Application Number: 241142

Facility Name: Montefiore Medical Center - Henry & Lucy Moses Div

Project Description:

Executive Summary

Montefiore Medical Center is proposing to renovate the space on the [redacted] at the Moses Division which is currently a medical/surgical unit and convert the space for an additional [redacted] bed Intensive Care Unit. The capital costs related to this project are estimated at $14,581,077. .

Background

Montefiore Medical Center – Montefiore Hospital at the Moses Campus currently is licensed for 48 adult Intensive Care beds. There are currently 24 adult Surgical and Cardiac Surgical ICU beds on [redacted], 13 adult Medical ICU beds on [redacted], and 11 adult Neuro ICU beds on [redacted].

There has been a need to increase this number of ICU beds, as the provision of tertiary and quaternary care has grown and the patients admitted to Montefiore present with increasing complexities. The Montefiore Moses campus currently consists of only 48 adult intensive care beds, 6% of the total bed capacity. Note that the national ratio of ICU beds to total beds has been found to be 14%-16%. Over the last several years, our complexity and the acuity of patients has continued to grow. In addition, we have experienced increases in our surgical volume necessitating the expansion of our intensive care capacity.

We continue to grow our external transfers into our facility. Since 2019, our transfer center has had a [redacted]% increase in transfers. Each day, [redacted]. We have seen growth in the Montefiore Health System, which requires our ability at the Moses hospital to be able to accept referrals from our member hospitals for quaternary care and intensive care.

This expansion will help us reallocate our existing bed resources to better serve our community. Montefiore continues to be focused on investing in the Bronx and in our communities.

Project Description

Through this project, Montefiore Medical Center will renovate space on [redacted] on the Moses campus to convert an existing medical/surgical inpatient unit into a state-of-the-art [redacted] bed intensive care unit. This project will result in a modern facility that will respond to the complicated clinical needs of the population with a patient-centered approach to care delivery. The new ICU will be designed to enhance the experience for patients and their families while supporting the care team in delivering advanced life-saving care.

Impact of the Project

There will be no substantive impact on staff, revenue and expenses as a result of this project. The impact of the project will increase the availability of intensive care services closer to the Bronx communities, where most of our patients live and will increase our capacity to care for patients with complicated clinical needs and life-threatening health issues. Increasing the number of intensive care beds in an addition unit will help to centralize intensive care resources into another specialized, geographic location will reduce staff burden, improve patient care and clinical outcomes.

Project Narrative

Montefiore Medical Center is proposing to renovate the space on the [redacted] at the Moses Division which is currently a medical/surgical unit and convert the space for an additional [redacted] bed Intensive Care Unit. The capital costs related to this project are estimated at $14,581,077.

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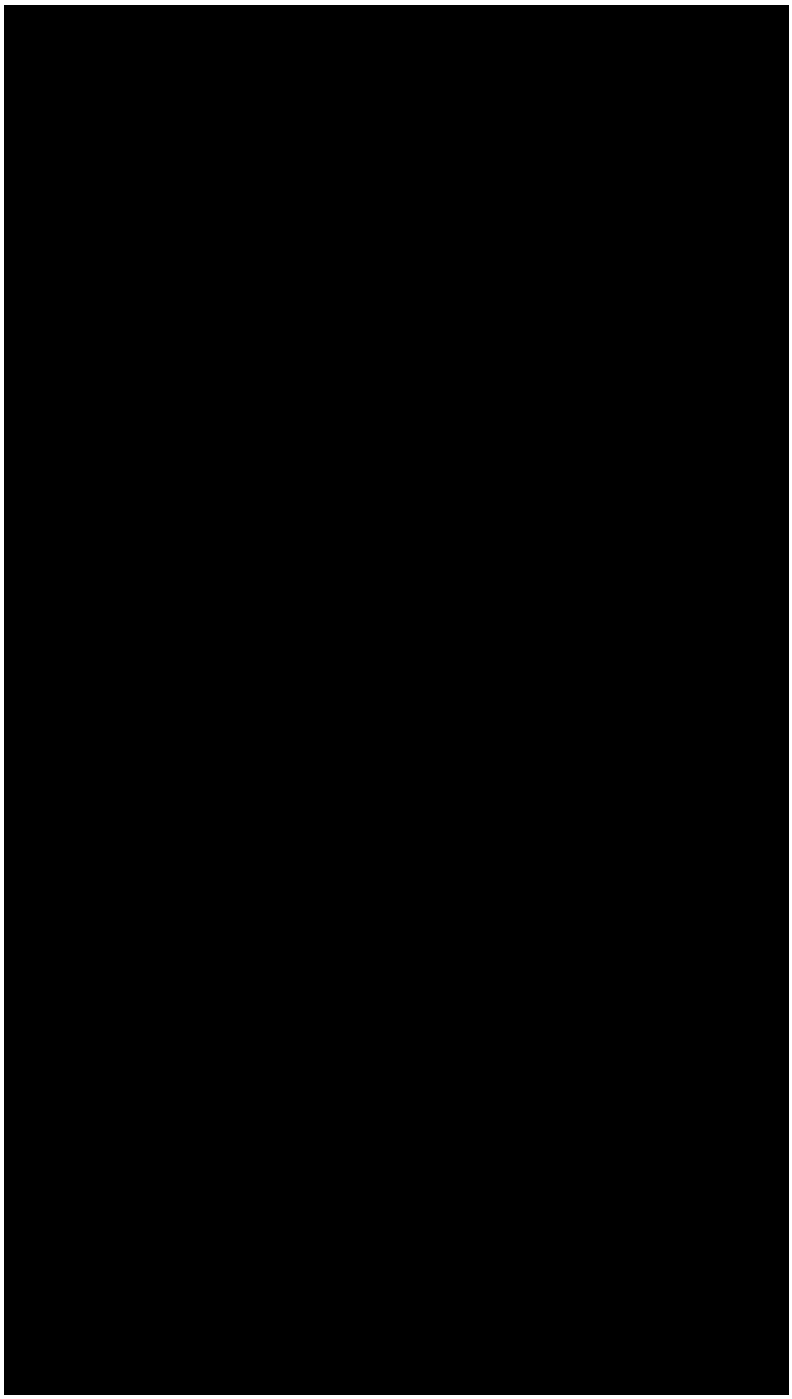
[redacted] currently consists of [redacted] medical/surgical beds and [redacted] medical/surgical step-down beds for a total of 40 beds. We would renovate this unit to for a new [redacted] bed adult surgical intensive care unit. In order to accomplish this goal, the unit will need general construction, additional monitoring capabilities and additional staff to accommodate the new mix of patients.

The ICU will be constructed to include the following:



Impact on Operations and Staffing

There will be no substantive impact on staff, revenue and expenses as a result of this project, rather there will be a redistribution of staff, revenue and expenses.

The new intensive care unit will be staffed based on the patient acuity. We will provide for the appropriate nurse/patient staffing ratio.

Impact of the Project

The impact of the project will increase the availability of intensive care services closer to the Bronx communities, where most of our patients live and will increase our capacity to care for patients with complicated clinical needs and life-threatening health issues. Increasing the number of intensive care beds in an addition unit will help to centralize intensive care resources into another specialized, geographic location will reduce staff burden, improve patient care and clinical outcomes.

Limited Review Application

State of New York Department of Health
Office of Primary Care and Health Systems Management

LRA Cover Sheet

Project to be Proposed/Applicant Information

This application is for those projects subject to a limited review pursuant to 10 NYCRR 710.1(c)(5)-(7). Please check the appropriate box(es) reflective of the project being proposed by your facility (**NOTE** – Some projects may involve requisite "Construction". If so, and ***total*** project costs are below designated thresholds, then **both boxes** must be checked and necessary LRA Schedules submitted). ***Please read the LRA Instructions to ensure submission of an appropriate and complete application:***

☒ **Minor Construction** – Minor construction project with total project costs of up to $15,000,000 for general hospitals and up to $6,000,000 for all other facilities, if not relating to clinical space – check "Non-Clinical" box below).

Necessary LRA Schedules: Cover Sheet, 2, 3, 4, 5, and 6.

☐ **Equipment** – Project related to the acquisition, relocation, installation or modification of certain medical equipment, with total project costs of up to $15,000,000 for general hospitals and up to $6,000,000 for all other facilities. (**NOT** necessary for "1-for-1" replacement of existing equipment without construction, pursuant to Chapter 174 of the Laws of 2011 amending Article 28 of the Public Health law to eliminate limited review and CON review for one for one equipment replacement)
Necessary LRA Schedules: Cover Sheet, 2, 3, 4, and 5.

☒ **Service Delivery** – Project to decertify a facility's beds/services; add services which involve a total project cost up to $15,000,000 for general hospitals and up to $6,000,000 for all other facilities; or convert beds within approved categories. (*If construction associated, also check "Construction" above.*)
Necessary LRA Schedules: Cover Sheet, 2, 6, 7, 8, 10, and 12. **If proposing to decertify beds within a nursing home, provide a description of the proposed alternative use of the space including a detailed sketch (unless the decertification is being accomplished by eliminating beds in multiple-bedded rooms). If proposing to convert beds within approved categories, an LRA Schedule 6 and all supporting documentation are required to confirm appropriate space for the new use.*

☐ **Cardiac Services** – Project by an appropriately certified facility to add electrophysiology (EP) services; or add, upgrade or replace a cardiac catheterization laboratory or equipment. (*If construction associated, also check "Construction" above.*)

Necessary LRA Schedules: Cover Sheet, 2, 7, 8, 10, and 12.

☐ **Relocation of Extension Clinic** – Project to relocate an extension clinic within the same service area which involve a total project cost up to $15,000,000 for general hospitals and up to $6,000,000 for all other facilities. (*If construction associated, also check "Construction" above.*)

Necessary LRA Schedules: Cover Sheet, 2, 3, 4, 5, 6 and 7. Also include a Closure Plan for vacating extension clinic.

☐ **Part-Time Clinic** – Project to operate, change services offered, change hours of operation or relocate a part-time clinic site – for applicants already certified for "part-time clinic". (*If construction associated, also check "Construction" above.*)

Necessary LRA Schedules: Cover Sheet, 2, 8, 10, 11, and 12.

OPERATING CERTIFICATE NO.	CERTIFIED OPERATOR	TYPE OF FACILITY
700006H	Montefiore Medical Center	Hospital

OPERATOR ADDRESS – STREET & NUMBER		PFI	NAME AND TITLE OF CONTACT PERSON		
111 E. 210th Street		1169	Randi Kohn, AVP, Regulatory Planning		
CITY	COUNTY	ZIP	STREET AND NUMBER		
Bronx	Bronx	10467	111 E. 210th Street		
PROJECT SITE ADDRESS – STREET & NUMBER		PFI	CITY	STATE	ZIP
111 E. 210th Street		1169	Bronx	NY	10467
CITY	COUNTY	ZIP	TELEPHONE NUMBER	FAX NUMBER	
Bronx	Bronx	10467	7189206080		
TOTAL PROJECT COST: $ 14581077			CONTACT E-MAIL: rkohn@montefiore.org		

(Rev 09/2019)

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 2

Total Project Cost

ITEM		ESTIMATED PROJECT COST
1.1 Land Acquisition (*attach documentation*)	$	
1.2 Building Acquisition	$	
	1.1-1.2 Subtotal:	0.00
2.1 New Construction	$	
2.2 Renovation and Demolition	$	8,786,038.40
2.3 Site Development	$	141,960.00
2.4 Temporary Power	$	
	2.1-2.4 Subtotal:	8,927,998.40
3.1 Design Contingency	$	853,013.44
3.2 Construction Contingency	$	853,013.44
	3.1-3.2 Subtotal:	1,706,026.88
4.1 Fixed Equipment (NIC)	$	134,200.00
4.2 Planning Consultant Fees	$	67,600.00
4.3 Architect/Engineering Fees (incl. computer installation, design, etc.)	$	782,452.17
4.4 Construction Manager Fees	$	
4.5 Capitalized Licensing Fees	$	
4.6 Health Information Technology Costs	$	
4.6.1 Computer Installation, Design, etc.	$	81,000.00
4.6.2 Consultant, Construction Manager Fees, etc.	$	
4.6.3 Software Licensing, Support Fees	$	
4.6.4 Computer Hardware/Software Fees	$	130,000.00
4.7 Other Project Fees (Consultant, etc.)	$	135,200.00
	4.1-4.7 Subtotal:	1,330,452.17
5.1 Movable Equipment	$	2,615,600.00
6.1 Total Basic Cost of Construction	**$**	**14,580,077.45**
7.1 Financing Cost (points, fees, etc.)	$	
7.2 Interim Interest Expense - Total Interest on Construction Loan: Amount $ @ % for months		
7.3 Application Fee	$	1,000
8.1 Estimated Total Project Cost (Total 6.1 – 7.3)	**$**	**14,581,077.45**

If this project involves construction enter the following anticipated construction dates on which your cost estimates are based.

Construction Start Date 9/1/2024

Construction Completion Date 08/31/2025

(Rev. 1/31/2013)

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 3

Proposed Plan for Project Financing

A. LEASE ☐

If any portion of the cost for land, building or Equipment is to be financed through a lease, rental agreement or lease/purchase agreement, complete the chart at the right.

A complete copy of each proposed lease must be submitted.

Attachment # _____

ITEM	COST AS IF PURCHASED
	$
	$
	$
	$
	$

B. CASH ☒

If cash is to be used, complete the chart at the right.

Attach a copy of the latest certified financial Statement and interim monthly or quarterly financial reports to cover the balance of time to date.

Attachment # 1 and 2

Accumulated Funds	$ 14,581,077.00
Sale of Existing Assets*	$
Other – (i.e. gifts, grants, **etc.)	$
TOTAL CASH	$ 14,581,077.00

*Attach a full and complete description of the assets to be sold.

Attachment # _____

** If grants, attach a description of the source of financial support

Attachment # _____

C. DEBT FINANCING ☐

If the project is to be financed by debt of any type, complete the chart at the right.

Attach a copy of the proposed letter of interest From the intended source of permanent financing. **This letter must include an estimate of the Principal, term, interest rate and pay-out period presently being considered.**

Attachment # _____

Principal	$
Interest Rate	%
Term	Yrs
Pay-out Period	Yrs
Type *	

* Commercial, Dormitory Authority Bonds, Dormitory Authority, TELP Lease, Industrial Development Agency Bonds, Other (identify).

Schedule LRA 4/Schedule 7
CON Forms Regarding
Environmental issues

Contents:

Environmental Assessment			
Part I.	The following questions help determine whether the project is "significant" from an environmental standpoint.	**Yes**	**No**
1.1	If this application involves establishment, will it involve more than a change of name or ownership only, or a transfer of stock or partnership or membership interests only, or the conversion of existing beds to the same or lesser number of a different level of care beds?	☐	☒
1.2	Does this plan involve construction and change land use or density?	☐	☒
1.3	Does this plan involve construction and have a permanent effect on the environment if temporary land use is involved?	☐	☒
1.4	Does this plan involve construction and require work related to the disposition of asbestos?	☐	☒
Part II.	If any question in Part I is answered "yes" the project may be significant, and Part II must be completed. If all questions in Part II are answered "no" it is likely that the project is not significant	**Yes**	**No**
2.1	Does the project involve physical alteration of ten acres or more?	☐	☒
2.2	If an expansion of an existing facility, is the area physically altered by the facility expanding by more than 50% and is the total existing and proposed altered area ten acres or more?	☐	☒
2.3	Will the project involve use of ground or surface water or discharge of wastewater to ground or surface water in excess of 2,000,000 gallons per day?	☐	☒
2.4	If an expansion of an existing facility, will use of ground or surface water or discharge of wastewater by the facility increase by more than 50% and exceed 2,000,000 gallons per day?	☐	☒
2.5	Will the project involve parking for 1,000 vehicles or more?	☐	☒
2.6	If an expansion of an existing facility, will the project involve a 50% or greater increase in parking spaces and will total parking exceed 1000 vehicles?	☐	☒
2.7	In a city, town, or village of 150,000 population or fewer, will the project entail more than 100,000 square feet of gross floor area?	☐	☒
2.8	If an expansion of an existing facility in a city, town, or village of 150,000 population or fewer, will the project expand existing floor space by more than 50% so that gross floor area exceeds 100,000 square feet?	☐	☒
2.9	In a city, town or village of more than 150,000 population, will the project entail more than 240,000 square feet of gross floor area?	☐	☒
2.10	If an expansion of an existing facility in a city, town, or village of more than 150,000 population, will the project expand existing floor space by more than 50% so that gross floor area exceeds 240,000 square feet?	☐	☒
2.11	In a locality without any zoning regulation about height, will the project contain any structure exceeding 100 feet above the original ground area?	☐	☒
2.12	Is the project wholly or partially within an agricultural district certified pursuant to Agriculture and Markets Law Article 25, Section 303?	☐	☒
2.13	Will the project significantly affect drainage flow on adjacent sites?	☐	☒

2.14	Will the project affect any threatened or endangered plants or animal species?	☐	☒
2.15	Will the project result in a major adverse effect on air quality?	☐	☒
2.16	Will the project have a major effect on visual character of the community or scenic views or vistas known to be important to the community?	☐	☒
2.17	Will the project result in major traffic problems or have a major effect on existing transportation systems?	☐	☒
2.18	Will the project regularly cause objectionable odors, noise, glare, vibration, or electrical disturbance as a result of the project's operation?	☐	☒
2.19	Will the project have any adverse impact on health or safety?	☐	☒
2.20	Will the project affect the existing community by directly causing a growth in permanent population of more than five percent over a one-year period or have a major negative effect on the character of the community or neighborhood?	☐	☒
2.21	Is the project wholly or partially within, or is it contiguous to any facility or site listed on the National Register of Historic Places, or any historic building, structure, or site, or prehistoric site, that has been proposed by the Committee on the Registers for consideration by the New York State Board on Historic Preservation for recommendation to the State Historic Officer for nomination for inclusion in said National Register?	☐	☒
2.22	Will the project cause a beneficial or adverse effect on property listed on the National or State Register of Historic Places or on property which is determined to be eligible for listing on the State Register of Historic Places by the Commissioner of Parks, Recreation, and Historic Preservation?	☐	☒
2.23	Is this project within the Coastal Zone as defined in Executive Law, Article 42? If Yes, please complete Part IV.	☐	☒

Part III.		**Yes**	**No**
3.1	Are there any other state or local agencies involved in approval of the project? If so, fill in Contact Information to Question 3.1 below.	☒	☐
	Agency Name:	NYC Department of Buildings	
	Contact Name:		
	Address:		
	State and Zip Code:		
	E-Mail Address:		
	Phone Number:		
	Agency Name:		
	Contact Name:		
	Address:		
	State and Zip Code:		
	E-Mail Address:		
	Phone Number:		
	Agency Name:		
	Contact Name:		

	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
	Agency Name:			
	Contact Name:			
	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
3.2	Has any other agency made an environmental review of this project? If so, give name, and submit the SEQRA Summary of Findings with the application in the space provided below.		Yes ☐	No ☒
	Agency Name:			
	Contact Name:			
	Address:			
	State and Zip Code:			
	E-Mail Address:			
	Phone Number:			
3.3	Is there a public controversy concerning environmental aspects of this project? If yes, briefly describe the controversy in the space below.		Yes ☐	No ☒
Part IV.	**Storm and Flood Mitigation**			
	Definitions of FEMA Flood Zone Designations			
	Flood zones are geographic areas that the FEMA has defined according to varying levels of flood risk. These zones are depicted on a community's Flood Insurance Rate Map (FIRM) or Flood Hazard Boundary Map. Each zone reflects the severity or type of flooding in the area.			
	Please use the FEMA Flood Designations scale below as a guide to answering all Part IV questions regardless of project location, flood and or evacuation zone.		Yes	No
4.1	Is the proposed site located in a flood plain? If Yes, indicate classification below and provide the Elevation Certificate (FEMA Flood Insurance).		☐	☒
	Moderate to Low Risk Area		Yes	No
	Zone	**Description**	☐	☒
	In communities that participate in the NFIP, flood insurance is available to all property owners and renters in these zones:			
	B and X	Area of moderate flood hazard, usually the area between the limits of the 100-year and 500-year floods. Are also used to designate base floodplains of lesser hazards, such as areas protected by levees from 100-year flood, or shallow flooding areas with average depths of less than one foot or drainage areas less than 1 square mile.	☐	

	C and X	Area of minimal flood hazard, usually depicted on FIRMs as above the 500-year flood level.	☐	
	High Risk Areas		**Yes**	**No**
	Zone	**Description**	☐	☒
	In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all these zones:			
	A	Areas with a 1% annual chance of flooding and a 26% chance of flooding over the life of a 30-year mortgage. Because detailed analyses are not performed for such areas; no depths or base flood elevations are shown within these zones.	☐	
	AE	The base floodplain where base flood elevations are provided. AE Zones are now used on new format FIRMs instead of A1-A30.	☐	
	A1-30	These are known as numbered A Zones (e.g., A7 or A14). This is the base floodplain where the FIRM shows a BFE (old format).	☐	
	AH	Areas with a 1% annual chance of shallow flooding, usually in the form of a pond, with an average depth ranging from 1 to 3 feet. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Base flood elevations derived from detailed analyses are shown at selected intervals within these zones.	☐	
	AO	River or stream flood hazard areas, and areas with a 1% or greater chance of shallow flooding each year, usually in the form of sheet flow, with an average depth ranging from 1 to 3 feet. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Average flood depths derived from detailed analyses are shown within these zones.	☐	
	AR	Areas with a temporarily increased flood risk due to the building or restoration of a flood control system (such as a levee or a dam). Mandatory flood insurance purchase requirements will apply, but rates will not exceed the rates for unnumbered A zones if the structure is built or restored in compliance with Zone AR floodplain management regulations.	☐	
	A99	Areas with a 1% annual chance of flooding that will be protected by a Federal flood control system where construction has reached specified legal requirements. No depths or base flood elevations are shown within these zones.	☐	
	High Risk Coastal Area		**Yes**	**No**
	Zone	**Description**		
	In communities that participate in the NFIP, mandatory flood insurance purchase requirements apply to all these zones:			
	Zone V	Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. No base flood elevations are shown within these zones.	☐	☒
	VE, V1 - 30	Coastal areas with a 1% or greater chance of flooding and an additional hazard associated with storm waves. These areas have a 26% chance of flooding over the life of a 30-year mortgage. Base flood elevations derived from detailed analyses are shown at selected intervals within these zones.	☐	
	Undetermined Risk Area		**Yes**	**No**
	Zone	**Description**	☐	☒

	D	Areas with possible but undetermined flood hazards. No flood hazard analysis has been conducted. Flood insurance rates are commensurate with the uncertainty of the flood risk.		
4.2	Are you in a designated evacuation zone?		☐	☒
	If Yes, the Elevation Certificate (FEMA Flood Insurance) shall be submitted with the application.			
	If yes which zone is the site located in?			
4.3	Does this project reflect the post Hurricane Lee, and or Irene, and Superstorm Sandy mitigation standards?		☐	☒
	If Yes, which floodplain?	100 Year	☐	
		500 Year	☐	

The Elevation Certificate provides a way for a community to document compliance with the community's floodplain management ordinance.

