Wyckoff Heights Medical Center

Established in 1889

Over a century of

Service to our Brooklyn and Queens communities

Three Year Community Service Plan

Submitted September 15, 2009

Second -Year Update for 2010, Submitted; September 15, 2011

Table of Contents

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

COMMUNITY SERVICE PLAN CONTACT INFORMATION SHEET

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County: Kings

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The New York State Department of Health requires all voluntary hospitals to submit a comprehensive Community Service Plan every three years. An annual report is required during the intervening three years.

This Report provides a brief, summary of Wyckoff Heights Medical Center's progress and accomplishment in meeting our communities' diverse healthcare needs at present and moving forward during the next 3 years

Despite economic conditions and a multitude of pressures in healthcare today, our goals remain steadfast.

III Mission Statement

Mission, Vision and Values

Wyckoff Heights Medical Center is a voluntary, not-for-profit, multi-site teaching center, established in 1889, serving the residents of both Brooklyn and Queens.

The Medical Center provides comprehensive primary and secondary level inpatient medical surgical, obstetrical/gynecological and pediatric care services. Teaching programs are allopathic and osteopathic. The Center also provides tertiary healthcare services including renal dialysis, oncology services, and nuclear medicine. Podiatric and dental services are also provided.

The Medical Center's policy emphasizes the implementation of ambulatory alternatives to inpatient care, with expanded community outreach programs, and ambulatory facilities. It stresses the importance of educational and teaching programs. The Medical Center is also committed to the concept of patient centered care.

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

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

The Medical Center will provide the highest level of care for all patients regardless of their ethnic origin, race, creed, color, national origin, sex, physical disabilities, sexual orientation, or ability to pay. The worth and dignity for each individual will be recognized.

The Medical Center will improve the health status of the community by actively participating in an organized, innovative integrated health care system, with a strong managed care focus.

The Medical Center will promote and support all efforts to provide a safe environment for our patients, employees and visitors.

The Medical Center will support and work in partnership with physicians, other health care providers and employees to encourage growth and development to better serve the community and understand and meet the needs of our culturally diverse population.

The Medical Center's health professionals will ensure the patients right to expect quick response to reports of pain.

The Medical Center, while unable to guarantee individual jobs in a changing health care environment, is committed to the ongoing employability of our employees through their growth and development. Working together responsibly with respect for each individual, effective leadership, and stewardship of our resources, we can achieve our goal of being the finest health care providers anywhere.

The Medical Center will foster a scholarly atmosphere and support educational programs that enhance the competency of all persons within the system, to foster delivery of health care that is safe, effective, patient-centered, timely, efficient and equitable.

The Medical Center will develop information systems specifically dedicated to monitoring, updating and improving the quality of clinical and service functions, evaluating market growth, planning proper development and wise use of financial assets.

The Medical Center will provide modern, progressive health care technologies that improve the quality of care.

The Medical Center will provide outreach to special segments of the community with unique needs, such as infants, young children and adolescents, persons with chronic, disabling and life-threatening disorders such as AIDS, and our senior citizens.

The Medical Center will promote and support preventive medicine programs to reduce occurrence of disease processes through education and proactive measures.

The Medical Center will measure its success by the degree that it can determine how well it meets, or exceeds the expectations of the community, and its patients.

The Medical Center will strive to create a service excellence culture and be recognized for it in every aspect of patient care. The Center will seek to establish lifelong relationships with patients by emphasizing that patient always comes first and providing outstanding service.

There have been no changes to our mission.

IV Hospital Service Area

Serving culturally diverse populations in the counties of Queens and Kings, Wyckoff is a full service community hospital.

Services	2009	2010	2011 (First 6 months)
Annual Discharges	19,000	19,808	9,535
Babies Delivered	2,000	1,498	750
Pediatric/Adult Emergency Room Visits	75,000	81,852	50,296
Clinic Visits	85,000	104,238	53,854

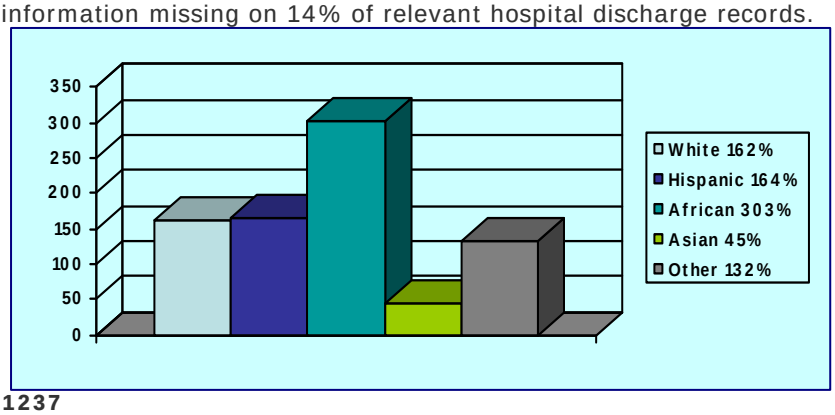
WHMC serves the following catchment areas Central Brooklyn, North Brooklyn, and Western Queens (including the neighborhoods of; Bushwick, Maspeth, Middle Village, Ridgewood/Glendale, East New York, and Bushwick/Bedford-Stuyvesant, Williamsburg/Bedford-Stuyvesant, Williamsburg, Woodhaven, Cypress Hills, Stuyvesant Heights, and Greenpoint).

[1]Wyckoff Heights Medical Center is situated within the zip code area of 11237

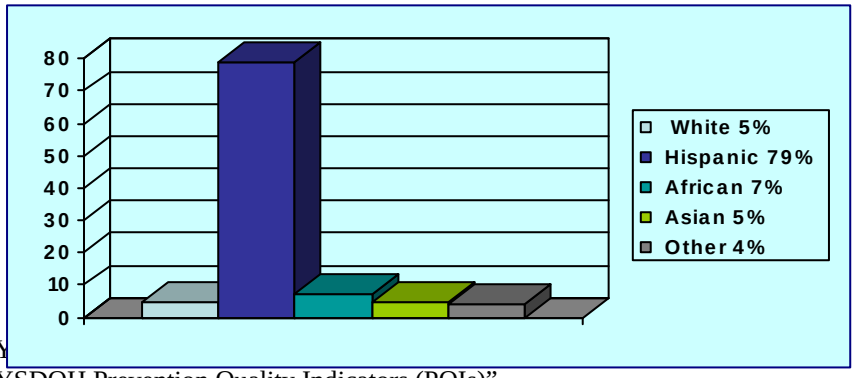
Hospital Admissions in Selected Area 11237	
Area Population	**34,776**
Admission for Condition	**682**
Area Rate	**1,963**
Admission as % Expected	**191%**
Statewide Rate	**1,854**
Area Rate Adjusted for Age & Sex	**3,541**

Admissions as % Expected by Race/Ethnicity[1]

Race/ethnicity information missing on 14% of relevant hospital discharge records.



Population in 11237



[1]"Data from NY

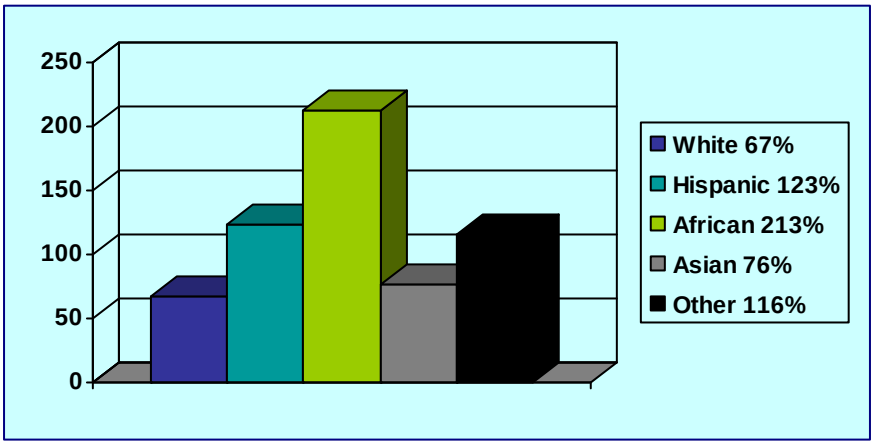
[1]"Data from NYSDOH Prevention Quality Indicators (PQIs)"

WHMC Expanded Catchment Area

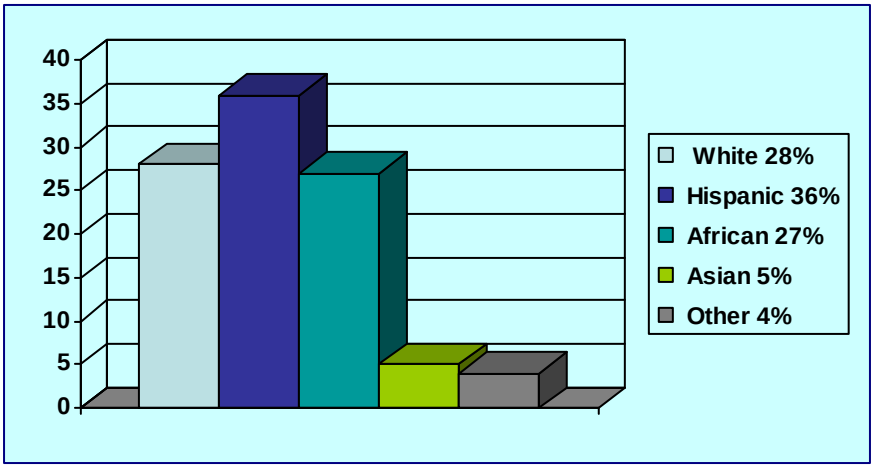
Areas: 11237-Bushwick, 11378-Maspeth, 11379 –Middle Village, 11385-Rigdewood/Glendale, 11207 –East New York, 11221 -Bushwick/Bedford-Stuyvesant 11206 - Williamsburg/Bedford-Stuyvesant, 11211 – Williamsburg, 11421 – Woodhaven 11208 – Cypress Hills, 11233 – Stuyvesant Heights, 11222- Greenpoint

