WYCKOFF HEIGHTS MEDICAL CENTER

COMMUNITY HEALTH NEEDS ASSESSMENT & COMMUNITY SERVICE PLAN

2022-2024

December 2022

Wyckoff
Wyckoff Heights Medical Center

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF HOSPITAL & PRIMARY CARE SERVICES
COMMUNITY SERVICE PLAN CONTACT INFORMATION SHEET

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FOREWORD

Wyckoff Heights Medical Center ("Wyckoff") is committed to providing 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.

Wyckoff's 2022-2024 Community Health Needs Assessment (CHNA) and Community Service Plan (CSP) detail the health needs of the hospital's primary service areas, and Wyckoff's strategic plans to address the most pressing of those community health needs. The CHNA and the CSP were developed in alignment with the New York State Prevention Agenda and satisfies the nonprofit hospital reporting requirements to the U.S. Internal Revenue Service.

Wyckoff's 2022-2024 CSP was approved by its Board of Trustees.

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

ABOUT WYCKOFF

Wyckoff
Wyckoff Heights Medical Center

ABOUT WYCKOFF HEIGHTS MEDICAL CENTER

Wyckoff is a 501(c)(3) voluntary, not-for-profit teaching hospital located in an ethnically diverse residential neighborhood on the border of northern Brooklyn and western Queens. Wyckoff has been providing medical care to the community since 1889 and has a dedicated staff of over 1,800 physicians, nurses and support personnel.

As a member of New York City's Safety Net Hospital Coalition, Wyckoff provides essential medical care to historically marginalized communities of color where social, health and economic disparities are the most severe. In 2021, more than 1,000 babies were delivered and over 200,000 clinic visits were completed at Wyckoff.

Table 1. Breakdown of services at Wyckoff in 2021

1. Annual discharges	**12,879**
2. Babies delivered	**1,023**
3. Emergency Room Visits	**63,417**
4. Clinic Visits	**204,480**

To help address the evolving health needs of the community, Wyckoff has not only strengthened its hospital's clinical capabilities, but has also expanded its community-based health programming.

MISSION

Wyckoff Heights Medical Center's mission is to provide a single standard of the highest quality care to our community through prevention, education and treatment in a safe environment.

In pursuit of this mission, Wyckoff targets improvements in the quality, accessibility and safety of its healthcare delivery system through continuous community outreach, education, monitoring and assessments of community needs; expansion and redesign of ambulatory care, primary care, behavioral health and preventive care services; and co-location of supportive services with clinical services, such as patient navigation, education, case management, advocacy and support. Wyckoff is committed to serving the community with respect and kindness, and this commitment is what has allowed Wyckoff to become the premier healthcare provider for the culturally diverse community it serves.

CLINICAL SERVICES & HEALTH PROMOTION

Wyckoff is a multi-site hospital system that has 324 patient beds and provides a broad array of adult and pediatric acute care services. These services include the following:

- 24-hour Emergency Department
- Pediatric Emergency Services
- Radiology Department
- Radiation Oncology Services
- 24-hour Laboratory Services
- Cardiac Therapeutic Service
- Cardiac Diagnostic Services
- Endoscopy Testing Services
- Endoscopy Treatment Services
- Prenatal Care
- Obstetric Care
- Neonatal care
- Rehabilitation Medicine
- Physical Therapy
- Speech Pathology
- Pain Management
- Infectious Disease Primary Care Management
- Oncology
- Neurosurgery

To better address the healthcare needs of Wyckoff's primary service area, the hospital has expanded their clinical programs and co-located supportive services. Over the past twenty years, Wyckoff has integrated crucial health promotion programs – such as, patient outreach, education, counseling, case management, navigation and linkage to care – into the clinical services for maternal, infant and child health; mental health and substance use; HIV and sexual health prevention and treatment; violence intervention and treatment for sexual assault and domestic violence; and asthma.

Wyckoff is dedicated to providing the highest level of care to all patients and has achieved notable success in areas of chronic disease management and pediatric care:

- Wyckoff is a New York State Designated Stroke Center
- Wyckoff is the first hospital in New York State to be certified by The Joint Commission for Pediatric Asthma
- Wyckoff is nationally accredited as a "Baby Friendly" hospital
- Wyckoff is a Patient-Centered Medical Home certified by New York State

TEACHING HOSPITAL

In addition to providing care to the community, Wyckoff also functions as a teaching hospital and training site for over 145 residents, interns, fellows and nursing students in a variety of specialties that include the following:

- Internal Medicine
- Dental Anesthesia
- General Surgery
- Pediatric Program
- Emergency Medicine

- Dentistry
- Podiatry
- Obstetrics and Gynecology
- Dental Pediatrics

Wyckoff is a clinical campus that has affiliation agreements in place with several academic institutions to support regular, ongoing student rotations throughout the year. In addition, Wyckoff is currently in the development phase and pursuing accreditation of a new Family Medicine residency program by December 2023 to better respond to the primary care provider shortages in our communities.

WYCKOFF'S COVID-19 RESPONSE

Amidst a global pandemic that plunged the NYC health system into chaos, Wyckoff quickly adapted hospital operating procedures and community outreach strategies to respond to an unprecedented health emergency.

With NYC being an epicenter of the COVID-19 pandemic, Wyckoff Heights Medical Center soon became one of the hardest hit hospitals in the world. In March 2020, the first COVID-19 death in NYC occurred at Wyckoff Heights Medical Center, and Wyckoff pivoted the majority of hospital resources towards the care and treatment of COVID-19 patients and shifted all non-emergency care to virtual visits. Wyckoff's clinical care spaces, primarily the emergency room and inpatient units, quickly filled beyond capacity as the pandemic raged through the city and Wyckoff worked tirelessly to expand emergency and inpatient care sites and redeploy staff to assist with COVID-19 response. Many of Wyckoff's staff contracted the virus and had to be out sick for prolonged periods with some succumbing to the disease, leading to hospital staff shortages and continuous reassessments of priorities and redeployment of staff. However, despite the fear, pain and loss that seemed to mark every day of the early pandemic, Wyckoff providers never stopped caring for their community. The awe-inspiring heroism of Wyckoff's staff during this moment of unprecedented crisis was captured by local, state and national media, with one of Wyckoff's nurses, Amy O'Sullivan, featured one of Time Magazine's 100 most influential people of 2020.[1]

1 Couric, K. (2020, September 22). The 100 Most Influential People of 2020: Amy O'Sullivan. Time Magazine. https://time.com/collection/100-most-influential-people-2020/5888224/amy-osullivan/

From 2020-2021, Wyckoff treated over 2,000 COVID-19 patients and housed one of the strongest COVID-19 vaccination programs in the state. Leveraging their ongoing relationships with nearby clinical campuses, Wyckoff was able to expand their nursing externship program to include practical experience at their COVID-19 vaccination site. With the additional support of new nurse externs, Wyckoff significantly expanded the reach and impact of their COVID-19 vaccination program.

"Wyckoff gained access to the vaccine at the end of 2020 and from there we rolled out a very strong and robust COVID-19 vaccination program. We administered about 75,000 vaccines during the pandemic. We helped a lot of people from all over the community and we are very proud of that." **– Dr. Gustavo Del Toro | Chief Medical Officer**

Although the pandemic severely strained hospital resources, Wyckoff's leaders refused to allow the community to go without access to essential healthcare services. Wyckoff continued community access to routine healthcare during the pandemic by revamping their community outreach strategy and bringing healthcare directly to the homes of children and families.

"In early 2021, Wyckoff health coaches visited the homes of pediatric patients that missed their scheduled immunization appointments. Since clinics closed due to COVID-19 and health coaches could not get in touch with pediatric patient families via phone – health coaches went door-to-door on Saturdays to ensure that a child's health would not fall through the cracks." **– Lorraine Woltman | Clinical Implementation Director**

POLICY LANDSCAPE

In an attempt to rebuild systems that were devastated by the COVID-19 pandemic, the US government passed the CARES Act which established a $150 billion Coronavirus Relief Fund to help address COVID-19 related costs incurred by state, local and tribal governments.[2] Although these funds provided healthcare systems across the United States with the financial assistance needed to begin patching budget holes, the CARES Act failed to address the root causes of chronic underfunding that continue to plague safety-net hospitals, such as Wyckoff.

Table 2: Payor breakdown - Wyckoff Hospital (2021)

Medicaid Managed Care	52.52%
Medicaid Managed Care	16.21%
Commercial	13.81%
Blue Cross	4.82%
Medicaid	4.29%
Medicare	4.26%
Self Pay	3.53%
Workers Comp	0.64%
No fault	0.44%
Champva	0.08%
Miscellaneous	0.03%
Grand Total	100.00%

2 U.S. Department of the Treasury. (2022, July 5). Coronavirus Relief Fund. https://home.treasury.gov/policy-issues/coronavirus/assistance-for-state-local-and tribal-governments/coronavirus-relief-fund.

Wyckoff is a not-for-profit, safety-net community hospital providing medical care to neighborhoods that are experiencing some of the most significant economic, social and health inequities in New York City. Today, Medicaid only pays 88 cents on the dollar for care provided by hospitals, which means for every dollar that Wyckoff spends only up to 88% gets reimbursed.[3]

With over 56% of Wyckoff's patients insured by Medicaid, over 20% insured by Medicare, and an additional 3.5 % of patients without insurance; Wyckoff relies on a significantly lower operating budget compared to other hospitals that serve a larger commercially insured population. However, despite these financial challenges, Wyckoff continues to provide high quality healthcare to its service area by leveraging a wide array of public and private funds.

In the past 6 years, one of the most impactful funding sources for Wyckoff's system-wide health promotion programs was the NYS Delivery System Reform Incentive Payment Program (DSRIP). The projects Wyckoff implemented with DSRIP funding cut across the hospital ambulatory, inpatient, and emergency medicine departments and were designed to improve coordination of care, reduce avoidable hospitalizations, and decrease the use of the Emergency Department for primary care sensitive conditions.

> *"DSRIP allowed us to invest in services that connected patients to community-based organizations that helped maintain their wellbeing outside of the hospital – but after the loss of DSRIP, we no longer had that extra coverage to address social determinants of health...and that is a void that needs to be filled in a robust way."*
>
> **– Dr. Tanveer Mir | Department of Medicine Chairperson**

While DSRIP funding ended on December 30, 2020, Wyckoff has made efforts to continue a few of the most impactful DSRIP programs. Key programs that Wyckoff has committed to maintaining after the discontinuation of DSRIP funding include: support for seniors through a partnership with the Jewish Association Serving the Aging (JASA), financial assistance for reproductive endocrinology services, inpatient care navigation and coordination by the transitional care team to support improved health outcomes outside the hospital once patients are discharged, and chronic disease management by trained Health Coaches who are co-located in Wyckoff's primary care clinics. In addition to these hospital-funded services, Wyckoff holds a portfolio of over 20 grant-funded health promotion programs which together serve over 8,000 individual clients annually on-site at Wyckoff and in the community with services such as case management, patient and community outreach and navigation, mental health and substance use counseling and treatments, and health prevention counseling, education, testing and advocacy; all offered to eligible clients regardless of insurance or ability to pay.

3 American Hospital Association. (2022, February). Fact sheet: Underpayment by Medicare and Medicaid. https://www.aha.org/fact-sheets/2020-01-07-fact-sheet-underpayment-medicare-and-medicaid#:~:text=caring%20for%20Medicare%20patients%20in,for%20Medicaid%20patients%20in%202020.&text=cost%2C%20while%2062%20percent%20of,Medicaid%20 payments%20 less%20than%20cost.

Support for the Uninsured and the Underinsured

To address healthcare access for the uninsured and underinsured patient population, Wyckoff subsidizes at least one well visit per patient per year and maintains several in-house patient support resources.

> *"Our policy is that anyone can come to any of our ambulatory sites and receive one visit for free, so that anything that needs immediate attention receives that attention. The last thing that we want to do is turn our back on the community."*
>
> **– Dr. Gustavo Del Toro | Chief Medical Officer**

Wyckoff's in-house patient support resources include a robust Medicaid Office and Social Work Department.

Wyckoff's Medicaid Office assists uninsured or under-insured patients with:

- Health insurance applications
- Income-adjustable payment plans
- Case management related to healthcare financing
- Health plan navigation

Wyckoff's Social Work Department assists all patients experiencing hardship with:

- Linkage to community-based organizations for specialized social and support services, including food, housing, insurance navigation, employment assistance, etc.
- Culturally-relevant health education

Wyckoff's grant-funded programs provide numerous services free-of-cost to the uninsured and underinsured, including mental health and substance use counseling; crisis intervention, counseling and support for survivors of sexual assault and domestic violence; HIV and STI testing; HIV prevention medications (PrEP and PEP) and HIV and STI treatment; nutrition services for mothers and children up to 5 years old through the on-site WIC program; prenatal and postnatal health education and community visits; medical insurance navigation and support with enrolling in patient assistance programs; and health education and referrals to off-site social services to support health outside the hospital. Beyond the initial provision of care, Wyckoff also finances initiatives that encourage patient adherence to care plans after discharge. This support includes:

- Free access to transportation to-and-from the hospital
- A free 30-day supply of medication after discharge

Wyckoff directly finances a significant portion of these programs, but aid from the federal 340B program ensures that Wyckoff can sustain their medication supply program.

In total, Wyckoff spent approximately $28 million on charity care for the community in 2021.

Notable Achievements from the CSP 2020-2022

In the CSP developed for the period 2020-2022, Wyckoff focused on two priorities:

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

To promote healthy women, infants and children, Wyckoff targeted maternal and child health disparities identified locally among both Black and Hispanic residents, including perinatal outcomes and breastfeeding. Some of the accomplishments in this area include:

- Established a doula training initiative championed by Dr. Ralph Ruggiero, Chairman of Obstetrics and Gynecology in partnership with the Hope and Healing Family Center in Brooklyn and trained two Wyckoff employees as Doulas
- Provided doula services on-site at Wyckoff to 24 clients through a collaboration between Wyckoff's Women's Health Clinic, the Maternal and Infant Community Health Collaborative (MICHC), and the NYC Doula Project
- Implemented maternal health education, in-home visits, and counseling to individuals of reproductive age through the Maternal and Infant Community Health Collaboratives (MICHC) to over 200 clients annually, including in 2020 during the height of the COVID-19 pandemic
- Provided WIC services, such as comprehensive nutrition and breastfeeding education, one-on-one support, and access to infant formula and food packages to over 5,000 women, infants, and children
- Maintained Wyckoff's Baby-Friendly Hospital Designation through Annual Quality Improvement (AQI) and data tracking activities
- Provided developmental and socioemotional screenings to over 2000 children ages 0-3 years and their mothers annually and tailored interventions including counseling, education, and referrals to early intervention to over 200 children via the Healthy Steps program at Wyckoff's Pediatric Care Center
- Hired a Medical Director for Adolescent Health, Dr. Marisol Gonzalez, who has championed the expansion of sexual health and HIV prevention services for adolescents including access to PrEP on site at the Pediatric Clinic

To prevent chronic disease in the community, Wyckoff targeted health disparities most prevalent within the Hispanic and African American populations. Interventions to address chronic disease emphasized diabetes, obesity and breast cancer. Some of the accomplishments in this area include:

- Provided tailored diabetes education to 50 patients per month
- Achieved recognition from the American Diabetes Association as a diabetes self-management program
- Provided free exercise classes on-site at Wyckoff open to staff and community residents, including Yoga, Zumba, cardio, and strengthening
- Maintained implementation of Wyckoff's Health Coaches program after DSRIP

funding ended in 2020, which provided chronic disease management assessments, education, care coordination on topics such as cardiovascular disease and diabetes to over 200 patients monthly across primary care sites

- Conducted in-person outreach and education to 20 primary care providers in the community about Wyckoff's breast cancer screening services

1. COMMUNITY HEALTH NEEDS ASSESSMENT

Wyckoff
Wyckoff Heights Medical Center

1.1. DATA SYNTHESIS

Wyckoff
Wyckoff Heights Medical Center

1.1. DATA SYNTHESIS

METHODOLOGY

We conducted a synthesis and analysis of public health data of the two counties and five neighborhoods that integrate Wyckoff's primary service area, as shown below in the map.

