Reimbursement rates should be increased across the board for safety net health providers and hospitals serving federally designated Medically Underserved Areas and/or Populations (or the functional equivalent) to adjust for care coordination (47).	Finance
		9	Improved patient access to appropriate, cost effective care, is necessary. Developing "one-stop shop" ambulatory care centers in walking distance of emergency departments would be a way to relieve ED overcrowding. Many of the hospitals in the B-HIP study area could potentially convert their underutilized inpatient space to this type of ambulatory care (47).	Multi-Specialty Facilities
		10	The PCMH model which includes enhanced access and communication to providers should be embraced in Brooklyn. Local providers should be incentivized to extend their operating hours to include more evenings and weekends. Access to providers for after hours prescriptions, questions, and ability to make appointments electronically should also be promoted. Availability of walk-in appointments should also be increased (47-48).	Primary Care Facilities
		11	Physician extenders such as nurse practitioners and physician assistants in retail locations such as pharmacies and mobile clinics could be used to provide walk-in access. This system could supplement the Regional Health Information Exchange (RHIO) by ensuring patients' regular providers have the most updated treatment information (48).	Primary Care Facilities
		12	Accurate reporting of the locations for providers should be required of health insurers by the state as a core quality measure of access under the New York Quality Assurance Reporting Requirements (QARR) -- and be linked to financial incentives. 19% of locations provided by insurance companies were inaccurate during the B-HIP canvassing effort (48).	Oversight
		13	Insurance companies should streamline the provider credentialing requirements and process to ease administrative burden on local primary care providers and expedite patients' access to care (48).	Oversight

Resource	Primary Topic		Key Points	Category
		14	Managed care plans should simplify their offerings by limiting "carve-outs." Much time is wasted navigating multiple sources of carved care by both patients and providers. Behavioral health services in particular should be consolidated with primary care coverage. It is widely accepted that mental health and addictions are inextricably linked to physical health and that the integration of these areas is both better for patients and more cost effective. The State should require, at the very least, plans to provide more assistance to patients and providers with transitions across carved-out services (49).	Oversight
		15	Payors should cap pharmaceutical co-payments (49).	Finance
		16	The State should consider creating additional Medicaid Health Homes to coordinate care for high cost/high risk patients in Northern and Central Brooklyn (49).	Oversight
		17	Funding be provided to establish local Health Navigation Centers in high need medically underserved areas such as the B-HP hotspots. These centers would offer free health education, health coaching, referrals and care navigation services for local residents and the community. Services could be accessed during business hours, evenings and weekends, in person or by telephone, and also through outreach by staff directly into the community. The Center would have current information and contacts at all of the local healthcare providers so that they can assist patients with access and scheduling of appointments. The Center would also develop relationships with the local pharmacies to facilitate patient connection to pharmacy drug discount programs and medication compliance education. Staff would be expected to work closely with area EDs and inpatient case managers to link patients to local ambulatory care providers and other community resources, as well as assist with coordinating discharge follow up and other care transitions, if requested by individual clients. Staff would also liaise with the Medicaid Health Homes to help identify and link local residents who may be assigned to the Health Homes (49-50).	Primary Care Facilities
		18	New reimbursement categories/codes and grant funding for start up and operations be made available to support the establishment of community-based disease-specific resource centers, in particular for diabetes/obesity. These centers would offer culturally and linguistically appropriate consultation/evaluation, treatment plan development and oversight, education on diet, healthy lifestyles and disease self-management, coaching, and referrals to needed support and social services. The centers would also provide some on-site labs and diabetic supplies. Investment in neighborhood level diabetes care centers could go far in stemming the exploding costs of diabetes to the system and human quality of life (50).	Primary Care Facilities
		19	Payers provide enrollees with Smartcards / Biometric ID swipe cards containing their personal health records. These cards should be able to interface with common electronic medical records systems and with SHIN-NY (50).	Care Management
		20	Payors reimburse primary care providers for tele-healthcare services.	Finance
		21	The State make periodic grant funding available for training of local provider staff on culturally relevant customer service and for upgrades to providers' facilities. Respondents in the ED survey and community focus groups have repeatedly voiced dissatisfaction with local care providers on issues such as treatment by staff, long wait times and shabby facilities. Investment in non-clinical interventions such as customer service and making spaces more attractive could improve patients' experience of local care providers and thereby attract more volume. Health insurance companies could also provide free customer service training and other customer service resources to local health centers. Any customer service training provided must include special attention to enhancing sensitivity to patient confidentiality concerns which may be heightened in densely populated communities like many of the B-HIP neighborhoods (50).	Quality Improvement

Resource	Primary Topic		Key Points	Category
		22	Programs to encourage recruitment and retention of culturally and linguistically competent and representative practitioners in underserved areas like Northern and Central Brooklyn be expanded, particularly in light of the expansion of the insured population under the ACA. In addition more efforts (such as high school/college pipeline and mentoring programs and financial assistance) should be made to increase enrollment of medical students from the local area, who may be more inclined to practice in this community after graduation. In this regard, the B-HIP supports the various health workforce initiatives in the MRT Multi-year Action Plan for training, recruitment and retention of physicians and non-physician clinicians in medically underserved areas and expansion of programs pertinent to the B-HIP populations such as the Nurse-Family Partnership which has been demonstrated to prevent pre-term births. Some of the responses from the ED staff survey reveal a disconnect between providers' perceptions of patients and reality with respect to patients' levels of insurance and education, among other issues, which also suggests a need for more training to foster a culturally competent workforce (51).	Quality Improvement
		23	Continuity of the provider-patient relationship be supported and strengthened, consistent with the PCMH practice of patient empanelment, whereby effort is made to ensure that the patient sees his or her selected PCP at each visit. Medicaid managed care plans should be required to re-assign members who have failed to timely re-enroll to the PCP to whom they were previously assigned in order to protect this relationship (51).	Care Management
		24	Payers reimburse providers for "non-medical" interventions that promote health and prevent illness. For example, providing education on healthy diet and free scales to new parents to monitor their children's weight can help address pediatric obesity and diabetes. Health providers should also receive compensation for developing wellness and disease management classes and programs for their patients (51).	Finance
		25	The State and local health agencies conduct additional public marketing and literacy campaigns on the importance of primary and preventive/well care (51).	Quality Improvement
		26	For the sake of future local research and planning projects the State may want to consider incorporating the SPARCS data cleaned by B-HIP into its own system, and to impose stricter data quality measures on Hospitals going forward (51).	Oversight
		27	Train and deploy community health workers or advocates (CHWs) to conduct outreach, education, referrals and navigation services in local venues and through social networks. CHWs are lay and para/clinical individuals from the local area who are culturally/linguistically competent and familiar with the local cultures and institutions. They can include 1) Healthcare Navigators, who can help patients identify and access appropriate community based healthcare resources, and 2) Health Coaches, persons with some clinical training who can assist patients with chronic disease in managing their specific conditions and in accessing appropriate care. The CHWs can target their outreach to people from their own social networks and home communities, for instance within public housing projects, church congregations or even local barbershops, beauty salons and businesses. The CHWs could also work on site or closely with the local EDs to help inform patients about and redirect them to nearby ambulatory care facilities accepting patients on a walk in basis. There are several Community Health Worker initiatives that have been started by local health organizations in various B-HIP study neighborhoods that could potentially be engaged and expanded upon (52).	Collaborative Efforts
		28	Tap into the great wealth of local faith-based and other community groups as conduits for health messages. Every community has houses of worship, Community Boards, civic and cultural associations, community action/organizing groups, and other groups often with their own health committees, which can be enlisted to help tailor and then disseminate health information throughout their constituencies and social networks. There are numerous initiatives in the B-HIP neighborhoods and Brooklyn that have engaged local pastors and health ministries to spread healthcare education and messages among their congregations. Multi-faith community organizing groups such as Brooklyn Congregations United have also mobilized many religious institutions around healthcare awareness and to perform community outreach via door-to-door surveys, interviews and educational/social visits with local residents including those who are house or bed-bound. Still other groups have organized health fairs, mobile van visits and the provision of free health services at churches (52).	Collaborative Efforts
		29	Identify and train local community leaders to be "champions" for community healthcare education. Each community has respected gatekeepers and natural leaders, whether religious, youth, parents, senior citizens, or other local figures. These leaders can be engaged to spread health information throughout their formal or informal networks and motivate others by example (52).	Collaborative Efforts

Resource	Primary Topic		Key Points	Category
		30	Create a multi-media public education campaign with the community divisions of local TV/radio stations such as WCBS and through internet/social marketing. The aim would be to build awareness and behavior change around preventive health, healthy lifestyles and health system utilization, while informing residents about local healthcare providers and resources like pharmacy benefit programs, etc. To engage younger residents (25% of B- HIP population is under 18 years old and another 42% are from the 18-44 age group) it will be critical to utilize technology and social media as educational and marketing resources, e.g. text messaging, phone "apps," G-chat (Google instant messaging), YouTube, Facebook and Twitter (53).	Collaborative Efforts
		31	Collect and share localized data on community health indicators, rates of ACSC ED visits and hospitalizations, health provider quality scorecards, the results of local focus groups and surveys and more. The data could be presented in the form of periodic report cards on the state of the community's health (53).	Oversight
		32	Partner with local libraries to conduct health awareness events and connect residents to library informational resources on healthcare (53).	Collaborative Efforts
		33	Create an all-purpose health hotline similar to the United Federation of Teachers' "Dial-a- Teacher" homework assistance service that residents can call to speak with a registered nurse and /or clinical care manager about health questions and for referrals to appropriate health resources. Depending on available funding, the service could be provided on a 24 hour basis or limited to the evening hours (53).	Patient Outreach
		34	Hold competitions for local residents to submit ideas for media health campaigns. The top ideas would be rewarded with cash prizes and utilized in the public campaigns, with credit given to the authors. In addition to cash prizes, local businesses or foundations could donate scholarships for youth contestants. Through the mechanism of the competition, multiple aims can be achieved simultaneously: ideas directly from the community can be mined and utilized, while the process of idea generation itself will serve to engage contestants and the community further into healthcare issues. Competitions can also be held to design engagement efforts around other selected healthcare issues that are relevant to the community (53).	Collaborative Efforts
		35	Spearhead an annual walkathon in Northern and Central Brooklyn to campaign and create dialogue around better care and better health and to empower the community to engage in healthy living (53).	Collaborative Efforts
		36	Hold multi-lingual focus groups and listening forums at local community meetings (churches, community boards) to share the B-HIP and other community-specific health data and elicit feedback and ideas for community engagement (53).	Collaborative Efforts
		37	Establish a system to regularly survey patients on their experiences with local care providers and disseminate the reviews. Create an interactive website through which the public can submit email inquiries, take surveys, post feedback and reviews on local providers and facilities, and access a wide variety of health information (54).	Oversight
		38	Conduct further research into the various cultural beliefs and practices around alternative medicine and ways to improve physician-patient communication around this issue. The B- HIP Coalition has heard a substantial number of anecdotal reports from providers of foreign-born patients and their families substituting herbal teas and other alternative remedies for their medically prescribed regimens. The extent and nature of these practices needs to be better understood by the medical provider community and culturally relevant communications strategies developed (54).	Quality Improvement
		39	Redirect state funding for managed care advertising to developing a program/bridging system to identify and help enrollees link to their assigned or selected providers. Currently the burden of engaging enrollees falls disproportionately on community providers, who have scarce resources for outreach. Often the contact information on the rosters provided by insurance companies is invalid. Some B-HIP insurance members have provided patient outreach resources to participating hospitals. Such assistance should also be made available to community level providers (54).	Quality Improvement
		40	The managed care plans should also communicate more effectively with enrollees about the frequent changes to benefits. Explanations should be simplified and a telephone number with a live person provided to the enrollee for questions (54).	Quality Improvement

Brooklyn Healthcare Delivery System

Proposed Solutions

Resource	Primary Topic		Key Points	Category
Brookdale Hospital Community Service Plan 2009	Community Health Needs Assessment	1	With a collaboration established with Brooklyn Care, efforts to educate primary care physicians on the importance of identifying patients who are smokers is being done. Smoking cessation, community education, and pamphlets are being promoted to these patients in order to increase awareness for the risks of smoking (8).	Quality Improvement
		2	A navigator program has been maintained to raise the community's awareness of colon cancer and the relative ease with which it can be detected and treated. Outreach to affiliated ambulatory care centers, at health fairs, inpatient units, hospital advisory boards, and community boards are all being pursued as well (8).	Patient Outreach
		3	Designated or chosen primary care providers in the ambulatory care clinics allow for continuity of care for patients. This relationship allows the provider to effectively prescribe appropriate screening, immunization, and health condition counseling (9).	Care Management
		4	The hospital has instituted a free vaccination program to uninsured, underinsured, and Medicaid pediatric patients through age 18. Flu vaccinations are offered to at risk patients of all ages and to all staff members (10).	Institutional Governance
		5	A WIC program operated by the hospital provides food vouchers and education to low income pregnant women and children up to the age of five (10).	Collaborative Efforts
		6	To integrate evaluation for insurance eligibility, uninsured patients are simultaneously considered for enrollment into Medicaid, HealthPlus, and/or the hospital's financial aid program. This eliminates unnecessary trips to the hospital to apply to the different programs. This effort has grown since it was implemented in 2006 because of increased patient awareness as well as positive feedback from eligible recipients (11).	Finance
The Brooklyn Hospital Center Community Service Plan 2012	Community Health Needs Assessment	1	For asthma patients, self-management plans have been developed through systematically increasing rates of patient education about medication use, asthma triggers, and awareness in the community about asthma (5).	Care Management
		2	For cancer, the partnership with the American Cancer Society must be maintained to sustain cancer support groups. Education and information to underserved, uninsured, and underinsured women about breast cancer prevention through the Breast Health Partnership must be promoted. Increasing the number of free screening events for women and minorities is necessary. Partnerships with local physicians and medical groups to increase pediatric cancer care are also of importance (5).	Collaborative Efforts
		3	Community education and outreach efforts aimed at reducing heart disease must be launched to increase awareness about the risks of smoking, cholesterol, high blood pressure, and sedentary lifestyle (5).	Patient Outreach
		4	Free glucose screenings at community health fairs and other large community events must be increased to facilitate distribution of diabetes information to the community (5).	Patient Outreach
		5	Establishing highly certified medical homes that increase follow-up and retention of patients will be critical to the hospital's PATH Center that treats patients with HIV/AIDS. Awareness of HIV/AIDS prevention through community outreach efforts should be pursued (6).	Quality Improvement
		6	Engaging new community organizations should be prioritized by the hospital (6).	Collaborative Efforts
		7	Engaging community-based organizations through the hospital's Community Health Planning Workgroup will help identify and create plans for improving the health status of residents (6).	Collaborative Efforts
		8	All outreach efforts should have measures to track progress towards achieving their goals (6-7).	Institutional Governance

