WYCKOFF HEIGHTS MEDICAL CENTER

Community Health Needs Assessment and Community Service Plan

WHMC DEPT. OF POPULATION HEALTH
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BUREAU OF HOSPITAL & PRIMARY CARE SERVICES
COMMUNITY SERVICE PLAN CONTACT INFORMATION SHEET

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Executive Summary

As healthcare enters into the next decade, we continue to live through a time of great change. There is continuing movement toward transitioning from a volume to a value-based care delivery system. There is also an increasing recognition that many of the drivers of both health care utilization and healthcare outcomes exist outside of the traditional healthcare delivery systems.

And while substantial government resources have been devoted to supporting hospitals and healthcare providers during the transition, sustainability remains a challenge. For example, there remains no consistent funding stream for non-traditional care providers such as community health workers and health coaches. While many organizations have begun receiving an increasing percentage of their payment via value based payment arrangements, the learning curve has been steep and there has not been enough experience with the arrangements to make this funding consistent and reliable.

As a result, many of the very promising programs put into place in Wyckoff Heights Medical Center’s last Community Health Improvement Plan have had interruptions in implementation or changes in funding. The assessment of community needs, as identified by the New York State Prevention Agenda, Take Care New York (TCNY) 2020 which is New York City’s health improvement plan, the New York City Community Health Profiles and our own survey conducted of local residents, has remained largely unchanged. For example, while improvements have been made in teen pregnancy, access to prenatal care and maternal and fetal outcomes, Wyckoff’s primary service area continues to have unacceptable rates of low or no prenatal care and of teen pregnancy.

Additionally, there remain higher risk factors for cardiovascular disease and diabetes such as smoking and obesity leading to higher risk of premature death related to these conditions when compared to New York City and the state as a whole. And while the HIV epidemic continues to be problematic for New York City, the Black and Hispanic populations are overly impacted and they represent majorities in the communities we serve. These disparities result in a disproportionate burden of HIV infection in the Wyckoff service area.

At the same time, this region is a Health Professional Shortage Area (HPSA) with sparse numbers of primary care and behavioral healthcare providers. In an effort to address this shortage and to insure that

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all residents in its service area has access to care, Wyckoff applied for and was awarded National Health Service Corp designation. This allows it to compete with neighboring institutions and private practices for talented young physicians pursuing primary care careers by providing student loan forgiveness opportunities.

Another challenge in the path to a transformed health care delivery system is the increasingly recognized role of social determinant of health in health care cost, utilization and outcomes. Hospitals and traditional health care providers have not been well equipped to manage these complex social issues and have struggled to first measure and then assist with them once identified. Though WHMC has had consistently strong ties to the community and the various community based and social service organizations that serve our mutual populations, work needs to be done to improve communication and coordination of activities.

Additionally, the WHMC service area has been one of the neighborhoods on NYC that has been identified as gentrifying. This adds another layer of complexity to the hospital’s planning for how to best meet the needs of the community. Our institution has recognized the importance of these factors and is putting processes in place to ensure that this data is routinely collected and that it is used as part of a risk stratification tool that will allow for proactive identification and targeted intervention for high risk patients.

In acknowledgement of this complicated journey, WHMC has created a Division of Population Health to oversee the variety of government and insurance programs, to act as a resource for the WHMC staff and to coordinate activities between historically siloed departments such as Finance, Information Technology and the Clinical Departments. With focus and recognition of the vital role the organization plays in the health and well-being of the vulnerable population it serves, Wyckoff Heights Medical Center is committed to assessing and serving the needs of our community while navigating the evolving health care environment.
Introduction

Healthcare is in the midst of undergoing a major transformation. The ACA had charged healthcare providers with restructuring the service delivery system to better support preventive care that meets the holistic health needs of individuals, families and communities. This transformation is grounded in guiding principles such as Patient-Centered Care and is embodied in emerging models such as the Accountable Care Organization and the Patient-Centered Medical Home. New payment methodologies are being rapidly implemented to finance the transition from a volume-based to a value-based system of reimbursement.

This healthcare transformation is being driven by policy initiatives on the national, state, and local levels. On the national front, the U.S. Department of Health and Human Services initiative approved the Healthy People 2030 (HP 2030) framework in June of 2018. The Health People initiative is the result of a multiyear process that reflects input from a diverse group of individuals and organizations and provides science-based, 10-year national objectives for improving the health of all Americans. This is the fifth edition of Healthy People and it aims to build on lessons learned from its first 4 decades. Its aims are to help people live high quality, longer lives free of preventable disease, disability, injury, and premature death; to improve health equity and reduce disparities; and to create social and physical environments that promote good health across all life stages.

Although much progress has been made, the United States lags other developed countries on key measures of health and well-being, including life expectancy, infant mortality, and obesity, despite spending the highest percentage of its gross domestic product on health. The challenge for Healthy People 2030 is to guide the United States in achieving our population’s full potential for health and address the areas where we lag behind other developed countries.

At the State level, New York has continued to support initiatives such as the Health Home Program and the Delivery System Reform Incentive Payment Program (DSRIP). These programs have been designed to help to reorganize service delivery with the aim of improving coordination of care, reducing avoidable hospitalizations, and reducing the use of the Emergency Departments for primary care sensitive conditions. The State also has been implementing its Prevention Agenda 2019-2024. The Prevention Agenda is New York State’s health improvement plan which is he blueprint for state and local action to improve the health and well-being of all New Yorkers and to promote health equity in all populations.
who experience disparities. This strategy includes an emphasis on social determinants of health — defined by Healthy People 2020 as the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

More locally, New York City’s Take Care New York (TCNY) 2020 is the City’s blueprint for giving all residents the chance to live a healthier life. TCNY has two goals — to improve every community’s health, and to make greater strides in groups with the worst health outcomes, so that the city becomes a more equitable place for everyone. Unlike previous Take Care New York plans, TCNY 2020 looks at social factors in addition to traditional health factors, such as how many people in a community graduate from high school or go to jail.

In its last annual report from Dec 2018, TCNY reported that they were not on track to meet all of their key targets for improving health and reducing health inequities. It also identified housing as one the many complex drivers of health inequities, further reinforcing the need to address social determinants of health. The report focused on case studies for programs and services such as Centering pregnancy, Community health workers, and Peer Educators that have shown promise in improving health outcomes in the boroughs of New York City.

It is against this backdrop that Wyckoff Heights Medical Center prepared this Comprehensive Community Service Plan (CSP). These global, national and local community health improvement initiatives informed Wyckoff’s CSP and provided the impetus for addressing and meeting the most pressing health care needs in the diverse communities we serve. In order to be effective in this effort, we must increasingly collaborate with the community and extend beyond our walls to address the non-medical structural, cultural, and social determinants of health specific to the neighborhoods we serve.

To better understand our population, we have systematically evaluated the prevention service needs and priorities of the local community. And through collaborative, cross-sector strategic planning, in partnership with residents and local stakeholders, we have developed a plan of services that will help people achieve and sustain good health.

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History and Scope of Services

Founded in 1889 as the German Hospital of Brooklyn, Wyckoff Heights Medical Center (Wyckoff) has been providing care to the residents of Brooklyn and Queens for more than 125 years. Located in an ethnically diverse residential neighborhood, Wyckoff is a 324-bed, voluntary, teaching hospital. A dedicated staff of nearly 1,900 physicians, nurses and support personnel care for patients of thirty-five distinct languages and cultures.

Wyckoff is a not-for-profit, safety-net community hospital providing medical care in a region that is experiencing some of the most significant economic, social and health inequities in New York City. At a time when many hospitals are experiencing significant reductions in resources and services, Wyckoff continues to respond to the growing healthcare requirements and concerns of the communities we serve by expanding and enhancing clinical programs.

Recent improvements include growing community-based ambulatory care sites including the Wyckoff Pediatric Care Center, and the Center for Positive Health, both NCQA recognized Patient Centered Medical Homes that have recently upgraded to the latest NYS PCMH standards. Wyckoff Doctors Practice, a primary care Article 28 facility, has expanded its services to include select specialists based on community needs and has recently became a NCQA recognized Patient Centered Medical Home, also under the latest NYS PCMH standards.

In the outpatient setting, Wyckoff has established innovative new community health engagement and improvement initiatives through a variety of community service projects to address a broad range of health-related concerns. We have pursued and received numerous grants specifically targeting identified areas of community need. These grants help support essential programs and the staff to support them in such areas as HIV prevention, medication adherence and treatment, childhood asthma, early childhood development through the Healthy Start program, screening for hepatitis C and navigation and linkage to services for people found to be hepatitis C positive, expansion of co-located behavioral health services with primary care through the Collaborative Care model, counseling and supportive services to survivors of sexual violence and outreach, and education and support to women during the course of their pregnancy.
Wyckoff Heights Medical Center operates a 24-hour New York City 911 receiving hospital emergency department, with an area devoted to pediatrics. The medical center is a New York State designated stroke center and level III perinatal center. The American Heart Association and the American Stroke Association have also awarded the hospital with a "Gold Plus Performance Achievement Award" every year since 2012 and with Honor Elite Achievement as of 2018. Today, Wyckoff provides 85,000 visits annually in our Pediatric/Adult Emergency Departments, delivers 1600 babies, and offers more than 160,000 outpatient services to thousands at our network of community ambulatory care centers.

Quality patient care is a team effort. At Wyckoff, we have created a warm, caring place for healing. Patients who receive care at Wyckoff observe extraordinary cooperation between the Hospital's clinical and non-clinical personnel. While physicians, nurses and other healthcare professionals oversee the medical management of patients, non-clinical staff ensure that their holistic needs are being met. Furthermore, the Hospital's ecumenical Chaplaincy Program provides for the spiritual needs of our patients and their families, and for those who so desire, the Hospital's chapel is open 24 hours a day for meditation and worship.

To ensure we meet the future healthcare needs of the communities we serve, Wyckoff undertakes the responsibility of training new generations of qualified physicians through our residency programs. Wyckoff offers Residency programs in Emergency, Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatrics, Surgery, Anesthesiology, Dentistry, Pediatric Dentistry, and Podiatry. The curricula includes patient care, didactic lectures, skills workshops, on-line modules, journal club, performance improvement and scholarship. Residents have the opportunity to care for acutely ill, chronically ill and healthy adults and children of all ages. Residents have opportunities to enhance knowledge, skills, and communication strategies in order to provide safe and effective care in cooperation with a healthcare team. They assume progressive responsibility throughout training, with the goal of becoming independent practitioners.

In order to prepare residents to practice in the evolving health care environment, emphasis is placed on community engagement and the importance of assessing and addressing the social determinants of health. In addition, education on continuous quality improvement, health care economics, health disparities and culturally competent care are an important part of all the residency curricula.
Wyckoff also operates a comprehensive continuing medical education (CME) program accredited by the Medical Society of the State of New York. The CME program is designed to meet the needs of the medical staff and community-based physicians in maintaining a contemporary base of scientific knowledge appropriate to their regular professional activities.

The CME program makes available a sufficient volume of presentations in all disciplines by reputable specialists, which provide ample opportunities for physicians to advance their knowledge and clinical skills so that they may continually enhance the quality of patient care. Teaching methods are tailored to the specific needs of the medical staff and community-based physicians and include didactic lectures, clinical case studies, live demonstrations, hands-on participatory workshops, and self-directed learning in the medical library using text, audiovisual and computer-assisted instruction.

Mission Statement and Community Vision

“Wyckoff Heights Medical Center is committed to providing a single standard of highest quality care to our community through prevention, education and treatment in a safe environment.”

The institutional goal is to continually improve the quality and safety of the healthcare delivery system, utilizing a strategy of constant community needs assessment in such areas as prevention, patient perception of care and safety, and adoption of best clinical and administrative practices. Community outreach, ambulatory care, primary care and preventive medicine are tools to be used in achieving the goal.

Wyckoff Heights Medical Center’s mission and goals will be achieved through the following objectives:

• The Medical Center will provide the highest level of care for all patients regardless of their ethnic origin, race, creed, color, national origin, sex, physical disabilities, sexual orientation, or ability to pay. The worth and dignity for each individual will be recognized.
• The Medical Center will improve the health status of the community by actively participating in organized, innovative system transformation, with a focus on value.
• The Medical Center will promote and support all efforts to provide a safe environment for our patients, employees and visitors.
The Medical Center’s mission and commitment to safe, quality service enables WHMC to become the premier health care provider for the culturally diverse community we serve. This vision statement, developed jointly by WHMC’s Board of Trustees and senior leadership representatives, provides WHMC’s direction for the future and reflects a commitment to respond to the changing healthcare environment and a vehicle through which WHMC can set priorities for new initiatives and investments. Foundational to WHMC’s vision is a commitment to safety and quality—the combination of the highest standards of patient care and services, education, sound financial performance, ethical practices and a commitment to the community.

Wyckoff Heights Medical Center will achieve its goals outlined in the strategic plan by capitalizing on existing strengths and opportunities, adapting to the changing healthcare environment, and placing patients first. The following five strategic initiatives will serve as the framework for the strategic plan:

- **Strategic Growth**: To grow the right type of services, in the right ways, at the right time to provide the mix of care that will best serve patients.

- **Performance Excellence**: To provide patients with the highest quality care and services while remaining financially sound, WHMC remains focused on safety, quality, compassionate service, and efficiency. A variety of tools and best practices are applied to develop goals, achieve targets, and measure results.

- **People Development**: A commitment to staff, through the hiring and retaining of qualified individuals; providing ongoing skills development and training, and offering opportunities for career growth. This is intended to lead to increased job satisfaction which has a positive impact on the overall patient care experience.

- **Information Technology**: The efficient operations of WHMC, dependent on the development and use of systems which help ensure safety and high quality patient care. Information technology is used to facilitate timely, accurate, and secure patient information and reduce error.

- **Innovation**: The provision of clinical breakthroughs and technologies to patients, as well as developing new and innovative strategies to deliver quality patient care.
Understanding WHMC’s Hospital Service Area

Wyckoff Heights Medical Center is a full service community hospital serving culturally diverse populations in the counties of Kings and Queens. To define our service area, we analyzed unique patients served in 2018 by zip code of residence. The area where more than 75% of individual patients reside is defined as Wyckoff’s primary service area, and the area where the next 10% of patients reside is termed the secondary service area. The two together will be referred to as the “Hospital Service Area.” The following table summarizes the zip code data and defines the primary and secondary service areas:

<table>
<thead>
<tr>
<th>Service Areas</th>
<th>Zip Codes (% Patients)</th>
<th>Neighborhoods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Service Area (&gt;75% of patients reside here)</td>
<td>11237 (19%) 11221 (17%) 11385 (16%) 11207 (9%) 11206 (6%) 11208 (6%)</td>
<td>Bushwick Bedford Stuyvesant Ridgewood East New York Williamsburg East New York</td>
</tr>
<tr>
<td>Secondary Service Area (&gt;10% of patients reside here)</td>
<td>11233 (3%) 11212 (3%) 11379 (2%) 11211 (1%) 11378 (1%) 11421 (1%)</td>
<td>Bedford Stuyvesant Brownsville Middle Village Williamsburg/Greenpoint Maspeth Woodhaven</td>
</tr>
</tbody>
</table>

Wyckoff is located on the border of Bushwick, Brooklyn and Ridgewood, Queens. Our service area is one of the most ethnically and culturally diverse constituencies in New York City. It includes the neighborhoods of Bushwick, Bedford Stuyvesant, East New York, Williamsburg and Brownsville in Brooklyn, as well as Ridgewood, Maspeth, Woodhaven, and Middle Village in Queens. The Hospital’s Service Area is home to over one million persons and is extremely diverse in age, racial and ethnic identity, culture, language, and country of origin.
Nearly a quarter of all Wyckoff patients reside in Bushwick, Brooklyn. Neighborhoods in New York do not have official boundaries, but the boundaries of Bushwick are approximately those of Brooklyn Community District 4 (BCD4). Sixty-five percent of BCD4’s 112,388 residents identify as Hispanic or Latino, making Bushwick the largest hub of Brooklyn’s Hispanic-American community. The other racial/ethnic groups include Blacks/African Americans (20%), Whites (9%), Asians (5%), and others (1%). It is important to note that 28% of Bushwick residents have limited English language proficiency, making linguistic competence, particularly in Spanish, crucial to the success of Wyckoff’s community service plan. Bushwick’s array of immigrant groups whose language, culture, religious affiliations, and other mores create a rich vibrancy to the community.

Approximately 19% of Wyckoff’s patient population reside in three zip codes that make up Brooklyn Community District 3 (BCD3), which roughly corresponds to the neighborhood of Bedford-Stuyvesant, or “Bed-Stuy.” For decades, Bed-Stuy has been a cultural center for Brooklyn's African American population. Beginning in the 2000s, the neighborhood began to become increasingly racially, economically, and ethnically diverse, with an increase of foreign-born Afro-Caribbean and African residents as well as residents of other ethnic backgrounds.

As a result, Bed-Stuy is the neighborhood in Brooklyn with the highest proportion of residents who are foreign born. Bed-Stuy is undergoing a process of gentrification, with an influx of new residents contributing to the displacement of poorer residents. Of Bed-Stuy’s 152,403 residents in 2014, 64% were Black/African American, 20% were Hispanic/Latino, 11% were White, 3% were Asian/Pacific Islander, and 2% reported other ethnicity.

Twenty-one (20%) of Wyckoff’s patients resides in Queens Community District 5 (QCD5) including Ridgewood, Glendale, Maspeth and Middle Village in Queens. In the early 20th century, Ridgewood attracted Germans, Italians and other European immigrants who found refuge from Manhattan’s crowded

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4 New York City Department of Health and Mental Hygiene: Community Health Profiles, 2018.
8 New York City Department of Health and Mental Hygiene: Community Health Profiles, 2018.
tenements in its spacious brick and stone townhouses. More recently, immigrants from Albania and Poland settled there, along with those from the Caribbean, Mexico and Latin America.

