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

- ***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	NICU Expansion
2. Name of Applicant	NYU Langone Health
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	Deb Zahn Consulting, LLC Lead Contact: Deborah Zahn, deb@debzahn.com, 347-834-5083 Team Members Conducting the HEIA: • Deborah Zahn, MPH • Lynnette Mawhinney, PhD, MEd • Andrea Mantsios, PhD, MHS • Jenné Massie, DrPH, MS • Melissa Corrado, MBA • Sydne Ashford
4. Description of the Independent Entity's qualifications	The Independent Entity and team members conducting the HEIA have decades of experience in health equity, stakeholder and community engagement, public health, and healthcare. **Deborah Zahn,** the lead contact, has more than 25 years of healthcare program and policy experience and stakeholder and community engagement. She has led and facilitated local, regional, and statewide stakeholder and community engagement strategies for healthcare providers and new health initiatives; developed and facilitated community and clinical advisory panels; conducted healthcare assessments; and developed and directed initiatives focused on improving access and health outcomes for medically underserved populations. **Lynnette Mawhinney** is a health equity and qualitative research expert with 20 years of experience in education. She completed a multi-year participatory evaluation of an equity audit tool that spanned three states. She is a professor and Chair of the Department of Urban Education at Rutgers University-Newark. **Andrea Mantsios** is a public health expert with 20 years of experience in public health and healthcare. She specializes in qualitative methods to promote health equity in research, policy, and programming. She completed a health equity needs assessment for a large-scale health insurance provider to inform development of an organizational health equity. **Jenné Massie** is the Deputy Director of the

	Intersectionality Research Institute and a Faculty Senior Research Associate and Project Director for the MOCHA Lab at John Hopkins Bloomberg School of Public Health. She also serves as a Commissioner of the DC Department of Health Regional Planning Commission on Health and HIV and the Chair of the Community Engagement and Education Committee. **Melissa Corrado** has more than 20 years of experience helping healthcare and community-based entities develop and conduct assessments and implement plans. She has designed and conducted stakeholder interviews to guide planning of community initiatives and for community-based healthcare and social service providers. **Sydne Ashford** is a Consulting Associate in CohnReznick's Healthcare Industry Practice. She serves ambulatory care facilities, such as Federally Qualified Health Centers, hospitals, and mental health focused organizations, and specializes in Medicaid rate setting and cost reporting, financial and regulatory reporting, financial feasibility studies, and financial and operational performance. She also supports program development and strategic business planning efforts.
5. Date the Health Equity Impact Assessment (HEIA) started	10/21/2025
6. Date the HEIA concluded	1/13/2026

7. Executive summary of project (250 words max)
The proposed project involves the expansion of the Neonatal Intensive Care Unit (NICU) located on the 9th and 12th floors of Tisch Hospital at 550 First Avenue, New York, NY 10016. This expansion will increase the NICU's capacity to serve more patients. The expansion will be implemented through two projects: the first—and the focus of this HEIA—will be to add 6 neonatal continuing care beds volume to the 12th floor. The second project, which will be addressed in a subsequent HEIA, will add 19 intensive care beds to the hospital's operating certificate on the 9th floor. Together, these projects will increase NICU's capacity by adding 25 additional beds to the Applicant's license. The expansion will enable the Applicant to meet existing demand for NICU services. In the first year of operation, the Applicant anticipates treating approximately 209 additional patients with the new continuing care beds, with an expected increase of 241 patients by the third year capacity levels. The expansion will address the growing demand for NICU services, including support for premature infants born before 37 weeks of gestation, infants with low birth weights, those requiring extracorporeal membrane oxygenation (ECMO), major surgeries

(particularly cardiac and neurosurgery), and advanced renal replacement therapies (dialysis). Additionally, the project will enhance the hospital's capability to accommodate patient transfers from other hospitals and providers for those requiring higher levels of neonatal care.

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

All the stakeholders were in support of the proposal to expand the NICU. Both staff and some caregivers mentioned the notable increase in NICU admissions and the need for more beds. They indicated that expanding the NICU to include additional beds would enhance capacity to serve current and future patients and potentially improve the quality of care by providing more space for caregivers and family members to engage in care activities and lactating mothers to pump near the bedside. They also stated that it will provide more space for modernized equipment and enhance caregiver privacy to care for themselves while caring for their children and discuss medical matters more privately with their providers.

They also emphasized the importance of ensuring sufficient staffing, particularly for social workers and interpreters, to appropriately support the additional patients and accommodate the increased bed capacity resulting from the expansion.

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.

See Scoping Table Sheets 1 and 2 in the "Scoping Sheets" document.

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**
   - ✓ **Immigrants**
   - ✓ **Women**
   - ❑ Lesbian, gay, bisexual, transgender, or other-than-cisgender people
   - ✓ **People with disabilities**

- ❑ Older adults
- ✓ **Persons living with a prevalent infectious disease or condition**
- ❑ Persons living in rural areas
- ✓ **People who are eligible for or receive public health benefits**
- ✓ **People who do not have third-party health coverage or have inadequate third-party health coverage**
- ❑ Other people who are unable to obtain health care
- ❑ Not listed (specify):

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?

To identify the medically underserved groups that may be affected by the project, the Independent Entity used the Applicant's internal data combined with the NICU staff's direct understanding of the patient population. While the Applicant gathers internal data, it does not include information regarding immigration or disability status. To supplement this, Independent Entity referenced publicly available data pertaining to these populations within the broader service area.

- Low-income people – internal electronic medical record data, American Community Survey, 2024
- Racial and ethnic minorities – internal electronic medical record data, American Community Survey, 2024
- Immigrants – American Community Survey, 2024
- Women – internal electronic medical record data, American Community Survey, 2024
- People with disabilities – American Community Survey, 2024
- Persons living with a prevalent infectious disease or condition – internal electronic medical record data
- People who are eligible for or receive public health benefits – American Community Survey, 2024
- People who do not have third-party health coverage or have inadequate third-party health coverage – American Community Survey, 2024

Overall, a combination of internal and external data sources was used to identify the medically underserved groups impacted by the proposed project.

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

The proposed project will expand the Neonatal Intensive Care Unit (NICU) at Tisch Hospital, located on the 9th and 12th floors at 550 First Avenue, NY 10016. The expansion will be implemented through two projects: the first—and the focus of this HEIA—will be to add 6 continuing care beds volume to the 12th floor. The second project, which will be addressed in a subsequent HEIA, will add 19 licensed intensive care beds to the 9th floor. Both of these projects will increase NICU's capacity by adding 25 additional beds, which will enable the Applicant to meet existing demand for NICU services.

This proposed project will move the current newborn nursery from its current location on the 12th floor to a new space on the same floor. This will enable the Applicant to build the 6 continuing care beds in the space previously occupied by the newborn nursery. This move will free up space on the 9th floor, where there are some surge capacity continuing care beds, which will enable the expansion of 19 licensed intensive care beds.

In the first year of operation, the Applicant anticipates that the continuing care beds will be used to serve approximately 209 additional patients, with an expected increase of 241 patients by the third year.

This expansion will impact all patients, including medically underserved groups by addressing the rising demand for neonatal critical care services. It will also support the increasing volume of high-risk pregnancies, enable the creation of private rooms for families, and accommodate long-term admissions.

Stakeholders noted that current spacing issues made it challenging to engage in care with their child in multiple ways, including when feeding and pumping, kangaroo care (i.e., skin-to-skin contact), keeping equipment and supplies nearby, and maintaining privacy. Caregivers and staff detailed the challenges the space issues caused during emergency situations and events involving loss of life when other caregivers are nearby in such close quarters.