Figure 1. Wyckoff Heights Medical Center's primary service area

Neighborhood	Primary zip codes
KINGS COUNTY (BROOKLYIN)	
Bushwick	11206, 11207, 11221, 11237
Bedford–Stuyvesant (Bedford)	11205, 11206, 11216, 11221, 11233
East New York	11207, 11208, 11239
Williamsburg	11211, 11206
QUEENS COUNTY	
Ridgewood	11385

Data sources

These are the data sets that were consulted to extract health and demographic indicators at the county and neighborhood levels.

County level data

New York State Community Health Indicator Reports (CHIRS): CHIRS were developed in 2012 and are regularly updated to consolidate and provide information regarding health indicators in the County Health Assessment Indicators (CHAI) for all communities in New York. The CHIRS Dashboard tracks about 350 indicators organized by 15 health topics including:

a. Cancer
b. Cardiovascular disease
c. Child and adolescent health
d. Cirrhosis, diabetes, and kidney indicators
e. Communicable diseases
f. Family planning
g. HIV/AIDS and sexually transmitted infections
h. Injuries
i. Maternal and infant health
j. Obesity

k. Occupational health
l. Oral health
m. Respiratory disease
n. Social determinants of health
o. Tobacco and alcohol use

CHIRS use numerous data sources including:

- **Mortality and natality data:** New York State birth and death files.
- **Hospitalization and emergency department (ED) visit data:** Statewide Planning and Research Cooperative Systems (SPARCS) files, based on hospital discharges and ED visits.
- **Disease and condition specific data:** Department of Health disease registries, including cancer, AIDS/HIV, communicable disease, tuberculosis, and sexually transmitted infection.
- **Program-based data:** WIC program, Childhood Lead Poisoning Prevention Program, and Heavy Metals Registry, Student Weight Status Category Reporting System (SWSCR), Expanded Behavioral Risk Factor Surveillance System (BRFSS), Oral Health Survey of 3rd Grade Children, Medicaid, New York State Governor's Traffic Safety Committee.
- **National data:** U.S. Census Bureau, Center for Disease Control and Prevention (CDC), U.S. Bureau of Labor Statistics, U.S. Department of Agriculture, Feeding America, Measure of America.
- **Population data:** The 2018 population estimates are also used to calculate rates for 2019 and 2020.

Neighborhood level data

New York City Neighborhood Health Atlas (NYCNHA): Provides data about 100 measures related to health and other social factors for 188 neighborhoods. The Neighborhood Atlas includes measures relate to health and neighborhood characteristics, such as:

a. **Demographics** (race, age, country of origin)
b. **Social conditions** (education, poverty, disabilities)
c. **Health outcomes** (hospitalization, rates of communicable diseases, premature mortality)
d. **Health care** (health insurance status, number of primary providers, Medicaid enrollment)
e. **Housing** (density, rent burden)
f. **Neighborhood conditions** (air quality, number of tobacco retailers, crime complaints)
    i. **New York City Community Health Profiles:** The New York City Community Health Profiles capture the health of 59 community districts across the city. They contain over 50 measures of neighborhood health. 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.

ii. **New York City COVID-19 Data:** The New York City Health department registers COVID-19 data by different demographic and socioeconomic data by zip code. Available data includes vaccinations, cases, and deaths. For vaccination, data are updated daily with a one-day lag. Trends and total data for case and death rates are published with a three-day lag.

Data synthesis framework

This community health needs assessment used the 2019-2024 New York State's Health Improvement plan as a framework to synthesize available information in data sets. The 2019-2024 prevention agenda includes five action plans, including:

i. Prevention of chronic diseases
ii. Promotion of safety and healthy environments
iii. Promotion of healthy women, infants, and children
iv. Promotion of well-being and prevention of mental and substance use disorders
v. Prevention of communicable diseases

Available data at county and neighborhood level was classified according to these dimensions. For county-level information, trends were explored among the most representative indicators within each group. At the neighborhood level, a comparison to New York City was performed. The following color coding was used to ease interpretation:

- **Green:** indicates a significantly better performance of the neighborhood compared to NYC for a specific indicator.
- **Yellow:** indicates a similar performance of the neighborhood compared to NYC for a specific indicator.
- **Red:** indicates a significantly worst performance of the neighborhood compared to NYC for a specific indicator.

FINDINGS

Summary of findings for County-level data

- All cancer incidence rate by 100,000 population in Queens increased between 2008 and 2018. For the same period, the cancer incidence rate remained relatively stable in Kings County.
- Between 2008 and 2018, breast cancer incidence increased by 27% and 15% among women in Queens and Kings, respectively.
- New HIV diagnoses have been decreasing significantly in Queens and Kings, however Kings/Brooklyn continues to be the leading borough in NYC with the highest number of HIV diagnoses in 2021 (416 out of the total 1594 new HIV diagnoses recorded by NYC DOHMH). Additionally, other sexually transmitted infections (STIs) such as gonorrhea are increasing.[4]

4 New York City Department of Mental Health & Hygiene. (2022, December). HIV Surveillance Annual Report, 2021. https://www.nyc.gov/assets/doh/downloads/pdf/dires/hiv-surveillance-annualreport-2021.pdf

- Suicide mortality rates are also increasing in both, Queens and Kings. However, there is a dearth of data in the mental health area.

Summary of findings for Neighborhood-level data

- Sociodemographic characteristics of Wyckoff's primary service area include higher representations of racial minorities and people aged 0-17 than NYC overall and social determinants of health include high prevalence of poverty, crowded housing, low English proficiency and low education levels.
- Several risk factors for non-communicable diseases are observed across neighborhoods including higher prevalence of current smokers than overall NYC, low physical activity, and high consumption of sweetened beverages.
- Like county-level data, a good progress against the HIV burden is observed, however new HIV diagnoses continue to disproportionately affect racial and sexual minorities such as the populations predominantly served by Wyckoff, with 1293 (81%) of the new 1594 HIV diagnoses in 2021 being among Black or Latino individuals. Additionally, rates of other STIs remain higher than overall NYC.
- Most neighborhoods in Wyckoff's primary service area present worse outcomes related to COVID-19 than overall NYC.
- Childhood obesity, and elementary school absenteeism are serious problems across neighborhoods in Wyckoff's primary service area
- Similar to county level data, there is also a dearth of mental health data at the neighborhood level.

County-level data

A total of 175 indicators were found on the CHIRS database. 41% (n=72) of available indicators were for chronic diseases, 18% (n=31) were for communicable diseases, and only 2% (n=4) of available indicators were for well-being, mental health and substance use.

Table 3. CHIRS county-level indicators available by framework area

Action Plan	Indicators
Prevent Chronic Diseases	72
Prevent Communicable Diseases	31
Promote a Healthy and Safe Environment	10
Promote Healthy Women, Infants and Children	58
Promote Well-Being and Prevent Mental and Substance Use Disorders	4

Source: New York State Department of Health (2022, February). Community Health Indicator Reports, www.health.ny.gov/CHIRSDashboard

As mentioned above, CHRIS data contain information of several health and county indicators for multiple time points. Related to the prevention of chronic diseases, Kings County improved in 5 of the available indicators while Queens improved in 10 of them. For most of the indicators, the performance of Kings and Queens was similar, with the exception of promotion of healthy and safe environments in which Kings showed an improvement in 8 of the available indicators while Queens showed no improvement.

Table 4. Comparison of time changes in County-level indicators by framework area

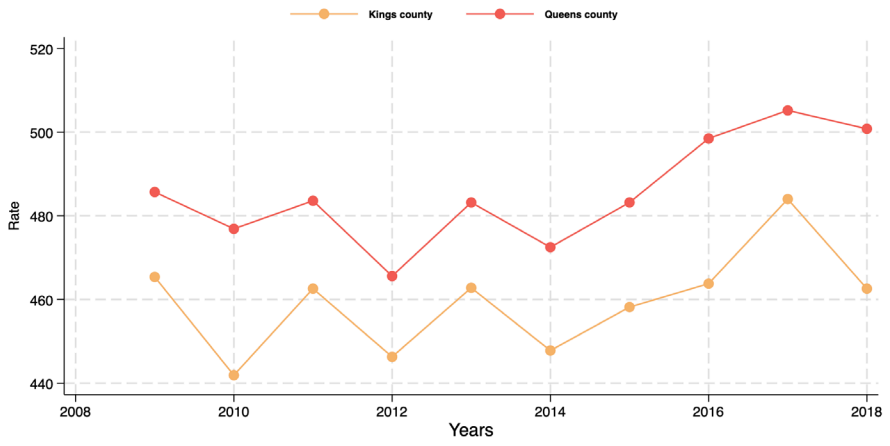
Area	Indicators	Kings County			Queens County		
		Improved	No Change	Worsened	Improved	No Change	Worsened
Prevent Chronic Diseases	72	5	54	13	10	50	12
Prevent Communicable Diseases	31	8	9	14	8	9	14
Promote a Healthy and Safe Environment	10	4	1	5	-	4	6
Promote Healthy Women, Infants and Children	58	28	20	10	24	22	12
Promote Well-Being and Prevent Mental and Substance Use Disorders	4	-	3	1	-	3	1

Source: New York State Department of Health (2022, February). Community Health Indicator Reports, www.health.ny.gov/CHIRSDashboard

Prevent Chronic Diseases

Chronic diseases behaved differently across time between Kings and Queens. **Figure 2** shows trends between 2008 and 2018 of all cancer incidence rate per 100,000. For all data points, chronic disease incidence was higher in Queens when compared to Kings. Also, incidence in Queens continues to grow during the observation period.

Figure 2. All cancer incidence rate by 100,000 in Kings and Queens



Source: New York State Department of Health (2022, February). Community Health Indicator Reports, www.health.ny.gov/CHIRSDashboard

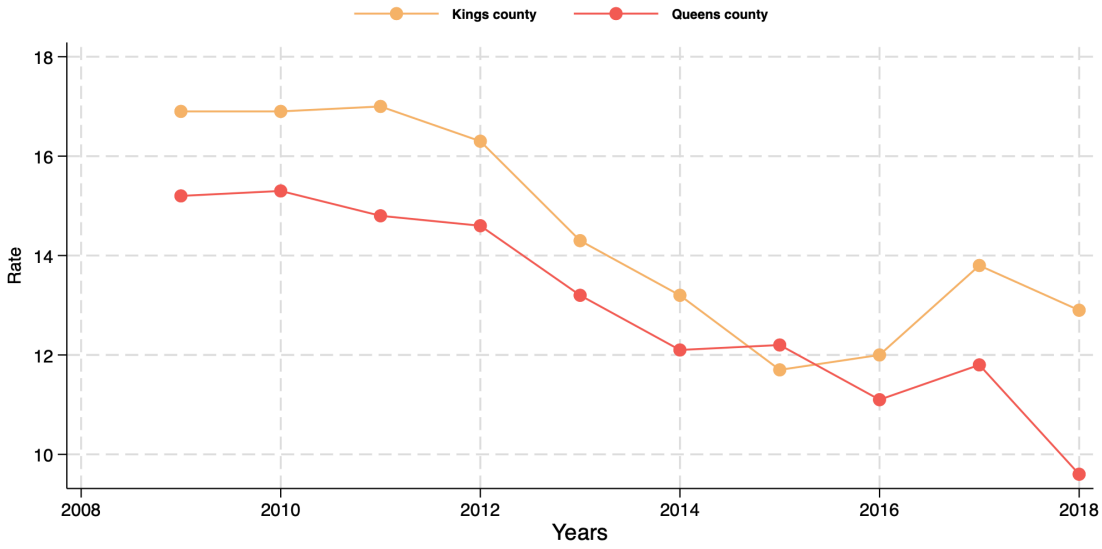
Data on female breast cancer also shows an increasing trend from 2009 to 2018. Incidence rate per 100,000 women in Queens increased by 27%, from approximately 130 in 2008 to almost 165 in 2018. Incidence also increased in Kings County by 15% going from 120 in 2008 to 140 in 2018.

Figure 3. Female breast cancer incidence rate by 100,000 in Kings and Queens

Source: New York State Department of Health (2022, February). Community Health Indicator Reports, www.health.ny.gov/CHIRSDashboard

Colon and rectum cancer mortality rates are significantly decreasing in both King and Queens. In the former, colon cancer mortality decreased by 22% going from 16.9 per 100,000 population in 2009 to 13.2 in 2014. In Queens, mortality decreased from 15.2 per 100,000 in 2009 to 12.1 in 2014 (20% reduction). Between 2015 and 2017, the mortality due to colon and rectum cancer increased in Kings.

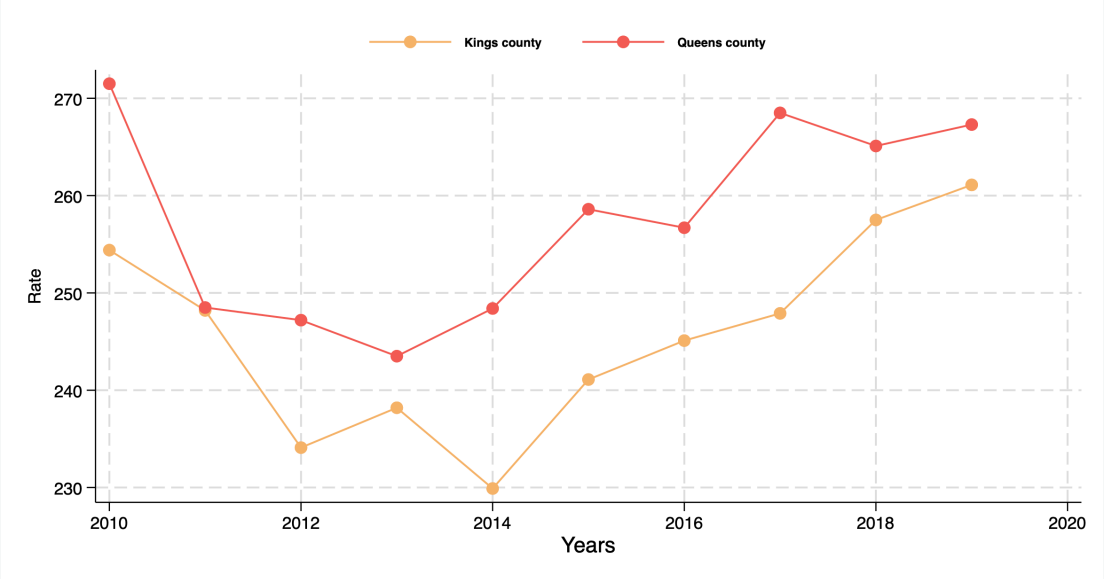
Figure 4. Colon and rectum cancer mortality rate by 100,000 in Kings and Queens



Source: New York State Department of Health (2022, February). Community Health Indicator Reports, www.health.ny.gov/CHIRSDashboard

Besides Cancer, cardiovascular disease appears to be a major health issue in both Kings and Queens counties, with a growing trend between 2012 and 2019. Mortality rates dramatically decreased between 2008 and 2012, but after 2012 the indicator showed a positive trend in both counties.