The NYC Department of Planning’s 2013 report on immigration trends, reported persons from Poland as the largest immigrant group in Ridgewood, followed by smaller numbers of Ecuadorians, Dominicans and Mexicans. As of 2018, QCD5 was home to 166,924 persons: 52% identified as White, 26% as Hispanic/Latino, 9% as Asian/Pacific Islander, 1% as Black, and 1% as other. Twenty-three percent of residents of QCD5 have limited English language proficiency.\(^9\)

In addition to Spanish, Polish and Russian are important language competencies at Wyckoff. Wyckoff also serves key subpopulations residing in parts of Queens Community Districts 6 and 9 (QCD6, QCD9), particularly seniors residing in the neighborhood of Woodhaven. Woodhaven is a mostly residential and semi-suburban neighborhood with a low-density population, consisting mostly of European and Hispanic Americans, a small number of African Americans, and a growing number of Asian Americans.

Approximately 22% of Wyckoff’s service population reside in the East New York zip codes 11207 and 11208. East New York is an under-resourced residential neighborhood in the eastern section of the borough of Brooklyn, represented by Brooklyn Community District 5 (BCD5). During the latter part of the twentieth century, East New York came to be predominantly inhabited by African Americans and Latinos who migrated to the region in search of employment.

Unfortunately, many of the manufacturing jobs they sought were leaving NYC during this wave of immigration, leaving many in the area without good employment prospects. Many social challenges associated with poverty from crime to drug addiction have been prevalent in the area for decades. As of 2018, the East New York community is represented by a 52% share of African-American population, 37% Latino, 7% Asian and 16% have limited English proficiency.

Approximately 8% of Wyckoff’s population reside in the neighborhoods of Williamsburg and Greenpoint, which constitute Brooklyn Community District 1 (BCD1). Williamsburg is an influential hub of contemporary music, with a large local hipster culture, a strong art community and vibrant nightlife. The area experiences a steady gentrification. Many ethnic groups have based enclaves within the

\(^9\) Ibid.
neighborhood, including Italians, Jews, Hispanics, Poles, Puerto Ricans and Dominicans. Greenpoint is the northernmost neighborhood in the New York City borough of Brooklyn. It has a large Polish immigrant and Polish-American community. As with Williamsburg, the recent and continuing building boom in the neighborhood, especially of multifamily dwellings, among other demographic changes, has led to a process of gentrification. Collectively, Williamsburg and Greenpoint are home to 199,190 residents, who are 61% White, 26% Hispanic, 6% Asian, 5% Black, and 2% Other Race. In addition, 20% of the residents have limited English proficiency.

The following table summarizes key demographics of Wyckoff’s Primary Service Area:

Table 1: Wyckoff primary service area (PSA) population, race/ethnicity, and English proficiency

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Total Pop.</th>
<th>Black</th>
<th>Latino</th>
<th>White</th>
<th>Asian</th>
<th>Other</th>
<th>Limited English</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bushwick</td>
<td>112388</td>
<td>20%</td>
<td>65%</td>
<td>9%</td>
<td>5%</td>
<td>1%</td>
<td>28%</td>
</tr>
<tr>
<td>Ridgewood, Glendale, Maspeth, Middle Village</td>
<td>166924</td>
<td>1%</td>
<td>26%</td>
<td>52%</td>
<td>9%</td>
<td>1%</td>
<td>23%</td>
</tr>
<tr>
<td>Bed Stuy</td>
<td>152403</td>
<td>64%</td>
<td>20%</td>
<td>11%</td>
<td>3%</td>
<td>2%</td>
<td>12%</td>
</tr>
<tr>
<td>East NY</td>
<td>181300</td>
<td>52%</td>
<td>37%</td>
<td>3%</td>
<td>7%</td>
<td>2%</td>
<td>16%</td>
</tr>
<tr>
<td>Williamsburg/Greenpoint</td>
<td>199190</td>
<td>5%</td>
<td>26%</td>
<td>61%</td>
<td>6%</td>
<td>2%</td>
<td>22%</td>
</tr>
<tr>
<td>Total PSA</td>
<td>812205</td>
<td>28%</td>
<td>33%</td>
<td>30%</td>
<td>6%</td>
<td>2%</td>
<td>20%</td>
</tr>
<tr>
<td>Change since 2015</td>
<td>2%</td>
<td>-1%</td>
<td>2%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>-1%</td>
</tr>
</tbody>
</table>

In addition, there has been an upward trend in the population of residents in the Primary Service area by 2% when compared with Year 2015. Also notable are the downward trend in the population of African American by 1%, an upward trend of Latino and White population by 2%, and Others increased by 1%. Wyckoff’s service area is characterized by extreme socioeconomic inequities.

There are stark contrasts between the neighborhoods where the majority of residents are white (Williamsburg/Greenpoint and Ridgewood), and those where the majority of residents identify as Hispanic or Black (Bushwick, East New York, and Bedford Stuyvesant). For example, in Bushwick, where Wyckoff is located, 35% of the population has less than a high school education, whereas just next door in

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10 Ibid
11 New York City Department of Health and Mental Hygiene: Community Health Profiles, 2018
Williamsburg/Greenpoint, the rate is only 17%. Likewise, more than 30% of East New York’s residents are living below federal poverty level, while in neighboring Ridgewood, the rate is only 19%.

The unemployment rates in Ridgewood, Glendale, Maspeth, Middle Village and Williamsburg/Greenpoint are 6% while the unemployment rate in Bushwick and Bedford Stuyvesant doubles at 13%\(^\text{12}\). Bedford Stuyvesant and East New York has the highest rates of jail incarceration in New York City, at 1045 per 100,000 persons and 1065 per 100,000 persons, a rate more than five times that of Ridgewood, at 235 per 100,000\(^\text{13}\).

Other socio-economic indices looking at our primary service areas shows that residents of the areas are carrying a very high rent burden with Bushwick area carrying an astronomical 55% of rent burden – a severe situation. The most common measure of housing affordability is a household’s rent-to-income ratio. A household is considered “rent burdened” if it spends more than 30 percent of its income on rent, and “severely rent burdened” if it dedicates more than 50 percent of its income to rent. From 2005 to 2016, rent as a percentage of income increased for New York City tenants regardless of how much money they made, although the challenge was most severe for the lowest-income families.

The following table summarizes these characteristics:

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Total Pop.</th>
<th>&lt;High School</th>
<th>Poverty</th>
<th>Unemployment</th>
<th>Rent Burden</th>
<th>Incarceration (per 100,000)</th>
<th>No Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bushwick*</td>
<td>112,388</td>
<td>35%</td>
<td>25%</td>
<td>13%</td>
<td>55%</td>
<td>610</td>
<td>18%</td>
</tr>
<tr>
<td>Ridgewood, Glendale, Maspeth, Middle Village*</td>
<td>166,924</td>
<td>16%</td>
<td>19%</td>
<td>6%</td>
<td>46%</td>
<td>235</td>
<td>13%</td>
</tr>
<tr>
<td>Bed Stuy*</td>
<td>152,403</td>
<td>21%</td>
<td>23%</td>
<td>13%</td>
<td>53%</td>
<td>1045</td>
<td>11%</td>
</tr>
<tr>
<td>East NY*</td>
<td>181,300</td>
<td>23%</td>
<td>30%</td>
<td>10%</td>
<td>52%</td>
<td>1065</td>
<td>7%</td>
</tr>
<tr>
<td>Williamsburg/Greenpoint*</td>
<td>199,190</td>
<td>17%</td>
<td>17%</td>
<td>6%</td>
<td>48%</td>
<td>305</td>
<td>7%</td>
</tr>
<tr>
<td>NYC</td>
<td>8,537,673</td>
<td>19%</td>
<td>20%</td>
<td>9%</td>
<td>51%</td>
<td>425</td>
<td>12%</td>
</tr>
<tr>
<td>Change since 2015</td>
<td></td>
<td>-1%</td>
<td>-1%</td>
<td>-2%</td>
<td>0%</td>
<td>332</td>
<td>-8%</td>
</tr>
</tbody>
</table>

\(^\text{12}\) New York City Department of Health and Mental Hygiene: Community Health Profiles, 2018
\(^\text{13}\) Ibid
In comparison to Year 2015 which data was used in the previous Community service plan, some of the facts noted as follows as it relates to resident in Wyckoff’s primary service area: there has been a reduction in residents with lower than a high school diploma by 1%, the poverty rate has reduced by 1%, the unemployment rate has reduced by 2%, the rent burden although severely high has been constant, there has been upward tick in the number of resident incarceration per 100,000 resident especially in the East New York and there has been a reduction in the percentage of residents without health insurance coverage.

In comparison to New York City, the communities of Bushwick, Bed-Stuy and East New York in Wyckoff’s primary service area has a higher percentage of residents that didn’t complete High School education, higher poverty level, higher unemployment rates, higher rent burden rates and higher incarceration rate. Bushwick and Bed-Stuy also have a higher percentage of residents without medical coverage. All of these factors shows that the socio-economic stress of these communities occupied largely by Latinos and Blacks are higher compared to the Ridgewood and Williamsburg that is predominantly White.

Bushwick and its surrounding Brooklyn neighborhoods constitute a Department of Health and Human Services designated Medically Underserved Area and are part of the Brooklyn Public Health District, one of three areas identified by NYC with the highest rates of health disparities and poor healthcare access. The region of Northern-Central Brooklyn accounts for the greatest proportion of patients without insurance, the largest numbers of preventable hospital admissions and the most potentially preventable emergency room visits in the borough. At the same time, this region is a Health Professional Shortage Area (HPSA) with sparse numbers of primary care and behavioral healthcare providers. In an effort to address this shortage and to insure that all residents in its service area has access to care, Wyckoff applied for and was awarded National Health Service Corp designation. This allows it to compete with neighboring institutions and private practices for talented young physicians pursuing primary care careers by providing student loan forgiveness opportunities.

Because of these gaps in healthcare services, Wyckoff is an essential healthcare provider for our primary and secondary service areas. Seventy-six percent of Wyckoff’s patients are insured by public insurance or are uninsured, which designates the medical center a safety-net hospital:

Table 3: Wyckoff’s safety net population

<table>
<thead>
<tr>
<th>Insurance</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid/Medicaid Managed Care</td>
<td>50.9%</td>
</tr>
<tr>
<td>Medicare/Medicare Managed Care</td>
<td>13.5%</td>
</tr>
<tr>
<td>Uninsured/Self-Pay</td>
<td>11.6%</td>
</tr>
<tr>
<td>Insured</td>
<td>24.0%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The services Wyckoff provides are crucial to addressing unmet medical need in the service area. Between 2015 through 2018, Wyckoff has discharged 55,886 patients from its inpatient services, including 6,492 births, and provided over 628,037 outpatient visits in its various Article 28 clinic. Additionally, some 319,573 were seen in the adult and pediatric emergency department as treats and releases.

The following service utilization data from 2015 - 2018 shows changes reflective of Wyckoff’s commitment to healthcare delivery system reform, with decreasing numbers of annual inpatient discharges, and rapidly growing outpatient services:

Table 4: 2015 - 2018 inpatient discharges, deliveries, emergency department visits, and clinic visits

<table>
<thead>
<tr>
<th>Service Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Discharges(^\text{15})</td>
<td>13,796</td>
<td>13,923</td>
<td>14,360</td>
<td>13,807</td>
</tr>
<tr>
<td>Babies Delivered</td>
<td>1,624</td>
<td>1,713</td>
<td>1,658</td>
<td>1,497</td>
</tr>
<tr>
<td>Emergency Room Visits (Treat and Release)(^\text{16})</td>
<td>76,889</td>
<td>79,076</td>
<td>79,603</td>
<td>84,005</td>
</tr>
<tr>
<td>Clinic Visits (Article 28 Locations)(^\text{17})</td>
<td>136,650</td>
<td>159,246</td>
<td>164,024</td>
<td>168,117</td>
</tr>
</tbody>
</table>

\(^{15}\) WHMC Internal Report, Dept. of Population Health. CCD Report 12162019. Drive

\(^{16}\) ibid

\(^{17}\) ibid
Hospital Service Area – Health Care Resources

Hospitals
Wyckoff Heights Medical Center (WHMC) operates as a standalone facility in the Bushwick neighborhood or Brooklyn, New York. WHMC is a 324 bed facility that offers a variety of healthcare services including, but not limited to: Emergency Room care, Dental and Eye Care, Health Education/Diabetic Education, Health Screenings, Hearing Tests, Nutrition Counseling, and Primary Care.

Based off the NowPow database, within a 5-mile radius of WHMC, there are 7 other hospitals including: Interfaith Medical Center, Kingsbrook Jewish Medical Center, NYC Health + Hospitals/Kings County, NYC Health + Hospitals/Woodhull, SUNY Downstate Medical Center – University Hospital of Brooklyn, NewYork-Presbyterian Brooklyn Methodist Hospital, and Northwell Health Maimonides Medical Center.

Many, if not all, of these facilities offer the same healthcare services as WHMC, a number of payment methods for patients including self-pay, Medicare/Medicaid, and sliding scale, services in multiple languages, and community support programs like high school equivalency courses. In addition to inpatient and emergency care, there are a number of primary care services in the area.

Such organizations providing primary care to the same 5-mile radius around WHMC include: Advantagecare Physicians – Bedford Medical Center, Advantagecare Physicians – Empire Medical Center, Bedford-Stuyvesant Family Health Center, Bishop Orris G. Walker, Jr. Health Care Center, Family Health Services – Lefferts Avenue, Marc-Antoine Reynolds Alerte M.D. P.C., Medcare, LLC, Prominis Medical Services – Bedford-Stuyvesant, Prominis Medical Services – Prospect Heights, and St. John’s Bread and Life Program

The payor mix for these hospitals are similar and these hospitals represents the safety net for these communities as the population of patients that utilizes their services imitates the community – Underinsured, Underemployed, living below the poverty level and are severely rent-burdened.
Federally Qualified Health Centers

Within Brooklyn, there are 97 Federally Qualified Health Centers (FQHCs). Of these 97 centers, 16 are school-based centers. There is one FQHC in Ridgewood – it is not school-based. These FQHCs are operated by a number of organizations throughout NYC; however, Sunset Park Health Council and New York City Health and Hospitals Corporation run 49 (32 and 17, respectively) of these centers throughout Brooklyn and Ridgewood. Services at the FQHC sites include comprehensive ambulatory care services.

Services include adult services (Internal Medicine, Complete Physicals, Flu and Pneumonia Vaccines, Chest Screening for Tuberculosis, Cancer Screening, Podiatry, and Vision Screening); pediatric services (Pediatrics, School Physicals, Children's Vaccines, Well-Baby Check-ups, and Sick Child Visits); women’s health services (Obstetrics, Office Gynecology, Mammography, Pap Smears, Prenatal Care Assistance Program, Medical Care, Nutritional Counseling, Baby Health Education, Birth Preparation Classes, Family Planning, Pregnancy Testing, Sexually Transmitted Infections, Birth Control, Emergency Contraceptives) and specialty services including Behavioral Health and Radiology.

FQHCs are located in areas of increased Medicaid enrollees. The offer multidisciplinary health care services focusing on engaging community members in primary care and chronic disease management. Many of the staff represents the ethnic diversity of their communities and language access services for patients are a priority. Evening and weekend hours also increase access to health care. One of the reasons cited for ED utilization by community member survey participants was that their doctor’s office was closed.

The table below compares healthcare provider workforce resources by County and State. In most provider category, both Kings and Queens’s counties shows serious understaffing when compared with New York City and New York State. This could be as a result of the high population density in the Counties of Kings and Queens.
Table 5. Kings and Queens County Provider Rates per 100,000\textsuperscript{18}

<table>
<thead>
<tr>
<th>Provider Category</th>
<th>Kings</th>
<th>Queens</th>
<th>New York City</th>
<th>New York State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>280.2</td>
<td>219.3</td>
<td>419.4</td>
<td>362.9</td>
</tr>
<tr>
<td>PCPs (Includes Peds and OB/GYN)</td>
<td>120.5</td>
<td>101.7</td>
<td>138.7</td>
<td>124.1</td>
</tr>
<tr>
<td>Specialists (Includes Psychiatrists)</td>
<td>159.7</td>
<td>116.8</td>
<td>279.2</td>
<td>237.4</td>
</tr>
<tr>
<td>General Psychiatrists</td>
<td>21.7</td>
<td>5.9</td>
<td>49.3</td>
<td>36.0</td>
</tr>
<tr>
<td>Dentists</td>
<td>52.5</td>
<td>69.6</td>
<td>48.6</td>
<td>70.4</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>35.7</td>
<td>45.9</td>
<td>60.0</td>
<td>56.1</td>
</tr>
<tr>
<td>Nurse Practitioners</td>
<td>38.5</td>
<td>40.3</td>
<td>11.7</td>
<td>24.3</td>
</tr>
<tr>
<td>Midwives</td>
<td>6.7</td>
<td>2.2</td>
<td>Combined with NPs</td>
<td>Combined with NPs</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>678.5</td>
<td>865.2</td>
<td>797.6</td>
<td>1039.0</td>
</tr>
<tr>
<td>Licensed Practical Nurses</td>
<td>194.8</td>
<td>207.2</td>
<td>176.5</td>
<td>261.3</td>
</tr>
<tr>
<td>Mental Health Counselors</td>
<td>13.4</td>
<td>15.1</td>
<td>346.2</td>
<td>360.4</td>
</tr>
<tr>
<td>Social Workers</td>
<td>203.3</td>
<td>157.6</td>
<td>488.3</td>
<td>449.2</td>
</tr>
<tr>
<td>Psychologists</td>
<td>30.8</td>
<td>22.1</td>
<td>125.6</td>
<td>122.9</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>44.7</td>
<td>80.6</td>
<td>63.1</td>
<td>84.0</td>
</tr>
<tr>
<td>Physical Therapist Assistants</td>
<td>12.7</td>
<td>27.2</td>
<td>20.8</td>
<td>23.5</td>
</tr>
<tr>
<td>Respiratory Therapist</td>
<td>21.4</td>
<td>20.4</td>
<td>16.8</td>
<td>25.2</td>
</tr>
<tr>
<td>Audiologist</td>
<td>3.3</td>
<td>3.4</td>
<td>3.7</td>
<td>6.1</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>37.5</td>
<td>43.6</td>
<td>34.2</td>
<td>45.3</td>
</tr>
<tr>
<td>Occupational Therapist Assistants</td>
<td>10.3</td>
<td>22.2</td>
<td>2.2</td>
<td>3.9</td>
</tr>
<tr>
<td>Optometrists</td>
<td>8.2</td>
<td>11.8</td>
<td>7.4</td>
<td>8.9</td>
</tr>
<tr>
<td>Speech Language Pathologist</td>
<td>55.4</td>
<td>51.7</td>
<td>45.1</td>
<td>67.8</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>67.0</td>
<td>114.9</td>
<td>71.2</td>
<td>90.6</td>
</tr>
<tr>
<td>Dieticians/Nutritionists</td>
<td>15.3</td>
<td>19.7</td>
<td>43.3</td>
<td>43.7</td>
</tr>
</tbody>
</table>

**Primary Care Providers**

Utilizing the data from the Center for Health Workforce Studies’ Health Workforce Planning Data Guide indicates that 3,055 primary care physicians (PCPs) are practicing in Kings County; 2,335 practice in Queens.\textsuperscript{19} This translates into a rate of 120.5 primary care physicians per 100,000 population in Kings, 101.7 primary care physicians per 100,000 population in Queens.\textsuperscript{20} Compared to a statewide rate of 124.1 primary care physicians to 100,000 population, both counties, Kings and Queens, have an under-supply of PCPs.\textsuperscript{21}

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\textsuperscript{18} The State University of New York, “New York State Workforce Planning Data Guide.”

