One Brooklyn Health

IRS IMPLEMENTATION STRATEGY & NYS COMMUNITY SERVICE PLAN

2025-2027

Brookdale Hospital Medical Center
1 Brookdale Plaza
718-240-5000

Interfaith Medical Center
1545 Atlantic Avenue
718-613-4000

Kingsbrook Jewish Medical Center
585 Schenectady Avenue
718-604-5000

Service Area
Kings County: Central and Northeastern Brooklyn

Plan Type
Individual

Hospital System Name
One Brooklyn Health

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

Interfaith Medical Center
1545 Atlantic Avenue
Brooklyn, NY 11213

Kingsbrook Jewish Medical Center
585 Schenectady Avenue
Brooklyn, NY 11203

Sandra R Scott
CEO
Phone: 718-240-5212
Email: sscott@bhmcny.org

Arthur Gianelli
President and Chief Transformation Officer
Phone: 718-240-5859
Email: arthur.gianelli@obhny.org

Community Service Plan Contact

Gwendolyn Lewis
Sr. Director of Community Health
Phone: 718-613-6835
Email: GLewis@INTERFAITHMEDICAL.org

I. Content

II. Introduction

One Brooklyn Health System, Inc. (OBH) is a not-for-profit, tax-exempt corporation licensed under Article 28 of the Public Health Law. OBH is the New York State Department of Health designated co-operator of Brookdale Hospital Medical Center (Brookdale), Interfaith Medical Center (Interfaith), and Kingsbrook Jewish Medical Center (Kingsbrook). OBH member hospitals have strong community ties, serving as vital anchor institutions and providing critical safety-net care to Central and Northeast Brooklyn.

OBH's mission statement is: "We provide greater access to high-quality medical care, keep our communities healthy through an integrated care system that respects the diversity of our communities, and address both the health needs and unique factors that shape them." To advance our mission, we are committed to ensuring our 2025-2027 Community Health Needs Assessment (CHNA) is aligned with state and regional priorities, our broader strategic plan, and guides all that we do to keep our diverse communities healthy. This report is more than a document to fulfill state and federal health law requirements. It reflects a core set of community needs that we are well-positioned and committed to addressing through our clinical programs and services. OBH will publish an Implementation Strategy/Community Service Plan outlining our approach to addressing the community needs identified in this report, in accordance with federal and state requirements.

The report will be made available on OBH's websites, such as https://onebrooklynhealth.org/; visitors to the website will be able to access, download, and print a hard copy of the report for free. A paper copy will be available to the public without charge by contacting the OBH Office of the Chief of Staff, OBH Office of External Affairs, or the OBH Ambulatory Care Department. In addition, OBH has committed to ongoing touchpoints with the community to discuss the need and content of this report. This may occur via Town Halls, Focus Groups, or through the system-wide Health Equity Community Advisory Board (HECAB).

III. Executive Summary

OBH is committed to delivering the right care, in the right place, at the right time, in a culturally responsive and cost-effective way.

In 2016, Brookdale Hospital Medical Center, Interfaith Medical Center, and Kingsbrook Jewish Medical Center received approval from the New York State Public Health and Planning Council to establish OBH, a tax-exempt, not-for-profit corporation dedicated to preserving and enhancing health care services in Central and Northeastern Brooklyn.

In April 2018, OBH became the active parent organization of the three hospitals, with representatives from their former boards joining the OBH Board of Trustees. As a not-for-profit health system, OBH is required to conduct a CHNA every three years. This document presents OBH's 2025–2027 CHNA.

To identify the most pressing health needs in its service area, OBH collaborated with the Greater New York Hospital Association (GNYHA) and the New York City Department of Health and Mental Hygiene (NYC DOHMH). After defining the service area, OBH collected and analyzed both secondary and primary data to understand health challenges faced by Central and Northeast Brooklyn.

To ensure the community voice is reflected in the final list of prioritized health needs, OBH used multiple approaches including two key informant interviews, six focus groups, and a HECAB session to intake feedback and inform future community health planning.

Based on this collaborative effort, OBH and the HECAB defined three shared priorities for the 2025–2027 planning period. These priorities are aligned with New York's State Health Improvement Plan, more commonly known as Prevention Agenda 2025-2030. They also support HealthyNYC goals and health needs identified by community boards in their Statements of Community District Needs (see the Appendix for the full list of goals).

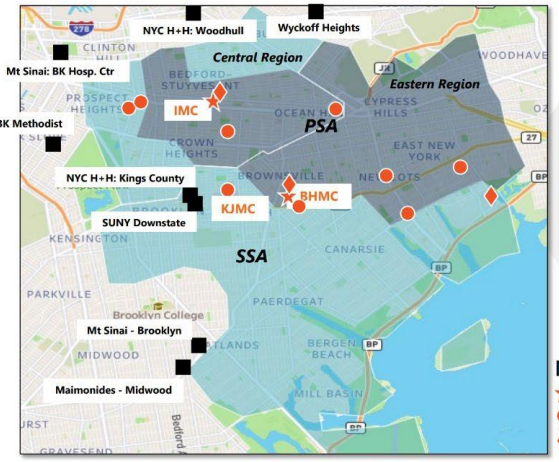
Domain	Priority	Goal	Objective
Economic Stability	Nutrition Security	Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods.	Increase food security in households with an annual total income of less than $25,000 from 42.0% to 51.1%
Social and Community Context	Anxiety and Stress	Increase the proportion of people living in New York who show resilience to challenges and stress.	Decrease the percentage of adults in households with an annual income of less than $25,000 who experience frequent mental distress from 21.0% to 18.9%.
Health Care Access and Quality	Preventive Services for Chronic Disease Prevention and Control	Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases. • *With a focus on hypertension*	Increase the percentage of adult Medicaid members aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 66.9% to 75.5%.

IV. Community Background

A. Service Area Geography

OBH and its member hospitals serve Central and Northeast Brooklyn in Kings County, New York. This area is designated as a Medically Underserved Area as defined by the Health Resources and Services Administration. OBH's service area was defined using 2024 hospital discharge data, and patient ZIP codes were ranked by frequency. The primary service area includes ZIP codes representing about 67% of inpatient discharges, while the secondary service area brings the total to approximately 89%. A full list of the ZIP codes within OBH's primary and secondary service area is available in the Appendix. OBH's service areas as well as facility locations are illustrated in the map in Figure 1.

Figure 1. One Brooklyn Health Facility Locations and Service Areas



	Primary Service Area (PSA)	Secondary Service Area (SSA)	Total
2024 Population (% of Total)	485K (45%)	587K (55%)	**1.07M**
% of 2024 Inpatient Discharges	67%	22%	**89%**
% of 2024 Outpatient Visits	58%	26%	**84%**

Competitor Inpatient Facility
OBH Inpatient Facility
BFCCs, Pierre Toussaint, Bishop Walker, KJMC, Interfaith Primary Care[1]
Future OBH locations at 888 Fountain Ave, 491 Herkimer St and 527 E 98th St.

This report utilizes community district-level data provided by New York City as well as neighborhoods defined by the United Hospital Fund (UHF).[i] These districts establish geographic boundaries that inform land use, zoning, health research, and other key planning decisions.[ii] OBH's service area spans ten community districts across Brooklyn and six UHF defined neighborhoods. The Appendix provides a list of the OBH service area by community district as well as UHF-defined neighborhoods.

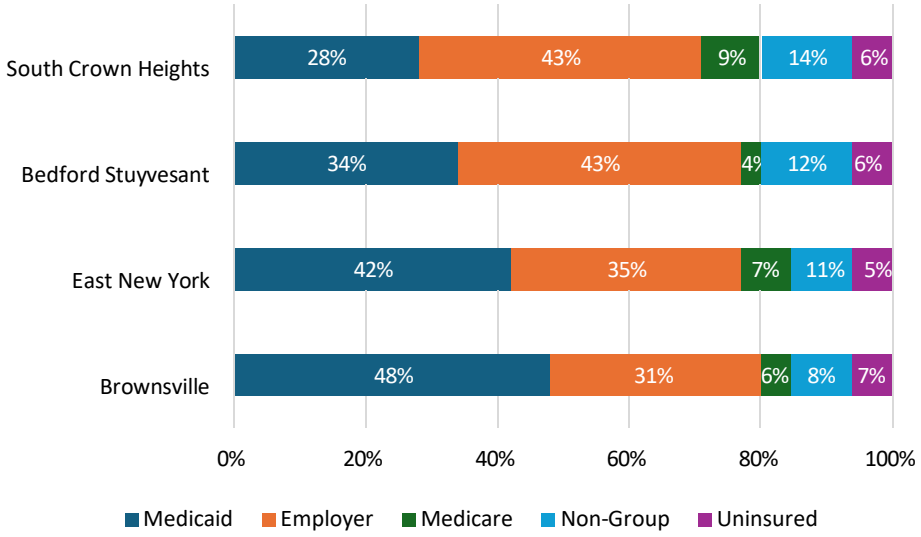
Secondary data for this assessment were drawn from publicly available sources such as the NYC DOHMH including the New York City Community Health Profiles, and Environment and Health Data Portal. Internal hospital records were also incorporated to provide additional context. These data sources include service utilization trends, quality and safety metrics, and other operational indicators that offer a more comprehensive understanding of OBH's community impact.

B. Demographics

The demographic composition of a community significantly influences the health status and needs of its service area, shaping the types of services required to effectively meet residents' needs and improve clinical and population health outcomes.

OBH's service area is home to 1.07 million residents equating to 40% of Brooklyn's population.[iii] Within OBH's primary service area, Brownsville has the highest Medicaid enrollment at 48%, followed by East New York at 42%. In contrast, South Crown Heights reports the highest rates of employer-sponsored and Medicare coverage among neighborhoods in the service area.[iv] Figure 2 shows the payer enrollment for neighborhoods in OBH's primary service area.

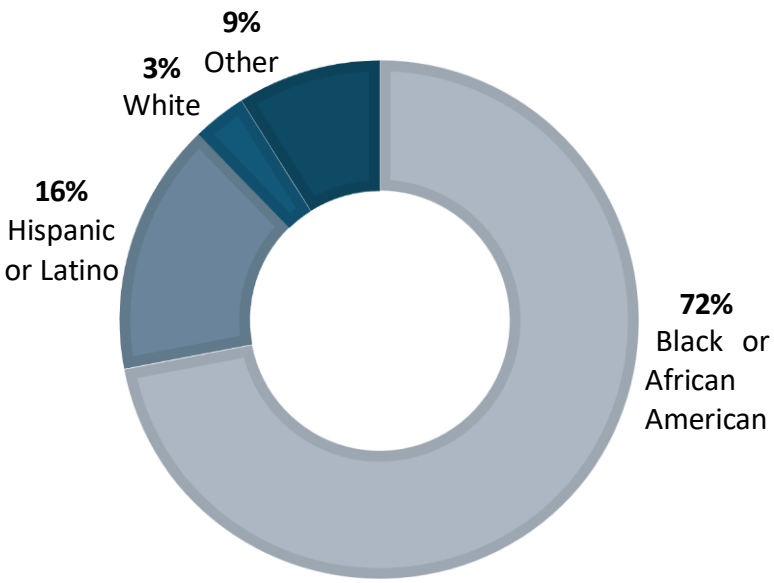
Figure 2. Payer Enrollment by Percent



Source: One Brooklyn Health

An analysis of OBH's 2023 electronic health record data revealed that 72% of OBH's patients that year were predominantly Black or African American. The next highest demographic was Hispanic or Latino at 15.8%. Figure 3 describes OBH's patient makeup by race/ethnicity.

Figure 3. OBH Patients by Race and Ethnicity*

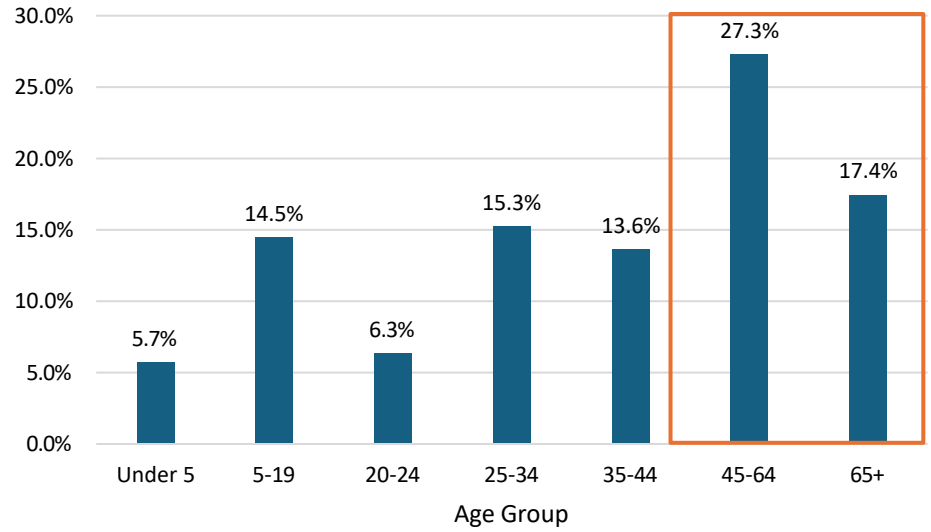


Source: One Brooklyn Health

* The "Other" category includes patients identified as Asian, American Indian/Alaska Native, Native Hawaiian or Pacific Islander, as well as those whose race was recorded as "unknown" or "other." Together, these groups represent less than 10% of OBH patient data.

The majority of OBH patients are female (54%). The age distribution shows that most patients are older, with 27.3% between 45-64 and 17.4% aged 65 or above[v]. Figure 4 describes the age distribution of OBH patients.

Figure 4. OBH Patients by Age



The majority of OBH's patient population is over 45 years old.

Source: One Brooklyn Health

Language barriers are among the most significant threats to healthcare access, undermining communication, comprehension, and continuity of care. Ensuring linguistic inclusivity is central to achieving equitable health outcomes. Populations with limited English proficiency experience greater health disparities compared to those who select English as their preferred language when queried. To combat these challenges, OBH offers robust translation services to reach the diverse population that the system serves

Similarly, research has shown foreign-born persons face access barriers and are more likely to be uninsured compared to those born in the U.S. [vi] Most community districts in OBH's primary and secondary service area have a smaller share of foreign-born residents than Brooklyn overall (36%). East Flatbush has the highest percentage of foreign-born residents at 52%, followed by Flatbush and Midwood at 41%. This directly impacts access and coverage for OBH's patient population.

C. Social Determinants of Health

Social determinants of health (SDOH) are defined as the social and physical conditions in which people are born, live, learn, work, play, worship, and age. Considerable research has shown these conditions have a significant impact on health and quality-of-life outcomes. Healthy People 2030, led by the U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion define SDOH in five categories: economic stability; education access and quality; health care access and quality; neighborhood and built environment; and social and community context.[vii] These categories align with the New York State Prevention Agenda, which sets forth state and local priorities through 2030.

Economic Stability

Poverty intensifies negative health outcomes and contributes to stress, creating significant barriers to living a healthy life. Most community districts in OBH's service area have a higher poverty rate than Brooklyn (19%) and New York City overall (18%). Brownsville has the highest poverty level with 29% of residents living in poverty. Figure 5 illustrates poverty rates across the four community districts in OBH's primary service area, which have the highest poverty levels among all OBH service areas.

Figure 5. Percent of Residents Living in Poverty

Source: NYC Community Health Profiles, 2023

Income and employment are closely linked to health outcomes and often affect both access to care and overall health status. Unemployed patients and those who receive below market wages often lack access to health insurance, which heightens barriers associated with payment for health care, medications, and ancillary services. The community districts in OBH's service area with the highest level of unemployment are Brownsville and Bedford Stuyvesant at 12% and 8%, respectively. Table 1 shows the unemployment rate for all community districts in OBH's service area. Only two community districts have lower unemployment rates than Brooklyn as a whole.

Table 1. Percent of People 16 and Over who are Unemployed

Community District	Unemployment Rate (%)
Brownsville	12
Bedford Stuyvesant	8
East New York and Starett City	7
South Crown Heights and Lefferts Gardens	7
Fort Greene and Brooklyn Heights	6
Crown Heights and Prospect Heights	6
Flatbush and Midwood	6
East Flatbush	6
Brooklyn Total	**6**
Greenpoint and Williamsburg	5
Flatlands and Canarsie	5

Source: NYC Community Health Profiles, 2023

Education Access and Quality

Education plays a critical role in shaping healthy behaviors, developing health literacy, and clinical outcomes. Elementary school absenteeism refers to public-school students in grades K-5 who have

missed more than 10% of reported school days. In OBH's service area, almost all community districts have a higher rate of elementary school absenteeism than Brooklyn as a whole. In Brownsville, 43% of public-school students in grades K-5 have missed more than 10% of reported school days. This rate is double the elementary school absenteeism rate in both Brooklyn and New York City, on average. Table 2 shows the percentage of public-school students in grades K-5 who have missed more than 10% of reported school days for all community districts in OBH's service area.

