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Healthy Brooklyn:
Community Centered Study

Proposed Health and
Wellness Interventions
in Brownsville and
East New York

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EXECUTIVE SUMMARY

In 2016, the Performing Provider System (PPS) known as Community Care of Brooklyn (CCB) supported a collaboration between the DuBois - Bunche Center for Public Policy at Medgar Evers College and the NextShift Collaborative, a team of consultants led by MIT Professor J. Phillip Thompson, to build a deeper understanding of the social determinants of cardiovascular health in Brownsville and East New York. They assembled a team of 28 young adults to engage in a Participatory Action Research (PAR) project to understand the community's priorities for health creation, guided by a core question: "How do we mobilize the Brownsville and East New York communities to address the social, physical and environmental inequalities that affect health?" Through a survey of 525 residents, the team explored the physical, mental, social, environmental and financial dimensions of health and developed a number of recommendations to lay the foundation for collective action.

Key Findings

- Less than half of respondents rated their own health as "Very Good" or "Excellent," and this figure was even lower among women than men. Residents face significant barriers to increased physical activity, including inaccessible and unaffordable facilities, a lack of connection and support, and social challenges such as violence and sexism.
- Over half indicated that there was at least one day per week when they could not eat nutritious meals, and for one quarter of respondents this was most days or every day. Similarly, only half of respondents reported having access to affordable quality produce in their neighborhood.
- Nearly four-fifths of respondents indicated that the community did not cope with stress and difficult changes well. Among the key challenges to mental health in the community are lack of employment, violence and police misconduct. When dealing with mental health challenges, most respondents seek support from family and friends, and desire additional outreach, therapeutic and peer-to-peer and group services.
- Over one-third of respondents indicated that environmental health in their community was "Poor" or "Very Poor." The most commonly-cited priorities for improving environmental health were park improvements, housing quality, street clean-up, sanitation, and more parks and playgrounds.
- Only one-fifth of respondents rated the community's financial health as "Good" or better. Almost 40% of respondents reported that they were either "Unsure" or "Very Unsure" of what their next month's income would be each month. Nearly three quarters of all respondents indicated that there were not adequate job opportunities for residents of their neighborhood.
- Social, cultural and human assets are plentiful in Brownsville and East New York, and ready to be leveraged in the service of a healthier community. Stakeholders and residents strongly emphasized that culture is the key to building a healthier future.
- Engagement and organizing efforts must address head-on the strong lack of trust between the community and the local healthcare system.



EXECUTIVE SUMMARY

Recommendations

Building on the social change framework at the core of Participatory Action Research, this study’s approach to nutrition and physical activity is grounded in community-building. The social determinants of cardiovascular health are complex in nature, and we believe a systems-change approach is the most effective way to meaningfully address this challenge and build the community’s capacity to withstand and adapt to difficult and/or transformative changes in the determinants of health.

Food Justice and Nutrition	Physical Activity
<ul style="list-style-type: none"> • Transform the local food system by: <ul style="list-style-type: none"> - Expanding urban farming on school, hospital and vacant land - Pooling community garden production to create economies of scale - Piloting subscription-based distribution models for locally-grown produce - Developing the local food pantry infrastructure - Organizing bodegas to offer fresh produce • Build a network of Community Chefs to lead nutrition outreach, education and coaching one household at a time 	<ul style="list-style-type: none"> • Foster connection and community through a lay health worker program that blends education, exercise and community-building • Improve the reach of free physical activity opportunities by: <ul style="list-style-type: none"> - Co-designing new programs with local fitness instructors and residents - Ensuring adequate space, flexible scheduling and diverse offerings - Making more explicit links to mental wellness in physical activity programs - Support the development of locally-owned gyms, exercise studios, and other facilities - Collaborate to improve public space through: <ul style="list-style-type: none"> • Using arts and culture to encourage active travel • Improving the pedestrian experience • Expanding the availability of outdoor exercise equipment • Advocating for green infrastructure



ACTION STEPS & KEY FUNDING PRIORITIES

Food Justice and Physical Activity In Brownsville and East New York



A report from the PAR project was presented to CCB's Workgroup on Cardiovascular Disease in the Community, a subcommittee comprised of key community leaders and other stakeholders. The recommendations of the PAR team were discussed at length and the following action steps and priorities for funding and/or other support were identified:



ACTION STEPS & KEY FUNDING PRIORITIES

<p>Recommendation #1: Transform the local food system by expanding urban farming on school campuses, hospital property and vacant land to support the development of gardens and nutritional education in schools. Several Community Based Organizations were identified to assist in this process, including Teens for Food Justice and Skyponics Urban Farming.</p>
<p>Recommendation #2: Work with the City to develop business plans for local farms to sell produce to hospitals, schools and City facilities.</p>
<p>Recommendation #3: Build on New York City DOHMH efforts to organize and support local bodegas seeking to offer fresh produce.</p>
<p>Recommendation #4: Study the feasibility of establishing a “community wellness hub.” Members of the group identified the Paerdegat basin facility as a potential site.</p>
<p>Recommendation #5: Expand the presence of Community Health Workers (CHWs) in the Brownsville and East New York communities in order to better connect residents to services and opportunities, similar to the model of the Harlem Health Advocacy Partnership.</p>
<p>Recommendation #6: Develop summer camp programs focused on nutrition and exercise, working in collaboration with community organizations and interested service providers.</p>
<p>Recommendation #7: Reduce violence by expanding economic opportunities (particularly for formerly incarcerated people) through education, apprenticeships and job placement in construction, green energy, building retrofits and healthcare. This can be achieved by working with the City and developers of new buildings or renovations of old buildings, and through expansion of already successful programs at area healthcare organizations.</p>
<p>Recommendation #8: Launch a Healthy Buildings program that tackles unhealthy residential conditions that exacerbate asthma. This can be combined with a program to improve building energy efficiency. This can be achieved by working with NYCHA and building on the model of the Harlem Health Advocacy Partnership to create healthy building initiatives for residents of NYCHA in Brooklyn.</p>



Introduction: Health Care Policy Reform

Context

New York State has the country's largest Medicaid program with approximately 17% of the state's total population listed as Medicaid recipients. It also has one of the highest levels of overall Medicaid spending at \$58.8 billion (FY13) although spending as a whole per recipient has shifted downward. This number is expected to increase annually by at least \$700 million for FY18-19 (New York State Department of Health, 2012). The system faces the challenges of reducing preventable hospital use and associated costs as well as improving persistent health inequities across sex, gender, income, and race. However, addressing healthcare accessibility and cost containment alone will only quicken the downward spiral for an already-struggling system. Only a transformative approach to address the social and environmental factors that drive health outcomes and disparities will improve quality and cost.

Starting with the implementation of Governor Cuomo's Executive Order #5 in 2011, which established the NYS Medical Redesign Team (MRT), New York State embarked upon a wholesale restructuring of its Medicaid program. This began immediately with the global spending Medicaid cap and expanded to numerous CMS- and NYS-approved recommendations related to finance, workforce, health information technology, healthcare delivery and quality, and workforce development.

The cornerstone of these recommendations, the Delivery System Reform Incentive Payment (DSRIP) program, is overseen by the New York State Department of Health (NYSDOH) and is the central policy framework of this study.

The main goal of DSRIP is to reduce preventable hospitalizations by 25% by 2020 through a mix of interventions within hospitals and in the communities that they serve. Through state and federal support, New York State expects to achieve three central outcomes. First, the Triple Aim: better health, better care, and lower costs. Second, a value based payment system to drive the shift to a performance based model. And most importantly, ensure the sustainability of health care reforms beyond 2020.

To help hospitals and other healthcare organizations implement and fund recommendations from the DSRIP projects, NYS allocated \$6.4 billion to groups of safety net providers, called Performing Provider Systems (PPS), to work collaboratively with hospitals, health care providers, and community based organizations (CBOs) within specific geographic areas to improve the health care system for Medicaid and uninsured patients by bringing to scale evidence-based interventions. To support state reform efforts, CMA has negotiated Section 1115 Waivers with NYS, which has provided it with an additional \$8.0 billion to support state reform efforts (New York State Comptroller, March 2015).

1 The Henry J. Kaiser Family Foundation. Medicare Beneficiaries as a Percent of Total Population. Accessed on September 20, 2016. <<http://kff.org/medicare/state-indicator/medicare-beneficiaries-as-of-total-pop/?activeTab=graph¤tTimeframe=0&startTimeframe=4&selectedRows=%7B%22nested%22:%7B%22new-york%22:%7B%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>>.



Introduction: Health Care Policy Reform

Context

About Community Care of Brooklyn

Across the state, there are twenty-five PPSs, ten of which are in New York City, and six of which affect residents of Brooklyn. Each PPS is responsible for implementing programs to transform healthcare by integrating primary, specialty and behavioral healthcare in the community. Ultimately, the goal is for each PPS to evolve into a highly effective integrated delivery system. Of the six PPSs that serve Brooklyn, Community Care of Brooklyn (CCB) is the largest, serving 600,000 patients and encompassing a robust network of member organizations representing a varied cross-section of medical and behavioral health providers, social services, community partners, and labor representatives.

Community Care of Brooklyn (CCB) includes 6 hospitals, 10 Federally Qualified Health Centers, 4,600 practitioners, and 850 organizations. Maimonides Medical Center serves as the fiduciary and the Maimonides Central Services Organization (CSO) provides technical and clinical management support to the entire PPS.