\textsuperscript{19} The State University of New York.

\textsuperscript{20} The State University of New York.

\textsuperscript{21} The State University of New York.
In spite of the higher ratio for Kings County, shortages of primary care resources are noted by the U.S. Department of Health and Human Services Health Resources and Services Administration which has designated 19 Health Profession Shortage Areas (HPSAs) for primary care.\textsuperscript{22} Queens has 3 designated primary care HPSAs.\textsuperscript{23}

**Physician Assistants and Nurse Practitioners**

When looking at non-physician primary care providers, both Kings and Queens fall significantly below state-wide averages for Physician Assistants, but above for Nurse Practitioners.\textsuperscript{24} Kings County has 38.5 nurse practitioners per 100,000 population and 35.7 physicians assistants per 100,000 population; Queens has 40.3 nurse practitioners per 100,000 population and 45.9 physician assistants per 100,000 population.\textsuperscript{25} These data compare to the statewide numbers of 24.3 nurse practitioners per 100,000 population and 56.1 physician assistants per 100,000 population.\textsuperscript{26}

**Specialty Medical Providers**

Specialty medical provider data from the Center for Health Workforce Studies indicates there is a rate of 159.7 and 116.8 specialist physicians per 100,000 in Kings and Queens counties, respectively, compared with a state-wide rate of 237.4 per 100,000.\textsuperscript{27} When assessing the surgical resources, the statewide rate per 100,000 is 8.8 for general surgeons and 21.6 for surgical subspecialists. In Kings the rates are 7.1 per 100,000 for general surgeons and 23.7 for surgical subspecialists. Queens is less well-resourced with 5.9 general surgeons per 100,000 and 5.9 surgical subspecialists per 100,000.\textsuperscript{28} The availability of psychiatrists is low in both counties: compared to a statewide average of 36 per 100,000 population, in Kings the rate is 21.7 and in Queens it is 5.9.\textsuperscript{29}

**Dental providers**

Queens has almost the statewide average of dentists, at 69.6 per 100,000 population compared with a statewide average of 70.4; Kings falls a below this average at 52.2 per 100,000. The availability of dentists does not necessarily translate into access to care for the Medicaid and uninsured populations.\textsuperscript{30}

\textsuperscript{22} HRSA, “HPSA Find.”
\textsuperscript{23} HRSA.
\textsuperscript{24} The State University of New York, “New York State Workforce Planning Data Guide.”
\textsuperscript{25} The State University of New York.
\textsuperscript{26} The State University of New York.
\textsuperscript{27} The State University of New York.
\textsuperscript{28} The State University of New York.
\textsuperscript{29} The State University of New York.
\textsuperscript{30} The State University of New York.
Rehabilitation Services

When looking at the workforce, Kings County has 37.5 occupational therapists per 100,000 population and 44.7 physical therapists per 100,000 population; in Queens, there are 43.6 occupational therapists per 100,000 population and 80.6 physical therapists per 100,000 population. This compares to the statewide average of 45.3 occupational therapists per 100,000 population statewide and 84 physical therapists per 100,000 statewide.

Behavioral Health Providers and Services

The SAMHSA Locator Database indicates that Kings County has 132 mental health programs accepting Medicaid, 114 serve adults and 71 serve children. Kings County has 58 outpatient mental health centers, operates 28 crisis intervention teams and has 26 psychiatric walk-in centers. The SAMHSA Locator Database also indicates that Queens County has 96 mental health programs accepting Medicaid, 80 serve adults and 50 serve children. Queens County has 50 outpatient mental health centers, operates 20 crisis intervention teams and has 23 psychiatric walk-in centers.

According to SAMHSA, Kings County has 63 substance abuse treatment providers who accept Medicaid and 46 providers who offer services in Spanish. There are 8 hospital-based detox programs and 10 outpatient detox resources. Queens County has 40 substance abuse treatment providers who accept Medicaid and 24 providers who offer services in Spanish. In Queens, there are 2 hospital-based detox programs and 6 outpatient detox resources.

Kings County is also home to 456 physicians certified for Buprenorphine treatment of addiction, and the borough has 35 treatment programs certified for Buprenorphine. Queens County has just over half that many as Kings; Queens is home to 287 physicians certified for Buprenorphine treatment of addiction, and the borough has 21 treatment programs certified for Buprenorphine.

Both Kings and Queens Counties have lower rates of psychiatrists per 100,000 population than New York State.

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31 The State University of New York.
32 The State University of New York.
33 SAMHSA, “Map - SAMHSA Behavioral Health Treatment Services Locator.”
34 SAMHSA.
35 SAMHSA.
36 SAMHSA.
37 SAMHSA.
38 SAMHSA.
Skilled Nursing Facilities
There are 40 skilled nursing facilities in Kings County with 113,054 beds, ranging in size from Boro Park Center for Rehabilitation and Healthcare, with 504 beds, to the Heritage Rehabilitation and Health Care Center, with 79 beds. Dr. Susan Smith McKinney Nursing and Rehabilitation Facility is the only public facility in the county. At 409.3 nursing home beds per 100,000 population, Kings County falls below the state-wide average of 591.2 per 100,000.

In Queens, there are 59 nursing homes with 114,742 beds, ranging in size from New York-Presbyterian/Queens, with 535 beds, to the Queen of Peace Residence, with 53 beds. At 555.6 nursing home beds per 100,000 population, Queens also falls below the state-wide average of 591.2 per 100,000.

Home Care Services
There are 706 home health care providers in Kings County, 30 of which are certified home health agencies. In Queens, there are 827 home care providers, of which 37 are certified home health agencies.

Laboratory and Radiology Services
There are 157 Diagnostic and Treatment Centers in Kings County; 69 of these are free-standing clinics, 98 are associated with a hospital or hospital system. In Queens, there are 97 Diagnostic and Treatment Centers; 37 are free-standing, 60 are associated with a hospital or hospital system.

Specialty service providers (Vision and DME)
In Kings County, there are 422 providers of durable medical equipment. In Queens, there are 272 providers of vision and durable medical equipment. In Wyckoff’s service area, there are 115 providers of durable medical equipment.

Pharmacies
Kings County has 379 pharmacies; Queens County has 347 pharmacies. The primary service area has a lot of small pharmacies.

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39 NYS DOH, “Health Facility General Information | Health Data NY”; NYS DOH, “Nursing Home Profile | Health Data NY.”
40 NYS DOH, “Home Care Agencies by Provider Type and Region/County.”
41 NYS DOH, “Health Facility General Information | Health Data NY.”
42 NYS DOH, “Directory of ESAP Registered Pharmacies.”
Local Health Departments

Kings and Queens Counties promote and protect the health of all who live, work, and play in Kings and Queens Counties. Both counties operate their health departments under the greater NYC Health program. Kings and Queens Counties protect their residents through a number of efforts, some of which include: Inspection grading of dining establishments, licensing dogs, low to no-cost local health clinics, birth certifications, and investigations of infectious disease outbreaks.

Along with these specific preventative actions and responsibilities, NYC Health also focuses on larger health issues its community members may face. Such issues include obesity, heart disease, diabetes, HIV/AIDS, tobacco addiction, substance abuse and even bioterrorism. Many of these focus areas align with the New York State Health Prevention Agenda. The main focus areas for the most recent Prevention Agenda are: Prevent Chronic Disease, Promote a Healthy and Safe Environment, Promote Healthy Women, Infants and Children, Promote Well-Being and Prevent Mental and Substance Use Disorders, and Prevent Communicable Diseases.

The New York City Department of Health and Mental Hygiene (DOHMH) is the local health department responsible for the public health and mental health needs in both Kings and Queens Counties which is addressed through its Take Care New York population health strategy. The DOHMH develops and implements community-based programs and initiatives, often with local partners. The DOHMH lead targeted health and communication strategies in these communities that experience an excess burden of disease.

Each office advances community health through home visiting programs, free exercise programs, efforts to increase access to healthy food, meetings with area doctors and coordination with local coalitions. DOHMH is also charged with working to reduce health disparities and promote health equity by targeting resources to high-need communities. Kings and Queens Counties are the two New York City counties that do not have a District Public Health Office. The absence of this resource can affect the impact of Take Care New York strategies and existing health partnerships in Kings and Queens Counties.
Managed Care Organizations

11 Medicaid managed care plans operate in Kings County, covering 505,496 Medicaid beneficiaries. In Queens, 11 Medicaid managed care plans operate, covering 468,341 beneficiaries. HealthFirst, Metroplus, FidelisCare and Healthplus Amerigroup are the biggest Medicaid managed care plans in NYC.

Hospital Service Area – Community Based Resources

Not-for-profit organizations and other agencies provide significant and impactful programs and resources to the greater Wyckoff community. These programs and resources are specific to the needs of the community and focus on providing services to low income, immigrant and, more generally, vulnerable populations. Many of these programs continue to expand and provide a wide variety of services to the community; because of this, they are vital to the neighborhood’s healthcare infrastructure. Through partnerships with these organizations, Wyckoff can leverage these resources and earned community trust to help support and achieve its goals for improving community health. Most, if not all, resources discussed in this section have been collected through the HITE or 211 databases for Brooklyn (Bushwick, Bedford Stuyvesant, East New York) Ridgewood, Middle Village, and Maspeth.

Community Service Organizations

Brooklyn has 953 organizations that provide a wide range of community services; Ridgewood has 13, Middle Village has 4, and Maspeth has 1. Among these organizations are chambers of commerce, publicly operated clinics, YMCAs, and more. Some examples of services offered by such organizations are early childhood and after school programs, housing assistance, women’s health, community gardens, family counseling, employment assistance, volunteer services, HIV prevention and treatment services, LGBTQ services and support programs, and many more.

Religious Service Organizations

There are over 150 religious services organizations in Brooklyn, and over 80 in Ridgewood, Middle Village, and Maspeth. These organizations reflect the ethnic diversity of the communities they are based in. Many

43 NYS DOH, “Managed Care Organization (MCO) Directory by County”; NYS DOH, “Medicaid Enrollees by Program and County.”
44 NYS DOH, “Managed Care Organization (MCO) Directory by County”; NYS DOH, “Medicaid Enrollees by Program and County.”
45 Health Information Tool For Empowerment
46 Ibid
of these organizations, in conjunction with CBOs, promote health insurance enrollment and creating connections to care.

Community Outreach Agencies
In Brooklyn, there are 15 community outreach agencies ranging from emergency assistance programs to crisis counseling. There are 12 community outreach agencies in Ridgewood, Maspeth and Middle Village. CBOs have a reputation in the community for helping people. In addition, these CBOs are more likely to speak the community’s language(s), and look like the community.

Local Government Social Service Organization
Local government social service programs refer to those programs that influence overall health status/socioeconomic factors and individual and community quality of life. Examples may include: organizations that offer financial assistance/professional financial counselling; housing services (including those that provide assistance to special populations e.g., Veterans); food banks and soup kitchens; food stamp programs; Medicaid offices; job centers; outreach mobiles; youth specific programming and employment. There are 17 organizations providing these services in Brooklyn, and 1 organization providing these services in Ridgewood.

Not for Profit Health and Welfare Agencies
Almost all organizations listed with the HITE and 211 databases can be considered not-for-profit health and welfare agencies – excluding government-operated services. There are 283 organizations fitting this classification in Brooklyn and 11 in Ridgewood, 2 in Middle Village and 1 in Maspeth.

Community Based Health Education
There are 26 community-based health education programs in Brooklyn, and 3 in Ridgewood. These organizations focus on providing their communities with disease information and support, harm reduction services, exercise and fitness classes and education, senior health education, and nutrition education.

Local Public Health Programs
Based on the NYSDOH’s glossary, a local public health services is defined as the local provision/delivery of services to fulfill mission of public health in communities. These services or programs include governmental public health agencies, social services providers, community-based organizations and
private institutions with an interest in population health. Examples include: immunization clinics; center for disease control and prevention (local); substance abuse/mental health organization. There are 54 organizations providing these services in Brooklyn; there are 2 in Ridgewood.

**Education**

Brooklyn has 210 education organizations ranging from adult education to early learning centers, continuing education, ESL, schools and/or certification programs. The HITE database identifies 3 education organizations in Middle Village, 2 in Ridgewood and 1 in Maspeth. Some of these organizations include education geared towards specific populations – continuing education, GED and academic enrichment, vocational training and job placement.

**Youth Development Programs**

In Brooklyn there are 64 youth development programs. The organizations offering these programs offer a wide range of services such as homework assistance, summer youth programs, tutoring and mentorship.

**Libraries**

The Brooklyn Public Library (BPL) has served the community since 1896, and is the sixth largest public library system in the United States. There is a branch library within a half-mile of almost all Brooklyn residents, and in 2018, the library offered of 69,000 free programs to residents. BPL remains a community leader in cultural offerings, literacy, after-school-time services, workforce development programs, and digital literacy.

The Queens Public Library includes a network of sixty-one community libraries featuring collections, programs, resources and services that are relevant to the individual community needs and interests, and provide easy access to library service across Queens – virtually no one in Queens is more than a mile from a public library. All community libraries offer free PC use with Internet access, wireless Internet access, and an extensive selection of online reference databases.

**Area Health Education Centers**

The Brooklyn-Queens-Long Island Area Health Education Center (BQLI-AHEC) is a not-for-profit 501(c) (3) organization established in 2003. The BQLI-AHEC is one of three New York Metropolitan Region AHEC’s that were developed to address health workforce issues in underserved communities. By providing
services to four counties (Kings, Queens, Nassau and Suffolk) BQLI-AHEC target area is one of the largest regions in the New York State.

Nine communities within this catchment area have been designated as Health Professional Shortage Areas (HPSA) by the United States Department of Health and Human Services. These areas include: Bedford Stuyvesant, Crown Heights, Coney Island, East New York, Bushwick and Williamsburg in Brooklyn; South Jamaica and Far Rockaway in Queens; North Valley Stream, Elmont, Hampstead, Roosevelt and Freeport in Long Island. Among these communities, four are within Wyckoff’s primary service area: Bedford Stuyvesant, East New York, Bushwick and Williamsburg.

**Basic Need Resources**

Affordable and safe housing, adequate transportation services, employment, access to food and clothing are all social determinants of health that, if available and utilized, support chronic disease prevention and management.

**Housing**

Housing services include organizations providing housing and rent assistance, housing, homeless services, shelters, immigrant housing, senior housing, resettlement services, and utility services.

There are 103 housing organizations in Brooklyn. Only one is a shelter, and five are transitional housing organizations. Given the fact most, if not all, communities Wyckoff’s served are experiencing the effects of gentrification and severely rent-burdened, it is not surprising the large number of organizations focused on housing assistance.

**Food Pantries, Community Gardens & Farmers Markets**

There are 183 food pantries, community gardens and farmers markets in Brooklyn. Most of these organizations are food pantries. In Ridgewood there are 4; in Middle Village and Maspeth there is only 1 organization in each community. For individuals residing in low-income neighborhoods, accessing fresh fruits and vegetables can be a challenge due to the absence of full-service grocery stores, so the availability of farmers markets is an important source to fulfill this gap. Within Wyckoff’s primary service area, the supermarket to bodega ratio ranges from a low of 0.02 in Bedford Stuyvesant (1 supermarket for 57 bodegas) to a high 0.08 in East New York (1 supermarket for 13 bodegas.)
Clothing and Furniture Banks
There are 6 clothing and furniture banks in Brooklyn. There is only one clothing bank in Ridgewood. These include thrift shops, as well as not-for-profit and religious groups that offer material goods for no charge for the community.

Transportation Services
Brooklyn has 30 transportation services; Ridgewood has 1 and Middle Village has 1. Some of these services are Medicaid medical transport services; other services are specific to a senior center or day treatment program.

Individual Employment Support Services
There are 86 employment support services listed in Brooklyn, and 1 in Ridgewood. These services include employment search services, vocational services and training, and some business assistance.

