EXECUTIVE SUMMARY

Kings County Hospital Center (KCHC, the "Hospital"), a 624-bed acute care hospital located at 451 Clarkson Avenue, Brooklyn (Kings County), New York 11203, and a member of New York City Health + Hospitals (H+H), is submitting this Limited Review Application seeking New York State Department of Health approval to: 1) Decertify five (5) Chemical Dependence – Detoxification beds; and 2) Convert the remaining 25 Chemical Dependence – Detoxification beds on KCHC's operating certificate to 25 Medical/Surgical beds (med/surg). The new total certified bed capacity of the Hospital after project completion will be 619 beds. There is no construction proposed for this project. A Health Equity Impact Assessment has been completed for this project, which is included with this submission.

The 30-bed Chemical Dependence – Detoxification ("detox") unit was temporarily closed on March 23, 2020 as part of the Hospital's COVID-19 Emergency Plan. The Hospital subsequently decided to permanently close the unit due to underutilization and a Provider Termination Plan was submitted to the Office of Addition Services and Supports (OASAS) on December 3, 2020 and subsequently approved by OASAS and the Substance Abuse and Mental Health Services Administration (SAMHSA). As a result, OASAS has already decertified the detox beds at the Hospital. This decision was based on a paradigm shift in the treatment of substance use disorders away from inpatient care and toward Medication Assisted Treatment (MAT), which is provided on an outpatient basis.

The proposed additional med/surg beds at KCHC are needed in order to be able to reduce congestion in the Hospital's Emergency Department (ED). The ED admits an average of 18 medicine patients per day, with the actual number of admissions ranging from 17 to 30 on any given day. However, an average of 36 patients per day are in the ED for an extended duration due to lack of available inpatient med/surg beds. The proposed additional med/surg beds will also improve overall throughput of patients in the ED. KCHC's ED has seen a steady increase in visits from 83,629 visits in FY 2021; 97,075 visits in FY 2022; and 109,196 visits in FY 2023. Reducing overcrowding in the ED will improve the patient experience, including providing more patient privacy.

The Hospital's 246 existing med/surg beds are consistently operating at 100% occupancy. The closure of nearby Kingsbrook Jewish Medical Center has also exacerbated the need for additional med/surg inpatient capacity in Brooklyn. In addition, Brooklyn has a large complement of patients with an Alternate Level of Care (ALC) status. These patients are no longer acutely ill but cannot be discharged safely to home or another appropriate care setting (i.e., nursing home). These circumstances have further contributed to the need to increase the number of med/surg beds at KCHC.

KINGS COUNTY HOSPITAL CENTER

SITE INFORMATION

Alternate contact: Anna Gorny
Email address: Anna.Gorny@nychhc.org

Type of Application: Establishment ☐ Construction ☐ Administrative ☐ Limited ☒
Total Project Cost: $398,413

Operator Information:
Operator: Kings County Hospital Center
Address: 451 Clarkson Avenue, Brooklyn (Kings County), New York 11203
PFI number: 1301

Project Site Information:
Project Site: Kings County Hospital Center
Impacted site: 451 Clarkson Avenue, Brooklyn (Kings County), New York 11203
PFI number of impacted site: PFI 1301

Site Proposal Summary (maximum of 1,000 characters):
Kings County Hospital Center (the "Hospital"), a 624-bed acute care hospital located at 451 Clarkson Avenue, Brooklyn (Kings County), New York 11203, and a member of New York City Health + Hospitals, is submitting this Limited Review Application seeking New York State Department of Health approval to: 1) Decertify five (5) Chemical Dependence – Detoxification beds; and 2) Convert the remaining 25 Chemical Dependence – Detoxification beds on KCHC's operating certificate to 25 Medical/Surgical beds. The new total certified bed capacity of the Hospital after project completion will be 619 beds. There is no construction proposed for this project.

Modify Name/Address: N/A – no change

Beds:

Category	Code	Current Capacity	Add	Remove	Proposed Capacity
AIDS	30		☐	☐	
BONE MARROW TRANSPLANT	21		☐	☐	
BURNS CARE	09		☐	☐	
CHEMICAL DEPENDENCE-DETOX *	12	30	☐	☒ 30	0
CHEMICAL DEPENDENCE-REHAB *	13		☐	☐	
COMA RECOVERY	26		☐	☐	
CORONARY CARE	03	8	☐	☐	8
INTENSIVE CARE	02	32	☐	☐	32
MATERNITY	05	30	☐	☐	30
MEDICAL/SURGICAL	01	246	☒ 25	☐	271
NEONATAL CONTINUING CARE	27	10	☐	☐	10

NEONATAL INTENSIVE CARE	28	10	☐	☐	10
NEONATAL INTERMEDIATE CARE	29	10	☐	☐	10
PEDIATRIC	04	28	☐	☐	28
PEDIATRIC ICU	10	7	☐	☐	7
PHYSICAL MEDICINE & REHABILITATION	07	23	☐	☐	23
PRISONER				☐	
PSYCHIATRIC**	08	190	☐	☐	190
RESPIRATORY				☐	
SPECIAL USE				☐	
SWING BED PROGRAM				☐	
TRANSITIONAL CARE	33		☐	☐	
TRAUMATIC BRAIN INJURY	11		☐	☐	
	TOTAL	624	☐ 25	☐ 30	619

Services: N/A – no change

Remove Site: N/A

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. ***N/A – Applicant is a hospital.***

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 less than or equal to $6,000 for all other facilities are eligible for a Limited Review.*	☒	☐

Establishment of an operator (new or change in ownership)	**Yes**	**No**
Is the project an establishment of a new operator or change in ownership of an existing operator providing services or care, AND will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?	☐	☒
Mergers, consolidations, and creation of, or changes in ownership of, an active parent entity	**Yes**	**No**
Is the project a transfer of ownership in the facility that will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?	☐	☒
Acquisitions	**Yes**	**No**
Is the project to purchase a facility that provides a new or similar range of services or care, that will result in one or more of the following: a. Elimination of services or care, and/or; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Change in location of services or care?	☐	☒
All Other Changes to the Operating Certificate	**Yes**	**No**
Is the project a request to amend the operating certificate that will result in one or more of the following: a. Elimination of services or care; b. Reduction of 10%* or greater in the number of certified beds, certified services, or operating hours, and/or; c. Expansion or addition of 10%* or greater in the number of certified beds, certified services or operating hours, and/or; d. Change in location of services or care?	☒	☐

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

- ***If you checked "yes" for one or more questions in Table B,*** the following HEIA documents are required to be completed and submitted along with the CON application:
  - HEIA Requirement Criteria with Section B completed
  - HEIA Conflict-of-Interest
  - HEIA Contract with Independent Entity
  - HEIA Template
  - HEIA Data Tables
  - Full version of the CON Application with redactions, to be shared publicly

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

APPENDIX 1

CHARTIS

HEALTH+F HOSPITALS Kings County

January 11, 2024

Desiree *Thompson*
Chief of Staff

NYC Health + Hospitals / Kings County
451 Clarkson Avenue
Brooklyn, NY 11203

Re: Request for Proposal - Health Equity Impact Assessment

Dear Desiree,

We appreciate the opportunity for The Chartis Group, LLC (Chartis) to provide NYC Health + Hospitals / Kings County (Kings County) with a proposal to conduct two independent Health Equity Impact Assessments (HEIAs) for two Certificate of Need (CON) applications for proposed projects in Brooklyn, NY:

- One HEIA for a Limited Review CON Application to Convert Chemical Dependency Beds to Med/Surg Beds
- [redacted]

The following proposal outlines our approach, timeline, and the required staffing resources to complete the HEIAs for your organization. As we describe below, our background and experience uniquely qualify Chartis to assist your organization with these assessments. Please do not hesitate to contact us directly if you have any questions or wish to discuss this proposal in more detail.

Sincerely,

Duane Reynolds, MHA (he/him)
Chief Health Equity Officer,
Director and President, Chartis Center for Health Equity & Belonging
614-354-3282; dreynolds@chartis.com

Shaifali Ray, MHA (she/her)
Principal Partner, Chartis Center for Health Equity & Belonging
312-608-6128; shray@chartis.com

CHARTIS

REQUEST FOR SERVICES FORM

NYC Health + Hospitals, Kings County ("Client") and The Chartis Group, LLC ("Chartis") entered into a Master Statement of Work effective May 20, 2024 under which Chartis agreed to perform for Client services with regard to Certificates of Need (CON) for the New York State Department of Health – Health Equity Impact Assessment ("Services") (the "Master Statement of Work"). For each engagement of Chartis to perform Services under the Master Statement of Work, Client must complete this form and it must be signed by both Client and Chartis.

1. **Project Title (as listed on Client's Certificate of Need application):**

   - One HEIA for a Limited Review CON Application to Convert Chemical Dependency Beds to Med/Surg Beds
   - [redacted]

2. **Date that Client anticipates starting the HEIA #1: week of June 17 and all HEIA documentation will be provided by July 29**
   Date that Client anticipates starting the HEIA #2: August 12 – and all HEIA documentation will be provided by September 9

3. **Date that Client anticipates submitting The Certificate of Need (CON) application for HEAI #1: To be determined by Client.**

   Date that Client anticipates submitting The Certificate of Need (CON) application for HEAI #2: To be determined by Client.

4. **Engagement Request Type Chartis will provide the Services outlined in Appendix 1.**

NYC Health + Hospitals, Kings County		**THE CHARTIS GROUP, LLC**	
By:	Desiree Thompson	By:	DocuSigned by: Duane Reynolds E164BE6117884AF...
Print Name:	Desiree Thompson	Print Name:	Duane Reynolds
Title:	Chief of Staff	Title:	Chief Health Equity Officer
Date:	6/11/24	Date:	6/11/2024

INVOICE

NYC Health and Hospitals - Kings County

Invoice Number	SIN035040
Invoice Date	05/31/2024
Due Date	06/30/2024
PO Number	

Project: NYCHHK01 - NYC Health & Hospitals Kings County CHEIA: Bed Conversion

For professional fees and expenses incurred by The Chartis Group in support of work during the month of May.

SUMMARY

Professional Fees	$59,503.00
Invoice Total	$59,503.00

Federal Tax ID# 36-4450952

FOR ELECTRONIC / ACH PAYMENT: Account Name: The Chartis Group
[redacted]

FOR PAYMENT VIA CHECK: The Chartis Group LLC
Department 5925

New York State Department of Health

Health Equity Impact Assessment Conflict-of-Interest

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

Section 1 – Definitions

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

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

Section 2 – Independent Entity

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

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

Section 3 – General Information

A. About the Independent Entity

1. Name of Independent Entity: **The Chartis Group LLC**
2. Is the Independent Entity a division/unit/branch/associate of an organization (Y/N)? **NO**
   - ❑ If yes, indicate the name of the organization: _____

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

   YES

   _____

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

Applicant	Project	Chartis Practice Area	Date
No previous work with NYC Health + Hospitals Kings County			
Applicant's Affiliate: NYC Health + Hospitals			
NYC Health + Hospitals	Clinical Quality Education	Chartis Clinical Quality Solutions	3/2019

Section 4 – Attestation

I, Duane Reynolds, having personal knowledge and the authority to execute this Conflict of Interest form on behalf of **The Chartis Group, LLC, (Chartis)** do hereby attest that the Health Equity Impact Assessment for the conversion **25 Chemical Dependency Beds to Medicine Beds with Psychiatric Consults** provided for **New York Health + Hospitals Kings County Hospital** 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 **Chartis** 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:  , Executive Director, Chartis Center for Health Equity and Belonging

Date: 8/6/2024

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	Convert 25 Chemical Dependency Beds (official closed March 2020) to 25 Medical/Surgical Beds with Psych Consults
2. Name of Applicant	NYC Health + Hospitals Kings County Hospital
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	The Chartis Group, LLC (Chartis Center for Health Equity and Belonging) • Shaifali Ray (shray@chartis.com) • Alexis Mayo-Tapp (amayo-tapp@chartis.com)
4. Description of the Independent Entity's qualifications	**We are experts in health and racial equity consulting.** Chartis is one of the first national consulting firms with a mission that includes the advancement of social and racial justice, health equity, and belonging. Through Chartis' March 2022 acquisition of Just Health Collective (founded in 2020), The Chartis Center for Health Equity and Belonging (CCHEB), is focused on creating a liberated healthcare system free of bias, discrimination, and disparities - resulting in equitable health for all. Our market research and insights indicate that healthcare is evolving to address a more comprehensive picture of health and wellness, which includes a focus on racial and health equity, population health, social drivers of health, diverse consumer market segmentation, cultural care program development and community alignment. Our health equity practice has dedicated resources to help clients create equitable and inclusive organizations for their workforce; equitable access, experience and quality for their patients; and equitable health status for their communities. Our engagements integrate quantitative insights from data and qualitative insights from internal and community stakeholder engagement. Engagement approaches include interviews, focus groups and surveys. This, coupled with our team's depth and breadth of experience in healthcare operations, racial equity, and patient and

	community engagement, gives us a deep understanding of the implications of health equity. When considering engagements with health equity and/or community health focus, Chartis has led more than 45 engagements in the past five years. These engagements have resulted in transformative impact for underserved communities and patient segments across the country. The leader on this engagement has more than 20 years' total healthcare experience with areas of strength in equitable access to care, hospital and medical group operations, performance improvement, disparities mitigation, patient experience, compliance, and diversity, equity, and inclusion education. CCHEB's President and Chartis' Chief Health Equity Officer, Duane Reynolds, is an advisor on this project and has 25 years' total healthcare experience. He has been recognized twice by Modern Healthcare as an 'up and comer' to one of the nation's top diversity leaders in healthcare. **Disclaimer.** In no event does Chartis take any position or offer any guarantee on whether: (i) an entity is required to perform a Health Equity Impact Assessment; or (ii) the Services will lead to any particular result.
5. Date the Health Equity Impact Assessment (HEIA) started	June 17, 2024
6. Date the HEIA concluded	August 7, 2024

7. Executive summary of project (250 words max)
Kings County Hospital is requesting to convert 25 chemical dependency beds, which were closed with approval from the Office of Addiction Services and Supports (OASAS) in 2020, to 25 medical/surgical beds with psychiatric consultations (i.e. inpatient beds). There are several mitigating circumstances that support adding these beds to the medicine bed complement: • Kings County is certified for 246 medical/surgical beds. The hospital runs a consistent census of 100% for this service • On average, the emergency department (ED) admits approximately 18 medicine patients (ranging from 17 to 30 medicine admissions) per day, with an average of 36 patients dwelling in the ED for extended times due to lack of adequate space to move admitted patients easily to an available inpatient bed

- The recent closure of a community hospital – Kingsbrook Jewish Medical Center – has resulted in an increase of patients seeking care at Kings County's emergency department
- Kings County has a large complement of patients with an Alternate Level of Care (ALOC) status. These patients are no longer acutely ill but cannot be discharged safely to home or appropriate care (i.e., nursing homes) because of social concerns or insurance status

These circumstances have contributed to the need to increase the number of medical/surgical beds at the hospital. In addition, many of the patients Kings County Hospital sees have a secondary psychiatric diagnosis. The patients that will be admitted to this new 25 bed unit will be provided with psychiatric consults as well as creative arts therapy as required.

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

The Independent Entity used data and information from public and proprietary sources, information provided by the Applicant, as well as insights from meaningful engagement of stakeholders in the community to conduct an independent, evidence-based market and community assessment to understand the health equity impact of the proposed conversion of 25 chemical dependency beds, which were closed with approval from the Office of Addiction Services and Supports (OASAS) in 2020, to 25 medical/surgical beds with psychiatric consultations (i.e. inpatient beds).

Market Assessment

This assessment focuses on the primary and secondary service areas of Kings County Hospital, which includes the following 11 zip codes: 11203, 11207, 11208, 11210,11212, 11213, 11225, 11226, 11233, 11234, 11236. Based on an assessment of the Applicant's data and data from the Statewide Planning and Research Cooperative System (SPARCS) claims data from 2018-2023, patients from these counties comprise 80% of Kings County Hospital's discharges. 8 of the 11 zip codes are considered medically underserved areas or populations (MUA/Ps). Together, the 8 zip codes make up 68% of the Applicant's discharges, which reflects the community members who will be impacted most. Patient ancestry data provided by the Applicant shows that ~43% of patients discharged have ancestral backgrounds outside of the United States.

Community Assessment

46 participants engaged in individual interviews or responded to a survey to share their insight and perspectives on the impact of the addition of 25 inpatient beds. Nearly 90% of participants indicated their support of the proposed project and 64% indicated they reside in the primary or secondary service areas. Individuals are represented from nearly every medically underserved group.

Health Equity Impact

Themes from the Independent Entity's (IE) meaningful engagement activities reveal that all medically underserved groups will collectively benefit from the proposed project by having increased access to care and reducing wait times for an inpatient bed for patients in the emergency department (ED). In addition, patients who need behavioral health support will benefit from the availability of psychiatric consultation services during their inpatient stay. Additionally, less overcrowding in the ED will lead to a better patient experience and more patient privacy.

Potential unintended barriers that could impact all medically underserved groups include:

- Staffing levels, as it may take time for the Applicant to reach and sustain optimal staffing levels to support patients for these needs
- Comprehensive training for staff to support caring for patients with both medical and behavioral health needs
- Possible reduction of the availability of resources for individuals who have a substance use disorder

Based on market and evidence-based data as well as information from meaningful engagement of the community, these impacts are described in more detail in this Health Equity Impact Assessment.

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 NIA 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.

The HEIA data tables have been populated for zip codes in Kings County.

Source(s): American Community Survey

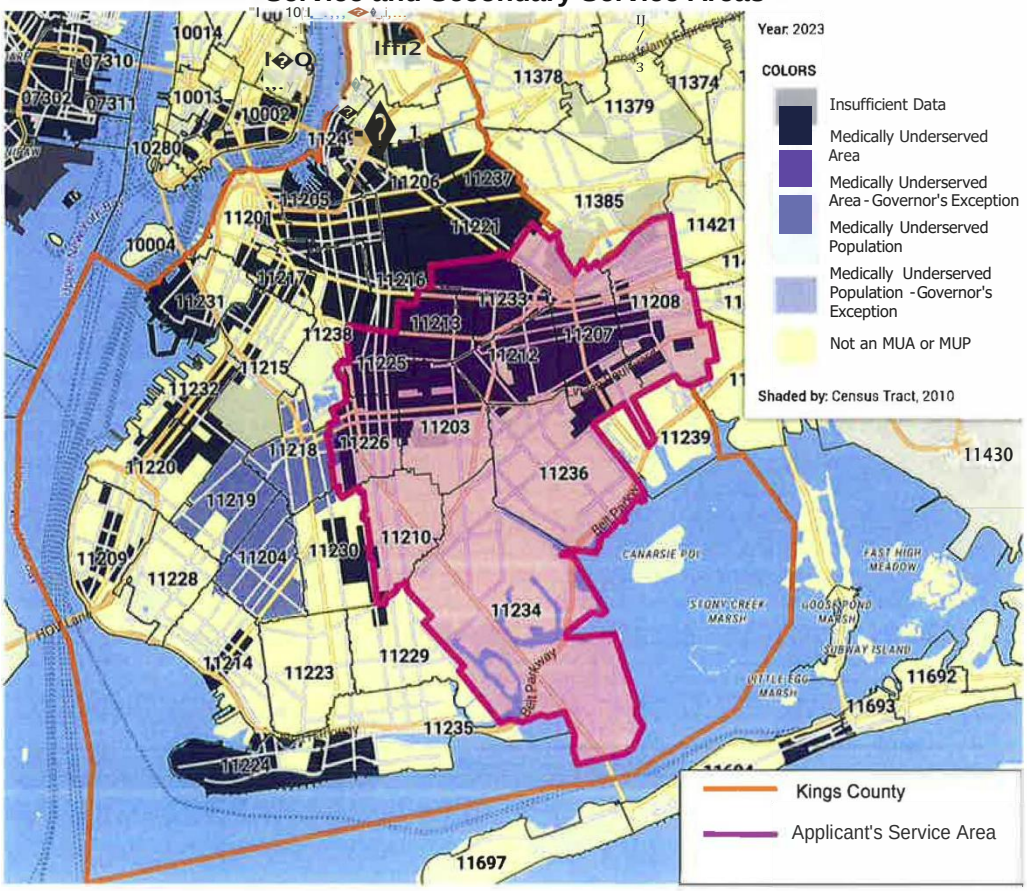
2. Medically underserved groups in the service area: Please select the medically underserved groups in the service area that will be impacted by the project:

✓ 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
- ✓ 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
- ✓ Not listed (specify):
    - o HRSA-designated medically underserved areas and medically underserved populations
    - o Individuals accessing behavioral healthcare services

80% of Kings County Hospital's inpatient discharges are from the following zip codes, which is the focus area for this assessment: 11203, 11207, 11208, 11210, 11212, 11213, 11225, 11226, 11233, 11234, and 11236. Medically underserved areas and populations (MUA/Ps) in Kings County were assessed by a review of the HRSA-designated MUA/Ps for Kings County. As Figure 1 below illustrates, 8 of the 11 zip codes noted above are designated as MUA/Ps.

Figure 1. Medically Underserved Areas and Populations (MUA/Ps) for Kings County in Primary Service and Secondary Service Areas



Source(s): American Community Survey, Data/information provided by the Applicant, PolicyMap, **2022-2024**

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

- Low-income people: PolicyMap, American Community Survey (2021) Communit y Health Needs Assessment, meaningful engagement responses by demographic breakdown
- Racial and ethnic minorities: PolicyMap, American Community Survey (2021), Community Health Needs Assessment, meaningful engagement responses by demographic breakdown
- Immigrants: American Community Survey (2021), meaningful engagement responses by demographic breakdown
- Women: PolicyMap, American Community Survey (2021), Community Health Needs Assessment, meaningful engagement responses by demographic breakdown
- Lesbian, gay, bisexual, transgender, or other-than-cisgender people: Behavioral Risk Factor Surveillance System (2021), meaningful engagement responses by demographic breakdown
- People with disabilities: American Community Survey (2021), meaningful engagement responses by demographic breakdown
- Older adults: American Community Survey (2021), Community Health Needs Assessment, meaningful engagement responses by demographic breakdown
- Persons living with a prevalent infectious disease or condition: New York State HIV/AIDS Annual Surveillance Report
- People who are eligible for or receive public health benefits: American Community Survey (2021)
- People who do not have third-party health coverage or have inadequate third-party health coverage: American Community Survey (2021)

✓ Not listed (specify):

  - HRSA-designated medically underserved areas and medically underserved populations: Health Resources and Services Administration, PolicyMap (2022-2024)

- Individuals accessing behavioral healthcare services: information provided by the Applicant

The following medically underserved groups were assessed and determined to not be impacted for this assessment.

- Persons living in rural areas: US Department of Agriculture's definition of Rural-Urban Commuting Areas (RUCA). 100% of population resides within the core metropolitan area.

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

Any individual that is a member of a medically underserved group listed above accessing inpatient services at Kings County Hospital will benefit from the additional beds. In addition, patients who need behavioral health support will benefit from the availability of psychiatric consultation services during their inpatient stay.

Furthermore, the Applicant serves a diverse group of patients and community members. The Center for Migration Studies of New York, which focuses on safeguarding the rights and policies for migrants and refugees, notes that Brooklyn is home to nearly 1 million immigrants, which is ~37% of the population. Each of the 8 MUA/P zip codes in the Applicant's service area has a higher representation of racial and ethnic minorities, immigrants, and people receiving public health benefits. Together, the 8 zip codes make up 68% of the Applicant's discharges, which reflects the community members who will be impacted most. Patient ancestry data provided by the Applicant shows that ~43% of patients discharged have ancestral backgrounds outside of the United States. Meaningful engagement activities also revealed high numbers of patients are from the Afro Caribbean community.

