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	Jacob Reingold Pavilion Closure
2. Name of Applicant	Hebrew Home for the Aged at Riverdale
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	Jeffrey A. Sachs and Associates, Inc – 212-827-0660 • Aisha King, MPH - aking@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 Jeffrey A. Sachs and Associates, Inc 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	January 15, 2025
6. Date the HEIA concluded	June 13, 2025

7. Executive summary of project (250 words max)
RiverSpring Living is a 32-acre campus in Riverdale, NY, which offers a range of senior living arrangements including independent-living, assisted-living, and nursing-care options. They also offer short-term rehab. Within the campus, Hebrew Home for the Aged at Riverdale is a long-term care community that offers comprehensive care, innovative programs, and a progressive approach to elder care. As of 2023, Hebrew Home had 751 certified skilled nursing facility beds. The applicant is seeking to decertify the Jacob Reingold Pavilion (JRP), which consists of 4 resident floors and 190 beds. The decertification proposal stems from both a census decline since the COVID-19 pandemic and the need for a financial survival strategy due to insufficient Medicaid reimbursement. Over the next 3-4 years, the Applicant intends to transition JRP into an assisted living facility. The transition plan will serve dual purposes of ensuring the organization's on-going financial and operational sustainability and meeting the growing demand for assisted living homes in the area. **The New York State Department of Health (DOH) approved the plan to transition residents from the Jacob Reingold Pavilion (JRP) to other Hebrew Home buildings on October 10, 2024.** At the time of this Assessment, the phased transition is underway, with a majority of JRP residents already relocated to clinically appropriate beds elsewhere on campus. No residents have been moved off-campus. The transition was carefully designed to preserve admission rates and ensure continued high-quality care with minimal disruption to residents. The Applicant has maintained weekly contact with the DOH regarding the transition.
8. Executive summary of HEIA findings (500 words max)

This Health Equity Impact Assessment (HEIA) utilized data from the census, academic and grey literature, and interviews with leadership, staff, residents, family members, community-based organizations, the local health department, and referral partners. The HEIA found that while some residents experienced challenges during the transition process, concerns were addressed quickly and appropriately. We did not identify any significant negative health equity impacts resulting from this project, either for current residents or the community.

On a local scale, current and potential residents of Hebrew Home are the most likely to be affected by this project. Specifically, older adults, low-income individuals, and Medicaid/Medicare beneficiaries – who comprise the majority of Hebrew Home's residents – are most likely to be impacted. More than 95% of Hebrew Home patients are covered by Medicaid, Medicare, or both. Bronx County, where the facility is located, has a poverty rate of 27.7%. It is possible that individuals who identify as racial and ethnic minorities may also be disproportionately impacted, as they often face barriers to accessing home and community-based services and are more likely to rely on institutional long-term care than White individuals. Current census data show that 38% of Bronx residents identify as Black/African American and 55% as Hispanic/Latino. Hebrew Home's current resident population identifies as 20.2% Black and 18.3% Hispanic.

Stakeholders unanimously agreed that the proposed project is essential to the financial viability and long-term sustainability of Hebrew Home, as well as to meet the growing demand for assisted living in New York City. They emphasized the importance of preserving access to long-term care services across the full continuum of care in the region. Stakeholders also praised the leadership and staff for their proactive, transparent, and honest communication, which helped build trust and foster understanding throughout the transition process.

Vitally, no residents have been - or will be - required to leave the Hebrew Home as a result of this project, and no residents have requested transfer to an external facility. While some stakeholders expressed concern that the project could reduce access to skilled nursing facility care in Bronx County, most emphasized the presence of a robust network of skilled nursing facilities in Riverdale, the broader Bronx, and neighboring Westchester County. In fact, Hebrew Home's occupancy rate has ranged between 80–90% in recent years, suggesting an oversupply of skilled nursing beds. In contrast, the RiverSpring on-campus assisted living facility has a long waitlist, highlighting a growing unmet demand for this level of care.

The following recommendations are suggested for continued monitoring and accountability:

1. Conduct resident surveys and track satisfaction
2. Collect and analyze equity-focused data
3. Monitor service utilization and access
4. Utilize standardized tools to ensure person-centered care

5. Monitor post-transition health outcomes
6. Maintain and strengthen community partnerships

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_HebrewHome.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
   - People with a disability

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, residents, family members, community-based organizations, and referral partners.