Employment Support Services
Employment support services include employment services, vocational services and training, as well as small business assistance. In Brooklyn 86 organizations provide employment support; Ridgewood has 1 program that offers one or more components of employment support.

Specialty Education, Community-Based Clinical Services and Advocacy Organizations
These organizations support community members with developmental disabilities and chronic disease, and support community members with developmental disabilities and chronic disease, and their families through services such as case management, entitlement enrollment, support groups and advocacy.

These organizations provide these community-based services to all age groups and coordinate care with medical and behavioral health providers including home care agencies. These organizations are health care extenders that interact with patients and their families on a continual basis and are vital to quality care and population health management.
Specialty Community-Based/Clinical Services for Individuals with Developmental Disabilities

In Brooklyn, there are 140 organizations dedicated to providing services for individuals with cognitive or developmental disabilities. There are 2 organizations in Middle Village and 1 in Ridgewood that provide specialty community-based services for individuals with development disabilities and their families. These services include Medicaid Service Coordination, habilitation services, rehabilitation services, respite, day treatment and other home and community support services.

Specialty Education for Special Needs Children

Brooklyn has 25 specialty education programs for special needs children; Middle Village has 1 specialty education program. These programs include day care and overnight care, as well as parent education and health resources.

Ryan White Programs

In Brooklyn, 12 organizations have been awarded Ryan White funds. These organizations provide an array of services which includes treatment adherence, supportive counseling, family stabilization, housing support, and medical care.

HIV Prevention/Outreach and Social Services

There are 78 HIV prevention and social service programs in Brooklyn. These programs provide preventative programs for youth and adults including high risk populations such as LGBT as well as medical and behavioral health services, case management, health education, support groups and referrals to local social services.

Peer/Family Mental Health Advocacy Organizations

In Brooklyn, there are 271 organizations that provide family support and training programs. There are 2 programs in Ridgewood and 1 in Middle Village. Some of these organizations are mental health providers that also offer peer programs and family support programs; some are community-based social services organizations. Many offer bilingual and multi-cultural programs.
Self-Advocacy and Family Support

Many of the peer and family mental health advocacy organizations also have programs directed at self-advocacy. In addition, there are organizations for people with physical, visual and developmental disabilities that include a self-advocacy component, such as the independent living centers and programs for families with children with autism. In Brooklyn, there are 157 organizations serving this community, in Ridgewood there is only 1.

Foster Care Agencies

In Brooklyn, there are 44 agencies that provide foster care services. Some of these agencies also provide foster/adoptive family support groups. Most organizations operate as not-for-profits providing specific programs for youth and families focused on support networks, child advocacy, service referrals, linkages for prospective foster parents, family team conferences, foster parent support groups and counseling.

Family Support/Training

Family support and training includes after-school programs and youth groups, childcare and day care, counseling for children, domestic abuse/victim’s services, family financial and welfare services, maternal and child health and family planning, home-based family support, parenting support and LGBTQ services. There are 197 organizations in Brooklyn and 3 in Ridgewood.
Community Health Needs Assessment

Overview – Broad Population Health

It has become increasingly clear that the ability to live a long and healthy life is not equally available to all New Yorkers. Many elements shape differences in health outcome including historic and current factors that determine access to resources and opportunities. As such, there are significant challenges to improving population health and the healthcare system in Northern and Central Brooklyn. Unmet health need is indicated by rates of chronic disease, premature mortality and avoidable Emergency Department visits and hospitalizations that are far greater here than in the rest of Brooklyn, NYC, New York State and the nation.

Late or no prenatal care is higher in Bushwick than the citywide rate. And while teen pregnancy has been decreasing across NYC, the rate of 31.7 per 1000 females ages 15-19 is significantly higher in Bushwick than in the rest of Brooklyn (19.9) and NYC (19.3) as a whole. In addition, there remains an unacceptably high percentage of adults without health insurance and this is higher in Bushwick ((18%) than in Brooklyn (12%) or NYC (12%)47. Brooklyn’s avoidable hospitalizations as a ratio of Hispanics to white non-Hispanics is the highest of all the counties that make up New York City48.

Demographic data indicates that the healthcare system in the area will become even more strained. With regard to Social and Economic conditions, Bushwick has a higher rate of poverty and unemployment and a lower rate of high school graduation and poorer housing quality when compared to Brooklyn as a whole or to all of NYC. Kings County ranked 60 out of 62 counties across the state with regard to clinical care. Data shows that Kings County has among the highest rate of uninsured and preventable hospital stays and among the lowest access to primary care and to behavioral health providers.

While the population growth seems to be slowing or reversing there is an increased demand for primary care from the aging population. The number of 85+ New Yorkers has increased 26% since 2007. The percentage of people over 65 years old has increased every year since 2000 in Bushwick and was 8.9% of the population in 2018. The birthrate in NYC as a whole and in the Bushwick region in particular has been

47 Community Health Profiles-Brooklyn Community District 4-Bushwick https://www1.nyc.gov/assets/doh/downloads/pdf/data
decreasing since 2000 but the rate of teen pregnancy and late/no prenatal care remains higher than the citywide rate\(^49\).

**Adolescent pregnancy rate per 1,000 females - Aged 15-17 years, three year average, 2012-2014**

*Kings County ZIP Code Map*

<table>
<thead>
<tr>
<th>Pregnancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kings County - 27.2</td>
</tr>
<tr>
<td>New York State - 18.4</td>
</tr>
<tr>
<td>New York City - 28.3</td>
</tr>
</tbody>
</table>

In addition, the largest proportion of Wyckoff’s patient population consists of publicly insured (Medicaid, Medicare, Medicaid Managed Care) individuals residing in Northern-Central Brooklyn. Analysis also showed that the odds of having an ambulatory care sensitive condition admission to the hospital were higher for blacks and Hispanics than for whites. In addition, Bushwick is one of the 17 neighborhoods identified by New York City as gentrifying\(^50\) which can increase the stress on long-time residents and businesses and make planning for the healthcare needs of the evolving population more complex. It is for all of these reasons that Wyckoff’s Community Service Plan has been developed in alignment with regional

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\(^50\) NYU Furman Center. State of New York City’s Housing and Neighborhoods in 2015. May 2016
processes for healthcare delivery system transformation. This transformation will address non-medical determinants of health through more accessible, community-based, preventive care.

**Chronic Diseases**

The Partnership to Fight Chronic Disease reports that without change, chronic disease will exact an enormous toll on Brooklyn. In 2019, there were 325,000 people with 3 or more chronic disease and this is expected to rise to 372,000 by 2028\(^{51}\). This disease burden disproportionately impacts African Americans and low income residents of Brooklyn. Wyckoff’s service area is profoundly affected by high rates of Chronic Diseases and their developmental antecedents\(^{52}\). The New York City Community Health Profiles for 2018 show that:

- The rate of child asthma emergency department visits is significantly higher than in the lowest rate NYC neighborhood.
- The rate of child asthma ED visits for children is higher than the NYC and NYS rates and is highest in the neighborhoods surrounding WHMC.
- 17% of Bushwick residents are current smokers, compared to 14% citywide\(^{53}\).
- In Bushwick, rates of obesity is 26% which is higher than the TCNY goal of 23\(^{54}\)%.
- Cancer and heart disease are the leading causes of premature death in Bushwick which is similar to the rest of NYC. However, Bushwick residents die prematurely at a higher rate\(^{55}\).

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\(^{51}\) Thrope, K. Partnership to Fight Chronic Disease. www.fightchronicdisease.org/New-York

\(^{52}\) Community Health Profiles-Brooklyn Community District 4-Bushwick https://www1.nyc.gov/assets/doh/downloads/pdf/data

\(^{53}\) ibid

\(^{54}\) ibid

\(^{55}\) ibid
When looking at the New York City Prevention Agenda, it is clear that there is a lot of work to be done. Across all the counties of New York City, there has been variable success in meeting the Prevention Agenda 2018 Objectives. However, in the area of chronic disease, Kings County is the only county that has failed to achieve the 2018 Objectives in every measure\(^\text{56}\).

\(^{56}\) New York State Prevention Agenda Dashboard-County Level 2018 https://webbi1.health.ny.gov
In fact, it has the highest rate of adult cigarette smoking and among the highest for asthma related emergency room visits for children and hospitalization for short term complications of diabetes in adults. The age adjusted heart attack hospitalization rate is higher in Brooklyn than in NYC or NYS and it is highest in the neighborhoods that surround WHMC.
Wyckoff’s service area is profoundly affected by high rates of Chronic Diseases and their developmental antecedents:

- The rate of child asthma hospitalization per 10,000 children in Bushwick, Bed Stuy and East New York is higher than the average of New York City.
- 31% of East New York residents consume one or more sugary beverage per day. The same can be said of the Bed Stuy and Bushwick communities.
- In Bedford-Stuyvesant and East New York, the rates of obesity are 29% and 33% respectively, compared to 24% in NYC overall.
- Diabetes rates are extremely high in East New York, Bedford-Stuyvesant and Bushwick, disproportionately affecting persons of Latino/a ethnicity.
- The Hypertension rates in the same three (33) communities - East New York, Bedford-Stuyvesant and Bushwick – are very high.
Between some neighborhoods in the service area, there are stark contrasts. For example, the rate of deaths by heart attacks in Bed Stuy is 58.3 per 100,000 population, whereas just next door in Williamsburg, the rate is only 34.5 per 100,000. Likewise, Bushwick’s childhood asthma hospitalization rate is 70 per 10,000 children, compared to neighbors Williamsburg and Ridgewood, which have a rate of 18 per 10,000 children; and Bushwick’s diabetes hospitalization rate is more than double that of Williamsburg. These data suggest targeted approaches to preventive intervention. The following table summarizes indicators of chronic diseases and their antecedents in Wyckoff’s service area:

Table 5: Chronic diseases and associated antecedents in Wyckoff’s service area

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Smoking</th>
<th>Soda</th>
<th>Physical Activity</th>
<th>Obesity</th>
<th>Diabetes</th>
<th>Hypertension</th>
<th>Child Asthma (per 10,000)</th>
<th>Heart Deaths (per 100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bushwick</td>
<td>17%</td>
<td>23%</td>
<td>75%</td>
<td>26%</td>
<td>13%</td>
<td>26%</td>
<td>290</td>
<td>42.3</td>
</tr>
<tr>
<td>Ridgewood, Glendale, Maspeth, Middle Village</td>
<td>20%</td>
<td>19%</td>
<td>68%</td>
<td>22%</td>
<td>8%</td>
<td>23%</td>
<td>115</td>
<td>30.5</td>
</tr>
<tr>
<td>Bed Stuy</td>
<td>19%</td>
<td>29%</td>
<td>70%</td>
<td>29%</td>
<td>13%</td>
<td>34%</td>
<td>375</td>
<td>58.3</td>
</tr>
<tr>
<td>East NY</td>
<td>13%</td>
<td>31%</td>
<td>70%</td>
<td>35%</td>
<td>14%</td>
<td>34%</td>
<td>315</td>
<td>53.2</td>
</tr>
<tr>
<td>Williamsburg/Greenpoint</td>
<td>17%</td>
<td>18%</td>
<td>66%</td>
<td>23%</td>
<td>11%</td>
<td>25%</td>
<td>136</td>
<td>34.5</td>
</tr>
<tr>
<td>NYC</td>
<td>14%</td>
<td>23%</td>
<td>73%</td>
<td>24%</td>
<td>11%</td>
<td>28%</td>
<td>223</td>
<td>32.9</td>
</tr>
<tr>
<td>Change since 2015</td>
<td>1%</td>
<td>-4%</td>
<td>-4%</td>
<td>0%</td>
<td>1%</td>
<td>N/A</td>
<td>-96</td>
<td>-169.7</td>
</tr>
</tbody>
</table>

* Indicates highest or lowest rate in the service area

In comparison between 2015 and 2019, there has been an upward tick of 1% in the percentage rates of smokers and numbers of diabetics in the primary service area for Wyckoff and a downward trend of 4% in the percentage of adults who participate in physical activity. On the positive side there has also been a 4% decline in adults who drink one or more 12-ounce sugary drinks per day.

Healthy, Safe Environment

The environmental conditions of Wyckoff’s neighborhoods contribute to disparate health outcomes. Environmental determinants of health reflect the physical conditions of the environment in which people

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57 New York City Department of Health and Mental Hygiene: Community Health Profiles, 2018.
are born, live, learn, play, work, and age. They impact a wide range of health, functioning, and quality-of-life outcomes.

Key indicators related to environmental health in Wyckoff’s service area include violence, housing quality, air pollution, tobacco retailer density, and supermarket square footage. The area is particularly impacted by violence, with non-fatal assault hospitalizations occurring twice as frequently as in New York City overall.

The table below summarizes environmental conditions in the service area:

**Table 6: Environmental conditions in the Wyckoff service area**

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Housing Defects</th>
<th>Air Pollution</th>
<th>Supermarket to Bodega Ratio</th>
<th>Violence (per 100,000)</th>
<th>Tobacco Retailers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bushwick</td>
<td>40%</td>
<td>8.1</td>
<td>0.03</td>
<td>72</td>
<td>73</td>
</tr>
<tr>
<td>Ridgewood, Glendale, Maspeth, Middle Village</td>
<td>62%</td>
<td>8</td>
<td>0.07</td>
<td>19</td>
<td>131</td>
</tr>
<tr>
<td>Bed Stuy</td>
<td>40%</td>
<td>8.1</td>
<td>0.02</td>
<td>117</td>
<td>99</td>
</tr>
<tr>
<td>East NY</td>
<td>38%</td>
<td>7.7</td>
<td>0.08</td>
<td>113</td>
<td>219</td>
</tr>
<tr>
<td>Williamsburg/Greenpoint</td>
<td>50%</td>
<td><strong>9.6</strong></td>
<td>0.04</td>
<td>34</td>
<td>83</td>
</tr>
</tbody>
</table>

* Indicates highest rate in the service area

Despite residing in severely rent-burdened communities, the majority of the accommodations in the primary service areas have housing defects- 62% of homes in Ridgewood, Glendale, Maspeth, Maspeth and Middle Village. Housing defects may include situations such as problems with heating or cooling, leaks, peeling paint, and insect infestations. Poorly maintained housing is associated with poor health outcomes.

New York City is also grappling to find solutions for its pollution problems. Pollution in New York City stems from sewer overflows, runoff, land pollution from plastic bottles and garbage and air pollution. In recent years, the city has developed innovative solutions to some of these problems, such as using hybrid buses and city vehicles to reduce emissions. Still, the larger issues remain.

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58 New York City Department of Health and Mental Hygiene: Community Health Profiles, 2018.
59 Ibid
NYC has a significant air pollution problem that causes premature death for many people. Ozone, or smog, is the biggest problem. It is caused by sunlight interacting with vapors released from motor vehicles, factories and fuel-burning sources. The American Lung Association says the NYC metropolitan area ranks 16th for ozone pollution when compared to 25 other American cities. It estimates that stricter soot controls could potentially save more than 3,000 lives every year in the greater New York metropolitan area. Fine particulate matter is another culprit, and it is caused by ash, soot, diesel fumes and chemical emissions. Particulates burrow their way deep into the lungs and cause asthma, chest pain, wheezing and cancer. Of the major neighborhoods in the Wyckoff Primary Service area, the communities of Williamsburg and Greenpoint has the highest level of air pollutants with 9.6 micrograms per cubic meter.

Current and historic structural factors that lead to poor, racially segregated neighborhoods also create community risk for diet-related conditions. While table 5 has highlighted that the poor communities in the primary service area (Bushwick, Bed Stuy and East New York) are struggling with high level of diabetes, hypertension and deaths related to heart diseases, our assessment in table 6 also notes that Supermarket to Bodega ratio are not acceptable. There are 31 bodegas for every supermarket in Bushwick and 57 bodegas for every supermarket in Bed Stuy. Not having access to healthy, high-quality, and affordable food can affect the health of a community’s residents. While bodegas are convenient and are undeniably part of the city’s lifeblood and as crucial to New York City’s landscape as its verdant parks, extensive subway system and soaring skyscrapers, they do damage to the health of the population because of the types of food items they carry – sugary drinks, salty meals etc.
**Healthy Women, Infants and Children**

**Perinatal Health.** In 2017, there were 11,414 births in Wyckoff’s service area zip codes, representing 9.75% of all births in NYC. The percent of residents who are 0-17 years old were higher in all five (5) major primary service areas than average in NYC. With the exception of mothers in Williamsburg and Bed Stuy, mothers in Wyckoff’s primary service area are more likely to receive late or no prenatal than are mothers in NYC (6.7%). In East New York, 10.7% of mothers receive late or no prenatal care. The area is also disproportionately affected by poor birth outcomes. East New York’s infant mortality rate is 6.2 per 1,000 live births (highest in the primary service area) and shares the highest teen births rates per 1,000 birth with Bushwick at 29.3.