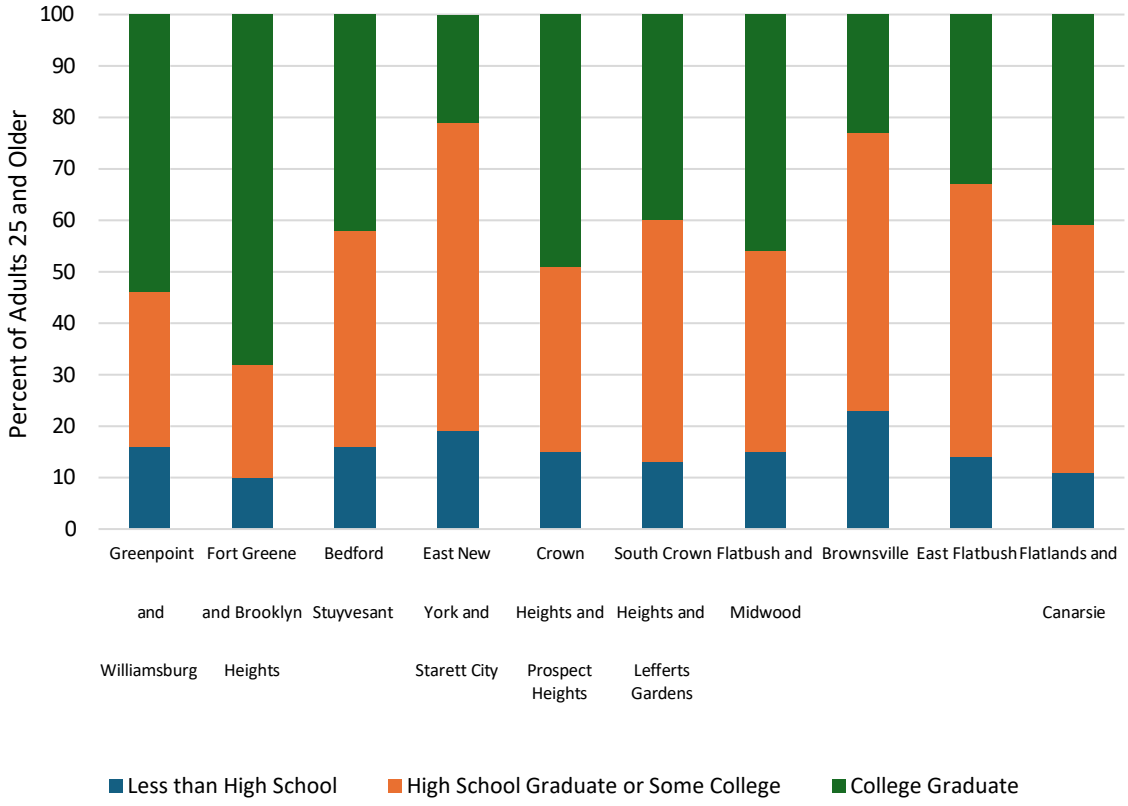
Table 2. Percent of Public-School Students in Grades K through 5 Missing >10% of Reported School Days

Community District	Elementary School Absenteeism (%)
Brownsville	43
East New York and Starett City	35
Bedford Stuyvesant	34
Crown Heights and Prospect Heights	29
East Flatbush	26
South Crown Heights and Lefferts Gardens	24
Greenpoint and Williamsburg	23
Flatlands and Canarsie	22
Brooklyn Total	21
Fort Greene and Brooklyn Heights	20
Flatbush and Midwood	20

Source: NYC Community Health Profiles, 2023

Educational attainment is a critical determinant of health, strongly linked to improved employment prospects and higher earning potential. Within OBH's service area, Fort Greene and Brooklyn Heights have the highest rate of college graduates. Brownsville and East New York and Starett City have the lowest. Figure 6 shows the percentage of adults 25 and older by highest level of education achieved.

Figure 6. Percent of Adults 25 and Older by Highest Level of Education Achieved



Source: NYC Community Health Profiles, 2023

Health Care Access and Quality

Health insurance plays a central role in the U.S. healthcare system, serving as the primary gateway to medical care. Coverage can come from employer-sponsored plans, individual purchases, or public programs such as Medicare and Medicaid. It reduces financial risk from medical expenses and expands access to care. For this reason, the uninsured rate serves as a critical indicator of healthcare accessibility.

Most communities in the OBH service area have a similar rate of uninsured adults when compared to Brooklyn and New York City overall. Bedford Stuyvesant has the highest rate of uninsured adults in the region at 18%. Table 3 shows the percentage of uninsured adults for all community districts in OBH's service area. Community districts with a reliability note (*) should be interpreted with caution due to high uncertainty or limited data.

Table 3. Percent of Uninsured Adults

Community District	Uninsured Rate (%)
Bedford Stuyvesant	18
East Flatbush	17
Flatbush and Midwood	14
Fort Greene and Brooklyn Heights*	13
South Crown Heights and Lefferts Gardens*	13
Brooklyn Total	12
Brownsville*	12
East New York and Starett City	11
Greenpoint and Williamsburg*	10
Crown Heights and Prospect Heights	8
Flatlands and Canarsie*	6

Source: NYC Community Health Profiles, 2023

Data indicating the health care quality available to residents in the OBH service area will be discussed in later sections.

Neighborhood and Built Environment

The environment where people live shapes their experiences, including their opportunities and challenges. In turn, these conditions play a major role in influencing health. Key data points related to OBH's neighborhood and built environment include:

- **Spending on Housing.** Over half of renter-occupied households in Bedford Stuyvesant, East New York and Starett City, South Crown Heights and Lefferts Garden, Flatbush and Midwood, Brownsville, and East Flatbush spend more than 30% on housing.
- **Threats to Affordable Housing.** The Association for Neighborhood and Housing Development, Inc. (ANHD) provides an annual analysis of threats to affordable housing among community districts across NYC. Among those located in OBH's service area, ANHD scored more than half as having an elevated threat to affordable housing.
- **Healthy Food Access.** Bedford Stuyvesant has the highest bodega-to-supermarket ratio in the OBH service area, with 18 bodegas for every 1 supermarket.
- **Food Insecurity.** OBH's service area has elevated levels of food insecurity with East Williamsburg having the highest rate in all of New York City at 36%. Brownsville and Spring Creek-Starett City also have particularly high rates at 24.3% and 22.4%, respectively.
- **Pedestrian Safety**. Brownsville has a pedestrian injury hospitalization rate of 32 per 100,000 residents. Pedestrian safety is a critical yet often underrecognized social determinant of health—fundamentally shaping access to essential services, opportunities for physical activity, and overall community well-being.

Social and Community Context

All people deserve to live in safe and supportive communities free from violence. Nearly all community districts in OBH's service area have higher rates of non-fatal assault hospitalizations per 100,000 than Brooklyn as a whole. In Brownsville, the rate is notably high, with 175 non-fatal assault hospitalizations

per 100,000 residents. Table 4 shows the non-fatal assault hospitalization rate per 100,000 for all community districts in OBH's service area.

Table 4. Non-Fatal Assault Hospitalization Rate per 100,000

Community District	Non-Fatal Assault
Brownsville	175
Bedford Stuyvesant	117
East New York and Starett City	113
Crown Heights and Prospect Heights	85
East Flatbush	80
South Crown Heights and Lefferts Gardens	73
Brooklyn Total	**59**
Flatlands and Canarsie	46
Flatbush and Midwood	42
Fort Greene and Brooklyn Heights	40
Greenpoint and Williamsburg	34

Source: NYC Community Health Profiles, 2023

Incarceration has profound negative effects on individuals, families, and communities. Children of incarcerated parents often experience emotional and mental health challenges, while formerly incarcerated individuals frequently struggle to secure employment and housing and face additional mental and physical health issues[viii]. Within OBH's service area, Brownsville has the highest jail incarceration rate among adults aged 16 and older, at 787 per 100,000. This rate is nearly four times higher than the jail incarceration rate in Brooklyn as a whole. Table 5 shows the jail incarceration rate per 100,000 adults aged 16 and older for all community districts in OBH's service area.

Table 5. Jail Incarceration per 100,000 Adults Aged 16 and Older

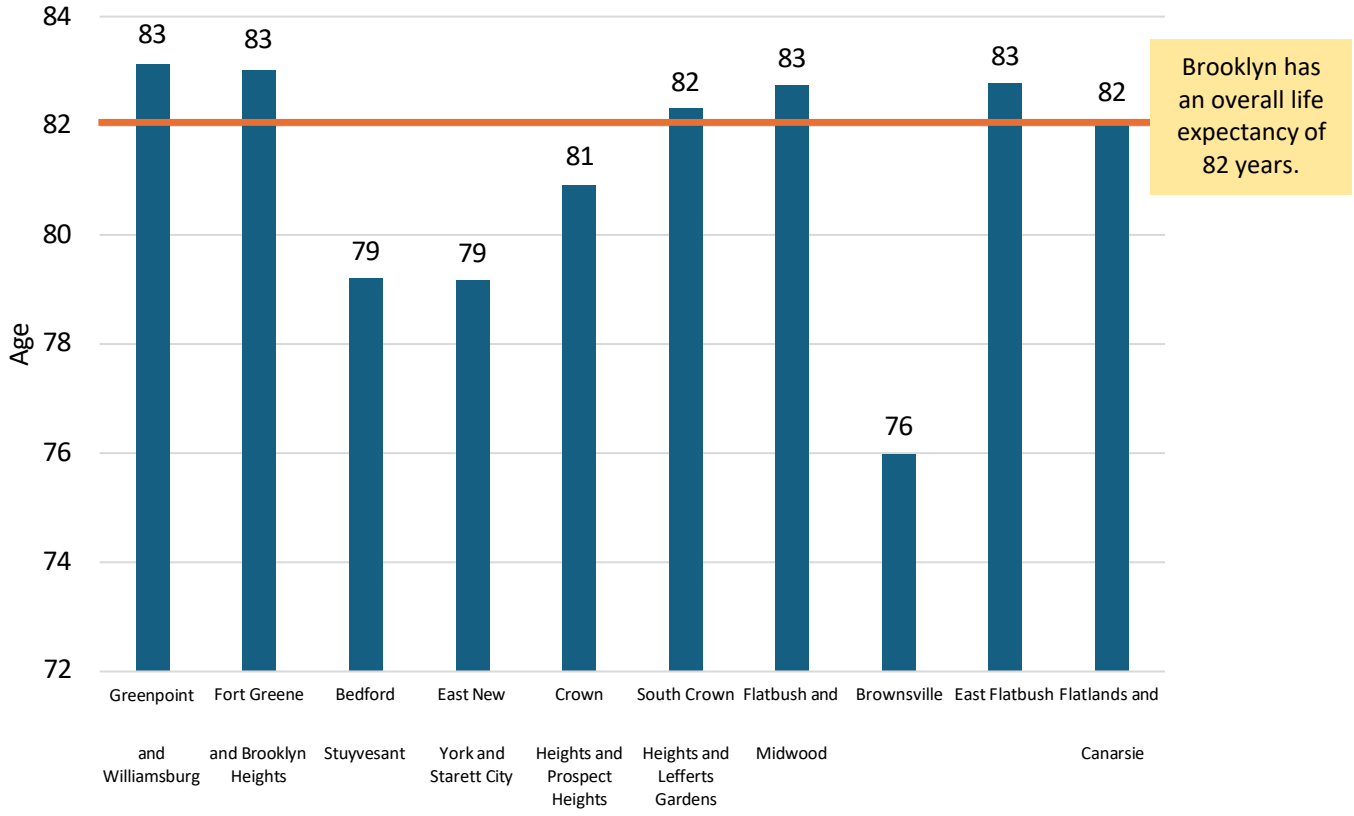
Community District	Incarceration
Brownsville	787
East New York and Starett City	509
Bedford Stuyvesant	472
Crown Heights and Prospect Heights	330
East Flatbush	291
South Crown Heights and Lefferts Gardens	263
Brooklyn Total	**210**
Flatlands and Canarsie	202
Flatbush and Midwood	173
Fort Greene and Brooklyn Heights	143
Greenpoint and Williamsburg	130

Source: NYC Community Health Profiles, 2023

D. Community Health Status

Data related to the health status of the community was analyzed to better understand the needs of the service area. Life expectancy across OBH's service area is comparable to Brooklyn's average of 82 years. In contrast, residents of Brownsville have the lowest life expectancy at 76 years, eight years shorter than the borough average. Figure 7 shows a comparison of life expectancy across the ten community districts and Brooklyn.

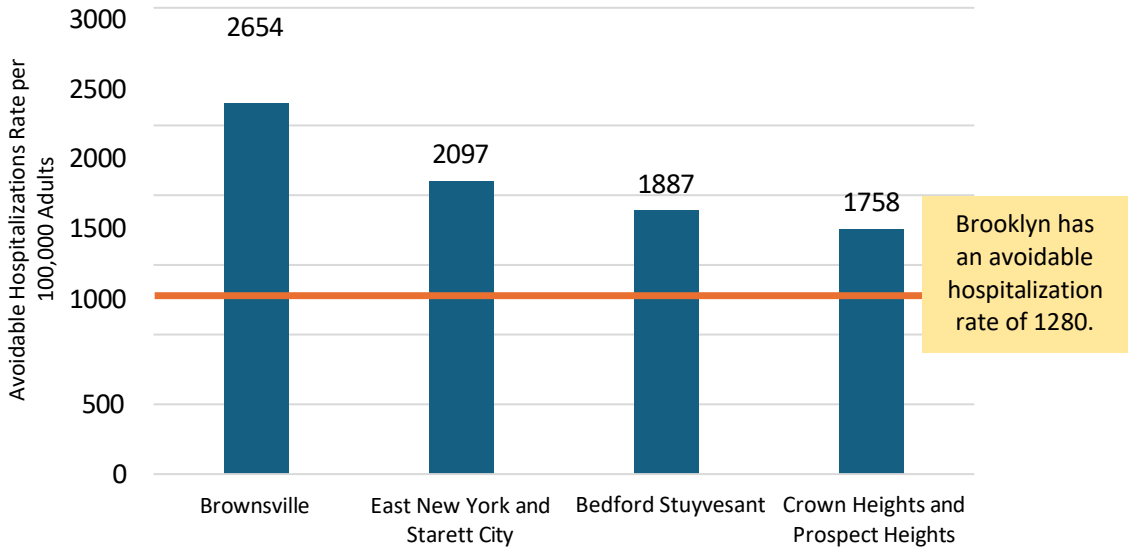
Figure 7. Life Expectancy



Source: NYC Community Health Profiles, 2023

The four community districts corresponding to OBH's primary service area have the highest rates of avoidable hospitalizations in the entire service area. Avoidable hospitalizations refer to hospitalizations that could have been prevented with timely access to high-quality primary care. Figure 8 shows the avoidable hospitalization rate in OBH's primary service area.

Figure 8. Avoidable Hospitalizations per 100,000 Adults



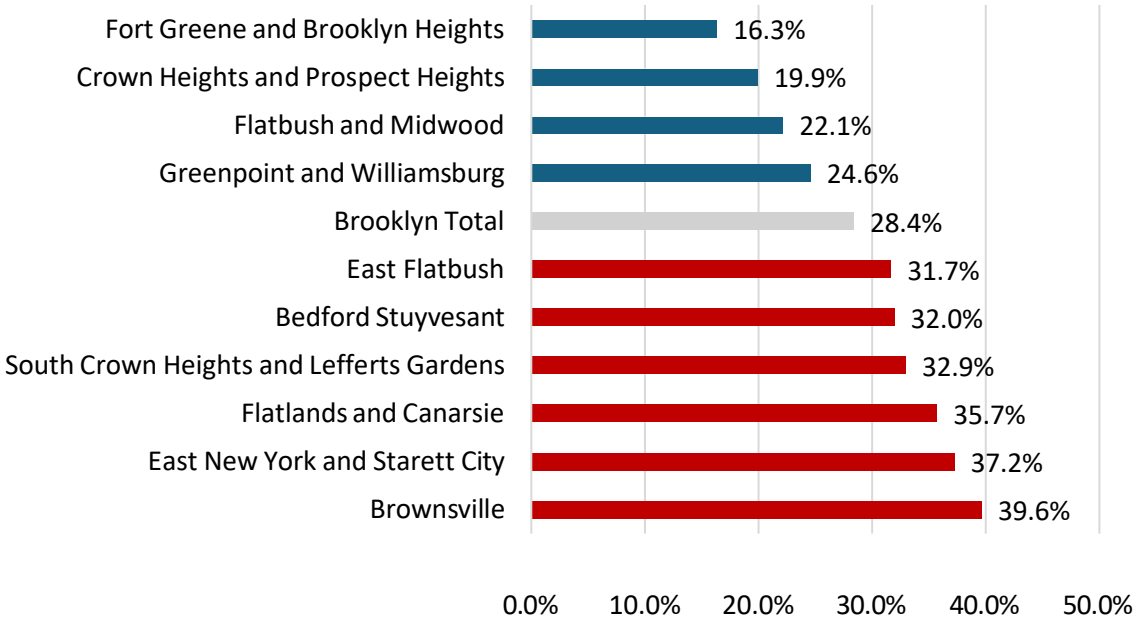
Source: NYC Community Health Profiles, 2023

Chronic Disease

Chronic disease refers to health conditions that last one year or more, require ongoing medical care, and typically limit daily activities in some way. In New York State, chronic disease is a leading cause of disability and death.[ix] Importantly, many chronic illnesses are preventable through consistent engagement in healthy behaviors. In the OBH service area, obesity, diabetes, and hypertension are widespread. More than half of the community districts within OBH's catchment report higher rates of these chronic conditions compared to the Brooklyn average.