FEMA **Elevation_Certificate**_and Instructions

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 5

Space & Construction Cost Distribution

☐ New

☒ Alteration

LOCATION			Code and Functional Category Description	Functional Gross SF	Construction Cost per SF	Total Construction Cost	(ALT) Scope of Work
Bldg. No. (1)	Floor No. (2)	Sect. No. (3)	(4)	(5)	(6)	(7)	(8)
	[redacted]	[redacted]	107 Intensive Care	[redacted]	[redacted]	$8,927,998.0	B
			946 Stafff lockers				
			Total Construction	[redacted]			

1. If new construction is involved, is it "freestanding"? Yes ☐ No ☐

2. (Check where applicable) The facilities to be affected by this project are located in a:
   ☒ Dense Urban Area ☐ Other Metropolitan or Suburban Area ☐ Rural Area

3. This submission consists of: ☐ New Construction Report Number of pages _____
   ☒ Alteration Construction Report Number of pages _____

Do not use the master copy. Photocopy master and then complete copy if this schedule is required.

Schedule 6
Architectural/Engineering Submission

Contents:

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

Schedule applies to all projects with construction, including Articles 28 & 40, i.e., Hospitals, Diagnostic and Treatment Centers, Residential Health Care Facilities, and Hospices.

Instructions

- Provide Architectural/Engineering Narrative using the format below.
- Provide Architect/Engineer Certification form:
  - Architect's Letter of Certification for Proposed Construction or Renovation for Projects That Will Be Self-Certified. Self-Certification Is Not an Option for Projects over $15 Million, or Projects Requiring a Waiver (PDF)
  - Architect's Letter of Certification for Proposed Construction or Renovation Projects to Be Reviewed by DOH or DASNY. (PDF) (Not to Be Submitted with Self-Certification Projects)
  - Architect's Letter of Certification for Completed Projects (PDF)
  - Architect's or Engineer's Letter of Certification for Inspecting Existing Buildings (PDF)
- Provide FEMA BFE Certificate. Applies only to Hospitals and Nursing Homes.
  - FEMA Elevation Certificate and Instructions.pdf
- Provide Functional Space Program: A list that enumerates project spaces by floor indicating size by gross floor area and clear floor area for the patient and resident spaces.
- For projects with imaging services, provide Physicist's Letter of Certification and Physicist's Report including drawings, details and supporting information at the design development phase.
  - Physicist's Letter of Certification (PDF)
- Provide Architecture/Engineering Drawings in PDF format created from the original electronic files; scans from printed drawings will not be accepted. Drawing files less than 100 MB, and of the same trade, may be uploaded as one file.
  - NYSDOH and DASNY Electronic Drawing Submission Guidance for CON Reviews
  - DSG-1.0 Schematic Design & Design Development Submission Requirements
- Refer to the Required Attachment Table below for the Schematic Design Submission requirements for Contingent Approval and the Design Development Submission requirements for Contingency Satisfaction.
  - Attachments must be labeled accordingly when uploading in NYSE-CON.
  - Do not combine the Narrative, Architectural/Engineering Certification form and FEMA BFE Certificate into one document.
  - If submitted documents require revisions, provide an updated Schedule 6 with the revised information and date within the narrative.

Architecture/Engineering Narrative

Narrative shall include but not limited to the following information. Please address all items in the narrative including items located in the response column. Incomplete responses will not be accepted.

Project Description	
Schedule 6 submission date: 3/21/2024	Revised Schedule 6 submission date: Click to enter a date.
Does this project amend or supersede prior CON approvals or a pending application? No If so, what is the original CON number? Click here to enter text.	
Intent/Purpose: Montefiore wishes to gut renovate less that half of the existing [redacted]. The [redacted] renovation will upgrade existing single and double step down bed unit to an [redacted]. The support areas will also be renovated to include the care station, meds, nourishment, clean, soiled, and equipment supply rooms as well as staff support areas including staff lounge, offices, multipurpose room, and oncall.	
Site Location:	

Montefiore Medical Center Moses Campus is located at 111 E 210th street. Bronx, NY 10467. This project scope is located [redacted].	
Brief description of current facility, including facility type: Montefiore Medical Center Moses Campus is an Inpatient hospital located on E 210th street, between Dekalb Avenue and Banbridge Avenue.	
Brief description of proposed facility: This project scope is within the existing facility. The existing medical surgical bed unit will be renovated to provide [redacted] Critical Care beds and related clinical and staff support.	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. [redacted]	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: N/A. No mixed occupancy.	
If this is an existing facility, is it currently a licensed Article 28 facility?	Yes
Is the project space being converted from a non-Article 28 space to an Article 28 space?	No
Relationship of spaces conforming with Article 28 space and non-Article 28 space: The entire floor is Article 28 space.	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. No Exceptions	
Does the project involve heating, ventilating, air conditioning, plumbing, electrical, water supply, and fire protection systems that involve modification or alteration of clinical space, services or equipment such as operating rooms, treatment, procedure rooms, and intensive care, cardiac care , other special care units (such as airborne infection isolation rooms and protective environment rooms), laboratories and special procedure rooms, patient or resident rooms and or other spaces used by residents of residential health care facilities on a daily basis? If so, please describe below. [redacted]	Choose an item. Yes.
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. [redacted].	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. [redacted]	

Describe existing and or new work for fire detection, alarm, and communication systems: [redacted].
If a hospital or nursing home located in a flood zone, provide a FEMA BFE Certificate from www.fema.gov, and describe the work to mitigate damage and maintain operations during a flood event. Click here to enter text.
Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe the equipment to be provided and or replaced. Ensure physicist's letter of certification and report are submitted. Click here to enter text.
Does the project comply with ADA? If no, list all areas of noncompliance. Yes Click here to enter text.
Other pertinent information: Click here to enter text.

Project Work Area	**Response**
Type of Work	Renovation
Square footages of existing areas, existing floor and or existing building.	[redacted]
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	[redacted]
Does the work area exceed more than 50% of the smoke compartment, floor or building?	[redacted]
Sprinkler protection per NFPA 101 Life Safety Code	Sprinklered throughout
Construction Type per NFPA 101 Life Safety Code and NFPA 220	Type I (443)
Building Height	[redacted]
Building Number of Stories	[redacted]
Which edition of FGI is being used for this project?	2018 Edition of FGI
Is the proposed work area located in a basement or underground building?	Not Applicable
Is the proposed work area within a windowless space or building?	No
Is the building a high-rise?	Yes
If a high-rise, does the building have a generator?	Yes
What is the Occupancy Classification per NFPA 101 Life Safety Code?	Chapter 18 New Health Care Occupancy
Are there other occupancy classifications that are adjacent to or within this facility? If yes, what are the occupancies and identify these on the plans. Click here to enter text.	No
Will the project construction be phased? If yes, how many phases and what is the duration for each phase? Click here to enter text.	No
Does the project contain shell space? If yes, describe proposed shell space and identify Article 28 and non-Article 28 shell space on the plans. Click here to enter text.	No
Will spaces be temporarily relocated during the construction of this project? If yes, where will the temporary space be? Click here to enter text.	No
Does the temporary space meet the current DOH referenced standards? If no, describe in detail how the space does not comply. Click here to enter text.	Not Applicable
Is there a companion CON associated with the project or temporary space? If so, provide the associated CON number. Click here to enter text.	Not Applicable
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be? Two offices and one conference area	Yes
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. Replacing 21 Med Surg beds with 21 ICU Beds	No Change
Changes in the number of occupants?	Yes

If yes, what is the new number of occupants? The occupant load will decrease. Proposed Occupants = [redacted]	
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? [redacted]	No
If an existing EES Type 1, does it meet NFPA 99 -2012 standards?	Not Applicable
Does the existing EES system have the capacity for the additional electrical loads? [redacted]	Not Applicable
Does the project involve Operating Room alterations, renovations, or rehabilitation? If yes, provide brief description. Click here to enter text.	No
Does the project involve Bulk Oxygen Systems? If yes, provide brief description. Click here to enter text.	No
If existing, does the Bulk Oxygen System have the capacity for additional loads without bringing in additional supplemental systems?	Yes
Does the project involve a pool?	No

REQUIRED ATTACHMENT TABLE			
SCHEMATIC DESIGN SUBMISSION for **CONTINGENT APPROVAL**	DESIGN DEVELOPMENT SUBMISSION (State Hospital Code Submission) for **CONTINGENCY SATISFACTION**	**Title of Attachment**	**File Name in PDF format**
•		Architectural/Engineering Narrative	A/E Narrative.PDF
•		Functional Space Program	FSP.PDF
•		Architect/Engineer Certification Form	A/E Cert Form. PDF
•		FEMA BFE Certificate	FEMA BFE Cert.PDF
•		Article 28 Space/Non-Article 28 Space Plans	CON100.PDF
•	•	Site Plans	SP100.PDF
•	•	Life Safety Plans including level of exit discharge, and NFPA 101-2012 Code Analysis	LSC100.PDF
•	•	Architectural Floor Plans, Roof Plans and Details. Illustrate FGI compliance on plans.	A100.PDF
•	•	Exterior Elevations and Building Sections	A200.PDF
•	•	Vertical Circulation	A300.PDF
•	•	Reflected Ceiling Plans	A400.PDF
optional	•	Wall Sections and Partition Types	A500.PDF
optional	•	Interior Elevations, Enlarged Plans and Details	A600.PDF
	•	Fire Protection	FP100.PDF
	•	Mechanical Systems	M100.PDF
	•	Electrical Systems	E100.PDF
	•	Plumbing Systems	P100.PDF
	•	Physicist's Letter of Certification and Report	X100.PDF

CONSTRUCTION PROJECT CERTIFICATION LETTER FOR AER REVIEWS ARCHITECTS & ENGINEERS

(For projects not meeting the prerequisites for Self-Certification submission.)

Date: 3/21/2024
CON Number: TBD
Facility Name: Montefiore Medical Center Moses Division
Facility ID Number: 1169
Facility Address: 110 E 210th Street, Bronx, NY 10467

NYS Department of Health/Office of Health Systems Management
Center for Health Care Facility Planning, Licensure, and Finance
Bureau of Architectural and Engineering Review
ESP, Corning Tower, 18th Floor
Albany, New York 12237

To The New York State Department of Health:

I hereby certify that:

1. I have been retained by the aforementioned facility, to provide professional architectural/engineering services related to the design and preparation of construction documents, including drawings and specifications for the aforementioned project. During the course of construction, periodic site observation visits will be performed, and the necessary standard of care, noting progress, quality and ensuring conformance of the work with documents provided for all regulatory approvals associated with the aforementioned project.

2. I have ascertained that, to the best of my knowledge, information and belief, the completed structure will be designed and constructed, in accordance with the functional program for the referenced construction project and in accordance with any project definitions, waivers or revisions approved or required by the New York State Department of Health.

3. The above-referenced construction project will be designed and constructed in compliance with all applicable local codes, statutes, and regulations, and the applicable provisions of the State Hospital Code -- 10 NYCRR Part 711 (General Standards for Construction) and Parts (check all that apply):

   a. _X_712 (Standards of Construction for General Hospital Facilities)
   b. __713 (Standards of Construction for Nursing Home Facilities)
   c. __714 (Standards of Construction for Adult Day Health Care Program Facilities)
   d. __715 (Standards of Construction for Freestanding Ambulatory Care Facilities)
   e. __716 (Standards of Construction for Rehabilitation Facilities)
   f. __717 (Standards of Construction for New Hospice Facilities and Units)

   PLEASE NOTE ANY EXCEPTIONS HERE:

   _____
   _____

4. I understand that as the design of this project progresses, if a component of this project is inconsistent with the State Hospital Code (10 NYCRR Parts 711, 712, 713, 714, 715, 716, or 717), I shall bring this to the attention of the Bureau of Architecture and Engineering Review (BAER) of the New York State Department of Health prior to or upon submitting final drawings for compliance resolution.

5. I understand that upon completion of construction, the costs of any subsequent corrections necessary to achieve compliance with applicable requirements of 10 NYCRR Parts 711, 712, 713, 714, 715, 716 and 717, when the prior work was not completed properly as certified herein, may not be considered allowable costs for reimbursement under 10 NYCRR Part 86.

This certification is being submitted to facilitate the CON review and subsequent to formal plan approval by your office. It is understood that an electronic copy of final Construction Documents on CD, meeting the requirements of DSG-05 must be submitted to PMU for all projects, including limited, administrative, full review, self-certification and reviews performed and completed by DASNY.

Project Name: [redacted]

Location: 110 E 210th Street, Bronx, NY 10467

Description: [redacted]bed ICU Renovation

Architectural or Engineering Professional Stamp

REGISTERED ARCHITECT
CHRISTINA GRIMES
046224
STATE OF NEW YORK

Signature of Architect or Engineer

Christina Grimes
Name of Architect or Engineer (Print)

046224
Professional New York State License Number

111 Fifth Avenue, 10th fl, New York, NY 10003
Business Address

The undersigned applicant understands and agrees that, notwithstanding this architectural/engineering certification the Department of Health shall have continuing authority to (a) review the plans submitted herewith and/or inspect the work with regard thereto, and (b) withdraw its approval thereto. The applicant shall have a continuing obligation to make any changes required by the Division to comply with the above- mentioned codes and regulations, whether or not physical plant construction or alterations have been completed.

Randi Kohn
Authorized Signature for Applicant

03/21/2024 — Date

Randi Kohn — Name (Print)

AVP, Regulatory Planning — Title

Notary signing required for the applicant

STATE OF ~~NEW YORK~~ MARYLAND)
) SS:
County of ~~Baltimore~~ HOWARD)

On the 21st day of March 20 24, before me personally appeared Randi Kohn, to me known, who being by me duly sworn, did depose and say that he/she is the AVP, Regulatory Planning of the Montefiore, the facility described herein which executed the foregoing instrument; and that he/she signed his/her name thereto by order of the governing authority of said facility.

(Notary) _____

SWORN TO AND SUBSCRIBED BEFORE ME
THIS 21 DAY OF MARCH, 20 23
WITNESS MY HAND AND OFFICIAL SEAL

MY COMMISSION EXPIRES 2/1/27

JOHN LIM
NOTARY PUBLIC
HOWARD COUNTY, MD.

Limited Review Application

Schedule LRA 7

State of New York Department of Health
Office of Primary Care and Health Systems Management

There is not substantive impact on the operating budget of MMC as a result of this project.

Proposed Operating Budget

Budget	Current Year	First Year (Projected)	Third Year (Projected)
Revenues			
Service Revenue			
Grants Funds			
Foundation			
Other			
Fees			
Other Income			
(1) Total Revenues	$	$	$
Expenses			
Salaries and Wage Expense			
Employee Benefits			
Professional Fees			
Medical & Surgical Supplies			
Non-Medical Equipment			
Purchased Services			
Other Direct Expense			
Utilities Expense			
Interest Expense			
Rent Expense			
Depreciation Expense			
Other Expenses			
(2) Total Expense	$	$	$
Net Total - (1-2) →	***$***	***$***	***$***

(Rev. 7/2015)

Limited Review Application

Schedule LRA 7A

State of New York Department of Health
Office of Primary Care and Health Systems Management

Various inpatient services may be reimbursed as discharges or days. Applicant should indicate which method applies to this table by choosing the appropriate checkbox.

Patient Days ☐ Patient discharges ☐

Inpatient Services Source of Revenue		Total Current Year			First Year Incremental			Third Year Incremental		
		Patient Days or dis-charges	Net Revenue*		Patient Days or dis-charges	Net Revenue*		Patient Days or dis-charges	Net Revenue*	
			%	Dollars ($)		% based on days or discharges	Dollars-$		% based on days or discharges	Dollars-$
Commercial	Fee for Service									
	Managed Care									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total			100%			100%			100%	

(Rev. 7/2015)

Outpatient Services Source of Revenue		Total Current Year			First Year Incremental			Third Year Incremental		
		Visits	Net Revenue*		Visits	Net Revenue*		Visits	Net Revenue*	
			%	Dollars ($)		%	Dollars ($)		%	Dollars ($)
Commercial	Fee for Service									
	Managed Care									
Medicare	Fee for Service									
	Managed Care									
Medicaid	Fee for Service									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total			100%			100%			100%	

Total of Inpatient and Outpatient Services									

	Title of Attachment	Filename of attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.		
2. In an attachment, provide the basis for charity care.		

*Net of Deductions from Revenue

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 8

There is no significant impact on staffing as a result of this project – there will primarily be a redistribution of staff.

Staffing

Staffing Categories	Number of FTEs to the Nearest Tenth		
	Current Year*	First Year of implementation	Third Year of implementation
Health Providers:**			
Support Staff*:**			
Total Number of Employees			

* Last complete year prior to submitting application

** "Health Providers" includes <u>all</u> providers serving patients at the site. A Health Provider is any staff who can provide a billable service – physician, dentist, dental hygienist, podiatrist, physician assistant, physical therapist, etc.

*** All other staff.

Describe how the number and mix of staff were determined:

PLEASE COMPLETE THE FOLLOWING:

1. Are staff paid and on Payroll? ☐ Yes ☐ No
2. Provide copies of contracts for any independent contractor.
3. Please attach the Medical Doctors C.V.
4. Is this facility affiliated with any other facilities? (If yes, please describe affiliation and/or agreement.) ☐ Yes ☐ No

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 10

The Sites Tab in NYSE-CON has replaced Schedule LRA 10. Schedule LRA 10 is only to be used when submitting a Modification, in hardcopy, after approval or contingent approval. *However, due to programming issues, you may still be required to upload a blank Schedule LRA 10 to submit a Service Delivery LRA application.*

Impact of Limited Review Application on Operating Certificate (services specific to the site)

Instructions:
"Current" Column: Mark "x" in the box only if the service ***currently*** appears on the operating certificate (OpCert), prior to any requested changes
"Add" Column: Mark "x" in the box if this CON application seeks to add.
"Remove" Column: Mark "x" in the box if this CON application seeks to decertify.
"Proposed" Column: Mark "x" in the boxes corresponding to all the services that will ultimately appear on the OpCert if this CON application is approved.

Category/Authorized Service	Code	Current	Add	Remove	Proposed
Intensive Care		☐	☒	☐	☐
Medical Surgical		☐	☐	☒	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
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		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

Does the applicant have any previously submitted Certificate of Need (CON) applications that have not been completed involving addition or decertification of beds?

☒ No

☐ Yes (*Enter CON numbers to the right)* _____ _____ _____

Limited Review Application

State of New York Department of Health/Office of Health Systems Management

Schedule LRA 12

Assurances

The undersigned, as a duly authorized representative of the applicant, hereby gives the following assurances:

a) The applicant has or will have a fee simple or such other estate or interest in the site, including necessary easements and rights-of-way, sufficient to assure use and possession for the purpose of the construction and operation of the facility.

b) The applicant will obtain the approval of the Commissioner of Health of all required submissions, which shall conform to the standards of construction and equipment in Subchapter C of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York (Title 10).

c) The applicant will submit to the Commissioner of Health final working drawings and specifications, which shall conform to the standards of construction and equipment of Subchapter C of Title 10, prior to contracting for construction, unless otherwise provided for in Title 10.

d) The applicant will cause the project to be completed in accordance with the application and approved plans and specifications.

e) The applicant will provide and maintain competent and adequate architectural and/or engineering inspection at the construction site to insure that the completed work conforms to the approved plans and specifications.

f) If the project is an addition to a facility already in existence, upon completion of construction all patients shall be removed from areas of the facility that are not in compliance with pertinent provisions of Title 10, unless a waiver is granted by the Commissioner of Health, under Title 10.

g) The facility will be operated and maintained in accordance with the standards prescribed by law.

h) The applicant will comply with the provisions of the Public Health Law and the applicable provisions of Title 10 with respect to the operation of all established, existing medical facilities in which the applicant has a controlling interest.

i) The applicant understands and recognizes that any approval of this application is not to be construed as an approval of, nor does it provide assurance of, reimbursement for any costs identified in the application. Reimbursement for all cost shall be in accordance with and subject to the provisions of Part 86 of Title 10.

03/20/2024

Date

Signature

Randi Kohn

Name (Please Type)

Assistant Vice President, Regulatory Planning

Title (Please Type)

Contents

New York State Department of Health – Health Equity Impact Assessment Template
Refer to the Instructions for Health Equity Impact Assessment Template for detailed instructions on each section.

SECTION A. SUMMARY

1. Title of project	Expansion of 21 ICU Beds (Foreman 7B) at Montefiore Medical Center – Moses Campus
2. Name of Applicant	Montefiore Medical Center
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	SmartRise Health Vanessa Guzman, CEO, SmartRise Health, vanessa@smartrisehealth.com, (646) 680-9046 Ruth Harmon, Vice President, Strategy & Operations, SmartRise Health, ruth.harmon@smartrisehealth.com, (914) 708-6878 Joe Hinderstein, Principal Consultant, SmartRise Health, Project Leader, jhinderstein@smartrisehealth.com, (914) 815-0902

4. Description of the Independent Entity's qualifications	SmartRise Health engages with health systems, Accountable Care Organizations (ACOs), payers, manufacturers, and technology companies on health equity, value-based care, population health, and quality improvement programs. The consultancy partners with payers, providers, manufacturers, and technology companies to address Health Equity goals, such as: • Readiness for NCQA Health Equity Accreditation requirements (Steward Health Care Network, Fallon Health Plan) • Learning Collaboratives and Fellowship Programs (Providence Health and Services) • Strategic Plan Design (Hospital for Special Surgery) • Value-Based Care Enablement (Crystal Run Healthcare) • Thought Leadership (Bill & Melinda Gates Foundation and the United Nations). SmartRise has designed a Health Equity Impact Assessment approach that integrates community and patient engagement concepts to drive health equity and ensure equitable representation on capital projects. • The framework uses stakeholder engagement as a fundamental component to understanding how capital projects impact marginalized populations, while developing equitable and achievable mitigation steps to ensure projects are approved. • In similar projects, SmartRise Health has leveraged this methodology using the Institute for Healthcare Improvement's (IHI) quality improvement model, across various stakeholders, including payers, policymakers (CMS, NCQA, ONC), provider networks, community-based organizations, pharmaceutical and technology organizations looking to promote equitable access to care.
5. Date the Health Equity Impact Assessment (HEIA) started	January 6th, 2024
6. Date the HEIA concluded	March 21st, 2024

7. Executive summary of project (250 words max)

Montefiore Medical Center – Moses Campus (the Applicant), a 816 bed acute care facility in the Bronx, is seeking to reallocate existing Medical/Surgical beds into a 21-bed adult Intensive Care Unit (ICU). The project will provide a modern facility that will respond to the complicated clinical needs of the Bronx, enhance the experience for patients and their families, and support the staff in delivering advanced life-saving care.

