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)?	x	
Does the Diagnostic and Treatment Center's CON application include a change in controlling person, principal stockholder, or principal member of the facility?		x

- ***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*		x

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?		x
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?		x
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?		x
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?	x	

*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.

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	FKC - Albany Regional
2. Name of Applicant	New York Dialysis Services, Inc.
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	The Vinca Group L.L.C. Lead Contact: Alice Katz President akatz@thevincagroup.com 410-998-9310 Other Contacts: Stephanie Heffernan Senior Vice President sheffernan@thevincagroup.com 410-998-9310 Claire Nooney Director of Operations cmilando@thevincagroup.com 410-998-9310
4. Description of the Independent Entity's qualifications	See Attachment A
5. Date the Health Equity Impact Assessment (HEIA) started	9/20/2023
6. Date the HEIA concluded	12/18/2023

7. Executive summary of project (250 words max)
The applicant intends to consolidate the FMS-Albany Dialysis Center extension clinic into the FMS-Albany Regional Kidney Center extension clinic and the to relocate the FMS-Albany Regional Kidney Center to a new extension clinic to be constructedf at 517 Delaware Ave, Albany NY 12209. The relocation site is in the same service area as the two existing extension clinics. The new facility will be operated by New York Dialysis Services, Inc. Payer mix projections for year one visits are estimated at 12.10% Commercial Insurance, 53.65% Medicare and 34.25% Medicaid. The center is projected to increase patient visits 17% from 29,375 this year to 34,488 in year three while maintaining the same payor mix. The facility will continue to serve patients who have End Stage Renal Disease (ESRD) and require dialysis services. The new facility will have 53 dialysis stations, a blood borne separation room and home therapy rooms that will provide both home hemodialyis and home peritoneal dialysis training and support services. The dialysis center's patient population is reported to be 58% male and 42% female; 45% White, 49% Black or African American, 5% Asian and 0.8% Native American.
8. Executive summary of HEIA findings (500 words max) The modality prevalence for ESRD patients is 59.8% in center hemodialysis, 1.5% home hemodialysis, 8.1% peritoneal dialysis, and 30.6% transplant. New York's adjusted incidence rate of new ESRD patients is 398/million with 89.9% using incenter hemodialysis. Diabetes mellitus, hypertension and cardiovascular disease are the leading causes of ESRD. People of color and racial and ethnic minorities have significantly higher incidence rates of ESRD and lower transplant rates than white people. The proposed project will combine two dialysis centers to create a center with improved patient care. The relocation will improve workflow and staffing efficiencies to provide high quality care. The outcome is anticipated to serve the needs of the existing patients and add additional shift capacity for future needs.

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.”

   Appendix B presents a map of the market area with locations of the licensed dialysis centers and a list of dialysis centers in the market area.

   The following table summarizes the population data from Scoping Table 1.

SEX AND AGE		
Total population	295,020	
Male	142,396	48.3%
Female	152,624	51.7%
RACE		
Total population	295,020	
One race	275,962	93.5%
Two or more races	19,058	6.5%
One race	275,962	93.5%
White	204,513	69.3%
Black or African American	43,783	14.8%
American Indian and Alaska Native	370	0.1%
Asian	20,932	7.1%
Native Hawaiian and Other Pacific Islander	211	0.1%
Some other race	6,153	2.1%
HISPANIC OR LATINO AND RACE	0	
Hispanic or Latino (of any race)	21,834	7.4%
Not Hispanic or Latino	273,186	92.6%
HEALTH INSURANCE COVERAGE		
Civilian noninstitutionalized population	290,707	
With health insurance coverage	280,555	96.5%
With private health insurance	211,976	72.9%
With public coverage	110,371	38.0%
No health insurance coverage	10,152	3.5%
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION		
Total Civilian Noninstitutionalized Population	290,707	
With a disability	38,418	13.2%

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:

   xLow-income people
   xRacial and ethnic minorities
   xWomen
   xLesbian, gay, bisexual, transgender, or other-than-cisgender people
   xPeople with disabilities
   xOlder adults
   xPersons living with a prevalent infectious disease or condition
   xPeople who are eligible for or receive public health benefits
   xPeople who do not have third-party health coverage or have inadequate third-party health coverage
   xOther-Native American

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?

   The following data sources were used to determine the groups that would be impacted:

   - US Census Data
   - USRDS Annual Data Report 2022, National Institute of Diabetes and Digestive and Kidney Diseases
   - Kidney Diseases Statistics for the United States, National Institute of Diabetes and Digestive and Kidney Diseases
   - Albany County Health Indicators 2018-2020
   - Prevalence of Chronic Kidney Disease Among Medicare Beneficiaries Ages Greater than or Equal To 65 Years, 2019: CMS
   - End Stage Renal Disease Network of NY Annual Report, 2021
   - Albany County Health Improvement Plan 2022-2024
   - 2022 Capital Region Health Needs Assessment
   - NY State Health Equity Report County Edition January 2016

   We were not able to identify specific data concerning ESRD for the following medically underserved groups: immigrant, LGBT or other than cisgender people, people with disabilities, persons living with a prevalent infectious disease or condition.