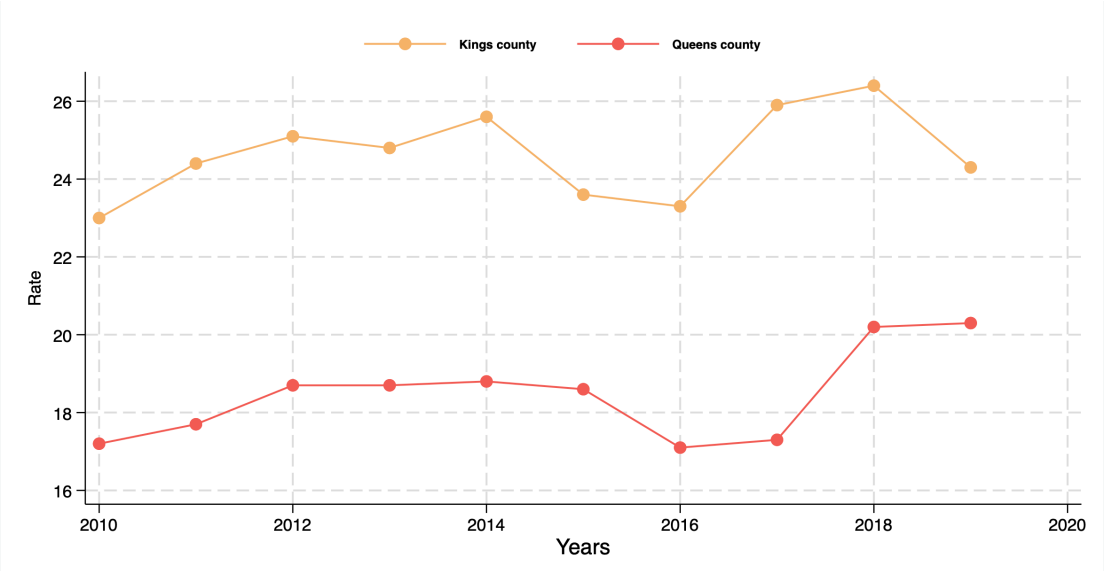
Figure 5. Cardiovascular disease mortality rate by 100,000 in Kings and Queens



Source: New York State Department of Health (2022, February). Community Health Indicator Reports, www.health.ny.gov/CHIRSDashboard

Diabetes mortality rate in the 2010 – 2019 period remained stable in both Kings and Queens counties. However, between 2018 and 2019, deaths per 100,000 people decreased from 27 to 24 in Kings County. Between 2017 and 2018, the mortality rate among Queens inhabitants increased from 17 to almost 20 per 100,000 population.

Figure 6. Diabetes mortality rate by 100,000 in Kings and Queens

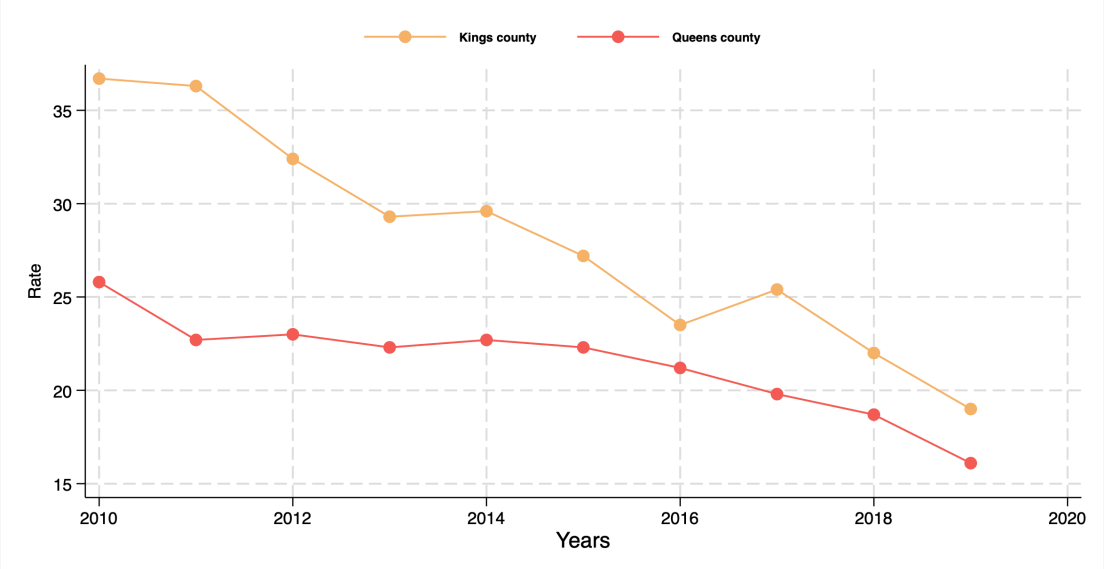


Source: New York State Department of Health (2022, February). Community Health Indicator Reports, www.health.ny.gov/CHIRSDashboard

Prevent Communicable Diseases

New HIV diagnoses have declined significantly in Kings and Queens between 2010 and 2019. Despite showing a downward trend in both counties, the rate per 100,000 was higher among Kings inhabitants.

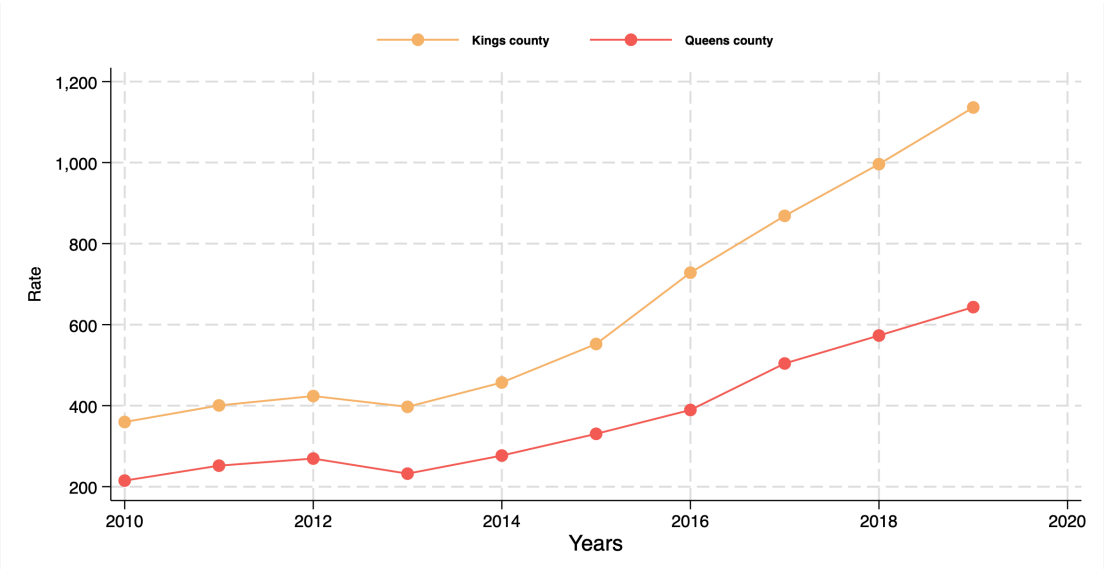
Figure 7. Newly diagnosed HIV rate by 100,000 in Kings and Queens



Source: New York State Department of Health (2022, February). Community Health Indicator Reports, www.health.ny.gov/CHIRSDashboard

While HIV is on the decline, some population groups show upward trends in other sexually transmitted infections (STIs). For example, cases of gonorrhea in men aged 15-44 years have grown significantly in both counties between 2010 and 2019. STIs increase the risk of HIV and contribute to the rise in antibiotic resistance.

Figure 8. Gonorrhea case rate by 100,000 15-44 males in Kings and Queens

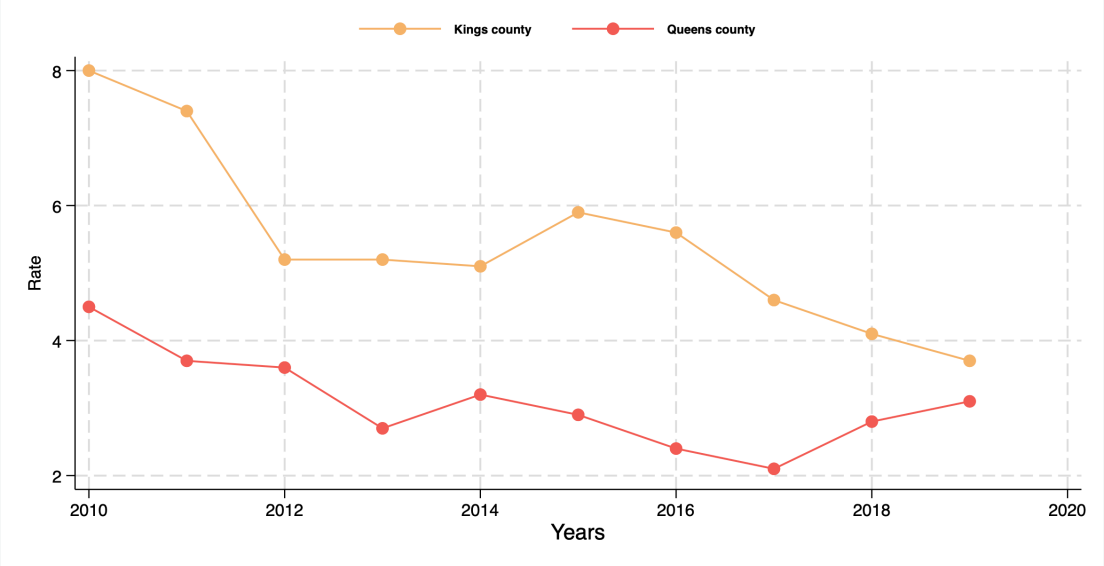


Source: New York State Department of Health (2022, February). Community Health Indicator Reports, www.health.ny.gov/CHIRSDashboard

Promote a Healthy and Safe Environment

Age-adjusted homicide mortality rates per 100,000 had significantly decreased in both, Kings and Queens. Between 2010 and 2019, homicides declined by 53% (from 8 in 2010 to 3.8 in 2019) and 33% (from 4.5 in 2010 to 3.5 in 2019) in Kings and Queens, respectively.

Figure 9. Age-adjusted homicide mortality rate by 100,000 in Kings and Queens

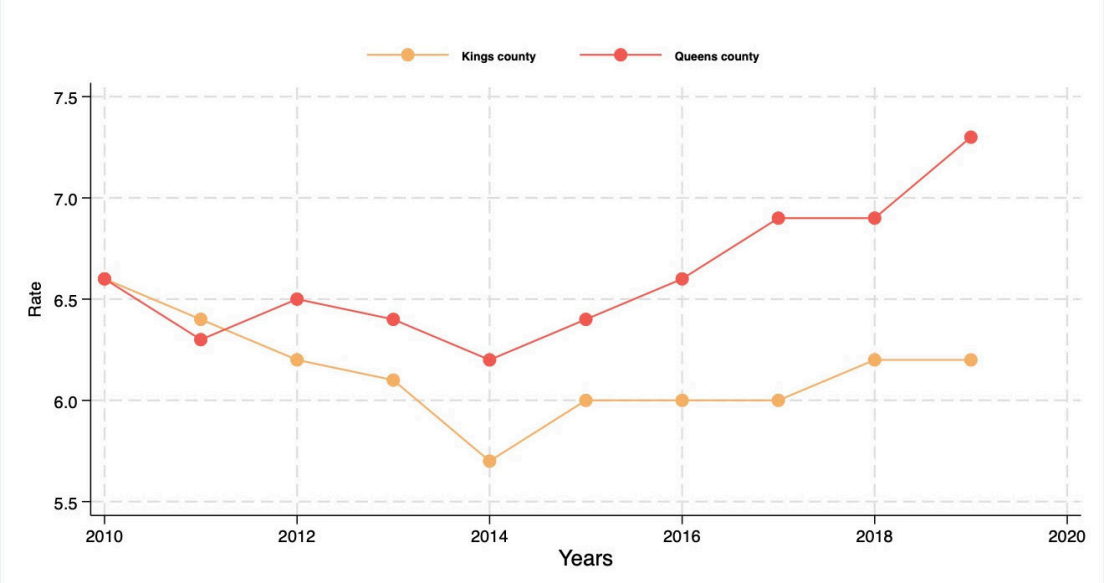


Source: New York State Department of Health (2022, February). Community Health Indicator Reports, www.health.ny.gov/CHIRSDashboard

Promote Healthy Women, Infants, and Children

Progress in this area has differed between Kings and Queens counties. For example, between 2010 and 2019, the percentage of low birthweight (<2.5kg) births remained relatively constant in Kings while in Queens it showed a positive trend.

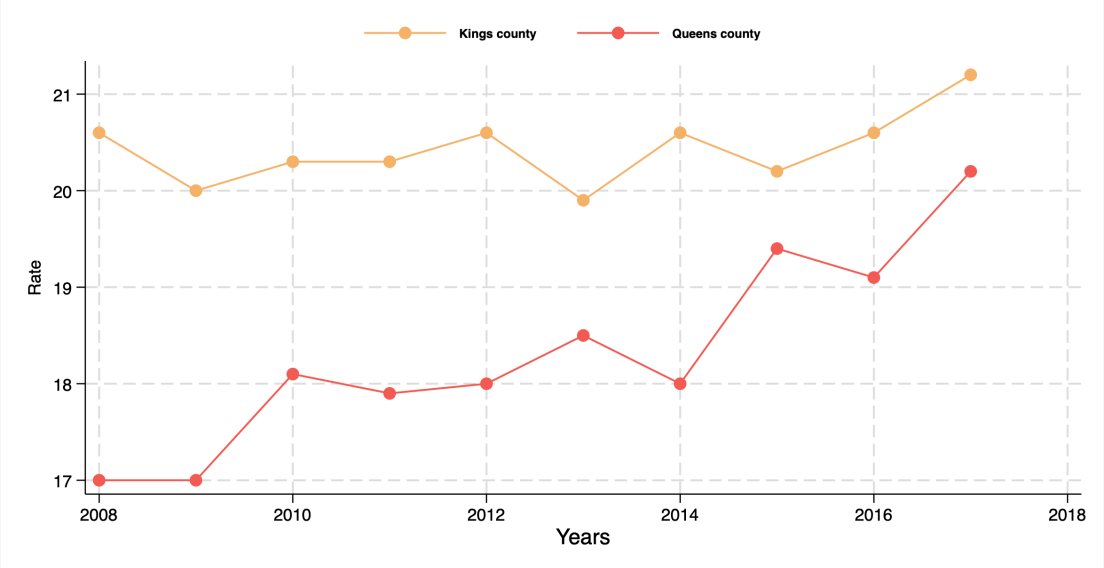
Figure 10. Percentage low birthweight (<2.5kg) singleton births in Kings and Queens



Source: New York State Department of Health (2022, February). Community Health Indicator Reports, www.health.ny.gov/CHIRSDashboard

Data from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) shows an increase in the proportion of obese (30 BMI or higher) pregnant women enrolled in both Kings and Queens Counties in the 2008 – 2018 period.