Proposed Solutions

Resource	Primary Topic		Key Points	Category
		9	Utilizing a HEAL 21 Grant would allow Brooklyn Hospital Center, Interfaith Medical Center, and Wyckoff Heights Medical Center to form a healthcare system. Creating a Brooklyn Health System could align a fragmented and inadequately capitalized delivery system with the health needs of the community. As of September 2012, a feasibility study is being completed (7).	Institutional Governance
		10	Utilizing a CMS Transitional Care Grant, Brooklyn Hospital Center along with Cobble Hill Health Center and Interfaith Medical Center are participating in a program to decrease preventable readmissions. This coalition of providers seeks to establish an interdisciplinary team to provide care transition services to an estimated 1,508 Medicare fee-for-service beneficiaries to be admitted through 2016 to generate a savings estimated at $1.9 million per year (7-8).	Collaborative Efforts
		11	A HealthFirst Member Satisfaction Grant is being used to provide language and culturally sensitive education and training as part of a strategy to enhance provider-patient communication across language and cultural barriers. This training is being provided at the hospital and at four community family health centers in partnership with Memorial Sloan-Kettering Cancer Center's Center for Immigrant Health and Cancer Disparities (8).	Quality Improvement
		12	The hospital has entered into an agreement to join the Brooklyn Health Information Exchange to be a member participant. Interoperable health information technology and analytics provided by this exchange will facilitate patient-centric care and promote improved healthcare quality. Sharing of data improves community clinical connectivity and will support the hospital's initiatives regarding preventable readmissions (8).	Quality Improvement
		13	Grant monies totaling $120,000 have been awarded to help the hospital advance its research into the underlying issues of re-hospitalizations and efforts to improve its patterns of preventable readmissions (8).	Quality Improvement
		14	The hospital participated in a Brooklyn-consortium grant application to the CMS Strong Start funding initiative. This project seeks to develop an innovative community-based model of care and support to advance maternal and infant health outcomes for vulnerable individuals. Hospitals, FQHCs, community-based organizations, and a district public health office came together for this effort. Hospitals included Brooklyn Hospital, Lutheran Medical Center, and Maimonides Medical Center. The consortium's goals are to serve 2,800 women over the life of the grant and reduce preterm birth rates and costly NICU admissions while improving engagement in and satisfaction with prenatal care. This model is being designed to be replicable in other urban communities around the country to improve material health outcomes and reduce health disparities (8-9).	Collaborative Efforts
		15	Patients discharged with chronic diseases were provided with care management plans -- a written protocol from their doctors -- to explain how to manage their daily treatment, when to take medicines, how to handle worsening symptoms, and when to call the physician and/or seek emergency care. This strategy is being used for asthmatic patients currently (11-12).	Care Management
		16	Partnerships with community organizations to offer low-cost or free cancer screenings were conducted at over 50 events in 2012 (12).	Collaborative Efforts
		17	Glucose screenings were offered at more than 30 community health fairs with more than 1,100 persons receiving glucose screens. Efforts were tailored to the unique audiences at these health fairs by age, gender, and ethnic group. A registered nurse or physician provided counseling regarding the test result and the necessary steps for a healthier lifestyle (14).	Patient Outreach
		18	The HIV/AIDS program is marketing its services to increase community members' awareness of where they can go for HIV testing, treatment, and care. Outreach staff have been designated to participate in community events to promote prevention, safe sex, and awareness of services (14-15).	Patient Outreach
		19	Medical Home demonstration project grants are being pursued by the hospital to transition outpatient training sites to patient-centered medical homes (15).	Quality Improvement
		20	HCAHPS overall ambulatory care patient satisfaction has been increased from 3.9 to 4.2 (on a scale of 5.0) since changes were instituted to limit roadblocks for follow-up care. Strategies include a telephone overflow call system to contact patients, check their status, provide instructions, and remind them of their appointments (16).	Quality Improvement

Resource	Primary Topic		Key Points	Category
		21	Obesity outreach is conducted through the Wellness for Life program that recognizes the challenges faced by the community by introducing seated body workouts, development of diet plans, weigh-in competitions, recipe tastings, and healthy cooking techniques for ethnic cuisines represented in the service area. Over 100 people are actively engaged by this program each month and 95% of surveyed participants indicate this program is "very helpful" (17-18).	Patient Outreach
		22	The hospital's WIC program collaborated with a community organization to provide nutrition education classes to parents and families at 10 different locations in the community. This pilot project seeks to increase breastfeeding initiation and duration rates which have been shown to prevent obesity and other chronic diseases (18).	Collaborative Efforts
		23	When patients are not insured, the hospital has set up affordable rates to ensure access to healthcare services. Financial aid program recipients who are recently unemployed and are in the process of applying for insurance are allowed to receive care at the affordable rate level. When patients are identified as self-pay, the patient is immediately informed of the Financial Assistance Program offered by the hospital. This information is also provided in all billing statements (19).	Finance
Coney Island Hospital CHNA 2013	Community Health Needs Assessment	1	The hospital has implemented a language bank and hired several certified Spanish, Russian, and English Sign Language interpreters. Telephonic services are used for languages not covered by in-person interpreters.	Outsourcing
		2	The most prevalent languages in the service area other than English are Russian, Urdu, Bengali, Chinese, and Spanish. Because of this diversity, the hospital is the only country that prints a patient guide in four languages: English, Spanish, Russian, and Urdu.	Quality Improvement
		3	The community has a large number of NORCs or Naturally Occurring Retirement Communities, where residents are over 60. Residents settling in these communities are being targeted by NORC-centric community organizations to provide healthcare and supportive services. Many of these organizations regularly partner with the hospital on a variety of activities including outreach, health screenings, and health education (11).	Collaborative Efforts
		4	To ease access concerns for patients, expanded hours have been implemented at many outpatient clinics, pharmacies, and ancillary services during evenings and weekends (13).	Capacity Expansion
		5	Access to walk-in/same day appointments have been increased for those patients who just do not feel well and need to see a physician but do not require emergency services (13).	Capacity Expansion
		6	An external call center, accessible 24/7 in multiple languages, has been established to schedule appointments and communicate with clinical staff (13).	Outsourcing
		7	Care coordinators have been added to the hospital and clinic staffs to monitor high risk patients' care by providing pre-appointment phone calls, coordination of all necessary ancillary tests in line with evidence-based guidelines (13).	Care Management
		8	The hospital's registration process is being redesigned to eliminate steps for patients while continuing to collect vital information needed to appropriately coordinate care. This should decrease wait times (13).	Quality Improvement
		9	A Registered Nurse Coordinator follows up with any patient with a HbA1c (blood glucose level biomarker) over 8.0 to coordinate care and patient education. Outcome information for diabetic patients is included in physician report cards (13).	Quality Improvement
		10	Classes staffed with bilingual instructors facilitate a curriculum that takes into account culturally influenced health beliefs, attitudes, and practices to help patients learn how to control obesity and prevent complications from related diseases such as diabetes (13).	Patient Outreach
		11	Discharge protocols have been redesigned for patients with select conditions (including diabetes, congestive heart failure or CHF, pneumonia, acute myocardial infarctions, chronic obstructive pulmonary disease, and asthma) to educate patients about their disease, medications, and the importance of following the care plan set up by the clinical staff (13-14).	Care Management

Resource	Primary Topic		Key Points	Category
		12	To address the communities behavioral health issues, all related clinical services will be consolidated in a new community site with an expanded scope of services to serve patients who struggle with alcoholism, abuse, and suicide attempts (14).	Multi-Specialty Facilities
		13	At a Farmer's Market located near the hospital, open air classes and screening services are provided (14).	Patient Outreach
Kings County Hospital CHNA 2013	Community Health Needs Assessment	1	HHC hospitals evaluate patients' eligibility for public health insurance, and assists patients in completing applications for public health insurance. Uninsured patients who do not qualify for coverage are assessed for financial assistance using an established sliding fee scale based on Federal Poverty Guidelines to ensure that access to care is not withheld based on the ability to pay. Fees are reduced to an affordable amount, based on family size and income, and are available without regard to immigration status (4).	Finance
		2	KCHC employs multi-lingual staff who can effectively communicate with and understand the needs of the community. Employees are fluent in 39 different languages and are part of the hospital's language bank. CyraCom phones and video remote interpreting terminals for person with hearing terminals for persons with hearing disabilities are strategically located throughout the hospital to facilitate the linguistic needs of the community (5).	Outsourcing
		3	A Diabetes Resource Center has been established to teach people with diabetes to manage the disease and how to eat and prepare meals; 100 participants complete this program each year (9).	Care Management
		4	The hospital has established a wellness center where customized exercise programs are developed for them. Separate programs for adolescents and pediatric sessions are available -- particularly for those children with obesity issues (9).	Care Management
		5	The cardiology ambulatory care providers work collaboratively with the Inpatient CHF team to follow-up with discharged patients to help them remain stable and avoid the need to be readmitted (9).	Care Management
		6	Because more than 70% of hospital staff reside in the surrounding communities, their health needs are consistent with the health needs of the community. Staff wellness programs, in partnership with NYCDOH, provide on-site exercise classes for staff several times per week. Staff wellness fairs provide staff with free health screenings, health information, and counseling (9).	Human Resources
		7	Ambulatory care services have partnered with Tunstall/AMAC Corporation to assist with the handling of patient telephone requests for appointments to reduce the amount of time patients wait on hold to schedule an appointment (9).	Outsourcing
		8	To meet expanding needs within the ambulatory cardiology clinic, treatment sessions will be increased and a dietician will be made available to assist patients with heart disease on how to make healthier food choice.	Care Management
		9	The hospital recently submitted a Certificate of Need Application to expand community outreach programs via a mobile health van to include additional screening services (blood glucose, cholesterol, etc.). The mobile health van will also allow for more community education and immediate primary care referrals. Targeted outreach programs for adolescent girls and young women will provide health screenings, obesity prevention, and wellness information to improve overall women's health and birth outcomes (10).	Primary Care Facilities
		10	Policies and procedures of the hospital have been updated to ensure early identification of victims of domestic violence and provide medical care, psychosocial assessment, and referral to community agencies that will be able to assist in their continued care and support (10).	Institutional Governance
		11	The KAVI/Cure Violence Program at the hospital has recently been implemented in collaboration with several community based organizations to address violence in communities served by the hospital (10).	Collaborative Efforts

Brooklyn Healthcare Delivery System

Proposed Solutions

Resource	Primary Topic		Key Points	Category
		12	Additional mental health screenings will be offered at various community events via the proposed mobile health van to identify persons at risk for mental illness. Referrals for further evaluation and treatment will be made, as appropriate (10).	Primary Care Facilities
		13	HIV testing hours in the emergency department have been expanded and an additional testing location has been added in the ambulatory care facility. More testing locations will be opened to make HIV counseling and testing more accessible to clinic patients (10).	Capacity Expansion
		14	The proposed mobile van will provide additional opportunities to educate the community on the availability of cancer screening tests, such as pap smears, mammograms, and colonoscopies (11).	Primary Care Facilities
Kingsbrook Jewish Medical Center Community Service Plan 2011	Community Health Needs Assessment	1	The hospital aims to provide a variety of free screening options to members of the community, particularly for those who are uninsured and under-insured with a goal of increasing screening participation rates by 10%. Collaborations with community providers and other not-for-profit entities so that they can independently provide screening and preventive treatment services to the particular parts of the community they serve. Partnerships include off-site events with local clergy, schools, and community based organizations. On-site events based on an annual screening calendar are facilitated at the hospital and off-site family health center. Screening efforts focus on early detection of breast and prostate cancer (1).	Collaborative Efforts
		2	In addition to screening, the hospital provided education and workshops to those who are not well informed about prostate cancer and its associated risk factor. The establishment of a Prostate Cancer Steering Committee with community organizations further supports this effort (1).	Collaborative Efforts
		3	A breast health education program, funded by the Susan G. Komen for the Cure Foundation, counsels women about the importance of breast screening while providing mammogram and follow-up coordination/referral services. Additional partners are being sought out to broaden outreach efforts and address this underserved population (2).	Collaborative Efforts
		4	Community volunteers and patients are trained in diabetes self-management protocols. This "learning for life" diabetes program is overseen by an advisory committee comprised of representatives from the community and certain clinical departments. These trainings are supported by the latest evidence-based best practices (2).	Care Management
		5	Kingsbrook's Designated AIDS Center (DAC) serves 400 clients each year and seeks to increase its community outreach by providing more early detection opportunities, community education, increased training opportunities for medical residents, and bolstering linkages with other HIV/AIDS providers -- particularly those with a focus on difficult-to-reach immigrant populations. Outreach must be targeted at individuals (2).	Quality Improvement
		6	Screenings for asthma, stroke, diabetes, hypertension, HIV, prostate cancer, and breast cancer impacted over 7,000 residents. This impact was achieved because of aggressive outreach including a partnership with the Brooklyn Borough President to facilitate "Take Your Man to the Doctor Week." Men were challenged by their partners to seek relevant screenings as a part of this effort (3).	Collaborative Efforts
		7	An online coupon is distributed by the hospital to increase prostate cancer screening examinations. In 2011, 1,007 men were screened leading to 107 abnormal findings (3).	Finance
		8	Through a grant from the Fan Fox & Leslie Samuel Foundation and from the New York State Senate, aggressive palliative care program expansion was supported through the hiring of new personnel and training. This allowed for their educational efforts to be possible. This program has increased awareness both among providers and the community about the benefits of palliative care.	Collaborative Efforts
Lutheran HealthCare Community Service Plan 2012	Community Health Needs Assessment	1	With a HEAL Phase 2 Grant to construct a new 25,000 square-foot primary care center annex to the Sunset Park Family Health Center, there has been a 9.9% increase in women's health visits and a 9.1% increase in pediatric visits for a total of 70,000 visits to the annex in 2011. In total, 141,000 medical visits occurred in 2011 in 40 exam rooms with extended hours at this clinic (3).	Primary Care Facilities
		2	A new Brooklyn Chinese Family Health Center was opened in February 2011 in the heart of Brooklyn's Chinatown -- an area with the largest concentration of Chinese residents in New York City. Increased hours were added in February 2012 to accommodate rapid growth of this population with a 5.6% increase in visit volume during the first year of operations (3).	Primary Care Facilities