   In our geographic analysis and scoping tables, we included the zip code where the facility is located (10471). We also discuss key characteristics of the county in which the facility is located (Bronx County).

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, or skilled nursing facilities (SNFs), provide vital 24/7 care, including skilled nursing, short-term rehabilitation, and long-term residential care for individuals needing assistance with activities of daily living (ADLs). The decertification of nursing home beds at Hebrew Home will primarily impact older

adults, racial/ethnic minorities, and low-income individuals who rely on public health benefits. While access to skilled nursing care at Hebrew Home will be reduced, it must be noted that there is a robust network of SNFs in Bronx County and in nearby counties. In this context, the medically underserved groups which may be affected by this project are highlighted below.

Older Adults

The prevalence of older adults (older than 65 years) is approximately 15% in Bronx County and almost 30% in the Applicant's service area.[1] Nationally, the elderly population 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 (and are therefore most likely to require skilled nursing care), are expected to quadruple between 2000 and 2040.[3]

Although SNFs serve individuals of all ages, approximately 82% of SNF residents are over the age of 65.[4] The Department of Health and Human Services estimates that over half of Americans turning 65 need long-term services and supports.[5] However, despite the growing elderly population, funding for their care is decreasing.

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

In Bronx County, 22.8% of families live below the poverty level, significantly higher than the statewide average of 10%.[1] Approximately 65% of individuals in the county are enrolled in Medicaid, which is also the primary payer (70%) for skilled nursing services in New York.[6] While the Applicant's service area has a lower poverty rate (3.7%) than the surrounding county, the area faces challenges due to the socioeconomic status of residents and the surrounding community.

Racial and ethnic minorities

Bronx County has a diverse population, with residents identifying as 38% Black/African American and 55% Hispanic/Latino, compared to state-level

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[1] U.S. Census Bureau. (2023). Retrieved from https://data.census.gov/

[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] 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

[6] 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

percentages (14% Black and 19.5% Hispanic/Latino).[7] In the Applicant's service area, 10.2% of the population is Black, and 32% is Hispanic/Latino.

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

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

Evidence indicates that the proportion of minority residents in nursing homes is increasing rapidly, in part due to unequal access to home and community-based alternatives among persons of color.[8] Research also demonstrates disparities in the quality of nursing home care among racial and ethnic minorities.[9,10,11]

Individuals with disabilities

Although statistics on disability vary widely by definition and measurement, the American Community Survey reports that the percent of the population living with a disability is 12.7% in the Applicant's service area and 16.5% in Bronx County.[1] Disabilities are more common among adults 65 years or older; approximately 2 in 5 adults in this group have a disability.[12] In New York State, 41.4% of individuals 65 years or older had at least one disability. Disability is also higher among racial and ethnic minorities and individuals living in poverty, indicating intersectional challenges.[13]

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 Hebrew Home among potentially medically underserved residents in 2024. The demographics of residents are not expected to change with the proposed bed reduction at the facility.

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[7] 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

[8] 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

[9] 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

[10] 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

[11] 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

[12] Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. Disability and Health Data System (DHDS) Data [online]. [accessed March 20, 2025]. URL: https://dhds.cdc.gov.

[13] Okoro CA, Hollis ND, Cyrus AC, Griffin-Blake S. Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults — United States, 2016. MMWR Morb Mortal Wkly Rep 2018;67:882–887. DOI: http://dx.doi.org/10.15585/mmwr.mm6732a3

Table 1. Race/Ethnicity

Race	% of Hebrew Home Residents	% JRP Residents
Non-Hispanic White	59.8%	65.0%
Non-Hispanic Black	18.6%	19.1%
Hispanic or Latino (any race)	19.2%	13.6%

Table 2. Age

Age	% of Hebrew Home Residents	% JRP Residents
0-44 years	0.3%	0%
45-54 years	2.7%	2.9%
55-59 years	2.6%	1.7%
60-64 years	6.4%	5.2%
65-74 years	15.9%	15.3%
75-84 years	30.4%	31.2%
85+	41.8%	43.6%