Figure 9 shows the percentage of adults with hypertension in OBH's service area.

Figure 9. Percent of Adults with Hypertension



Source: NYC Community Health Profiles, 2023

Figure 10 shows the percentage of adults with obesity in OBH's service area.

Figure 10. Percent of Adults with Obesity

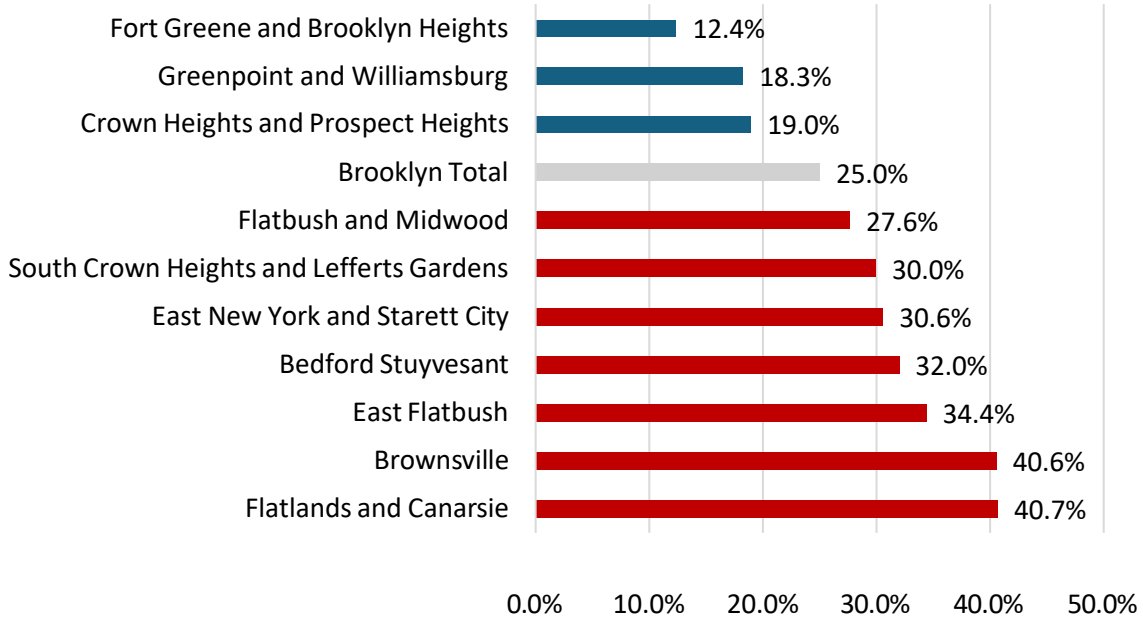
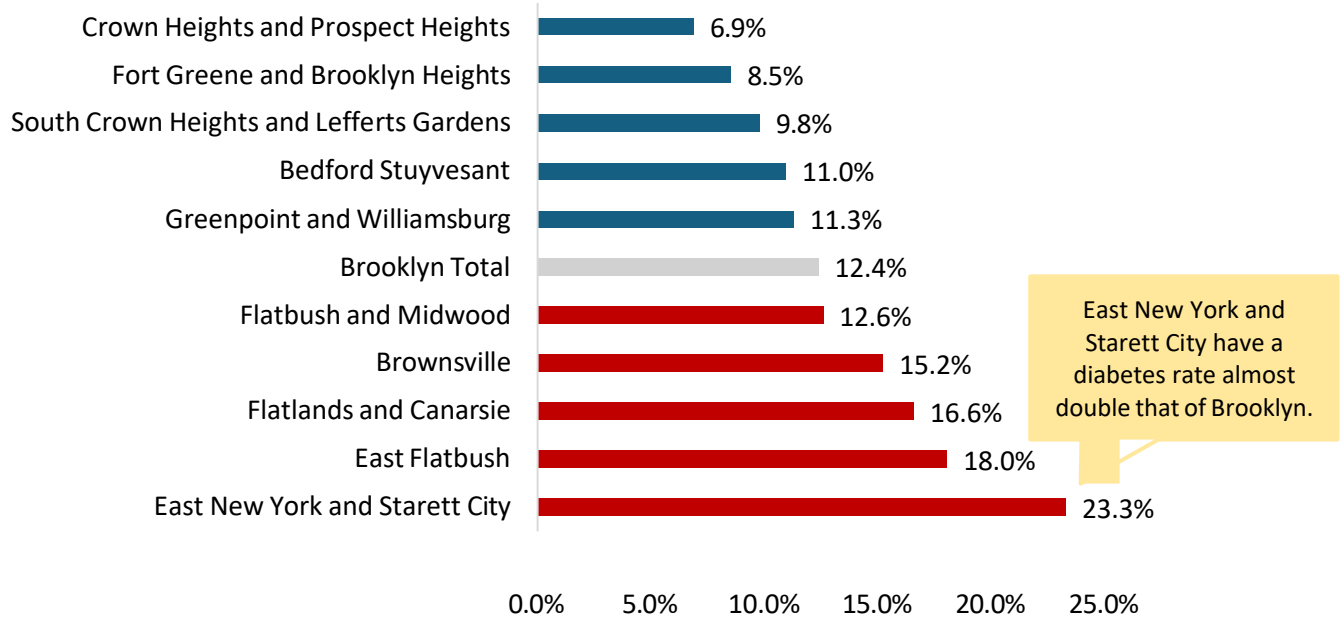


Figure 11 shows the percentage of adults with diabetes in OBH's service area.

Figure 11. Percent of Adults with Diabetes

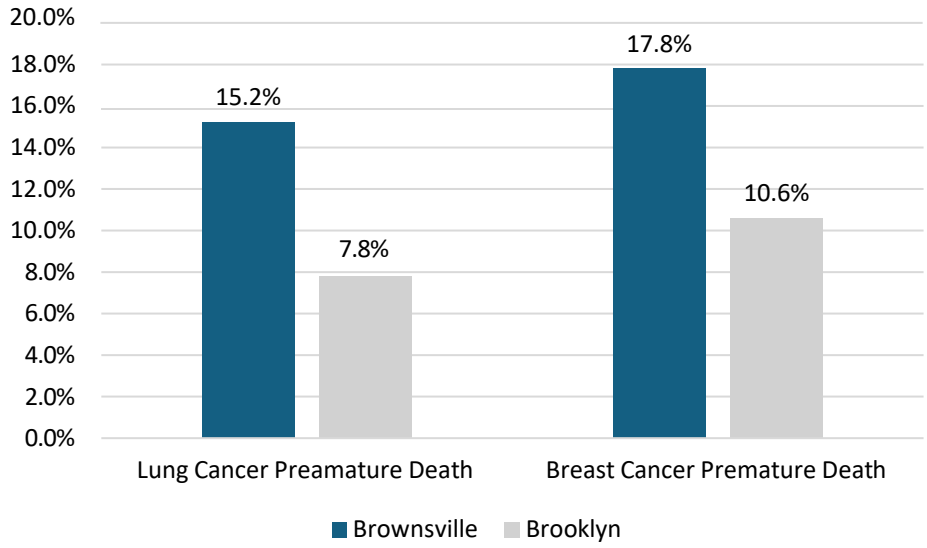


Source: NYC Community Health Profiles, 2023

Cancer

Cancer remains one of the leading causes of death in the United States and is often associated with premature mortality. Within OBH's service area, lung cancer is the primary contributor to premature cancer-related deaths, followed by breast cancer. In Brownsville, rates of premature death from lung and breast cancer are significantly higher than the Brooklyn average. Figure 12 illustrates these disparities.

Figure 12. Premature Cancer Mortality Rates in Brownsville and Brooklyn



Source: NYC Community Health Profiles, 2023

Infectious Disease

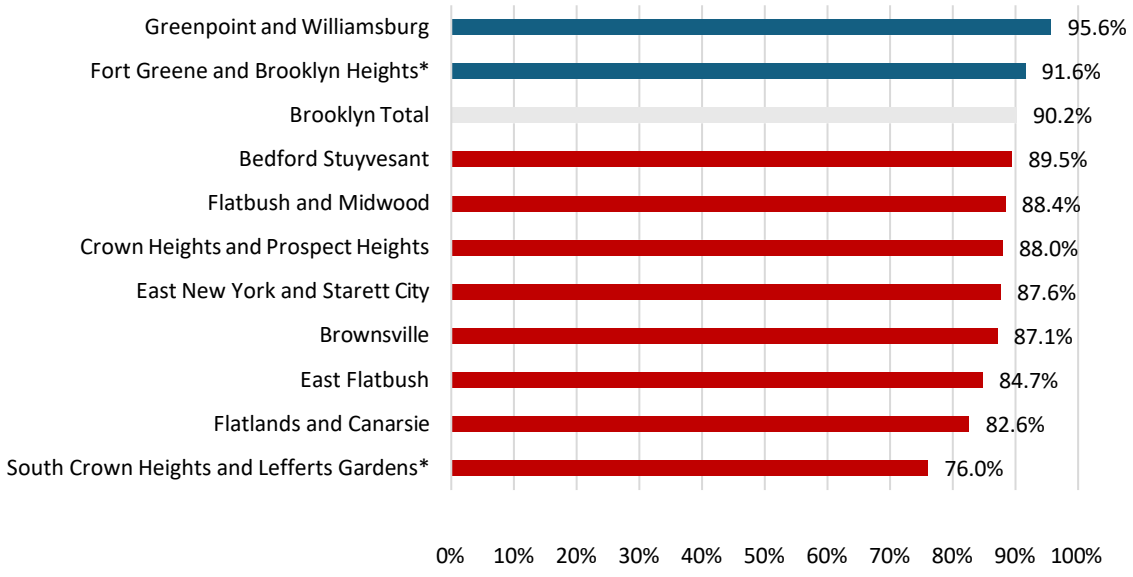
Infectious diseases are caused by microorganisms such as a virus or bacteria. Infectious diseases spread through direct contact, airborne particles, and other vectors. Many infectious diseases, such as the flu and Human Papillomavirus, can be prevented by vaccination. Vaccination rates in OBH's service area generally align with Brooklyn-wide averages. However, in Greenpoint and Williamsburg, only 24.8% of teens aged 13 to 17 have received all recommended HPV doses, 34.3 percentage points below the borough average.

Physical Activity and Nutrition

Physical activity and nutrition are risk factors for many chronic conditions including type 2 diabetes, obesity, and hypertension. The Centers for Disease Control and Prevention recommend adults get at least 150 minutes of moderate-intensity physical activity a week.[x] Most community districts in OBH's service area have a higher percentage of adults reporting any physical activity in the last 30 days. Proper nutrition is also essential for reducing the risk of chronic disease. Sugary beverages such as soda pose a significant public health risk, as they are high in added sugars and linked to weight gain, dental cavities, and chronic conditions like obesity and type 2 diabetes. In contrast, consuming fruits and vegetables offers protective health benefits and is essential for maintaining a balanced diet. Flatlands and Canarsie have the highest rates of sugary drink consumption, with 31% of adults drinking at least one sugary drink daily. They also have one of the lowest rates of fruit and vegetable consumption, with only 82.6% of adults reporting eating at least one serving in the previous day. Figure 13 shows fruit and vegetable consumption for each community district in the service area. illustrates these disparities.

Community districts with a reliability note (*) should be interpreted with caution due to high uncertainty or limited data.

Figure 13. Percent of Adults Reporting Eating At Least 1 Serving of Fruits or Vegetables in the Last Day



Source: NYC Community Health Profiles, 2023

Mental Health

Mental health plays a key role in quality of life, yet mental illness is widespread, impacting roughly 1 in 5 adults.[xi] Fortunately, many mental illnesses can be managed with proper treatment and care. In the OBH service area, psychiatric hospitalization is prevalent. Brownsville's psychiatric hospitalization rate (2,032 per 100,000 adults) is almost three times the Brooklyn average of 692. These rates suggest a lack of access for preventive mental health care services. Depression is a prevalent concern across the OBH service area. Table 6 presents the rates of depression among adults within UHF-defined neighborhoods, highlighting the scope of this mental health challenge.

Table 6. Age-Adjusted Percent of Adults with Depression

UHF	Neighborhood Name	Age-Adjusted Rate of Depression
211	Williamsburg - Bushwick	15.7%
202	Downtown - Heights - Slope	14.5%
204	East New York	13.3%
3	**Brooklyn Total**	**13.1%**
203	Bedford Stuyvesant - Crown Heights	12.3%
208	Canarsie - Flatlands	12.2%
207	East Flatbush - Flatbush	11.0%

Source: NYC Environment and Health Data Portal, 2021-2022

Substance Use

Substance use refers to the consumption of substances such as illicit drugs, alcohol, or tobacco, which can lead to dependence or negatively impact a person's health and daily life.[xii] Key data points related to substance use in OBH's service area include:

- **Drug use.** Brownsville, East New York and Starett City, and Bedford Stuyvesant have the highest rates of premature mortality due to drugs at 25.3, 19.2, and 17.7 per 100,000 adults, respectively.
- **Tobacco use.** Brownsville, East New York and Starett City, and Bedford Stuyvesant also have the highest rates of current smokers at 15%, 12.3%, and 14.3%, respectively.
- **Alcohol use.** Notably, almost all community districts except Flatbush and Midwood in OBH's service area, have a higher rate of binge drinking than Brooklyn.

Sexually Transmitted Infections

Sexually transmitted infections (STIs) are common illnesses caused by bacteria, viruses, and other pathogens transmitted through sexual contact. They are largely preventable by practicing safe sexual behaviors, including consistent condom use and regular testing.[xiii] In the OBH service area, STIs are widespread. Data shows:

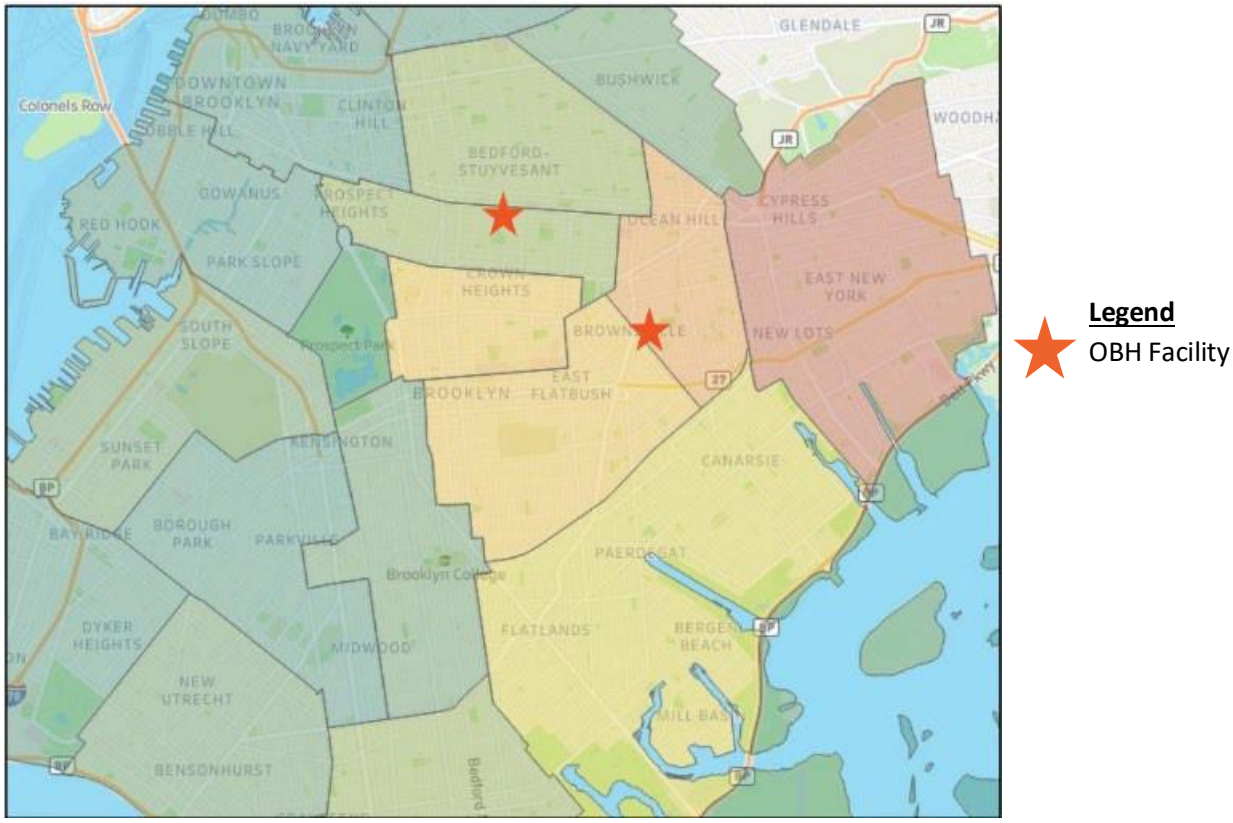
- Bedford and Stuyvesant and Crown Heights report the highest rates of early syphilis, gonorrhea, and chlamydia within the service area.
- For new human immunodeficiency virus (HIV) diagnoses, Brownsville has a rate of 44 per 100,000 people, compared to 12 per 100,000 in Flatlands and Canarsie.

