Wyckoff Heights Medical Center

Established in 1889

Over a century of Service to our Kings and Queens County Communities

Hospital Community Service Plan
2014 – 2017

Submitted November15, 2013

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF HOSPITAL & PRIMARY CARE SERVICES

COMMUNITY SERVICE PLAN CONTACT INFORMATION SHEET

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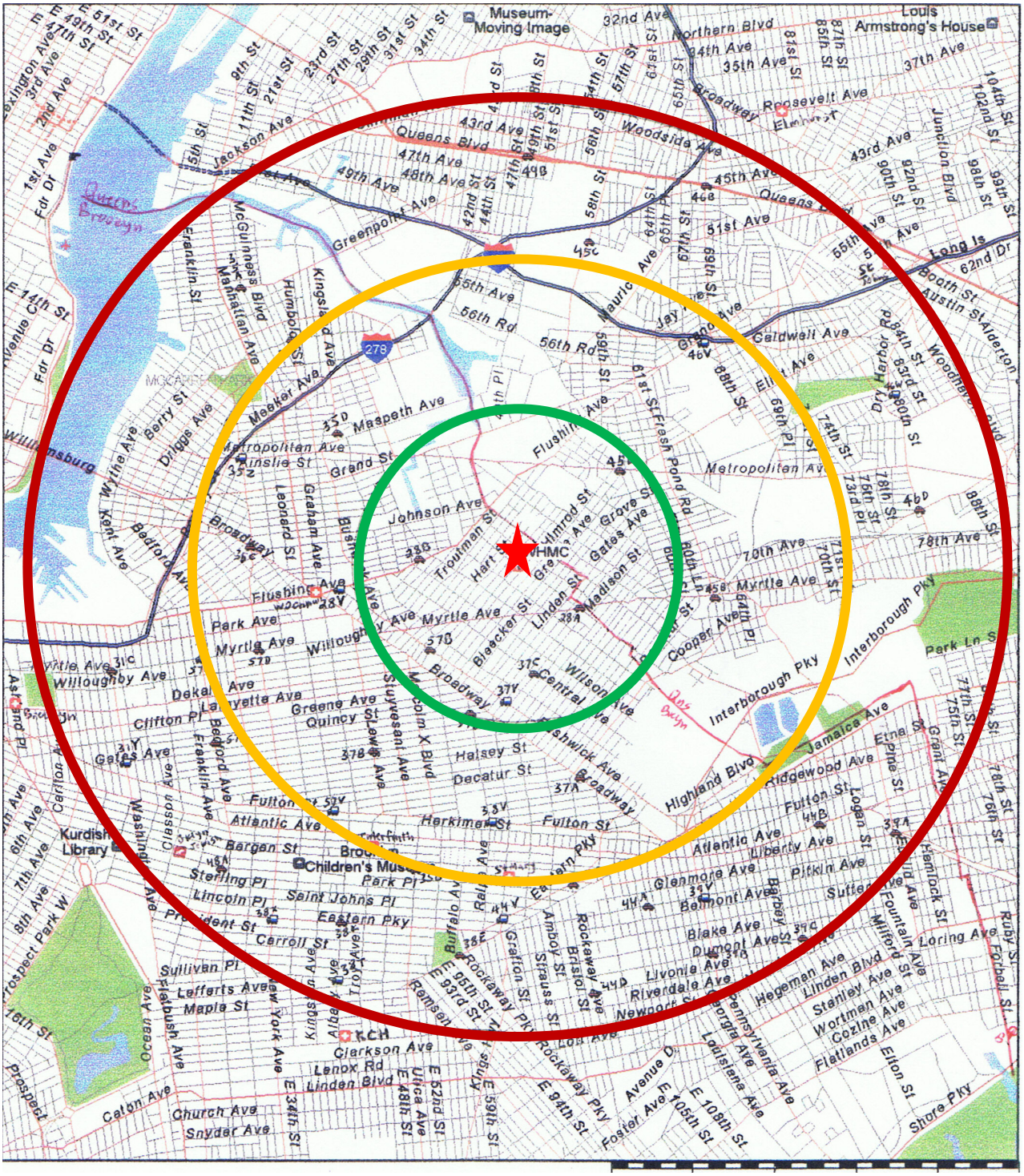
Wyckoff Heights Medical Center
&
Surrounding Community



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REFERENCES:

Baby-Friendly USA: http://www.babyfriendlyusa.org/
Greater New York Hospital Association: http://www.gnyha.org/304/Default.aspx
Healthcare Association of New York State:
http://www.hanys.org/community_health/community_service_plan/
March of Dimes: http://www.marchofdimes.com/
New York State Department of Health: http://www.health.ny.gov/
NYC Mayor's Community Affairs Unit: http://www.nyc.gov/html/cau/html/cb/brooklyn.shtml
NYS Partnership for Patients: https://www.nyspfp.org/

PART 1 – INTRODUCTION

The focus and interest in health care today is unprecedented. On the international level, the World Health Organization (WHO), under the auspices of the Coalition for Healthier Cities and Communities, is leading the movement to improve health around the globe. On the national front, the U.S. Department of Health and Human Services' initiative, *Healthy People 2020*, outlines this decade's "health promotion and disease prevention efforts to improve the health of all people in the United States."[1] Similarly, the New York City Department of Health and Mental Hygiene's (NYC DOHMH) *Take Care New York 2016* shapes "health promotion policies and activities and further helps create, sustain and strengthen community collaborations."[2] These programs are also in sync with the New York State Department of Health's (NYSDOH) Prevention Agenda 2013-2017: New York State's Health Improvement Plan; which focuses on making New York the healthiest state.

It is against this backdrop that Wyckoff Heights Medical Center prepared this Comprehensive Community Service Plan (CSP). These global, national and local community health improvement initiatives informed Wyckoff's CSP and provided the impetus for addressing, and meeting, the most pressing health care needs in the diverse communities the medical center serves.

Founded in 1889, as the German Hospital of Brooklyn, Wyckoff Heights Medical Center has been providing care to the residents of north Brooklyn and western Queens for almost 125 years. Today, Wyckoff is a vibrant, 374-bed community medical center which offers a broad range of preventative care, primary care and specialized inpatient and outpatient services. Wyckoff also provides state-of-the-art diagnostic, therapeutic and supportive treatments. Additionally, the hospital operates a 24-hour New York City 911 receiving hospital emergency department, with an area devoted to pediatrics.

Mission Statement

Wyckoff Heights Medical Center is committed to providing a single standard of highest quality care to our community through prevention, education and treatment in a safe environment. The institutional goal is to continually improve the quality and safety of the healthcare delivery system, utilizing a strategy of constant community needs assessment in such areas as prevention, patient perception of care and safety, pain management, and adoption of best clinical and administrative practices. Community outreach, ambulatory care, primary care and preventive medicine are tools to be used in achieving the goal.