The Applicant also will continue to accept neonatal patient transfers from other hospitals for those requiring higher levels of care and continue to collaborate with regional hospitals to provide transportation services. This will ensure timely access to NICU care for neonatal patients. As a regional resource, the NICU expansion will better equip the Applicant to serve critically ill newborns requiring specialized treatments and increase their capacity for accepting transfers.

The additional beds may also allow neonatal patients to remain in their private rooms with consistent care teams as their clinical condition improves, aligning with best practices in neonatal care.

Overall, this expansion is expected to strengthen the Applicant's ability to deliver comprehensive, high-quality care to all neonatal patients in need of intensive care, including those from medically underserved groups. The Applicant anticipates the following benefits for these underserved groups:

Low-income people, people who are eligible for or receive public health benefits, and **people who do not have third-party health coverage or have inadequate third-party health coverage** will have increased access to services and reduced time, travel, and financial burdens. In Fiscal Year 2023, 36% of patients treated by the NICU within the service area relied on Medicaid as their primary payer, which serves as a proxy for low-income status and confirms eligibility for public benefits. It is also likely that many caregivers of NICU patients who are on Medicaid are themselves Medicaid recipients, which could extend the reach of the expansion to families and improve continuity of care.

NICU patients often have extended admissions that last from weeks to months, which can be a considerable time, travel, and financial burden on most families, particularly low-income families and people who do not have third-party health coverage or have inadequate third-party health coverage. This expansion should increase access to NICU services and reduce some of the burden experienced most acutely by low-income families, including those with no or not enough healthcare coverage.

Racial and ethnic minorities will benefit from improved access to services. In Fiscal Year 2023, 23% of NICU patients within the service area identified as racial or ethnic minorities.

Women will benefit through increased access to services. In Fiscal Year 2023, 45% of NICU patients within the service area were assigned female at birth. Although data on caregiver gender is not available, it is assumed that a significant proportion of caregivers are women, indicating that expanded NICU access could provide additional support to women in both patient and caregiving roles.

Birthing women will benefit from the proposed expansion with more space for designated chairs, logistical space to support and encourage bedside pumping, breast/chest feeding, or related activities. Stakeholders described the trauma of being separated from their child for days post C-section, difficulties navigating the cramped NICU spaces post-surgery, challenges traveling to the NICU once they were discharged and given their post-surgery condition, and medical complications caused by sitting upright in non-lounge style chairs due to limited space.

Immigrants, particularly those with limited English proficiency, will benefit by avoiding the need to establish new interpretation services or navigate to unfamiliar locations. The Applicant will continue to make interpreter services available throughout the care process, as noted through stakeholder feedback.

Stakeholders noted that having more space for private meeting rooms may better facilitate interpretation services, particularly when time and privacy is needed to clearly communicate important health information, make informed decisions on their babies' care, and enable caregivers to feel comfortable and empowered to ask questions of their provider and care team.

People with disabilities, including caregivers with mobility limitations, will benefit by not needing to transfer to different rooms as their clinical condition changes, which can be challenging when mobility or access needs are involved.

Persons living with a prevalent infectious disease or condition will benefit because the project will allow for designated areas for improved infection control and modernized equipment of NICU babies who need higher levels of care or intervention. For NICU babies with more severe health conditions, infection control is critical for optimal health outcomes. With limited space for isolation, the current NICU space constraints make infection control more challenging.

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?

Of the patients seen by the Applicant's NICU within the service area in Fiscal Year 2023, 36% relied on Medicaid as their primary source of payment (with Medicaid as the primary source of payment serving as a proxy for low-income populations and those eligible to receive public health benefits), 23% identified as racial or ethnic minorities, and 45% were assigned female at birth. Although the Applicant expects that the expansion will attract new patients, it is anticipated that service utilization proportions by all medically underserved groups will remain constant following the expansion of NICU.

As noted above, internal data limitations include a lack of robust data related to people with disabilities and immigrants, both for patients and caregivers. Therefore, the Independent Entity is unable to quantify current or expected utilization specific to these groups.

There is no available method to identify patients discharged from the NICU who had a prevalent infectious disease. Additionally, in 2025, seven patients, representing 1% of NICU discharges, lacked third-party health coverage or had inadequate coverage.

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

Within the service area, Neonatal ICU Beds are located at the following facilities:

Facility	County	Zip code
NYP Weill Cornell Medical Center	New York	10065

Mount Sinai Hospital	New York	10029
Mount Sinai West	New York	10019
NYP Columbia University Irving Medical Center	New York	10032
Lenox Hill Hospital	New York	10021
NYU Langone Tisch Hospital	New York	10016
NYC Health + Hospitals/Bellevue	New York	10016
NYC Health + Hospitals/Harlem	New York	10037

Source: DOH NYS Health Profiles website: https://profiles.health.ny.gov/hospital/bed_type/Neonatal+Intensive+Care+Beds

As a result of this project, the Applicant does not anticipate disruptions of service. The two projects that enable the expansion are sequenced to minimize disruption. Relevant to this first project, patients and caregivers utilizing the newborn nursery will only move once the new nursey is built, and patients using surge capacity continuing care beds will be moved to the new space once it is completed.

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

Based on volume data from SPARCS, in 2024, the Applicant's Manhattan location accounted for an 8% market share within the service area among the listed facilities, a figure that has remained steady since 2022 (SPARCS, 2024). For this analysis, market share is defined as the proportion of neonatal inpatient discharges from facilities with NICU beds within the project service area, which includes Kings and New York counties. Due to limitations in data availability related to patient privacy, it is not feasible to identify individual patients cared for in NICU beds at facilities within the service area.

Table 1: Volume and Market Share of NICU Services Provided to Patients in the Service Area, 2022-2024

Hospital Name	2022 Volume	2022 Market Share	2023 Volume	2023 Market Share	2024 Volume	2024 Market Share
NYP Weill Cornell Medical Center	1,816	25.51%	1,940	25.31%	2,226	26.37%
Mount Sinai Hospital	1,636	22.96%	1,602	20.89%	1,614	19.12%
Mount Sinai West	1,032	14.49%	1,283	16.74%	1,434	16.99%
NYP Columbia University Irving Medical Center	1,044	14.67%	947	12.37%	1,030	12.20%
Lenox Hill Hospital	592	8.31%	543	7.09%	659	7.81%
NYU Langone Tisch Hospital	570	8.01%	664	8.66%	655	7.76%
NYC Health + Hospitals/Bellevue	178	2.50%	315	4.11%	452	5.36%
NYC Health + Hospitals/Harlem	254	3.57%	372	4.85%	372	4.41%

Grand Total	7,122	7,666	8,442

Between 2022 and 2023, the neonatal inpatient discharge volume within the service area increased by approximately 7.64%, rising from 7,122 to 7,666 discharges. From 2023 to 2024, the volume continued to grow by 10.12%, reaching 8,442 discharges. Healthcare facilities serving patients in this region demonstrated consistent growth in patient volume trends across the calendar years 2022 through 2024.

Additionally, projecting future market share presents certain challenges, as publicly available data on clinic visits is limited, making it difficult to establish a baseline for market share estimates. Furthermore, assumptions regarding market share are complex to determine, given that a hospital's market position in a particular service line is also substantially influenced by the strategic activities of other hospitals—such as service line expansions or closures—which are often unpredictable.

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.