Resource	Primary Topic		Key Points	Category
		3	The hospital has worked with school administrators, teachers, and parents to increase the number of students that receive oral health services at 16 school-based dental sites. In 2011, there was a 57.4% increase in school-based dental patients (3-4).	Collaborative Efforts
		4	The hospital has worked with HealthPlus to facilitate insurance enrollment for residents. Collaborating with its school-based dental program, Lutheran seeks to maximize students' health insurance rate. Enrollment in insurance has increased at the 16 sites by 34% to 915 students in total for 2011 (4).	Collaborative Efforts
		5	Lutheran has created a local coalition of organizations within its service area to increase knowledge of the community in the areas of breast, cervical, colorectal, and prostate cancer. With these community partners, promotion of community education, prevention/screening, provider education, improvement of organizational practices, and efforts to influence policy/legislation are all increasing awareness of cancer screening. The percentage of women between 40-69 years of age who had a mammogram within the past two years over the project's life (2008-2011) increased from 35% to 59%. The percentage of women between the ages of 24-64 who received one or more Pap tests during this same period increased from 73% to 81%. Grant funding was unfortunately lost in early 2010 and resulted in this program being discontinued (4-5).	Collaborative Efforts
		6	Modeled after an existing breast cancer patient navigator program, the colonoscopy patient navigator program successfully navigated over 1,400 patients through colonoscopy screenings. While state grant funding has ended, the program has received funding by the American Cancer Society with limited numbers of free colonoscopies provided by the Brooklyn Healthy Living Partnership in 2011 (5).	Patient Outreach
		7	Introduction of the PCMH model of care has led to increased organization, coordination, and integration of care -- factors that influence long-term health outcomes in the primary care setting. Eight of the nine Lutheran Family Health Center sites received a Level 3 PCMH designation because of their elevated standards of quality in care with a focus on prevention (6).	Quality Improvement
		8	From 2008-2012, the percentage of type 2 diabetes patients who biomarker HbA1c has fallen below 9% has increased by 4% from 68% to 72%. This was observed while the hospital intensified efforts to provide education on self-monitoring, diet and nutrition, and healthy life style tips to empower patients to take charge of their diabetes and engage in lifestyle changes that will result in long-term positive health outcomes (6).	Patient Outreach
		9	Partnering with the NYCDOH, the Fund for Public Health in New York, and the Robert Wood Johnson Foundation, a community-oriented hypertension program utilizing telemedicine technology for blood pressure monitoring was developed. Automatic blood pressure monitors with modems transmitting readings for evaluation were distributed to 1,000 patients and community members. 800 participants were enrolled with 69% of hypertensive patients controlled with a reference value of less than 130/80 mmHg. Data is monitored on a real time basis to identify uncontrolled blood pressure in patients; PCMH advocates call these patients to make appointments and help facilitate further methods of care (7).	Collaborative Efforts
		10	The hospital created a Community-Based Adolescent Pregnancy Prevention Program to address high rates of adolescent pregnancy and births in Sunset Park. The program is hosted in a community center established by the Lutheran Health System to serve adolescents. Group education and school-based services have been implemented to reduce risky behaviors and negative outcomes such as unintended pregnancy and function as a trusted point-of-entry to prenatal care for adolescents that do become pregnant. 2,653 youth were served in 2011 with a high percentage of minorities served: 42% Hispanic, 39% Black/African-American, and 5% Asian. 93% of total participants indicated an increase in knowledge about community resources and how to access them and 66% of participants indicated an intent to change behavior due to the program's intervention (8-9).	Collaborative Efforts
		11	Many studies have shown that nurse midwives improve access to care for expectant mothers and significantly improve birth outcomes. In 2011, Lutheran increased midwifery staff to 9 from 4 in 2010 to enable a higher patient volume earlier in their pregnancy. However, the percentage of women receiving prenatal care within their first trimester remained the same for 2011. Norms of receiving prenatal care in the third trimester in other cultures have been addressed through outreach within local churches and community based organizations to help teach women the importance of prenatal care and how to seek healthcare regardless of citizenship status. In 2012, 72% of women have accessed prenatal care during their first trimester, up from 61% in 2008 (9).	Patient Outreach

Brooklyn Healthcare Delivery System

Proposed Solutions

Resource	Primary Topic		Key Points	Category
		12	Lutheran HealthCare has established a pregnancy project focusing on providing prenatal care to low-income/high-risk pregnant women to replace traditional 1:1 prenatal visits with a physician with in-depth 2-hour group visits involving enhanced education, social support, and self-empowerment. As a result of the project, improved birth outcomes and health behaviors during and after pregnancy for adolescents aged 14-21 are observed. Specifically, the percentage of newborns weighing less than 2,500 grams has decreased to 5.2% in 2011 -- significantly better than the rates observed on average in Brooklyn and New York City, 8.4% and 8.7% respectively (9-10).	Quality Improvement
		13	Site-specific and organization-wide report cards track performance with respect to clinical measures and goals established by clinical and administrative leadership. Measures are based on demonstrated community health needs, accreditation standards, and regulatory requirements. The measures have been updated to include goals pertaining to maternal, perinatal, and pediatric health. Periodically, with community stakeholders, these standards are reviewed as well as the progress towards the goals set for the organization (10-11).	Institutional Governance
Maimonides Medical Center Community Service Plan 2011	Community Health Needs Assessment	1	Maimonides has taken a leadership role in the development and implementation of health information technology enhance access to information and support care management coordination. The hospital has been involved in developing the Brooklyn Health Information Exchange, a regional health information organization (RHIO), with partners including Lutheran Medical Center, Kingsbrook Jewish Medical Center, Brookdale Medical Center, First to Care, Visiting Nurse Service of New York, Visiting Nurse Association of Brooklyn, HealthPlus, Elderplan, 1199 Benefit Funds, Metropolitan Jewish Health System, Sephardic Home, and Housing Works. This platform provides an infrastructure to support care management to minimize hospitalizations and support residents in the community (2).	Collaborative Efforts
		2	Executive leadership of the hospital engages leaders from surrounding neighborhoods in a council of community organizations to foster a dialogue to discuss new programs and initiatives focused on community service (2).	Collaborative Efforts
		3	Meeting with the contracted ambulance service quarterly has allowed clinical outcomes to be improved as they relate to emergency services (2).	Collaborative Efforts
		4	Once financial aid eligibility is established, the aid program extends throughout the Maimonides ambulatory care network to boost the likelihood patients will seek and receive continuity in meeting their ongoing medical care needs (5).	Finance
New York Community Hospital Community Service Plan 2009	Community Health Needs Assessment	1	The hospital created an Advisory Board that meets on a monthly basis to disseminate information to members of the local community, volunteers, and clergy. They provide feedback to inform the health prevention agenda priorities of the hospital (12).	Collaborative Efforts
		2	The hospital is re-designing its website to expand coverage of future events, hospital news, and increase the ability for public input necessary to provide input about community health needs, its prevention priorities, and general performance. The website also includes a consumer health library with articles written for a consumer audience (13).	Patient Outreach
		3	The hospital and community agencies have pursued an effort to educate community members willing to participate in any in-house programs for smoking cessation. Utilizing staff members of the same culture as the majority of the community served by the hospital is thought to be an effective way to promote counseling and education services. The hospital has also become a smoke free campus (15).	Patient Outreach
		4	Lectures and workshops for patients at risk for complications from chronic diseases as well as post-discharge counseling to check on recently discharges patients to reduce barriers to compliance are being utilized to improve chronic disease management in the community. Partnerships with community organizations are thought to ensure success of this project (16).	Care Management
		5	Selected discharged patients with a diagnosis of diabetes mellitus will receive scripted outreach from mature volunteers over the phone to inquire about their comprehension of their discharge instructions, the quality of communication with caregivers, the availability of recommended services, current compliance with medication orders, and question or problems that can be referred to professional hospital staff. The effectiveness of the program will be evaluated through patient surveys, interviews with participating physicians, and monitoring re-admission rates (16-17).	Care Management

Brooklyn Healthcare Delivery System

Proposed Solutions

Resource	Primary Topic		Key Points	Category
		6	The hospital has established relationships with local hospitals in Brooklyn as well as the Cornell Campus of New York Presbyterian Hospital in order to have enough support during a public health crisis -- particularly to ensure resources, experience, and expertise is on hand to be mobilized to respond effectively to unanticipated needs (18-19).	Collaborative Efforts
		7	Partnerships have been established to train future nursing students, create volunteer opportunities to allow students to earn community service credits, help young disabled individuals learn work skills as volunteers, and a summer youth employment program to instill good work habits in students (22).	Collaborative Efforts
New York Methodist Hospital Community Service Plan 2012	Community Health Needs Assessment	1	Increased Diabetes Education classes offered by the hospital's Diabetes Education and Resource Center by doubling the number of courses with a goal of increasing attendance by 30% (3).	Capacity Expansion
		2	By improving breastfeed education and counseling efforts, has improved breastfeeding rates from 91.1% in April to a high of 96.5% in June 2012. While there has been a decline observed since this high, it is something the hospital is working towards improving (3).	Quality Improvement
		3	Instituted a program funded by a grant through the United Hospital Fund (UHF) to train hospital volunteers to provide bedside education to CF patients. This has improved the 30-day CHF readmission rate to 14% as of 2012 (3). Partnerships with various other local community organizations have provided support for this efforts (6).	Collaborative Efforts
		4	Working with Google Analytics tools and utilizing in-house improvement strategies, the website now features keywords to increase page view for pages relevant to the hospital's prevention agenda (3).	Patient Outreach
		5	The hospital utilizes social media, particularly Facebook, to increase awareness of services and of public health issues through direct engagement with users tracked by Facebook Insights -- an analytics tool (3). Promoting healthy habits with daily posts to nearly 2000 fans, 15 tips health tips have been viewed by 1000 of these fans in the monitored months of 2012 (8).	Patient Outreach
		6	The hospital has posted links to charity care policies along with financial aid applications on the homepage of the public website, nym.org, to increase awareness of financial support and increase patient access. Links and materials are provided in English and Spanish (8).	Finance
		7	Hospital speakers are made available to provide health-related lectures and workshops to classroom groups, assemblies, and parents. These speakers are also available to speak at senior centers, community centers, places of worship, and health fairs. There is also a health literacy project staffed by hospital volunteers. Staff physicians regularly author health-related columns on current medical issues in local press (8).	Collaborative Efforts
Woodhull Medical Center CHNA 2013	Community Health Needs Assessment	1	Regular partnerships with community-based organizations on a variety of activities including outreach, health screenings, and health education (10).	Collaborative Efforts
		2	Improving access for adult ambulatory care with a specific focus on improving the time to get an appointment and the time waiting to be seen for a scheduled appointment. Expanded hours have also been implemented (12).	Capacity Expansion
		3	Better care management to address complex needs of our community - for diseases such as diabetes and asthma and issues such as medication education (12).	Care Management
		4	Reorganized ambulatory care services into comprehensive service lines including Women's Health, Adult Medicine, and Children's Health by decertifying inpatient beds and converting inpatient units to primary care. These efforts have expanded capacity, decompressed the ED, and allowed for services that are easier for patients to access (12).	Capacity Expansion
		5	Expanding PCMH capacity with the addition of at least one more team of clinical staff (13).	Capacity Expansion

Brooklyn Healthcare Delivery System

Proposed Solutions

Resource	Primary Topic		Key Points	Category
		6	Improving care management in the emergency department in psychiatry with the hiring of social work care managers who will serve patients on a 24/7 basis for those with chronic diseases (14).	Care Management
		7	Hospital relies on other providers to fill gap for bariatric surgery services to treat obese patients. Outpatient practices council patients on issues of weight management and has established a bi-weekly Obesity Clinic to monitor overweight and at-risk children. Summer programs to engage overweight youth have also been developed to encourage healthy behaviors (15).	Collaborative Efforts
		8	Developing a psychiatric emergency program to provide a full continuum of care and coordinated clinical services to facilitate a rapid return to community care for adult psychiatric patients (16).	Multi-Specialty Facilities
		9	Expansion of clerical support for diabetic patient outreach was pursued. Efforts such as follow-up calls, letters, and assistance in making appointments are done to maintain patients in care. A registry, educational resources, support groups, care management, and specialty care resources are all made available to these patients (17-18).	Care Management
Wyckoff Heights Medical Center Community Service Plan 2011	Community Health Needs Assessment	1	Wyckoff Heights Medical Center continues to respond to the growing healthcare needs of the communities it serves by acquiring new equipment and expanding clinical programs. On-site MRI ensures that community residents do not have to travel outside the neighborhood to access radiological services (11).	Capacity Expansion
		2	In order to honor the religious traditions of certain communities, the hospital developed a bloodless medicine and surgery program (11).	Quality Improvement
		3	Acquired hyperbaric chambers to aid in the healing of wounds encountered by the increasing number of diabetic patients (11).	Quality Improvement
		4	Established the "President's Community Advisory Council" to ensure that the communities served by Wyckoff play a role in fostering its mission. Discussions held during the meeting provide hospital administration with feedback from the community -- requests on areas of improvement (13).	Collaborative Efforts
		5	Established several community partnerships to provide health care services for a youth program, to help unemployed community residents get trained as nursing assistants, patient care technicians, and medical coders/billers, and to improve HIV/AIDS services outreach for a harm reduction program. Other collaborations have been formed with a pediatric obesity program which works with local elementary schools and daycare centers as well as senior citizen outreach program that works with senior centers and senior housing (14).	Collaborative Efforts
		6	A new customer service focus has been introduced to the Emergency Department. A liaison was hired to assist patients and families with questions. "Huddles" conducted by management have helped enhance communication and promote excellent customer service. Triage, registration, and patient visit work-flows have been redesigned to decrease ALOS (19).	Capacity Expansion
		7	Established a home visit program to keep the elderly healthy, functional, and independent in the community as well as reducing ER visits, length of stay, and readmissions. Since launching in May 2009, 245 patients have been enrolled and a 71% decline in 30-day admissions to the hospital has been observed (21).	Care Management
		8	Developing an IRB approved research project to predict, based on rate of change of Hemoglobin A1c levels, the level and intensity of services a diabetic patient requires (28).	Collaborative Efforts
		9	Designated a staff member to enroll mothers in the community into prenatal care and education programs hosted by the hospital to improve statistics related to the incidence of low weight babies that generally have poor health outcomes (32).	Patient Outreach

Brooklyn Healthcare Delivery System

Proposed Solutions

Resource	Primary Topic		Key Points	Category
		10	Partnered with local WIC agency to provide yoga and Zumba classes to help children reach a healthy weight. 60% decrease in BMI for overweight and obese children participating in program (34-35).	Collaborative Efforts
		11	Instituted a sliding scale fee that offers discounts for patients that do not qualify for Medicaid and require healthcare services. Introduced an aggressive Medicaid application program that is outsourced to a third party vendor (40).	Finance
		12	Developing a PCMH to coordinate healthcare services provided to patients residing in the primary and secondary service areas (41).	Quality Improvement
		13	Relationships have been established to help private physician office practices adopt electronic health records systems that are interoperable with Wyckoff's IT infrastructure to establish the ability to share clinical information electronically (41).	Collaborative Efforts

Exhibit Number Four, Payment Inadequacy to Physicians and Physician Organizations

Attached is an exhibit on two pages.