Maternal and Infant Health

Maternal health has become a central focus for government and healthcare initiatives in recent years. One key indicator of maternal health is the timing of prenatal care, as early and consistent care is critical for a healthy pregnancy. Among OBH community districts, East Flatbush and Brownsville report the highest rates of live births with late or no prenatal care at 12.2% and 11.3%, respectively. In comparison, Fort Greene and Brooklyn Heights have a significantly lower rate, with only 2.5% of pregnant individuals receiving late or no prenatal care.

Infant health is a critical measure of overall community well-being. The infant mortality rate serves as a key indicator of healthcare quality within the region. In the OBH service area, East New York and Starett City report the highest infant mortality rate at 7.5 deaths per 1,000 live births. In contrast, Fort Greene and Brooklyn Heights have a significantly lower rate of 1.9 per 1,000. Figure 14 illustrates the variation of infant mortality across the OBH service area.

Figure 14. Infant Mortality in the OBH Service Area



Source: One Brooklyn Health

Children's Health

Childhood health is the cornerstone of lifelong success. Access to preventive care, supportive environments, and healthy habits enables children to develop essential physical, cognitive, and social skills that carry into adulthood. When these needs are unmet, whether through limited healthcare access or developmental gaps, children face increased risks of academic challenges, diminished opportunities, and chronic health conditions later in life. [xiv] Key data points related to children's health in OBH's service area include:

- **Childhood obesity.** Childhood obesity rates among OBH community districts range from 21% to 26%, with most areas similar to or higher than the Brooklyn average, particularly in East New York and Starett City.
- **Asthma-related emergency department visits.** Within the OBH service area, asthma-related emergency department visits show stark disparities. Brownsville (451) and East Flatbush (336) have averages that far exceed the borough average of 166 child asthma emergency department visits per 10,000 children aged 5-17.
- **Avoidable hospitalizations among children.** A similar trend exists for avoidable hospitalizations among children in OBH's service area. Brownsville (1358) and East Flatbush (1308) have rates significantly higher than the borough average of 502 avoidable hospitalizations among children per 100,000 children aged 4 years or younger.

Quality and Safety

OBH places the highest priority on delivering safe, high-quality care to its patients. To gain deeper insights into patient experiences and the quality of care provided, OBH analyzed data from the Hospital Consumer Assessment of Healthcare Providers and Systems survey, a standardized questionnaire that collects feedback directly from patients. The following data points illustrate OBH's performance in quality and safety:

- **Communication.** OBH patients identified communication from doctors and nurses highly, with 73% noting clear communication provided by OBH physicians.
- **Hospital environment.** 53.3% of respondents considered the hospital environment to be restful.
- **Responsiveness of hospital staff.** Only 42.43% of patients felt the OBH hospital staff responded in a timely manner to their needs.
- **Discharge information.** OBH's highest ranking was providing discharge information with 75.8% of patients noting the OBH staff provided clear instructions before they left the hospital.

V. Community-Identified Needs

Community input was collected from residents served by One Brooklyn Health to ensure their perspectives and experiences informed this assessment. These insights, drawn from the GNYHA CHNA Survey, key informant interviews, and OBH Community Advisory Board build on the secondary data collected to create a complete view of community health needs.

GNYHA CHNA Survey

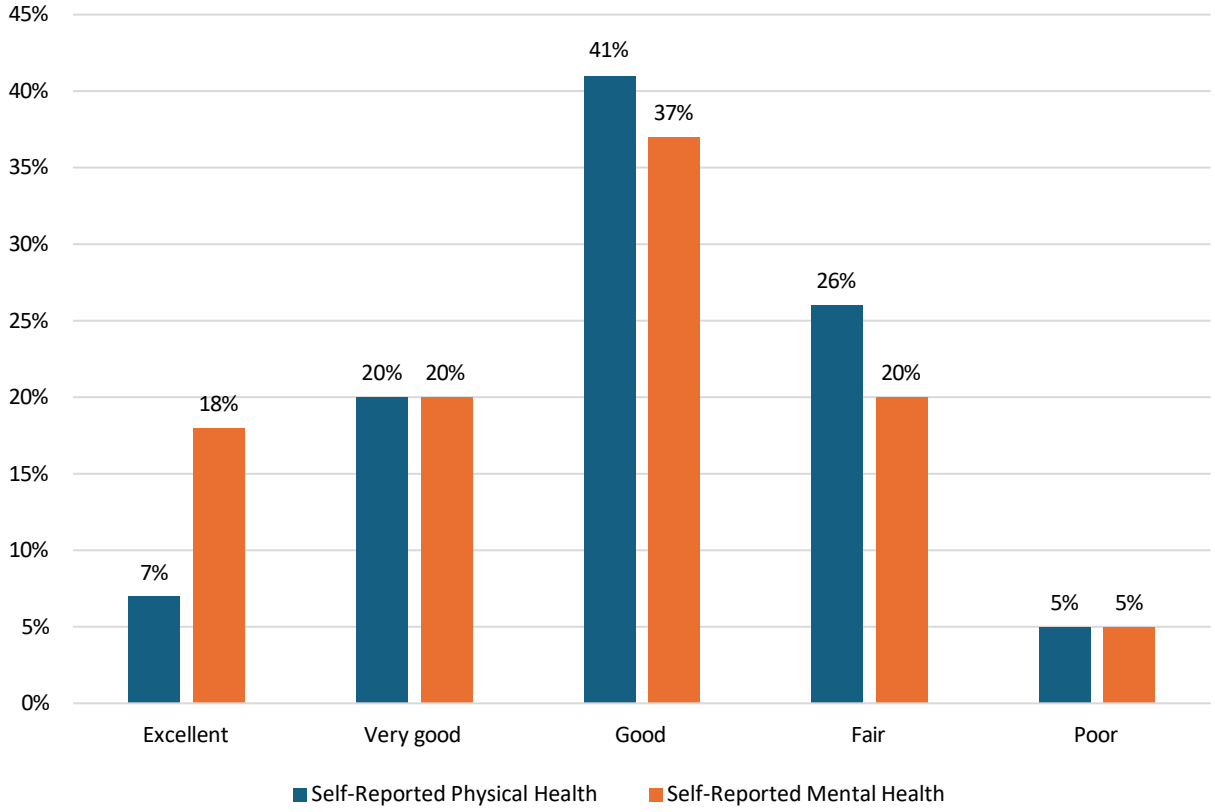
One Brooklyn Health participated in the GNYHA Survey Collaborative's CHNA survey which helps hospitals collect community input to better inform the health needs of their service area. OBH, a participating hospital, distributed the online survey link in their email newsletter, staff intranet portals, member hospital websites, and on social media accounts. The survey link was also shared with community partners, and at outreach events, community board meetings, health fairs, and ambulatory sites. OBH distributed the survey at events between the dates of June 2 – July 26, 2025. After compiling and analyzing survey responses, GNYHA provided OBH with data specific to its defined service area.

The CHNA survey gathered 1,489 responses from residents of OBH's service area. Of these respondents, 91% primarily speak English and 8% primarily speak Spanish. The majority of respondents receive health coverage through their employer or union (42%), with 22% of respondents enrolled in Medicaid and 21% enrolled in Medicare. Most respondents identified as Black or African American, were cisgender women, and between the ages of 45 and 64 years old.

In response to ranking the overall health of the people in their neighborhood, 46% answered "fair", with 3% answering "excellent" and 11% responding "poor."

When asked to provide an indication of their physical and mental health, 41% said their physical health was "good" and 37% said their mental health was "good." Of those surveyed, a higher percentage of respondents noted their mental health was "excellent" (18%) compared to their physical health (7%). Figure 15 compares the self-reported physical and mental health status of respondents.

Figure 15. Self-Reported Health Status Among Respondents from OBH Service Area



Source: GNYHA CHNA Survey, 2025

Respondents were asked about their experiences with food and housing insecurity. When asked if they currently receive food stamps or Supplemental Nutrition Assistance Program (SNAP) benefits, 23% indicated that they do. To further assess food insecurity in the region, respondents were asked: 'During the past 12 months, how often did the food that you bought not last, and you didn't have enough money to get more?'. Among respondents in OBH's service area, 49% answered 'Always', 'Usually', or 'Sometimes'.

Survey participants were also asked about housing insecurity. In response to the question: 'During the last 12 months, was there a time when you were not able to pay your mortgage, rent, or utility bills?' 40% of respondents in OBH's service area replied 'Yes'.

Finally, community members were presented a list of 21 health issues and asked to rank each by level of importance and satisfaction with current neighborhood services addressing that issue. Responses were scored on a 1-5 scale (1 = not at all, 2 = a little, 3 = somewhat, 4 = very, and 5 = extremely). For each health issue, an average Importance Score and Satisfaction Score were calculated ranked from highest to lowest. These scores were then compared to the overall averages and categorized as Above Average or Below Average. The health conditions were then grouped into three priority levels: Needs Attention, Maintain Efforts, and Relatively Lower Priority.

The Relatively Lower Priority category includes health issues with a below average Importance Score. The Maintain Efforts category covers issues with above average scores for both the Importance Score and Satisfaction Score. The Needs Attention category includes health issues with above average Importance Scores and below average Satisfaction Scores. Table 7 highlights the health issues identified by OBH community members as Needs Attention or Maintain Efforts. The Appendix provides the complete list of results for all three categories.

Table 7. Ranking of Health Issues Categorized as "Needs Attention"

Domain	Health Condition
Needs Attention	
Neighborhood and Built Environment	Violence (including gun violence)
Economic Stability	Affordable housing and homelessness prevention
Social and Community Context	Mental health disorders (such as depression)
Economic Stability	Assistance with basic needs like food, shelter, and clothing
Health Care Access and Quality	Obesity in children and adults
Maintain Efforts	
Health Care Access and Quality	Dental care
Economic Stability	Access to healthy/nutritious foods
Health Care Access and Quality	Cancer
Health Care Access and Quality	Women's and maternal health care
Health Care Access and Quality	High blood pressure
Health Care Access and Quality	Diabetes and high blood sugar
Health Care Access and Quality	Heart disease
Health Care Access and Quality	Adolescent and child health
Neighborhood and Built Environment	Stopping falls among elderly
Health Care Access and Quality	Infant health
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)

Source: GNYHA CHNA Survey, 2025

Key Informant Interviews

Key informants were chosen for their expertise in public health, their knowledge of local community health needs, their ability to represent the broad interest of OBH's service area, and their insight into the needs of medically underserved or vulnerable populations. Two key informants from the NYC DOHMH and OBH were interviewed for this assessment.

Key themes from interviews conducted included:

Chronic Disease Management. Key informants stressed the prevalence of chronic disease in the community as well as the lack of access to care for individuals with chronic disease needs.

Mental Health. Key informants noted the high rates of mental health and lack of appropriate available care in the community. One participant explained:

"Isolation is still there, even in a city of over 8 million people…isolation, lack of feelings of belonging, and lack of community have been challenges that all impact mental health and well-being"

Community Safety and Violence. Both key informants highlighted concerns about violence and safety within the community. Participants also emphasized the link between community violence and elevated rates of mental health issues and substance use disorders.

Other Themes. Key informants revealed additional themes, including community trust in the healthcare system, carriers to care for immigrants who may avoid services due to fear related to immigration status, and the impacts of racism. These factors affect access to high-quality care, whether through intentional delays or inadequate treatment, and are compounded by low health literacy across the area. Despite these challenges, one key informant noted:

"I think it's really important that as we [OBH] continue this work, we continue to challenge ourselves in how we are partnering with the community and how the community has an active voice, not only in sharing grievances but also understanding hospital operations."

Focus Groups

To better understand the challenges residents in OBH's service area face, six focus groups were conducted. Focus groups were conducted during the week of November 10, 2025. The focus groups were conducted to gather community perspectives on needs and on satisfaction with existing services. Participants were recruited through direct outreach to key segments of the community, including Bishop Walker's adult patients who frequently utilize the facility, elder faith-based community members (Janes United Methodist Church, located in Bedford Stuyvesant), Parent-Teacher Association members (MS935, a school located in district 19 – East New York), Women from East and Central Brooklyn aged 25 - 36 and Men aged 18+ from East and Central Brooklyn or surrounding neighborhoods. This allowed for a diverse representation of experiences, priorities, and insights from people who live and engage within the communities served by OBH.

Key themes from focus groups conducted included:

Healthcare Access. Every group raised concerns about the difficulty of accessing care, including lack of awareness of OBH services and programs, long wait times to be seen in clinic and hospital, rising cost of care, lack of sufficient healthcare coverage, language barriers, and transportation barriers. Focus group participants noted:

"Many people face challenges accessing health care due to high costs, lack of insurance, language barriers and fear of seeking services, especially among everyone or low-income families. These barriers can lead to untreated illnesses and greater health risks in the community."

"Most people don't have insurance or they are underinsured…co-pays with high deductibles makes it very difficult for people to go to the clinic because they know they will be sent a co-insurance or something to pay after their visit."

"A lot of times you get a 9:00 AM appointment and you don't get seen until 2:00 PM. Because of so many appointments they have made in one day."

"Sometimes people get fed up waiting and when they give them the next appointment they don't bother to go."

"Communicate…health information to people…for example, one of my specialists…encouraged us to sign up for a newsletter and there are interesting facts that come to my e-mail...it can [also] be pushed out through social media."

Mental Health. Focus groups noted the growing need for mental health services—especially for youth and the unhoused—and the role it plays in community violence and self-harm. Mental health is exacerbated by social isolation and loneliness. Focus group participants noted:

"I feel like some of the pressing health issues in my younger generation is that many youth…are being diagnosed with behavioral health problems."

"We've had students who have gone to hospitals with mental health issues…and then there's no follow-up. There's no follow-through. They're sent back to school without…[a] guidance counselor or social worker to help support."

"I feel like after COVID, there's been a huge spike [in mental health]."

Violence. Focus groups participants noted personal incidents of violence in the community and a need to feel safer. This was closely tied to the need to address the growing mental health crisis. Focus group participants noted:

"My main concern [is] about walking the street sometime after a certain time."

"Sometimes I have people walking up on me asking for dollars…I'll say no and I'm getting verbally abused…when you have patients such as me…on walkers and in wheelchairs, we should have priority to be able to get in and out [of the hospital or clinic] without having to run in through that type of situation."

Access to Healthy and Affordable Food. Access to convenient, local, and affordable healthy food is a significant challenge in the community. The high cost of nutritious options, combined with the

widespread availability of fast food, makes maintaining a healthy diet difficult. Focus group participants noted:

"There's a lot of fast food around and very few amounts of…health food stores or there are bodegas that sell healthy foods, but they're pricey."

"Undocumented students and their families frequently struggle with limited access to health care, housing, and financial aid, as well as fear of sharing personal information to truly support every student."

"Diet also ties into hypertension and also diabetes."

Chronic Diseases. There is a need for a greater focus on prevention, health, and wellness over treatment of symptoms. Lack of healthy, affordable food options and insufficient access to care contribute to the growing need to address chronic diseases like hypertension, diabetes, and obesity. Focus group participants noted:

"Sometimes when programs come to the community, they come…for that one time only. But if there could be some kind of consistent access to a wellness and wholeness for the community…people won't just see health care as something I just go get when I'm sick, but…a holistic way in which…lives could be changed."

"When we go to a doctor, they treat mostly our symptoms. Unless we're our own best advocates. They treat our symptoms…They don't share with us the things that they want us to do to get off the treadmill we're on."

"High blood pressure, obesity, diabetes…these are things, again, because of our busy lifestyles that maybe we are more prone to eating fast food because it's right there, it's accessible, it's cheap, it's quick."

Affordable Housing. Gentrification impacts displacement and access to affordable housing, particularly for the elderly residents of gentrifying neighborhoods, individuals with mental health conditions, and differently abled people. Focus group participants noted:

"Even our own communities, they're out pricing us because they are zhuzhing up their markets and whatnot for the newer generation coming in. And those of us who are older, still living in the community, are being priced out."

"I've been trying to get housing for years now."

Trust. Communication and trust emerged as critical barriers to healthcare access. Cultural barriers and historical mistrust of the healthcare system impact doctor-patient communication and willingness to attend wellness/preventative health visits. One focus group participant noted:

> *"It's a historic mistrust with the healthcare system…Black communities have always experienced discrimination and ethical medical practices when it comes to the healthcare and so that much stress has been passed down."*

HECAB

OBH also convened a session of its HECAB on November 18, 2025, to compile input from the community members on the CHNA and inform the selected priorities.

Key themes from the session conducted included:

Need for a communication strategy. OBH needs to develop a multimodal communication strategy to share information on OBH services, programs, and priorities. It must also more clearly communicate the integration of Kingsbrook, Interfaith, and Brookdale under OBH through consistent signage and branding. The strategy should account for the different ways people intake information and may include brochures, presentations to community boards, newsletters, social media, texts, emails, and more. And it should be bidirectional—the community needs to feel heard.

Statements of Community District Needs. Community boards develop Statements of Community District Needs that list important issues related to healthcare. These are a critical input to any prioritization of community needs.

Priorities. Priorities emerging from the session include mental health, assistance with basic needs (with a focus on food), and chronic diseases (with a focus on obesity).