Additional beds and the availability of psychiatric consultations for patients occupying these beds will increase access to care and support the improvement of the quality of life and health outcomes for medically underserved groups. Currently, patients are awaiting in the ED for a bed. With increased capacity, patients dwelling in the ED will not wait as long for a bed and patients who need both medical and psychiatric care during the inpatient stay will have access to specialized behavioral healthcare support alongside treatment of their medical condition. Additionally, less overcrowding in the ED will lead to a better patient experience and more patient privacy.

As outlined in New York State's Prevention Agenda and in NYC Health+ Hospitals Community Health Needs Assessment, mental health and substance use are priority needs in the community. Among NYC Health + Hospitals, Kings County ranked 2nd in substance use encounters (17.7%) and third in mental health encounters (11.4%). The proposed beds will support the strategies listed

in the NYC Health + Hospitals Behavioral Health Blueprint to assist individuals with behavioral healthcare needs.

Source(s): RE_2022.01.20_Black-Immigrants_FINAL.pdf (pewresearch.org), Mapping-Key-Health-Determinants-for-Immigrants-Report-Center-for-Migration-Studies.pdf (cmsny.org), Community Health Needs Assessment, BehavioralHealthBlueprint.pdf (hhinternet.blob.core.windows.net)

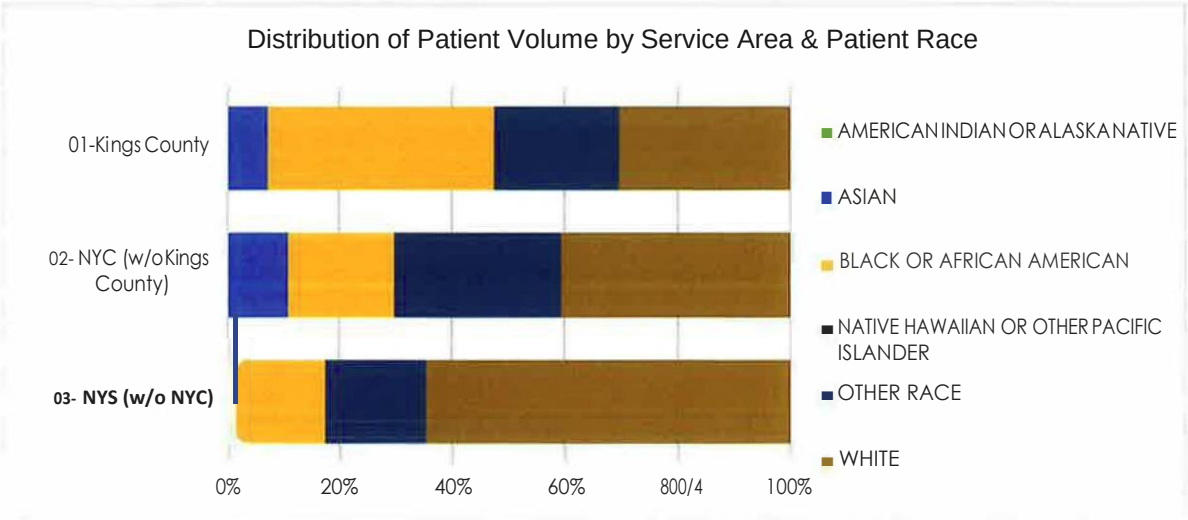
5. To what extent do the medically underserved groups (identified above) currently use the service(s) or care impacted by or as a result of the project? To what extent are the medically underserved groups (identified above) expected to use the service(s) or care impacted by or as a result of the project?

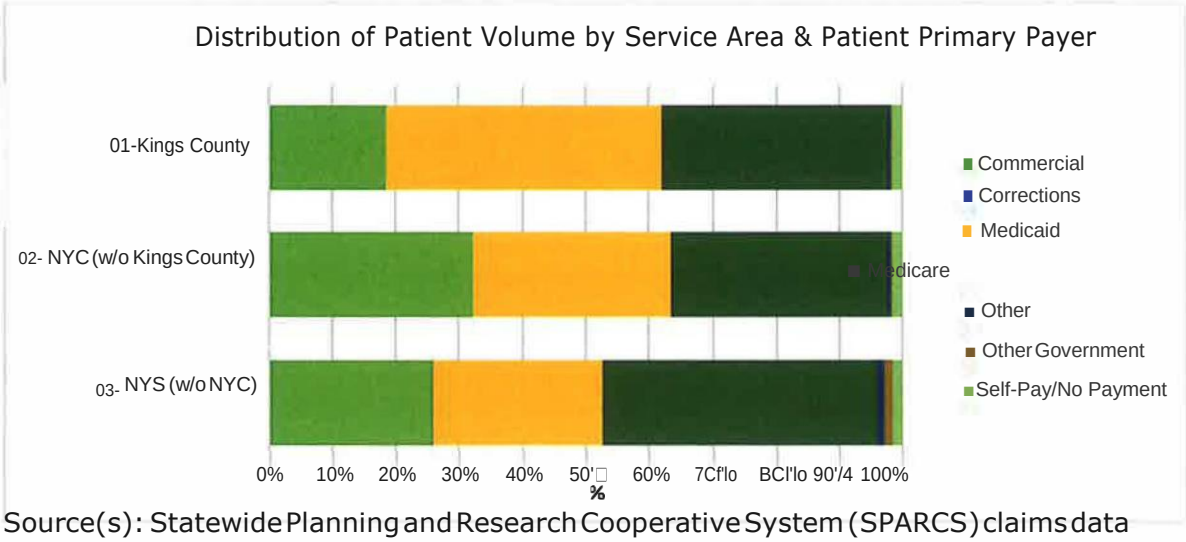
Current Use of Services

Based on the Applicant's discharge data for FY22 and FY23, inpatient discharges increased by 16% (from 9,355 in FY22 to 10,828 in FY23). In our independent review of Statewide Planning and Research Cooperative System (SPARCS) data for inpatient claims by facility in King's County, we also observed an increase in the Applicant's claims volumes from 2018-2023.

Analysis of SPARCS data from 2018-2023 shows that facilities in Kings County have a higher percent inpatient volume from patients who identify as Black/African American (40%) and a higher proportion of patients with Medicare or Medicaid insurance (79%) as compared to other hospital facilities in New York.

Figure 2: Distribution of Patient Volume by Service Area by Patient Race and Patient Primary Payer





Source(s): Statewide Planning and Research Cooperative System (SPARCS) claims data

Analysis of the Applicant's discharge data from FY22 and FY23 confirmed that 87% of inpatient discharges from the 11 primary and secondary service area zip codes are from patients who identified as Black/African American and 81% have Medicare or Medicaid as the primary payer.

The Applicant also collects patient ancestry data. Analysis of the Applicant's discharge data from FY22 and FY23, identified patients with the following ancestral backgrounds in Figure 3:

Figure 3: Ancestral Background and % of Discharges from Primary and Secondary Service Areas Zip Codes

Jamaican	10%
Haitian	8%
Guyanese	6%
Trinidadian	6%
Grenadian	3%
Barbadian	2%
African	2%
Panamanian	2%
Puerto Rican	2%
West Indian	2%

Source(s): Data provided by the Applicant

Additional analysis of the Applicant's inpatient discharge data confirmed that in addition to English, the predominant languages spoken by patients are Spanish and Haitian Creole.

Based on the CHNA and information provided by the Applicant, most substance use and mental health encounters at Kings County Hospital are provided in an outpatient setting, however, approximately 30% of admitted patients have a psychiatric component to their diagnosis.

Expected Use of Services

Based on current utilization rates, the Applicant would expect similar and potentially increased utilization due to the growth in the aging population and inpatient utilization trends by age and payer[1]. The New York City Population Projections by Age and Borough forecasted overall population growth in Brooklyn with the highest projected growth in 2030 from adults aged 65+. In addition, the Applicant has absorbed more patients due to recent hospital closures and will likely absorb more patients with future anticipated closures.

The additional availability of and access to inpatient beds is expected to support the increased utilization of inpatient services. The Applicant shared that on average, 36 people/day are dwelling in the ED, waiting to be admitted to a hospital bed. Further, the additional beds, which would be located in the Applicant's behavioral health building, would increase capacity for inpatient services and psychiatric care for patients who present with both medical and behavioral health needs.

Furthermore, NYC Health + Hospitals 2024-2026 Behavioral Health Blueprint outlines the health system's strategies and investment for the next three years for maximizing inpatient and outpatient capacity for behavioral health and substance use services and targeting support for high-risk individuals enrolled in Medicaid Managed Care. This includes expanding programs and services at Kings County Hospital.

Source(s): Statewide Planning and Research Cooperative System (SPARCS) claims data, data/information provided by the Applicant, 2022 Community Health Needs Assessment, NYC H+H Behavioral Health Blueprint, independent research conducted by IE

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

Disclaimer: The data used to produce this publication comes from New York State Department of Health. However, the calculations, metrics, conclusions derived, and views expressed herein are those of the author(s) and do not reflect the work, conclusions, or views of NYSDOH. NYSDOH, its employees, officers, and agents make no representation, warranty or guarantee as to the accuracy, completeness, currency, or suitability of the information provided here.

[1] Table P-10. Number of overnight hospital stays during the past 12 months. by selected characteristics: United Stales. 2018 (cdc.gov)

Data Notes: The results shown below use the Statewide Planning and Research Cooperative System (SPARCS) as a data source. The calculated results are derived from inpatient claims for services rendered during calendar years 2018-2023 from hospital facilities located in Kings County. Small cell sizes have been compiled into 'Other' in order to maintain required confidentiality.

Due to limitations in the data analysis, utilization rates are for all inpatient claims, including those with and without psychiatric consultations. Through the analysis of SPARCS data for inpatient claims for services rendered in Kings County from 2018-2023, inpatient services are offered at the following facilities:

001286: BROOKDALE HOSPITAL MEDICAL CENTER
001288: BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS
001293: NEW YORK COMMUNITY HOSPITAL OF BROOKLYN, INC
001294: NYC HEALTH+ HOSPITALS/SOUTH BROOKLYN HEALTH
001301: KINGS COUNTY HOSPITAL CENTER
001304: NYU LANGONE HOSPITAL-BROOKLYN
001305: MAIMONIDES MEDICAL CENTER
001306: NEWYORK-PRESBYTERIAN BROOKLYN METHODIST HOSPITAL
001309: INTERFAITH MEDICAL CENTER
001315: KINGSBROOK JEWISH MEDICAL CENTER*
001318: WYCKOFF HEIGHTS MEDICAL CENTER
001320: UNIVERSITY HOSPITAL OF BROOKLYN
001324: MOUNT SINAI BROOKLYN
001692: WOODHULL MEDICAL & MENTAL HEALTH CENTER

Services reduced in 2021
Due to its focus on hospice and palliative care, Calvary Hospital is excluded

Source(s): Statewide Planning and Research Cooperative System (SPARCS) claims data

The Applicant's market share grew from 2018 to 2023. In addition, the hospital has absorbed more patients due to recent closures or expected closures. Communications related to the 2024 announcement regarding the proposed closure of University Hospital of Brooklyn suggest that more patients would shift to the Applicant. Concerns were shared about the capacity for the Applicant to absorb these patients, given their current overcrowding situation.

Source(s): Statewide Planning and Research Cooperative System (SPARCS) claims data; information provided by the Applicant

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

Figure 4 provides a summary of the facilities in Kings County and total inpatient claim count and percent of claims for services rendered in each facility, regardless of patient origin from 2018-2023.

Figure 4. 2018-2023 Claim Volume for All Inpatient Care Rendered in Kings County Hospitals, Regardless of Patient Origin

2018-2023 Inpatient Claims in Kings County		
Facility County 11 Facility Name	Total Claim Count	Total County Claim Percent
001286: BROOKDALE HOSPITAL MEDICAL CENTER	79,839	6.5%
001288: BROOKLYN HOSPITAL CENTER - DOWNTOWN CAMPUS	77,276	6.3%
001293: NEW YORK COMMUNITY HOSPITAL OF BROOKLYN, INC	30,352	2.5%
001294: NYC HEALTH+ HOSPITALS/SOUTH BROOKLYN HEALTH	78,127	6.3%
001301: KINGS COUNTY HOSPITAL CENTER	107,016	8.7%
001304: NYU LANGONE HOSPITAL-BROOKLYN	157,757	12.8%
001305: MAIMONIDES MEDICAL CENTER	221,211	17.9%
001306: NEWYORK-PRESBYTERIAN BROOKLYN METHODIST HOSPITAL	191,511	15.5%
001309: INTERFAITH MEDICAL CENTER	40,062	3.2%
001315: KINGSBROOK JEWISH MEDICAL CENTER	26,855	2.2%
001318: WYCKOFF HEIGHTS MEDICAL CENTER	69,438	5.6%
001320: UNIVERSITY HOSPITAL OF BROOKLYN	48,246	3.9%
001324: MOUNT **SINAI** BROOKLYN	49,479	4.0%
001692: WOODHULL MEDICAL & MENTAL HEALTH CENTER	56,751	4.6%
Grand Total	**1,233,920**	**100%**

Notes: Kingsbrook Jewish Hospital Services reduced in 2021; due to its focus on hospice and palliative care, Calvary Hospital is excluded from this analysis

Source(s): Statewide Planning and Research Cooperative System (SPARCS) claims data

Based on the average growth rate observed from 2018-2023 SPARCS data, the Applicant's market share is expected to increase to 9.5% next 5 years. This does not include an additional increase of 1-3% if other anticipated hospital closures are approved.

Source(s): Statewide Planning and Research Cooperative System (SPARCS); information provided by the Applicant, NYC Health+ Hospitals 2024-2026 Behavioral Health Blueprint

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.

Applicant's obligations under Public Health Law § 2807-k (General Hospital Indigent Care Pool}

A review was conducted of the following information provided by the Applicant:

- 2020 DSH Report Pro forma and Analysis by NYC Health + Hospitals, dated as of 12/12/2023
- NYC Health + Hospitals Financial Assistance Policy
- External NYC Health + Hospitals Financial Assistance website
- Review of Kings County Hospital's total charity care from 2021-2023

Based upon the review of this information, the Applicant appears to be meeting its obligations stated under Public Health Law § 2807-k. Based on the 2020 DSH analysis, the hospital had $126 million in total annual uncompensated care costs and $89 million in total uninsured inpatient/outpatient uncompensated care costs.

Community Services

Below is a summary of the community engagement activities shared by the Applicant:

- Collaborate with NYC Health + Hospitals to conduct the triennial community health needs assessment
- NYC Health + Hospital's Board hosts annual public meetings for community members to share concerns with hospital leadership. The meetings are held in each NYC borough – Brooklyn meetings are hosted at Kings County Hospital
- Monthly Community Advisory Board (CAB) meetings with hospital leadership to discuss programmatic updates, issues, and to obtain input from CAB members. The Applicant also collaborates with the CAB to host an Annual Legislative Breakfast, which includes participation of elected officials representing the service area, community leaders and community-based organizations
- Hosted a health equity conference on June 15, 2023, with community stakeholders, providers and leaders from other community hospitals to discuss disparate health outcomes, their impact on the community, and potential mitigation strategies
- Conduct monthly Patient-Family Advisory Council meetings to discuss opportunities to create more person-centered care
- Published content that is shared on social media platforms to discuss/showcase health-related programs and education. Many topics are showcased such as behavioral health, men's health, cultural awareness, nutrition and healthy lifestyles, substance use, breast cancer, and more

- The Applicant's medical experts provide health education at forums hosted by local schools, faith-based organizations, community planning boards, and community-based organizations
- The Applicant has documented community partnerships with many organizations that provide resources for various health and social needs including education, food, housing, transportation, financial assistance, medical supplies, legal aid, care transitions, and much more.

Medicaid Population

Figure 5 below reflects an estimate of the Medicaid population as a percentage of the population in Kings County. In FY23, 43% of the Applicant's discharged inpatients were insured through Medicaid and Medicaid Managed plans.

Figure 5. Medicaid Enrollees as a % of Kings County Population

County	Medicaid Enrollment, March 2024	Population, 2020	Medicaid Enrollees as a% of Population
Kings	1,354,196	2,736,074	49.5%

Information on the total number of licensed medical-surgical beds were not available to us during to comment on how the comparison of licensed beds to people served/residents of the region.

Source(s): NYS Medicaid Enrollment Databook: Census Bureau Data; information provided by the Applicant

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.

We reviewed the Applicant's FTE needs and staffing plan for the 25-bed unit, which includes hiring all new staff. Feedback from the meaningful engagement activities suggests that specialized training and support will be critical for patients who are being treated for both medical conditions and behavioral health. We recommend that training includes education on the impact of mental health stigma, unconscious bias, cultural humility, trauma-informed care, de-escalation techniques, and psychological safety. Employing dedicated staff for the unit who have received comprehensive training and who have experience in supporting patients with behavioral health needs will be important for the well-being of both staff and patients.

Source(s): information provided by the Applicant and meaningful engagement activities

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

    The Applicant confirmed there are no civil rights access complaints reported against the Applicant.

    Source(s): information provided by the Applicant

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

    During the COVID pandemic, in March 2020, the Applicant opened the unit in this application (R2E; previously chemical dependency) for one month to accommodate medical/surgical patients (5/9/2020 to 6/17/2020), in addition to opening other units throughout the hospital to increase inpatient capacity necessary to meet the high demand during the pandemic. Among the units that opened during this time, a 36-bed unit (A5) has remained open since 9/9/2020 and continues to be operational today to support inpatient demand needs. Even with this unit open, as described in the above sections, the demand for inpatient beds continues to remain high.

    Source(s): information provided by the Applicant

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

    As noted in section B, Question 4, all individuals accessing inpatient services at Kings County Hospital during the inpatient stay will benefit from the additional medical/surgical beds. The beds will provide more capacity and help to reduce the time patients are dwelling in the ED. In addition, 30% of patients who are admitted also require behavioral health support. The location, operational and staffing plans support providing psychiatric consultation services to all patients who are admitted to this unit.

Responses from meaningful engagement highlighted additional improvements related to both patient and staff experience. For example, currently staff who provided psychiatric consultations to inpatients on the medical/surgical units practice in another building on campus. The location of the additional beds in the behavioral health building will reduce staff transit time, allowing for more timely care. In addition, staff will be able to provide more coordinated and efficient care to patients in the unit who need behavioral health support, optimizing workflows that incorporate behavioral health associates, social workers, and case workers. The Applicant also plans to employ creative arts therapists, who would provide specialized therapies for inpatients who qualify for this service. According to the Applicant, Creative Arts Therapies are used at the bedside or in group settings for patients with select psychological diagnoses such as schizoaffective disorder, dementia, bipolar disorder, and adjustment disorder. The therapies help to create connections between staff and patients and regulate patients' mood, which can impact physical well-being and compliance with prescribed treatment.

Feedback from the meaningful engagement activities also suggests that wait times for inpatients admitted through the ED are lengthy and inpatient stays are longer due to the limited number of beds that are available. The proposed project will decrease wait times, which can improve time to admission and prevent worsening of conditions or other potential long-term complications.

The Applicant shared programmatic information provided to patients to help address social drivers of health. In addition to screening for a variety of social needs, the Applicant has partnerships with many community resources that help to support the improvement of health equity and reduce healthcare disparities for medically underserved groups. Examples of such programs include:

- Referrals for care management programs such as Healthlink, to support patients with mental health illness and complex chronic conditions
- Food distribution programs to provide access to or deliver food to seniors, single mothers, disabled or homebound residents residing in the service area
- Lifestyle Medicine Program that provides patients the tools to make healthy lifestyle changes, including access to plant-based diet resources and one-on-one counseling. Adults living with prediabetes, type 2 diabetes, high blood pressure, heart disease, or health concerns related to excess weight are eligible to enroll
- Free or discounted transportation for individuals including those who are below the designated federal poverty guidelines, formerly incarcerated persons, elderly, Veterans, LGBTQIA+, immigrants or individuals requiring transitional living arrangements

- Domestic Violence Clinics to assist those who are adversely impacted by domestic and gender-based violence, offering trauma-informed mental health services, screenings, individual and group therapy, and medication management to nearly 3,000 patients each year
- NYC Cares, a health insurance program that is offered across NYC Health + Hospitals to provide health insurance to those without coverage

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.

Feedback from the meaningful engagement activities suggest that the additional medical/surgical beds will be a positive impact on all groups. As described in the sections above, the beds will help to reduce the bottleneck for ED patients waiting for an inpatient bed. The beds will help to improve the Applicant's ability to deliver psychiatric care to individuals who need both medical and behavioral healthcare during the inpatient stay, and the additional services will help to increase the visibility and importance of addressing mental health issues in multiple care delivery settings.

Potential unintended impacts that were identified include:

- Ensuring full staffing levels for dedicated staff to the unit who have specialized training and support to care for patients who are being treated for both medical and behavioral health conditions. Healthcare providers are experiencing a shortage of providers, including mental health providers. It may take time for the Applicant to reach and sustain optimal staffing levels to support patients for these needs. As one stakeholder shared, "having the beds available and no providers won't solve the issue at hand"
- Potentially reducing the availability of resources for individuals who have a substance use disorder

Source(s): Data/information provided by the Applicant

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.

As described in Step 1, Question 8, based on the 2020 DSH analysis, the hospital had $126 million in total annual uncompensated care costs and $89 million in total uninsured inpatient/outpatient uncompensated care costs.

The Applicant's financial assistance policy is set by NYC Health+ Hospitals and states that assistance is provided beyond the requirements of Public Health Law 2807-k(9a) or "HFAL" to support the role of NYC Health+ Hospitals as the public safety net healthcare system of New York City. NYC Health + Hospitals offers two financial assistance programs for qualifying patients and publishes a financial assistance sliding fee schedule.

Between 2021 and 2023, there was a 4% increase in the total number of patients that received Financial Assistance. Financial Assistance Program information is also translated into multiple languages including Spanish, Albanian, Arabic, Bengali, French, Haitian Creole, Hindi, Korean, Polish, Russian, simplified Chinese, and Urdu.

Source(s): Data/information provided by the Applicant

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.

Kings County Hospital can be accessed by public and private transportation. The Applicant provides information about driving directions and parking options listed on their website, including https://www.kingscountyparking.com/rates/ which range from $5-$30. The cost may be prohibitive for certain populations.

The Applicant's website also provides details on the New York City public transit options. Public transit options include bus and subway. As illustrated in Figure 6, the closest bus station is 8-12/ Clarkson Ave/Kings County Hospital. According to Google Maps, this station is a 2-minute walk from the ED entrance. The closest subway station to Kings County Hospital is Winthrop Street Station (Flatbush Avenue line). According to Google Maps, this station is a 9-minute walk from the ED entrance.

Free metro cards to access the public transit system are provided to patients that meet income eligibility requirements. There are also circumstances when transportation is covered by insurance. However, if a patient's insurance does not provide transportation coverage, and it is deemed medically necessary, the Applicant will absorb the cost of their transportation.

Figure 6: Kings County Hospital Bus Stop and Parking

The Applicant also shared that transportation is one of the top needs identified by patients during the social needs screening process. The hospital offers taxi services for patient who have coverage through insurance and for patients who meet the income eligibility for coverage. The Applicant confirmed that rideshare was used prior to the pandemic but is no longer operationally used at Kings County Hospital. Further understanding the need for transportation and identifying other mitigation strategies to reduce transportation barriers for patients who are discharged from the hospital is recommended for the Applicant to consider.