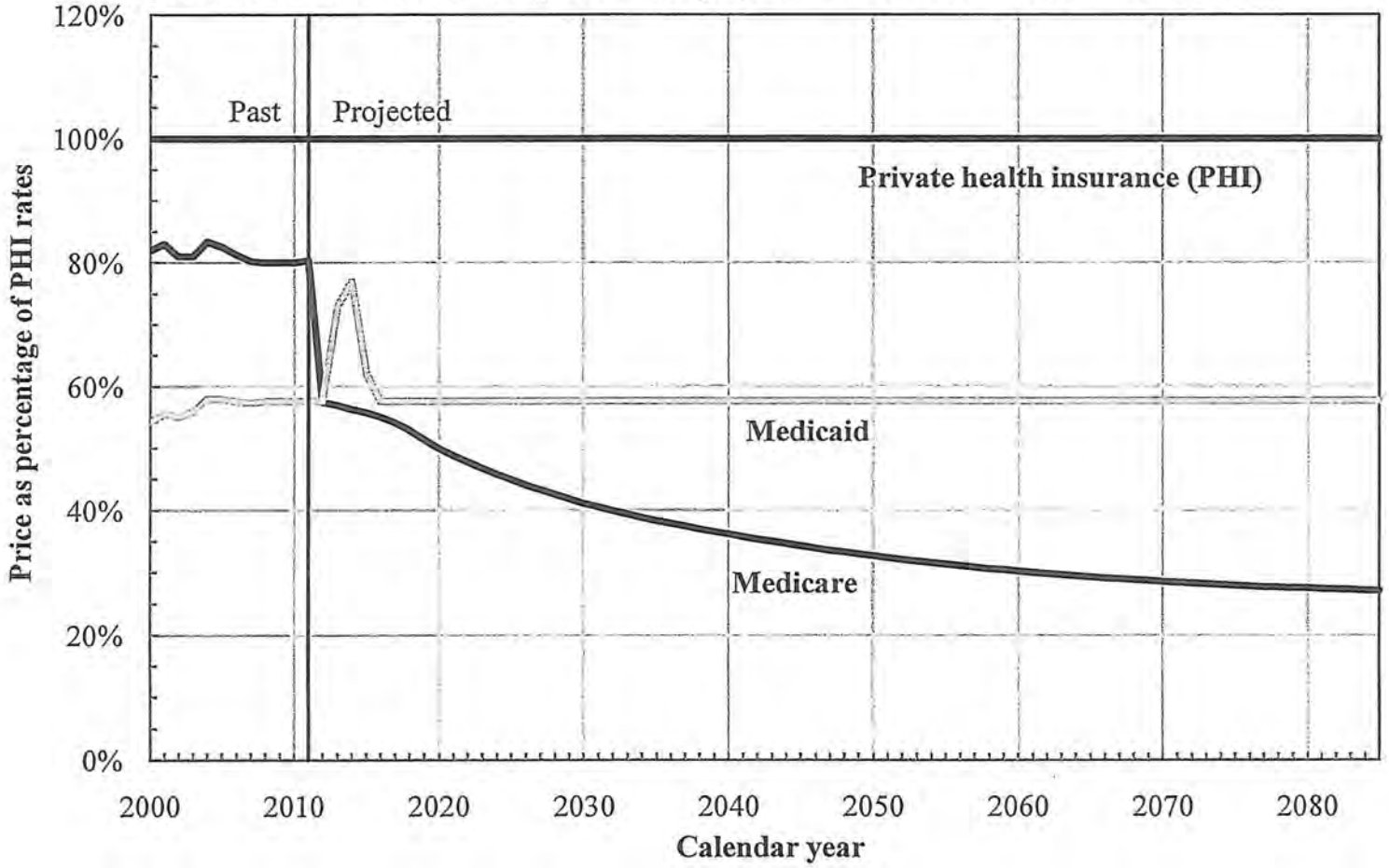
The first page shows that payment to physicians from public programs is unlikely to improve in the near future. Taken from Shatto and Clemens, CMS Office of the Actuary, 5-13-2011, it is a projection of relative Medicare, Medicaid and private health insurance prices for physician services under "current [federal] law," namely the Patient Protection and Affordable Care Act.

The second page shows Medicaid reimbursement rates for primary care, relative to private insurers. This study is five years old, not found in similar form more recently. It shows (prior to the recent increase in Medicaid managed care, which can be expected to exacerbate the results) that New York has the worst performance of any of the measured states (29%). That is, Medicaid pays for primary care at a rate of 29% of that which is paid by private insurers, tying Rhode Island for lowest in the nation, lower than many states with far fewer resources.

The purpose of this exhibit is as follows: to illustrate the gap that would exist should the State of New York attempt to "fix" the health care delivery system by paying physicians more adequately in safety-net settings. Payment is already so astonishingly low that correction would require resources beyond those the State may be able willing to invest, with unpredictable results for the future. Recruiting physicians, staffing physicians in non-hospital ambulatory care clinics, and primary care development activities will all prove inadequate.

As a consequence, Brooklyn must rely on its hospitals, strengthening those hospitals, to address the problems described.

Figure 2—Illustrative comparison of relative Medicare, Medicaid, and private health insurance prices for physician services under current law



Medicaid Reimbursement Rates for Primary Care, Relative to Private Insurers, 2008 (est.)

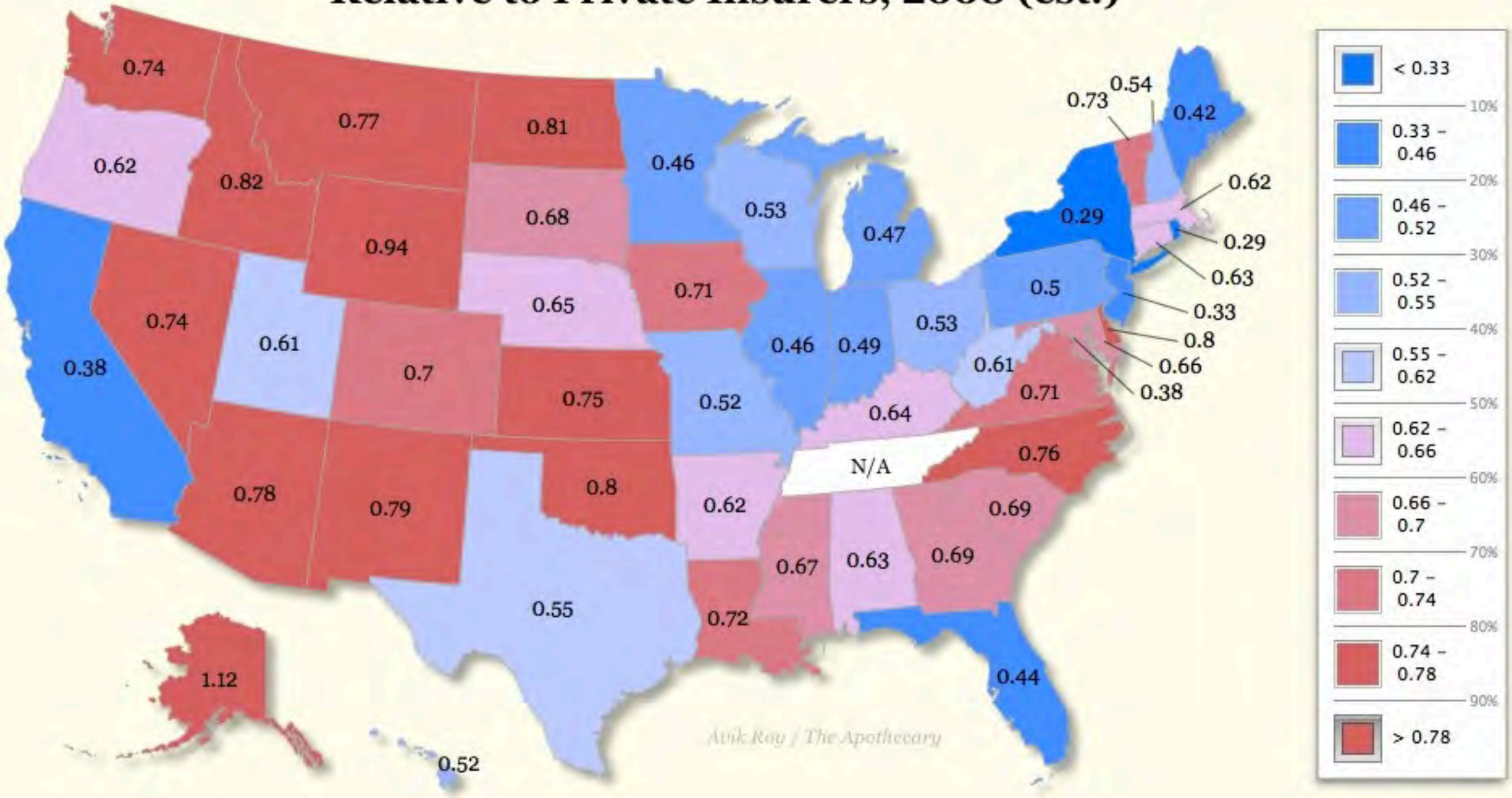


Exhibit Number Five, Medicaid Managed Care, Consequences for Hospitals

Medicaid managed care is growing in New York State (see bibliography, 2012 Managed Care Plan Enrollment Report; also, Gahan, Sept. 2013 report).

The managed Medicaid penetration for the State on average is a little less than 30%, 22% outside of New York City. In New York City this penetration is over 40%, with 42% in Kings County.

The first page on the attached exhibit, taken from the NYS DoH website, shows the difference between inpatient case payment rates for Medicaid managed care vs. Medicaid fee-for-service. The second page shows an extract of the same information for the fifteen Brooklyn hospitals. The bottom line is this: whereas Medicaid fee-for-service rates recorded by DoH were $11,148 per discharge, Medicaid managed care rates were only $7,576. The difference may be partly associated with case mix.

The higher the penetration of Medicaid managed care - - and the greater the "savings" recorded by the State - - the worse will be the financial health of Brooklyn hospitals.

Medicaid Managed Care (MA HMO) vs. Fee For Service (FFS) Rates for Brooklyn Hospitals, Inpatient

Source: NYSDOH

INPATIENT CASE PAYMENT RATES EFFECTIVE 4/1/2012 - 12/31/2012 (MA HMO ONLY)

INPATIENT CASE PAYMENT RATES EFFECTIVE 4/1/2012 - 12/31/12 (MA FFS ONLY)

Note: Does not include ALC daily rate and HCRA surcharge for bad debt (7.04%).

BOROUGH	HOSPITAL NAME	DISCHARGE RATES	ISAF	CAPITAL RATE - PER DISCH	NON-COMPARABLE ADD-ONS			SUM	ADMISSION RATE	DISCHARGE RATE	ISAF	IME %'s	DME RATE	CAPITAL RATE - PER DISCH	SUM	NET
		"DEFAULT & CONTRACT" DISCHARGE CASE PAYMENT RATE (INCLUDING PHL § 2807-c(33) - Excluding IME)	INSTITUTION SPECIFIC ADJUSTMENT FACTOR (ISAF)	CAPITAL PER DISCHARGE (EXCLUDING NON-COMPARABLE ADD-ONS)	AMBULANCE ADD-ON	TEACHING ELECTION AMENDMENT PHYSICIANS ADD-ON	SCHOOL OF NURSING ADD-ON		ADMISSION CASE PAYMENT RATE (INCLUDING PHL § 2807-c(33))	DISCHARGE CASE PAYMENT RATE (INCLUDING PHL § 2807-c(33))	INSTITUTION-SPECIFIC ADJUSTMENT FACTOR (ISAF)	INDIRECT MEDICAL EDUCATION (IME) %	DIRECT MEDICAL EDUCATION (DME) ADD-ON	CAPITAL PER DISCHARGE PLUS NON-COMPARABLES: AMBULANCE, SCHOOL OF NURSING, TEACHING ELECTION AMENDMENT PHYS & TRANSITION ADD-ONS		
BROOKLYN	BETH ISRAEL / KINGS HIGHWAY	$7,577.29	1.1652	$203.33	$0.00	$0.00	$0.00	$7,780.62	$8,031.03	$7,592.44	1.1652	0.20%	$605.62	$203.33	$8,401.39	($620.77)
BROOKLYN	BROOKDALE HOSPITAL MED CTR	$6,803.64	1.0476	$409.98	$0.00	$0.00	$0.00	$7,213.62	$10,887.98	$8,220.84	1.0476	20.83%	$1,315.63	$1,556.86	$11,093.33	($3,879.71)
BROOKLYN	BROOKLYN HOSPITAL	$6,685.39	1.0296	$503.02	$0.00	$0.00	$0.00	$7,188.41	$8,053.18	$8,059.24	1.0296	20.55%	$612.89	$1,776.80	$10,448.93	($3,260.52)
BROOKLYN	CONEY ISLAND HOSPITAL	$6,553.37	1.0110	$749.57	$0.00	$0.00	$0.00	$7,302.94	$8,203.25	$7,661.54	1.0110	16.91%	$1,173.02	$3,698.37	$12,532.93	($5,229.99)
BROOKLYN	INTERFAITH MEDICAL CENTER	$6,779.81	1.0538	$779.60	$0.00	$0.00	$0.00	$7,559.41	$9,942.78	$8,883.59	1.0538	31.03%	$866.42	$4,427.67	$14,177.68	($6,618.27)
BROOKLYN	KINGS COUNTY HOSPITAL CENTER	$6,604.59	1.0145	$944.03	$0.00	$460.14	$0.00	$8,008.76	$11,765.03	$8,813.83	1.0145	33.45%	$2,405.63	$2,345.42	$13,564.88	($5,556.12)
BROOKLYN	KINGSBROOK JEWISH MED CTR	$7,420.19	1.1482	$339.44	$0.00	$0.00	$0.00	$7,759.63	$11,622.56	$8,502.05	1.1482	14.58%	$1,083.42	$3,948.19	$13,533.66	($5,774.03)
BROOKLYN	LUTHERAN MEDICAL CENTER	$6,626.16	1.0172	$276.42	$204.40	$0.00	$0.00	$7,106.98	$8,883.06	$8,216.44	1.0172	24.00%	$961.59	$1,358.84	$10,536.87	($3,429.89)
BROOKLYN	MAIMONIDES MEDICAL CENTER	$7,750.52	1.1904	$757.45	$115.92	$0.00	$0.00	$8,623.89	$13,416.47	$9,544.77	1.1904	23.15%	$1,006.36	$873.37	$11,424.50	($2,800.61)
BROOKLYN	NY COMMUNITY / BROOKLYN	$7,153.57	1.1128	$333.95	$0.00	$0.00	$0.00	$7,487.52	$6,691.45	$7,153.57	1.1128	0.00%	$0.00	$333.95	$7,487.52	$0.00
BROOKLYN	NY METHODIST HOSP / BROOKLYN	$6,912.22	1.0683	$333.70	$0.00	$0.00	$0.00	$7,245.92	$10,218.08	$8,072.09	1.0683	16.78%	$781.00	$333.70	$9,186.79	($1,940.87)
BROOKLYN	STATE UNIV HOSP / DOWNSTATE	$7,055.59	1.0909	$997.28	$0.00	$0.00	$0.00	$8,052.87	$13,467.86	$8,858.29	1.0909	25.55%	$1,882.99	$997.28	$11,738.56	($3,685.69)
BROOKLYN	SUNY DOWNSTATE MED CTRAT LICH	$7,055.59	1.0909	$997.28	$0.00	$0.00	$0.00	$8,052.87	$13,467.86	$8,858.29	1.0909	25.55%	$1,882.99	$997.28	$11,738.56	($3,685.69)
BROOKLYN	UNIV HOSP SUNY HLTH SCI CTR	$5,971.15	0.9184	$804.12	$0.00	$0.00	$0.00	$6,775.27	$14,327.40	$7,704.57	0.9184	29.03%	$1,013.90	$804.12	$9,522.59	($2,747.32)
BROOKLYN	WOODHULL MEDICAL	$6,591.51	1.0175	$687.02	$0.00	$366.78	$0.00	$7,645.31	$8,614.99	$7,957.27	1.0175	20.72%	$1,664.32	$3,324.99	$12,946.58	($5,301.27)
BROOKLYN	WYCKOFF HEIGHTS HOSPITAL	$6,895.77	1.0677	$493.37	$18.37	$0.00	$0.00	$7,407.51	$8,437.88	$7,992.89	1.0677	15.91%	$950.14	$1,094.04	$10,037.07	($2,629.56)
	AVERAGE BROOKLYN RATES	$6,902.27	$1.07	$600.60	$21.17	$51.68	$0.00	**$7,575.72**	# $10,376.93	$8,255.73	$1.07	$0.20	$1,137.87	$1,754.64	**$11,148.24**	($3,572.52)

Exhibit Number Six, Interfaith Medical Center, an Example of the Impact of Medicaid Rate Changes

This exhibit shows the impact of a decision by the New York State Department of Health to lower the inpatient Medicaid fee-for-service rate at Interfaith Medical Center from $17,146 to $10,295 between 2009 and 2010. This dramatic lowering was offset somewhat by a transition pool. Nevertheless, see the second page of the attached; the immediate result for Interfaith Medical Center was an operating loss of $62,798,000 in fiscal year 2010.

