# Wyckoff Heights Medical Center's 2025-2027 Community Health Needs Assessment and Community Service Plan

## Kings and Queens County

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# EXECUTIVE SUMMARY:

**Prevention Agenda Priorities:**

The top priorities identified by Wyckoff Heights Medical Center (Wyckoff) for the 2025-2027 CSP are: 1. Anxiety and Stress, 2. Depression, 3. Primary Prevention, Substance use, and Overdose, 4. Preventive Services for Chronic Disease Prevention and Control, and 5. Housing Stability and Affordability. These priorities will be especially aimed at addressing disparities in limited access to outpatient mental health services available in Wyckoff's primary service area (PSA) in North-Central Brooklyn, providing overdose prevention services to high-risk Hispanic and Black populations on-site at Wyckoff, and enhanced chronic disease prevention and management for diabetes and hypertension. Housing stability and affordability was the leading social need identified by Wyckoff's patients and community partners and will be the social determinants of health (SDOH) priority for our hospital. Wyckoff will screen patients routinely for SDOH/health-related social needs (HRSN) including housing needs and create an internal housing referral and navigation network that will collaborate with the housing navigators and agencies available in our regional Social Care Newtork (SCN) WholeYou NYC.

**Data Review:**

The primary data sources for the Community Health Needs Assessment (CHNA) included community survey data, internal and external interviews, observational neighborhood research, and a literature review on neighborhood and county level health and social data. Limited trend data was included due to sources not having updated data available. The 2025 community surveys and interviews confirmed that mental health services remain a top need for service expansion and diabetes increased from the second-ranked health priority from the 2022-2024 CSP to the top priority for the 2025-2027 CSP. Data also revealed that the proportion of individuals able to save money monthly decreased from 43% to 28%, according to the 2025 survey data. Affordable housing remained the leading social need and immigrant support rose to the second highest social support wanted, after ranking third in 2022.

**Partners and Roles:**

Wyckoff Medical Center worked with trusted partners to ensure a comprehensive and inclusive Community Health Needs Assessment (CHNA). ACU Innovation & Consulting, led by Anton Castellanos Usigli, DrPH, MPH, provided strategic guidance, conducted interviews, and analyzed survey data, building on its prior support for Wyckoff's 2022–2024 CHNA to maintain continuity and expertise. To broaden outreach beyond clinical settings, Wyckoff partnered with Make the Road New York, administering surveys at their Brooklyn location to engage individuals who may not regularly access hospital-based care. Additionally, Wyckoff conducted interviews with ten external organizations representing diverse sectors to capture community perspectives on health priorities, policy context, and patient experience. These insights,

combined with survey findings, informed the identification of the health priorities for the Community Service Plan.

**Interventions and Strategies:**

After determining which were the greatest health priorities for the Wyckoff community, interventions and strategies were tailored to these needs aligned with available resources. To address mental health service requests, Wyckoff hired a new Psychiatric Nurse Practitioner in December 2025 who will provide mental health services to patients in ambulatory settings. To reduce opioid overdoses in the community, the Wyckoff Emergency Department (ED) began implementation of the NYC DOHMH-funded Relay and Opioid Overdose Prevention Program which helps connect individuals who experienced non-fatal overdoses with support and education on site in our ED, and all individuals who are interested in receiving a Narcan kit and education on how to prevent an overdose. To address chronic disease management and prevention priorities, Wyckoff is investing in new clinics and programs to help close gaps for those who are struggling with managing their chronic health conditions, such as the "High A1C Clinic", "Gap Closure Clinic", and enhanced gestational diabetes care coordination efforts. These clinics and programs aim to prevent obstetric and fetal complications related to diabetes and to decrease the number of patients with uncontrolled diabetes and high blood pressure. Finally, to address the housing stability and affordability SDOH priority, Wyckoff will continue to conduct routine Health-related social needs (HRSN) screenings and navigation referrals through our regional SCN.

**Progress and Evaluation:**

The following process and impact measures that will be tracked and reported on a quarterly basis to evaluate the effectiveness of the chosen interventions. The quarterly reports will be shared and discussed with the hospital Executive team and with community partners to assess the progress and make project alterations as necessary.

- **Anxiety and Stress, Depression:** The number of patients who receive evaluations for anxiety and distress, the number of patients who receive treatment for anxiety and distress, and the percentage increase in the number of patients receiving services year to year.
- **Primary Prevention, Substance use, and Overdose:** The number of patients referred by the Wyckoff ED to the Relay Program, the number of referred patients who accept the Relay services, and the number of naloxone kits that are distributed. Neighborhood level rates on opioid overdoses can also be tracked, although direct correlations cannot be drawn due to the large variety of factors that contribute to these outcomes.
- **Preventive Services for Chronic Disease Prevention and Control:** The percentage of patients who screen positive for Gestational Diabetes Mellitus (GDM) during prenatal care and who are linked to follow up diabetes care postpartum, the number of enrolled patients who transition from uncontrolled to improved or controlled A1C levels (<9%),

the percentage of overall diabetes patients who have controlled A1c levels (<9%), the number of enrolled patients that complete 2 or more diabetes care visits in 1 year, the number of enrolled patients that are receiving their recommended referrals for follow up care, the number of patients (or % increase) who had a visit with the Certified Diabetes Educator from year to year, the number of patients who are using continuous glucose monitors (CGM) with support from the Clinic, the percentage improvement of A1C levels for patients enrolled in the clinic, and the number of patient visits with the Clinic pharmacist.

- **Housing Stability and Affordability:** By the end of 2026, Wyckoff will create a housing navigation & referral network that will support all Wyckoff care settings (ED, inpatient, and ambulator care) and will link patients to a NYC housing agency or service within a timely fashion. The goal of this internal housing support team at Wyckoff is to refer, track and link at least 50% of patients in need to a housing navigator or resource within 7 days screening positive on a housing need.

## ABOUT WYCKOFF HEIGHTS MEDICAL CENTER:

Wyckoff Heights Medical Center is a 501(c)(3) voluntary, not-for-profit Article 28 teaching hospital with 324 licensed beds located in the ethnically diverse neighborhood of Bushwick, Brooklyn. Wyckoff has provided medical care to its service area of northern Brooklyn and western Queens since 1889 and has a dedicated staff of over 2,300 physicians, nurses and support personnel. Wyckoff is a safety net hospital, providing care in a medically underserved area to historically marginalized communities of color who face severe health, social, and economic disparities. In 2024, Wyckoff served over 85,000 unique patients, including nearly 1000 deliveries, over 84,000 ED visits, 12,500 inpatient discharges and over 310,000 outpatient services.

**Table 1: Payor Mix for 2024 Inpatient Discharges: 12,567 Total**

| Payor Type: | % of Inpatient Discharges: |
|---|---|
| Medicaid | 45.8 |
| Medicare | 36.7 |
| Uninsured/Self-Pay | 2.2 |
| Commercial | 10.7 |
| Other | 4.6 |

*Data from Wyckoff's 2024 Financial Statistics reports.

**Table 2: Payor Mix for Outpatient Services: 310,268 Total**

| Payor Type: | % of Outpatient Visits: |
|---|---|
| Medicaid | 47.5 |
| Medicare | 22.8 |
| Uninsured/Self-Pay | 4.4 |
| Commercial | 12.8 |
| Other | 12.5 |

* Data from Wyckoff's 2024 Financial Statistics reports.

**Mission:**

Wyckoff's mission is to provide a single standard of the highest quality of care to the community through prevention, education and treatment in a safe environment. To meet the complex health and social needs of its service area, Wyckoff has developed clinical programs that integrate supportive services to deliver coordinated, whole-person care. For more than two decades, the hospital has implemented health promotion initiatives that include patient education, outreach, counseling, case management, navigation, and linkage to care. These efforts span maternal, infant, and child health; mental health and substance use; HIV and sexual health prevention and treatment; and interventions for sexual assault and domestic violence. Wyckoff also offers a universal subsidy for one annual well visit per patient to promote access and provides resources to support continuity of care after discharge, such as complimentary transportation to and from the hospital and a free 30-day supply of prescribed medications.

**Clinical Services and Health Promotion:**

Wyckoff operates as a multi-site hospital network with 324 certified beds, delivering a comprehensive range of acute care services for adults and children. These services include:

- 24-hour Emergency Department
- 24-hour Laboratory Services
- Ambulance
- Ambulatory Surgery – Multi Specialty
- Adult Outpatient Primary Care
- Adult Outpatient Specialty Care
- Behavioral Health
- Diabetes Care Services
- Cardiac Diagnostic & Therapeutic Services
- Endoscopy Testing & Treatment Services
- Infectious Diseases
- Neonatal Care
- Neurosurgery
- Obstetric & Gynecological Care
- Oncology (Medical and Surgical)
- Pain Management
- Pediatric Emergency Services
- Pediatric Outpatient Primary Care
- Pediatric Outpatient Specialty Care
- Physical Therapy
- Prenatal Care
- Radiation Oncology
- Radiology
- Rehabilitation Medicine
- Speech Pathology

**Teaching Hospital:**

Wyckoff serves not only as a community hospital but also as a teaching institution, providing training opportunities for more than 200 residents, interns, fellows, and nursing students across multiple specialties, including:

- Internal Medicine
- Pediatrics
- Obstetrics & Gynecology
- Emergency Medicine
- Dental Medicine and Anesthesia
- Pediatric Dentistry
- General Surgery
- Podiatry
- Pediatric Nurse Practitioner Fellowship Program

**Wyckoff Credentials and Achievements:**

Wyckoff's commitment to high-quality care is evident through its achievements in chronic disease management and pediatric services, including:

- Wyckoff Height Medical Center has received the American College of Cardiology's NCDR Chest Pain−MI Registry Platinum Performance Achievement Award for 2025.
- Wyckoff was awarded by The American Heart Association and American Stroke Association with the Get With The Guidelines – Stroke GOLD PLUS with Target: Stroke Honor Roll and Target: Type 2 Diabetes Honor Roll
- Wyckoff is a New York State Designated Primary 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 New York State certified Patient-Centered Medical Home

# COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA):

## Community Description:

Wyckoff Heights Medical Center serves a broad and vibrant region that includes Bushwick, Ridgewood, Bedford-Stuyvesant, East New York and Williamsburg – communities defined by rich cultural diversity and varied socioeconomic backgrounds. Hispanic residents represent a significant portion of Bushwick and Ridgewood residents, while Bedford-Stuyvesant and East New York have predominantly Black populations, and Williamsburg reflects a mix of long-standing immigrant communities and newer, higher-income residents. The population skews young overall, with nearly 40% of residents in North-Central Brooklyn aged 25–44, though Bedford-Stuyvesant has more older adults. Health outcomes vary widely: Williamsburg and Ridgewood report lower chronic disease rates and higher self-rated health, while East New York faces the greatest burden of poverty, chronic illness, and environmental risks. Across neighborhoods, gentrification pressures, housing affordability challenges, and disparities in access to care underscore the need for targeted interventions addressing both health and social determinants.

## Service Area:

Wyckoff Heights Medical Center is located on the border of Bushwick, Brooklyn, and Ridgewood, Queens, with one main hospital and five smaller separate clinic locations. Wyckoff's primary service area spans both Kings and Queens counties and includes the neighborhoods of Bushwick, Bedford-Stuyvesant (Bedford), East New York, Williamsburg, and Ridgewood, and all listed zip codes, as shown in Figure #1 below. According to 2024 patient data, approximately 73% of all Wyckoff patients reside within this primary service area, with higher rates for ED and Inpatient patients, closer to 78 and 79%, respectively. These figures reflect Wyckoff's deep integration within its surrounding neighborhoods and its commitment to addressing local health priorities.

**Figure 1. Wyckoff 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 |

*Figure from Wyckoff's 2022-2024 Community Service Plan

**Table 3: Percentage of Wyckoff patients who live in the Primary Service Zip Codes:**

| Visit Category: | ED | | Inpatient | | Outpatient | | Hospital | |
|---|---|---|---|---|---|---|---|---|
| Primary Service Area | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients |
| Yes | 38852 | 78.08% | 7953 | 78.95% | 34369 | 71.17% | 62997 | 73.49% |
| No | 10770 | 21.64% | 2117 | 21.02% | 13797 | 28.57% | 22469 | 26.21% |
| (blank) | 136 | 0.27% | 3 | 0.03% | 123 | 0.25% | 261 | 0.30% |
| **Grand Total** | **49758** | **100.00%** | **10073** | **100.00%** | **48289** | **100.00%** | **85727** | **100.00%** |

*Based off 2024 Wyckoff EHR Patient Data

**Demographics:**

Wyckoff Heights Medical Center serves a diverse community across Brooklyn and Queens, providing care to individuals of a wide range of ages, races, and ethnicities. The hospital's patient population reflects the cultural richness of New York City, including large Hispanic and Black communities, immigrant families, and multilingual households. This diversity underscores persistent health disparities driven by social and economic challenges such as poverty, housing instability, and limited access to preventive care. Wyckoff's role as a regional safety net provider positions it at the center of efforts to address these disparities and improve health outcomes for some of the city's most vulnerable populations.

**Summary - Neighborhood and County-level Demographics:**

***Age and Life Expectancy***

The age distribution and life expectancy Greenpoint & Williamsburg has the largest share of young adults (39% aged 25–44), while East New York & Starrett City has the highest proportion of children (25% aged 0–17) and older adults (14% aged 65+). Ridgewood's age profile is similar to Bushwick, with a strong concentration of working-age adults and families. Life expectancy ranges from 79.2 years in Bedford-Stuyvesant and East New York to 83.1 years in Greenpoint & Williamsburg, reflecting underlying social and economic differences.

***Race, Ethnicity, and Language***

Bushwick is predominantly Hispanic (65%), Bedford-Stuyvesant is 63% Black, East New York & Starrett City is 50% Black and 37% Hispanic, and Greenpoint & Williamsburg is 61% White. Ridgewood adds further diversity, with a mix of Hispanic and Eastern European populations. Foreign-born residents represent 31% in Bushwick and 35% in East New York, though all

neighborhoods fall below the NYC average of 37%. Limited English proficiency is highest in Bushwick (24%) and Ridgewood, underscoring the need for targeted language services.

***Socioeconomic and Environmental Factors***

Community survey data reveal persistent economic strain: 72.2% of respondents could not save money monthly, 36.4% struggled to pay rent or utilities, and 28% reported food insecurity in the past year. Housing affordability and employment opportunities emerged as top social priorities, alongside immigrant support services. Educational attainment is mixed—while 29.3% of respondents completed college or higher, 24.7% hold only a high school diploma or GED. Most households are small (1–3 people), yet 36.7% report annual income below $20,000, highlighting vulnerability to financial shocks.

***Gender, Sexual Orientation, and Identity***

Survey participants were predominantly female (72.7%), and most identified as straight/heterosexual (92.7%), with 7.3% identifying as gay, lesbian, or bisexual. Gender identity data show small but important representation of non-binary and other identities, reinforcing the need for inclusive care practices.

**Summary - Wyckoff Patient Demographics:**

Hospital data mirror these community trends: 54% of patients identify as women, 45% as men, and approximately 1% as transgender or non-binary. Hispanic or Latino patients account for 63.7% of visits, while 17.4% of patients identify as Black/African American and 67.3% identify as “Other Race”, reflecting race documentation patterns where Latino ethnic identity is also captured under “Other race”. Approximately 40% of Wyckoff patients prefer speaking a language other than English, with 36% preferring Spanish and others speaking languages such as Arabic, French, and Polish, reinforcing the need for language interpretation services which Wyckoff provides 24/7 via video interpreter services. Most patients identify as straight/heterosexual (85.5%), though refusal rates (8.4%) and small counts for LGBTQ+ identities indicate opportunities to improve SOGI data completeness.

Age distribution varies by service line: Emergency Department visits are concentrated among younger adults (18–44 years = 47.8%), while inpatient admissions skew older (65+ = 34.8%). These patterns suggest distinct care needs—geriatric and chronic disease management for inpatient populations, and preventive and behavioral health for younger adults in ambulatory and ED settings.

**Table 4: Neighborhood Indicators**

| Indicator | Bushwick: | Bedford Stuyvesant | East NY and Starrett City | Greenpoint & Williamsburg: | Ridgewood and Maspeth | NYC: |
|---|---|---|---|---|---|---|
| **Total Population:**[1] | 109,284 | 148,149 | 174,829 | 200,333 | 161,860 | -- |
| **Overall, Health: % that report their own health is good, very good, or excellent**[2] | 77% | 82% | 72% | 89% | 81% | -- |
| **Life expectancy: (Years)**[3] | 81.8 | 79.2 | 79.2 | 83.1 | 81.9 | -- |
| **% of residents were born outside of the US**[4] | 31% | 19% | 35% | 23% | 39% | 37% |
| **% of residents that have limited English proficiency**[4] | 24% | 11% | 15% | 21% | 24% | 22% |

* Percentages may not sum to 100% due to rounding. Data not listed was not available.