   Stakeholder feedback information was difficult to obtain. We emailed survey

forms, mailed survey forms and placed multiple telephone calls to potential stakeholders.

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

   For each medically underserved group the project will provide care and support to people who are dependent upon ESRD treatment. ESRD treatment is required to sustain life for patients with ESRD.

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?

   According to the USRDS 2020 Annual Report, Black people are nearly four times more likely to develop ESRD than White People. Hispanic people and Native American people are more than twice as likely to develop ESRs. Black people make up approximately 13% of the US population but account for 30% of the people with ESRD.

   Black people are more likely to have ESRD caused by hypertension than White or Hispanic people. Hispanic people are more likely to have ESRD caused by diabetes than White or Black people.

   Among patients with ESRD who were initially waitlisted for kidney transplant in 2015, women were more likely to receive a transplant by five years (57.4%) than men (54.8%). White people were more likely to receive a transplant by five years (63.2%) than Black, Hispanic and Asian people (approximately 50%) and Native American and Native Hawaiian/Pacific Islander (approximately 40%.)

   The following table presents the incidence rate/ million population by race:

Race/Ethnicity	**Incidence Rate/Million Population**
Black	949
Native American	596
Hispanic	511
Asian	349
White	249

The following table documents the ESRD incident rate by age group reported by USRDS:

Age	Incidence Rate/Million Population
0-17	12
18-44	18
45-64	598
65-74	1,225
75 and older	1,447

The following table presents the treatment modality by primary cause of ESRD:

Percent Treatment Modality by Primary Cause of ESRD				
Primary Cause of ESRD	**In-Center Hemodialysis**	**Home Hemodialysis**	**Peritoneal Dialysis**	**Transplant**
Diabetes	72.72	1.40	8.59	17.29
Hypertension	68.06	1.49	8.87	21.59
Glomerulonephritis	35.45	1.73	8.02	54.80
Cystic Kidney	27.60	1.47	7.83	63.10
Other Urologic	43.39	1.53	5.99	49.08
Other/Unknown	48.04	1.44	6.00	44.51

USRDS reports the following percentage use of modality by race:

Race/Ethnicity	In-Center Hemodialysis	Home Hemodialysis	Peritoneal Dialysis	Transplant
White	51.89	1.84	9.37	36.90
Black	70.16	1.56	6.51	21.76
Hispanic	65.32	0.88	7.49	26.32
Asian	55.84	0.83	11.66	31.68
Native American	71.66	1.01	7.58	19.75
NH/PI	71.87	1.16	8.28	18.69
Other	58.28	1.52	8.71	31.48
Unknown	15.37	0.53	1.07	83.03

USRDS Annual Data Report 2022 reported the following concerning race and access to care:

"In the 2021 ADR, we did not observe disparities in rates of outpatient nephrology visits or receipt of medications to treat CKD or its complications, including angiotensin converting enzyme inhibitors or angiotensin receptor blockers, oral potassium or phosphorus binders, or sodium-glucose cotransporter-2 inhibitors, by race/ethnicity. Rates of nephrology encounters also differed little by level of neighborhood deprivation. These results suggest that Medicare coverage, including Part D and the Low Income Subsidy, appeared to provide comparable access to care for CKD across race/ethnicity groups and across levels of neighborhood deprivation. We hypothesized that barriers to access to care prior to Medicare eligibility likely contribute to the higher rates and earlier onset of diabetes and hypertension among Black and Hispanic individuals as well as to the higher risk of subsequent CKD and ESRD. To address this question, this year's ADR includes data on younger Medicaid beneficiaries aged 18 to 64 years, in which we examined access to medications and nephrology care in these younger patients. We again found little disparity by race/ethnicity or by neighborhood in receipt of medications or nephrology encounters. However, rates of nephrology encounters among younger Medicare beneficiaries were less than half those among older Medicare beneficiaries. Thus, the younger, more heavily Black, Hispanic, and lower socioeconomic status (SES) Medicaid population appeared to have considerably less access to nephrology care. Medicaid coverage may provide less access to nephrology care than Medicare coverage, or insurance coverage may be insufficient to overcome barriers to accessing care experienced by younger patients with low SES, such as transportation or concerns about loss of work income. Furthermore, limitations in access to Medicaid (e.g., across U.S. states) likely introduce further disparities that cannot be examined using medical claims, as uninsured patients almost certainly have more limited access to care. Further examination of these issues using more detailed data sources will be critical to developing and implementing strategies to address healthcare disparities."

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

   The following facilities and the number of patient stations are listed by the NY State Department of Health to provide similar services in the service area:

Facility Name	Stations
DCI - Mount Hope	18
DCI-Rubin Dialysis Centers	19
Dialysis Clinic Inc	18
FKC - Latham Dialysis Center	12
FMS - Westmere Dialysis Center	17
Fresenius Kidney Care - Troy	12
Latham Dialysis	17

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

   Based on number of stations the historic market share is presented below. We do not anticipate any change in market share.