Many households are headed by single mothers, who are at higher risk for problems that compromise their health, expose them to various forms of violence and produce adverse birth outcomes for their babies. The table below summarizes maternal, infant and child health indicators for the Wyckoff primary service area:

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Births (2017)</th>
<th>Late/No Prenatal</th>
<th>Infant Mortality (per 1,000 live births)</th>
<th>Pre-Term Births</th>
<th>% 0-17 year olds</th>
<th>Teen Births (per 1,000 ages 15-19)</th>
<th>Absenteeism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bushwick</td>
<td>1,195</td>
<td>9.3%</td>
<td>6.2</td>
<td>8.3%</td>
<td>24.0%</td>
<td>29.3</td>
<td>22.0%</td>
</tr>
<tr>
<td>Ridgewood, Glendale, Maspeth, Middle Village</td>
<td>1,805</td>
<td>7.9%</td>
<td>1.8</td>
<td>7.0%</td>
<td>22.0%</td>
<td>17.6</td>
<td>14.0%</td>
</tr>
<tr>
<td>Bed Stuy</td>
<td>2,160</td>
<td>5.9%</td>
<td>5.7</td>
<td>9.5%</td>
<td>24.0%</td>
<td>26.9</td>
<td>30.0%</td>
</tr>
<tr>
<td>East NY</td>
<td>2,659</td>
<td>10.7%</td>
<td>6.2</td>
<td>11.0%</td>
<td>27.0%</td>
<td>29.3</td>
<td>31.0%</td>
</tr>
<tr>
<td>Williamsburg/Greenpoint</td>
<td>3,595</td>
<td>2.6%</td>
<td>2.4</td>
<td>5.4%</td>
<td>23.0%</td>
<td>16</td>
<td>21.0%</td>
</tr>
<tr>
<td>NYC</td>
<td>117,013</td>
<td>6.7%</td>
<td>4.4</td>
<td>8.7%</td>
<td>21.0%</td>
<td>19.3</td>
<td>20.0%</td>
</tr>
<tr>
<td>Change since 2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Indicates highest rate in the service area

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60 New York City Department of Health and Mental Hygiene: Community Health Profiles, 2018.
61 Ibid
**Breastfeeding.** The benefits of breastfeeding for both mother and baby are numerous and well documented. Breastfed babies are less likely to have respiratory problems, ear infections and diarrhea. Mothers who breastfeed are less likely to develop breast or ovarian cancer and cardiovascular disease. The American Academy of Pediatrics recommends that babies be exclusively breastfed for the first six months of life, with the continuation of breastfeeding until one year of age or longer as mutually desired by mother and baby. While the benefits of breastfeeding are well known, many mothers face barriers to continued breastfeeding including hospital policies and practices, formula marketing and social norms, and work related factors. In New York City, breastfeeding rates differ by race/ethnicity, poverty, neighborhood poverty, education and age. Women residing in high poverty neighborhoods, those who give birth as a teenager, and those with low educational attainment are much less likely to breastfeed beyond initiation, and these populations are highly represented among the women who give birth at Wyckoff.

**Breast Cancer.** In Brooklyn, the mortality rate for breast cancer among women is significantly higher than that of New York City (NYC) and the State. Within NYC, Brooklyn has the lowest proportion of cases diagnosed at early stage, and one of the highest breast cancer mortality rates. Locally, there are few support services, and patient navigation services are limited and differ in quality. Low rates of screening may be due to the many competing priorities in the lives of local women that often act as barriers to care. The cultural value that a mother or grandmother should place the needs of her family before her own is often encountered and expressed by our patients, as well as avoidance of healthcare due to fear of financial burden, and lack of insurance due to immigration status.

**Mental Health and Substance Use**

Most of Wyckoff’s catchment area is designated as medically underserved for both Primary Care and Behavioral Health, with significant access disparities for Primary Care and Psychiatry. According to the Center for Health Workforce Studies, in 2013 there were only 282 physicians per 100,000 persons in Brooklyn, a rate 34% lower than NYC’s overall rate of 428 per 100,000. The disparity for Psychiatry was

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68 2019 Komen Greater NYC Community Profile Report.
even greater, with only 21 Psychiatrists per 100,000 persons in Brooklyn, a rate 57% lower than the NYC rate of 49 per 100,000. At the same time, Brooklyn, and particularly Northern and Central Brooklyn, have some of the highest rates of Psychiatric, Alcohol, and Drug related hospitalizations in NYC.69

Lack of access to behavioral health is likely a significant causal factor for the high hospitalization rates seen in the region, and so providing accessible treatment options in primary care may help reduce these rates, as well as the overall morbidity and mortality caused by behavioral health conditions. As healthcare delivery transformation unfolds, how service sectors share responsibility for a community’s behavioral health care is changing, with more care provided by medical providers in primary care settings. Primary care training enhancement is needed to ensure that people who would benefit have access to the necessary treatment modalities.70 Providers need to be knowledgeable about, and in some cases treat the most common mental health and substance use conditions in primary care.71,72

The need for new substance use treatment approaches is critical in Wyckoff’s service area. The communities of Bushwick, Bed Stuy, East New York and Williams have some of the highest rates of drug-related hospitalizations in Brooklyn – Bushwick and Williamsburg’s rate is 1,514/100,000; East New York’s rate is 1,477/100,000; and Bed-Stuy with the astronomical rate of 3,007/100,00073. These rates indicate a significant unmet need for treatment.

The following table summarizes behavioral hospitalizations in the Wyckoff service area:

### Table 8: Behavioral hospitalizations in the Wyckoff service area

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Psych Hosp (per 100,000)</th>
<th>Alcohol Hosp*</th>
<th>Drug Hosp*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bushwick</td>
<td>574</td>
<td>1,149</td>
<td>1,514</td>
</tr>
<tr>
<td>Ridgewood, Glendale, Maspeth, Middle Village</td>
<td>299</td>
<td>769</td>
<td>440</td>
</tr>
<tr>
<td>Bed Stuy</td>
<td>1,002</td>
<td>2,708</td>
<td>3,007</td>
</tr>
<tr>
<td>East NY</td>
<td>1,113*</td>
<td>1,398</td>
<td>1,477</td>
</tr>
<tr>
<td>Williamsburg/Greenpoint</td>
<td>440</td>
<td>1,449</td>
<td>1,514</td>
</tr>
</tbody>
</table>

* Indicates highest rate in the service area

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69 New York City Department of Health and Mental Hygiene: Community Health Profiles, 2018
71 Interorganizational Work Group on Competencies for Primary Care Psychology Practice. Competencies for Psychology Practice in Primary Care. March 2013.
73 New York City Department of Health and Mental Hygiene: Community Health Profiles, 2018.
Psychiatric Inpatient and Emergency Room Utilization\textsuperscript{74}

For Children and Adults, the average daily census (ADC) and ADC per 10,000 residents Statewide, in NYC region, Kings County and Queens County has been on a downward trend since Year 2012 through 2017. This is part of a deliberate plan by New York States Office of Mental Health to shift unnecessary inpatient hospitalizations to outpatient care and reflects a loss in total bed capacity for psychiatry rather than a decrease mental illness. In some cases, this has increased pressure at the local level in areas such as and increasing seriously mentally ill homeless population, spending at mental health shelters and increasing number of seriously mentally ill inmates in NYC jails. \textsuperscript{75}

A further drilldown looking specifically at Psych Inpatient utilization for Medicaid patients in Year 2018 shows that 6,640 unique individuals from Queens County were admitted into inpatients psych beds (77\% adults, 17\% children and 6\% were seniors)\textsuperscript{76} while in Kings County, 7,917 unique individuals were admitted into inpatients psych beds (81\% adults, 11\% children and 8\% were seniors)\textsuperscript{77}.

Looking specifically at Psych Emergency room utilization for Medicaid patients in Year 2018 shows that 14,165 unique individuals from Queens County were admitted into inpatients emergency beds (70\% adults, 24\% children and 6\% were seniors)\textsuperscript{78} while in Kings County, 18,834 unique individuals were admitted into inpatients emergency beds (72\% adults, 21\% children and 7\% were seniors)\textsuperscript{79}.

\textsuperscript{74} County Level Utilization Data – NYS Office of Mental Health https://www.omh.ny.gov/omhweb/tableau/county-profiles.html
\textsuperscript{75} Systems under Strain: Deinstitutionalization in New York State and City. S Edie Manhattan Institute Nov 2018
\textsuperscript{76} ibid
\textsuperscript{77} ibid
\textsuperscript{78} ibid
\textsuperscript{79} ibid
Human Immunodeficiency Virus (HIV), Sexually Transmitted Infections (STI), Vaccine-Preventable Diseases (VPD), and Healthcare-Associated Infections (HAI)

Human Immunodeficiency Virus (HIV) New York City continues to have one of the largest HIV epidemics in the United States, with over 127,287 persons living with an HIV diagnosis. In 2018, there were 1,917 new diagnoses in NYC. Within NYC, disparities by sex, race/ethnicity, risk factor, geography, and poverty level have persisted, resulting in a disproportionate burden among men who have sex with men (MSM), blacks and Hispanics, and persons living in high poverty neighborhoods.

The HIV epidemic continues to disproportionately impact minority populations such as the Hispanic and Black populations served by Wyckoff. In New York City, the rates of new HIV diagnoses among Black men are 1.5 times higher than Latino/Hispanic men and over 5 times higher than the rate for White men. In New York City, Hispanic and Black persons accounted for 36.4% and 45.9%, respectively, of new HIV diagnoses in 2018. In the Wyckoff service area, the rate of HIV diagnosis is 26.8-83.7 per 100,000 population.

In addition to racial and ethnic disparities in the burden of HIV infection, Wyckoff’s service area also reflects the national trend that men who have sex with men (MSM) remain the population at greatest risk of HIV infection, and are the only group with increasing HIV incidence. Almost half of new diagnoses in Brooklyn and the Wyckoff service area are attributed to sexual transmission by MSM.

These disparities result in a disproportionate burden of HIV infection in the Wyckoff service area. In New York City, HIV-positive Blacks and Hispanics are least likely to be virally suppressed. Based on this evidence, the marginalized populations served by Wyckoff are also likely to have lower awareness of HIV status, lower rates of linkage to and retention in care, and inadequate access to anti-retroviral treatment.

Sexually Transmitted Infections (STI) New York City STI data is reported by the NYC Department of Health and Mental Hygiene, as opposed to the community districts. The Wyckoff Service Area includes

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81 NYC DOHMH; NYC DOHMH, “TCNY 2020 Annual Update, 2018.”
82 Ibid
83 Ibid
large portions of Williamsburg-Bushwick, Ridgewood-Forest Hills, Bedford Stuyvesant-Crown Heights, East New York, and West Queens.

The Chlamydia and Gonorrhea rates amongst both genders are highest in the Bushwick, Bed Stuy and East-New York in Wyckoff’s primary service area. When compared to Year 2015, the Gonorrhea cases has increased in Bushwick and the Chlamydia cases has reduced for female (per 100,000) in Bushwick. There has been a spike in Gonorrhea and Chlamydia amongst the male in all five neighborhoods reviewed.

**Table 9.** 2017 STI rates in Wyckoff Service Area as reported by NYC-DOHMH

<table>
<thead>
<tr>
<th>Neighborhood</th>
<th>Chlamydia Rate Female (per 100,000)</th>
<th>Chlamydia Rate Male (per 100,000)</th>
<th>Gonorrhea Rate Female (per 100,000)</th>
<th>Gonorrhea Rate Male (per 100,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Williamsburg-Bushwick</td>
<td>1,268</td>
<td>1,205</td>
<td>140</td>
<td>930*</td>
</tr>
<tr>
<td>Ridgewood-Forest Hills</td>
<td>412</td>
<td>337</td>
<td>26</td>
<td>188</td>
</tr>
<tr>
<td>Bedford Stuyvesant/Crown Heights</td>
<td>1,516</td>
<td>1,330*</td>
<td>228</td>
<td>843</td>
</tr>
<tr>
<td>East New York</td>
<td>1,742*</td>
<td>1,057</td>
<td>310*</td>
<td>532</td>
</tr>
<tr>
<td>NYC</td>
<td>907</td>
<td>764</td>
<td>116</td>
<td>448</td>
</tr>
</tbody>
</table>

*Indicates highest rate in the service area

**Vaccine Preventable Diseases (VPD)** New York State and New York City have made progress towards meeting Health People 2020 goals for VPDs, but challenges remain in specific areas. New York City met or exceeded childhood immunization goals for Polio, MMR (Measles, Mumps, and Rubella), Haemophilius influenzae type b (Hib), Hepatitis B, Pneumococcal Conjugate Vaccine (PCV), Varicella and influenza. However, NYC fell short of the Healthy People 2020 goals for the following VPDs:

- **Hepatitis A** performance was only 56.2% compared to the 85% HP2020 goal
- **Rotavirus Vaccination** rate was 74.3% compared to the 80% HP2020 goal

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85 Bureau of Sexually Transmitted Infections, “NYC DOHMH STI Quarterly Report, 2018.”
86 CDC, “ChildVaxView Coverage of Local Areas Sampled by NIS | CDC.”
87 “Hep A State Data Map | Healthy People 2020.”
88 “Rotavirus State Data Map | Healthy People 2020.”
Regarding adolescent vaccination rates, New York City is behind of the HP 2020 goal of 80%, with a 67.5% completion rate.\textsuperscript{89} Significant effort is needed, however, in uptake of the human papillomavirus (HPV) vaccine. Though ahead of the national average, only 53.6% of adolescent females in New York State have completed the HPV vaccinations, while the HP2020 goal is 80%.\textsuperscript{90} There has also been an anti-vaccination movement that has had a deleterious effect on both vaccination rates and in vaccine preventable conditions. In 2019, there were 1276 reported cases of measles nationwide which is nearly 4 times the number that was reported in 2018. The 2019 outbreak in New York accounted for 654 of those cases and were largely restricted to 4 Brooklyn neighborhoods\textsuperscript{91}. The city spent over $6 million dollars and instituted a mandatory vaccination order before finally declaring the outbreak over in Sept of 2019.\textsuperscript{92}

\textbf{Healthcare-Associated Infections (HAI)} Working toward the elimination of HAIs is a national priority. New York is one of ten state health departments in the Centers for Disease Control’s Emerging Infections Programs (EIP) network. Between 2016 and 2017, significant decreases were observed in New York State in Central-Line Associated Bloodstream Infections (CLABSI), Catheter-Associated Urinary Tract Infection (CAUTIs), Surgical Site Infections (SSIs) during Colon surgery and Coronary Artery Bypass Graft (CABG), and C. \textit{difficile} Infections (CDI).\textsuperscript{93}

Antibiotic stewardship is becoming more important in light of increasing incidence of resistant strains of bacteria. New York was among 51 states and territories that received funding through the American Recovery and Reinvestment Act (ARRA) to strengthen the capacity for HAI surveillance and prevention. This funding is being used to implement and evaluate \textit{Clostridium difficile} (CD) Laboratory Identified Event reporting. The New York State Department of Health has funded and is continuing to support the CD prevention project in the greater New York City (NYC) metropolitan area.

\textsuperscript{89} “Adolescent Vaccination State Data Map | Healthy People 2020.”
\textsuperscript{90} “HPV State Data Map | Healthy People 2020.”
\textsuperscript{91} Lena Sun (2019) - New York City declares end to largest measles outbreak in nearly 30 years. Washington Post Sept 3, 2019
\textsuperscript{92} Ibid
\textsuperscript{93} NYS DOH, “Hospital-Acquired Infections in New York State, 2017.”
**Community Input and Prioritization Process**

**Methodology.** Wyckoff developed a short survey to obtain service provider, community and other stakeholder input on the local importance of the New York State Prevention Agenda focus areas. Surveys were completed online via Survey Money. Participants were asked to think about the local community’s health and then rank the following focus areas, from most important (1) to least important (5):

- Preventing chronic diseases (obesity, tobacco use, nutrition)
- Promoting a healthy and safe environment (air, water, land use, injuries, violence)
- Promoting healthy women, infants and children (maternal and child health, reproductive health)
- Promoting mental health and preventing substance abuse
- Preventing HIV, Sexually Transmitted Diseases (STDs), Vaccine-preventable Diseases (VPDs), and Healthcare Associated Infections (HAIs)

The survey was administered to community 108 stakeholders (residents, community-based partners, and employees of Wyckoff Heights Medical Center) at the health fair through the Survey Monkey platform. The survey questionnaire were both in English and Spanish language.

The evaluation of the survey responses indicated that the top priorities for the primary service areas were: Preventing chronic diseases (obesity, tobacco use, and nutrition), Promoting healthy women, infants and children (maternal and child health, reproductive health), and Preventing HIV, Sexually Transmitted Diseases (STDs), Vaccine-preventable Diseases (VPDs), and Healthcare Associated Infections (HAIs).

**Table 10: Average priority score and corresponding rank by community health survey respondents**

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Overall</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoting Healthy Women, Infants and Children</td>
<td>3.17</td>
<td>1&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
<tr>
<td>Preventing Chronic Diseases</td>
<td>3.16</td>
<td>2&lt;sup&gt;nd&lt;/sup&gt;</td>
</tr>
<tr>
<td>Preventing HIV, STDs, VPDs, and HAIs</td>
<td>3.03</td>
<td>3&lt;sup&gt;rd&lt;/sup&gt;</td>
</tr>
<tr>
<td>Promoting mental health and preventing substance abuse</td>
<td>2.95</td>
<td>4&lt;sup&gt;th&lt;/sup&gt;</td>
</tr>
<tr>
<td>Promoting a healthy and safe environment</td>
<td>2.75</td>
<td>5&lt;sup&gt;th&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
In addition to the community surveys, the New York City Department of Health and Mental Hygiene (NYC-DOHMH) provided Community Health Profiles for Take Care New York 2020 in all five (5) regions served by Wyckoff Heights Medical Center. The New York City Community Health Profiles captured the health of 59 community districts across the city. They contain over 50 measures of neighborhood health, emphasizing that our health starts where we live, work and play. These reports highlight the disparities among neighborhoods and can be used by policymakers, community groups, health professionals, researchers and residents to encourage community engagement and action.

The following table summarizes their findings from the Community Health Profiles and connects them to New York State’s Prevention Agenda Focus Areas, where possible. Areas where Take Care New York 2020 and community health survey priorities overlap will be specifically targeted by Wyckoff’s three year plan.

