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

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		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

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		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

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		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

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		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

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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

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		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

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		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

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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

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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

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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

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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