**Table 5: Neighborhood Population by Age**

| Population by Age:[5] | Bushwick: | Bedford Stuyvesant | East NY and Starrett City | Greenpoint and Williamsburg | Ridgewood and Maspeth | NYC |
|---|---|---|---|---|---|---|
| **0-17:** | 23% | 23% | 25% | 24% | 22% | 21% |
| **18-24:** | 11% | 9% | 9% | 9% | 7% | 8% |
| **25-44:** | 34% | 33% | 27% | 39% | 29% | 30% |
| **45-64:** | 21% | 22% | 24% | 17% | 26% | 25% |
| **65+:** | 11% | 13% | 14% | 11% | 15% | 16% |

* Percentages may not sum to 100% due to rounding. Sources listed below

[1] NYC DOHMH population estimates, modified from US Census Bureau interpolated intercensal population estimates, 2000-2021; updated September 2022.
[2] NYC DOHMH Community Health Survey, 2019-2020.
[3] NYC DOHMH Bureau of Vital Statistics, 2010-2019 (community district and borough) and 2019 (NYC).
[4] Born outside the U.S. and English proficiency: U.S. Census Bureau, American Community Survey, 2015-2019.
[5] NYC DOHMH population estimates, modified from US Census Bureau interpolated intercensal population estimates, 2000-2021; updated September 2022.

**Table 6: Neighborhood Population by Race**

| Population by Race:[5] | Bushwick: | Bedford Stuyvesant | East NY and Starrett City | Greenpoint and Williamsburg | Ridgewood and Maspeth | NYC |
|---|---|---|---|---|---|---|
| Latino | 65% | 20% | 37% | 26% | 36% | 29% |
| Black | 20% | 63% | 50% | 5% | 1% | 22% |
| White | 9% | 11% | 4% | 61% | 51% | 32% |
| Asian | 6% | 3% | 7% | 6% | 9% | 15% |
| Other | 1% | 3% | 2% | 2% | 1% | 2% |

* Percentages may not sum to 100% due to rounding. Sources listed below

**Wyckoff 2024 Patient Demographic Data:**

* Tables 7- 14 reflect 2024 patient data from Wyckoff's EHR (AllScripts). Patients can overlap categories so the three categories will not add up to the whole hospital numbers.

**Table 7: Wyckoff Patient Population by Age**

| Visit Category: | ED | | Inpatient | | Outpatient | | Hospital | |
|---|---|---|---|---|---|---|---|---|
| Age: | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients |
| 0-17 | 11554 | 22.01% | 1503 | 13.86% | 10653 | 20.85% | 18985 | 20.95% |
| 18-24 | 6108 | 11.64% | 590 | 5.44% | 3519 | 6.89% | 8388 | 9.26% |
| 25-44 | 18800 | 35.82% | 2505 | 23.10% | 12999 | 25.44% | 27753 | 30.63% |
| 45-64 | 10469 | 19.95% | 2468 | 22.76% | 13765 | 26.94% | 21160 | 23.35% |
| 65+ | 5558 | 10.59% | 3777 | 34.83% | 10168 | 19.90% | 14316 | 15.80% |
| **Grand Total** | **52489** | **100.00%** | **10843** | **100.00%** | **51104** | **100.00%** | **90602** | **100.00%** |

**Table 8: Wyckoff Patient Population by Gender Identity**

| Visit Category: | ED | | Inpatient | | Outpatient | | Hospital | |
|---|---|---|---|---|---|---|---|---|
| Gender Identity | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients |
| F to M, Transgender Male | 24 | 0.05% | 6 | 0.06% | 21 | 0.04% | 44 | 0.05% |
| Female | 25531 | 51.27% | 5469 | 54.26% | 28584 | 59.14% | 46507 | 54.20% |
| Gender Queer | 20 | 0.04% | 4 | 0.04% | 9 | 0.02% | 30 | 0.03% |
| M to F, Transgender Female | 64 | 0.13% | 11 | 0.11% | 33 | 0.07% | 89 | 0.10% |
| Male | 23958 | 48.11% | 4578 | 45.42% | 19425 | 40.19% | 38687 | 45.09% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Non-Binary | 21 | 0.04% | 6 | 0.06% | 18 | 0.04% | 37 | 0.04% |
| Patient Refuses to Answer | 78 | 0.16% | 5 | 0.05% | 152 | 0.31% | 217 | 0.25% |
| (blank) | 104 | 0.21% | 1 | 0.01% | 89 | 0.18% | 193 | 0.22% |
| **Grand Total** | **49800** | **100.00%** | **10080** | **100.00%** | **48331** | **100.00%** | **85804** | **100.00%** |

**Table 9: Wyckoff Patient Population by Sex at Birth**

| Visit Category: | ED | | Inpatient | | Outpatient | | Hospital | |
|---|---|---|---|---|---|---|---|---|
| Sex at Birth | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients |
| Female | 25597 | 51.40% | 5482 | 54.38% | 28664 | 59.31% | 46677 | 54.40% |
| Male | 24190 | 48.57% | 4598 | 45.62% | 19659 | 40.68% | 39107 | 45.58% |
| Unknown | 13 | 0.03% | | 0.00% | 8 | 0.02% | 20 | 0.02% |
| **Grand Total** | **49800** | **100.00%** | **10080** | **100.00%** | **48331** | **100.00%** | **85804** | **100.00%** |

**Table 10: Wyckoff Patient Population by Race:**

| Visit Category: | ED | | Inpatient | | Outpatient | | Hospital | |
|---|---|---|---|---|---|---|---|---|
| Race: | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients |
| American Indian or Alaska Native | 336 | 0.64% | 43 | 0.40% | 331 | 0.65% | 573 | 0.63% |
| Asian | 804 | 1.53% | 226 | 2.08% | 756 | 1.48% | 1463 | 1.61% |
| Black Or African American | 10102 | 19.25% | 2398 | 22.12% | 7949 | 15.55% | 16076 | 17.74% |
| Declined To Provide | 118 | 0.22% | 21 | 0.19% | 1009 | 1.97% | 1106 | 1.22% |
| More than one race | 1487 | 2.83% | 258 | 2.38% | 976 | 1.91% | 2006 | 2.21% |
| Other Race | 35055 | 66.79% | 6741 | 62.17% | 35877 | 70.20% | 60937 | 67.26% |
| White | 4473 | 8.52% | 1156 | 10.66% | 4134 | 8.09% | 8255 | 9.11% |
| (blank) | 114 | 0.22% | | 0.00% | 72 | 0.14% | 186 | 0.21% |
| **Grand Total** | **52489** | **100.00%** | **10843** | **100.00%** | **51104** | **100.00 %** | **90602** | **100.00%** |

**Table 11: Wyckoff Patient Population by Ethnicity:**

| Visit Category | ED | | Inpatient | | Outpatient | | Hospital | |
|---|---|---|---|---|---|---|---|---|
| Ethnicity | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients |
| Declined To Provide | 6 | 0.01% | 0 | 0.00% | 3 | 0.01% | 7 | 0.01% |
| Hispanic or Latino | 34792 | 66.28% | 6599 | 60.86% | 33321 | 65.20% | 57682 | 63.67% |
| Not Hispanic or Latino | 16480 | 31.40% | 4070 | 37.54% | 15815 | 30.95% | 29817 | 32.91% |
| Undisclosed | 1066 | 2.03% | 174 | 1.60% | 1860 | 3.64% | 2847 | 3.14% |
| (blank) | 145 | 0.28% | 0 | 0.00% | 105 | 0.21% | 249 | 0.27% |
| **Grand Total** | **52489** | **100.00%** | **10843** | **100.00%** | **51104** | **100.00%** | **90602** | **100.00%** |

**Table 12: Wyckoff Patient Population by Sexual Orientation:**

| Visit Category | ED | | Inpatient | | Outpatient | | Hospital | |
|---|---|---|---|---|---|---|---|---|
| Sexual Orientation | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients |
| Bisexual | 33 | 0.06% | 4 | 0.04% | 25 | 0.05% | 47 | 0.05% |
| Lesbian, gay or homosexual | 279 | 0.53% | 64 | 0.59% | 232 | 0.45% | 448 | 0.49% |
| Non-attraction | 3336 | 6.36% | 588 | 5.42% | 1928 | 3.77% | 4772 | 5.27% |
| Patient refuses to answer | 3300 | 6.29% | 462 | 4.26% | 4847 | 9.48% | 7635 | 8.43% |
| Straight or Heterosexual | 45430 | 86.55% | 9724 | 89.68% | 43971 | 86.04% | 77487 | 85.52% |
| (blank) | 111 | 0.21% | 1 | 0.01% | 101 | 0.20% | 213 | 0.24% |
| **Grand Total** | **52489** | **100.00%** | **10843** | **100.00%** | **51104** | **100.00%** | **90602** | **100.00%** |

**Table 13: Wyckoff Patient Population by Primary Language:**

| Visit Category | ED | | Inpatient | | Outpatient | | Hospital | |
|---|---|---|---|---|---|---|---|---|
| Language: | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients | # of Patients | % of Patients |
| English | 31828 | 60.64% | 6540 | 60.32% | 29824 | 58.36% | 54870 | 60.56% |
| Spanish | 19150 | 36.48% | 3840 | 35.41% | 19571 | 38.30% | 32665 | 36.05% |
| Arabic | 407 | 0.78% | 69 | 0.64% | 204 | 0.40% | 520 | 0.57% |
| Other | 250 | 0.48% | 77 | 0.71% | 241 | 0.47% | 452 | 0.49% |
| French | 199 | 0.38% | 22 | 0.20% | 59 | 0.12% | 233 | 0.26% |
| Polish | 129 | 0.25% | 81 | 0.75% | 84 | 0.16% | 232 | 0.26% |
| Bengali | 106 | 0.20% | 24 | 0.22% | 72 | 0.14% | 156 | 0.17% |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| (blank) | 59 | 0.11% | 0 | 0.00% | 53 | 0.10% | 112 | 0.12% |
| Unknown | 55 | 0.10% | 9 | 0.08% | 665 | 1.30% | 722 | 0.80% |
| Romanian | 54 | 0.10% | 17 | 0.16% | 28 | 0.05% | 73 | 0.08% |
| Albanian | 53 | 0.10% | 20 | 0.18% | 73 | 0.14% | 115 | 0.13% |
| Chinese | 41 | 0.08% | 40 | 0.37% | 45 | 0.09% | 95 | 0.10% |
| Creole | 40 | 0.08% | 12 | 0.11% | 29 | 0.06% | 65 | 0.07% |
| Russian | 33 | 0.06% | 11 | 0.10% | 46 | 0.09% | 80 | 0.09% |
| Cantonese | 30 | 0.06% | 43 | 0.40% | 24 | 0.05% | 77 | 0.08% |
| Italian | 29 | 0.06% | 31 | 0.29% | 62 | 0.12% | 97 | 0.11% |
| Sign Language | 26 | 0.05% | 7 | 0.06% | 24 | 0.05% | 38 | 0.04% |
| Grand Total | 49800 | 100.00% | 10080 | 100.00% | 48331 | 100.00% | 85804 | 100.00% |

## Health Status Description:

Residents in Wyckoff's service area generally perceive their health positively, yet notable disparities remain. Most survey participants rated their physical and mental health as good or very good, though a meaningful proportion reported poor health. Chronic conditions such as diabetes, hypertension, and obesity are prevalent and were identified as leading community concerns, alongside mental health issues including anxiety and stress. Behavioral risk factors—such as smoking, sugary drink consumption, and inconsistent physical activity—contribute to these challenges, while social determinants like housing instability, financial strain, and food insecurity further impact health outcomes. Access barriers persist, with one-third of respondents unable to see a doctor when needed in the past year, often due to cost, scheduling difficulties, or insurance gaps. These patterns underscore the complex relationship between health status and socioeconomic conditions, highlighting the need for strategies that integrate clinical care with social support.

### Data Sources and Collection Methods

***Primary Data:***

- **Community Health Needs Assessment Surveys**
  A total of 176 surveys were conducted between October 23, 2025, and November 13, 2025, with Wyckoff patients and community members. The survey instrument was adapted from the 2022–2024 CSP report to align with priorities outlined in the 2025–2030 Prevention Agenda. Health coaches, Patient Ambassadors, community health workers, and population health staff were trained on the purpose of the survey and best practices for administration. Surveys were conducted in the entryway and waiting areas of Wyckoff ambulatory clinics and at the Make the Road Brooklyn location. Participants received a $25 Amazon gift card as a token of appreciation. Surveys were

available in English and Spanish in paper format, and participants could complete them independently or with staff assistance. Detailed findings are presented in subsequent sections.

- **Key Informant Interviews**
  A total of 22 semi-structured interviews were conducted with Wyckoff staff between October 10 and November 20, 2025, and an additional 10 interviews were conducted with external organizations between October 10 and November 24, 2025. Detailed findings are presented in subsequent sections.

- **Neighborhood Observations**
  Observational research was introduced as a new data collection method for this CHNA. One to two staff members spent 1–2 hours walking through each primary service area neighborhood using a structured observation checklist. Notes were taken on housing conditions, open spaces, shopping areas, schools, faith-based organizations, human services, economic conditions, transportation, protective services, and overall neighborhood life. This qualitative data provided valuable context for understanding community assets and challenges and informed the interpretation of health disparities identified in other data sources. Observations also helped identify potential contributors to health challenges, such as environmental conditions, access to resources, and neighborhood infrastructure.

***Secondary Data:***

A comprehensive literature review was conducted to collect neighborhood-, county-, and state-level data on health indicators. Data collection occurred between August and December 2025 and included the following sources:

- **Public Health & Community Data Databases**
  - New York State Department of Health Community Health Indicator Reports
  - New York City Neighborhood Health Atlas (NYCNHA)
  - NYC Department of Health and Mental Hygiene HIV Surveillance Annual Report
  - The Comprehensive Plan for Brooklyn, October 2023 produced by the Office of Brooklyn Borough President Antonio Reynoso, in partnership with the Regional Plan Association, the New York Academy of Medicine, and Hester Street
  - Additional state and city-level datasets
- **Internal Data Sources**
  - EHR (AllScripts) data reports facilitated by Wyckoff's Clinical Informatics, Finance, and Population Health Departments

    - Safety Net Hospital Transformation Program Application Form
- **Other Sources**
    - Google Maps for virtual neighborhood assessments
    - Qualitative data from community organizations and prior reports

Combining primary and secondary data sources strengthened the validity and depth of this Community Health Needs Assessment. Primary data provided firsthand insights into community perceptions, experiences, and priorities, while secondary data offered a broader view of health trends and disparities at the neighborhood, county, and state levels. The addition of neighborhood observations introduced a new qualitative dimension, enriching the analysis by highlighting environmental and social factors that may contribute to health challenges. Together, these methods ensured a comprehensive understanding of the service area's health status and informed the development of targeted strategies aligned with the 2025–2030 Prevention Agenda.

**Community Engagement:**

Wyckoff Medical Center collaborated with multiple partners to ensure a comprehensive and inclusive Community Health Needs Assessment (CHNA) process.

**Consulting Support**
Wyckoff engaged Anton Castellanos Usigli, DrPH, MPH, Founder and CEO of ACU Innovation & Consulting, to assist with planning and conducting parts of the assessment. ACU Innovation & Consulting is a New York City-based firm specializing in healthcare strategy, innovation, evaluation, quality improvement, multi-sectoral partnerships, and patient insights. The firm supported Wyckoff in conducting staff and community interviews and analyzing survey and interview data. ACU also previously assisted in performing Wyckoff's 2022–2024 CHNA and Community Service Plan (CSP), bringing continuity and expertise to the process.

**Community Partnerships**
Wyckoff partnered with Make the Road New York to expand outreach beyond clinical settings. Make the Road NY facilitated survey administration at its Brooklyn location, where Wyckoff staff conducted surveys with individuals receiving services and training. This collaboration allowed Wyckoff to engage community members who may not regularly access hospital-based care, ensuring broader representation in the assessment.

**Community Input and Integration**
To incorporate community perspectives, Wyckoff conducted 10 interviews with external organizations representing diverse sectors. Interview topics included community health priorities, Wyckoff's presence in the community, policy context, and patient experience. Insights from these interviews were compared with survey findings and other data sources to inform the identification of health priorities for the CSP. A detailed list of organizations interviewed is provided in subsequent sections.

**Sharing Preliminary Findings**

Preliminary findings were shared internally with Wyckoff leadership to validate interpretations and ensure alignment with hospital priorities and initiatives. Feedback from interviews and surveys was integrated into the prioritization process, shaping the final health focus areas for the 2025–2030 Prevention Agenda.

**Relevant Health Indicators:**

- **Summary of findings for hospital-level data:**
    - Out of the 4 chronic health conditions and smoking status, hypertension was found to have the highest prevalence with an average of 19 % among all Wyckoff patients in 2024.
    - Diabetes was found to have the second highest prevalence out of the listed conditions with an average prevalence of 12.08% among all Wyckoff patients in 2024.
    - Both prevalences for Hypertension and Diabetes are lower than the neighborhood and city averages according to the NYC DOHMH's 2019-2020 Community Health Survey.
    - HIV rates averaged at 1.28% in 2024, which is at the higher end of what is to be expected for Wyckoff's primary service area neighborhoods
- **Summary of findings – Neighborhood-level data:**
    - Sociodemographic characteristics of Wyckoff's primary services area include higher representations of racial minorities including Hispanics and Black individuals, and lower rates of people aged 65+.
    - Neighborhood and built environmental factors include higher pedestrian and biking injuries, asthma hospitalizations, and child lead poisoning, compared to NYC overall.
    - Most neighborhoods were found to have higher rates of child poverty (under age 5) and higher rates of serious psychological stress were found specifically in Williamsburg/Bushwick and East New York.
    - Communities within the service area exhibit notable risk factors for non-communicable diseases, including higher-than-average smoking rates, low engagement in physical activity, and significant consumption of sweetened drinks.
    - Sociodemographic characteristics of Wyckoff's primary service area reflect elevated rates of non-fatal assault hospitalizations, jail incarcerations, uninsured adults, and adults lacking access to needed medical care compared to NYC overall.
- **Summary of findings- County-level data:**
    - Unemployment rates and food insecurity in Kings and Queens counties exceed the state average, suggesting economic instability and food access challenges may be more pronounced locally.

