Leading To Health

Local action: People stand near a deli and the staircase leading to a subway station in Brownsville, a Brooklyn, New York, neighborhood that has long lagged behind other nearby communities on indicators of residents’ health and access to care.

For A Big-City Health Department, A New Focus On Health Equity

New York City officials have shifted resources to focus on once underserved communities such as the Brownsville neighborhood, in Brooklyn.

BY REBECCA GALE

Jelanini Bromfield is thirty-five weeks pregnant and familiar with Brownsville, a neighborhood in Brooklyn. Her grandmother lives here, so when Bromfield’s doula recommended a free childbirth class being offered at the Brownsville Neighborhood Health Action Center—a new outpost of the New York City Department of Health and Mental Hygiene (DOHMH)—Bromfield decided it was worth taking the trip from her home on Long Island.

“In Brooklyn the class is free,” Bromfield explains. “Everything else in Long Island you have to pay or go through insurance, and then you still have to pay. Most of my friends aren’t moms yet. I don’t have anyone to talk to about this kind of stuff.”

The class is taught by Gabriela Ammann, a Lamaze-certified instructor who also serves as the community programs manager of the By My Side Birth Support Program and Healthy Start Brooklyn. The series runs for eight classes, but women can enroll at any point. Each woman is given a Metro card for attending, to cover the round-trip fare. Bananas, whole-grain chips, nuts, carrots, and hummus are on offer during class today. Ammann says at every class she makes sure to bring healthful snacks.

In her class Ammann talks about what to expect immediately following a birth—cord clamping, vitamin K shots, antibiotic eye ointment. The women pay attention, some typing notes on their phones, and follow up with detailed questions: How does the placenta get out? Does it hurt? How would skin-to-skin contact work if the baby is delivered via cesarean section? How long does pitocin stay in a woman’s body?

Before the women leave the two-hour class in the basement multipurpose room of the Brownsville Neighborhood Health Action Center, Ammann gives a pitch for the other no-cost offerings through the center. There’s the Baby Cafe, where women can bring their babies to nurse and meet with a certified lactation consultant. And there are other classes on infant cardiopulmonary resuscitation (CPR) and newborn care. There’s even a fatherhood class, which is sometimes co-taught in the demonstration kitchen on the building’s first floor, where dads can learn how to cook to support new moms, while competing in Iron Chef-like demonstrations.

This is Bromfield’s first baby, and she’s found the childbirth class so helpful that she plans to attend the newborn
care and infant CPR classes here in Brownsville after the baby is born. For Bromfield, it makes sense to keep coming back: She knows the neighborhood, the classes are free, and she is already familiar with the high-quality instructors and offerings. The only question that remains is, Why aren’t more communities able to offer similar support?

Communities In Need
What makes the Brownsville Neighborhood Health Action Center unique isn’t the types of services offered, but the fact that they are available in a neighborhood that has historically had poorer health outcomes than other parts of the region. As part of the push over the past four years for more racial equity in health care across the city, DOHMH has sought to redefine what it means to be a big-city health department. The richest example of this experiment so far has been the creation of a small number of Neighborhood Health Action Centers, targeting three key neighborhoods that bear the highest disease burden in New York City: the South Bronx, East and Central Harlem, and North and Central Brooklyn—where the Brownsville Neighborhood Action Center opened its doors in June 2017.

Bringing these no-cost services to Brownsville is part of a deliberate effort to create more equitable health outcomes throughout New York City. In 2014, with a new health commissioner, Mary Bassett, at the helm, DOHMH decided to make a change. Instead of evaluating programs in the context of public health and what could be done to change behaviors around actions such as smoking or diet, DOHMH added equity as a lens through which it studies public health outcomes. In 2015 it created the Center for Health Equity to advance this work.