Source(s): Google Maps, Rates I Kings County Parking Garage, Directions - NYC Health + Hospitals (nychealthandhospitals.org)

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

   The Applicant confirmed that they are ADA compliant and all areas providing patient care are accessible for patients and staff, inclusive of this project. All work, including construction and renovation projects, consider NYS DOH codes and ADA codes to ensure reduction of any potential architectural barriers for people with mobility impairments.

   Source(s): Data/information provided by the Applicant

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?

This project will not have an impact on or provide reproductive and maternal health services.

Source(s): Data/information provided by the Applicant

Meaningful Engagement

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

NYC Department of Health and Mental Hygiene
125 Worth Street
New York, NY 10013
(212) 639-9675

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

We contacted the Commissioner of the NYC Department of Mental Health and Hygiene on July 15, 2024, to request participation in a survey, via the department's online form. A survey response was not received.

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

The file has been completed in accordance with the DOH's instructions.

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?

As noted in section B, Question 4, any individual that is a member of a medically underserved group accessing inpatient services at Kings County Hospital and needing psychiatric consultation services during the inpatient stay will benefit from the additional inpatient beds. Furthermore, those who identity as a racial or ethnic minority or those who live in a designated MUA/P will also be most

affected given the high percent of racial and ethnic minorities that receive care by the Applicant and live in the 8 zip codes identified above.

Stakeholders representing these groups did not express additional concern regarding the project.

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?

We believe input received through community engagement is an important component of the Health Equity Impact Assessment. 46 participants engaged in individual interviews or responded to a survey to share their insight and perspectives on the project. Nearly 90% (41 out of 46 participants) indicated their support of the proposed project. Among the remaining 10%, 6% opposed the project (3 out of 46). The remaining 4% (2 out of 46) indicated they were neutral to the project. 65% of the participants reside in the service area.

Participants include individuals that self-identified from the following medically underserved groups:

- 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
- 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

Surveys were distributed to the following stakeholder groups:

- Members of the Applicant's Community Advisory Board
- Members of the Applicant's Patient-Family Advisory Council
- Community Partners
- Providers and staff in the behavioral health units
- Providers and staff in the medical/surgical units

We believe the terms benefit and burden are subjective and individuals will be impacted differently based on individual circumstances. Not all participants chose to provide a 250-word statement, but themes from the collective feedback shared via the survey and through conversations reflected the following.

- The additional beds will reduce delays for accessing inpatient care
- The additional beds will reduce the time and number of patients that are dwelling in the ED
- Patients with dual needs, both medical and psychiatric, will benefit from more specialized and efficient care
- The additional beds will combat the overall mental health challenges the community is facing with more capacity to support individuals in need of behavioral healthcare
- The additional beds will allow more patients, especially medically underserved populations, including immigrants and racial and ethnic minorities to access care close to home and not have to travel outside of the community due to longer wait times for admission
- The additional beds will require dedicated staff including mental health providers, behavioral health associates, social workers, and case workers with specialized training for patients with medical and psychiatric needs
- There is a growing need to expand access to substance use treatment in the community

While it was not shared explicitly in feedback through the meaningful engagement activities, the IE does recommend the Applicant consider the additional burden on patients who screen positive for a social need. The applicant shared that they have a large complement of patients that cannot be discharged safely to home or appropriate care because of social concerns. In a separate review of the Applicant's social needs screening data from January – May 2024, transportation and food were identified as the 2 most frequently occurring and pressing patient needs. In addition, patients with no insurance had the highest number of positive screens (for any social need).

The Applicant stratifies screening data by age, payer, gender and zip code. Our review confirmed that patients residing in zip codes 11203, 11226, 11212 had the highest volume of positive screens for social needs over the 5-month period. These zip codes are also designated MUA/Ps and may require additional hospital and community resources to support safe and timely discharge.

Source(s): Data/information provided by the Applicant, meaningful engagement, Rates I Kings County Parking Garage

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.

    We do not believe any individuals who are considered medically underserved were excluded from the meaningful engagement portion of the HEIA.

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's external communications plan for the proposed project includes the following:

    - The Office of Communications & Public Affairs intends to collaborate closely with the Language Access Services team to ensure comprehensive translation of information into multiple languages and provision of accessible formats
    - Strategic partnerships with local community boards, schools, and religious institutions will facilitate widespread dissemination. Additionally, the Applicant's monthly digital magazine, accessible globally, will regularly feature updates and success stories, ensuring broad understanding and support for the project
    - The Applicant plans to use social media platforms including X (formerly known as Twitter) and Facebook to conduct live Q&A sessions and YouTube to share informative videos
    - The Applicant plans to engage with their Community Advisory Board and Patient & Family Advisory Council to amplify outreach efforts, complimented by media relations strategies like press releases and potential interviews to highlight project milestones and benefits

    The proposed project has also been discussed at internal meetings with the hospital's clinical and administrative directors and staff. Additionally, the Applicant has discussed the proposed project with its Community Advisory Board and Patient-Family Advisory Council during its formal meeting forums.

    In addition to what is listed above, we recommend:

    - Utilizing existing community partnerships as an additional communication channel to inform medically underserved members of the community about increased capacity for medical/surgical beds with psychiatric consultations.
    - Consider translating educational content on social media platforms (such as offering YouTube videos) in Spanish and Haitian Creole
    - Offering town hall meetings to inform and collect input from staff on the availability of the new services and the impact on the community

Source(s): Data/information provided by Applicant

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

   We recommend the Applicant continue with the plans they have set to engage the community, Community Advisory Board and Patient-Family Advisory Council.

   In addition, while not directly connected to the impact of this project, we recommend that the Applicant evaluate if there are any additional unintended impacts to individuals seeking chemical dependency treatment. We outlined these recommendations in Step 4: Monitoring, Question #2. We also learned through feedback from stakeholder interviews that evaluating signage across the campus could help to direct patients to the appropriate care setting.

   Source(s): Behavioral Health - NYC Health + Hospitals (nychealthandhospitals.org)

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

   The IE recommends the Applicant:

   - Leverage current partnerships with community organizations and continue to engage the Community Advisory Board and Patient-Family Advisory Council to ensure information regarding the project is distributed to individuals in medically underserved groups in appropriate languages within the community
   - Leverage trusted sources of communications, which may include community organizations, community and public leaders, faith-based leaders, current provider relationships
   - Explain why the beds were opened and what changes patients can expect
   - Share information regarding increased capacity and opportunity to support patients who present with both medical and psychiatric needs using plain language in appropriate languages and suitable for individuals with vision and hearing impairments
   - Collect input from behavioral health and medical/surgical unit teams on the availability of the new services and the impact they will have on the community

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

Systemic barriers are obstacles that place unequal value on individuals and communities[2]. Addressing these barriers requires the participation and engagement of multiple stakeholders internal and external to the organization.

As outlined in the NYC Health + Hospitals Behavioral Health Blueprint, the proposed project is part of a larger plan to support the mental health crisis within the community and address barriers and access to healthcare.

Below are additional recommendations for actions the Applicant can continue take or expand upon to address systemic barriers to equitable access:

- Integrated Care: Continue to collaborate with the Community Advisory Board, the Patient-Family Advisory Council and community-based organizations, especially those in the most impacted zip codes in the Applicant's service area to address the root causes of healthcare disparities, including transportation, housing and income

- Quality Improvement: The Applicant shared that they function as a data-driven health system and has confirmed that health equity advancement is core to the clinical and operational strategy for the organization. They currently have a uniform framework for capturing data for race, ethnicity, age, language, and gender, and expressed that every reported quality improvement initiative includes a health equity lens that captures this data. Sharing these data with leaders across the system will be important for building visibility to health equity efforts as well as identifying and sustaining progress on reducing disparities in healthcare outcomes

- Social Needs Screenings and Referrals: The Applicant screens for social needs across all care settings and screens for the following risk factors: food, transportation, housing, utilities, and other support, as well as interpersonal violence. The Applicant maintains lists of CBO partners to support these needs. Tracking closed loop referrals to CBOs for positively screened patients, tracking the number of referrals to each CBO and measuring the impact of the partnership will help to inform gaps and opportunities for supporting needs and systemic barriers

- Advocacy related to mental health stigma and care: Continue to integrate and expand support for mental health services and advocate for the impact these services can have on leading to better overall mental health outcomes

STEP 4 – MONITORING

[2] Source: What We Mean/ FAQ – SpiritHouse Inc (spirithouse-nc.org)

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

   The Applicant has the following existing mechanisms and measures in place to monitor health equity related impacts:

   - Participation in the NYS Health + Hospital's Implementation Strategy Plan
   - Participation in the NYS Health + Hospital's Behavioral Health Report
   - Participation in the New York State Department of Health Brooklyn Borough, Health Equity Report
   - Evidence of partnerships with organizations that represent and support medically underserved populations
   - Involvement of a Chief Quality Officer to monitor the quality and safety of patient care and services
   - Collection of patient demographic data including race, ethnicity, ancestry, and language
   - Collection of social needs screening data and stratification of social needs data by age, gender, payer and zip code
   - Integration of health equity in clinical and operational performance monitoring and improvement
   - Partnerships and programs with community organizations to address patient needs
   - Involvement of the Community Advisory Board and Patient/Family Advisory Council

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?

   - While not directly connected to the inpatient impact of this project, we recommend that the Applicant evaluate if there are any additional unintended impacts to individuals seeking chemical dependency treatment given that these beds were originally in use for that purpose. Through our independent review and as confirmed by the Applicant, we understand that these health needs are being addressed in the ambulatory setting and through referrals. However, in our review, we identified substance use is still a pressing health need for the community and the Applicant's outpatient services for chemical dependency treatment are available Monday through Friday from 8:00 a.m. - 3:00 p.m., which may limit access for certain population segments. Offering alternative hours or evaluating other partners who could help increase access for individuals who need chemical dependency treatment

   - Continue to monitor volume and access metrics for patients who present with substance use diagnoses

- Consider sharing clinical and operational data with the Community Advisory Board, the Patient-Family Advisory Council and strategic community partners to drive continuous quality improvement efforts, with a focus on addressing gaps in care and disparities to promote a positive and equitable care experience for individuals receiving inpatient services

- Consider specific barriers and referral options for patients who screen positive for transportation and food needs. For example, host focus groups with patients and community members from the zip codes that are designated as MUA/Ps and have the highest volume of patients who screen positively for a social need to understand gaps and opportunities

- Evaluate the educational needs and opportunities to enhance training for behavioral healthcare staff. Our recommendations include education on mental health stigma, unconscious bias, cultural humility, trauma-informed care, de-escalation techniques, and psychological safety

- Continue efforts to reduce stigma around mental health and improve education to encourage earlier intervention and support for mental health needs. Consider partnering with other community leaders in support of these efforts

STEP 5 – DISSEMINATION

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

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

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

SECTION C. ACKNOWLEDGEMENT AND MITIGATION PLAN

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

I. Acknowledgement

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

SHELDON P. McLEOD

Name

C..D

Title

Signature

tlrf:u.¥

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.*

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

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

This narrative must be made available to the public and posted conspicuously on the Applicant's website until a decision on the application has been made by either the Commissioner of Health or the Public Health and Health Planning Council, as applicable.

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, (Kings County Hospital's CEO, Sheldon P. McLeod), attest that I have reviewed the Health Equity Impact Assessment for the Conversion of Chemical Dependency Beds to Medicine Beds with Psych Consults that has been prepared by the Independent Entity, The Chartis Group, LLC.

Name

Sheldon P. McLeod

Title

Chief Executive Officer

Signature

Date: 12/3/24

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.

Potential Negative Impact #1:
"Potentially reducing the availability of resources for individuals who have a substance use disorder."

Response:
As noted in the HEIA, Kings County Hospital closed 30 chemical detox beds back in late 2020 with the approval of OASAS, and is now seeking to convert these closed beds to 25 medical surgical beds with psych consults to address the growing community need for inpatient medical care with the co-morbidity of mental health.

This is consistent with NYC Health and Hospitals' decision to close all inpatient detox units throughout the system, which took effect in 2020. This decision was based on a paradigm shift in the treatment of substance use disorder. Currently, Medicated Assisted Treatment (MAT) is the preferred treatment option. According to SAMHSA, MAT is "clinically effective" and significantly reduces the need for inpatient detoxification. MAT is a holistic approach that combines FDA-approved medication (Buprenorphine, Methadone, Naltrexone) and therapy to treat substance use disorders. MAT does not require detoxification.

MAT is immediately available for any patient seeking care for substance use disorder at Kings County Hospital. Patients can access our Centralized Intake office on the 1st floor of the R-Building. A credentialed alcoholism and substance abuse counselor (CASAC) will screen the patient and determine the best program for the presenting problem. The options include CDTOPS, Methadone program, Ambulatory Detox, and MAT with Buprenorphine. Patients can be seen by our CATCH (Consult for Addition Treatment and Care in Hospital) program team in the CPEP and ED.

Consistent with NYC H+H's strategic priority to increase services for special populations, the system implemented a Substance Use Workforce Training Program (SUD WTP) for providers and clinicians to support its goal to provide comprehensive, evidence-based addiction care at the time and location that best meets patients' needs.

NYC Health + Hospitals has 10 Outpatient Substance Use Disorder clinics systemwide, one of which is located right at Kings County Hospital. The SUD program treatment services at Kings County are linked together through an integrated team of Addiction Medicine providers, Addiction Counselors, Social Workers, Peer Counselors,

Psychiatrists, Psychologists, Nurses, Vocational Specialists, Nutritionists, Licensed Creative Art Therapists and non-clinical administrative support. The SUD program offers a cadre of services including MAT, group, individual and vocational counseling, among other services.

Kings County has not reduced resources; and has expanded treatment options to align with the paradigm shift to MAT. At the current time, there is no wait-list for substance use disorders treatment at Kings County Hospital.

Potential Negative Impact #2:
"Ensuring full staffing levels for dedicated staff to the unit who have specialized training and support to care for patients who are being treated for both medical and behavioral health conditions. Healthcare providers are experiencing a shortage of providers, including mental health providers. It may take time for the Applicant to reach and sustain optimal staffing levels to support patients for these needs. As one stakeholder shared, "having the beds available and no providers won't solve the issue at hand."

Response:
The Staffing levels for this 25-bed unit (medical/surgical with psych consults) was determined through collaboration with our multidisciplinary team of department leadership and staff, inclusive of the Chiefs of Service for both the Behavioral Health and Medicine Services, Chief Nurse Officer, Operations, Human Resources, Social Work, and other stakeholders.

Recognizing the issue of healthcare workforce shortages, especially in behavioral health, and consistent with our health system strategies to develop our workforce to meet the needs of our patients, Kings County has implemented a multi-faceted strategy that invests in recruitment, training, and retention to ensure that we continue to adequately staff all inpatient beds to maximize capacity.

A multidisciplinary team with the requisite skills sets and training to manage the complex needs of this population is slated to be hired and in place prior to the opening of this unit. Consistent with current practice, only staffed beds will be accessible for admission to the unit. We do not foresee any obstacles related to recruitment.

Note: Blanks in column I indicate that the contact's support of the project is neutral.											
Identifier (i.e., Patient A, Employee B, Respondent 1) or Name (only if requested by stakeholder)	**Organization (if applicable)**	**Date(s) of outreach**	**What required stakeholder group did they represent?**	**If other, please describe**	**Is this person/ organization a resident of the project's service area?**	**Method of engagement (i.e., phone calls, community forums, focus groups, surveys, etc.)**	**Did this person/ organization participate in the meaningful engagement?**	**Is this person/ organization supportive of this project?**	**Did this person/ organization provide a statement?**	**If permission is granted to share a statement or quote (250 word max), please include below:**	**If permission is not granted to share a verbatim statement, please include a summary of the statement(s) below:**
Employee 1	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	No		Medical team and patients would be impacted in a positive way.
Employee 2	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	no	Yes	I believe these beds should be reserved for those who have a substance use disorder. If more beds are needed open other units in the A building.	
Employee 3	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	no	survey	yes	yes	No		Increase capacity to care for more patients that need medical and psychiatric support.
Employee 4	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes		No		Need for pediatric beds and for substance abuse support for adolescents in the community.
Employee 5	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	Blank	survey	yes	yes	Yes	Not at this time, but visibility is important. and ensuring the interdisciplinary treatment is offered to our patients. By offering more services to our community, we educate our patients to what is available, and then it raises awareness in their own communities.	
Patient 1		18-Jun	other	Patient (current or former)	yes	survey	yes	yes	Yes	The conversion of chemical dependency beds to standard inpatient beds will be beneficial to patients as previously explained in the questionnaire, as an option for patients to get the help they need that's available at Kings County Health and Hospital and it's community.	
Employee 6	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	Yes	I am in support of the conversion. It is important to align with the mission of H+H to serve underserved communities and illogical to leave an area of the hospital vacant.	
Employee 7	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	No		Anticipates patients with high acuity needs will have access to the care that is needed.
Employee 8	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	Blank	survey	yes		Yes	Any change we make in the system is a 50/50. Moving forward is needed but tricky.	
Employee 9	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	No		Patients will get appropriate care that is needed.

Identifier (i.e., Patient A, Employee B, Respondent 1) or Name (only if requested by stakeholder)	Organization (if applicable)	Date(s) of outreach	What required stakeholder group did they represent?	If other, please describe	Is this person/ organization a resident of the project's service area?	Method of engagement (i.e., phone calls, community forums, focus groups, surveys, etc.)	Did this person/ organization participate in the meaningful engagement?	Is this person/ organization supportive of this project?	Did this person/ organization provide a statement?	If permission is granted to share a statement or quote (250 word max), please include below:	If permission is not granted to share a verbatim statement, please include a summary of the statement(s) below:
Employee 10	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	no	No		Wait times will be shortened. Need support for chemical dependent patients.
Patient 2		18-Jun	other	Patient (current or former)	Blank	survey	yes	yes	yes	Long overdue, much needed, let's get started!!!	
Community Member 1		18-Jun	other	Community member	yes	survey	yes	yes	yes	From what I read these specific beds were closed down and not being used so why not use where they are needed. There is already a lack of medical care to the underserved. I think the conversion of chemical dependency beds would impact the health of the community in a good way. Having such a diverse community of immigrants who were probably not able to get the best medical care they needed and many with poor health. I feel these beds can be better served in this way. In my opinion chemical addiction should be treated As its own in an environment catering and focusing only on that specialty specifically.	
Employee 11	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	No		The additional beds will have a positive impact.
Employee 12	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	Yes	survey	yes	yes	No		More beds are needed.
Employee 13	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	yes	This project could impact our community both ways positive and negative at the same time, depending on what side are you on. But for me the benefits of the project are grater than having an unused unit, empty beds, equipment deteriorating because of no use, Thanks for the opportunity to express my point of view	
Employee 14	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	no	survey	yes	yes	No		There is a shortage inpatient psychiatric beds in our community and this project will improve our delivery of psychiatric care.

Identifier (i.e., Patient A, Employee B, Respondent 1) or Name (only if requested by stakeholder)	Organization (if applicable)	Date(s) of outreach	What required stakeholder group did they represent?	If other, please describe	Is this person/ organization a resident of the project's service area?	Method of engagement (i.e., phone calls, community forums, focus groups, surveys, etc.)	Did this person/ organization participate in the meaningful engagement?	Is this person/ organization supportive of this project?	Did this person/ organization provide a statement?	If permission is granted to share a statement or quote (250 word max), please include below:	If permission is not granted to share a verbatim statement, please include a summary of the statement(s) below:
Employee 16	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	No	survey	yes	yes	yes	The beds are sitting empty now and have been empty for sometime. They should be used for the benefit of the community.	
Employee 16	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	yes	I enjoyed this survey because I know a lot of people in our community can benefit from this idea of increasing beds and getting the help they need.	
Employee 18	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	No		Will provide specialized care for patients with psychiatric conditions.
Patient Family 1		18-Jun	other	Parent of former patient	yes	survey	yes	yes	No		Will increase the number of patients who are able to receive care and reduce wait times.
Employee 19	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	yes	Kings County Hospital is the center and most important health care provider in the community. Expanding capacity will provide the community with the help and safety it needs. Mental health is now a public crisis.	
Employee 20	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	Blank	survey	yes	yes	yes	20 beds are not enough! To really remedy this issue you need at less 100 new beds	
Employee 21	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	No		More beds will drastically improve the community. Many patients are in need of additional beds across the community and Kings County Hospital has the capacity to expand inpatient beds.
Employee 22	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	yes	The stigmatization of mental health has continued to plague our society. I strongly believe this is a positive move and can be described as advocacy. We have seen sometimes when it comes to mental health how ethical and moral values have been diminished. Convincingly there is no doubt that this is one way for advocating for mental health concerns.	

Identifier (i.e., Patient A, Employee B, Respondent 1) or Name (only if requested by stakeholder)	Organization (if applicable)	Date(s) of outreach	What required stakeholder group did they represent?	If other, please describe	Is this person/ organization a resident of the project's service area?	Method of engagement (i.e., phone calls, community forums, focus groups, surveys, etc.)	Did this person/ organization participate in the meaningful engagement?	Is this person/ organization supportive of this project?	Did this person/ organization provide a statement?	If permission is granted to share a statement or quote (250 word max), please include below:	If permission is not granted to share a verbatim statement, please include a summary of the statement(s) below:
Employee 23	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	yes	At present time, our community is experiencing a mental health crisis due to COVID and other health disparities. As a result, having the option to convert unused chemical dependency beds to medical /psych inpatient beds will be of great benefit to our community. I strongly support this conversion.	
Employee 24	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	No		More beds will help patients.
Employee 25	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	yes	Conversion of Chemical Dependency beds to Standard inpatient beds would be ideal for our community especially for patients with low to moderate incomes - and for those without health insurance coverage. I am 100% in favor of increasing bed capacity in our facility. Our community deserve more access to Medical and Healthcare.	
Employee 26	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	no	survey	yes	yes	No		It will improve access to vital services.
Employee 27	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	no	survey	yes	yes	No		The additional beds will help people in need.
Employee 28	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	yes	I would like to make sure that this doesn't become a "dumping ground" for patients that the medical side "don't know what to do with." I would also make sure all staff are more than adequately trained on both pieces of the human before them and that the hospital doesn't just "float" people there if they haven't been trained on that unit. The hospital is moving into more specialized units which means specialized training and support and if it's not there and the care won't be different then the unit should NOT be opened.	

Identifier (i.e., Patient A, Employee B, Respondent 1) or Name (only if requested by stakeholder)	Organization (if applicable)	Date(s) of outreach	What required stakeholder group did they represent?	If other, please describe	Is this person/ organization a resident of the project's service area?	Method of engagement (i.e., phone calls, community forums, focus groups, surveys, etc.)	Did this person/ organization participate in the meaningful engagement?	Is this person/ organization supportive of this project?	Did this person/ organization provide a statement?	If permission is granted to share a statement or quote (250 word max), please include below:	If permission is not granted to share a verbatim statement, please include a summary of the statement(s) below:
Employee 29	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	no	survey	yes	yes	yes	Kings County Hospital is vital to the health of the people of Brooklyn. The community knows that Brooklyn cannot thrive without Kings County Hospital, which is why so many people come to seek healthcare here. We are bursting at the seams and the resulting wait times are uncomfortable for our patients and staff. The resources needed to right-size our Emergency Department and Inpatient units are the key to improving the experience of care for patients, their loved ones, and the hospital staff. These additional beds are needed to relieve the current bottlenecks, and can make a major difference from the instant they become available.	
Employee 30	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	Blank	survey	yes	yes	yes	There are inadequate resources to treat the mentally ill in Brooklyn. We have many homeless people with mental illness who need intensive treatment that can only be obtained on inpatient psychiatric units. This will relieve some of the burden on the system and allow us to help a marginalized group of people who deserve better from society.	
Employee 31	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	yes	survey	yes	yes	yes	Cannot stress enough she importance of high quality, well trained staff. The unit will be harmful without them.	
Employee 32	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	no	survey	yes	yes	yes	While converting chemical dependency beds to standard inpatient beds is very important, we still have to take into consideration that we are facing a shortage of mental health providers, not only physicians and nurse practitioners but very importantly nurses. Having the beds available and no providers won't solve the issue at hand.	