Wyckoff Heights Medical Centers Mission, vision, and purpose will be achieved through the attainment of the following objectives:

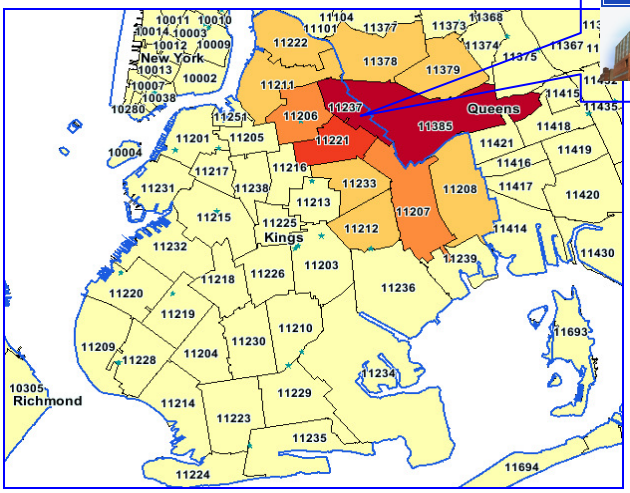
- The Medical Center will provide the highest level of care for all patients regardless of their ethnic origin, race, creed, color, national origin, sex, physical disabilities, sexual orientation, or ability to pay. The worth and dignity for each individual will be recognized.
- The Medical Center will improve the health status of the community by actively participating in an organized, innovative integrated health care system, with a strong managed care focus.
- The Medical Center will promote and support all efforts to provide a safe environment for our patients, employees and visitors.

Hospital Service Area

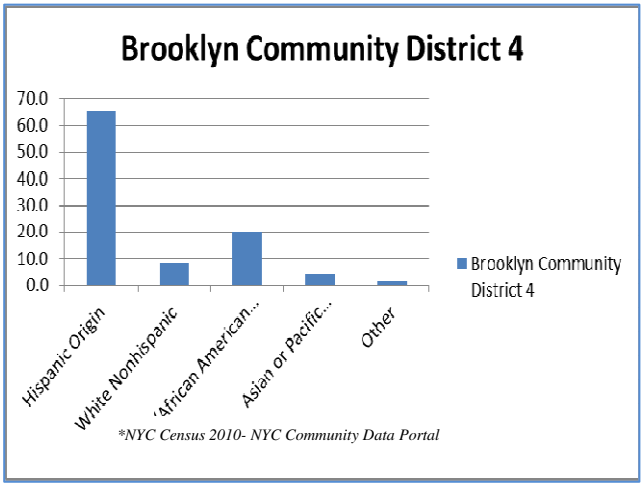
Serving culturally diverse populations in the counties of Kings and Queens, Wyckoff is a full service community hospital. In 2012, Wyckoff discharged 18,769 patients, including 1,433 births, and provided over 105,280 outpatient visits. Additionally, some 72,109 were seen in the adult & pediatric emergency department. This discharge data also defines the hospital's service area.

Service Year	2009	2010	2011	2012	2013 (First 6 months)
Annual Discharges	19,000	19,808	19,024	18,769	8,034
Babies Delivered	2,000	1,498	1,419	1,433	591
Pediatric/Adult Emergency Room Visits	75,000	81,852	70,633	72,109	44,229
Clinic Visits	85,000	104,238	101,066	105,280	54,194

Wyckoff's geographic service area can also defined by zip code.
The primary zip codes are: 11237 - Bushwick and 11207 - Rigdewood/Glendale.
Secondary zip codes include 11378 - Maspeth, 11379 - Middle Village, 11385 - East New York, 11221- Bushwick/Bedford-Stuyvesant, 11206 - Williamsburg/Bedford-Stuyvesant, 11211 – Williamsburg, 11421 – Woodhaven, 11208 – Cypress Hills, 11222- Greenpoint, and 00000 – Richmond Hill.



Wyckoff's service area is one of the most ethnically and culturally diverse constituencies in New York City. According to the 2010 census*, Bushwick's area (Brooklyn Community District 4) is 65.4 percent Hispanic; which has it remaining as "the largest hub of Brooklyn's Hispanic-American community." The other ethnic groups include 8.5 percent White, 20.1 percent African American, 4.3 percent Asian, and 1.7 percent identifying with other racial or ethnic groups. This population boasts an array of immigrant groups whose language, culture, religious affiliations, and other mores infuse a rich vibrancy within the neighborhoods.



WYCKOFF'S EXPANDED CATCHMENT AREA SHOWS THE FOLLOWING STATISITCS OF CHRONIC CONDITIONS PER PQI'S DATA IN NYSDOH.

Hospital Admissions in Selected Area	PN	CHF	HTN	DM	Respiratory
Area Population (499,741)					
Admissions for Condition	1,116	1,975	506	1,841	2,348
Area Rate	223	395	101	368	470
Admissions as % Expected	99%	142%	160%	182%	150%
Statewide Rate	273	352	72	224	357
Area Rate Adjusted for Age & Sex	269	500	115	407	535
Admissions as % Expected by Race/Ethnicity1	PN	CHF	HTN	DM	Respiratory
White	62%	73%	55%	65%	58%
Hispanic	81%	118%	121%	152%	148%
African	130%	253%	311%	335%	224%
Asian	61%	80%	105%	68%	66%
Other	105%	131%	208%	119%	97%
Population in Selected Area Population					
White 31%					
Hispanic 37%					
African 23%					
Asian 4%					
Other 4%					

Hospital Admissions in Selected Area 11237 Plus 11378, 11379, 11385, 11207 11221, 11206, 11211, 11421, 11208, & 11222.	
Area Population	**499,741**
Admission for Condition	**9,167**
Area Rate	**1,834**
Admission as % Expected	**139%**
Statewide Rate	**1,563**
Area Rate Adjusted for Age & Sex	**2,165**

Data Sources: https://apps.health.ny.gov/statistics/prevention/quality_indicators/start.map
Hospital Admissions
This site uses 2008 and 2009 acute-care hospital discharge data from the Statewide Planning and Research Cooperative System (SPARCS). Discharges from both years were processed with software from the federal Agency for Healthcare Research and Quality (AHRQ), which identifies hospital admissions for each Prevention Quality Indicator (PQI) based on Diagnostic Related Group and other criteria. The hospital admission rates derived on this site are based on an average of those two years of patient records. The number of PQI hospital admissions is converted into a rate using 2008-2009 estimates of the population developed for New York State ZIP codes by Claritas, a leading national demographic firm.
Population:
All population figures expressed on site come from Claritas estimates for 2008 and 2009. The patient counts by ZIP code reflect total hospital inpatient discharges (for adults as well as children) for 2008 and 2009

Information was culled from the following sources for purposes of defining the community service area for Wyckoff Heights Medical Center:

- New York State Department of Health
- Prevention Quality Indicators (PQIs)
- Statewide Planning and Research Cooperative System (SPARCS)
- Agency for Healthcare Research and Quality (AHRQ),
- NYC Department of Health and Mental Hygiene, Neighborhood Health Profiles, produced periodically.
- Marketing studies, which reflect trends in patient utilization rates across the region and provide data about patient health care service preferences
- Utilization data
- Healthy People 2010
- Federal Community Health Indicator Data, complied by the Health Research Services Administration of the US Department of Health and Human Services
- US Bureau of the Census
- NYS Vital Statistics
- GNYHA (Greater New York Hospital Association) reports
- HANYS (Health Care Association of New York State) reports and bulletins.
- New York – Presbyterian Healthcare System bulletins and reports
- NYC Census 2010- NYC Community Data Portal; http://www.nyc.gov/html/dcp/html/neigh_info/nhmap.shtml

Community Health Needs Assessment

The Affordable Care Act (ACA) requires hospitals to conduct community health needs assessments to solicit input for determining health priorities and to adopt strategies that foster improvements in community health. The NYS DOH has a similar mandate for its Prevention Agenda 2013-2017: New York State's Health Improvement Plan. In keeping with both requirements, Wyckoff Heights Medical Center's met with various Communities Based Organizations (Public Heath Solutions, CAMBA, Opportunities for Health, Faith-Based Organizations, YMCA and neighborhood schools), Wyckoff's President Community Advisory Committee and conducted a Community Health Needs Assessment during a three-month period in 2013.