Leaders at DOHMH now examine racial disparities as an aspect of health and consider relocating services so that they can target and be accessible to populations that have traditionally been underserved. This approach is also about shifting resources and staff away from DOHMH’s headquarters in Long Island City and bringing them closer to the people and organizations they serve. Anecdotes abound on how effective such shifts can be on local health and attitudes, as well as a neighborhood’s willingness to trust government services. But empirical data have been slow to come out, leaving many researchers and advocates to ask whether such a transformational model could work in other parts of the country.

Elevating Health Equity
The Centers for Disease Control and Prevention defines health equity as the attainment of the highest level of health for all people, requiring that everyone be valued equally and that the focus be on addressing avoidable inequalities and injustices. The Center for Health Equity has embraced four approaches to advancing health equity. One is that shift of resources into the neighborhoods with the city’s most detrimental health outcomes, such as Brownsville, through the creation of Neighborhood Health Action Centers. Another is changing the DOHMH structure—including the composition of its staff—to make sure that the people employed by the department are as diverse, and come to the work from as many different backgrounds, as the city’s general population. The third approach is building partnerships. And the fourth is making injustice visible through data and storytelling.

Bassett, who is now director of the François-Xavier Bagnoud Center for Health and Human Rights at Harvard University, explains that in New York City the administration of Mayor Michael Bloomberg had focused on policy-based initiatives for health, using legislative and procurement tools to change health outcomes—such as increasing the tobacco tax or bringing 1 percent milk into schools. But under the current mayor, Bill de Blasio, DOHMH revamped its community engagement efforts.

“One without the other is just not going to be as effective,” Bassett says, referring to the combination of community engagement with legislative and procurement actions. As a deputy commissioner in the early 2000s, Bassett had worked to revise the district health centers, which had their roots in the administration of famed Mayor Fiorello La Guardia in the 1930s and 1940s. Mayor La Guardia had new buildings—designed by leading architects of the time—commissioned for district health centers and other city services. “It demonstrated their commitment to government presence at the neighborhood level,” Bassett says.

The Brownsville Neighborhood Health Action Center is in an art deco building that was constructed in the 1940s and is currently undergoing some modernizing renovations. The building is on Bristol Street, a primarily residential street several blocks from the Rockaway Avenue subway stop. It was established as a district health center in 2002, when Bassett was deputy commissioner. Though the building did house health care providers, such as the Brownsville Multi-Service Family Health Center (BMS), a federally qualified health center, there was limited access to other services and few resources or incentives to focus on getting more people in the door.

The basement multipurpose room is the hub of the center activities: The childbirth class is held there, as well as the Baby Cafe, infant CPR, and community meetings. There are Mylar snowflakes pinned up on the wall and murals painted in the stairwells, to encourage people to use the steps instead of waiting for the elevator. Across the street is a park, newly renovated, and in the blocks between the center and the 3 subway line there is a mixture of high- and low-rise apartment homes.

“The intention was: can we put people and organizations under the same roof, in order to work together and be teamwork and coordination,” says Aletha Maybank, DOHMH’s deputy commissioner and founding director of the Center for Health Equity. Such conversations and meetings have changed the way DOHMH views the neighborhood as a unit, she says, and it prevents duplication of services and integrates neighborhood residents to be part of the structure—both by soliciting feedback via advisory committees and by hiring neighborhood residents to meet its staffing needs.

“Once the Department of Health took the building over, they breathed life into the building,” explains Genese Morgan, the senior project and business manager of BMS, who also acts as the liaison between the health center and the Brownsville Neighborhood Health Ac-
tion Center. BMS has been housed in the Brownsville building on Bristol Street since 2005 and today considers itself the building’s “anchor tenant”—a role for which it applied in response to a call for “expression of interest” put out by DOHMH in July 2015, the same year the Center for Health Equity was created. After interviews and meeting with DOHMH’s legal team, the organization worked out a licensing arrangement, beginning in December 2015, to stay in the building and expand its space and offerings. As part of the conversations with DOHMH, BMS demonstrated its commitment to the principles of health equity and participates in a monthly Governance Council meeting with other co-located partners.