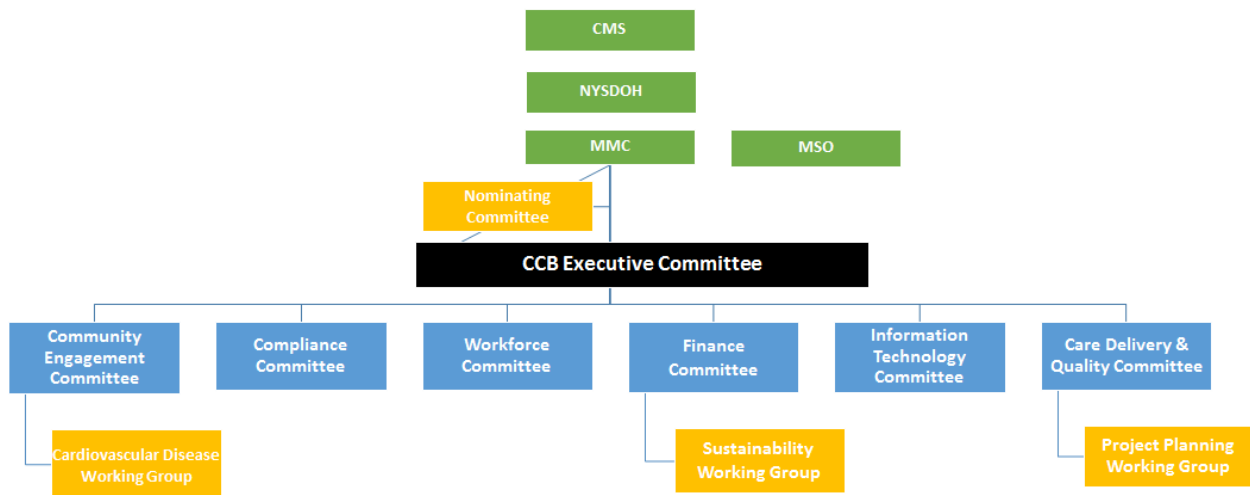
CCB's governance structure and working committees are consensus-based with a clear decision-making process (see Fig. 1.1). Using a collaborative framework, each committee serves to provide strategic leadership and guide the development and implementation of DSRIP projects. In order to meet DSRIP goals, CCB selected ten projects which fall into one of four broad categories:

1. creating an Integrated Delivery System;
2. improving Care Transitions: Hospital-based projects focused on reducing 30 day readmissions and reducing preventable Emergency Department visits;
3. transforming Primary Care Practices into Patient Centered Medical Homes (PCMH): Ensuring practices meet PCMH standards, focusing on care management and integration of behavioral health;
4. improving Population Health, with a focus on mental health and HIV.



Introduction: Governance Structure & the Cardiovascular Workgroup

Figure 1. CCB Governance Structure



The Community Engagement Committee’s Cardiovascular Workgroup

The overall purpose of the Community Engagement Committee is to provide strategic leadership on community engagement of Brooklyn residents; to guide strategies to reduce health disparities and gaps in care; to increase cultural competency and health literacy; and to report to the CCB Executive Committee. The Cardiovascular Workgroup, a subcommittee of the Community Engagement Committee (CEC) is the sponsor of this report. The workgroup includes members from organizations representing sectors that are a part of the PPS.² This workgroup was formed to initiate a community project using cardiovascular disease as a basis for addressing health disparities in two neighborhoods: Brownsville (11212) and East New York (11207), within Community Board 16 and Community Board 5 respectively.

To help launch the first phase of this project, CCB supported a collaboration between the DuBois - Bunche Center for Public Policy at Medgar Evers College and the NextShift Collaborative, a team of consultants led by MIT Professor J. Phillip Thompson, to initiate a community-based research process and develop a strategic plan for improving cardiovascular disease and overall community health. NextShift Collaborative is a mission driven organization that builds strategic partnerships for generating collective wealth and wellbeing in communities that have been marginalized by traditional economic development. They help clients develop and implement strategies that enable communities to harness their existing assets and capture the value they create to promote inclusive economic development that is environmentally sustainable, socially just, and deeply democratic. NextShift brings expertise from academia, urban planning, municipal government, business, journalism, civil rights advocacy and community and labor organizing.

² For a full listing of working group members please see Appendix XX



METHODOLOGY

Background Research and Stakeholder Interviews

The core research team was composed of:

- Eight urban planning graduate students from the Massachusetts Institute of Technology and the Pratt Institute: Sabrina Bazile, Channa Camins, Abigail Ellman, Alexis Harrison, Jessie Heneghan, Doug McPherson, Obiamaka Ude, Case Wyse;
- Eight undergraduate students from Medgar Evers College: Rossi Arroyo, Idriss Cheriff El Farissy, Greshawna Clement, Bert Griffith, Annastesia Harris, Khaalida Jones, Catherine Vautor-Laplaceliere, Leozard Simon;
- Leadership from Prof. Thompson, Dr. Flateau, Prof. Green, Prof. Burrage, Andrew Binet and Wilnelia Rivera.

This team spent the month of June conducting background research on local community leadership and organizations, local politics and policy, the local healthcare system, and community efforts to address the social determinants of health in Brownsville and East New York. Based on this research, they developed a list of key stakeholders with whom to conduct in-depth interviews about the intersection between their respective areas of work and community health. Ultimately, 23 stakeholders were interviewed; they are listed in Appendix 1.

The team engaged each stakeholder in brainstorming about different community assets across six domains: social, human, physical, political, institutional and financial. The intention was to understand how to leverage community resources to further community health and to learn about community based organizations, their goals and relationships.

Stakeholder interviews were coded across three domains: assets, conditions and interventions. Assets included anything that could produce economic, social, and political value for those who live and work in the community, and which could be leveraged to foster greater community health. Conditions included factors which would either facilitate or impede the ability to leverage assets to improve community health. Interventions included specific activities that would contribute to community health.

Participatory Action Research

To develop a strategy for leveraging local assets, the core team turned to the community. Through Participatory Action Research (PAR), the team sought a better understanding of how the community perceives its own health and gauge priorities for improving health in their own neighborhood. Participatory Action Research centers on the lived experience and intelligence of those most affected by the problems it seeks to address, based on the premise that they will have the most insight into how best to address problems and find solutions that benefit the community as a whole. In PAR, community members serve as equal members of the research team, and experiential and cultural knowledge are valued equally alongside academic expertise.



METHODOLOGY

PAR is oriented towards using inquiry to bring about social change through action, and asks the question “What do we need to know *in order to act?*” With the explicit aim of changing conditions rather than merely observing them, PAR sets itself apart from conventional social science and public health research. PAR aims to change the conditions and address the problem using the data generated by the research. Additionally, through participation in the process, the power balance shifts and changes who determines what is true. In low-income urban communities of color, PAR is an opportunity to model grassroots approaches to creating positive social change.

Participatory Action Research is rooted in the pedagogical practice of mid-20th century educators such as Paulo Friere in Brazil, and John Dewey in the United States, both of whom saw the development of “critical consciousness” about the forces impacting one’s own life as essential to citizenship and a well-functioning democracy. As a methodology, it has been used in social movements across the Americas since the mid-20th century, but remains on the fringes of academia due to the numerous ways in which it challenges conventional notions of expertise.

In early July, a team of 28 young adults from Brooklyn was assembled to conduct the Participatory Action Research. The team was comprised of students from Medgar Evers College, World Academy for Total Community Health (W.A.T.C.H.) High School, and the New York City Summer Youth Employment Program, as well as community health workers from the New York City Department of Health and Mental Hygiene. The collaborative research team adopted the name Wellness Empowerment for Brooklyn (WEB).

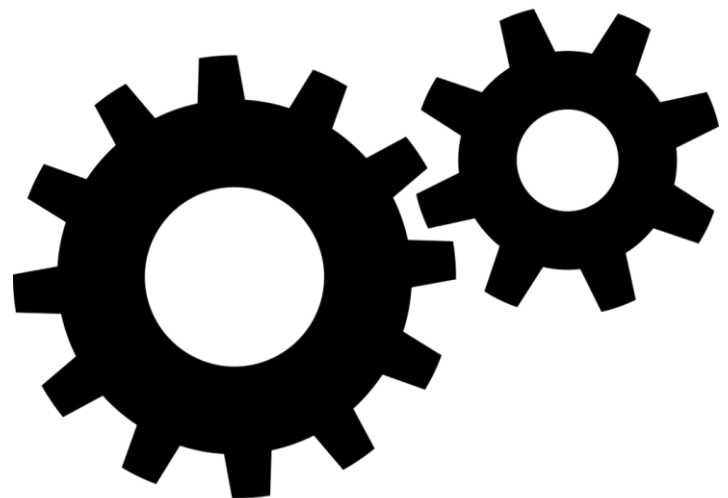
WEB went through a six-week collaborative research design and data-gathering process supervised by a team of graduate students. Drawing from their own understanding of the social determinants of health in Central Brooklyn, the group developed a research question to guide their inquiry: “How do we mobilize the Brownsville and East New York communities to address the social, physical and environmental inequalities that affect health?” By articulating this single question, the group identified issues that could lead to the transformation of community health: motivating individuals to bring about community change; educating neighborhood residents about health; creating unity; changing and taking control of the narrative about Brownsville, East New York and black communities in general; improving quality of life without bringing about displacement; and changing the statistics that drive policy and funding.



METHODOLOGY

WEB proceeded to collaboratively design research tools to answer the research question by exploring five dimensions of health - physical, mental, environmental, social and financial - which were defined by the team as follows:

- **Environmental health** refers to the natural and built environment. The built environment includes buildings, parks, water and energy infrastructure, and transportation systems. The natural environment includes vegetation, air, water, climate, radiation, and heat.
- **Physical health** refers to nutrition and diet, alcohol and drugs, healthy and safe sex, medical and self-care for minor ailments and injuries, emergency care, rest and sleep, regular physical activity and exercise, and access to medical care.
- **Mental health** refers to an individual's psychological wellbeing, an individual's ability to enjoy life, being able to cope with the normal stresses of life, the ability to do productive work and activities, and contributions to the community. It also includes the ability to have connections with others, adapt to change, and cope with adversity or hardships. It does not simply refer to mental illness.
- **Social health** refers to interpersonal conditions including having reliable support systems, community connectedness and cohesion, the ability to form satisfying and healthy relationships, and the ability to adapt comfortably to different social situations.
- **Financial health** refers to the availability of financial institutions including banks, access to credit and capital, schools, daycare facilities, supermarkets, or transit options. A financially healthy community provides opportunity for affordable housing, reasonable rent costs, energy bills, and medical costs.



METHODOLOGY

WEB designed three research tools: a survey, a neighborhood observation and photo documentation tool, and a participatory mapping activity. The survey was designed to gather information on residents' priorities for improving community health across the five dimensions above. The neighborhood observation tool was designed to inventory healthy and unhealthy features of the neighborhood environment. The participatory mapping activity was designed to gather resident input on where in their community they felt safe or unsafe, and healthy or unhealthy.