Facility Name	Stations	Market Share
DCI - Mount Hope	18	10.5%
DCI-Rubin Dialysis Centers	19	11.1%
Dialysis Clinic Inc	18	10.5%
FKC - Latham Dialysis Center	12	7.0%
FMS - Westmere Dialysis Center	17	9.9%
FMS-Albany Dialysis Center	24	14.0%
FMS-Albany Regional Kidney Center	34	19.9%
Fresenius Kidney Care - Troy	12	7.0%
Latham Dialysis	17	9.9%

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.

   4.4% of the services are for indigent care patients. The dialysis center's patient population is reported to be 58% male and 42% female; 45% White, 49% Black or African American, 5% Asian and 0.8% Native American. We do not anticipate the payor mix, gender or racial profile will change.

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.
   No physician or professional staffing issues are anticipated related to the project or that might result from implementation of the project. Current staff will relocate to the project.

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

    New York State Division of Human Rights on the Complaint of Sheila M. Gaddy v. Fresenius Kidney Care Albany Dialysis Center
    Forum: New York State Division of Human Rights, Case No. 10213941
    Description: Ms. Gaddy filed a complaint with the NY State Division of Human Rights alleging discrimination based on her disability (having ESRD) and her race.
    Status: Pending
    Dialysis Clinic: New York Dialysis Services, Inc. d/b/a Albany Dialysis Center

    Martha Evans v. Fresenius Medical Care Holdings, Inc d/b/a Fresenius Medical Care of North America, Inc.
    Forum: Fed. Dist. Ct. - S.D.N.Y., Case No. 1:18-cv-07725
    Description: Deaf patient alleged that she was denied equal access to benefits, services and effective communications due to the clinic's failure to provide a qualified sign language interpreter or auxiliary aids.
    Status: Resolved
    Dialysis Clinic: New York Dialysis Services, Inc d/b/a FMS - Eastchester Dialysis a/k/a FKC Montefiore Medical Center

    Fred Korman v. FRESENIUS MEDICAL CARE HOLDINGS, INC. d/b/a FRESENIUS MEDICAL CARE OF NORTH AMERICA, INC.
    Forum: Fed. Dist. Ct. - S.D.N.Y., Case No. 1:16-cv-04365
    Description: Deaf patient alleged that he was denied equal access to benefits, services and effective communication because clinic failed to provide him with qualified sign language interpreter services or auxiliary aids.
    Status: Resolved
    Dialysis Clinic: New York Dialysis Services, Inc. d/b/a FMS Eastchester Dialysis a/k/a Fresenius Medical Care Montefiore Dialysis Center IV

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.

Clifton Park (CON 202082) 4 station chronic renal dialysis and home hemodialysis/peritoneal dialysis
Latham Dialysis (CON 181034) 12 station chronic renal dialysis

The projects provided ESRD care to members of the medically underserved groups.

The Albany Relocation Project will continue to serve patients who have ESRD and require dialysis services. The relocation will improve workflow and staffing efficiencies to provide high quality care. The relocation will include new equipment and a new water delivery system. The outcome of the improved workflow, staffing efficiencies, and equipment of the relocation will service the needs of existing patients and expand/add additional shift capacity for future capacity needs.

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 project will serve patients who require dialysis care for ESRD. It will serve patients from each identified medically underserved group who have ESRD and require dialysis.

The project will improve health equity because the Applicant currently uses operating protocols for dialysis services that serve each patient's clinical needs and coordinates care that incorporates the patient's psychosocial needs. The project will support additional therapy shifts as needed.

For each identified underserved group the project will improve access to health services due to increasing the number of dialysis stations and peritoneal dialysis/home therapy rooms in one location making providing more options for treatment times and the dialysis center's location providing access to private and public transportation routes.

As discussed previously younger Medicare dialysis patients are reported to have fewer nephrology encounters than older Medicare dialysis patients. No data was reported concerning the effect of comorbidities related to age. The ADR reported

"Medicaid coverage may provide less access to nephrology care than Medicare coverage, or insurance coverage may be insufficient to overcome barriers to accessing care experienced by younger patients with low SES, such as transportation or concerns about loss of work income. Furthermore, limitations in access to Medicaid (e.g., across U.S. states) likely introduce further disparities." We anticipate that any patient in each of the identified medically underserved groups will have better access to nephrology care, other clinical services and referrals to other social and support services when they become patients at the proposed project which will decrease disparities.

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.

   Dialysis serves are a critical care element for all patients with ESRD who have not received a treatment. We anticipate patients from each medically underserved from each underserved group will have improved access to nephrology care, referrals to other clinical care and social services, and assistance with qualifying for Medicare once they become Fresenius patients. We anticipate that patients will benefit from the ongoing monitoring of their physical status and clinical laboratory results.

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.

   Payor mix data supplied by the Applicant included 4.4% indigent care. We do not expect this to change.