Methodology

The 8 question study was designed and conducted by the hospital's Organizational Performance Evaluation Committee (OPEC). The survey was distributed to groups within the hospital's service area at the following events and dates:

Wyckoff's Community Health Fair August 3, 2013
Wyckoff Heights Medical Center's Out-patient Lab: September 7, 15, 17, &18, 2013
WIC-August & September 2013
Positive Health Program August to October 2013
Neighborhood Fairs in which WHMC has participated.

The results are as follows:

WYCKOFF HEIGHT MEDICAL CENTER
COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY

548 ***Number of people Surveyed***

1. Which of the following is important to you?
   - 76% Preventing chronic diseases such as heart disease, cancer, respiratory disease, diabetes; and shared risk factor of diet, exercise, tobacco, alcohol, and associated obesity
   - 55% Improving the quality of air, water, etc. and the physical environment where people live work, play and learn
   - 54% Improving health for women and mothers, birth outcomes and child health, including dental health
   - 46% Promoting mental health and prevent substance abuse
   - 52% Preventing HIV and other sexually transmitted diseases

2. In your opinion, which of these community health services need to be expanded? Please check all that apply
   - 58% Primary care services
   - 48% Dental Care
   - Medical
   - 46% Specialties
   - 47% Mental health/Substance abuse services
   - 47% Pediatric care
   - 44% Health programs for seniors

3. Do you think the community needs more emergency services?
   - 96% More emergency services
   - 4% Less emergency services

   Why?

4. Do you think members of this community need health insurance?
   - 92% YES
   - 8% NO

   Why?

5. How would you describe your health? Check the one which applies.
   - 22% Excellent
   - 62% Good
   - 12% Adequate
   - 4% Poor

6. Do you smoke?
   - 12% YES
   - 88% NO

7. Would you mind telling us about yourself?

Gender:
   - 21% MALE
   - 79% FEMALE

	TRANSGENDER
Age:	
25%	18-25
37%	26-35
20%	36-45
12%	45-55
1%	56-65
4%	66-75
1%	76-85
0%	85+
Marital Status:	
36%	Single
26%	Married
5%	Divorced
31%	Widowed
2%	Other
Race:	
6%	Asian
21%	Black
55%	Hispanic
40%	Native American
9%	White
5%	Other
Education	
	Elementary
15%	School
40%	High School
38%	College
7%	Other
Veteran	
2%	YES
98%	NO

8. What other suggestions do you have about health care needs in this community?

Bring Health fairs in to Schools
Teach kids how to cook and about nutrition
Continue to expand facilities outside the hospital
Improve emergency response time
Mental health services need to be added
More Emergency Doctors
More outreach on hospital programs available within community

In Summary:

Wyckoff Heights Medical Center is located in the community of Bushwick/Williamsburg and serves both the community of Northern Brooklyn and Queens. According to the 2010 US Census there are 210,468 people living the areas of Bushwick/Williamsburg and while this community boosts many assets, such as our ethnic diversity, according to the last NYCDOH Community Health profile in 2006, Bushwick/Williamburg is below other Brooklyn neighborhoods and NYC overall in the following areas:

- 38% of the residents living being below the poverty level
- 50% of the residents have not completed High School
- Our death rate is 15% to 20 % higher
- 1 in 10 adults suffers from serious psychological distress
- Our Alcohol and Drug related hospitalization are also higher

The data identifying hospital admissions (2008-2009) from Prevention Quality Indicator (PQI) showed prevalence in several chronic diseases in our community and the Community Health Needs Assessment Survey also indicates that chronic diseases linked to risk factors of diet, exercise, alcohol and associated obesity ranked first.

Data indicates that Brooklyn women are receiving prenatal care, but they are still twice as likely to receive late or no prenatal care as are mothers nationwide. Most children of poor, inner-city families residing in the WHMC's service area, over 100,000 are headed by single mothers, in our targeted service area. They are at much higher risk for problems that compromise their health, expose them to various forms of violence and produce adverse birth outcomes for their babies. We have 100,000 female-headed households in our targeted area and nearly 57 percent of them have a child under 18. This group is a targeted priority population in our improvement plan. Also contributing to our profile of community need is a higher birth rate and increasing numbers of immigrants moving into the service area. Much of the service area is characterized by poverty, typically one in three individuals live in poverty and a high proportion of families headed by women, poverty increases to 40 percent in some communities.

Women with significant Co-morbidities: Obesity, Diabetes, and Heart Disease: The Table below demonstrates the relationship between obesity and infant mortality rates and low birth rates. Not surprisingly, the higher the rates of obesity, the worse the outcomes.

Infant Mortality Rate By Pre-Pregnancy BMI, 2008-2010, Brooklyn New York			
Neighborhood	**Infant Mortality Rate**	**Percent Obese**	**% Macrosomic (Birth Weight < 4,000 grams**
Targeted Communities			
Williamsburg, Greenpoint	2.5	31.9	7.9
Bedford Stuyvesant	8.5	51.6	6.0
Bushwick	5.0	52.6	7.6
East New York	8.7	56.2	6.2
Crown Heights North	5.8	47.9	6.1
Crown Heights South	5.1	45.4	7.7
Brownsville	9.9	57.8	4.8
Source: New York City Department of Health and Mental Hygiene			