The remainder of the Interfaith story (from 2010 to 2013) is entirely predictable; once the Medicaid rate was lowered, the outcome for Interfaith was certain. Representations of "overbedding," "mismanagement," "difficult [multi-morbidity] patients," have no evidence; the evidence is that the State cut the Interfaith rate 40%.

Moreover, the lowering of hospital inpatient payment rates in the Medicaid program in New York State in 2010 was not by any means uniform or across the board. For example, Westchester Medical Center's rate was increased from $18,039 to $19,425. Mount Sinai Hospital's rate was increased from $16,403 to $17,703. New York Presbyterian's rate was increased from $16,292 to $16,844.

Other hospitals in Brooklyn which have struggled since this reduction include Brookdale (decreased from $16,722 to $12,682).

Fiscal Impact of December 1, 2009 Medicaid FFS Reform Rates (Acute Care)
Source: NYS Department of Health

OPCERT	HOSPITAL NAME	Medicaid FFS Acute Cases (Less Detox)	Current FFS Revenue (July 2008 Rates, Adjusted for 2009 Cuts)			Medicaid FFS Reform Revenue (December 1, 2009 Rates)				Fiscal Impact		Transition Pool Allocations			
						Inlier Revenue	High Cost Outlier	Transfers	Total			Dec 1, 2009-March 31, 2010	April 1, 2010-March 31, 2011	April 1, 2011 - March 31, 2012 (Estimated)	April 1, 2012-March 31, 2013 (Estimated)
	New York State Total	268,382	2,949,466,163	10,990		2,579,526,285	90,750,199	54,188,223	2,724,464,707	(225,001,456)	10,151	33,500,000	75,000,000	50,000,000	25,000,000
7002012	HOSPITAL FOR SPECIAL SURGERY	177	5,367,026	30,322	1	3,480,140	83,407	141,298	3,704,845	(1,662,181)	20,931	-	-	-	-
5957001	WESTCHESTER MEDICAL CENTER	3,135	56,552,098	18,039	5	53,332,651	5,767,518	1,796,624	60,896,793	4,344,695	19,425	-	-	-	-
7002024	MOUNT SINAI HOSPITAL	5,843	95,841,646	16,403	11	96,398,632	5,808,588	1,233,146	103,440,366	7,598,720	17,703	-	-	-	-
7002054	NY PRESBYTERIAN HOSPITAL	11,621	189,329,487	16,292	12	173,171,958	17,616,746	4,958,981	195,747,685	6,418,198	16,844	-	-	-	-
0101005	ALB MED CTR SO CLINICAL CAMP	3	76,786	25,595	2	50,487	-	-	50,487	(26,299)	16,829	-	-	-	-
2953000	ST FRANCIS HOSP / ROSLYN	197	3,502,558	17,779	7	3,156,165	3,791	36,398	3,196,353	(306,205)	16,225	-	-	-	-
7002053	NYU HOSPITALS CENTER	1,351	24,204,377	17,916	6	19,464,830	1,486,171	856,153	21,807,154	(2,397,223)	16,141	-	-	-	-
2951001	NORTH SHORE UNIVERSITY HOSP	1,889	30,152,130	15,962	13	28,007,769	963,718	469,081	29,440,568	(711,562)	15,585	-	-	-	-
3301007	UNIV HOSP SUNY HLTH SCIENCE	1,823	22,740,234	12,474		26,772,815	1,458,100	176,983	28,407,898	5,667,664	15,583	-	-	-	-
7001020	MAIMONIDES MEDICAL CENTER	3,349	51,774,111	15,460	17	47,457,808	3,016,825	350,828	50,825,461	(948,650)	15,176	-	-	-	-
7001037	STATE UNIV HOSP / DOWNSTATE	2,991	40,355,021	13,492		39,536,354	4,711,753	590,403	44,838,510	4,483,489	14,991	-	-	-	-
7003004	LONG ISLAND JEWISH	3,083	45,697,255	14,822		41,372,688	2,140,886	2,282,317	45,795,891	98,636	14,854	-	-	-	-
7002001	BELLEVUE HOSPITAL CENTER	6,315	107,966,886	17,097	9	91,357,021	-	2,425,486	93,782,507	(14,184,379)	14,851	-	-	-	-
2701005	STRONG MEMORIAL HOSPITAL	3,589	55,562,017	15,481	16	49,999,184	2,014,726	810,572	52,824,482	(2,737,535)	14,718	-	-	-	-
5151001	UNIV HOSP AT STONY BROOK	2,763	33,921,201	12,277		34,714,028	3,999,381	480,104	39,193,513	5,272,312	14,185	-	-	-	-
7000006	MONTEFIORE HOSPITAL	14,218	193,545,483	13,613		194,468,401	5,824,139	1,298,410	201,590,950	8,045,467	14,179	-	-	-	-
7001033	KINGSBROOK JEWISH MED CTR	944	17,718,080	18,769	4	12,777,021	47,084	327,876	13,151,981	(4,566,099)	13,932	948,975	2,124,571	1,416,380	708,190
7000002	JACOBI MEDICAL CENTER	5,442	81,187,318	14,919	20	73,103,692	-	1,375,990	74,479,683	(6,707,636)	13,686	-	-	-	-
1401005	ERIE COUNTY MEDICAL CENTER	1,603	24,417,419	15,232	18	21,184,366	282,377	399,005	21,865,748	(2,551,671)	13,641	-	-	-	-
7002037	SVCMC ST VINCENTS MANHAT	2,349	36,898,196	15,708	14	29,395,269	1,401,374	431,524	31,228,166	(5,670,030)	13,294	679,428	1,521,107	1,014,071	507,036
7001016	KINGS COUNTY HOSPITAL CENTER	7,186	103,415,869	14,391		92,689,555	-	2,195,805	94,885,360	(8,530,509)	13,204	-	-	-	-
7002017	LENOX HILL HOSPITAL	1,168	15,935,827	13,644		14,564,832	669,562	78,750	15,313,143	(622,684)	13,111	-	-	-	-
0101000	ALBANY MEDICAL CENTER HOSP	3,080	37,910,973	12,309		36,669,648	1,995,883	874,950	39,540,481	1,629,508	12,838	-	-	-	-
7001002	BROOKDALE HOSPITAL MED CTR	4,675	78,176,435	16,722	10	54,547,012	3,531,382	1,212,184	59,290,577	(18,885,858)	12,682	3,766,816	8,433,170	5,622,113	2,811,057
7002032	ST LUKES / ROOSEVELT HOSP	5,983	70,163,637	11,727		67,468,496	3,481,424	454,142	71,404,062	1,240,425	11,934	-	-	-	-
7002009	HARLEM HOSPITAL CENTER	3,551	48,819,050	13,748		40,417,908	-	804,780	41,222,688	(7,596,362)	11,609	-	-	-	-
7002002	BETH ISRAEL MEDICAL CENTER	3,923	48,896,458	12,464		41,953,974	1,845,622	1,873	43,801,469	(5,094,989)	11,165	104,281	233,465	155,644	77,822
7000001	BRONX-LEBANON HOSPITAL CTR	8,302	110,778,928	13,344		85,989,874	2,548,287	775,090	89,313,251	(21,465,677)	10,758	3,557,256	7,964,006	5,309,337	2,654,669
7002026	NY EYE AND EAR INFIRMARY	80	1,509,618	18,870	3	842,453	-	-	842,453	(667,165)	10,531	173,562	388,572	259,048	129,524
1401002	KALEIDA HLTH/WOMAN & CHILDRENS	2,827	23,951,146	8,472		26,677,749	2,036,719	875,175	29,589,643	5,638,497	10,467	-	-	-	-
7001021	NY METHODIST HOSP / BROOKLYN	2,933	32,358,624	11,033		29,158,214	1,047,107	221,075	30,426,396	(1,932,228)	10,374	-	-	-	-
7001046	INTERFAITH MEDICAL CENTER	1,942	33,296,928	17,146	8th highest rate	19,504,924	88,095	399,188	19,992,206	(13,304,722)	10,295	3,357,980	7,517,867	5,011,911	2,505,956
7003000	ELMHURST HOSP CTR	5,957	59,974,531	10,068		59,706,832	-	985,852	60,692,684	718,153	10,188	-	-	-	-
5903000	MOUNT VERNON HOSPITAL	470	6,209,300	13,211		4,621,270	46,559	74,879	4,742,709	(1,466,591)	10,091	282,288	631,988	421,325	210,663
7001045	WOODHULL MEDICAL	4,074	43,636,122	10,711		40,058,420	-	870,932	40,929,352	(2,706,770)	10,046	-	-	-	-
7004003	STATEN ISLAND UNIV HOSP	2,624	30,321,387	11,555		25,500,609	418,082	410,606	26,329,297	(3,992,090)	10,034	337,383	755,336	503,557	251,779
7001017	LONG ISLAND COLLEGE HOSPITAL	2,694	29,337,642	10,890		24,360,764	1,897,132	581,402	26,839,298	(2,498,344)	9,963	-	-	-	-
5149000	JOHN T MATHER MEMORIAL HOSP	227	3,229,211	14,226		2,091,916	64,330	91,565	2,247,811	(981,400)	9,902	-	-	-	-
7000008	LINCOLN MEDICAL	6,911	64,276,158	9,301		65,254,975	-	2,931,808	68,186,783	3,910,625	9,866	-	-	-	-
2952006	NEW ISLAND HOSPITAL	151	1,984,995	13,146		1,251,029	64,851	166,354	1,482,234	(502,761)	9,816	-	-	-	-
7003010	NY MED CTR OF QUEENS	2,836	29,479,158	10,395		27,073,080	377,823	18,359	27,469,262	(2,009,896)	9,686	-	-	-	-
7001019	LUTHERAN MEDICAL CENTER	2,221	26,376,063	11,876		20,748,893	296,525	294,617	21,340,035	(5,036,028)	9,608	809,945	1,813,311	1,208,874	604,437
7001024	EPISCOPAL HEALTH SERVICES	1,731	19,665,066	11,361		15,188,902	1,085,687	246,059	16,520,648	(3,144,418)	9,544	412,109	922,633	615,089	307,544
7002021	METROPOLITAN HOSPITAL CENTER	3,208	32,878,725	10,249		30,145,480	-	465,451	30,610,930	(2,267,795)	9,542	-	-	-	-
1401014	KALEIDA HEALTH	1,797	18,129,431	10,089		16,245,653	273,967	417,162	16,936,782	(1,192,649)	9,425	-	-	-	-
7003003	JAMAICA HOSPITAL	4,033	44,910,318	11,136		35,659,907	1,033,957	1,160,590	37,854,454	(7,055,864)	9,386	865,196	1,937,005	1,291,337	645,668
7003006	PENINSULA HOSPITAL CENTER	711	8,999,727	12,658		6,334,704	160,734	142,223	6,637,662	(2,362,065)	9,336	496,276	1,111,065	740,710	370,355
1302000	ST FRANCIS HOSP / POUGH	316	4,947,310	15,656	15	2,657,456	164,968	46,833	2,869,257	(2,078,053)	9,080	532,673	1,192,551	795,034	397,517
7000014	ST BARNABAS HOSPITAL	5,871	52,497,570	8,942		51,718,344	222,368	552,946	52,493,657	(3,913)	8,941	-	-	-	-
7001003	BROOKLYN HOSPITAL	3,265	37,628,962	11,525		27,796,186	687,080	543,422	29,026,688	(8,602,274)	8,890	1,650,387	3,694,896	2,463,264	1,231,632
7003007	QUEENS HOSPITAL CENTER	4,304	44,339,174	10,302		36,284,356	-	1,934,010	38,218,365	(6,120,809)	8,880	-	-	-	-
7001009	CONEY ISLAND HOSPITAL	3,220	19,297,218	5,993		27,619,099	-	683,192	28,302,291	9,005,073	8,790	-	-	-	-
2950002	NASSAU UNIV MED CTR	4,602	47,903,725	10,409		39,127,308	922,357	351,296	40,400,961	(7,502,764)	8,779	-	-	-	-
4329000	GOOD SAMARITAN / SUFFERN	509	5,220,847	10,257		4,113,993	187,633	153,125	4,454,751	(766,096)	8,752	86,508	193,674	129,116	64,558
7003001	FLUSHING HOSPITAL MED CTR	1,322	13,685,417	10,352		10,894,324	351,899	281,218	11,527,441	(2,157,976)	8,720	258,636	579,036	386,024	193,012
7001035	WYCKOFF HEIGHTS HOSPITAL	4,108	39,839,125	9,698		34,653,732	283,084	583,820	35,520,637	(4,318,488)	8,647	147,991	331,324	220,882	110,441
2901000	GLEN COVE HOSPITAL	209	2,926,933	14,004		1,748,525	(22)	38,399	1,786,902	(1,140,031)	8,550	-	-	-	-
2910000	FRANKLIN HOSPITAL	435	4,061,256	9,336		3,371,607	180,892	164,900	3,717,399	(343,857)	8,546	-	-	-	-
7004008	RICHMOND UNIV MEDICAL CENTER	1,870	17,985,757	9,618		14,921,852	565,711	310,394	15,797,957	(2,187,800)	8,448	124,777	279,350	186,234	93,117
3202002	ST ELIZABETH MEDICAL CENTER	530	6,058,389	11,431		4,339,322	80,868	49,041	4,469,231	(1,589,158)	8,433	-	-	-	-
2908000	WINTHROP UNIVERSITY HOSPITAL	1,471	14,003,279	9,520		11,676,504	418,770	278,636	12,373,910	(1,629,369)	8,412	-	-	-	-
2902000	LONG BEACH MEDICAL CENTER	225	3,370,043	14,978	19	1,803,139	8,862	64,202	1,876,202	(1,493,841)	8,339	388,949	870,782	580,521	290,261
7002052	NORTH GENERAL HOSPITAL	2,122	23,221,835	10,943		16,541,902	380,465	494,080	17,416,447	(5,805,388)	8,208	1,170,895	2,621,408	1,747,605	873,803
7001041	BETH ISRAEL / KINGS HIGHWAY	526	3,877,706	7,372		4,006,658	8,606	81,330	4,096,594	218,888	7,788	-	-	-	-
7002000	NEW YORK DOWNTOWN HOSP	998	10,294,967	10,316		7,193,574	354,697	117,261	7,665,532	(2,629,435)	7,681	536,084	1,200,188	800,126	400,063

Interfaith Medical Center

Statements of Operations

(In Thousands)

	Year Ended December 31	
	2011	**2010**
		(As Adjusted)
Operating revenue		
Net patient service revenue	**$ 194,531**	$ 191,188
Other revenue	**7,754**	3,130
Net assets released from restrictions	**6,500**	4,101
Total operating revenue	**208,785**	198,419
Operating expenses		
Salaries and wages	**104,070**	114,943
Employee benefits	**31,458**	33,153
Supplies and other expenses	**46,651**	75,173
Provision for bad debts	**14,505**	8,270
Depreciation and amortization	**14,952**	15,484
Asset impairment loss	**–**	7,300
Interest	**6,603**	6,894
Total operating expenses	**218,239**	261,217
Deficiency of operating revenue over operating expenses	**(9,454)**	(62,798)
Change in net assets related to defined benefit pension plans liability to be recognized in future periods	**(23,807)**	(2,673)
Decrease in unrestricted net assets	**$ (33,261)**	$ (65,471)

See accompanying notes.