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 project site is close to an exit on I87 and is located on Route 9W. There are bus stops within one block walking distance of the proposed project site that serve five different local bus routes.

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

   The design will meet current ADA and regulatory standards to reduce

architectural barriers for people with mobility impairments.

Meaningful Engagement

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

   The project is located in the area covered by Albany Health Department. Patients live in areas covered by Rensselaer Health Department.

7. Did the local health department(s) provide information for, or partner with, the Independent Entity for the HEIA of this project?
   We did not receive a response to inquries to the Health Department.

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

   Women, racial and ethnic minorities, older adults and low income stakeholders are most affected by the project.

   Acacia Network - Capital District LATINOS (CDL) - Cultural Empowerment & Community Engagement Center Micky Jimenez stated that her organization is supportive of this project primarily because of the location. She stated that the neighborhood for the site of the new dialysis center is close to her organization and is an underserved area. She stated that the most positive impact to the Latino community and low income community will be the center's accessibility. She stated that access to most other centers is by car. Most of her clients do not have cars and rely on the bus system. The new dialysis center will be in an area where the Latinos live. She stated that there has been an increase of Latinos to the area, particularly as a result of the recent migrant influx. Her organization supports those that are low income/Medicaid, uninsured and/or below the poverty line. She stated that historically, Latinos have been underserved in terms of access to care and health education. Her organization has sponsored kidney disease workshops with "kidney coaches" to education the population. She stated that a dialysis center in this neighborhood would be very beneficial.

10. 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?

We did not identify any groups who would be burdened by the project.

11. 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.

    See attached list of organizations representing stakeholders contacted.

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?

Fresenius will follow company guidelines, policy, and procedures. See attached Language and Communication Barriers Policy & United-Language Group guidelines. See Appendix C.

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

    Fresenius currently serves the needs of each medically underserved group. We suggest staff be trained on health equity and culturally sensitive approaches to improve communication and service coordination with community stakeholders.

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

    Fresenius has patient advocacy procedures that can be focused on specific needs for each medically underserved group. In addition, meeting with organizations representing members of medically underserved groups can elicit suggestions for culturally sensitive and responsive 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 will serve a diverse population that reflects the demographics,

racial and clinical profiles of ESRD patients discussed earlier. The project does not need to be modified.

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?

Fresenius utilizes internal project management team(s) to monitor the potential impact of the Albany Regional Relocation Project. Team(s) includes, but are not limited to Operations, Compliance, Regulatory, Project Management/Planning, Legal, IT, Finance and Construction Management.

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?

   Operations, compliance and regulatory team functions could include HEIA goals, action plans, monitoring functions and revisions as needed.

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, (APPLICANT), attest that I have reviewed the Health Equity Impact Assessment for the (PROJECT TITLE) that has been prepared by the Independent Entity, (NAME OF INDEPENDENT ENTITY).

____

Name

____

Title

____

Signature

____

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.

New York State Department of Health

Instructions for Health Equity Impact Assessment Template

Contents:

I. Background
II. Definitions
III. Instructions

I. BACKGROUND

What is a Health Equity Impact Assessment (HEIA)?

Purpose

The requirement for a Health Equity Impact Assessment was established by New York State legislation so that an independent assessment on potential health equity impacts of projects proposed by Article 28 health care facilities across New York State can be completed and considered as part of the project's Certificate of Need application.

Structure

The standard format of the Health Equity Impact Assessment ("Template") issued by the New York State Department of Health ("Department") reflects a "stepwise" structure that the Independent Entity follows:

1. Scoping
2. Potential Impact
3. Mitigation
4. Monitoring
5. Dissemination

II. DEFINITIONS

Applicant

The organization, entity, facility, or facility system that is submitting the Certificate of Need application for the project.

Medically underserved group

Medically underserved groups, as defined in the Health Equity Impact Assessment legislation and statute, consist of:

- 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; and
- Other people who are unable to obtain health care.

Tribal Nations are included in "Other people who are unable to obtain health care"

<u>Health Equity</u>

The New York State Legislature has defined health equity to mean "measurable differences in health status, access to care, and quality of care as determined by race, ethnicity, sexual orientation, a preferred language other than English, gender expression, disability status, aging population, immigration status, and socioeconomic status."

<u>Independent Entity</u>

The organization, entity, business, or individual(s) contracted by the Applicant to conduct the Health Equity Impact Assessment for the Applicant's project.

<u>Service Area</u>

Geographical region where the Applicant's facility is located as well geographical regions where populations that use the facility are located. The Service Area should match the service area in the Certificate of Need application correlating with this Assessment.

<u>Stakeholders</u>

Individuals or organizations currently or anticipated to be served by the Applicant's facility, employees of the facility including facility boards or committees, public health experts including local health departments, residents of the facility's service area and organizations representing those residents, patients or residents of the facility and their representatives, community-based organizations, and community leaders.