Identifier (i.e., Patient A, Employee B, Respondent 1) or Name (only if requested by stakeholder)	Organization (if applicable)	Date(s) of outreach	What required stakeholder group did they represent?	If other, please describe	Is this person/ organization a resident of the project's service area?	Method of engagement (i.e., phone calls, community forums, focus groups, surveys, etc.)	Did this person/ organization participate in the meaningful engagement?	Is this person/ organization supportive of this project?	Did this person/ organization provide a statement?	If permission is granted to share a statement or quote (250 word max), please include below:	If permission is not granted to share a verbatim statement, please include a summary of the statement(s) below:
Employee 33	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	no	survey	yes	no	yes	Substance abuse present as a growing healthcare issue in this community and having available resources along with access will allow healthcare facilities such as King County Hospital the ability to provide services in this area.	
Employee 34	Kings County Hospital	18-Jun	other	Employee of Kings County Hospital	no	survey	yes	yes	No		The additional inpatient beds will positively impact the community.
Patient 3		18-Jun	other	Patient (current or former)	yes	survey	yes	yes	yes	This project will help in the services and allow a faster placement of inpatients.	
Patient 4		18-Jun	other	Patient (current or former)	yes	survey	yes	yes	yes	I have nothing further to add. I think that the conversion chemical dependency beds to inpatient bed will really help and enhance the community as well as the operation of the hospital.	
Employee 35	Kings County Hospital	1-Jul	other	Employee of Kings County Hospital	yes	interview	yes	yes	No		There is more demand for beds than Kings County Hospital has capacity for. Additionally, the hospital is located in the middle of a highly populated area with high psychiatric needs.
Employee 36	Kings County Hospital	26-Jun	other	Employee of Kings County Hospital	no	interview	yes	yes	No		In the new unit, most patients will a have similar level of need for both medical and psychiatric care.
Community Member 2	Kings County Hospital	27-Jun	community leaders		yes	interview	yes	yes	No		The additional beds will help with faster patient admissions.
Employee 37	Kings County Hospital	1-Jul	other	Employee of Kings County Hospital	no	interview	yes	yes	No		For people who have psychiatric inpatient needs, the additional beds will provide more specialized care and better patient experience.
Employee 38	Kings County Hospital	27-Jun	community leaders		yes	interview	yes	yes	No		ED wait times are long and the additional beds will be helpful in decreasing the wait times for patients.
Employee 39	Kings County Hospital	11-Jul	other	Employee of Kings County Hospital	yes	interview	yes	yes	No		The additional beds will help with faster admissions, patient satisfaction and patient privacy challenges.
Employee 40	Kings County Hospital	28-Jun	other	Employee of Kings County Hospital	yes	interview	yes	yes	No		The additional beds will help increase access to the health care that is needed.

	ZCTA5 11223				ZCTA5 11224			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	80113	3288	100 (X)		47893	2183	100 (X)	
Male	38338	1734	47.9	1.2	22112	1539	46.2	1.7
Female	41775	2053	52.1	1.2	25781	1148	53.8	1.7
Sex ratio (males per 100 females)	91.8	4.3 (X)	(X)		85.8	6 (X)	(X)	
Under 5 years	6642	725	8.3	0.8	2274	486	4.7	0.9
5 to 9 years	6199	677	7.7	0.7	2441	422	5.1	0.8
10 to 14 years	5278	613	6.6	0.7	2997	520	6.3	1
15 to 19 years	4917	498	6.1	0.6	2580	472	5.4	1
20 to 24 years	4486	579	5.6	0.6	2530	540	5.3	1
25 to 34 years	10111	841	12.6	0.9	5213	661	10.9	1.2
35 to 44 years	10122	876	12.6	0.9	4158	459	8.7	0.9
45 to 54 years	9436	804	11.8	1	5152	617	10.8	1.2
55 to 59 years	5609	775	7	0.9	3558	647	7.4	1.3
60 to 64 years	4790	513	6	0.6	3322	671	6.9	1.4
65 to 74 years	6762	633	8.4	0.8	6833	820	14.3	1.7
75 to 84 years	3514	407	4.4	0.5	4734	579	9.9	1.2
85 years and over	2247	468	2.8	0.6	2101	412	4.4	0.9
Median age (years)	37.3	1.5 (X)	(X)		49.4	2.3 (X)	(X)	
RACE (Census Table DP05)								
Total population	80113	3288	100 (X)		47893	2183	100 (X)	
One race	77035	3215	96.2	0.8	44968	2407	93.9	2.4
Two or more races	3078	642	3.8	0.8	2925	1154	6.1	2.4
One race	77035	3215	96.2	0.8	44968	2407	93.9	2.4
White	40820	2225	51	2.4	24538	1983	51.2	3.7
Black or African American	4475	916	5.6	1.1	10241	1352	21.4	2.7
American Indian and Alaska Native	287	189	0.4	0.2	168	145	0.4	0.3
Asian	21861	1556	27.3	1.7	4542	1087	9.5	2.2
Native Hawaiian and Other Pacific Islander	11	16	0	0.1	0	28	0	0.1
Some other race	9581	1968	12	2.3	5479	1627	11.4	3.3
Two or more races	3078	642	3.8	0.8	2925	1154	6.1	2.4
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	80113	3288	100 (X)		47893	2183	100 (X)	
Hispanic or Latino (of any race)	11907	1887	14.9	2.1	9321	1888	19.5	3.6
Not Hispanic or Latino	68206	2888	85.1	2.1	38572	2084	80.5	3.6
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	80094	3289	100 (X)		47028	2182	100 (X)	
With health insurance coverage	75363	3118	94.1	0.8	44699	2156	95	1.2
With private health insurance	38424	2696	48	2.8	20023	1898	42.6	3.4
With public coverage	42624	2711	53.2	2.6	30376	1720	64.6	2.9
No health insurance coverage	4731	707	5.9	0.8	2329	549	5	1.2
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	80094	3289	100 (X)		47028	2182	100 (X)	
With a disability	8777	665	11	0.9	9417	764	20	1.8

	ZCTA5 11225				ZCTA5 11226			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	58476	3018	100	(X)	101053	4193	100	(X)
Male	27373	1684	46.8	1.7	46615	2251	46.1	1.3
Female	31103	1931	53.2	1.7	54438	2672	53.9	1.3
Sex ratio (males per 100 females)	88	6 (X)	(X)		85.6	4.4 (X)	(X)	
Under 5 years	3053	615	5.2	1	5566	808	5.5	0.7
5 to 9 years	2400	510	4.1	0.8	4878	637	4.8	0.6
10 to 14 years	2782	677	4.8	1.1	5186	725	5.1	0.6
15 to 19 years	2690	595	4.6	1	5199	834	5.1	0.7
20 to 24 years	3573	698	6.1	1.1	6613	811	6.5	0.7
25 to 34 years	13762	1233	23.5	1.7	21657	1164	21.4	1.2
35 to 44 years	7483	656	12.8	1	15203	1410	15	1.1
45 to 54 years	7637	988	13.1	1.4	12377	1099	12.2	1
55 to 59 years	3306	592	5.7	1	5954	809	5.9	0.8
60 to 64 years	2840	451	4.9	0.8	5185	661	5.1	0.6
65 to 74 years	4970	594	8.5	1.1	8521	801	8.4	0.8
75 to 84 years	2877	518	4.9	0.9	3224	459	3.2	0.5
85 years and over	1103	315	1.9	0.5	1490	283	1.5	0.3
Median age (years)	36	1.5 (X)	(X)		35.7	0.7 (X)	(X)	
RACE (Census Table DP05)								
Total population	58476	3018	100	(X)	101053	4193	100	(X)
One race	54577	2968	93.3	1.2	94018	4175	93	0.9
Two or more races	3899	714	6.7	1.2	7035	908	7	0.9
One race	54577	2968	93.3	1.2	94018	4175	93	0.9
White	17325	1988	29.6	2.9	15171	1360	15	1.4
Black or African American	32363	2396	55.3	3.1	65186	3550	64.5	2
American Indian and Alaska Native	61	106	0.1	0.2	1549	763	1.5	0.7
Asian	1927	569	3.3	0.9	3186	641	3.2	0.6
Native Hawaiian and Other Pacific Islander	0	31	0	0.1	0	31	0	0.1
Some other race	2901	845	5	1.4	8926	1398	8.8	1.3
Two or more races	3899	714	6.7	1.2	7035	908	7	0.9
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	58476	3018	100	(X)	101053	4193	100	(X)
Hispanic or Latino (of any race)	6330	976	10.8	1.7	15023	1594	14.9	1.4
Not Hispanic or Latino	52146	3108	89.2	1.7	86030	3687	85.1	1.4
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	58348	3008	100	(X)	100529	4211	100	(X)
With health insurance coverage	54881	2896	94.1	1.1	91338	3881	90.9	1.2
With private health insurance	38257	2484	65.6	3	53194	2856	52.9	1.9
With public coverage	21788	2171	37.3	3.1	43931	2442	43.7	1.8
No health insurance coverage	3467	672	5.9	1.1	9191	1351	9.1	1.2
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	58348	3008	100	(X)	100529	4211	100	(X)
With a disability	5582	750	9.6	1.3	6733	707	6.7	0.7

	ZCTA5 11228				ZCTA5 11229			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	44196	2179	100	(X)	81109	2814	100	(X)
Male	22098	1360	50	1.5	39428	1545	48.6	1
Female	22098	1168	50	1.5	41681	1731	51.4	1
Sex ratio (males per 100 females)	100	5.9	(X)	(X)	94.6	3.9	(X)	(X)
Under 5 years	2279	398	5.2	0.8	4778	562	5.9	0.7
5 to 9 years	2467	356	5.6	0.7	4956	521	6.1	0.6
10 to 14 years	2080	287	4.7	0.6	5565	673	6.9	0.7
15 to 19 years	2185	313	4.9	0.7	4110	554	5.1	0.6
20 to 24 years	2498	374	5.7	0.8	3758	454	4.6	0.5
25 to 34 years	5751	767	13	1.5	10393	893	12.8	1
35 to 44 years	5753	555	13	1	9651	659	11.9	0.7
45 to 54 years	6447	699	14.6	1.4	9270	780	11.4	0.9
55 to 59 years	3053	454	6.9	0.9	5701	611	7	0.7
60 to 64 years	2734	375	6.2	0.9	6076	627	7.5	0.8
65 to 74 years	4926	524	11.1	1.2	9960	661	12.3	0.9
75 to 84 years	2951	371	6.7	0.8	4712	605	5.8	0.8
85 years and over	1072	257	2.4	0.6	2179	358	2.7	0.5
Median age (years)	43.2	1.5	(X)	(X)	42.2	1.2	(X)	(X)
RACE (Census Table DP05)								
Total population	44196	2179	100	(X)	81109	2814	100	(X)
One race	42607	2116	96.4	0.7	76958	2840	94.9	1.1
Two or more races	1589	343	3.6	0.7	4151	860	5.1	1.1
One race	42607	2116	96.4	0.7	76958	2840	94.9	1.1
White	23623	1687	53.5	2.9	49135	2458	60.6	2.3
Black or African American	552	224	1.2	0.5	5069	981	6.2	1.2
American Indian and Alaska Native	129	142	0.3	0.3	194	133	0.2	0.2
Asian	15583	1358	35.3	2.7	19501	1523	24	1.8
Native Hawaiian and Other Pacific Islander	0	28	0	0.1	56	84	0.1	0.1
Some other race	2720	788	6.2	1.7	3003	950	3.7	1.1
Two or more races	1589	343	3.6	0.7	4151	860	5.1	1.1
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	44196	2179	100	(X)	81109	2814	100	(X)
Hispanic or Latino (of any race)	5607	1026	12.7	2.1	7163	1171	8.8	1.4
Not Hispanic or Latino	38589	1966	87.3	2.1	73946	2629	91.2	1.4
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	44044	2181	100	(X)	80912	2814	100	(X)
With health insurance coverage	41448	2020	94.1	1.2	76921	2758	95.1	0.8
With private health insurance	27005	1531	61.3	2.5	48276	2679	59.7	2.2
With public coverage	19345	1473	43.9	2.4	37272	1897	46.1	2.2
No health insurance coverage	2596	575	5.9	1.2	3991	639	4.9	0.8
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	44044	2181	100	(X)	80912	2814	100	(X)
With a disability	4504	521	10.2	1.1	8443	560	10.4	0.8

	ZCTA5 11230				ZCTA5 11231			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	90245	2834	100	(X)	38829	2393	100	(X)
Male	44876	1844	49.7	1	18277	1298	47.1	2.2
Female	45369	1497	50.3	1	20552	1654	52.9	2.2
Sex ratio (males per 100 females)	98.9	4	(X)	(X)	88.9	7.9	(X)	(X)
Under 5 years	7918	808	8.8	0.8	3167	605	8.2	1.4
5 to 9 years	6037	749	6.7	0.7	2715	686	7	1.6
10 to 14 years	6904	715	7.7	0.7	1990	442	5.1	1.1
15 to 19 years	5729	528	6.3	0.6	1546	340	4	0.9
20 to 24 years	4464	457	4.9	0.5	1524	467	3.9	1.1
25 to 34 years	13163	1217	14.6	1.2	6061	752	15.6	2.2
35 to 44 years	10458	778	11.6	0.7	8015	1049	20.6	2.3
45 to 54 years	10207	620	11.3	0.7	5489	975	14.1	2
55 to 59 years	4396	540	4.9	0.6	2524	420	6.5	1.1
60 to 64 years	5351	673	5.9	0.7	1876	341	4.8	0.9
65 to 74 years	9467	792	10.5	0.9	2399	338	6.2	0.9
75 to 84 years	3841	469	4.3	0.5	1256	322	3.2	0.8
85 years and over	2310	446	2.6	0.5	267	151	0.7	0.4
Median age (years)	35.8	1.1	(X)	(X)	37.7	1.1	(X)	(X)
RACE (Census Table DP05)								
Total population	90245	2834	100	(X)	38829	2393	100	(X)
One race	85392	2714	94.6	1	35211	2186	90.7	1.6
Two or more races	4853	956	5.4	1	3618	673	9.3	1.6
One race	85392	2714	94.6	1	35211	2186	90.7	1.6
White	56510	2502	62.6	2.2	25045	1496	64.5	3.4
Black or African American	7916	1129	8.8	1.2	4958	1284	12.8	3.1
American Indian and Alaska Native	683	457	0.8	0.5	126	108	0.3	0.3
Asian	14427	1697	16	1.8	2154	400	5.5	1
Native Hawaiian and Other Pacific Islander	48	51	0.1	0.1	458	464	1.2	1.2
Some other race	5808	1170	6.4	1.3	2470	1079	6.4	2.6
Two or more races	4853	956	5.4	1	3618	673	9.3	1.6
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	90245	2834	100	(X)	38829	2393	100	(X)
Hispanic or Latino (of any race)	10644	1531	11.8	1.7	5812	1178	15	2.7
Not Hispanic or Latino	79601	2886	88.2	1.7	33017	2113	85	2.7
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	90055	2833	100	(X)	38819	2392	100	(X)
With health insurance coverage	83690	2776	92.9	1.2	37003	2222	95.3	1.4
With private health insurance	42964	2286	47.7	2.2	29072	1962	74.9	2.6
With public coverage	49111	2428	54.5	2.1	10072	1072	25.9	2.5
No health insurance coverage	6365	1090	7.1	1.2	1816	583	4.7	1.4
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	90055	2833	100	(X)	38819	2392	100	(X)
With a disability	11708	693	13	0.9	2813	437	7.2	1.1

	ZCTA5 11201				ZCTA5 11203			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	69755	2608	100 (X)		78506	2674	100 (X)	
Male	33195	1663	47.6	1.4	36032	1634	45.9	1.2
Female	36560	1598	52.4	1.4	42474	1664	54.1	1.2
Sex ratio (males per 100 females)	90.8	5.1 (X)	(X)		84.8	4.2 (X)	(X)	
Under 5 years	4950	599	7.1	0.8	4037	617	5.1	0.8
5 to 9 years	3421	534	4.9	0.7	3832	518	4.9	0.6
10 to 14 years	2650	546	3.8	0.7	4134	455	5.3	0.5
15 to 19 years	2792	447	4	0.6	4342	620	5.5	0.7
20 to 24 years	3972	546	5.7	0.7	4100	508	5.2	0.6
25 to 34 years	16871	967	24.2	1.4	11443	868	14.6	1
35 to 44 years	12739	1225	18.3	1.5	10373	778	13.2	0.9
45 to 54 years	7975	783	11.4	1.1	9168	648	11.7	0.8
55 to 59 years	3283	565	4.7	0.8	5602	519	7.1	0.6
60 to 64 years	2357	354	3.4	0.5	6020	664	7.7	0.8
65 to 74 years	4616	472	6.6	0.7	9002	554	11.5	0.7
75 to 84 years	3048	472	4.4	0.7	4580	430	5.8	0.6
85 years and over	1081	324	1.5	0.5	1873	381	2.4	0.5
Median age (years)	35.1	0.6 (X)	(X)		42.3	0.8 (X)	(X)	
RACE (Census Table DP05)								
Total population	69755	2608	100 (X)		78506	2674	100 (X)	
One race	63346	2110	90.8	1.5	72709	2521	92.6	1.3
Two or more races	6409	1171	9.2	1.5	5797	1072	7.4	1.3
One race	63346	2110	90.8	1.5	72709	2521	92.6	1.3
White	42394	1655	60.8	1.9	4399	737	5.6	1
Black or African American	8399	1017	12	1.4	64474	2544	82.1	1.9
American Indian and Alaska Native	132	107	0.2	0.2	110	84	0.1	0.1
Asian	9960	1143	14.3	1.6	1462	354	1.9	0.5
Native Hawaiian and Other Pacific Islander	0	31	0	0.1	22	36	0	0.1
Some other race	2461	843	3.5	1.2	2242	630	2.9	0.8
Two or more races	6409	1171	9.2	1.5	5797	1072	7.4	1.3
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	69755	2608	100 (X)		78506	2674	100 (X)	
Hispanic or Latino (of any race)	7705	1382	11	1.8	5388	985	6.9	1.2
Not Hispanic or Latino	62050	2257	89	1.8	73118	2572	93.1	1.2
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	69061	2606	100 (X)		77339	2678	100 (X)	
With health insurance coverage	67231	2606	97.4	0.6	72766	2638	94.1	0.9
With private health insurance	57943	2444	83.9	1.5	43275	2375	56	2.1
With public coverage	14776	1200	21.4	1.6	34094	1777	44.1	2
No health insurance coverage	1830	406	2.6	0.6	4573	733	5.9	0.9
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	69061	2606	100 (X)		77339	2678	100 (X)	
With a disability	5634	709	8.2	1	8094	612	10.5	0.8

	ZCTA5 11204				ZCTA5 11205			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	80575	3431	100	(X)	50319	2405	100	(X)
Male	39889	1940	49.5	1	23065	1381	45.8	1.7
Female	40686	1882	50.5	1	27254	1541	54.2	1.7
Sex ratio (males per 100 females)	98	4.1	(X)	(X)	84.6	5.6	(X)	(X)
Under 5 years	7209	750	8.9	0.8	4751	705	9.4	1.3
5 to 9 years	6869	730	8.5	0.7	4366	625	8.7	1.1
10 to 14 years	6574	665	8.2	0.7	4031	473	8	0.8
15 to 19 years	5394	663	6.7	0.7	4515	592	9	1
20 to 24 years	4391	605	5.4	0.7	3759	619	7.5	1.2
25 to 34 years	10160	869	12.6	0.9	9202	1016	18.3	2
35 to 44 years	9550	910	11.9	1.1	7673	783	15.2	1.4
45 to 54 years	9460	805	11.7	0.9	4438	508	8.8	1
55 to 59 years	5034	749	6.2	0.9	1621	289	3.2	0.6
60 to 64 years	4406	378	5.5	0.5	1606	379	3.2	0.7
65 to 74 years	6311	560	7.8	0.7	2393	371	4.8	0.7
75 to 84 years	3364	413	4.2	0.5	1392	314	2.8	0.6
85 years and over	1853	371	2.3	0.5	572	307	1.1	0.6
Median age (years)	34.7	1.1	(X)	(X)	29.7	1.2	(X)	(X)
RACE (Census Table DP05)								
Total population	80575	3431	100	(X)	50319	2405	100	(X)
One race	77210	3309	95.8	0.9	46809	2396	93	1.1
Two or more races	3365	756	4.2	0.9	3510	560	7	1.1
One race	77210	3309	95.8	0.9	46809	2396	93	1.1
White	44660	2701	55.4	2.5	28236	2242	56.1	2.7
Black or African American	658	240	0.8	0.3	11640	1370	23.1	2.6
American Indian and Alaska Native	800	453	1	0.6	279	232	0.6	0.5
Asian	24763	2132	30.7	2.3	3781	578	7.5	1.2
Native Hawaiian and Other Pacific Islander	14	20	0	0.1	10	20	0	0.1
Some other race	6315	1422	7.8	1.7	2863	871	5.7	1.8
Two or more races	3365	756	4.2	0.9	3510	560	7	1.1
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	80575	3431	100	(X)	50319	2405	100	(X)
Hispanic or Latino (of any race)	9128	1477	11.3	1.8	7107	1052	14.1	2
Not Hispanic or Latino	71447	3321	88.7	1.8	43212	2393	85.9	2
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	80481	3421	100	(X)	50292	2408	100	(X)
With health insurance coverage	74785	3343	92.9	1.1	48528	2341	96.5	0.7
With private health insurance	32213	2039	40	2.1	27611	1774	54.9	3.2
With public coverage	47797	2764	59.4	2.2	24950	2289	49.6	3.2
No health insurance coverage	5696	930	7.1	1.1	1764	341	3.5	0.7
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	80481	3421	100	(X)	50292	2408	100	(X)
With a disability	6710	581	8.3	0.7	4395	626	8.7	1.2