The Applicant plans to leverage and modify existing space, which is currently designated as 25 medical/surgical beds and 15 medical/surgical step-down, to create 21 modern Intensive Care Unit patient rooms. The project will include 2 isolation rooms, 2 care team stations, a staff lounge, on-call rooms, and a multi-purpose room. The project requires general construction to renovate the space.

8. Executive summary of HEIA findings (500 words max)

Montefiore Medical Center contracted SmartRise Health to serve as the Independent Entity for its Health Equity Impact Assessment (HEIA). During the assessment, SmartRise conducted community-centered interviews and solicited written opinion/letters of recommendation. Feedback from the community engagement activities with public health experts, community members, community leaders, and residents of the project's service areas confirmed the need for the additional ICU beds proposed. Based on data and feedback from community members, the project will increase access, improve equity and reduce disparities in the Bronx.

Community background: The Bronx has the highest proportion of racial/ethnic minorities and the most persons living in poverty as compared to other boroughs, as well as higher rates of infection, hospitalization and death related to COVID-19 than the other four boroughs (described in a JAMA article by Wadhera et. al in 2020.) While Manhattan has the most ICU beds in New York City, it had the lowest COVID hospitalization burden during the first wave of COVID-19, as compared to other boroughs (JAMA). The higher availability and access of ICU beds in Manhattan (for New York City's most affluent borough and composed of a predominately white population) reflects a systemic inequity.

Key benefits: Among the benefits of the project are preparedness for future pandemics and other emergencies/disasters, increasing the availability of intensive care services closer to where patients live, and increasing the capacity to care for patients with complicated clinical needs and life-threatening health issues. Centralizing adult intensive care resources into another specialized, geographic location will reduce staff burden, improve patient care and clinical outcomes.

Current state: Today, the Applicant's Moses Campus has 48 adult intensive care beds (which is 6% of the facility's total bed capacity), which is low in comparison to facilities of similar size and case mix complexity in other boroughs. A majority of patients who receive intensive care services at the Applicant's Moses Campus represent multiple medically underserved populations, including Older Adults, Individuals with Public Insurance, Racial & Ethnic Minorities, People with Chronic Conditions, and other underserved populations. A lack of ICU beds negatively impacts patient care through prolonged wait times for transfer (which have been associated with increased mortality) and longer travel times for patients & family members.

Summary of activities: SmartRise Health conducted community engagement activities with 15 individuals, including interviews and letters of recommendation. Community engagement activities with public health experts, community members, community leaders, and residents of the project's service areas confirmed the need for these services. All community members supported the project.

SECTION B: ASSESSMENT

For all questions in Section B, please include sources, data, and information referenced whenever possible. If the Independent Entity determines a question is not applicable to the project, write N/A and provide justification.

STEP 1 – SCOPING

1. Demographics of service area: Complete the "Scoping Table Sheets 1 and 2" in the document "HEIA Data Tables". Refer to the Instructions for more guidance about what each Scoping Table Sheet requires.

SmartRise Health has submitted the data for the service area, the Bronx Borough of New York City, in the designated spreadsheet.
The service area includes the following 25 zip codes: 10451, 10452, 10453, 10454, 10455, 10456, 10457, 10458, 10459, 10460, 10461, 10462, 10463, 10464, 10465, 10466, 10467, 10468, 10469, 14070, 14071, 14072, 14073, 14074.

2. Medically underserved groups in the service area: Please select the medically underserved groups in the service area that will be impacted by the project:

X Low-income people
X Racial and ethnic minorities
X Immigrants
X Women
X Lesbian, gay, bisexual, transgender, or other-than-cisgender people
X People with disabilities
X Older adults
X Persons living with a prevalent infectious disease or condition
Persons living in rural areas
X People who are eligible for or receive public health benefits
X People who do not have third-party health coverage or have inadequate third-party health coverage
X Other people who are unable to obtain health care

3. For each medically underserved group (identified above), what source of information was used to determine the group would be impacted? What information or data was difficult to access or compile for the completion of the Health Equity Impact Assessment?

- **Low-Income People** was determined through Income Disparities In Access To Critical Care Services by Kanter et. Al and stakeholder interviews.
- **Racial and Ethnic Minorities** was determined through Racial & ethnic disparities in geographic access to critical care in the United States: A geographic information systems analysis by Burdick et. al.
- **People who are eligible for or receive public health benefits** determined through Applicant's Community Health Needs Assessment.
- **People who do not have third-party health coverage** determined through Applicant's Community Health Needs Assessment and stakeholder interviews.
- **Children and adolescents** determined through New York State Prevention Dashboard – Bronx County.
- **Immigrant population** determined through "The Disproportionate Burden of COVID-19 for Immigrants in the Bronx, New York," "Improving Access to Health Care for Immigrants in New York City," and stakeholder interviews.
- **Lesbian, gay, bisexual, transgender, or other-than-cisgender people** was determined through stakeholder interviews.
- **Older adults** was determined through stakeholder interviews.

It was difficult to obtain information regarding the refugee and immigrant populations in the Bronx.

4. How does the project impact the unique health needs or quality of life of each medically underserved group (identified above)?

The Adult Intensive Care Unit services will enhance the experience and quality of care for all medically underserved populations.

- **Address shortage of ICU beds in the Bronx**. The Bronx has the second fewest ICU beds by borough, despite much of its population belonging to underserved patient groups. While the statewide 7-day average of available ICU beds is 21%, and the Bronx has 18%, the Applicant's Moses Campus had the lowest availability of all hospitals in the Bronx (12%).
- **Intensive Care is the last stop for underserved populations**. While underserved populations are often apprehensive about accessing care and are less likely to access medical care until critically necessary, intensive care is critical for patients in a crisis.
- **The right number of beds for the next pandemic or disaster.** The Bronx has the highest number of minority residents and the highest prevalence of COVID-related hospitalization and deaths. The care that patients needed during the height of the COVID-19 pandemic was intensive care, rather than standard medical surgical care, which led to facilities rationing beds and supplies.
- **Aligning patient acuity with designations**. Due to a supply and demand imbalance at the Applicant's Moses Campus, many patients who require intensive care services are cared for in non-designated floors and rooms throughout the hospital (i.e. 'ICU without walls'). To accommodate this, the Applicant moves equipment from one end of the hospital to the other, while leveraging flexible staffing plans to ensure appropriate ratios. By geographically centralizing ICU care in an additional specialized location and formalizing staffing ratios through this designation, the Applicant will be able to standardize care in a way that benefits medically underserved patients.
- **Better intensive care for the entire Bronx.** The Moses Campus is a quaternary care referral center, receiving ICU transfers from other Montefiore Hospitals (Montefiore Medical Center Weiler and Montefiore Medical Center Wakefield), in addition to other Bronx facilities (i.e. BronxCare and NYC Health + Hospitals/Jacobi).

- **Additional intensive care capacity to match the complexity of patients in other care settings**. 6% of the Applicant's total adult beds provide intensive care services, despite having a high case mix index and complexity of cases.

SOURCE: NEW YORK STATE HOSPITAL BED CAPACITY DASHBOARD (3/15/24), WADHERA ET. AL

5. To what extent do the medically underserved groups (identified above) currently use the service(s) or care impacted by or as a result of the project? To what extent are the medically underserved groups (identified above) expected to use the service(s) or care impacted by or as a result of the project?

The Applicant provided information on current utilization of ICU services at its Moses, Wakefield, and Weiler Campuses by Race/Ethnicity and Insurance (displayed below). Given that patients from medically underserved groups disproportionately use these services today, expanding the number of available ICU beds/rooms will increase utilization by these populations. In 2023, the Applicant received 274 inbound transfers from its satellite hospitals for intensive care services outside the Bronx (not including the Applicant's 3 Bronx hospitals).

Information provided by the Applicant demonstrated the most common zip codes of ICU patients at Montefiore Medical Center's Moses Campus below. (inclusion criteria defined as patients who spent one or more days in a designated intensive care bed). The 20 zip codes below represent 74% of all ICU patients.

FIGURE 1: ZIP CODE BREAKDOWN OF MOSES CAMPUS ICU PATIENTS

Zip Code	Neighborhood	Moses	Wakefield	Weiler
10467	Van Cortlandt Park	433	119	103
10466	North Baychester	187	155	45
10469	Pelham Gardens	138	66	123
10473	Soundview	111	20	137
10462	Van Nest	116	17	118
10472	Soundview Bruckner	122	15	114
10458	Belmont	182	19	34
10461	Westchester Square	98	19	104
10468	Jerome Park	164	19	27
10465	Eastchester Bay	67	17	105
10475	Coop City	80	29	80
10463	Riverdale	138	18	20
10460	Bronx Park South	94	12	51
10457	Bathgate	106	6	28
10456	Melrose	95	8	26
10453	Morris Heights	89	11	13
10550	Mount Vernon	73	12	24
10459	Longwood	72	5	27
10701	Northwest Yonkers	78	6	16
10451	Melrose	58	2	25

FIGURE 2: DEMOGRAPHIC BREAKDOWN OF PATIENT DISCHARGES AT MONTEFIORE MOSES, WAKEFIELD, AND WEILER CAMPUSES.

Race/Ethnicity of ICU Discharges at Montefiore Medical Center - Moses				
Race/Ethnicity	2021	2022	2023	Grand Total
Other	2,296	2,209	1,963	6,468
Black or African-American	2,084	2,060	1,702	5,846
White	1,209	1,140	963	3,312
Unknown	359	300	236	895
Patient Unavailable	211	241	179	631
Patient Declined	208	196	195	599
Asian	195	184	173	552
Other Pacific Islander	20	12	27	59
American Indian or Alaska Native	17	12	8	37
Native Hawaiian	1	4	2	7
Blank	2			2

Payer Mix, Montefiore Medical Center - Moses				
Row Labels	2021	2022	2023	Grand Total
MEDICARE HMO	500	446	348	1294
MEDICARE FFS	504	406	296	1206
HEALTHFIRST MCARE INN	180	145	142	467
MEDICAID FFS	191	165	102	458
HEALTHFIRST MCAID INN	128	104	103	335
BLUE CROSS COMMERCIAL	127	97	69	293
FIDELIS MEDICAID	104	88	75	267
MEDICAID HMO	123	65	63	251
HEALTHFIRST MCARE OON	73	59	60	192
HEALTHFIRST MCAID OON	69	58	49	176
AFFINITY MEDICAID	40	23	26	89
AETNA COMMERCIAL	28	33	15	76
LOCAL 1199	25	23	25	73
IPA HIP COMMERCIAL	34	22	5	61
HIP COMMERCIAL	20	16	21	57
COMMERCIAL FFS	29	11	11	51
COMMERCIAL HMO	16	8	17	41
MONTE-SELF INS	14	9	13	36

SOURCE: INFORMATION PROVIDED BY THE APPLICANT.

6. What is the availability of similar services or care at other facilities in or near the Applicant's service area?

The Independent Entity leverage the New York State's Hospital Bed Capacity Dashboard, which pulls data from the COVID-19 survey through the State Health Electronic Response Data System (HERDS). This data export was pulled on 1/8/24, using data that was updated on 1/6/24.

FIGURE 3: NEW YORK STATE HOSPITAL BED CAPACITY DASHBOARD

ICU Bed Counts at Bronx Hospitals (as of 1/6/24), New York State Hospital Bed Capacity Dashboard (HERDS)					
Bronx Hospitals	Total Hospital Beds (Prior Day)	Total ICU Beds (Prior Day)	ICU Beds Available (Prior Day)	% Available ICU Beds (Prior Day)	% Available ICU Beds (7-Day Average)
Total	2,861	324	53	16%	16%
Jacobi Medical Center	248	52	7	13%	19%
Montefiore Medical Center-Wakefield Campus	321	16	2	13%	19%
Montefiore Medical Center – Henry and Lucy Moses Division	818	84	13	15%	14%
Lincoln Medical and Mental Health Center	292	35	3	9%	16%
SBH Health System	230	38	10	26%	20%
BronxCare Hospital Center	432	37	3	8%	9%
North Central Bronx Hospital	99	16	7	44%	31%
Montefiore Medical Center – Jack D Weiler Hospital of Albert Einstein College of Medicine	421	46	8	17%	14%

In addition to its service area of the Bronx, roughly 20% of ICU patients at the Applicant's Moses campus are transferred in from a Montefiore Health System member hospital in Rockland, Westchester or Orange County. The deficit of ICU beds today creates prolonged wait times for these patients. The remaining 80% are directly admitted to the ICU, or through the Emergency Room.

SOURCE: NEW YORK STATE HOSPITAL BED CAPACITY DASHBOARD (HERDS), INFORMATION PROVIDED BY THE APPLICANT.

7. What are the historical and projected market shares of providers offering similar services or care in the Applicant's service area?

The project is not expected to impact market share. The Applicant's Moses Campus has a 6% ratio of ICU beds to total beds, which is consistent with other Bronx hospitals, including Bronx-Lebanon Hospital Center (6%), Montefiore Medical Center Wakefield (5%), Montefiore Medical Center Weiler (5%), NYC Health + Hospitals Corporation Jacobi Medical Center (6%), NYC Health + Hospitals Corporation Lincoln Medical & Mental health Center (6%), NYC Health + Hospitals North Central Bronx Hospital (9%), and St. Barnabas Hospital (6%). Bronx-Lebanon Hospital Center is 3.3 miles away, Montefiore Medical Center Wakefield is 2 miles away, NYC H+H Jacobi is 3 miles away, NYC H+H Lincoln is 5.2 miles away, NYC H+H North Central Bronx is .1 miles away, and St. Barnabas Hospital is 2.3 miles away. Presently, the Applicant transfers patients between hospitals in its system based on the availability of ICU beds.

Several Manhattan and Westchester hospitals have higher ratios, including New York-Presbyterian Columbia (10%), New York-Presbyterian Cornell (11%), New York University Langone (20%), Montefiore Mont Vernon (10%), and Westchester Medical Center (10%).

FIGURE 4: BED BREAKDOWN BY FACILITY, BRONX

Hospital	DOH Licensed Adult ICU Beds	DOH Licensed Adult CCU Beds	2021 Adult Med/Surg Discharges with CMI > 1.5	Licensed ICU beds per 1,000 Discharges (Med/Surg CMI > 1.5)	Licensed CCU beds per 1,000 Discharges (Med/Surg/CMI > 1.5)
Bronx-Lebanon Hospital Center	26	11	4,967	5.2	2.2
Montefiore Medical Center Moses	48	12	14,124	3.4	0.8
Montefiore Medical Center Wakefield	16	0	5,491	2.9	0.0

Montefiore Medical Center Weiler	20	10	7,235	3.0	1.4
NYC-HHC Jacobi Medical Center	24	12	4,911	4.9	2.4
NYC-HHC Lincoln Medical & Mental Health Center	23	7	3,988	5.8	1.8
NYC-HHC North Central Bronx Hospital	20	0	959	20.9	0.0
St. Barnabas Hospital	26	0	3,247	8.0	0.0

SOURCE: INFORMATION PROVIDED BY THE APPLICANT

8. Summarize the performance of the Applicant in meeting its obligations, if any, under Public Health Law § 2807-k (General Hospital Indigent Care Pool) and federal regulations requiring the provision of uncompensated care, community services, and/or access by minorities and people with disabilities to programs receiving federal financial assistance. Will these obligations be affected by implementation of the project? If yes, please describe.

Implementation of the project will not affect provisioning of uncompensated care, community services and/or access by minorities and people with disabilities to programs receiving federal assistance.
The Applicant's Indigent Care Pool (ICP) in 2023 was $48.7 million, which is close to 100% of the uninsured volume priced at the Medicaid rate and then reduced by any collections from uninsured patients.
Montefiore Health System campuses provide a high amount of Indigent Care. This includes $2,593,275 at Montefiore Mount Vernon Hospital, $3,661,019 at Montefiore New Rochelle Hospital, $5,262,860 at Montefiore Nyack Hospital, and $5,758,121 at White Plains Hospital.
The Independent Entity reviewed the Applicant's Medicare cost report. The Applicant provided $30,507,202 in Charity Care. The total cost of Non-Medicare Uncompensated Care in 2022 was $35,521,483. This does not include the indigent & uncompensated care that other hospitals in Montefiore Health System provide.
SOURCE: INFORMATION PROVIDED BY THE APPLICANT, NYS MEDICAID ENROLLMENT DATABOOK BY MONTH

9. Are there any physician and professional staffing issues related to the project or any anticipated staffing issues that might result from implementation of project? If yes, please describe.

While the Independent Entity does not expect staffing issues related to the project, it's important to note that there is an industry-wide shortage of ICU nurses and other staff members that has been exacerbated by the COVID-19 pandemic. ICU nurses are susceptible to burnout, given the stress related to ICU patient acuity and necessary ratios. This is compounded by the generalized challenges of burnout of healthcare workers, which is attributed to a loss of autonomy and control, balancing the nuances of practice and insurance requirements, electronic medical record documentation fatigue, and other factors. Nursing shortages impact patient care and the ICU is a setting that requires full staffing in order to function properly. The Applicant offers wellness program for all employees, which includes benefits such as care guidance to help employees when recovering from an illness, chronic condition management services, fitness programs, nutrition services, supportive counseling, and other wellness services.
Members of the ICU care team will include intensivists, nurses, pharmacists, dietitians, respiratory therapists, physical therapists, occupational therapists, and mid-level providers. The Independent Entity stresses the importance of in-person (rather than virtual or telephonic) interpretation services to accommodate non-English speaking patients.

10. Are there any civil rights access complaints against the Applicant? If yes, please describe.

During the last 10 years, there have been 7 civil rights access complaints filed against the Applicant.

- There was a suit filed against Montefiore Medical Center by a 43-year-old female patient who alleged negligent post-operative care and treatment leading to kidney failure and dialysis. Additional claims include statutory discrimination because she is deaf and was not provided a sign language interpreter. The case closed in October 2017.
- A suit was filed against Montefiore Medical Center to the New York State Division of Human Rights for racial and gender discrimination and emotional distress. The plaintiff felt threatened by other patients, and alleged that they were neglected by nurses, social work, and security guards. Closed in May 2018.
- A suit was filed against Montefiore Medical Center by a 42-year-old male with a history of Deaf Mutism who presented to the Emergency Room in 2018. The patient alleged discrimination in failing to provide an ASL interpreter during the hospitalization, with damages including exacerbation of condition. Medical records indicate that written and text communication was provided. There was no mention in the chart of ASL interpreter. Closed in January 2018.
- 55-year-old male sent letter of complaint claim to New York State Division of Human Rights alleging discrimination based on race, disability, and sexual orientation. Closed in May 2017.
- Complaint received from NYS Division of Human Rights where a patient saw two providers at Montefiore Medical Center, and inferred medical practice, despite not providing tangible examples. Closed in August 2022.
- 31-year-old male patient with visual impairment submitted a claim, seeking pre-suit resolution for failure to provide reasonable accommodation for disability in violation of the ADA and Rehabilitation Act. The plaintiff seeks compensation for emotional injury and injunctive relief and attorney's fees.
- A deaf daughter of a patient filed a suit against Montefiore medical Center alleging violation of the ADA in failing to provide a sign language interpreter. Closed in March 2014.

SOURCE: INFORMATION PROVIDED BY THE APPLICANT.

11. Has the Applicant undertaken similar projects/work in the last five years? If yes, describe the outcomes and how medically underserved group(s) were impacted as a result of the project. Explain why the applicant requires another investment in a similar project after recent investments in the past.

No project or expansion efforts have taken place to build intensive care unit beds in the past 5 years.

STEP 2 – POTENTIAL IMPACTS

1. For each medically underserved group identified in Step 1 Question 2, describe how the project will:

a. Improve access to services and health care
b. Improve health equity
c. Reduce health disparities

The Applicant's ICU project expansion will improve access to services and health care, improve health equity, and reduce health disparities for all mentioned underserved populations. Underserved populations will experience the following, specific benefits.

Low-income people

- **The Bronx is the poorest county in New York State**. Pollack et. al (COVID-19 and Health Disparities: Insights From Key Informant Interviews) draw attention to the inequitable distribution of ICU beds; with 49% of the lowest-income communities do not have any ICU eds, compared to 3% for the highest-income communities. Low-income individuals have higher population density, job-related exposures, more frequent use of mass transit, and less ability to quarantine, all factors which disproportionately impacted this population. The COVID-19 Pandemic highlighted the importance of equitable distribution of ICU beds,

which this project would help address. By making more beds available to provide intensive care services, the project will improve access to healthcare services.

Racial and ethnic minorities

- **Improve access to care**. As an example, Black patients have the highest incidence of illnesses requiring intensive care unit-level care, and are more likely to die from sepsis and out-of-hospital cardiac arrests (Healthcare Disparities in Critical Illness). Therefore, increasing ICU bed capacity would directly benefit Black patients and other racial & ethnic minorities by improving access (bed availability) and reducing inequities (providing a service that is disproportionately used by a specific population).

Persons living with a prevalent infectious disease or condition

- **Underserved populations have a high prevalence of conditions that patients are admitted to the ICU for**. Patients admitted to the ICU are experiencing life threatening illness or injury, such as a heart attack, heart or kidney failure, sepsis, stroke, and severe infections and bleeding. Many different types of equipment are used, such catheters, feeding tubes and ventilators. These conditions are very complex and rely on literacy and health literacy.

Women

- There is **no expected negative impact** on Gay, Bisexual, Transgender, or Other-Than-Cisgender people.

Immigrants & Refugees

- **Improved experience through reduction in transfers**. While many immigrants & refugees are fluent or proficient in English, many come to the United States without the ability to speak English. For patients who speak English as a second language, or speak little to no English at all, the intricacies of navigating complex care and transfers can be overwhelming.

Disabilities

- **Increased bed availability, in a centralized geographic location.** Centralizing intensive care staff and equipment into another specialized, geographic location will promote less movement within the hospital, which will benefit patients with disabilities and their families. Improved bed availability will also improve access for patients with disabilities.

Older Adults

- **Much needed services for the most vulnerable members of the community**. During COVID-19 Pandemic, older adults were more likely to be hospitalized for COVID-19. By increasing the number of available beds, it improves access through quicker availability of the correct bed designation. Greater availability of ICU beds will reduce inequities for older adults, who often suffer from multiple chronic conditions and co-morbidities. An anecdote from Applicant interviews surfaced that during the height of the COVID-19 Pandemic, the Applicant more than doubled the number of ICU by converting pediatric and procedural areas that had monitoring capabilities to adult intensive care beds.

People who are eligible for or receive public health benefits, people who do not have third-party health coverage or have inadequate third-party health coverage, & other people who are unable to obtain health care

- The Applicant provides services regardless of the patient's ability to pay, so having additional beds will increase access.

Lesbian, Gay, Bisexual, Transgender, or Other-Than-Cisgender People

- There is no expected negative impact on Gay, Bisexual, Transgender, or Other-Than-Cisgender people. Like all other sub-populations, they will benefit from the highest-quality care, delivered in units that have the most up-to-date equipment.