Figure 11. Percentage of pregnancy obese women in WIC in Kings and Queens

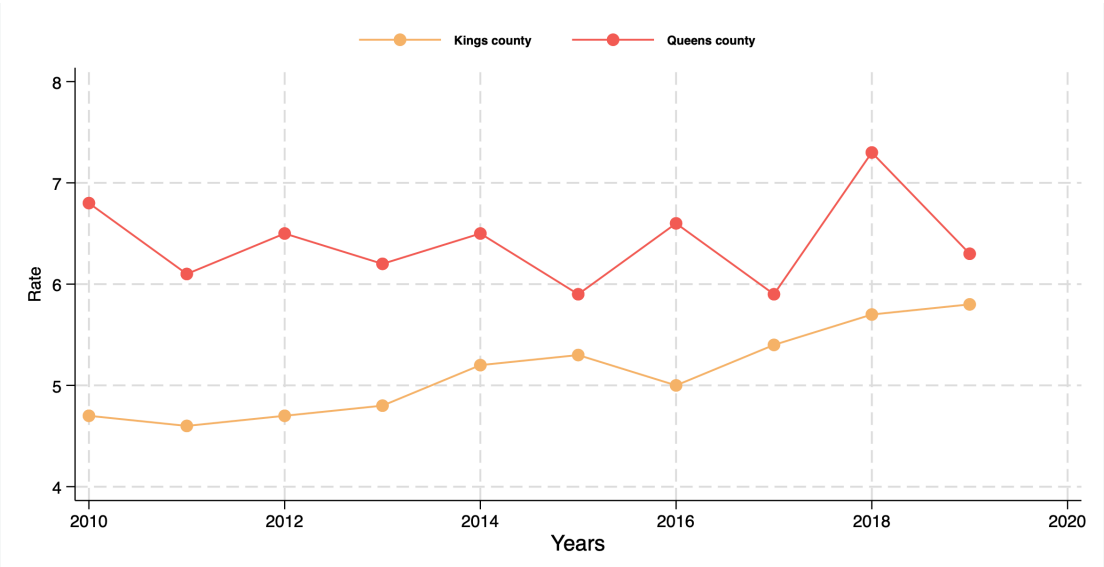


Source: New York State Department of Health (2022, February). Community Health Indicator Reports, www.health.ny.gov/CHIRSDashboard

Promote Well-being and Prevent Mental and Substance Use Disorders

Data on this topic is scarce for both counties. Trends in suicide mortality rates by 100,000 showed an increase in this indicator between 2008 and 2017 for Kings County and a downward behavior among Queens, particularly between 2018 and 2019. However, suicide mortality rate is still higher among Queens inhabitants.

Figure 12. Suicide mortality rate per 100,000 in Kings and Queens



Source: New York State Department of Health (2022, February). Community Health Indicator Reports, www.health.ny.gov/CHIRSDashboard

Neighborhood-level data – General Overview

Demographics

Demographic data indicates several disparities for the healthcare system in the area. For example, compared to New York City, the proportion of population aged 0-17 is higher among all neighborhoods in Wyckoff's primary service area. Racial minorities (Hispanic/Latino, black, Asian and Pacific Islander) represent 97% of total population in East New York, up to 87% in Bushwick, and 67% in Bedford, compared with only 65% in NYC. Epidemiological data show that racial and ethnic minority groups, throughout the United States, experience higher rates of illness and death across a wide range of health conditions, including diabetes, hypertension, obesity, asthma, and heart disease, when compared to their White counterparts[5]. Additionally, racial and ethnic minorities experience higher poverty rates than their White counterparts and are more likely to spend a higher proportion of their income on rent/housing and food.

Limited English proficiency is higher in four out of six neighborhoods compared with NYC average. Language barriers have been frequently associated with unequal access to healthcare and health outcomes[6]. There is a strong link between health equity, language access, and cultural competency in healthcare. Patients who are not English-proficient are less likely to get the care they need because of lacking language access and cultural competency. Therefore, the health disparities among groups with limited English proficiency can be especially prominent[7]. Finally, the youth ages 0-17 are more likely to be vulnerable to health disparities especially in households that are low income and where English proficiency is limited, due to fewer resources related to income, food, education, and housing leading to food insecurity and poor nutrition and overcrowded and/or poorly maintained housing that can exacerbate health issues like asthma.

Table 5. Demographics in the Wyckoff's primary service area

Indicator		NYC	Kings				Queens
			Bushwick	Bedford	East New York	Williamsburg	Ridgewood
Total Population		8,354,889	112,388	71,706	91,139	32,094	70,234
Age groups[a]	0-17	21.4	23.4	30.0	29.0	46.9	23.5
	18-24	10.1	14.2	11.9	11.8	10.5	10.5
	25-44	31.4	35.6	32.3	26.6	19.6	32.6
	45-64	24.6	19.4	18.2	23.1	15.4	23.9
	65+	12.5	7.4	7.5	9.5	7.6	9.4

5 Centers for Disease Control and Prevention. Racism and Health. (2021). https://www.cdc.gov/minorityhealth/racism-disparities/index.html

6 Al Shamsi, H., Almutairi, A. G., Al Mashrafi, S., & Al Kalbani, T. (2020). Implications of language barriers for healthcare: a systematic review. Oman medical journal, 35(2), e122.

7 Espinoza, J. & Derrington, S. How should clinicians respond to language barriers that exacerbate health inequity? (2021). https://pubmed.ncbi.nlm.nih.gov/33635190/

Indicator		NYC	Kings				Queens
			Bushwick	Bedford	East New York	Williamsburg	Ridgewood
Race[a]	Hispanic/Latino	28.8	65.4	19.3	27.0	11.0	48.5
	White (Not Hispanic/Latino)	32.7	11.9	30.6	1.8	85.4	40.4
	Black (Not Hispanic/Latino)	22.6	17.3	45.4	67.8	3.1	2.0
	Asian and Pacific Islander	13.2	4.5	2.7	2.1	0.1	7.8
	All other races	2.7	1.1	2.0	1.4	0.5	1.3
Foreign Born Residents[a]		37.1	36.5	19.3	29.2	11.7	44.7
Limited English Proficiency[a]		23.2	34.2	15.8	9.9	33.4	29.5

[a] Percentage respect to total population

Source: New York City Department of Health and Mental Hygiene (2022). New York City Neighborhood Health Atlas. https://public.tableau.com/app/profile/nyc.health/viz/NewYorkCityNeighborhoodHealthAtlas/Home

Social and Economic Conditions

Wyckoff's primary service area encompasses significant social and economic disparities. The rate of inhabitants with education less than high school is twice as high in Bushwick than NYC. Also, more than half (56.5%) of Williamsburg population lives below the federal poverty level. Additionally, crowded housing levels in Williamsburg and Bushwick are 184% and 74% higher and poverty rates are 42% and 174% higher than those observed in NYC, respectively. Health insurance coverage is also limited among inhabitants of some of the neighborhoods across Wyckoff's primary service area. For example, in Bushwick, health insurance coverage is 13% lower compared to NYC.

Table 6. Social and economic conditions in the Wyckoff's primary service area

Neighborhood	Education Less than High School[a]	Poverty[a]	Unemployment[a]	Health Insurance[a]	Rent Burden Greater than 50%[a]	Crowded Housing[a]
Bushwick	40.1	29.4	14.2	74.8	33.0	15.5
Bedford	22.5	34.3	13.2	89.0	31.9	11.9
East New York	22.1	33.2	13.9	89.0	33.8	13.6
Williamsburg	30.5	56.5	5.8	94.8	43.6	25.3
Ridgewood	23.0	20.1	8.1	79.0	30.5	7.7
NYC	19.9	20.6	10.3	86.5	29.8	8.9

[a] Percentage respect to total population

Source: New York City Department of Health and Mental Hygiene (2022). New York City Neighborhood Health Atlas. https://public.tableau.com/app/profile/nyc.health/viz/NewYorkCityNeighborhoodHealthAtlas/Home

Neighborhood-level data – Findings by New York State's Health Improvement Plan Area

Prevent Chronic Diseases

Wyckoff's service area is profoundly affected by high rates of chronic diseases and their developmental antecedents. Obesity rates in East New York, Bedford, and Bushwick are, respectively, 46%, 21%, and 8% higher than the NYC overall rate. The prevalence of diabetes in these neighborhoods is also 27%, 18%, and 18% higher than the NYC overall rate, respectively. Hypertension rates in Bedford and East New York are 21% higher than the NYC average.

On the behavioral side, consumption of one or more sugary drinks per day in Bedford and East New York is, respectively, 26% and 35% higher than the NYC average. Also, the proportion of current smokers in the adult population in Bushwick, Bedford, Williamsburg, and Ridgewood are, respectively, 17%, 19%, 17%, and 20% while in NYC it is 14%. Only one (Bushwick) of five neighborhoods across Wyckoff's primary service area showed higher levels of any physical activity in the past 30 days than overall NYC.

Table 7. Chronic diseases and associated risk factors in the Wyckoff's primary service area

Neighborhood	Any physical activity past 30 days (%)	Current smokers (%)	One or more 12-ounce sugary drinks per day (%)	Obesity (%)	Diabetes (%)	Hypertension (%)
Bushwick	75	17	23	26	13	26
Bedford	70	19	29	29	13	34
East New York	70	13	31	35	14	34
Williamsburg	66	17	18	23	11	25
Ridgewood	68	20	19	22	8	23
NYC	73	14	23	24	11	28

Source: Hinterland K, Naidoo M, King L, Lewin V, Myerson G, Noumbissi B, Woodward M, Gould LH, Gwynn RC, Barbot O, Bassett MT (2018). https://www.nyc.gov/site/doh/data/data-publications/profiles.page

Prevent Communicable Diseases

According to the New York City Department of Health and Mental Hygiene, new reports of chronic hepatitis B per 100,000 adults aged 18 and older are significantly lower in all neighborhoods of Wyckoff's primary service area compared with the overall NYC. Rates of chronic hepatitis C were also lower in all neighborhoods with the exception of East New York. In this neighborhood hepatitis C cases were only 2% higher than the overall NYC.

Compared with NYC, Bushwick, Bedford, and East New York have higher new HIV diagnoses per 100,000 population respectively, 2%, 43%, and 57% higher. Chlamydia rates were also 9%, 15% and 47% higher in Bushwick, Bedford, and East New York than NYC. Three out of five neighborhoods in Wyckoff's primary service area presented higher rates of gonorrhea and syphilis than overall NYC.

Table 8. STIs in the Wyckoff's primary service area

Neighborhood	New HIV Diagnoses[a]	New Reports of Chronic Hepatitis B[b]	New Reports of Chronic Hepatitis C[b]	Tuberculosis[c]	Chlamydia[c]	Gonorrhea[c]	Syphilis[c]
Bushwick	34.4	37.0	98.5	8.2	4,712.1	269.0	59.9
Bedford	48.2	43.6	104.1	4.2	4,916.9	271.2	77.4
East New York	52.8	66.3	121.4	6.6	6,284.1	301.7	55.4
Williamsburg	9.1	19.4	52.1	1.0	553.3	40.5	10.9
Ridgewood	21.3	63.8	84.9	7.1	2,423.7	71.2	15.7
NYC	33.6	122.0	119.5	7.2	4,286.3	185.0	43.4

Source: New York City Department of Health and Mental Hygiene (2022). New York City Neighborhood Health Atlas. https://public.tableau.com/app/profile/nyc.health/viz/NewYorkCityNeighborhoodHealthAtlas/Home

[a] Crude rate of new HIV diagnoses per 100,000 population, all ages

[b] Age-adjusted rate of newly reported chronic hepatitis B or C per 100,000 adults aged 18 and older

[c] Crude rate per 100,000 population, all ages

Specific to COVID-19, the case rate per 100,000 population is almost three times higher among Wyckoff's primary service area neighborhoods than the NYC average. Death rates were higher than NYC in most of the neighborhoods served by Wyckoff Vaccination rates (at least one dose) were lower than NYC in four out of five neighborhoods.

Table 9. COVID-19 indicators in the Wyckoff's primary service area

Neighborhood	Case rate[a]	Death rate[b]	People vaccinated (%)
Bushwick	34,602	400	94
Bedford	33,523	447	85
East New York	35,378	582	81
Williamsburg	34,367	428	70
Ridgewood	34,676	340	83
NYC	12,611.06	407.55	89.14

Source: City of New York (2022). COVID-19 data. https://www.nyc.gov/site/doh/covid/covid-19-data.page

[a] Rate per 100,000 population

Promote a Healthy and Safe Environment

According to the World Health Organization, healthier environments could prevent almost one quarter of the global burden of disease. It is estimated that 13.7 million of deaths per year in 2016, amounting to 24% of the global deaths, are due to modifiable environmental

risks[8]. Key indicators related to environmental health in Wyckoff's service area include violence, housing quality, air pollution, and tobacco retailer density. Air pollution levels were higher than NYC overall for all the neighborhoods in the Wyckoff's service area. Density of Tobacco retailers was also higher for all neighborhoods with the exception of Williamsburg. Incarceration rates in Bushwick, Bedford, and East New York were from almost two to four times the overall rates in NYC. **Table 10** summarizes the environmental conditions in the service area.

Table 10. Environmental conditions in the Wyckoff's primary service area

Neighborhood	Housing defects (%)[a]	Air pollution[a,e]	Tobacco retailers[b,c]	Jail incarceration[b,d]
Bushwick	60	8.10	15.3	7.1
Bedford	60	8.10	13.8	9.4
East New York	62	7.70	15.0	12.8
Williamsburg	50	9.60	1.9	1.8
Ridgewood	48	8.00	17.7	3.1
NYC	56	7.50	10.9	3.9

[a] Source: Hinterland K, Naidoo M, King L, Lewin V, Myerson G, Noumbissi B, Woodward M, Gould LH, Gwynn RC, Barbot O, Bassett MT (2018). Community Health Profiles. https://www.nyc.gov/site/doh/data/data-publications/profiles.page

[b] Source: New York City Department of Health and Mental Hygiene. New York City Neighborhood Health Atlas. https://public.tableau.com/app/profile/nyc.health/viz/NewYorkCityNeighborhoodHealthAtlas/Home

[c] Rate per 10,000 population all ages

[d] Rate per 1,000 population ages 18 and older

[e] Micrograms of fine particulate matter per cubic meter

Promote Healthy Women, Infants, and Children

Ensuring healthy lives and promoting well-being for all ages are key elements of the United Nations' Sustainable Development Goals. Data from New York City's Department of Health and Mental Hygiene shows several opportunity areas for neighborhoods across Wyckoff's primary service area. For example, in East New York,
preterm births were 38% higher than NYC overall. Teenage pregnancy is also a public health problem in Bushwick, Bedford, and East New York where rates were 64%, 39%, and 52% higher than the NYC average.

On the side of children's well-being, several threats are identified: elementary school absenteeism was 50% and 55% higher in Bedford and East New York, respectively, than the average of NYC. Rates of on-time high school graduation were also lower in three out of five neighborhoods when contrasted with NYC. Infant mortality was also higher in Bedford and East New York than the observed in NYC.