	ZCTA5 11206				ZCTA5 11207			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	89949	3787	100 (X)		96801	3579	100 (X)	
Male	42868	2395	47.7	1.3	43296	1934	44.7	1.2
Female	47081	2012	52.3	1.3	53505	2367	55.3	1.2
Sex ratio (males per 100 females)	91.1	4.7 (X)	(X)		80.9	4 (X)	(X)	
Under 5 years	7202	1030	8	1	6376	839	6.6	0.8
5 to 9 years	6512	831	7.2	0.8	6311	747	6.5	0.7
10 to 14 years	7040	885	7.8	0.9	6071	659	6.3	0.6
15 to 19 years	6177	832	6.9	0.9	5208	695	5.4	0.7
20 to 24 years	7181	845	8	0.9	7502	673	7.7	0.6
25 to 34 years	18884	1334	21	1.4	16173	992	16.7	1
35 to 44 years	12277	1079	13.6	1.1	13512	1018	14	1
45 to 54 years	8018	876	8.9	0.9	11468	988	11.8	0.9
55 to 59 years	3754	565	4.2	0.6	5080	620	5.2	0.6
60 to 64 years	3951	561	4.4	0.6	5784	646	6	0.7
65 to 74 years	5287	613	5.9	0.7	7440	641	7.7	0.6
75 to 84 years	2641	434	2.9	0.5	3848	558	4	0.6
85 years and over	1025	343	1.1	0.4	2028	537	2.1	0.5
Median age (years)	30.4	0.6 (X)	(X)		35.4	0.7 (X)	(X)	
RACE (Census Table DP05)								
Total population	89949	3787	100 (X)		96801	3579	100 (X)	
One race	81693	3699	90.8	1.5	88768	3392	91.7	1.3
Two or more races	8256	1390	9.2	1.5	8033	1351	8.3	1.3
One race	81693	3699	90.8	1.5	88768	3392	91.7	1.3
White	39368	2919	43.8	2.5	12169	1576	12.6	1.6
Black or African American	20210	2176	22.5	2.1	58936	2945	60.9	2.4
American Indian and Alaska Native	1140	455	1.3	0.5	161	104	0.2	0.1
Asian	5785	965	6.4	1.1	1440	368	1.5	0.4
Native Hawaiian and Other Pacific Islander	198	273	0.2	0.3	1	3	0	0.1
Some other race	14992	1894	16.7	2	16061	2166	16.6	2
Two or more races	8256	1390	9.2	1.5	8033	1351	8.3	1.3
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	89949	3787	100 (X)		96801	3579	100 (X)	
Hispanic or Latino (of any race)	32583	2544	36.2	2.5	31777	2732	32.8	2.3
Not Hispanic or Latino	57366	3382	63.8	2.5	65024	2915	67.2	2.3
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	89901	3786	100 (X)		96282	3572	100 (X)	
With health insurance coverage	84593	3576	94.1	0.9	90458	3527	94	0.9
With private health insurance	40005	2523	44.5	2.4	48143	2750	50	2.3
With public coverage	52671	3078	58.6	1.9	54783	3116	56.9	2.2
No health insurance coverage	5308	901	5.9	0.9	5824	843	6	0.9
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	89901	3786	100 (X)		96282	3572	100 (X)	
With a disability	11347	846	12.6	1	13296	988	13.8	0.9

	ZCTA5 11208				ZCTA5 11209			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	108180	4765	100 (X)		71812	2099	100 (X)	
Male	51983	2879	48.1	1.3	34635	1293	48.2	1
Female	56197	2637	51.9	1.3	37177	1254	51.8	1
Sex ratio (males per 100 females)	92.5	4.8 (X)	(X)		93.2	3.8 (X)	(X)	
Under 5 years	8276	1155	7.7	1	4186	550	5.8	0.7
5 to 9 years	7084	886	6.5	0.7	3739	464	5.2	0.6
10 to 14 years	8535	841	7.9	0.7	3518	443	4.9	0.6
15 to 19 years	8064	896	7.5	0.8	4183	527	5.8	0.7
20 to 24 years	6615	861	6.1	0.8	3488	518	4.9	0.7
25 to 34 years	17053	1452	15.8	1.2	10598	862	14.8	1.1
35 to 44 years	14201	1287	13.1	1	10819	659	15.1	0.8
45 to 54 years	12256	1084	11.3	0.9	9170	678	12.8	0.9
55 to 59 years	7289	983	6.7	0.8	4725	568	6.6	0.8
60 to 64 years	6201	633	5.7	0.6	4067	479	5.7	0.7
65 to 74 years	7976	914	7.4	0.8	7670	493	10.7	0.7
75 to 84 years	3283	571	3	0.5	3779	437	5.3	0.6
85 years and over	1347	449	1.2	0.4	1870	292	2.6	0.4
Median age (years)	33.8	1.1 (X)	(X)		40.6	1.1 (X)	(X)	
RACE (Census Table DP05)								
Total population	108180	4765	100 (X)		71812	2099	100 (X)	
One race	101208	4373	93.6	1.3	66385	2069	92.4	1
Two or more races	6972	1550	6.4	1.3	5427	756	7.6	1
One race	101208	4373	93.6	1.3	66385	2069	92.4	1
White	18676	2132	17.3	1.8	48145	1970	67	2.2
Black or African American	52901	3543	48.9	2.2	2427	756	3.4	1
American Indian and Alaska Native	76	122	0.1	0.1	592	320	0.8	0.4
Asian	8740	1470	8.1	1.3	9712	982	13.5	1.3
Native Hawaiian and Other Pacific Islander	256	188	0.2	0.2	33	23	0	0.1
Some other race	20559	2349	19	2.2	5476	833	7.6	1.1
Two or more races	6972	1550	6.4	1.3	5427	756	7.6	1
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	108180	4765	100 (X)		71812	2099	100 (X)	
Hispanic or Latino (of any race)	42173	2572	39	2.1	14178	1328	19.7	1.7
Not Hispanic or Latino	66007	4028	61	2.1	57634	1951	80.3	1.7
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	107901	4780	100 (X)		71504	2104	100 (X)	
With health insurance coverage	101870	4602	94.4	0.7	67537	1986	94.5	0.8
With private health insurance	51213	3105	47.5	2	48678	1927	68.1	2.2
With public coverage	59078	3809	54.8	2.2	25805	1722	36.1	2.2
No health insurance coverage	6031	820	5.6	0.7	3967	600	5.5	0.8
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	107901	4780	100 (X)		71504	2104	100 (X)	
With a disability	8761	963	8.1	0.9	7795	623	10.9	0.9

	ZCTA5 11232				ZCTA5 11233			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	28137	1833	100	(X)	83125	3181	100	(X)
Male	15242	1030	54.2	1.6	37663	1886	45.3	1.3
Female	12895	1010	45.8	1.6	45462	1991	54.7	1.3
Sex ratio (males per 100 females)	118.2	7.7	(X)	(X)	82.8	4.5	(X)	(X)
Under 5 years	1542	385	5.5	1.3	5703	769	6.9	0.9
5 to 9 years	1673	397	5.9	1.2	5072	760	6.1	0.9
10 to 14 years	1728	336	6.1	1	4069	566	4.9	0.6
15 to 19 years	1299	388	4.6	1.2	3661	653	4.4	0.7
20 to 24 years	1600	361	5.7	1.3	6371	1041	7.7	1.1
25 to 34 years	5895	702	21	2.3	16760	1299	20.2	1.5
35 to 44 years	5055	590	18	1.7	10870	959	13.1	1.1
45 to 54 years	4039	486	14.4	1.9	10686	948	12.9	1.1
55 to 59 years	1936	413	6.9	1.4	5141	858	6.2	1
60 to 64 years	1228	327	4.4	1.1	4620	611	5.6	0.8
65 to 74 years	1378	352	4.9	1.3	6100	760	7.3	0.9
75 to 84 years	598	165	2.1	0.6	2853	452	3.4	0.5
85 years and over	166	98	0.6	0.4	1219	382	1.5	0.4
Median age (years)	35.5	1.2	(X)	(X)	35	0.9	(X)	(X)
RACE (Census Table DP05)								
Total population	28137	1833	100	(X)	83125	3181	100	(X)
One race	25045	1951	89	2.7	77963	3187	93.8	1.1
Two or more races	3092	744	11	2.7	5162	896	6.2	1.1
One race	25045	1951	89	2.7	77963	3187	93.8	1.1
White	10725	1175	38.1	3.8	11851	1425	14.3	1.7
Black or African American	2021	468	7.2	1.6	58706	3032	70.6	2.3
American Indian and Alaska Native	614	345	2.2	1.2	459	229	0.6	0.3
Asian	4345	695	15.4	2.6	1086	412	1.3	0.5
Native Hawaiian and Other Pacific Islander	14	26	0	0.1	26	42	0	0.1
Some other race	7326	1586	26	4.7	5835	1237	7	1.4
Two or more races	3092	744	11	2.7	5162	896	6.2	1.1
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	28137	1833	100	(X)	83125	3181	100	(X)
Hispanic or Latino (of any race)	14736	1828	52.4	4.2	13061	1606	15.7	1.9
Not Hispanic or Latino	13401	1096	47.6	4.2	70064	3135	84.3	1.9
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	26471	1823	100	(X)	82863	3179	100	(X)
With health insurance coverage	23300	1666	88	2.3	77145	2740	93.1	1.3
With private health insurance	14027	1107	53	3.6	47224	2582	57	2.2
With public coverage	11186	1468	42.3	4	36287	1947	43.8	2
No health insurance coverage	3171	665	12	2.3	5718	1149	6.9	1.3
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	26471	1823	100	(X)	82863	3179	100	(X)
With a disability	2966	475	11.2	1.8	10304	950	12.4	1.1

	ZCTA5 11234				ZCTA5 11235			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	89976	2620	100 (X)		83069	2433	100 (X)	
Male	41815	1596	46.5	1.1	40192	1677	48.4	1.3
Female	48161	1721	53.5	1.1	42877	1573	51.6	1.3
Sex ratio (males per 100 females)	86.8	3.9 (X)	(X)		93.7	4.9 (X)	(X)	
Under 5 years	4665	617	5.2	0.7	4313	624	5.2	0.7
5 to 9 years	4667	589	5.2	0.6	3593	472	4.3	0.6
10 to 14 years	6506	763	7.2	0.8	3942	515	4.7	0.6
15 to 19 years	5279	578	5.9	0.6	3679	463	4.4	0.5
20 to 24 years	5141	532	5.7	0.6	3984	626	4.8	0.7
25 to 34 years	9846	771	10.9	0.8	10078	1046	12.1	1.1
35 to 44 years	11534	731	12.8	0.8	10180	767	12.3	0.8
45 to 54 years	11533	906	12.8	0.9	10307	889	12.4	1
55 to 59 years	5847	458	6.5	0.5	6141	707	7.4	0.8
60 to 64 years	6572	556	7.3	0.6	5796	589	7	0.7
65 to 74 years	10468	721	11.6	0.8	11789	884	14.2	1.1
75 to 84 years	5770	730	6.4	0.7	5813	641	7	0.8
85 years and over	2148	363	2.4	0.4	3454	477	4.2	0.6
Median age (years)	42.6	1.3 (X)	(X)		46.7	1.3 (X)	(X)	
RACE (Census Table DP05)								
Total population	89976	2620	100 (X)		83069	2433	100 (X)	
One race	84907	2433	94.4	1.1	76862	2670	92.5	1.7
Two or more races	5069	1022	5.6	1.1	6207	1388	7.5	1.7
One race	84907	2433	94.4	1.1	76862	2670	92.5	1.7
White	33915	1652	37.7	1.7	57750	2510	69.5	2.2
Black or African American	39296	2324	43.7	2	2130	538	2.6	0.7
American Indian and Alaska Native	390	269	0.4	0.3	23	25	0	0.1
Asian	7312	933	8.1	1	12344	1322	14.9	1.5
Native Hawaiian and Other Pacific Islander	0	31	0	0.1	0	31	0	0.1
Some other race	3994	922	4.4	1	4615	1016	5.6	1.2
Two or more races	5069	1022	5.6	1.1	6207	1388	7.5	1.7
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	89976	2620	100 (X)		83069	2433	100 (X)	
Hispanic or Latino (of any race)	8004	1191	8.9	1.3	7557	1349	9.1	1.6
Not Hispanic or Latino	81972	2790	91.1	1.3	75512	2473	90.9	1.6
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	89898	2619	100 (X)		82039	2435	100 (X)	
With health insurance coverage	86024	2534	95.7	0.7	75356	2493	91.9	1.1
With private health insurance	60563	2453	67.4	1.9	40883	2174	49.8	2
With public coverage	36179	1886	40.2	1.8	42995	2101	52.4	2.2
No health insurance coverage	3874	607	4.3	0.7	6683	883	8.1	1.1
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	89898	2619	100 (X)		82039	2435	100 (X)	
With a disability	9278	770	10.3	0.8	12333	867	15	1

	ZCTA5 11236				ZCTA5 11237			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	100082	3175	100 (X)		47183	2242	100 (X)	
Male	45553	1751	45.5	0.9	24514	1549	52	2
Female	54529	1934	54.5	0.9	22669	1362	48	2
Sex ratio (males per 100 females)	83.5	3.1 (X)	(X)		108.1	8.5 (X)	(X)	
Under 5 years	5712	762	5.7	0.7	2014	508	4.3	1
5 to 9 years	6338	709	6.3	0.7	1530	339	3.2	0.7
10 to 14 years	5875	522	5.9	0.5	2544	430	5.4	0.9
15 to 19 years	5927	642	5.9	0.6	2281	508	4.8	1
20 to 24 years	6319	605	6.3	0.5	3860	550	8.2	1.2
25 to 34 years	13887	1101	13.9	0.9	13880	1349	29.4	2.3
35 to 44 years	12595	809	12.6	0.7	7677	648	16.3	1.2
45 to 54 years	12490	935	12.5	0.8	5537	660	11.7	1.4
55 to 59 years	7152	625	7.1	0.6	1748	423	3.7	0.9
60 to 64 years	6838	596	6.8	0.6	1817	469	3.9	0.9
65 to 74 years	9986	642	10	0.7	2784	441	5.9	0.9
75 to 84 years	5087	498	5.1	0.5	1265	546	2.7	1.1
85 years and over	1876	333	1.9	0.3	246	132	0.5	0.3
Median age (years)	39.8	1.1 (X)	(X)		32.6	0.9 (X)	(X)	
RACE (Census Table DP05)								
Total population	100082	3175	100 (X)		47183	2242	100 (X)	
One race	93828	3056	93.8	0.9	40894	2215	86.7	2.1
Two or more races	6254	981	6.2	0.9	6289	1048	13.3	2.1
One race	93828	3056	93.8	0.9	40894	2215	86.7	2.1
White	5075	722	5.1	0.8	15083	1212	32	2.7
Black or African American	81608	2987	81.5	1.5	5890	1087	12.5	2.3
American Indian and Alaska Native	81	57	0.1	0.1	885	536	1.9	1.1
Asian	2639	527	2.6	0.5	3107	509	6.6	1.1
Native Hawaiian and Other Pacific Islander	21	25	0	0.1	36	45	0.1	0.1
Some other race	4404	774	4.4	0.7	15893	2027	33.7	3.4
Two or more races	6254	981	6.2	0.9	6289	1048	13.3	2.1
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	100082	3175	100 (X)		47183	2242	100 (X)	
Hispanic or Latino (of any race)	9116	1016	9.1	1	26247	2061	55.6	2.9
Not Hispanic or Latino	90966	3081	90.9	1	20936	1469	44.4	2.9
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	99403	3179	100 (X)		47177	2242	100 (X)	
With health insurance coverage	93453	3115	94	0.6	41451	1864	87.9	2
With private health insurance	57990	2497	58.3	1.9	25771	1582	54.6	3.2
With public coverage	43500	2303	43.8	1.8	20436	1465	43.3	2.6
No health insurance coverage	5950	608	6	0.6	5726	1075	12.1	2
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	99403	3179	100 (X)		47177	2242	100 (X)	
With a disability	7743	662	7.8	0.7	4544	632	9.6	1.4

	ZCTA5 11238				ZCTA5 11210			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	58047	2189	100 (X)		63426	2543	100 (X)	
Male	26680	1281	46	1.3	31315	1526	49.4	1.3
Female	31367	1358	54	1.3	32111	1530	50.6	1.3
Sex ratio (males per 100 females)	85.1	4.3 (X)	(X)		97.5	5.2 (X)	(X)	
Under 5 years	4452	763	7.7	1.2	3475	515	5.5	0.8
5 to 9 years	2038	343	3.5	0.6	4286	467	6.8	0.7
10 to 14 years	2441	521	4.2	0.8	4394	517	6.9	0.7
15 to 19 years	1218	335	2.1	0.6	4093	537	6.5	0.8
20 to 24 years	2136	476	3.7	0.8	4182	582	6.6	0.8
25 to 34 years	16300	1087	28.1	1.8	8536	911	13.5	1.3
35 to 44 years	10472	804	18	1.2	8158	682	12.9	1
45 to 54 years	7250	885	12.5	1.4	7601	796	12	1.1
55 to 59 years	2954	519	5.1	0.9	4104	593	6.5	0.9
60 to 64 years	1946	343	3.4	0.6	3989	395	6.3	0.6
65 to 74 years	4366	523	7.5	0.9	6316	628	10	1
75 to 84 years	1616	320	2.8	0.6	2852	365	4.5	0.6
85 years and over	858	201	1.5	0.3	1440	386	2.3	0.6
Median age (years)	35.3	0.6 (X)	(X)		38.2	1.5 (X)	(X)	
RACE (Census Table DP05)								
Total population	58047	2189	100 (X)		63426	2543	100 (X)	
One race	51210	2024	88.2	1.4	59793	2538	94.3	1.2
Two or more races	6837	880	11.8	1.4	3633	796	5.7	1.2
One race	51210	2024	88.2	1.4	59793	2538	94.3	1.2
White	29650	1491	51.1	2.1	19245	1560	30.3	2.2
Black or African American	15622	1429	26.9	2	33680	2214	53.1	2.5
American Indian and Alaska Native	296	193	0.5	0.3	84	62	0.1	0.1
Asian	3850	531	6.6	0.9	3658	765	5.8	1.2
Native Hawaiian and Other Pacific Islander	0	31	0	0.1	0	31	0	0.1
Some other race	1792	443	3.1	0.8	3126	872	4.9	1.4
Two or more races	6837	880	11.8	1.4	3633	796	5.7	1.2
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	58047	2189	100 (X)		63426	2543	100 (X)	
Hispanic or Latino (of any race)	8122	988	14	1.5	4741	868	7.5	1.4
Not Hispanic or Latino	49925	1829	86	1.5	58685	2756	92.5	1.4
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	57634	2185	100 (X)		63377	2543	100 (X)	
With health insurance coverage	55579	2158	96.4	0.8	60167	2522	94.9	0.9
With private health insurance	45231	1884	78.5	2.1	40705	2139	64.2	2.1
With public coverage	14292	1389	24.8	2.1	26473	1635	41.8	2
No health insurance coverage	2055	475	3.6	0.8	3210	597	5.1	0.9
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	57634	2185	100 (X)		63377	2543	100 (X)	
With a disability	5020	621	8.7	1.1	6836	671	10.8	0.9

	ZCTA5 11211				ZCTA5 11212			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	65511	3000	100 (X)		84006	4268	100 (X)	
Male	32868	2197	50.2	2	35682	2609	42.5	1.7
Female	32643	1719	49.8	2	48324	2491	57.5	1.7
Sex ratio (males per 100 females)	100.7	7.9 (X)	(X)		73.8	5.2 (X)	(X)	
Under 5 years	4961	732	7.6	1	5889	1055	7	1.1
5 to 9 years	3419	649	5.2	0.9	5470	853	6.5	0.9
10 to 14 years	3611	624	5.5	0.8	5480	908	6.5	1
15 to 19 years	2977	542	4.5	0.7	4292	715	5.1	0.8
20 to 24 years	5240	764	8	1.2	5011	769	6	0.9
25 to 34 years	18837	1283	28.8	2	13665	1527	16.3	1.4
35 to 44 years	10035	1036	15.3	1.3	10581	1060	12.6	1.2
45 to 54 years	5873	710	9	1	9233	940	11	1.1
55 to 59 years	2583	442	3.9	0.6	6436	977	7.7	1.1
60 to 64 years	2288	408	3.5	0.6	6316	910	7.5	1
65 to 74 years	3135	499	4.8	0.8	7024	803	8.4	1
75 to 84 years	1629	317	2.5	0.5	3424	473	4.1	0.6
85 years and over	923	361	1.4	0.5	1185	305	1.4	0.4
Median age (years)	31.3	0.6 (X)	(X)		37.2	1.5 (X)	(X)	
RACE (Census Table DP05)								
Total population	65511	3000	100 (X)		84006	4268	100 (X)	
One race	60891	3068	92.9	1.1	75563	3891	89.9	2.2
Two or more races	4620	721	7.1	1.1	8443	1944	10.1	2.2
One race	60891	3068	92.9	1.1	75563	3891	89.9	2.2
White	43092	2744	65.8	3.1	5582	1587	6.6	1.8
Black or African American	4318	975	6.6	1.4	61370	3612	73.1	3.4
American Indian and Alaska Native	377	236	0.6	0.4	261	178	0.3	0.2
Asian	3999	1036	6.1	1.5	659	404	0.8	0.5
Native Hawaiian and Other Pacific Islander	0	31	0	0.1	66	60	0.1	0.1
Some other race	9105	1920	13.9	2.8	7625	1797	9.1	2
Two or more races	4620	721	7.1	1.1	8443	1944	10.1	2.2
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	65511	3000	100 (X)		84006	4268	100 (X)	
Hispanic or Latino (of any race)	17036	1839	26	2.5	16365	2113	19.5	2.2
Not Hispanic or Latino	48475	2766	74	2.5	67641	3777	80.5	2.2
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	65450	2999	100 (X)		83303	4267	100 (X)	
With health insurance coverage	61528	2944	94	1.1	77222	4032	92.7	1
With private health insurance	36966	1959	56.5	2.7	32578	2727	39.1	2.5
With public coverage	28624	2550	43.7	2.6	51577	3239	61.9	2.6
No health insurance coverage	3922	734	6	1.1	6081	868	7.3	1
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	65450	2999	100 (X)		83303	4267	100 (X)	
With a disability	5551	626	8.5	0.9	12591	1534	15.1	1.8

	ZCTA5 11213				ZCTA5 11214			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	69131	2761	100 (X)		90796	3329	100 (X)	
Male	32227	1832	46.6	1.6	44699	1988	49.2	1
Female	36904	1643	53.4	1.6	46097	1833	50.8	1
Sex ratio (males per 100 females)	87.3	5.4 (X)	(X)		97	4 (X)	(X)	
Under 5 years	4835	644	7	0.9	5230	749	5.8	0.8
5 to 9 years	4386	576	6.3	0.8	5176	600	5.7	0.6
10 to 14 years	4347	606	6.3	0.8	5916	694	6.5	0.7
15 to 19 years	4082	598	5.9	0.8	4758	590	5.2	0.6
20 to 24 years	5570	709	8.1	1	5266	547	5.8	0.6
25 to 34 years	12401	1070	17.9	1.4	12177	895	13.4	0.9
35 to 44 years	9102	1035	13.2	1.3	11804	916	13	0.9
45 to 54 years	7694	684	11.1	1	11684	829	12.9	0.9
55 to 59 years	3951	602	5.7	0.8	6222	639	6.9	0.7
60 to 64 years	3648	465	5.3	0.7	6245	622	6.9	0.6
65 to 74 years	5161	624	7.5	0.9	8483	718	9.3	0.8
75 to 84 years	2900	524	4.2	0.7	5168	645	5.7	0.7
85 years and over	1054	263	1.5	0.4	2667	402	2.9	0.4
Median age (years)	34	1 (X)	(X)		40.6	1.1 (X)	(X)	
RACE (Census Table DP05)								
Total population	69131	2761	100 (X)		90796	3329	100 (X)	
One race	64694	2827	93.6	1.3	85958	3174	94.7	1.2
Two or more races	4437	882	6.4	1.3	4838	1172	5.3	1.2
One race	64694	2827	93.6	1.3	85958	3174	94.7	1.2
White	17829	1491	25.8	2.1	39627	2418	43.6	2.2
Black or African American	40794	2498	59	2.5	1963	473	2.2	0.5
American Indian and Alaska Native	8	14	0	0.1	640	392	0.7	0.4
Asian	1116	300	1.6	0.4	33336	1936	36.7	1.9
Native Hawaiian and Other Pacific Islander	26	34	0	0.1	8	13	0	0.1
Some other race	4921	1396	7.1	1.9	10384	1671	11.4	1.7
Two or more races	4437	882	6.4	1.3	4838	1172	5.3	1.2
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	69131	2761	100 (X)		90796	3329	100 (X)	
Hispanic or Latino (of any race)	9866	1435	14.3	2	15982	1792	17.6	1.7
Not Hispanic or Latino	59265	2674	85.7	2	74814	2769	82.4	1.7
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	68786	2757	100 (X)		90143	3328	100 (X)	
With health insurance coverage	64188	2787	93.3	1.1	81557	3008	90.5	1.3
With private health insurance	40485	2454	58.9	2.4	41704	2304	46.3	2.2
With public coverage	33750	2045	49.1	2.4	47169	2442	52.3	2
No health insurance coverage	4598	788	6.7	1.1	8586	1310	9.5	1.3
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	68786	2757	100 (X)		90143	3328	100 (X)	
With a disability	8571	758	12.5	1.2	10179	861	11.3	0.9