<table>
<thead>
<tr>
<th>Community</th>
<th>Community Health Profiles Identified Priority</th>
<th>New York State Prevention Agenda Focus Area*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bushwick</td>
<td>-Child Care</td>
<td>-Promoting healthy women, infants and children*</td>
</tr>
<tr>
<td></td>
<td>-High School Graduation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Unmet Medical Need (Avoidable Hospitalization, Adults without needed medical care, HPV/Flu vaccination, New HIV Diagnosis)</td>
<td>-Preventing chronic diseases* -Preventing HIV, Sexually Transmitted Infections, vaccine-preventable diseases, and healthcare-associated infections</td>
</tr>
<tr>
<td></td>
<td>-Unmet Mental Health Need</td>
<td>-Promoting mental health and preventing substance abuse</td>
</tr>
<tr>
<td></td>
<td>-Violence</td>
<td>-Promoting a healthy and safe environment</td>
</tr>
<tr>
<td>Bedford Stuyvesant</td>
<td>-Controlled High Blood Pressure</td>
<td>-Preventing chronic diseases*</td>
</tr>
<tr>
<td></td>
<td>-Obesity (Childhood)</td>
<td>-Preventing chronic diseases* -Promoting healthy women, infants and children*</td>
</tr>
<tr>
<td></td>
<td>-High School Graduation</td>
<td>-Promoting healthy women, infants and children*</td>
</tr>
<tr>
<td></td>
<td>-Late or No Prenatal Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Pre-term Births</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Teen Pregnancy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Unmet Medical Need (Avoidable Hospitalization, Adults without needed medical care, HPV/Flu vaccination, New HIV Diagnosis)</td>
<td>-Preventing chronic diseases* -Preventing HIV, Sexually Transmitted Infections, vaccine-preventable diseases, and healthcare-associated infections</td>
</tr>
<tr>
<td></td>
<td>-Unmet Mental Health Need</td>
<td>-Promoting mental health and preventing substance abuse</td>
</tr>
<tr>
<td></td>
<td>-Violence</td>
<td>-Promoting a healthy and safe environment</td>
</tr>
<tr>
<td>Brownsville/East New York</td>
<td>-Obesity</td>
<td>-Preventing chronic diseases*</td>
</tr>
<tr>
<td></td>
<td>-Physical Activity</td>
<td>-Preventing chronic diseases* -Promoting a healthy and safe environment</td>
</tr>
<tr>
<td>Priority</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td>Preventing chronic diseases*&lt;br&gt;Promoting a healthy and safe environment&lt;br&gt;Promoting healthy women, infants and children*&lt;br&gt;Promoting a healthy and safe environment&lt;br&gt;Promoting mental health and preventing substance abuse</td>
<td></td>
</tr>
<tr>
<td>Violence</td>
<td>Preventing chronic diseases*&lt;br&gt;Promoting a healthy and safe environment&lt;br&gt;Promoting healthy women, infants and children*&lt;br&gt;Promoting a healthy and safe environment&lt;br&gt;Promoting mental health and preventing substance abuse</td>
<td></td>
</tr>
<tr>
<td>Jail Incarceration</td>
<td>Preventing chronic diseases*&lt;br&gt;Promoting a healthy and safe environment&lt;br&gt;Promoting healthy women, infants and children*&lt;br&gt;Promoting a healthy and safe environment&lt;br&gt;Promoting mental health and preventing substance abuse</td>
<td></td>
</tr>
<tr>
<td>Unmet Medical Need (Avoidable Hospitalization, Adults without needed medical care, HPV/Flu vaccination, New HIV Diagnosis)</td>
<td>Preventing chronic diseases*&lt;br&gt;Promoting HIV, Sexually Transmitted Infections, vaccine-preventable diseases, and healthcare-associated infections*&lt;br&gt;Promoting healthy women, infants and children*&lt;br&gt;Promoting a healthy and safe environment&lt;br&gt;Promoting mental health and preventing substance abuse</td>
<td></td>
</tr>
<tr>
<td>Unmet Mental Health Need</td>
<td>Preventing chronic diseases*&lt;br&gt;Promoting healthy women, infants and children*&lt;br&gt;Promoting a healthy and safe environment&lt;br&gt;Promoting mental health and preventing substance abuse</td>
<td></td>
</tr>
</tbody>
</table>

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### Priorities for Primary Service Area

**Ridgewood, Glendale, Maspeth, Middle Village**

- **Air Pollution**<br>Promoting a healthy and safe environment
- **Obesity (Childhood)**<br>Promoting healthy women, infants and children*
- **Physical Activity**<br>Promoting chronic diseases*<br>Promoting a healthy and safe environment
- **Smoking**<br>Promoting chronic diseases*<br>Promoting a healthy and safe environment
- **Unmet Medical Need (Avoidable Hospitalization, Fall-related hospitalization among older adults, Adults without needed medical care, HPV/Flu vaccination)**<br>Promoting chronic diseases*<br>Promoting HIV, Sexually Transmitted Infections, vaccine-preventable diseases, and healthcare-associated infections*

**Williamsburg/Greenpoint**

- **Obesity (Childhood)**<br>Promoting chronic diseases*<br>Promoting healthy women, infants and children*
- **Physical Activity**<br>Promoting chronic diseases*<br>Promoting a healthy and safe environment
- **Smoking**<br>Promoting chronic diseases*<br>Promoting a healthy and safe environment
- **Unmet Medical Need (Avoidable Hospitalization, Adults without needed medical care, HPV/Flu vaccination)**<br>Promoting chronic diseases*<br>Promoting HIV, Sexually Transmitted Infections, vaccine-preventable diseases, and healthcare-associated infections*

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**Partnerships**

In order to address the preventative health needs of our local community, Wyckoff engages in both multiple partner collaborations as well as individual community partnerships. Through these networks and partnerships, Wyckoff is able to better address non-medical determinants of health.

**Multiple Partner Collaborations and Networks.** Wyckoff participates in a number of multiple partner collaborations and networks aimed at improving health in the local community:
**Delivery System Reform Incentive Payment Program.** Wyckoff is an active member of the Community Care of Brooklyn (CCB) Performing Provider System (PPS) of the Delivery System Reform Incentive Payment Program (DSRIP). DSRIP brings together local hospitals, health centers, and community-based organizations into a system that aims to achieve better outcomes through coordinated care. CCB manages care collaboratively, sharing information via a DSRIP dashboard. Through DSRIP, Wyckoff has developed several programs related to prevention agenda focus areas:

- **30-Day Readmissions Project** - A team of Transitional Care Nurses and Care Managers develops care plans with patients prior to discharge and ensures supports and follow-up care are available in the home as needed. Through this project, Wyckoff is collaborating with the Jewish Association Serving the Aging (JASA), whose home-visiting team meets with select patients on the inpatient unit and follows up with them in the home within 48 hours.

- **Emergency Department Triage Project** - Two ED Navigators work to reduce unnecessary ED utilization by meeting with patients and scheduling their follow-up care with Primary Care Providers and Behavioral Health Providers. This team also works closely with onsite Health Home Navigators to coordinate care, in an attempt to reduce ED utilization for primary care or behavioral health sensitive conditions.

- **PCMH+/IMPACT Project** - Health Coaches work with patients on chronic disease self-management goals, coordinate care with primary care providers, and provide and follow-up on specific referrals to ensure high quality, patient-centered care. Primary Care Providers screen for and manage common mental disorders including depression and anxiety with the support of Depression Care Managers and a consulting Psychiatrist.

- **Breathe Easy Asthma Team (BEAT)** - Community Health Workers conduct home visits to identify triggers, provide asthma education to individuals and families, and ensure effective engagement in Asthma action plans with Primary Care Providers. This program is a resource to the entire PPS, meaning Wyckoff works to reduce unnecessary ED utilization and hospitalizations for all community members, not just those who receive medical care at Wyckoff. The program also includes a partnership with the local community-based organization, Make the Road New York, who trains Spanish-speaking Community Health Workers.
**Brooklyn Health Home.** A Health Home is a care management service model whereby all of an individual's caregivers communicate with one another which enables all of a patient's needs to be addressed in a comprehensive manner. This is done primarily through a "care manager" who oversees and provides access to all of the services an individual needs to assure that they receive everything necessary to stay healthy, out of the emergency room and out of the hospital. Health records are shared among providers so that services are not duplicated or neglected. Health Home services are provided through a network of organizations – providers, health plans and community-based organizations.

Wyckoff has established a highly effective partnership with Maimonides Medical Center and the National Association on Drug Abuse Problems (NADAP) to establish a health home in Brooklyn with a special competency in caring for patients with two or more chronic conditions. As part of the previous Wyckoff Heights Medical Center Community Service Plan, Wyckoff currently houses NADAP Care Managers in the Emergency Department to identify patients at high-risk for inappropriate ED utilization or avoidable admission, and connects them to needed primary care and behavioral health services.

**Maternal Depression Quality Collaborative.** In 2015, Wyckoff joined several other hospitals, the New York City Department of Health and Mental Hygiene and the Greater New York Hospital Association to form the Maternal Depression Quality Collaborative. Participating hospitals share best practices and implement quality improvement processes to screen all expectant and postpartum mothers for depression, and connect them with services as necessary. Despite an estimated 13% of mothers who suffer from postpartum depression, with half of these cases originating during pregnancy, screening for depression among pregnant and postpartum women currently is still not routine. As a part of this collaborative, Wyckoff introduced universal depression screening into the Women’s Health Center workflow and established a behavioral health care manager at the site to connect women to depression treatment and support services. Between 2015 and 2018, Wyckoff has had 6,682 unique patients (women) with visits to the OB/Gyn services completed either a GAD-7 (Anxiety screening) or a PHQ-2/9 (Depression screening).

**New York City Breastfeeding Hospital Collaborative.** The aim of the New York City Breastfeeding Hospital Collaborative is to increase the number of NYC’s maternity facilities that achieve Baby-Friendly Designation by September 2020. Wyckoff achieved the Baby Friendly Hospital Designation in 2019. The teaching and learning collaborative consists of birthing centers that work together to institute Baby
Friendly-USA’s Ten Steps to Successful Breastfeeding. Each hospital assigns a multidisciplinary leadership team to participate in quarterly meetings and to report their quality improvement efforts and breastfeeding data. The team includes nursing and physician leadership from Obstetrics and Gynecology, Wyckoff’s Lactation Consultant, and representatives of the WIC Program, to ensure support for breastfeeding across the perinatal continuum.

**HIV and Hepatitis C Regional Planning and Prevention Groups.** Wyckoff is an active participant in regional collaborative groups working to end the HIV and Hepatitis C epidemics. Wyckoff leadership has been appointed by the Mayor of NYC to serve on the Ryan White Planning Council to develop and implement effective HIV primary care support services. Wyckoff also is active on NYC’s HIV Planning Group, a network of more than 100 HIV prevention service providers across the city. Wyckoff participates in the “Brooklyn Knows” campaign, which aims to make every Brooklyn resident aware of his or her HIV status through awareness and testing activities. Physicians and administrative leadership also participate in NYC’s Hepatitis C Research Consortium and Hepatitis C Clinical Information Exchange Network to share and disseminate best practices in Hepatitis C screening, linkage to care, and treatment. The hospital also has been award a number of grants to support its work in both HIV and Hepatitis C detection, treatment and linkage to care.

**Individual Partners and Collaborative Service Agreements.** Wyckoff has established an extensive and diverse network of individual community partners through linkage and service agreements, memoranda of understanding, and subcontracts to meet the holistic needs of our patients and address the full range of determinants of health.

**Table 12:** Wyckoff collaborative partners, services provided and related prevention focus area

<table>
<thead>
<tr>
<th>Collaborative Partner</th>
<th>Services Provided</th>
<th>Prevention Agenda Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>After Hours Project</td>
<td>Substance Use Prevention and Treatment</td>
<td>Promoting Mental Health and Preventing Substance Use</td>
</tr>
<tr>
<td>Bushwick Brightstart</td>
<td>Home-Based Child-Development Services</td>
<td>Promoting Healthy Women, Infants and Children</td>
</tr>
<tr>
<td>Brownsville Multiservice Center</td>
<td>Medical Care for the Uninsured</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>Organization</td>
<td>Services Provided</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Bushwick Center for Adult Day Care</td>
<td>Adult day care services, senior services, comfort care, palliative care services</td>
<td></td>
</tr>
<tr>
<td>Brooklyn District Attorney’s Office</td>
<td>Violence Prevention and Intervention</td>
<td></td>
</tr>
<tr>
<td>Brooklyn Plaza Medical Center</td>
<td>Medical Care for the Uninsured</td>
<td></td>
</tr>
<tr>
<td>CAMBA</td>
<td>Housing, Legal and HIV support services</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>Centering Healthcare Institute</td>
<td>Centering Pregnancy Training</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>Centerlight PACE Program</td>
<td>Preventive Services for Seniors</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>Cicatelli Associates</td>
<td>HIV Prevention Education</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>Coalition for Hispanic Family Services</td>
<td>After school and youth services in Spanish</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>Community Cares of Brooklyn (CCB)</td>
<td>Delivery System Reform Incentive Payment Program (DSRIP)</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>Community Healthcare Network</td>
<td>Mobile mammography, medical care for the uninsured</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>Cornerstone Treatment Facilities Network</td>
<td>Comprehensive Substance Use Treatment Services</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>Daya Yoga</td>
<td>Exercise Classes</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>El Puente Youth Center</td>
<td>After school and youth development services</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>Family Services Network of New York</td>
<td>Syringe-exchange and Harm Reduction Program</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>Fund for Public Health in New York</td>
<td>Healthy Start Brooklyn, Centering Pregnancy</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>Gay Men of African Descent</td>
<td>Outreach to younger men who have sex with men (YMSM)</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>Organization</td>
<td>Program/Service</td>
<td>Promoting Objectives</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>God's Love We Deliver</td>
<td>Meal Delivery</td>
<td>Promoting a Healthy and Safe Environment</td>
</tr>
<tr>
<td>Hope Gardens</td>
<td>Housing Project with Community Center</td>
<td>Promoting a Healthy and Safe Environment</td>
</tr>
<tr>
<td>Housing Works</td>
<td>Housing and support services for persons living with HIV/AIDS</td>
<td>Promoting a Healthy and Safe Environment, Preventing HIV, STDs, VPDs, and HAIs</td>
</tr>
<tr>
<td>Jewish Association Serving the Aging</td>
<td>Post-discharge home visiting program</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>La Nueva Esperanza</td>
<td>Food and nutrition services for persons living with HIV</td>
<td>Preventing HIV, STDs, VPDs, and HAIs</td>
</tr>
<tr>
<td>Latinos Diferentes</td>
<td>Outreach to Hispanic persons who identify as transgender</td>
<td>Preventing HIV, STDs, VPDs, and HAIs</td>
</tr>
<tr>
<td>Make the Road New York</td>
<td>Insurance navigation and support services for undocumented persons and new immigrants</td>
<td>All</td>
</tr>
<tr>
<td>NADAP</td>
<td>Home Health Enrollment</td>
<td>Preventing Chronic Diseases, Promoting Mental Health and Preventing Substance Use</td>
</tr>
<tr>
<td>New Directions</td>
<td>Outpatient Substance Use Treatment and Harm Reduction Services</td>
<td>Promoting Mental Health and Preventing Substance Use</td>
</tr>
<tr>
<td>New Life Child Development Center</td>
<td>Day care/child care</td>
<td>Promoting Healthy Women, Infants and Children</td>
</tr>
<tr>
<td>New York Council on Adoptable Children</td>
<td>Parenting, Legal Services, Daycare</td>
<td>Promoting Healthy Women, Infants and Children</td>
</tr>
<tr>
<td>New York Psychotherapy and Counseling Center</td>
<td>Mental Health Services</td>
<td>Promoting Mental Health and Preventing Substance Use</td>
</tr>
<tr>
<td>NYC Alliance Against Sexual Assault</td>
<td>Violence Prevention and Intervention Training</td>
<td>Promoting a Healthy and Safe Environment</td>
</tr>
<tr>
<td>NYC Department of Parks</td>
<td>Exercise Classes</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>NYPD 83rd Police Precinct</td>
<td>Collaborate in response to violence and sexual assault</td>
<td>Promoting a Healthy and Safe Environment</td>
</tr>
<tr>
<td>Organization</td>
<td>Services Provided</td>
<td>Health Promotion Areas</td>
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<tr>
<td>Opportunities for a Better Tomorrow</td>
<td>Educational and vocational services</td>
<td>Promoting a Healthy and Safe Environment</td>
</tr>
<tr>
<td>Outreach Project</td>
<td>Outpatient Substance Use treatment, syringe exchange and harm reduction</td>
<td>Preventing Substance Use, Preventing HIV, STDs, VPDs, and HAIs</td>
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<tr>
<td>Partnership for the Homeless</td>
<td>Housing and homelessness services</td>
<td>Promoting a Healthy and Safe Environment</td>
</tr>
<tr>
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<td>Home-delivered meals, transportation, case management and elder abuse services for seniors and persons with disabilities</td>
<td>Preventing Chronic Diseases, Promoting a Healthy and Safe Environment</td>
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<tr>
<td>Ridgewood Bushwick Senior Citizens Council</td>
<td>Housing and senior services</td>
<td>Promoting a Healthy and Safe Environment, Preventing Chronic Diseases</td>
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<tr>
<td>Ridgewood YMCA</td>
<td>Exercise classes; Cancer Support Group; Children and Youth services</td>
<td>Preventing Chronic Diseases, Promoting Healthy Women, Infants and Children</td>
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<tr>
<td>Translatina Network</td>
<td>Health education and outreach to Hispanic Transgender persons</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>Unidine</td>
<td>Healthy meals program; Nutrition education; Farmer’s market</td>
<td>Preventing Chronic Diseases</td>
</tr>
<tr>
<td>University of Washington AIMS Center</td>
<td>Technical Assistance for Behavioral Health Integration</td>
<td>Promoting Mental Health and Preventing Substance Use</td>
</tr>
<tr>
<td>Violence Intervention Program (VIP Mujeres)</td>
<td>Bilingual psychotherapy for survivors of violence</td>
<td>Promoting a Healthy and Safe Environment</td>
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</table>
Addressing Prevention Agenda Focus Areas

Wyckoff Heights Medical Center is a community service oriented hospital with a diverse portfolio of special projects designed to address New York State’s Prevention Agenda areas of focus. While two priorities were selected to include in the three-year community service plan, this section will describe Wyckoff’s work to address all areas of focus.