8 World Health Organization (2021). Environmental health. https://www.who.int/health-topics/environmental-health#tab=tab_1

Table 11. Maternal, infant and child health indicators for the Wyckoff's primary service area

Neighborhood	Pre term births (%)	Teen pregnancy[b]	Childhood obesity (%)	Infant mortality	Elementary school absenteeism (%)	On-time high school graduation (%)
Bushwick	9.2	31.7[a]	28	3.8[a]	22	70
Bedford	8.0	26.9	22	5.7	30	70
East New York	12.6	29.3	25	6.2	31	68
Williamsburg	4.5	16	23	2.4	21	77
Ridgewood	7.6	17.6	19	1.8	14	82
NYC	9.2	19.3	20	4.4	20	75

Source: New York City Department of Health and Mental Hygiene (2022). New York City Neighborhood Health Atlas. https://public.tableau.com/app/profile/nyc.health/viz/NewYorkCityNeighborhoodHealthAtlas/Home

[a] Source: Hinterland K, Naidoo M, King L, Lewin V, Myerson G, Noumbissi B, Woodward M, Gould LH, Gwynn RC, Barbot O, Bassett MT (2018). Community Health Profiles. https://www.nyc.gov/site/doh/data/data-publications/profiles.page

[b] Rate per 1,000 women ages 15-19

Promote Well-being and Prevent Mental and Substance Use Disorders

Available data on mental health indicators showed that binge drinking was higher in Bushwick, Bedford, and Williamsburg than NYC overall. Also, psychiatric hospitalizations per 100,000 adults were significantly higher in Bedford and East New York than the rates in NYC. Similar to county level data, there is also a dearth of data in this area at the neighborhood level.

Table 12. Psychiatric hospitalizations and binge drinking in the Wyckoff's primary service area

Neighborhood	Binge drinking (%)	Psychiatric hospitalizations[a]
Bushwick	20	574
Bedford	21	1002
East New York	14	1113
Williamsburg	19	440
Ridgewood	17	299
NYC	17	676

Source: Hinterland K, Naidoo M, King L, Lewin V, Myerson G, Noumbissi B, Woodward M, Gould LH, Gwynn RC, Barbot O, Bassett MT (2018). Community Health Profiles. https://www.nyc.gov/site/doh/data/data-publications/profiles.page

[a] Rate per 100,000 adults

1.2. SURVEY WITH COMMUNITY RESIDENTS

Wyckoff
Wyckoff Heights Medical Center

1.2. SURVEY WITH COMMUNITY RESIDENTS

METHODOLOGY

A short survey was developed to obtain input of residents from the neighborhoods that integrate Wyckoff's primary service area on their health and social needs. The survey took elements from the 2022 Community Health Needs Assessment Model Survey developed by the Greater New York Hospital Association. Surveys were conducted at the waiting areas of the following Wyckoff sites from November 2nd to November 10th 2022: Wyckoff Doctors, the Pediatric and Adolescent Health Center, Women's Health Clinic, the Endocrinology Clinic, the Infectious Disease Clinic (Positive Health), the WIC Program, the Internal Medicine Clinic and the patient phlebotomy lab in the hospital. Surveys were also conducted from November 30th to December 2nd 2022 at three different community organizations located in Bushwick: church Iglesia de la Santa Cruz, the Audrey Johnson Day Care Center and the New Life Child Development Center. Survey results included here represent input from 202 respondents across Wyckoff and community sites.

DEMOGRAPHICS

As shown in **Table 13**, 70.8% of respondents came from Bushwick and Ridgewood, which borders Wyckoff; 51.3% were aged between 20 and 39 years old. Most survey respondents were women and identified themselves as Latino/Latina. Spanish was the primary language reported among survey participants (65.7%) and 19.1% reported to be college graduates.

Table 13. Demographic characteristics of community health survey participants

Demographic	n	%
Neighborhood		
Bushwick	106	52.5
Ridgewood	37	18.3
Bedford–Stuyvesant (Bedford)	5	2.5
Williamsburg	5	2.5
East New York	20	9.9
Other	29	14.4
Age[a]		
10-19	7	3.5
20-29	51	25.4
30-39	52	25.9
40-49	43	21.4
50-59	26	12.9
60-69	12	6.0
>70	10	5.0

Gender[b]		
Male	35	17.4
Female	166	82.6
Sexual orientation[c]		
Straight	180	89.6
Gay / Lesbian / Bisexual	11	5.5
Something else / not answered	10	4.9
Race		
Latino/Latina	176	87.6
White	6	3.0
Black or African American	10	4.9
American Indian	3	1.5
Asian	3	1.5
Native Hawaiian or other Pacific Islander	0	0
Other	3	1.5
Primary language at home		
English	65	32.3
Spanish	132	65.7
Other[e]	4	2.0
Education[f]		
Grades 8 (Elementary) or less	39	19.6
Grades 9 through 11 (Some High School)	26	13.1
Grade 12 or GED (High School Graduate)	67	33.4
Some college or technical school	29	14.6
College graduate or more	38	19.1

[a] Missing values=1; [b] Missing values=1; [c] Missing values=1; [d] Other includes: White, Black or African American, American Indian, Asian, and Native Hawaiian; [e] Other includes: Hindi (n=1) and Kichwa (n=3); [f] Missing values=3

Source: Own elaboration based on results from the Community Service Plan Survey

Table 14 shows the social determinants of health of survey participants. 64.3% of respondents considered their neighborhood to be very safe (4.9%) or safe (59.4%). On the other hand, 30.7% considered their neighborhoods to be unsafe. Approximately 70% of respondents were employed, 47% live in households with 4-6 members, and more than half reported a household annual income less than $30,000. When asked about any problems paying rent, bills, or food in the past 12 months, 37.1% responded they have struggled paying at least once and 26.2% reported problems getting their food.

Table 14. Participants' Social Determinants of Health

Variable	n	%
Perception of neighborhood safety		
Very safe	10	4.9
Safe	120	59.4
Unsafe	62	30.7
Extremely unsafe	10	5.0
Able to save money at the end of the month	86	42.6
Employment		
Employed	142	70.6
Out of work	19	9.5
Homemaker	24	11.9
Retired	9	4.5
Unable to work	7	3.5
Number of people living at the household[a]		
1-3	90	45.0
4-6	94	47.0
>6	16	8.0
Household annual income[b]		
Less than $20,000	64	32.5
$20,000 - $29,999	48	24.4
$30,000 - $49,999	41	20.8
$50,000 - $59,000	20	10.2
$60,000 - $74,999	12	6.1
$75,000 - $99,000	8	4.1
$100,000 or more	4	2.0
Problems to pay rent or bills in the last 12 months	75	37.1
Problems to buy food in the last 12 months	53	26.2

[a] Missing values=2

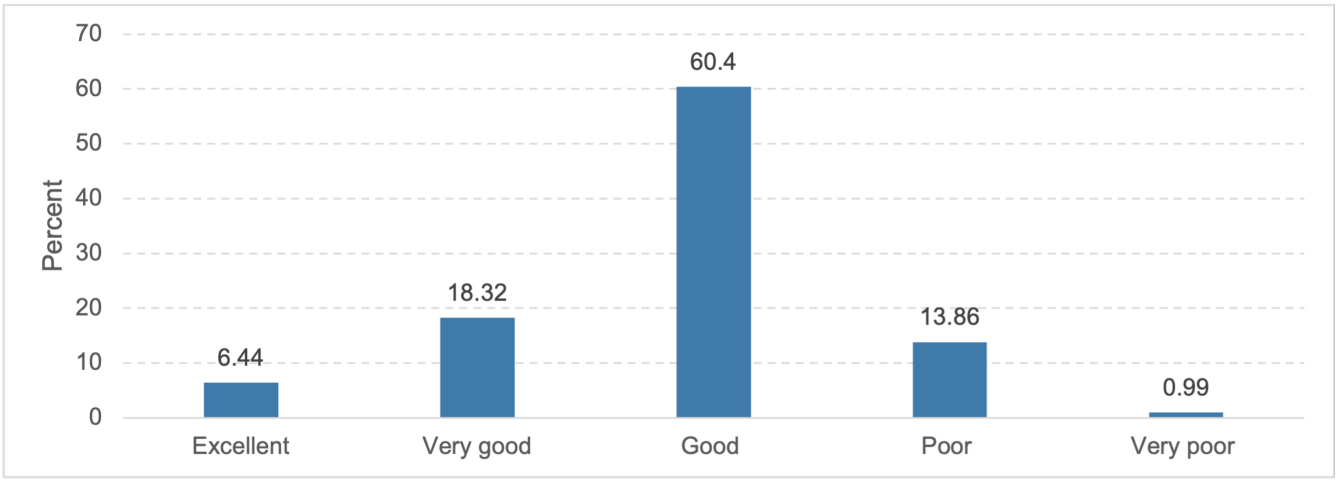
[b] Missing values=5

Source: Own elaboration based on results from the Community Service Plan Survey

PERCEPTIONS AND PRIORITIES AROUND NEIGHBORHOOD HEALTH NEEDS

Survey participants were asked to rate the overall health of the people in their neighborhood. Results are shown in the figure below. 60% of respondents rate their neighborhood inhabitants' health as good and about 15% as poor or very poor. Team members who administered the survey noted that some respondents wanted to express that the health of their neighbors was "regular", but given that this option was not included as an answer, they selected "good".

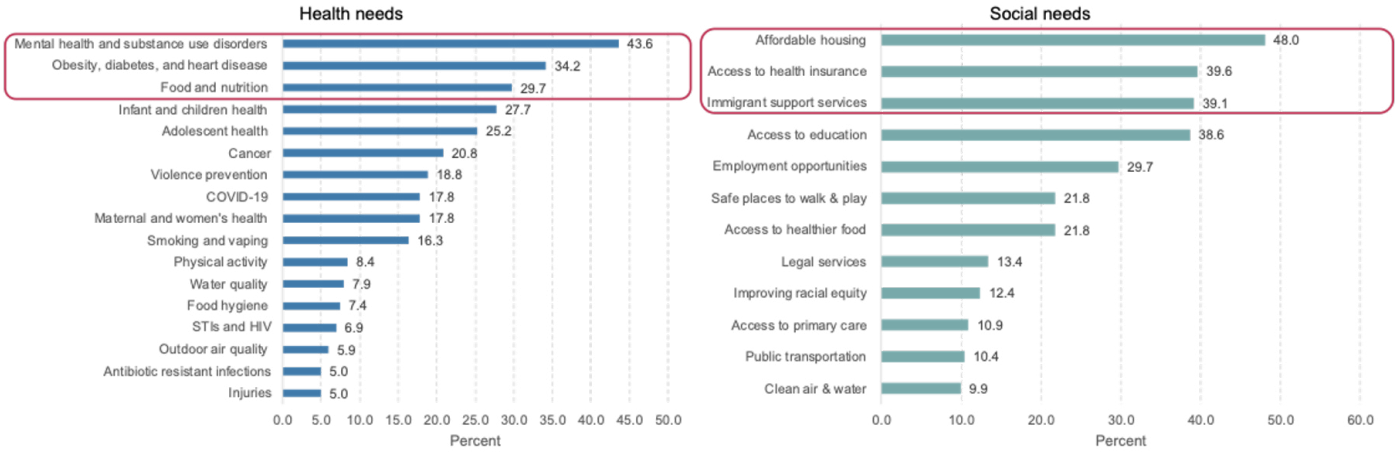
Figure 13. Perception of the health of the inhabitants of participant's neighborhood



Source: Own elaboration based on results from the Community Service Plan Survey

From a list of 17 health and 12 social needs, survey participants were asked to select the top three needs in their neighborhood from each category. **Figure 14** shows the results. The top three health needs were mental health and substance use disorders (43.6%), obesity, diabetes and heart disease (34.2%), and food and nutrition (29.7%). The top three social needs were: affordable housing (48.0%), access to health insurance (39.6%), and immigrant support services (39.1%).

Figure 14. Health and social needs of Wyckoff's primary service area



Source: Own elaboration based on results from the Community Service Plan Survey

WYCKOFF PATIENT EXPERIENCE

Almost three quarters (74.7%) of survey participants mentioned that Wyckoff is the hospital they usually go to for health care and 77.1% reported having received care at Wyckoff in the last year. Among those who used Wyckoff's services, 28.4% rated their experience at their last visit as excellent and only 5.8% as poor or very poor. More than 80% of respondents mentioned that it was very easy (26.0%) or easy (55.8%) to make an appointment at the hospital and 69% mentioned that waiting time to see a doctor at their last visit was less than one hour. Overall trust in Wyckoff among survey participants was high.

Table 15. Wyckoff's user experience

Variable	n	%
Is Wyckoff the hospital participant usually goes to		
Yes	151	74.7
No	51	25.3
Hospital participant usually goes[a]		
Woodhull	18	37.5
Mount Sinai	4	8.3
New York Presbyterian	2	4.2
NYU Langone	1	2.1
Other	23	47.9
Received health services at Wyckoff last year	155	77.1
Experience at last visit to Wyckoff[b]		
Excellent	44	28.4
Very good	52	33.5
Good	51	32.9
Poor	5	3.2
Very poor	3	1.9
Ease of making an appointment[b, c]		
Very easy	40	26.0
Easy	86	55.8
Difficult	26	16.9
Very difficult	2	1.3
Waiting time to see a doctor at last visit[b]		
>1 hour	48	31.0
30-60 minutes	81	52.3
<20 minutes	26	16.7
Trust in Wyckoff[d]		
I always trust Wyckoff	99	49.8
I trust Wyckoff sometimes	77	38.7
I trust Wyckoff a little	17	8.5
I don't trust Wyckoff	6	3.0

[a]Only among those who reported that Wyckoff is not the hospital they usually go to. Missing values =3

[b]Only among those who received health services at Wyckoff last year

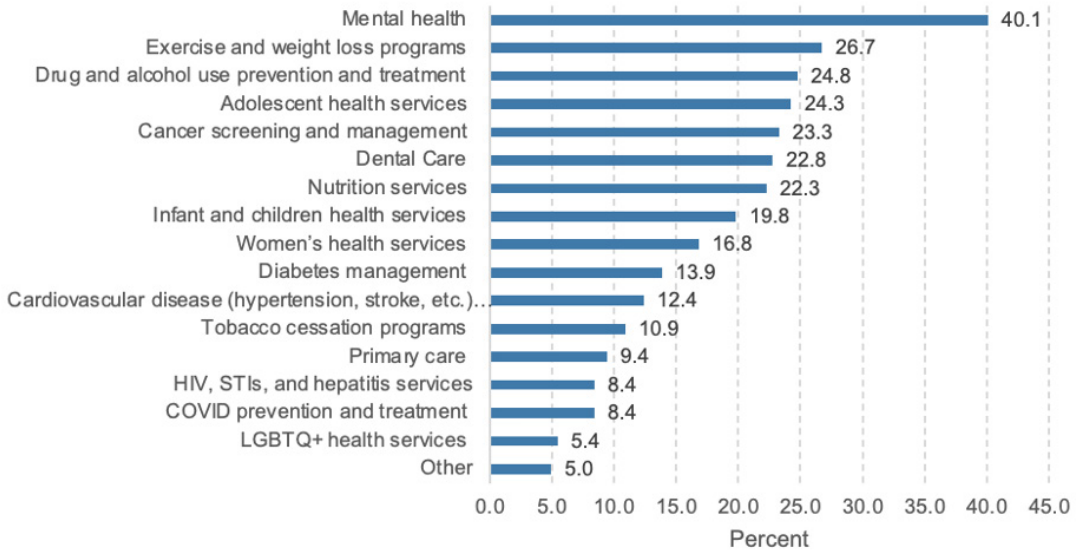
[c]Missing values=1

[d]Missing values =3

Source: Own elaboration based on results from the Community Service Plan Survey

Survey participants were also asked to rank the three services they would like to see more at Wyckoff. Results are shown in **Figure 15**. Very consistent with the participant's report of their community health needs, the top three services were: mental health (40.1%), exercise and weight loss programs (26.7%), and drug and alcohol use prevention and treatment (24.8%). Other services like adolescent health, cancer screening, dental and nutrition services were ranked towards the top as well.