Exhibit Number Seven, the Future of Inpatient Hospital Reimbursement

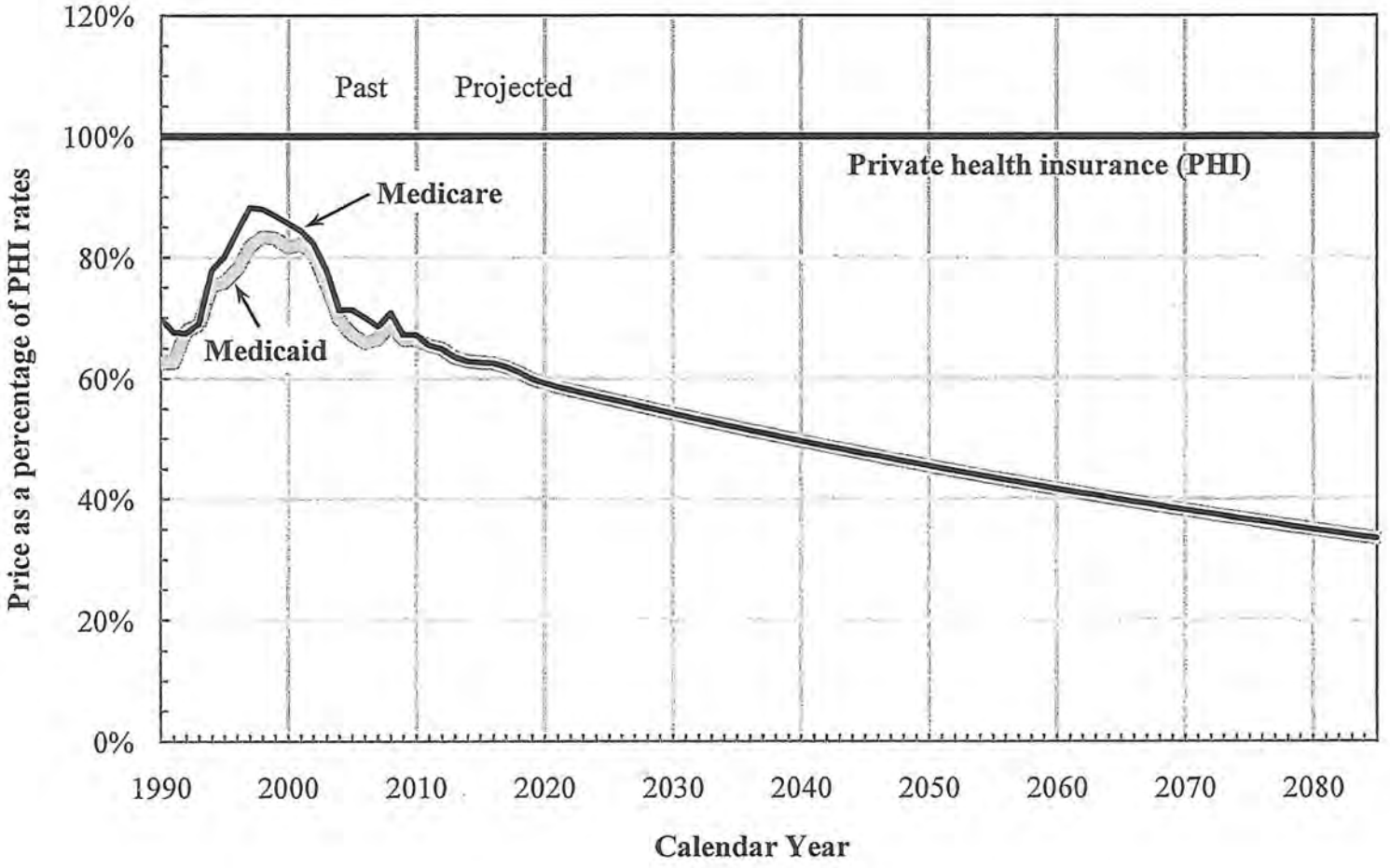
The financial future of hospital inpatient care is generally bleak.

The first page on the attached exhibit (from Shatto and Clemens, CMS Office of the Actuary, 5-13-2011) shows the relative projection of private health insurance, Medicare and Medicaid for hospital inaptient services under current law.

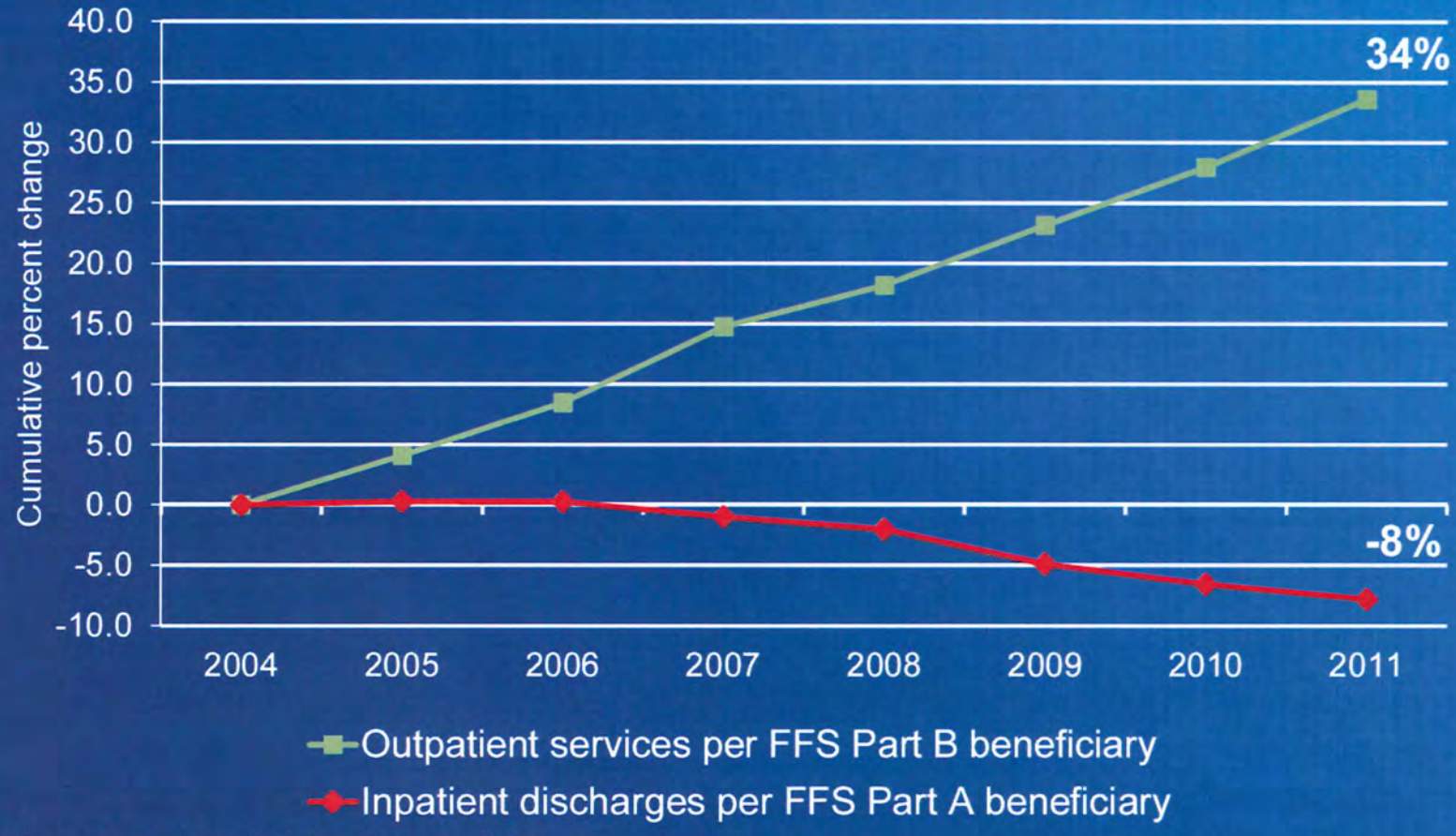
At present, for inpatient hospital services Medicare and Medicaid payment rates (including Medicaid Disproportionate Share Hospital or DSH payments) are about two-thirds to three quarters of those of private health insurance. The projection shows those rates declining to less than 40% of private health insurance rates, assuming the latter remain stable.

The second page of this exhibit shows what is happening in the hospital world, in part as a consequence of the decreased revenue associated with inpatient care, namely spectacular growth in outpatient services.

Figure 1—Illustrative comparison of relative Medicare, Medicaid, and private health insurance prices for inpatient hospital services under current law



Hospital inpatient and outpatient volume growth



Source: Medicare claims data

Preliminary data subject to change

MEDPAC

Exhibit Number Eight, Resident Physicians in Brooklyn Hospitals

Physicians in training are extremely important for the success of the Brooklyn hospital plan.

First, they represent physicians whose assignments can be planned - - that is, they are not practitioners settled in a specific area.

Second, residents are associated with hospitals - - that is, they are not “freestanding” or dependent on evanescent grants and contract support.

Finally, they are in training, that is, what they learn and absorb will shape the way they practice and, therefore, the way in which patients receive care, during their careers. This latter point is arguably the most important of all, given the long-term impact of training on physician practices.

Resident physicians frequently come to hospitals in the five boroughs of New York from foreign medical schools. This plan proposes that SUNY Downstate Medical Center work collaboratively with the other fourteen private sector and municipal hospitals in Brooklyn, to this end: placement of well-educated physicians of the future in residency positions more highly structured and supported in comprehensive and urgent ambulatory care facilities.

Name of Hospital	Medical School Affiliation	Sponsored Residency Programs	Affiliated Residency Programs
Beth Israel Medical Center - Brooklyn (Kings Highway Division)	Albert Einstein	Addiction Psychiatry, Adult Reconstructive Orthopaedics, Cardiovascular Disease, Clinical Cardiac Electrophysiology, Emergency Medicine, Gastroenterology, Geriatric Medicine, Geriatric Psychiatry, Hand Surgery, Hematology, Hematology and Oncology, Hospice and Palliative Medicine, Infectious Disease, Internal Medicine, Interventional Cardiology, Nephrology, Neurology, Neuroradiology, Obstetrics and Gynecology, Pain Medicine, Psychiatry, Psychosomatic Medicine, Pulmonary Disease and Critical Care Medicine, Diagnostic Radiology, General Surgery, Urology, Vascular and Interventional Radiology	Anesthesiology, Child and Adolescent Psychiatry, Dermatology, Geriatric Medicine, Internal Medicine, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Anatomic and Clinical Pathology, Pediatric Pulmonology, Plastic Surgery, Radiation Oncology, Diagnostic Radiology
Brookdale University Hospital and Medical Center	SUNY Health Science Center at Brooklyn	Child and Adolescent Psychiatry, Hematology and Oncology, Internal Medicine, Nephrology, Pediatrics, Psychiatry, Surgery-General, and Urology	Cardiovascular Disease, Clinical Cardiac Electrophysiology, Dermatology, Emergency Medicine, Gastroenterology, Obstetrics and Gynecology, Ophthalmology, Orthopaedic Surgery, Pediatric Emergency Medicine, Pediatrics, Psychiatry
Brooklyn Hospital Center	Weill Cornell, Saint George	Emergency Medicine, Family Medicine, Gastroenterology, Hematology and Oncology, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Pulmonary Disease, General Surgery	Cardiovascular Disease, Urology
Coney Island Hospital	SUNY Health Science Center at Brooklyn, Saint George	Internal Medicine	Cardiovascular Disease, Gastroenterology, Geriatric Medicine, Hematology and Oncology, Infectious Disease, Obstetrics and Gynecology, Ophtalmology, Pediatrics, Psychiatry, Pumonary Disease and Critical Care Medicine, General Surgery, Urology
Interfaith Medical Center	No Affiliation	Internal Medicine and Pulmonary Disease	Cardiovascular Disease, Emergency Medicine, Gastroenterology, Obstetrics and Gynecology
Kingsbrook Jewish Medical Center	SUNY Health Science Center at Brooklyn, Saint George	Internal Medicine, Orthopeadic Surgery, Physical Medicine and Rehabilitation	Family Medicine, Geriatric Psychiatry, Psychiatry
Kings County Hospital Center	SUNY Health Science Center at Brooklyn, Saint George	No Sponsored Residency Programs	Adolescent Medicine, Allergy and Immunology, Anesthesiology, Cardiovascular Disease, Child Neurology, Child and Adolescent Psychiatry, Clinical Neurophysiology, Critical Care Medicine, Dermatology, Dermatopathology, Emergency Medicine, Endocrinology/Diabetes/Metabolism, Family Medicine, Gastroenterology, Geriatric Medicine, Hematology and Oncology, Infectious Disease, Internal Medicine, Internal Medicine/Emergency Medicine, Neonatal-Perinatal Medicine, Nephrology, Neurology, Neuropathology, Neuroradiology, Obstetrics and Gynecology, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Anatomic and Clinical Pathology, Pediatric Emergency Medicine, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric Infectious Diseases, Pediatric Nephrology, Pediatric Pulmonology, Pediatrics, Physical Medicine and Rehabilitation, Psychiatry, Pulmonary Disease and Critical Care Medicine, Radiation Oncology, Diagnostic Radiology, Rheumatology, General Surgery, Urology, Vascular and Interventional Radiology
Long Island College Hospital (SUNY Downstate at LICH)	SUNY Health Science Center at Brooklyn	No Sponsored Residency Programs	Allergy and Immunology, Anesthesiology, Clinical Neurophysiology, Critical Care Medicine, Emergency Medicine, Gastroenterology, Hematology and Oncology, Infectious Disease, Internal Medicine, Nephrology, Neurology, Obstetric Anesthesiology, Obstetrics and Gynecology, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Pediatrics, Physical Medicine and Rehabilitation, Pulmonary Disease and Critical Care Medicine, Radiation Oncology, General Surgery, Urology, Vascular Neurology
Lutheran Medical Center	SUNY Health Science Center at Brooklyn, New York College of Osteopathic Medicine	Family Medicine, Internal Medicine, Obstetrics and Gynecology	Gastroenterology, Geriatric Medicine, Infectious Disease, Obstetric Anesthesiology, Orthopaedic Surgery, Pediatrics, Pulmonary Medicine and Critical Care Medicine, Vascular and Interventional Radiology
Maimonides Medical Center	SUNY Health Science Center at Brooklyn, Mount Sinai, New York College of Osteopathic Medicine, Saint George	Anesthesiology, Cardiovascular Disease, Child Abuse Pediatrics, Critical Care Medicine, Emergency Medicine, Gastroenterology, Geriatric Medicine, Hematology and Oncology, Infectious Disease, Internal Medicine, Interventional Cardiology, Nephrology, Obstetrics and Gynecology, Orthopaedic Surgery, Pediatric Emergency Medicine, Pediatric Endocrinology, Pediatrics, Psychiatry, Pulmonary Disease, Diagnostic Radiology, General Surgery, Urology, Vascular Surgery	Endocrinology/Diabetes/Metabolism, Family Medicine, Geriatric Medicine, Neonatal-Perinatal Medicine, Obstetrics and Gynecology, Otolaryngology, Pediatric Cardiology, Pediatric Endocrinology, Pediatrics, Diagnostic Radiology, Vascular Neurology
New York Community Hospital of Brooklyn, Inc.	Weill Cornell		