Additionally, NYC DOHMH STD surveillance indicates that transmission rates for STD's for the communities we serve, which also includes East NY, are higher than the city average. East NY in particular ranks very high in chlamydia rates and in fact, women in East NY top all other city neighborhoods with respect to chlamydia transmission. The rate of infection of infection with Gonorrhea again finds East NY, where men here rank in the 6th percentile and women in the 10th percentile in all of NYC. Finally, the NYC DOHMH ranks all of our local communities (Williamburg-Bushwick and East NY) has having very high rates of Syphilis transmission amongst men (24-51 per 100,000) with the primary risk behavior being men having sex with other men (MSM). Finally, the NYCDOH HIV Surveillance Statistics reported that by the end of 2011, there were a total 3,707 people living with HIV/AIDS (PLWHA's) in the Williamsburg/Bushwick community and another 2,740 PLWHA's in East NY. That same year, WB reported 154 new HIV diagnoses and ENY had 88. As in many other communities in NYC, our HIV transmission rates have adversely affected communities of color primarily. By the close of 2011, HIV was concentrated in Black and Latinos, who accounted for 93% of all PLWHA. Amongst these PLWHA, males are most over-represented, making up close to 65% of PLWHA. The majority of PLWHA in the community are within the 30-39 age range but it is worth noting that two other distinct community members emerge as well. These are seniors, aged 60+, and on the other end of the spectrum, young people, within 20-29 years old. As far as risk, in the total PLWHA population, there is a broad range of reported risk: MSM (23%), heterosexual contact (22.8%), and IDU (22.7 %) but the largest percentage was for persons whose risk was unknown (29%). In terms of those newly diagnosed, majority were reported as Black, male, MSM and within the age range of 20-29.
The data is very similar in ENY, with several key exceptions. The majority of PLWHA report their risk as being heterosexual (29.7%) versus unknown (29.6%) followed by IDU (18.8%) and MSM (18.4%). Furthermore, the majority of PLWHA are between the age ranges of 30-49 and males and females are almost equally distributed in terms of impact (males at 56% vs. females at 43%). Distinctions can also be found in those newly diagnosed in that even though males are overrepresented (62 vs. 26) the risk reported is found in both the MSM and the heterosexual community almost equally (40% vs. 31%).

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

1. **Improving health for women and mothers, birth outcomes and child health.**
2. **Preventing HIV and other sexually transmitted diseases.**

Partnerships

Women, Infant & Children (WIC) Program

Currently our local agency collaborates and coordinates our services to assist our clients. The following agencies have been very helpful:

1. Medicaid/some of the Food Stamp Program Access Project
2. Early Intervention Programs, NYC & Private
3. Bushwick Bright Start Program
4. Early Learn/Early Childhood Education
5. School Lunch Programs
6. Senior Citizens Centers
7. Brooklyn Observer (Newspaper)
8. Cornell Extension Services
9. HIV AIDS/Positive Health
10. NYC Lead Poisoning Program
11. Brooklyn Alliance for Breastfeeding Empowerment
12. Various HMO's (United Healthcare, Health Plus)
13. Home Based Program
14. Various Community Health Provider
15. Hispanic Coalition
16. NYC Dept of Health Clinics
17. Hospital Health Clinics/Pediatrics Maternal/Labor Delivery PCAP

New York State Partnership for Patients (NYSPFP)

March 2012 began our engagement with The New York State Partnership for Patients (NYSPFP). The is a joint initiative of the Healthcare Association of New York State (HANYS) and the Greater New York Hospital Association (GNYHA)—hospital trade associations representing not-for profit and public health care institutions, including large health systems, acute and long-term care hospitals, skilled nursing facilities, hospices, and home care. Wyckoff participates in all of the program focus areas including the Obstetrical Safety Initiative that focuses on improving perinatal outcomes by reducing the number of scheduled deliveries performed without medical indication in women between 36 0/7 and 38 6/7 weeks gestation.

Latch On NYC

Wyckoff Heights Medical Center has partnered with Latch On NYC, an initiative to support mothers choosing to breastfeed. The goal is to improve the health of mothers and children by increasing breastfeeding initiation and duration, and exclusive breastfeeding.

The initiative includes the following components:
A call to all NYC maternity hospitals to make a voluntary commitment to support mothers who choose to breastfeed by providing additional support to breastfeeding mothers and minimize practices that can interfere with that choice such as supplementing breastfeeding infants with formula, unless medically indicated or at the mother's specific request. Hospitals also pledge to end the distribution of promotional formula and materials during the hospital stay and at discharge.

A public awareness campaign to promoting the health benefits of breast milk; and to inform women of their right to receive education, encouragement and support to breastfeed their babies if they choose to do so.

The initiative has been endorsed by the New York State Department of Health, the Greater New York Hospital Association, Health and Hospitals Corporation, and the NYS chapters of the American Academy of Pediatrics, Academy of Family Physicians and the Society for Adolescent Health and Medicine.

Positive Health Management program (PHM)

Since 2009 WHMC and the Positive Health Management program (PHM) has had a formal agreement with the NYCDOH Field Surveillance Unit (FSU) in order to ensure that all newly diagnosed HIV positive patients receive Partner Notification services and that they are linked into medical treatment. The FSU team comes to the hospital on a weekly basis to review lab results identifying new cases which are then discussed with the PHM team to determine how we can work together to ensure that the patients receive the required services. PHM also identifies cases and reports them to the FSU team for follow-up. This partnership is very important to ensure that we are complicate with our local and federal contracts. As well as meeting the guidelines of the NHAS which requires that we work towards reducing new infections by making sure patients are linked into medical treatment and that their partners are aware of their own HIV status. This partnership has led to the successful linkage of several patients into medical care and has helped many others who were named as partners gain the knowledge of their own HIV status. This collaboration has helped both program reach those hardest to reach patients and link them into care. This is an ongoing relationship.

Since 2010 WHMC and the Positive Health Management –HOAP program has had formal linkage agreements with various New Life and Bushwick United Health Start and Daycare programs as part of their Community PROMISE program. Community PROMISE is a CDC proven effective, community level HIV/STD prevention intervention that relies on role model stories and peer advocates from the community. The role model stories are based on members of the target population who have made positive HIV/STD behavior change in their life. The peer advocates who are also from the community are recruited and trained to distribute the role model stories and prevention materials within their social networks. PHM-HOAP program meets with these agencies at minimum a bi-monthly basis to do educational groups, recruitment and community assessment or mapping. Over the course of the past 3 years through this project we have had 16 peer advocates that have distributed over 3,000 role model stories in the community. This program has also promoted HIV testing and other supportive services. This program will continue through June of 2014.

WHMC –PHM also have many other bi-directional linkage agreements with the following agencies in the community including.

Make the Road New York
New York Psychotherapy
Family Services Network of New York
Case Raices Bienstar
La Nueva Esperanza
God's Love We Deliver
Brooklyn Public Library
Brooklyn Legal Services Corp A
El Sol Services
Denis Blumber, LCSW CSAC
Opportunites for a Better Tomorrow
Help Roads USA
Cornerstone Medical Arts
Outreach Project
NYCDOH – Rikers Island
NYCDOH – STD clinics
Partnership for the Homeless

PART 2 – NYS DOH HEALTH AGENDA PRIORITIES

First Prevention Agenda Priority: Improving health for women and mothers, birth outcomes and child health

Wyckoff Heights Medical Center is utilizing a multifaceted approach to address this priority:

<u>Maternal and Infant Community Health Collaborative</u>

In 2013, Wyckoff Heights Medical Center received 5 year grant totaling $408K per year.
With MICHC funding, we are building a health enterprise zone, i.e., a broad community-based medical home for women for northern and eastern Brooklyn utilizes the community assessment, consensus building, and the development of education, outreach and marketing strategies to reach women throughout all stages of life course and their children to reduce the considerable health disparities that still exist. An underlying principal is to bring the patient and doctor back together to provide superior health care services through patient empowerment and physician engagement. With the support of Public Health Solution's WHMC will host community baby showers every two months with the goal of educating women and their families on safe pregnancy and safe parenting. With MICH funds, we will establish several innovative programs that include a women's pregnancy medical home model and a pregnancy-centering program to improve maternal and infant health outcomes. We seek to instill cultural competency and a standard of care throughout our health care network. This improvement, we trust, may encourage our women to seek out family planning services, to seek more preventive care and thus reduce their reliance on costly emergency care, seek prenatal care earlier and maintain healthy lifestyles.