Hospital Admissions in Selected Area 11237 Plus 11378, 11379, 11385, 11207 11221, 11206, 11211, 11421, 11208, 11233 & 11222.	
Area Population	**574,922**
Admission for Condition	**10,736**
Area Rate	**1,867**
Admission as % Expected	**141%**
Statewide Rate	**1,854**
Area Rate Adjusted for Age & Sex	**2,605**

Admissions as % Expected by Race/Ethnicity1 Population Admissions as % Expected



Population in Selected Area Population % Total



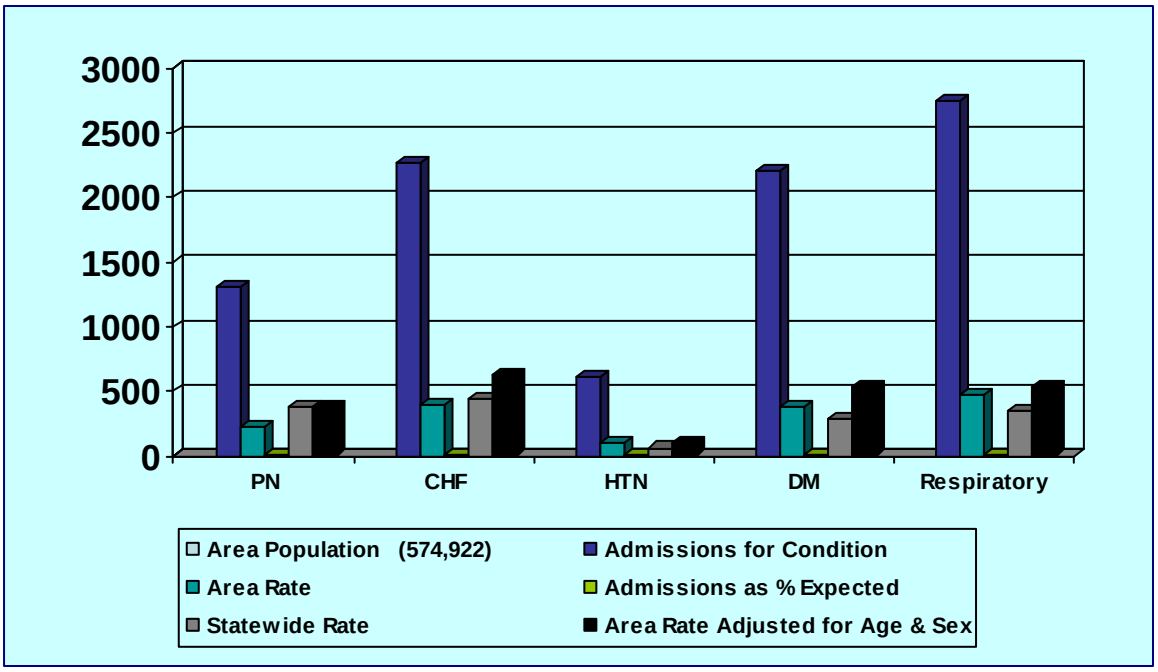
[1]"Data from NYSDOH Prevention Quality Indicators (PQIs)"

Population: All population figures expressed on site come from Claritas estimates for 2006. "Poor adults" refers to adults living below the federal poverty level, as estimated in the 2000 census. The patient counts by ZIP code reflect total hospital inpatient discharges (for adults as well as children) for 2005-2006.

WHMC Expanded Catchment Area *Chronic Conditions*

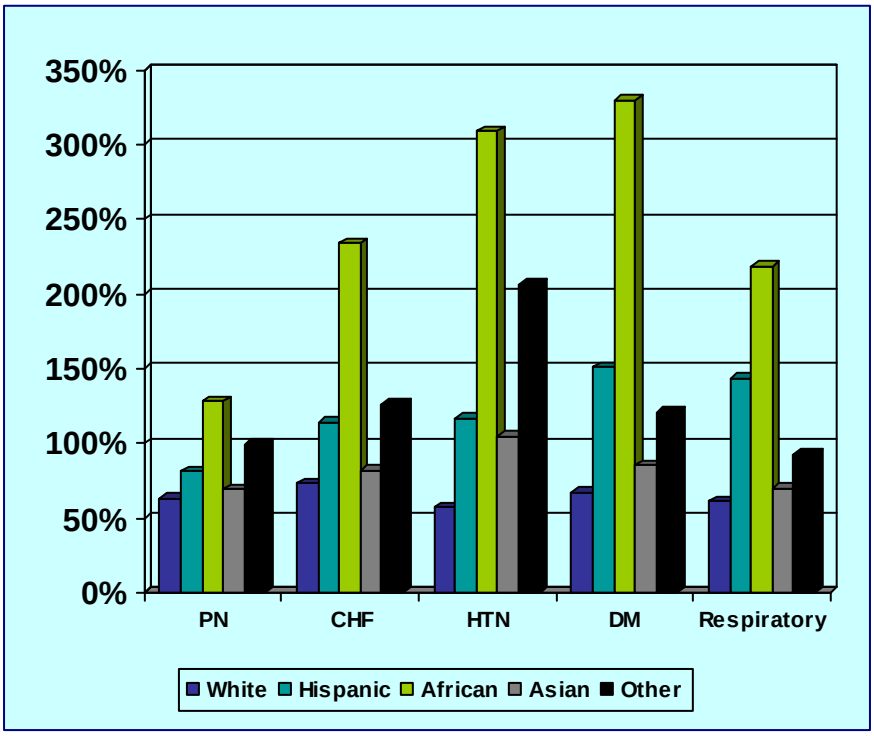
Hospital Admissions in Selected Area	PN	CHF	HTN	DM	Respiratory
Area Population (594,922)					
Admissions for Condition	1,303	2,271	608	2,203	2,739
Area Rate	227	395	106	383	476
Admissions as % Expected	100%	141%	166%	189%	151%
Statewide Rate	381	443	61	283	351
Area Rate Adjusted for Age & Sex	380	626	101	534	531
Admissions as % Expected by Race/Ethnicity1	PN	CHF	HTN	DM	Respiratory
White	63%	73%	57%	67%	61%
Hispanic	81%	114%	117%	151%	143%
African	128%	234%	309%	330%	219%
Asian	69%	82%	105%	85%	70%
Other	99%	126%	207%	121%	93%
Population in Selected Area Population					
White 23%					
Hispanic 36%					
African 33%					
Asian 4%					
Other 4%					

Hospital Admissions in Selected Area



[1]"Data from NYSDOH Prevention Quality Indicators (PQIs)"

Admissions as % Expected by Race/Ethnicity1



[1]"Data from NYSDOH Prevention Quality Indicators (PQIs)"

Methods Used to determine the service area.

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

WHMC Medical Services

WHMC provides a broad array of adult and pediatric acute care services to the community including:

- A 24-hour Emergency Department with separate dedicated pediatric Emergency Services
- Radiology Department providing CT scanning, mammography, ultrasound, nuclear medicine, interventional radiology and MRI services
- Radiation Oncology services
- 24-hour Laboratory services
- Cardiac diagnostic services, including stress testing, echocardiography, electrophysiology and cardiac catheterization
- Complete state-of-the-art Endoscopy testing and treatment
- Pre-natal, Obstetric, and Neonatal care
- Rehabilitation Medicine, Physical Therapy and Speech Pathology
- Pain Management
- Infectious Disease Primary Care Management Program, emphasizing HIV and other STDs
- Oncology
- Neurosurgery
- Cytogenetic Services
- Advanced Wound Healing and Hyperbaric Medicine
- Bloodless Surgery and Medicine

For over 120 years Wyckoff Heights Medical Center has been dedicated to providing continuous preventive health care education options for the communities it serves.

Located in an ethnically diverse residential neighborhood directly on the border of northern Brooklyn and western Queens, Wyckoff Heights Medical Center is a 324-bed teaching hospital. WHMC has a dedicated staff of over 1,973 employees (we have over 400 physicians and 500 nurses) representing thirty-five distinct languages and cultures.

Wyckoff Heights Medical Center has been providing medical care to the community since 1889. Wyckoff offers outpatient services to thousands at our network of community ambulatory care centers and present extensive community health education and screening programs.

Additionally, at a time when many hospitals are experiencing significant reductions in resources and services, Wyckoff Heights Medical Center continues to respond to the growing healthcare needs of the communities we serve by acquiring new equipment and expanding clinical programs. On-site MRI to ensure that community residents do not have to travel outside the neighborhood to access advanced radiological procedures; bloodless medicine and surgery program to accommodate those individuals who for religious or other reasons choose treatment options that do not include blood; hyperbaric chambers to aid in the healing of wounds encountered by diabetic patients in response to a high incidence of wounds due to diabetes; and access to a discrete Women's Health Center that offers a comprehensive range of obstetrical and gynecological services in maximum privacy and comfort for female patients of all ages.

Wyckoff Heights Medical Center provides all cardiology services including clinical, non-invasive, electrophysiology; and diagnostic cardiac catheterization. The cardiac catheterization lab implemented in 2006, now in its fifth year continues to maintain an excellent outcome data. Due to the high prevalence of cardiovascular disease in Wyckoff's population, our experience shows that the severity of coronary artery disease is much higher than other areas. Due to our current service limitations; approximately 900 patients are transferred or visit other major tertiary care center for diagnostic and/or angioplasty/stent placements. We will continue to strive for service expansion essential to accommodate our current patient population.

The hospital has received approval from the NYSDOH for providing Lithotripsy for treatment of kidney stones; services were implemented on December 16, 2009.