- Binge drinking prevalence among adults is slightly higher in Kings County than the state average, while Queens County reports a lower rate, reflecting varied behavioral health risks.
- Commute times are significantly longer in Kings and Queens counties than the state average, which may contribute to stress and reduced time for health-promoting activities.
- Dental care access among Medicaid-enrolled youth is slightly better in Queens County than in Kings County and the state overall, though rates remain low, indicating gaps in preventive care.
- New HIV diagnoses are substantially higher in Kings and Queens counties than the state average, highlighting ongoing public health challenges in sexual health.

**Wyckoff Patient Health Data and Trends 2021-2024:**

The following data was extracted from Wyckoff's EHR (AllScripts). Patients can overlap categories so the three categories will not add up to the whole hospital numbers.

**Figure 2: Wyckoff Patients Prevalence Rates by Year**

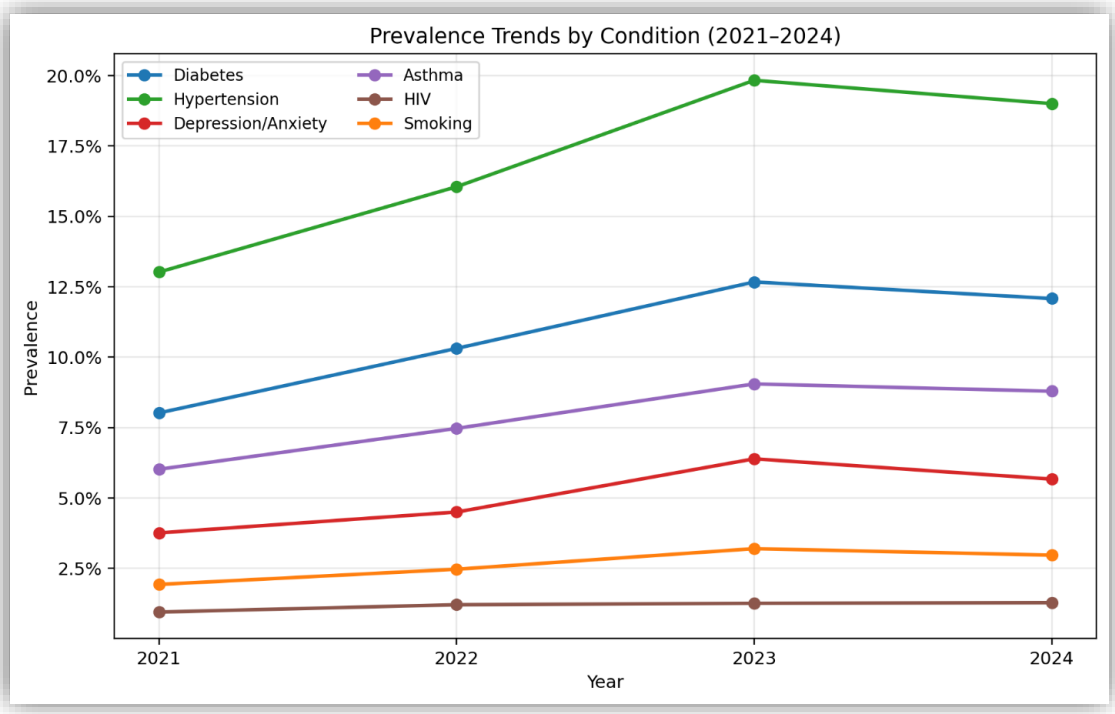


**Figure 3: 2024 Wyckoff Health Data by Race**

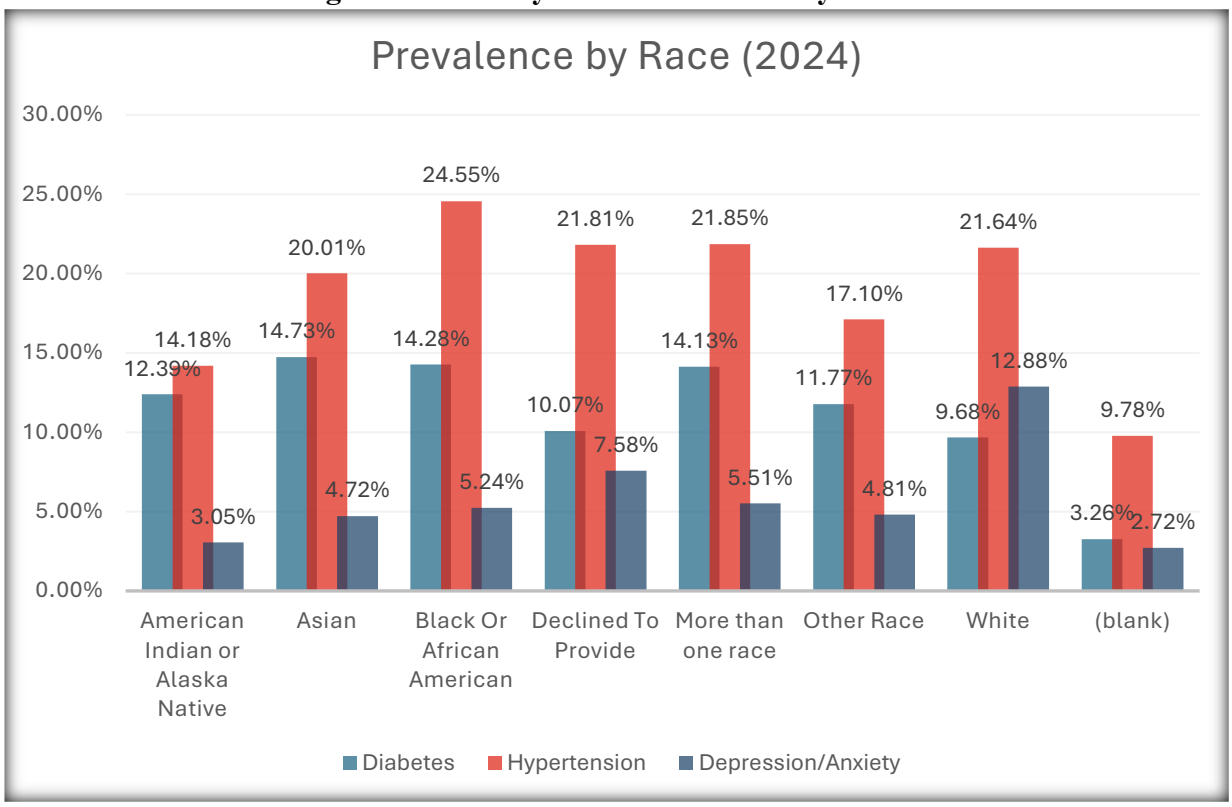
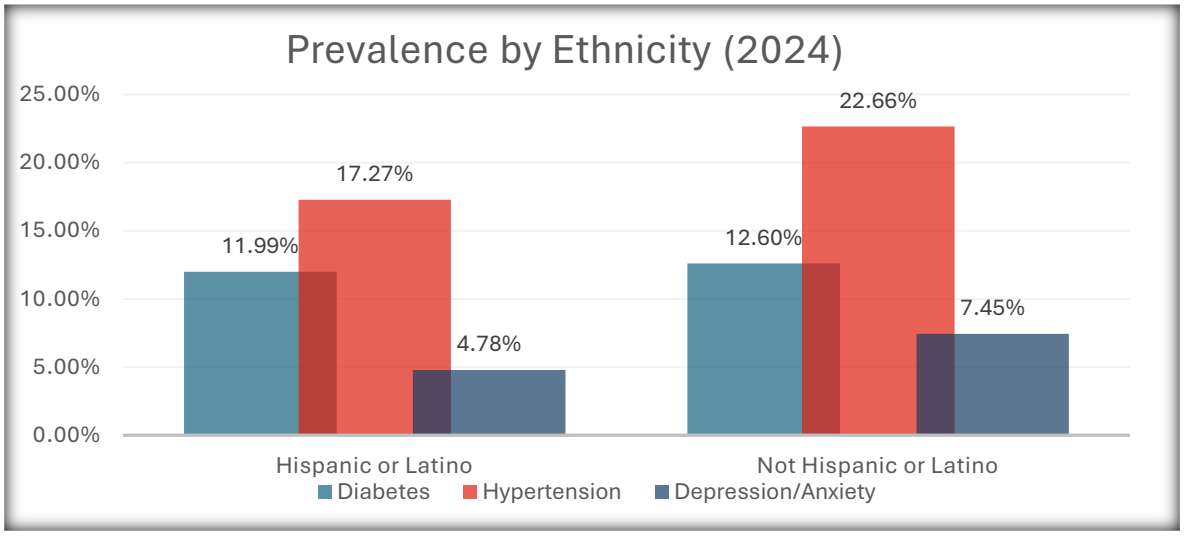



**Figure 4: 2024 Wyckoff Health Data by Ethnicity**



**Neighborhood level data:**

- Yellow Shading: Value is approximately equal to the NYC average.
- Green Shading: Value is more favorable compared to the NYC average.
- Red: Value is less favorable compared to the NYC average.
- Gray: Relationship to the NYC average is unknown.

**Table 16: Neighborhood Social and Economic Indicators**

| Neighborhood | Poverty[6] | Child Poverty (under age 5)[7] | Serious Psychological Stress[8] | Rent Burdened Households[6] | Crowded Housing[7] |
|---|---|---|---|---|---|
| **Williamsburg - Bushwick** | 26.10% | 44.1% | 8.6% | 50.7% | 9.4% |
| **Bedford Stuyvesant – Crown Heights** | 22.6% | 25.2% | 2.1% | 49% | 5.6% |
| **East New York** | 23.4% | 31.2 | 14.10% | 51.6% | 14.1% |
| **Ridgewood - Forest Hills** | 10.3% | 10.3% | 2.6% | 46% | 7% |

**Table 17: Social and Economic Indicators Continued**

| Neighborhood | Adults reporting that their neighbors are willing to help one another[9] | Non-fatal assault hospitalizations[10] | Jail incarcerations[11] | Adults without Health Insurance[12] | Adults without needed medical care[12] |
|---|---|---|---|---|---|
| **Bushwick** | 73% | 72 | 267 | 25% | 21% |
| **Bedford Stuyvesant** | 81% | 117 | 472 | 18% | 15% |
| **East New York and Starrett City** | 73% | 113 | 509 | 11% | 16% |

[6] Data from the American Community Survey (2019-2023)
[7] Environment and Health Data Portal (2017-2021).
[8] Environment and Health Data Portal (2012).
[9] NYC DOHMH, Community Health Survey (2017-2018).
[10] New York Department of Health, Statewide Planning and Research Cooperative System (SPARCS) (2012-2014).
[11] NYC Department of Corrections (2019-2020).
[12] NYC DOHMH, Community Health Survey (2019-2020).

| | | | | | |
|---|---|---|---|---|---|
| **Greenpoint and Williamsburg** | 78% | 34 | 130 | 10% | 10% |
| **Ridgewood and Maspeth** | 84% | 19 | 96 | 15% | 11% |
| **NYC** | **77%** | **59** | **196** | **13%** | **13%** |

**Table 18: Chronic diseases and associated risk:**

| Neighborhood[13] | Any physical activity past 30 days (%) | Current smokers (%) | One or more 12-ounce sugary drinks per day (%) | Obesity (%) | Diabetes (%) | Hypertension (%) |
|---|---|---|---|---|---|---|
| **Bushwick** | 76% | 25% | 29% | 15% | 19% | 27% |
| **Bedford Stuyvesant** | 67% | 15% | 28% | 32% | 11% | 32% |
| **East New York and Sarrett City** | 70% | 12% | 27% | 31% | 23% | 37% |
| **Greenpoint and Williamsburg** | 71% | 9% | 24% | 18% | 11% | 25% |
| **Ridgewood and Maspeth** | 76% | 8% | 27% | 28% | 9% | 24% |
| **NYC** | **73%** | **11%** | **22%** | **25%** | **12%** | **27%** |

*All percentages listed are respectful to the total population

[13] NYC DOHMH, Community Health Survey, 2019-2020

**Neighborhood and Built Environmental Factors:**

| Neighborhood | Pedestrian Injuries[14] | Biking Injuries[15] | Deaths from PM2.5[15] | Asthma Hospitalizations[16] | Child Lead Poisoning[17] |
|---|---|---|---|---|---|
| **Williamsburg - Bushwick** | 133.0 | 211.9 | 32.0 | 16.6 | 14.8 |
| **Bedford Stuyvesant – Crown Heights** | 131.7 | 120.5 | 37.0 | 32.1 | 15.0 |
| **East New York** | 133.2 | 102.5 | 34.0 | 33.3 | 16.4 |
| **Ridgewood - Forest Hills** | 79 | 77.9 | 28.0 | 7.7 | 7.3 |

**County-level Data:**

| Indicator:[18] | NY State: | Kings County: | Queens County: | Data Year: |
|---|---|---|---|---|
| **Percentage of population who did not have access to a reliable source of food during the past year** | **9.6%** | **15.2%** | **12.5%** | **2022** |
| **Percentage of labor force unemployed** | **4.2%** | **5.5%** | **4.6%** | **2023** |
| **Age-adjusted percentage of adults binge drinking during the past month** | **16%** | **16.6%** | **14.4%** | **2021** |
| **Mean travel time in minutes to work** | **33.2** | **42.7** | **43.6** | **2017-2021** |
| **Violent Crime Rate per 100,000** | **430.6** | **661.2** | **519.9** | **2022** |
| **Percentage of Medicaid enrollees (aged 2-20 years) with at least one dental visit in government sponsored insurance programs** | **52.7%** | **52.7%** | **54.9%** | **2022** |
| **Newly Diagnosed HIV case rate per 100,000** | **11.3** | **18.5** | **16.8** | **2020-2022** |

[14] Age-adjusted per 100,000. New York City Department of Health and Mental Hygiene. Environment and Health Data Portal (2014).
[15] Estimates annual rate, age 30+, per 100,000. Environment and Health Data Portal (2023).
[16] Estimated per 10,000, ages 5 to 17. Environment and Health Data Portal (2023).
[17] Rate (5+ mcg/dL) per 1,000 tested. Environment and Health Data Portal (2023).
[18] (CHIRS) Dashboard. Retrieved September 5, 2025

**Health Challenges and Associated Risk Factors:**

1. **Contributing Causes of Health Challenges by Neighborhood:**

Health challenges across Wyckoff's service area are shaped by a variety of interconnected social, economic, environmental, and behavioral factors. Increased poverty and housing instability rates contribute to financial strain, with East New York and Bedford-Stuyvesant reporting some of the highest poverty rates, and Bushwick and Williamsburg facing elevated child poverty. Rent burden affects nearly half of households across all service area neighborhoods, while rising housing costs and gentrification pressures in Williamsburg and Bushwick impact displacement risks for current residents and uneven investment.

Behavioral risk factors compound these challenges. For example, smoking and sugary drink consumption remain elevated in Bushwick and Bed-Stuy, while physical activity levels vary, with rates being stronger in Ridgewood and Bushwick, but lower in Bed-Stuy. Chronic disease prevalence, including hypertension and obesity, is highest in East New York and Bed-Stuy, reflecting the combined impact of socioeconomic stressors and limited access to health services.

Environmental and safety concerns further influence health outcomes. Asthma hospitalizations and child lead poisoning rates were found highest in East New York and Bed-Stuy, pointing to poorer housing quality and environmental hazards. Pedestrian and biking injuries are seen to be elevated in Williamsburg and Bushwick, where dense urban layouts and active street life can increase risk. Observational research noted abandoned lots, exposed wires, and poor lighting in East New York and Bed-Stuy, contributing to safety concerns.

Access to healthcare remains uneven across the service area, with uninsurance rates highest in Bushwick and East New York and unmet medical needs reported in all neighborhoods. Mental health and substance use services are scarce, despite clear indicators of need, including observed substance use among unhoused individuals. In addition, gaps in affordable fresh food access persist throughout the service area, limiting opportunities for healthy eating and contributing to diet-related health risks.

Overall, these factors significantly shape the health outcomes of Wyckoff's service community, driving disparities in chronic disease, access to care, and opportunities for healthy living.

2. **Health Disparities:**

The hospital's service area includes neighborhoods in Brooklyn and Queens that experience significant health disparities and social inequities. These disparities are driven by chronic disease prevalence, environmental conditions, and social determinants such as poverty, housing instability, and limited access to healthy food and preventive care. Observational research, neighborhood-level data, and county-level indicators all point to high-risk populations and high-need communities requiring targeted interventions.

**Clinical Disparities (2024 Data)**

- **Diabetes:** Elevated among Asian, Black/African American, and individuals identifying as more than one race.
    - Note: The Asian population represents less than 2% of Wyckoff's patient population, so these disparities may be influenced by small sample size.
- **Hypertension:** Highest among Black/African American residents (24.6%), followed by more than one race and Asian populations.
- **Depression/Anxiety:** White residents report the highest prevalence (12.9%), more than double the overall rate (5.7%). Black/African American residents follow at 5.2%.
- **Asthma:** Highest among Black/African American, more than one race, and "Other" race groups.
- **HIV Positive:** Black/African American residents have rates more than double the second-highest group, followed by individuals identifying as more than one race.
- **Smoking:** Highest among White residents, followed by Black/African American residents.