VI. Priority Community Health Needs

Community health needs were developed based on:

- High prevalence or incidence of health issues (e.g., rates exceeding regional averages)
- Community-identified priorities gathered through the GNYHA survey, key informant interviews, focus groups, and HECAB session
- OBH's service profile

Health needs that appear in both primary and secondary data will form the final list of Identified Community Health Needs.

The IRS mandates hospitals to list the needs generated from this assessment in priority order. The criteria below guided the prioritization of the Identified Community Health Needs:

- Alignment with state and local priorities (e.g., Prevention Agenda 2025-2030, HealthyNYC, Statements of Community District Needs)
- Alignment with OBH's strategic plan, services, and capabilities
- Community scores and ranking
- Ability to drive measurable change and population health impact at scale

Using these criteria, the OBH community confirmed the final prioritized list of community health needs presented below:

Table 8.

Domain	Priority	Goal	Objective
Economic Stability	Nutrition Security	Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods.	Increase consistent household food security from 71.1% to 75.9%
			Increase food security in households with an annual total income of less than $25,000 from 42.0% to 51.1%
Social and Community Context	Anxiety and Stress	Increase the proportion of people living in New York who show resilience to challenges and stress.	Decrease the percentage of adults who experience frequent mental distress from 13.4% to 12.0%
			Decrease the percentage of adults in households with an annual income of less than $25,000 who experience frequent mental distress from 21.0% to 18.9%.
Health Care Access and Quality	Preventive Services for Chronic Disease Prevention and Control	Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases. • *With a focus on hypertension*	Increase the percentage of adults aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%

VII. Community Assets

The OBH service area offers a broad range of community resources, and OBH actively partners with local organizations to advance initiatives that improve care across Central and Eastern Brooklyn. These collaborations strengthen OBH's ability to address diverse and specific community needs. Examples of OBH's key community programs and partnerships related to the final list of prioritized community health needs include:

Table 9. Community Assets in the OBH Service Area

Domain	Priorities	OBH Programs/Services
Economic Stability	Assistance with Basic Needs (Food, Shelter, Clothing)	• SDH screening and referrals - FindHelp and other community-based programs • Partnerships with home meal delivery services • Food Justice program • Community Pantry (food distributions to the community) • Bed-Stuy restoration cooperation for personal financial health - financial counselling program, legal services
Social and Community Context	Stress (Chronic) - Preventive Services for Chronic Disease Prevention and Control	• Collaborative care program (anxiety and depression management) • East Flatbush Community Partnership (patient referrals for breast health and diabetes education)
Health care Access and Quality	Chronic Diseases (e.g., High Blood pressure, Diabetes, Heart Disease) - Preventive Services for Chronic Disease Prevention and Control	• Chronic disease self-management programs (living healthy with chronic conditions and living healthy with diabetes) • Center for Diabetes Excellence (Kingsbrook) • Remote patient monitoring for patients with uncontrolled diabetes and hypertension, obesity and cardiovascular diseases • Medication management clinics • Nutritional services

Examples of OBH's key community programs and partnerships related to other community health needs include:

Domain	Priorities	OBH Programs/Services
Neighborhood and Built Environment	Violence (Including Gun Violence) - Injuries and Violence	• VITAL - Violence Intervention through Advocacy and Leadership Program • It Starts Here (anti-gun violence program, provides children with counselling and job training)

Domain	Priorities	OBH Programs/Services
Economic Stability	Affordable Housing & Homelessness Prevention - Housing Stability and Affordability	• Bed-Stuy personal financial help center • CAMBA • Riseboro senior services • Building affordable housing across campuses through VITAL Brooklyn
Social and Community Context	Mental Health Disorders (e.g., Depression) – Depression	• Collab care program in partnership with OMH, inpatient and outpatient behavioral health programs (Comprehensive Mental Health, Chemical Dependence Outpatient Services, Intensive Outpatient Program)
	Substance Use Disorder/Addiction (Including Alcohol Use Disorder) - Primary Prevention, Substance Misuse, and Overdose Prevention	• Methadone maintenance and treatment program • Buprenorphine treatment program Chemical dependency outpatient program (alcohol and substance abuse
Health Care Access and Quality	Chronic Diseases (e.g., High Blood pressure, Diabetes, Heart Disease) - Preventive Services for Chronic Disease Prevention and Control	• Chronic disease self-management programs (living healthy with chronic conditions and living healthy with diabetes) • Center for Diabetes Excellence (Kingsbrook) • Remote patient monitoring for patients with uncontrolled diabetes and hypertension, obesity and cardiovascular diseases • Medication management clinics • Nutritional services
	Obesity in Children & Adults - Preventive Services for Chronic Disease Prevention and Control	• Nutritional services • Chronic disease management • Remote patient monitoring
	Cancer - Preventive Services for Chronic Disease Prevention and Control	• Prevention and screening services for cancer (mammograms, cervical cancer screening, prostate cancer screening, colorectal screening, including colonoscopies)

Domain	Priorities	OBH Programs/Services
	Women's and Maternal Health Care - Prevention of Infant and Maternal Mortality	• HealthySteps, HealthyFamilies, and Centering Pregnancy (prenatal and postpartum care)

VIII. Impact Statement

IMPACT STATEMENT - OBH 2022 – 2024 CHNA (Prioritized Health Needs)

The data provided is based on OBH performance on HEDIS measures and internal reports of department and program leads for the priorities selected for the Community Service Plan for the period 2022-2024.

Goal: Prevent Chronic Diseases

Impact

In December 2023, the Bishop Walker Health Care Center of OBH partnered with the NYC DOHMH, Bureau of Brooklyn Neighborhood Health Center for Health Equity and Community Wellness to provide/include community residents in our **Chronic Disease Self-Management and Diabetes Self-Management programs.** As of December 2024, 359 community residents and patients participated in the program. Bishop Walker was recognized by the DOHMH as a Chronic Disease Champion in October 2024.

The Remote Patient Monitoring Program

The Remote Patient Monitoring Program began in mid-October 2023. The program, led by our health coaches and community health workers, in collaboration with our Primary Care Providers and Specialists, focuses on bringing patients with poor glycemic control and uncontrolled hypertension into compliance, monitoring oxygen saturation for patients with lung diseases and monitoring weights for patients living with heart failure and obesity. The program provides at-home self-monitoring devices that include scales, glucometers, Brownsville Partnership (BP) monitoring devices, and pulse oximeters. As of December 2024, over 100 patients were enrolled in the Remote Patient Monitoring program enabling the program to bring patients into compliance and to close care gaps.

Preventative Care and Screening

In December 2024, **the United Way of New York City's Health Equity Unit**, awarded Bishop Walker with a multiple year grant to provide preventative care screenings, vaccinations, behavioral and SDH screenings, in communities across the borough of Brooklyn. Patients without primary care providers were referred to OBH primary care providers to establish care and to specialty care providers, as necessary. In 2024, twenty-six (26) preventative care screening events were held at faith-based institutions, community-based organizations, food pantries, and other community-based locations.

Helping You

One Brooklyn Health entered into a partnership with Healthfirst to offer the Helping You Program to Healthfirst members served by One Brooklyn Health. The Helping You Program was developed to support primary care practices in their efforts to advance access, equity, quality, and clinical goals by

building stronger relationships across the practices, social service organizations, and clinical systems that jointly serve Healthfirst members. The Healthfirst Helping You Program is a highly structured and standardized set of initiatives aimed to:

- Connect members with a trusted primary care physician and healthcare services
- Offer Healthfirst members screening for potential barriers to care and optimal health, and to facilitate access to community-based services to mitigate those barriers
- Support members' self-management skills and knowledge expansion. To achieve these goals, the Helping You Program offers navigation, coaching and self-management support services tailored to members' needs and preferences.

Through the Helping You Program, multiple patients have been enrolled in the program since 2023. OBH will expand this program in 2026 to all ambulatory sites.

Table 10. Helping You Program Key Metrics, 2022 - 2024

Measures	LOB	Location	2022			2023			2024		
			NUM	DEN	RATE	NUM	DEN	RATE	NUM	DEN	RATE
Controlling High Blood	PHSP	IMC	85	134	63%	142	212	67%			
	PHSP	BHMC	676	1153	59%	778	1077	72%			
	PHSP	OBH	*Combined in the 2024 Measurement Year*						1015	1226	83%
	MCR	IMC	67	125	54%	117	185	63%			
	MCR	BHMC	521	812	64%	622	825	75%			
	MCR	OBH							1070	1204	89%
Diabetes Care: HbA1c in	PHSP	IMC	61	88	69%	104	149	70%			
	PHSP	BHMC	661	863	77%	649	835	78%			
	MCR	IMC	48	59	81%	55	88	63%			
	MCR	BHMC	354	411	86%	364	431	84%			
Glycemic Status	PHSP	OBH							799	1021	78%
	MCR	OBH							558	657	84%
Medication Adherence for	MCR	IMC	163	214	76%	192	223	86.1%			
	MCR	BHMC	960	1066	90%	1002	1105	90.7%			
	MCR	OBH							1399	1556	90.0%
Medication Adherence for	MCR	IMC	140	176	80%	149	168	88.7%			
	MCR	BHMC	830	913	91%	865	950	91.1%			
	MCR	OBH							1186	1321	90.0%
Medication Adherence for Oral Diabetes	MCR	IMC	59	81	73%	63	83	81.9%			
	MCR	BHMC	444	488	91%	491	541	90.8%			
	MCR	OBH							698	795	88.0%
HIV Viral Load Suppression	PHSP	OBH							n/a	n/a	74%

The Diabetes Center of Excellence

The five operating principles of the Diabetes Center of Excellence:

- **Exquisite access to care:** daily weekends, evenings, telemedicine, and timely guidance through the epic portal
- Peer-led Self-management Education: empowering patients
- **Advancing Diabetes Technology:** broadening access to continuous glucose monitors (CGM) and insulin pump technology

- **Continuous Team Improvement:** integrated team-based care by endocrinologists, NPs, RNs, CDEs, PharmD, health coaches, dietitians, social services.
- **Commitment to learning (and humility):** grounded in scientific evidence, clinical rigor, and intellectual humility.

Figure 16. Diabetes Center of Excellence Performance Highlights

Access and Timeliness

- 3,526 total visits, compared to 2,860 visits through Q3 2024 — a **+23.3% year-over-year increase.**
- Unique patients diabetes registry 3rd QTR-598 (compared to 473 Q3-24* (**26% Increase)**
- **81% of NEW patients seen within 30 days** compared to 78% in 2024, and 58% in 2023

Patient-Centered Care

- **Likelihood of Recommending Practice to others: 94.93%** (33nd percentile nationally-PressGaney June 2025)
- Clinical Portal Messaging answered within 2 days YTD= **99.6%** **(2316/2325 year to date)- High Reliability Measure**

Efficiency

- Clinical messaging via MyOneBrooklyn has increased to **~12 messages/day** compared to 8 messages a day in 2024.

Safety:

- **One level 3 hypoglycemia** for insulin pump patients due **to food insecurity (see patient story)**

Equity

- Continuous glucose monitoring increased to 763 active patients- 2024 → 2025: **+201 patients (+27%)**
- Automated Insulin Delivery System pumps unique patients with visits 3rd QTR 2025-**71** compared to 46 in 3rd QTR 2024 (54% more unique patients in Q3 2025 (71) than in Q3 2024 (46))
- **55 patients** high risk added for Health Coaching initiative
- 478 patients completed DSME full 6 week course program to date (36 completed the class through 2nd QTR 2025)

Effectiveness

- Of 745 patient on CGM, those with A1c > 9% dropped from **63% to 26%**
- A1c closed loop automated insulin pumps decreased from **10.7% to 7.5% (n=75)**
- For DSME class participants, **reduction in A1c =0.8%,** and improvement in depression, healthy behaviors and medication adherence

Figure 17. Unique Patients with Diabetes Seen Q1 2022 - Q3 2025 (15 Consecutive Quarters of Growth in Unique Diabetes Registry Patients)

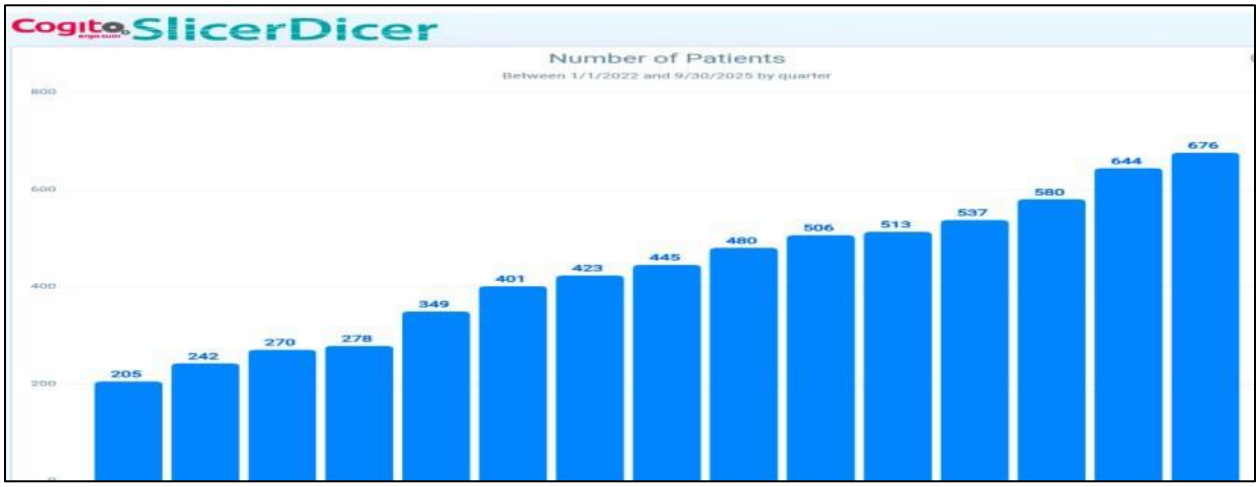


Figure 18. Visits with ICD 10.Z96.41 (Presence of Insulin Pump), Oct 2021 - June 2025 (Quarter-to-Quarter, Saw 54% More Unique Patients in Q3 2025 (71) than in Q3 2024 (46) on Automated Insulin Delivery Systems)

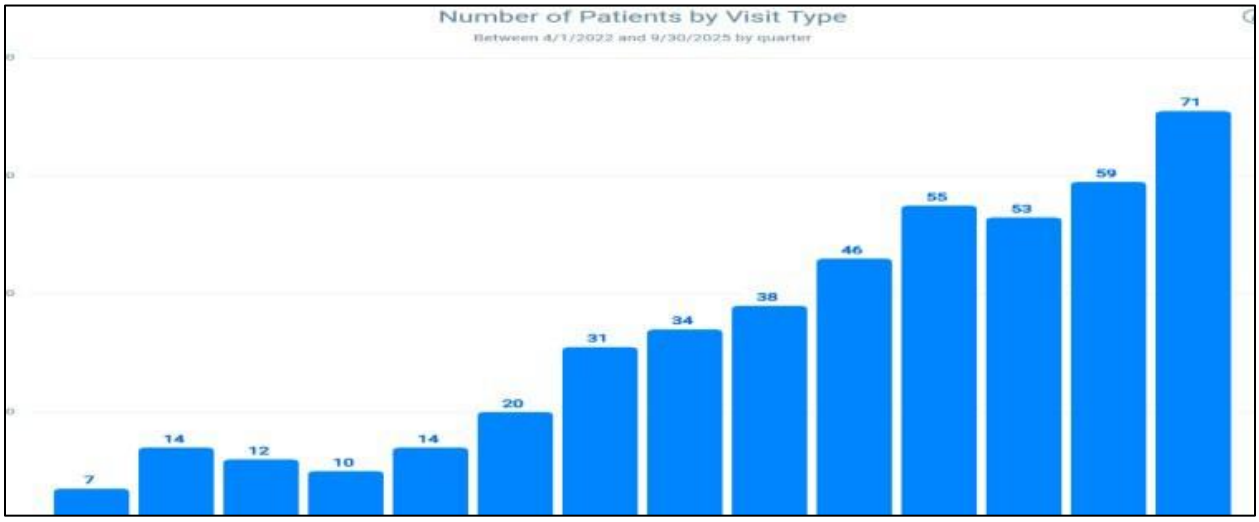


Figure 19. Effect on A1c of Initiating Automated Insulin Delivery System (Key to Success: Superb and Accessible Nursing Care)