Patients who are hospitalized at Wyckoff Heights Medical Center observe uncommon cooperation between the Hospital's clinical and non-clinical personnel. While physicians, nurses and other healthcare professionals oversee the medical management of the patients, non-clinical staff members visit with patients to ensure that their personal non-medical comfort needs are being met. Furthermore, the Hospital's ecumenical Chaplaincy Program provides for the spiritual needs of our patients and their families, and for those who so desire, the Hospital's chapel is available for meditation and worship.

To ensure the future healthcare needs of the communities we serve, Wyckoff Heights Medical Center, residency programs in medicine, family medicine, surgery, podiatry, and dentistry, undertake the responsibility of training new generations of qualified physicians. Upon graduation, a large number of these physicians remain in the surrounding neighborhoods, setting up private practices in order to serve the communities from whom they have learned.

Quality patient care is a dedicated team effort. At Wyckoff Heights Medical Center, we have created a warm, caring place for healing, and our team is ready for you whenever you need us.

V Public Participation:

In addition to WHMC participating with community groups and local health department activities, Wyckoff's outreach efforts include:

- President's Community Advisory Council (PCAC)
- Health Workshops
- Participation in Community Health Fairs

President's Community Advisory Council
In accordance with the direction of its Board of Trustees, Wyckoff has established a President's Community Advisory Council to ensure that the communities served by Wyckoff play a role in fostering its mission. Discussions held during the meeting provide the administration of Wyckoff with feedback from the community, its requests on areas of improvement. Because of the number of patients going through our Emergency Department, changes to the functions and design of the ED were a priority to the community and hospital administration.

1. Wyckoff's President and CEO chairs the President's Community Advisory Council.

2. The President's Community Advisory Council is composed of a member of the Board of Trustees, elected officials, community group leaders and the medical and administrative leadership of the Medical Center.

3. The President's Community Advisory Council meetings take place on a quarterly basis. Emails and letters are sent to all members throughout the surrounding communities.

Community Partnerships

- **Health care provider linkage agreement with Grand Street Settlement (GSS)**
  - Wyckoff Heights Medical Center offers services/information to the Teen Action Program. GSS and WHMC have historically collaborated in providing comprehensive healthcare services to residents of Bushwick/Brooklyn. GSS will refer Teen Action Program participants to WHMC to facilitate access to diverse and comprehensive teen-friendly health care services, including sexual reproductive health (SRH) services. GSS maintains all initial intake and assessment data for each participant to share relevant information with WHMC. This linkage will help participants accomplish program outcomes by expanding access to needed medical and SRH services.
  - GSS partnership with WHMC assists in providing teen pregnancy prevention. The youth development program adapts to age and stage appropriate reproductive and sexuality education. The Teen Pregnancy Prevention Program is meant to provide youth with comprehensive medical, dental and mental health services that go beyond short term interventions.

- **Ridgewood Bushwick Senior Citizens Council, Inc. (RBSCC)**
    - This linkage supplements our program by providing services to our participants at no cost to the program. All referrals are tracked and logged in an intake log. Clients requiring assistance are given a referral form to take to linkage group. A follow-up call is made to ascertain status of referral. The call is logged and includes contact name, telephone number and result of referral.

    - RBSCC partners with WHMC to provide through the healthcare Profession, opportunity grants to serve Teen Action Program recipients and other low income individuals. RBSCC and WHMC will collaborate to enable unemployed community residents to complete training and obtain certifications as certified nursing assistants (CNAs) patient care technicians (PCTs) and medical coders/billers (MCBs).

- **Bushwick Making Children Important (BMCI)**

  BMCI provides participants, primarily in the child welfare system, services such as foster care recruitment and trainings. This has been one of the earliest and most important collaborative relationships formed with WHMC since early 2010. BMCI initiated a dialogue with Wyckoff and together have started several initiatives to better serve our clients, especially focusing on providing conferences and direct support to families in Adult and Children Services (ACS). These volunteer community representatives come not from Bushwick, but its surrounding community partners in Brooklyn, Manhattan and the Bronx.

- **After Hours Project, Inc. (AHP)**

  AHP is a community-based harm reduction program that addresses the continued spread of HIV/AIDS in the predominantly low income and minority neighborhoods where AHP's founders live and work, involving some of our catchment areas such as Bushwick, Bedford-Stuyvesant, East New York in Brooklyn and Ridgewood, Queens.

  AHP provides participants, primarily intravenous drug users, and sex workers, homeless and marginalized people who have little or no regular contact with traditional service providers, with an array of health and social services. AHP and WHMC worked collaboratively to initiate services and better serve our clients, especially focusing on providing HIV/AIDS and Hepatitis medical services.

Other partnerships' in development are:

1. Pediatrics Obesity Program in the local elementary schools and daycare centers.
2. Senior Citizen Outreach Program in the senior buildings and senior centers.

Partnerships through Social Work Department:

Violence Intervention and Treatment Program Community linkage:
VITP maintains memorandum of understanding and/or linkage agreement with following agencies in the community:
Please refer to page 29 for more detailed information on VITP.

- HELP R.O.A.D.S.
- Hope Gardens Healthy Babies Program
- After Hours Project
- Safe Horizon
- Bedford Stuyvesant Alcoholism Treatment Center
- El Puente Academy for Peace and Justice
- Ridgewood Bushwick Senior Citizens Council
- Bushwick Bright Start
- Family Dynamics
- APICHA
- Diana Reyna, Council Member 34th District
- Sakhi for South Asian Women
- Vito J. Lopez, Member of Assembly 53rd District
- Coalition of Hispanic Family Services
- NYC Alliance Against Sexual Assault

Community Education:
Social Work Department provides training/education to community per request at churches, senior citizen centers, day care centers, ethnic groups, high school students on topics such as:

- Insurance information
- Services available from Medicaid & Medicare
- Nursing Home Placement & procedures
- Child abuse laws
- Parenting education
- Benefits for seniors
- Hospital discharges planning
- Disease related biopsychosocial factors and solutions

Linkage with Community Organizations:
Social Work Department maintains relationships with following community/professional organizations:

- Bushwick Bright Start: Home Visiting Program for healthy babies. Director of SW serves on advisory board

- St. Nicholas Homecare Agency: Supervisor of SW serves on Q.A. Committee
- Ridgewood Bushwick Senior Citizen Interagency Council: Director, of SW is a member of the council
- Queensboro Council on Social Welfare: Membership
- Sun B – Senior Umbrella Network of Brooklyn: Membership
- Greater Brooklyn Health Coalition: Membership
- Adult Protective Services: Case Conference Meetings
- Society for Social Work Leaders in Health Care
- Greater New York Hospital Association: Discharge Planning Committee
- Council of Nephrology Social Workers
- National Association of Social Workers

VI Assessment of Public Health Priorities

Access to Quality Health Care:

In our efforts to address our communities' access to quality health care in 2010-2011, all our existing programs have grown in one form or another. The following pages will show the enhancements made in vast areas.

Stroke Care Program

The care our patients receive continues to be our number one priority. That's why we're proud to be among the hospitals recognized by the American Heart Association / American Stroke Association's Get With The Guidelines® in the "*US News & World Report* "America's Best Hospitals" for our excellence in improving quality of patient care and outcomes. Receiving ***Get With The Guidelines Silver Performance Award*** means we have reached an aggressive goal of treating (stroke) patients with 85% or higher compliance to core standard levels of care as outlined by the American Heart Association/American Stroke Association for 12 consecutive months.

Our achievement in implementing and maintaining a elevated standard of stroke care, is ensuring that stroke patients receive treatment set by evidence based best practice recommendations and standards.

"Time Lost is Brain Lost' is the mantra with stroke. The Get With The Guidelines Silver Performance Award makes evident the clear commitment by our staff. We will persevere in our mission as a New York State designated stroke center, to provide optimal care to the communities of Brooklyn and Queens counties in the management of cerebrovascular disorders* (TIAs, Ischemic and

Hemorrhagic strokes) utilizing compassionate care, medical expertise, state-of-the art technology, and rehabilitation prevention through education.

Designation Impact	2009	2010	2011 (First 6 Months)
Cerebrovascular Disorders*	525	474	267
Discharges potentially related to neurological diagnosis.		2803	

Our Stroke Awareness Day, observed on May 3rd, 2011 was a great success. We had participation from several departments; Outreach Program (Diabetic Education plus), Nutritional information from our registered dieticians, Home Care information from participating agencies, an example of which was VNS. We had educational sessions that included EMS & Emergency Department by Betty O'Hagan –ED Director of Nursing; Stroke Care Program details by Dr. Anil Mendiratta – Medical Director, Stroke Care Program; Stroke Prevention Guidelines by Dr. Vijay Saaraswat- Associate Program Director Internal Medicine; Stroke Rehabilitation by Dr. Aruna Thyagaraj- Director of Physical Medicine & Rehabilitation; and to finish Recovery Services by Jackie Lutchmidat, LMSW from Social Work department. We were able to reach over 160 participants.