**High-Risk Populations according to Wyckoff EHR Data:**

- Black/African American residents face consistently higher rates of chronic disease (hypertension, asthma, HIV).
- Asian residents show elevated diabetes rates (should be interpreted cautiously due to small sample size).
- White residents have disproportionately high depression/anxiety rates.

**Neighborhood-Level Disparities**

Observational research across Bedford-Stuyvesant, Bushwick, East New York, Williamsburg, and Ridgewood revealed:

- **Food Access:** Limited grocery stores and fresh food options; dollar stores and fast-food chains dominate commercial areas.
- **Physical Activity & Safety:** Parks exist but often lack amenities for community gatherings, and bike infrastructure is minimal, limiting active transportation.

Additionally, very few gyms or dedicated fitness facilities were observed across the neighborhoods, which may further restrict opportunities for structured physical activity.

- **Housing & Environment:** Older residential properties, abandoned lots, and construction zones were noted; these conditions may contribute to asthma and safety concerns.
- **Access Gaps:** Observational research revealed that several neighborhoods within the service area, particularly Bedford-Stuyvesant, Bushwick, and East New York, have limited access to health services and childcare options.

**High-Need Neighborhoods:**

- Bedford-Stuyvesant and Bushwick show concentrated poverty, limited healthy food access, and environmental health risks.
- East New York faces high crime rates and housing instability.
- Ridgewood and Williamsburg exhibit mixed development pressures and affordability challenges.

**County-Level Context**

- Kings County (Brooklyn) has higher rates of asthma hospitalizations and child lead poisoning compared to NYC averages.
- Poverty and rent burden remain significant, amplifying health risks for vulnerable populations.
- Kings County and Queens County were found to have worse conditions, compared to state averages, in almost every category, including:
    - Higher unemployment levels
    - Greater percentage of residents without access to a reliable source of food in the past year
    - Elevated violent crime rates
    - Longer commute times

**Trend Data:**

**Increasing Prevalence:** From 2021 to 2024, prevalence rates for all tracked conditions (diabetes, hypertension, depression/anxiety, asthma, HIV, and smoking) showed an upward trend, with the highest rates observed in 2023.

**Potential Influencing Factors:**

- COVID-19 Aftermath: Long-term effects of the pandemic, including social isolation and increased reliance on social media, may have contributed to rising mental health concerns such as depression and anxiety.
- System Transition: Wyckoff transitioned to a new EHR system around 2020. The observed increase in prevalence rates may partially reflect improved documentation practices or initial inconsistencies during the transition period.

## Community Assets and Resources:

### Bushwick:

Bushwick's cultural vibrancy and infrastructure offer significant strengths. Maria Hernandez Park serves as a major recreational hub with a children's playground, fitness equipment, and courts, though seating for gatherings is limited. Transportation access throughout Bushwick is strong, with multiple subway lines, bus routes, bike lanes, and Citi Bike stations supporting mobility. Faith-based institutions provide outreach, such as holiday meal programs, and human services include WIC offices and Wyckoff clinics. Local Hispanic-owned restaurants, street vendors, and thrift shops reflect community resilience and identity, while murals, Puerto Rican flags, and public art reinforce cultural pride.

### Bedford-Stuyvesant:

Bed-Stuy's assets reflect deep African American cultural roots, strong community engagement, and housing diversity. Parks such as Herbert Von King and Saratoga provide green space, playgrounds, and cultural programming. The neighborhood includes iconic brownstones alongside affordable housing complexes like the Roosevelt Houses, offering a mix of market-rate and income-restricted units. Faith-based institutions including Baptist, Episcopal, and Presbyterian churches offer spiritual and social support. Childcare centers and tutoring programs also are present and serve families' needs. Observations noted active community youth sports leagues and cultural events. Commercial sections of the neighborhood feature small businesses, soul food and Hispanic restaurants, reinforcing neighborhood identity. Murals and compost bins signal strong community involvement community and multiple bus routes promote accessible transportation throughout the neighborhood.

### East New York:

East New York's strengths center on affordability and faith-based presence. Parks like MLK Jr. and Linden Park offer green space and walking loops, providing opportunities for community gathering and exercise. Numerous churches across denominations provide spiritual support, and programs like CAMBA Beacon at Achievement First Linden Elementary highlight limited but present community investment in youth. Shelters and transitional housing facilities address housing instability in the area and schools with murals and clean playgrounds reflect community investment. Public transportation is also limited but present via the 2/3 subway line and local bus routes.

**Williamsburg:**

Williamsburg's assets include cultural vibrancy, accessibility, and recreational infrastructure. Waterfront parks and green spaces encourage physical activity in the community, complemented by bike lanes and Citi Bike stations. Observations confirmed active school-community partnerships, with programs like Hoops Academy and St. Nick's Alliance fostering youth engagement. Faith-based institutions such as Devoe Street Baptist and Annunciation Roman Catholic Church offer multilingual services and accessibility features. Human services include MedRite Health Clinic and Curated Mental Health, while Leonard Library serves as a cooling center and community hub. Williamsburg offers multiple transportation options and proximity to Manhattan, evolving into a "trendy" hotspot for young professionals and development.

**Ridgewood:**

Ridgewood's primary assets lie in its quiet residential character and community-oriented resources. Parks such as Rosemary's Playground and Grover Cleveland High School field provide well-maintained recreational spaces with benches, playgrounds, and accessible bathrooms. Schools display strong engagement through flyers for after-school programs and clean outdoor areas. Faith-based institutions including Roman Catholic and Pentecostal churches offer multilingual services and Gotham Health banners signal healthcare presence. Small businesses and ethnic food stores reflect cultural diversity, and transportation options including bike lanes and Citi Bike stations support local mobility.

# COMMUNITY SURVEYING, INTERVIEWS, AND KEY INSIGHTS

## Survey with Community Residents

### *Methodology*

A structured, bilingual (English–Spanish) survey was administered to Wyckoff patients and community members to assess community health needs, experiences with the hospital, and key social determinants of health. The instrument included sections on perceived health priorities and social needs within respondents' neighborhoods, recent use of Wyckoff services, satisfaction with care, access to appointments, wait times, and trust in the hospital. Participants were also asked to identify services they would like to see expanded. Additional items captured self-reported physical and mental health, health insurance coverage, barriers to accessing care, use of telehealth, food and housing insecurity, financial insecurity, perceptions of neighborhood safety, and stress. Finally, the survey collected detailed demographic information, including age, ethnicity, race, gender identity, sexual orientation, language, education, employment, household size, and income.
The survey was conducted in the following locations:

- Wyckoff Main Campus (in the main lobby and in the waiting areas across several floors)
- Wyckoff's Women's Health Center
- Wyckoff's 1610 Dekalb Clinic
- Wyckoff Doctors
- Wyckoff Pediatrics
- Wyckoff PICHC and WIC offices
- Make the Road NY – Brooklyn location (301 Grove St, Brooklyn, NY 11237)

### *Demographics*

Table 1 presents the demographic profile of the 176 survey participants. Nearly half of respondents lived in Bushwick (43.4%), followed by Ridgewood (19.4%) and East New York (12.6%). Participants were predominantly female (72.7%) and most commonly between 25–34 years (27.3%) and 35–44 years (24.4%). The sample was evenly split between Spanish (50.3%) and English (49.1%) speakers at home. Educational attainment varied widely, with 29.3% completing college or higher and 24.7% reporting a high school diploma or GED.

Table 1. Demographic characteristics of community health survey participants

| Demographic** | n | % |
|---|---|---|
| **Neighborhood** | | |
| Bushwick | 76 | 43.4 |
| Ridgewood | 34 | 19.4 |
| Bed-Stuy | 10 | 5.7 |
| Williamsburg | 8 | 4.6 |
| East New York | 22 | 12.6 |
| Flatbush | 4 | 2.3 |
| Other[a] | 21 | 12.0 |
| **Age** | | |
| 14-24 | 19 | 11.1 |
| 25-34 | 47 | 27.3 |
| 35-44 | 42 | 24.4 |
| 45-54 | 34 | 19.8 |
| 55-64 | 14 | 8.1 |
| >64 | 16 | 9.3 |
| **Gender** | | |
| Male | 44 | 25.6 |
| Female | 125 | 72.7 |
| Other[b] | 3 | 1.7 |
| **Sexual orientation** | | |
| Straight | 153 | 92.7 |
| Gay/lesbian/bisexual | 12 | 7.3 |
| **Race** | | |
| Latino/Latina | 127 | 73.0 |
| Black or African American | 27 | 15.5 |
| White | 9 | 5.2 |
| American Indian | 0 | 0.0 |
| Asian | 7 | 4.0 |
| Other | 4 | 2.3 |
| **Primary language at home** | | |
| Spanish | 87 | 50.3 |
| English | 85 | 49.1 |
| Arabic | 1 | 0.6 |
| **Education** | | |
| Grades 8 (Elementary) or less | 22 | 12.6 |
| Grades 9 through 11 (Some High School) | 20 | 11.5 |
| Grade 12 or GED (High School Graduate) | 43 | 24.7 |
| Some college or technical school | 38 | 21.8 |
| College graduate or more | 51 | 29.3 |

**Notes:** **Sample size can change due to missing information; [a]Includes neighborhoods with 2 or less observations (Astoria=1, Bronx=2, Brooklyn=2, Crown Heights=1, East Elhmurst=1, Flushing Queens=1, Glendale=1, Greenpoint=1, Kings county=1, Manhattan=1, Middle Village=2, New Jersey=2, Ozone Park=1, Queens=1, Queens Far – Rockaway=1, Sunset Park=1, Woodside – Queens=1); [b]Other (another gender=1, non-binary=2)

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

Table 2 summarizes socioeconomic and living conditions among respondents. While a majority considered their neighborhood safe (57.4%), over one-third reported feeling unsafe (37.5%). Financial insecurity was widespread—72.2% were unable to save money monthly, 36.4% struggled to pay rent or utilities, and 28.0% reported problems buying food in the past year. Most respondents lived in households of 1–3 people (59.3%), and 36.7% reported annual income below $20,000, with only 3.6% earning $100,000 or more. Employment data showed 60.0% were employed, while 16.0% were unable to work.

Table 2. Social determinants of health

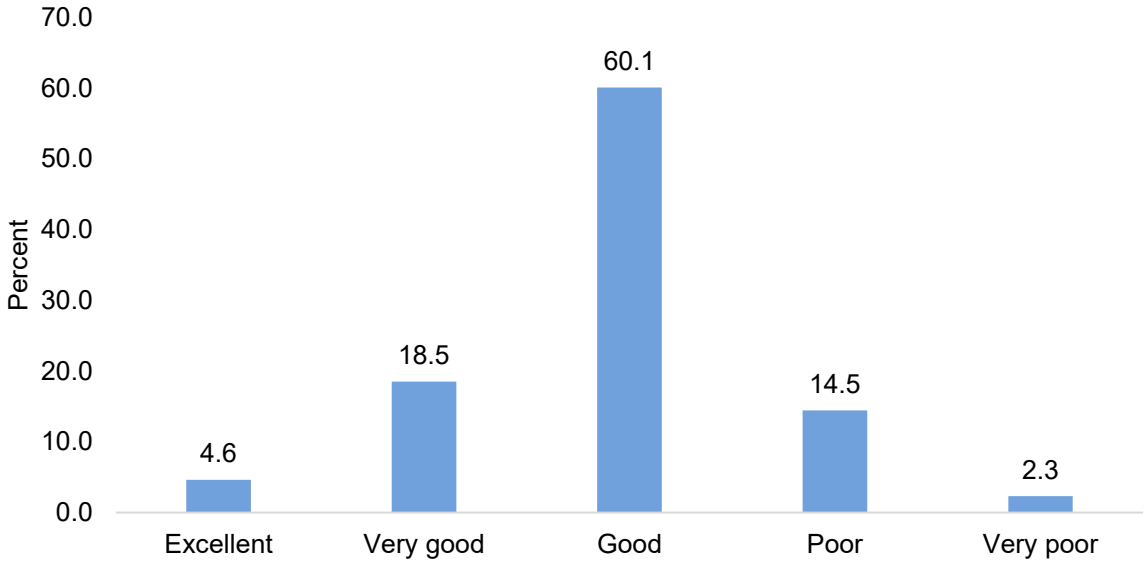
| Variable** | n | % |
|---|---|---|
| **Perception of neighborhood safety** | | |
| Very safe | 7 | 4.0 |
| Safe | 101 | 57.4 |
| Unsafe | 66 | 37.5 |
| Extremely unsafe | 2 | 1.1 |
| **Able to save money at the end of the month** | | |
| Yes | 49 | 27.8 |
| No | 127 | 72.2 |
| **Employment** | | |
| Employed | 105 | 60.0 |
| Out of work | 20 | 11.4 |
| Homemaker | 13 | 7.4 |
| Retired | 9 | 5.1 |
| Unable to work | 28 | 16.0 |
| **Number of people living at the household** | | |
| 1-3 | 102 | 59.3 |
| 4-6 | 65 | 37.8 |
| >6 | 5 | 2.9 |
| **Household annual income** | | |
| Less than $20,000 | 62 | 36.7 |
| $20,000 - $29,999 | 27 | 16.0 |
| $30,000 - $49,999 | 28 | 16.6 |
| $50,000 - $59,000 | 21 | 12.4 |
| $60,000 - $74,999 | 14 | 8.3 |
| $75,000 - $99,000 | 11 | 6.5 |
| $100,000 or more | 6 | 3.6 |
| **Problems to pay rent or bills in the last 12 months** | | |
| Yes | 64 | 36.4 |
| No | 112 | 63.6 |
| **Problems to buy food in the last 12 months** | | |
| Yes | 49 | 28.0 |
| No | 126 | 72.0 |

**Notes:** **Sample size can change due to missing information
**Source:** Own elaboration based on results from the Community Service Plan Survey

### *Perceptions and priorities around neighborhood health needs*

Figure 1 illustrates how respondents rated the overall health of their neighborhood. More than half described community health as good (60.1%), while 18.5% rated it as very good. In contrast, 14.5% perceived health as poor, and 2.3% as very poor, indicating that although general perceptions are favorable, a meaningful proportion recognizes significant health challenges.

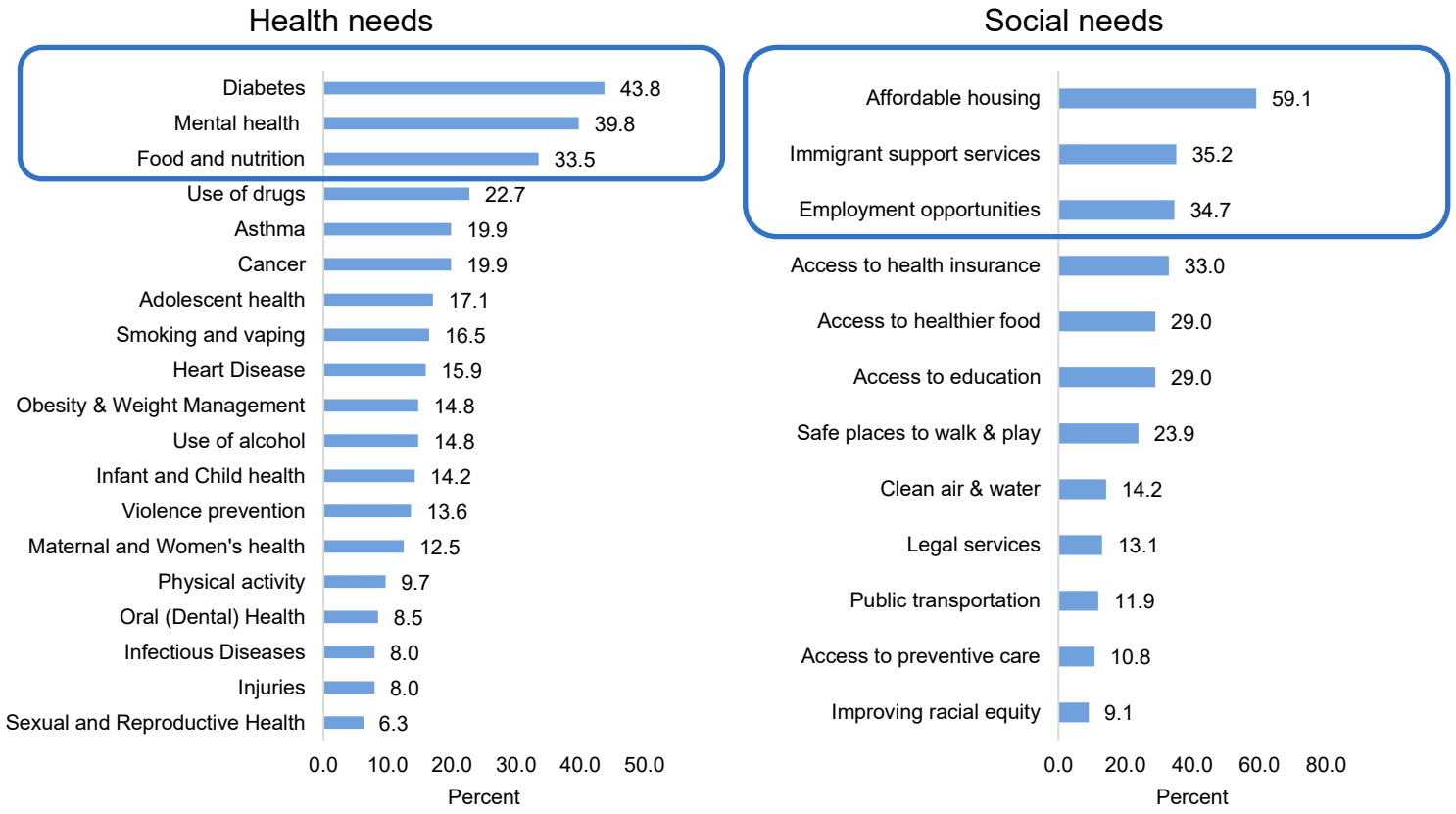
Figure 1. Perception of the health of the inhabitants of participant's neighborhood




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

Figure 2 displays the top-ranked health and social needs selected by participants. The most frequently identified health priorities included diabetes (43.8%), mental health (39.8%), and food and nutrition (33.5%). Among social needs, the top three priorities were affordable housing (59.1%), immigrant support services (35.2%), and employment opportunities (34.7%).