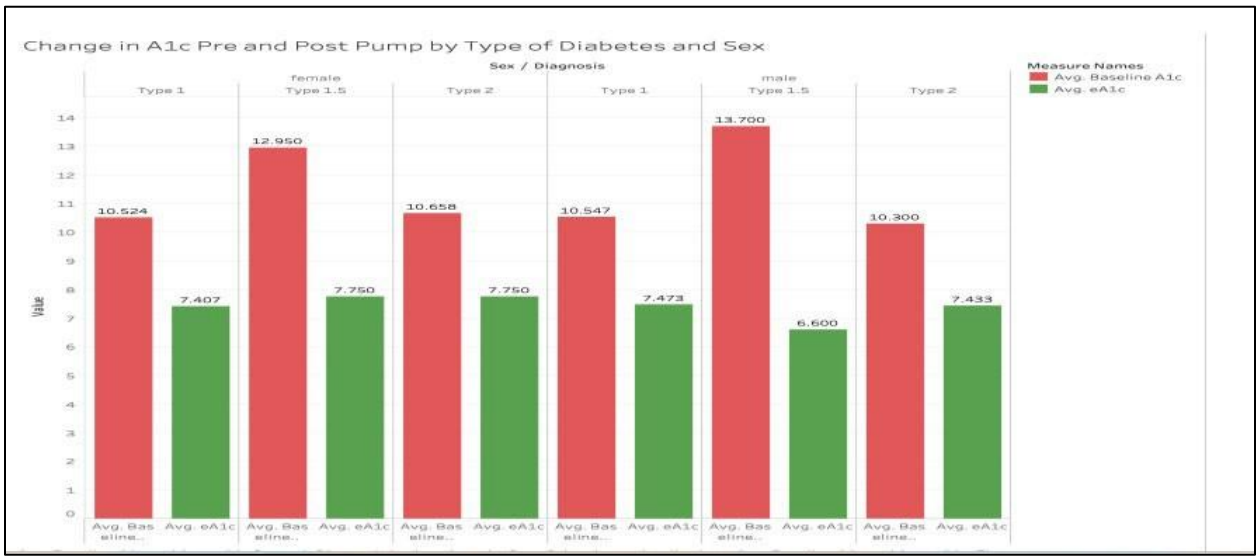


Figure 20. A1c Improvement for Participants in the DSME Peer Led Class (Overall Mean ΔA1c: −0.80 % ($p = 5.7 \times 10^{-5}$); Interpretation: Highly Significant A1c Improvement Overall)

A1c by Age Group

Age Group	Mean ΔA1c	Median	n
<50	−1.55	−1.55	6
50–59	−1.49	−1.40	15
60–69	−0.67	−0.55	32
70–79	−0.59	−0.50	29
80+	0.00	0.05	6

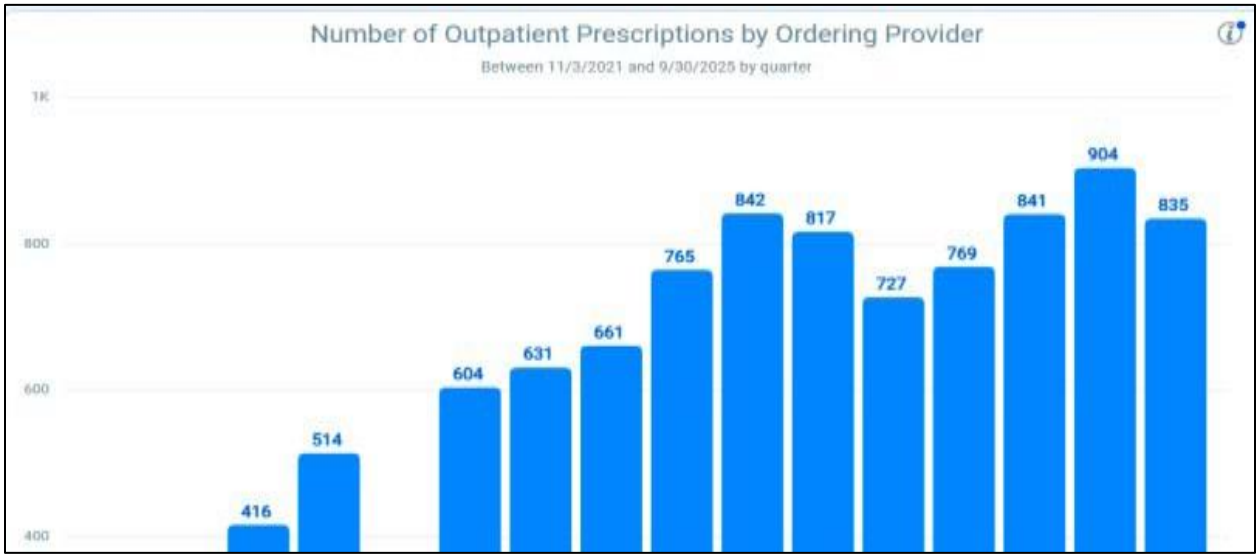
- The mean reduction (~−1.23%) **exceeds** the typical 0.45–0.57% seen in broader DSMES programs
- Roughly **7 in 10** patients at PTC improved their A1c after participation.
- With ~70% of participants improving (vs ~59% benchmark), the program appears to be **performing above national average**, especially given the older-age cohort.

In a specific case study of a patient with Type 1 Diabetes since the age of one years old, with a medical history of multiple episodes of severe hypoglycemia requiring 911 calls and ED visits, retinal scarring (poor vision). The patient had a social history of homelessness and lived in a shelter, placing this patient on an insulin pump and CGM, resulting in the following outcomes:

Context: Improvements occurred despite substantial SDOH (food insecurity, homelessness)

- Patient safety: Fewer acute events; CGM alerts + pump automation reduce hypo/hyper excursions
- Costs/Utilization: Avoided ED use and shift to outpatient care → lower total cost of care. In this high-risk patient, CGM then pump corresponded with a ~89% drop in
- ED use, supporting continued diabetes technology and ambulatory endocrine follow up

Figure 21. Growth of CGM across OBH System: All Clinics 2021 - 2025 (Transition from Hypergrowth to High-Volume, ~9% Year-Over-Year Growth)



Goal: Promote Well-Being And Prevent Mental And Substance Abuse Disorders

Impact

The following provides a graphic summary of the impact of our mental health programs including the treatment and management of our patients living with substance use disorders and screenings completed for depression and anxiety to identify patients living with depression and/or anxiety.

The Buprenorphine Treatment Program

Table 11. Buprenorphine Treatment Program Patients and Visits, 2022 - 2024

Buprenorphine Treatment Program		
Year	**Number of patients**	**Total combined visits**
2022	15	73
2023	20	86
2024	22	94

Healthcare Effectiveness Data and Information Set (HEDIS) Measures

Table 12. HEDIS Measure Performance, Depression Screening and Follow-Up, 2022 -2024

Measures	LOB	Location	2022			2023			2024		
			NUM	DEN	RATE	NUM	DEN	RATE	NUM	DEN	RATE
Depression Screening and Follow-Up	PHSP	IMC	n/a	n/a	n/a	18	721	2%			
	PHSP	BHMC	n/a	n/a	n/a	2263	5340	42%			
	PHSP	OBH	*TINs Combined in the 2024 Measurement Year*						3805	7378	52%

Goal: Promote A Healthy and Safe Environment

Impact

BP and United Healthcare (UHC) began a relationship in November 2022 to demonstrate the health impact of Community Action for Health Homes (CAHH). This was a bold approach to addressing the

complex intersection of disparities in housing, individual health, and population health by pioneering the adaptation of an internationally recognized health improvement project. Through our collaboration, we connected with various health providers and brought meaningful improvements to the lives of nearly two hundred individuals living in a low-income, predominantly Black community where residents have advocated for better conditions in their homes and equitable health outcomes for decades. Based on our first 60 homes we know that at least 30% of heads of households reported asthma-related ER visits in 6 months prior to their home being surveyed and 20% reported a trip or fall at home that required medical attention. These are just two indicators of how prevalent home-related illness and injuries are in the community, which are considerably more effective to prevent than treat. While we await UHC's analysis of the health impact of this project to date, we know based on UHC's online member resources that a single preventable ER visit would nearly cover the cost of a CAHH home repair during this phase of the project, not to mention relieving the burdens that come from not being able to safely shower, cook, or use the bathroom at home. Moreover, we are at the precipice of demonstrating a home improvement intervention to be integrated within a Medicaid 1115 waiver, which will create a sustainable, scalable model for preventive health. CAHH has:

- Surveyed 60 UHC member homes and surveyed 108 homes overall during this phase of the CAHH projects, 43 homes were referred by One Brooklyn Health
- Of the 43 homes referrals came from Kingsbrook (7) and Brookdale (36)
- 4 non UHC homes were recruited and surveyed from tabling at Brookdale Family Care Center (BFCC)- Bristol site
- Educated over 150 patients on Healthy Living Principles through tabling efforts at BFCC-Bristol site.
- Program wide- made 329 improvements preventing common causes for emergency and long-term health care in those homes benefiting 189 individuals.
- Program wide- Achieved a positive experience rating from 97% of homes involved.
- Through June 2024, BP completed surveys in 60 UHC member homes. The average family size was three individuals per home with approximately 60% of units surveyed being a part of a building with six or more units. In addition, 75% of homes reported being minority led households with the majority being female led. The average cost of home repairs was $2,320 with a range of $650 - $3,410. The most common list of repairs included:
    - Entrance door lock & lights
    - Bathroom door locks
    - Broken toilets
    - Drainage for bathroom sink and shower
    - Window access
    - Adding Bathtub rail
    - Electrical outlets & light fixtures
    - Mold remediation

<u>Goal: Promote Healthy Women, Infants, And Children</u>

Impact

The goal of the Maternal and Child Health Initiative at One Brooklyn Health is to enhance the fidelity of three evidence-based models to reach at least 250 families through Healthy Families, 600 families

through Healthy Steps and at least 117 women through Centering Pregnancy and to position the programs to serve more mothers and children throughout the One Brooklyn network.

During the period from July 1, 2024, through April 30, 2025, 92 patients were actively enrolled in Centering Pregnancy and 44 of these patients gave birth. Of the 44 patients who gave birth, 11 (25%) were C-Section births, 2 (5%) were C-Section births, 2 (5%) were preterm births, and 3 (7%) were LBW.

During this reporting period, 95% of Centering patients who gave birth, completed at least 6 of 10 prenatal visits and (86%) completed their postpartum visits. The Centering Coordinator continues to work in partnership with the Centering Midwives and Medical Office Assistants, to support families in navigating around barriers to care such as transportation and childcare to improve attendance and participation in Centering Pregnancy Groups. The Centering Coordinator uses anticipatory guidance by reaching out to patients prior to appointments to increase attendance. Childcare continues to be a challenge. Centering providers offer flexibility as much as possible to accommodate patients with young children. The coordinator also reaches out to patients after appointments to ensure patients follow up with prescriptions, lab work, and simply to provide a wellness check.

Healthy Families

Over the 12-month period, May 1, 2024 to April 30, 2025, Healthy Families served 233 families. During the period beginning July 1, 2024 – April 30, 2025. Sixty-four (64) new families were enrolled; 73 families were discharged and 23% successfully completed the program. The program received 232 new referrals during this 10-month reporting period, 185 continued to screening, 37 (16%) were closed at referral, and the outcome is still pending for 10 (4%). Of all referrals closed prior to screening, 39% terminated due to the family residing out of the target area, 18% target children aged out, 10% refused home visiting services, and 18% could not be contacted and 1% were transferred to another program.

Of the 232 new referrals received during this period, 88 (38%) of the referrals were made by the Brookdale staff. The greatest number of Brookdale referrals are made by Centering Pregnancy and the NICU staff.

HealthySteps

From July 1, 2024 through April 30, 2025, HealthySteps made a total of 1230 encounters for 606 patients aged 0 – 5 years old at the Brookdale Family Care Centers (BFCC) Eastern Parkway, New Lots and Linden. This includes 14 newly enrolled Tier 3 patients during the reporting period.

Of the 606 HealthySteps patients, New Lots served 271 patients, Eastern Parkway served 216 patients, and Linden served 119 patients. During this reporting period, one physician at BFCC Linden retired thus reducing our expected patient volumes

Table 13. Maternal and Child Health Initiative Key Metrics, July 2024 - April 2025

Key Metrics	One Brooklyn Health	Centering Pregnancy	Healthy Families	HealthySteps
# Births	501	47	52	
# 0-5 patients	1406		220	915
C-Section rate	36%	25%		
# LBW	13%	7%	10%	

Exclusive Breastfeeding	5%		Any at 3 months (61%)	
Maternal Depression Screening/ Connection	*In progress to retrieve data*		67 screened/ 25 connected	222 screened/ 6 connected
% Prenatal Visits Kept	70%	89%		
% Post-partum Visits Kept	58%	86%	73%	
Referrals for Social Needs	*In progress*		574	112
0-5 Immunization Rates			95%	
EI Referrals			14	68

Comparison of maternal and child health outcomes across the system and programs indicate that patients who are participating in our evidence-based programs are at an advantage. C-Section rates for Centering patients are 11% lower than for all OBH birthing patients. Low birth weight outcomes are also lower for Centering Patients and Healthy Families participants (6% and 3% respectively) than they are for all OBH birthing patients. In fact, the LBW for Healthy Families participants enrolled postnatally was 28%, highlighting the impact of prenatal enrollment. Prenatal visits are being kept at a rate of 19% higher, and postpartum visits 28% higher for Centering patients than for OBH birthing patients. Healthy Families participants are also keeping postpartum visits at a rate of 15% higher than all OBH birthing patients. Healthy Families and HealthySteps participants are receiving referrals and connections for maternal depression and social needs, as well as Early Intervention referrals.

<u>Goal: Prevent Communicable Diseases</u>

Impact

The following data reflect the impact of our infectious disease program on the increase in testing of communicable diseases:

Table 14. STI Testing and Detection, 2022-2024

STI TESTING (2022 – 2024)								
2024- CHLAMYDIA, GONORRHEA, TRICHOMONAS, HUMAN IMMUNODEFICIENCY VIRUS (HIV)								
Year	**BHMC**		**IMC**		**KJMC**		**Total**	
	Patient tested, n=	**Patient positive, n=**	**Patient tested, n=**	**Patient positive, n=**	**Patient tested, n=**	**Patient positive, n=**	**Patient tested, n=**	**Patient positive, n=**
Chlamydia	**2792**	**163**	**2212**	**85**	**264**	**8**	**5268**	**256**
Gonorrhea	**2791**	**152**	**2208**	**69**	**264**	**3**	**5263**	**224**
Trichomonas	**302**	**40**	**475**	**51**	**81**	**3**	**858**	**94**
HIV	**1583**	**999**	**845**	**683**	**3**	**2**	**2431**	**1684**
Total	**7468**	**1354**	**5740**	**888**	**612**	**16**	**13820**	**2258**
2023- CHLAMYDIA, GONORRHEA, TRICHOMONAS								
Chlamydia	**3408**	**233**	**2101**	**91**	**935**	**135**	**6444**	**459**
Gonorrhea	**3406**	**127**	**2085**	**83**	**935**	**33**	**6426**	**243**
Trichomonas	**199**	**22**	**375**	**36**	**116**	**7**	**690**	**65**
Total	**7013**	**382**	**4561**	**210**	**1986**	**175**	**13560**	**767**
2022- SYPHILIS, CHLAMYDIA, GONORRHEA, TRICHOMONAS, HUMAN PAPILLOMAVIRUS (HPV)								
Chlamydia	**3081**	**211**	**2293**	**132**	**880**	**45**	**6254**	**388**
Gonorrhea	**2917**	**147**	**2071**	**103**	**872**	**40**	**5860**	**290**
Trichomonas	**159**	**12**	**267**	**25**	**72**	**8**	**498**	**45**
HPV	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**0**
Total	**6158**	**370**	**4631**	**260**	**1824**	**93**	**12613**	**723**

Table 15. Monkeypox Testing and Detection, 2022-2025

MONKEYPOX (ORTHOPOXVIRUS), DNA, PCR (2022 – 2025)								
Year	**BHMC**		**IMC**		**KJMC**		**Total**	
	Patient tested, n=	Patient positive, n=	Patient tested, n=	Patient positive, n=	Patient tested, n=	Patient positive, n=	Patient tested, n=	Patient positive, n=
2025	4	2	2	0	0	0	**6**	**2**
2024	3	0	2	0	0	0	**5**	**0**
2023	6	1	4	0	3	0	**13**	**1**
2022	73	18	45	12	16	5	**134**	**35**
Total	**86**	**21**	**53**	**12**	**19**	**5**	**158**	**38**

Table 16. COVID-19 Testing and Detection, 2022-2024

COVID (2022 – 2024)								
Year	BHMC		IMC		KJMC		Total	
	Patient tested, n=	Patient positive, n=	Patient tested, n=	Patient positive, n=	Patient tested, n=	Patient positive, n=	Patient tested, n=	Patient positive, n=
2024	16856	954	8113	574	50	14	**25019**	**1542**
2023	32048	1333	14062	869	22790	415	**68900**	**2617**
2022	58508	3784	16449	2336	39594	1174	**114551**	**7294**
Total	**107412**	**6071**	**38624**	**3779**	**62434**	**1603**	**208470**	**11453**

Table 17. Influenza Testing and Detection, 2022-2024

INFLUENZA (2022 – 2024)								
Year	BHMC		IMC		KJMC		Total	
	Patient tested, n=	Patient positive, n=	Patient tested, n=	Patient positive, n=	Patient tested, n=	Patient positive, n=	Patient tested, n=	Patient positive, n=
2024	12290	1065	6434	540	29	0	**18753**	**1605**
2023	13424	587	8732	379	17411	120	**26143**	**1086**
2022	11944	775	7724	394	4124	241	**23792**	**1410**
Total	**24234**	**2427**	**22890**	**1313**	**21564**	**361**	**68688**	**4101**

Table 18. Respiratory Syncytial Virus Testing and Detection, 2022-2024

RESPIRATORY SYNCYTIAL VIRUS (RSV) (2022 – 2024)								
Year	BHMC		IMC		KJMC		Total	
	Patient tested, n=	Patient positive, n=	Patient tested, n=	Patient positive, n=	Patient tested, n=	Patient positive, n=	Patient tested, n=	Patient positive, n=
2024	7075	295	932	58	29	1	**8036**	**354**
2023	4793	239	475	53	14693	78	**19961**	**370**
2022	4847	320	243	27	228	15	**5318**	**362**
Total	**16715**	**854**	**1650**	**138**	**14950**	**94**	**33315**	**1086**

IX. Community Service Plan (CSP) 2025 - 2027

A. Major Community Health Needs

Based on the results of the CHNA, One Brooklyn Health (OBH) has decided to address the following three (3) priorities through the use of evidence-based interventions:

1. Nutrition Security
2. Anxiety and Stress
3. Preventative Services for Chronic Disease Prevention and Control

B. Prioritization Methods

The prioritization process involved a structured multi-step approach grounded in evidence, community voices and organizational resources, and capacity. The process was a collaborative effort led by OBH and the Health Equity Community Advisory Board (HECAB), which met monthly and played a central role in decision-making. The process included a series of meetings that were centered on:

(1) Prevention Agenda 2025 – 2030 Briefing

- Prior to beginning the prioritization process, a representative from the Greater New York Hospital Association (GNYHA) was invited to provide an overview of the New York State 2025 – 2030 Prevention Agenda to members who had an essential background context to make informed decisions that aligned with the stated guidance and goals.