*Table 3. Payor Mix**

Payor	% of Hebrew Home Residents	% JRP Residents
Medicaid	49.0%	57.5%
Medicare	47.1%	37.0%
Dual Eligible (Medicaid & Medicare)	39.6%	58.1%
Commercial	1.5%	3.8%
Uninsured	2.4%	1.7%

*Percentages do not add up to 100 due to overlapping coverage

Table 4. Disability status

Disability Status	% of Hebrew Home Residents	% JRP Residents
With a disability	100.0%	100.0%

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

Table 5 shows Bronx County SNFs, number of beds, occupancy rates, and distance from Hebrew Home. There are additional SNFs close by available in Yonkers, Manhattan, Queens, and New Jersey (not shown).

Table 5. Nursing Homes in the Bronx[14]

[14] 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

Name	Number of Beds	Occupancy Rate	Distance from Hebrew Home
ArchCare at Providence Rest	200	98%	6.9 miles
Bainbridge Nursing & Rehabilitation Center	200	99%	2.6 miles
Beth Abraham Center for Rehabilitation and Nursing	448	98%	3.7 miles
Bronx Center for Rehabilitation & Health Care	200	99%	6.2 miles
Bronx Gardens Rehabilitation and Nursing Center	199	98%	4.1 miles
Bronx Park Rehabilitation & Nursing Center	240	96%	2.8 miles
Bronxcare Special Care Center	240	95%	5.4 miles
Casa Promesa*	108	73%	4.4 miles
Concourse Rehabilitation and Nursing Center, Inc	240	96%	5.5 miles
East Haven Nursing & Rehabilitation Center	200	96%	4.9 miles
Eastchester Rehabilitation and Health Care Center	200	81%	4.6 miles
Fieldston Lodge Care Center	200	88%	2.1 miles
Fordham Nursing and Rehabilitation Center	240	95%	2.7 miles
Gold Crest Care Center	175	97%	5.3 miles
Grand Manor Nursing & Rehabilitation Center	240	83%	6.7 miles
Highbridge Woodycrest Center*	90	98%	5.6 miles
Hope Center for HIV and Nursing Care*	66	95%	4.7 miles

Hudson Pointe at Riverdale Center for Nursing and Rehabilitation	159	94%	1.7 miles
Kings Harbor Multicare Center	720	86%	5.3 miles
Laconia Nursing Home	240	97%	3.5 miles
Manhattanville Health Care Center	200	90%	2 miles
Methodist Home for Nursing and Rehabilitation	120	87%	1.4 miles
Morningside Nursing and Rehabilitation Center	314	93%	4.5 miles
Morris Park Nursing and Rehabilitation Center	191	90%	4.6 miles
Mosholu Parkway Nursing and Rehabilitation Center	122	91%	2.9 miles
New Riverdale Rehab and Nursing	146	97%	1.9 miles
Park Gardens Rehabilitation & Nursing Center LLC	200	92%	0.7 miles
Pelham Parkway Nursing Care and Rehabilitation Facility LLC	200	95%	4.3 miles
Pinnacle Multicare Nursing and Rehabilitation	480	96%	4.7 miles
Rebekah Rehab and Extended Care Center	213	94%	6.4 miles
Regeis Care Center	236	95%	4.4 miles
Schervier Nursing Care Center	364	96%	2 miles
Split Rock Rehabilitation and Health Care Center	240	93%	4.1 miles
St. Patrick's Home	264	98%	2.1 miles
St. Vincent Depaul Residence	200	59%	6.3 miles

The Citadel Rehab and Nursing Center at Kingsbridge	385	98%	2 miles
The Plaza Rehab and Nursing Center	744	99%	7.8 miles
Throgs Neck Rehabilitation & Nursing Center	205	98%	4.4 miles
Triboro Center for Rehabilitation and Nursing	405	99%	5.4 miles
University Center for Rehabilitation and Nursing	46	96%	3.1 miles
Wayne Center for Nursing & Rehabilitation	243	100%	2.6 miles
Williamsbridge Center for Rehabilitation and Nursing	77	99%	5.4 miles
Workmen's Circle Multicare Center	524	97%	4.5 miles

*These facilities provide specialized care and do not serve all nursing home residents.

