



Executive Summary: CSP and Comprehensive Community Needs Assessment 2016-2018

The New York State Public Health and Health Planning Council approved a State Health Improvement Plan, *The State Prevention Agenda*, designed to serve as a guide to focus efforts to improve the health of all New York State residents over the course of five years. In conjunction with the *NYS DOH's Prevention Agenda*, the two key areas of Kingsbrook's focus are (1.) **Prevention of chronic disease** (*focus area: to increase access to high-quality chronic disease prevention care and management in both clinical and community settings*) and (2.) **Prevention of infectious disease/HIV** (*focus area: to decrease HIV morbidity and increase early access to and retention of HIV care*). The following are Kingsbrook's areas of focus pertaining to these categories and outlined in our CSP. Changes to our focus include our participation in the Delivery System Reform Incentive Program (DSRIP) and our partnership in the Brooklyn Hospital Transformation Project.

(1.) Prevention of Chronic Disease:

Patient Centered Medical Home. Kingsbrook has been recognized by NCQA as a Level 3 PCMH practice, providing primary care and chronic disease treatment via a set of standards that describe clear and specific criteria; including organizing care around patients, working in teams and coordinating and tracking care over time. The NCQA PCMH standards strengthen and add to the issues addressed by NCQA's original program. As such, we will be committed to this model beyond 2017.

- The overall goal for Kingsbrook's PCMH programs is to improve the quality and continuity of care that patients receive while enhancing the ambulatory training experience of the primary care residents. The chronic disease focuses include: comprehensive diabetes care; blood pressure/nephropathy monitoring/HbA1 control/, monitoring colorectal cancer screenings, MU tobacco use/smoking cessation, cervical cancer screening, MU breast cancer screening, post specialty care visits/wait times, referrals & inadequate documentation.

Prevention of Infectious Disease/HIV:

- Designated AIDS Center (DAC): Care to patients infected with HIV/AIDS and Hepatitis is provided by Kingsbrook's Designated AIDS Center (the "DAC") which serves more than 600 clients each year and offers a broad array of services. The HIV program provides a collaborative approach in the management of patients, some who are poor, homeless, illiterate, substance dependent, mentally challenged and others who are socially isolated (immigrants, the incarcerated and the elderly).
- Goals include the implementing the new 4th Generation Testing technology to better identify acute cases of the virus starting in 2015. From Jan – Sept, 2015, 2,557 individuals received Rapid HIV testing conducted using Ora Quick method. As such, from Sept – Dec. 2015, 533 individual received HIV testing using 4th Generation Testing method. 90% percent of all HIV positive patients were linked to care in the DAC program.
- In 2015, the Designated AIDS Center scale up Hepatitis C screening with the 4th Generation new testing technology. For those patients with positive reactive test results, they are referred to the DAC providers for treatment. From Nov-Dec 2015, 1,248 patient were tested for HCV and 25 patients were identified o be HCV positive and 65% were linked to care for treatment. Thirty-five percent of the HIV positive patients are also co-infected with HCV and 25% are currently on HCV treatment.

Additional Prevention Agenda Focus:

Understanding how these health disparities affect the overall wellness of the community, Kingsbrook has implemented the following programs and services, many pre-existing from our last assessment, to address these issues especially as it pertains to *increase access to high-quality chronic disease prevention care and management in both clinical and community settings*) and *decrease HIV morbidity and increase early access to and retention of HIV care*).

Cancer	<ul style="list-style-type: none"> • KJMC Cancer Rehabilitation • Radiology Advancements • Cancer Education & Screening efforts
Diabetes	<ul style="list-style-type: none"> • Diabetes Self Management (PCMH) • NCQA Diabetes Recognition Program • Diabetes Prevention Program (CDC)
HIV	<ul style="list-style-type: none"> • Designated AIDS Center • HIV Screening Program (Ambulatory, ED and Inpatient) • Hep C Screening Focus
Behavioral Health	<ul style="list-style-type: none"> • Comprehensive Behavioral Health Center • Mind & Body Program (Ambulatory) • ED Mental Health Screenings
Stroke	<ul style="list-style-type: none"> • Stroke Rehabilitation Program • Tele-Stroke Program • Stroke Quality Advancements

The Delivery System Reform Incentive Program: The goal of the DSRIP program is to promote community-level collaborations and focus on system reform in order to reduce avoidable inpatient admissions and emergency room visits by 25% over 5 years for the Medicaid and uninsured populations in New York State. Efforts include a focus on: clinical support backup, access to GSI Health Coordinators and PCMH recognition support. Kingsbrook projects within this focus include:

Creating an Integrated Delivery System	<p>➤ Health Home Sustain a health home at risk intervention program. Each hospital paired with a care management agency that deploys on site home health care coordinators to facilitate referrals. Actively identifies eligible patients.</p>
Reduce 30 Day Readmissions	<p>➤ Care Transitions Intervention Model Creating care plans for high risk-patients including collaborations with TCN's for assessment of best practices.</p>
ED Care Triage	<p>➤ Reduce Numbers of Avoidable ED Visits Patient navigator embedded in the ED, targeting frequent utilizers presenting with low severity needs. Follow ups with patients and providers re: appointments.</p>
PCMH	<p>➤ Level 3 Standards Focus on care management integration of behavioral health and chronic disease management.</p>
Population Health	<p>➤ Mental Health & Substance Abuse Strengthen mental health and substance abuse infrastructure across systems.</p> <p>➤ HIV Care Increase early access to and retention in HIV Care</p>

Community Health Needs Assessment

The Affordable Care Act requires hospitals to conduct community health needs assessments every three years and to develop implementation plans to address identified needs. New York State has similar Community Service Plan requirements. GNYHA keeps members apprised of updated requirements and provides technical assistance.

Community Health Needs Assessment Committee

Kingsbrook's Community Leadership Council:

Pastor Monroe	Mt. Zion 7 th Day Church
Jenny Griffith	Health Ministry of St. Albans Church
Monique Brizz Walker	Lions Club
Tony Beadanuir	Lions Club
Rev. John Williams	New Creation Ministries
Dr. Janice Emmanuel	APC Community Service
Renee Muir	Brownsville Multiservice Center

Department of Health Assessment Team:

Dr. Torian Easterling	Local Department of Health/Brooklyn
Brittany Howard	Local Department of Health/Brooklyn

KJMC Assessment Team:

Dr. Neil Pasco	Ambulatory Care
Becky Bigio	Mind & Body Program Pierre Toussaint
Joyce Leiz	DSRIP Coordinator
Enid Dillard	Public Affairs/Community Partnerships

Process & Methods:

The data and information reviewed at our community health needs assessment is as follows:

1. *Community Health Profiles NYS DOH*, for Flatbush, Central Brooklyn and Canarsie 2015,
2. *County Health Rankings for Kings County 2013*, health, socioeconomic and socio-demographic information from the *2000/2010 Census and the 2006*
3. *The New York Academy of Medicine Health Needs Assessment (DSRIP)*
4. *Indicators from Prevention Status Report (CDC)*

Assessment of Needs:

The issues of the overall community were addressed, noting that Central Brooklyn residents experience more barriers to health care access than those in NYC overall. The underinsured population and those with limited access to healthcare services contribute to the overwhelming disease rates, which are higher than the state and national averages. In East Flatbush 24% of residents are uninsured with 14% going without needed medical care. In Canarsie 17% are uninsured with 9% going without needed medical care, Crown Heights reflects 20% of residents are uninsured with 14% going without need medical care and in Brownsville it is reported that 18% of the community is uninsured with 11% going without needed medical care.

Assessment of Needs (Continued):

Kingsbrook's Primary service areas include: 11203, 11212, 11213, 11236. Kingsbrook's secondary areas: 11225, 11226, 11207, 11208 and 11233. The issues of the overall community were addressed, noting that Central Brooklyn residents experience more barriers to health care access than those in NYC overall. The leading causes of death in this area of Brooklyn are (1) Heart disease (2) Cancer (3) Flu (4) Diabetes. Reports identify Central Brooklyn as one of the epicenters of diabetes in New York City, reflecting the following rates within our primary services areas (East Flatbush 12%, Crown Heights 16%, Canarsie 15%, Brownsville 15%). Additionally, obesity rates are four times higher than most areas in the city: (East Flatbush 30%, Crown Heights 33%, Canarsie 32%, Brownsville 32%).

In Central Brooklyn, most HIV diagnoses are late stage, (HIV already progressed to AIDS). As such, new diagnoses are reported in the following areas: (East Flatbush 46.8%, Crown Heights 40.9%, Canarsie 22.3%, Brownsville 66.0%). Asthma hospitalizations for adults in Central Brooklyn per 100,000 adults are as follows: (East Flatbush 246, Crown Heights 325, Canarsie 192, Brownsville 621).