Figure 2. 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*

Table 3 summarizes patient experience with Wyckoff services. Most participants reported Wyckoff as their usual hospital (74.7%) and 71.0% had received care there in the past year. Satisfaction was generally positive, with 35.2% rating their last visit as very good and 27.2% as excellent, while only 6.4% reported poor or very poor experiences. Appointment access was mostly rated easy or very easy (81.6%), yet wait times remained long—35.8% waited over one hour and 52.0% waited 30–60 minutes during their last visit. Trust levels were high, with 47.6% always trusting Wyckoff and only 3.6% reporting no trust.

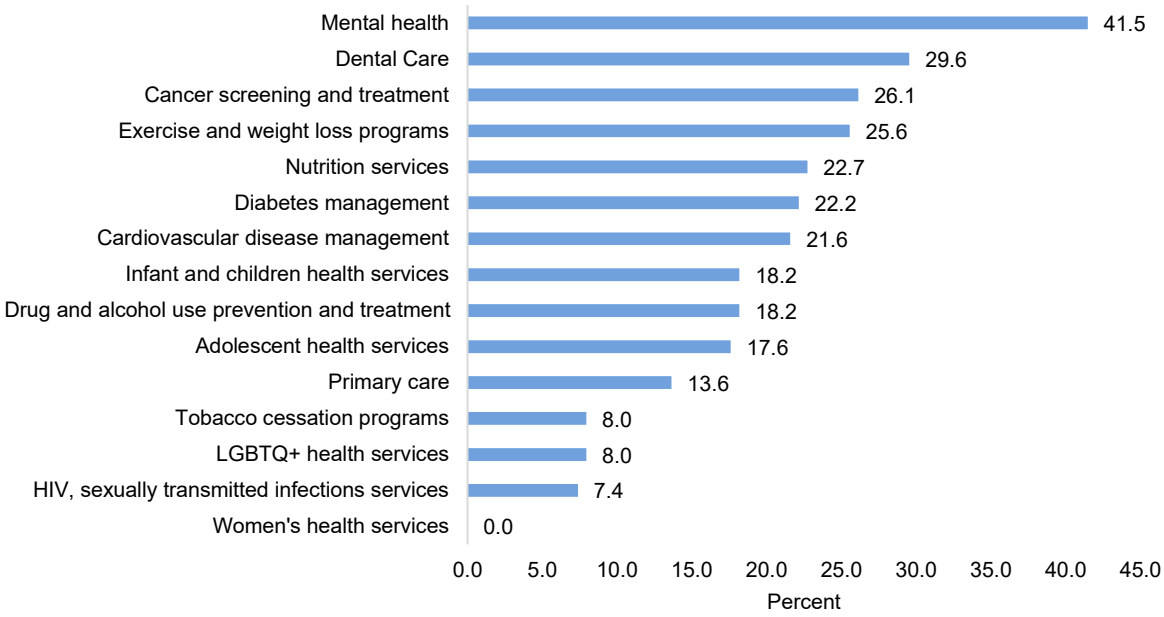
Table 3. Wyckoff's user experience

| Variable** | n | % |
|---|---|---|
| **Is Wyckoff the hospital participant usually goes to** | | |
| Yes | 130 | 74.7 |
| No | 44 | 25.3 |
| **Hospital participant usually goes[a]** | | |
| Woodhull | 8 | 20.5 |
| Mount Sinai | 8 | 20.5 |
| New York Presbyterian | 7 | 18.0 |
| NYU Langone | 3 | 7.7 |
| Kings County | 2 | 5.1 |
| Other[b] | 11 | 28.2 |
| **Received health services at Wyckoff last year** | | |
| Yes | 125 | 71.0 |
| No | 51 | 29.0 |
| **Experience at last visit to Wyckoff[c]** | | |
| Excellent | 34 | 27.2 |
| Very good | 44 | 35.2 |
| Good | 39 | 31.2 |
| Poor | 5 | 4.0 |
| Very poor | 3 | 2.4 |
| **Ease of making an appointment[c]** | | |
| Very easy | 43 | 34.4 |
| Easy | 59 | 47.2 |
| Difficult | 16 | 12.8 |
| Very difficult | 7 | 5.6 |
| **Waiting time to see a doctor at last visit[c]** | | |
| A long time (> 1 hour) | 44 | 35.8 |
| Some time (30-60 minutes) | 64 | 52.0 |
| Almost nothing (<20 minutes) | 15 | 12.2 |
| **Trust in Wyckoff** | | |
| I always trust Wyckoff | 80 | 47.6 |
| I trust Wyckoff sometimes | 53 | 31.6 |
| I trust Wyckoff a little | 29 | 17.3 |
| I don't trust Wyckoff | 6 | 3.6 |

**Notes:** **Sample size can change due to missing information; [a]Only for those for whom Wyckoff is the hospital they usually go to; [b]Includes hospitals with only one count (Bellevue, Brooklyn Hospital, Elmhurst, Flushing, Jacobi and Saint Barnabas, Mercy Hospital, Northwell/Lennox Hill, Maimonides); [c]Only for those receiving care at Wyckoff in the last year.
**Source:** Own elaboration based on results from the Community Service Plan Survey

Figure 3 shows the services that participants would like to see expanded, based on selection of up to three options. The most frequently requested services included mental health care (41.5%), dental care (29.6%), cancer screening and treatment (25.6%), nutrition services (22.7%), and diabetes management (22.2%).

Figure 3. 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*

Table 4 provides an overview of respondents' health status and access to care. While most participants reported good physical health (52.3%) and good mental health (45.1%), 10.2% rated their physical health as poor and 6.9% rated their mental health as poor. The majority were insured through Medicaid (57.1%), with only 15.5% holding private insurance and 3.6% uninsured. Although 82.4% reported having a primary care provider, 33.0% were unable to see a doctor when needed in the past 12 months. Stress was common—64.0% experienced stress sometimes and 17.7% all the time in the past 30 days.

Table 4. Participant's health characteristics

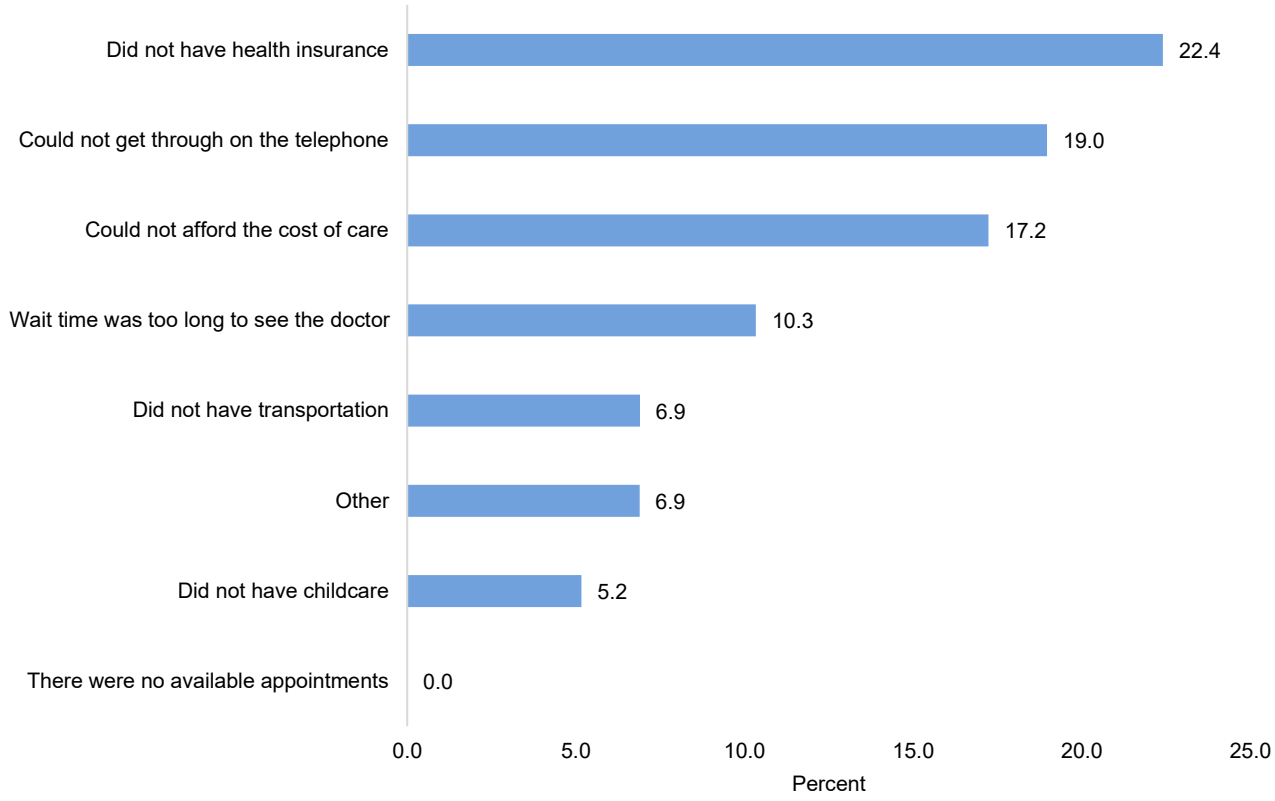
| Variable** | n | % |
|---|---|---|
| **Self-perceived physical health** | | |
| Excellent | 19 | 10.8 |
| Very good | 45 | 25.6 |
| Good | 92 | 52.3 |
| Poor | 18 | 10.2 |
| Very poor | 2 | 1.1 |
| **Self-perceived mental health** | | |
| Excellent | 33 | 18.9 |
| Very good | 49 | 28.0 |
| Good | 79 | 45.1 |
| Poor | 12 | 6.9 |
| Very poor | 2 | 1.1 |
| **Health insurance** | | |
| Private health insurance | 26 | 15.5 |
| Medicare | 25 | 14.9 |
| Medicaid | 96 | 57.1 |
| No insurance | 6 | 3.6 |
| Other | 15 | 39.9 |
| **Has a personal doctor or primary care provider** | | |
| Yes | 145 | 82.4 |
| No | 31 | 17.6 |
| **Could not see a doctor when needed in the last 12 months** | | |
| Yes | 58 | 33.0 |
| No | 118 | 67.1 |
| **Someone offered a telehealth appointment in the last 12 months** | | |
| Yes | 67 | 39.6 |
| No | 102 | 60.4 |
| **Had a telehealth appointment in the last 12 months** | | |
| Yes | 56 | 32.0 |
| No | 119 | 68.0 |
| **Felt any kind of stress in the last 30 days** | | |
| All the time | 31 | 17.7 |
| Sometimes | 112 | 64.0 |
| Never | 32 | 18.3 |

**Notes:** **Sample size can change due to missing information
**Source:** Own elaboration based on results from the Community Service Plan Survey

As the table above shows, 33.0% of interviewees reported they could not see a doctor when needed at least once in the last 12 months. The main reasons were:

- Not having insurance (22.4%)
- Could not get through on the telephone (19.0%)
- Could not afford the cost of care (17.2%)

Figure 4. Reasons not to see a doctor when needed in the last 12 months




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

## *Comparative analysis of 2022 and 2025 survey data*

When comparing the 2022 community resident survey results with the 2025 survey exercise, the following key similarities and differences emerge:

### Demographics

- **Latino/a residents continued to represent the largest share of Wyckoff's patient population in 2025**, although the proportion declined from 87.6% in 2022 to 73.0% in 2025. During the same period, the proportion of participants identifying as Black or African American increased from 4.9% to 15.5%, indicating a shift in the demographic composition of those served.
- **Language distribution shifted**: in 2025, English and Spanish speakers were almost evenly split (49.1% vs. 50.3%), whereas in 2022 Spanish speakers were the clear majority (65.7% vs. 32.3%).
- **Educational attainment improved**: the proportion of participants with a college degree or higher increased from 19.1% in 2022 to 29.3% in 2025.
- **Financial strain worsened**: the proportion of participants able to save money monthly decreased from 42.6% in 2022 to 27.8% in 2025, indicating rising economic challenges.

**Perceptions and priorities around neighborhood health and social needs**

- **Diabetes remained a key health priority**, increasing from the second-ranked need in 2022 (34.2%) to the top priority in 2025 (43.8%). Mental health and food/nutrition continued to be consistently identified as major community needs.
- **Affordable housing remained the leading social need** across both surveys.
- **Immigrant support services shifted upward**, ranking second in 2025 after ranking third in 2022.
- **Employment opportunities newly emerged** as a prominent social need in 2025.

**Wyckoff patient experience**

- **Ease of making appointments improved modestly**, with the share of participants reporting it was "very easy" increasing from 26.0% in 2022 to 34.4% in 2025.
- **Trust in Wyckoff remained stable**, with consistently high levels of trust across both surveys.
- **Mental health care continued to be the top service expansion need**, while **dental care and cancer screening** rose to the second and third most requested services in 2025 (up from sixth and fifth in 2022).

**Participant's health status**

- **Self-rated physical health declined slightly**, with "excellent" health decreasing from 15.8% in 2022 to 10.8% in 2025.
- **Self-rated mental health also declined**, with "excellent" mental health falling from 23.3% in 2022 to 18.9% in 2025.
- **Uninsurance decreased significantly**, from 11.0% in 2022 to 3.6% in 2025.
- **Primary care access improved**, with the proportion reporting having a personal doctor or primary care provider rising from 75.7% (2022) to 82.4% (2025).
- **However, the unmet need increased**: participants unable to see a doctor when needed rose from 26.2% in 2022 to 33.0% in 2025.
- Among 2025 respondents who could not access care, the main reasons were **lack of insurance (22.4%)**, **inability to get through by phone (19.0%)**, and **cost of care**, which remained the third most common reason across both surveys.

## Interviews with staff members and external organizations

### Methodology

From October 10, 2025, to November 20th, we conducted 22 semi-structured interviews, each lasting between 40 and 60 minutes, with Wyckoff staff members. The following areas were covered during the interviews:

- **Community health priorities:** Community health priorities that staff members considered the most important for Wyckoff to address over the next couple of years.
- **Current community health programs and initiatives at Wyckoff:** Programs available at Wyckoff that aim to address community health needs.
- **Financial support:** We examined the availability of financial assistance programs for the uninsured and underinsured.
- **Community partnerships:** We discussed both existing and potential partnerships that could help improve patient outcomes.
- **Strategies to promote more equitable and diverse care:** Strategies Wyckoff could implement to make patient care more equitable and diverse.
- **Staff well-being:** Strategies to strengthen staff recruitment and retention.
- **Patient experience:** We discussed opportunities to improve the patient experience.

From October 22, 2025, to November 24th, 2025, we also conducted semi-structured interviews with 10 external organizations, each lasting between 30 and 60 minutes. The following areas were covered:

- **Overview of the organization:** We discussed the current programs and resources offered by the organization being interviewed.
- **Partnership with Wyckoff:** Current, past, and potential partnerships with Wyckoff.
- **Community health priorities:** Community health priorities that organizations considered the most important for Wyckoff to address over the next few years.
- **Wyckoff's Community Presence:** We assessed strategies to enhance Wyckoff's community presence.
- **Policy context:** Current policies that impact the health of the Bushwick and Ridgewood populations.
- **Patient experience:** We examined ways in which Wyckoff can improve the experience of its patients.

Table 1. List of external organizations interviewed for the CHNA

| Organization name | Services provided |
|---|---|
| **Community Board 4 Brooklyn** | Local government advisory board that represents community interests, connects residents with city services, and supports neighborhood planning and advocacy. |
| **Community Healthcare Network** | Provides quality and affordable healthcare services to New Yorkers. |
| **God's Love We Deliver** | Prepares and delivers medically tailored meals to individuals living with serious illnesses, including nutrition counselling and ongoing support. |
| **Buena Vida Nursing Home** | Long-term care and rehabilitation facility offering skilled nursing, physical therapy, and support services for older adults. |
| **Bridge Back to Life** | Outpatient substance use treatment center providing counseling, group therapy, relapse prevention, and support programs for individuals and families. |
| **St Nicks Alliance Elder Care** | Organization focused on empowering low-income residents through housing, education, workforce development and elder care in in Northern Brooklyn. |
| **Dry Harbor** | Rehabilitation and nursing center providing short-term physical therapy, skilled nursing care, and long-term residential care for older adults. |
| **Make the Road** | Legal assistance, worker-rights campaigns, health access support, youth leadership development, and multilingual civic engagement programming. |
| **Centerlight Health Systems** | Comprehensive PACE services—including medical care, rehabilitation, social work, transportation, and in-home supports—to help older adults with complex needs remain safely in their homes and communities. |
| **Betances Health Center** | Primary care, preventive services, and chronic disease management, with a focus on culturally competent and accessible care. |

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

# Key insights

## Community health needs

The following areas were identified as priority health needs by each group in descending order:

**Wyckoff Staff**

1. Mental health (anxiety and stress)
2. Primary prevention, substance misuse, and overdose
3. Preventive services for chronic disease prevention and control

**External Organizations**

1. Mental health (anxiety and stress)
2. Primary prevention, substance misuse, and overdose
3. Preventive services for chronic disease prevention and control

## Social and community context: Mental health (anxiety and stress)

### *Wyckoff Staff Insights*

Staff members consistently emphasized an increased trend of anxiety and other mental health problems in the community. They highlighted that these issues are deeply connected to broader social and economic stressors affecting the neighborhoods Wyckoff serves, such as the current political climate around immigrants. When discussing current initiatives at Wyckoff aimed at addressing this growing trend, staff mentioned key initiatives to make mental health services more accessible, including hiring a psychiatric nurse practitioner who will provide support in ambulatory and ED settings to patients identified as having psychological needs. Additionally, staff described how Wyckoff relies on a network of New York City–based mental health programs to connect patients to ongoing counseling and psychiatric support that extends beyond what the hospital can provide internally. These resources include the New York Psychotherapy and Counseling Center (NYPCC), the Coalition of Hispanic Family Services, and online-based therapy platforms such as Headway and Aurora of Hope Psychotherapy—all of which were highlighted as trusted referral pathways for patients with depression, anxiety, trauma, and other behavioral health needs. Staff emphasized that these community programs are essential in ensuring continuity of care, particularly for patients who face barriers to accessing traditional outpatient mental health services and noted that Wyckoff takes full advantage of these resources to meet the high volume of mental health needs in its catchment area.

