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	Decertify 80 general residential health care facility beds
2. Name of Applicant	ArchCare
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	Sachs Policy Group (SPG) – 212-827-0660 • Jaclyn Pierce, MPH jpierce@sachspolicy.com • Anita Appel, LCSW - AnitaAppel@sachspolicy.com • Maxine Legall, MSW, MBA - mlegall@sachspolicy.com Qualifications: • Health equity – 6 years • Anti-racism – 6 years • Community engagement – 25+ years • Health care access and delivery – 10+ years
4. Description of the Independent Entity's qualifications	The Health Equity Impact Assessment (HEIA) Team at Sachs Policy Group (SPG) is a diverse and experienced group dedicated to addressing health disparities and promoting equitable access to care. The team comprises experts with extensive backgrounds in health policy, population health, data analysis, community engagement, and anti-racism. They are committed to understanding and improving how social, environmental, and policy factors impact health equity, particularly for historically marginalized communities. The team collaborates with a wide range of health care organizations, government agencies, and communities to provide strategic support with an overarching goal of advancing diversity, equity, and inclusion. Their work encompasses research and evaluation of health programs and initiatives, stakeholder engagement, policy analysis, and development of mitigation and monitoring strategies. In particular, the team has experience analyzing policy proposals that impact medically underserved groups, such as Medicaid programs serving low-income individuals and maternal health initiatives that aim to reduce pre- and post-partum health disparities. They are

	dedicated to supporting organizations that serve vulnerable populations, including safety net hospitals, community health centers, long-term care organizations, behavioral health providers, child welfare agencies, and providers that support individuals with intellectual and developmental disabilities. The SPG HEIA team is deeply passionate about improving the health care delivery system, especially for underserved populations. The team is unwavering in its commitment to promoting equity through rigorous research, insightful consulting, and strategic advisory work.
5. Date the Health Equity Impact Assessment (HEIA) started	December 2, 2024
6. Date the HEIA concluded	February 21, 2025

7. Executive summary of project (250 words max)

ArchCare is a long-term care provider with locations in New York City, Westchester, and Dutchess County, New York. The ArchCare service array includes nursing homes, short-term rehabilitation, a Program of All-Inclusive Care for the Elderly (PACE) plan, end-of-life care, memory care, a hospital for children with disabilities, and independent housing for people with autism.

ArchCare's San Vicente de Paúl (SVDP) Nursing Home and Rehabilitation Center is located at 900 Intervale Avenue, Bronx, NY 10459. The facility is currently certified for 120 beds and the Applicant is seeking to decertify 80 beds, resulting in a total bed capacity of 40 beds at SVDP. The Applicant intends to use the space to expand its PACE center and double its capacity, allowing it to serve 500 individuals.

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

The HEIA identified both challenges and opportunities associated with the reduction of beds at SVDP for medically underserved populations, including low-income individuals, racial and ethnic minorities, older adults, and Medicaid beneficiaries.

One key concern is the reduced availability of skilled nursing facility beds, which may limit inpatient care options for older adults requiring long-term nursing or short-term rehabilitation services. Bronx County has a growing aging population, and with 82% of nursing home residents nationwide being over 65, the bed reduction could create access barriers for some medically underserved individuals. However, the project also aligns with broader state and federal efforts to prioritize home and community-based care over institutionalization. Repurposing the space to expand the PACE center will increase access to

comprehensive, interdisciplinary health care services that allow older adults to receive coordinated care while aging in their own homes.

Low-income individuals and Medicaid beneficiaries—who make up the majority of SVDP's resident population—will also be affected. Over 25% of the service area population lives below the poverty level, and Medicaid funds over 70% of skilled nursing services in New York State. While reducing capacity at SVDP may increase competition for nursing home placements, the expanded PACE model provides an alternative for those eligible for both Medicaid and Medicare, ensuring seamless access to medical, social, and support services.

The project also has significant implications for racial and ethnic minorities, who disproportionately rely on institutional long-term care due to barriers in accessing home and community-based services. With 38% of Bronx residents identifying as Black and 55% as Hispanic or Latino, and SVDP's current resident population being 68% Hispanic and 23% Black, the expansion of PACE may help bridge disparities by providing culturally competent, person-centered care in a more accessible setting. National trends indicate that Black and Hispanic older adults face quality and access gaps in long-term care, making investments in community-based alternatives essential for improving equity.

While the reduction in skilled nursing beds presents access challenges, the stakeholders interviewed for this HEIA ultimately viewed it as necessary to ensure financial sustainability and maintain long-term services at SVDP for the community. Stakeholders, including staff and advocacy groups, supported the transition, recognizing its potential to enhance health care access and stability for Bronx residents. To mitigate any negative effects, we recommend the Applicant strengthen partnerships with other nursing homes, maintain robust community engagement, and implement monitoring measures such as resident and PACE participant surveys to ensure quality care and equitable access.