Obligations under Public Health Law and federal regulations

The obligations under Public Health Law § 2807-k (General Hospital Indigent Care Pool) and federal regulations apply to the Applicant, and the organization is currently meeting its obligations to the best of the Independent Entity's knowledge. The Applicant's obligations under Public Health Law § 2807-k (General Hospital Indigent Care Pool) and federal regulations will not be affected by the implementation of this project.

As a non-profit healthcare system, the Applicant's stated mission above all is to provide the highest-quality healthcare that patients deserve. The Applicant provides care regardless of a patient's ability to pay, and the Applicant has a financial assistance policy available to patients who are in need. In addition, the Applicant offers charity care, which covered approximately $108 million in care in FY24. In the same time period, there was another $1.3 billion gap between the cost of care for patients who are covered by government insurance programs and the reimbursement the Applicant received for that care in FY24.

The Applicant's Charity Care and Financial Assistance policy can be found online (https://nyulangone.org/files/charity-care-financial-assistance.pdf).

The Applicant also indicated that they work with patients who are under- or uninsured to assist them in enrolling in emergency Medicaid.

Impact on community services

The project will not alter the Applicant's current responsibilities.

NYULH will collaborate closely with two community-based organizations—PromptCare and AdaptHealth—that provide support to patients and their families throughout their NICU experience.

Description of 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.

The Applicant projects that 38% of visits to the NICU will be for Medicaid or uninsured patients in the first year. The overall payor mix comprises 64% Commercial insurance, including fee-for-service and managed care, 33% Medicaid, and 3% uninsured/self-pay. According to U.S. Census data, at the New York state level in 2024, the payer distribution was approximately 55% public health insurance coverage (including 19% Medicare alone or in combination, and 36% Medicaid alone or in combination), 55% private health insurance coverage, and 6% uninsured.

Description of 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.

The Applicant accounts for approximately 8% of the New York City NICU market share, totaling around 655 patients (SPARCS, 2025). In terms of medical-surgical beds, it is estimated that New York City has approximately 11,000 such beds across the five boroughs, with the Applicant representing approximately 5% to 9% of this capacity.

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.

The Applicant does not expect any staffing issues. The Applicant will hire additional staff to support the expanded services. The Applicant employs established staffing practices, including analyzing volume trends and regularly assessing staffing requirements based on patient volume, care models, and service demands. If needed and as they have been doing with the surge beds, the Applicant also flexes their staffing to accommodate patient needs.

The Applicant follows a standard recruitment process. Their recruitment process includes hiring and retaining personnel who represent the diverse populations they serve. They also are engaged in building a pipeline of candidates from the communities they serve and from historically underserved medical communities, including through an internship and mentorship programs across the five boroughs.

The Applicant implements recruitment and retention strategies—such as competitive compensation and professional development opportunities—to attract and retain qualified staff.

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

Following is a summary of civil rights access complaints against the Applicant, including a summary of the complaint and the current status of the complaint. Note these are not specific to NICU.

- 6 total complaints filed with the NYC Commission on Human Rights
    - 1 race discrimination complaint was investigated and dismissed
    - 1 race discrimination complaint was closed for administrative cause
    - 1 gender discrimination complaint is in settlement discussions
    - 3 are pending open investigation:
        - 1 related to disability access
        - 2 related to gender discrimination
- 11 total complaints filed with the New York State Division of Human Rights
    - 9 have been dismissed
        - 5 related to disability discrimination
        - 1 related to national origin discrimination
        - 2 related to discrimination of national origin, race, color
        - 1 related to discrimination of national origin, race, color, and marital status
    - 1 national origin discrimination complaint is pending an open investigation
    - 1 related to discrimination on the basis of disability, military status, national origin, domestic violence victim status, relationship or association, and opposed discrimination/retaliation is pending an open investigation

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.

The Applicant has not undertaken similar NICU projects in the last five years.

STEP 2 – POTENTIAL IMPACTS

1. For each medically underserved group identified in Step 1 Question 2, describe how the project will:
    a. Improve access to services and health care
    b. Improve health equity
    c. Reduce health disparities

The expansion of the Neonatal Intensive Care Unit (NICU) to occupy the entire 9th floor and part of the 12th floor will enhance healthcare accessibility for medically underserved

groups. This expansion will add 25 beds to the hospital's operating certificate, starting with 6 continuing care beds under this project. This will increase capacity to accommodate more patients, reduce wait times, and decrease patient transfers within the hospital, thereby improving access and overall patient experience. Stakeholders validated these benefits.

The expanded facility will specifically improve access to NICU beds for preterm infants (born before 37 weeks), low-birth-weight infants, and patients requiring advanced interventions such as extracorporeal membrane oxygenation (ECMO), complex surgeries (e.g., cardiac and neurosurgery), or therapies like dialysis. These enhancements are expected to improve health outcomes for critically ill neonatal patients.

The expansion should also improve continuity of care as it may allow patients to remain in familiar rooms with their existing care teams as their conditions stabilize, in alignment with patient-centered care practices.

Furthermore, increased capacity will enable the NICU to manage a higher volume of neonatal transfers from other hospitals. The hospital collaborates with regional facilities to facilitate timely transportation, ensuring specialized care for newborns requiring ECMO, major surgeries, or advanced therapies.

While the scope of NICU services and payor mix is expected to remain unchanged, the increased capacity will advance health equity by enabling the Applicant to serve more patients, including underserved communities. This growth aligns with the goal of expanding access to specialized care and maintaining continuity of care, thereby indirectly addressing healthcare disparities by improving resource availability for patients with higher acuity needs.

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

The expansion of the NICU will enhance health equity by increasing access to NICU services for the community, including all medically underserved groups identified. The Independent Entity does not expect there to be any unintended impacts—positive or negative—of this project for patients or caregivers and confirmed with the Applicant that staffing requirements and support services will continue to be maintained for the expanding NICU patient population

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

The Applicant offers charity care, which covered approximately $108 million in care in FY24. The level of indigent care provided—both free and below-cost services—is not

expected to be affected by this project. The Applicant follows a financial assistance policy and expects no reduction in the scope or volume of uncompensated care.

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.

Access to the facility via public and private transportation is anticipated to remain consistent. Since the project involves expanding the NICU within the same building, patients are expected to continue using the existing public transportation options to attend their appointments.

Some patients may use public transit such as the subway, bus, or ferry, while others may use Access-A-Ride Paratransit Services provided by the MTA. The closest MTA subway station will remain the 6 train at 33rd Street. The M34 and M34A Select Bus Service stops are located at 34th Street and 1st Avenue, conveniently near both the NICU and the hospital campus. Additionally, these buses serve the East 34th Street Pier, which accommodates travelers via the New York City ferry service.

The Applicant has established a process to assist patients who need transportation assistance and are unable to afford the cost. In such cases, the hospital coordinates and covers the transportation expenses to ensure patients can access their care safely and promptly. This service is available to patients who express a need, regardless of their income level.

Given the significant travel burdens that some stakeholders noted, especially for low-income caregivers, it is critical for the Applicant to continue to offer transportation assistance and ensure all families are aware of available support.

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

N/A. Kimmel Pavilion was built under the 2008 NYC Building Code including Chapter 11 – Accessibility, and as such is already compliant with the ICC A117.1(Accessible and Usable Buildings and Facilities.) ANSI A117.1 is consistent with both ADA regulations and U.S. Department of Housing and Urban Development (HUD) Fair Housing Accessibility Guidelines, and, as a publication by the International Code Council (ICC), it is compatible with the International Building Code.

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?

Although not the direct focus on this project, maternal health care services will be enhanced by the project indirectly. The additional physical space will provide benefits both pre- and postpartum, including improved infection control, access to maternal mental health and lactation services, and better care coordination for both mother and child.