Stroke Awareness Day, May 3rd, 2011

Emergency

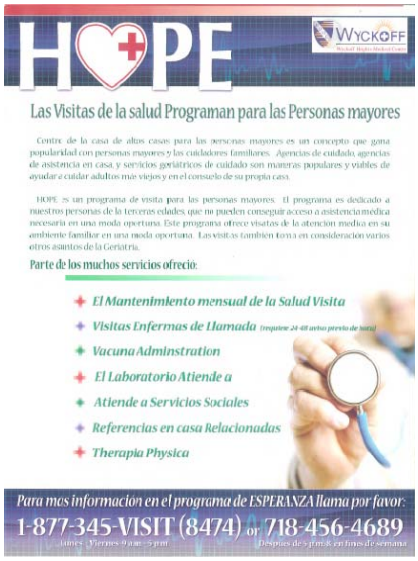
Emergency Services 2010		Update 2011
Patient Satisfaction	***New Emergency Department Ribbon Cutting Ceremony / Aesthetic Enhancements***	***Improved Emergency Department Thru-put times and Patient Flow***
Emergency Department Patient Satisfaction scores are trending upward and have shown consistent improvement throughout the second quarter of 2010. A new ED patient liaison was hired in July 2010, whereby customer service rounds are conducted throughout the Emergency Department treatment and waiting areas. A Hospitality desk has been placed in the ED waiting area, whereby ED staff is assigned to assist patients and family members with their questions and concerns. Customer service rounds and "huddles" are conducted by ED management and staff every shift to help enhance communication and promote excellent customer service.	On July 8th, 2010, Wyckoff Heights Medical Center celebrated the grand opening of the new emergency department. Throughout the first and second quarter of 2010, the emergency department underwent the following renovations: • Fifteen (15) added treatment spaces, from 40 to 55 • New four (4) bedded Fast Track Unit. New Pediatric Trauma Room Doubled size of Pediatric Treatment area (8 more beds) • Added Counseling/Grieving Room Increased Medical gases capability throughout the ED • New EMS entrance and Triage Station New Six (6) bedded Asthma Treatment Area Enhanced Information Technology (60 new computer work stations) Extended and additional nursing stations	The emergency department thru-put time has seen improvements in 2011 for both treat and release and admitted patients. The average length of stay for treat and release patients was 2 hours and 48 minutes and 3 hours and 15 minutes for admitted patients. The average length of stay for admitted patients awaiting a bed assignment has improved by 28% compared to 2010. Patient walk-out rate is 2%, improving from the 2.6% from 2010. The emergency department has cut down on EMS Diversion time in 2011. The emergency department is open to receiving 911 ambulances more than 99% of the time. A corrective action plan to address ED overcrowding was submitted to Administration during the first quarter of 2011. A bed flow team monitors management of beds on a daily basis to ensure timely discharges.
New Triage Process	***Decentralized Registration***	
In January 2010, a shortened triage form was introduced to decrease current triage form completion from approximately 10 minutes to 5minute. In September 2010, a new triage process, the Emergency Severity Index (ESI) Triage, will be adopted and implemented in the emergency department. The ESI triage model yields rapid and clinically relevant stratification of patients into five groups, from level 1 (most urgent) to level 5 (least urgent). The ESI provides a method for categorizing ED patients by both acuity and resource needs. It is considered the best practice by both, the American College of Emergency Physicians (ACEP) and the Emergency Nurses Association (ENA). The new ED triage form has been approved and the nursing staff has completed ESI training in August.	In June 2010, registration processes were decentralized throughout the emergency department. Quick registration is now initiated at the time of triage and registration is completed in different areas of the ED: Fast Track, Main Adult, and Pediatric ED. This registration process has proven to be very effective in rapidly generating an emergency department account number for patients so that lab tests can be ordered at time of triage. Numerous steps have been eliminated or shortened from the registration process which in turn, has increased patient satisfaction. All registration staff has been cross-trained to perform both, registration and admission processes, affording the department with a more flexible and efficient operation.	

Emergency Services 2010		**Update 2011**
Eliminate Holding Area	***Ambulance Electronic Software***	***Meditech Electronic Medical Record***
The ED Holding area was eliminated during the second quarter of 2010. The Emergency Department has newly assigned treatment spaces which utilize the entire emergency department to treat ED patients. There is no longer a designated "holding area" for admitted patients in the Emergency Department. The length of stay for admitted patients in the emergency department has been reduced by almost 50% during the second quarter of 2010, opening up additional treatment spaces to accommodate more patients and reduce ED wait times.	In September 2010, the Wyckoff Ambulance service is projected to begin electronic documentation. The Ambulance Call Report (ACR) will be completed electronically which will in turn, enhance legibility and quality assurance capabilities, as well as improve and maximize billing efficiency. In 2009, the hospital added two additional ambulances in Queens that participate in the NYC-911 system. Wyckoff ambulances transport approximately 1,500 transports a month.	The Emergency Department went live with its Electronic Medical Record (EMR) System in June 2011. The EMR interfaces with the hospital inpatient medical record, allowing a smooth stream of information throughout a patient's hospital stay, as well as on any returning visits. The EMR is equipped with a Tracking Board system that tracks patients' status from arrival until they leave the ED. The new EMR will enhance bed management and patient flow capabilities, as well as provide legible, more comprehensive documentation. Improvement in access and retrieval of medical records has also been noted. Quality of care, patient access to care, and hospital revenue will all improve with the new EMR system.
Therapeutic Hypothermia Program		***Therapeutic Hypothermia Program***
The Emergency Department staff is undergoing Hypothermia Post Cardiac Arrest training and the Medical Center expects to be designated as a Therapeutic Hypothermia Center in October 2010 by the NYC Fire Department. The necessary equipment has been purchased and the protocols have been developed. Therapeutic Hypothermia is a medical treatment that lowers a patient's body temperature to help reduce the risk of ischemic injury to tissue following a period of insufficient blood flow. Studies have demonstrated that patients at risk for ischemic brain injuries (particularly in patients that have experienced loss of spontaneous circulation due to cardiac arrest) have better outcomes if treated with therapeutic hypothermia.		Wyckoff Heights Medical Center was designated as a Therapeutic Hypothermia Center on April 21, 2011 by the NYC Fire Department. The hospital staff has been trained on Hypothermia Post Cardiac Arrest, the necessary equipment has been purchased and the protocols have been developed. Therapeutic Hypothermia is a medical treatment that lowers a patient's body temperature to help reduce the risk of ischemic injury to tissue following a period of insufficient blood flow. Studies have demonstrated that patients at risk for ischemic brain injuries (particularly in patients that have experienced loss of spontaneous circulation due to cardiac arrest) have better outcomes if treated with therapeutic hypothermia.
Sexual Assault Forensic Examiner (SAFE) Program		***Sexual Assault Forensic Examiner (SAFE) Program***
The Medical Center's Domestic Violence and Sexual Assault program was surveyed successfully by the Department of Health during the second quarter of 2010. Emergency Department staff is currently undergoing training and we expect to have a sufficient amount of trained sexual assault examiners to provide around-the-clock coverage by the fourth quarter of 2010. The Sexual Assault Volunteer Advocate On-call schedule has also been enhanced over the last few months, providing patients with additional emotional support. SAFE programs, and specifically trained health professionals, ensure that victims of sexual assault are provided with competent, compassionate and prompt care, while providing the most advanced technology associated with DNA and other sexual assault forensic evidence collection and preservation. The forensic examinations that are performed by trained emergency staff may also increase the successful prosecution of sex offenders for victims who choose to report the crime to law enforcement		The Medical Center's Domestic Violence and Sexual Assault program was surveyed successfully by the Department of Health in 2010 and we expect to be designated as a Sexual Assault Forensic Examiner Center in 2011. The Emergency Department has a sufficient amount of trained sexual assault examiners to provide around-the-clock coverage. The Sexual Assault Volunteer Advocate On-call schedule has also been enhanced over the last few months, providing patients with additional emotional support. SAFE programs, and specifically trained health professionals, ensure that victims of sexual assault are provided with competent, compassionate and prompt care, while providing the most advanced technology associated with DNA and other sexual assault forensic evidence collection and preservation. The forensic examinations that are performed by trained emergency staff may also increase the successful prosecution of sex offenders for victims who choose to report the crime to law enforcement.

Emergency Services 2010		Update 2011
		Sepsis Protocol
		The Emergency Department initiated a Sepsis protocol in 2011, whereby patients are identified during the initial nursing evaluation as being risk of having sepsis. Any potential septic patient will be immediately referred to the Emergency physician for enrollment into the Sepsis protocol to initiate early goal directed therapy for the treatment of septic shock. The protocol will ensure rapid assessments and appropriate and timely interventions while caring for these patients. Sepsis is a condition in which the body is fighting a severe infection that has spread via the bloodstream. World-wide, 750,000 people are diagnosed annually and approximately 500 people die each day.
		Ambulance Service
		WHMC operates a total of three ambulances within the New York City Fire Department 911 System, each unit running 24/7. There is one Basic Life Support unit in Brooklyn and one Basic Life Support Unit in Queens, and one Advanced Life Support Unit in Queens. All of WHMC ambulances are staffed with two (2) NYS Certified EMTs or Paramedics, all with additional training in Weapons of Mass Destruction (WMD) and HazMat events, incident command, and safe vehicle operations. Wyckoff's ambulance service responds to over 1,500 calls per month, in all kinds of weather and conditions.

Please refer to pages for Community Preparedness, also part of Emergency Department

Division of Geriatrics
Elder Care Services:



HOPE: Home Visits Program for the Elderly

Goal: The program aims at keeping the elderly healthy, functional, and independent in our community as well as reducing ER visits, length of stay and re-admissions.

HOPE is dedicated to providing comprehensive health management by various health care providers to homebound seniors in our community. While the program is mainly dedicated to our frail elders, we are also servicing younger patients who are fully or partially homebound and unable to access appropriate health care. Elderly patients mostly suffer from multiple illnesses, functional decline, and dementia; while some younger patients may suffer morbid obesity, cerebral palsy, multiple sclerosis etc. By providing home visits on a regular basis, patients are closely monitored for their functional decline, medication compliance, and provide preventative care.

Since the official launch in May 2009, we have enrolled over 245 patients and observed a 71% reduction in the rate of 30 day-readmissions to the hospital. We are able to manage complex patients, including those requiring tracheostomy and ventilator support, with quality home based care. Additionally, our efforts extend to the nursing home, allowing for better coordination and follow up care.