"We're bringing on a psychiatric nurse practitioner who will be embedded in select primary care and specialty clinics. Her role is to assist with evaluations when medical patients present with underlying mental health concerns, such as depression or suicidal thoughts. By integrating this support into medical settings, we can strengthen collaboration with primary care providers and partner with them to better assess suicide risk and determine appropriate referral and treatment pathways." **– Dr David Trachtenberg | Psychiatrist**

"For mental health, we work a lot with the New York CCP—like New York Psychotherapy—which is one of the main places we refer our patients to. We also use the Coalition of Hispanic Services. And then there's Headway, an online therapy platform that works with patients' insurance and matches them with the best therapist after an assessment. More recently, we also started referring patients to Aurora of Hope Psychotherapy. That one is online-based as well, which makes it easier for our patients who might need support." **- Eleanor Juray | Program Director, Family Community and Beyond**

Related to mental health and violence, Wyckoff is currently training selected staff members to have a dedicated sexual assault team at the Emergency Department who will be able to do evidence collection with victims. Staff members who are part of this team must be certified through the New York State's Sexual Assault Forensic Examiner (SAFE) courses and need to have training on trauma informed care.

### *External Organizations Insights*

Participants from external organizations also highlighted an increasing trend in mental health issues—particularly anxiety, stress, and depression— which intensified since the COVID-19 pandemic. Some organizations also noted the need to improve healthcare providers' competence in managing psychiatric patients effectively and providing a holistic patient experience.

"If we don't address some of the mental health issues, nothing else is going to work. Patients won't engage in care, they won't come in for follow-up, and they'll continue to cycle back into the emergency room. Until we treat the mental health and trauma at the core, everything else becomes a temporary fix." **– Kalliope Angelos-Caceres | Corporate Compliance Officer, Bridge Back to Life**

Interviewees underscored that chronic disease and mental health are deeply interconnected. While conditions like diabetes, heart failure, and COPD are longstanding challenges, the real difficulty lies in ongoing management—particularly as the emotional burden of chronic illness can lead to anxiety and depression.

"Chronic illness itself can be depressing. When someone wakes up and takes ten pills every day, that takes a toll, and we need to intervene early, not only when a PHQ-9 is off the charts. The trend is recognizing that high-risk patients need a stronger, coordinated team. When we work together and make care more integrated, we improve outcomes—both objectively and subjectively." **– Dr Lotus Ahmed | CenterLight Health System**

Participants from external organizations also highlighted a clear connection between worsening economic conditions and rising mental health and substance-use concerns in the neighborhoods surrounding Wyckoff. They described how housing instability and rising living costs are driving higher levels of anxiety, depression, and reliance on alcohol or tobacco as coping responses.

"Housing insecurity and the rapid changes in the neighborhood are creating a lot of anxiety and stress for our patients. People are worried they won't be able to afford to stay in Bushwick, and those pressures are showing up as increased depression and as coping mechanisms—like higher alcohol or tobacco use" **– Community leader**

## Social and community context: Primary prevention, substance misuse, and overdose

### *Wyckoff Staff Insights*

Wyckoff staff consistently identified substance misuse and overdose prevention as a significant need in the community. Staff working in the ED also reported a noticeable increase in alcohol-related presentations. To address these needs, Wyckoff has put in place several key initiatives:

1. **RELAY program.** The Relay program supports people who have experienced a nonfatal overdose by sending a peer Wellness Advocate to participating emergency departments to provide support, overdose risk reduction education, and naloxone. Participating hospitals can contact Relay at any time, and a Wellness Advocate is immediately sent to the ED to engage

individuals who have experienced a nonfatal overdose. Wellness advocates stay in contact with Relay participants for up to 90 days and connect them to appropriate services, including overdose prevention, harm reduction, substance use disorder treatment, and social services. Wyckoff staff described this as one of the hospital's most effective substance-use interventions, due to the credibility and trust afforded by peers with lived experience[19].

"NP—I love it. It offers so many resources. If patients need help with things like housing applications or other practical support, the program steps in. The approach is, 'We get it—you may still be using, so let's keep you safe.' They stay connected with patients for up to 90 days and link them to the services they need." **-– Wyckoff leader**

2. **Opioid Overdose Prevention Program (OOPP).** The OOP aims to reduce the harm and mortality associated with opioid use by increasing access to Naloxone and educating the public on how to recognize and respond to an overdose[20]. This is a state-funded initiative that will provide training to Wyckoff staff on how to provide Naloxone (Narcan kits) to patients and community members. Wyckoff launched this initiative in November 2025.

### *External Organizations Insights*

External organizations working closely with Wyckoff emphasized that substance misuse, overdose, and behavioral health challenges remain pervasive across Bushwick and Ridgewood. Interviewed external organizations described a high and persistent need for addiction treatment, noting that many residents continue to experience barriers to accessing detox, long-term recovery programs, and consistent behavioral health care. They stressed the need for continuing to implement peer-based programs, which, when paired with structured care coordination, can be powerful tools for recovery, especially in a community where stigma and fear often deter people from seeking help.

"Sometimes patients that come to Wyckoff Hospital Emergency department or are admitted with excessive alcohol consumption or drug use will say they don't have a problem, but I tell the staff, 'Even if they say they don't need help, call me so I can talk to them—because that's a red flag.' I try to educate the doctors and other staff about what these patients are going through. Even though I'm just a peer, they call me often for advice. I draw from my own lived experience in treatment, and I advocate for the patients so I can help get them into the right care as quickly as possible." – **Carlos Miranda CRPA | Bridge Back to Life**

## Healthcare access and quality: access to preventive services

### *Wyckoff Staff Insights*

#### *Social determinants of health screenings*

Wyckoff has integrated routine Social Determinants of Health (SDH) screenings into ambulatory and inpatient workflows to identify better the non-medical factors impacting patients' ability to follow through with care. Staff emphasized that challenges such as housing insecurity, food access,

[19] New York City Department of Health and Mental Hygiene. (2023, November 2). Hospital-based overdose prevention program expands. https://www.nyc.gov/site/doh/about/press/pr2023/relay-overdose-prevention-program-expands-to-15th-nyc-hospital.pag

[20] New York State Department of Health. (n.d.). Opioid overdose prevention. Retrieved November 28, 2025, from https://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/

transportation barriers, unemployment, and immigration-related stress directly affect patients' health outcomes and their capacity to engage consistently with treatment. This screening has been implemented in collaboration with Public Health Solutions and the WholeYouNYC network (https://www.wholeyou.nyc)[21], as part of a citywide initiative aimed at addressing the deep and persistent health inequities faced by New Yorkers. WholeYouNYC seeks to bridge this gap by placing individuals at the center of care and connecting them to a coordinated network of over 300 community-based organizations. These partners offer resources that span food assistance, housing support, legal services, employment, maternal health, youth programs, sexual health services, and health insurance navigation. Through SDH screenings, clinical teams can identify these needs and refer patients to community resources, social work, or external partners for assistance. Key aspects are documented through this screening process, including: housing and utilities (i.e., living situation, having asked for shelter or sleeping outside, inability to pay for essential services such as oil, water, gas); food security (lack of money to buy food); transportation (lack of a reliable transportation); employment (having a job); education; and interpersonal safety (physical or verbal violence). Overall, staff perceive that SDH screenings are yielding positive results and referrals, with more than 13,291 patients having already completed the SDH screening since April 2025.

"We are getting positive SDH screens, which is interesting. I think from the time we launched it, we've had about 1,800 positive screens, which is more than I thought we would have. This means the screenings are being conducted correctly. And that patients are giving accurate responses to it." **- Ganesh Ram | Director of Population Health**

*Patient Portal Progress*

Wyckoff has recently expanded the functionality of its patient portal, introducing secure messaging (although not yet available at all hospital facilities) and online appointment scheduling for select departments. Although the portal is not fully integrated with the EHR and remains English-only, a bilingual portal coordinator provides hands-on support to patients, including help creating email accounts and navigating their medical information. This effort is framed as part of Wyckoff's strategy to promote digital access and health equity, particularly for patients with limited digital literacy. So far, more than 18,000 patients have connected to *FollowMyHealth* (Wyckoff portal).

"We have a dedicated patient portal coordinator who gets about 10 to 15 calls a day. She's bilingual, so patients often email her in Spanish, and she responds in Spanish. She walks patients through how to navigate the system, how to find their lab results, and if something is missing, she contacts the department to make sure the results are pushed out to the portal." **– Jebashini Jesurasa | Chief of Informatics**

*Referral Follow-Up Team*

To address longstanding gaps in post-discharge continuity and ambulatory referral coordination, Wyckoff is creating a centralized referral department. The new team will be responsible for contacting patients to arrange specialty appointments, confirming follow-up details, and communicating with community primary care providers. This initiative responds to repeated reports from clinicians that patients often leave without clear next steps, as well as from community doctors who receive little to no feedback after referring patients to Wyckoff.

"We've started a referral department, and now any patient who receives a referral from their primary care provider is supported by a dedicated team. They review and triage each referral, contact the patient

[21] WholeYouNYC. (n.d.). Pathways to Better Health. https://www.wholeyou.nyc/

directly, schedule the appointment, and essentially set everything up for them. The goal is to make sure patients understand where they need to go, when to go, and to close that communication gap that's been missing." **– Christine Scaminaci | Chief of Operations**

*Access to the "Equipo" Platform for Referrals from External Organizations*

Wyckoff has started using the Equipo external referral tracking platform (https://www.equipo.io) to improve collaboration between hospital services and external partners. The system is designed to let community organizations and primary care practices refer patients directly to Wyckoff clinics and track the status of these referrals. Equipo collects orders, prerequisites, supporting documents, and communications from referring physicians. It enables automated referral tracking, bidirectional updates (so specialists' reports are integrated back into the system), and analytics to pinpoint referral bottlenecks and gaps. This tool aims to reduce the current fragmentation in referrals, which are often manual, inconsistent, and lost, particularly in outpatient care.

"Currently, we're working with a company called Equipo, which provides a referral-tracking system. It's not 100% perfect yet, but the idea is that it provides us with a dashboard that clearly shows us where each patient is in the referral process. Some parts are still manual, but the goal is that, over time, more of it will become electronic and much less labor-intensive." **– Lois Collins | Assistant Vice President of Ambulatory Services**

*Telehealth NP Appointments for Recently Discharged Patients*

In November 2025, Wyckoff launched a program in which nurse practitioners will conduct telehealth follow-up visits within 24 to 72 hours of discharge. The goal is to ensure patients understand their medication regimen, appointments, and warning signs, helping prevent avoidable readmissions. This model also serves as a bridge where social needs, confusion, or mental health concerns can be identified early, especially for patients who may not return to the clinic promptly after hospitalization.

"We've invested in expanding our primary care team, which increases access and strengthens our ability to provide preventive care. In addition, we're launching a post-discharge telemedicine program. Within 24 to 48 hours of leaving the hospital, every patient will receive a virtual follow-up to confirm they understood their discharge instructions, picked up their medications, and have the support they need at home. This added layer of follow-up is intended to prevent readmissions and reduce the risk of a patient's condition worsening." **– Christine Scaminaci | Chief of Operations**

*Family, Community & Beyond Program*

The Family, Community & Beyond Program at Wyckoff—part of the Perinatal and Infant Community Health Collaborative (PICHC)—supports high-need, low-income birthing people and families across Bushwick, East New York, Bedford-Stuyvesant, Crown Heights, and Williamsburg. Using a Community Health Worker model, the program provides tailored one-on-one support during pregnancy, postpartum, and the interconception period, connecting families to resources and maintaining engagement until a child turns two or their needs are met. In addition to individualized services, the program provides group education in partnership with local organizations, covering topics such as nutrition, breastfeeding, mental health, financial stability, and safe sleep practices. It also hosts quarterly Community Baby Safety Showers to promote infant safety and raise awareness of early intervention. Together, these efforts aim to reduce disparities, strengthen family wellbeing, and advance health equity across the community.

### *Women, infants and children (WIC)*

The New York State Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) works to safeguard the health of low-income women, infants, and children up to age five who are at nutritional risk by providing supplemental nutritious foods, personalized nutrition education, breastfeeding support, and referrals to essential health services. Wyckoff's WIC program serves over 7,000 families and proudly supports this mission through in-person and virtual appointments, online education, group discussions, breastfeeding assistance, including pumps, and access to community resources such as our garden and family workshops. It also offers tailored nutrition assessments, promote healthy growth through carefully selected food packages, and create opportunities for dietetic interns to gain experience in community nutrition and sustainability. Whether connecting virtually or in person, the WIC program is committed to helping families achieve better health and wellness.

Currently, the WIC program provides numerous referrals to services such as health care providers, breastfeeding support and promotion, dental care, early intervention programs, educational programs, Head Start and Early Head Start, hospital services, immunization screenings, bloodwork and lead testing, prenatal and postpartum care, smoking cessation programs, temporary and disability assistance, and WIC Strong.

In 2022, the clients of Wyckoff's WIC program redeemed 6.4 million dollars in WIC benefits. This figure increased to 8 million in 2023 and 8.6 million in 2024.

### *Substance Abuse Mental Health Services Administration (SAMHSA)*

The primary goal of the SAMHSA – IMPACT program is to assist patients with linkage to behavioral care services such as mental health and substance abuse treatment, and also provides case management services to address their Social Determinants of Health (SDOH). During 2024, the SAMHSA – IMPACT team made over 55 referrals to enrolled patients to the following agencies based on their need assessment.

- Integrity Social Work Services: 9
- New York Psychotherapy and Counseling Center: 3
- Interborough Development and Consultation: 16
- RAICES Casa Bien Estar:1
- New Horizon Counseling Center: 1
- Woodhull Medical and Mental Health Center: 3
- Rego Park Counseling Center: 8
- Elmhurst Hospital Center: 2
- Spring Hill Wellness NY: 2
- MTA's Paratransit Access – A – Ride: 2
- Human Resources Administration (HRA)/DSS: 3
- St. John's Bread and Life: 5

### *Wyckoff's Charity Care*

Wyckoff's charity care and Medicaid enrollment support programs were described as one of the hospital's most effective and widely utilized services. The Medicaid office assists not only patients currently receiving care, but also community members who come to the hospital specifically to obtain help with insurance enrollment. Leadership views this as a critical part of Wyckoff's mission to serve uninsured or underinsured populations, particularly given the high burden of financial and immigration-related stress in the surrounding community.

"We'll see anybody who needs care. If a patient says they don't have the money to pay, we don't turn them away. We provide them with the necessary information to visit the Medicaid office, and the Medicaid office informs them of the required documents to bring. But we never say, 'You can't come because you can't pay.' We see the patient first, and then we figure out how to help them on the back end." **– Lois Collins | Assistant Vice President of Ambulatory Services**

In 2025, Wyckoff's Medicaid office has completed 306 Medicaid applications for ED patients, 978 Medicaid applications for hospitalized patients and 241 for ambulatory patients.

### *External Organizations Insights*

Interviews with external organizations have underscored that access to preventive services in Bushwick and Ridgewood remains limited, despite a significant community need. Partners consistently reported that many residents delay seeking care until conditions become acute, driven by barriers such as appointment delays, low health literacy, immigration-related fears, and competing social needs like food insecurity and unstable housing. Overall, the organizations stressed the need for more proactive, community-embedded preventive services.

"Access to preventive care is definitely a challenge. Sometimes people don't go to the doctor simply because the office isn't open outside of their work hours, or they're discouraged by long wait times. We often see cases where someone seeks care only after a fall or a serious event, and then we realize they haven't visited a doctor in five or even ten years. When they finally come in, you discover all these unmanaged comorbidities—diabetes, COPD, and so on. It really shows how gaps in access to regular preventive care can lead to bigger problems down the line." **– Community leader**

## Healthcare access and quality: Preventive services for chronic disease prevention and control

### *Wyckoff Staff Insights*

#### *Population Health Care Coordination*

During fall 2025, Wyckoff established a multidisciplinary Population Health Care Coordination team, which includes a Nurse Practitioner (NP), medically trained Care Manager, and Outreach Specialist, and 3 Community Health Workers - all dedicated to proactively contacting patients who experience gaps in care and supporting them in accessing preventive health services and to better manage their chronic conditions. The team collaborates to address gaps in HEDIS quality measures, including cancer screening, hypertension, diabetes control, and routine follow-up for chronic conditions. Previous outreach had faced challenges such as low patient responses rates largely due to limited resources allocated to this effort. A dedicated outreach team and the NP role are key to building continuity and proactive follow-up rather than crisis driven care.