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 (NYC DOHMH)

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

The Independent Entity conducted a group interview about this project with six representatives from the NYC DOHMH: two Policy Managers, a Health Policy and Engagement Analyst, a General Pediatrician, a Senior Advisor, and a Medical Director. The group noted that the proposed project has the potential to expand access to NICU services, identifying several benefits of the proposed addition of continuing care beds, additional and modernized NICU rooms/spaces, and renovated nursery. While the representatives stated that the proposed NICU expansion is generally positive as it introduces an opportunity to serve more babies and their families, they offered several suggestions on how to ensure the proposed project is equitable and best meets the needs of medically underserved communities.

The DOHMH representatives raised key points related to 1) the applicant choosing a narrow service area for the proposed project to expand NICU services rather than considering their other NICU locations in nearby boroughs; 2) ensuring appropriate and sufficient staffing to support the expansion; 3) engaging in broad community outreach to other boroughs to ensure organizations who support local residents during pregnancy and post-partum are aware of the Applicant's expanded NICU; 4) support services for caregivers such as insurance navigation, transitioning baby home safely, and mental health of caregivers and family members; and 5) enhanced data monitoring for tracking more granular data on NICU admissions.

Equitable Prioritization of Service Area

DOHMH representatives questioned how the Applicant chose the Manhattan NICU as a location to expand services in comparison to their NICU locations in neighboring boroughs without level 4 NICU care services available and/or less NICU beds overall. They recommended the Applicant review the makeup of their NICU admissions by borough to see what other NICU service areas may need additional beds and/or the option of NICU patients nearing discharge to transfer their step-down care to neighboring NICUs that may be closer to home for residents outside the service area to ease transportation barriers.

Note: The Applicant stated that this project will enable them to meet existing demand for NICU services in the service area. As part of their enterprise-wide planning process, they will continue to monitor demand for services across all geographies they serve and will plan other projects as those demands change.

Staffing

DOHMH representatives stressed the importance of hiring within community given the large population of immigrants, racial and ethnic minorities, and non-English speaking people in the service area and surrounding boroughs. They noted that while interpreter services are a helpful tool for addressing language barriers, hiring within the community would increase representation and cultural competence among the staff. Recruiting and retention practices should ensure that staff reflect the patient population and understand the medically underserved populations they serve. The representatives also recommended anti-bias training for all NICU staff.

Noting the importance of hiring more staff to maintain the necessary staff to patient ratios needed to provide quality care, the representatives highlighted the importance of hiring more physicians, rather than relying solely on nurses, residents, and fellows for coverage of the expected increased patient population. The Applicant confirmed that they consistently maintain required staffing ratios and monitor and respond to changes in patient demand.

Community Outreach

For most caregivers, NICU is not part of their birth plan and never mentioned or thought of prior to admission. DOHMH representatives suggested the Applicant do outreach to community-based organizations, particularly in neighboring boroughs to help educate community members on the NICU services available for babies/families who need them. Optimally, community outreach will engage immigrants and low-income communities through trusted local organizations who may need to access these services, so they have existing familiarity with the unit in the case that their babies are admitted to the NICU once born. This could help ease the stress some families experience in the early days post birth as they navigate the NICU.

Support Services

While expanding the number of beds will potentially increase access to critical NICU services, the DOHMH representatives also noted the importance of increasing additional services to help better support medically underserved populations. These support services include but are not limited to social work, transportation assistance, insurance assistance and navigation, residential support, and education and training for discharge such as “rooming-in” training. Specifically, representatives suggested pursuing arrangements with an organization like Ronald McDonald House which provides lodging assistance for pediatric patients and their families.

Data Monitoring

With New York and national data showing an increase in NICU admissions,[1] the DOHMH representatives recommended the applicant review their internal data for top drivers of this increase such as causes of pre-term birth. While the additional NICU beds help to address the increase in NICU admissions, researching and understanding the cause of the increase will help inform additional solutions to address the problem. The analysis of this data should examine intersectional positions including race, ethnicity, age, and disability and be made available on the Applicant's public dashboard.

The verbatim statement provided by DOHMH can be found in the Meaningful Engagement tab of the HEIA Data Table.

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

See Meaningful Engagement table in HEIA Data Table attached.

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

The stakeholder interviews revealed multiple overall benefits of the NICU expansion and modernization, including increased access to Level 4 NICU care and improved quality of care for patients and caregivers. Stakeholders expressed that the increase in space will potentially improve the quality of care by providing more space for caregivers and family members to engage in care activities and lactating mothers to pump near the bedside. They also stated that it will provide more space for modernized equipment and enhance caregiver privacy to care for themselves while caring for their children and discuss medical matters more privately with their providers, putting them slightly more at ease. Both staff and some caregivers mentioned the notable increase in NICU admissions and the need for more beds to address the increase while maintaining the current high quality of care.

This applies to all patient populations, including the following medically underserved groups:

- Low-income people
- Racial and ethnic minorities
- Immigrants
- Women
- Persons living with a prevalent infectious disease or condition
- People who are eligible for or receive public health benefits

[1] SOURCE: Increases in Neonatal Intensive Care Admissions in the United States, 2016–2023; https://www.cdc.gov/nchs/products/databriefs/db525.htm?utm_source=chatgpt.com

- People who do not have third-party health coverage or have inadequate third-party health coverage

The details are provided in Question 11 with supporting quotes.

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 meaningful engagement of stakeholders, we spoke with 21 stakeholders about the project. We conducted interviews with 3 employees representing the facility – a NICU Senior Social worker, Nurse Discharge Coordinator, and Registered Nurse; 3 representatives from local community-based organizations; 5 caregivers for patients currently receiving NICU services; and 10 members of the Family Advisory Group who are former NICU families. The stakeholders we spoke with included 4 low-income individuals; 9 members of a racial or ethnic minority groups; 3 immigrants or refugees; 17 women; 1 lesbian, gay, bisexual, transgender, or other-than-cisgender individual; 1 person with a disability; 2 older adults; 4 people eligible for or receiving public health benefits; 2 people who do not have third-party health coverage or have inadequate third-party health coverage; and 1 person who is otherwise unable to obtain healthcare.

All the stakeholders were in support of the proposal to expand the NICU.

All Patients

While most caregivers praised the quality of care they received, they noted that spacing concerns made it challenging to engage in care with their child in multiple ways. Current spacing on the NICU posed challenges for feeding and pumping, kangaroo care (i.e., skin-to-skin contact), keeping equipment and supplies nearby, and maintaining privacy. Caregivers and staff detailed the challenges the space issues caused during emergency situations and events involving loss of life when other caregivers are nearby in such close quarters. Caregiver 006 described a traumatic experience being trapped in the designated pumping space in the NICU while another patient was having a medical emergency:

> "A private place to pump would have been necessary for me… one time, we were pumping, and there was a baby that went into crisis, and they needed to bring the crash team, and it was an hour, hour and a half before the team cleared. We were stuck in that pumping area behind the curtain for that whole time. So, I couldn't get out, I couldn't get back to my babies. We couldn't leave. None of us could get back to our babies…We had to sit there and listen to the whole thing happen as our babies were in the next bay over…And so I think having a separate area to pump…Having a designated pumping area I think is important and even essential. No mom should have to be trapped behind a curtain, listening to someone else's baby crash." – Caregiver 006

Due to limited NICU and continuing care beds, patients who are closer to discharge are sometimes moved to other units, such as the PICU, to accommodate overflow. Caregivers and staff described the challenges of having to move to other units due to limited beds:

> "We're constantly having babies being born that need the NICU…sometimes we're having to move NICU babies, and then sometimes they're having to look for other beds in the PICU or in other areas of the hospital like the general pediatric floor, where I think our population would be better served here, so we definitely need the beds." – Staff 003

Both current caregivers and staff members mentioned that the current lack of beds is a stress point for everyone. Nationwide, NICUs have been seeing a steep increase in admissions. One staff member explained that the main focus has been a need for beds for patients:

> "We're always having admissions. We've been very busy lately. I think it's just the new normal now. I'm hearing all the time about 'Needing beds, needing beds. We have this many beds left.' Focusing on discharges. If we had the appropriate amount of beds, we could be more focused not on that aspect of discharge." – Staff 001

One current caregiver mentioned that she has observed firsthand the need for more beds and that this proposed expansion would address the limited capacity to meet current need:

> "The positive impact is that there is more space for cases. And I've certainly seen cases, from my purview or heard, cases need to come here, but there's no bed. So having more beds, you will still run into the issue of capacity, but it is a positive." – Caregiver 003

Yet, this caregiver also cautions that just adding more beds needs to be mitigated with consideration of staffing needs:

> "However, just adding more beds, in and of itself, is just one thing. It allows the NICU to service more people, but the NICU also has to provide those services and needs to have enough staffing… There's also a staffing issue. The NICU is already understaffed. If there are more beds, and there's not special staffing, that would be concerning. If the plan intends to mean more beds with more space, more nurses, and more space for the parents and child to potentially see more privacy, but that comes at a cost." – Caregiver 003

Another current caregiver emphasized the same message that more space needs to be accompanied by more staffing saying:

> "If there was more space, I feel like there could be more opportunities to bring more nurses. It's definitely with staffing. Sometimes you might not see a nurse for

> a while. You know, nurses that you've gotten familiar with. And so that I think they would be able to be in the new unit, they wouldn't be moved around too much." –Caregiver 004

Ultimately, most stakeholders mentioned that the expanded beds, especially beds with privacy, are needed as long as there is proper staffing to follow the growth of the expansion. If spacing and staffing are done well, one staff member mentioned that this will help to mitigate the current stress that care teams are feeling that moves down to families:

> "Obviously, we're not just focused on that [more beds], but it does take up some brain space to think about we're everyone's gonna go. I think it would be wonderful to have back because when we did have the right amount of beds, and we weren't capped all the time, there was a less level of stress on the care team. And also, inherently, families will feel that everyone is not feeling…everyone kind of has more space." – Staff 001

Finally, stakeholders noted the importance of caregivers feeling welcome at their baby's bedside, starting with ensuring that any caregiver who wishes to be present has a comfortable chair available when they arrive, along with space to provide bedside care such as kangaroo care and feeding. Being able to receive support services by their baby's bedside (e.g., massages, mental health counseling, social work visits, etc.) was an important part of quality care. Caregivers felt additional space will make support services more accessible without disrupting their babies' daily routine care and service delivery within the NICU.

Low-Income People, People Who Are Eligible For or Receive Public Health Benefits, and People Who Do Not Have Third-Party Health Coverage or Have Inadequate Third-Party Health Coverage

NICU patients often have extended admissions that last from weeks to months, which can be a considerable burden on most families, particularly low-income families. The extended stay can have a complex impact on time, travel, and consequently financial burden on low-income families who want to engage in their child's care daily. Caregivers described multi-million-dollar healthcare bills, multiple-hour daily commutes using public transportation, and limited visitation because of having to return to work. Staff also discussed challenges with communication and accessing digital dashboards for families that lacked access to technology.

One caregiver detailed the financial and mental impact extensive NICU-related medical bills can have on low-income, medically uninsured families and the importance of Medicaid navigation, even for those with insurance:

> "I think for somebody that doesn't have private insurance, where you're getting the bill… I will tell you she was born at the end of November; by February, I had a $3 million bill. So, if you're somebody that doesn't have insurance and doesn't

> understand how that works, and you've got a $3 million bill that lands in your mailbox. It's terrifying." – Caregiver 008

They went on to describe the lengthy process of Medicaid navigation and reimbursement and highlighted the importance of the Applicant's social work team in providing Medicaid navigation.

Staff described the importance of caregiver involvement in daily care regimen, including feeding and kangaroo care to improve the health outcomes of NICU patients. Given that caregiver presence and involvement is a key to quality care, support for insurance navigation, financial support, transportation support, residential support, additional means for communication (e.g., AngelEye Health live video feed), and flexible visitation and care hours are critical to better serve NICU patients from low-income families. Recognizing that many families face complex responsibilities, such as caring for other children, that limit their ability to be at the bedside, it is critical to provide services that enable caregivers to engage in their baby's care as much as they wish, regardless of income, work schedule, or other constraints.

Racial and Ethnic Minorities and Immigrants

Caregivers, staff, and other stakeholders consistently identified linguistically accessible and culturally responsive care as critical aspects to ensuring equitable service delivery. Stakeholders noted that having more space for private meeting rooms may better facilitate interpretation services, particularly when time and privacy is needed to clearly communicate important health information, make informed decisions on their babies' care, and enable caregivers to feel comfortable and empowered to ask questions of their provider and care team. In addition to having interpretation services, caregivers and staff noted that having translated paper resources in multiple languages could benefit non-English speaking families. Staff noted that there is currently limited space to host paper communication or resources for families. Caregiver 010 detailed a fellow NICU caregiver who was non-English speaking and had limited access to lactation information, highlighting the negative impact of language barriers:

> "This woman didn't have those resources, and therefore found that it was affecting her milk supply, and that eventually she wasn't able to produce milk, and she just didn't have the framework to support that part of it [her child's care] that she wanted to be involved in…I don't know what kind of resources were available to help her understand that part of the journey, and in addition to caring for her son." – Caregiver 010

Considering the large population of racial and ethnic minorities served by the unit, stakeholders also noted barriers to communication for those caregivers that cannot use technology for religious or cultural reasons. Additionally, the limited space also created barriers for kangaroo care, pumping, and breast/chest feeding for caregivers that required private space for cultural, religious, and personal reasons.

Accordingly, the proposed project should ensure that there are space, communication resources, and culturally competent staff to help support the language, care, and additional support services needed to best serve immigrants, racial and ethnic minorities, and non-English speaking populations.

Women

The proposed expansion would allow for more space for there to be designated chairs for birthing women, logistical space to support and encourage bedside pumping, breast/chest feeding, or related activities. This will mitigate the current concerns outlined by current caregivers, former caregivers, staff, and community-based organization representatives.

Women and birthing people faced challenges fundamentally caused by the limited space in the current NICU. Stakeholders described the trauma of being separated from their child for days post C-section, difficulties navigating the cramped NICU spaces post-surgery, challenges traveling to the NICU once they were discharged and given their post-surgery condition, and medical complications caused by sitting upright in non-lounge style chairs due to limited space.

One issue is that there are limited chairs by the bedside. Caregivers often strategically coordinate the time of their visit or are forced to wait to acquire a chair. One former caregiver explained she had to wait hours before getting a chair:

> "They have some chairs for parents to sit on but not really. Like, what would happen is I would stand nearby, and I guess for an hour or two. They realized I was gonna be there all day, then they would go find the seat and bring it to me. But it wasn't like there was an actual place where you can sit for me to be able to watch from a close distance." – Caregiver 015

A current caregiver mentioned that getting a chair to sit in and sufficient space to comfortably spend time by the bedside is still a challenge. She mentioned that "staff bring a chair every day" but ultimately, "that pod is really cramped. Really, there is nowhere to sit. There was nowhere to put things. Ostensibly, there is a cabinet behind the bed…it was a logistical challenge" (Caregiver 003). The logistical challenges of space impacted women's ability to hygienically pump and breast/chest feed bedside.