Figure 15. Rank of services needed at Wyckoff according to survey participants



Source: Own elaboration based on results from the Community Service Plan Survey

PARTICIPANTS' HEALTH STATUS

Among survey participants, 37.1% reported their physical health as excellent or very good and more than a half (53%) as good. When asked about their mental health, most of the participants rated it good, very good or excellent. Fieldwork staff also noted that participants rated their physical and mental health as good in the absence of a more neutral answer in the questionnaire. For example, 58.7% of participants mentioned that they sometimes felt stress in the last 30 days which was perhaps a more relatable measure of mental health for the participants than the general question of self-perceived mental health . The majority of interviewees had Medicaid insurance and nearly three quarters mentioned to have a primary care provider. One third of participants had been offered telehealth or had a telehealth appointment in the past 12 months.

Table 16. Participant's health characteristics

Variable	n	%
Self-perceived physical health		
Excellent	**32**	**15.8**
Very good	**43**	**21.3**
Good	**107**	**53.0**
Poor	**20**	**9.9**
Very poor	**0**	**0.0**

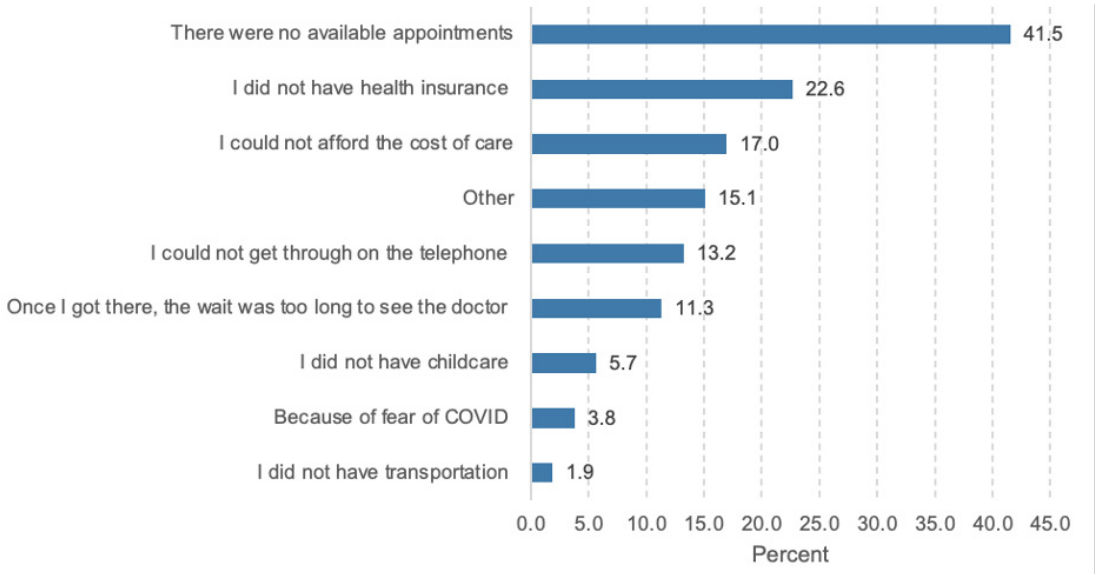
Self-perceived mental health		
Excellent	**47**	**23.3**
Very good	**51**	**25.3**
Good	**88**	**43.6**
Poor	**15**	**7.4**
Very poor	**1**	**0.5**
Health insurance		
Private health insurance	**27**	**13.4**
Medicare	**16**	**8.0**
Medicaid	**108**	**53.7**
ADAP	**1**	**0.5**
No insurance	**22**	**11.0**
Other	**27**	**13.4**
Has a personal doctor or primary care provider	**153**	**75.7**
Could not see a doctor when needed in the last 12 months	**53**	**26.2**
Someone offered a telehealth appointment in the last 12 months	**74**	**38.7**
Had a telehealth appointment in the last 12 months	**65**	**32.2**
Felt any kind of stress in the last 30 days		
All the time	**33**	**16.4**
Sometimes	**118**	**58.7**
Never	**50**	**24.9**

Source: Own elaboration based on results from the Community Service Plan Survey

As the table above shows, 26.2% of interviewees reported they could not see a doctor when needed at least once in the las 12 months. The main reasons were:

1. Lack of appointments (41.5%)
2. Lack of health insurance (22.6%), and
3. Lack of resources to afford the cost of care (17.0%).

Figure 16. Reasons to not see a doctor when needed in the last 12 months



Source: Own elaboration based on results from the Community Service Plan Survey

1.3. INTERVIEWS WITH STAFF MEMBERS AND COMMUNITY-BASED ORGANIZATIONS (CBOs)

Wyckoff
Wyckoff Heights Medical Center

1.3. INTERVIEWS WITH STAFF MEMBERS AND COMMUNITY-BASED ORGANIZATIONS (CBOs)

METHODOLOGY

From October 11, 2022 to November 28, 2022, we conducted 22 semi-structured interviews, each lasting between 30-90 minutes in length, with Wyckoff staff members. The following areas were covered in the interviews with Wyckoff staff:

- **Community Health Priorities**: We explored community health priorities that staff perceived as most important for Wyckoff to address in the next few years.
- **Wyckoff Programs and Resources**: We explored the available Wyckoff resources and special programs that address community health priorities.
- **Wyckoff Community Partnerships**: We discussed both existing and potential community partnerships that would help improve patient health outcomes.
- **Policy Impact**: We explored the impact that local, state and federal policies have on the health of Wyckoff patients.
- **Patient Experience**: We examined the opportunities available to improve patient experience.
- **Wyckoff Staff Wellbeing**: We explored the impact of recent health system events on staff wellbeing.

From October 25, 2022 to November 30, 2022, we also conducted semi-structured interviews, each lasting 30 - 60 minutes in length, with 10 community-based organizations that have operations in the neighborhoods served by Wyckoff.

Table 17. List of consulted community-based organizations

Organization Name	Services Provided
Jewish Association Serving the Aging (JASA)	Provides supportive services, such as social and functional needs assessments, legal support, and home care support, to seniors
Iglesia de la Santa Cruz	Provides charity service, such as food distributions, community fridge access, and vaccination events, to all members of the community
Expecting Relief	Provides additional resources to low income mothers, expecting mothers and families
Audrey Johnson Day Care Center	Provides educational services to low income children and their families
New Life Child Development Center	Provides educational services to low income children and their families
Community Board 4	Provides Bushwick residents with political representation
El Puente	Provides educational and mentorship services to youth and young adults
Coalition for Hispanic Families	Provides supportive services, such as youth education programs, foster care support and mental health services, to low income Hispanic families
Bushwick Community Partnerships	Provides children and their families with access to the support needed to improve/ maintain safety and wellbeing
Make the Road New York	Provides supportive services to immigrant populations

The following areas were covered in the interviews with the CBOs:

- **Overview of Organization:** We discussed the available community programs and services offered by the organization.
- **Wyckoff Partnerships:** We discussed past, existing and potential opportunities for partnership between the organization and Wyckoff.
- **Community Health Priorities:** We explored community health priorities that the organization perceived to be the most important.
- **Policy Impact:** We explored the impact that local, state and federal policies have on the health of the community.

In this section, we present the results of our thematic analysis on the interviews conducted with staff members and CBOs.

KEY INSIGHTS

In asking Wyckoff's staff members and CBOs to identify the top three health concerns they observed within the community, we found that both groups identified "Prevent Chronic Disease" and "Promoting Wellbeing and Preventing Mental and Substance Use Disorders" as two of their three top health priorities.

Below are the priority areas that each group identified in descending priority:

Wyckoff Staff Priorities

1. Preventing Chronic Disease
2. Promoting Wellbeing and Preventing Mental and Substance Use Disorders
3. Promoting Healthy Women, Infants and Children

CBOs Priorities

1. Promoting Wellbeing and Preventing Mental and Substance Use Disorders
2. Preventing Chronic Disease
3. Preventing Communicable Disease

Through analysis of the additional context provided by both groups, we found that the variation in priority reflects the differences between the day-to-day experiences of hospital-based work versus community-based work. For example, patients seek out Wyckoff providers when struggling with chronic disease management, while clients seek out CBOs when in need of mental and behavioral health support.

Prevent Chronic Disease

Wyckoff Staff Insights

Wyckoff staff identified diabetes, obesity and cardiovascular diseases as the priority chronic disease concerns in their primary service area. More specifically, Wyckoff staff stated that

patients predominantly seek care for chronic disease management, rather than prevention and struggle with adherence to lifestyle and diet adjustments. When discussing potential programming that could increase patient compliance with their disease management plan, staff mentioned that culturally-relevant diet and lifestyle interventions would be key to achieving sustained patient behavior change.

> *"Cultural foods don't always align with the nutritional needs of a patient dealing with chronic disease management, however culture is an integral part of people's lives and identities. Here at Wyckoff, we try to have providers that reflect our patient population so that we are able to make true connections that allow us to have honest and effective conversations with patients about their wellbeing."*
>
> **– Garfield Patrick | Director of Nursing Quality Improvement**

In terms of chronic disease prevention, staff identified an opportunity to increase Wyckoff's chronic disease prevention efforts, and noted that community-based and/or family-based interventions would likely be the most impactful with their patient population.

Community Based Organizations Insights

Although many community based organizations agreed that chronic diseases (such as obesity, diabetes and cardiovascular disease) continue to be an ongoing concern, most organizations identified food security as the most pressing community health need related to chronic disease. Organizations noticed an increase in food insecurity during the pandemic and, as a result, increased their food distribution efforts in 2020 and 2021. However, these efforts have continued to expand due to the rising cost of living in the neighborhoods served by each organization.

> *"When it comes to the area most impacted by the COVID-19 pandemic, food security is number one. Many people have not recovered from the food insecurity brought on by COVID-19 pandemic and some families still have to choose between paying their utility bills and putting dinner on the table."*
>
> **– Celestina León, Brooklyn Community Board 4 District Manager**

Promote Healthy Women, Infants, and Children

Wyckoff Staff Insights

In discussing opportunities to promote healthy women, infants and children, staff identified chronic disease prevention and management as an integral aspect of those health promotion efforts. Similar to the provider commentary on chronic disease management as a whole, Wyckoff providers identified diabetes, obesity and cardiovascular disease as primary areas of concern during pregnancy.

"When it comes to maternal health, the most important thing is to prevent chronic diseases. If patients managed their diseases appropriately, their health would then be optimized for pregnancy and we would ultimately reach the goal of having healthy women, infants, and children."

– Dr. Ralph Ruggiero | Department of OB/GYN Chair

Additionally, staff highlighted the importance of patient-centered care models when treating expecting and new mothers. Key examples of successful patient-centered care interventions were Wyckoff's breastfeeding and doula programs. With Wyckoff serving a large immigrant population, staff made special note of the cultural competency, effective healthcare navigation, and readily available community resources required for effective healthcare delivery to patient populations.

Community Based Organizations Insights

"We have partnered with Wyckoff on a few community events and we would love to continue collaboration between our two organizations. Our goal is to increase community awareness of the resources available to new and expecting moms and I think that continued cross-promotion of our programs would help us both reach more people in need."

– Vanessa Bracetty-Ormsby | Expecting Relief Founder & Executive Director

When discussing care for expecting/new mothers, many organizations focused on providing supportive services, such as free access to food, diapers and childcare, to families. Although the rising cost of living has made it difficult for parents to support their children in many ways, many organizations specifically noted that rising costs have significantly impacted parents' ability to purchase healthy foods.

Additionally, many organizations interviewed noted that CBOs often lack awareness and knowledge of other available resources in the community. To help fill the gaps in communication and knowledge-sharing between CBOs, interviewed organizations expressed an interest in increased cross-promotion and event-collaboration with Wyckoff.

Promote Wellbeing and Prevent Mental Health and Substance Use Disorders

Wyckoff Staff Insights

When reflecting on Wyckoff's efforts to promote mental health and wellbeing, staff highlighted the hospital's success with integrating screenings for depression, anxiety and alcohol use as part of each primary care department's care delivery model:

"Although we work with diabetes patients, we screen clients for mental health disorders and make referrals to psychiatry, because we are seeing that mental health impacts a patient's ability to manage their diabetes. Many of our patients cope with depression and anxiety through food, so addressing their mental health is a priority as we try to manage their chronic diseases."

– Amanda Sterbenz | FNP-BC – Endocrinology Clinic

Although these patient screening tools and mental wellbeing initiatives have been adopted by many departments, staff noted that complete program adoption has not yet been reached. To increase the rate of program adoption, staff recommended increasing internal program awareness initiatives.

Lastly, staff mentioned that patient wellbeing and mental health initiatives were negatively impacted by the COVID-19 pandemic and that there is an internal appetite to rebuild patient wellbeing programs to better match its pre-pandemic program plan.

Community Based Organizations Insights

Many interviewed organizations linked client wellbeing and mental health challenges to external factors and stressors.

"Many folks who have lived in the community for a while are finding themselves being displaced by rising rents and general increases to the cost of living - this has contributed enormously to instability and stress on the population."

– The Reverend Nell Archer | Iglesia de la Santa Cruz & Bushwick Abbey

While CBOs are seeing a general rise in depression, anxiety and substance use within the community, organizations mentioned particular concern over the mental health and wellbeing of children, youth and men. With COVID-19 restrictions upending the normal process of child and adolescent development, community based organizations are experiencing a change in the type of mental and behavioral health support that is now needed in their youth programming.

"Isolation due to COVID-19 really impacted young people in this community. Being separated from your peers for long periods of time is not natural for young people, and it negatively impacts their social development. Additionally, many of these young people were exposed to hardship that they were not prepared for. In the past parents would be able to manage conversations about housing and food instability without having to expose their children, but with kids unable to leave the house during lockdowns, these young people were now aware of instability that they themselves are unable to change."

– Asenhat Gomez | Deputy Director of Programs, El Puente

Additionally, many organizations noted a rise in suicides completed by men in the community and highlighted the need for mental health resources that specifically target men.

> *"In recent years we have noticed more men in the community in need of mental health support, however there are not many mental health resources that are tailored to the men in the community. Although we are seeing a small increase in the number of men attending our peer support groups, a majority of attendees are women."*
>
> **– Anonymous | Community-Based Organization**

Staff Wellbeing

In addition to supporting the community outside of Wyckoff's clinics, staff also recognized the need to support their healthcare workers. Although the nationwide provider and nurse shortage is being acutely felt at Wyckoff, the hospital has instituted new policies to prevent staff burnout and to support worker wellbeing.

To spearhead staff wellbeing initiatives, Wyckoff created a multidisciplinary wellness committee in charge of developing wellness programs and initiatives that are tailored to the staff's needs. In response to the stresses of the COVID-19 pandemic, the wellness committee notably expanded employee access to mental health & wellbeing benefits and created safe spaces for employees within the hospital itself. To ensure that all staff remain aware of the wellness benefits available to them, the wellness committee regularly emails staff wellness tips and links to the employee benefits portal.