Overall, the findings suggest that while the project may reduce residential care options, it expands sustainable, community-based care that aligns with evolving health care needs, particularly for vulnerable populations. By shifting resources from institutional care to home-based alternatives, the project has the opportunity to support long-term health equity goals, enhance care coordination, and improve quality of life for older adults in the Bronx who wish to age in place.

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.**

   Please see attached spreadsheet titled "heia_data_tables_ArchCare.xlsx"

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:**
   - Low-income people
   - Racial and ethnic minorities
   - Older adults
   - People who are eligible for or receive public health benefits

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?**

   We analyzed utilization data from the Applicant, census data for the community/service area, DOH nursing home census data, academic literature, and information obtained from interviews with leadership, staff, community-based organizations, and referral partners.

   In our geographic analysis and scoping tables, we included the zip code where the facility is located (10459) and the zip codes where residents originated from, as this information was readily available from the Applicant.

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

   Nursing homes, also known as skilled nursing facilities (SNFs), are inpatient residential health facilities that provide a range of health and personal care services to individuals on a 24/7 basis. Along with skilled nursing, nursing homes provide short-term rehabilitation and/or long-term residential care for individuals who need help with activities of daily living (ADLs).

   We expect the decertification of nursing home beds at SVDP to primarily impact older adults, racial/ethnic minorities, and low-income individuals/those eligible for or receiving public health benefits due to their prevalence in the community and utilization of nursing services at SVDP as outlined below. For all populations, the decertification of

beds will reduce access to inpatient skilled nursing and short-term rehabilitation in the community. However, these populations may also benefit from the Applicant's intention to repurpose the space to expand its PACE home and community-based services for individuals who require nursing home level of care but who prefer to age in place in their home with the necessary community-based supports.

Older Adults

Approximately 15% of the population in Bronx County is over the age of 65.[1] The prevalence of older adults is similar in the Applicant's service area (15%) and in the zip code where the nursing facility is located (16%). The older adult population continues to grow and is projected to more than double over the next 40 years.[2,3] Individuals over the age of 85, who most often require help with personal care and activities of daily living, will quadruple between 2000 and 2040.[3]

Although nursing homes do not only serve older adults, the overwhelming majority (~82%) of nursing home residents nationally are over the age of 65.[4] The Department of Health and Human Services estimates that over half of Americans turning 65 will need long-term services and supports.[5] The decertification of nursing home beds at SVDP will reduce access to residential skilled nursing and short-term rehabilitation for certain older adults in the community who require these services.

Low-income people and people who are eligible for or receive public health benefits

Over 25% of individuals and families in the Applicant's service area live below the poverty level, compared to 10% statewide, and the median household income is $35,813.[6] Approximately 65% of individuals in Bronx County were enrolled in the New York State Medicaid program as of September 2024.[7]

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[1] U.S. Census Bureau. (2023). *ACS 1-year estimates subject table S0101: Age and sex, Bronx County, New York*. Retrieved from https://data.census.gov/table/ACSST1Y2023.S0101?q=Bronx%20County,%20New%20York

[2] U.S. Census Bureau. (2023, May). *2020 Census: The United States' older population grew.* Retrieved from https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-population-grew.html

[3] Urban Institute. (n.d.). *The U.S. population is aging.* Retrieved from https://www.urban.org/policy-centers/cross-center-initiatives/program-retirement-policy/projects/data-warehouse/what-future-holds/us-population-aging

[4] National Center for Health Statistics. (2024). *Data brief no. 208: [Overview of Post-acute and Long-term Care Providers and Services Users in the United States, 2020]*. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data/nhsr/nhsr208.pdf

[5] Assistant Secretary for Planning and Evaluation. (2022). *Long-term services and supports for older Americans: Risks and financing, 2022*. U.S. Department of Health and Human Services. https://aspe.hhs.gov/reports/ltss-older-americans-risks-financing-2022

[6] U.S. Census Bureau. (2023). *Selected characteristics of the native and foreign-born populations: Bronx County, New York.* Retrieved from https://data.census.gov/table/ACSST1Y2023.S0501?q=Bronx%20County,%20New%20York%20ehtnicity

[7] United Hospital Fund. (n.d.). *Medicaid enrollment by county*. Retrieved December 13, 2024, from https://uhfnyc.org/our-work/initiatives/medicaid-institute/dashboards/mi-current-enrollment/#Medicaid%20Enrollment%20by%20County

Medicaid is the primary payer of skilled nursing services nationally and statewide; over 70% of New York's skilled nursing facility resident care is paid for by Medicaid.[8,9] However, residents in socioeconomically disadvantaged communities experience disparities in accessing nursing homes with higher star ratings, as these communities often lack sufficient resources and have high staff turnover.[10] Nursing homes that primarily serve Medicaid recipients have fewer nurses, worse quality measures, and more health-related deficiencies.[11]

Given the socioeconomic status of the community where the facility is located and the fact that Medicaid is the primary payer of nursing services, low-income individuals and those who are eligible for or receive public benefits and who require long-term services and supports will be impacted by the project.