2. For each medically underserved group identified in Step 1 Question 2, describe any unintended positive and/or negative impacts to health equity that might occur as a result of the project.

There will be positive impacts to Health Equity for each underserved group.

- **Improved health outcomes**. The project has the opportunity to improve health outcomes, including outcomes important for the patient (Quality of Life, Mortality, Capacity after discharge) and clinical outcomes (such as Organ Failure, Adverse Events, Infections, Pain, Level of Consciousness, etc.). One such outcome is survival. A multicenter cohort study published in JAMA Internal Med by Gupta et. Al (Factors Associated With Death in Critically Ill Patients With Coronavirus Disease 2019 in the US) found that there were higher odds of death in hospitals with fewer ICU beds during COVID-19.
- **Better use of hospital resources**. The project will repurpose existing space on the Applicant's campus.

There are also some negative potential impacts for all underserved groups. These include the following.

- **Staff wellbeing**. Burnout and exhaustion of intensive care unit workforce threatens the unit's long-term viability.
- **Availability will lead to unnecessary usage**. It's possible that available beds will result in liberal usage of ICU beds, even if patient acuity doesn't necessitate it.
- **Project could disproportionately serve non-Bronx residents.** Concern that new ICU beds could serve predominantly patients from Westchester. Furthermore, a negative impact could include new services predominantly serving White and commercially insured patients.
- **Unsustainable increased capacity at New York City Health + Hospitals/North Central Bronx.**

There are also some unintended positive and negative impacts for specific underserved groups.

Non-English Speakers and Immigrants

- Research found that Non-English speaking patients were more likely to be admitted to the ICU during the COVID-19 Pandemic (source) than they were pre-pandemic. Non-English speaking patients are less able to self-advocate and communicate their health status. The presence of more ICU beds risks that patients receive ICU care, less-based on need and more based on availability.

Women

- **The project could negatively impact access for women**. Various studies demonstrated gender bias in assessment, diagnosis, diagnosed, and treatment. As an example, male patients are admitted more often than female patients and discrepancies in care exist and women receive a less timely initiation of antibiotics for Sepsis (Gender Differences in Critical Illness and Critical Care Research). This inequality can lead to worse outcomes for women, including higher morbidity, mortality, and complication rates.

People with disabilities

- Patients with disabilities may be vulnerable to bias in treatment, because of their perceived diminished quality of life, the assumption that individuals with disabilities are not capable of making decisions about their own care (i.e., absence of autonomy).

3. How will the amount of indigent care, both free and below cost, change (if at all) if the project is implemented? Include the current amount of indigent care, both free and below cost, provided by the Applicant.

The Applicant has indicated they do not expect any change in the amount of community benefit or indigent care support. Figure 5 below shows the Applicant's 2021 990 Form Filing, which details their indigent care distribution.

FIGURE 5: 2021 990 FORM FILING, DETAILING FINANCIAL ASSISTANCE AND COMMUNITY BENEFITS PROVIDED BY APPLICANT.

7 Financial Assistance and Certain Other Community Benefits at Cost

Financial Assistance and Means-Tested Government Programs	(a) Number of activities or programs (optional)	(b) Persons served (optional)	(c) Total community benefit expense	(d) Direct offsetting revenue	(e) Net community benefit expense	(f) Percent of total expense
a Financial Assistance at cost (from Worksheet 1)			48,214,293.	19,718,403.	28,495,890.	0.61
b Medicaid (from Worksheet 3, column a)			1,594,759,612.	1,013,662,573.	581,097,039.	12.47
c Costs of other means-tested government programs (from Worksheet 3, column b)						
d **Total.** Financial Assistance and Means-Tested Government Programs			1,642,973,905.	1,033,380,976.	609,592,929.	13.08
Other Benefits						
e Community health improvement services and community benefit operations (from Worksheet 4)			82,139,603.	43,301,581.	38,838,022.	0.83
f Health professions education (from Worksheet 5)			371,085,620.	188,658,459.	182,427,161.	3.91
g Subsidized health services (from Worksheet 6)			105,974,398.	70,221,118.	35,753,280.	0.77
h Research (from Worksheet 7)			72,633,134.	42,962,119.	29,671,015.	0.64
i Cash and in-kind contributions for community benefit (from Worksheet 8)			109,659,481.	NONE	109,659,481.	2.35
j **Total.** Other Benefits			741,492,236.	345,143,277.	396,348,959.	8.50
k **Total.** Add lines 7d and 7j			2,384,466,141.	1,378,524,253.	1,005,941,888.	21.58

For Paperwork Reduction Act Notice, see the Instructions for Form 990. Schedule H (Form 990) 2021

4. Describe the access by public or private transportation, including Applicant-sponsored transportation services, to the Applicant's service(s) or care if the project is implemented.

The Montefiore Moses Campus is located at 111 East 210th Street, Bronx, NY 10467. The facility is accessible through public transit via the #4 Train and D Train, as well as the Bx1, Bx10, and Bx28 buses. The Applicant has partnered with New York City's 511 Rideshare program, which offers free assistance for carpooling and public transportation. The Applicant has historically provided MetroCards to enable patients to navigate New York City transit at no or reduced costs.

5. Describe the extent to which implementation of the project will reduce architectural barriers for people with mobility impairments.

The Applicant will be renovating space at their Moses Campus. This will be in compliance with the Americans with Disabilities Act (ADA).

6. Describe how implementation of the project will impact the facility's delivery of maternal health care services and comprehensive reproductive health care services, as that term is used in Public Health Law 2599-aa, including contraception, sterility procedures, and abortion. How will the project impact the availability and provision of reproductive and maternal health care services in the service area? How will the Applicant mitigate any potential disruptions in service availability?

The Independent Entity does not expect any impact or interruption to the Applicant's delivery of maternal health care services and comprehensive reproductive health care services.

Meaningful Engagement

7. List the local health department(s) located within the service area that will be impacted by the project.

New York City Department of Health and Mental Hygiene

8. Did the local health department(s) provide information for, or partner with, the Independent Entity for the HEIA of this project?

Yes, the local health department provided information for, and partnered with the Independent Entity for the HEIA of this project. The Independent Entity met with Duncan Maru, MD, PhD (Assistant Commissioner for the Bureau of Equitable Health Systems & Center for Health Equity and Community Wellness), Rebecca Friedman (Healthcare Justice Legal Fellow), and Emma Clippinger (Director of Policy, Office of Healthcare Systems and Policy) at the New York City Department of Health and Mental Hygiene (DOHMH). The representatives for DOHMH provided the following statement of support.

Concerns and Mitigation Measures Expressed by the Reviewers:

- The Bronx clearly needs expanded ICU beds. The key health equity question is: will this expand access to inpatient and ICU care for lower income and BIPOC Bronx residents, or lead to increased Westchester base that is higher income and more white? Moses Hospital is located in North-Central Bronx, 10-15 minutes by private vehicle to many wealthier communities whose demographic profile is more likely to be higher income, commercially insured, white, US-born, and English-speaking than in the Bronx.
    - Measure demographics, including race, ethnicity, zip and county overtime.
    - We must assume that the likelihood is that this expansion will benefit disproportionately advantaged groups through various forms of structural barriers and discriminatory practices that restrict access for marginalized populations. Flip that reality and commit to increasing access for lower income, BIPOC, Bronx residents through measurement and iterative action.
    - There must be a benchmark by payor including the uninsured for the ICU population.
- How will this impact H+H/North-Central Bronx volume, ED wait times, and financial viability?
    - At present, H+H bears a disproportionate burden of undercompensated (Medicaid, Emergency Medicaid, uninsured) care. Non-profit private institutions such as Montefiore's Moses Campus are accountable under law to provide meaningful community benefit as a result of their large public subsidies in the form of tax exemptions on income and real estate holdings. Meaningful community benefit in this case fundamentally comes down to the payor mix of those who receive expanded ICU services.

General Guidance re: Community Engagement and Accountability:

- Be asset based: Utilize HEIAs to further animate and improve existing patient and community advisory board structures. This will be more efficient for your institution and also reduce redundancies.
- Be rigorous with proactive tracking of measures and targets: We cannot improve what we don't measure. This is particularly true for health equity, where systematic/societal structures are insidious and pervasive. Service expansion and health equity is fundamentally constrained by who benefits? Who gets left behind? Commit to transparency of data sharing specifically on current demographic mix (race, ethnicity, gender identity, county, zip code, insurance mix, immigration/documentation status mix, language mix), anticipated changes to those demographics and ways to mitigate. With community input, set targets and commit to achieving those targets.
- Create real channels for community/patient advisory groups to input: Community and patient advisory groups that lack real avenues for change are harmful. People who are being tokenized as part of a check box exercise will be very aware of this.
- Ensure meaningful community benefit attendant to non-profit tax status: Private, non-profit institutions require under tax law to provide community benefit. The most robust and rigorous way in which hospitals can meet the letter and spirit of tax exempt law is through ensuring care to all those people in their catchment area regardless of their insurance status or ability to pay. Additionally, we view all forms of

proactive debt collection as being aggressive, unnecessary, and counter to health equity aims, certainly those patients who are sick enough to require ICU-level care.

9. Meaningful engagement of stakeholders: Complete the "Meaningful Engagement" table in the document titled "HEIA Data Table". Refer to the Instructions for more guidance.

Completed.

10. Based on your findings and expertise, which stakeholders are most affected by the project? Has any group(s) representing these stakeholders expressed concern the project or offered relevant input?

Based on the Independent Entity's findings and expertise, the stakeholders most affected by the project are older adults, people with chronic conditions, racial and ethnic minorities, and other Bronx residents who are socially vulnerable or marginalized. Other themes included:

- Respondents were appreciative of being included in the planning process and recommended that the Applicant continue to involve them additional planning and improvement efforts. Specifically, community groups recommended that the Applicant share updates in different literacy levels (with an emphasis on photos) to ensure comprehension about upcoming projects.
- All respondents were aware of health inequities in the community and viewed any increase in available services as a positive development. Respondents welcomed the facility modernization and were encouraged by how the project would allow the Applicant to deliver services in a more integrated way (i.e. 'more services under one roof.' Respondents also cited the project as a benefit to healthcare workers.
- Respondents emphasized the importance of thoughtful communication with family members, citing the stress of having a loved one who is receiving intensive care.
- Many respondents cited the lack of preparedness for the COVID-19 Pandemic and viewed the project as an opportunity to improve that.
- Multiple respondents voiced concerns around traffic congestion and air pollution during construction, questions about how long the project will take and how patients will be impacted while the unit is under construction (where they will go to receive those services and what will happen because of it).
- While all respondents were enthusiastic about increasing the availability of intensive care unit services, many shared concerns about other healthcare access issues, including high out-of-pocket costs.

11. How has the Independent Entity's engagement of community members informed the Health Equity Impact Assessment about who will benefit as well as who will be burdened from the project?

The Independent Entity engaged Community Advisory Boards, Community Boards, Elected Officials, Community-Based Organizations, Residents, and Patients. Community members were provided with written and verbal explanations of the project. Many community members cited the Bronx's diversity, and thus felt that the project would positively impact all underserved groups. 100% of community members who were surveyed supported the project.

12. Did any relevant stakeholders, especially those considered medically underserved, not participate in the meaningful engagement portion of the Health Equity Impact Assessment? If so, list.

The Independent Entity believes that no medically underserved stakeholders have been excluded from the meaningful engagement activities. All key stakeholders provided support of the project.

STEP 3 – MITIGATION

1. If the project is implemented, how does the Applicant plan to foster effective communication about the resulting impact(s) to service or care availability to the following:
    a. People of limited English-speaking ability
    b. People with speech, hearing or visual impairments
    c. If the Applicant does not have plans to foster effective communication, what does the Independent Entity advise?

The Applicant plans to provide in-person interpreters for patients with limited English-speaking abilities, and already offers in-person interpreter services for acute care and ICU patients. The Applicant does not have a specific plan for communicating with community-based organizations who represent patients who have limited English-speaking ability and people with speech, hearing, or visual impairments at this time, though they indicated that these details will be solidified at a later date.

Across all service lines and departments, the Applicant's Customer Service Department provides assistance for those non-English speakers and those who are hearing impaired. The Applicant provides other complimentary resources, such as foreign-language interpreters, sign-language interpreters, American Sign Language interpreters, TTYs (text messaging for the hearing impaired), amplified phones, closed captioning for television, and other assistive and auxiliary devices as required.

The Independent Entity recommends creating easily understood communication materials and distributing to community-based organizations and community boards.

2. What specific changes are suggested so the project better meets the needs of each medically underserved group (identified above)?

The Independent Entity suggests that the Applicant develop processes, protocols, and procedures to eliminate disparities in access and quality. These include:

- Stratify what treatments patients receive by race & ethnicity, insurance, and other factors
    - Research has demonstrated that Racial & Ethnic minorities receive less intensive treatment in the ICU (source). A study published in Critical Care medicine by Soto et al. in 2014 found that Black patients received fewer blood transfusions, cardiovascular procedures, organ transplantations. To mitigate these differences across patient populations, the Independent Entity recommends monitoring trends in what type of care patients receive in order to ensure that care is equitable and incorporating these learnings and discussions during daily rounds.
- Create a specific workplace wellness initiative specific for ICU staff to lessen impact of burnout
    - While the Applicant has organizational-wide initiatives to promote staff wellbeing, specific initiatives should be developed to promote wellbeing amongst ICU staff, given the emotional impact associated with delivering intensive care services.
- Establish standards, best practices, and measurement for Goals of Care conversations
    - While Goals of Care conversations are an evidence-based practice used to establish the patient's values through shared decision making, health systems continue to struggle with ensuring that these conversations happen. These conversations are even more challenging to have when there are language and cultural barriers. The impact is that patients are admitted to the ICU towards the end of life, without any clear benefit.
    - The Applicant should develop policies and procedures across the care settings to ensure goals-of-care conversations for chronically ill patients happen, they are clearly documented, and inpatient attending physicians are made aware of them.
- Expect staffing issues and plan accordingly

- Leverage nonphysician providers, ICU telemedicine, and clinical decision support where possible to lessen the burden on staff.
- Promote activities, staff, and programs to ensure family members are supported.
  - The Applicant should offer care management services and devote extra attention to reducing the burden on family members for communicating with insurance companies. Insurers and healthcare providers are often at odds with discharge timing, and this is not something that family members have the knowledge or emotional bandwidth to deal with.
  - The Applicant should design culturally sensitive patient education. Traditional health information and education is often not written at the appropriate health literacy level, saturated with medical jargon, and in dense formats (long PDFs and print outs). The Applicant should explore alternate ways to deliver this information, such as short videos with trusted messengers.
- Increase medical decision-making/advance directive capture through conventional and non-conventional approaches
  - Unfortunately, there are scenarios where patients in the ICU are unable to speak, and without an advanced directive or family member contact on file, staff don't know who to call (leaving that patient's care to a medical ethics board). Wherever possible, the Independent Entity encourages the Applicant to increase Advance Directive capture through traditional clinical settings, but also through community settings, especially for patients with chronic conditions.

3. How can the Applicant engage and consult impacted stakeholders on forthcoming changes to the project?

The Independent Entity highly recommends working with community-based organizations, patient focus groups, and patients to audit existing education and health information content (for patients and family members) to ensure that it is culturally appropriate and easily understood. If current materials are inadequate, the Applicant should work with said stakeholders to develop education and health information that is easily understood and delivered in familiar mediums, such as videos.

The Applicant should use existing patient and community forums (and create new ones) to ensure open and frequent opportunities for feedback and engagement on the project, including notifying the community about these services.

4. How does the project address systemic barriers to equitable access to services or care? If it does not, how can the project be modified?

The project invests in crucial infrastructure that will be predominantly used by members of underserved patient groups. The Bronx needs more ICU beds. Multiple stakeholder interviews uncovered the sentiment that although these services are deeply important, especially as we emerge from the COVID-19 pandemic, the project will not magically solve the structural gaps in the healthcare delivery system. Specifically, multiple stakeholders reported difficulties with moving patients from the ICU to an Acute Care bed or Step-Down unit, given that insurances vary in coverage as it relates to post-discharge support. Some insurances provide more home care and nursing home coverage, while many underserved groups do not have the adequate

STEP 4 – MONITORING

1. What are existing mechanisms and measures the Applicant already has in place that can be leveraged to monitor the potential impacts of the project?

The Applicant currently monitors the following metrics:

- Readmissions
- Case mix Index

- Length of Stay
- Volume and Surgical Volume
- Quality measures, such as Falls, Catheter-Associated Urinary Tract Infections, Surgical Site Infections, and C. Diff
- Patient Experience Scores
- Percentage of patients who require a translator and received one
- Comparison of Length-of-Stay between White & Commercially-insured patients, versus those who belong to underserved populations
- Breakdown of ICU admissions by race, ethnicity, disability status, primary language, age, insurance, sexual orientation & gender identity, citizenship status, and income level
- Percentage of patients who received timely case management and discharge/ home care

2. What new mechanisms or measures can be created or put in place by the Applicant to ensure that the Applicant addresses the findings of the HEIA?

Suggested opportunities for the Applicant to monitor the findings presented in the HEIA include:

- Percentage of family members who successfully complete teach-backs regarding post-discharge instructions and follow-up
- Waiting time from when a patient needs a bed to when they receive it
- Quality of waiting experience
- Emergency Room wait times and percentage of uninsured patients for ICU services at New York City Health + Hospital/North Central Bronx

Additionally, the Independent Entity recommends that there is a structured mechanism for sharing this reporting internally, on an ongoing basis. In the Independent Entity's experience, even when the right data is collected, it doesn't always get reviewed by the right individuals to facilitate improvement. The Independent Entity recommends forming a committee to review these data elements on a monthly basis, while infusing performance improvement methodologies (LEAN, Six Sigma) to focus on addressing inequities and reducing disparities.

Lastly, the Applicant should share data with community members and organizations about who is receiving care from this new unit, stratified by income, insurance, race/ethnicity, disability status, sexual orientation & gender identity, age, and other factors.

STEP 5 – DISSEMINATION

The Applicant is required to publicly post the CON application and the HEIA on its website within one week of acknowledgement by the Department. The Department will also publicly post the CON application and the HEIA through NYSE-CON within one week of the filing.

OPTIONAL: Is there anything else you would like to add about the health equity impact of this project that is not found in the above answers? (250 words max)

---------- SECTION BELOW TO BE COMPLETED BY THE APPLICANT ----------

SECTION C. ACKNOWLEDGEMENT AND MITIGATION PLAN

Acknowledgment by the Applicant that the Health Equity Impact Assessment was reviewed by the facility leadership before submission to the Department. This section is to be completed by the Applicant, not the Independent Entity.

I. Acknowledgement

I, Randi Kohn, attest that I have reviewed the Health Equity Impact Assessment for the Adolescent and Child Inpatient Psychiatric Unit at NYCCC that has been prepared by the Independent Entity, SmartRise Health.

Randi Kohn_____
Name

Assistant Vice President, Regulatory Planning
Title

_____
Signature

03/21/2024

_____
Date

II. Mitigation Plan

If the project is approved, how has or will the Applicant mitigate any potential negative impacts to medically underserved groups identified in the Health Equity Impact Assessment? (1000 words max)
Please note: this narrative must be made available to the public and posted conspicuously on the Applicant's website until a decision on the application has been made.

Montefiore will mitigate any potential negative impacts to medically underserved groups identified in the Health Equity Impact Assessment as follows:

- Staff wellbeing. Montefiore has a robust ongoing initiative: Associate Wellness: To Your Health! which recognizes that Montefiore's most valued asset is a healthy, caring and committed workforce, and that in caring for others, we also need to care for ourselves and others in our workforce. To Your Health! aims to promote a worksite culture that supports the physical and mental well-being of our associates. Montefiore will build on this existing initiative to foster the wellbeing of the staff that will be working on this intensive care unit, as well as all of the Montefiore Associates.
- Availability will lead to unnecessary usage. Montefiore's utilization review and quality improvement functions will work to ensure that there is available intensive care capacity.
- Disproportionately serve non-Bronx residents. Montefiore is doing this project to invest in the Bronx and the Bronx communities. The primary service area of Montefiore Medical Center is the Bronx, and we expect that the majority of our patients will continue to be from Bronx communities. As Montefiore Medical Center is part of Montefiore Health System, we expect some referrals from our Westchester member hospitals, but the numbers would be a small percentage, as they are today. In addition, many of the patients that are transferred from Westchester County represent similar demographics and payer mix as the Bronx population.
- Underserved groups - Non-English Speakers and Immigrants, Women, and People with disabilities. Montefiore is establishing a governance structure for health equity to achieve objectives and address the needs of the members of our organization and patient community. Added governance in health equity at MMC will encourage members of the organization and patients to come together in a central hub for health equity initiatives. Montefiore is a national leader in health equity work, founded on its mission of social justice in medicine. For the past decade, Montefiore Medical Center has espoused the five values of humanity, innovation, teamwork, diversity, and equity. Each of these pillars demonstrates our commitment to achieving the most current, evidenced-based healthcare delivery standards in a fair and equitable way. Montefiore Medical Center remains committed to combatting structural racism and its effects on the health of the communities we care for, as well as continuing to address unmet health-related social needs while providing state of the art medical care. In all, Montefiore has a great opportunity to provide cutting edge, world-class care to the underserved communities of the Bronx and a responsibility to do everything possible to close gaps in health equity that pervade all parts of community well-being and health.