	ZCTA5 11215				ZCTA5 11216			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	72014	2662	100	(X)	62373	2591	100	(X)
Male	35708	1742	49.6	1.2	28654	1583	45.9	1.6
Female	36306	1451	50.4	1.2	33719	1674	54.1	1.6
Sex ratio (males per 100 females)	98.4	4.9	(X)	(X)	85	5.4	(X)	(X)
Under 5 years	5712	525	7.9	0.7	3107	515	5	0.8
5 to 9 years	4381	653	6.1	0.8	2829	535	4.5	0.8
10 to 14 years	4221	553	5.9	0.7	2468	530	4	0.8
15 to 19 years	2465	345	3.4	0.4	1924	429	3.1	0.6
20 to 24 years	2033	358	2.8	0.5	3851	687	6.2	1
25 to 34 years	13350	1041	18.5	1.4	18331	1117	29.4	1.8
35 to 44 years	15089	980	21	1.2	10497	985	16.8	1.3
45 to 54 years	10052	918	14	1.1	7010	751	11.2	1.1
55 to 59 years	3837	529	5.3	0.7	3045	642	4.9	1
60 to 64 years	3018	467	4.2	0.6	2561	398	4.1	0.7
65 to 74 years	5108	602	7.1	0.8	4181	727	6.7	1.2
75 to 84 years	2095	395	2.9	0.5	1724	372	2.8	0.6
85 years and over	653	234	0.9	0.3	845	253	1.4	0.4
Median age (years)	37.2	0.6	(X)	(X)	34.2	0.7	(X)	(X)
RACE (Census Table DP05)								
Total population	72014	2662	100	(X)	62373	2591	100	(X)
One race	65507	2737	91	1.2	56081	2450	89.9	1.5
Two or more races	6507	847	9	1.2	6292	977	10.1	1.5
One race	65507	2737	91	1.2	56081	2450	89.9	1.5
White	52263	2582	72.6	2.1	20718	1327	33.2	2
Black or African American	2910	625	4	0.9	28802	2272	46.2	2.7
American Indian and Alaska Native	241	187	0.3	0.3	56	62	0.1	0.1
Asian	6674	958	9.3	1.3	2999	564	4.8	0.9
Native Hawaiian and Other Pacific Islander	0	31	0	0.1	23	37	0	0.1
Some other race	3419	887	4.7	1.2	3483	820	5.6	1.3
Two or more races	6507	847	9	1.2	6292	977	10.1	1.5
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	72014	2662	100	(X)	62373	2591	100	(X)
Hispanic or Latino (of any race)	10855	1563	15.1	1.9	8459	1148	13.6	1.7
Not Hispanic or Latino	61159	2225	84.9	1.9	53914	2444	86.4	1.7
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	71888	2661	100	(X)	62242	2593	100	(X)
With health insurance coverage	69931	2687	97.3	0.6	58483	2638	94	0.9
With private health insurance	62367	2390	86.8	1.4	43910	2393	70.5	2
With public coverage	14130	1317	19.7	1.7	19941	1516	32	2.1
No health insurance coverage	1957	439	2.7	0.6	3759	571	6	0.9
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	71888	2661	100	(X)	62242	2593	100	(X)
With a disability	4015	522	5.6	0.7	6377	796	10.2	1.2

	ZCTA5 11239				ZCTA5 11249			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	16808	1347	100 (X)		45087	2556	100 (X)	
Male	6797	824	40.4	3.6	22459	1538	49.8	1.6
Female	10011	992	59.6	3.6	22628	1395	50.2	1.6
Sex ratio (males per 100 females)	67.9	10.3 (X)	(X)		99.3	6.3 (X)	(X)	
Under 5 years	487	198	2.9	1.1	4774	815	10.6	1.7
5 to 9 years	843	277	5	1.5	3286	697	7.3	1.3
10 to 14 years	1063	382	6.3	2.1	3100	642	6.9	1.2
15 to 19 years	1342	328	8	1.7	2867	718	6.4	1.4
20 to 24 years	885	274	5.3	1.5	2429	527	5.4	1.1
25 to 34 years	1545	407	9.2	2.2	11176	805	24.8	2.3
35 to 44 years	2088	434	12.4	2.3	7667	818	17	1.4
45 to 54 years	1793	355	10.7	2	3752	630	8.3	1.3
55 to 59 years	1102	402	6.6	2.4	1798	501	4	1.1
60 to 64 years	1059	254	6.3	1.6	1123	322	2.5	0.7
65 to 74 years	1569	374	9.3	2.2	2195	398	4.9	0.9
75 to 84 years	1946	547	11.6	3.1	584	209	1.3	0.5
85 years and over	1086	260	6.5	1.6	336	199	0.7	0.4
Median age (years)	45.7	4.4 (X)	(X)		30.2	0.9 (X)	(X)	
RACE (Census Table DP05)								
Total population	16808	1347	100 (X)		45087	2556	100 (X)	
One race	15816	1280	94.1	2.4	40876	2527	90.7	1.9
Two or more races	992	416	5.9	2.4	4211	843	9.3	1.9
One race	15816	1280	94.1	2.4	40876	2527	90.7	1.9
White	2899	654	17.2	3.8	30733	2332	68.2	3.8
Black or African American	11133	1112	66.2	4.3	3989	1360	8.8	2.9
American Indian and Alaska Native	308	243	1.8	1.4	217	218	0.5	0.5
Asian	444	265	2.6	1.5	2601	531	5.8	1.1
Native Hawaiian and Other Pacific Islander	0	21	0	0.2	0	28	0	0.1
Some other race	1032	383	6.1	2.2	3336	930	7.4	2
Two or more races	992	416	5.9	2.4	4211	843	9.3	1.9
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	16808	1347	100 (X)		45087	2556	100 (X)	
Hispanic or Latino (of any race)	2674	757	15.9	3.9	8932	1276	19.8	2.6
Not Hispanic or Latino	14134	1095	84.1	3.9	36155	2294	80.2	2.6
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	16610	1366	100 (X)		44911	2556	100 (X)	
With health insurance coverage	16205	1384	97.6	1.3	43497	2507	96.9	0.8
With private health insurance	8773	1209	52.8	5.4	25053	1411	55.8	3.2
With public coverage	9092	1095	54.7	4.9	20521	2322	45.7	3.3
No health insurance coverage	405	208	2.4	1.3	1414	378	3.1	0.8
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	16610	1366	100 (X)		44911	2556	100 (X)	
With a disability	3981	566	24	3.2	2950	702	6.6	1.5

	ZCTA5 11217				ZCTA5 11218			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	43045	1831	100	(X)	73318	3415	100	(X)
Male	19759	938	45.9	1.4	37486	2132	51.1	1.3
Female	23286	1257	54.1	1.4	35832	1805	48.9	1.3
Sex ratio (males per 100 females)	84.9	4.8	(X)	(X)	104.6	5.6	(X)	(X)
Under 5 years	3694	534	8.6	1.1	4931	614	6.7	0.8
5 to 9 years	1617	298	3.8	0.7	5473	597	7.5	0.8
10 to 14 years	1593	402	3.7	0.9	5641	782	7.7	1
15 to 19 years	1363	325	3.2	0.7	5092	657	6.9	0.8
20 to 24 years	1649	329	3.8	0.8	3536	650	4.8	0.8
25 to 34 years	10785	837	25.1	1.9	9530	992	13	1.3
35 to 44 years	8199	686	19	1.4	11393	860	15.5	1.1
45 to 54 years	5458	577	12.7	1.2	9976	1074	13.6	1.1
55 to 59 years	1940	357	4.5	0.8	4113	768	5.6	1
60 to 64 years	1757	255	4.1	0.6	3569	501	4.9	0.7
65 to 74 years	2711	508	6.3	1.2	6012	669	8.2	0.9
75 to 84 years	1560	280	3.6	0.7	3146	513	4.3	0.7
85 years and over	719	274	1.7	0.6	906	243	1.2	0.3
Median age (years)	35.8	0.9	(X)	(X)	37.3	0.9	(X)	(X)
RACE (Census Table DP05)								
Total population	43045	1831	100	(X)	73318	3415	100	(X)
One race	37813	1651	87.8	2.2	67023	3525	91.4	1.5
Two or more races	5232	1016	12.2	2.2	6295	1064	8.6	1.5
One race	37813	1651	87.8	2.2	67023	3525	91.4	1.5
White	23952	1371	55.6	2.8	41158	2543	56.1	2.7
Black or African American	7636	1062	17.7	2.3	7033	1375	9.6	1.8
American Indian and Alaska Native	66	70	0.2	0.2	258	124	0.4	0.2
Asian	3935	575	9.1	1.3	13231	1888	18	2.3
Native Hawaiian and Other Pacific Islander	12	17	0	0.1	0	31	0	0.1
Some other race	2212	588	5.1	1.3	5343	1181	7.3	1.6
Two or more races	5232	1016	12.2	2.2	6295	1064	8.6	1.5
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	43045	1831	100	(X)	73318	3415	100	(X)
Hispanic or Latino (of any race)	6221	885	14.5	2	11989	1444	16.4	2
Not Hispanic or Latino	36824	1787	85.5	2	61329	3433	83.6	2
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	42530	1816	100	(X)	72969	3415	100	(X)
With health insurance coverage	41329	1821	97.2	0.6	69641	3445	95.4	0.8
With private health insurance	33994	1522	79.9	2.2	43439	2569	59.5	2.5
With public coverage	11017	1214	25.9	2.4	33243	2548	45.6	2.6
No health insurance coverage	1201	256	2.8	0.6	3328	606	4.6	0.8
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	42530	1816	100	(X)	72969	3415	100	(X)
With a disability	3914	478	9.2	1.2	6676	831	9.1	1.1

	ZCTA5 11219				ZCTA5 11220			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	92283	3961	100	(X)	93008	4021	100	(X)
Male	47258	2326	51.2	1.1	46378	2181	49.9	0.9
Female	45025	2131	48.8	1.1	46630	2167	50.1	0.9
Sex ratio (males per 100 females)	105	4.7	(X)	(X)	99.5	3.5	(X)	(X)
Under 5 years	12125	1158	13.1	1	5782	797	6.2	0.7
5 to 9 years	10259	974	11.1	0.8	7321	643	7.9	0.6
10 to 14 years	8726	970	9.5	0.8	7169	741	7.7	0.7
15 to 19 years	7561	821	8.2	0.7	5055	556	5.4	0.5
20 to 24 years	6164	645	6.7	0.7	4906	661	5.3	0.6
25 to 34 years	11873	1139	12.9	1.1	14361	1209	15.4	1.1
35 to 44 years	9991	1209	10.8	1.1	14434	1057	15.5	0.9
45 to 54 years	7639	687	8.3	0.7	11896	862	12.8	0.8
55 to 59 years	3425	465	3.7	0.5	4770	532	5.1	0.5
60 to 64 years	3965	624	4.3	0.7	5111	552	5.5	0.5
65 to 74 years	6659	720	7.2	0.9	7673	711	8.2	0.8
75 to 84 years	2254	416	2.4	0.5	3377	357	3.6	0.4
85 years and over	1642	315	1.8	0.4	1153	215	1.2	0.2
Median age (years)	25.8	1	(X)	(X)	36	0.8	(X)	(X)
RACE (Census Table DP05)								
Total population	92283	3961	100	(X)	93008	4021	100	(X)
One race	90541	3959	98.1	0.6	87544	3903	94.1	1.1
Two or more races	1742	549	1.9	0.6	5464	1090	5.9	1.1
One race	90541	3959	98.1	0.6	87544	3903	94.1	1.1
White	57607	3891	62.4	2.9	22067	2085	23.7	2
Black or African American	1444	512	1.6	0.6	2298	738	2.5	0.8
American Indian and Alaska Native	599	380	0.6	0.4	1271	498	1.4	0.5
Asian	20305	1834	22	2	37912	2275	40.8	2.3
Native Hawaiian and Other Pacific Islander	39	44	0	0.1	0	31	0	0.1
Some other race	10547	1907	11.4	2	23996	2774	25.8	2.5
Two or more races	1742	549	1.9	0.6	5464	1090	5.9	1.1
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	92283	3961	100	(X)	93008	4021	100	(X)
Hispanic or Latino (of any race)	12095	1548	13.1	1.6	38012	2871	40.9	2.2
Not Hispanic or Latino	80188	3849	86.9	1.6	54996	2773	59.1	2.2
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	91526	3958	100	(X)	92978	4022	100	(X)
With health insurance coverage	85838	3801	93.8	0.9	82217	3562	88.4	1
With private health insurance	25950	2402	28.4	2.3	30955	1792	33.3	1.7
With public coverage	65053	3639	71.1	2.3	55939	3129	60.2	1.7
No health insurance coverage	5688	824	6.2	0.9	10761	1087	11.6	1
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	91526	3958	100	(X)	92978	4022	100	(X)
With a disability	6259	670	6.8	0.8	7819	806	8.4	0.9

	ZCTA5 11221				ZCTA5 11222			
Label	Estimate	Margin of Error	Percent	Percent Margin of Error	Estimate	Margin of Error	Percent	Percent Margin of Error
SEX AND AGE (Census Table DP05)								
Total population	91236	4062	100	(X)	40137	1540	100	(X)
Male	42539	2352	46.6	1.4	19852	1026	49.5	1.8
Female	48697	2404	53.4	1.4	20285	1061	50.5	1.8
Sex ratio (males per 100 females)	87.4	4.8	(X)	(X)	97.9	6.9	(X)	(X)
Under 5 years	4616	875	5.1	0.9	2443	487	6.1	1.1
5 to 9 years	4278	653	4.7	0.6	1447	286	3.6	0.7
10 to 14 years	4439	658	4.9	0.6	793	225	2	0.5
15 to 19 years	4080	626	4.5	0.6	628	196	1.6	0.5
20 to 24 years	8694	1020	9.5	0.9	2045	580	5.1	1.4
25 to 34 years	24749	1612	27.1	1.4	12961	1004	32.3	2.3
35 to 44 years	12690	1027	13.9	1.1	9015	808	22.5	1.8
45 to 54 years	10143	973	11.1	0.9	3551	473	8.8	1.2
55 to 59 years	4344	757	4.8	0.8	1717	369	4.3	0.9
60 to 64 years	3910	581	4.3	0.7	1578	291	3.9	0.7
65 to 74 years	5543	665	6.1	0.7	2046	371	5.1	1
75 to 84 years	2643	381	2.9	0.4	1301	320	3.2	0.8
85 years and over	1107	218	1.2	0.2	612	177	1.5	0.4
Median age (years)	32.3	0.5	(X)	(X)	34.8	0.8	(X)	(X)
RACE (Census Table DP05)								
Total population	91236	4062	100	(X)	40137	1540	100	(X)
One race	80869	3869	88.6	2	35711	1381	89	1.8
Two or more races	10367	1891	11.4	2	4426	765	11	1.8
One race	80869	3869	88.6	2	35711	1381	89	1.8
White	21286	1587	23.3	1.7	29683	1240	74	2.2
Black or African American	39370	3168	43.2	2.7	1203	341	3	0.8
American Indian and Alaska Native	693	406	0.8	0.4	189	229	0.5	0.6
Asian	4668	1059	5.1	1.1	2055	355	5.1	0.9
Native Hawaiian and Other Pacific Islander	82	90	0.1	0.1	0	28	0	0.1
Some other race	14770	1867	16.2	1.9	2581	740	6.4	1.8
Two or more races	10367	1891	11.4	2	4426	765	11	1.8
HISPANIC OR LATINO AND RACE (Census Table DP05)								
Total population	91236	4062	100	(X)	40137	1540	100	(X)
Hispanic or Latino (of any race)	28299	2294	31	2.2	6258	860	15.6	2
Not Hispanic or Latino	62937	3506	69	2.2	33879	1487	84.4	2
HEALTH INSURANCE COVERAGE (Census Table DP03)								
Civilian noninstitutionalized population	90997	4060	100	(X)	40116	1540	100	(X)
With health insurance coverage	83371	3670	91.6	1.1	37169	1428	92.7	1.6
With private health insurance	55570	3024	61.1	2.2	30048	1520	74.9	2.2
With public coverage	37776	2711	41.5	2.4	9533	842	23.8	2.2
No health insurance coverage	7626	1151	8.4	1.1	2947	689	7.3	1.6
DISABILITY STATUS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION (Census Table DP02)								
Total Civilian Noninstitutionalized Population	90997	4060	100	(X)	40116	1540	100	(X)
With a disability	8901	765	9.8	0.9	2864	421	7.1	1

GEO_ID	NAME	DP03_0119PE	DP03_0119PM	DP03_0062E	DP03_0062M	DP03_0074PE	DP03_0074PM	DP03_0005PE	DP03_0005PM	DP02_0067PE	DP02_0067PM	DP04_0058PE	DP04_0058PM
Geography	ZCTA Name	Percent!!PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL!!All families	Percent Margin of Error!!PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL!!All families	Estimate!!INCOME AND BENEFITS (IN 2021 INFLATION-ADJUSTED DOLLARS)!!Total households!!Median household income (dollars)	Margin of Error!!INCOME AND BENEFITS (IN 2021 INFLATION-ADJUSTED DOLLARS)!!Total households!!Median household income (dollars)	Percent!!INCOME AND BENEFITS (IN 2021 INFLATION-ADJUSTED DOLLARS)!!Total households!!With Food Stamp/SNAP benefits in the past12 months	Percent Margin of Error!!INCOME AND BENEFITS (IN 2021 INFLATION-ADJUSTED DOLLARS)!!Total households!!With Food Stamp/SNAP benefits in the past12 months	Percent!!EMPLOYMENT STATUS!!Population 16 years and over!!In labor force!!Civilian labor force!!Unemployed	Percent Margin of Error!!EMPLOYMENT STATUS!!Population 16 years and over!!In labor force!!Civilian labor force!!Unemployed	Percent!!EDUCATIONAL ATTAINMENT!!Population 25 years and over!!High school graduate or higher	Percent Margin of Error!!EDUCATIONAL ATTAINMENT!!Population 25 years and over!!High school graduate or higher	Percent!!VEHICLES AVAILABLE!!Occupied housing units!!No vehicles available	Percent Margin of Error!!VEHICLES AVAILABLE!!Occupied housing units!!No vehicles available
860Z200US11204	ZCTA5 11204	14.6	2.6	58850	4665	22.2	2.9	4.4	0.7	72.2	1.8	43.5	2.4
860Z200US11205	ZCTA5 11205	22.2	4	68607	4839	22.9	2.6	5.9	1.1	84.1	2	65.7	3.1
860Z200US11206	ZCTA5 11206	31.8	3.4	49013	3388	34.1	2.6	5.4	0.9	76.6	1.8	69.9	2.5
860Z200US11207	ZCTA5 11207	22.2	2.4	45616	2643	35.6	2.1	6.9	0.8	80.9	1.3	60.3	2
860Z200US11208	ZCTA5 11208	19.5	2.4	49679	3003	32.6	2.6	3.7	0.8	82.4	1.6	60.7	2.4
860Z200US11209	ZCTA5 11209	8.2	2.2	84145	5152	10	1.3	3.6	0.6	89.6	1.1	45.7	2.2
860Z200US11210	ZCTA5 11210	7.4	1.5	77378	3936	15.9	1.9	4.5	0.7	89.9	1.3	40.7	2.4
860Z200US11211	ZCTA5 11211	20	3.2	89091	6368	19.5	2.1	4.6	0.9	83.7	2	68.2	2.1
860Z200US11212	ZCTA5 11212	24.3	4.1	30733	2339	46.1	3	9.3	1.8	78.7	1.8	73	2.6
860Z200US11213	ZCTA5 11213	16.2	3	48896	4319	27.5	2.3	6.8	0.9	81.9	2	69.1	2.3
860Z200US11214	ZCTA5 11214	14.3	1.6	58487	3055	24.6	2	4.2	0.7	76.7	1.4	41.3	2
860Z200US11215	ZCTA5 11215	3.6	1.3	156930	8212	3.9	0.7	4.7	0.8	94.7	0.8	49.3	2.5
860Z200US11216	ZCTA5 11216	9.4	2.2	84661	5694	13.8	1.8	4.5	0.9	89.5	1.3	66.4	2.4
860Z200US11217	ZCTA5 11217	6.6	1.9	133269	12241	10.6	1.7	5	1.6	91.6	1.7	69.7	2.4
860Z200US11218	ZCTA5 11218	9.8	1.8	81857	5488	14.7	2.1	4.3	0.6	86.1	1.4	47.2	2.7
860Z200US11229	ZCTA5 11229	11.8	1.7	69076	3802	18.7	1.6	2.9	0.4	86.9	1.1	38.7	1.8
860Z200US11230	ZCTA5 11230	13.6	1.7	61017	3209	23.8	2.1	3.7	0.6	83.5	1.8	47.3	2
860Z200US11231	ZCTA5 11231	12.6	3.5	121638	6696	15	2.1	5.9	1.5	91.3	1.9	55.9	3.4
860Z200US11232	ZCTA5 11232	15.8	4	77031	9457	17.6	3.4	4	0.9	68.1	3.5	61.5	5.3
860Z200US11233	ZCTA5 11233	21.6	2.8	52380	3126	26.8	2.1	3.5	0.7	85.2	1.7	63.2	2.4
860Z200US11234	ZCTA5 11234	7	1.7	86185	2465	10.4	1.1	3.3	0.4	88.6	1.1	25.1	1.9
860Z200US11235	ZCTA5 11235	12.9	1.7	58669	3780	24.2	1.6	2.9	0.5	88.2	1.2	47.8	2.1
860Z200US11236	ZCTA5 11236	10.4	1.5	73562	2963	15.2	1.2	3.2	0.5	88.2	0.9	34.5	1.8
860Z200US11237	ZCTA5 11237	19.5	4	65908	9623	19.5	2.1	4.5	0.8	74.5	2.3	67	3.1
860Z200US11238	ZCTA5 11238	7.3	2.3	114427	7767	11.1	1.7	4.7	1	91.8	1.3	66.4	2.2
860Z200US11239	ZCTA5 11239	20.8	7.4	33736	5023	40.2	4.8	3.7	2	86.8	2.5	66.9	4.6
860Z200US11249	ZCTA5 11249	20.9	3.9	105222	3946	20.5	2.7	4.4	1.1	85.6	2.5	64.6	3.3
860Z200US11201	ZCTA5 11201	7.4	2.1	148282	7688	7.6	1.2	4.4	0.9	95.2	0.7	67.6	2
860Z200US11203	ZCTA5 11203	10.7	1.6	61414	3077	16.6	1.6	3.9	0.7	88.9	1	48.9	2.1
860Z200US11219	ZCTA5 11219	29.5	2.7	44450	2802	35.4	2.4	4.7	0.8	68.7	1.7	54.1	2.4
860Z200US11220	ZCTA5 11220	18.9	2	57046	2456	24.8	2	5	0.9	60.5	1.7	62.3	2.2
860Z200US11221	ZCTA5 11221	20.1	3	66923	4211	21.9	1.7	5.3	0.9	84.4	1.4	63.7	2.3
860Z200US11222	ZCTA5 11222	5.3	2	110385	7390	7.7	2	5.7	1.2	92.9	1.3	60.9	2.8
860Z200US11223	ZCTA5 11223	15.7	2.2	57281	5244	27.3	2	4.8	0.8	78.3	1.4	41.2	2.3
860Z200US11224	ZCTA5 11224	21.2	3.4	37241	3595	41.1	3	3.9	0.9	81.6	2.3	53.1	3.4
860Z200US11225	ZCTA5 11225	12.2	2.9	68542	5938	16.6	2.1	4.4	0.9	87.9	1.7	66.4	3.1
860Z200US11226	ZCTA5 11226	10.9	1.8	66173	1913	24.7	2.1	3.4	0.5	87	1.4	66.8	2
860Z200US11228	ZCTA5 11228	10.1	2	77189	6741	12.1	1.5	3.6	0.8	81.7	1.7	28.6	2.4

Limited Review Application

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

LRA Cover Sheet

Project to be Proposed/Applicant Information

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

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

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

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

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

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

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

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

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

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

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

Please refer to the Project Summary under LRA Cover Sheet Attachment.