Survey Methodology and Sample

The WEB team conducted 525 surveys through a convenience sample of residents of Brownsville and East New York. In groups of 2-4, WEB members visited parks, recreation facilities, NYCHA and senior housing buildings, and a range of events including farmers markets and cultural festivals. Given their focus on research as a tool for community mobilization, WEB connected with residents spending time in public space and at community events, on the premise that they would be among those most eager to take an active role in the transition to a more healthy community. The team also decided not to survey door-to-door due to safety concerns. As a result, the sample was not random and is not fully representative of the entire population of Brownsville and East New York.

Of the 525 survey respondents, 51.9% identified as female, 47.4% identified as male, and 0.5% identified as transgender. This compares to 2014 ACS Census estimates of 58.3% female and 41.7% male. The age distribution of respondents who provided their age bracket is listed in Figure 2.1. The survey did not include young children.



METHODOLOGY

Figure 2.1 Age of Survey Respondents

Age	Study Sample	Brownsville	East New York
Under 18	11%	29%	28%
18 - 24	18%	12%	12%
25 - 44	34%	27%	27%
45 - 64	26%	22%	23%
65+	11%	10%	11%

Source of Brownsville and East New York Data: DOHMH 2015 Community Health Profiles, Community Board Districts 16 and 5.

In terms of racial and ethnic identification, the breakdown of respondents is as follows in Figure 2.2.

Figure 2.2 Racial and Ethnic Identification of Survey Respondents

Racial or Ethnic Identification	Percent of Respondents
Black or African American	56%
Hispanic or Latino/a	17%
Caribbean or Caribbean-American	17%
American Indian or Native Alaskan	3.5%
White	3%
Mixed	2.5%
Asian	1%

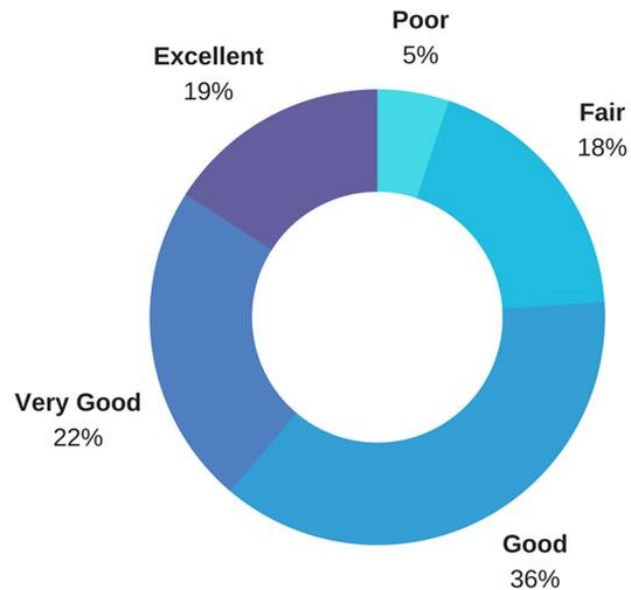


SURVEY RESULTS: PHYSICAL HEALTH

Survey Results: Five Dimensions of Health

The following section reports resident perceptions of five key dimensions of health as identified by the WEB research team: physical, mental, social, environmental and financial. Survey results pertaining directly to the twin priorities of nutrition and physical activity will be discussed in more detail in the following section.

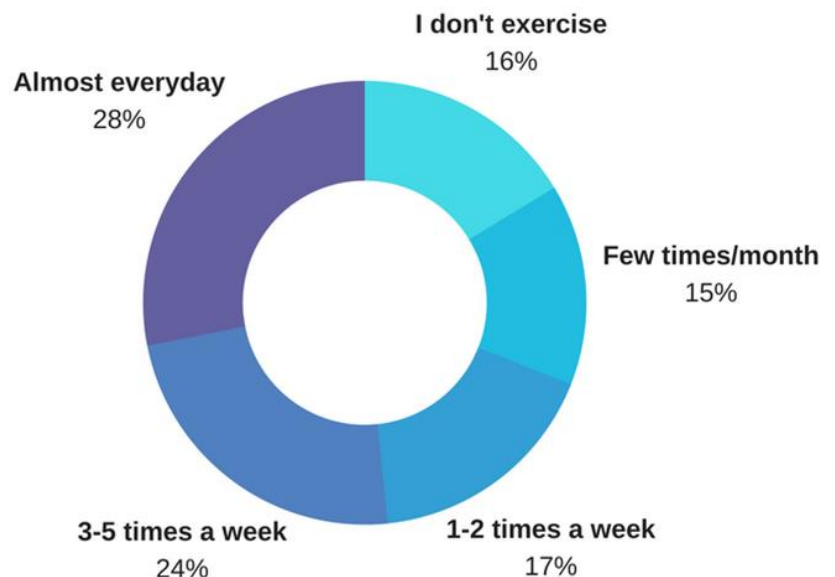
Self-Rated Physical Health



Physical Health

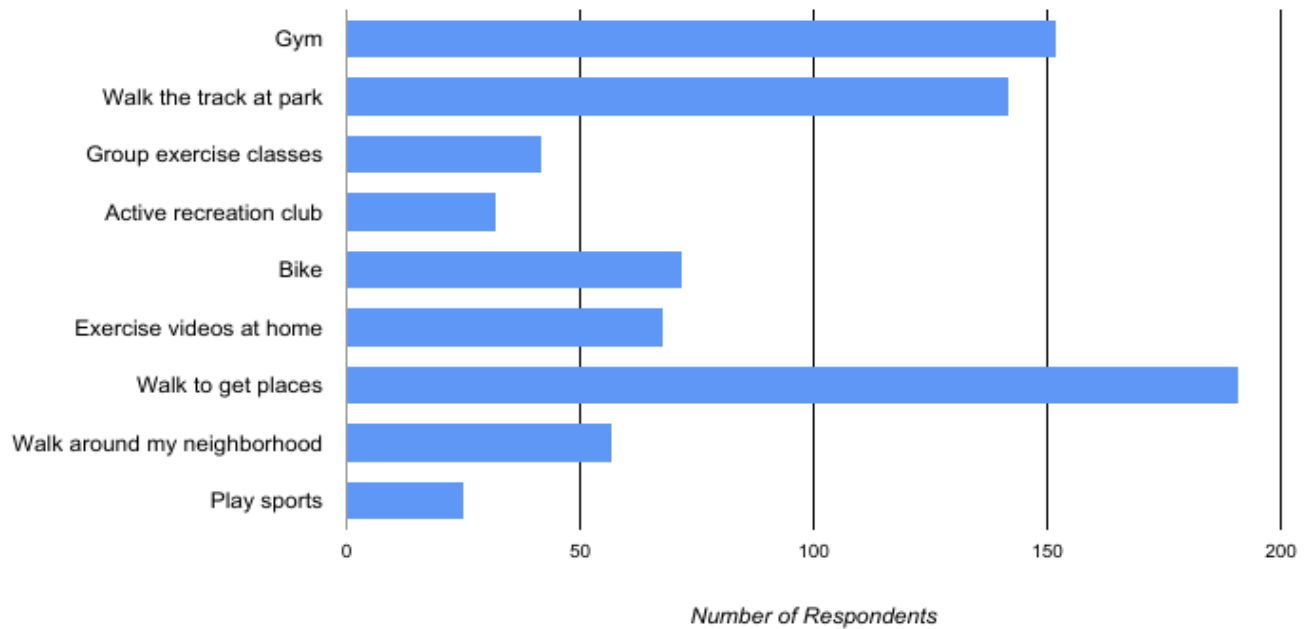
Less than half (42%) of respondents rated their own health as Very Good or Excellent, and this figure was even lower among women than men. Roughly half of the community reported exercising more than 3 times per week, but for many respondents, walking around the neighborhood was their major source of physical activity.