Racial and ethnic minorities

In Bronx County, approximately 38% of the population identifies as Black and 55% of the population is Hispanic or Latino.[5] In the Applicant's service area, approximately 26% of the population is Black and 39% are Hispanic or Latino, compared to 14% Black and 19.5% Hispanic/Latino statewide.

Nationally, the demographic breakdown of nursing home residents is as follows:[4]

- 73.7% non-Hispanic white
- 15.7% non-Hispanic Black
- 5% Hispanic
- 5.6% other race, non-Hispanic

However, evidence indicates that the proportion of minority residents in nursing homes is increasing rapidly, in part due to unequal minority access to home and community-based alternatives.[12] Research also demonstrates consistent disparities in quality of

[8] Chidambaram, P., & Burns, A. (2024, December 6). *A look at nursing facility characteristics between 2015 and 2024*. KFF. https://www.kff.org/medicaid/issue-brief/a-look-at-nursing-facility-characteristics/

[9] New York State Senate. (2021). *Long-term care workforce hearing report 2021.* Retrieved from https://www.nysenate.gov/sites/default/files/article/attachment/long-term_care_workforce_hearing_report_2021.pdf

[10] Yuan, Y., Louis, C., Cabral, H., Schneider, J. C., Ryan, C. M., & Kazis, L. E. (2018). Socioeconomic and geographic disparities in accessing nursing homes with high star ratings. *Journal of the American Medical Directors Association, 19*(9), 784-791. https://doi.org/10.1016/j.jamda.2018.06.003

[11] Mor, V., Zinn, J., Angelelli, J., Teno, J. M., & Miller, S. C. (2004). Driven to tiers: Socioeconomic and racial disparities in the quality of nursing home care. *The Milbank Quarterly, 82*(2), 227–256. https://doi.org/10.1111/j.0887-378X.2004.00309.x

[12] Feng, Z., Fennell, M. L., Tyler, D. A., Clark, M., & Mor, V. (2011). Growth of racial and ethnic minorities in US nursing homes driven by demographics and possible disparities in options. *Health Affairs, 30*(7), 1358–1365. https://doi.org/10.1377/hlthaff.2011.0126

nursing home care for racial and ethnic minorities.[13,14,15] The proposed project will impact Black and Hispanic/Latino populations requiring long-term services and supports, as these populations represent a substantial portion of the community, are increasingly reliant on skilled nursing facilities, and experience disparities in access to and quality of long-term care.

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 tables below outline the utilization of skilled nursing and short-term rehabilitation services at SVDP among medically underserved residents.[16] The demographics of residents are not expected to change significantly with the proposed bed reduction at the facility.

Table 1. Race/Ethnicity

Race	% of Residents
Non-Hispanic White	9%
Non-Hispanic Black	23%
Hispanic or Latino (any race)	68%

Table 2. Age

Age	% of Residents
0-44 years	0%
45-54 years	4.7%
55-59 years	2.8%
60-64 years	6.5%
65+	86%

Table 3. Payor Mix

Payor	% of Residents

[13] Fennell, M. L., Feng, Z., Clark, M. A., & Mor, V. (2010). Elderly Hispanics more likely to reside in poor-quality nursing homes. *Health Affairs, 29*(1), 65–73. https://doi.org/10.1377/hlthaff.2009.0003

[14] Li, Y., & Cai, X. (2018). Disparities in nursing home use and quality among African American, Hispanic, and White Medicare residents with Alzheimer's disease and related dementias. *Journal of Aging and Health, 30*(8), 1371–1389. https://doi.org/10.1177/0898264318767778

[15] Smith, D., Chai, E., & Temkin-Greener, H. (2020). Racial/ethnic disparities in nursing home end-of-life care: A systematic review. *Journal of the American Medical Directors Association, 21*(10), 1445–1450. https://doi.org/10.1016/j.jamda.2020.05.026

[16] Data provided by Applicant

Medicaid	62%
Medicare	0%
Dual Eligible (Medicaid & Medicare)	38%
Commercial	0%
Uninsured	0%

Table 4. Income

Category	**% of Residents**
% of Families/Individuals Living Below the Poverty Level	~28%
Median Household Income	$47,260

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

Table 5. Nursing Homes in the Bronx[17]

Facility	**Number of Beds**	**Occupancy Rate**	**Distance from SVDP**
ArchCare SVDP	120	88%	-
ArchCare at Providence Rest	200	98%	4.7 miles
Bainbridge Nursing & Rehabilitation Center	200	99%	5.6 miles
Beth Abraham Center for Rehabilitation and Nursing	448	98%	4.9 miles
Bronx Center for Rehabilitation & Health Care	200	99%	2.0 miles
Bronx Gardens Rehabilitation and Nursing Center	199	98%	2.9 miles

[17] New York State Department of Health. (n.d.). *Nursing home profiles: Bronx County*. Retrieved December 4, 2024, from https://profiles.health.ny.gov/nursing_home/county_or_region/?countyRegion=county:005