OPERATING CERTIFICATE NO.	CERTIFIED OPERATOR	TYPE OF FACILITY
7000002H	Kings County Hospital Center	Hospital

OPERATOR ADDRESS – STREET & NUMBER 451 Clarkson Avenue		PFI 1301	NAME AND TITLE OF CONTACT PERSON Frank M. Cicero, Consultant		
CITY Brooklyn	COUNTY Kings	ZIP 11203	STREET AND NUMBER 925 Westchester Avenue, Suite 201		
PROJECT SITE ADDRESS – STREET & NUMBER 451 Clarkson Avenue		PFI 1301	CITY White Plains	STATE NY	ZIP 10604
CITY Brooklyn	COUNTY Kings	ZIP 11203	TELEPHONE NUMBER (914) 682-8657	FAX NUMBER (914) 682-8895	
TOTAL PROJECT COST: $398,413			CONTACT E-MAIL: conadmin@ciceroassociates.com		

(Rev 06/2017)

KINGS COUNTY HOSPITAL CENTER

SCHEDULE LRA COVER SHEET ATTACHMENT

PROJECT SUMMARY

KINGS COUNTY HOSPITAL CENTER

PROJECT SUMMARY

Kings County Hospital Center (KCHC, the "Hospital"), a 624-bed acute care hospital located at 451 Clarkson Avenue, Brooklyn (Kings County), New York 11203, and a member of New York City Health + Hospitals (NYC H+H), is submitting this Limited Review Application seeking New York State Department of Health (NYSDOH) approval to: 1) Decertify five (5) Chemical Dependence – Detoxification beds; and 2) Convert the remaining 25 Chemical Dependence – Detoxification beds on KCHC's operating certificate to 25 Medical/Surgical (med/surg) beds. The new total certified bed capacity of the Hospital after project completion will be 619 beds. A Health Equity Impact Assessment has been completed for this project, which is included with this submission.

There is no construction required for this project as the unit meets applicable codes for med/surg beds. Please refer to Schedule LRA 6 Attachment for more detailed architectural information.

Under separate cover, KCHC is also submitting a Closure Plan to NYSDOH for the closure of the 30 Chemical Dependence – Detoxification beds. The closure of the beds will be effective upon completion of this Limited Review Application and issuance of a revised operating certificate to the Hospital. A draft of the Closure Plan is included under **Attachment 1** of this Project Summary.

As background, KCHC's 30-bed Chemical Dependence – Detoxification unit was temporarily closed on March 23, 2020 as part of the Hospital's COVID-19 Emergency Plan. The Hospital subsequently decided to permanently close the unit due to underutilization and a Provider Termination Plan was submitted to the New York State Office of Addition Services and Supports (OASAS) on December 3, 2020 and subsequently approved by OASAS and the Substance Abuse and Mental Health Services Administration (SAMHSA). Copies of the submitted Provider Termination Plan and subsequent approvals from OASAS and SAMHSA are included with the draft Closure Plan under **Appendix A**. As a result, OASAS has already decertified the detox beds at the Hospital.

Closure of the detox beds at KCHC was based on a paradigm shift in the treatment of substance use disorders away from inpatient care and toward Medication Assisted Treatment (MAT), which is provided on an outpatient basis, and which resulted in underutilization of the KCHC's inpatient detox

beds. MAT is a holistic approach that combines FDA-approved medications (e.g., buprenorphine, methadone, naltrexone) and therapy to treat substance use disorders. According to SAMHSA, MAT is clinically effective and significantly reduces the need for inpatient detoxification.

It should be noted that KCHC maintains a robust complement of outpatient behavioral health services including adult and child outpatient mental health clinics; substance use disorder treatment programs; a Comprehensive Psychiatric Emergency Program; adult and child inpatient psychiatric programs; and consultation/liaison services including a Neuropsychological team and Behavioral Analysis Support Team that support teams within and outside of KCHC's behavioral health service. The Hospital's substance use clinical care team also functions in a consultation role, providing significant support and treatment to patients across KCHC's campus, especially those needing substance use withdrawal management and treatment initiation within the Emergency Department and inpatient medicine units.

The proposed additional med/surg beds at KCHC are needed in order to be able to reduce congestion in the Hospital's Emergency Department (ED). The ED admits an average of 18 medicine patients per day, with the actual number of admissions ranging from 17 to 30 on any given day. However, an average of 36 patients per day are in the ED for an extended duration due to lack of available inpatient med/surg beds. The proposed additional med/surg beds will also improve overall throughput of patients in the ED. KCHC's ED has seen a steady increase in visits from 83,629 visits in FY 2021; 97,075 visits in FY 2022; and 109,196 visits in FY 2023. Reducing overcrowding in the ED will improve the patient experience, including providing more patient privacy.

The Hospital's 246 existing med/surg beds are consistently operating at 100% occupancy. The closure of nearby Kingsbrook Jewish Medical Center has also exacerbated the need for additional med/surg inpatient capacity in Brooklyn. In addition, Brooklyn has a large complement of patients with an Alternate Level of Care (ALC) status. These patients are no longer acutely ill but cannot be discharged safely to home or another appropriate care setting (i.e., nursing home). These circumstances have further contributed to the need to increase the number of med/surg beds at KCHC.

Patients admitted to the new 25-bed med/surg unit will also be provided with psychiatric consults and creative arts therapy, as required. Among NYC H+H hospitals, KCHC ranked second in substance use encounters and third in mental health encounters. As a result, KCHC serves many patients who

have a secondary behavioral health diagnosis. This project will therefore support strategies outlined in the NYC H+H Behavioral Health Blueprint to improve access to care for individuals with behavioral healthcare needs. Per the NYC H+H Community Health Needs Assessment, mental health and substance use treatment are priority needs in Kings County.

Attachment 1

Draft Closure Plan

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Systems Management
Division of Hospitals and Diagnostic & Treatment Centers

Closure Plan Guidelines

Date: XXXX
Facility Name: Kings County Hospital Center
Address: 451 Clarkson Avenue, Brooklyn (Kings County), New York 11203
Operator Name: New York City Health and Hospitals Corporation
Email Address: guliang@nychhc.org
Related CON #: To be submitted
CON Application Date: To be submitted

1. Target Closure Date	
Closure Date	**Kings County Hospital Center (KCHC, the "Hospital"), a member of New York City Health + Hospitals (NYC H+H, the "System"), is requesting approval to close its 30 Chemical Dependence – Detoxification ("detox") beds. The detox unit was temporarily closed on March 23, 2020 as part of the Hospital's COVID-19 Emergency Plan. The Hospital subsequently decided to permanently close the unit and a Provider Termination Plan was submiꞇed to the Office of Addition Services and Supports (OASAS) on December 3, 2020 and subsequently approved by OASAS and the Substance Abuse and Mental Health Services Administration (SAMHSA). Copies of the Provider Termination Plan and the approval leꞇers from OASAS and SAMHSA are included under Appendix A of this Closure Plan. The last detox inpatient was discharged on March 23, 2020 and the unit has been vacant since that date.** **Under separate cover, KCHC is submiUng a Limited Review Application (LRA) to: 1) Decertify five (5) Chemical Dependence – Detoxification beds; and 2) Convert the remaining 25 Chemical Dependence – Detoxification beds to 25 Medical/Surgical (med/surg) beds. Approval of the LRA is expected on or around July 1, 2025, which will be the closure date for the detox unit.**
Scope of Closure	[Clearly specify if the entire facility is closing or if only particular services are closing] **KCHC is requesting approval to close its 30 Chemical Dependence – Detoxification beds. The Hospital is not closing.**
Remaining services	[Detail what services, if any, will continue to operate] **The Hospital will continue to operate all other services currently provided.**

2. Reasons for Closure	
Detailed Reason(s):	[Provide a comprehensive explanation of the reasons for closure, including data, Financials, or other relevant details] **As noted above, the detox unit has been vacant since the initial COVID-19 closure on March 23, 2020. The Hospital subsequently decided to permanently close the detox unit and a Provider Termination Plan was submi†ed to OASAS, which was approved. This decision was based on a paradigm shi† in the treatment of substance use disorders away from inpatient care and toward outpatient services, including Medication Assisted Treatment (MAT), which is provided on an outpatient basis and resulted in underutilization of KCHC's inpatient detox beds. MAT is a holistic approach that combines FDA-approved medications (e.g., buprenorphine, methadone, naltrexone) and therapy to treat substance use disorders. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), MAT is clinically effective and significantly reduces the need for inpatient detoxification.** **Under separate cover, KCHC is submiUng a Limited Review Application to: 1) Decertify five (5) Chemical Dependence – Detoxification beds; and 2) Convert the remaining 25 Chemical Dependence – Detoxification beds to 25 Medical/Surgical (med/surg) beds. Converting 25 detox beds to 25 med/surg beds will enable the Hospital to be†er meet the need for this service in the community.** **The proposed additional med/surg beds at KCHC are needed in order to be able to reduce congestion in the Hospital's Emergency Department (ED). The ED admits an average of 18 medicine patients per day, with the actual number of admissions ranging from 17 to 30 on any given day. However, an average of 36 patients per day are in the ED for an extended duration due to lack of available inpatient med/surg beds. The proposed additional med/surg beds will also improve overall throughput of patients in the ED. KCHC's ED has seen a steady increase in visits from 83,629 visits in FY 2021; 97,075 visits in FY 2022; and 109,196 visits in FY 2023. Reducing overcrowding in the ED will improve the patient experience, including providing more patient privacy.** **The Hospital's 246 existing med/surg beds are consistently operating at 100% occupancy. The closure of nearby Kingsbrook Jewish Medical Center has also exacerbated the need for additional med/surg inpatient capacity in Brooklyn. In addition, Brooklyn has a large complement of patients with an Alternate Level of Care (ALC) status. These patients are no longer acutely ill but cannot be discharged safely to home or another appropriate care seUng (i.e., nursing home). These circumstances have further contributed to the need to increase the number of med/surg beds at KCHC.** **Patients admi†ed to the new 25-bed med/surg unit will also be provided with psychiatric consults and creative arts therapy, as required. Among**

	NYC H+H hospitals, KCHC ranked second in substance use encounters and third in mental health encounters. As a result, KCHC serves many patients who have a secondary behavioral health diagnosis. This project will therefore support strategies outlined in the NYC H+H Behavioral Health Blueprint to improve access to care for individuals with behavioral healthcare needs. Per the NYC H+H Community Health Needs Assessment, mental health and substance use treatment are priority needs in Kings County.

3. Operator's Contact Person	
Name:	Graham Gulian
Title:	Chief Operating Officer
Telephone Number:	(718) 245-7444
Email Address:	guliang@nychhc.org
Mailing Address:	451 Clarkson Avenue, Brooklyn (Kings County), New York 11203

4. Closure Plan Coordinator(s) [if different from #3]	
Name:	Graham Gulian
Title:	Chief Operating Officer
Telephone Number:	(718) 245-7444
Email Address:	guliang@nychhc.org
Mailing Address:	451 Clarkson Avenue, Brooklyn (Kings County), New York 11203
Specific Closure Duties:	[List Specific Duties for each person if there are multiple people.] **N/A**
Additional Closure Coordinators: (Include this section *ONLY* if there are multiple Individuals):	
Name:	[Insert Additional Coordinator's Name]
Title:	[Insert Additional Coordinator's Title
Telephone Number:	[Insert Additional Coordinator's Telephone Number]
Email Address:	[Insert Additional Coordinator's Email Address]
Mailing Address:	[Insert Contact Person's Mailing Address]
Specific Closure Duties:	[List the specific duties for each additional coordinator listed such as discharge coordination, directing care, media contacts, equipment disposal, record disposition, etc.]

5. Communication with the Department	
Plan for Communication:	[Describe in detail how the facility will establish and maintain ongoing communication with the Department throughout each milestone of the closure process] **Mr. Graham Gulian, COO of the Hospital and the contact person for this Closure Plan, will contact the New York State Department of Health (NYSDOH) Metropolitan Area Regional Office (MARO) on a weekly basis, or more o†en when necessary, to provide an executive summary of the week's events related to the closure of the detox beds.**

	This communication process will continue until MARO issues approval of the Closure Plan.

6. Patient Visit Statistics	
Annual Visits:	[Provide number of annual patient visits to the facility or unit/service per year for the previous 3 years. If the facility was open for *less than* three years, please provide the number of visits for the service that is closing for each year of operation.] **The detox unit has been vacant since it initially closed on March 23, 2020 as part of the Hospital's COVID-19 Emergency Plan. Total patient days in the detox unit in 2019 (the last full year of operation) was 3,759 days, or 34.3% occupancy. As noted above, the Hospital subsequently decided to permanently close the unit due to a paradigm shi† in the treatment of substance use disorders away from inpatient care and toward Medication Assisted Treatment which is provided on an outpatient basis and contributed to underutilization of the KCHC's inpatient detox beds.**

7. Staff Affected	
Number and Type of Staff Affected by the Closure:	[Insert the number of affected staff for each role/job title] **As noted above, the detox unit has been vacant since it initially closed on March 23, 2020 as part of the Hospital's COVID-19 Emergency Plan.**

8. Notification To Department's Hospital Program Director in the Regional Office	
Verbal and Written Notification Evidence:	[Insert Evidence and Date of Notifications] **Verbal notification was provided to Ms. Kathleen Gaine at MARO on XXXX. Submission of this Closure Plan serves as the wri†en notification to the Regional Office.**

9. Notification Plan for Patients, staff, and physicians	
NOTE: Prior to the closure plan submission, the provider must notify federal, state, and local-level elected officials (county, city, town, and village, as applicable) and the community about the proposed closure. The facility must hold a public meeting with the Chief Executive Officer (CEO) or Chief Operating Officer (COO) in attendance to answer questions from the public regarding the proposed closure. In addition, the facility must notify any organizations that represent their staff about the closure. If the proposal is to close psychiatric or substance abuse disorder beds or services, the proposed closure must also be discussed with the New York State Office of Mental Health (OMH) and the New York State Office of Addiction Services and Supports (OASAS).	
Narrative Description of Notification Plan:	[Insert a narrative description of how patients, staff, physicians, and elected officials were notified about the facility closure. This *must* include written notifications and meetings. Include dates and times of all meetings.]

	Written notification will be sent to all patients who were admitted to the detox unit during the last full year of operation prior to the COVID-19 closure. A sample of the letter to patients is included under <u>Appendix B</u> of this Closure Plan. **As noted above, the detox unit has been vacant since it initially closed on March 23, 2020 as part of the Hospital's COVID-19 Emergency Plan. All staff of the detox unit have been transferred to other units within KCHC's Behavioral Health Department in keeping with the transition away from inpatient treatment to outpatient services for substance use disorders, including Medication Assisted Treatment. NYC H+H has 10 outpatient substance use disorder clinics Systemwide, one of which is located at KCHC. In addition, consistent with NYC H+H's strategic priority to increase services for special populations, the System implemented a Substance Use Workforce Training Program for providers and clinicians to support its goal to provide comprehensive, evidence-based addiction care at the time and location that best meets patients' needs. The Hospital has not been able to locate any notification or correspondence to staff regarding the closure of the inpatient detox unit; however, it should be noted that the closure was occurring during the initial height of the COVID-19 pandemic. All efforts at that time were focused on the response to the pandemic.** **Similarly, the Hospital has not been able to locate any letters to elected officials regarding closure of the inpatient detox unit as its efforts at the time were focused on the responses to the pandemic.**
Staff Representation Organizations/Unions Notification:	[Insert description of plan to inform any organizations that represent staff. If staff are not represented, put N/A] **As noted above, the Hospital has not been able to locate any correspondence to staff or organizations representing staff as the initial closure of the detox unit occurred during the initial height of the COVID-19 pandemic and all efforts were focused on the response to the pandemic. All staff of the detox unit have since been transferred to other units within the Hospital's Behavioral Services Department.**
Public Meeting Information:	[Insert Date and Time of Public Meeting held with Chief Executive Officer or Chief Operating Officer in attendance] **No public meeting will be held as the detox unit has been closed since 2020.**
For closures that include Psychiatric or Substance Abuse Services:	
Written Communication Copies:	[Attach *all* written notifications distributed (e.g., patients' letters, referring physicians' letters, etc.). The letters *must* include contact

	person name and phone number for inquiries. Please indicate who will be signing the letters.] **Samples of the le†er to patients and the le†er to referring institutions/providers are included under Appendix B of this Closure Plan. The le†er will be signed by Graham Gulian, Chief Operating Officer of KCHC.**

10. Submission of Required Reports	
Required Reports:	[Confirm that all required reports e.g., Financial Reports and Census Report submissions are up to date. If not, provide an explanation.] **KCHC confirms that all report submissions are up to date.**
Health Commerce System (HCS) Information:	[Confirm that all required Health Commerce System information including but not limited to email addresses and telephone numbers for administration and leadership and submissions are up to date. If not, provide an explanation.] **KCHC confirms that all required Health Commerce System information is up to date.**

11. Media Contact Management Plan	
Description of Media Management:	[Describe the plan to manage media contacts initially and throughout the process, including coordination with the Department prior to release.] **In preparation for receipt of an approved Closure Plan, KCHC will prepare a media holding statement to be used only as media inquiries prior to official communication are received.** **Media contacts and releases will be coordinated and managed by Alexis Davis, Director of Communications at KCHC. Any media releases will be coordinated with NYSDOH and the NYSDOH Press Office prior to release. Contact information for Ms. Davis is as follows:** **Alexis Davis** **Director of Communications** **NYC Health + Hospitals|Kings County** **451 Clarkson Avenue** **Brooklyn, NY 11203** **(718) 245-3910** **davisa34@nychhc.org**

12. Discontinuation of Admissions Plans	
Plan to Discontinue New admissions:	[Provide a detailed narrative on the plan to cease accepting new admissions.] **KCHC's 30-bed Chemical Dependence – Detoxification unit was temporarily closed on March 23, 2020 as part of the Hospital's COVID-19 Emergency Plan. All admi†ed patients at that time completed their course of treatment and the unit achieved a census of zero on March 19, 2020. The Hospital subsequently decided to permanently close the unit and a Provider Termination Plan was submi†ed to OASAS on December 3, 2020 and subsequently approved by OASAS and SAMHSA. The detox unit has been vacant since the initial temporary COVID-19 closure.**
Date when New Admissions will Officially Stop:	[Specify Date] **The detox unit has been vacant since the initial temporary COVID-19 closure on March 23, 2020.**
Notification plan for all Referring Institutions/Providers:	[Detail the plan to notify all referring institutions/providers. Attach a copy of written communication, including any referring physicians' letter from Section 9 if applicable. Include date and times of all meetings.] **Wri†en notification will be sent to referring institutions/providers regarding the closure of the detox beds at KCHC. A copy of the dra† notification is included under Appendix B.**

13. Financial and Asset Summary	
Current Financial Condition Summary:	[Provide a summary of the Facility's financial condition.] **As shown on the June 30, 2024 audited financial statement of NYC H+H included under Appendix C, the System had positive revenue from operations and positive working capital at the end of the fiscal year. Net assets was ($1,345,140) at the end of FY 2024, an improvement from ($2,227,950) in the previous year.**
Asset Description to Maintain Services:	[Describe the assets available to maintain appropriate services during the closure period in detail.] **The Hospital is not closing and will continue to operate all other services currently provided.**

14. Population Served and Access to Care	
Population Description:	[Describe the population served by the facility and detail how they will access care post-closure. The process must include an assessment of patients' needs addressing factors such as language concerns, transportation, etc.]

	The primary services area of KCHC is Brooklyn (Kings County). The following 11 ZIP Codes (ZCs) comprise 80% of the Hospital's inpatient discharges: 11203, 11207, 11208, 11210, 11212, 11213, 11225, 11226, 11233, 11234, 11236. The Hospital's service area includes high percentages of groups that are traditionally underserved for medical services, including the poor and minorities. Analysis of KCHC's discharge data from FY22 and FY23 confirmed that 87% of inpatient discharges from the 11 primary ZCs are from patients who identified as Black/African American and 81% have Medicare or Medicaid as the primary payer. In addition, patient ancestry data shows that 43% of patients discharged have ancestral backgrounds outside of the United States, indicating a large immigrant population served by the Hospital. Eight (8) of the 11 ZCs have received designation as Medically Underserved Areas (MUA) by the Health Resources and Services Administration. **Closure of the inpatient detox unit and conversion of 25 detox beds to 25 med/surg beds is in keeping with the paradigm shi† in the care of substance use disorders away from inpatient care toward outpatient services for substance use disorders, including Medication Assisted Treatment. NYC H+H has 10 outpatient substance use disorder clinics Systemwide, one of which is located at KCHC.** **The Hospital maintains a robust complement of outpatient behavioral health services including adult and child outpatient mental health clinics; substance use disorder treatment programs; a Comprehensive Psychiatric Emergency Program; adult and child inpatient psychiatric programs; and consultation/liaison services including a Neuropsychological team and Behavioral Analysis Support Team that support teams within and outside of KCHC's behavioral health service. The Hospital's substance use clinical care team also functions in a consultation role, providing significant support and treatment to patients across KCHC's campus, especially those needing substance use withdrawal management and treatment initiation within the Emergency Department and inpatient medicine units.** **KCHC is centrally located in Brooklyn and is readily accessible by public transportation.**
Number of Patients Affected:	[Insert Number] **As noted above, the Hospital's detox unit was temporarily closed on March 23, 2020 as part of the Hospital's COVID-19 Emergency Plan. All admi†ed patients prior to that time completed their course of treatment and the unit achieved a census of zero on March 19, 2020. The unit has been vacant since that time.**
Originating Zip codes:	[List zip codes of at least 80% of the patient population]

	The following 11 ZIP Codes (ZCs) comprise 80% of the Hospital's inpatient discharges: 11203, 11207, 11208, 11210, 11212, 11213, 11225, 11226, 11233, 11234, 11236.