Wyckoff has instituted the following changes to support staff wellness:

- All staff have been given access to the employee assistance program (EAP) benefit
- Wyckoff has provided staff with access to group therapy sessions about bereavement
- Staff has begun planning the implementation of Code Lavender – a crisis intervention tool developed by the Cleveland clinic to help staff cope with stressful/traumatic events[9]
- On the 5th floor, Wyckoff has created a meditation room that is open 24 hours a day, 7 days per week. This room is intended to act as a retreat from the stresses of the hospital and can be used for meditation, prayer, self-reflection and quiet decompression.
- On the 11th floor, Wyckoff has developed a recharge room that encourages mental, emotional, spiritual and physical restoration. This room uses light and sound to create an immersive, sensory experience that is tailored to each staff member's current health needs.
- Wyckoff has allowed all staff to carry over unused vacation hours with no limits until

9 Stone, R. S. B. (2018). Code Lavender: a tool for staff support. Nursing2022, 48(4), 15-17.

spring 2023 so that they can have the opportunity for time off that might have been postponed during the 2020-2022 COVID-19 emergency response years.

Prevent Communicable Disease

Wyckoff Staff Member Insights

- Although COVID-19 continues to have health impacts on Wyckoff's service area communities, provider confidence in treating COVID-19 has notably increased since 2020. Paired with the success of Wyckoff's extraordinary vaccination efforts in 2020-2021, Wyckoff staff is now finding a decrease in the volume of severe COVID-19 cases within the community. With standardized COVID-19 prevention and treatment protocol now in place, Wyckoff has begun to integrate their COVID-19 prevention and treatment efforts into their primary care service model.
- One of the areas of growing priority amongst Wyckoff staff is antimicrobial resistance within the community. To address the threat of antimicrobial resistance, staff have begun to take a multi-pronged approach to addressing the problem. Interventions include patient education, provider education, cross departmental collaboration and data sharing to ensure that antimicrobials are being used appropriately.

> *"Antibiotic resistance is at the forefront of our concern and one of the main ways we are addressing this concern is through our antimicrobial stewardship program. This program aims to optimize antimicrobial use through cross department collaboration, facilitate regular staff education on the subject and increase patient involvement and awareness of the issue."*
>
> **– James McCracken | Clinical Pharmacist Specialist, Antimicrobial Stewardship Program**

Community Based Organizations Insights

Organizations mentioned an increased need for community-based immunization efforts. In particular, interviewed organizations highlighted a need to combat growing vaccine misinformation and missed childhood vaccinations in the community. Seeing Wyckoff as a valuable community health resource, several organizations expressed a strong interest in partnering with Wyckoff on vaccination events in the community.

> *"It would be great if we could use the church as a site to provide our congregation access to vaccinations and health education – we could serve as a location outside of the hospital and we would be happy to publicize that. There are so many new immigrants and young children in the neighborhood and it would be helpful if we could offer them access to free healthcare resources that supported their needs regardless of income or immigration status."*
>
> **– The Reverend Nell Archer | Iglesia de la Santa Cruz & Bushwick Abbey**

Previous Experiences with Community Partnerships

In discussing the barriers to healthcare engagement, staff noted that community residents may be discouraged from engaging in the healthcare system due to the complexity of the healthcare navigation and financing.

> *"The communities that we serve do not always prioritize health, and, often, it is because they feel neglected and unheard. Understanding all of the parts of the healthcare system is incredibly overwhelming – particularly for immigrants and refugees – and just the thought of trying to navigate such a complex system deters folks from even trying to engage with a provider."*
>
> **– Eleanor Juray | Program Director, Wyckoff's Family, Community and Beyond Program**

To help build community trust, Wyckoff has partnered with several CBOs to help ensure that care provision continues after hospital discharge. While Wyckoff recognizes the immense value that all of their CBO partners offer, staff noted that organizations with an onsite presence at Wyckoff typically have the smoothest and most heavily utilized referral pathways.

Similarly, interviewed organizations emphasized the importance of a warm patient hand-off between the provider and the CBO in developing client trust. Additionally, Wyckoff's onsite partners noted that their physical presence at Wyckoff facilitates a greater level of communication and better ensures client retention and satisfaction.

> *"We've had a longstanding and successful partnership with Wyckoff based on a shared commitment to the local communities we serve. Wyckoff's clinical staff has integrated JASA's transitional care services into their workflows and consider us an extension of their team. This type of community collaboration, spearheaded by Wyckoff, enhances (medical and social) care coordination, strengthens clinical-community linkages, and improves health outcomes for patients. Wyckoff's focus on continuous and coordinated care - both in the hospital and outside in the community at large - is effective."*
>
> **– Arielle Basch | Senior Director of Health Services & Business Development, JASA**

Potential Opportunities with Community Partnerships

While not all organizations can support an onsite presence at the hospital, there is still a large opportunity for Wyckoff to create strong and strategic offsite partnerships. In particular, there is a large interest on behalf of community partners to revive communication channels with Wyckoff that were lost in the early years of COVID-19 pandemic.

"Wyckoff has developed partnerships with community-based organizations, but continuing to expand those partnerships would help Wyckoff build community trust. Community-based organizations have strong connections in the neighborhood, and showcasing that Wyckoff has the trust of those organizations would help encourage members to be more willing to access Wyckoff services."

– Rebecca Telzak | Deputy Director, Make the Road New York

Additionally, Wyckoff staff and CBOs also expressed a desire for a readily accessible list of client resources and programs that could be utilized when making client referrals.

"When people in the community think about Wyckoff, the only thing that they think about is the emergency room. A lot of people in the community are not aware of all the different services being offered at Wyckoff, and even us, as partners, are not aware of everything – so if Wyckoff had a comprehensive list of all the services and programs that they had available, that would go a long way in helping us refer clients."

– Sonia Mercado | Board Member, Bushwick Community Partnerships

In terms of effective health education efforts, Wyckoff's partners noted the importance of educating members in the environment where they are most comfortable. Given the insecurity that many community members face with immigration status, housing, and personal safety, there can often be resistance to or suspicion of authority. In acknowledgement of this tension, CBOs mentioned that social support networks, particularly around chronic disease and mental/behavioral health management, can be effective drivers of sustained behavior change.

While several CBOs are quick to develop new programs that address evolving community health needs, many interviewees identified specific opportunities where Wyckoff's support and resources would be especially impactful. A few key collaborative opportunities that CBOs highlighted were the promotion and coordination of vaccination events with Wyckoff staff being present to administer the vaccines and provide health education, the hosting of community health fairs, and the expansion of food distribution sites in the community.

Patient Experience

In discussing opportunities for future collaboration between CBOs and Wyckoff, interviewees noted that there is an opportunity to decrease the community perceived barriers to engaging with Wyckoff by improving the patient's experience. In an effort to successfully engage and retain patients, Wyckoff is working on decreasing wait times and increasing the bilingual competency of all providers.

SUMMARY OF TOP HEALTH PRIORITIES FOR CONSULTED STAKEHOLDERS

Staff Members

1. Preventing Chronic Disease
2. Promoting Wellbeing and Preventing Mental and Substance Use Disorders
3. Promoting Healthy Women, Infants and Children

Community Organizations

1. Promoting Wellbeing and Preventing Mental and Substance Use Disorders
2. Preventing Chronic Disease
3. Preventing Communicable Disease

Community Residents

1. Promoting Wellbeing and Preventing Mental and Substance Use Disorders
2. Preventing Chronic Disease
3. Promoting Healthy Women, Infants and Children

2. COMMUNITY SERVICE PLAN 2022-2024

Wyckoff
Wyckoff Heights Medical Center

2. COMMUNITY SERVICE PLAN 2022-2024

Based on the results of the CHNA, Wyckoff Hospital has decided to focus on the following four areas:

1. Promote Wellbeing and Prevent Mental Health and Substance Use Disorders
2. Prevent Chronic Disease
3. Promote Healthy Women, Infants, Children and Adolescents
4. Prevent Communicable Disease

A majority of financial resources that Wyckoff will dedicate towards fulfilling the objectives of its 2022-2024 CSP include the annual delivery of charity care ($28 million as of 2021) and grant-funded population health programs and services ($7.3 million awarded for 2023).

Goal	Objective	Year 1 Actions	Year 2 Actions
PROMOTE WELLBEING AND PREVENT MENTAL HEALTH AND SUBSTANCE USE DISORDERS	1. Promote Wellbeing and Prevent Mental Health and Substance Use Disorders	• Institute provider awareness campaign on mental health and substance use screening tools with quarterly site-specific trainings, data monitoring, and QI • Increase SUD referrals, including weekend options, to IMPACT/SAMHSA and Bridge Back to Life programs by 5% from baseline • Identify outpatient mental health treatment options for Wyckoff patients and establish referral agreements • Institute a targeted mental health and substance use disorder education campaign for young people in collaboration with CBOs	• Increase annual and new patient mental health and substance use screening rates by 10% from baseline at each primary care site • Increase referrals (including weekend options) to IMPACT/SAMHSA and Bridge Back to Life programs by 5 % from Year 1 • Increase referrals to outpatient mental health treatment partners by 10% from Year 1 • Deliver bi-annual mental health and substance use disorder education events for young people in collaboration with CBOs
	2. Expand mental wellbeing programs for Wyckoff staff	• Institute an initiative for department leaders to design and implement best practices for promoting mental wellbeing in the workplace • Institute Code Lavender program to provide mental health support to staff after a traumatic event	• Department leaders design and implement 1-2 activities that promote staff wellbeing in the workplace • Continue Code Lavender program to provide mental health support to staff after a traumatic event

Goal	Objective	Year 1 Actions	Year 2 Actions
PREVENT CHRONIC DISEASE	1. Expand obesity, heart disease and diabetes prevention and management education	• Institute food and nutrition education, and physical activity programs in collaboration with CBOs • Expand community awareness of Wyckoff's free fitness classes offered weekly (e.g. Zumba, Cardio, Yoga) by advertising through grant-funded programs & CBO partnerships • Establish an internship placement collaboration with undergraduate and/or graduate programs focused on providing food and nutrition education to Wyckoff patients, particularly women, children, adolescents • Health Coaches to provide supportive services to 25-50 patients with chronic disease per clinic per month	• Deliver bi-annual food and nutrition education, and physical activity events in collaboration with CBOs • Expand community awareness of Wyckoff's free fitness classes offered weekly (e.g. Zumba, Cardio, Yoga) by advertising through grant-funded programs & CBO partnerships • Place 2-3 student interns per year at Wyckoff who will deliver group- and individual-level nutrition education to Wyckoff patients and community residents • Health Coaches to provide supportive services to 25-50 patients with chronic disease per clinic per month
	2. Improve and expand diabetes management services for Wyckoff patients to make them more patient-friendly and more accessible	• Collaborate with the Joslin Diabetes Center to redesign Wyckoff's diabetes management process to meet latest standards of care & train providers in Ambulatory Care to use new system by end of 2023 • Build Diabetes Center of Excellence at Myrtle Avenue by end of 2023 to provide comprehensive diabetes and weight management, counseling and support services	• Continue collaboration with the Joslin Center to enhance the capacity of providers and update diabetes management tools • Provide comprehensive diabetes services at Wyckoff's Diabetes Center of Excellence & collaborate with CBO partners to establish strong referral systems
	3. Increase cancer screenings among eligible patients	• Institute patient awareness campaign on cancer prevention and screening and provider trainings on screening tools • Assess & procure tools and service necessary to perform lung cancer screening at Wyckoff • Offer colorectal, breast, and lung cancer screenings to 85% of eligible outpatient clients • Screen 80% of eligible patients for colorectal, breast, and lung cancer	• Deliver quarterly awareness events on colorectal, breast, and lung cancer prevention and screening • Offer colorectal, breast, and lung cancer screenings to 90% of eligible outpatient clients • Screen 85% of eligible patients for colorectal, breast, and lung cancer

Goal	Objective	Year 1 Actions	Year 2 Actions
PROMOTE HEALTHY WOMEN, INFANTS, CHILDREN AND ADOLESCENTS	1. Increase engagement with and use of preventive and primary care services for women of reproductive age, mothers, infants, and children	• Increase internal referrals from Wyckoff's women's health services to the Family, Community & Beyond and the WIC Programs by 10% from baseline • Increase education on doula services and referrals of expecting mothers to the NYC Doula Initiative through the Family, Community & Beyond program with a goal of connecting 20 expecting mothers to Doula Services	• Increase internal referrals from Wyckoff's women's health services to the Family, Community & Beyond and the WIC Programs by 10% from year 1 • Increase education on doula services and referrals of expecting mothers to the NYC Doula Initiative through the Family, Community & Beyond program with a goal of connecting 25 expecting mothers to Doula Services
	2. Expand sexual health education for adolescents in the community	• The Positive Health Management Program will partner with the Pediatric Clinic to provide universal sexual health screenings including HIV testing and individualized counseling to adolescents seen in-clinic with a focus on wellness, risk-reduction tools, and preventive care • Institute a collaboration between Wyckoff and 2 CBOs or schools serving adolescents in the community to provide sexual health workshops and education	• Provide comprehensive sexual health screenings to 80% of all adolescents seen during annual and new patient visits and refer 20% of sexually active adolescents to Wyckoff's Positive Health Management program for individualized counseling • Deliver 4 sexual health workshops and education to adolescents in partnership with community CBOs

Goal	Objective	Year 1 Actions	Year 2 Actions
PREVENT COMMUNICABLE DISEASE	1. Increase number of community health promotion events to deliver medically-accurate and up-to-date information on diseases like COVID-19, flu, HIV, Hepatitis, and STIs	• Identify 1-2 CBO partners to collaborate with on at least 2 community-based health promotion events	• Identify 2-4 CBO partners to collaborate with on at least 3 community-based health promotion events
	2. Increase community awareness and education campaigns on the importance of immunizations for women, infants and children	• Institute a community immunization education initiative in collaboration with the Pediatric Clinic, the Family, Community and Beyond program, the WIC program and CBOs	• Conduct bi-annual community immunization education events in collaboration with the Pediatric Clinic, the Family, Community and Beyond program, the WIC program and CBOs

Goal	Objective	Year 1 Actions	Year 2 Actions
APPLICABLE TO ALL AREAS OF NYS FRAMEWORK	1. Expand Wyckoff's community engagement and reach	• Institute a hospital-wide Community Advisory Board • Institute a rotating community member position on Wyckoff's Board of Trustees • Establish a comprehensive directory of all Wyckoff services and programs	• Conduct 2 meetings with Wyckoff's Community Advisory Board per year • Conduct 4 Board of Trustees meetings with one community member present • Disseminate list at community events, via email to community partners, and through Wyckoff's website

Table 18. List of Wyckoff's active community partnerships

Organization Name	Services Provided	Collaboration(s) with Wyckoff
Coalition for Hispanic Health Services	Provides youth and their families with parenting, foster care, adoption, mental/behavioral health, after/summer school programs and child abuse prevention services.	Receives referrals from Wyckoff providers, social workers and/or the transitional care team for child behavioral health services
Northwell Health Home	Provides those enrolled in Medicaid with medical, mental health, substance use, social and support services	Receives referrals from Wyckoff providers, social workers and/or the transitional care team to support medicaid patients with at-home care
Bridge Back to Life	Provides those struggling with substance use with access to assessments, counseling, interventions, and community resources	Receives referrals from Wyckoff providers, social workers and/or the transitional care team to provide patients struggling with substance use with onsite support and assessment
Jewish Association Serving the Aging (JASA)	Provides supportive services to seniors and those enrolled in Medicaid	Receives referrals from Wyckoff providers, social workers and/or the transitional care team to provide Medicaid patients with an onsite assessment and suggested care plan
Donor Human Milk	Provides mothers of premature babies with access to breastmilk	Provides new mothers who are struggling to produce breast milk with access to breast milk
YMCA	Provides children and their parents with education services and the support needed to promote a healthy lifestyle	Receives referrals from Wyckoff providers, social workers and/or the transitional care team to provide children with access to educational support and physical activities
Headstart – New Life **Headstart – Audrey Johnson**	Provides children from low-income families with educational, nutritional, health, social and other services	Receives referrals from Wyckoff providers, social workers and/or the transitional care team to children with education and developmental support
Fidelity	Provides patients with the navigation support needed for health insurance enrollment	Receives referrals from Wyckoff providers, social workers and/or the transitional care team to provide patients with onsite insurance application support
Health First	Provides patients with the navigation support needed for health insurance enrollment	Receives referrals from Wyckoff providers, social workers and/or the transitional care team to provide patients with onsite insurance application support
Make the Road New York	Provides immigrants with legal, education, advocacy, and support services	Receives referrals from Wyckoff providers for patient housing navigation and support
Expecting Relief	Provide children from low-income families and their parents with the support needed to tackle diaper, food and literacy insecurities	Collaborates with the Family Community & Beyond program on community baby showers for expecting mothers in the community
Healthy Families 4 Bushwick	Provides families with resources and referrals to entitlement programs, education, employment assistance, legal assistance, housing, transportation, and mental/health services	Receives referrals from Wyckoff providers, social workers and/or the transitional care team to provide patients with supportive services

Organization Name	Services Provided	Collaboration(s) with Wyckoff
El Puente	Provides educational and mentorship services to youth and young adults	Collaborates with Wyckoff providers on a summer program for young women interested in entering the healthcare field
Coalition for Hispanic Families	Provides supportive services to low income Hispanic families	Collaborates with Wyckoff providers to provide health education sessions and seminars in the community
Riseboro	Provides supportive services across a variety of age groups and engages in community building efforts	Receives referrals from Wyckoff providers for patient access to their healthy cooking classes, health talks and food pantry

SPECIAL PROGRAMS

Wyckoff is a community service-oriented hospital with a diverse portfolio of special projects designed to address the areas of focus identified in New York State's Prevention Agenda. This section will describe Wyckoff's work to address the areas of the prevention agenda.