Bronx Park Rehabilitation & Nursing Center	240	96%	5.8 miles
Bronxcare Special Care Center	240	95%	1.6 miles
Casa Promesa	108	73%	2.3 miles
Concourse Rehabilitation and Nursing Center, Inc	240	96%	1.9 miles
East Haven Nursing & Rehabilitation Center	200	96%	5.7 miles
Eastchester Rehabilitation and Health Care Center	200	81%	6.1 miles
Fieldston Lodge Care Center	200	88%	9.1 miles
Fordham Nursing and Rehabilitation Center	240	95%	8.5 miles
Gold Crest Care Center	175	97%	6.4 miles
Grand Manor Nursing & Rehabilitation Center	240	83%	2.5 miles
Hebrew Home for the Aged at Riverdale	607	67%	11.2 miles
Highbridge Woodycrest Center	90	98%	2.4 miles
Hope Center for HIV and Nursing Care	66	95%	5.5 miles
Hudson Pointe at Riverdale Center for Nursing and Rehabilitation	159	94%	9.1 miles

Kings Harbor Multicare Center	720	86%	5.5 miles
Laconia Nursing Home	240	97%	7.5 miles
Manhattanville Health Care Center	200	90%	9.7 miles
Methodist Home for Nursing and Rehabilitation	120	87%	9.8 miles
Morningside Nursing and Rehabilitation Center	314	93%	4.6 miles
Morris Park Nursing and Rehabilitation Center	191	90%	4.9 miles
Mosholu Parkway Nursing and Rehabilitation Center	122	91%	5.3 miles
New Riverdale Rehab and Nursing	146	97%	9.1 miles
Park Gardens Rehabilitation & Nursing Center LLC	200	92%	8.3 miles
Pelham Parkway Nursing Care and Rehabilitation Facility LLC	200	95%	4.9 miles
Pinnacle Multicare Nursing and Rehabilitation	480	96%	7.6 miles
Rebekah Rehab and Extended Care Center	213	94%	3.0 miles
Regeis Care Center	236	95%	7.4 miles

Schervier Nursing Care Center	364	96%	9.1 miles
Split Rock Rehabilitation and Health Care Center	240	93%	7.4 miles
St. Patrick's Home	264	98%	6.0 miles
The Citadel Rehab and Nursing Center at Kingsbridge	385	98%	6.6 miles
The Plaza Rehab and Nursing Center	744	99%	6.7 miles
Throgs Neck Rehabilitation & Nursing Center	205	98%	4.4 miles
Triboro Center for Rehabilitation and Nursing	405	99%	2.0 miles
University Center for Rehabilitation and Nursing	46	96%	5.6 miles
Wayne Center for Nursing & Rehabilitation	243	100%	5.5 miles
Williamsbridge Center for Rehabilitation and Nursing	77	99%	3.7 miles
Workmen's Circle Multicare Center	524	97%	7.3 miles

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

Current Market Share		
Facility	Number of Beds	Market Share
ArchCare SVDP	120	1%
ArchCare at Providence Rest	200	2%
Bainbridge Nursing & Rehabilitation Center	200	2%
Beth Abraham Center for Rehabilitation and Nursing	448	4%
Bronx Center for Rehabilitation & Health Care	200	2%
Bronx Gardens Rehabilitation and Nursing Center	199	2%
Bronx Park Rehabilitation & Nursing Center	240	2%
Bronxcare Special Care Center	240	2%
Casa Promesa	108	1%
Concourse Rehabilitation and Nursing Center, Inc	240	2%
East Haven Nursing & Rehabilitation Center	200	2%

Projected Market Share		
Facility	Number of Beds	Market Share
ArchCare SVDP	40	0.4%
ArchCare at Providence Rest	200	2%
Bainbridge Nursing & Rehabilitation Center	200	2%
Beth Abraham Center for Rehabilitation and Nursing	448	4%
Bronx Center for Rehabilitation & Health Care	200	2%
Bronx Gardens Rehabilitation and Nursing Center	199	2%
Bronx Park Rehabilitation & Nursing Center	240	2%
Bronxcare Special Care Center	240	2%
Casa Promesa	108	1%
Concourse Rehabilitation and Nursing Center, Inc	240	2%
East Haven Nursing & Rehabilitation Center	200	2%

Eastchester Rehabilitation and Health Care Center	200	2%
Fieldston Lodge Care Center	200	2%
Fordham Nursing and Rehabilitation Center	240	2%
Gold Crest Care Center	175	2%
Grand Manor Nursing & Rehabilitation Center	240	2%
Hebrew Home for the Aged at Riverdale	607	5%
Highbridge Woodycrest Center	90	1%
Hope Center for HIV and Nursing Care	66	1%
Hudson Pointe at Riverdale Center for Nursing and Rehabilitation	159	1%
Kings Harbor Multicare Center	720	6%
Laconia Nursing Home	240	2%
Manhattanville Health Care Center	200	2%