Services Offered (in home):

- Monthly health maintenance visits
- Sick call visits
- Vaccination Administration
- Lab/Radiology Services
- Social services
- Home Attendant Referrals
- Physical therapy

Acute Geriatric Unit

This year we established an acute geriatric unit, with ten dedicated beds, geared towards providing both standard medical services and advanced geriatric interventions. Our goal is focused towards a multidisciplinary approach for preventing functional decline and sentinel events (falls, decubitus ulcers), decreasing length of stay and averting readmissions; leading to improved transition of care and enhanced patient/family satisfaction.

Services Provided:

- Functional assessment of the elderly/ assistance in ADL's
- Polypharmacy / Beers list drugs monitoring
- Wound care management/ Decubitus Ulcer Prevention & Management
- Early mobilization and rehabilitation/ Fall prevention
- Psychosocial assessment
- Multi-denominational spiritual services

Palliative Care Services

At Wyckoff Heights Medical Center, we have a dedicated palliative care team to address issues regarding management of patients with terminal illness or chronic discomfort. Patients that benefit most from this service are diagnosed with conditions such as cancer, advanced COPD (emphysema), congestive heart failure, HIV/AIDS, dementia, and multi organ failure. The goal is to help patients and their families understand the prognosis of the disease and provide appropriate options for comfort care, including pain management and other non-aggressive treatments. We strive to improve the patient's quality of life through early detection and comprehensive assessment of pain, especially related to advanced illness and end of life status.

Palliative Care Team:

- Provides relief from pain and other distressing symptoms
- Affirms life and regards dying as a normal process
- Intends neither to hasten or postpone death
- Integrates the psychological and spiritual aspects of patient care
- Offers a support system to help patients live as actively as possible until death
- Offers a support system to help the family cope during the patients illness and in their own bereavement
- Uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated
- Will enhance quality of life, and may also positively influence the course of illness
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications

Geriatric Clinic

Geriatric clinic is available for our functional seniors in the community. It focuses on managing co-morbid illnesses, maintaining functional status, evaluating memory, and exploring any psychosocial issues.

Nursing Home

We maintain a strong partnership with the local skilled nursing facilities, which have sustained improvements in the coordination of care and superior quality of health related outcomes for the patient population. Regular meetings are held to monitor and evaluate nursing home placements; with special attention to readmissions and acute care transfers to the hospital. The INTERACT program was established to effectively manage acute care transfers of nursing home patients to the hospital, maintain continuity of care, avoid

unnecessary inpatient admissions, reduce length of stay at the hospital and facilitate timely discharge back to the nursing care facility with thorough discharge planning.

Future Goals

Moving ahead, our vision comprises of a Multi-Disciplinary Geriatric Center, with more trained staff and additional outpatient services for our patients. These services will provide a complete package of health care delivery and would include:

- Geriatrician
- PT/OT
- ENT
- Dental
- Audiology
- Optometry
- Ophthalmology
- Podiatry
- Memory Evaluation
- Mental Health/Psychology
- Elder Care Attorney
- Social Services
- Home Health care agencies
- Meds to Beds Program
- HOPE Program/Sick calls
- Lab/radiology services
- Palliative Medicine / Hospice Care

Community Medicine at the Department of Family Medicine

A. Elderly Home Visit Program:

This program has been part of an ongoing educational curriculum for our residency program to teach our residents the whole spectrum of Family Medicine and Primary Care. It also serves our needy elderly patients with continuity of the care in their familiar home environment, thereby preventing the anxiety of going out of their house to seek medical attention. These patients are home bound and have multiple medical conditions such as DM, HTN, COPD, CHF, Parkinson's disease, and dementia. This program reduces the rate of readmissions for these patients by providing medical care at the comfort of their own home. Once a week, our resident physicians, under the supervision of an attending physician, visit 3 homebound patients to ensure that the home environment is safe for these patients. They assess these patients' general health and provide prescription for their medical condition. If any immunization required, it will be administered. They assess these patients' living conditions, fall risk, and provide devices according to

patient's needs. In addition, they evaluate the nutritional status of these patients and ensure that they have information to obtain food from different sources, such as food pantries, Meals-on-Wheels.

B. Adult Home Day Care Program:

Our residency program has established a partnership with the Brooklyn United Methodist Church (BUMC) Adult Day Care Program. Our resident physicians provide educational workshops for their clients, some of whom are also patients at LaMarca Family Health Center.

C. Domestic Violence:

Under the guidance of an attending physician, our resident physicians provide educational information to women involved in a domestic violence at a nearby Church based community center (Buena Vista). We also provide psychosocial support to patients involved in domestic violence through the WHMC - domestic violence program.

D. Women's Shelter at the Broadway House/CAMBA:

The Department of Family Medicine provides physicians to operate a clinic at this shelter. The physicians and residents provide healthcare maintenance as well education and counseling services to this high risk population.

E. Tar Wars:

For past 4 years our resident physicians have been part of this nationally-recognized, the AAFP sponsored effort. They go to 3-4 elementary schools to teach fifth graders about the consequences of smoking and teach them how to say "no" to smoking. In addition, the students learn to stay away from secondhand smoking and encourage their families to quit smoking. This program encourages them to make a poster of their understanding that is then submitted for a national contest.

F. Alcohol and Substance Abuse Program:

The Department of Family Medicine schedules our resident physicians to provide educational sessions for our neighborhood drug and alcohol abuse center, Door to Life, which is a Church- run program located next door to the La Marca Family Health Center. Many of the center's residents are our patients at La Marca, and these sessions, along with the continuous follow- up at FHC, help this population live healthy.

Community Outreach Program

In beginning of September, our resident physicians start visiting neighborhood schools, churches, and attend community meetings and events. During these visits, our physician provides educational lectures to the audience. This activity is aimed towards population's awareness of preventive medicine and staying healthy throughout life. The lectures series include: Dyslipidemia, DM, HTN, Smoking, Obesity, Sexually Transmitted Infections, Exercise, healthy eating habits and many more health- related issues.

Queens Outreach Program
Queens Community Based Healthcare Services

Objectives are to improve the coordination of community-based care for patients with chronic diseases and reduce patient non-compliant behavior.

Goals are to reduce overcrowding in emergency rooms and preventable hospitalizations.

Wyckoff Heights Medical Center's "Queens Community Based Healthcare Services" project has been awarded funding by the Federal/State governments through the HEAL NY Grant program.
Physician private office practices located in the 11385, 11378, and 11379 ZIP Code Areas are eligible to take part in the Project.

Benefits of participation include:
Patient Navigator Services which provide patient oversight and improved patient specific communication between Wyckoff and physician office practices.
Patient Education and Prevention Services provide support for patient needs related to educational, psychological, psychosocial and/or cultural issues, which typically influence patient behavior.
Private Office Practice Electronic Medical Records and NCQA Recognition Support provides assistance with the installation and subsidizes the cost of an electronic health record system in physician private office practices, and in physician efforts to obtain Level 3 recognition by the NCQA.
The Project's objectives are to improve the coordination of community-based care for patients with chronic diseases and reduce patient non-compliant behavior.
Primary goals are to reduce overcrowding in emergency rooms and preventable hospitalizations.
The Project's infrastructure is a patient centered medical home model of care (PCMH) which is comprised of an administrative coordinator, patient navigators and patient educators who work in conjunction with private physician office practices.

In addition:

The Outreach Program at Wyckoff Heights Medical Center is working to improve community health services offered to in and outpatients, as well as communication between patients, primary care physicians and the Wyckoff Hospital.
Community Organizations, like Senior Centers are also a vital part of community outreach, where sessions on variety of health topics and health fairs are held and provided by Wyckoff doctors.

The main goal of the Outreach Program is to improve the care of patients with chronic diseases: Asthma, COPD, Congestive Heart Failure and Diabetes.

Queens Community11385, 11378, and 11379 ZIP Code Areas

Hospital Admissions in Selected Area	Asthma	COPD	CHF	DM
Area Population (132,871)				
Admissions for Condition	179	172	355	225
Area Rate	135	130	268	170
Admissions as % Expected	77%	72%	75%	76%
Statewide Rate	174	178	443	283
Area Rate Adjusted for Age & Sex	134	128	332	216
Admissions as % Expected by Race/Ethnicity1				
White	40	77	69	62
Hispanic	164	47	88	107
African	Population below threshold			
Asian	14	28	47	24
Other	Population below threshold			
Population in Selected Area Population				
White 61%				
Hispanic 29%				
African 1%				
Asian 7%				
Other 2%				

[1]"Data from NYSDOH Prevention Quality Indicators (PQIs)"

Services for both in and outpatients are offered.
Inpatients affected by above mentioned illnesses are evaluated by Patient Navigator, who on recognizing their educational needs will refer them to the Educator.
After discharge follow up phone calls are made to patients at home by the Patient Navigator and the Educator to address post discharge needs.

Diabetes Education Sessions are offered in the community at 5 different locations, including Senior Centers and Wyckoff Hospital by the Certified Diabetes Educator/ Nurse Practitioner.

Everybody who wants to learn how to effectively control disease is welcome.
Education is offered with Spanish and Polish interpretation, focusing on addressing individual needs so that patient's awareness about diabetes and their compliance is increased.

Diabetes Sessions' participants receive free diabetes education tools to increase their understanding of this chronic illness. We have had about 166 participants to date, 51% of which are known diabetics.
After completion of the session each patient is evaluated and their primary care physician is informed about their patient's health improvements or continued care needs.

Wyckoff's Outreach also attempts to work more closely with community physicians, as it is an important factor in patient's overall health care.

A team is presently working on achieving AADE (American Association of Diabetes Educators) diabetes education accreditation.
Moving forward, an evening session will be added to the diabetes education schedule, to meet the needs of working population of patients with diabetes.

The Diabetes Program at Wyckoff Heights Medical Center aims to offer best care for patients with diabetes so that they live their lives to the fullest.
The Diabetes Education Program will also participate in supporting the **Diabetes Research** being conducted at Wyckoff.