<u>Meaningful engagement</u>

Providing advance notice to stakeholders and an opportunity for stakeholders to provide feedback concerning the facility's proposed project, including phone calls, community forums, surveys, and written statements. Meaningful engagement must be reasonable

and culturally competent based on the type of stakeholder being engaged (for example, people with disabilities should be offered a range of audiovisual modalities to complete an electronic online survey).

INSTRUCTIONS

SECTION A. SUMMARY

1. **Title of project**

   List the full title of the project as listed on the Applicant's Certificate of Need application.

2. **Name of Applicant**

   List the full name (business/DBA name) of the organization/entity/facility/system that is submitting the Certificate of Need application for the project.

3. **Name of Independent Entity, including lead contact and full names of individuals conducting the HEIA**

   List the full name (i.e. business or DBA name, first and last name of individual) of the Independent Entity. List the lead contact (email address and phone number) for the Independent Entity (could be the President/CEO, or the principal/lead investigator) as well as the full names of individuals conducting the HEIA.

4. **Description of the Qualifications of Independent Entity**

   Describe and list the qualifications of the Independent Entity staff conducting the assessment. Explain expertise and experience in the following mandatory areas, including years of experience for each: health equity, anti-racism, and stakeholder and community engagement. If applicable, describe the expertise and experience the Independent Entity staff have in: health care access and delivery of health care services, and any other relevant areas of expertise or background.

5. **Date the Health Equity Impact Assessment started**

   List date (MM/DD/YYYY) that the Independent Entity was contracted (I.e. effective date of contract, agreement, memorandum of understanding, etc.) by the Applicant to conduct the Health Equity Impact Assessment for the proposed project.

6. **Date the Health Equity Impact Assessment concluded**

   List date (MM/DD/YYYY) that the Independent Entity provided the final Health Equity Impact Assessment to the Applicant for review.

7. **Executive summary of project (250 words max)**

In 250 words or less, provide an executive level summary of the project being proposed by the Applicant. What is the purpose and “end goal” of the project?

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

   In 500 words or less, provide an executive level summary of the findings from the Health Equity Impact Assessment. Based on the Independent Entity’s conclusion of the data and information from meaningful engagement of the community, what is the health equity impact of the project being proposed? Would the project make health outcomes, quality of life, and/or quality of care better, the same, or worse for medically underserved groups?

   The above-stated definitions of health equity is offered as a starting point for how the Independent Entity should prepare to answer this question.

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” in the document “HEIA Data Tables” as part of the HEIA submission. The service area definition should be consistent with the Applicant’s definition of how they answer service area in other parts of the Certificate of Need application. If the project will result in a change to the service area, include demographics for both the current service area and the new service area. The purpose of the Scoping Table is to provide demographic information about the service area for the project, including:

   - Zip codes/Zip code tabulation area (ZCTAs) associated with the current service area
   - Zip codes/ZCTAs associated with the new service area, if applicable
   - Population size of zip codes/ZCTAs in the service area(s)
   - Age distribution of zip codes/ZCTAs in the service area(s)
   - Racial and ethnic makeup of zip codes/ZCTAs in the service area(s)
   - Disability status of people in zip codes/ZCTAs in the service areas(s)
   - Median household income in zip codes/ZCTAs the service area(s)
   - Percent of families in poverty in zip codes/ZCTAs in the service area(s)
   - Percent unemployed in zip codes/ZCTAs in the service area(s)
   - Percent of households with food assistance in zip codes/ZCTAs in the service area(s)

- Percent of adults (25+) with high school or above in zip codes/ZCTAs in the service area(s)
- Percent insurance coverage in zip codes/ZCTAs in the service area(s)
- Percent of housing units with no vehicle in zip codes/ZCTAs in the service area(s)

For up-to-date data, the Department suggests the most recent year of the U.S. Census American Community Survey 5-year Estimates. General information from the U.S. Census on how to acquire data for a specific neighborhood or service area is available here. (This general method can be used to compile scoping sheet 1.) Information on how to acquire specific variable data from U.S. census zip files is available here and here. (This general method can be used to compile scoping sheet 2.)

2. **Medically underserved groups in the service area**

   Identify which specific medically underserved group(s) in the service area will be impacted by the proposed project. The Independent Entity can list a specific population or stakeholder that is not covered by the statute's list of medically underserved groups (defined above) by selecting "Not listed" and typing in the group or stakeholder.

3. **Sources of information for identification of medically underserved groups**

   For each medically underserved group (identified in Step 1, Question 2), briefly describe the specific source of information used to determine which group(s) are impacted (for example, U.S. census data, hospital discharge data, insurance claim data, U.S. Health Resource and Services Administration shortage designation, stakeholder interviews, secondary sources, medical literature, or grey literature, etc.) Describe what kinds of information or data were difficult to access or compile for the completion of the Health Equity Impact Assessment.

4. **Unique health needs or quality of life of medically underserved groups**

   Describe how the project specifically impacts the unique health needs or quality of life of individuals in each medically underserved group (identified in Step 1, Question 2).