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

   The total number of available nursing beds and the occupancy rates (i.e., the percentage of total nursing home beds that are occupied) for each nursing home in the county are outlined in Table 5 above. The reporting date for these rates is October 30, 2024. According to the most recent data available, there are 11,475 registered skilled nursing home beds in Bronx County. The Applicant currently manages 6.5% of skilled nursing home beds in Bronx County. After the planned decertification of 190 beds, the Applicant will manage 5% of skilled nursing home beds in Bronx County.

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.**

   No staff have lost or will lose employment as a result of this transition plan. Wherever possible, staff will continue to care for residents with whom they have previously built relationships, in their new homes.

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

    There are no civil rights access complaints against the Applicant.

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

    Yes, the Applicant closed two other skilled nursing facility buildings in the past five years. The closure of JRP is part of a broader strategic effort. The current plan is to relocate the residents of JRP into existing clinically-appropriate nursing home beds in the facility, and over the next 3-4 years convert JPR into an assisted living facility. This will enable the facility to preserve the mission of caring for older adults at all levels of care irrespective of payment source.

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**

   <u>Continuation of services at Hebrew Home</u>

   Stakeholders indicated that while the closure of the JRP and reduction of beds is not ideal, the project is a strategic financial decision made by the organization to ensure long-term sustainability and continued service to the community. Like many SNFs that primarily serve Medicaid beneficiaries, the Applicant is facing financial and operational challenges due to rising costs, workforce shortages, and reimbursement obstacles. Leadership emphasized that the decision to close

the JRP is essential to preserving access to institutional long-term care services for those in need. Without this reduction in beds, the SNF would not be financially viable, placing its continued operation at risk. The Applicant is one of the few not-for-profit skilled nursing facilities still operating in the Bronx, highlighting the importance of its survival. By ensuring the financial viability of the whole organization, this project will protect access to and quality of care for current and future residents, a majority of whom are older adults, low-income populations, and/or racial or ethnic minorities.

Re-utilization of space as an assisted living facility

While the project involves a reduction in SNF beds, stakeholders emphasized that there is a robust network of SNFs in Riverdale, the broader Bronx, and neighboring Westchester County. As such, the closure of the JRP is not expected to result in significant negative impacts on access to skilled nursing care.

The planned repurposing of the JRP into an assisted living facility will increase the availability of supportive residential care options for older adults in the region. Assisted living provides a less intensive, yet essential level of care for individuals who require help with daily activities such as bathing, dressing, and medication management. By expanding access to this level of care, the project addresses a clear service gap - evidenced by the waitlist for the Applicant's current assisted living facility - particularly for older adults who may not qualify for skilled nursing care but are no longer able to live independently. Although assisted living services are typically not covered by Medicaid and often require private payment, the expansion is expected to benefit middle-income older adults who fall into a "coverage gap" - earning too much to qualify for Medicaid but lacking the resources to afford private home care or high-end senior living communities. This group is often underserved in long-term care planning. The project contributes to greater equity by offering new care options for an often-overlooked demographic.

By increasing assisted living capacity, the project may ease inappropriate or premature admissions to SNFs among individuals whose needs could be met in a less intensive setting. This helps preserve SNF resources for individuals with more complex medical conditions. Importantly, no former JRP residents are on the waitlist for assisted living. In fact, one JRP resident requested and was granted the opportunity to move to an on-campus assisted living facility rather than to a different SNF building.

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.**

Unintended negative impacts may include:

- Reduced access to highly rated skilled nursing care in Bronx County. The closure of JRP could reduce access to highly rated skilled nursing services for individuals with complex medical needs, especially for those

on Medicaid who may not be able to afford alternative care. This could burden individuals and/or families if they are not able to access a bed of their choice. This could particularly impact individuals of limited resources, who likely cannot pay out-of-pocket for care and therefore will have fewer options for where they can be placed. However, the Applicant will still accept Medicaid patients and stakeholders emphasized that SNF capacity in Bronx County is sufficient to meet current and future demand. Leadership and external stakeholders highlighted the importance of policy shifts to establish sustainable funding mechanisms for elder care to 1) avoid strain on emergency departments and 2) ensure that high-quality SNFs can remain open and financially sustainable.