Name of Hospital	Medical School Affiliation	Sponsored Residency Programs	Affiliated Residency Programs
New York Methodist Hospital	Weill Cornell	Anesthesiology, Cardiovascular Disease, Clinical Cardiac Electrophysiology, Emergency Medicine, Gastroenterology, Gereiatric Medicine, Hematology and Oncology, Internal Medicine, Interventional Cardiology, Obstetrics and Gynecology, Pediatric Emergency Medicine, Pediatrics, Pulmonary Disease and Critical Care Medicine, Radiation Oncology, General Surgery	Adult Cardiothoracic Anesthesiology, Internal Medicine, Pediatric Emergency Medicine, Psychiatry, Pulmonary Disease, Urology
University Hospital of Brooklyn (Downstate Medical Center)	SUNY Health Science Center at Brooklyn	No Sponsored Residency Programs	Adolescent Medicine, Allergy and Immunology, Anesthesiology, Cardiovascular Disease, Child Neurology, Child and Adolescent Psychiatry, Clinical Cardiac Electrophysiology, Clinical Neurophysiology, Critical Care Medicine, Dermatology, Dermatopathology, Emergency Medicine, Endocrinology/Diabetes/Metabolism, Family Medicine, Gastroenterology, Geriatric Medicine, Geriatric Psychiatry, Hematology and Oncology, Infectious DIsease, Internal Medicine, Internal Medicine/Emergency Medicine, Interventional Cardiology, Neonatal-Perinatal Medicine, Nephrology, Neurology, Neuropathology, Neuroradiology, Obstetrics and Gynecology, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Pathology-Anatomic and Clinical, Pediatric Emergency Medicine, Pediatric Endocrinology, Pediatric Gasteroenterology, Pediatric Infectious Diseases, Pediatric Nephrology, Pediatric Pulmonology, Pediatrics, Physical Medicine and Rehabilitation, Procedural Dermatology, Psychiatry, Pulmonary Disease, Pulmonary Disease and Critical Care Medicine, Radiation ONcology, Radiology-Diagnostic, Rheumatology, General Surgery, Urology, Vascular Neurology, Vascular and Interventional Radiology
Woodhull Medical Center	SUNY Health Science Center at Brooklyn	Internal Medicine and Pediatrics	Emergency Medicine, Endocrinology/Diabetes/Metabolism, Gastroenterology, Obstetrics and Gynecology, Ophthalmology, General Surgery
Wyckoff Heights Medical Center	Weill Cornell	Family Medicine and Internal Medicine	Family Medicine, Gastroenterology, Hematology and Oncology, Pediatrics, Psychiatry, Pulmonary Disease

Name of Hospital	Number of Residents	Emergency Services Dept. Director	Satellite/Decentralized Outpatient Facilities
Beth Israel Medical Center - Brooklyn (Kings Highway Division)	0	Mark Rogers, MD, Director, Brooklyn Division, Emergency Medicine	One primary care clinic, onsite ambulatory clinics
Brookdale University Hospital and Medical Center	16	Lewis W. Marshall, Jr., MD, JD, Chairman, Department of Emergency Medicine	50+ specialty clinics, community mental health center, amb surg center, dental center, six primary care centers
Brooklyn Hospital Center	62	Lisandro Irizarry, MD, MPH, Chairman, Department of Emergency Medicine	5 outpatient clinics for pediatrics, dentistry, AIDS, prenatal care, and women's health
Coney Island Hospital	0		50+ outpatient clinics, amb surg
Interfaith Medical Center	0	Charles Lawrence, MD Interim Chairman, Department of Emergency Medicine, 718-613-6630, clawrence@interfaithmedical.org	16 clinics in Crown Heights and Bedford-Stuyvesant
Kingsbrook Jewish Medical Center	13	Vijay Akkapeddi, MD, MBA	One family health care center offsite, onsite outpatient services for orthopedics, pain, gynecology, podiatry, ophthalmology, mental health, neurology, radiology, urology, vascular labs, dialysis, and dental services
Kings County Hospital Center	0		
Long Island College Hospital (SUNY Downstate at LICH)	0	Eric Legome, MD, Chief of Service Michael Lucchesi, MD, Chairman, Department of Emergency Medicine	
Lutheran Medical Center	28	Bonnie Simmons, DO, Senior Vice President and Chair of Emergency Medicine	
Maimonides Medical Center	128	John Marshall, MD, Chair, Department of Emergency Medicine	
New York Community Hospital of Brooklyn, Inc.	0	Diane Sixsmith, MD, MPH, Chariman, Department of Emergency Medicine	

Name of Hospital	Number of Residents	Emergency Services Dept. Director	Satellite/Decentralized Outpatient Facilities
New York Methodist Hospital	22	Joseph Bove, MD, Chairman, Department of Emergency Medicine	
University Hospital of Brooklyn (Downstate Medical Center)	184	Michael Lucchesi, MD, Chairman, Department of Emergency Medicine	10 onsite ambulatory care clinics including medicine, family medicine, neurology, general pediatrics, emergency care, obstetrics and gynecology, surgery, urology, ophthalmology, and otolaryngology. Other outpatient clinical services include radiation oncology, orthopaedic surgery and rehabilitation medicine, physical therapy, occupational therapy, joint replacement, spine, sports medicine, hand surgery, radiology services, and vascular lab testing. A comprehensive multi-specialty ambulatory care center sponsored by the hospital is located in Bay Ridge.
Woodhull Medical Center	28		
Wyckoff Heights Medical Center	66	Theophine Abakporo, MD, Medical Director, Emergency Medicine	

Exhibit Number Nine, Neighborhoods, Geography

For reference, this exhibit includes a profile of Brooklyn neighborhoods with special emphasis on health care delivery systems, drawn from a United Hospital Fund publication.

Brooklyn Healthcare Delivery System

Brooklyn Community Health: Neighborhood Profiles Excerpt (2007)

Neighborhood (UHF)	Topic	Key Points
Greenpoint	Summary	A predominantly working-class neighborhood, Greenpoint was known in former times for its shipbuilding and maritime industry. The neighborhood has been rezoned from manufacturing to mixed use and is undergoing major construction of new housing and open spaces. Despite continuing gentrification, nearly one in three families lives below the poverty level; most of these are married couples with children under 18. Forty percent of residents do not have a high school diploma. While Greenpoint does not have one of the largest immigrant populations in Brooklyn, many of its residents do not speak English well; more than 25 percent are linguistically isolated.
	Comparison	Greenpoint residents have similar views of their health as other Brooklynites, and they rate it more favorably than people living in New York City's poorest neighborhoods. While a good percentage report that they received cancer screenings, they did less well in having their cholesterol levels checked and being tested for HIV infection. Compared to other borough residents, a larger percentage say they do not have a personal doctor and did not get a prescription filled because of cost. Greenpoint has the highest percentage of residents who report not seeing a dentist in two years and is tied with Coney Island for the greatest percentage of current smokers. It also has a high rate of binge drinking.
Williamsburg and Bushwick	Summary	This community was once a center of manufacturing, until high energy costs and other factors caused the factories and breweries to close down. Today the neighborhood has a thriving art community and is home to many ethnic groups; 53 percent of its residents are Hispanic -- more than twice that of Brooklyn as a whole. A large proportion of neighborhood residents are economically disadvantaged. Over 35 percent of families live below the poverty line, and 60 percent of these families are headed by single women with children under 18. Half the residents -- the highest percentage in the borough -- do not have a high-school diploma, and only 8 percent have a college education.
	Comparison	Williamsburg/Bushwick has the greatest percentage of residents of any neighborhood in Brooklyn who rate their health as fair or poor and who report that they cannot afford quality health care due to cost and lack of insurance. They also report using the ER more than others. Even so, with the exception of cholesterol screening, residents report taking steps to promote their health through screenings and vaccinations on a par, or better, than other Brooklynites. The high percentage of residents who report that they were recently tested for HIV may reflect the prevalence of infection in this neighborhood, which has the second highest percentage of people living with HIV/AIDS in Brooklyn (NYC DOHMH 2004).
Downtown/Heights and Park Slope	Summary	The Downtown/Heights/Park Slope region of Brooklyn is a neighborhood of contrasts. It has the highest family income in the borough but also significant pockets of poverty. Nearly half the population has a bachelor’s degree or higher and more than two-thirds are employed in business, finance, and professional occupations. It has a very high percentage of single mothers with children under 18 living in poverty and a low percentage of impoverished married couples with children under 18. Compared to other neighborhoods, it has the smallest proportion of foreign-born residents, but their contribution to the cultural life of the community is evident.
	Comparison	Residents of Downtown/Heights/Park Slope report having more resources and better access to health care than most Brooklyn residents. They also have a better perception of their health and the best overall record of using disease-prevention services, with the exception of testing for HIV. When compared to the richest neighborhoods in New York City, however, Downtown/Heights/Park Slope residents have less health insurance and lower levels of seeking preventive services that promote or maintain good health. While fewer have medical or emotional complaints, they report highest levels of binge drinking than other Brooklynites.
Bedford Stuyvesant and Crown Heights	Summary	Bedford Stuyvesant/Crown Heights has the second largest population of the 11 UHF neighborhoods in Brooklyn. Largely made up of African- and Caribbean-American families, it is also world headquarters of the Chabad-Lubavitch Hasidic Jewish community (in Crown Heights). While nearly a third of the population is employed in management and professional fields, almost one in three families live below the poverty level. This neighborhood also has the highest percentage of families living below poverty that are headed by single mothers under 18.

Brooklyn Healthcare Delivery System

Brooklyn Community Health: Neighborhood Profiles Excerpt (2007)

Neighborhood (UHF)	Topic	Key Points
	Comparison	Compared to the rest of Brooklyn, far more Bedford Stuyvesant/Crown Heights residents report that they do not have health insurance and rely on the ER instead of seeing a regular doctor or health provider. Fewer residents report taking preventive measures such as teeth cleanings, Pap tests, and having their cholesterol levels checked. This section of Brooklyn has the highest percentage of elderly residents who have not been immunized against pneumonia. It also has one of the highest levels of testing for HIV, which may indicate that HIV/AIDS is a major concern for this community. It has the highest rates of reported HIV diagnoses and people living with HIV/AIDS in Brooklyn (NYC DOHMH 2004).
East New York	Summary	East New York, located on the eastern edge of central Brooklyn, has a rich history as a manufacturing center. Its large Hispanic population reflects the post-World War II era, when many families immigrated from Puerto Rico to work in its then-thriving factories. Today, East New Yorkers are predominantly Black and Hispanic, with many from the Caribbean and Dominican Republic. It is one of Brooklyn's poorest neighborhoods. Nearly a third of families live below poverty, and single mothers head close to 60 percent of these households. East New York compares with Williamsburg-Bushwick in having the lowest family incomes for families with children under 18. More than 40 percent of residents do not have a high school diploma and a comparatively small percent have a college education.
East New York	Comparison	Residents of East New York have a similar view of their health as residents of New York City's five poorest neighborhoods. Many report having recently experienced poor physical health and emotional distress. East New York ranks second among Brooklyn neighborhoods for residents who report not having a personal health provider and has a mixed record for the use of preventive health measures. While a higher percentage of residents went for Pap smears and mammograms in the past year, fewer over the age of 50 have had a colon exam. This neighborhood also has the third highest percentage of residents over 65 who are not immunized against pneumonia. East New York has the highest level of testing for HIV in the borough and the third highest percentage of people with HIV/AIDS in Brooklyn (NYC DOHMH 2004).
Sunset Park	Summary	Sunset Park developed as a thriving community of Irish, Polish, and Norwegian residents, many of whom worked in the Brooklyn Navy Yard and on Brooklyn's waterfront. The area declined economically after World War II, following the closing of the Navy Yard and the loss of many longshoreman jobs. A second wave of immigrants arrived from Puerto Rico, Mexico, the Dominican Republic, and China. Today Sunset Park has the highest percentage of Asian residents and the second largest Hispanic population in Brooklyn. A quarter of its families live below the poverty line. Similar to Greenpoint, married couples with children under 18 make up the highest percentage of families living in poverty. Nearly half of its residents are foreign-born, and many have a limited command of English. The percentage of residents who are linguistically isolated is more than twice that of Brooklyn and the rest of the city.
	Comparison	Sunset Park has the highest percentage of residents who report they are without health insurance or a personal doctor, and the second highest percentage without the means to pay for a prescription. Residents give their health low ratings -- more so even than the people living in New York City's five poorest neighborhoods. Despite this, the residents of Sunset Park appear to have had fewer bouts of recent illness or emotional distress, compared to others. The neighborhood also has one of the lowest rates of binge drinking in the borough and city. And except for getting tested for cervical cancer, residents report doing as well or better than most Brooklynites to promote their health through health screenings.
Borough Park	Summary	Borough Park is the most populous Brooklyn neighborhood and has one of the largest Orthodox Jewish communities in the United States. Though not a wealthy neighborhood, neither is it economically disadvantaged. Relatively few families living in poverty are headed by single women with children; however, over 50 percent of families living in poverty are headed by married couples with children (the highest percentage in the borough). Borough Park has a very diverse immigrant population, the third largest in Brooklyn. Its residents hail from Eastern Europe, the former Soviet Union, Israel, China, Pakistan, and Bangladesh, as well as from Mexico and the Caribbean. Nearly 40 percent of the borough's South Asian and Israeli populations live in Borough Park. Almost a quarter of its households are linguistically isolated.
	Comparison	Residents of Borough Park report slightly better access to health care than the majority of Brooklyn residents, and a greater percentage have health insurance and a personal doctor. With the exception of HIV testing, Borough Park residents use health screenings and other preventive health services roughly on a par with the rest of the borough.