Physical Exercise Rates

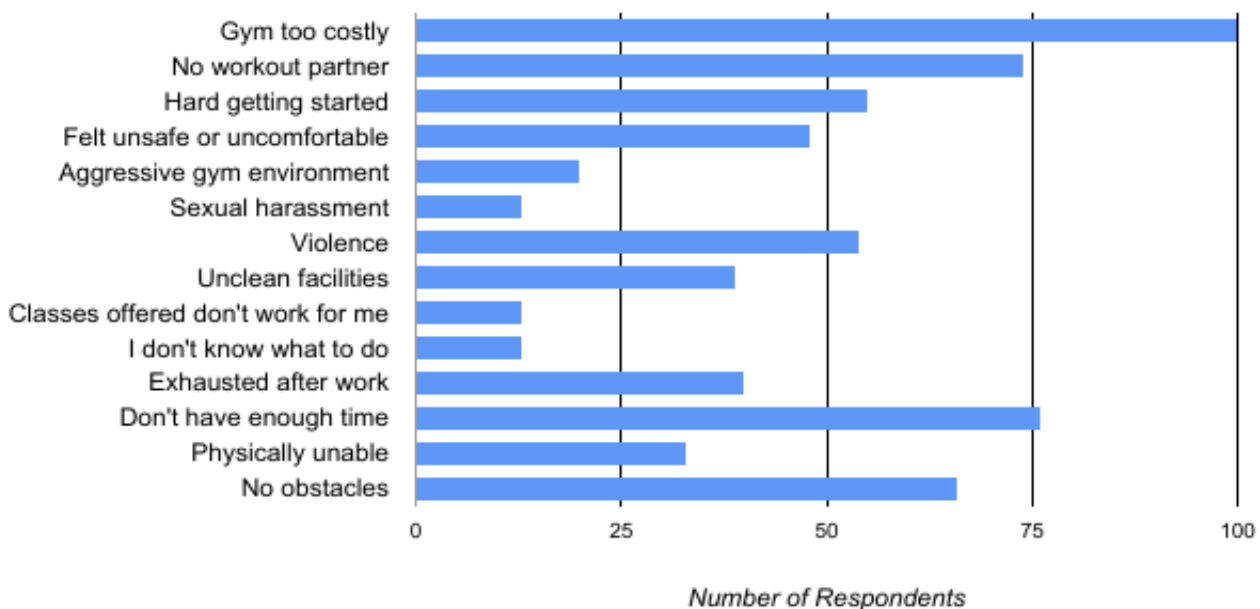


SURVEY RESULTS: PHYSICAL HEALTH

Physical Exercise Activities



Barriers to Increased Physical Activity

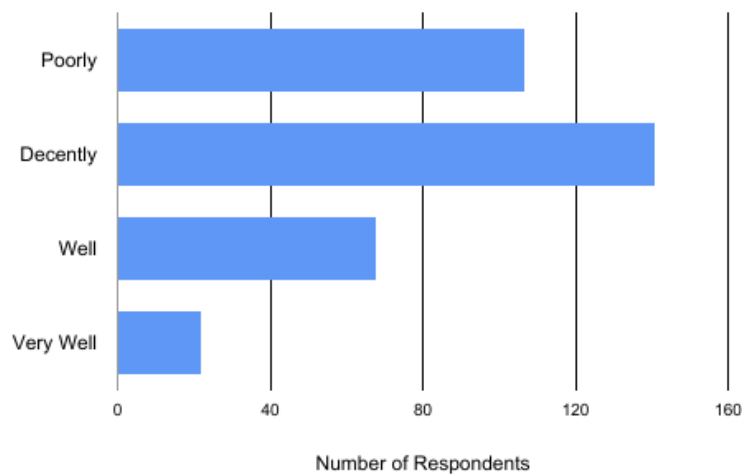


SURVEY RESULTS: MENTAL HEALTH

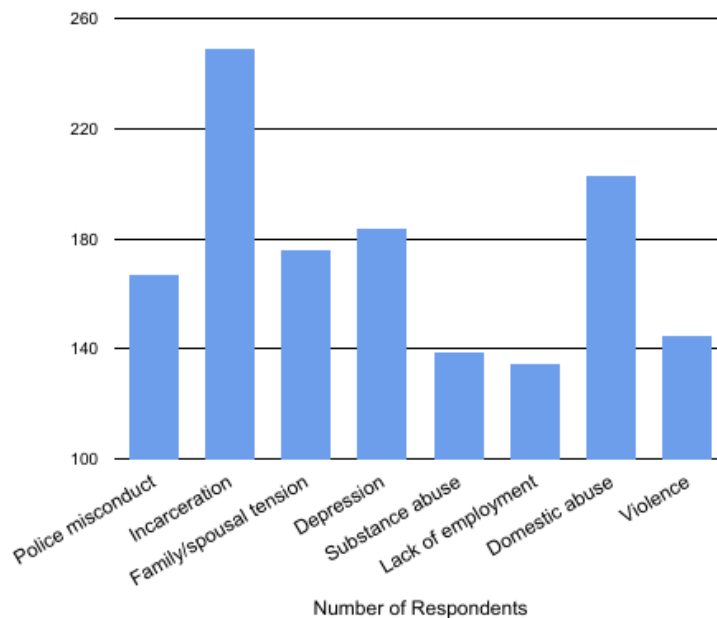
Mental Health

Respondents were asked about their perception of mental health in the community at large, because team members were concerned that personal questions would elicit negative reactions and biased responses due to the stigma that persists around mental health. Nearly 80% of respondents indicated that the community did not cope well with stress and life changes; 45% said the community's ability to cope was either poor or very poor.

Community Coping

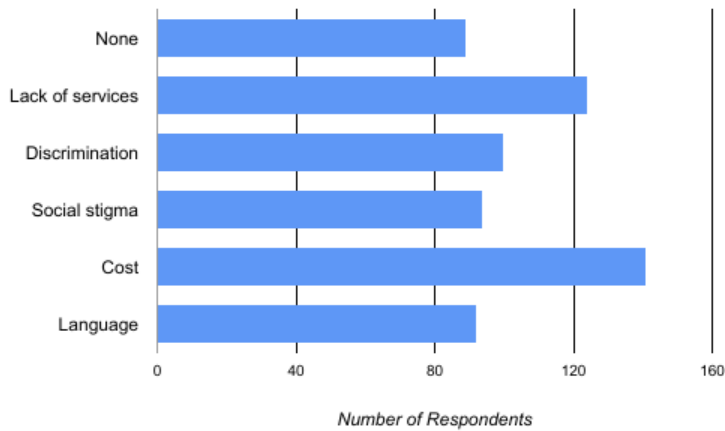


Key Challenges to Mental Health

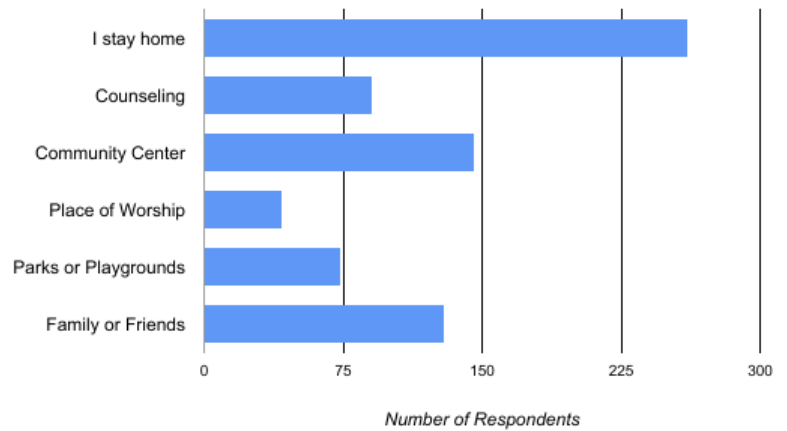


SURVEY RESULTS: MENTAL HEALTH

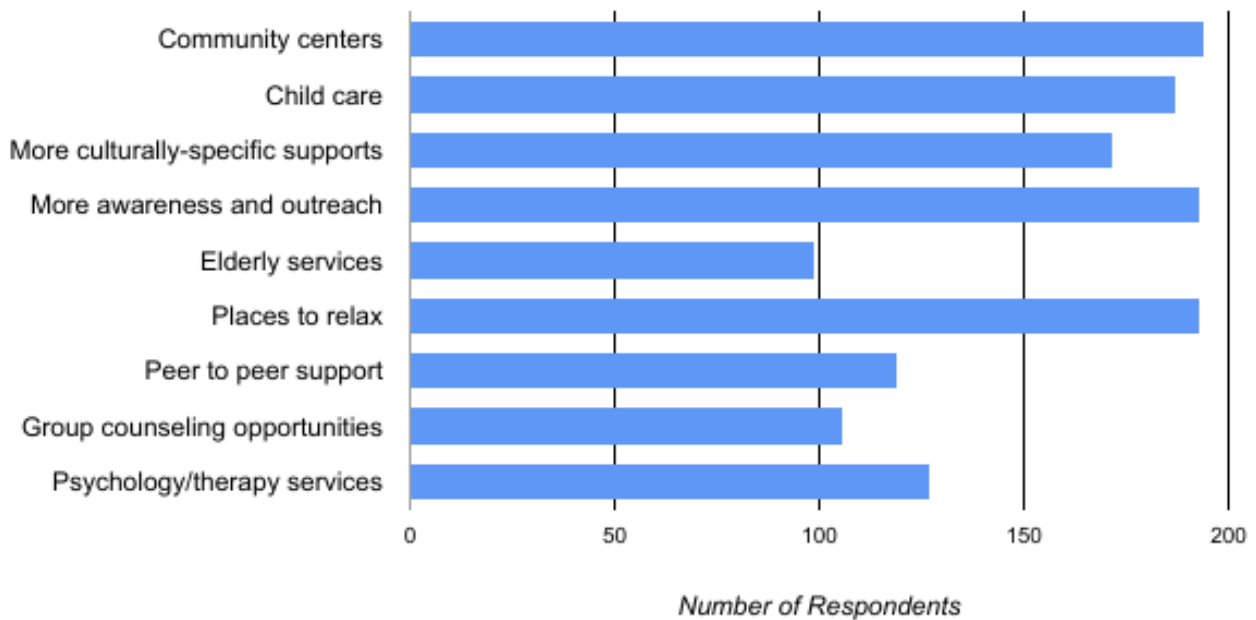
Barriers to Mental Health Support



Sources of Support



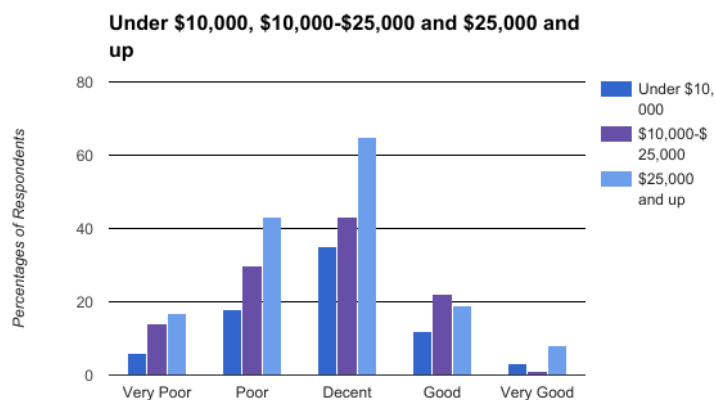
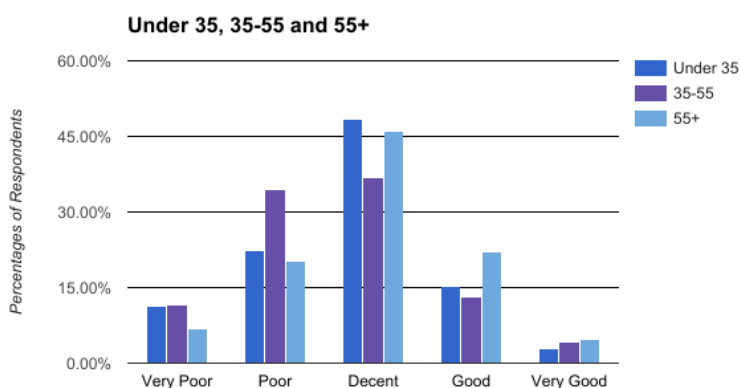
Community Supports Needed