"We're onboarding a nurse practitioner in Population Health who will focus on coordinating care for patients with chronic conditions and those who need medication support or annual wellness visits. She'll be working alongside another NP in a tag-team model to make sure patients don't fall through the cracks. We're also assembling an outreach team within Population Health to support transitions of care and help us meet the quality metrics we report to our health plans." **- Ganesh Ram | Director of Population Health**

The outreach team of Population Health has taken Wyckoff's HealthFirst cervical cancer screening rates from 1 star to 4 stars, as well as the well-child visit completion rate from 1 star to 4 stars—with 5 stars in the horizon.

### *Smoking cessation program*

Wyckoff has recently launched a structured smoking cessation initiative as part of its Community Service Plan to reduce COPD- and asthma-related readmissions and strengthen preventive care. Interviewees described the program as a new hospital-based clinic led by a pulmonary nurse practitioner, offering counseling and medication support to patients who smoke. The initiative focuses particularly on individuals identified during hospitalization and is supported through internal referrals and community outreach, including the distribution of flyers and digital promotion. Early implementation data shared by staff indicate steady growth, with 13 patients served in August and 31 in September, with a target of reaching 200–300 patients by year-end.

"We've just launched a smoking cessation program—our first one. It applies to any patient, but especially those who are hospitalized with conditions related to smoking, like stroke or cardiac issues. Before they're discharged, we refer them to the program so they can continue getting support once they leave the hospital. It's an in-house service that's already up and running." **– Wyckoff leader**

The NP who leads the tobacco cessation program has completed certification under the Roswell tobacco treatment model. The NP participated in a five-day on-site professional workshop that provided an in-depth understanding of the biopsychosocial underpinnings of tobacco use and dependence, as well as the conceptual and empirical framework for evidence-based treatment of tobacco dependence. The program covered the following areas:

- Tobacco Treatment Specialists: roles, responsibilities, professional development, ethics, and credentialing
- Overview of a comprehensive approach to tobacco control
- Evidence-based tobacco dependence treatment approaches
- Tobacco products: marketing, design, prevalence of use, and health consequences
- Electronic Nicotine Delivery Systems (ENDS)
- Treating tobacco use and dependence
- Principles of evidence-based, patient-centered, behavior change treatment strategies.
- Comprehensive clinical assessment of the tobacco user
- Basic pharmacotherapy for tobacco use
- Advanced pharmacologic treatment planning
- Tobacco-related social determinants, intersectionality, diversity, and tobacco-related health disparities
- Relapse prevention and recovery
- Telephone, individual, and group treatment models
- Documentation, coding, billing, and tobacco treatment program evaluation

### *Weight management program*

Wyckoff offers both adult and pediatric weight management services through its ambulatory clinics, supported by diabetic educators and nutrition-focused staff. The adult program is described as high-volume and consistently busy, reflecting strong demand in the community. Currently, there is a NP leading the adult weight management clinic twice per week at Wyckoff. On each clinic day, the NP sees an average of 20 patients, accounting for an approximate total of 160 in-person patient visits per month.

The pediatric service is also actively utilized, seeing multiple children per session, with an emphasis on engaging not just the patient but the entire family unit—acknowledging that dietary and lifestyle changes depend on household support rather than individual counseling alone.

In 2023, Wyckoff also started a weight management internship program in partnership with Universidad Iberoamericana ("Ibero") in Mexico City. For three years in a row, the Ibero has sent graduate students from its Specialty program in Obesity and Comorbidities to do summer rotations at Wyckoff. The rotations take place at Wyckoff's weight management clinic for adults and children, Wyckoff's endocrinology clinic, the Women's Health Center and the bariatric surgery department. The interns also collaborate with Wyckoff's Family, Community and Beyond program by organizing nutritional education workshops for women that have delved into topics like nutritional labeling, breastfeeding, nutrition during pregnancy and diabetes.

"We have a certified diabetes educator, and we offer both adult and pediatric weight management services in ambulatory care. The adult program is very busy, and pediatrics is also active—we see about seven children, which is significant for a pediatric population. And with pediatric patients, you're really treating the whole family. The child isn't coming in alone or preparing their own meals, so pediatric weight management has to involve the entire family." **– Lois Collins | Assistant Vice President of Ambulatory Services**

### *External Organizations Insights*

External organizations emphasized that preventive services for chronic disease remain a critical need in the communities surrounding Wyckoff, particularly for conditions such as diabetes, hypertension, obesity, and cardiovascular disease. Partners noted that many residents delay seeking primary or preventive care, often arriving at the hospital only when conditions have worsened—sometimes after years without seeing a provider. Beyond access challenges, interviewees highlighted that effective prevention requires more than one-time education during a visit; patients need ongoing, coordinated support that addresses nutrition, physical activity, behavioral health, and social needs. As several organizations have noted, managing chronic disease successfully depends on collaborative care models that integrate medical treatment with culturally informed counseling, social service linkage, and consistent follow-up, rather than relying solely on physicians. Social and cultural barriers—including food insecurity, limited health literacy, work-related scheduling constraints, and immigration-related fears—underscore the need for a comprehensive and team-based approach to prevention.

"Chronic disease isn't new, but the real challenge is how—and through whom—we manage it. We can provide education during a visit, whether it's diabetes, heart failure, or COPD, but that doesn't mean patients fully understand or follow through. No single physician can do it all. Effective chronic care now requires collaborative management—bringing in nutritionists, dietitians, physical therapists, and behavioral health." **– Dr Lotus Ahmed | CenterLight Health System**

## Community partnerships

Wyckoff Heights Medical Center maintains a vast network of strong, mission-aligned partnerships with external organizations across Bushwick, Ridgewood, and neighboring areas. These collaborations enhance the hospital's ability to meet patient needs beyond clinical care, supporting smooth care transitions, chronic disease management, behavioral health, nutrition, and social support. Community partners consistently described Wyckoff as a trusted and accessible anchor institution, with relationships built on responsiveness, shared commitment to community health, and longstanding engagement.

"When I hear Wyckoff, what immediately comes to mind is care and support. It's a place where people can get the medical attention they need, along with financial assistance if they don't have insurance. It's close to the community, easy for clients to reach, and overall, our patients have had a good experience there" **– Arline Cruz Escobar | Make the Road**

"People have talked about the emergency room being good and pretty quick. There are also certain specialties that patients specifically mention—they say they liked the care they received and felt genuinely taken care of while they were there" **– Community leader**

**Types of Community Partnerships**

**1. Post-Acute and Long-Term Care Partners (Nursing Homes & Rehab Centers)**
Wyckoff works closely with nursing homes and rehabilitation centers, including **Buena Vida**, **Dry Harbor**, and **CenterLight Health System**, to ensure coordinated transitions for older adults and patients with complex needs. These collaborations establish communication pathways for discharge planning, expedite specialist access, and provide ongoing support to help patients remain safely in the community.

**2. Federally Qualified Health Centers and Primary Care Partners**
Longstanding partnerships with healthcare organizations such as the **Community Healthcare Network (CHN)** expand patient access to prenatal services, chronic disease management, and primary care follow-up. Wyckoff's adoption of the **Equipo referral platform** is helping standardize communication and make shared patient pathways more reliable and trackable across organizations.

**3. Food and Nutrition Support Partners**
Through formal linkage agreements with God's Love We Deliver, Wyckoff connects eligible patients—including those with HIV, chronic illness, and prenatal needs—to medically tailored meals and nutritional counseling. These partnerships reinforce Wyckoff's commitment to addressing food insecurity and other social determinants of health.

**4. Behavioral Health, Substance Use, and Recovery Support Partners**
Collaborations with **Bridge Back to Life** and other community behavioral health providers expand access to counseling, outpatient addiction treatment, and peer-based recovery supports. The **RELAY program**, embedded in the ED, links patients experiencing non-fatal overdoses with trained peers who provide harm-reduction education and navigation for up to 90 days.

**5. Community Boards and Civic Organizations**
Partnerships with **Community Board 4** and other civic groups help Wyckoff maintain a close connection to neighborhood priorities. These organizations support outreach initiatives related to senior wellness, mental health awareness, and the needs of immigrant communities, reinforcing Wyckoff's role as a locally responsive health resource.

## Patient experience enhancements

### *Training*

Wyckoff has implemented a range of initiatives to strengthen staff capacity in delivering a positive and compassionate patient experience across all clinical and non-clinical settings. Through structured trainings—such as the Patient & Family Experience Workshop and the Compassionate Connected Care

program—employees are equipped with practical skills in communication, empathy, cultural awareness, and service recovery.

The nursing staff at Wyckoff has been working closely with Press Ganey in the rollout of a four-hour training of the Compassionate Connected Care model. To this date, Wyckoff has delivered this training to more than 500 nursing staff members and 200 medical doctors.

**Overview of patient experience trainings taken at Wyckoff:**

**1. Patient & Family Experience Workshop (Northwell)**
This workshop introduces core foundations of patient experience, including Wyckoff's mission and behavioral expectations, and emphasizes that every interaction along the care continuum shapes that experience. Key modules cover patient-centered communication through the **C.O.N.N.E.C.T. model**—contact, greeting, naming, identifying needs, explanation, and closing with thanks—to standardize respectful, clear interactions across roles. The training also addresses **service recovery** strategies, HCAHPS domains, and cultural competency, including barriers and components of culture, to support more inclusive care delivery. Scenario-based practice reinforces essential skills, including managing expectations, addressing concerns, and maintaining professionalism in everyday interactions.

**2. Compassionate Connected Care (Press Ganey)**
This training introduces the Compassionate Connected Care model, which links empathy, clinical excellence, and operational efficiency to reduce patient suffering and strengthen teamwork. The curriculum highlights the following themes:

1. The importance of acknowledging suffering.
2. Understanding that body language matters.
3. Understanding that anxiety is suffering.
4. Coordination of care.
5. Caring transcends diagnosis.
6. Autonomy reduces suffering.[22]

Modules include body language and first-impression techniques, strategies for addressing coordination gaps without eroding confidence, and tools for de-escalation and empathy-based responses. The training reinforces that every staff member—whether clinical or not—contributes directly to the patient experience and emotional well-being.

Staff members who take this training increase their awareness around the behaviors that increase patient anxiety (such as long wait times without updates, rushed communications, seeing staff socializing with coworkers, lack of cleanliness and turning away without wearing ID badges appropriately) and behaviors that help reduce patient anxiety (when the staff introduces themselves, talking with patients about something meaningful to them, coordinating care with colleagues, keeping the patient informed, smiling and saying hi).

*Patient ambassadors on inpatient floors*

[22]Assi, M. J. (2023, May 9). Operationalizing Compassionate Connected Care: A path to improved workforce engagement and patient outcomes. Press Ganey Blog: Healthcare Experience Insights. https://info.pressganey.com/press-ganey-blog-healthcare-experience-insights/operationalizing-compassionate-connected-care-path-to-improved-workforce-engagement-patient-outcomes

Wyckoff has introduced a patient ambassador program designed to strengthen communication, responsiveness, and overall patient experience on inpatient units. Ambassadors—many of whom are bilingual—serve as an accessible point of contact for patients and families, helping address practical questions, improve comfort, and close small but meaningful gaps in day-to-day communication. While they are often early-career staff, interviewees noted that ambassadors play a valuable role in supporting navigation, conducting follow-up calls, and assisting with nonclinical needs that contribute to a more positive stay. Their presence reflects Wyckoff's commitment to approachable, patient-centered care and to expanding supportive roles within the care team.

"The ambassadors are going into the different patient rooms, greeting people and asking them if they can help them in anyway. They're really acting as an extra set of hands for the nurses. Their role is to step in, talk to patients, and determine what they need—things like whether they're hungry, confused about what's happening next, or simply waiting for someone to check on them. They're there to bridge that gap and make sure patients feel seen and heard." – **Wyckoff leader**

*Patient and family advisory council*

Wyckoff's Patient and Family Advisory Council (PFAC) serves as a structured mechanism for incorporating community perspectives into hospital improvements. The council meets monthly and includes diverse community members who share feedback on care processes, communication, and service needs. PFAC is supported by a dedicated grant, which sustains participation and facilitates consistent engagement. Interviewees highlighted PFAC as one of the hospital's most meaningful avenues for elevating patient voice and ensuring that improvement efforts reflect the lived experience of Wyckoff's surrounding communities.

"We have a Patient and Family Advisory Council that is primarily led by nursing. The council includes community members—some of whom have received care here or previously worked at Wyckoff—who share their perspectives on what the hospital can improve. We've held about five or six meetings so far, and the group has been very engaged. We also secured a small grant that allows us to provide lunch during the sessions. Through this committee, we've already began working on several initiatives to enhance the patient experience at the hospital. The council meets once a month." **– Catherine Simon | Chief Nursing Officer**

*AI tools to transcribe during consultations*

Wyckoff has begun implementing AI-based scribing tools in ambulatory care to improve the quality of patient–provider interactions. These tools facilitate real-time documentation, enabling clinicians to maintain better eye contact, listen more actively, and reduce the administrative burden that often interrupts the flow of patient visits. By freeing providers from computer-facing tasks, the AI system enables a more empathetic and connected form of communication—an essential element of a positive patient experience. Early feedback suggests improvements in efficiency and patient engagement.

"We've just instituted a very interesting AI program that hopefully will help to avoid sitting and typing while the patient is talking. Instead, I can maintain direct eye-to-eye contact throughout the interview. The tool—called Nabla—records the conversation, translates it, and automatically categorizes what the patient says. It can distinguish when the patient is talking about their past medical history or past surgical history and organizes the information under clear headings. It really makes the conversation, especially the initial interview process, much clearer and faster." **– Dr Maxine Orris | Internist**

**Appendix**

Table 1. Total mentions of each area, either as a first or second priority for the CSP, Wyckoff staff and community interviews

| Area | Mentions<br>Staff interviews | Mentions<br>Community partners interviews |
|---|---|---|
| Neighborhood and built environment | 2 | 2 |
| Economic stability | 9 | 2 |
| Social and community context | 21 | 11 |
| Healthcare access and quality | 11 | 5 |
| Education access & quality | 1 | 0 |

Table 2. Total mentions of each area and subarea, either as a first or second priority for the CSP, Wyckoff staff and community interviews

| Area | Mentions Staff interviews | Mentions Community partners interviews |
|---|---|---|
| **Neighborhood and built environment** | **2** | **2** |
| Opportunities for Active Transportation and Physical Activity | 0 | 0 |
| Access to community services and Support | 1 | 0 |
| Injuries and Violence | 1 | 2 |
| **Economic stability** | **9** | **2** |
| Poverty | 1 | 0 |
| Unemployment | 0 | 0 |
| Nutrition security | **4** | **2** |
| Housing stability and affordability | **4** | 0 |
| **Social and community context** | **21** | **11** |
| Anxiety and stress | **11** | **8** |
| Suicide | 0 | **1** |
| Depression | 2 | 0 |
| Primary prevention, substance misuse and overdose prevention | **5** | 2 |
| Tobacco/e-cigarette use | 1 | 0 |
| Alcohol use | 2 | 0 |
| Adverse childhood experiences | 0 | 0 |
| Healthy eating | 0 | 0 |
| | | 0 |
| **Healthcare access and quality** | **11** | **5** |
| Access to and use of prenatal care | 1 | 0 |
| Prevention of infant and maternal mortality | 1 | 0 |
| Preventive services for chronic disease prevention and control | **5** | **3** |
| Oral health care | 0 | 0 |
| Preventive services | **4** | **2** |
| Early interventions | 0 | 0 |
| Childhood behavioral health | 0 | 0 |
| **Education access & quality** | **1** | **0** |
| Health and wellness promoting schools | 0 | 0 |
| Opportunities for continued education | 1 | 0 |

# COMMUNITY SERVICE PLAN (CSP):

1. **Major Community Health Needs:**

The three top community health needs identified during the 2025 Community Health Needs Assessment (CHNA) were Mental Health, Chronic Diseases prevention and control, and Substance Misuse and overdose prevention. In addition, Housing Stability and Affordability was a top social determinant priority need identified by our survey respondents.

The CHNA included 176 surveys that were conducted with Wyckoff patients and community members between October-November 2025 at 6 different Wyckoff clinic and community program locations and a 7th location at an off-site CBO partner office. Of the 176 survey responses, Diabetes was the top health issue identified (43.8%), followed by Mental Health (49.8%), then followed by Food and Nutrition (33.5%). The CHNA also included 22 semi-structured interviews with Wyckoff staff members and 10 semi-structured interviews with external organizations that collaborate with Wyckoff. The 32 total interviews lasted between 30-60 minutes each and were conducted between October 10 – November 24, 2025. The interviews with both Wyckoff staff and external community partners revealed the same top three priority health needs, in highest ranking order: (1) Mental Health; (2) Primary prevention, substance misuse, and overdose; and (3) Preventive services for chronic disease prevention and control.