Three year plan:

Our focus is on a reduction in the following:

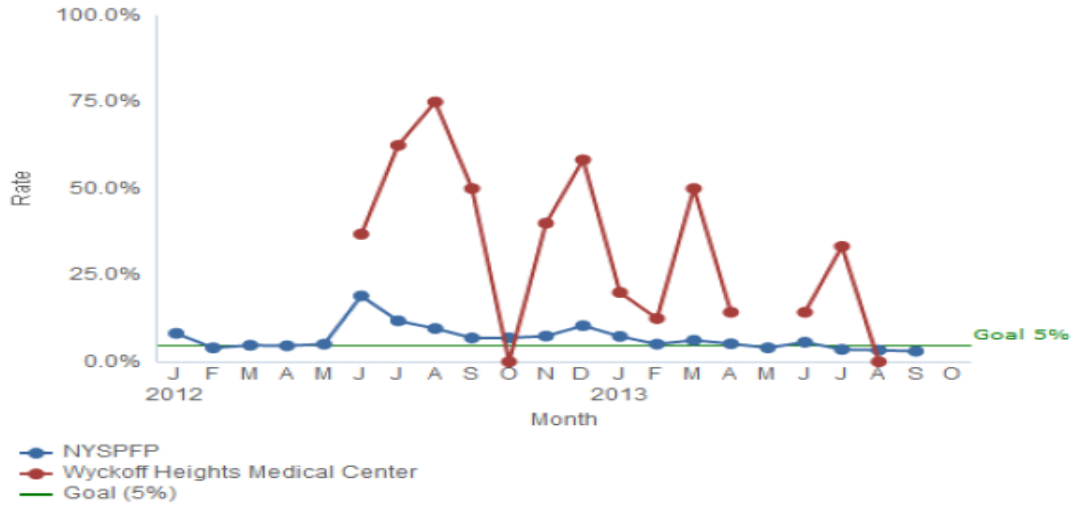
1. Our *teenage pregnancy rates* are stratospheric, ranging from 104.1 to 111.1 per thousand in Bedford-Stuyvesant in contrast to 63.8 for Brooklyn. Birth outcomes remain seriously compromised and the amount of prenatal care remains low despite major gains in other communities in New York City. HIV/AIDS and STDs rates in these communities remain among the highest in the city and indeed the nation.
2. *Premature Births.* Approximately half the time, the reasons for premature birth are unknown. We can reduce prematurity, if not prevent it, and other adverse birth outcomes such as low birth weight, major birth defects and pregnancy complications. For the best possible odds for a full-term pregnancy, our program will provide women with the tools they need to become healthy *before* they become pregnant.
3. *Unwanted pregnancies.* Without adequate access to family planning information and services, women may have unplanned and unwanted pregnancies. Unwanted pregnancies can threaten a woman's health or well-being.
4. *Prenatal Care.* We have many communities that still have very high percentage of late or no prenatal care. In the Bed-Stuyvesant zip codes, the percentage runs the gamut of between 18 to 23 percent. Our goal is to reduce that percent to 10 percent or less. About 31% of women who give birth have serious complications.
5. *Complications of pregnancy* (e.g., gestational diabetes or hypertension) are the second leading cause of short-term disability and the sixth leading cause of long-term disability in the United States.

NYSPFP: Obstetrical Safety Initiative

Obstetrical Safety Initiative focuses on reducing the number of scheduled deliveries performed without medical indication in women between 36 0/7 and 38 6/7 weeks gestation and improving maternal and newborn outcomes. One aspect of the initiative centers on educating expectant mothers about the risks and benefits of scheduled deliveries at 36 0/7 to 38 6/7 weeks gestation.

Wyckoff Heights Medical Center
OB
Outcome Measure

Percent of all scheduled deliveries at 36 0/7 to 38 6/7 weeks gestation without documentation of listed maternal or fetal reason.



	2012 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2013 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Numerator	–	–	–	–	–	7	5	3	2	0	2	7	2	1	2	1	–	1	1	0	–	–
Denominator	–	–	–	–	–	19	8	4	4	3	5	12	10	8	4	7	–	7	3	10	–	–
Hospital Rate	–	–	–	–	–	36.84	62.50	75.00	50.00	0.00	40.00	58.33	20.00	12.50	50.00	14.29	–	14.29	33.33	0.00	–	–
NYSPFP Rate	8.19	4.00	4.76	4.62	5.08	19.00	11.80	9.60	6.88	6.90	7.41	10.42	7.34	5.07	6.19	5.22	4.03	5.64	3.54	3.34	3.05	–
Hospitals	13	12	13	13	13	85	84	85	85	86	86	84	85	84	84	84	82	85	77	79	66	0

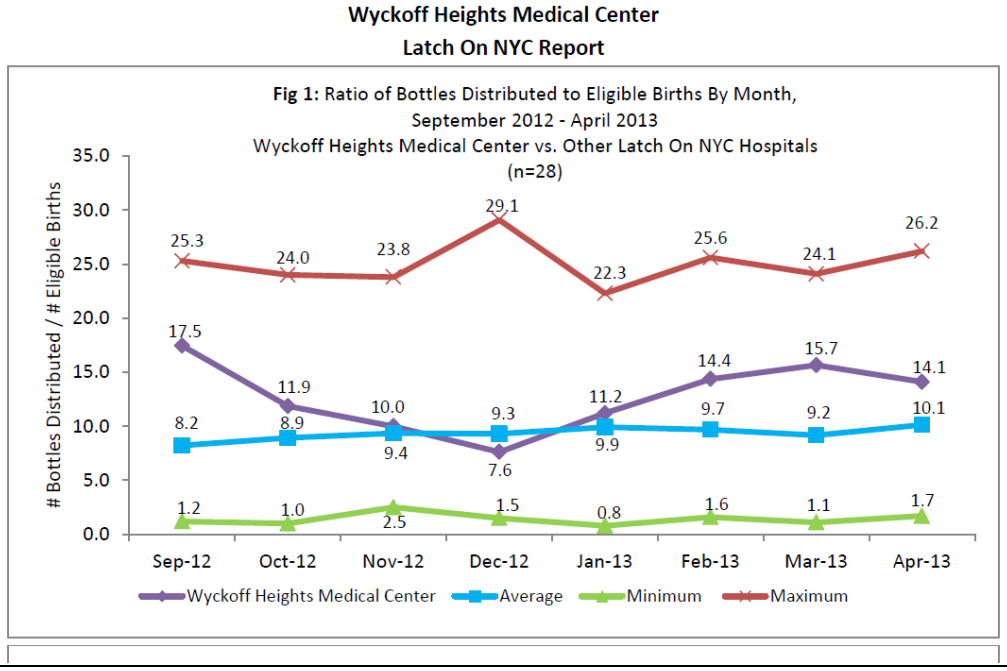
o Numerator: Number of all scheduled deliveries at 36 0/7 to 38 6/7 weeks gestation without documentation of listed maternal or fetal reason
o Denominator: All scheduled deliveries of infants between 36 0/7 to 38 6/7 weeks gestation