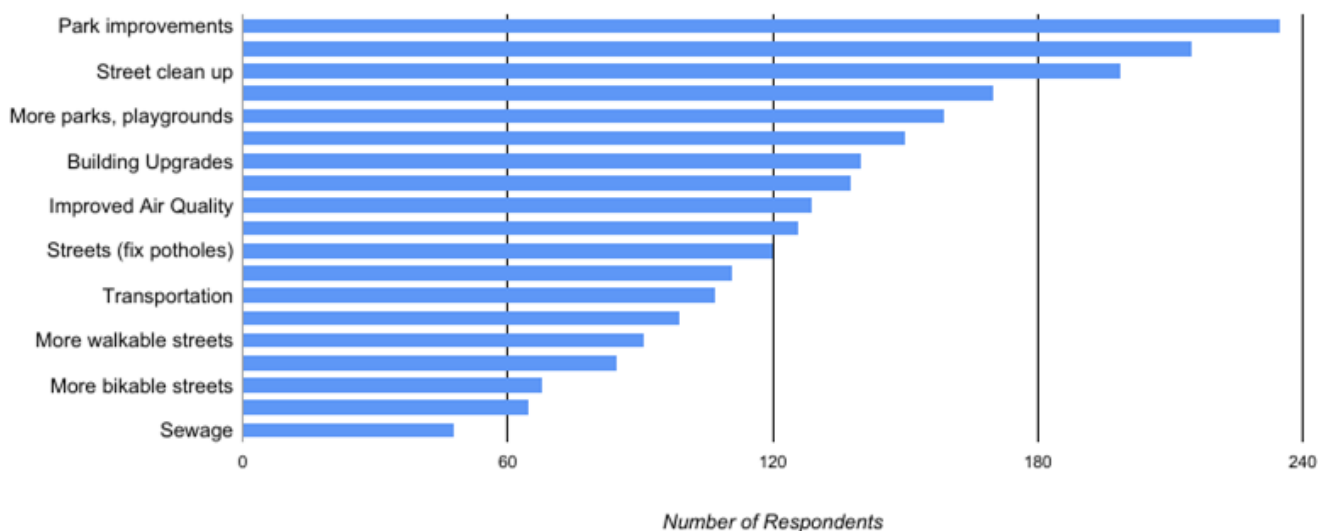
SURVEY RESULTS: ENVIRONMENTAL HEALTH

Environmental Health

Respondents were asked to rate the environmental health of their community, as well as indicate priorities for improving the local environment. Environmental health was defined as both the built and natural environments. Only about 20% of respondents indicated that the environmental health of their community was “Good” or “Very Good,” and 36% indicated that environmental health in their community was “Poor” or “Very Poor.” The most commonly-cited priorities for improving environmental health were park improvements, housing quality, street clean-up, sanitation, and more parks and playgrounds.

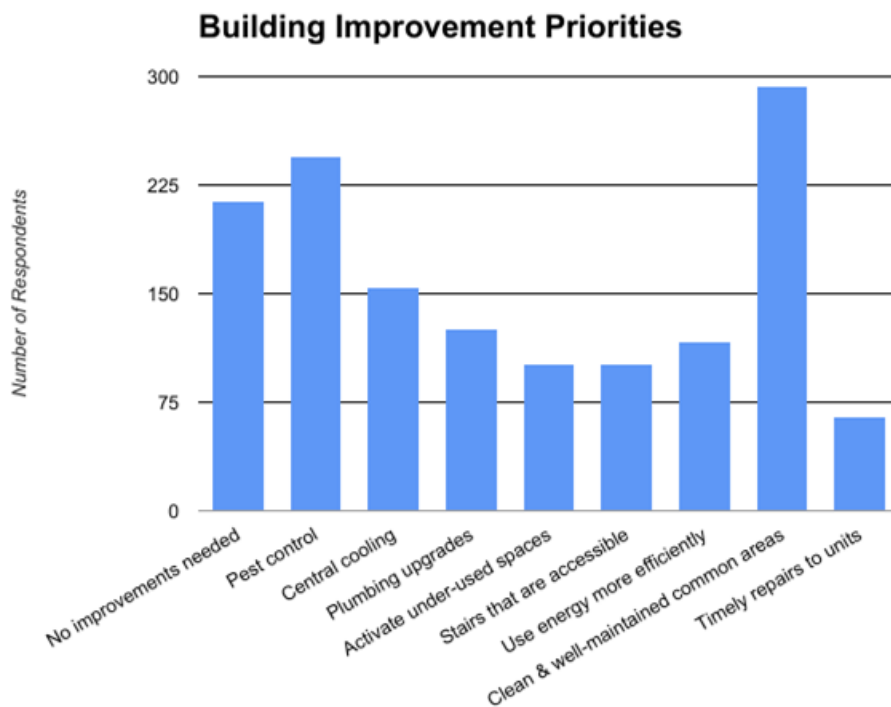
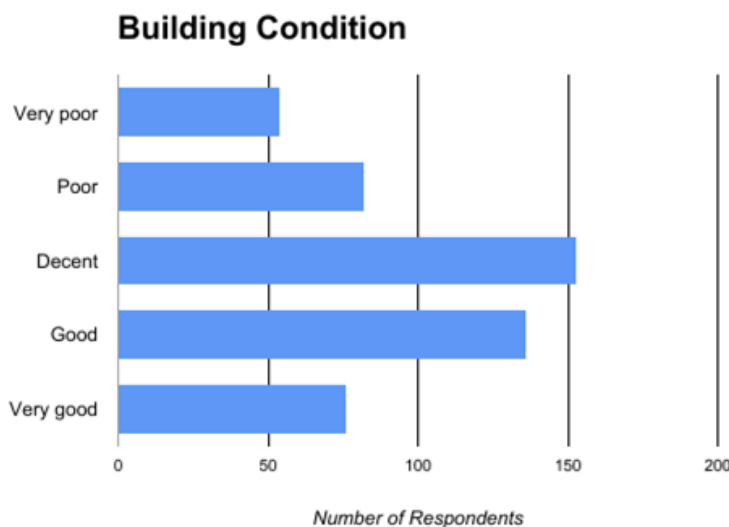


Environmental Health Improvement Priorities



SURVEY RESULTS: ENVIRONMENTAL HEALTH

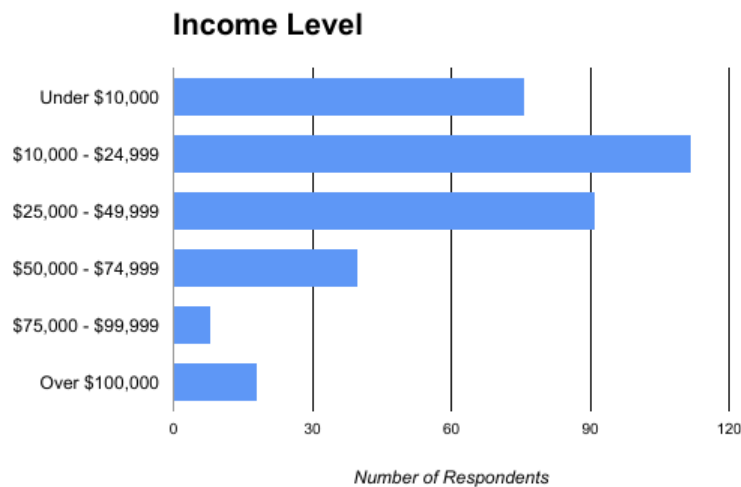
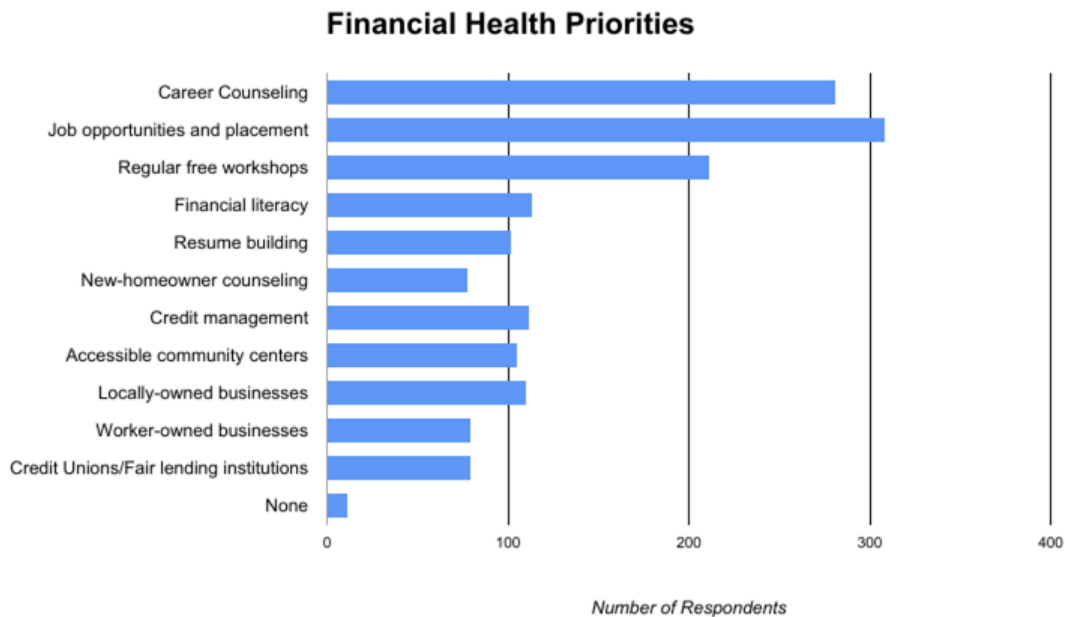
Respondents were also asked to rate the conditions of the building in which they lived, as well as indicate priorities for building improvements. Only 42% of respondents reported that the condition of the building they lived in was Good or Very Good. Of the priorities indicated for improving building conditions, maintenance of common areas ranks first, followed by pest control and other issues.