The lack of space to sit is a two-fold issue. First, most women and birthing parents with children in the NICU most likely have had a medically complex and/or emotionally traumatic birthing experience. For example, birthing mothers who had C-sections prior to their child/children's NICU admission and are recovering from the surgery. One caregiver talked about navigating the NICU on the heels of having had a C-section:

> "I had a C-section, and when I got discharged, I had a hard time getting dropped off up here if I didn't have my husband or someone to help because it was pretty hard for me to walk for the first two weeks. Once I started to be mobile, it was a lot easier, and because my husband had to go back to work." – Caregiver 005

Caregivers stated that navigating both getting to the NICU and the challenge of getting a chair in the NICU after having a C-section further complicating their recovery. A staff member even discussed the importance of a chair after a C-section:

> "Even come down and have a comfortable place to sit and stay and hold their baby a day after a C-section is very huge. And yes, we have that everyone has the ability to hold and do skin-to-skin. It's just, again, cramped." – Staff 001

The importance of having a suitable chair for post-surgery birthing women was echoed by Caregiver 013 who detailed undergoing secondary surgery due to scar tissue caused by sitting up-right in rigid office chairs during her daily NICU visits. Additional space to accommodate more lounge chairs would have made these secondary complications avoidable.

The second issue with not having a chair due to limited space is that having a chair ready helps create a welcoming environment for women and birthing parents after a traumatic event. The representative of a community-based organization stated:

> "There should be a chair available at every bedside for every parent, whether they use it or not. Because what does that chair represent? That there's a place for you, and you are paramount…There was not a chair available. You had to ask, which felt really uncomfortable. If a mom has to ask for a chair, doesn't that automatically signal to her that they just didn't already make a place for her, that she wasn't already assumed to be part of the story. Many times, mothers then don't ask for a chair because they feel kind of weird about it." – CBO 002

One current caregiver explains that having more space for a chair makes the environment calmer for both mother and baby:

> "And more, honestly, less for me and more for a baby to just have a calmer environment while she's out of the incubator. It's a lot more noise and stuff like that she's not used to…definitely having more space to just bring in a chair to do skin-to-skin." – Caregiver 005

Not having a chair also means there is no place to sleep overnight to help recovery for a birthing woman. One caregiver described, "The thing that's missing is a place to sleep. You can't sleep in the same cube…they let me just stay up." (Caregiver 003).

A staff member also talked about the impact of not being able to stay overnight:

> "Because of our limited space that parents are not able to stay overnight by the bedside. I think that would be a major change. We have seen the benefits of it over in the other parts of the Children's Hospital, and I think especially if someone is recovering from childbirth, having the ability to decide, 'hey, I may not go home tonight, I'm going to sleep at the bedside,' that will improve a patient's, the family's well-being overall. Especially if the child is critically ill, and they don't feel they can leave the bedside." – Staff 001

As previously mentioned, the lack of appropriate space and logistics makes pumping and breast/chest-feeding bedside difficult, given the limited space, privacy, and inadequate number of kangaroo/lounge chairs that the space could accommodate. While there is a designated pumping area, caregivers often described the pumping area within the NICU as a “closet” with a curtain that did not provide adequate space for privacy or hygienic pumping practices.

Several stakeholders, both caregivers and staff, reflected on how the lack of space impacts the mental health of the birthing parent. Since there is currently minimal space between babies, there is no privacy when discussing medical matters with clinicians. Birthing parents described having to delay conversations with their OB/GYN post birth because of lack of space for medical team members and families in the bay. One current caregiver described this discomfort with the lack of privacy as follows:

> “I’m very conscious about people’s personal space. There are other families there who are getting updates on their baby or different things going on. You feel like you’re sort of in people’s privacy a bit. You can’t help but to be there, and then someone’s talking to them, and I try to be as considerate as possible, walk out of the pod a little bit, but it’s just so impossible or hard for you not be in people’s personal space.” – Caregiver 004

This lack of privacy can lead to secondary trauma for the surrounding birthing mothers. One community-based organization’s representative explained the mental health burdens that come with close proximity of the babies:

> “When you talk about the mental health effects, you know the post-traumatic stress disorder or even just traumatic stress, hearing the added layers of the other sounds and other alarms from other babies who may be much, much sicker than your own. We have so many, unfortunately, I’m one of those too, but we have so many first-hand stories from parents. Who have witnessed the death of another baby very close to where they are. When you’re in an open baby or pod, you’re not protected from any of those kind of secondary trauma factors. So, you’re witnessing your baby hearing the demise or the struggles of other families, other families who are in grief, who are crying, who are upset with staff.” – CBO 002

Both a staff member and CBO representative said how this lack of privacy when discussing serious and complex medical matters can lead to caregivers comparing their situation against that of others and can really impact the mental health of the birthing mothers:

> “Having those private conversations and you’re constantly seeing what’s going on in the pod around you, and it’s hard not to compare yourself to what you are seeing across the hall. I think it has a mental health impact, and it also has concerns of, ‘could this happen to my baby.’ We see that a lot.” – Staff 001

> "You're privy to conversations that are just really difficult, that don't relate to your baby. You being comparing. And there's just so much lost in the bonding experience, when you can't just privately, skin-to-skin, with your gown open, holding your baby on your body for as long as you frickin' want without the interruption." – CBO 002

The proposed expansion facilitating more privacy in NICU rooms will lessen the mental health burdens on birthing mothers.

> "Just by having the nature of a NICU admission and really just have that privacy that they need to bond with their child and feel that not everyone around them can hear what's happening…Even in private rooms, not everything will be private, but the ability to have more options for families where private rooms would be appropriate…the feedback parents have given to be able to benefit from the private rooms, and not just from a medical reason, shifts the experience in the NICU." – Staff 001

Individuals with Prevalent Infectious Diseases or Conditions

For NICU babies with more severe health conditions, infection control is critical for optimal health outcomes. With limited space for isolation, the current NICU space constraints make infection control more challenging.

> "The pods allow you to get to know other parents but also carry a higher infection risk because not everyone chooses to wear a mask in flu season. Also, the beds are close to each other. If someone's getting an X-ray, their baby's gonna get X-rayed too." – Caregiver 003

As alluded to by Caregiver 003, there is the added complication with babies getting X-rayed and the pods being less than the standard 6 feet away from each other. This was also mentioned by another caregiver who explained:

> "If a baby next to you needs X-ray, there's no way for your baby to really be out of the way. If you're there, you can step away or step out of the pod, but your baby, there not 6 feet away to be out of the zone of exposure. There's really nothing that you can do about it because you can't move your baby out of the way. So, in the pods, if another baby's getting the X-ray, your baby is sort of going with them." – Caregiver 004

The addition of beds and space will allow for designated areas for improved infection control and modernized equipment of NICU babies who need higher levels of care or intervention.