Data as of: November 5, 2013

Report Generated on: 11/8/2013 10:09:46 AM

Latch On NYC

Wyckoff Heights Medical Center joined Latch On NYC in September 2012.
There was a 13.0% increase in exclusive breastfeeding from September 2012 to April 2013 at Wyckoff Heights Medical Center, from 12.4% to 14.0%. This compares to a 15.5% decrease on average for all hospitals participating in Latch On NYC.
There was a 4.4% decrease in formula supplementation of breastfed infants from September 2012 to April 2013 at Wyckoff Heights Medical Center, from 86.2% to 82.4%. This compares to an 8.6% increase on average for all hospitals participating in Latch on NYC.



Baby-Friendly USA

Wyckoff is has initiated the process to be a Baby-Friendly Hospital. This *implementation of the Baby-Friendly Hospital Initiative (BFHI) in the United States is predicated on the fact that human milk fed through the mother's own breast is the normal way for human infants to be nourished. There is an abundance of scientific evidence that points to lower risks for certain diseases and improved health outcomes for both mothers and babies who breastfeed. Breastfeeding is the natural biological conclusion to pregnancy and an important mechanism for the continued normal development of the infant. With the correct information and the right supports in place, under normal circumstances, most women who choose to breastfeed are able to successfully achieve their goal.*

Women, Infant & Children (WIC) Program

WIC is a short-term intervention program designed to influence lifetime nutrition and health behaviors in a targeted, high-risk population. During critical times of growth and development, WIC achieves positive health outcomes by providing:

- Quality nutrition counseling and education
- Breastfeeding promotion and support.
- Monthly checks for a nutritious food prescription – at no cost to the participant
- Immunization screening and referrals
- Referrals to health and social services.

WIC is a federally-funded program, administered by the New York State Department of Health. WIC services are available through more than 100 local service providers located in every county in the State.

Population Served: WHMC WIC Program is comprised of on site operation at 316A Himrod Street and two other sites: Williamburg Sites and the LaMarca Family Health Center Site. We serve 8,000 eligible clients. 50% children, 25% infants and 25% women. The age ranges from 0 – 12 months for infants, 1 – 5 years old for children and women (Pregnant, Breastfeeding and Postpartum). Our population includes Bushwick, Ridgewood, Greenpoint and Williamsburg.

BREASTFEEDING PROMOTION AND SUPPORT

- Maintains a clinic environment that promotes breastfeeding
- Purchase and issues breastfeeding breast pumps which directly support the initiation and continuation of breastfeeding in accordance with the policies and procedures of the program.
- Provide breastfeeding information to all prenatal participants, and promote and support breastfeeding among participants.
- Maintains and makes available for distribution a list of resources for breastfeeding counseling and support services.
- Maintain an Enhanced Breastfeeding Peer Counselor program for breastfeeding support among WIC women as outlined in NYS WIC Program Manual. Utilize the Breastfeeding Prenatal List and Breastfeeding Infant List reports to ensure that peer counselors are assigned to participants
- Evaluates breastfeeding initiation, duration and status reports routinely and review breastfeeding activities, education and peer counseling for effectiveness annually.
- Complete monthly and annual breastfeeding reports within specified timeframes.
- Expend annually at least 1.4 percent of the total Nutrition Services and Administration funds of the WIC local agency budget on breastfeeding promotion and support. Provide documentation of breastfeeding costs to the State as required.

PROGRAM ACTIVITIES

We have incorporated healthy lifestyle into program activities in the following manner:

- Implementation of Healthy Lifestyle/FITWIC contact for overweight children. Healthy recipes, food demonstration and physical activities are provided as needed. Toys which encourage movement, such as hoola-hoops are provided.
- Initiated/Annual “Open House” to promote our Healthy Lifestyle in house activities to share with the community agencies.
- Ongoing Healthy Lifestyle messages during nutrition education.
- Office displays which promote healthy eating such as amount of sugar contained in commonly consumed sweet drinks and salt in foods.
- We have incorporated Healthy Lifestyle to women, infant, children and their families to prevent chronic disease on an ongoing basis.
- Breastfeeding promotion of fruits and vegetables, physical activities have all help improve the health of our community.
- Implementation of weekly yoga and Zumba alternately scheduled for the clients and their families.
- Showcase our backyard summer vegetables for families
- Annual WIC Activities at the public park showcasing FIT WIC, breastfeeding walks, and WIC Health Fair.
- Media promotion of WIC activities in the community monthly “The Bushwick Observer” announcements, nutrition articles, and FIT WIC activities.
- We have consistently lowered BMI of Children between 2 – 5 years (high risk children) 50 – 60%.

Second Prevention Agenda Priority: Prevent HIV, STI’s and Vaccine Preventable Diseases

Our hospital and its Positive Health Management program has always been at the forefront in addressing the HIV/AIDS epidemic and its related cofactors. In 2012, within WHMC programming, 7,088 HIV tests were conducted where 26 new HIV positive persons were identified. Since the enactment of the updated New York State HIV testing laws, Wyckoff has been working with many departments in the hospital in order to simplify the HIV testing process and to make HIV testing more accessible to our patients. Within this context, we hope to increase the number of HIV tests completed with the goal of not only increasing the number of people uncovering their HIV status but also increasing the number of people linked to medical care within our hospital setting.

PROGRAM DESCRIPTION

Positive Health Management (PHM) is a comprehensive HIV primary care, Prevention and Compliance program that is associated with the ambulatory care system of Wyckoff Heights Medical Center since 1995. The program boosts culturally competent services which are provided by bilingual service providers. Our services are targeted to those living in the communities of Northern Brooklyn and Ridgewood/Glendale areas of Queens. The goal of Positive Health Management is to provide excellent and safe care to persons who are at risk for or who are already infected with HIV. Our program holds quarterly Community Advisory Board (CAB) meetings which are open to the community and monthly Primary Care and Prevention Sub Committee meetings.

The **Primary Care** services are located at WHMC and the medical services are provided by a group of HIV specialists to over 500 patients a year. Our ancillary program staff members are also accredited in their fields and support the clients as their receive primary care. The following is a listing of our services according to their funding source with the goals of: Increasing the number of people who are previously or newly diagnosed with HIV to clinical care;
Increase the number of patients with undetectable viral loads and Identifying people with Hepatitis C and linking them to treatment.