SURVEY RESULTS: FINANCIAL HEALTH

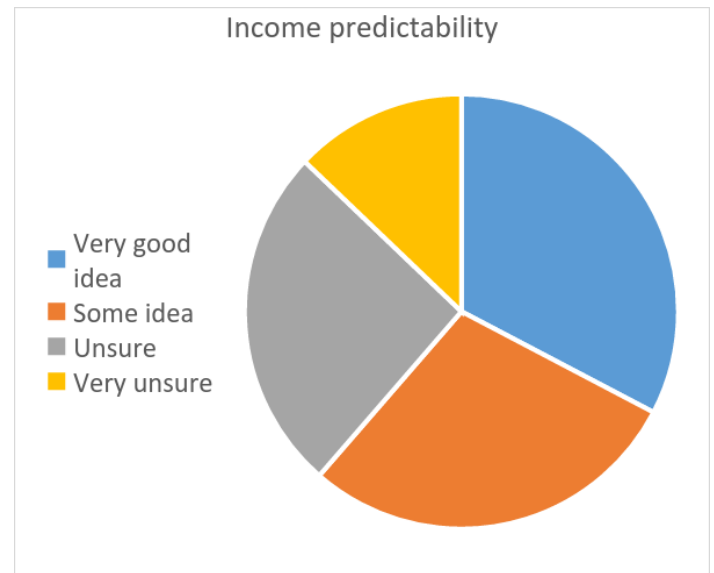
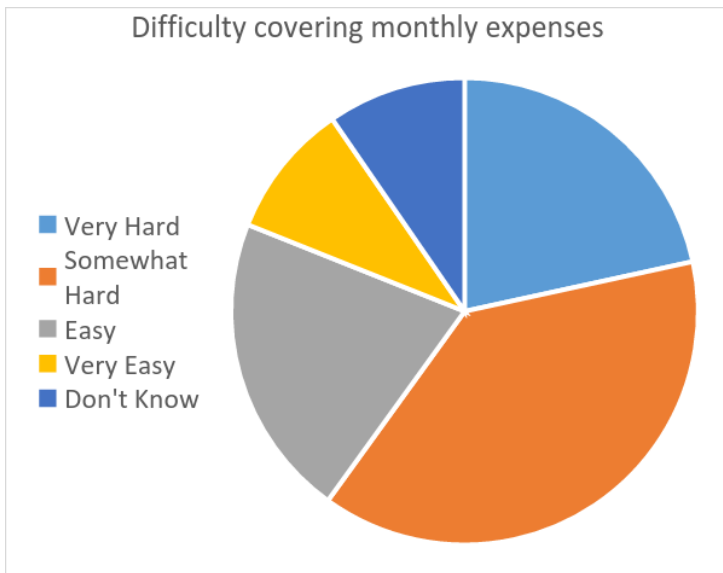
Financial Health

Respondents also rated the overall financial health of their community, and indicated priorities for improving their community's financial health. Only 19% of respondents rated the community's financial health as "Good" or better. Respondents showed a clear interest in job placement and career counseling opportunities. Limited knowledge of the benefits of worker-owned businesses and cooperatives and fair lending institutions indicates that there is the potential for popular education about economic democracy.



SURVEY RESULTS: FINANCIAL HEALTH

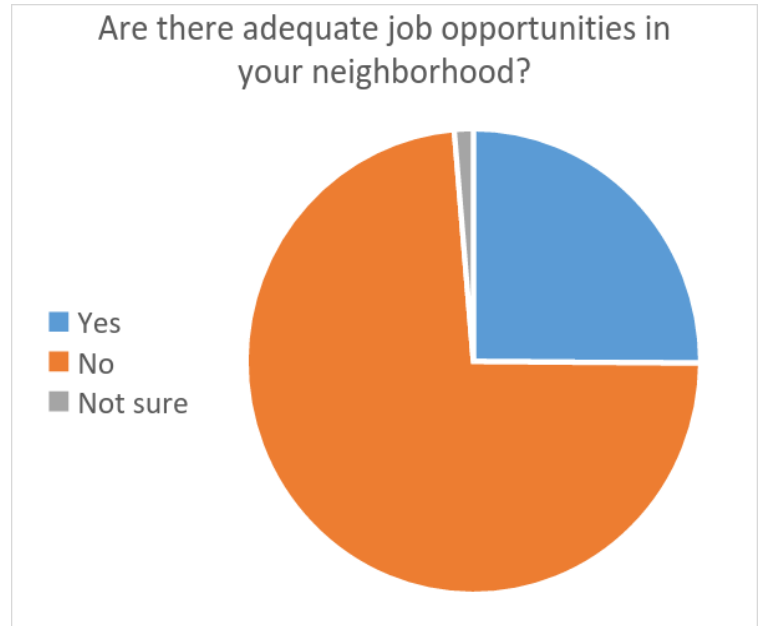
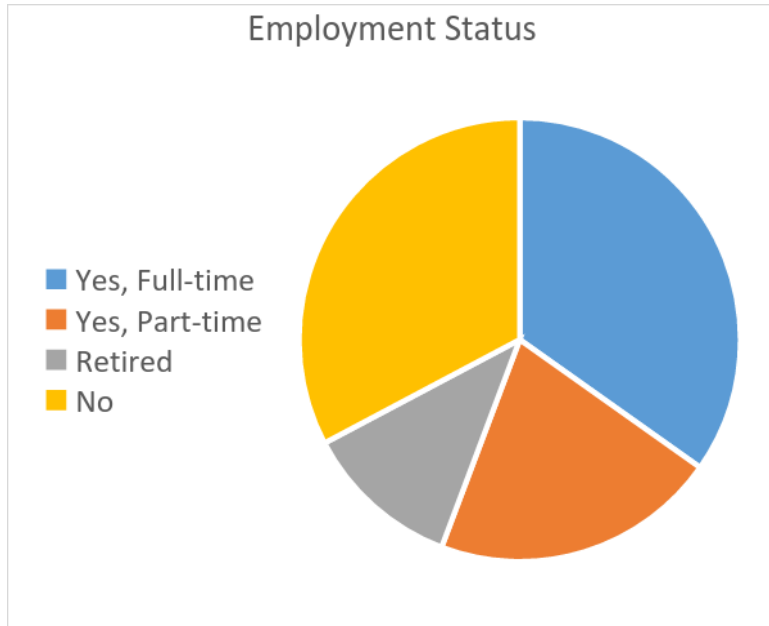
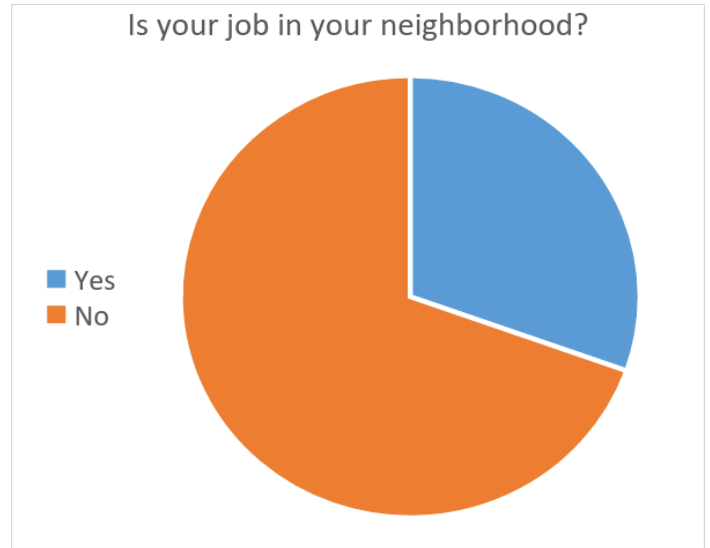
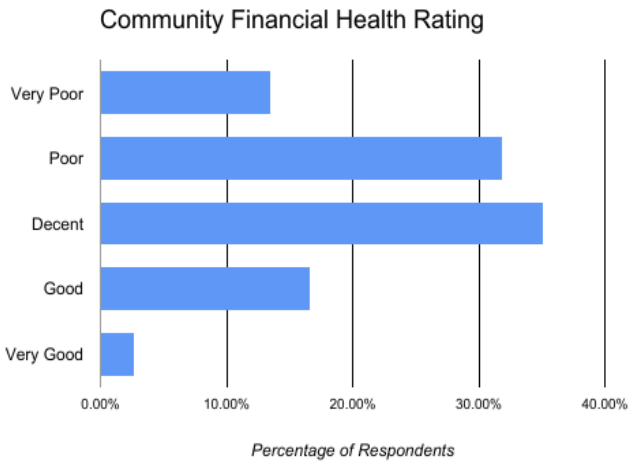
In terms of household income, 54% of respondents had a household income of less than \$25,000 per year; 26% of respondent households had an income of between \$25,000 and \$50,000 per year; 11% of respondents earned between \$50,000 and \$75,000 per year, and the remaining 8% of respondents had household incomes of over \$75,000 each year. 39% of respondents reported that they were either “Unsure” or “Very Unsure” of what their income would be each month, and only 33% had a “Very Good Idea.” In terms of covering monthly expenses such as bills, groceries or rent, 60% reported that it was “Somewhat Hard” or “Very Hard” to do this with the income they had at their disposal.



Respondents were also asked about their employment status, whether their job was in their neighborhood, and whether they perceived that there were adequate job opportunities in their community. Of respondents who were not retired, 37% did not have a job, 39% had a full-time job, and 23% had a part-time job. Only 30% of those with a job reported that their job was in their neighborhood, and nearly three quarters of all respondents indicated that there were not adequate job opportunities for residents of their neighborhood.