2. **Prioritization Methods:**

a) Description of prioritization process:

We identified the 2025-2027 CSP priorities by reviewing and analyzing data from the community health needs assessment (CHNA) we conducted during fall 2025, as well as by reviewing data from Wyckoff's EHR showing the most prevalent chronic health conditions among Wyckoff patients in 2024. We then triangulated this data with local county and neighborhood data on various health conditions and social factors and took observational qualitative factors into account as well. Based on the responses from the surveys and interviews, we ranked the top three priorities in each data set. Additionally, we ranked the top three highest prevalence rates of chronic conditions among Wyckoff patients and stratified them by race and ethnicity to further assess for health disparities and care gaps. These processes and criteria allowed us to be as comprehensive as possible about selecting our priority community health needs and social needs for the CSP.

b) Community Engagement:

Wyckoff cares deeply about having the community's voice be at the center of the CSP. When deciding on which priorities to focus the CSP on, the community input from the surveys and interviews was taken as the top consideration. Again, during the surveys and interviews patients, staff, and community members were asked to rank what were seen as the three highest health and social needs. The community was given a long list of options to pick from based off the priorities highlighted in the 2025-2030 Prevention Agenda.

c) Justification for Unaddressed Health Needs:

The third highest ranked health priority found in our community survey was food and nutrition. This health need was not included in our three main CSP objectives because it was not consistently found to be a high priority among the interview data. Food and nutrition are also a health topic that Wykoff invests in through their WIC office that offers supplemental nutritional foods, nutrition and health education, and breastfeeding support and promotion. Nutrition is also an important part of the weight management program and includes educating individuals on healthy eating habits and cooking tips. The department includes a registered dietitian who provides nutritional counseling, meal planning guidance, and support to help patients make healthy dietary choices.

**3. Developing Objectives, Interventions, and an Action Plan**

**a) Alignment with Prevention Agenda:**

Priority #1: Anxiety & Stress (Domain 2: Social and Community Context)

- Objective 1: Decrease the percentage of adults who experience frequent mental distress from 13.4% to 12.0%.
    i. Intervention: Increase the number of mental health providers in ambulatory care settings in Bushwick, Brooklyn.
    ii. This intervention is aligned with the CDC's mental health strategy with the pillar of "strengthening mental health systems and supporting providers" and the goal of "increasing access to and awareness and availability of services and supports".[23]

Priority #2: Depression (Domain 2: Social and Community Context)

- Objective 1: Increase the number of adults with PTSD who experience trauma-related symptoms that interfere with social functioning who are engaged in mental health services at Wyckoff by 10% annually.
    i. Intervention: Increase the number of mental health providers in ambulatory care settings at Wyckoff Hospital.
    1. Desired outcome: Decrease the number of adults with PTSD who experience trauma-related symptoms that interfere with social functioning
    2. Population/subgroup: Wyckoff patients/community members with PTSD who have limited access to mental health care
    3. Data source: Wyckoff EHR
    4. Baseline: 2025 – data is still being collected & analyzed
    5. 2030 target: Increase the number of adults with PTSD who experience trauma-related symptoms that interfere with social functioning who are

[23] Protecting the Nation's Mental Health | Mental Health | CDC (2025).

engaged in mental health services at Wyckoff by 10% annually between 2026-2030.

Priority #3: Primary Prevention, substance misuse, and overdose prevention (Domain 4: Health Care Access and Quality)

- Objective 1: Reduce the crude rate of overdose deaths involving drugs, per 100,000 population, from 32.3 to 22.6.
    i. Intervention: Relay Program/Wyckoff ED
    ii. This aligns with HealthyNYC's Overdose Prevention strategy, specifically implementing the components "implement culturally appropriate, trauma-informed, evidence-based treatment options, especially for people who are highly marginalized; and increase access to social support and recovery systems." The Relay program is a NYC DOHMH-funded evidence-based intervention that provides overdose prevention services and linkage to care for patients who present to the Wyckoff ED following a drug overdose (e.g. Fentanyl) and survive. Relay dispatches Wellness Advocates, trained peers with lived experience to provide supportive services bedside in Wyckoff's ED to overdose survivors and offer continued support and follow-up for 90 days after the ED visit.

- Objective 2 (optional): Increase the number of naloxone kits distributed from 397,620 to 596,430.

  Intervention: The Opioid Overdose Prevention Program (OOPP)/Wyckoff ED.

  i. This aligns with HealthyNYC's Overdose Prevention strategy, specifically implementing the components "implement culturally appropriate, trauma-informed, evidence-based treatment options, especially for people who are highly marginalized; and increase access to social support and recovery systems." The OOPP is a NYS-funded program that since 2006 has established over 1000 eligible providers and programs in hospitals, community health centers, and community-based organizations. OOPP provides resources including naloxone kits to train community members (lay responders), other paraprofessionals, professionals, clients or patients and their families on how to recognize an overdose, respond and give Naloxone. OOPP allows for non-medical persons in the general community to administer Naloxone to another person to prevent an opioid/heroin overdose from becoming fatal.

Priority #4: Preventative Services for Chronic Disease Prevention and Control (Domain 4: Health Care Access and Quality)

- Objective 1: Increase the % of Hispanic and Black patients who screen positive for gestational diabetes and who are linked to follow up diabetes care by 10% annually.

    i. Intervention: Diabetes Care Coordination/ADA Grant

        1. Desired outcome: Achieve higher rates of GDM and diabetes screening, monitoring and treatment throughout the perinatal period for women of color.
        2. Population/subgroup: women of color who screen positive for gestational diabetes.
        3. Data source: Wyckoff EHR
        4. Baseline and baseline year: 2025 – data is still being collected & analyzed.
        5. 2030 target: Increase the % of Hispanic and Black patients who screen positive for gestational diabetes and who are linked to follow up diabetes care by 10% annually between 2026-2030.

        ii. This aligns with HealthyNYC's Maternal Health priority, specifically the strategy "Improve the quality of health care for pregnant and postpartum New Yorkers" and the sub-strategy "Improve clinical care."

- Objective 2: Increase the % of Wyckoff Diabetes patients who have controlled diabetes/A1C levels from 43% to 75%
    i. Intervention: High A1C Clinic. This clinic was started in July 2025 and as of December 2025 operates 3 sessions per week. It includes a team of Diabetic care specialists – two Endocrinologists, one Nurse Practitioner, and a Clinical Pharmacist – who work together with the patient to provide care coordination and education support for patients with uncontrolled A1C levels.
        1. Desired outcome: Improve diabetes management and health outcomes for Diabetic patients at Wyckoff. In 2024, Wyckoff provides services to over 9200 patients with Diabetes (over 10% of all patients).
        2. Population/subgroup: Diabetes patients who have uncontrolled A1C levels (>9%)
        3. Data source: Wyckoff EHR
        4. Baseline and baseline year: 44% of Wyckoff patients have controlled diabetes, 13% uncontrolled, and 43% are missing A1C data so their A1C status is unknown (2024)
        5. 2030 target: Increase the % of Wyckoff Diabetes patients who have controlled diabetes/A1C levels from 43% to 75%
- Objective 3: Increase the percentage of adults aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%.

ii. Gap Closure Clinic: This clinic started in December 2025 and operates 4 sessions per week. It includes a multidisciplinary team of chronic care specialists – one Nurse Practitioner, one medically-trained Care Manager, and Outreach Specialist and a Community Health Worker who work together with the patient to provide care coordination, education and counseling, and timely medication access for patients with uncontrolled blood pressure.

Priority #5: Housing Stability & Affordability (Domain 1: Economic Stability)

- Objective 1: Increase the % of Wyckoff patients who report unstable or unaffordable housing and who are successfully referred and linked to a NYC housing agency or service

  i. Health-related social needs (HRSN) screening and navigation through our regional SCN

  1. Desired outcome: Increase the number of patients who report housing needs and who access housing resources in a timely manner
  2. Population/subgroup: patients who report housing needs
  3. Data source: Wyckoff EHR
  4. Baseline and baseline year: 2025 HRSN navigation and referrals data is still being analyzed
  5. 2030 target: Refer, track and link at least 50% of patients in need to a housing navigator or resource within 7 days screening positive on a housing need.

**b) Action Plan:**

Priority #1 & 2: Anxiety and Stress, and Depression

- Actions and Impact: In December 2025, Wyckoff hired a new Psychiatric Nurse Practitioner to provide mental health services to Wyckoff patients in an ambulatory setting. The anticipated impact is that more Wyckoff patients will be assessed and treated for a variety of mental health conditions, including anxiety, stress, depression and PTSD.
- Geographic Focus: The services will be offered in Bushwick, Brooklyn.
- Resource Commitment: Wyckoff is utilizing 1115 Waiver funds to cover the salary cost of the new Psych NP through March 2027. After March 2027, Wyckoff will be utilizing our own hospital funds and revenue from behavioral health clinic visits to sustain this resources and to possibly expand the service in outpatient care.
- Participant Roles: N/A Wyckoff is the only participant at this time for this intervention
- Health Equity: The Bushwick/Kings County zip code 11237 where Wyckoff is located as well as the neighboring zip codes that constitute Wyckoff's primary service area (PSA) are classified by HRSA as both Medical Underserved Areas (MUDs) and as Health

Professional Shortage Areas (HPSAs). According to the Center for Health Workforce Studies, in 2013 there were only 21 psychiatrists per 100,000 persons in Brooklyn, a rate 57% lower than the NYC rate of 49 per 100,000. Given the predominantly Hispanic and Black ethnic and racial makeup of Wyckoff's patients, this intervention will address several aspects of health equity including increasing local access to mental health services for medically underserved neighborhoods and improving access for low-income Hispanic and Black, at-risk populations.

Priority #3: Primary Prevention, substance misuse, and overdose prevention

- Actions and Impact: The Relay Program and the Opioid Overdose Prevention Program (OOPP) – both programs began implementation in the Wyckoff ED starting in October 2025 with funding and resource support from NYC DOHMH and NYS DOH respectively. The anticipated impact is that more individuals struggling with opioid substance abuse who present to the Wyckoff ED following a non-fatal overdose will have access to preventive tools and supportive resources such as Wellness Advocates who are trained peers with lived experience and Narcan kits for prevention of future overdoses. Additionally, more community members will be trained on how to recognize overdoses and how to use Narcan. The ultimate goal is to reduce local opioid overdose rates.
- Geographic Focus: The services will be offered in Bushwick, Brooklyn.
- Resource Commitment: We have a grant commitment for 9 years from the NYC DOHMH for the Relay Program.
- Participant Roles: NYC's Department of Health and Mental Hygiene runs the Relay program and deploys Wellness Advocates to local Emergency Departments when they receive referrals of patients who are being treated for a non-fatal overdose. The Advocates also provide education and support for up to 90 days to referred individuals who are interested in participating in the program. The Opioid Overdose Prevention Program is run by New York State's Department of Health and provides naloxone kits and training to the Wyckoff ED staff for distribution to patients and community members.
- Health Equity: Unintentional Drug Overdose Deaths Remain at Epidemic Levels in NYC, having climbed from 10.2 in 2000 to 44.5 in 2023 per 100,000 residents – over 3000 drug overdose deaths were recorded in NYC in 2023. According to NYC DOHMH data, during 2023, someone died of a drug overdose in NYC every 3 hours. While in 2024, NYC saw significant decreases in the rate of overdose death (29% from 44.5 in 2023 to 31.7 in 2024 per 100,000 residents), death disparities remain significant among Black and Hispanic New Yorkers. In 2024, overdose death rates decreased for the first time since 2018 among Black and Latino New Yorkers but remain about twice as high as the rate of overdose death among white New Yorkers.[24] Given the predominantly Hispanic and

[24] NYC Department of Health and Mental Hygiene: Unintentional Drug Poisoning (Overdose) Deaths. Epi Data Brief No. 150. October 2025.

Black ethnic and racial makeup of Wyckoff's patients, these two interventions will aim to opioid overdoses among the populations at the highest risk of dying of opioid overdose.

Priority #4: Preventative Services for Chronic Disease Prevention and Control

- Actions and Impact: Between July and December 2025, Wyckoff developed and established several new clinics and care coordination initiatives focused on preventing and treating chronic diseases, including the High A1C Clinic, the Gap Closure clinic, and the Gestational Diabetes Care Coordination Program funded by a CVS Foundation grant and managed by the American Diabetes Association.
- Geographic Focus: The services will be offered in Bushwick, Brooklyn.
- Resource Commitment: We have a resource commitment from the 1115 Medicaid Waiver through 3/31/2027 for the chronic diseases management clinics, and from the ADA and the CVS Foundation through November 2028 for the Gestational Diabetes Care Coordination program. Wyckoff is planning to reinvest savings in the cost of care and additional revenue from VBP earnings for enhanced follow up care/closing gaps of care to continue funding the most successful initiatives beyond 2027.
- Participant Roles: The CVS Health Foundation is providing the funds for this 3-year grant initiative, and the American Diabetes Association (ADA) is the grant officer and capacity building partner for Wyckoff. The grant funds will support a new Diabetes Care Coordinator role at Wyckoff who will be working closely with our Medical Champion Dr. Abraham to support all perinatal patients who test positive for gestational diabetes and need to be monitored for follow up after they have their babies. The ADA will also provide training and education for Wyckoff providers and clinics that manage prenatal care and gestational diabetes, as well as regular data reports to help monitor the impact of the initiative. Wyckoff's goal is to enroll and track at least 100 patients over the course of the 3-year grant initiative.
- Health Equity: Wyckoff's EHR data reports from 2024 show that diabetes and hypertension are the two most prevalent chronic conditions among the patients we serve: over 14,000 or 16.6% of our patients have hypertension, and over 9,000 or 10.8% of our patients have diabetes. Black patients at Wyckoff have higher prevalence rates of Hypertension and Diabetes - 21% and 13% of Black patients are diagnosed with hypertension and diabetes respectively. While prevalence rates among Hispanic-identified patients seem similar to the overall patient prevalence rate, we know that over 50% of Wyckoff patients identify as Hispanic and therefore we believe that ethnic disparities are higher than what our data shows given that over 10% of diabetes patients over 34% of hypertension patients had undisclosed or missing ethnicity data in our EHR. Moreover, of the over 9000 diabetic patients seen at Wyckoff in 2024, only 44% have controlled

in New York City in 2024https://www.nyc.gov/assets/doh/downloads/pdf/epi/databrief150-unintentional-drug-death-2025.pdf

diabetes, 13% are uncontrolled, and 43% are missing A1C data so their A1C status is unknown. meaning that they are not engaged in diabetes management care at Wyckoff. Of the over 14,000 hypertension patients seen at Wyckoff in 2024, only 38% had their blood pressure under control and 61% did not. These reflect large gaps in care and future health outcomes for our patients. Therefore, these interventions will address multiple health disparities and improve equity and access to care for diabetes and hypertension, by improving care coordination, patient-tailored education and support, and timely access to medication and medical equipment.

Priority #5: Housing Stability & Affordability

- Actions and Impact: Starting in January 2025, Wyckoff joined our regional Social Care Network (SCN) and committed to routinely screening patients for social determinants of health via a standardized 12-question screening tool of which 3 questions touch on housing needs. We partner with our SCN lead, Public Health Solutions, who provides navigation services to eligible Medicaid patients within 3-5 days of screening positive for a social need. Additionally, in fall 2025 Wyckoff became a member of the NYC Health & Housing Consortium and will be able to access ongoing staff trainings and identify best practices for responding to housing needs of patients in healthcare settings. Finally, by the end of 2026, Wyckoff will create a housing navigation & referral network that will support all Wyckoff care settings (ED, inpatient, and ambulator care) and that will link patients to a NYC housing agency or service within a timely fashion.
- Geographic Focus: The services will be offered in Bushwick, Brooklyn.
- Resource Commitment: We have a resource commitment from Public Health Solutions to provide navigation services and have also allocated hospital funds from the 1115 Medicaid Waiver to support SDOH navigation through 3/31/2027.
- Participant Roles: Public Health Solutions leads our regional WholeYou NYC Social Care Network (SCN) and provides housing navigation services within 3-5 days of a positive housing screen for SCN-eligible Medicaid patients. The Health & Housing consortium - provides training and capacity building support for Wyckoff to identify best practices and intervention to implement a housing navigation network within a hospital setting.
- Health Equity: More than two-thirds of Brooklynites are renters and rents in Brooklyn have risen more than 20% between 2010-2021, leaving more than half of Brooklyn renters and 46% of its homeowners burdened by housing costs.[25]

[25] Office of Brooklyn Borough President Antonio Reynoso: The Comprehensive Plan for Brooklyn, October 2023. Produced in partnership with the Regional Plan Association, the New York Academy of Medicine, and Hester Street

4. **Partner Engagement and Monitoring Plan**

Each of Wyckoff's priorities and objectives will be tracked on a quarterly basis to assess progress and program evaluation metrics will be shared with Wyckoff's Executive leaders, department and program heads involved in the implementation of each intervention, and partners who are funding certain initiatives where applicable. Twice per year, we plan to share outcomes of our interventions and initiatives with our local community partners who participate in the 2025 CHNA as well as others who are active partners and resources in our network of medical and social needs providers for our patients and communities. As part of the continuous assessment and quality improvement activities, we will evaluate if each intervention is running smoothly, if we are on track with achieving the set goals, and make corrections mid-course as needed to further refine the interventions.

5. **Sharing Findings with Community:**

Wcykoff's Community Health Needs Assessment and Community Service Plan will be posted on our website, broadcast to all employees via email, and key findings and CSP priorities will be disseminated internally to the Executive leaders and department heads who will be encouraged to further disseminate these with their teams. The report will be shared via email with each of the community organizations that were interviewed for the CHNA, and all other local partners with whom we have active collaborations.