- Reduced access to certain features valued by residents. Former residents of JRP were accustomed to private rooms and some were required to move to shared rooms. This transition caused some discontent, sadness, and feelings of resentment. However, the Applicant has addressed resident concerns related to living arrangement changes to the extent possible, and residents reported having adjusted to the changes. In addition, all services have remained the same; from clinical care to religious services and art classes.

Unintended positive impacts may include:

- Relieved pressure on skilled nursing beds. The planned introduction of assisted living could help alleviate demand for skilled nursing beds by providing increased places for individuals without complex medical needs, allowing those with more complex needs to access appropriate care. There is an increasing need for assisted living facilities to accommodate aging populations.
- Increased sense of community. The transition of patients from JRP to other buildings on campus may increase opportunities for residents to socialize with each other and foster new connections. This may be particularly beneficial for patients with dementia or those who experience social isolation, who will be in closer proximity to more residents and have more opportunities for socialization. Former JRP residents may also increase community by remaining connected with fellow former JRP residents, fostering continuity and mutual support during the transition.
- Increased social activities. The closure of JRP could allow for a reallocation of resources to the development and implementation of more activities for residents.
- Centralization of workflows. The transition may centralize clinical workflows by moving all residents into one building. This may improve efficiency of medical care.
- Improve profit margins for local skilled nursing facilities. The closure of JRP could lead to increased occupancy rates for other local skilled nursing facilities. This in turn could improve the profit margins of those facilities, allowing them to remain open and to continue providing high quality care.

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.**

   N/A

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.**

   Hebrew Home is accessible by NYC bus services, taxi, and the Metro North train with Link Service. The closest bus stop is a 9 minute (0.4 mile) walk from the entrance on Palisades Avenue. All new admissions from the hospital arrive via ambulette services. This project will not affect the availability of public, private, or Applicant-sponsored transportation services.

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

   The project does not present any architectural barriers for individuals with mobility impairments.

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 and Mental Hygiene

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

   Yes, representatives from the New York City Department of Health and Mental Hygiene met with the Independent Entity to discuss the project and provided a statement. Findings are integrated into the HEIA.

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_HebrewHome.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 about the project or offered relevant input?**

    Current and potential future residents will be the most affected by this project. As noted above, the closure plan was approved by the New York State DOH in October 2024 and a majority of JRP residents have since moved to other buildings on the Applicant's campus. Residents are predominantly older adults who require long-term nursing or short-term rehabilitation care.

    No stakeholders, including the residents themselves, expressed significant concern about the project's impact on residents, although some issues were noted. Several staff members noted that change is difficult for older adults, but that the Applicant put extensive effort into the planning process in order to make the transition processes as easy as possible. Some families were initially upset about the plan and/or anxious about logistics, but the open, honest, and early communication by staff and leadership assuaged concerns and fostered understanding in the necessity of the project. No complaints were escalated to external authorities. The closure of the building itself, rather than one floor or a certain number of beds, helped frame the decision as necessary rather than optional.

    Some residents with cognitive impairments had initial difficulty understanding the change, and some residents were nervous about moving – particularly if they had never lived in a different building. However, there was relief among residents that they would be able to remain on campus. One resident said that the closure of JRP was distressing and indicated that some staff could have been more empathetic towards transitioning residents. However, they emphasized that leadership was highly receptive to concerns and tried to ease the transition as much as possible, including making psychologists, psychiatrists, and social workers available. Another resident was worried about losing access to cherished activities, but transport assistance allowed them to continue attending all activities. This resident also noted that their new common area has more people, creating more opportunities for social interaction. Despite initial reactions, residents, staff, and family all indicated that the transition went as smoothly as possible. Leadership helped residents remain in proximity to social circles and with the same care team, which were key to a smooth transition. Most importantly, no residents left Hebrew Home as a result of the transition. Stakeholders reported no anticipated transportation, housing, or access barriers, and that residents were described as settled, happy, and engaged.

No stakeholders expressed any concerns about negative physical health consequences of the move. Residents moved to rooms that allowed for equivalent levels of care and often remained with the same care team. Physicians provided care for the same individuals, ensuring continuity of care for all residents equally.