The Diabetic Research Program (DERMS Project)
As previously stated, the incidence of Diabetes in our community is extremely high. Wyckoff's commitment to improving the health of our patients has forced us to look at different alternatives to predicting and preventing the progression of this disease in our surrounding population. Through our Institutional Review Board (IRB) Committee, The Diabetic Research Program (DERMS) has been created and approved.

BACKGROUND
Diabetes Mellitus type 2 (DM 2) is the fastest growing epidemic in United States and with the increase in the incidence and prevalence of obesity, the 2050 projection shows that we will have every third to fifth person suffering from the disease[1]. About 1.9 million people were newly diagnosed with diabetes in 2010, out of which 24.3% were in the age group of 20-45 years[2]. According to National Institutes of Health (NIH) and Centers for Disease Control and Prevention (CDC), total cost of diagnosed diabetes in the United States in 2007 was $174 billion for about 24 million Americans[3]. About 1 in 10 adults in 2007 had diabetes, of which one-quarter were unaware of their status, according to CDC.

We need to intervene earlier in the course of the disease to prevent diabetes related morbidity and mortality. However the biggest challenge that physicians face is to predict which subsets of the patient population have the highest risk of progression to diabetes mellitus. A number of diabetes prediction models have been proposed but most of them are too cumbersome for the physician to apply on their patient population. There is no known diabetes model for predicting incident diabetes in an individual which takes into account HbA1c and the rate of its change over duration of time. The purpose of this study

is to determine whether the rate of change of HbA1c predicts diabetes with accuracy comparable to the QD diabetes prediction model.

We hypothesize that the HbA1c shows a rising trend in pre-diabetics and normal population with risk factors of developing type 2 DM. There is no known diabetes model for predicting incident diabetes in an individual which takes into account the rate of change of HbA1c (dx/dt). In such cases, the rate of change of HbA1c may give the physicians lead time needed to implement the Diabetes Prevention Program measures.

METHODS AND STUDY DESIGN

Definition: In our study, we will follow the American Diabetes Association (ADA) recommended guidelines to use HbA1c to diagnose diabetes mellitus and pre-diabetes as shown below. Tests will be performed in a laboratory using a National Glycohemoglobin Standardization program (NGSP) - certified to Diabetes and Complications Trial (DCCT) assay.

- Diabetes: HbA1c level is 6.5% (47 mmol/mol) or higher
- Pre-diabetes (increased risk of developing diabetes in the future): HbA1c is 5.7% - 6.4% (39 - 46 mmol/mol)

Primary Objective:

1. Study the rate of change of HbA1c in normal population with known risk factors of diabetes
2. To develop a mathematical model which will predict the onset of type 2 DM based on the rate of change in HbA1c valued leading to development of pre-diabetes

Secondary Objective:

1. To evaluate the rate of change of HbA1c as a predictor of Diabetes Mellitus type 2 in patients stratified based on the number of risk factors defined as no risk, low risk, intermediate and high risk (described below).
2. To evaluate the precision of prediction model based on rate of change with the QD score model.

Study Populations

Patients will be screened in the ambulatory medicine clinic at Wyckoff Heights Medical Center and those meeting the inclusion criteria will be recruited in the study. These patients will be tested for HbA1c, random blood glucose, uric acid and lipid profile at baseline and every two months interval for next one year. At each visit, a detailed questionnaire will be given to the patient regarding their demographic parameters, history of hypertension, stroke, TIA, angina, heart attack, family history of diabetes mellitus, dietary habits, physical activity and weight, waist circumference and blood pressure. We will calculate the QD diabetes prediction score by using online available calculator in each patient at every visit and compare the change in score over time from last visit and then compare it with the rate of change of HbA1c over time.

Study Interventions
Standard lifestyle recommendations, which include conventional instructions regarding diet and exercise, will be provided to all participants.

Study Design

Outcome Measures: Primary end-point will be taken as the point when the HbA1c will touch 5.7 or greater. Values will be extrapolated over time to reach the end-point of HbA1c 6.5%.

Estimated Enrollment:	1000
Study Start Date:	March 2011
Estimated Study Completion Date:	June- July 2012
Estimated Primary Completion Date:	July-August 2012 (Final data collection date for primary outcome measure)

Duration of follow up: 1 year

Elimination/Termination Criteria: Any patient with HbA1c value $\geq$ 5.7% will be terminated from this study as primary end-point will be reached. This patient will then be enrolled in the Diabetes Prevention Program (DPP).

Eligibility

Ages Eligible for Study: Greater than 18 years

Genders Eligible for Study: Both

Social Work Department Outreach:

Violence Intervention and Treatment Program
VITP is a community program funded by Department of Health (DOH) and Office of Victim Services (OVS). Following activities are carried out by the program:

Project Envision-Williamsburg is a primary prevention, community mobilization effort to support the Williamsburg community in preventing sexual violence in a sustainable way. VITP's Program Coordinator holds a leadership role in the Envision-Williamsburg Coalition, responsible for primary prevention programming and for working with other Rape Crisis Programs such as Safe Horizon Queens and Brooklyn, St. Luke's Crime Victims Treatment Center-Downtown office, and the NYC Alliance Against Sexual Assault. Currently, Envision-Williamsburg is partnering with St. Nick's Alliance to bring sexual violence prevention training and support to male staff, in order to deliver prevention programming to male youth in this community center.

Volunteer Advocate Program empowers community members to help victims of Rape and Domestic Violence. VITP's Program Coordinator trains and supervises Volunteer Advocates in providing crisis intervention and advocacy in the case of an adolescent or adult reporting sexual assault in the WHMC emergency department. Volunteer Advocates also offer their skills at VITP outreach and education events at the hospital and within the Bushwick community. Currently, we have *40* community members as active volunteer advocates.

Community Connections & Outreach: VITP staff has presented at the Sexual Assault Forensic Nurse Examiner (SAFE) training at NYC Alliance Against Sexual Assault, CONNECT domestic violence organization, and various local schools and Community Based Organizations (CBOs). Staff also actively participates in city-wide task forces including the NYC Sexual Violence Direct Service Collaborative, Brooklyn Sexual Assault Task Force, Downstate Crime Victims Task Force, NYPD Sexual Assault Task Force and Mayor's Office's Task Force on DV; in addition, they collaborate with RCPs in local legislative and criminal justice actions. The Spanish speaking staff offers Spanish-language workshops to local CBOs.

Outreach Connections	2010 Outreach		2011 Outreach (Jan-Jul)	
People Reached by Categories:	# Events	# Reached	# Events	# Reached
Outreach Events	23	475 people	12	300 people
Training/Workshops	36	550 people	21	400 people

Counseling, Support & Referral Services: VITP offers language appropriate counseling services to victims & families of sexual assault & domestic violence. Services are free regardless of insurance and immigration status. Anyone from the community can call program's hotline 1-888-992-5699 to access services. Evening hours for individual counseling & therapy are also available if needed.

	2010	2011 (Jan – Jul)
# Counseling/Therapy Sessions	279	205
# Helped via Counseling/Therapy Sessions	88 clients	97 clients

Healthy Mothers, Healthy Babies, Healthy Children

Goal: To Increase Percentage of Breastfeeding Initiation to 85% by 2012

For May of 2011, latest WICSIS Breastfeeding report is 81.8% compared to 74.8% in June of 2010.

a. Peer Counselors teach breastfeeding classes to mothers of newborns on hospital maternity floor (facilitate latch and positioning).
b. Peer Counselors provide breastfeeding classes to pregnant women at Women's Health Clinic (breastfeeding outreach/ anticipatory guidance).
c. WIC clients receive prenatal breastfeeding classes designed to promote breastfeeding and inform pregnant women about their breastfeeding rights in the hospital and in public (anticipatory guidance).
d. For our activities of promotion and support, we have added a monthly meeting of the "Breastfeeding Mothers Club" to increase social support and increase breastfeeding duration.
e. Availability of walk in breastfeeding clinic to provide one on one technical breastfeeding support and increase duration.

Encouragement and promotion of breastfeeding among prenatal women, as well as providing support to breastfeeding women, is one of the goals at WIC. Breastfeeding an infant creates a strong foundation of health, development, and growth.

Infant mortality rate can be significantly reduced by breastfeeding. The American Academy of Pediatrics recommends breastfeeding for at least the first six months of life in order to improve infant outcomes.

Ways in which the hospital promotes breastfeeding are:

- Referring eligible pregnant mothers and infants to WIC.
- Allowing 24 hours rooming in for mothers and their newborns.
- Early initiation of breastfeeding within the first hour after birth.
- Working toward becoming a Baby Friendly Hospital
- Providing prenatal breastfeeding education classes which discuss the risks of formula use vs. the benefits of breastfeeding.
- Promoting breastfeeding as the natural way to feed an infant.
- Facilitating the transition from pump to breast for infants in NICU when such babies are developmentally ready.
- Discharged breastfeeding mothers with an appointment to return within 2 days for observation on breastfeeding routine.
- Utilizing WIC Peer Counselors to provide basic breastfeeding skills and support to the mothers and their babies on the maternity floor.