Organization	Name/Organization - if organization, please include contact(s)	Date(s) of outreach	What required stakeholder group did they represent?	Is this person/group a resident of the project's service area?	Method of engagement (I.e. phone calls, community forums, surveys, etc.)	Is this group supportive of this project?	Did this group provide a statement?	If a statement was provided (250 word max), please include below:
Manna of Life Food Pantry	[redacted]	2/5/2024	community leaders	Yes	Teleconference	Yes	Yes	"I would love to see a project like this that creates more places that are accessible in the community I serve (transportation is often an issue). I represent a church and we are the liason between the medical field and people in the community. I encourage Montefiore to have a community engagement/advertising strategy and prioritizing making patients feel safe. Perhaps Montefiore could have block parties and other activities to connect more with the community. While this is a great project, I'd like to note that patients still struggle with high out-of-pocket costs, even when they have insurance."
Presbyterian Senior Services (PSS) Life!	[redacted]	2/5/2024	community leaders	Yes	Teleconference	Yes	Yes	The project sounds like a good idea in general. We work with the older population and this population needs these services. Anything that provides more services to seniors is a good thing. Moses borders on lower income and ethnically diverse neighborhoods. Montefiore is known for world-class doctors and medical services and it's great that we can have this service in our community.
Northwest Bronx Community and Clergy Coalition	[redacted]	2/5/2024	community leaders	Yes	Teleconference	Yes	Yes	I support the project and feel that it will improve access to important services in our community. The reality is we have an aging population, and the extra space is a good idea that will benefit patients that won't need to wait longer for care, while getting them the care they need in a timely basis and closer to home. The project will be especially important for people with disabilities and LGBTQ+ population, though all populations stand to benefit. I encourage Montefiore to think about how they will offset the emissions of new construction (as the Bronx has the highest asthma rate in the nation) and make people of differing cultural and religious backgrounds feel respected when they seek this
Mind-Builders	[redacted]	2/5/2024	community leaders	No	Teleconference	Yes	No	
Mosholu Montefiore Community Center	[redacted]	2/5/2024	organizations representing en	Yes	Teleconference	Yes	Yes	This is a project that the community needs. However, Montefiore needs to be mindful of doing any substantial construction, given the high rates of asthma in the Bronx.
Mosholu Montefiore Community Center	[redacted]	2/5/2024	organizations representing en	Yes	Teleconference	Yes	No	
Mosholu Montefiore Community Center	[redacted]	2/5/2024	organizations representing en	Yes	Teleconference	Yes	No	
New York State Assembly	[redacted]	2/16/2024	community leaders	Yes	Letter of Support	Yes	Yes	Center – Moses Campus to receive the Health Equity Impact Assessment (HEIA) in order to advance this important project. The shortage of ICU beds is a critical issue in the Bronx and nationwide. I am optimistic that this project will create a lasting impact for patients and community members. This project will provide a modern facility that allows Montefiore to support complicated patient needs with life-saving support. Modernizing and expanding ICU beds will create a better experience for patients, their families, staff, and the community. As we saw during COVID-19, our healthcare organizations play a crucial role in the well-being of our communities, and they need to prepare to care for the most vulnerable and sickest patients. The proposed ICU expansion project will give vulnerable
New York City Council	[redacted]	2/14/2024	community leaders	Yes	Letter of Support	Yes	Yes	I would like to offer support for the ICU Expansion project at Montefiore Medical Center – Moses Campus. The Montefiore system in the Bronx is a vital resource for the borough's residents. Montefiore hospitals serve approximately one-third of the Bronx's 1.4 million residents, and is the largest hospital system in the borough. It is an especially critical system for seniors and those of limited financial means, with 73% of revenues from inpatient discharges coming from Medicare or Medicaid. As the Council Member representing Norwood, I can attest to the high importance that the community places on the Montefiore Medical Center – Moses Campus. The shortage of ICU beds is a critical issue in The Bronx and nationwide, and I am optimistic that this project will create a lasting impact for patients and community members. This project will provide a modern facility that allows Montefiore to support complicated patient needs with life-saving supports. Modernizing and expanding ICU beds will create a better experience for patients, their families, staff, and the community as a whole. As we saw during COVID-19, our healthcare organizations play a crucial role in the wellbeing of our communities, and they need to be prepared to care for the most vulnerable and sickest patients. The proposed ICU expansion project will give more access to life-saving services to all Bronx residents, especially those from vulnerable communities. Sincerely, Eric Dinowitz
Bronx Borough	[redacted]		community leaders	Yes	Letter of Support	Yes	Yes	To whom it may concern: As Bronx Borough President, I write in support of the ICU expansion project at Montefiore Medical Center – Moses Campus. This project will bring an additional 21 ICU beds to the Montefiore campus through a conversion of existing inpatient space. As we saw at the height of the COVID-19 pandemic, ICU beds can face a shortage in emergency situations. This is a critical issue for The Bronx, and I am optimistic that this project will create a lasting impact for patients and community members. This project will provide a modern facility that allows Montefiore to support complicated patient needs with lifesaving support. Modernizing and expanding ICU beds will create a better experience for patients, their families, staff, and the whole community and will allow more patients with severe cases to be treated than before. Our healthcare organizations play a crucial role in the wellbeing of our communities, and they need to be prepared to care for the most vulnerable and sickest patients. Bronx communities are particularly underserved when it comes to healthcare access and resources. Expanding the number of ICU beds will be a strong step towards health equity and closing health disparities in our community. The proposed ICU expansion project will give more access to life-saving services to vulnerable residents in The Bronx, and I fully support the expansion.

Organization	Name/Organization - if organization, please include contact(s)	Date(s) of outreach	What required stakeholder group did they represent?	Is this person/group a resident of the project's service area?	Method of engagement (I.e. phone calls, community forums, surveys, etc.)	Is this group supportive of this project?	Did this group provide a statement?	If a statement was provided (250 word max), please include below:
New York City Department of Health and Mental Hygiene	[redacted]	2/19/2024	organizations representing en	No	Teleconference	Yes	Yes	•The Bronx clearly needs expanded ICU beds. The key health equity question is: will this expand access to inpatient and ICU care for lower income and BIPOC Bronx residents, or lead to increased Westchester base that is higher income and more white? Moses Hospital is located in North-Central Bronx, 10-15 minutes by private vehicle to many wealthier communities whose demographic profile is more likely to be higher income, commercially insured, white, US-born, and English-speaking than in the Bronx. oMeasure demographics, including race, ethnicity, zip and county overtime. oWe must assume that the likelihood is that this expansion will benefit disproportionately advantaged groups through various forms of structural barriers and discriminatory practices that restrict access for marginalized populations. Flip that reality and commit to increasing access for lower income, BIPOC, Bronx residents through measurement and iterative action. oThere must be a benchmark by payor including the uninsured for the ICU population. •How will this impact H+H/North-Central Bronx volume, ED wait times, and financial viability? oAt present, H+H bears a disproportionate burden of undercompensated (Medicaid, Emergency Medicaid, uninsured) care. Non-profit private institutions such as Montefiore's Moses Campus are accountable under law to provide meaningful community benefit as a result of their large public subsidies in the form of tax exemptions on income and real estate holdings. Meaningful community benefit in this case fundamentally comes down to the payor mix of those who receive expanded ICU services. General Guidance re: Community Engagement and Accountability: •Be asset based: Utilize HEIAs to further animate and improve existing patient and community advisory board structures. This will be more efficient for your institution and also reduce redundancies. •Be rigorous with proactive tracking of measures and targets: We cannot improve what we don't measure. This is particularly true for health equity, where systematic/societal structures are insidious and pervasive. Service expansion and health equity is fundamentally constrained by who benefits? Who gets left behind? Commit to transparency of data sharing specifically on
Bronx Community Board 7	[redacted]	2/5/2024	residents of the project's servi	Yes	Teleconference	Yes	Yes	
Bronx Community Board 7	[redacted]	2/5/2024	residents of the project's servi	Yes	Teleconference	Yes	Yes	
Bronx Community Board 7	[redacted]	2/5/2024	residents of the project's servi	Yes	Teleconference	Yes	Yes	
New York State Senate, 33rd District, The	[redacted]	2/5/2024	organizations representing en	Yes	Letter of Support	Yes	Yes	I am State Senator Gustavo Rivera and I represent the 33rd Senate District in the Bronx and the Montefiore Medical Center Moses Campus. I would like to offer support for the Intensive Care Unit (ICU) Expansion project at Montefiore's Moses Campus. The shortage of ICU beds is a critical issue in the Bronx, and I am optimistic that this project will create a lasting impact for patients and community members. A state-of-the-art 21 bed intensive care unit will provide a modern facility for our community that also allows Montefiore to support complicated patient needs with life-saving supports. Modernizing and expanding ICU beds will create a better experience for patients, their families, staff, and the community as a whole. As we saw during COVID-19, our healthcare organizations play a crucial role in the wellbeing of our communities, and they need to be prepared to care for the most vulnerable and sickest patients. The proposed ICU expansion project will give more access to life-saving services to vulnerable residents in the Bronx. Sincerely, Gustavo Rivera

Label	ZCTA5 10451				ZCTA5 10452				ZCTA5 10453				ZCTA5 104
	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate
SEX AND AGE (Census Table DP05)													
Total population	51,311	±2,999	51,311	(X)	78,624	±3,253	78,624	(X)	80,385	±3,125	80,385	(X)	41,073
Male	23,365	±1,830	45.50%	±2.1	37,307	±2,085	47.40%	±1.7	37,656	±1,917	46.80%	±1.6	19,272
Female	27,946	±1,891	54.50%	±2.1	41,317	±2,156	52.60%	±1.7	42,729	±2,142	53.20%	±1.6	21,801
Sex ratio (males per 100 females)	83.6	±7.2	(X)	(X)	90.3	±6.3	(X)	(X)	88.1	±5.7	(X)	(X)	88.4
Under 5 years	3,494	±796	6.80%	±1.5	5,461	±887	6.90%	±1.0	5,476	±793	6.80%	±1.0	2,870
5 to 9 years	3,602	±666	7.00%	±1.2	5,955	±1,084	7.60%	±1.2	6,164	±646	7.70%	±0.8	2,975
10 to 14 years	3,571	±660	7.00%	±1.2	6,709	±818	8.50%	±1.0	6,693	±952	8.30%	±1.0	3,486
15 to 19 years	3,444	±620	6.70%	±1.1	5,901	±770	7.50%	±0.9	5,426	±717	6.80%	±0.8	2,598
20 to 24 years	3,668	±770	7.10%	±1.4	5,485	±890	7.00%	±1.1	6,056	±811	7.50%	±1.0	3,363
25 to 34 years	8,720	±1,401	17.00%	±2.3	11,861	±1,223	15.10%	±1.4	11,914	±1,184	14.80%	±1.4	6,668
35 to 44 years	7,046	±963	13.70%	±1.7	10,515	±975	13.40%	±1.2	11,016	±1,144	13.70%	±1.3	5,860
45 to 54 years	6,450	±836	12.60%	±1.6	9,919	±945	12.60%	±1.2	10,223	±1,146	12.70%	±1.3	4,418
55 to 59 years	2,814	±562	5.50%	±1.1	5,192	±726	6.60%	±0.9	5,421	±653	6.70%	±0.8	2,063
60 to 64 years	2,205	±417	4.30%	±0.8	3,239	±506	4.10%	±0.6	4,462	±633	5.60%	±0.8	2,290
65 to 74 years	3,214	±511	6.30%	±1.0	5,136	±623	6.50%	±0.8	4,855	±537	6.00%	±0.7	2,627
75 to 84 years	1,899	±451	3.70%	±0.9	2,344	±538	3.00%	±0.7	2,182	±507	2.70%	±0.6	1,444
85 years and over	1,184	±376	2.30%	±0.7	907	±369	1.20%	±0.5	497	±197	0.60%	±0.2	411
Median age (years)	34.3	±1.1	(X)	(X)	33.1	±1.7	(X)	(X)	33.8	±1.0	(X)	(X)	33.1
RACE (Census Table DP05)													
Total population	51,311	±2,999	51,311	(X)	78,624	±3,253	78,624	(X)	80,385	±3,125	80,385	(X)	41,073
One race	46,438	±2,949	90.50%	±2.1	68,499	±3,281	87.10%	±2.0	68,794	±2,392	85.60%	±1.9	37,046
Two or more races	4,873	±1,103	9.50%	±2.1	10,125	±1,580	12.90%	±2.0	11,591	±1,795	14.40%	±1.9	4,027
One race	46,438	±2,949	90.50%	±2.1	68,499	±3,281	87.10%	±2.0	68,794	±2,392	85.60%	±1.9	37,046
White	6,985	±1,690	13.60%	±3.1	10,687	±1,782	13.60%	±2.2	9,782	±1,662	12.20%	±2.1	5,379
Black or African American	23,231	±2,085	45.30%	±4.0	28,025	±2,718	35.60%	±3.1	26,072	±1,973	32.40%	±2.5	13,083
American Indian and Alaska Native	234	±190	0.50%	±0.4	758	±349	1.00%	±0.4	1,214	±711	1.50%	±0.9	959
Asian	713	±405	1.40%	±0.8	868	±326	1.10%	±0.4	1,265	±524	1.60%	±0.7	180
Native Hawaiian and Other Pacific Islander	293	±450	0.60%	±0.9	64	±291	0.10%	±0.4	285	±253	0.40%	±0.3	374
Some other race	14,982	±2,098	29.20%	±3.4	28,097	±2,778	35.70%	±3.2	30,176	±2,665	37.50%	±3.0	17,071
Two or more races	4,873	±1,103	9.50%	±2.1	10,125	±1,580	12.90%	±2.0	11,591	±1,795	14.40%	±1.9	4,027
HISPANIC OR LATINO AND RACE (Census Table DP05)													
Total population	51,311	±2,999	51,311	(X)	78,624	±3,253	78,624	(X)	80,385	±3,125	80,385	(X)	41,073
Hispanic or Latino (of any race)	28,202	±2,853	55.00%	±3.9	51,450	±2,795	65.40%	±2.5	55,618	±3,074	69.20%	±2.2	28,854
Not Hispanic or Latino	23,109	±2,171	45.00%	±3.9	27,174	±2,333	34.60%	±2.5	24,767	±1,873	30.80%	±2.2	12,219
HEALTH INSURANCE COVERAGE (Census Table DP03)													
Civilian noninstitutionalized population	51,301	±3,000	51,301	(X)	78,520	±3,253	78,520	(X)	80,140	±3,108	80,140	(X)	41,017
With health insurance coverage	47,919	±2,846	93.40%	±1.4	73,086	±3,345	93.10%	±1.1	72,367	±2,772	90.30%	±1.4	36,822
With private health insurance	19,858	±1,733	38.70%	±3.3	29,707	±3,320	37.80%	±3.7	28,402	±1,986	35.40%	±2.0	11,412
With public coverage	32,888	±2,653	64.10%	±3.0	51,334	±3,130	65.40%	±3.1	50,961	±2,593	63.60%	±2.5	28,250
No health insurance coverage	3,382	±767	6.60%	±1.4	5,434	±845	6.90%	±1.1	7,773	±1,195	9.70%	±1.4	4,195
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)													
Total Civilian Noninstitutionalized Population	51,301	±3,000	51,301	(X)	78,520	±3,253	78,520	(X)	80,140	±3,108	80,140	(X)	41,017
With a disability	10,282	±1,123	20.00%	±2.1	12,617	±1,125	16.10%	±1.6	12,524	±1,320	15.60%	±1.6	8,727

Label	54			ZCTA5 10455				ZCTA5 10456				ZCTA5 10457		
	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent
SEX AND AGE (Census Table DP05)														
Total population	±2,161	41,073	(X)	44,380	±2,803	44,380	(X)	88,575	±4,052	88,575	(X)	79,817	±3,759	79,817
Male	±1,548	46.90%	±2.3	20,762	±1,592	46.80%	±2.1	40,207	±2,496	45.40%	±1.5	37,001	±2,183	46.40%
Female	±1,325	53.10%	±2.3	23,618	±1,796	53.20%	±2.1	48,368	±2,280	54.60%	±1.5	42,816	±2,279	53.60%
Sex ratio (males per 100 females)	±8.3	(X)	(X)	87.9	±7.6	(X)	(X)	83.1	±4.9	(X)	(X)	86.4	±5.3	(X)
Under 5 years	±630	7.00%	±1.5	2,507	±580	5.60%	±1.3	6,718	±961	7.60%	±1.0	6,785	±879	8.50%
5 to 9 years	±467	7.20%	±1.0	3,874	±831	8.70%	±1.7	6,044	±889	6.80%	±0.9	6,324	±673	7.90%
10 to 14 years	±627	8.50%	±1.5	3,520	±722	7.90%	±1.5	7,100	±906	8.00%	±0.9	6,929	±943	8.70%
15 to 19 years	±415	6.30%	±1.0	4,167	±819	9.40%	±1.5	6,616	±870	7.50%	±0.9	5,257	±671	6.60%
20 to 24 years	±601	8.20%	±1.4	2,967	±449	6.70%	±1.0	7,045	±920	8.00%	±0.9	6,555	±797	8.20%
25 to 34 years	±997	16.20%	±2.2	7,191	±894	16.20%	±1.9	12,670	±1,371	14.30%	±1.3	13,517	±1,290	16.90%
35 to 44 years	±839	14.30%	±1.9	5,895	±936	13.30%	±1.6	11,287	±1,210	12.70%	±1.1	9,899	±904	12.40%
45 to 54 years	±610	10.80%	±1.4	5,477	±686	12.30%	±1.5	10,668	±1,222	12.00%	±1.5	9,030	±736	11.30%
55 to 59 years	±371	5.00%	±0.9	2,486	±406	5.60%	±0.9	5,869	±800	6.60%	±0.8	4,438	±514	5.60%
60 to 64 years	±366	5.60%	±0.9	1,830	±316	4.10%	±0.7	4,559	±509	5.10%	±0.6	3,655	±548	4.60%
65 to 74 years	±448	6.40%	±1.0	2,756	±435	6.20%	±1.1	6,546	±990	7.40%	±1.2	4,735	±743	5.90%
75 to 84 years	±367	3.50%	±0.9	1,414	±331	3.20%	±0.8	2,766	±431	3.10%	±0.5	2,220	±408	2.80%
85 years and over	±268	1.00%	±0.6	296	±184	0.70%	±0.4	687	±260	0.80%	±0.3	473	±209	0.60%
Median age (years)	±1.3	(X)	(X)	32.2	±1.4	(X)	(X)	33.6	±1.1	(X)	(X)	30.8	±1.0	(X)
RACE (Census Table DP05)														
Total population	±2,161	41,073	(X)	44,380	±2,803	44,380	(X)	88,575	±4,052	88,575	(X)	79,817	±3,759	79,817
One race	±2,202	90.20%	±2.8	38,441	±2,505	86.60%	±3.2	78,613	±3,928	88.80%	±2.2	68,002	±3,518	85.20%
Two or more races	±1,166	9.80%	±2.8	5,939	±1,541	13.40%	±3.2	9,962	±2,002	11.20%	±2.2	11,815	±2,618	14.80%
One race	±2,202	90.20%	±2.8	38,441	±2,505	86.60%	±3.2	78,613	±3,928	88.80%	±2.2	68,002	±3,518	85.20%
White	±1,093	13.10%	±2.5	5,102	±976	11.50%	±2.3	11,426	±1,973	12.90%	±2.1	11,647	±1,769	14.60%
Black or African American	±1,593	31.90%	±3.9	13,232	±1,491	29.80%	±3.4	41,499	±2,649	46.90%	±3.0	34,138	±2,497	42.80%
American Indian and Alaska Native	±642	2.30%	±1.6	543	±343	1.20%	±0.7	1,243	±551	1.40%	±0.6	876	±465	1.10%
Asian	±157	0.40%	±0.4	708	±362	1.60%	±0.8	627	±286	0.70%	±0.3	378	±205	0.50%
Native Hawaiian and Other Pacific Islander	±278	0.90%	±0.7	87	±135	0.20%	±0.3	0	±31	0.00%	±0.1	85	±104	0.10%
Some other race	±2,026	41.60%	±4.1	18,769	±2,296	42.30%	±3.9	23,818	±3,036	26.90%	±2.8	20,878	±1,831	26.20%
Two or more races	±1,166	9.80%	±2.8	5,939	±1,541	13.40%	±3.2	9,962	±2,002	11.20%	±2.2	11,815	±2,618	14.80%
HISPANIC OR LATINO AND RACE (Census Table DP05)														
Total population	±2,161	41,073	(X)	44,380	±2,803	44,380	(X)	88,575	±4,052	88,575	(X)	79,817	±3,759	79,817
Hispanic or Latino (of any race)	±2,290	70.30%	±3.7	32,886	±2,828	74.10%	±2.9	49,895	±3,869	56.30%	±2.9	52,152	±3,369	65.30%
Not Hispanic or Latino	±1,563	29.70%	±3.7	11,494	±1,206	25.90%	±2.9	38,680	±2,633	43.70%	±2.9	27,665	±2,285	34.70%
HEALTH INSURANCE COVERAGE (Census Table DP03)														
Civilian noninstitutionalized population	±2,155	41,017	(X)	44,363	±2,805	44,363	(X)	87,527	±4,060	87,527	(X)	79,471	±3,756	79,471
With health insurance coverage	±2,259	89.80%	±2.8	40,137	±2,747	90.50%	±2.1	81,119	±3,799	92.70%	±1.2	71,739	±3,633	90.30%
With private health insurance	±1,616	27.80%	±3.5	15,085	±1,629	34.00%	±3.1	33,764	±2,930	38.60%	±2.6	24,511	±2,033	30.80%
With public coverage	±2,218	68.90%	±4.2	29,032	±2,345	65.40%	±2.9	58,307	±3,089	66.60%	±2.5	53,191	±3,121	66.90%
No health insurance coverage	±1,147	10.20%	±2.8	4,226	±935	9.50%	±2.1	6,408	±1,106	7.30%	±1.2	7,732	±1,251	9.70%
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)														
Total Civilian Noninstitutionalized Population	±2,155	41,017	(X)	44,363	±2,805	44,363	(X)	87,527	±4,060	87,527	(X)	79,471	±3,756	79,471
With a disability	±946	21.30%	±2.3	8,634	±1,612	19.50%	±3.3	16,871	±1,427	19.30%	±1.6	12,930	±1,341	16.30%