No stakeholders indicated concerns about reduced bed capacity, highlighting that the facility has been operating under capacity for several years and that there is an abundance of SNFs with open beds in area.

Local community leaders praised the Applicant for its thorough and collaborative approach in working with families, caregivers, clients, and community organizations. The Applicant's longstanding commitment to minimizing care disruptions was noted as a strength. While some stakeholders voiced concern about the increasing prevalence of for-profit nursing homes, they underscored the high-quality, person-centered care provided by the Applicant, which remains one of the few non-profit skilled nursing facilities still operating in the area. Several emphasized the urgent need for increased State-level investment in elder care to support the sustainability and quality of local skilled nursing services.

Internal and external stakeholders were positive about the proactive nature of communication from leadership and the exacting way that the transition was carried out. Staff highlighted the project's goal of enabling Hebrew Home to remain open and financially sustainable and were understanding of the need to close JRP. Staff emphasized that Hebrew Home provides individualized care, that all residents were treated equally throughout the transition, and that translational, psychological, and medical support were provided as needed.

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 internal stakeholders, including leadership, staff, residents, and family members of residents who transitioned out of JRP. We also interviewed several external stakeholders, including referral partners, the Ombudsman, and a local pastor. Lastly, we met with the local Health Department to discuss the project.

Our stakeholder and community engagement complemented our data analysis by providing qualitative insights into the medically underserved populations that could be impacted by this project. 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 6 interviews with staff and leadership, 3 interviews with residents and family members and 6 interviews with external stakeholders, including the Ombudsman and a local pastor. We believe that relevant stakeholders participated in meaningful engagement.

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?**

    This project has been planned for over a year. In that time, the Applicant has proactively communicated the changes to the community, the department of health, community-based organizations, current residents, and family members. Leadership has held multiple meetings, both large and small, among residents and families. They also sent out letters, emails, and memos to inform residents and family members proactively about the change.

    The Applicant has robust mechanisms in place to foster effective communication among people with limited English-speaking ability and people with speech, hearing, or visual impairments. Interpreter services are readily available and staff ID cards have the phone number of a trusted translation service on the back. 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.

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

    We recommend the following specific changes:

    - **Strengthen existing partnerships and develop new partnerships with local skilled nursing facilities.** This will help ensure that the Applicant can provide effective referrals for individuals from the community who require skilled nursing care.
    - **Continue to prioritize individualized care.** We recommend that the Applicant continue to prioritize individualized medical and psychological care for all patients, regardless of payer, complexity of medical needs, or any other relevant factors. Mental health care staff should continue to remain available to all residents and be particularly attentive to the mental health and needs of former JRP residents.

- **Maintain transparent communication.** Transparent communication has been the key to a successful transition thus far, and we recommend that the Applicant continue to be open and honest with residents and families about any upcoming changes. Tailored communication methods, such as providing printed materials in multiple languages, will likely continue to be helpful. Resident and family engagement is essential to upholding dignity and autonomy.
- **Monitor resident wellbeing post transition.** Continued monitoring of resident wellbeing will ensure resident satisfaction and equitable health outcomes among all residents.
- **Enhance staff training on compassionate care.** Clinical staff indicated close relationships with residents, and administrative staff are encouraged to volunteer on resident floors to build relationships with residents. Compassionate care is essential to making residents feel safe in their own homes, and offering additional sensitivity training for all staff can help to ensure increased empathy, kindness, and understanding during difficult transitions.
- **Document all practices.** Staff recommended that the process used to guide this project be documented, given its success. Emphasis was placed on managing expectations, maintaining continuity of care and team, prioritizing communication and comfort, and engaging nonclinical staff in weekly resident interactions.

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

   The most common throughline across interviews was the positive reaction towards the transparency and proactiveness of communication by the leadership team about this project. As noted above, the organization held multiple meetings, both large and small, among residents and families. They also sent letters, emails, and memos to inform residents and family members. Key stakeholders such as the DOH, the Ombudsman, and local pastors were involved from the beginning of the planning of the project and throughout the transition process.