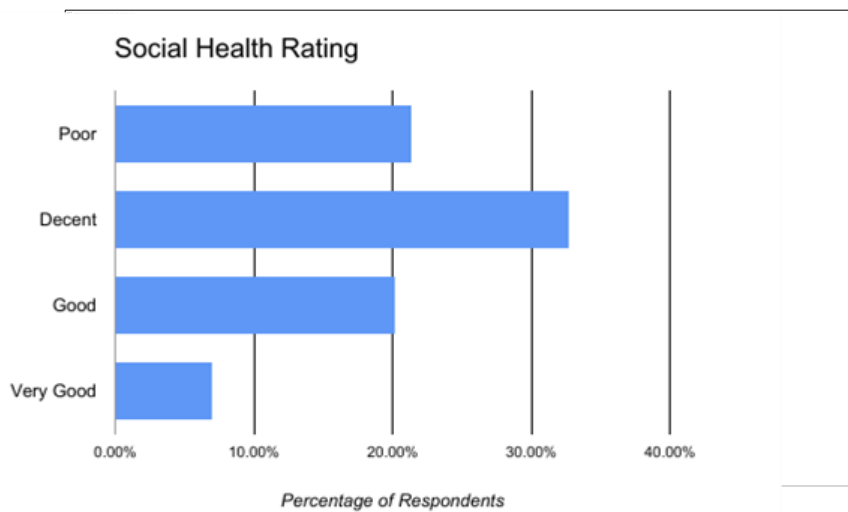
SURVEY RESULTS: FINANCIAL HEALTH



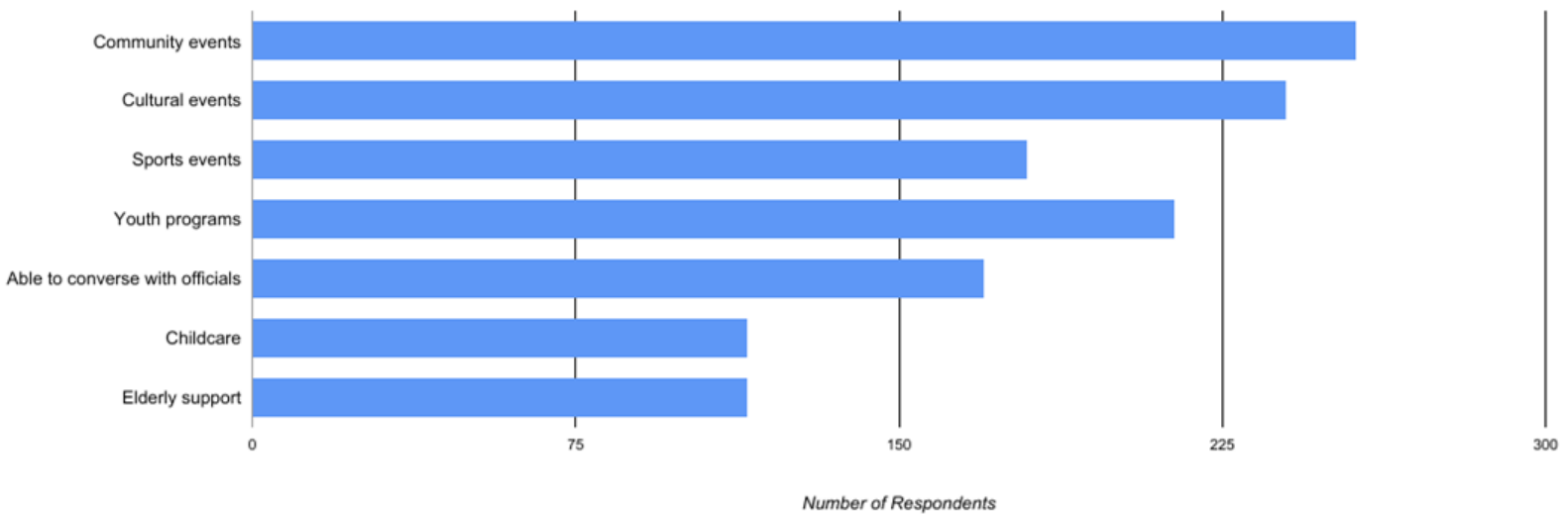
SURVEY RESULTS: SOCIAL HEALTH

Social Health

Lastly, respondents were asked about the social health of the community as a whole. Less than 30% of those who responded to the survey reported that the social health of the community was “Good” or better. All respondents were also asked to prioritize a number of strategies for improving social health, such as increasing community, cultural and religious-based events, additional youth programming, and providing opportunities to speak to elected officials, the results of which are shown below.

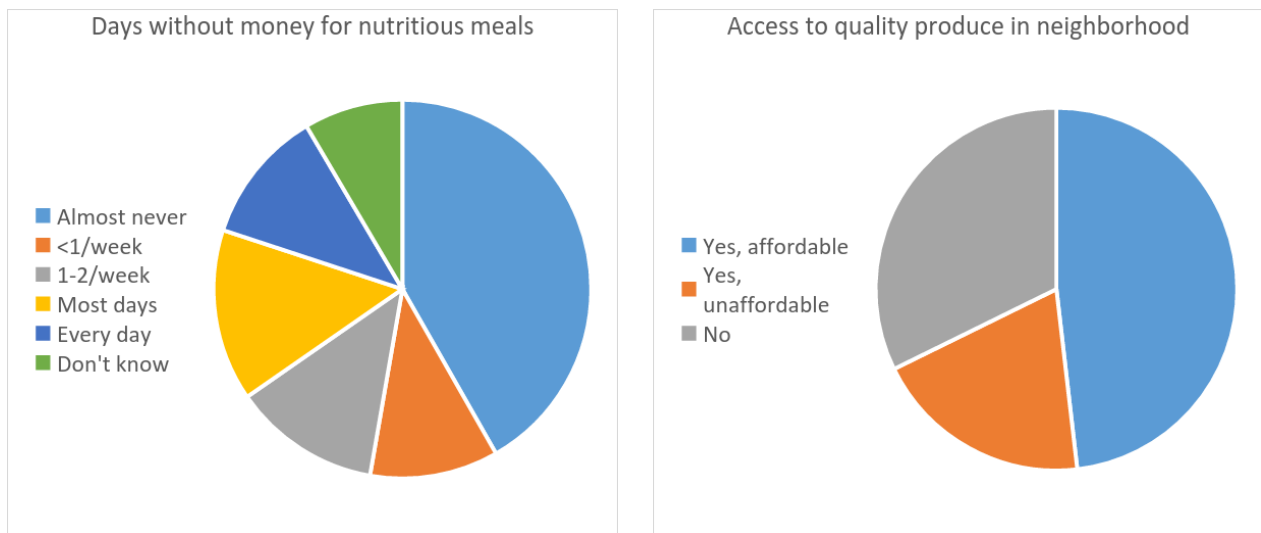


Priorities for Improving Unity and Strength

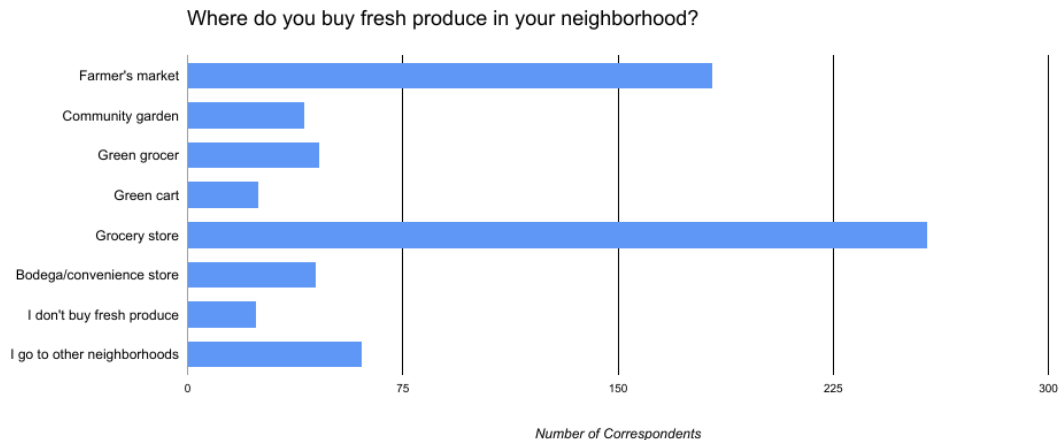


SURVEY RESULTS: NUTRITION

In addition to the five dimensions of health, the PAR team gave priority to understanding some of the barriers to better nutrition in Brownsville and East New York. Respondents were asked how many days per week they do not have enough money for nutritious, well-balanced meals; over half indicated that there was at least one day per week when they could not eat nutritious meals, and for one quarter of respondents this was most days or every day. Similarly, only half of respondents reported having access to affordable quality produce in their neighborhood; an additional 20% said that while they did have access to produce in their neighborhood, they could not afford it, while 40% reported that quality produce was not available in their neighborhood at all.



Respondents were also asked where they buy fresh produce in their neighborhood. Supermarkets were the most common choice, though a substantial share of respondents also reported using farmers markets.



COMMUNITY PROFILES:

East New York and Brownsville

“We are one of the poorest urban communities in the US and we are still here. We have survival skills to keep going in this environment, to support children and raise them up. There is a culture that exists that has a framework and set of survival skills based on this environment; it’s not criminality but strengths that propel the middle class forward. We have a belief in better life for future, work ethic, and the capacity to be able to use imagination to make something out of nothing. We have the tenacity to propel our family forward in the face of difficulties.” - From stakeholder interview, Salema Davis, Director of Community Outreach, George Walker Jr. Community Coalition

The spaces where we live, work, and play are among the biggest determinants of our health status. The strength of this relationship leads us to the intersection of community wellness and economic justice, where we find that low-income communities endure housing insecurity, low access to healthy food, limited venues for active recreation, and insufficient opportunities for high-quality employment. These communities also possess key assets of human and cultural resiliency, which is where we contend we will find the healing power fundamental to any community health transformation in Central Brooklyn.

Understanding the key social determinants of health at a neighborhood level is essential to promoting equity and the achievement of better health outcomes. This section provides a brief social demographic and community health data profile of our study neighborhoods, Brownsville and East New York. It highlights what is similar and different between them, and delves into the resiliency at the heart of both communities that should be the foundation for building community health moving forward.

According to Table 3.1, residents in both communities are predominantly younger, Black, Hispanic/Latino, foreign-born, and low-income. Poverty is experienced at higher levels in Brownsville and East New York than in Brooklyn and NYC overall, with 37 percent and 32 percent of residents, respectively, living under the federal poverty line. This further supports findings from our survey that 40.4 percent (215) of respondents ranked the financial health of their community as “very poor” or “poor,” and an additional 31.6 percent (166) ranked it as “decent.” Similar patterns of inequality stubbornly persist across education, unemployment, housing quality and rent burden. For instance, only one in two residents graduated from high school or attended some college and one in four residents have less than a high school education. Moreover, Brownsville’s unemployment rate ranks tenth (16 percent) and East New York ranks seventeenth (14 percent) among community districts citywide. The lack of adequate local job opportunities compounds this problem: 63 percent (328) of respondents to our survey reported that there are not adequate job opportunities in their neighborhood. Poor housing quality and rent burden also disproportionately affect residents of Brownsville and East New York, while air pollution is consistent with levels in Brooklyn and NYC overall.



COMMUNITY PROFILES:

Residents of Brownsville and East New York experience more gaps in care and negative health outcomes than Brooklyn or New York City in general. The avoidable death rate in Brownsville is 54 percent and 40 percent in East New York, which is an indication of the need for community health transformation. Brownsville and East New York have worse statistics in the following measures relative to other communities in New York City:

- higher rates of injury due to assault;
- higher rates of chronic disease and preventable death;
- higher rates of teen and preterm births;
- higher rates of formerly incarcerated individuals;
- higher rates of substance abuse;
- highest rates of school absenteeism.