5. **Current and expected utilization by medically underserved groups**

   Describe to what extent are the medically underserved groups (identified in Step 1, Question 2) currently use the service(s) or care impacted by or as a result of the project? Describe to what extent are the medically underserved groups (identified in Step 1, Question 2) expected to use the service(s) or care impacted by or as a result of the project?

6. **Availability of similar services or care**

   Provide a brief summary of the availability of similar services or care at nearby facilities. The purpose of this question is to 1) understand where else individuals can seek and utilize such services if/when there is a disruption of services or care during/after the project, and/or 2) to identify projects in an area with an existing health care shortage/need. If the project will result in a disruption of services or care, provide any plans the Applicant has for assisting patients or residents when services/care are down.

   A Health Data NY map including locations of Article 28, Article 36, and Article 40 health care facilities and programs from the Health Facilities Information System (HFIS), can be found here. A U.S. Health Resources and Services Administration tool for identifying shortage designation areas can be found here.

7. **Historical and projected market shares**

   If applicable, provide information about the historical market shares of providers offering similar services or care in the Applicant's service area. If the market shares are anticipated to change with the project, explain those changes in market shares. For new facilities, provide the projected market shares. If not applicable to the project, write N/A and provide justification.

8. **Performance of obligations**

   If applicable, summarize the current 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. If the Applicant has not met any one of these obligations that apply, please describe. If none of these obligations and federal regulations do not pertain to the project nor facility, write N/A and explain.

   Also describe how these obligations will be affected by the project. Will these obligations be affected by implementation of the project? If yes, please describe.

   Regarding community services, suggestions of what can be described are community benefit (i.e. grants or resources offered to partners that are to benefit the general public) or partnerships with community-based organizations (i.e. working with neighboring providers to meet social service needs of patients or residents).

   If applicable to the facility, please describe the number of Medicaid or uninsured discharges/people served/residents in this facility compared to the total number of Medicaid or uninsured discharges/people served/residents in the region. Describe how this compares to the total number of licensed medical-surgical

beds/people served/residents for this facility compared to the total number of licensed medical-surgical beds/people served/residents in the region.

9. **Project's impact on staffing**

   If applicable, provide a description of any, and to what extent, staffing issues may result from the project. This can include, but are not limited to, a decreased number of full and part time doctors, nurses, medical assistants, and other technicians needed to perform the services or care. Whereas other Schedules may ask the Applicant to provide a breakdown of staffing, the purpose of this question in the Health Equity Impact Assessment is for a perspective on anticipated staffing impacts that could result from the project. If not applicable to the project, write N/A and provide justification.

10. **Civil rights access complaints**

    If there are civil rights access complaints filed in the last ten years against the Applicant with the New York State Division of Human Rights, the U.S. Department of Health and Human Services Office of Civil Rights, or any other federal, state, or local agency within the last ten years, provide a brief summary of the complaints and status of each complaint. Indicate "No" if there are no civil rights access complaints filed against the Applicant.

11. **Similar projects/work in the last five years**

    If applicable, indicate whether the Applicant has undertaken similar projects/work in the last five years. The intent of this question is to better understand whether a singular project is related to a broader strategic effort by the facility (I.e. strategic plan, series of renovations that will apply to a number of facilities over a period of time, etc). If yes, describe the outcomes of the project/work and how medically underserved group(s) were impacted as a result of the project/work. If applicable, explain why the Applicant proposes another investment in a similar project after recent investments in the past.

    Describe whether the Applicant has proposed or completed similar projects/work in the last five years. If so, describe the outcomes of similar project/work and how medically underserved group(s) were impacted as a result of the project/work?

STEP 2 – POTENTIAL IMPACTS

1. **Intended impacts on health care access, health equity, and health disparities**

   Provide an assessment of whether, and if so how, the project will: 1) improve access to services and health care, 2) improve health equity, and 3) reduce health disparities for each medically underserved group identified in Step 1 Question 2. This question is to understand the intended impacts of the project on

medically underserved groups as a whole, so the Independent Entity is welcome to describe any other intended impacts that do not necessarily fall under the three criteria above.

If applicable to the project, describe specific health outcome, and/oor quality of life, and/or safety measures which may be impacted, such as those described in New York State's Health Improvement Plan, the Prevention Agenda. If appropriate, include outcome measures available at the sub-county level (such as zip code, census tract, minor civil division, etc). Sub-county level data sources are available from the Prevention Agenda dashboard, Health Data NY, the New York State County/Zip Perinatal Data Profile, and the NYS Cancer Registry and Cancer Statistics, as well as other New York State, local and national sources.

2. **Unintended impacts**

   For each medically underserved group identified in Step 1 Question 2, provide a description of the unintended positive and/or negative impacts the project may have on health equity and medically underserved groups. Explain how the project could positively or negatively affect medically underserved groups in getting high quality, timely, comprehensive, and accessible service or cares. If applicable, how would the currently proposed project either compound or mitigate any negative impacts from other projects carried over the last five years?