Goal: To Decrease the Percentage of Low Birth Weight and Poor Health Outcomes for Babies

A. *The WIC Program implements strategies to enroll prenatal visits as early as possible at least by the first trimester.*
   1. *Our WIC Program State Generated Report for June 2010/2011:*

	6/2010		*6/2011*	
	WHMC	***NYS***	***WHMC***	***NYS***
First Trimester Prenatal Enrollment	*40.2%,*	*37.57%*	*42.9%*	*39%*

- In both years, our First Trimester Prenatal Enrollment performance rate exceeded the NYS rate
- Also our 2011 performance rate exceeded 2010 performance

   2. *A designated community liaison visits maternity & women's health clinic to provide appointments for prenatal women at their first or second prenatal visits.*

B. *WIC provides prenatal nutrition education to decrease low birth weight percentages, and provides early care for better health outcome.*
   1. *WIC State Computer Generated (WICSIS) Report for our local agency's low birth weight (LBW) infant enrollment.*

	WHMC		***WHMC***	***Natl. Avg.***
	1Q 2010	*2Q 2010*	*1Q-2Q 2011*	*Y10/11*
Low Birth Weight Infant Enrollment	*6.3%,*	*5.78%*	*7.2%*	*10-12%*

- Although our 2011 performance rate exceeded 2010 performance, there remains significant opportunity for improvement when compared to the national LBW enrollment threshold.
- The department is working to sustain this upward trend to improve our early LBW enrollment rate

Our consideration for focusing on early prenatal care is a result of the following:

New York City Health Indicators Premature Births by Race/Ethnicity	2005	2006-2008
African-Americans	19.4%	16.8%
Hispanics	12.9%	13.2%
Caucasians	12.5%	10.9%

[1]"Data from NYSDOH Prevention Quality Indicators (PQIs)"

Risk Factors for Premature Births

- Congenital anomalies
- Previous premature birth
- Multiple gestations
- Placental disorders
- Incompetent cervix
- Infections

- Anemia
- Stress
- Poor nutrition
- Inadequate prenatal care
- Maternal age (<18 or >40)
- Low socioeconomic status
- Alcohol and Substance abuse

Early prenatal care is crucial for optimal fetal growth and development and the well being of the mother. The hospital positively impacts early pregnancy detection and early enrollment by the following:

- The hospital offers free pregnancy tests.
- We offer family planning counseling and referrals to the hospital OBGYN clinic as needed.
- All patients desiring prenatal care receive an appointment with the OBGYN clinic.
- We provide verbal and written instructions on documents required to apply for Medicaid for Pregnant Women (formerly PCAP). This facilitates and expedites the application process.

Prenatal and Postnatal care of newborn and mother is enhanced by the following offered at Wyckoff:

Parental Education

- Introduction to NICU
- Promote and encourage Breast-Feeding with Lactation and NICU Nurses
- Encourage Kangaroo Care
- Provide emotional support to parents
- Neonatal CPR education to parents prior to discharge

Parental Counseling

- Social Services
- Parental Support Groups
- Psychiatric Specialty Care
- Care for Postpartum Depression and/or Post Traumatic Stress Disorder

Developmental Assessment Clinic

- Follow-Up of premature and high risk newborns
- Evaluation of Growth and Development
- Coordination of Specialty Care
- Early Intervention Program – ICC (Intra-agency Coordinating Council)

Prenatal participation in the WIC Program has been shown to reduce the incidence of low birth weight babies. WIC also reinforces the importance of ongoing prenatal care and healthy lifestyle choices for pregnant women. Accordingly it is recommended that the hospital prenatal clinic complete the WIC medical form and refer all eligible women to the WIC Program. It is also crucial for the hospital to continue its relationships with *Newborn Home Visiting Program* in order to provide a complete support to the pregnant women.

Please refer back, Access to Quality Health Care: Community Medicine at the Department of Family Medicine; Home Visit Program-where program detail is defined.

Future Plans:

Early prenatal outreach may also be accomplished through community outreach campaigns. Outreach workers will be sent to health fairs/street festivals to promote the importance of early and ongoing prenatal care. They will also develop a network with other community partners in order to promote/facilitate linkages and referrals to the OBGYN clinic.

Physical Activity and Nutrition:

Goal: Healthier Lifestyle through Increased Physical Activity and Improve Eating Habits

WIC provides Physical Activities and Improve Eating Habits of our WIC population, targeting also our overweight/ obese children. Our FIT WIC initiative targeting overweight children has been in place for over three years and this initiative has been continued by NYSDOH due to the improvement in children's BMI (Body Mass Index). Our results through annual follow up (statistics) shows 60% decrease in BMI for overweight/obese children for FFY 2009 and mid FFY 2010. Our promotion of Healthy Lifestyle for our WIC families and their children will be ongoing.

For the first and second quarter of 2011, a 60% average decrease in BMI has been shown with our obese/overweight children (consistent with previous year 2010).

	WHMC			***Natl. Avg.***
	1Q 2010	*2Q 2010*	*Jan 2010 to June 2011*	*Y10/11*
Enrolled Overweight Children (children on the 95th percentile for weight/height)	*13.2%*	*12.9%*	*12.4%*	*10-12%*
o The combined 2010 –June 2011 performance rate exceeded prior years' performance by 12.4% o *Through ongoing nutrition intervention, we endeavor to continue to assist the decrease in children's BMI and likewise the percentage of overweight children that need to be enrolled*				

This years 2011 FIT WIC innovation, our agency initiated and introduced Yoga for kids, and Zumba dance activities for this same group. Compared to Yoga, Zumba focuses more on constant movement and raising the heart rate. Yoga on the other hand teaches concentration, strength, and flexibility. When done on a regular basis, both activities can help children reach a healthy weight. We hope to continue on going physical activity intervention for our overweight children to improve their health.

This prevention agenda is about physical activity and nutrition. The goal of this is to develop strategies to motivate participants and their families to adopt a healthier lifestyle. This effort also support the mission of the New York State Strategic Plan for overweight and obesity prevention to decrease the prevalence and reduce the burden of obesity-related diseases by improving healthy eating and increasing physical activity.

The WIC Program provides nutrition education and food vouchers to low income women, infants and children up to 5 years of age. The *FIT WIC program* is a Healthy Lifestyle Initiative that supports prevention of childhood obesity through nutrition education, food demonstration and physical activity classes.

Our nutritionist shows parents and caretakers how to shop for nutritious foods and instruct them on how to prepare healthy easy to cook recipes.

Future Plans:

As we look ahead to the future WHMC wants to ensure that our program services and facilities meet the changing needs of all residents in our community.

Community Preparedness

Hospital Emergency Operations Plan Updates and Revisions 2011

1. Hazard Vulnerability Analysis: The Medical Center has conducted a review and revision of the Hospital's Hazard Vulnerability Analysis in the Emergency Operations Plan to reflect the likelihood of event occurrences and the preparation required for each event.
2. Updated Industrial Chemical List: Updated Toxic Release Inventory (TRI) from the EPA as it relates to the neighborhood factories and businesses located within Wyckoff's catchment area. Having knowledge and information on the different chemicals that exist in the community helps better prepare the Medical Center for a pending disaster.

3. Disaster Privileges: Added new section titled Disaster Privileges with description of various government agency sponsored services. The section discusses the

rapid credentialing of volunteer staff and use of staff from services such as the Disaster Medical Assistance Team (DMAT). In the event of a disaster, the Medical Center has a plan to incorporate volunteer assistance from the community.

4. Mass Fatality Management Plan: Revision and updates to the Mass Fatality Management Plan to reflect the DOH recommendations. The Medical Center has a plan that addresses a high mortality rate in the event of a disaster such as a pandemic or terrorist attack.

5. Critical Asset/ Equipment: Critical Asset Survey was completed in accordance with the DOH requirements. Hospital equipment and supply inventory has been updated. Inventory of hospital Disaster pharmaceuticals has also been updated. The Medical Center works jointly with the Department of Health and other area hospitals to ensure that the medication needs of the community are met in the event of a disaster.

6. Evacuation Plan: Revisions and updates have been made to the Evacuation Plan. These revisions have been made as a result of conducting a Table-top exercise and hospital-wide evacuation drill in 2010 and 2011.

7. Bomb Threat Plan: Revisions were made to the Hospital's response to a bomb threat in 2011.

8. Weather Related Emergencies: Updated Weather Related Emergencies section which provides checklist for weather alerts and advisories. These updates were made as a result of the snow storms, heat advisories and tornado which impacted the Medical Center in 2010 and 2011. WHMC works extremely close with the New York Presbyterian System Emergency Preparedness Forum members, City agencies such as OEM, DOH, CDC, FDNY, and NYPD in preparing and responding to city-wide weather related emergencies.

9. Mental Health Plan: In 2012, WHMC is looking to enhance the Mental Health Plan during a disaster for members of the community and hospital staff.

10. Training Center, EMS and Emergency Preparedness division:

    - As "Partners in Preparedness" with the NYC Office of Emergency Management (OEM), we have informational displays regarding obtaining notification from OEM of what is going on in their area, preparedness for hurricanes, Go Bags, etc.
    - We have gone out to the community and offered informational seminars on emergency preparedness and how Wyckoff has prepared for many events, and also conducted these seminars in Spanish to our primarily-Hispanic community.

- We have involved the 83rd Precinct Auxiliary Police Officers and the area Community Emergency Response Team (CERT) to participate in our disaster drills in order to incorporate and familiarize them with our facility, staff, and operations.
- We have offered CPR classes to the community at either a discounted rate or for free during CPR Week, especially to those from the Church groups.
- We've reached out to the community to promote heart healthy eating and lifestyle, and to take first aid / CPR courses at health fairs, along side the Community Coach, through handouts supplied by the American Heart Association, etc.
- We provided Ambulance Service stand-by's for some fund raisers such as the Cancer Walks at Maurice Park.
- We have provided free check of vital signs (BP, pulse regularity, lung sounds) at various health fairs or mass events and church bazaars.
- We have offered ride-a-longs on the 911 EMS ambulances to those over 18 years of age that are interested in a career in EMS or emergency medicine to see if it is something they would like to pursue. NOTE: They must sign a waiver before riding.
- We donated a used ambulance to the Pastor Jose Cambero, affiliated with Wyckoff, for him to bring to the Dominican Republic to use over there
- We offer our CPR courses for free to anyone that volunteers at Wyckoff as a way to say "thank you" and to help give something back to those that have given to us.
- We have mentored several HS students that have come to our facility to learn about medicine and prehospital medicine careers.
- We have attended numerous "Career Day" affairs at various junior and high schools, to inform students of careers in the medical field and emergency services.