Eastchester Rehabilitation and Health Care Center	200	2%
Fieldston Lodge Care Center	200	2%
Fordham Nursing and Rehabilitation Center	240	2%
Gold Crest Care Center	175	2%
Grand Manor Nursing & Rehabilitation Center	240	2%
Hebrew Home for the Aged at Riverdale	607	5%
Highbridge Woodycrest Center	90	1%
Hope Center for HIV and Nursing Care	66	1%
Hudson Pointe at Riverdale Center for Nursing and Rehabilitation	159	1%
Kings Harbor Multicare Center	720	6%
Laconia Nursing Home	240	2%
Manhattanville Health Care Center	200	2%

Methodist Home for Nursing and Rehabilitation	120	1%
Morningside Nursing and Rehabilitation Center	314	3%
Morris Park Nursing and Rehabilitation Center	191	2%
Mosholu Parkway Nursing and Rehabilitation Center	122	1%
New Riverdale Rehab and Nursing	146	1%
Park Gardens Rehabilitation & Nursing Center LLC	200	2%
Pelham Parkway Nursing Care and Rehabilitation Facility LLC	200	2%
Pinnacle Multicare Nursing and Rehabilitation	480	4%
Rebekah Rehab and Extended Care Center	213	2%
Regeis Care Center	236	2%

Methodist Home for Nursing and Rehabilitation	120	1%
Morningside Nursing and Rehabilitation Center	314	3%
Morris Park Nursing and Rehabilitation Center	191	2%
Mosholu Parkway Nursing and Rehabilitation Center	122	1%
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Pelham Parkway Nursing Care and Rehabilitation Facility LLC	200	2%
Pinnacle Multicare Nursing and Rehabilitation	480	4%
Rebekah Rehab and Extended Care Center	213	2%
Regeis Care Center	236	2%

Schervier Nursing Care Center	364	3%
Split Rock Rehabilitation and Health Care Center	240	2%
St. Patrick's Home	264	2%
The Citadel Rehab and Nursing Center at Kingsbridge	385	3%
The Plaza Rehab and Nursing Center	744	7%
Throgs Neck Rehabilitation & Nursing Center	205	2%
Triboro Center for Rehabilitation and Nursing	405	4%
University Center for Rehabilitation and Nursing	46	0.4%
Wayne Center for Nursing & Rehabilitation	243	2%
Williamsbridge Center for Rehabilitation and Nursing	77	1%
Workmen's Circle Multicare Center	524	5%
Total	*11,251*	*100%*

Schervier Nursing Care Center	364	3%
Split Rock Rehabilitation and Health Care Center	240	2%
St. Patrick's Home	264	2%
The Citadel Rehab and Nursing Center at Kingsbridge	385	3%
The Plaza Rehab and Nursing Center	744	7%
Throgs Neck Rehabilitation & Nursing Center	205	2%
Triboro Center for Rehabilitation and Nursing	405	4%
University Center for Rehabilitation and Nursing	46	0.4%
Wayne Center for Nursing & Rehabilitation	243	2%
Williamsbridge Center for Rehabilitation and Nursing	77	1%
Workmen's Circle Multicare Center	524	5%
Total	*11,171*	*100%*

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.**

   N/A

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.**

   As a result of the reduced bed count, the nursing facility will require less clinical, administrative, and support services staff. The Applicant has reported that the current level of staffing at the facility will be maintained and is sufficient to support residents and required nurse-to-resident ratios. An increased census at the PACE center would require the Applicant to hire additional staff.

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

    There have been no civil rights access complaints filed against the Applicant in the last 10 years.

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.**

    N/A

STEP 2 – POTENTIAL IMPACTS

1. **For each medically underserved group identified in Step 1 Question 2, describe how the project will:**
    1. **Improve access to services and health care**

2. **Improve health equity**
3. **Reduce health disparities**

Our assessment has identified two primary benefits of this project:

1. **Continuation of Services at SVDP**
It was communicated to us by several stakeholders that while the reduction of beds at the SVDP facility is not ideal, it was a strategic decision made by the organization to ensure long-term sustainability and continued service to the community. Like many nursing facilities that serve primarily Medicaid beneficiaries, SVDP is facing financial and operational challenges due to rising costs, workforce shortages, and reimbursement obstacles. The leadership and several stakeholders felt that the decision is a necessary step to ensure that the community maintains access to institutional long-term care services for those in need rather than risking closure. By ensuring financial viability of the facility, the project will both protect access to care and preserve quality of care for current and future residents, who are predominantly older adults, low-income populations, and racial or ethnic minorities.

2. **Re-utilization of Space to Expand Community Services for Older Adults**
While the Applicant is reducing access to one service in the community, it is important to also recognize the project's broader impact – repurposing the space to enhance community services for older adults by expanding their PACE center. PACE is a comprehensive health care program designed as a nursing home alternative model of care for frail, elderly individuals who prefer to live independently in their communities. PACE provides a coordinated range of medical, behavioral, long-term care, and social services to support participants' health and well-being. This transition ensures that while facility-based care is being scaled back, an alternative, community-based model of care is being strengthened, allowing individuals to receive the support they need while remaining in their homes and communities whenever possible. One stakeholder we interviewed, an expert in long-term care services for older adults, said: "We will always need nursing homes for certain people, but a lot of institutionalization can be prevented or delayed if we have better access to community-based resources such as PACE."