Stakeholder Concerns | Potential Negative Impact

While not specifically related to health equity, stakeholders did have concerns and notes of potential negative impact of the proposed project. All stakeholder groups noted the delicate balance of noise pollution that NICU patients and caregivers experience in the

current open-bay layout of the unit in contrast to the potential inadequate noise and interaction for babies if they are isolated in the proposed project. A NICU caregiver detailed the high level of noise pollution currently being monitored on the unit:

> "You're also drowning in noise from everyone's beeping monitors. The noise in [Room] 911, there's a noise monitor over on that side. It's constantly over what you're supposed to have babies." – Caregiver 003

However, single-family accommodations pose the risk for inadequate stimulation for NICU patients. This risk can be compounded for medically underserved groups such as low-income working families that may be limited in their visitation hours due to the social and structural barriers detailed above. Stakeholders suggested using current research and support services to ensure all NICU patients and caregivers are exposed to an appropriate amount of noise and interaction. A staff person thoroughly described means to mitigate this potential negative impact:

> "There are studies that talk about potential speech delay because of the lack of stimulus. So you go from complete overstimulation and your neural circuits going haywire, to underdeveloped neural circuits because there are potential too much quiet…I think those studies by Pineda were amazing, they're pivotal, important for us to know, but there are things that we can do, it's not a reason to not have single rooms. So, what can we do? There are also studies by the Nurture Science Program that talk about parent voice, and the power of parent voice, encouraging our parents to speak softly, quietly, singing to baby… even when we have a unit with single-family rooms, we have twin rooms, and so if we have a baby that we know is going to not have visitors very much, we're putting that baby in a twin room with another baby. There are ways to mitigate this, mindfully. There are also child life specialists. There are opportunities to use parent advisors. There are opportunities to use snugglers. There are lots of opportunities to give appropriate feedback to these babies. A very overcrowded pod is not appropriate feedback." – Staff 002

In addition to establishing appropriate staffing levels to serve the expanded unit and providing support services to caregivers (discussed above), caregivers and staff noted that in order to maintain and potentially improve the current level of care provided by the NICU, improved communication will be important for equitable service delivery to all patients and particularly the medically underserved groups detailed above. Standardized communication for caregivers was seen as critical to ensure that all patients, including those from medically underserved groups, are receiving quality care. However, caregivers detailed varying experiences with communication and connection with support services. For example, although all stakeholder groups acknowledged the critical role social workers play during NICU care, introduction to the social work team widely varied. One caregiver noted being connected to the social work team prior to having emergency birth and feeling burdened by repeated social work visits during her child's NICU stay. Another caregiver was not aware there was a social work team until

one month into her child's stay, despite her daily NICU visits. Given that immigrants, racial and ethnic minorities, women, and low-income people often face numerous barriers to engaging in their baby's care, standardized communication is essential to making sure caregivers have an equitable opportunity to be informed of the services available to support them in engaging in and making informed care decisions. The expansion of the NICU unit and care team only heightens the need for coordinated, standardized communication within the care team and between the care team and NICU families.

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

The following medically underserved groups did not participate in the meaningful engagement portion of the HEIA:

- Persons living in rural areas
- Person living with a prevalent infectious disease or condition

STEP 3 – MITIGATION

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

The Applicant will implement multiple strategies to inform patients' caregivers and community members about the changes in services and care availability resulting from the project. To effectively communicate with individuals with limited English proficiency, the Applicant plans to adopt a comprehensive language access strategy. This includes translating all relevant materials, such as marketing flyers, press releases, and signage within the facility, into the most spoken languages within the community. Additionally, signage at current locations will display information in both English and Spanish, clearly indicating the expansion of the NICU. Letters explaining the move will be sent in both languages to current patients' caregivers, and NICU staff will communicate these details during patient appointments and via telephone calls as needed.

The communication plan will also include outreach to targeted publications that serve individuals who speak languages other than English. The website will be updated with information regarding the move, and social media posts will be made to further disseminate this information. (Note that the majority of these communications will be in English.)

To support interpretation needs, the Applicant will supplement in-person interpreter services with VOYCE™, a language interpretation application integrated into the EPIC electronic health record (EHR) system. This app provides access to real-time medical interpretation in over 240 languages and dialects, including American Sign Language.

Additionally, the Applicant will continue their existing process of greeting patients' families at the hospital entrance, assisting with check-in, and providing clear instructions regarding the appropriate floor and room for visiting their newborn.

To address concerns about communication between caregivers and the medical team, the Applicant will provide caregivers with information about scheduled rounds. When possible, caregivers will have the opportunity to speak directly with the medical team; if they are unable to attend, a team member will follow up with them via phone at a convenient time.

For individuals with speech, hearing, or visual impairments, the Applicant employs digital accessibility practices aligned with the Web Content Accessibility Guidelines (WCAG) 2.2, the industry standard for ensuring equitable access for users with disabilities. This includes providing alternative text for images, captions for videos, and ensuring all digital content can be navigated via keyboard for users unable to use a mouse.

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

Stakeholders had the following specific suggestions for how the project can better meet the needs of NICU patients and their families as they considered the impact of the expansion:

Consult with Family-Centered Care Task Force. One community-based organization representative mentioned the Family-Centered Care Task Force out of Stanford University. They are a research hub that has data on the effects of family-centered care within NICUs. Consulting with the Task Force prior to the finalization of proposed plan could help ensure that common concerns are addressed during the expansion.

Explore Opportunities for Residential Support. Stakeholders noted that there is a significant commute and travel burden related to daily visitation, particularly for low-income families living in neighboring boroughs. In addition to the transportation support, parking vouchers, and flexible visiting hours recommended by other stakeholders, the Applicant should explore opportunities to provide residential or lodging support. Similar to pediatric cancer-care models where patients and caregivers require extended admission stays for treatment, DOHMH stakeholders suggested the applicant inquire with organizations such as the Ronald McDonald House on opportunities to provide lodging support for low-income NICU caregivers and families. Related to this inquiry, they suggested the Applicant explore providing NICU families with the option to have step-down care transferred to the Applicant's NICU units in neighboring boroughs that

may be closer to patient's residence. While this option may not be feasible in all cases given fluctuation in NICU patient care needs, the option could mitigate travel and commute burden for some families.

Standardize and Expand Communication. All stakeholders stressed that clear communication between the caregivers and NICU medical team/staff are a critical aspect to ensuring high-level equitable care. With medically underserved groups facing a multitude of challenges caused by the complexity of their intersectional-position (e.g., language barriers, health literary, limited availability for visitation, technology barriers, limited privacy, etc.), having diverse means to communicate pertinent information to all caregivers is key. This should include a combination of digital, remote, and printed resource materials in multiple languages common for the patient population. The Applicant should also consider additional digital access resources for caregivers such as AngelEye Health live video feeds, often offered in NICUs as an additional means for caregivers to engage in their child's care and for staff to communicate updates when caregivers cannot be physically present on the unit. Finally, communication about standard resources, such as social workers, care coordinators, and transportation assistance, should be introduced to caregivers upon patient admission.

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

The Independent Entity provides three recommendations. First, the Applicant should speak with the current caregiver population once the expansion has been completed. Their insights will be critical to understanding how best to support their needs and accommodate the patient and caregiver experience for members of different medically underserved groups receiving NICU services. Second, the Applicant should implement a caregiver engagement coordinator to gain insights from NICU caregivers on an ongoing basis. This suggestion came from a CBO representative:

> "At [hospital name], they actually have a staff member that is so unique. I haven't heard of many of them…they're a parent engagement coordinator. And [person's name] sole job is to get to know each and every family, to show up in their room, Twenty-four-hour admission with one of [CBOs] care packages with some items in it, some personal care hygiene items and things like that, but more importantly, resources so that they know that they're not alone." – CBO 002

Third, the applicant should engage with community-based organizations and non-level 4 NICU facilities in the neighboring boroughs. Many of the NICU patients reside in neighboring boroughs and may even be transferred to the proposed unit given the elevated care provided. Engaging with stakeholders serving patients and caregivers that reside in these communities can help provide insight on how best to support medically underserved patients traveling from these areas.