3. **Indigent care**
   If applicable, provide a description of the changes that may happen to the Applicant's amount of indigent care if the project is implemented, compared to the amount of indigent care provided currently. Indigent care is defined as both free and below cost care. If possible, quantify the percent change anticipated compared to the current level, such as in the percent change in the number of uninsured and low-income people served. If not applicable to the project, write N/A and provide justification.

4. **Access by transportation**

   If applicable, provide a description of the main types (public, private) and sources (car, bus, shuttle) of transportation for individuals that currently or are projected to utilize the service(s) or care impacted by or as a result of the project. Discuss how those main types and sources of transportation may need to change if the project is implemented. If not applicable to the project, write N/A and provide justification.

5. **Architectural barriers for people with mobility impairments**

   If applicable, provide a description of the architectural barriers that currently exist in the facility and negatively impact individuals with mobility impairments.

Describe the extent to which the project reduces or mitigates existing architectural barriers for patients or residents with mobility impairments. If the project newly creates or exacerbates existing architectural barriers for people with mobility impairments, describe how construction changes to the facility will help eliminate or mitigate the architectural barriers. If not applicable to the project, write N/A and provide justification.

Meaningful Engagement

Local health department(s) that are part of the geographical and/or population service area are not required to contribute, collaborate, or comment in the Health Equity Impact Assessment. However, the Independent Entity is strongly advised to reach out to the local health department(s) to request expertise on a facility's project or service area.

The Independent Entity is required to seek, consider, and document the totality of voices, input, and perspectives of stakeholders including but not limited to public health experts, organizations representing facility staff, community-based organizations, community leaders, and residents in the project's service area.

6. **List of local health department(s)**

   List the name(s) of the local health department(s) that are located within the service area that will be impacted by the project. This includes local health departments that are either within the geographical service area (i.e. the facility is within their county) or population service area (i.e. residents from a neighboring county travel across county lines to access a particular facility or health-related service offered by the Applicant).

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

   Provide a summary of the outreach to and, if applicable, input from the local health department(s) related to the project.

   If the local health department(s) provided information, indicate the point(s) of contact and key findings.

   If the local health department(s) did not respond, please indicate lack of response.

   If the local health department(s) declined to provide information or participate, indicate the reason provided or any context given, as applicable. It is not required for a local health department to provide input and/or participate in the Health Equity Impact Assessment. Reasons a local health department may not participate could be staff capacity or bandwidth at the time.

8. **Meaningful engagement of stakeholders**

Review and complete the “Meaningful Engagement” table in the document titled “HEIA Data Table” as part of the submission. The purpose of this table is to provide detail of stakeholders engaged in the Health Equity Impact Assessment. The Independent Entity should offer to all stakeholders the opportunity to provide a statement (250 word max). If a stakeholder wishes to offer a statement in their own words, the Independent Entity must include as submitted. Otherwise, the Independent Entity can summarize the high-level topline findings of stakeholders' input and include direct quotes wherever helpful.

Column 1: Name/Organization

- ➢ Provide the point of contact for the stakeholder organization. Include the email address of the person contacted for comment on the HEIA.

Column 2: What stakeholder group did they represent?

- ➢ List the stakeholder group that the contact person represents. Stakeholder groups that must be included: public health experts, organizations representing employees of the Applicant, community leaders, residents of the project's service area.

Column 3: Is this person/group a resident of the project's service area?

- ➢ Provide a yes or no answer from the drop-down menu for this column.

Column 4: Method of engagement

- ➢ List the methods of engagement for the person or organization. Methods can include but are not limited to: phone calls, in-person and/or virtual community forums, electronic, written, or telephonic surveys, written or online statements). The Independent Entity is advised to conduct timely engagement that is appropriate for the size and scope of project, region, stakeholders, and other factors and as needed. The Independent Entity is expected to give reasonable advance notice for outreach using any of the methods above.

Column 5: Date(s) of outreach

- ➢ Include the date of first outreach and any follow-ups that were sent to the person or organization for comments.

Consumers, particularly those considered as medically underserved, are a vital part of the meaningful engagement component and should be included in community outreach and engagement.

9. Most affected community members

Based on your findings and expertise, which stakeholder(s) should be considered the most affected by the project? Has any group(s) representing these

stakeholders expressed concern with the project or offered relevant input? If stakeholders have different perspectives, include a brief description.

10. Results of engaging community members

Describe how the Independent Entity's engagement of community members has informed the development of the Health Equity Impact Assessment. What are the findings in terms of who will benefit from the project? What are the findings in terms of who will be most burdened from the project?

11. Relevant community members that did not participate

If there are any relevant stakeholders, especially those considered medically underserved, that did not participate in the meaningful engagement portion of the Health Equity Impact Assessment, list with any relevant information including the Applicant's historical efforts to engage these stakeholders.

STEP 3 – MITIGATION

1. Effective communication of services or care (language access)

Based on the findings, describe the ways in which the Applicant can most effectively communicate the facility's services or care to the community. If applicable, provide a summary of the Applicant's intended plans to address language access with the proposed project. If applicable, be specific to the populations of interest: a) people of limited English-speaking ability and b) people with speech, hearing, or visual impairments.