(2) Preliminary Prioritization

- From the CHNA surveys administered in the community, twenty-seven (27) distinct health needs were identified based on participants' ranking of priority concerns and levels of satisfaction. These findings were presented to the HECAB for review.
- Through a facilitated session, the HECAB then selected the top ten (10) priorities using three key lenses: feasibility & resources, equity & community impact, and strategic partnerships.

(3) Final Prioritization:

- OBH leadership presented the organization’s mission, vision, and strategic pillars to provide the HECAB with an understanding of the organization’s long-term goals and values.
- A presentation was also given on the neighborhood profiles served by OBH, along with qualitative insights from focus groups and key informant interviews. The top ten (10) priorities were also presented along with the supporting qualitative data, mapped to the organization’s current programs and services to identify where existing initiatives already address these needs.
- The HECAB then made consensus-based selection to finalize the top three (3) priorities from the ten (10) by thinking about overlapping priorities that appear to be driving causes of other health outcomes and alignment of the system’s strategic plan and resources.

C. Community Engagement

Community engagement was one of the key components of the CHNA development process to ensure that prioritization reflected the community's voices and to support the organization’s commitment to trust-building and collaborative efforts.

OBH continues to maintain active partnerships and year-round engagement with populations in the organization's service area, including elected officials, faith-based organizations, community advisory boards, and other established coalitions and community stakeholders.
Throughout the assessment period, community members were invited to participate in the following ways:

(1) **Surveys:** surveys served as a direct means of gathering community input and promoting community participation
(2) **HECAB Meetings:** these meetings included representatives from a wide range of diverse groups, including patients, caregivers, residents, and representatives from grassroots organizations.
(3) **Key Informant Interviews:** this involved representation within the organization and external leadership from a government agency.
(4) **Focus Groups:** multiple virtual focus groups were held to engage with and capture the voices of key groups within the service area, including adult men and women, patients, elderly church members, parent-teacher association, and mothers of children with special needs

D. Developing Objectives, Interventions, Measures, and Action Plan

Geographic Focus: Central and Northeast Brooklyn

Domain: Economic Stability

Priority: Nutrition Security					
Objective	**Intervention**	**Measure**	**Action Plan Year 1**	**Action Plan Year 2**	**Action Plan Year 3**
3.0 Increase consistent household food security from 71.1% to 75.9%	Conduct standardized screening of unmet Nutrition Security needs and provide referrals to state, local, and federal benefit programs and community-based, health-related social needs providers to address unmet needs. Including: • Emergency food programs/food pantries • Supplemental Nutrition Assistance Program (SNAP) • Women, Infants, and Children (WIC) • Medically Tailored Meals • Food Prescription Programs	Percentage of persons identified as experiencing food insecurity through screening and referred to available resources	***Screening and Referral Programs:*** Integrate food and nutrition security screening into clinical visits and provide referrals to public and community-based food assistance programs.		
3.1 Increase food security in households with an annual total income	Implement values-based food procurement practices, such as increasing food purchases from NYS farms and from minority and women-owned businesses, to create a more equitable, accountable, and transparent food system	Percentage of patients identified and enrolled in the Food as Medicine program, including the Food Box Program, and refer	***Nutrition Counseling and Education:*** Provision of Medical Nutrition Therapy (MNT) and culinary education, delivered by a RDN, to help individuals manage conditions through healthy eating habits and build healthy shopping/cooking skills.		

of less than $25,000 from 42.0% to 51.1% SMARTIE Objective	Expand Food as Medicine approaches across the lifespan, especially for populations at a higher risk of nutrition-related health disparities (e.g. medically tailored meals and groceries, produce prescription programs, etc.)	eligible participants for medically tailored meals	***Medically Tailored Meals/Groceries (MTMs):*** Identification and referral of patients for home-delivery of pre-prepared meals or grocery items tailored by a registered dietitian nutritionist (RDN) to meet the specific medical and dietary needs of patients with chronic or complex conditions. **Partners:** God's Love We Deliver, Riseboro, Mom's Meals, and Healthfirst		
	Promote and expand the availability of fruit and vegetable incentive programs.		***Food Box Program:*** Increase access and affordability of fresh, locally grown produce for staff, patients, and community members to address nutrition-related chronic disease, food insecurity, and support resilient food systems through the identification of partners, suppliers, and resources for the provision of fresh produce. **Partners:** Isahbalia Farms, Skyponic Farms, and NYCDOHMH	***Food Box Program:*** Continue development of food box program expanding the reach of the program assuring availability of fresh produce to all eligible patients and community residents	**Food Box Program:** Continue development of food box program expanding the reach of the program assuring availability of fresh produce to all eligible patients and community residents and exploring other options and resources to obtain fresh produce for population served.

			Develop Hydroponics Greenhouse (Skyponics): Planning phase for the building of a Hydroponics lab on Kingsbrook Estates on the Kingsbrook Campus. The benefits of this program include: (1) **Year-Round Growing**: Creates a controlled environment that allows for consistent, year-round food production, regardless of external weather conditions or climate, which provides continuous learning opportunities and a reliable food source. (2) **Improved Nutritional Health:** Provides a	***Develop Hydroponics Greenhouse (Skyponics):*** *Building phase for the building of a Hydroponics lab on Kingsbrook Estates on the Kingsbrook Campus.*	***Hydroponics Greenhouse (Skyponics):*** Completion and opening of the Skyponics Greenhouse on the Kingsbrook Jewish Medical Center Campus

			consistent supply of fresh, nutritious produce for purchase, which can lead to healthier eating habits among students. (3) **Community Engagement:** The greenhouse provides a platform for collaboration among students, staff, and local community organizations. Surplus produce can be purchased, and shared, with the campus cafeteria, generating revenue, promoting access to healthy produce, and strengthening community ties. The space will also be used as an event space for healing and wellness		

			activities such as yoga. **Partners:** Skyponic Farms and Monadnock Construction		

**Note: Intervention strategies in the table above are sourced from the NYS Prevention Agenda.*

Domain: Social & Community Context

Priority: Anxiety & Stress					
Objective	**Intervention**	**Measure**	**Action Plan Year 1**	**Action Plan Year 2**	**Action Plan Year 3**
5.0 Decrease the percentage of adults who experience frequent mental distress from 13.4% to 12.0%	Promote awareness and use of screening through social care networks (SCNs) Promote and implement models that screen people for stress, anxiety, and their social needs. Promote resilience-building strategies for people living with chronic illness by enhancing protective factors (e.g., independence, social support, positive explanatory styles, self-care, self-esteem, reduced anxiety)	Number of anxiety/depression screenings using the validated screening tools GAD-7 and PHQ-9	***Promote and increase awareness*** of evidence-based resources available to patients and the community through OBH to reduce the negative impact of stress and trauma ***Promote awareness and identification of the presence*** of anxiety/depression and stress through screening using the Generalized Anxiety Disorder 7-item Scale (GAD-7) and the PHQ-9 to determine need for intervention (e.g., collaborative care, Center of Mental Health, or other interventions.		
5.1 Decrease the percentage of adults in households with an annual income of less than $25,000 who experience frequent mental distress from 21.0% to 18.9%.		Percentage of adults who report decreased experiences of mental distress in households with an annual income of less than $25,000	***Utilize Behavioral Health programs*** to teach patients and community anxiety and stress reduction techniques. **Partners:** OBH collaborative care program team. Comprehensive Mental Health Services Team including CDOS (Chemical Dependency Out-Patient Services) and MMTP (Methadone Maintenance and Treatment Program) and buprenorphine treatment program		

SMARTIE Objective

**Note: Intervention strategies in the table above are sourced from the NYS Prevention Agenda.*

Domain: Healthcare Access & Quality

<table>
<tr><td colspan="6">Priority: Preventative Services for Chronic Disease Prevention and Control</td></tr>
<tr><th>Objective</th><th>Intervention</th><th>Measure</th><th>Action Plan Year 1</th><th>Action Plan Year 2</th><th>Action Plan Year 3</th></tr>
<tr><td rowspan="5">32.0 Increase the percentage of adults aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%.</td><td rowspan="5">Increase the percentage of adults with hypertension who are currently taking medication to manage their high blood pressure through a six-week living healthy chronic disease self-management program -- (base on the evidence-based Self-Management Resource Center (SMRC) program or participation in a 12-week lifestyle medicine program).

Work with identified patients on reaching readiness to change and modify unhealthy behaviors.

Hypertension management (percentage of adults reporting medication use to manage their hypertension, aged 18 years and older</td><td rowspan="5">Percentage of adults reporting medication use to manage their hypertension, aged 18 years and older</td><td colspan="3">Remove barriers to care by increasing the number of patients with active insurance coverage. Increase awareness of onsite enrollers for insurance (EmblemHealth, Fidelis/Wellcare, Healthfirst, Metroplus)</td></tr>
<tr><td>Pilot Lifestyle Medicine Program: Pilot 12-week lifestyle medicine program focusing on two chronic conditions, Diabetes and Hypertension. Enroll a minimum of 80 patients in the program</td><td>Phase I – Lifestyle Medicine Program: Continue lifestyle medicine program, increasing enrollment to 160 participants.</td><td>Phase II - Lifestyle Medicine Program: Continue lifestyle medicine program increasing enrollment to 302 participants.</td></tr>
<tr><td colspan="3">Chronic Disease self-management: Six-week program (Modeled on the evidence-based Self-Management Resource Center program (SMRC) offered to patients and community residents living with Hypertension and other chronic conditions in partnership with the NYCDOHMH, the Brooklyn Neighborhood Health Center and Healthfirst (Helping You program)</td></tr>
<tr><td>Implement the ACTion Program in partnership with the NYCDOHMH, NYC REACH, the Bureau of Equitable Health Systems. CHW will</td><td colspan="2">Continue the ACTion program in partnership with the NYCDOHMH,NYC REACH, the Bureau of Equitable Health Systems. CHW will conduct outreach and engagement, and City Corp Worker will conduct SDH screenings and refer patients to services if positive screen.</td></tr>
</table>

			conduct outreach and engagement, and City Corp Worker will conduct SDH screenings and refer patients to services if positive screen.	
			Expand Care Management/Care Coordination team across the system to enhance care management and care coordination for patients living with Hypertension and other chronic conditions	***Provide Care Management/Care Coordination team*** support for patients living with Hypertension and other chronic conditions
			Work with Healthfirst to develop CAT Teams (Community Advocacy Teams) to increase community awareness of Hypertension prevention and management and the programs and services offered at OBH for the management of Hypertension.	

**Note: Intervention strategies in the table above are sourced from the Self-Management Resource Center*

E. Justification of Unaddressed Needs

While many community health needs have been identified, OBH cannot address all of them due to limited resources and the necessity to focus on areas with potential for sustainability and the greatest measurable impact. Although not all the priority needs mentioned were selected as core focus areas, OBH is committed to supporting these needs and will continue to drive actionable efforts for 7 of the 10 priorities selected by the HECAB in the initial phases of the priority selection. These include injury and violence prevention, housing stability and affordability, substance use disorder/addiction, cancer care, and maternal healthcare. For example, OBH operates a violence prevention program called Violence Intervention Through Advocacy and Leadership (VITAL) at Brookdale Hospital Medical Center. This program helps ensure that victims of violence who seek treatment are connected to necessary wraparound services that address social determinants of health. Through HECAB meetings and other marketing channels, OBH aims to raise awareness of the services and programs it offers. During focus group sessions, a common theme identified was a lack of awareness, prompting OBH to respond immediately (the day after the respective focus groups) by distributing flyers detailing available programs and services to local churches and schools to help bridge these awareness gaps. There were other concerns that were voiced by the HECAB around maternal and child health (MCH), violence, and behavioral/mental health services resulting in OBH requesting leadership personnel from the MCH, violence intervention, and behavioral/mental health departments to attend the next HECAB meeting to present the programs and services they offer.

Additionally, OBH plans to hold immunization sessions in December 2025 at the Bishop Walker Clinic for students from a middle school in District 19. This initiative aims to address access limitations. These vaccination efforts will help ensure that children do not have to remain at home due to lack of appropriate immunization, thereby facilitating their re-entry into the school year.

F. Alignment with Prevention Agenda

OBH aligns with the New York State Department of Health and the local Department of Health (DOH) by means of strategic partnerships. Through this partnership, OBH can take advantage of state resources and put into practice scalable models to lessen health disparities and build healthier communities. Our collaborative partnerships are not limited to, but also demonstrated through the following:

(1) **The "ACTion" program:** a program designed to address conditions to improve population health. The objective of this program at OBH is to reduce uncontrolled hypertension in Brownsville and East New York through clinical-community linkages.

(2) **NYC Reach Program:** as a part of the Reach network, the system is accredited to offer chronic disease self-management, including diabetes self-management

(3) **HealthyNYC and Diabetes Prevention Initiatives:** OBH recognizes the importance of Diabetes Prevention Programs (DPP) and partners with the DOH to promote referral pathways and increase enrollment of prediabetic patients through screening initiatives

G. Partner Engagement

Throughout the prevention agenda cycle, community partners, including food access partners, chronic disease management program partners, internal behavioral health providers, and the HECAB, will participate in regular monitoring and review of the intervention and its metrics, and in refinement if any gaps arise. This partnership engagement will enable collaborative problem-solving.

A dashboard will be built in the organization's Electronic Health Records (EHR) system, Epic, to monitor progress toward the selected objectives. The results from this dashboard will be presented to partners during quarterly meetings. Before these meetings, the internal project team will meet monthly to validate data.

At the mid-course point of the prevention agenda cycle, if activities are not meeting goals and a programmatic remediation is needed, corrective actions will be taken to modify strategies while staying within the prevention agenda's scope and the organization's capacity. All adjustments will be communicated to partners to promote transparency and shared accountability.

H. CHNA/CSP Dissemination Plan

The CHNA CSP will be disseminated using the following methods, whilst taking into account cultural competence, language barriers, and technology gaps:

- **Online:** OBH's CHNA and CSP 2025 – 2027 will be posted on the organization's website: **https://onebrooklynhealth.org/** where visitors to the website will be able to access, print and download the material for free. An official post will also be made on the organization's social media platforms (Instagram, LinkedIn, & Facebook) directing viewers to a comprehensive copy of the CHNA and CSP.
- **Community Dissemination:** the CHNA and CSP 2025 – 2027 will be distributed to stakeholders within the system's service area, including HECAB members, faith-based organizations, community boards, educational institutions, and focus group participants.
- **Patients and Public Access:** flyers/cards will be available across the system's hospital sites, nursing homes, and clinics that provide a summary of the CHNA and CSP and a QR code for access to the more comprehensive version of the document.
- **Internal Dissemination:** the Sr. Director of Community Health Dr. Gwendolyn Lewis will present CHNA and CSP 2025 – 2027 at key internal meetings to ensure departmental and executive awareness. The organization's chief of staff will also support leadership engagement with the materials.

For any feedback on the CHNA/CSP, OBH will provide an email and phone number for the point of contact to receive these communications. This information will be included in all materials disseminated, and feedback will be reviewed and considered in the next cycle of the CHNA/CSP process.

X. Appendix

Healthy NYC

HealthyNYC is the City's vision and campaign for healthier, longer lives. It includes goals to improve health outcomes related to the following key drivers:

- **Chronic and diet-related diseases**: Reduce heart- and diabetes-related deaths by 5% and screen-able cancer deaths by 20% by 2030.
- **Mental health**: Reduce drug overdose deaths by 25% and suicide deaths by 10% by 2030.
- **COVID-19**: Reduce deaths due to COVID-19 by 60% by 2030.
- **Homicide**: Reduce homicide deaths by 30% by 2030.
- **Maternal mortality**: Reduce material death rates by 10% by 2030.

Annual Statements of Community District Needs and Community Board Budget Requests

Each year, each of NYC's community boards prepares an official document describing their respective community district's most pressing needs and related budget requests. These documents are integral parts of the city's broader budget process, influencing decision-making on local planning and budget priorities.