   The Applicant can continue to engage and consult stakeholders on the progress of the project through Resident Council Meetings and Community Board Meetings. Community-based partners should continue to be actively involved to ensure broad outreach and engagement. Key updates to share with stakeholders may include the timeline for the final closure of JRP and plans for the new assisted living facility.

   The Applicant could consider implementing additional resident and family surveys to assess satisfaction with care quality following the transition and proactively address any potential budding issues. Lastly, the Applicant can continue to ensure that affected residents and families, including those from

limited-English proficiency and low-literacy backgrounds, continue to receive accessible information and resources.

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?**

   This project addresses systemic barriers to equitable access to services and care as follows:

   - **Preserving access to skilled nursing services:** While the project reduces the total number of skilled nursing beds, the closure of JRP is a strategic decision aimed at supporting the long-term viability of the Hebrew Home, which predominantly serves low-income and Medicaid-dependent residents. Through the planned changes, the facility can continue to provide institutional long-term care to those who need it most, preventing a broader closure that would further limit access to high quality skilled nursing services for underserved populations. This project ensures that Hebrew Home will remain operational and can continue to serve those who need institutional long-term care, particularly older adults, low-income individuals, and racial/ethnic minorities who disproportionately rely on Medicaid-funded services. All residents will retain access to a skilled nursing facility bed at the level of care that they require. No residents were required to relocate to an external nursing facility as a result of this project.
   - **Workforce stability:** The financial restructuring helps retain and stabilize staffing levels, addressing one of the primary drivers of disparities in care quality for Medicaid-dependent residents – high staff turnover and limited resources in underfunded facilities. Ensuring that staff remain in place to care for existing residents helps maintain continuity and quality of care for the most vulnerable populations. Retaining all staff also ensures that residents can maintain their care teams through the transition, as possible.
   - **Expanding access to care options across the spectrum of needs:** The planned addition of an assisted living facility will provide alternative housing and care options for individuals who do not require full-time skilled nursing care but need assistance with activities of daily living (lower level of care). The plan is designed in order to meet growing demands for less institutionalized but supportive environments among the local aging population. This may in turn reduce pressure on nursing home beds by expanding choices for those seeking support in a more community-oriented setting.

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 are required to collect quality metrics and conduct comprehensive assessments to ensure compliance with federal and state standards. In addition, nursing and social services teams actively track gaps in care and health outcomes and intervene if any issues are detected. Special attention is given to end-of-life care, religious considerations, and social connections. There is regular monitoring of residents' health, including mood changes and physical health indicators like weight, depression, and the use of psychotropic medications. Physicians are promptly alerted to any health concerns, so that they may be addressed as soon as possible. These mechanisms, in addition to resident council and community board meetings, can be leveraged to monitor the potential impacts of the project, including any changes to quality of care or access. We suggest that the Applicant compare conversations and ongoing dialogues from before and after the transition to ensure that patients are not experiencing diminished quality of care or lifestyle as a result of the project. We also recommend that the Applicant track the waitlists and census of the SNF over time to ensure that they remain able to meet the needs of the local community.

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:

   - **Conduct resident surveys and track satisfaction.** Implement regular resident surveys to assess ongoing satisfaction and overall well-being, especially among former JRP residents, to ensure the transition has not negatively affected quality of life.
   - **Monitor post-transition health outcomes.** Continue monitoring the health outcomes of former JRP residents - including hospitalization rates, emergency department visits, and changes in overall health status - to evaluate the longer-term impacts of the transition.
   - **Collect and analyze equity-focused data.** Gather and analyze detailed demographic and health outcomes data - such as age, race, ethnicity, income level, and insurance status - to identify how the transition may be impacting different resident groups and to inform equity-centered planning. The Applicant should monitor decisions to move individuals from single to shared rooms to ensure they are made equitably. This will help make sure that patients from medically underserved groups aren't disproportionately placed in less preferable living situations.
   - **Monitor service utilization and access.** Track key metrics including enrollment rates, service utilization patterns, and wait times, stratified by demographic characteristics, to monitor access and identify any disparities that may emerge over time.
   - **Utilize standardized tools to ensure person-centered care.** Use validated, standardized assessment tools to evaluate the quality of care and ensure the continued delivery of comprehensive, person-centered services that adapt to residents' evolving needs.