Morgan says she pays below-market rent, though BMS is paying for its own renovation costs for the first-floor dental suite, which will be completed in 2019. Currently the clinic offers adult primary care with a special focus on HIV/AIDS and other infectious diseases; obstetrics-gynecology, podiatry, and surgical consultations; specialty services such as pulmonology, nephrology, gastroenterology, cardiology, and psychology; case management services; and behavioral health and care coordination services. The building also houses two other provider organizations: Gotham Health provides pediatric services, and the Brooklyn Perinatal Network provides myriad services aimed at reducing infant mortality. All of these services are available to the community, regardless of people’s ability to pay.

Not all of the partners within the Neighborhood Health Action Center require permanent space in the building. Some organizations are run under DOHMH’s umbrella, such as Shop Healthy, which aims to connect residents with healthier prepared food options; the Fatherhood Program; and the Breastfeeding Empowerment Zone. Each program has access to the facilities, including multipurpose rooms, as needed. Ammann’s childbirth class is one such example.

“We wanted people to know it wasn’t just about coming in to see the doctor and get the checkup,” says Torian Easterling, the assistant commissioner at DOHMH who oversees the Brownsville Neighborhood Health Action Center. “People need information about housing and legal aid services. We were trying to shift the story of what creates health in someone’s lives and in the neighborhood.”

Easterling says that since the center’s block-party kickoff in summer 2017 (“Brooklyn is known for their block parties,” he says), they’ve nearly doubled the number of people walking into the building to roughly a thousand a month, for clinical services; cooking demonstrations; or classes on childhood, newborn care, or breast-feeding. He expects traffic to continue to increase as the dental suite and Family Wellness Suite get up and running. “Dental service [in the area] is a critical piece that is needed,” he says.

Understanding Brownsville

To understand the focus on health equity in New York City requires an understanding of neighborhoods like Brownsville and the policies—from the systematic denial of home loans to the disinvestment of health care resources, transportation, and other public infrastructure—that have plagued their history.

Brownsville has been a victim of red-lining, a practice of denying mortgages for homes in the area that began in the 1930s and led to nearly nonexistent levels of home ownership and tremendous gaps in personal and intergenerational wealth among people of color. Regulatory changes and activists’ efforts have begun to counteract those policies in recent years. But closing the gaps created by such systemic discrimination requires a shift in thinking across the city’s institutions and leaders—a shift that Maybank believes began with the creation of the Center for Health Equity and continues with a whole generation of new city employees and public health workers who are integrating equity into all of their performance metrics.

The center’s focus on childbirth and infancy is intentional, from the twin perspective of health equity and preventable outcomes. While New York City’s infant mortality rate is at an all-time low, rates of infant death, premature birth, and illness are far higher in central and eastern Brooklyn than elsewhere in New York City and the United States. African Americans in New York City experience especially poor health outcomes compared with other groups.

Nationwide, babies born to African American mothers are three times more likely to die in the first year of life than are babies born to white mothers. Similar trends are found in severe maternal morbidity, or instances of life-threatening complications, for women of color during childbirth.

Brownsville has the highest rate of premature mortality in New York City, one of the highest rates of infant mortality, and one of the lowest life expectancies. DOHMH maintains Community Health Profiles—which include meticulous health records detailing life expectancies, hospitalizations, and illness by neighborhood—and found Brownsville to have a poor performance on a number of preventable health care metrics, including many outside of childbirth and infancy. Brownsville has the second-highest rate of preterm births among the fifty-nine community districts in New York City.

Detailed in the profile are other socioeconomic factors that correlate to poor health outcomes for Brownsville’s residents. For example, Brownsville has the highest citywide percentage of elementary school students who miss twenty or more days of school. And Brownsville residents have the second-highest rate of incarceration in the city—over three times the Brooklyn and citywide rates.