Below lists the identified needs for each community district in the OBH service area and the issue ranked as most important related to healthcare and human services by the community board.

Community District 1 identified environmental health issues such as noise, respiratory illness, moisture, mildew and mold as the most important issue related to healthcare and human services in their community district. The top three pressing issues overall as identified by the community board for FY 2026 are:

- Affordable housing
- Infrastructure resiliency
- Parks and open space

Community District 2 identified services to reduce or prevent homelessness as the most important issue related to healthcare and human services in their community district. The top three pressing issues overall as identified by the community board for FY 2026 are:

- Affordable housing
- Homelessness
- Crime and public safety

Community District 3 identified services for low-income and vulnerable New Yorkers as the most important issue related to healthcare and human services in their community district. The top three pressing issues overall as identified by the community board for FY 2026 are:

- Affordable housing
- Parks and open space
- Trash removal and cleanliness

Community District 5 identified access to healthy food and lifestyle programs as the most important issue related to healthcare and human services in their community district. The top three pressing issues overall as identified by the community board for FY 2026 are:

- Social services
- Trash removal and cleanliness
- Other – access to health food

Community District 8 identified mental health and substance abuse treatment and prevention programs as the most important issue related to healthcare and human services in their community district. The top three pressing issues overall as identified by the community board for FY 2026 are:

- Affordable housing
- Other – street uses
- Parks and open space

Community District 9 identified access to healthy foods and lifestyle programs as the most important issue related to healthcare and human services in their community district. The top three pressing issues overall as identified by the community board for FY 2026 are:

- Affordable housing
- Infrastructure resiliency
- Trash removal and cleanliness

Community District 14 selected 'other' and wrote in their most important issues related to healthcare and human services. In their write-up, they identified housing as a core issue in the community. They also chose to write in their community needs. The full write-up is available here.

Community District 16 identified services for low-income and vulnerable New Yorkers as the most important issue related to healthcare and human services in their community district. The top three pressing issues overall as identified by the community board for FY 2026 are:

- Affordable housing
- Health care services
- Transit (buses & subways)

Community District 17 identified services to reduce or prevent homelessness as the most important issue related to healthcare and human services in their community district. The top three pressing issues overall as identified by the community board for FY 2026 are:

- Affordable housing
- Street conditions (roadway maintenance)
- Land use trends

Community District 18 identified programs, services or facilities for seniors (incl. remote programming, cooling centers) as the most important issue related to healthcare and human services in their community district. The top three pressing issues overall as identified by the community board for FY 2026 are:

- Infrastructure resiliency
- Parks and open space
- Street conditions (roadway maintenance)

OBH Service Area Definition

Data collected for this report focused on communities in OBH's primary and secondary service area. Table 8 lists the ZIP codes in OBH's primary and secondary service area as defined by OBH discharge data.

Table 19. One Brooklyn Health Service Area

ZIP Code	Geographic Region	Service Area
11207	Eastern Region	Primary Service Area
11208	Eastern Region	Primary Service Area
11212	Eastern Region	Primary Service Area
11213	Central Region	Primary Service Area
11216	Central Region	Primary Service Area
11233	Central Region	Primary Service Area
11203	Eastern Region	Secondary Service Area
11210	Eastern Region	Secondary Service Area
11226	Eastern Region	Secondary Service Area
11234	Eastern Region	Secondary Service Area
11236	Eastern Region	Secondary Service Area
11239	Eastern Region	Secondary Service Area
11205	Central Region	Secondary Service Area
11206	Central Region	Secondary Service Area
11221	Central Region	Secondary Service Area
11225	Central Region	Secondary Service Area
11238	Central Region	Secondary Service Area

This report utilizes data by New York City community districts. Table 9 lists the community districts that correspond to OBH's service area.

Table 20. One Brooklyn Health Community Districts

Community Districts	District Name
301	Greenpoint and Williamsburg
302	Fort Greene and Brooklyn Heights
303	Bedford Stuyvesant
305	East New York and Starrett City
308	Crown Heights and Prospect Heights
309	South Crown Heights and Lefferts Gardens
314	Flatbush and Midwood
316	Brownsville
317	East Flatbush
318	Flatlands and Canarsie

This report also incorporates data by UHF-defined neighborhoods. Table 10 lists the neighborhoods that correspond to OBH's service area.

Table 21. One Brooklyn Health UHF Neighborhoods

Neighborhood	Neighborhood
204	East New York/New Lots
203	Bedford Stuyvesant/Crown Heights
207	Flatbush
208	Canarsie and Flatlands
202	Downtown Brooklyn/Heights/Slope
211	Williamsburg/Bushwick

GNYHA Survey

Primary data was collected from the GNYHA CHNA Collaborative to inform OBH's community identified needs. The following section presents the survey questions, followed by Table 11, which summarizes the Importance and Satisfaction rankings based on the responses.

GNYHA Survey Questions

1. Are you 18 years of age or older?
    - Yes
    - No à Thank you very much, but we are only asking this survey of people who are ages 18 and older.

2. We want people from all different neighborhoods to take part in this survey. Please tell us the zip code where you live so we can identify your neighborhood.

    Zip code: _____

    IF YOU PROVIDED A ZIP CODE, PLEASE GO TO QUESTION 6. YOU DO NOT NEED TO ANSWER THESE QUESTIONS.

3. Do you live in New York City?
    - Yes
    - No à Skip to 5

4. If you live in New York City, please select the borough where you live:
    - The Bronx à Go on to page 3
    - Brooklyn à Go on to page 3
    - Manhattan à Go on to page 3
    - Queens à Go on to page 3
    - Staten Island à Go on to page 3
    - I do not live in New York City à Answer 5

5. If you do not live in New York City, please tell us the county where you live:

○ Albany County	○ Herkimer County	○ Schenectady County
○ Allegany County	○ Jefferson County	○ Schoharie County
○ Broome County	○ Lewis County	○ Schuyler County
○ Cattaraugus County	○ Livingston County	○ Seneca County
○ Cayuga County	○ Madison County	○ St. Lawrence County
○ Chautauqua County	○ Monroe County	○ Steuben County
○ Chemung County	○ Montgomery County	○ Suffolk County

- Chenango County
- Clinton County
- Columbia County
- Cortland County
- Delaware County
- Dutchess County
- Erie County
- Essex County
- Franklin County
- Fulton County
- Genesee County
- Greene County
- Hamilton County
- Nassau County
- Niagara County
- Oneida County
- Onondaga County
- Ontario County
- Orange County
- Orleans County
- Oswego County
- Otsego County
- Putnam County
- Rensselaer County
- Rockland County
- Saratoga County
- Sullivan County
- Tioga County
- Tompkins County
- Ulster County
- Warren County
- Washington County
- Wayne County
- Westchester County
- Wyoming County
- Yates County
- Other_____

Health Status

6. In general, how is the overall health of the people of your neighborhood?
   - Poor
   - Fair
   - Good
   - Very good
   - Excellent

7. In general, how is your physical health?
   - O Poor
   - O Fair
   - O Good
   - O Very good
   - O Excellent

8. In general, how is your mental health?
   - Poor
   - Fair
   - Good
   - Very good
   - Excellent

9. For each of the following, please tell us: How important is each of the following to you and how satisfied are you with the current services in your neighborhood to address each issue?

Figure 22.

	How important is this issue to you?						How satisfied are you with current services?					
	Not at all	A little	Somewhat	Very	Extremely	Don't know	Not at all	A little	Somewhat	Very	Extremely	Don't know
1 Access to continuing education and job training programs	○	○	○	○	○	○	○	○	○	○	○	○
2 Access to healthy/nutritious foods	○	○	○	○	○	○	○	○	○	○	○	○
3 Adolescent and child health	○	○	○	○	○	○	○	○	○	○	○	○
4 Affordable housing and homelessness prevention	○	○	○	○	○	○	○	○	○	○	○	○
5 Arthritis/disease of the joints	○	○	○	○	○	○	○	○	○	○	○	○
6 Assistance with basic needs like food, shelter, and clothing	○	○	○	○	○	○	○	○	○	○	○	○
7 Asthma, breathing issues, and lung disease	○	○	○	○	○	○	○	○	○	○	○	○
8 Cancer	○	○	○	○	○	○	○	○	○	○	○	○
9 Cigarette smoking/tobacco use/vaping/ e-cigarettes/hookah	○	○	○	○	○	○	○	○	○	○	○	○
10 Infectious diseases (COVID-19, flu, hepatitis)	○	○	○	○	○	○	○	○	○	○	○	○
11 Dental care	○	○	○	○	○	○	○	○	○	○	○	○
12 Diabetes and high blood sugar	○	○	○	○	○	○	○	○	○	○	○	○
13 Heart disease	○	○	○	○	○	○	○	○	○	○	○	○
14 Hepatitis C/liver disease	○	○	○	○	○	○	○	○	○	○	○	○
15 High blood pressure	○	○	○	○	○	○	○	○	○	○	○	○
16 HIV/AIDS (Acquired Immune Deficiency Syndrome)	○	○	○	○	○	○	○	○	○	○	○	○
17 Infant health	○	○	○	○	○	○	○	○	○	○	○	○
18 Job placement and employment support	○	○	○	○	○	○	○	○	○	○	○	○
19 Mental health disorders (such as depression)	○	○	○	○	○	○	○	○	○	○	○	○
20 Obesity in children and adults	○	○	○	○	○	○	○	○	○	○	○	○
21 School health and wellness programs	○	○	○	○	○	○	○	○	○	○	○	○
22 Sexually Transmitted Infections (STIs)	○	○	○	○	○	○	○	○	○	○	○	○
23 Stopping falls among elderly	○	○	○	○	○	○	○	○	○	○	○	○
24 Substance use disorder/ addiction (including alcohol use disorder)	○	○	○	○	○	○	○	○	○	○	○	○
25 Violence (including gun violence)	○	○	○	○	○	○	○	○	○	○	○	○
26 Women's and maternal health care	○	○	○	○	○	○	○	○	○	○	○	○

Long-term COVID Effects

10. Have you ever tested positive for COVID-19 (using a rapid point-of-care test, self-test, or laboratory test) or been told by a doctor or other health care provider that you have or had COVID-19?

- Yes
- No [Skip to question 13]

11. Do you currently have symptoms lasting three months or longer that you did not have prior to having coronavirus or COVID-19?

- ○ Yes
- ○ No [Skip to question 13]

12. Do these long-term symptoms reduce your ability to carry out day-to-day activities compared with the time before you had COVID-19?

- ○ Yes, a lot
- ○ Yes, a little
- ○ Not at all

Social Determinants of Health

13. During the past 12 months, have you received food stamps, also called SNAP (Supplemental Nutrition Assistance Program), on an EBT card?

- ○ Yes
- ○ No

14. During the past 12 months, how often did the food that you bought not last and you didn't have money to get more?

- Always
- Usually

- Sometimes
- Rarely
- Never

15. During the last 12 months, was there a time when you were not able to pay your mortgage, rent or utility bills?
    - ○ Yes
    - ○ No

Health Care Access

16. What is the current source of your primary health insurance (the one you use most often)?
    - ○ A plan purchased through an employer or union (including plans purchased through another person's employer)
    - ○ A private nongovernmental plan that you or another family member buys on your own
    - ○ Medicare
    - ○ Medigap
    - ○ Medicaid
    - ○ Children's Health Insurance Program (CHIP)
    - ○ Military related health care: TRICARE (CHAMPUS) /VA health care /CHAMP-VA
    - ○ Indian Health Services
    - ○ State sponsored health plan
    - ○ Other government program
    - ○ No coverage of any type

Demographic Information

17. What is your race and/or ethnicity? (Select all that apply)
    - American Indian or Alaska Native
      For example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.
    - Asian
      For example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.
    - Black or African American
      For example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.
    - Hispanic or Latino
      For example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.
    - Middle Eastern or North African
      For example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.
    - Native Hawaiian or Pacific Islander
      For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marshallese, etc.
    - White
      For example, English, German, Irish, Italian, Polish, Scottish, etc.

18. Do you speak a language other than English at home?
    - Yes
    - No [Skip to question 21]

19. What is this language? (Select all that apply)
    - Spanish
    - Arabic
    - Bengali
    - Burmese
    - Chinese
    - French
    - Haitian Creole
    - Hindi
    - Italian
    - Japanese
    - Korean
    - Nepali
    - Polish
    - Russian
    - Urdu
    - Yiddish
    - Other

20. How well do you speak English?
    - Very well
    - Well
    - Not well
    - Not at all

21. Which of the following best represents how you think of yourself?
    - Gay or lesbian
    - Straight, that is not gay or lesbian
    - Bisexual
    - I use a different term

22. How do you currently describe yourself? (Select all that apply)
    - Woman
    - Man
    - Non-binary
    - I use a different term

23. Are you transgender?
    - Yes
    - No

24. What is your age?
    - 18 - 24
    - 25 - 34
    - 35 - 44
    - 45 - 54
    - 55 - 64
    - 65 - 74
    - 75+

25. What is the highest grade or year of school that you have completed?
    - Grades 8 (Elementary) or less
    - Grades 9 through 11 (Some High School)
    - Grade 12 or GED (High School Graduate)
    - College 1 year to 3 years (Some college or technical school)
    - College 4 years or more (College graduate)

26. Including yourself, how many people usually live or stay in your home or apartment?
    - _____ person(s)

27. Are you currently…?

- Employed for wages
- Self-employed
- Out of work for 1 year or more
- Out of work for less than 1 year
- A homemaker
- A student
- Retired
- Unable to work

28. What is your household's annual household income from all sources, before taxes, in the last year? By household income we mean the combined income from everyone living in the household including even roommates or those on disability income.

- Less than $20,000
- $20,000 to $24,999
- $25,000 to $34,999
- $35,000 to $49,999
- $50,000 to $74,999
- $75,000 to $99,999
- $100,000 to $149,999
- $150,000 to $199,999
- $200,000 or more

Table 22. 2025 GNYHA CHNA Collaborative, OBH, Importance and Satisfaction Rankings

SDOH Domain	Health Condition	Importance Rank*	Importance Score^
Need Attention			
Neighborhood and Built Environment	Violence (including gun violence)	1	4.52
Economic Stability	Affordable housing and homelessness prevention	3	4.43
Social and Community Context	Mental health disorders (such as depression)	10	4.34
Economic Stability	Assistance with basic needs like food, shelter, and clothing	15	4.27
Health Care Access and Quality	Obesity in children and adults	16	4.26
Maintain Efforts			
Health Care Access and Quality	Dental care	2	4.45
Economic Stability	Access to healthy/nutritious foods	4	4.43
Health Care Access and Quality	Cancer	5	4.41
Health Care Access and Quality	Women's and maternal health care	6	4.37
Health Care Access and Quality	High blood pressure	7	4.36
Health Care Access and Quality	Diabetes and high blood sugar	8	4.36
Health Care Access and Quality	Heart disease	9	4.34
Health Care Access and Quality	Adolescent and child health	11	4.32
Neighborhood and Built Environment	Stopping falls among elderly	12	4.31
Health Care Access and Quality	Infant health	13	4.29
Health Care Access and Quality	Infectious diseases (COVID-19, flu, hepatitis)	14	4.29
Relatively Lower Priority			
Education Access and Quality	Access to continuing education and job training programs	19	4.22
Economic Stability	Job placement and employment support	20	4.21
Social and Community Context	Substance use disorder/addiction (including alcohol use disorder)	22	4.12
Social and Community Context	Cigarette smoking/tobacco use/vaping/e-cigarettes/hookah	26	3.84
Education Access and Quality	School health and wellness programs	17	4.25
Health Care Access and Quality	Asthma, breathing issues, and lung disease	18	4.24
Health Care Access and Quality	Arthritis/disease of the joints	21	4.18
Health Care Access and Quality	STIs	23	4.09
Health Care Access and Quality	HIV/AIDS (Acquired Immune Deficiency Syndrome)	24	4.05
Health Care Access and Quality	Hepatitis C/liver disease	25	3.86

*How important is this issue to you?

^Rated on a 5-point scale from 1='Not at all' to 5='Extremely'

[i] United Hospital Fund (UHF 34) Neighborhood Index". NYC DOHMH. Available here.
[ii] "Neighborhood boundaries on the EH Data Portal". NYC DOHMH. Available here.
[iii] OBH provided data
[iv] OBH provided data
[v] OBH provided data
[vi]"Disparities in Access to Health Care Among US-Born and Foreign-Born US Adults by Mental Health Status, 2013–2016". American Journal of Public Health. Available here. D
[vii] "Social Determinants of Health". Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Available here.
[viii] "Community Health Profiles". NYC DOHMH. Available here.
[ix] "Chronic Diseases and Conditions". New York State Department of Health. Available here.
[x] "Adult Activity: An Overview". Centers for Disease Control and Prevention. Available here.
[xi] "Mental Health By the Numbers". National Alliance on Mental Illness. Available here.
[xii] "Substance Use". Centers for Disease Control and Prevention. Available here.
[xiii] "About Sexually Transmitted Infections". Centers for Disease Control and Prevention. Available here.
[xiv] "Child Health and Health Care: Uniqueness, Societal Importance, and Vision for the Future. The National Academies Press. Available here.