Preventing Chronic Diseases

Primary Care Expansion and PCMH Work

Regular engagement in primary medical care is a crucial factor in preventing chronic diseases and mediating their deleterious effects. As described in the needs assessment, Wyckoff is located in a severe primary care shortage area, which is likely contributing to poor health outcomes. To better prevent chronic diseases, Wyckoff has greatly expanded its primary care service and between 2015 and 2018, the visit volume for the Article 28 clinic has increased by 28%. The local community-based primary care sites had been established, including the Pediatric Care Center (2014), the Wyckoff Medical Arts Building (2015), and Wyckoff Doctors (2016) continue to expand and add services based on community needs.

While primary care access is critical, systems, processes, and coordination are also important in preventing chronic diseases and poor chronic disease outcomes. Therefore, Wyckoff is engaged in several collaborative initiatives involving community partners to better coordinate care and improve management of chronic diseases. Under DSRIP, Wyckoff achieved PCMH Level III status under the 2014 standards across multiple primary care sites. More recently, the recognition has been updated to the NYS PCMH standards released in 2017.

As part of the PCMH model, Health Coaches identify patients with specific chronic disease risk profiles (Cardiovascular and Diabetes risk) and work with those patients and their providers to develop self-management goals. Health coaches then work with patients to develop these goals into a patient-centered care plan.

Wyckoff has continues to support Emergency Department navigators responsible for intervening with patients who present for primary care or behavioral health sensitive conditions and ensuring they obtain follow-up care. Since transitional periods create vulnerable periods for patients who have been hospitalized, Wyckoff had established a Transitions of Care Unit that develops post discharge care plans.
and follows up with patients. This unit obtains patient consent to share medical information across multiple providers for effective coordination of care, and collaborates with the Jewish Association of Services for the Aging (JASA) whose staff meet with patients prior to discharge and follow-up in the home post-release to ensure food security, prescriptions are filled, caregivers are present, and patients attend follow-up outpatient care visits. For the 1st 12 months of operations of the Transitional Care Clinic, the clinic engaged more than 1,000 patients and more than 500 patients actually completed their visits. Of the cohorts that had a transition of care visit, only 5.9% were readmitted in the 30-days post-hospital discharge period which represents a dramatic improvement over the 20.2% readmission rate for the patients that did not attend the transition of care visit as scheduled.

Unidine Services

In 2016, Wyckoff engaged a new partner, Unidine, in the delivery of food services to patients, staff and the community. Unidine is committed to cooking from scratch with fresh, seasonal, and responsibly sourced ingredients. Through Unidine, Wyckoff offers OH SO GOOD, kitchen-tested recipes supporting healthy food and lifestyle choices. OH SO GOOD menu items’ nutritional guidelines include high fiber, high vitamins and minerals content, only lean proteins, unsaturated fat sources only, low sodium, and health promoting culinary techniques only. Unidine has been leveraged to address community needs and build Wyckoff’s presence in the community with programs including nutrition education, cooking demonstrations, health fairs, farmers markets, and community dinners.

Wyckoff Employee and Community Wellness Programs

In an effort to prevent obesity and reduce risk of cardiovascular disease and other chronic conditions through physical activity, Wyckoff renovated space in 2015 to create an exercise room, where a variety of wellness offerings are provided for staff and the community. Wyckoff has partnered with local businesses and the parks department to offer free weekly Yoga and Zumba classes. Wyckoff has been recognized by the American Diabetes Association as a Diabetes Self-management Program and is committed to helping patients achieve behavioral and clinical goals in the management of their diabetes. Diabetes self-management and support has been shown to be a cost effective way to reduce hospital admissions and readmissions, as well as improving clinical outcomes and quality of life for people diagnosed with diabetes.
Wyckoff has also recently been recognized as a Bariatric Center of Excellence. The Bariatric Surgery Center of Excellence (BSCOE) designation from the American Society for Metabolic and Bariatric Surgery helps identify where patients can expect to receive safe and effective surgical treatment. Our Surgeons at Wyckoff are board certified in general and bariatric surgery, specializing in advanced laparoscopic or minimally invasive surgery. The following three bariatric surgeries are offered at Wyckoff Hospital: Laparoscopic Roux-en-Y Gastric Bypass, Laparoscopic Sleeve Gastrectomy, and Laparoscopic Adjustable Gastric Banding.

**Promoting a Healthy and Safe Environment**

**Violence Intervention and Treatment Program**

WHMC’s Violence Intervention and Treatment Program (VITP) is the only hospital-based rape crisis program (RCP) certified by the New York State Department of Health (NYSDOH) in the borough of Brooklyn. Since 2004, VITP has been an experienced provider of sexual assault, rape, childhood sexual abuse, stalking, dating violence, and domestic/intimate partner violence services, including 24/7 hotline, crisis and ongoing counseling, personal advocacy, criminal justice advocacy, accompaniments, compensation assistance, information and referrals, as well as prevention and education services within the hospital and larger community. All services are free, confidential and available in English and Spanish, regardless of immigration or insurance status. In 2015, the VITP served more than 250 survivors of domestic violence and/or sexual assault. The VITP works with community partners including the Police Department, District Attorney’s office, New York Alliance against Sexual Assault, and VIP Mujeres, a local Hispanic survivor’s services organization.

The VITP is integrated with clinical services in the Emergency Department (ED) where every sexual assault survivor is treated by a physician, and our ED staff has experience treating the wide range of violence related injuries. The ED also has established post-exposure prophylaxis (PEP) and emergency contraception rapid access protocols. The VITP has 24 trained Rape Crisis Volunteer Advocates who provide calm, consistent, knowledgeable support to enhance the efforts of ED staff and ensure no survivor is ever left alone.
In 2014, New York State signed into law the most aggressive policy in the nation to fight against sexual assault on college campuses. The new “Enough is Enough” legislation requires all colleges to adopt a set of comprehensive procedures and guidelines, including a uniform definition of affirmative consent, a statewide amnesty policy, and expanded access to law enforcement. In 2015, the Wyckoff’s VITP was funded to provide technical assistance, education, and access to VITP services for colleges in Brooklyn and Queens, and has established multiple memoranda of understanding with local colleges to engage them in violence prevention work.

**Participation in Community Board 4 (CB4)**
Wyckoff is a regular participant in CB4 meetings, where the hospital provides input into many community board planning processes related to the neighborhood environment, including land use and zoning, identifying community needs as part of the City’s budget process, and working with government agencies to improve the local delivery of services. A significant focus area for CB4 in recent areas has been in addressing issues related to the gentrification of the neighborhood, and how this has affected the health and well-being of local families.

**Partnerships with Housing Organizations**
Factors related to housing have the potential to help—or harm—our health in major ways. Housing stability, physical conditions, conditions in the neighborhoods surrounding homes, and housing affordability not only shape home and neighborhood conditions but also affects the overall ability of families to make healthy choices. For these reasons, Wyckoff has established strong relationships with local organizations working to provide access to housing, housing subsidies, eviction prevention, advocacy, and other housing-related services, including Make the Road New York, Housing Works, Ridgewood-Bushwick Senior Citizen’s Council, and CAMBA.

**Promoting Healthy Women, Infants and Children**
Wyckoff Heights Medical Center has instituted several community service projects to promote healthy Women, Infants and Children:

**Women’s Health Center**
The Women’s Health Center provides a medical home for women including Primary Care, Obstetrics/Gynecology, and family planning. Because the community is majority Hispanic, with a
significant proportion who use Spanish as their primary language, Wyckoff has employed several bi-lingual Spanish medical providers at the Women’s Health Center. The Women’s Health Center also collaborates with Wyckoff’s Positive Health Management program to provide individual and group risk reduction counseling, free HIV, Hepatitis C, and Sexually Transmitted Infections (STI) screening and STI treatment to uninsured women and their partners. Risk for depression in women increases during pregnancy and in the first post-partum year. Therefore, the Women’s Health Center participates in the New York State maternal Depression Collaborative. As a participant, the Women's Health Center has committed to screening 100% of pregnant and postpartum women for depression, and connecting them with treatment. In order to help provide emotional, physical and educational support to expectant mothers, Wyckoff participates in a doula training program and provides a training site for enrolled students.

**Pediatric Care Center**

Wyckoff has a growing Department of Pediatrics, which includes both inpatient and outpatient services and a newly established (2014) Pediatric Residency Program with eight active residents. Wyckoff’s community-based, outpatient Pediatric Care Center has grown to 20,067 in 2018. The growth is a result of both a local community with an extremely high birth rate, and Wyckoff’s strategic objective to meet the needs of the local community by expanding accessible Pediatric outpatient services.

In 2013, Wyckoff opened a new community-based Pediatric site at 1411 Myrtle Avenue, the Wyckoff Pediatric Care Center, which offers comprehensive Pediatric Primary Care and co-located subspecialties including hematology, neurology, endocrinology, pulmonology, podiatry, nutrition and gastroenterology. The Pediatric Care Center was established at its location because it is adjacent to several child care centers, a school, and other key services for children and families.

In 2014, the Pediatric Care Center integrated behavioral health at the site, and now offers seven sessions of Pediatric Behavioral Health per week, delivered by a bi-lingual Pediatric Clinical Psychologist. The site also employs a Child Life Specialist who uses a combination of psychology, play therapy, and a wide array of calming techniques to improve the pediatric experience as part of Healthy Steps. In order to further expand on available behavioral health services, tele-psychiatry was added in 2018. This program allows patients to be seen remotely and treated by a psychiatrist if the conditions warrants.
The Department of Pediatrics is the recipient of a grant from the American Lung Association to provide childhood asthma educational services for Headstart programs in Queens. This grant allows Wyckoff to provide education for both parents and for the staff who work in the pre-K programs. Topics covered range from identifying triggers and symptoms to practical advice on what to do and when to seek a higher level of care.

**Women, Infants and Children (WIC) Program**

Wyckoff’s WIC program has provided a longstanding and critical mechanism to reduce obesity, improve food security, promote positive birth outcomes, increase breastfeeding rates, and reduce health disparities and the risk for chronic disease among local women, infants and children. WIC offers participant-centered and culturally-responsive nutrition assessment and education; breastfeeding promotion and support, including Breastfeeding Peer Counseling and breast pumps; referrals to health and social services; and a variety of nutritious foods. The WIC program is approved to serve approximately 5,000 unique participants.

WIC is a key component to Wyckoff’s strategy to improve breastfeeding within our community. A key component of the program is the Enhanced Breastfeeding Peer Counselor Program, which connects with women prenatally, engages them on the Obstetrics unit, and supports breastfeeding across the first year of life. Breastfeeding Peer Counselors utilize a prenatal participant list and a newborn infant list to ensure all eligible women are assigned a counselor, and the Breastfeeding Coordinator evaluates breastfeeding initiation, duration and status reports routinely and reviews breastfeeding activities, education and peer counseling for effectiveness monthly.

The WIC Program’s community-based centers maintain a breastfeeding friendly environment, encouraging women to breastfeed openly or in any way that is comfortable for them. WIC promotes and supports breastfeeding through the provision of breastfeeding education and counseling; the purchase and issuance of breast pumps; and the coordination of care with lactation consultants and health care providers to ensure that medical challenges to breastfeeding are addressed.

The WIC Program is also a part of the hospital’s plan to address obesity, through its Obesity Intervention Program for children ages 2-5 years old and its health lifestyle program, “FitWIC.” FitWIC includes a farmer’s market incentive program, healthy recipes, food demonstration and physical activities, such as
Zumba in the Park. The program has an on-site community garden, where participants can learn about healthy and nutritious vegetables.

**Maternal and Infant Community Health Collaborative (MICHC Program)**

With MICHC funding, Wyckoff has built a health improvement zone for women of northern and eastern Brooklyn. The MICHC Program was designed to reach and engage women of childbearing age and provide education and support services that address specific health inequities within the local populations we serve. These include education and support services for teen-age mothers and Hispanic, African American, and Foreign-Born women and their families.

The program uses community assessment, consensus building, and the development of education, outreach and marketing strategies to reach women and their children. The program has also implemented approaches that have strong evidence based support of their ability to reduce disparities in outcomes, including Baby Basics, a program to integrate evidence-based materials and health literacy strategies into prenatal care, and the use of community health workers to engage high risk pregnant women. MICHC also hosts community baby showers every month.

A fundamental principle of MICHC is to bring the patient and doctor together to provide superior health care services through patient empowerment and physician engagement. MICHC activities encourage women to seek out family planning services, to seek more preventive care and thus reduce their reliance on costly emergency care, seek prenatal care earlier and maintain healthy lifestyles.

**Healthy Steps Program**

The goal of Wyckoff’s implementation of the Healthy Steps program is to improve children’s social and emotional well-being and growth; improve child development outcomes; reduce health disparities; and improve quality and the patient experience. The Healthy Steps program works towards these goals by establishing a multidisciplinary Healthy Steps Implementation team and embedding a Healthy Steps Specialist within the Wyckoff’s Pediatric Care Center.
Together, the implementation team and Healthy Steps Specialist have established the following: enhanced screening practices, enhanced well-child visits, home visits, child development and family health check-ups, a child developmental telephone information line, expanded Reach Out and Read program to promote literacy, parent support groups, improved management of community referrals, and dissemination of prevention and health promotion informational materials in English and Spanish.

The Healthy Steps program collaborates with select local child and family services organizations, including Bushwick Brightstart Healthy Families Program; Brooklyn Healthy Start; the local YMCA; the Council on Adoptable Children; El Puente Youth Center; Opportunities for a Better Tomorrow; Hope Gardens; Coalition for Hispanic Family Services; local day-care centers; and Make The Road New York, that provides significant programming and services for undocumented persons and new immigrant families.

Promoting Mental Health and Preventing Substance Abuse

A primary gap identified within the Wyckoff system of care is the lack of Mental Health and Physical health integration. Empirical evidence suggests that behavioral health integration will be central to health system transformation and improving access, population health, experience of care, and per-capita costs. The organization has implemented a number of programs to address the lack of adequate behavioral care services. Available behavioral health services at Wyckoff are co-located with primary care. Resident trainees in internal medicine, pediatrics and Ob. /Gyn as well as all primary care providers currently receive training in behavioral health, and exposure to co-located behavioral health providers.

Behavioral Health Screening Initiatives

Critical to behavioral health integration is the identification of behavioral health needs through screening. In 2015, Wyckoff launched initiatives to improve depression screening, including participation in the Maternal Depression Quality Collaborative, training of medical providers and nursing staff on depression screening tools (PHQ2/9), and institution of universal depression screening across Wyckoff’s primary care settings.

In 2016, Wyckoff incorporated additional behavioral health screenings into the electronic medical record, including the Generalized Anxiety Disorder Assessment (GAD-7), the Drug Abuse Screening Test (DAST-10) and the Alcohol Use Disorders Identification Test (AUDIT-C).
Collaborative Care/IMPACT
Wyckoff has implemented the Collaborative Care/IMPACT model across all of its Article 28 primary care settings. The Collaborative Care/IMPACT Model is an approach to integration in which primary care providers, care managers, and psychiatric consultants work together to provide care and monitor patients’ progress. These programs have been shown to be both clinically-effective and cost-effective for a variety of mental health conditions in primary care settings, using several different payment mechanisms.

Collaborative Care/IMPACT is supported at Wyckoff through a Primary Care Training Enhancement grant from the Health Resources and Services Administration, which trains Primary Care Providers, Residents and Behavioral Health Providers across multiple departments to implement the model. The DSRIP program supports the start-up costs for Depression Care Managers to work in the primary care sites as well as tele-psychiatry consults. The service will be sustained through new enhanced payments and value-based payment methodologies being rolled out statewide.

Buprenorphine Program
In 2016, Wyckoff began the process of instituting buprenorphine treatment by primary care providers using a Nurse Care Manager (NCM) model, based on the Buprenorphine Collaborative Care model implemented at Boston Medical Center in Massachusetts. In this model, and consistent with the principles of the patient-centered medical home (PCMH), a dedicated NCM works with physicians to deliver team-based care for patients being treated for opioid use disorders. Together, the team screens and assesses patients, performs medication management and motivational counseling, and refers for more intensive treatment as necessary. The model also includes access to local mentors who are experienced in buprenorphine prescribing to provide additional support and case review as needed.

Behavioral Health Partners
In addition to behavioral health integration projects, Wyckoff meets community needs through formal partnerships with behavioral health service providers, including New York Psychotherapy and Counseling Center, Cornerstone Treatment Facilities Network, New Directions Outpatient Substance Abuse Treatment Center, the After Hours Project Syringe Exchange and Harm Reduction Program, the NYC Lesbian, Gay, Bisexual and Transgender Community Center Wellness Program, the Outreach Project,
Housing Works, the Coalition for Hispanic Family Services, and others. Wyckoff has active service agreements with all of these mental health and substance use disorder treatment programs.

Preventing HIV, Sexually Transmitted Infections (STI), Vaccine-Preventable Diseases (VPD), and Healthcare-Associated Infections (HAI)
Prevent HIV and STDs

**Pediatric Care Center.** The NYC Unity Project is a citywide commitment to supporting and empowering LGBTQ young people. Through this project, the Pediatric Care Center has been awarded a grant to provide sexual and reproductive health education to 13-24 year olds. The grant also provider pre and post exposure prophylaxis treatment for HIV to adolescents and young adults. The Pediatric Care Center provides the services for these patients up to the age of 21. For the 21-24 year olds also covered by the grant, they are referred to the Center for Positive Health for education and treatment services.