Label		ZCTA5 10458				ZCTA5 10459				ZCTA5 10460				ZCTA5 104
	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate
SEX AND AGE (Census Table DP05)														
Total population	(X)	82,678	±3,681	82,678	(X)	51,964	±3,001	51,964	(X)	59,852	±2,741	59,852	(X)	50,868
Male	±1.5	39,967	±2,096	48.30%	±1.4	25,618	±2,064	49.30%	±1.8	28,068	±1,937	46.90%	±2.1	23,934
Female	±1.5	42,711	±2,268	51.70%	±1.4	26,346	±1,421	50.70%	±1.8	31,784	±1,733	53.10%	±2.1	26,934
Sex ratio (males per 100 females)	(X)	93.6	±5.3	(X)	(X)	97.2	±7.1	(X)	(X)	88.3	±7.3	(X)	(X)	88.9
Under 5 years	±1.0	5,585	±810	6.80%	±0.8	3,973	±776	7.60%	±1.4	3,983	±686	6.70%	±1.0	2,750
5 to 9 years	±0.8	6,282	±868	7.60%	±0.9	3,488	±520	6.70%	±0.9	4,025	±572	6.70%	±0.9	3,178
10 to 14 years	±1.0	6,248	±786	7.60%	±0.8	4,001	±655	7.70%	±1.1	4,676	±619	7.80%	±1.0	3,320
15 to 19 years	±0.8	7,524	±709	9.10%	±0.8	3,969	±643	7.60%	±1.1	4,402	±615	7.40%	±0.9	2,688
20 to 24 years	±0.8	7,758	±883	9.40%	±1.0	3,915	±595	7.50%	±1.1	4,366	±731	7.30%	±1.1	2,905
25 to 34 years	±1.4	13,170	±1,214	15.90%	±1.4	8,056	±937	15.50%	±1.7	9,463	±823	15.80%	±1.3	8,409
35 to 44 years	±1.0	10,200	±958	12.30%	±1.1	6,550	±705	12.60%	±1.2	7,649	±861	12.80%	±1.2	6,691
45 to 54 years	±0.9	10,524	±973	12.70%	±1.1	5,916	±885	11.40%	±1.5	7,549	±670	12.60%	±1.1	6,789
55 to 59 years	±0.6	4,456	±633	5.40%	±0.8	3,297	±489	6.30%	±0.9	3,863	±453	6.50%	±0.8	3,556
60 to 64 years	±0.7	2,937	±484	3.60%	±0.6	3,206	±504	6.20%	±0.9	3,074	±520	5.10%	±0.9	2,768
65 to 74 years	±0.9	4,894	±841	5.90%	±1.0	3,405	±478	6.60%	±1.0	4,263	±728	7.10%	±1.3	4,007
75 to 84 years	±0.5	2,330	±473	2.80%	±0.5	1,738	±348	3.30%	±0.7	1,765	±336	2.90%	±0.6	2,549
85 years and over	±0.3	770	±245	0.90%	±0.3	450	±159	0.90%	±0.3	774	±309	1.30%	±0.5	1,258
Median age (years)	(X)	30.5	±1.1	(X)	(X)	32.9	±1.5	(X)	(X)	34	±1.1	(X)	(X)	37.8
RACE (Census Table DP05)														
Total population	(X)	82,678	±3,681	82,678	(X)	51,964	±3,001	51,964	(X)	59,852	±2,741	59,852	(X)	50,868
One race	±3.0	75,944	±3,780	91.90%	±1.4	44,923	±2,944	86.50%	±2.8	49,293	±2,478	82.40%	±2.5	46,554
Two or more races	±3.0	6,734	±1,178	8.10%	±1.4	7,041	±1,506	13.50%	±2.8	10,559	±1,625	17.60%	±2.5	4,314
One race	±3.0	75,944	±3,780	91.90%	±1.4	44,923	±2,944	86.50%	±2.8	49,293	±2,478	82.40%	±2.5	46,554
White	±2.1	9,276	±1,033	11.20%	±1.2	5,605	±1,120	10.80%	±1.9	8,055	±1,326	13.50%	±2.2	21,074
Black or African American	±2.7	15,287	±1,831	18.50%	±2.1	17,702	±2,205	34.10%	±3.5	20,942	±1,981	35.00%	±3.0	5,029
American Indian and Alaska Native	±0.6	1,053	±701	1.30%	±0.8	327	±226	0.60%	±0.4	623	±325	1.00%	±0.5	487
Asian	±0.3	2,760	±642	3.30%	±0.8	154	±116	0.30%	±0.2	962	±385	1.60%	±0.6	6,646
Native Hawaiian and Other Pacific Islander	±0.1	10	±19	0.00%	±0.1	28	±46	0.10%	±0.1	28	±46	0.00%	±0.1	0
Some other race	±2.1	47,558	±3,216	57.50%	±2.7	21,107	±2,063	40.60%	±3.9	18,683	±2,069	31.20%	±3.2	13,318
Two or more races	±3.0	6,734	±1,178	8.10%	±1.4	7,041	±1,506	13.50%	±2.8	10,559	±1,625	17.60%	±2.5	4,314
HISPANIC OR LATINO AND RACE (Census Table DP05)														
Total population	(X)	82,678	±3,681	82,678	(X)	51,964	±3,001	51,964	(X)	59,852	±2,741	59,852	(X)	50,868
Hispanic or Latino (of any race)	±2.5	58,929	±3,587	71.30%	±2.4	34,990	±2,329	67.30%	±3.3	38,921	±2,476	65.00%	±2.7	25,302
Not Hispanic or Latino	±2.5	23,749	±2,003	28.70%	±2.4	16,974	±2,164	32.70%	±3.3	20,931	±1,788	35.00%	±2.7	25,566
HEALTH INSURANCE COVERAGE (Census Table DP03)														
Civilian noninstitutionalized population	(X)	82,522	±3,648	82,522	(X)	51,749	±3,008	51,749	(X)	59,834	±2,741	59,834	(X)	50,056
With health insurance coverage	±1.5	74,526	±3,363	90.30%	±1.2	48,082	±3,025	92.90%	±1.2	55,919	±2,617	93.50%	±1.3	47,286
With private health insurance	±2.2	29,505	±2,064	35.80%	±2.4	18,967	±2,180	36.70%	±3.2	19,831	±1,599	33.10%	±2.5	30,376
With public coverage	±2.3	50,166	±3,357	60.80%	±2.5	34,263	±2,759	66.20%	±3.1	41,338	±2,701	69.10%	±2.8	22,444
No health insurance coverage	±1.5	7,996	±1,093	9.70%	±1.2	3,667	±608	7.10%	±1.2	3,915	±788	6.50%	±1.3	2,770
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)														
Total Civilian Noninstitutionalized Population	(X)	82,522	±3,648	82,522	(X)	51,749	±3,008	51,749	(X)	59,834	±2,741	59,834	(X)	50,056
With a disability	±1.6	9,684	±974	11.70%	±1.0	9,419	±1,215	18.20%	±2.0	10,907	±1,023	18.20%	±1.6	6,569

Label	61			ZCTA5 10462				ZCTA5 10463				ZCTA5 10464		
	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent
SEX AND AGE (Census Table DP05)														
Total population	±2,160	50,868	(X)	77,230	±2,809	77,230	(X)	70,296	±2,985	70,296	(X)	4,292	±801	4,292
Male	±1,300	47.10%	±1.5	37,848	±1,681	49.00%	±1.4	32,104	±1,934	45.70%	±1.8	2,115	±448	49.30%
Female	±1,362	52.90%	±1.5	39,382	±1,838	51.00%	±1.4	38,192	±1,966	54.30%	±1.8	2,177	±468	50.70%
Sex ratio (males per 100 females)	±5.5	(X)	(X)	96.1	±5.3	(X)	(X)	84.1	±6.0	(X)	(X)	97.2	±20.4	(X)
Under 5 years	±499	5.40%	±0.9	5,581	±696	7.20%	±0.8	4,453	±676	6.30%	±0.9	75	±80	1.70%
5 to 9 years	±629	6.20%	±1.2	4,432	±600	5.70%	±0.7	3,468	±662	4.90%	±0.8	329	±301	7.70%
10 to 14 years	±564	6.50%	±1.0	5,584	±789	7.20%	±0.9	4,614	±636	6.60%	±0.8	191	±209	4.50%
15 to 19 years	±343	5.30%	±0.6	4,291	±515	5.60%	±0.6	3,783	±569	5.40%	±0.8	147	±115	3.40%
20 to 24 years	±492	5.70%	±0.9	5,466	±697	7.10%	±0.9	3,907	±780	5.60%	±1.1	82	±53	1.90%
25 to 34 years	±908	16.50%	±1.6	13,114	±1,077	17.00%	±1.2	8,928	±1,108	12.70%	±1.3	639	±262	14.90%
35 to 44 years	±737	13.20%	±1.3	11,132	±910	14.40%	±1.0	8,739	±938	12.40%	±1.3	439	±160	10.20%
45 to 54 years	±707	13.30%	±1.2	8,911	±816	11.50%	±1.0	9,243	±856	13.10%	±1.1	872	±417	20.30%
55 to 59 years	±504	7.00%	±1.0	4,854	±552	6.30%	±0.7	4,565	±642	6.50%	±0.9	165	±75	3.80%
60 to 64 years	±427	5.40%	±0.9	3,986	±441	5.20%	±0.6	4,329	±757	6.20%	±1.1	113	±79	2.60%
65 to 74 years	±479	7.90%	±1.0	6,108	±642	7.90%	±0.8	8,100	±598	11.50%	±0.9	431	±158	10.00%
75 to 84 years	±376	5.00%	±0.8	2,807	±416	3.60%	±0.5	4,127	±422	5.90%	±0.6	682	±343	15.90%
85 years and over	±248	2.50%	±0.5	964	±215	1.20%	±0.3	2,040	±323	2.90%	±0.5	127	±97	3.00%
Median age (years)	±1.7	(X)	(X)	35.1	±0.9	(X)	(X)	41.4	±1.5	(X)	(X)	49.4	±5.3	(X)
RACE (Census Table DP05)														
Total population	±2,160	50,868	(X)	77,230	±2,809	77,230	(X)	70,296	±2,985	70,296	(X)	4,292	±801	4,292
One race	±2,250	91.50%	±1.8	70,590	±2,806	91.40%	±1.4	61,375	±2,695	87.30%	±1.9	4,063	±791	94.70%
Two or more races	±917	8.50%	±1.8	6,640	±1,099	8.60%	±1.4	8,921	±1,419	12.70%	±1.9	229	±226	5.30%
One race	±2,250	91.50%	±1.8	70,590	±2,806	91.40%	±1.4	61,375	±2,695	87.30%	±1.9	4,063	±791	94.70%
White	±1,615	41.40%	±3.2	12,991	±1,121	16.80%	±1.4	29,139	±2,293	41.50%	±2.9	3,293	±732	76.70%
Black or African American	±1,052	9.90%	±2.0	19,601	±1,945	25.40%	±2.3	10,914	±1,646	15.50%	±2.3	66	±77	1.50%
American Indian and Alaska Native	±332	1.00%	±0.6	776	±444	1.00%	±0.6	1,097	±452	1.60%	±0.6	0	±13	0.00%
Asian	±958	13.10%	±1.8	12,945	±1,352	16.80%	±1.7	2,738	±611	3.90%	±0.9	105	±57	2.40%
Native Hawaiian and Other Pacific Islander	±31	0.00%	±0.1	0	±31	0.00%	±0.1	0	±31	0.00%	±0.1	0	±13	0.00%
Some other race	±2,102	26.20%	±3.7	24,277	±2,185	31.40%	±2.5	17,487	±1,743	24.90%	±2.1	599	±397	14.00%
Two or more races	±917	8.50%	±1.8	6,640	±1,099	8.60%	±1.4	8,921	±1,419	12.70%	±1.9	229	±226	5.30%
HISPANIC OR LATINO AND RACE (Census Table DP05)														
Total population	±2,160	50,868	(X)	77,230	±2,809	77,230	(X)	70,296	±2,985	70,296	(X)	4,292	±801	4,292
Hispanic or Latino (of any race)	±2,214	49.70%	±3.5	36,434	±2,432	47.20%	±2.4	36,790	±2,565	52.30%	±2.2	1,240	±595	28.90%
Not Hispanic or Latino	±1,948	50.30%	±3.5	40,796	±2,190	52.80%	±2.4	33,506	±1,697	47.70%	±2.2	3,052	±627	71.10%
HEALTH INSURANCE COVERAGE (Census Table DP03)														
Civilian noninstitutionalized population	±2,155	50,056	(X)	76,984	±2,807	76,984	(X)	68,568	±2,982	68,568	(X)	4,292	±801	4,292
With health insurance coverage	±2,118	94.50%	±1.1	72,035	±2,549	93.60%	±1.0	65,683	±2,953	95.80%	±0.7	4,027	±823	93.80%
With private health insurance	±1,773	60.70%	±2.8	39,216	±2,529	50.90%	±2.5	43,027	±2,086	62.80%	±2.2	3,390	±878	79.00%
With public coverage	±1,865	44.80%	±3.1	39,431	±2,179	51.20%	±2.5	32,334	±2,346	47.20%	±2.3	1,680	±479	39.10%
No health insurance coverage	±559	5.50%	±1.1	4,949	±827	6.40%	±1.0	2,885	±505	4.20%	±0.7	265	±127	6.20%
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)														
Total Civilian Noninstitutionalized Population	±2,155	50,056	(X)	76,984	±2,807	76,984	(X)	68,568	±2,982	68,568	(X)	4,292	±801	4,292
With a disability	±766	13.10%	±1.5	10,328	±809	13.40%	±1.1	11,914	±1,313	17.40%	±1.8	1,152	±390	26.80%

Label		ZCTA5 10465				ZCTA5 10466				ZCTA5 10467				ZCTA5 104
	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate
SEX AND AGE (Census Table DP05)														
Total population	(X)	46,311	±2,368	46,311	(X)	72,273	±3,432	72,273	(X)	98,713	±3,929	98,713	(X)	81,397
Male	±5.2	22,534	±1,329	48.70%	±1.5	32,005	±2,091	44.30%	±1.7	46,807	±2,341	47.40%	±1.3	39,976
Female	±5.2	23,777	±1,438	51.30%	±1.5	40,268	±2,130	55.70%	±1.7	51,906	±2,342	52.60%	±1.3	41,421
Sex ratio (males per 100 females)	(X)	94.8	±5.9	(X)	(X)	79.5	±5.5	(X)	(X)	90.2	±4.7	(X)	(X)	96.5
Under 5 years	±1.9	3,268	±526	7.10%	±1.1	4,393	±742	6.10%	±1.0	6,341	±796	6.40%	±0.7	6,671
5 to 9 years	±6.5	2,118	±414	4.60%	±0.9	4,261	±700	5.90%	±0.9	6,625	±876	6.70%	±0.8	5,292
10 to 14 years	±4.8	3,034	±594	6.60%	±1.1	5,512	±818	7.60%	±1.0	6,864	±923	7.00%	±0.8	6,148
15 to 19 years	±2.8	3,554	±664	7.70%	±1.4	4,555	±547	6.30%	±0.7	6,197	±745	6.30%	±0.7	5,521
20 to 24 years	±1.3	3,148	±518	6.80%	±1.0	4,735	±901	6.60%	±1.2	6,416	±814	6.50%	±0.7	5,412
25 to 34 years	±5.0	6,589	±968	14.20%	±1.9	10,391	±1,158	14.40%	±1.4	15,427	±1,245	15.60%	±1.1	13,595
35 to 44 years	±3.9	5,504	±530	11.90%	±1.0	8,388	±710	11.60%	±0.9	13,523	±1,214	13.70%	±1.0	10,916
45 to 54 years	±7.3	6,044	±768	13.10%	±1.5	9,951	±1,096	13.80%	±1.3	12,798	±998	13.00%	±1.1	9,519
55 to 59 years	±1.7	3,235	±683	7.00%	±1.4	4,907	±772	6.80%	±1.0	7,114	±818	7.20%	±0.7	5,010
60 to 64 years	±2.0	2,371	±382	5.10%	±0.8	4,514	±515	6.20%	±0.7	5,307	±520	5.40%	±0.6	4,209
65 to 74 years	±3.7	3,472	±375	7.50%	±0.8	6,364	±777	8.80%	±1.2	7,228	±698	7.30%	±0.7	5,299
75 to 84 years	±8.7	2,605	±445	5.60%	±1.0	3,093	±565	4.30%	±0.8	3,435	±443	3.50%	±0.5	2,815
85 years and over	±2.2	1,369	±303	3.00%	±0.6	1,209	±371	1.70%	±0.5	1,438	±264	1.50%	±0.3	990
Median age (years)	(X)	37.9	±2.2	(X)	(X)	37.3	±1.6	(X)	(X)	35.9	±0.9	(X)	(X)	33.4
RACE (Census Table DP05)														
Total population	(X)	46,311	±2,368	46,311	(X)	72,273	±3,432	72,273	(X)	98,713	±3,929	98,713	(X)	81,397
One race	±5.3	40,361	±2,026	87.20%	±3.2	67,554	±3,377	93.50%	±1.4	88,515	±3,851	89.70%	±1.5	70,731
Two or more races	±5.3	5,950	±1,613	12.80%	±3.2	4,719	±1,060	6.50%	±1.4	10,198	±1,552	10.30%	±1.5	10,666
One race	±5.3	40,361	±2,026	87.20%	±3.2	67,554	±3,377	93.50%	±1.4	88,515	±3,851	89.70%	±1.5	70,731
White	±9.4	22,150	±1,380	47.80%	±2.5	6,019	±1,217	8.30%	±1.7	18,732	±1,832	19.00%	±1.6	10,404
Black or African American	±1.9	7,193	±1,271	15.50%	±2.6	46,408	±3,038	64.20%	±3.3	31,581	±2,045	32.00%	±1.9	19,491
American Indian and Alaska Native	±0.9	57	±51	0.10%	±0.1	346	±225	0.50%	±0.3	1,062	±478	1.10%	±0.5	734
Asian	±1.4	2,286	±857	4.90%	±1.9	1,872	±785	2.60%	±1.1	6,256	±911	6.30%	±0.9	1,873
Native Hawaiian and Other Pacific Islander	±0.9	126	±195	0.30%	±0.4	10	±22	0.00%	±0.1	38	±61	0.00%	±0.1	249
Some other race	±8.7	8,549	±1,279	18.50%	±2.7	12,899	±2,050	17.80%	±2.6	30,846	±2,798	31.20%	±2.3	37,980
Two or more races	±5.3	5,950	±1,613	12.80%	±3.2	4,719	±1,060	6.50%	±1.4	10,198	±1,552	10.30%	±1.5	10,666
HISPANIC OR LATINO AND RACE (Census Table DP05)														
Total population	(X)	46,311	±2,368	46,311	(X)	72,273	±3,432	72,273	(X)	98,713	±3,929	98,713	(X)	81,397
Hispanic or Latino (of any race)	±11.4	21,668	±2,085	46.80%	±3.2	21,217	±2,635	29.40%	±3.3	52,267	±3,028	52.90%	±1.9	63,467
Not Hispanic or Latino	±11.4	24,643	±1,666	53.20%	±3.2	51,056	±3,241	70.60%	±3.3	46,446	±2,336	47.10%	±1.9	17,930
HEALTH INSURANCE COVERAGE (Census Table DP03)														
Civilian noninstitutionalized population	(X)	45,864	±2,369	45,864	(X)	71,764	±3,438	71,764	(X)	97,496	±3,925	97,496	(X)	80,507
With health insurance coverage	±3.3	44,364	±2,283	96.70%	±0.7	65,316	±3,155	91.00%	±1.6	88,842	±3,507	91.10%	±1.2	73,136
With private health insurance	±7.9	33,466	±2,038	73.00%	±2.5	38,350	±2,647	53.40%	±2.5	45,398	±2,570	46.60%	±2.4	30,466
With public coverage	±11.5	17,708	±1,446	38.60%	±2.7	34,725	±2,344	48.40%	±2.7	54,112	±2,946	55.50%	±1.9	51,906
No health insurance coverage	±3.3	1,500	±356	3.30%	±0.7	6,448	±1,259	9.00%	±1.6	8,654	±1,284	8.90%	±1.2	7,371
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)														
Total Civilian Noninstitutionalized Population	(X)	45,864	±2,369	45,864	(X)	71,764	±3,438	71,764	(X)	97,496	±3,925	97,496	(X)	80,507
With a disability	±9.1	9,229	±1,166	20.10%	±2.2	10,863	±1,256	15.10%	±1.6	14,215	±1,236	14.60%	±1.1	9,829

Label	68			ZCTA5 10469				ZCTA5 10470				ZCTA5 10471		
	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent
SEX AND AGE (Census Table DP05)														
Total population	±3,732	81,397	(X)	71,862	±3,122	71,862	(X)	15,390	±966	15,390	(X)	22,888	±1,499	22,888
Male	±2,161	49.10%	±1.5	33,820	±1,528	47.10%	±1.6	7,378	±748	47.90%	±3.4	10,731	±884	46.90%
Female	±2,331	50.90%	±1.5	38,042	±2,336	52.90%	±1.6	8,012	±661	52.10%	±3.4	12,157	±884	53.10%
Sex ratio (males per 100 females)	±5.9	(X)	(X)	88.9	±5.9	(X)	(X)	92.1	±12.5	(X)	(X)	88.3	±7.3	(X)
Under 5 years	±1,143	8.20%	±1.2	4,483	±789	6.20%	±1.0	1,311	±278	8.50%	±1.7	1,015	±268	4.40%
5 to 9 years	±776	6.50%	±0.9	3,968	±757	5.50%	±1.0	578	±180	3.80%	±1.2	790	±189	3.50%
10 to 14 years	±791	7.60%	±0.9	4,216	±545	5.90%	±0.7	442	±158	2.90%	±1.0	1,172	±273	5.10%
15 to 19 years	±740	6.80%	±0.9	4,862	±695	6.80%	±0.9	528	±188	3.40%	±1.2	1,999	±583	8.70%
20 to 24 years	±704	6.60%	±0.8	4,517	±601	6.30%	±0.8	952	±335	6.20%	±2.1	1,488	±490	6.50%
25 to 34 years	±1,105	16.70%	±1.1	10,412	±1,087	14.50%	±1.4	2,995	±466	19.50%	±2.7	2,159	±328	9.40%
35 to 44 years	±1,180	13.40%	±1.2	8,399	±853	11.70%	±1.1	2,258	±406	14.70%	±2.5	2,562	±451	11.20%
45 to 54 years	±1,133	11.70%	±1.3	8,610	±834	12.00%	±1.1	1,639	±373	10.60%	±2.4	2,368	±361	10.30%
55 to 59 years	±586	6.20%	±0.8	4,972	±467	6.90%	±0.7	1,120	±356	7.30%	±2.3	1,451	±371	6.30%
60 to 64 years	±544	5.20%	±0.6	5,200	±706	7.20%	±0.9	974	±211	6.30%	±1.3	1,309	±253	5.70%
65 to 74 years	±604	6.50%	±0.8	5,913	±649	8.20%	±0.8	1,218	±355	7.90%	±2.2	3,071	±461	13.40%
75 to 84 years	±612	3.50%	±0.7	4,170	±699	5.80%	±0.9	944	±230	6.10%	±1.5	2,017	±387	8.80%
85 years and over	±379	1.20%	±0.5	2,140	±493	3.00%	±0.7	431	±170	2.80%	±1.1	1,487	±337	6.50%
Median age (years)	±0.9	(X)	(X)	39.7	±1.3	(X)	(X)	38.6	±1.6	(X)	(X)	45.8	±2.8	(X)
RACE (Census Table DP05)														
Total population	±3,732	81,397	(X)	71,862	±3,122	71,862	(X)	15,390	±966	15,390	(X)	22,888	±1,499	22,888
One race	±4,060	86.90%	±2.2	67,038	±3,140	93.30%	±1.3	14,367	±959	93.40%	±2.6	19,672	±1,140	85.90%
Two or more races	±1,742	13.10%	±2.2	4,824	±977	6.70%	±1.3	1,023	±411	6.60%	±2.6	3,216	±1,057	14.10%
One race	±4,060	86.90%	±2.2	67,038	±3,140	93.30%	±1.3	14,367	±959	93.40%	±2.6	19,672	±1,140	85.90%
White	±1,607	12.80%	±1.9	11,105	±1,192	15.50%	±1.8	6,679	±805	43.40%	±4.7	13,205	±947	57.70%
Black or African American	±2,341	23.90%	±2.6	39,587	±2,882	55.10%	±3.0	5,332	±933	34.60%	±5.3	2,340	±548	10.20%
American Indian and Alaska Native	±574	0.90%	±0.7	546	±209	0.80%	±0.3	188	±139	1.20%	±0.9	116	±94	0.50%
Asian	±580	2.30%	±0.7	4,033	±848	5.60%	±1.1	312	±205	2.00%	±1.3	910	±272	4.00%
Native Hawaiian and Other Pacific Islander	±266	0.30%	±0.3	10	±16	0.00%	±0.1	0	±21	0.00%	±0.3	0	±25	0.00%
Some other race	±3,433	46.70%	±3.3	11,757	±1,884	16.40%	±2.5	1,856	±505	12.10%	±3.3	3,101	±657	13.50%
Two or more races	±1,742	13.10%	±2.2	4,824	±977	6.70%	±1.3	1,023	±411	6.60%	±2.6	3,216	±1,057	14.10%
HISPANIC OR LATINO AND RACE (Census Table DP05)														
Total population	±3,732	81,397	(X)	71,862	±3,122	71,862	(X)	15,390	±966	15,390	(X)	22,888	±1,499	22,888
Hispanic or Latino (of any race)	±3,482	78.00%	±2.2	21,234	±2,091	29.50%	±2.7	3,505	±590	22.80%	±3.6	7,333	±1,178	32.00%
Not Hispanic or Latino	±1,900	22.00%	±2.2	50,628	±3,017	70.50%	±2.7	11,885	±915	77.20%	±3.6	15,555	±972	68.00%
HEALTH INSURANCE COVERAGE (Census Table DP03)														
Civilian noninstitutionalized population	±3,732	80,507	(X)	69,760	±3,108	69,760	(X)	15,361	±965	15,361	(X)	21,530	±1,500	21,530
With health insurance coverage	±3,430	90.80%	±1.5	66,414	±3,107	95.20%	±0.9	14,427	±957	93.90%	±2.1	20,754	±1,477	96.40%
With private health insurance	±2,452	37.80%	±2.8	42,029	±2,265	60.20%	±2.5	10,151	±814	66.10%	±4.1	16,718	±1,500	77.60%
With public coverage	±3,153	64.50%	±2.4	31,689	±2,568	45.40%	±2.8	5,813	±835	37.80%	±4.7	7,620	±881	35.40%
No health insurance coverage	±1,265	9.20%	±1.5	3,346	±625	4.80%	±0.9	934	±323	6.10%	±2.1	776	±214	3.60%
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)														
Total Civilian Noninstitutionalized Population	±3,732	80,507	(X)	69,760	±3,108	69,760	(X)	15,361	±965	15,361	(X)	21,530	±1,500	21,530
With a disability	±1,179	12.20%	±1.3	8,368	±839	12.00%	±1.2	2,507	±631	16.30%	±3.8	2,735	±386	12.70%