NYS DOH/AI and CDC Primary Care, Medical Case Management and Health Education
NYCDOHMH/Public Health Solutions - Care Coordination (CC)
NYSDOH/AI – Women's Supportive Services (WSS)

The **Prevention services** component provides an array of prevention services both on site at WHMC and in the community. These services are all free and have limited qualifications to participate in the services. The 4 programs listed below work to toward the achieving the following goals: Increasing access to HIV testing within the hospital setting; Increase the number of HIV tests conducted; Increase the number of people who are previously or newly diagnosed with HIV to clinical care; Identify opportunities to screen, vaccinate and treat community members at the highest risk for STD's including Hepatitis A, B and C.

SAMHSA - HIV TCE HIV Outreach
Center for Disease Control and Prevention – Community Based project

NYCDOHMH/AI – Public Health Solutions for Routine Testing in Clinical Settings: Provides free routine HIV testing in the adult emergency room or in the Dental Clinic at WHMC to patients that do not insurance or those whose insurance does not pay for HIV testing. HIV testing is confidential and is testing is conducted in 2 manners; through the use of 4th generation HIV blood screening that aims to identify HIV infection earlier than other HIV tests or Oral fluid testing using OraQuick is also available. All patients who test positive for HIV are provided with confirmatory testing and linkage to care services, including the completion of the ADAP applications. Since the beginning of the program in December 2011 we have tested 3018 patients for HIV, identified 14 cases (.4% positivity rate) of HIV and linked 11 people into medical treatment.

NYCDOHMH-Public Health Solutions-Sexual Behavioral Health Services: In 2013, WHMC was awarded this new 3 year contract. This program targets uninsured negative or unknown HIV status gay, bisexual or MSM aged 18-30 and provides the following free services: STD screening & treatment, PEP assessment & medication, and Hepatitis A & B vaccinations. The program also screens clients for depression, anxiety and substance/alcohol use and provides short-term individual and group level mental health and substance abuse counseling services. All clients also receive individual and group health education as well as social services referrals.

The **HIV testing and Compliance** aspect of the program was added in October 2013 through **Gilead's HIV FOCUS program.** The goal of this project is to strengthen the delivery of routine HIV testing by addressing barriers that are contributing to stagnant HIV testing rates.
These barriers include:

- Medical staff conducting targeted testing which is contrary to the concept of routine testing.
- Staff lacking the knowledge or have misconceptions regarding regulations governing routine HIV testing
- Staffs belief that asking someone to be tested or even ordering the test can be burdensome along with their other duties.

These barriers will be addressed through training and upgrading our EMR system in order to better integrate HIV screening into patient care across the institution.
Our project incorporates FOCUS's four pillars of routine screening.

- **Institutional Policy Change**: WHMC's institution of a new HIV testing policy and integration of the consent form with the general medical consent.

- **Integrated HIV Screening Process**- The new policy calls for HIV testing follow-up by the nursing team with the result being delivered by the medical provider.
- **Electronic Health Record and use of technology to support screening**; Updating our current EMR (Meditech) in the ER/Inpatient units and implementing a new EMR platform- eClinicalWorks into Ambulatory clinics, that will better track and monitor scale-up of HIV testing.

Part 3-Action Plans

Year 1		Year 2	Year 3
Goal/Objectives	**Improvement Strategies/Performance Measures**	**Improvement Strategies/Performance Measures**	**Improvement Strategies/Performance Measures**
Reduce premature births	**Our goal is to make WHMC and its consortium a medical home for women, a place they can go for routine care and go to when they need advice about their health. At all points of care, the WHMC network will seek to maintain women's health during the reproductive years, 14-55 to include disease screening, preventive care and health promotion.**	**Through the Maternal and Infant Community Health Collaborative; our program will provide women with the tools they need to become healthy *before* they become pregnant.**	**Encourage our women to seek out family planning services, to seek more preventive care and thus reduce their reliance on costly emergency care, seek prenatal care earlier and maintain healthy lifestyles**
	To reduce the number of scheduled deliveries without medical or obstetrical indication in women of 36 0/7 to 38 6/7 weeks gestation to 5%.	**Reduce the number of scheduled deliveries without medical or obstetrical indication in women of 36 0/7 to 38 6/7 weeks gestation to Zero.**	**Maintain the number of scheduled deliveries without medical or obstetrical indication in women of 36 0/7 to 38 6/7 weeks gestation at Zero.**
Increase number of breastfed babies	**Upon delivery, the newborn is placed skin-to-skin with the mother, allowing uninterrupted time for breastfeeding when appropriate.**	**Complete the 4-D Pathway to become a Baby-Friendly Hospital: D1 Discovery, D2: Development Phase, D3: Dissemination Phase , and D4: Designation Phase.**	**Receive designation as a Baby - Friendly Hospital.**
	Eliminate unnecessary supplementation by 10%.	**Eliminate unnecessary supplementation by 15% .**	**Eliminate unnecessary supplementation by 20% .**
	Improve patient education and assistance by addressing lactation education during the antepartum visit and continuing to train breastfeeding counselors to promote and support breastfeeding initiation, duration and eliminate "WIC Supports Formula" concept in the community.	**Continue to track breastfeeding initiation, duration and its impact on eliminating "WIC Supports Formula".**	**Evaluate breastfeeding initiation, duration and status reports routinely and review breastfeeding activities, education and peer counseling for effectiveness.**

	Eliminate unnecessary separations between mothers and infants.		
	Provide staff training to 100% of nurses on breastfeeding management and support.		
Reduce Obesity in Children	**Improve the weight status of children and their families through increased physical activity and healthy diets.**	**Continue to schedule and send WIC staff to needed trainings such as CLS, High Risk, TC, Immunization, FIT WIC, Nutrition Assessment and Motivational interview.**	
	Promote the Healthy Lifestyle Initiative and decrease children's Body Mass Index (BMI) for high risks overweight and obese clients by 55%.	**Continue to monitor client BMI's assessing programs impact.**	
Prevent HIV and STDs	**Improve the number of HIV tests offered within the hospital by 50%**	**Improve the number of people linked to care at our hospital's HIV program by 20%.**	**Increase the number of routine tests accepted by 25%.**
	Increase by 25% the number of MSM who are offered STD screenings and vaccinations through our ER and ambulatory care clinics.	**Improve by 20% the number of patients who achieve viral suppression.**	**Increase the number of STD screenings and Hepatitis A & B vaccinations by 10%.**

PART 4 – FINANCIAL PROGRAM

Financial Aid Program

The biggest challenge for Wyckoff related to the provision of financial aid is that Wyckoff serves an indigent and underserved community. 50% of Wyckoff's patients are covered under the state's Medicaid program and most of those (78%) opted to have their coverage administered by a Managed Care carrier. Another 3-5% of Wyckoff's patients are completely uninsured.

One Wyckoff initiative to provide healthcare to the uninsured is an aggressive Medicaid application program. Wyckoff will prescreen patients, based on financial status, to qualify patients for the State's Medicaid program. If the patient is determined to be a candidate, Wyckoff will complete the Medicaid application for the patient at Wyckoff's expense. If successful, Wyckoff will be paid for the services provided by Medicaid and in turn, the patient will have Medicaid coverage for future healthcare needs.