**Positive Health Management (PHM).** Wyckoff and its Positive Health Management program has been at the forefront in addressing the HIV/AIDS epidemic and its related cofactors since the early years of the HIV epidemic. PHM is dedicated to providing excellent, accessible, and quality prevention and medical care to persons who are at risk for or who are living with HIV, Hepatitis C (HCV), and sexually transmitted infections (STI). Our multidisciplinary team includes physicians who are specialists in the treatment of HIV and infectious disease, nurses, social workers, case managers, mental health counselors, and prevention specialists. Our caring and compassionate staff represent the diversity of our community, and are multilingual, LGBT friendly, and culturally competent. We provide an array of individual and group activities and resources in the clinic, and maintain strong and effective relationships with community partners to support patients in achieving their holistic goals.

**Routine HIV and HCV Screening Initiatives.** Wyckoff’s PHM has been an integral part of preventing HIV by ensuring the hospital’s compliance with New York State’s HIV and HCV testing laws. The department has worked closely with leadership and multiple divisions and departments to institute policy changes, integrate routine screening processes, optimize electronic systems and conduct quality improvement projects related to HIV and HCV screening and linkage to care. As a result of these efforts, Wyckoff has seen significant volume increases in HIV and HCV testing, conducting more than 26,359 HIV tests and more than 3,120 HCV tests between 2015 and 2018.
Targeted HIV Prevention Projects. In addition to routine screening efforts, PHM works to prevent HIV infections through multiple targeted HIV prevention projects as outlined in the previous community service plan. These efforts target disproportionately affected and vulnerable populations including Hispanic and black young men who have sex with men (YMSM), transgender persons, Hispanic women, and undocumented persons. PHM utilizes novel approaches to engaging high risk persons including outreach through social media applications. PHM partners with local community organizations to engage hard-to-reach persons at high risk. These organizations include Gay Men of African Descent (to reach Black YMSM), Latinos Diferentes (to engage Young Hispanic Men), Translatina Network (to reach Hispanic Transgender Persons), and Wyckoff’s WIC Program (to engage Hispanic Women). All prevention services and screenings for targeted populations, including HIV, HCV, and STI screening, as well as STI treatment, are provided free of charge to the uninsured.

Biomedical HIV Prevention. PHM provides rapid access to biomedical prevention interventions including HIV Post-Exposure Prophylaxis (PEP) and Pre-Exposure Prophylaxis (PrEP). Wyckoff has been funded to institute access to these interventions across all of its primary care sites. In 2015, PHM became a New York State designated PrEP Assistance Program site, meaning it can bill for medications and treatment that it provided to the uninsured free of charge. PHM also provides PEP and PrEP to young adults through a grant from the NYC Unity Project.

Through participation in the Governor’s Ending the Epidemic Initiative, Wyckoff was selected as a site to institute “Status-Neutral Care Coordination,” a program that provides care coordination, patient navigation, and supportive services to HIV negative persons at high risk for acquiring HIV, to help them maintain their HIV negative status. Over the last 4 years, Wyckoff has increased the number of patients that are actively on Truvada – see below
Treatment as Prevention. PHM operates several programs that aim to support patients in achieving HIV viral suppression, which prevents transmission of HIV to partners. These include the Retention and Adherence Program, which provides case management and peer delivered services for newly diagnosed persons and persons with a detectable viral status; the Care Coordination program, which provides health education, home visits, patient navigation, and directly observed therapy for persons at risk for poor medication adherence; and “The Undetectables,” a social marketing campaign developed by one of Wyckoff’s community partners, Housing Works. The Undetectables honors viral suppression as a heroic act and provides financial incentives to patients who achieve and maintain suppression. Through these innovative projects, Wyckoff’s HIV Primary Care population has achieved the best viral suppression rate, 86%, in New York City.
Hepatitis C Screening, Navigation and Treatment. Wyckoff has worked to expand capacity to better identify cases of untreated HCV, improve linkage to clinical evaluation and treatment, and cure patients using the latest advanced pharmacological treatment options. As a result of participating in NYC’s Hepatitis C Research Consortium and Hepatitis C Clinical Information Exchange Network, Wyckoff has been able to increase data collection capacity to measure its performance on the HCV care continuum and track patients through screening, diagnosis, treatment and cure.

The data has demonstrated an increasing number of people identified as Hepatitis C positive between 2016 (132) and 2018 (342. It was also one of the early adopters of reflex Hepatitis C RNA testing in NYC and this has resulted in our meeting the NY State performance goal for this measure:
Wyckoff has also established an HCV navigation program to support patients move along the continuum of care, providing health education, navigation, outreach, and psychosocial support.

**STI Screening and Treatment Program.** PHM operates a comprehensive sexual health clinic that includes prevention education, screening, and treatment to the community, including free services for the uninsured. PHM follows up with STI cases from other departments, including pediatrics, women's health center, and emergency department, to support patients in completing treatments, testing partners, and providing health education and risk reduction counseling.

**Prevent Vaccine-Preventable Diseases**

**Communicable Disease Outbreaks and Legislative Changes**

As of June 2019, New York State and New York City have rescinded any religious exemption from the required child vaccination schedule. This action came in response to NYC's significant Measles outbreaks which have occurred in recent years. In these instances, NYC sat at the center of “the worst measles outbreak in over a quarter century.” As of June 2019, 1,000 Measles cases had been reported throughout the United States – 800 of these cases occurred in New York State alone. Of these cases within New York State, over 300 occurred within the borough of Brooklyn. These substantial outbreaks of a disease once

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94 New York State Assembly, “Legislation to Protect New Yorkers from Dangerous, Preventable Diseases.”
thought to be eradicated led NYC Mayor Bill de Blasio to declare a public health emergency in April of 2019. Due to this new legislative action, all medically-able children living in New York State will be required to complete the recommended vaccination series in order to attend all levels of school from day care to high school.\textsuperscript{95}

**Prevent Health Care-Associated Infections**

**Healthcare Associated Infections and Antibiotic Stewardship**

Wyckoff has instituted a comprehensive quality improvement plan for improving HAIs. In addition, the Infectious Disease Division in collaboration with Pulmonary-Critical Care Division updated and implemented new Adult and Pediatric Sepsis Protocols in 2015. This allows Wyckoff to quickly identify patients with severe sepsis and septic shock, to improve adherence to early goal directed therapy and fast administration of appropriate broad-spectrum antibiotics, and to improve pressure support management and patient’s disposition. This quality improvement initiative is aimed at improvement of sepsis management and clinical outcomes.

Antibiotic misuse and overuse has emerged as an important health care quality and patient safety issue. While antibiotic usage has undoubtedly reduced mortalities caused by infections, resistance to these drugs has also increased. Studies show that up to 50\% of antimicrobial use is inappropriate, resulting in increased rates of serious infections such as Clostridium difficile. A recent Morbidity and Mortality Weekly Report estimated that immediate, nationwide infection prevention and antibiotic stewardship interventions could avoid approximately 619,000 hospital-acquired infections resulting from Clostridium difficile and other multi-drug resistant organisms.

Wyckoff is currently involved in the Healthcare Association of New York State (HANYS) Quality Institute Antibiotic Stewardship Collaborative. We are collecting data on hospital-wide use of specific antibiotics and we will be submitting the data to HANYS. We started pilot interventions including ID-pharmacist-critical care team rounding to assure timeliness and appropriateness of antibiotic use in critical care units. The goal of this initiative is to identify and implement the most efficacious strategies to decrease over/under/mis-use of antibiotics, to decrease antibiotic use by 20\%, to improve clinical outcomes and to decrease cost of care.

\textsuperscript{95} New York State Assembly.
Although antibiotic stewardship commonly has been prioritized within inpatient hospital settings, there is a critical need to better understand how much variability in prescribing exists in ambulatory settings and whether practice-level data can offer useful information to guide stewardship efforts. Research has shown that a modest reduction of 10% in outpatient antibiotic prescribing could yield a substantial decrease in community-acquired Clostridium difficile. Therefore, implementing outpatient interventions to reduce inappropriate antibiotic use is essential. Studies of outpatient antibiotic use have been conducted across the nation, and findings suggest a high degree of inappropriately prescribed antibiotics for acute respiratory infections.

Wyckoff, through a grant from the United Hospital Fund, established an Antibiotic Stewardship quality improvement demonstration project in two of its primary care sites: Wyckoff’s Medicine Clinic and Wyckoff Doctors. Through this project, in 2016, baseline data on patients presenting with acute respiratory infections was established and benchmarked against 31 other practices across the State.

WHMC aimed to pilot our Outpatient Antimicrobial Stewardship Initiative to track and reduce antibiotic prescriptions among adult patients presenting with common acute respiratory infections at Wyckoff Heights Medical Center adult outpatient primary care settings. The team implemented a robust outpatient antimicrobial stewardship initiative with a dedicated team including a data analyst that was based on the CDC core elements for outpatient antimicrobial stewardship and a prior UHF initiative that included a retrospective and prospective cohort study from October, 2017 to March, 2019.

Data of common respiratory tract infections and the respective rates of antibiotic prescriptions from 3 adult primary care sites was collected from the EMR. A series of educational interventions were performed between June 2018 and September 2018.

WHMC disseminated resources from the CDC and DOH such as brochures, posters, viral prescription pads, pocket guidelines, grand rounds and electronic lectures to the providers and provided periodic provider feedback reports. The findings revealed that the physician compliance rate of with not prescribing antibiotics for common respiratory tract infections remarkably improved from 72 % to 85 % after implementing our interventions and the data was statistically significant with a p value <0.05.
**Three Year Community Service Plan**

Wyckoff Heights Medical Center has analyzed the data and has chosen to concentrate its Three Year Community Service Plan on two of the New York State Department of Health Agenda Priorities:

1. Promoting Healthy Women, Infants and Children
2. Preventing Chronic Diseases

Wyckoff’s community service plan targets maternal and child health disparities identified locally among both Blacks and Hispanics, including perinatal outcomes and breastfeeding. The plan also targets chronic disease health disparities within the Hispanic population, including disparities in diabetes, obesity and breast cancer.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Objective</th>
<th>Year One (2020)</th>
<th>Year Two (2021)</th>
<th>Year Three (2022)</th>
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<tbody>
<tr>
<td>Promoting Healthy Women, Infants and Children</td>
<td>Improve birth outcomes and disparities in birth outcomes including preterm birth, low birth weight, infant mortality and maternal mortality.</td>
<td>Increase early access to prenatal care through expanding OB clinic sessions including adding open access visits.</td>
<td>Increase participation in prenatal care and evidence-based prenatal care interventions by 5% from baseline through increased internal communications and outreach to community partners.</td>
<td>Increase participation in prenatal care and evidence-based prenatal care interventions by 10% from baseline through increased internal communications and outreach to community partners.</td>
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<tr>
<td>Establish doula training program to help address disparate birth outcomes.</td>
<td>Increase the number of doula trainee spots and recruit graduates to work with the high risk prenatal community</td>
<td>Continue to expand doula program based on community need and institutional resources</td>
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<td>Recruit and hire pediatrician with focus on adolescent medicine to improve education and referral for teens</td>
<td>Establish ambulatory quality metrics in pediatrics around screening for sexual activity and birth control counseling</td>
<td>Improve screening for sexual activity and birth control discussions by 5% from baseline</td>
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<tr>
<td>Maintain Maternal and Infant Community Health Collaborative Initiative grant to fund community health workers to improve maternal and infant health outcomes for high-need, low income women and their families</td>
<td>Monitor low birth weight and infant mortality and compare outcomes of women with and without community health worker assistance</td>
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<td>Increase the percentage of infants born who are exclusively breastfed during the birth hospitalization and across the first year of life and reduce disparities in breastfeeding</td>
<td>Continue <strong>WIC Peer Breastfeeding</strong></td>
<td>Improve exclusive breastfeeding rates at six month and one year follow-up points for mother’s participating in WIC. Improve percent fully breast feeding by 10%.</td>
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<td>Improve children’s social-emotional development, child development outcomes, and reduce disparities in developmental outcomes</td>
<td>Re-establish Healthy Steps program and developmental specialist at the Pediatric Care Center (the position had been unfilled for 1 year), serving at least 100 participants age 0-5 and their families.</td>
<td>Continue Healthy Steps program and developmental specialist at the Pediatric Care Center, serving at least 200 participants age 0-5 and their families.</td>
<td>Continue Healthy Steps program and developmental specialist at the Pediatric Care Center, serving at least 300 participants age 0-5 and their families expanding staff as required by demand.</td>
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<td>Reduce childhood obesity and disparities in childhood obesity</td>
<td>Increase community participation in FitWIC including a farmer’s market incentive program, healthy recipes, food demonstration and physical activities, such as Zumba in the Park. The program has an on-site community garden, where</td>
<td>Increase community participation in FitWIC by increased internal communications and outreach to community partners. Improve linkage to WIC from</td>
<td>Increase referral of eligible children who are in enrolled for care at WHMC pediatric to WIC.</td>
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<td>Program and Certified Lactation Consultant services on the Obstetrics unit, with ongoing support and follow-up by the Peer Breastfeeding program</td>
<td>Maintain Baby-Friendly Hospital Designation</td>
<td>Maintain Baby-Friendly Hospital Designation</td>
<td>Maintain Baby-Friendly Hospital Designation</td>
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<tr>
<td>Preventing Chronic Diseases - Obesity, Diabetes, and Cardiovascular Diseases</td>
<td>Create an environment that promotes and supports healthy food and beverage choices and physical activity</td>
<td>Maintain Unidine “OH SO GOOD”</td>
<td>Increase uptake of “OH SO GOOD” menu options by 5% from baseline through promotion and marketing</td>
<td>Continue to increase uptake of “OH SO GOOD” menu options by 10% from baseline through promotion and marketing</td>
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<td><strong>Healthy Food and Lifestyle Choices Program</strong> and collect baseline utilization data</td>
<td>Increase patients with documented self-management goals and care plans by 5% from baseline</td>
<td>Increase patients with documented self-management goals and care plans by 10% from baseline</td>
<td>Increase patients with documented self-management goals and care plans by 10% from baseline</td>
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<tr>
<td>Institute collaborative community-based programs to increase preventive activities targeting obesity, diabetes, and cardiovascular disease</td>
<td>Update PCMH to the most recent standards across all Article 28 primary care sites. Expand health coaches’ role to identify patients with chronic condition risk factors and include social determinants of health (SDH). Health coaches will work with patients to identify self-management goals and develop care plans in collaboration with</td>
<td>Increase % of patients screened for SDH to 10%</td>
<td>Increase % of patient screened for SDH to 25%</td>
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primary care providers. Establish risk stratification tool to identify patients at high risk for complications and include SDH. Monitor % of patients who have SDH information collected

| Offer wellness program including **Zumba** and **Yoga** for employees and community members | Increase staff and community resident participation by 5% from baseline through increased internal communications and outreach to community partners. | Increase staff and community resident participation in wellness program by 5% from baseline through increased internal communications and outreach to community partners. |
| Measure staff and community resident participation in wellness program | Increase number of patients with at least one behavioral goal and one clinical goal documented by 5% | Increase number of patients with at least one behavioral goal and one clinical goal documented by 10% |

Achieve recognition by the American Diabetes Association for a Diabetes Self-management Program. Track number of patients with at least one behavioral goal and one clinical goal.
<table>
<thead>
<tr>
<th>Preventing Chronic Diseases - Obesity</th>
<th>Institute collaborative community-based programs to increase preventive activities targeting obesity, diabetes, and cardiovascular disease</th>
<th>Maintain Bariatric Center of Excellence designation. Establish community sites for clinical evaluation and referral for appropriate patients for surgical treatment of weight loss. Establish transportation program for patients to improve access to weight loss evaluation and surgery.</th>
<th>Expand weight management services to include a Comprehensive Weight Management Center to include medical management of weight loss and psychological counseling as warranted. Expand transportation services as necessary.</th>
<th>Increase the number of patients getting weight loss surgery.</th>
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<tr>
<td>Establish community outreach services to include meeting with primary care providers in the surrounding communities and providing patient education seminars in English and Spanish</td>
<td>Expand community outreach to local community based organizations, religious organizations and social service agencies. Increase the number of outreach events by 5 over baseline</td>
<td>Increase the number of outreach education events by 10 over baseline</td>
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</table>
Disseminating the Community Service Plan

**Website.** A summary of the CSP will be available through the hospital’s website at [www.wyckoffhospital.org](http://www.wyckoffhospital.org) with a prominent link to the full report.

**Community Advisory Boards.** The Community Service Plan will be distributed to all key contacts at relevant Community Boards for the neighborhoods we serve. These include Brooklyn Community Boards 1, 3, 4, and 5 and Queens Community Boards 5. The Community Board Contacts are listed at the end of this section. The Comprehensive Community Service Plan will be distributed to Wyckoff Heights Medical Center’s President’s Community Advisory Council and Wyckoff’s Community Advisory Board.

**Internal Communications and Intranet.** The Community Service Plan will be sent out to the Wyckoff Heights Medical Center listserv which reaches all 1,500 staff members. Staff will also be able to access the plan through the employee intranet. In addition, a link will be posted on Wyckoff’s Facebook Page and sent out via Twitter.

**Presentations at Key Meetings.** The Community Service Plan will be presented at key meetings, including the President’s Town Hall meeting which is open to the staff and public. The Plan will also be presented at leadership meetings including Executive Committee meeting, Department Managers meeting, and the Medical Board meeting.

Additionally, copies of the CSP will be available by request from the following offices and contacts:

Office of the President and CEO
Wyckoff Heights Medical Center
374 Stockholm Street
Brooklyn, NY 11327

CSP Contact Person(s): Dr. Laurie Ward
Title: Director of Population Health and Value Care
Phone: 718-907-6132
E-mail: lward@wyckoffhospital.org
References


CDC. “ChildVaxView Coverage of Local Areas Sampled by NIS | CDC,” April 1, 2019.


https://www1.nyc.gov/site/doh/about/about-doh.page.


———. “Home Care Agencies by Provider Type and Region/County." Accessed December 18, 2019.