While PACE is open to individuals with all types of insurance, it primarily serves participants who are eligible for both Medicare and Medicaid and effectively integrates benefits from both programs to cover all necessary medical and social services.[18,19] This eliminates the need for participants to navigate multiple health care plans. Older adults

[18] National PACE Association. (2024, September). *PACE: Frequently asked questions.* https://www.npaonline.org/docs/default-source/public-files/pace_faq_part-d_092024.pdf

[19] Centers for Medicare & Medicaid Services. (n.d.). *Program of All-Inclusive Care for the Elderly (PACE)*. Medicare.gov. Retrieved February 18, 2025, from https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/other-medicare-health-plans/PACE

will benefit from the PACE expansion, as it is designed for individuals aged 55 and above and is associated with improved quality of care, reduced mortality, preservation of function, fewer unmet assistance needs, greater participant and caregiver satisfaction, and less hospital and nursing home utilization.[20,21] PACE programs are also an effective approach for improving care quality and delaying institutional admissions for Black and Hispanic older adults, who have seen a disproportionate rise in nursing home care.[22]

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.

The primary negative impact associated with this project stems from the reduction of capacity at the facility from 120 beds to 40 beds, which may exacerbate any existing disparities in access, quality, and health outcomes for the medically underserved populations identified in this assessment. Fewer beds may lead to reduced long-term care options in the community, which will particularly impact older adults who are more likely to require long-term care services, low-income individuals and Medicaid beneficiaries who face limited provider acceptance and may have fewer placement options, and racial and ethnic minorities who make up the majority of the community and many of whom rely on publicly funded care. Without sufficient alternative services, this reduction in capacity could widen health disparities and require individuals to seek care further away from family and community supports, particularly if SVDP and other local facilities reach their maximum bed capacity.

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 reported that 101 residents, who are Medicaid beneficiaries, receive care that is not fully covered by Medicaid. The facility reported losing more than $100 per resident per day for these individuals.

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[20] Wieland, D., Kinosian, B., Stallard, E., & Boland, R. (2013). Does Medicaid pay more to a program of all-inclusive care for the elderly (PACE) than for fee-for-service long-term care? *The Journals of Gerontology: Series A, 68*(1), 47–55. https://doi.org/10.1093/gerona/gls137

[21] White, A. J., Abel, R., Kidder, D., & Heller, E. (2015). *Effect of PACE on costs, nursing home admissions, and mortality: 2006–2011*. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. https://aspe.hhs.gov/reports/effect-pace-costs-nursing-home-admissions-mortality-2006-2011

[22] Travers, J. L., D'Arpino, S., Bradway, C., Kim, S. J., & Naylor, M. D. (2022). Minority older adults' access to and use of Programs of All-Inclusive Care for the Elderly. *Journal of Aging & Social Policy, 34*(6), 976–1002. https://doi.org/10.1080/08959420.2021.2024411

The total amount of indigent care provided by the Applicant may be reduced as a result of this project, as the proportion of individuals served by the nursing facility will be reduced and the services provided at the PACE center are more adequately covered by health insurance.

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 facility is close to public transportation; SVDP is a 6 min (0.3 mile) walk from the 2 and 5 trains and a 5 minute (0.2 mile) walk from the 6 train. The facility is also close to four different bus line stops; one stop is a 1-minute walk away and the other stops are 4-minutes walking distance.

Residents coming from the hospital to the nursing facility are transferred via ambulance, which is coordinated by the hospital's discharge planners/social workers. The ArchCare PACE center provides door-to-door, wheelchair accessible transportation that is organized by a transportation coordinator on the ArchCare care team.

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

N/A

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?**

N/A

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 (DOHMH)

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

We reached out multiple times to the Long Term Care Ombudsman for the Bronx Borough given their knowledge of the organization and their advocacy work for individuals residing in long term care facilities. Despite our outreach attempts we did not receive a response. We did speak to NY State Senator Luis R. Sepúlveda, who represents the district in which the facility is located and who provided a Letter of Support for the project. We did not connect with NYC DOHMH on this project.

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

Please refer to attached spreadsheet titled "heia_data_tables_ArchCare.xlsx"

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?

The stakeholders most affected by this proposed project include older adults and their families residing in the community who may require long-term nursing or short-term rehabilitation care in the future. These individuals may be required to receive services at another location if the SVDP facility's 40 beds are at capacity at the time in which the individual requires inpatient nursing care.

Several staff members initially voiced concerns about the reduced bed capacity, particularly given the high poverty levels in the community and the limited alternative service options in the immediate vicinity (the closest nursing facility is 1.6 miles away). However, most staff members were ultimately supportive of the project, recognizing that it enables SVDP to remain operational while also expanding access to community-based care through the PACE program.