In addition, Brownsville has the highest rates in the city for injury assaults and avoidable diabetes hospitalizations. Brownsville residents rank high for consuming sugary drinks and low for consuming fruit and vegetables—and high again for diabetes, mental health risks, and avoidable asthma hospitalizations. The neighborhood’s rate of alcohol- and drug-related hospitalizations is nearly twice the average in both Brooklyn and the whole city.

Measuring Impact

Easterling had been optimistic about forthcoming data to show improvements in health outcomes in Brownsville, but current data on change in health outcomes were not available from DOHMH.

But Bassett cautions against relying on empirical data to show improvement in such important “unmeasurables” as
trust in the government system and access to high-quality care.

“How do you show a health department has impact?” Bassett asks. “A health department is never one thing. Community views, trust in the health department and government more broadly are part of that relationship building when you [co-locate],” she says.

Elana Martins, health coordinator at the Brownsville Neighborhood Health Action Center and a resident of the neighborhood, cites the collaboration to get more students immunization-ready for schools with the co-located health centers and neighborhood partners. “We did a presummer collaboration and did numerous [types of] outreach on getting school ready. School partners did see an uptick in students who were immunized,” she says.

Impact can also be measured by examining which programs that rely on the Brownsville Neighborhood Health Action Center to connect with residents have seen increased use of services among the Brownsville population, including infant and newborn classes, Baby Cafes, and exercise options.

Shameika Williams, a program coordinator for the Center for Health Equity’s Breastfeeding Empowerment Zone initiative, manages the Baby Cafe out of the Brownsville center. It is an effort to reduce barriers to breast-feeding and provide lactation support, so more women can breast-feed longer and are able to take advantage of the subsequent health benefits that go along with that. “Prior to the launch of Baby Cafe, there were no free supports in Brownsville for breast-feeding,” Williams says. “We wanted to provide equitable choices, with lactation consultants, so women would get the same services as if someone was paying $400 an hour to have that home visit, just by coming into the Baby Cafe.”

In the first six months since April 2018, when the Baby Cafe began in the Brownsville Neighborhood Health Action Center, they’ve had over 160 visitors. A spokesperson from DOHMH estimates that an average of 55 participants took part each month in childbirth classes, infant safety and CPR training, newborn care, “Move It Mama Fitness,” “Dancing Thru Pregnancy,” fatherhood programs, and farmers market visits. And Martins says that the co-located health service providers have also reported an increase in the number of patients accessing their services.

Bassett also notes that these are not new models: There are more instances of success outside the United States. “The model for the health action centers draws on strategies that have been used in developing countries, where health systems strive to be places that people enter but reach out to people in their daily lives where they live. We in the United States have a lot to learn from those models that have sought to invest more in community-level interventions, which is what the Neighborhood Health Action Centers are seeking to do,” she says.

Maybank points to other indicators that the Center for Health Equity’s focus on racial disparities is effective within the current DOHMH structure.

“Several examples of different divisions have looked at their data differently,” she says, now that equity is one of the lenses by which programs are examined for effectiveness. She cites the example of the department’s emergency preparedness unit, which puts plans in place for responders to distribute medicines in the event of a citywide emergency. “The way to distribute medicines was not equitable. Boroughs like the Bronx didn’t have enough coverage,” she says.

The South Bronx, one of the areas of focus of another Neighborhood Health Action Center, has a population that is predominantly people of color and low income. The assistant commissioner who heads the Bronx Neighborhood Health Action Center, Jane Bedell, also serves on an advisory board for DOHMH’s emergency preparedness, so she was able to lend her expertise on how best to respond in the event of an emergency.

Persistent Challenges

Acquiring data to define success has been a challenge for the Center for Health Equity’s Neighborhood Health Action Centers. Another has been the fatigue or skepticism among community members that can deflate many a well-intentioned government initiative as it enters previously underserved communities for the first time.

Maybank says that after Mayor de Blasio came into office in 2014, he gave a directive to city agencies: Go out and talk to people. So the agencies embraced the task. In quick order, numerous entities went into places like Brownsville, which had historically gone without resources and citywide attention.