Brooklyn Healthcare Delivery System

Brooklyn Community Health: Neighborhood Profiles Excerpt (2007)

Neighborhood (UHF)	Topic	Key Points
Flatbush and East Flatbush	Summary	Flatbush/East Flatbush is predominantly a working class community with income levels comparable to Brooklyn as a whole. It has the highest percentage of foreign-born residents in the borough -- more than 50 percent. More than 80 percent emigrated from the non-Hispanic regions of the Caribbean. Given that most came from English-speaking countries, this neighborhood has a far lower percentage of residents who are linguistically isolated, compared to Sunset Park, Borough Park, Coney Island-Sheepshead Bay, and Greenpoint. While the number of families living in poverty -- roughly 1 in 5 -- is similar to the neighboring community of Borough Park, the composition is different. Over 55 percent of impoverished families living in Flatbush/East Flatbush are headed by single mothers with children under 18. The neighborhood is among the top four in the borough for population under the age of 18, residents without health insurance, and individuals who use the ER when sick.
	Comparison	Although a slightly greater percentage of Flatbush/East Flatbush residents report that they do not have health insurance, they give their health a better rating than do other Brooklyn residents. Their use of preventive services is on a par with other Brooklynites, with these exceptions: this neighborhood equals Canarsie/Flatlands in having the lowest percentage of female residents who have had a mammogram in the past year, and the second lowest percentage of elderly residents who have been vaccinated against pneumonia. This neighborhood has the fourth highest percentage of persons with HIV/AIDS in Brooklyn (NYC DOHMH 2004) but also has a good record of seeking HIV testing. Flatbush/East Flatbush residents report the lowest level of binge drinking and the second lowest percentage of smokers in the borough.
Canarsie and Flatlands	Summary	One of the five original Dutch towns of Kings County, Canarsie/Flatlands is a neighborhood graced by many parks. With half its residents employed in service or sales, and a third in higher-wage business and professional sectors, this working-class community has a median family income approximately 9 percent above the borough's. It has the lowest percentage of families living below poverty; however, single mothers head 45 percent of these families. At one time a predominantly Italian and Jewish community, the community is now far more culturally diverse. The percentage of foreign- born residents is the same as the borough's, and most are from the English-speaking countries of the Caribbean.
Canarsie and Flatlands	Comparison	Compared to the rest of Brooklyn, residents of Canarsie/Flatlands give their health a higher rating and report being better able to afford medical care and prescription drugs. Residents do as well or better than other Brooklynites in seeking preventive health services, except for breast cancer screening; Canarsie/Flatlands (along with Flatbush/East Flatbush) has the lowest percentage of residents getting mammograms. Elderly residents report the highest levels of vaccination against pneumonia in the borough and city. Canarsie/Flatlands also has the lowest level of smoking and, with Borough Park, the second lowest level of binge drinking.
Bensonhurst and Bay Ridge	Summary	Known for its large, Italian-American community, Bensonhurst/Bay Ridge has become increasingly multicultural with the arrival of new immigrants from Asia, the former Soviet Union, and the Middle East. This diversity can be seen in the restaurants and small businesses that line the main thoroughfare along 86th Street. Today, 41 percent of the neighborhood's residents are foreign born. Almost 20 percent of residents are linguistically isolated. After Canarsie/Flatlands, this neighborhood has the lowest percentage of families living below poverty. However, like Borough Park, families living in poverty in Bensonhurst/Bay Ridge tend to be headed by married couples with children, rather than by single mothers.
	Comparison	Bensonhurst/Bay Ridge has the greatest percentage of residents who report having health insurance and a health provider. Even so, they have a mixed record of seeking preventive health care. For a neighborhood with one of the largest elderly populations, more than half report not having a pneumonia shot. Female residents have the best record of breast cancer screening in the borough but the third poorest for getting a Pap test to detect cervical cancer. The neighborhood has among the lowest levels of testing for colon cancer, and with Borough Park, testing for HIV is the lowest in the borough and city.
Coney Island and Sheepshead Bay	Summary	Coney Island/Sheepshead Bay is a residential community with many restaurants and tourist attractions near the shore. It is characterized by recent waves of immigration from Europe and the former Soviet Union, China, the Middle East, and South Asia. Nearly half its residents are foreign-born, and roughly a quarter of them are linguistically isolated -- the third highest level in Brooklyn. Family incomes are on a par with the rest of the borough, and a lower percentage of families live in poverty compared to Brooklyn as a whole.

Brooklyn Healthcare Delivery System

Brooklyn Community Health: Neighborhood Profiles Excerpt (2007)

Neighborhood (UHF)	Topic	Key Points
	Comparison	Coney Island/Sheepshead Bay residents report having levels of health insurance and care by a personal doctor similar to Brooklyn as a whole, yet they tend to seek fewer preventive health measures. This neighborhood has the highest percentage of residents who report not getting regular Pap tests or blood pressure screenings; the second highest not getting HIV testing, and the third highest not seeking colonoscopies and mammograms. In a neighborhood with the largest concentration of elderly residents in Brooklyn, over 60 percent of those over 65 say they are not immunized against pneumonia. Close to a quarter of the resident are smokers, and binge drinking levels are the third highest in Brooklyn.

Bibliography

Abelson, R., E.R.s Account for Half of All Admissions, Study Says, *The New York Times*, May 20, 2013

ACHA [Florida Regulatory Agency], Freestanding Emergency Departments, a Report to the President of the Senate and Speaker of The House Representatives of The State of Florida, December 31, 2004

Alvarez, L., Life and Death, Stat, *The New York Times*, October 1, 2010

American Hospital Association, "Prepared to Care: The Standby Role of America's Hospitals," www.aha.org, 2012

Andrews, Michelle, "Emergency Care, But Not At A Hospital," *Kaiser Health News*, May 31, 2011

Ayers, Alan A., "Emerging Business Models: Freestanding Emergency Rooms," Urgent Care Association of America, February 2012

Bentley, Fred and Ashley Waters, "Freestanding ED: New Models of Urgent and Emergent Care Beyond the Hospital," Innovation Brief, Health Care Advisory Board, 2006

Boyle, Michael F. and Daniel G. Kirkpatrick, "The Healthcare Executive's Guide to Urgent Care Centers and Freestanding EDs," *HealthLeaders Media*, 2012

Brubaker, Harold, "Urgent-care centers drawing investor attention," *The Philadelphia Inquirer*, April 27, 2013\

California HealthCare Foundation, "Freestanding Emergency Departments: Do They Have a Role in California?" Issue Brief, July 2009

Carlson, Kerri and Katie Owen, "Strategies for Site Selection of Urgent Care Centers," Original Inquiry Brief, The Advisory Board Company, October 5, 2007

Carrier, Emily R., Dowling, Marisa, and Robert A. Berenson, "Hospitals' Geographic Expansion In Quest Of Well-Insured Patients: Will The Outcome Be Better Care, More Cost, Or Both?" *Health Affairs*, Vol 31, No. 4, 2012: 827-835

Chen, P., The Costs of Emergency Room Cost-Cutting, *The New York Times*, March 28, 2013

Committee on Pediatric Emergency Medicine, American Academy of Pediatrics, Policy Statement: Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children, *Pediatrics*, July 2005, Vol. 116, No. 1

Culver, Cliff and Julia Travis, "Operations of Select Fast Track EDs," Original Inquiry Brief, The Advisory Board Company, February 21, 2007

Daly, R., Reform Update: HHS rule allows hospitals to bill state for some presumed-eligible Medicaid patients, *Modern Healthcare*, July 9, 2013

Daugherty, Alicia, "Maximizing Primary Care Access," The Advisory Board Company, 2011

Decker, Sandra L., Two-Thirds Of Primary Care Physicians Accepted New Medicaid Patients In 2011-12: A Baseline To Measure Future Acceptance Rates, *Health Affairs*, July 2013, Vol. 32, No. 7:1183-1187

DerGurahian, Jean, "Launching satellites," *Modern Healthcare*, March 23, 2009

Dolan, Pamela Lewis, "Urgent care surge fueled by pressures on health system," *American Medical News*, April 15, 2013

Feibel, Carrie, "Patients Can Pay A High Price For ER Convenience," www.npr.org, August 13, 2013

Ferenc, Jeff, "Are freestanding emergency departments a cure for crowding? *HFM Magazine*, July 2011

Frazier, M., Drive-through healthcare or top-of-the-line treatment? *Healthcare Design Magazine*, November 2011

Gahan, Jr., John W., "Bureau of Vital Access Provider Reimbursement, New York State Medicaid Updates," September 2013

Galewitz, P., Stand-alone emergency rooms popping up, *Kaiser Health News*, July 14, 2013

Gold, Jennifer, "Hospitals Gamble On Urgent Care Clinics To Keep Patients Healthy," *Kaiser Health News*, November 8, 2012

Green, S., Congruence of Disposition After Emergency Department Intubation in the National Hospital Ambulatory Medical Care Survey, Research Methods/Brief Research Report, American College of Emergency Physicians, 2012, *Annals of Emergency Medicine*, Vol. XX., No. X

Greene, Jay, "Cost savings, accessibility give boost to region's urgent care centers," *Crain's Detroit Business*, June 25, 2013

Hentges, Christina and Julia Travis, "Ensuring Adequate Call Coverage at Freestanding EDs," The Advisory Board Company, Original Inquiry Brief, August 28, 2006

Hsia, Renee, Kellermann, Arthur and Yu-Chu Shen, "Factors Associated with Closures of Emergency Departments in the United States," *JAMA*, May 18, 201, Vol. 305, No. 19

Hoot, Nathan and Dominik Aronsky, "Systematic Review of Emergency Department Crowding: Causes, Effects, and Solutions," *Annals of Emergency Medicine*, Vol. 52, No. 2, August 2008
Jaspen, Bruce, "A Boom In Urgent Care Centers As Entitlement Cuts Loom," *Forbes*, March 11, 2013

Kaiser State Health Facts, 2010 Emergency Room Visits by Ownership, www.statehealthfacts.kff.org, 2012

Kangovi, S., et al, Understanding Why Patients Of Low Socioeconomic Status Prefer Hospitals Over Ambulatory Care, *Health Affairs*, 2013, 32, No. 7: 1196-1203

Kassen, Diana and Julia Travis, "Strategies to Increase Cash Collection and Reduce Bad Debt in the ED," Original Inquiry Brief, The Advisory Board Company, February 9, 2007

Kliff, Sarah, "The rise of the freestanding emergency room," *The Washington Post's* Wonkblog, November 29, 2011

Kutscher, B., One-stop shop for care, *Modern Healthcare*, May 27, 2013

Laks, Eugene M., "New York 2012-2013 Medicaid Reimbursement Guide With Medicaid Redesign," Healthcare Association of New York State

LiBassi, P., A new front door: Expanding the hospital's reach with freestanding EDs, *Health Facilities Management Magazine*, June 14, 2013

Morgan, Scott, "St. Peter's Looks to Fill Void Left by UPMC," *U.S. 1 Newspaper*, January 25, 2012

Morganti, K., et al, The Evolving Role of Emergency Departments in the United States, Research Report, RAND Health, Rand Corporation, 2013

Nestor, Constance, "Essentials of freestanding emergency centers," *HFM Magazine*, July 2008

New England Healthcare Institute, "Bend the Curve: A Health Care Leader's Guide to High Value Health Care," NEHI, Cambridge, MA, 2011

Newton, M., et al, Uninsured Adults Presenting to US Emergency Departments, *JAMA*, October 22/29, 2008, Vol. 300, No. 16

North Shore Long Island Jewish Health System, Certificate of Need Application, Center for Comprehensive Care, Lenox Hill Hospital, June 23, 2011

O'Malley, Ann S., "After-Hours Access To Primary Care Practices Linked with Lower Emergency Department Use and Less Unmet Medical Need," *Health Affairs*, 32. No. 1 (2013): 175-183

Ostrom, Carol M., “ER building boom is wrong prescription, critics say,” The Seattle Times, November 26, 2011

Pallin, D. et al, The Care Span, Population Aging and Emergency Departments: Visits Will Not Increase, Lengths-Of-Stay And Hospitalizations Will, *Health Affairs*, July 2013, Vol. 32, No. 7:1306-1312

Pines, J., Mutter, R. and Zocchi, M., Variation in Emergency Department Admission Rates Across the United States, *Medical Care Research and Review*, 2012, 70(2), 218-231

Pitts, S., et al, Where Americans Get Acute Care: Increasingly, It’s Not At Their Doctor’s Office, *Health Affairs*, September 2010, Vol. 29, No. 9: 1620-1629

Raven, M., et al, Comparison of Presenting Complaint vs. Discharge Diagnosis for Identifying “Nonemergency” Emergency Department Visits,” *JAMA*, March 20, 2013, Vol. 309, No. 11

Rudin Management Company, Inc., The Plan to Restore Healthcare to the Westside, North Shore LIJ, May 31, 2011

Saltzman, Michael and Kate Lewandowski, “Urgent Care Centers for ED Volume Compression,” Original Inquiry Brief, The Advisory Board Company, October 5, 2009

Schuur, J. and Venkatesh, A., The Growing Role of Emergency Departments in Hospital Admissions, *The New England Journal of Medicine*, July 11, 2012

Shaffer, Rachel and Kate Lessard, “Current Trends in Freestanding EDs,” The Advisory Board Company, Original Inquiry Brief, December 3, 2008

Shatto, John and M. Kent Clemens, “Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers,” CMS, Office of the Actuary, May 13, 2011

Sokou, K., Kaiser Permanente completes first phase of Largo facility’s expansion, *The Washington Post*, July 14, 2013

Sparer, Michael, Medicaid and the Limits of State Health Reform, Philadelphia: Temple University Press, 1996

State of New York, Department of Health, “Managed Care Plan Enrollment,” 2012 New York State

Sullivan, Ashley F., et al, “ Profile of Freestanding Emergency Departments in The United States, 2007,” *The Journal of Emergency Medicine*, Vol. 43, No. 6 pp. 1175-1180, 2012

Tang, N., et al, Trends and Characteristics of US Emergency Department Visits, 1997-2007, *JAMA*, August 11, 2010, Vol. 304, No. 6

Weichselbaum, Simone, "Brookdale University Hospital to open $4 million urgent care center in Brownsville," *New York Daily News*, June 25, 2013

Weinick, R., Burns, R. and Mehrotra, A., Many Emergency Department Visits Could Be Managed At Urgent Care Centers and Retail Clinics, *Health Affairs*, September 2010, Vol. 29, No. 9: 1630-1636

Yee, T., Lechner, A. and Boukus, E., The Surge in Urgent Care Centers: Emergency Department Alternative or Costly Convenience?, HSC Research Brief No. 26, July 2013

Zeman, Dave and Jared Landis, "Urgent Care and After-Hours Primary Care Offerings," Original Inquiry Brief, The Advisory Board Company, August 13, 2010

Zuckerman, S., Williams, A. and Stockley, K., "Trends in Medicaid Physician Fees, 2003-2008," *Health Affairs*, April 28, 2009, 28, No. 3: w510-w519