Infectious Disease

Goal: Reduce incidence of and Mortality from HIV in the Community

2011 update:

Positive Health Management is a comprehensive HIV primary care and Prevention program that is associated with the ambulatory care system of Wyckoff Heights Medical Center since 1995. The program boosts culturally competent services which are provided by bilingual service providers. Our services are targeted to those living in the communities of Northern Brooklyn and Western Queens. The goal of Positive Health Management is to provide excellent and safe care to persons who are at risk for or who are already infected with HIV. Below is an updated summary of each of Positive Health Management's program.

The **Primary Care** services are located at WHMC and the medical services are provided by a group of HIV specialists. Our ancillary program staff members are also accredited in their fields and support the clients as their receive primary care. The following is a listing of our services according to their funding source. .

NYS DOH/AI and CDC Primary Care, Medical Case Management and Health Education: Primary Care services are provided by 3 HIV Specialist who are supported by a team of Medical Case Managers, a Social Workers and a Health Educator. The services including: several approved interventions as part of the Centers for Disease Control and Prevention (CDC) Diffusion of Effective Behavioral interventions (DEBI): Healthy Relationships, CLEAR, and Partnership in Health in addition to Motivational Interviewing

NYCDOHMH/Public Health Solutions - Care Coordination (CC):
As of August 1, 2011 we have met and exceed our target enrollment for this program by 6%, and we are looking to expand the program. Also in 2011 we were the 1st CC program to invite our NYCDOH Senior Project Officer (SPO) along w/ interns from the DOH to observe one of our Curriculum Training sessions. Mr. Dugan, SPO note he was very impressed w/ the way in which we provided the training.

NYSDOH/AI – Women's Supportive Services (WSS) In 2010 the WSS program provided services to 117 clients and it anticipates providing services to 125 clients in 2011. Additionally, in 2010 outreach services conducted 360 client contacts and distributed over 500 condoms.

The **Prevention services** component provides an array of prevention services both on site at WHMC and in the community on our mobile screening van. These services are all Free and have limited qualifications to participate in the services. The 3 programs include the following:

NYCDOHMH/AI – Public Health Solutions for Cofactors of HIV Transmission:
In June 2011 we received notification from Public Health Solutions and the NYCDOHMH that as of July 1, 2011 due to budgetary cuts on the federal, state and local level that all COF projects would receive a funding cut. For WHMC this resulted in a 21% cut in funding to this project. Additionally, WHMC was notified that our COF program would be eliminated at the end of 2011 due to these same budget cuts. WHMC is currently grieving this cut since we were the only COF program eliminated although we have an exemplary record, according to PHS and NYCDOH, in providing the COF services. If the decision is not over turned WHMC's-COF program is expected to end on 12/31/11.

To date the COF program has provided the following
2996 screening for MH and SU issues
2420 screenings for Chlamydia and Gonorrhea
2385 for Syphilis, Hepatitis B and C (2% positive rate for urine and blood)
335 HIV tests (.5 positive rate)

In 2010 WHMC was 1 of only 2 programs asked by the NYCDOHMH to participate in the piloting of 2 new screening tools for the COF project. At the end of the project these tool were implemented into program services.

Center for Disease Control and Prevention – Community Based project:
In 2011 we entered into our 2nd project year under this contract. In the 1st year of the contract we tested 335 people for HIV and identified 1 new person (.3% positivity rate) with HIV. This person was also linked into medical care and enrolled in Care Coordination services at WHMC.

SAMHSA - HIV TCE HIV Outreach:
In October 2011 we will enter into our 3rd contract year for this project. Over the course of this project we have enrolled 409 people into our case management services and had 86% complete the program. We have also tested 373 people for HIV and identified 5 new individuals with HIV (1.3% positivity) rate and linked 100% of them to medical care.

NEW in 2011:

WHMC-PHM was awarded a new grant from the NYCDOHMH and Public Health Solutions for Routine HIV testing in clinical settings. This grant is for 4 years for $214,365 per year. This new grant will allow us to introduce the new HIV testing technology to WHMC by using a Multi Platform Analyzer (MPA) which according the published articles may allow us to detect HIV up to 20 days earlier than antibody-only tests, which is important in controlling the spread of the virus. This is important because

people who receive false negative results because they are acutely infected with HIV remain are at the highest risk to transmit the HIV virus, unknowingly to others. This project is expected to start on October 1, 2011.

VII Financial Aid Program

The biggest challenge for Wyckoff related to the provision of financial aid is that Wyckoff serves an indigent and underserved community. 55-60% of Wyckoff's patients are covered under the state's Medicaid program and most of those 60% opted to have their coverage administered by a Managed Care carrier. Another 5-10% of Wyckoff's patients are completely uninsured.

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

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

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

In 2010, Wyckoff provided $5.3 million in charity care and an additional $17.5 million in uncollectible patient billing for a total of $22.8 million uncompensated care. Having to provide uncompensated healthcare at this disproportionate level weakens the financial viability of Wyckoff. However, Wyckoff will continue to fulfill its mission of providing healthcare to our community without compromising safety or quality.

VIII Changes Impacting Community Health/Access to Services

Recent federal healthcare reform legislation and ongoing reductions in Medicare and Medicaid reimbursement will require Wyckoff, as well as most hospitals around the

country, to develop a tightly integrated service model which provides for an increased coordination of patient care and reduces duplicative efforts and services. System fragmentation among doctors, medical groups, outpatient centers and hospitals will need to be minimized.

Wyckoff has begun efforts to improve the integration of clinical relationships with private physician office practices in the Hospital's primary and secondary service areas. We have developed a patient centered medical home model of care to improve the coordination of healthcare services provided to patients residing in these areas. We are currently working with the New York City Division of Health Care Access and Improvement to assist local physicians with the installation of electronic health records in their private office practices. Wyckoff's intent is to provide an interoperable IT infrastructure for all of its service area healthcare providers to establish the ability to share clinical information electronically.

IX Dissemination of the Report to Public

Our CSP will be posted on our public website: http://www.wyckoffhospital.org/.
We will make it available to the Community Boards of Brooklyn and Queens and our community partners.
Each member of the President's Advisory Council will also receive a copy.

Brooklyn			
Community Board 1			
Neighborhoods: Williamsburg, Greenpoint	CB Address: Brooklyn Community Board 1 435 Graham Avenue, Brooklyn, NY 11211 Phone: 718.389.0009 Fax: 718.389.0098 Email: bk01@cb.nyc.gov Web site Chair: Mr. Christopher H. Olechowski District Manager: Mr. Gerald A. Esposito Board Meeting: Second Tuesday, 6:30pm Cabinet Meeting: Third Thursday, 10:30am		
Community Board 2			
Neighborhood: Fort Greene	CB Address: Brooklyn Community Board 2 350 Jay Street, 8th Floor Brooklyn, NY 11201 Phone: 718.596.5410		

	Fax: 718.852.1461 Email: cb2k@nyc.rr.com Chair: Mr. John Dew District Manager: Mr. Robert Perris Board Meeting: Second Wednesday, 6:00pm Cabinet Meeting: Per agenda		
Community Board 3			
Neighborhoods: Bedford-Stuyvesant, Stuyvesant Heights	CB Address: Brooklyn Community Board 3 1360 Fulton Street, Brooklyn, NY 11216 Phone: 718.622.6601 Fax: 718.857.5774 Email: bk03@cb.nyc.gov Web site Chair: Henry Butler District Manager: Ms. Charlene Phillps Board Meeting: First Monday, 7:00pm Cabinet Meeting: Fourth Thursday, 9:30am		
Community Board 4			
Neighborhoods: Bushwick and Ridgewood	CB Address: Brooklyn Community Board 4 315 Wyckoff Avenue, Brooklyn, NY 11237 Phone: 718.628.8400 Fax: 718.628.8619 Email: bklcb4@verizonesg.net Web site Chair: Ms. Julie Dent District Manager: Ms. Nadine Whitted Board Meeting: Third Wednesday, 6:00pm Cabinet Meeting: Second Wednesday, 10:00am		
Community Board 5			
Neighborhoods: East New York, Cypress Hills	CB Address: Brooklyn Community Board 5 127 Pennsylvania Avenue, Brooklyn, NY 11207 Phone: 718.498.5711		

	Fax: 718.345.0501 Email: bklcb5@verizon.net Chair: Mr. Nathan Bradley District Manager: Mr. Walter Campbell Board Meeting: Fourth Wednesday, 6:30pm Cabinet Meeting: Third Wednesday, 10:00am		
Queens			
Community Board 5			
Neighborhoods: Ridgewood, Glendale, Middle Village, Maspeth	CB Address: Queens Community Board 5 61-23 Myrtle Avenue Glendale, NY 11385 Phone: 718.366.1834 Fax: 718.417.5799 Email: qnscb5@nyc.rr.com Web site Chair: Mr. Vincent Arcuri, Jr. District Manager: Mr. Gary Giordano Board Meeting: Second Wednesday, 7:30pm Cabinet Meeting: First Wednesday of every other month, 10:00am		
Community Board 9			
Neighborhood: Woodhaven	CB Address: Queens Community Board 9 Queens Borough Hall, 120-55 Queens Boulevard, Rm. 310A Kew Gardens, NY 11424 Phone: 718.286.2686 Fax: 718.286.2685 Email: communitybd9@nyc.rr.com Web site Chair: Ivan Mrakovcic District Manager: Ms. Mary Ann Carey Board Meeting: Second Tuesday, 7:45pm Cabinet Meeting: Third Thursday, 10:00am		

X Financial Statement

Financial data has been submitted to the Department of Health through the Institutional Cost Report (ICR).