Such an apparently sudden flood of interest left some residents on guard and posed a hurdle for agencies looking to build truly collaborative community partnerships. “What it pushed agencies to do is make the agencies better at coming together and being collaborative,” says Maybank. But it also blurred the lines of what each individual agency could do in meeting residents’ needs.

“It can be hard to describe to folks what this is. There isn’t a model out there that is like this, so it is hard to get attention and funding,” says Maybank. Going forward, she says, “our role and responsibility” need to include “better ways for us to figure out how to explain and do the work.”

Another challenge has been the question of how exactly to foster collaboration between the many existing community-based organizations that now co-locate in Brownsville. Sharon Marshall—the program manager of the Center for Health Equity’s Family Wellness Suite, which works to improve infant and maternal outcomes—says that she has worked hard to make sure the Neighborhood Health Action Center would not be seen as a competitor with other community-based organizations, many of which had been operating in Brownsville for decades. “We are not case management,” she clarifies, a service some of their partners offer. Rather, she focuses on the other services that the center offers and the monthly meetings of the Governance Council, which Morgan also attends, in which they can collaborate with and update one another.

In setting up the Neighborhood Health Action Centers, Bassett found that it was hard to convince DOHMH staff to move away from the centralized headquarters to the neighborhood centers. The department has 7,000 employees, approximately 233 of whom work under the Center for Health Equity. Many employees work in a modern of-
office building in Long Island City, in Queens.

Not all staff members were eager to leave the main office. “Many people feel the closer you are to headquarters, the closer you are to the heartbeat of an organization,” says Bassett. To some extent, moving staff into the neighborhoods has meant rethinking how they recruit and retain staff. “If you’re seeking people who wanted to make their daily life far from the mother ship, you needed to get a special group of people,” she says. Bassett credits Maybank with creating teams of people who are committed to the mission of health equity—a mission without immediate results and data, which can make it hard to fully appreciate the impact of the work.

A Vision For The Future

Bassett says that there has always been a contest over the type of model a major municipal health agency should have: a centralized department with services delivered through contractors, or a robust on-the-ground presence. She credits de Blasio with being more committed to community-facing activities and acknowledges that New York City has both the resources and the innovative mindset to try something new.

“It sounds sensible to people,” says Bassett. “You have to spend money on it. The timeline to assess impact of the changes and models is not one or even two years. It requires an ongoing commitment to the model and a level of certainty that it will have certain effects.”

Maybank agrees that the lack of immediate data surrounding the Neighborhood Health Action Centers and health outcomes should not be a deterrent. Transformational changes, such as creating a focus on health equity and targeting the neighborhoods historically deprived of resources, will take years of work before measurable outcomes are available.

“When you think of big movements—civil rights or women’s or labor—I don’t know how measurable they were. Were they measuring with numbers? Was there a requirement? No. They were started by those who were experiencing injustice,” Maybank says. “We see ourselves as a health department. We are an institution—we have to justify where we go. But a lot of time people have lived experience and they know it works.”

Maybank says that other localities have contacted their office to learn more, both about the Center for Health Equity and about the Neighborhood Health Action Centers. A center requires a building, though, and not all health departments have the resources of New York City. It also requires a strong sense of cooperation between longstanding, local community-based organizations, which are often pitted against each other to fight for a limited pool of funding. “It’s always good when a funder requires you to work collaboratively with others,” Maybank says. But once those partners are identified and shared space can be found, those with trusted relationships in the community can begin assessing community interest and gauging what the needs are.

DOHMH recently spoke with an organizing body of community residents in Southern California, who wanted to follow New York City’s process in creating a similar health center.

But even with all of the supports and engaged partners, health equity work requires a persistence and vigilance that can test the patience of people looking for instant gains in health outcomes.

“That is the intention of equity work: You have to be persistent with health equity. It is not going to be easy work. You have to be courageous and know it’s the right thing. We are doing this for the sake of excellence,” Maybank says.

NOTES

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