Prevent Chronic Disease

Wyckoff's chronic disease programs target a variety of different disease types and address both chronic disease prevention and management.

Colorectal Screening FIT Program

To increase colorectal screenings amongst eligible patients, Wyckoff offers a fecal immunochemical test (FIT), as an alternative to a colonoscopy. The FIT screens for colon cancer by detecting blood in the stool, and unlike other tests, patients do not have to follow a special diet beforehand. Eligible patients are 45-75 years old and have not had a previous colorectal cancer screening or are due for re-screening. To ensure that all eligible patients are aware of FIT screens, providers are reminded on a daily basis to recommend FIT as an alternative for patients who refuse colonoscopy and to review the importance of colorectal cancer screenings with patients.

Breast Cancer Screening Community Outreach

To encourage prevention and early detection of breast cancer within the community, Wyckoff has increased targeted outreach to primary care physicians. This new awareness raising initiative includes door-to-door promotion and phone calls to primary care physicians with the objective of increasing provider knowledge of Wyckoff's breast screening and breast health programs. Ultimately, this program seeks to improve linkage to breast cancer screenings, diagnosis, and treatment within the community.

Exercise Promotion and Health Classes

In an effort to prevent obesity and reduce the risk of chronic disease in the community, Wyckoff renovated their space to create an exercise room in 2015. Wyckoff offers a variety of free wellness classes to staff and the community, such as Yoga and Zumba. 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.

Yearly Summer Health Fair

To promote a healthy lifestyle and physical activity, Wyckoff collaborates with several community based organizations to host their yearly summer health fair. At this free event, Wyckoff and its partners offer all attendees health information, educational resources and giveaways that promote wellbeing and community connectedness. Wyckoff seeks to make healthcare accessible to all members of the community and is committed to supporting broad-based community health and wellbeing.

Wyckoff Summer Health Fair 2022 | Bee Serene Photography

Diabetes Patient Education & Management

To reduce the risk of negative health outcomes amongst diabetes patients, Wyckoff offers high-risk patients with access to a diabetes educator via one-on-one clinic visits, home visits or telehealth visits. The diabetes health educator works with patients on diabetes self-management skills and makes patient referrals to community organizations that would support the patient in managing their diabetes at-home. Furthermore, providers also supplement this education through patient re-education during clinic visits and continued promotion of diabetes self-management best practices (ex. food and blood sugar journals). The diabetes educator and providers are located in Wyckoff's endocrinology clinic.

Health Coaches

To better support patients in the management of their chronic disease, Wyckoff offers patients access to health coaches that work with them on chronic disease self-management goals, coordination of care with primary care providers, and follow-up on specific referrals. Health coaches are located in 4 different Wyckoff sites, and engage with patients in one-on-one educational sessions to ensure that each patient receives high quality, patient-centered care.

Family Medicine Residency Program

In an effort to further integrate the ambulatory, community, and inpatient environments, Wyckoff has begun to develop a new Family Medicine Residency Program. This program will be accredited by the Accreditation Council for Graduate Medical Education (ACGME) and will require three postgraduate years of training. During the program, residents will complete rotations in each of the following areas: obstetrics, pediatrics, general surgery, emergency medicine, and inpatient hospital care. The aim of this program is to increase community accessibility to healthcare and to expand Wyckoff's ability to provide primary care service to all age groups.

Comprehensive Diabetes Management Center & Joslin Center Partnership

In an effort to better coordinate diabetes management and care, Wyckoff has partnered with the Joslin Center to create a comprehensive diabetes management center at Wyckoff. With the goal of streamlining diabetes care delivery, Wyckoff and the Joslin Center have engaged in thorough assessments of Wyckoff's current operating procedures and have developed a phase 1 blueprint for creating a Wyckoff diabetes center of excellence. Further planning and execution efforts for this comprehensive diabetes management center are underway.

Asthma Prevention and Education

To address some of the asthma prevention and treatment needs in the community, Wyckoff offers specialized pediatric pulmonology services in the pediatric clinic. In 2016, Wyckoff achieved joint commission certification for pediatric asthma care. Wyckoff has continued

to improve our clinical asthma outcomes by providing culturally competent, patient-centered care, evidence-based care to patients and their families who suffer from asthma. Through supporting families and clinicians in effective asthma management, Wyckoff has seen decreased emergency room visits related to asthma and an increase in outpatient asthma management.

Promote Wellbeing and Prevent Mental and Substance Use Disorders

Wyckoff has established several programs that promote wellbeing and prevent mental and substance use disorders. Below is a summary of available mental and behavioral health programs:

Collaborative Care Program

To further integrate behavioral health services into Wyckoff's healthcare service model, Wyckoff has created a Collaborative Care Program that ensures that patients in need of behavioral health support are linked to such services. The Collaborative Care Program includes a Behavioral Care Manager that provides individual therapy, completes assessment, refers to higher levels of care, and coordinates psychopharm treatment with PCPs as needed. The service is provided in the following ambulatory locations: Pediatrics, Adult Medicine, Infectious Disease, and Women's Health.

Project IMPACT (Improving Access to Comprehensive Treatment)

As part of the suite of behavioral health programs that Wyckoff offers, Project IMPACT which is funded through a grant by the Substance Abuse and Mental Health Services Administration (SAMHSA), provides patients with substance use and mental health issues and patients living with or at high risk for HIV or Hepatitis, with the support needed for engaging in risk reduction, treatment and recovery. The program's Treatment Manager provides individual and group therapy to patients with substance use issues and conducts assessments and referrals to higher levels of care. Additionally, two Linkage Specialists provide case management services and linkage to more intensive or specialized treatment services including both inpatient and outpatient treatment facilities and to supportive services such as housing, nutrition, and legal services.

Psychiatric Nurse Practitioner

To prevent the misuse of medication amongst patients struggling with mental health issues, Wyckoff offers patients access to a psychiatric nurse practitioner that provides medication management to non-substance-using patients with mental health issues. This nurse practitioner supports both adult and pediatric patients and is located in the Adult Medicine clinic for 8 hours per week and the Pediatrics clinic for 8 hours per week.

Healthy Steps Program

The goal of Wyckoff's Healthy Steps program is to improve children's social-emotional well-being and growth; improve child development outcomes; reduce health disparities; and improve quality and the patient experience. The Healthy Steps program establishes a multidisciplinary implementation team and embeds 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.

Promote a Healthy and Safe Environment

In an effort to promote a healthy and safe environment, Wyckoff has ensured that the hospital is equipped to support survivors of violence and trauma. Below is a summary of available trauma-informed programs:

Violence Intervention & Treatment Programs (VITP)

The Violence Intervention and Treatment Program (VITP) at Wyckoff Heights Medical Center (WHMC) is the first Hospital-based comprehensive program in Brooklyn serving clients who are primary or secondary victims of domestic violence, sexual assault/rape or other crime. Services for this program are grant-funded, free and confidential regardless of sex, gender expression or immigration status. Grant funding is provided by various NYS offices and cover the cost of counseling, case management, coordination of care, advocacy and empowerment for survivors of domestic violence and sexual assault. VITP is proud to have a robust Rape Crisis Advocate on-call service to assist in the Emergency Department during the evenings, weekends and holidays. These advocates provide emotional support, advocacy, information and assistance to the victim (age 12 and above) in the Emergency Department. They are certified by NYS Department of Health to become advocates after the completion of required training. Additionally, VITP offers free trainings on sexual misconduct and bystander intervention to colleges and graduate schools and provides technical assistance for colleges and graduate schools interested in implementing or strengthening their violence prevention programs on campus. VITP is a leader in providing trauma-informed care and trainings in the hospital and the community.

Promote Healthy, Women, Infants, and Children

To promote healthy women, infants, and children, Wyckoff has established several programs and initiatives to support mothers and pregnant individuals, their children and their families:

WIC Program

The Wyckoff WIC program is grant-funded by the NYS DOH with federal funding and provides nutritious food, nutrition and health education, breastfeeding promotion and support, and referral services to low income women, infants and children who are at high risk for poor nutrition and health outcomes. The program specifically targets pregnant, breastfeeding, and postpartum women and their children up to 5 years of age. Nutrition education, including individualized contacts and facilitated group discussions, is provided by qualified nutrition staff and is personalized to meet the needs, interests and learning style of each participant. Breastfeeding education, promotion and support is provided to assist participants in reaching their breastfeeding goals. The foods in the WIC food packages are specifically selected to include key nutrients to supplement the dietary needs of participants to positively influence good health, growth, and development. WIC's participant-centered approach promotes partnerships with participants allowing for services to be tailored to meet nutrition and cultural needs, concerns, and preferences. This close collaboration enables families to make lifelong healthy eating and lifestyle choices and attain positive health outcomes.

Family Community & Beyond Program

The Family, Community and Beyond program at Wyckoff is funded by the NYS DOH Perinatal and Infant Community Health Collaboratives grant and is designed to reach and engage women of reproductive age (15-44 years) and their families to improve maternal and infant health outcomes. The Family Community & Beyond program provides culturally-tailored education and support services, with a focus on reaching populations experiencing the highest maternal morbidity and mortality and poor infant health outcomes such as teenage mothers and Hispanic, African American, and foreign-born women and their families. This program uses individual health assessments, care plans, community health visits, coaching, community assessments, networking and consensus building to collectively address the social determinants that impact health outcomes for individuals and families.

Baby Friendly Designation

Wyckoff achieved the Baby Friendly Hospital Designation in 2019. The teaching and learning collaborative consists of birthing centers that work together to institute Baby 55 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.

Breastfeeding Quality Improvement Plan

In an effort to improve rates of breastfeeding amongst Wyckoff's patient population, Wyckoff has enhanced their implementation of the "Ten Steps to Successful Breastfeeding" initiative to highlight patient education. The additional patient education efforts include the expansion of the Healthy Steps Packet at newborn, 1-month, and 2-month well child visits to include evidence-based findings and recommendations from Lactation Specialists. Additionally, Pediatric Residents, inpatient and outpatient nursing staff, Nurse Practitioners, House Officers, support staff are trained on the techniques and benefits of breastfeeding so that they may implement tailored education with clients after each visit.

Prevent Communicable Disease

In an effort to prevent communicable disease within the community, Wyckoff has developed several programs that address a wide range of communicable diseases. Below is a summary of available programs:

Antibiotic Stewardship Program

Wyckoff's Antibiotic Stewardship program aims to decrease the use of broad spectrum microbials in the clinic setting. To achieve this goal, this program offers regular staff and patient education on antibiotic resistance. Additionally, leaders of this program conduct a regular review of hospital practices, identify areas of improvement, and implement disease-state specific interventions.

COVID-19 Education and Vaccinations

To continue supporting the community in the fight against new COVID-19 outbreaks, Wyckoff continues to offer COVID-19 education, vaccinations and boosters to the community at all of their ambulatory sites.

Positive Health Management

Positive Health Management (PHM) is the most comprehensive HIV services program in our geographic area and provides culturally-competent and LGBTQ-friendly prevention and treatment services for HIV, hepatitis and sexual health. Medical services at PHM are co-located with mental health and substance use counseling as well as supportive services including case management, risk-reduction counseling, community outreach and education, client navigation and linkage to care, peer educators and patient education and support groups. PHM is a trusted and well-known service provider due to its comprehensive and high-quality services. The goal of Positive Health Management is to provide excellent, accessible, quality care to persons who are at risk for or who are living with HIV, Hepatitis C, and sexually transmitted infections. The wide options in supportive and case management services are provided through grant funding from various city, state, and federal sources and all services are provided regardless of insurance status.

PHM has over 25 years' experience providing respectful, culturally sensitive HIV services to members of priority populations at highest risk for HIV: Hispanic and Black individuals, immigrants and undocumented individuals, people who use drugs or have a history of

substance use and men who have sex with men (MSM). PHM has made a concerted effort over the past 10 years to recruit, hire, and promote Latino and Black men, women, MSM and transgender and gender non-conforming individuals to lead and implement these programs and initiatives and to facilitate trainings on LGTBQ care competencies across the hospital.

DISSEMINATING THE COMMUNITY SERVICE PLAN

- **Website**. The full CHNA and CSP 2022-2024 will be available on Wyckoff's website: www.wyckoffhospital.org. In addition, infographics (in English and Spanish) that summarize the main points of this document will be available on the hospital's website with a prominent link to the full report.
- **Community Dissemination.** The CHNA and CSP 2022-2024 information will be disseminated in-person across community boards, churches, schools and CBOs meetings in the neighborhoods that Wyckoff serves.
- **Internal Communications.** The CSP infographics will be sent out to the Wyckoff Heights Medical Center staff and patients via text and/or email blasts.
- **Presentations at Key Meetings.** The Community Service Plan will be presented at key leadership meetings including: executive meetings, departmental meetings, and the Medical Board meeting. Digital copies of the CSP will be available by request from the following contact:

CSP Contact Person(s):

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- Evelyn Peterkin, Audrey Johnson Day Care Center
- Raquel Palomino, New Life Child Development Center

- Vanessa Bracetty-Ormsby, Expecting Relief
- Celestina León, Brooklyn Community Board 4
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- Sonia Mercado, Bushwick Community Partnerships
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- Becca Telzak, Make The Road New York
- Sinthia Peña Ortiz, Coalition for Hispanic Family Services

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