- **Maintain and strengthen community partnerships.** Continue to foster strong relationships with local nursing homes and actively engage community stakeholders - including residents, families, advocacy groups, and other partners - in both current and future planning and evaluation activities. Including residents early on can maintain dignity among residents.

By systematically implementing these strategies, the Applicant can effectively monitor any 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, (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).

Ann Marie Hennessy

Name

Chief Clinical Officer

Title

Ann Marie Hennessy

Signature

July 23, 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.

See Attachment A Hebrew Home at Riverdale Mitigation Plan

Hebrew Home for the Aged at Riverdale

Attachment A

HEIA Mitigation Plan

August 20, 2025

Hebrew Home for the Aged at Riverdale (HHAR) is distinguished by a longstanding and widely acknowledged reputation as an innovative, forward thinking and comprehensive provider of high-quality long-term care services to its community. As one of the county's leading not-for-profit providers, administration has the earned a reputation for its leadership role, setting the standards in elder care, and continually responding to market forces through development of cutting-edge services in response to the needs and preferences of its constituency. Throughout, HHAR has remained ever cognizant of the utmost importance of safety, accessibility, successful outcomes, and resident/family satisfaction.

The current proposed project- the decertification of 190 beds from the Jacob Reingold Pavilion (JRP), speaks to HHAR's recognition of the need to respond to operational and market forces in an effort to both safeguard the organization's on-going financial and operational status through reducing inpatient bed capacity in response to census decreases, while recognizing the clinical needs and the preference to receive care in the least restrictive environment. Through these actions, the reduction in bed census will certainly have a positive impact on both the organization and importantly, on the community it serves.

Subsequently, as a result of the October 2024 approval by the Department of Health of the submitted Transition Plan for JRP, the transition of residents from JRP to available beds on campus, with on-going communication with the area office is now essentially complete. Throughout the process, HHAR maintained frequent and direct contact with residents and families. Neighborhood meetings were conducted and are on-going. Additionally, unit social work staff as well as the Vice President of Social Services were and continue to be available to discuss and resolve any move-related matters. To this end, as has been our practice, maintenance of the well-being and satisfaction of our residents is paramount and as such, HHAR will implement an annual survey to assess and monitor the continuous satisfaction and well-being of our residents. It is also important to note that as part of our established Quality Assurance Program, HHAR continually monitors the health outcomes of *all residents*, inclusive of hospitalization rates, emergency department visits and any changes in overall health status and will continue this practice. Additionally, HHAR has in place a well-established practice in the use of standardized assessment tools for evaluating the individual care needs of each resident. The focus of care delivery at HHAR is that all residents receive person-centered services meeting their needs. These practices will continue in an effort to ensure continued care delivery in this manner.

Moreover, as part of its ongoing mission, HHAR continually monitors for and works to ensure equity in care for all residents in all its programs. The facility's mission of care has supported the health and well-being of all older New Yorkers living in the community and on the Riverdale campus through managed care, home care, senior residences, rehabilitation and at the nationally acclaimed Hebrew Home at Riverdale. Further, in acknowledgment of the importance of monitoring both service utilization and access, Hebrew Home will continue its current practice of tracking metrics, including admission rates, demographics, and service utilization patterns to monitor access and identify any patterns that may emerge over time. The facility currently has an

Assisted Living Residence for those individuals meeting that level of service. As well, the vacant space in the JRP building will be repurposed for the development of additional licensed supportive senior housing, creating access to essential residential care options for older adults in the region.

HHAR has over time developed a comprehensive outreach strategy that has been effective in its development of strong and fruitful community relationships with area hospitals, nursing facilities, health care providers and community-based organizations. As noted, HHAR leadership has evidenced a proactive and robust communication process in continuous engagement of the community, local health departments, community-based organizations as well as residents and family members. The facility will continue this practice to foster and maintain these strong relationships and actively engage community stakeholders - including residents, families, advocacy groups, and other partners - in both current, future planning and evaluation activities.

In summary, Hebrew Home leadership and administration appreciates and concurs with the findings of the Health Equity Impact Assessment participants, which noted that "*we did not identify any significant negative health impacts resulting from this project, either for current residents or the community."*