Generally, how does the Applicant intend to convey what is going to happen at the facility to patients or residents? How will the communication be tailored (or the outreach be unique) to individuals with Limited English Proficiency (LEP) and/or individuals with speech, hearing, or visual impairments? The Independent Entity should consider the Applicant's "usual" means of communication, and identify gaps or opportunities to improve general communication to impacted stakeholders.

c) If the Independent Entity determines that the Applicant does not plan to nor is able to effectively communicate these services to both populations, what does the Independent Entity advise? From the perspective of the Independent Entity, what opportunities does the Applicant have to more effectively and competently communicate the availability of services or care?

2. Suggested project changes to better meet medically underserved group needs

Based on the findings of the HEIA, describe suggested changes to the project so the project can better meet the needs of each medically underserved group identified in Step 1, Question 2. If applicable, how can the project be improved, enhanced, or targeted? Provide a description of modifications, customizations, and adaptations that can be undertaken by the Applicant to better deliver services or care for medically underserved groups identified. Consider the various stakeholders impacted and points brought up by them.

3. **Engaging community members on project changes**

   If applicable, provide a summary of community engagement techniques the Applicant can utilize to better engage stakeholders about the project and forthcoming changes to the project. Make recommendations specific to the community or stakeholder of interest. Provide information about best practices for community engagement and successes from the meaningful engagement portion of the HEIA.

4. **Addressing systemic barriers to equitable access**

   Describe how specific components of the project address systemic barriers to services or care. Provide a rationale of why those components address systemic barriers. If the project increases barriers, describe what parts of the project do so and provide an example of how the project can be adapted to decrease systemic barriers instead.

STEP 4 – MONITORING

The intent of this section is to incorporate the Independent Entity's recommendations on how the Applicant can monitor the health equity impacts of a project even after the project is completed. Under the Health Equity Impact Assessment requirement, the Independent Entity is not required to remain contracted with the Applicant for services related to monitoring, but rather to offer perspective on ways the Applicant can establish monitoring "best practices" on their own.

1. **Existing mechanisms and measures to monitor impacts**
   If applicable, describe how the Applicant is currently equipped to keep track of health equity impacts even after the project is completed. The Independent Entity can identify existing mechanisms and measures (i.e. policies, procedures, internal controls, systems, or accountability measures) that the Applicant already has in place and can be leveraged to monitor the potential impacts even after the project is completed. Describe specific indicators and/or objectives.

   Existing mechanisms and measures can include but are not limited to:

- Ongoing involvement of a committee or advisory group charged with health equity projects
- Ongoing involvement of a chief equity officer or equity staff and their advisement on a facility project
- Requiring health equity training for staff responsible for the project
- Contracting a third-party vendor (i.e. consultant) to provide services related to monitoring and/or related impact assessments
- Health equity quality measures built into electronic record systems
- Health equity related consumer satisfaction surveys

2. **Potential mechanisms and measures Applicant can put in place to monitor impacts**

   List potential evidence-based measures and mechanisms (I.e. policies, procedures, internal controls, systems, or accountability measures) that can be put in place by the Applicant with respect to the proposed project and can address the findings of the Health Equity Impact Assessment. From the Independent Entity's viewpoint, provide any suggestions for mechanisms and measures that fit the proposed project well. Describe suggested indicators and/or objectives for potential mechanisms and measures.

   Though monitoring by the Applicant nor the Independent Entity is not necessarily required, the purpose of this question is to encourage thinking on ways for the Applicant to build in potential measures or actions for monitoring.

   Step 4 Question 1 is to identify existing mechanisms already in place, while Step 4 Question 2 is to identify potential evidence-based mechanisms or practices that could be put in place.

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: ADDITIONAL COMMENTS FROM THE INDEPENDENT ENTITY

In 250 words or less, provide any additional points of information the Independent Entity feels is relevant to the proposed project. Add any relevant information that was not asked about in the Template but was found through the development of the Health Equity Impact Assessment.

SECTION C: ACKNOWLEDGEMENT AND MITIGATION PLAN

The purpose of Section C is to provide attestation that the Applicant received and reviewed the Health Equity Impact Assessment from the Independent Entity. Additionally, the Applicant must provide a narrative for how it has, or will, mitigate any potential negative impacts to medically underserved groups identified in the Health Equity Impact Assessment.

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 by either the Commissioner of Health or the Public Health and Health Planning Council, as applicable.

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: The Vinca Group L.L.C.
2. Is the Independent Entity a division/unit/branch/associate of an organization (Y/N)? NO
   - ❑ 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)? Yes
____
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? No

Section 4 – Attestation

I, Alice Katz, having personal knowledge and the authority to execute this Conflict-of-Interest form on behalf of The Vinca Group L.L.C., do hereby attest that the Health Equity Impact Assessment for project FKC Albany Regional Dialysis Center provided for New York Dialysis Services, Inc. (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 Vinca Group L.L.C. 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: ___________________________

Date:12/18/2023