Label		ZCTA5 10472				ZCTA5 10473				ZCTA5 10474				ZCTA5 104
	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate
SEX AND AGE (Census Table DP05)														
Total population	(X)	65,283	±2,415	65,283	(X)	60,087	±2,488	60,087	(X)	11,280	±1,344	11,280	(X)	43,517
Male	±2.1	31,831	±1,496	48.80%	±1.7	28,136	±1,823	46.80%	±2.1	5,691	±814	50.50%	±5.1	20,249
Female	±2.1	33,452	±1,771	51.20%	±1.7	31,951	±1,683	53.20%	±2.1	5,589	±943	49.50%	±5.1	23,268
Sex ratio (males per 100 females)	(X)	95.2	±6.5	(X)	(X)	88.1	±7.4	(X)	(X)	101.8	±20.9	(X)	(X)	87
Under 5 years	±1.2	5,321	±589	8.20%	±0.8	3,742	±717	6.20%	±1.1	1,001	±299	8.90%	±2.3	3,115
5 to 9 years	±0.8	4,406	±644	6.70%	±1.0	3,311	±463	5.50%	±0.7	1,151	±452	10.20%	±3.4	2,284
10 to 14 years	±1.1	4,439	±572	6.80%	±0.8	4,414	±662	7.30%	±1.1	749	±282	6.60%	±2.1	1,762
15 to 19 years	±2.2	4,883	±678	7.50%	±1.0	3,592	±594	6.00%	±0.9	590	±229	5.20%	±2.1	2,075
20 to 24 years	±2.0	5,155	±590	7.90%	±0.9	4,489	±946	7.50%	±1.4	1,002	±296	8.90%	±2.5	3,102
25 to 34 years	±1.5	10,828	±864	16.60%	±1.2	8,870	±1,138	14.80%	±1.8	1,727	±413	15.30%	±2.9	5,703
35 to 44 years	±1.7	7,848	±739	12.00%	±1.0	6,150	±653	10.20%	±1.0	1,924	±563	17.10%	±4.2	4,331
45 to 54 years	±1.4	7,263	±802	11.10%	±1.1	7,038	±870	11.70%	±1.4	941	±248	8.30%	±2.3	5,195
55 to 59 years	±1.5	3,776	±406	5.80%	±0.6	3,670	±503	6.10%	±0.9	673	±210	6.00%	±1.9	2,832
60 to 64 years	±1.2	3,047	±469	4.70%	±0.8	4,424	±655	7.40%	±1.0	391	±157	3.50%	±1.4	2,765
65 to 74 years	±1.8	4,701	±536	7.20%	±0.8	5,431	±707	9.00%	±1.2	585	±192	5.20%	±1.8	5,755
75 to 84 years	±1.8	2,443	±398	3.70%	±0.6	3,831	±558	6.40%	±0.9	440	±139	3.90%	±1.4	3,421
85 years and over	±1.4	1,173	±270	1.80%	±0.4	1,125	±420	1.90%	±0.7	106	±79	0.90%	±0.7	1,177
Median age (years)	(X)	32.5	±1.2	(X)	(X)	37.6	±1.8	(X)	(X)	31.7	±1.9	(X)	(X)	43.5
RACE (Census Table DP05)														
Total population	(X)	65,283	±2,415	65,283	(X)	60,087	±2,488	60,087	(X)	11,280	±1,344	11,280	(X)	43,517
One race	±4.1	60,881	±2,340	93.30%	±1.4	53,690	±2,402	89.40%	±2.0	9,600	±938	85.10%	±6.4	39,860
Two or more races	±4.1	4,402	±957	6.70%	±1.4	6,397	±1,271	10.60%	±2.0	1,680	±854	14.90%	±6.4	3,657
One race	±4.1	60,881	±2,340	93.30%	±1.4	53,690	±2,402	89.40%	±2.0	9,600	±938	85.10%	±6.4	39,860
White	±4.4	5,317	±990	8.10%	±1.5	10,307	±1,323	17.20%	±2.2	1,074	±443	9.50%	±3.6	3,899
Black or African American	±2.3	17,450	±1,621	26.70%	±2.3	22,716	±1,997	37.80%	±2.9	3,674	±692	32.60%	±6.5	27,844
American Indian and Alaska Native	±0.4	773	±457	1.20%	±0.7	353	±256	0.60%	±0.4	93	±72	0.80%	±0.6	204
Asian	±1.2	5,656	±1,088	8.70%	±1.6	1,361	±531	2.30%	±0.9	52	±74	0.50%	±0.7	1,014
Native Hawaiian and Other Pacific Islander	±0.2	39	±90	0.10%	±0.1	0	±31	0.00%	±0.1	0	±21	0.00%	±0.4	0
Some other race	±2.7	31,646	±2,083	48.50%	±2.8	18,953	±2,026	31.50%	±3.0	4,707	±800	41.70%	±6.4	6,899
Two or more races	±4.1	4,402	±957	6.70%	±1.4	6,397	±1,271	10.60%	±2.0	1,680	±854	14.90%	±6.4	3,657
HISPANIC OR LATINO AND RACE (Census Table DP05)														
Total population	(X)	65,283	±2,415	65,283	(X)	60,087	±2,488	60,087	(X)	11,280	±1,344	11,280	(X)	43,517
Hispanic or Latino (of any race)	±3.8	40,254	±2,290	61.70%	±2.6	37,376	±2,217	62.20%	±2.9	7,921	±1,308	70.20%	±5.7	13,319
Not Hispanic or Latino	±3.8	25,029	±1,881	38.30%	±2.6	22,711	±2,058	37.80%	±2.9	3,359	±634	29.80%	±5.7	30,198
HEALTH INSURANCE COVERAGE (Census Table DP03)														
Civilian noninstitutionalized population	(X)	65,087	±2,411	65,087	(X)	59,844	±2,479	59,844	(X)	10,745	±1,353	10,745	(X)	42,597
With health insurance coverage	±1.0	57,104	±2,274	87.70%	±1.4	56,642	±2,494	94.60%	±1.5	9,825	±1,160	91.40%	±3.6	40,594
With private health insurance	±3.9	21,682	±1,699	33.30%	±2.4	31,103	±2,442	52.00%	±3.1	4,282	±1,002	39.90%	±6.6	25,192
With public coverage	±3.5	40,136	±2,011	61.70%	±2.1	32,140	±2,242	53.70%	±3.4	6,330	±811	58.90%	±7.5	20,330
No health insurance coverage	±1.0	7,983	±987	12.30%	±1.4	3,202	±917	5.40%	±1.5	920	±435	8.60%	±3.6	2,003
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)														
Total Civilian Noninstitutionalized Population	(X)	65,087	±2,411	65,087	(X)	59,844	±2,479	59,844	(X)	10,745	±1,353	10,745	(X)	42,597
With a disability	±1.6	8,035	±916	12.30%	±1.4	11,406	±1,077	19.10%	±1.7	1,813	±370	16.90%	±4.2	6,859

Label	75		
	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)			
Total population	±3,448	43,517	(X)
Male	±2,113	46.50%	±2.7
Female	±2,038	53.50%	±2.7
Sex ratio (males per 100 females)	±9.4	(X)	(X)
Under 5 years	±949	7.20%	±2.0
5 to 9 years	±716	5.20%	±1.5
10 to 14 years	±602	4.00%	±1.2
15 to 19 years	±790	4.80%	±1.7
20 to 24 years	±978	7.10%	±2.1
25 to 34 years	±1,022	13.10%	±2.5
35 to 44 years	±876	10.00%	±1.8
45 to 54 years	±959	11.90%	±2.0
55 to 59 years	±637	6.50%	±1.5
60 to 64 years	±610	6.40%	±1.5
65 to 74 years	±1,124	13.20%	±2.4
75 to 84 years	±744	7.90%	±1.8
85 years and over	±373	2.70%	±0.9
Median age (years)	±3.7	(X)	(X)
RACE (Census Table DP05)			
Total population	±3,448	43,517	(X)
One race	±3,366	91.60%	±2.8
Two or more races	±1,235	8.40%	±2.8
One race	±3,366	91.60%	±2.8
White	±1,084	9.00%	±2.6
Black or African American	±2,795	64.00%	±4.3
American Indian and Alaska Native	±188	0.50%	±0.4
Asian	±587	2.30%	±1.4
Native Hawaiian and Other Pacific Islander	±28	0.00%	±0.1
Some other race	±2,183	15.90%	±4.6
Two or more races	±1,235	8.40%	±2.8
HISPANIC OR LATINO AND RACE (Census Table DP05)			
Total population	±3,448	43,517	(X)
Hispanic or Latino (of any race)	±2,261	30.60%	±4.5
Not Hispanic or Latino	±3,042	69.40%	±4.5
HEALTH INSURANCE COVERAGE (Census Table DP03)			
Civilian noninstitutionalized population	±3,448	42,597	(X)
With health insurance coverage	±3,335	95.30%	±1.5
With private health insurance	±2,165	59.10%	±4.0
With public coverage	±2,586	47.70%	±3.9
No health insurance coverage	±667	4.70%	±1.5
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)			
Total Civilian Noninstitutionalized Population	±3,448	42,597	(X)
With a disability	±977	16.10%	±2.2

GEO_ID	NAME	DP03_0119PE	DP03_0119PM	DP03_0062E	DP03_0062M	DP03_0074PE	DP03_0074PM	DP03_0005PE	DP03_0005PM	DP02_0067PE	DP02_0067PM	DP04_0058PE	DP04_0058PM
Geography	ZCTA Name	Percent!!PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL!!All families	Percent Margin of Error!!PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL!!All families	Estimate!!INCOME AND BENEFITS (IN 2021 INFLATION-ADJUSTED DOLLARS)!!Total households!!Median household income (dollars)	Margin of Error!!INCOME AND BENEFITS (IN 2021 INFLATION-ADJUSTED DOLLARS)!!Total households!!Median household income (dollars)	Percent!!INCOME AND BENEFITS (IN 2021 INFLATION-ADJUSTED DOLLARS)!!Total households!!With Food Stamp/SNAP benefits in the past 12 months	Percent Margin of Error!!INCOME AND BENEFITS (IN 2021 INFLATION-ADJUSTED DOLLARS)!!Total households!!With Food Stamp/SNAP benefits in the past 12 months	Percent!!EMPLOYMENT STATUS!!Population 16 years and over!!In labor force!!Civilian labor force!!Unemployed	Percent Margin of Error!!EMPLOYMENT STATUS!!Population 16 years and over!!In labor force!!Civilian labor force!!Unemployed	Percent!!EDUCATIONAL ATTAINMENT!!Population 25 years and over!!High school graduate or higher	Percent Margin of Error!!EDUCATIONAL ATTAINMENT!!Population 25 years and over!!High school graduate or higher	Percent!!VEHICLES AVAILABLE!!Occupied housing units!!No vehicles available	Percent Margin of Error!!VEHICLES AVAILABLE!!Occupied housing units!!No vehicles available
Concourse/Melrose	ZCTA 10451	34.20%	±5.3	34,316	±5,828	0.416	±3.7	5.2%	±1.2	72.30%	±3.2	75.3%	±2.8
Concourse/Highbridge	ZCTA 10452	31.40%	±3.9	36,536	±3,180	0.473	±3.3	7.1%	±1.3	69.50%	±2.2	80.2%	±2.5
Morris Heights/Mount Hope/University Heig	ZCTA 10453	29.80%	±3.2	34,800	±4,035	0.487	±2.8	8.1%	±1.0	67.60%	±2.3	74.9%	±2.7
Mott Haven/Port Morris	ZCTA 10454	36.70%	±5.0	26,400	±4,309	0.52	±3.6	7.1%	±1.5	60.70%	±3.0	73.4%	±3.4
Mott Haven	ZCTA 10455	25.20%	±4.9	35,813	±3,294	0.48	±3.8	7.0%	±1.6	67.90%	±2.9	75.1%	±3.7
Claremont/Morrisania	ZCTA 10456	31.30%	±4.1	33,317	±2,916	0.498	±3.6	8.0%	±1.2	66.6%	±2.1	76.4%	±2.4
Belmont/Claremont/Mount Hope/Tremont	ZCTA 10457	29.60%	±3.3	41,145	±5,310	0.489	±3.1	7.8%	±1.4	69.5%	±1.9	72.1%	±2.5
Belmont/Fordham University/Kingsbridge	ZCTA 10458	24.40%	±3.1	41,550	±2,405	0.457	±3.0	8.9%	±1.2	68.1%	±2.5	71.6%	±2.6
Charlotte Gardens/Hunts Point	ZCTA 10459	24.70%	±3.4	41,270	±3,387	0.395	±3.7	8.4%	±1.5	68.3%	±2.9	65.7%	±3.0
Charlotte Gardens/Tremont/Van Nest/West I	ZCTA 10460	31.50%	±3.6	33,080	±3,535	0.505	±3.5	8.5%	±1.2	70.4%	±2.3	69.6%	±2.6
Morris Park/Pelham Bay/Westchester Square	ZCTA 10461	14.10%	±3.2	64,444	±5,712	0.213	±2.5	5.1%	±1.0	81.0%	±2.4	38.5%	±2.7
Parkchester/Pelham Parkway/Van Nest/West	ZCTA 10462	15.60%	±2.5	63,431	±2,878	0.236	±2.1	6.0%	±0.9	83.3%	±1.5	55.0%	±2.7
Kingsbridge/Marble Hill/Riverdale/Spuyten D	ZCTA 10463	14.50%	±3.1	66,780	±5,146	0.216	±2.6	5.0%	±1.0	83.2%	±1.8	49.4%	±2.5
City Island	ZCTA 10464	0.00%	±3.2	129,109	±27,791	0.079	±6.3	4.7%	±4.9	95.3%	±3.3	12.7%	±8.5
Country Club/Throgs Neck	ZCTA 10465	9.00%	±2.0	85,946	±6,630	0.17	±2.9	4.2%	±0.9	85.8%	±1.7	24.2%	±2.8
Edenwald/Wakefield	ZCTA 10466	16.80%	±2.9	60,892	±6,496	0.275	±2.4	6.1%	±1.3	80.5%	±2.3	42.6%	±3.2
Allerton/Norwood/Pelham Parkway/William	ZCTA 10467	20.40%	±2.8	46,228	±2,151	0.342	±2.2	6.7%	±0.9	74.6%	±2.0	61.6%	±2.0
Fordham/Kingsbridge/University Heights	ZCTA 10468	24.00%	±3.3	43,985	±3,495	0.418	±3.6	7.2%	±1.0	71.7%	±2.0	71.8%	±2.9
Allerton/Baychester/Pelham Gardens/Williar	ZCTA 10469	13.00%	±2.6	76,731	±6,438	0.235	±2.6	5.0%	±0.9	82.5%	±1.6	34.7%	±2.9
Wakefiled/Woodlawn	ZCTA 10470	7.30%	±3.7	75,750	±8,351	0.13	±3.0	3.2%	±1.1	85.9%	±2.8	39.2%	±5.2
Fieldston/North Riverdale/Riverdale	ZCTA 10471	3.70%	±1.5	111,418	±8,884	0.06	±1.8	3.6%	±0.8	91.5%	±1.5	30.3%	±4.6
Soundview	ZCTA 10472	28.80%	±2.8	40,025	±3,730	0.377	±2.7	5.1%	±0.8	68.1%	±2.5	61.6%	±2.7
Castle Hill/Clason Point/Soundview	ZCTA 10473	17.20%	±3.4	51,379	±3,396	0.323	±3.0	5.8%	±1.2	75.4%	±2.3	44.3%	±3.2
Hunts Point	ZCTA 10474	29.00%	±8.2	40,795	±7,131	0.394	±6.4	7.6%	±2.6	75.4%	±5.1	70.4%	±6.2
Co-op City/Edenwald	ZCTA 10475	9.70%	±4.5	57,003	±7,118	0.193	±3.6	4.9%	±1.7	85.2%	±2.8	44.5%	±4.5

Proposal: Expansion of ICU bed capacity at the Montefiore Mose Campus to "state-of the art" 25 bed ICU.

Institutional Lead(s): Randi Kohn, VP reg planning; Shivani Agarwal, Endocrinologist and Health Equity Lead

Independent Entity / Consultant Leads: Smartrise Health/ Joe Hinderstein

DOHMH Content Experts / Reviewers: Duncan Maru, Rebecca Friedman

Concerns and Mitigation Measures Expressed by the Reviewers:

1. **The Bronx clearly needs expanded ICU beds. The key health equity question is: will this expand access to inpatient and ICU care for lower income and BIPOC Bronx residents, or lead to increased Westchester base that is higher income and more white?** Moses Hospital is located in North-Central Bronx, 10-15 minutes by private vehicle to many wealthier communities whose demographic profile is more likely to be higher income, commercially insured, white, US-born, and English-speaking than in the Bronx.
    a. Measure demographics, including race, ethnicity, zip and county overtime.
    b. We must assume that the likelihood is that this expansion will benefit disproportionately advantaged groups through various forms of structural barriers and discriminatory practices that restrict access for marginalized populations. Flip that reality and commit to *increasing* access for lower income, BIPOC, Bronx residents through measurement and iterative action.
    c. There must be a benchmark by payor including the uninsured for the ICU population.
2. **How will this impact H+H/North-Central Bronx volume, ED wait times, and financial viability?**
    a. At present, H+H bears a disproportionate burden of undercompensated (Medicaid, Emergency Medicaid, uninsured) care. Non-profit private institutions such as Montefiore's Moses Campus are accountable under law to provide meaningful community benefit as a result of their large public subsidies in the form of tax exemptions on income and real estate holdings. Meaningful community benefit in this case fundamentally comes down to the payor mix of those who receive expanded ICU services.

General Guidance re: Community Engagement and Accountability:

1. **Be asset based:** Utilize HEIAs to further animate and improve existing patient and community advisory board structures. This will be more efficient for your institution and also reduce redundancies.
2. **Be rigorous with proactive tracking of measures and targets:** We cannot improve what we don't measure. This is particularly true for health equity, where systematic/societal structures are insidious and pervasive. Service expansion and health equity is fundamentally constrained by who benefits? Who gets left behind? Commit to transparency of data sharing specifically on current demographic mix (race, ethnicity, gender identity, county, zip code, insurance mix, immigration/documentation status mix, language mix), anticipated changes to those demographics and ways to mitigate. With community input, set targets and commit to achieving those targets.

3. **Create real channels for community/patient advisory groups to input:** Community and patient advisory groups that lack real avenues for change are harmful. People who are being tokenized as part of a check box exercise will be very aware of this.
4. **Ensure meaningful community benefit attendant to non-profit tax status:** Private, non-profit institutions require under tax law to provide community benefit. The most robust and rigorous way in which hospitals can meet the letter and spirit of tax exempt law is through ensuring care to all those people in their catchment area regardless of their insurance status or ability to pay. Additionally, we view *all* forms of proactive debt collection as being aggressive, unnecessary, and counter to health equity aims, certainly those patients who are sick enough to require ICU-level care.

JEFFREY DINOWITZ
Assemblyman 81st District
Bronx County

THE ASSEMBLY
STATE OF NEW YORK
ALBANY

CHAIRMAN
Codes Committee

COMMITTEES
Rules
Ways and Means
Health
Election Law

MEMBER
Puerto Rican/Hispanic Task Force

CHAIRMAN
Bronx Delegation

February 16th, 2024

Health Equity Impact Assessment (HEIA)
New York State Department of Health
90 Church St
New York, NY 10007

Letter of support for Montefiore Moses ICU expansion

I am delighted to offer my support for the ICU Expansion project at Montefiore Medical Center – Moses Campus to receive the Health Equity Impact Assessment (HEIA) in order to advance this important project.

The shortage of ICU beds is a critical issue in the Bronx and nationwide. I am optimistic that this project will create a lasting impact for patients and community members. This project will provide a modern facility that allows Montefiore to support complicated patient needs with life-saving support. Modernizing and expanding ICU beds will create a better experience for patients, their families, staff, and the community. As we saw during COVID-19, our healthcare organizations play a crucial role in the well-being of our communities, and they need to prepare to care for the most vulnerable and sickest patients.

The proposed ICU expansion project will give vulnerable residents in the Bronx more access to life-saving services.