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 care by providing a 25-NICU bed expansion. The proposed project would provide space for birthing parents to sit and bond with their child while recovering from childbirth, reduce mental health burdens on the birthing parent and child, and offers the possibility of less exposure to pathogens for an already particularly vulnerable population of neonates.

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?

At the institutional level, NYU's Institute for Excellence in Health Equity develops, implements, and disseminates evidence-based strategies to promote health equity in clinical care, medical education, and research. The Applicant has developed a health equity impact dashboard and has enhanced efforts to collect self-reported demographic data within the electronic medical record to better monitor the effects of various projects on medically underserved populations. This dashboard specifically includes data on Neonatal Intensive Care Unit (NICU) patients across all services and captures information such as race, ethnicity, gender/gender identity, age, preferred language, socioeconomic status, insurance type, median household income, and other relevant factors. The Applicant will utilize this dashboard and data to identify and address health disparities throughout the implementation of projects.

Furthermore, dashboards are used to monitor and evaluate multiple outcome measures within the NICU. These measures include hospital mortality rates, mortality events, 30-day readmission rates, and observed-to-expected length of stay. The Applicant can analyze these metrics based on demographic variables such as age, gender, insurance provider, and primary language, enabling the identification and mitigation of health disparities.

In addition, children's health services and outcomes are monitored through an existing dashboard, which provides a comprehensive overview of health and healthcare services for newborns across the NYU Langone Health delivery system. The NICU's safety and quality committee reviews this dashboard at least monthly and follows a standardized process for addressing areas requiring improvement.

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?

The Applicant may consider implementing new strategies, such as requiring health equity training for staff and incorporating questions related to health equity into consumer satisfaction surveys. Using the definitions provided by the state, the Applicant can also revise their internal dashboards to report changes in metrics for the specified

medically underserved groups, ensuring alignment with the measurement and monitoring practices of other organizations and New York State. Additionally, ongoing engagement with patients' caregivers involved in this process, as well as community groups, can provide valuable qualitative feedback regarding the reception of these changes and suggestions for improvement. This approach will support the successful implementation of the project and inform future initiatives of a similar nature.

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, Joseph J. Lhota, attest that I have reviewed the Health Equity Impact Assessment for the Tisch Hospital NICU that has been prepared by the Independent Entity, Deb Zahn Consulting, LLC.

Joseph J. Lhota

Name

Executive Vice President and Vice Dean, Chief of Staff, Chief Financial Officer

Title

Joseph J. Lhota

Signature

Jan 26, 2026

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.

NICU Mitigation Plan

Through this initiative, NYULH aims to enhance the patient and family experience while ensuring that neonates receive comprehensive, lifesaving care. The HEIA has identified important stakeholder considerations; we are currently in the early planning stages and committed to addressing these considerations:

- **Increased Demand**: This project increases our current certified bed capacity of 25 beds to more closely align with actual daily utilization and improves physical space through flexible room designs capable of accommodating varying levels of acuity.
- **Physical space**: The updated room designs will incorporate adequate space for visitor seating, therefore mitigating current issues with having enough floor space for chairs.
- **Staffing**: Maintaining appropriate staffing levels is a key component of our approach. NYULH will determine optimal staffing configurations based on trends in volume and acuity, supported by proactive recruitment efforts prior to opening, competitive compensation packages, opportunities for professional development, and a positive work environment. We will implement evidence-based staffing ratios to ensure that families maintain consistent and reliable access to medical teams.
- **Medicaid Navigation**: To promote equitable access and reduce barriers, Medicaid navigation will be integrated into routine caregiver support. On-site financial counselors and social workers will assist families with enrollment, eligibility verification, managed care selection, and renewal processes. They will also coordinate prior authorizations for transportation, medications, durable medical equipment, home nursing, and follow-up care. Additionally, a standardized transition-of-care process will ensure continuity after discharge.
- **Equitable Prioritization of Service Area:** NYU Langone Health cares for all patients regardless of their origin, and there is no “prioritization” of service areas. While this project is located in Manhattan, it supports patients from every borough and beyond. The specialists required to care for the most vulnerable babies in a regional perinatal center are physically located at Hassenfeld Children’s Hospital, so this is the ideal place to expand services. There will be consistent reviews of opportunities to care for patients in nearby boroughs and clinical pathways will be put in place to transfer patients to NICUs closer to their homes once they’re healthy enough to transfer to a lower acuity NICU.
- **Community Awareness:** NYU Langone Health will create marketing materials that make residents and members of the community aware of the care available in the expanded NICU. This will be completed in general marketing and can be integrated into the care NYU Langone Health provides in the obstetrics and gynecology practices throughout the NYU Langone Health ambulatory network.
- **Support Services:** NYU Langone Health’s Sala Institute for Child and Family Centered Care provides family resilience and support services for families. These

services include social work, nutrition, child life specialists, psychologists, creative arts therapy, pain management, palliative care and spiritual support. These services will increase as part of the expansion to ensure there are resources to support families with insurance navigation, mental health care and any other support needs they may have. Additionally, a care coordination program will be created as part of the Sala Institute, which will also support families as they transition home.

Key performance metrics—including occupancy rates, length of stay, transfer rates, staffing fill rates, interpreter utilization, Medicaid enrollment completion, authorization processing times, and caregiver satisfaction—will be monitored regularly. We will engage stakeholders continuously for quality improvement and apply an equity-focused approach to ensure services remain accessible across different languages, insurance types, and socioeconomic backgrounds.

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: Deb Zahn Consulting, LLC
2. Is the Independent Entity a division/unit/branch/associate of an organization (Y/N)? N
   - ❑ If yes, indicate the name of the organization:

     _____

3. Is the Independent Entity able to produce an objective written Health Equity Impact Assessment on the facility's proposed project (Y/N)?
   Y
4. Briefly describe the Independent Entity's previous experience working with the Applicant. Has the Independent Entity performed any work for the Applicant in the last 5 years?

   Deb Zahn Consulting, LLC has worked or is working with the Applicant on previous HEIAs. The Independent Entity has not worked with the Applicant in the last 5 years.

Section 4 – Attestation

I, Deborah Zahn (individual name), having personal knowledge and the authority to execute this Conflict of Interest form on behalf of Deb Zahn Consulting (INDEPENDENT ENTITY), do hereby attest that the Health Equity Impact Assessment for project NICU Expansion (PROJECT NAME) provided for NYU Langone Health (APPLICANT) has been conducted in an independent manner and without a conflict of interest as defined in Title 10 NYCRR § 400.26.

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

Signature of Independent Entity: _____

Date: 1 /15 / 2026

SOW 9: NICU Health Equity Impact Assessment

100% Complete

Deb Zahn Consulting, LLC
347-834-5083
PO Box 529
Ghent, NY 12075

Billed To
NYU Langone Health
One Park Avenue, 4th Floor
New York, NY 10016

Date of Issue
01/21/2026

Due Date
02/20/2026

Invoice Number
000177

Reference
Vendor ID:
0000012112

Amount Due (USD)
$69,042.41

Description	Rate	Qty	Line Total
Independent Entity Project plan and management, NYULH meetings and communication, team meetings and communication, engagement plan, instrument design, engagement, report writing and editing, data and data review	$69,042.41	1	$69,042.41

Subtotal	69,042.41
Tax	0.00
Total	69,042.41
Amount Paid	0.00
Amount Due (USD)	$69,042.41

Terms
Payment within 30 days