Since patients have to be at the poverty level to qualify for Medicaid, another Wyckoff program to provide healthcare to the needy is our sliding scale fee that offers discounts for patients that do not qualify for Medicaid. Patients can qualify for discounts with family income levels up to 300% of the federal poverty level. This enables those working poor without insurance to receive healthcare that they otherwise could not afford.

Traditionally, the hospital industry charged self-pay patients higher rates than the hospitals receive from government or commercial payers. Wyckoff has instituted a discounted self-pay fee schedule to alleviate this burden. Again, this enables uninsured patients, regardless of financial status, to receive healthcare that they otherwise may not seek.

In 2012 Wyckoff provided to the communities it serves a total of $19.5 million of uncompensated care in the form of charity care and uncollectible accounts. Having to provide uncompensated healthcare at this disproportionate level weakens the financial viability of Wyckoff. However, Wyckoff will continue to fulfill its mission of providing healthcare to our community without compromising safety or quality.

Changes Impacting Community Health/Access to Services
Recent federal healthcare reform legislation and ongoing reductions in Medicare and Medicaid reimbursement will require Wyckoff, as well as most hospitals around the country, to develop a tightly integrated service model which provides for an increased coordination of patient care and reduces duplicative efforts and services. System fragmentation among doctors, medical groups, outpatient centers and hospitals will need to be minimized.
Wyckoff has begun efforts to improve the integration of clinical relationships with private physician office practices in the Hospital's primary and secondary service areas. We have developed a patient centered medical home model of care to improve the coordination of healthcare services provided to patients residing in these areas. We are currently working with the New York City Division of Health Care Access and Improvement to assist local physicians with the installation of electronic health records in their private office practices. Wyckoff's intent is to provide an interoperable IT infrastructure for all of its service area healthcare providers to establish the ability to share clinical information electronically.

PART 5 – DISSEMINATING THE PLAN

1. Distribution to the public
   The Comprehensive Community Service Plan will be distributed to Wyckoff Heights Medical Center's President's Community Advisory Council and the Positive Health Management Community Advisory Board.

2. Website
   A summary of the CSP will be available on the hospital's website www.wyckoffhospital.org with a prominent link to the full report. Additionally, copies of the CSP will be available by request from the following offices and contacts:

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

   Karen Carey, Vice President
   Vice President, Regulatory Services/ Compliance Officer
   374 Stockholm Street
   Brooklyn, NY 11327 Phone: 718-963-7276
   E-mail: kcarey@wyckoffhospital.org

Community Boards Contact Information:
Brooklyn

Community Board 1

Neighborhoods:	Flushing Avenue, Williamsburg, Greenpoint, Northside, and Southside
CB Info:	**Address:** Brooklyn Community Board 1 435 Graham Avenue, Brooklyn, NY 11211 **Phone:** 718-389-0009 **Fax:** 718-389-0098 **Email:** bk01@cb.nyc.gov Website **Chair:** Christopher H. Olechowski **District Manager:** Gerald A. Esposito

	Board Meeting: Second Tuesday, 6:30pm **Cabinet Meeting:** Third Thursday, 10:30am
Precinct(s):	90, 94
Precinct Phone(s):	90: 718-963-5311 94: 718-383-3879

Community Board 2

Neighborhoods:	Brooklyn Heights, Fulton Mall, Boerum Hill, Fort Greene, Brooklyn Navy Yard, Fulton Ferry, and Clinton Hill
CB Info:	**Address:** Brooklyn Community Board 2 350 Jay Street, 8th Floor Brooklyn, NY 11201 **Phone:** 718-596-5410 **Fax:** 718-852-1461 **Email:** cb2k@nyc.rr.com Website **Chair:** John Dew **District Manager:** Robert Perris **Board Meeting:** Second Wednesday, 6:00pm **Cabinet Meeting:** Per agenda
Precinct(s):	84, 88
Precinct Phone(s):	84: 718-875-6811 88: 718-636-6511

Community Board 3

Neighborhoods:	Bedford-Stuyvesant, Stuyvesant Heights, and Ocean Hill
CB Info:	**Address:** Brooklyn Community Board 3 1360 Fulton Street, Brooklyn, NY 11216 **Phone:** 718-622-6601

	Fax: 718-857-5774 **Email:** bk03@cb.nyc.gov Website **Chair:** Henry Butler **District Manager:** Charlene Phillps **Board Meeting:** First Monday, 7:00pm **Cabinet Meeting:** Fourth Thursday, 9:30am
Precinct(s):	79, 81
Precinct Phone(s):	79: 718-635-6611 81: 718-574-0411

Community Board 4

Neighborhoods:	Bushwick
CB Info:	**Address:** Brooklyn Community Board 4 315 Wyckoff Avenue, Brooklyn, NY 11237 **Phone:** 718-628-8400 **Fax:** 718-628-8619 **Email:** bk04@cb.nyc.gov Website **Chair:** Julie Dent **District Manager:** Nadine Whitted **Board Meeting:** Third Wednesday, 6:00pm **Cabinet Meeting:** Second Wednesday, 10:00am
Precinct(s):	83
Precinct Phone(s):	718-574-1605

Queens

Community Board 5

Neighborhoods:	East New York, Cypress Hills, Highland Park, New Lots, City Line, Starrett City, and Ridgewood

CB Info:	**Address:** Brooklyn Community Board 5 127 Pennsylvania Avenue, Brooklyn, NY 11207 **Phone:** 718-498-5711 **Fax:** 718-345-0501 **Email:** bklcb5@verizon.net **Chair:** Nathan Bradley **District Manager:** Walter Campbell **Board Meeting:** Fourth Wednesday, 6:30pm **Cabinet Meeting:** Third Wednesday, 10:00am
Precinct(s):	75
Precinct Phone(s):	718-827-3511

Community Board 5

Neighborhoods:	Ridgewood, Glendale, Middle Village, Maspeth, and Liberty Park
CB Info:	**Address:** Queens Community Board 5 61-23 Myrtle Avenue Glendale, NY 11385 **Phone:** 718.366.1834 **Fax:** 718.417.5799 **Email:** qnscb5@nyc.rr.com **Chair:** Vincent Arcuri, Jr. **District Manager:** Gary Giordano **Board Meeting:** Second Wednesday, 7:30pm **Cabinet Meeting:** First Wednesday of every other month, 10:00am
Precinct(s):	104
Precinct Phone(s):	718-386-3004

Community Board 9

Neighborhoods:	Richmond Hill, Woodhaven, Ozone Park, and Kew Gardens

CB Info:	**Address:** Queens Community Board 9 Queens Borough Hall, 120-55 Queens Boulevard, Rm. 310A Kew Gardens, NY 11424 **Phone:** 718-286-2686 **Fax:** 718-286-2685 **Email:** communitybd9@nyc.rr.com Website **Chair:** Andrea Crawford **District Manager:** Mary Ann Carey **Board Meeting:** Second Tuesday, 7:45pm **Cabinet Meeting:** Third Thursday, 10:00am
Precinct(s):	102
Precinct Phone(s):	718-805-3200