Sincerely,

Jeffrey Dinowitz
Member of Assembly

□ ALBANY OFFICE: Room 941, Legislative Office Building, Albany, New York 12248 ● 518-455-5965, FAX 518-455-4437
□ DISTRICT OFFICE: 3107 Kingsbridge Avenue, Bronx, New York 10463 ● 718-796-5345, FAX 718-796-0694
dinowitzj@assembly.state.ny.us

DISTRICT OFFICE
277 West 231st Street
Bronx, NY 10463
TEL: (718) 549-7300
FAX: (718) 549-9945

CITY HALL OFFICE
250 Broadway, Suite 1868
New York, NY 10007
TEL: (212) 788-7080
FAX: (212) 442-7827

Dinowitz@council.nyc.gov

THE
COUNCIL
OF
THE CITY OF NEW YORK
ERIC DINOWITZ
COUNCIL MEMBER, DISTRICT 11, BRONX

CHAIR
Higher Education

CHAIR
Jewish Caucus

CO-CHAIR
Bronx Delegation

COMMITTEES
Aging
Civil Service and Labor
Cultural Affairs, Libraries, and International Intergroup Relations
Education
Housing and Buildings
Parks and Recreation
Standards and Ethics

To Whom It May Concern:

I would like to offer support for the ICU Expansion project at Montefiore Medical Center – Moses Campus.

The Montefiore system in the Bronx is a vital resource for the borough's residents. Montefiore hospitals serve approximately one-third of the Bronx's 1.4 million residents, and is the largest hospital system in the borough[1]. It is an especially critical system for seniors and those of limited financial means, with 73% of revenues from inpatient discharges coming from Medicare or Medicaid[2]. As the Council Member representing Norwood, I can attest to the high importance that the community places on the Montefiore Medical Center – Moses Campus.

The shortage of ICU beds is a critical issue in The Bronx and nationwide, and I am optimistic that this project will create a lasting impact for patients and community members. This project will provide a modern facility that allows Montefiore to support complicated patient needs with life-saving supports. Modernizing and expanding ICU beds will create a better experience for patients, their families, staff, and the community as a whole. As we saw during COVID-19, our healthcare organizations play a crucial role in the wellbeing of our communities, and they need to be prepared to care for the most vulnerable and sickest patients.

The proposed ICU expansion project will give more access to life-saving services to all Bronx residents, especially those from vulnerable communities.

Sincerely,

Eric Dinowitz
Council Member, District 11

[1] https://www.montefiore.org/documents/communityservices/MMC-2022-CHNA-CSP-Report-FINAL.pdf
[2] https://www.montefiore.org/montefiore-overview

BRONX BOROUGH PRESIDENT VANESSA L. GIBSON

February 27, 2024

To whom it may concern:

As Bronx Borough President, I write in support of the ICU expansion project at Montefiore Medical Center – Moses Campus. This project will bring an additional 21 ICU beds to the Montefiore campus through a conversion of existing inpatient space.

As we saw at the height of the COVID-19 pandemic, ICU beds can face a shortage in emergency situations. This is a critical issue for The Bronx, and I am optimistic that this project will create a lasting impact for patients and community members. This project will provide a modern facility that allows Montefiore to support complicated patient needs with lifesaving support. Modernizing and expanding ICU beds will create a better experience for patients, their families, staff, and the whole community and will allow more patients with severe cases to be treated than before. Our healthcare organizations play a crucial role in the wellbeing of our communities, and they need to be prepared to care for the most vulnerable and sickest patients.

Bronx communities are particularly underserved when it comes to healthcare access and resources. Expanding the number of ICU beds will be a strong step towards health equity and closing health disparities in our community. The proposed ICU expansion project will give more access to life-saving services to vulnerable residents in The Bronx, and I fully support the expansion.

Sincerely,

Vanessa L. Gibson
Bronx Borough President

SENATOR
GUSTAVO RIVERA
33RD DISTRICT

NEW YORK
STATE
SENATE
ALBANY, NEW YORK 12247

CHAIRMAN, MAJORITY MEMBER
HEALTH
COMMITTEES:
ALCOHOLISM AND SUBSTANCE ABUSE
CRIME VICTIMS, CRIME AND CORRECTION
FINANCE
HIGHER EDUCATION
HOUSING, CONSTRUCTION AND
COMMUNITY DEVELOPMENT
MENTAL HEALTH

March 18, 2024

To Whom It May Concern:

I am State Senator Gustavo Rivera and I represent the 33rd Senate District in the Bronx and the Montefiore Medical Center Moses Campus. I would like to offer support for the Intensive Care Unit (ICU) Expansion project at Montefiore's Moses Campus.

The shortage of ICU beds is a critical issue in the Bronx, and I am optimistic that this project will create a lasting impact for patients and community members. A state-of-the-art 21 bed intensive care unit will provide a modern facility for our community that also allows Montefiore to support complicated patient needs with life-saving supports. Modernizing and expanding ICU beds will create a better experience for patients, their families, staff, and the community as a whole. As we saw during COVID-19, our healthcare organizations play a crucial role in the wellbeing of our communities, and they need to be prepared to care for the most vulnerable and sickest patients.

The proposed ICU expansion project will give more access to life-saving services to vulnerable residents in the Bronx.

Sincerely,

Gustavo Rivera
New York State Senator
33rd District, The Bronx

- Thanks so much for your time today!
- Montefiore Medical Center is planning to repurpose existing space to build 21 intensive care unit beds. As part of that, they have hired SmartRise Health to completing a Health Equity Impact Assessment (HEIA), a New York state requirement. The HEIA provides information on whether a proposed project impacts the delivery of or access to services for the service area, particularly medically underserved groups in order to ensure community voices are considered and provide an objective, independent assessment of the anticipated impact of the project on public health.
- The purpose of the Health Equity Impact Assessment is to demonstrate how a facility's proposed project affects the accessibility and delivery of services, and whether the project will enhance health equity and contribute to mitigating health disparities in the project's service area, specifically for medically underserved groups.
- Today, I'm going to ask you a few questions about you, your organization, healthcare in your community. Does that sound okay?
- Tell me about the organization you work for? What's the catchment area of the organization you serve?
- Does your organization serve medically underserved groups? New York State uses the following groupings
    - Low-income people
    - Racial and ethnic minorities
    - Immigrants
    - Women
    - Lesbian, gay, bisexual, transgender, or other-than-cisgender people
    - People with disabilities
    - Older adults
    - Persons living with a prevalent infectious disease or condition
    - Persons living in rural areas
    - People who are eligible for or receive public health benefits
    - People who do not have third-party health coverage or have inadequate third-party health coverage
    - Other people who are unable to obtain health care
- Now I'm going to provide an overview of the project.
    - Montefiore Medical Center is repurposing existing acute care rooms at its Moses Campus into 21 new ICU beds to accommodate a higher level of care and patients who have more complex conditions.
    - As part of the Health Equity Impact assessment, we're asking community leaders and residents like you about their thoughts.
    - This project will provide a modern facility that will responds to the complicated clinical needs of the population with a patient-centered approach to care delivery. The new ICU will be designed to enhance the xperience for patients and their families while supporting the care team in delivering advanced life-saving care.
    - The space currently consists of 25 medical/surgical beds and 15 medical/surgical step-down beds for a total of 40 beds. Montefiore is planning to turn this into a 21 bed intesnsive care unit.

    - To accomplish the project, Montefiore will do some general construction, additional monitoring capabilities and additional staff.
- What is your reaction to Montefiore making change?
- How will this initiative impact underserved stakeholders overall, and the specific groups of underserved groups?
- How will this impact health equity, health disparities, and access to care?
- What concerns do you have?
- What ideas would you share with Montefiore about how they can enhance this project?
- Do you support this project?
- Do you wish to provide a statement of support?

New York State Department of Health
Health Equity Impact Assessment Requirement Criteria

Effective June 22, 2023, a Health Equity Impact Assessment (HEIA) will be required as part of Certificate of Need (CON) applications submitted by facilities (Applicant), pursuant to Public Health Law (PHL) § 2802-b and corresponding regulations at Title 10 New York Codes, Rules and Regulations (NYCRR) § 400.26. This form must be used by the Applicant to determine if a HEIA is required as part of a CON application.

Section A. Diagnostic and Treatment Centers (D&TC) - *This section should only be completed by D&TCs, all other Applicants continue to Section B.*

Table A.

Diagnostic and Treatment Centers for HEIA Requirement	Yes	No
Is the Diagnostic and Treatment Center's patient population less than 50% patients enrolled in Medicaid and/or uninsured (combined)?	N/A	
Does the Diagnostic and Treatment Center's CON application include a change in controlling person, principal stockholder, or principal member of the facility?	N/A	

- ***If you checked "no" for both questions in Table A,*** you do not have to complete Section B – this CON application is considered exempt from the HEIA requirement. This form with the completed Section A is the only HEIA-related document the Applicant will submit with this CON application. Submit this form, with the completed Section A, along with the CON application to acknowledge that a HEIA is not required.

- ***If you checked "yes" for either question in Table A***, proceed to Section B.

Section B. All Article 28 Facilities

Table B.

Construction or equipment	Yes	No

Is the project minor construction or the purchase of equipment, subject to Limited Review, AND will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Expansion or addition of 10%* or greater in the number of certified beds, certified services or operating hours? *Per the Limited Review Application Instructions: Pursuant to 10 NYCRR 710.1(c)(5), minor construction projects with a total project cost of less than or equal $15,000,000 for general hospitals and*		✔

less than or equal to $6,000,000 for all other facilities are eligible for a Limited Review.		
Establishment of an operator (new or change in ownership)	**Yes**	**No**
Is the project an establishment of a new operator or change in ownership of an existing operator providing services or care, AND will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?		✔
Mergers, consolidations, and creation of, or changes in ownership of, an active parent entity	**Yes**	**No**
Is the project a transfer of ownership in the facility that will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?		✔
Acquisitions	**Yes**	**No**

Is the project to purchase a facility that provides a new or similar range of services or care, that will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?		✔
All Other Changes to the Operating Certificate	**Yes**	**No**
Is the project a request to amend the operating certificate that will result in one or more of the following: a. Elimination of services or care; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Expansion or addition of 10%* or greater in the number of certified beds, certified services or operating hours, and/or; d. Change in location of services or care?	✔	

*Calculate the percentage change from the number of certified/authorized beds and/or certified/authorized services (as indicated on the facility's operating certificate) specific to the category of service or care. For example, if a residential health care facility adds two ventilator-dependent beds and the facility had none previously, this would exceed the 10% threshold. If a hospital removes 5 out of 50 maternity certified/authorized beds, this would meet the 10% threshold.

- ***If you checked "yes" for one or more questions in Table B***, the following HEIA documents are required to be completed and submitted along with the CON application:
  - HEIA Requirement Criteria with Section B completed
  - HEIA Conflict-of-Interest

  - HEIA Contract with Independent Entity
  - HEIA Template
  - HEIA Data Tables
  - Full version of the CON Application with redactions, to be shared publicly

- ***If you checked "no" for all questions in Table B***, this form with the completed Section B is the only HEIA-related document the Applicant will submit with this CON application. Submit this form, with the completed Section B, along with the CON application to acknowledge that a HEIA is not required.

June 2023

New York State Department of Health

Health Equity Impact Assessment Conflict-of-Interest

This Conflict-of-Interest form must be completed in full, signed by the Independent Entity, and submitted with the Health Equity Impact Assessment.

Section 1 – Definitions

Independent Entity means individual or organization with demonstrated expertise and experience in the study of health equity, anti-racism, and community and stakeholder engagement, and with preferred expertise and experience in the study of health care access or delivery of health care services, able to produce an objective written assessment using a standard format of whether, and if so how, the facility's proposed project will impact access to and delivery of health care services, particularly for members of medically underserved groups.

Conflict of Interest shall mean having a financial interest in the approval of an application or assisting in drafting any part of the application on behalf of the facility, other than the health equity assessment.

Section 2 – Independent Entity

What does it mean for the Independent Entity to have a conflict of interest? For the purpose of the Health Equity Impact Assessment, if one or a combination of the following apply to the Independent Entity, the Independent Entity **HAS** a conflict of interest and must **NOT** perform the Health Equity Impact Assessment:

- The Independent Entity helped compile or write any part of the Certificate of Need (CON) application being submitted for this specific project, other than the Health Equity Impact Assessment (for example, individual(s) hired to compile the Certificate of Need application for the facility's project cannot be the same individual(s) conducting the Health Equity Impact Assessment);
- The Independent Entity has a financial interest in the outcome of this specific project's Certificate of Need application (i.e. individual is a member of the facility's Board of Directors or advisory board); or
- The Independent Entity has accepted or will accept a financial gift or incentive from the Applicant above fair market value for the cost of performing the Health Equity Impact Assessment.

Section 3 – General Information

A. About the Independent Entity

1. Name of Independent Entity: SmartRise Health
2. Is the Independent Entity a division/unit/branch/associate of an organization (Y/N)? N
   - ❑ If yes, indicate the name of the organization:

     _____

3. Is the Independent Entity able to produce an objective written Health Equity Impact Assessment on the facility's proposed project (Y/N)? Y

4. Briefly describe the Independent Entity's previous experience working with the Applicant. Has the Independent Entity performed any work for the Applicant in the last 5 years?

The Independent Entity previously completed an HEIA for the Applicant for their NYCCC project; the assessment was conducted from 10/16/23 through 1/10/2024.

Section 4 – Attestation

I, Ruth Harmon name), having personal knowledge and the authority to execute this Conflict of Interest form on behalf of SmartRise Health (INDEPENDENT ENTITY), do hereby attest that the Health Equity Impact Assessment for project Expansion of 21 ICU Beds (Foreman 7B) at Montefiore Medical Center – Moses Campus (PROJECT NAME) provided for Montefiore Medical Center (APPLICANT) has been conducted in an independent manner and without a conflict of interest as defined in Title 10 NYCRR § 400.26.

I further attest that the information provided by the INDEPENDENT ENTITY in the Health Equity Impact Assessment is true and accurate to the best of my knowledge, and fulfills the intent of the Health Equity Impact Assessment requirement.

Signature of Independent Entity: Ruth Harmon

Date: 3/13/2024

STATEMENT OF WORK 2

This Statement of Work (Statement of Work 2), is governed by the terms and conditions of the MCSA signed on the 25th day of September 2023, by and between Montefiore Medical Center ("MMC"), a New York not-for-profit corporation located at 111 East 210th Street, Bronx, NY, 10467 and SmartRise Health ("Consultant") located at 447 Braodway 2nd fl., Suite 303, New York, NY, 10013.

I. A complete and accurate description of the services to be performed:

MONTEFIORE MEDICAL CENTER (MMC).

MMC seeks to convert existing medical/surgical inpatient beds to 15 ICU beds, creating an additional Intensive Care Unit at Montefiore Medical Center Moses Division. Since 2019, MMC has seen an increase in requests for transfers from outside facilities to Montefiore for critical care services. The Montefiore Moses campus currently has 58 critical care beds, which is 8% of the total bed capacity, well under national standards. The project will require construction, additional equipment and monitoring capabilities and additional staff. To submit the Certificate of Need Application to the New York State Health Department, Montefiore Medical Center must have a Health Equity Impact Assessment completed by a qualified independent entity. To that end, Montefiore has engaged SmartRise Health, an accomplished and reputable consulting firm in the areas of health equity, anti-racism, stakeholder and community engagement, and health care access and delivery of to conduct the assessment. SmartRise Health will assess the demographics of the service area, availability of similar services, current access barriers for underserved populations, staffing impacts, and other relevant considerations as part of the HEIA using qualitative and quantitative data.

MMC is part of the Montefiore Health System, one of New York's premier academic health systems and a recognized leader in providing exceptional quality and personalized, accountable care to approximately three million people in communities across the Bronx, Westchester and the Hudson Valley. It is comprised of 10 hospitals, including the Children's Hospital at Montefiore, Burke Rehabilitation Hospital and more than 200 outpatient ambulatory care sites. The advanced clinical and translational research at its medical school, Albert Einstein College of Medicine, directly informs patient care and improves outcomes. From the Montefiore-Einstein Centers of Excellence in cancer, cardiology and vascular care, pediatrics, and transplantation, to its preeminent school-based health program, Montefiore is a fully integrated healthcare delivery system providing coordinated, comprehensive care to patients and their families.

SMARTRISE HEALTH

SmartRise Health has designed a **Health Equity Impact Assessment** approach that integrates community and patient engagement concepts to drive health equity and ensure equitable representation on capital projects. The framework uses stakeholder engagement as a fundamental component to understanding how capital projects impact marginalized populations, while developing equitable and achievable

mitigation steps to ensure projects are approved. In similar projects, SmartRise Health has le methodology using the Institute for Healthcare Improvement's (IHI) quality improvement m various stakeholders, including payers, policymakers (CMS, NCQA, ONC), provider networks, based organizations, pharmaceutical and technology organizations looking to promote equi to care.

This scope is focused on Montefiore Health system's Montefiore Medical Center Moses Campus. Options to contract to perform HEIA's for other hospital CONs within the system will be discussed on an as needed basis following evaluation of existing scope performance.

As part of the scope of work, SmartRise Health will provide industry advisory and consulting services for the management, coordination, and finalization of Montefiore Medical Center's Health Equity Impact Assessment. SmartRise Health will "meet you where you are at," optimizing the outcomes of HEIA, supporting support data collection and meaningful engagement of community stakeholders.

SmartRise Health will recommend solutions for tracking and monitoring results to ensure that the MMC promotes a sustainable, equitable environment for healthcare delivery. Goals include improving quality, lowering costs, improving outcomes, and enhancing the experience of patients, while ensuring that all patients have equitable access and outcomes regardless of income, race, gender, disability status, age, insurance coverage, and zip code.

SmartRise Health will provide industry advisory and consulting services for the management, coordination, and finalizing of Montefiore Medical Center's Health Equity Impact Assessment. SmartRise Health will "meet you where you are at," optimizing the outcomes of HEIA. SmartRise will support data collection efforts, while also supporting a meaningful engagement of community stakeholders.

SUMMARY OF DELIVERABLES AND RESULTS

Expected deliverables include:

- Completed HEIA Template
- Completed Data Tables
- Completed Conflict of interest form

Expected results:

- Approved Health Equity Impact Assessment to support the Certification of Need application.

BREAKDOWN OF ACTIVITIES AND DELIVERABLES

SmartRise Health will **collaborate with** the Program Sponsor and planning team in the identification of programs, people and processes associated with the Health Equity Impact Assessment – including alignment of project goals, stakeholders, and data collection.

Key SmartRise Health Activities:

1. Project Kick-off and Discovery
    a. Gather details regarding the project for CON.
    b. Provide critical SmartRise Health insights, structure, and framework.
2. Data Collection and Montefiore Stakeholder Engagement
    a. Review and synthesize data shared by MMC around service area, market share, competitors, business and staffing plan, and any additional supporting documents.
    b. Leverage data sources (such as census data, hospital discharge data, HRSA shortage designation, stakeholder interviews, secondary sources, medical literature, or grey literature, etc.) to understand impact to medically underserved populations.
    c. Meet with Montefiore departmental owners as directed and assigned by project sponsor.
    d. Capture potential impacts and prepare mitigation strategies as needed.
3. Community Engagement
    a. Identify and meet with contacts for community stakeholder groups including city and borough health department leaders and community representatives from under-represented groups.
4. Synthesis and Submission

SmartRise Health Deliverables:

- Program management framework
    - Project plan with milestones
    - Project dashboard and status reporting
- Completed HEIA Template
- Completed Data Tables
- Completed conflict of interest form

Key Montefiore Medical Center Requirements

1. Access to project plan, deliverables and intended use.
2. Access to demographics data within service area
3. Provide data sources (such as census data, claims, hospital discharge data, HRSA shortage designation, stakeholder interviews, secondary sources, medical literature, or grey literature, etc.)
4. Provide business plan documentation regarding existing service landscape, staffing plan, similar projects in the last 5 years, and existing efforts to address health inequities.
5. Contact information and pre-engagement or communication with project stakeholders.

II. Project implementation plan, including a timetable:

PROJECT PLAN

The snapshot below shows a visualization of the Montefiore Health Impact Assessment timeline, with high-level milestones.

Detail will be added to the timeline during as Montefiore shares information during discovery. An updated timeline, with Montefiore work activities and deadlines is a SmartRise deliverable.

The timeline shows four periods which may be modified during discovery:

1. Project Kick-Off and Discovery
2. Stakeholder Data Collection and Montefiore Stakeholder Engagement
3. Community Engagement
4. Synthesis and Submission

	Weeks (targeting 8 weeks, updates will be made to timeline as needed based on discovery)							
Phase	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
1. Project Kick-Off and Discovery								
2. Data Collection and Montefiore Stakeholder Engagement								
3. Community Engagement								
4. Synthesis and Submission								

III. The terms of the SOW and the schedule for performance of the services:

FEES AND PAYMENT TERMS

DURATION AND COST MODEL
Duration • Scope Estimated duration: 2 – 3 months (targeting 8 weeks) • Schedule/Timeframe for Services Completion (Contract Term) • Term: Effective Date: January 8, Expiration Date: April 8, 2024 Cost Model • **Fixed Cost**

ASSUMPTIONS

The Health Equity Impact Assessment is focused on MMC's Moses Campus.

LABOR EXPENDITURES				
Role/Title	# Resources	Resource Hours	Hourly Rate	Total
Health Equity SME	1	6	[redacted]	[redacted]
Program Management	1	40		
Analytics and Implementation Analyst	1	35		
Total				

COST BREAKDOWN			
Phase	Key Milestone / Deliverable	Invoice Period	Expenditure by Month
0	Program Setup/At Signing	Project start	[redacted]
1	Project Kick-off and Discovery	Invoiced monthly after project start	
2	Data Collection		
3	Stakeholder and Community Engagement		
		Total	

IV. Procedures for testing and acceptance of the services and deliverables:

QUALITY AND ACCEPTANCE CRITERIA

Indicator/Metric	Measurement Criteria	Frequency
Approach Delivery	Proposed approach and project reviewed and agreed upon	Monthly
Timeliness	Content turnaround times, including curriculum, project charter and content delivered within agreed upon timeframes	Monthly
Content alignment	Content displays alignment as agreed upon programs and models, as agreed upon	Monthly
Contractor performance and reporting	100% on time deliverables Creation of technical and operational structure to support accreditation	Reporting out monthly against status of key workstreams

V. Names and contact information of the consultant's main point of contact and any key personnel:

SMARTRISE HEALTH CONTACT INFORMATION

- Joe Hinderstein, Consultant, SmartRise Health, Project Leader, jhinderstein@smartrisehealth.com, (914) 815-0902
- Ruth Harmon, Vice President, Strategy and Operations, SmartRise Health, ruth.harmon@smartrisehealth.com, (914) 708-6878
- Vanessa Guzman, CEO, SmartRise Health, vanessa@smartrisehealth.com, (646) 680-9046

SMARTRISE HEALTH

Signature _____

Name Vanessa Guzman

Title CEO and President

MONTEFIORE MEDICAL CENTER

Signature _____

Name Philip O. Ozuah, MD

Title President + CEO