Family members and friends of residents who attended the Family Council Meeting expressed initial concerns on how this would impact residents with no supplemental income. However, ArchCare staff reiterated that these individuals would not be impacted, as the facility will not be implementing any involuntary discharges and all current residents will be able to remain at the facility unless they choose to transfer or return home. Family and friends also asked if the project would reduce the number of

nurses and nurse aides. ArchCare staff said that the necessary nurse-to-resident ratios would continue to be maintained.

One respondent representing an organization dedicated to advocating for aging-related infrastructure and support in New York, expressed strong support for the proposed project to de-certify nursing home beds and expand the PACE center at ArchCare and did not express any concerns for the project. They emphasized that while nursing homes will always be necessary for some individuals, the growing aging population and shift in preferences toward aging at home highlight the increasing need for community-based services like PACE. They noted that historically, nursing home expansion was prioritized, but as perspectives on aging have evolved, so has the recognition that institutionalization can often be prevented or delayed with the right resources. They underscored economic disparities, stating that lower-income individuals—who are more likely to rely on Medicaid/Medicare—have fewer options for home care, making accessible and bundled services like PACE essential.

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?

As part of our stakeholder engagement, we interviewed staff from ArchCare (including leadership, the PACE Center, and the SVDP facility), an advocacy group for aging adults, a local catholic school that partners with the organization, and a state representative. We also attended the facility's Family Council Meeting, during which current family members were notified of the proposed changes and were able to provide feedback to leadership and staff on the project. We also distributed a survey at this meeting, allowing family members to provide feedback directly to SPG to support our independent assessment. Despite initial interest at the meeting, we did not receive any responses to the survey. Family members were given contact information for the SPG lead contact, the SVDP facility director, and the ArchCare Senior Vice President of Residential Services and were encouraged to reach out with any additional questions or concerns. Our stakeholder and community engagement complemented our data analysis by providing qualitative insights into the medically underserved populations that may be impacted. This engagement also helped identify specific needs and challenges faced by these individuals and informed strategies for how the organization can effectively support them if the project is implemented.

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.

SPG's stakeholder engagement process involved developing a comprehensive outreach strategy to community-based organizations, staff, providers, and community members from which we sought feedback for the assessment. As part of this effort, we conducted ten interviews with staff, advocacy groups, and state representatives, and considered feedback received at the Family Council Meeting, which was attended by 17 family and friends of current residents. We reached out to two home care providers, two hospital referral partners, a community-based organization that serves older adults, and the Long Term Care Ombudsman for the Bronx, but we did not receive any responses despite multiple outreach attempts.

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 communicated the changes to community and family members at its Family Council Meeting, which was attended by the Independent Entity. SPG also distributed surveys to attendees so they could provide independent feedback to us on the project. Surveys were available in English and Spanish and were accessible as paper copies and electronically via QR codes. The Applicant has also notified the district's state representative and intends to notify and receive feedback from Community Board members at a meeting in March.

The majority of SVDP staff is Hispanic and Spanish-speaking, and the facility also provides translation services. As the facility is a nursing home that primarily serves older adults, it has policies and procedures in place to support individuals with speech, visual, and hearing impairments.

If the project is approved, the PACE center will likely host a grand opening and invite local stakeholders and community-based partners, as well as host several open houses.

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

The Applicant operates another nursing facility, ArchCare at Providence Rest, which has 200 beds and is 4.7 miles from SVDP. In addition to this facility, we recommend the Applicant strengthen partnerships – if not already established – with other local nursing home facilities that accept Medicaid beneficiaries. This will help ensure that individuals from the community seeking care nursing care at SVDP or PACE program participants who require inpatient care are referred to a facility that accepts their insurance and is convenient for their families. Additionally, ArchCare should develop a streamlined process that allows individuals to easily transition to SVDP if a bed becomes available and SVDP is a more accessible option or closer to their community supports.

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

The Applicant can continue to engage and consult stakeholders on the progress of the project through Family Council Meetings, Community Board Meetings, and ArchCare's monthly Diversity, Equity, and Inclusion (DEI) Committee meetings. Additionally, community-based partners, including the local church, should be actively involved to ensure broad outreach and engagement.

Key updates to share with stakeholders may include the timeline for reducing bed capacity—expected to be completed by the end of 2026 through natural attrition—as well as construction progress on the PACE center expansion. To further enhance transparency and responsiveness, the Applicant may also consider implementing additional resident and family surveys to assess satisfaction with care quality and staffing levels following the bed reduction. Notably, during the recent Family Council Meeting, several family members expressed a desire for more opportunities to provide positive feedback about the facility and staff, with many attendees voicing appreciation for the care provided.

Furthermore, PACE participants and their families/caregivers should be engaged through surveys or focus groups to gather insights on accessibility, service quality, and overall experience at the PACE center. This feedback will help identify opportunities for improvement and ensure that the expansion aligns with the needs and expectations of the community.

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?