Many similarities exist between Brownsville and East New York, but there are differences in population demographics, land use, and economic development. East New York is larger, with 183,571 residents compared to Brownsville's population of 86,337. The population of Brownsville may be undercounted due to apartment sharing (Greene-Walker, 2015).

Land use in each neighborhood is primarily residential. Limited commercial zones include small bodegas, convenience stores, and fast food restaurants. Brownsville has more affordable housing, more residents living in NYCHA housing, and more shelters than East New York. East New York, on the other hand, has an industrial zone that has been a local engine for economic development (Brooklyn Community Board 6; NYC Department of Planning, 2015). Brownsville also has many shelters operated by New York City's Department of Homeless Services, which may help explain the higher rates of negative health outcomes.

One major challenge in both communities is the lack of permanent and affordable housing. Overall, New York City finds itself in the midst of an affordable housing crisis for low and moderate income residents with a shortage of 700,000 units. The DeBlasio Administration (2014 - present) has established a five-year goal of "building or preserving" over 200,000 units. However, this goal will not fully counteract the forces of gentrification - including increasing rent prices, rezoning, and displacement. A report from the New York City Comptroller's office clearly states that "there is nothing affordable about a housing plan that is beyond the reach of more than half of the community" (New York State Comptroller's Office, 2015:2).

These trends are in full force in Brownsville and East New York, but both communities face a different future. New affordable housing and renovations are taking place, but are not enough to meet local demand. For instance, recent and ongoing zoning battles in East New York between developers and neighborhood residents will likely change the landscape of the neighborhood to a mixed income community (NYC Department of Planning, 2015).

³ Population figures taken from DPH Community Profiles, 2015.



COMMUNITY PROFILES:

In fact, the Coalition for Community Advancement, a local collaboration of stakeholders from East New York working together to promote an alternative vision for development, expects the neighborhood population to more than double. With more and more long time residents being squeezed out by increasing rents, the displacement of residents will change the community's health profile. Brownsville, on the other hand, is experiencing a renewed focus of city investments in local public housing, infrastructure, parks, and youth programming (Green-Walker, 2015; Murphy, 2016; Murphy 2015; Murphy, 2014; NYC Housing Authority, 2014). A cornerstone of the city's investment in Brownsville is the DOHMH Center for Health Equity's Neighborhood Health Action Center (NHAC), slated to open in 2016. NHACs will provide primary care, mental health care and, in some cases, dental care; health and wellness classes and programs; community space for groups to work on neighborhood health planning; and links to social services. The goal is to integrate community based organizations and health department staff in one location to advance community health.

In addition to these efforts, a group of nearly 40 government agencies, community organizations and experienced developers have come together to jumpstart a broad range of initiatives in Brownsville and East New York, laying the groundwork for a new model of intergovernment agency coordination. Those efforts are in different stages of the planning process but CCB is poised to help forge strategic alliances with support community health transformation.

Community health care transformation must take into consideration the impact that rezoning and other City planning efforts have on Central and East Brooklyn. Resiliency is a key community asset in both neighborhoods that should be leveraged in the service of community health. Long-time residency is a key indicator of resiliency; 47.6 percent (333) of survey respondents have lived in Brownsville or East New York for at least 10 years or more. Resiliency reflects the capacity and ability of a community to recover and adapt to change. More importantly, it represents the potential that residents and local stakeholders have to be active participants in their community's health transformation.

4 New York City Department of Public Health. Neighborhood Health Action Centers. <https://www1.nyc.gov/site/doh/health/neighborhood-health/neighborhood-health-action-centers.page> <Accessed on September 5, 2016>.



COMMUNITY PROFILES:

Stakeholder interviews clearly revealed a desire for deeper engagement and collaboration among those seeking to create positive change in Brownsville and East New York. Transit Workers Union Local 100 member, Kelebohile Nkhereanye, shared:

“There needs to be more advocacy ... to be taken seriously on the policy level. People in the office are self interested and care more about the violence issue. Now they are jumping to housing, but there are other issues, such as low performing schools and other things. We need local city and state officials to pay more attention to other things that aren't the hot-button issues. I hope that this research will be publicized like the rezoning fight to hear what people have to say, and the people participating need to go to the community board to talk about this research.”

Participants also shared the that transformation requires economic mobility of residents. This was best captured by Renee Muir from Brownsville Multi-Service:

“In a transformed Brownsville, economic opportunities wouldn't simply be limited to people getting more jobs but to people being able to be more entrepreneurial. There is enough money and there are enough resources, but we don't do a good enough job of tapping into the existing workforce. There is an insufficient matching of skills with opportunities for people to use them.”

Residents in both communities face significant changes to their community, yet this study's community action research demonstrates the strength of culture, political, and human assets in both neighborhoods. From East New York's activist spirit being reactivated by recent rezoning efforts to key stakeholders such as BMS, BCJC, ArtsENY, the Coalition for Community Advancement, 1199SEIU, and NYSNA, the resiliency of the community is an asset that must be tapped into in future intervention efforts.



COMMUNITY PROFILES:

Table 3.1 - Demographic & Community Health Comparison Table

Category	NYC	Brooklyn	Brownsville	East New York
Population	8,550,405	2,636, 735	86,337	35,384
Population by race & ethnicity	44% White 25.5% Black 28.6 % Hispanic/Latino 12.7% Asian	49.3% White 34.8% Black 19.5% Hispanic/Latino 12.4% Asian	76% Black 20% Hispanic/Latino 2% Other 1% Asian 1% White	50% Black 40% Hispanic/Latino 5% Asian 2% White 3% Other
Population by age			0-17: 29% 18-24: 12% 25-44: 27% 45-64: 22% 65+: 10%	0-17: 28% 18-24: 12% 25-44: 27% 45-64: 23% 65+: 11%
Foreign Born	37%	38%	30%	35%
Limited English Proficiency			9%	16%
Poverty	20.60%	24%	37%	32%
Life Expectancy			74.1 years	77.7 years
Level of Education	College Graduate: 41% HS Graduate or some college: 39% Less than HS: 20%	College Graduate: 38% HS Graduate or some college: 41% Less than HS: 21%	College Graduate: 18% HS Graduate or some college: 53% Less than HS: 28%	College Graduate: 19% HS Graduate or some college: 57% Less than HS: 24%
Unemployment (% of adults 16 years and older)	11%	11%	16% (ranks 10th)	14% (ranks 17th)



COMMUNITY PROFILES:

Category	NYC	Brooklyn	Brownsville	East New York
Rent Burden (spend 30% of income)	51%	52%	56% (ranks 17th)	66%
Avoidable Death Rate			54%	40%
Reported Positive Health			81%	74%
Leading Causes of Death (per 100,000 population)			Heart Disease, Cancer, Diabetes, HIV	Heart Disease, Cancer, Diabetes, Stroke
Went without need to medical care	11%	12%	11% (ranks 28th)	15% (ranks 5th)
No Health Insurance	20%	20%	18% (ranks 35th)	26% (ranks 8th)
Medicaid Recipients	2,050,286	738,970	23,680	55,997
Housing maintenance defects	59%	62%	73% (ranks 12th)	70% (ranks 17th)
Air Pollution	8.6 micrograms	8.7 micrograms	8.8 micrograms (ranks 29th)	8.7 micrograms (ranks 34th)
Tobacco Retailers (per 10,000 population)	11	11	15 (ranks 10th)	13 (ranks 16th)
Supermarket square footage (per 100 population)	177	156	277 (ranks 7th)	180 (ranks 22nd)
Preterm births	9	8.8	13.3 (ranks 2nd)	11.6 (ranks 4th)
Teen births (per 1000 girls 15-19)	23.6	24	38.5 (ranks 8th)	34.1 (ranks 11th)



COMMUNITY PROFILES:

Category	NYC	Brooklyn	Brownsville	East New York
Elementary school absenteeism (% of students missing 20 or more days)	20	19	40 (ranks 1st)	30 (ranks 8th)
Incarceration (per 100,000 adults 16 years and older)	93	96	338 (ranks 2nd)	181 (ranks 11th)
Injury assault rate	64	66	180 (ranks 1st)	120 (ranks 10th)
Alcohol related hospitalization (per 100,000 adult)	1,019	1,041	2,285 (ranks 4th)	1,534 (ranks 13th)
Drug related hospitalization (per 100,000 adult)	907	921	2,682 (ranks 4th)	1,435 (ranks 13th)
<p>Data Sources: NYC Department of City Planning, Brooklyn Borough Profiles, Community District 5, Community District (2014); (US Census 2015, Quick Facts, NYC and Brooklyn); NYC Department of Mental Health & Hygiene, NYC Community Profiles, East New York (2015).</p> <p>Methodology Note: Community profiles created by NYC Department of Mental Health & Hygiene ranks all 59 community districts across NYC</p>				



5 Please note that this data column combines New York City Department of Planning and New York city Department of Mental Health & Hygiene.

APPENDIX: STAKEHOLDERS INTERVIEWED

Stakeholder	Affiliation
Viola Greene-Walker	Community Board 16
Renee Muir	BMS
Karen Nelson	Maimonides Medical Center
Catherine Green	Arts East New York
Bruce Richard	SEIU1199
Michelle Neugebauer	CHLDC
Eric Smith	NYSNA
Denise West	Brooklyn Perinatal Network
Yvette Rouget	Brownsville Partnership
Quardean Lewis-Allen	Made in Brownsville
James Brodick	Brownsville Community Justice Center
Duane Kinnon	Friends of Brownsville Parks
David Vigil + Sadatu	East New York Farms
Ana Aguirre	United Community Centers
Reggie Bowman	Former NYCHA Citywide Council of Presidents
Layman Lee	Community Solutions/Brownsville Partnership
Anne Heller and Erasma Monticciolo,	Power of Two
Salema Davis	The George Walker Junior Community Coalition
Cruz Fuksman	NY Psychotherapy and Counseling Center
Jennifer Fields	Women's Prison Association
Grant Lindsay, Lead Organizer	East Brooklyn Congregations (EBC)
Kelebohile Nkhereanye	TWU and ENYFarms
Raphael Marte	Liberty Cafe



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