By reducing nursing home capacity and expanding the organization's PACE center, this project addresses systemic barriers to equitable access to services and care as follows:

1. **Supporting access to community-based long-term care:** Transitioning resources from institutional settings to the PACE center enables more older adults to receive care in their community, promoting aging in place and reducing reliance on nursing homes. While aging at home with the support of home and community-based services is the preferred option for older adults, it occurs less often for racial and ethnic minorities compared to older adults.[23] Increasing access to community-based long-term care in a community predominantly comprised of people of color and Hispanic populations may help address this systemic barrier to equitable access. Additionally, this effort is aligned with previous and ongoing State efforts to incentivize nursing facilities to convert unneeded nursing home beds to other levels of care.[24,25] These initiatives aim to promote the development of alternative care models and discourage unnecessary institutionalization.
2. **Improving person-centered and culturally competent care:** PACE includes a collaborative team of health care professionals – including physicians, nurses, social workers, and therapists – who develop personalized care plans and ensure that an individual's medical, social, and cultural needs are met. Additionally, PACE programs have greater flexibility than other inpatient or community-based programs, allowing them to adapt to the specific needs of individuals and communities more effectively.[26]

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?

Medicaid-certified nursing homes, including SVDP, are required to collect quality metrics and conduct comprehensive assessments to ensure compliance with federal and state standards. SVDP also administers ongoing resident/family surveys as part of its quality assurance and compliance program. These mechanisms, in addition to the ongoing family council and community board meetings mentioned previously, can be leveraged

[23] Travers, J. L., D'Arpino, S., Bradway, C., Kim, S. J., & Naylor, M. D. (2022). Minority older adults' access to and use of Programs of All-Inclusive Care for the Elderly. *Journal of Aging & Social Policy, 34*(6), 976–1002. https://doi.org/10.1080/08959420.2021.2024411

[24] New York State Department of Health. (2012, January 31). *Rightsizing demonstration program solicitation letter*. https://www.health.ny.gov/facilities/rightsizing/2012-01-31_solicitation_letter.htm

[25] LeadingAge New York. (n.d.). *Statewide Health Care Facility Transformation Grant Q&As reveal helpful details*. Retrieved from https://www.leadingageny.org/providers/nursing-homes/doh-notices-and-policies/statewide-health-care-facility-transformation-grant-qas-reveal-helpful-details/

[26] Centers for Medicare & Medicaid Services. (2019, May 28). *Programs of All-Inclusive Care for the Elderly (PACE) final rule (CMS-4168-F).* https://www.cms.gov/newsroom/fact-sheets/programs-all-inclusive-care-elderly-pace-final-rule-cms-4168-f

to monitor the potential impacts of the project, including any changes to quality of care or access.

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?

We encourage the Applicant to implement a comprehensive evaluation strategy of the project, including:

- Gathering detailed demographic and health data on both nursing home residents and PACE participants, focusing on variables such as age, race, ethnicity, income level, and insurance status. This data will help identify any disparities in service access or health outcomes among different population groups.
- Continuing to engage and involve community stakeholders in the planning and evaluation processes, including residents, families, advocacy groups, and community partners.
- Monitoring metrics such as enrollment rates, service utilization patterns, and wait times stratified by demographic factors. This will help assess whether the transition from nursing home care to PACE services is equitably benefiting all segments of the community.
- Implementing standardized tools to evaluate the quality of care provided, ensuring that all participants receive comprehensive, person-centered services and identifying areas of improvement to ensure that the care model adapts to the evolving needs of the population.
- Tracking health outcomes, including hospitalization rates, emergency department visits, and overall health status, to determine the effectiveness of PACE services compared to traditional nursing home care. Positive trends in these metrics can indicate successful mitigation of health disparities.

By systematically implementing these strategies, the Applicant can effectively monitor and address potential health equity impacts, ensuring that the transition enhances access to quality care for all individuals, regardless of their background or socioeconomic status.

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, (ArchCare), attest that I have reviewed the Health Equity Impact Assessment for the ("Decertify 80 general residential health care facility beds") that has been prepared by the Independent Entity, (Sachs Policy Group).

John Jason Hutchens

Name

Senior Vice President Residential Services

Title

John Jason Hutchens

Signature

2.21.2025

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.

San Vicente de Paúl (SVDP) is seeking to close 80 beds to expand our PACE program and better serve the Bronx community. SVDP will continue to operate with a reduced complement of 40 beds. The decrease in census down to 40 residents is expected to occur through attrition over the course of approximately 5 months as current short-term residents no longer in need of skilled nursing care are discharged back to their homes, as appropriate. SVDP will utilize a phased approach to the closure of the 80 beds, closing out one unit at a time and consolidating

patients and staff in a stepwise manner as the census declines to the remaining 40 beds. SVDP's Admission Coordinator has already reduced the acceptance of long-term care residents. SVDP will not be closed, only reducing beds. There will be no involuntary discharges, and we will commit to keeping all current residents with no forced relocation while providing high-quality care and continuing with our proper staffing pattern.

We will share updates on the project at Family Council Meetings and Community Board Meetings. We will continue to use standardized tools to measure care quality and adjust services as needed for changing population needs. We will continue to track hospitalization rates and ER visits; ensuring our current residents continue to receive the care they need and are able to readmit to the facility.