15. Availability of Services at other Facilities	
Facility Information:	[For each facility contacted, provide the following details: Name, address, distance from closing facility, date and time of contact, name of the contact person, and specific information confirmed including services available, capacity to accept new patients, and whether Medicaid patients can be accommodated.] **As noted above, KCHC's detox unit achieved a census of zero on March 19, 2020 and the unit has been closed since the initial COVID-19 closure on March 23, 2020.** **The closest hospital to KCHC with inpatient detoxification beds is Interfaith Medical Center (IMC), located 2.2 miles away at 1545 Atlantic Avenue in Brooklyn. IMC is certified for 20 inpatient detox beds. KCHC has been unable to determine if contact was made with IMC at the time of closure of the detox beds in March of 2020. However, as noted above, the closure occurred during the initial height of the pandemic and all efforts were focused on the response to the pandemic at that time. Please also refer to the enclosure to the letter of patients (Appendix B) for a complete list of hospitals in New York City with inpatient detox beds.**
Process to provide information about other facilities to patients:	[Outline the process for informing patients and families about the closure and continuing care at other facilities, ensuring information is provided in the patient's preferred language] **Written notification will be sent to all patients who were admitted to the detox unit during the last full year of operation prior to the COVID-19 closure. A sample of the letters to patients is included under <u>Appendix B</u> of this Closure Plan.**
Respect for Wishes:	[Describe how the facility will honor current patient and family preferences and address concerns regarding geographic location, public transportation, facility/provider type, medical care, etc. when identifying future placement options and ensuring continuity of care during the transition] **As noted above, KCHC's detox unit achieved a census of zero on March 19, 2020 and the unit has been closed since the initial COVID-19 closure on March 23, 2020. All admitted patients at the time completed their course of treatment before being discharged. The closure of the unit was in keeping with a paradigm shift in the treatment of substance use**

	disorders away from inpatient care and toward outpatient services, including Medication Assisted Treatment.
NOTE: it is the responsibility of hospitals to ensure that individual patients are offered choices and that the patients accept the transfer prior to any movement taking place.	

16. Patients Belonging Security:	
Security Measures:	[Detail the plan to secure patient belongings during hospital transfers. If the facility is not a hospital, please indicate not applicable (N/A).] **As noted above, KCHC's detox unit achieved a census of zero on March 19, 2020 and the unit has been closed since the initial COVID-19 closure on March 23, 2020.**

17. Transport Method for Patient Transfers	
Transport Method Determination Plan:	[Outline the plan to determine the method of transport for inpatient care transfers. If the facility is not a hospital, please indicate not applicable (N/A).] **As noted above, KCHC's detox unit achieved a census of zero on March 19, 2020 and the unit has been closed since the initial COVID-19 closure on March 23, 2020. All admi†ed patients at the time completed their course of treatment before being discharged.**

18. Disposal of Drugs, Biologicals, Chemicals, and Hazardous Materials	
Disposal plan for Drugs/Biologicals/ Chemicals/Radioactive Materials:	[Outline the plan for safe disposal of drugs, biologicals, chemicals, and hazardous materials.] **As appropriate, drugs, biologicals, chemicals and/or radioactive materials were maintained at the Hospital for use by outpatients or by departments within the Hospital.**

19. Medical Records Management	
Record Completion Strategy:	[Outline the procedure for completing medical records prior to closure.] **As noted above, KCHC's detox unit achieved a census of zero on March 19, 2020 and the unit has been closed since the initial COVID-19 closure on March 23, 2020. All admi†ed patients at the time completed their course of treatment before being discharged.** **All member hospitals of NYC H+H utilize an integrated medical records system that can be accessed at any System hospital. Patients may access their medical records through the System's on-line patient portal. Alternatively, patients can contact the Hospital to request their records directly.**

	In cases where patients are transferred to a hospital outside the NYC H+H System, records are securely transferred to the patient's new provider at time of discharge from KCHC to the new facility. Where possible, the records are transmi†ed electronically to the new provider. If the record cannot be electronically transferred to the new provider, the patient's medical record documentation is placed in a sealed envelope with the resident's name on the outside. This first sealed envelope is placed into another sealed envelope, with the name and address of accepting new provider, as well as the name of the authorized person accepting the documents noted on the outside of this second envelope. Both envelopes are marked "CONFIDENTIAL." KCHC delivers the documents either via messenger and/or designated agency personnel to the accepting provider. A form is used to identify the courier from KCHC, which indicates the date, time of delivery, and the signature of the authorized person from the accepting provider.
Record Maintenance Plan:	[Describe the Plan for the maintenance, storge, and retrieval of records, ensuring compliance with federal, state, and local regulations.] **All member hospitals of NYC H+H utilize an integrated medical records system that can be accessed at any System hospital. Medical records including current assessments, care plans, medications and treatment records, histories, discharge summaries, identifying information, etc. are maintained by KCHC for the statutorily required amount of time.**
Custodian Designation:	[Identify the custodian of medical records, as approved by the Department of Health, and provide their address and contact information.] **Felicia Jones** **Director of Medical Records** **NYC Health + Hospitals|Kings County** **451 Clarkson Avenue** **Brooklyn, N.Y. 11203** **(718) 245-4206** **jonesf1@nychhc.org**
Post-Closure Information Process:	[Explain the process for handling medical information received aGer facility is closed.] **KCHC is not closing. Patients may continue to access their medical records through the Hospital's on-line patient portal. Alternatively, patients can contact the Hospital to request their records directly.**

20. Staff Transition	
Staffing During Closure:	[Outline plan to maintain essential staff until closure.]

	As noted above, KCHC's detox unit achieved a census of zero on March 19, 2020 and the unit has been closed since the initial COVID-19 closure on March 23, 2020.
Information on New Opportunities:	[Describe how staff will be notified of other job opportunities.] **As noted above, the detox unit has been vacant since it initially closed on March 23, 2020 as part of the Hospital's COVID-19 Emergency Plan. All staff of the detox unit have been transferred to other units within KCHC's Behavioral Health Department in keeping with the transition away from inpatient treatment to outpatient services for substance use disorders, including Medication Assisted Treatment. The Hospital has not been able to locate any correspondence to staff regarding the closure of the inpatient detox unit; however, it should be noted that the closure was occurring during the initial height of the COVID-19 pandemic. All efforts at that time were focused on the response to the pandemic.**

21. Post-Closure Building Utilization	
Building Use Disclosure:	[Please indicate the future use of the building and the disposition of its contents] **Under separate cover, KCHC is submiUng a Limited Review Application to: 1) Decertify five (5) Chemical Dependence – Detoxification beds; and 2) Convert the remaining 25 Chemical Dependence –Detoxification beds on KCHC's operating certificate to 25 Medical/Surgical (med/surg) beds. Conversion to med/surg beds will enable the Hospital to beꞇer meet the need for this service in the community.**

22. Certificate Surrender on Closure	
Certificate Return Confirmation:	[If the facility is closing, confirm that the operating certificate will be mailed to the Department's Hospital Program Director at the Regional Office on the last operational day. If the facility will remain open, enter 'N/A'] **KCHC is not closing. The current operating certificate will be surrendered to the Department upon issuance of a revised operating certificate pursuant to a Limited Review Application (described above) to convert 25 of the detox beds to med/surg beds and decertify the remaining five (5) detox beds. A copy of the current operating certificate of the Hospital is included under Appendix D of this Closure Plan.**

NYSDOH Review/Recommendation

Review Date	
Reviewer	
Review Comments	
Recommendation (Approve/Disapprove)	

Appendix A

Provider Termination Plan

OASAS Approval Letter

SAMHSA Approval Letter

New York State
Office of Alcoholism and Substance Abuse Services
Provider Termination Plan

Any provider of chemical dependence services planning to terminate an OASAS certmed service Is required to complete and submit a copy the Terminat on Plan *six months prior to tho terminat on of services.* The Executive Director or Chief Executive Officer must sign and date the form and the plan must be submitted to the appropriate OASAS Field Office and to Local Governmental Officials. Providers of an Opioid Treatment Service must also submit a copy to the OASAS Treatment Bureau within the Division of Practice Innovation Care Management. Attach additional 1heets, If neceasary.

Provider Identifying Information		
Provider Legal Name NYC H+H/ Kings County		
Contact Poraon/Tllle Susan Whitley/ Director of Integrated Ambulatory BH	Telephone Number 718-245-2304	
Service Sita to Ba Closed		
Service Naino Part 816.6 Medically Supervised Withdrawal & Stabllization Services		OASAS OC# (last 5 digits) 10307
Stroot Address 410 Winthrop Street; R Building 2nd Floor	City Brooklyn	ZlpCodo 11203-2097
County Kings	Region I	Provider N o \r o2o	PRU#(s) S0\'5'2
Termination Plan		

1. wdentify the final date services date ba avallablu (must bu no luH than six months after the this of Termination Plan).

The NYC H+H/ Kings County Medically Supervised Withdrawal & Stabilization Service was temporarily closed on 3/23/2020 as part of the NYC H+H/ Kings County COVID Emergency Plan. The beds were re-purposed to accommodate medically Ill patients and staff were redeployed to support the operations of crltlcal areas.

2. Provide a detailed explanation of the reason(al for closing and efforts undertaken to avoid the clo1lng.

The Hospital Administration, NYC H+H System Leadership, and the Department have weighed the pros and cons of reopening and concluded that the unit should remain closed. The service has been chronically underutlli2:ed with an average census of approximately 60% capacity for the past 10-years, Supported by the redeployment of staff from the Inpatient Service, the Department Is Implementing more person-centered and evidence-based strategies to address the needs of the community. These Include Ancillary Withdrawal Management, addiction specialists in the Medical and Psychiatric Emergency Departments, and Increasing the availability of Addiction Consults to all service areas.

3. Identify all local community co acls, referral sources and government agancla■ that have b an notlrled of the Impending aav lce clo1lng. (Providers of an Opioid Tr H tmant Service muat Indicate how and when notlflcallona ware provided to CSAT and DEA).

Discussions have been held with NYC H+H/ Kings County Community Advisory Board.
Notifications to CSAT and the DEA wlll occur concurrent to submissio□ of this plan.

Transfer of Patients

4. Complete the following:

a. Number of enrolled patients on the date of this Termination Plan O

b. Numbar of enrolled pallents expected to complete treatment before the proposed date of termination (aa Indicated In Mem #1 of thle Plan) 0

c. Number of currently enrolled patients to ba transferred before or upon date of service termination 0

5. Providers must retain responsibility for the continued provision of patient care during the transition period prior to the Service closing. Deecrlbe plans to notify all patients In advance about the ■arvlce clo■lng end about their options for continued tr1111111111111t (rur provltlars of an Opioid Treatment Program, the nollco must bo glvon at loast three monthe before clo■lng).

We halted admissions on Thursday March 19, 2020. All admitted patients completed their course of treatment, the unit achieved a census of zero and was closed effective Monday March 23, 2020.

6. Deacrlbe the proce11 to be u■ad In assessing the clinical naeds or each patient prior to their referral or transfer to another certified provider. De■crlba plans to addreea the ongoing clinical naads (Including continued methadone maintenance), any legal requirements (auch as notifications to Probation or Parole Departments) or other traatmenl•relaled needs of all enrolled patients, as appropriate, prior to the Service closing.

There are no patients who currently require referral or transfer.

7. List all OASAS•certifled providers to which patient■ will be transferred. Include for each provider a contact parson and telephone number. Attach documentation of each provider's agreement to cooperate in the transfer proce11.

There are no patients who currently require referral or transfer.

Patient Consents and Disposition of Patient Records

II. Describe the procedures to be used to obtain each patlant'a consent to transfer and to complete tha transfer of such records.

There are no patients who currently require referral or transfer.

9. Describe the procedures to ba used to settle the patient flnanclal accounts before completlon of the transfer.

There are no patients who currently require referral or transfer.

10. Describe plans for maintenance and/or disposition or l)atlent records In conformance with Federal Rogulallons [42 CFR Part 2) regarding confldontlallty, Attach a limo aohedule showing how the plan Is going to be Implemented. OASAS Regulatlon 14 NVCRR 814.3(el(7) requires all patient records to be retained for six yeara after lha date of discharge or last conlect or throe years after the patient reachaa the age of eighteen, whichever time period Is longor.

Electronic records will not be impacted. Paper records are maintained by the Hospital's HIT Department in compliance with all applicable regulations.

Other Termination Plan Requirements

11. a. Ifthe Service I■ also certified by the Department of Health (DOH), has notification been provided? D Vas D No liZJ N/A

b. If yes, enter the date DOH was notified.

12. a. Ifthe Service to be closed I■ an Opioid Treatment Program, has the CSAT and DEA been notified'? D Yes r;zJ No

b. If yes, ha■ the DEA Form 41 bean lliad: ☐ Yes fZI No Date Flied

c. Ifmedication Is to be transferred or destroyed, Indicate the stepa that will be taken to mHt all DEA requirements.

All controlled substances purchased under the Medically Supervised Withdrawal & Stabilization Service DEA Registration will be destroyed through a reverse distributor. CSAT and DEA will be notified concurrently with submission of this application.

13. Othor - Provide any addlllonal Information necessary to complote the termination of tile Service, If opplioablo.

None.

Provider Authorization to Tennlnate Services		
I certify that all Information Includ1d or attached to this Termination Plan la accurate, complete and true to tha beat of my knowledge.		
Executive Director (Full Nama} Sheldon McLeod, CEO NYC H+H/ Kings	Executive DlOC or Signature 1?4	Data 12/3/2020
Board of Directors Chairl Preaident (Full Name) Mitchell Katz, President NYC H+H	Board of Directors Chair/President Signature	Date 12/15/2020

Addltlonal Requirements for CASAS-Certified and Funded Providers

A provider supported in whole or In part with State funds administered by OASAS must also complete Appendix A - Provider Termination Plan Checklist, including the provider certification and signature block.

New York State
Office of Alcoholism and Substance Abuse Services

Appendix A• Provider Termination Plan Closeout Checklist

To Be Completed by CASAS Certified and Funded Provider■ Only

1. Describe plans for maintenance and/or dlsposlUon of financlal records, required for audits by 0ASAS and/or the Local Governmental Unit, including designation of a specific location for accessing records.

All electronic and paper records will be maintained by HYC H+H/ Kings County consistent with regulatory requirements.

2. Attach a current Inventory of equipment in which the OASAS or the Local Governmental Unit has a financial interest.

N/A· There Is no equipment In which 0ASAS has any rlnanclal Inieresl.

3. Attach a listing of outstanding liabililies relative to the OASAS runded oroaram.

IN/A- Tl1ere are no outstanding llablllties related to 0ASAS funding.

Closeout Checklist

A. Has a budget change been submitted/processed through the appropriate 0ASAS Field Office?

0Yes ONo fll NIA

B. If yes to Question A, does the budget change reflect appropriate adjustments for security deposits, staff vacation credits and other closeout revisions?

0Yes QNo IZI NIA

C. Were any Capital Funds provided by 0ASAS pertaining to the current site of the Service?

0Yes 12] No ☐ NIA

D. Has the budget been changed to phase out personnel, including administrative staff, and services?

nYes 171 No

E. Has the final CFR been submitted to 0ASAS?

OYes I2J No If yes, date submitted N/A

If no, date the CFR will be submitted

F. Was the Client Data System (CDS) updated to reflect the status (transferred/discharged) of all patients?

IZ)Yes ONo If yes, date CDS transfers/discharges were completed 3/23/2020

If no, date the CDS transfers/discharges will be completed

G. Has the equipment inventory been verified?

D Yes ONo IZI N/A If yes, identify (name and title)

Date verified

H. Have arrangements been made to transfer/dispose of equipment, including rental equipment? Equipment purchased with OASAS funding must be disposed of In accordance with OASAS policy.

Oves 0No 12) N/A If yes, date equipment will be transferred by

I. Have employees been given appropriate written notice as well as W-2 forms and all other necessary documents?

Oves III No If yes, date notice was given

If no, explain:

All employees were reassig ed as pat of the COVID Emergency Plan. Reassignments will be made permanent in coordination with our Human Resources and Labor Relations Teams.

J. Does the lease have an early termination clause?	Oves	0No	III N/A
If yes, are there any time requirements for notification?	Oves	nNo	nN/A
If yes, are there any penalties for improper notification?	Oves	0No	☐ NIA
If yes, has the landlord been notified?	0Yes	ONo	0NIA

Dale landlord was or will be notified N/A- Unit is located on hospital groups.

K, Have arrangements been made for return of security deposits or other prepaid items?

Oves 0No 17JN/A

L. Have arrangements been made to read meters, disconnect phones, utilities and/or other services?

nves nNo 171 N/A If ves date of notification

M. Are patient records properly stored in conformity wilh Federal [42 CFR Part 2] and State [814.3(e)(7)] requirements?

III Yes 0No 0 N/A

Provider Certification and Signature

I certify that all information Included or attached to the Plan Is accurate, complete and true to the bast of my knowledge.

	Tille
Executive Director/Chief Executive Officer Sheldon McLeod	CEO NYC H+H/ Kings
Sl cullve Officer	Dale
Board of Directors Chair/President Mitchell Katz	
e	

President NYC H+H

Signature of Board of Directors Chair/Pre denl Date

4 W RK TE | Office of Addiction Services and Supports

ANDREW M. CUOMO
Governor

ARLENE GONzALEZ-SANCHEZ, M.S., L.M.S.W.
Commissioner

December 28, 2020

UPS GROUND

Mr. Sheldon Mcleod
Chief Executive Officer
Kings County Hospital Center (NYC HHC)
451 Clarkson Avenue
Brooklyn, New York 11203-2054

Re: Provider #87030
Operating Certificate#210610307
PRU#501 2

Dear Mr. Mcleod:

The Office of Addiction Services and Supports (OASAS) acknowledges receipt of Kings County Hospital Center (NYC HHC)'s Service Provider Termination Plan submitted to, and approved by, the OASAS New York City Regional Office.

Since Kings County Hospital Center (NYC HHC) is no longer operating the certified Medically Managed Withdrawal & Stabilization Services at 410 Winthrop Street, Brooklyn, effective December 23, 2020, Operating Certificate #210610307 is no longer valid. Pursuant to 14 NYCRR Section 810.17, the Operating Certificate (original document) must be retumed to OASAS' Bureau of Certification immediately following the effective date of the termination.

Sincerely,

Aruh- sir

'-6anet L. Paloski
Director
Bureau of Certification

cc: Keith J. McCarthy
Zoraida Diaz
Ivan Garcia
Claudia Cabanas
Healthcare Financing
Stephanie Saporito
Maria Melideo
Karen Telfeyan
Diane McCrady
Ashley Bowery
Janet Rucki
Colleen Carroll-Barbuto (Justice Center)
Justice Center Data Integrity and Reporting
Connie Chin (DOH)
Nilova (Tina) Saha, LCSW (NYC Dept. of Health and Mental Hygiene)
Gail Goldstein (NYC Dept. of Health and Mental Hygiene)
Norma Carmona-Rodriguez (NYC Dept. of.Health and Mental Hygiene)
Jose Pagan (Board Chair, Kings County Hospital Center (NYC HHC)
Robert Musacchio (Program Manager, Kings County Hospital Center (NYC HHC)

SAMHSA
Substance Abuse and Mental Health Services Administration
5600Flshers Lane• Rockvflle, MD 20857
www.samhsa.eov• 1-877-SAMHSA-7 (1-877-726-4727)

January 12, 2021

Renuka Ananthamoorthy (Sponsor)
NYC H and H/ Kings County, BH
Administration 451 Clarkson Ave, A Building
Brooklyn, NY 11203

NYC H and H/ Kings County, Chemical Dependency, Detoxification Unit
410 Winthrop Street, R-2 East
Brooklyn, NY 11203

Re: OTP No. NYS0334H, DEA No. RC0236516

Dear Renuka Ananthamoorthy:

The Substance Abuse and Mental Health Services Administration (SAMHSA) acknowledges receipt of your letter dated January 04, 2021, indicating your opioid treatment program's (OTP) voluntary decision to discontinue opioid treatment.

In accordance with 42 CFR § 8.1l(c) (2), certification for OTP NY50334H is considered withdrawn. It will be necessary to apply for provisional certification under 42 CFR § 8.1l(e) if you decide to re-open this OTP in the future. Application for provisional certification may be submitted to SAMHSA on form SMA-162. For your convenience, the SMA-162 form can be submitted online at http://www.samhsa.gov/medication-assisted-treatment.

Any questions concerning this should be directed to Barbara Howes, at 240-276-2547 or by e-mail at Barbara.Howes@samhsa.hhs.gov.

Sincerely,

Joseph Bullock, Ed.D

Joseph Bullock, Ed.D
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration

cc: DEA
State Opioid Treatment Authority
Joint Commission
Barbara Howes, CSAT

Appendix B

Sample Patient Letter

Sample Notification to Referring Institutions/Providers

Sample Patient Notification

(Hospital Letterhead)

(Date)

Dear [patient name],

We are writing to inform you of an important update regarding health care services at Kings County Hospital Center (KCHC, the "Hospital"). In our continuing efforts to meet the needs of our community in an evolving health care environment, the Hospital closed its 30-bed Chemical Dependence – Detoxification ("detox") unit in 2020 and transitioned substance use services towards outpatient treatment. The Hospital has submitted an application to the New York State Department of Health to convert the 30 detox beds to 25 medical/surgical beds in order to better meet the changing needs of our patients. The change will be effective on or around DATE.

Closure of the detox beds at KCHC was consistent with a paradigm shift in the treatment of substance use disorders away from inpatient care and toward outpatient services, including Medicated Assisted Treatment (MAT). For those still in need of inpatient detox services, the closest hospital to KCHC with detox beds is Interfaith Medical Center (IMC), located 2.2 miles away at 1545 Atlantic Avenue in Brooklyn. A complete list of hospitals with inpatient detox beds in New York City is also included following this letter.

Your medical records will still be accessible through NYC Health + Hospital's online patient portal. If at any time in the future you need a copy of your medical records, you may also contact Felicia Jones, Director of Medical Records, at (718) 245-4206.

If you have any questions or concerns regarding substance use treatment programs at KCHC, please contact our clinic front desk at 718-245-4878. In addition, our Opioid Treatment Program can be reached directly at 718-245-2621.

We wish to thank you for being a patient of Kings County Hospital Center and wish you continued good health.

Very Truly Yours,

NAME
TITLE

NEW YORK CITY HOSPITALS WITH INPATIENT DETOX BEDS

Facility Name	Address	# of Detox Beds	County
Brooklyn Hospital Center - Downtown Campus	121 Dekalb Avenue, Brooklyn, NY 11201	10	Kings
South Brooklyn Health	2601 Ocean Parkway, Brooklyn, NY 11235	15	Kings
Kings County Hospital Center	451 Clarkson Avenue, Brooklyn, NY 11203	30	Kings
Interfaith Medical Center	1545 Atlantic Avenue, Brooklyn, NY 11213	20	Kings
BronxCare Hospital Center	1276 Fulton Avenue, Bronx, NY 10456	36	Bronx
Jacobi Medical Center	1400 Pelham Parkway, Bronx, NY 10461	16	Bronx
SBH Health System	4422 Third Avenue, Bronx, NY 10457	24	Bronx
Bellevue Hospital Center	462 First Avenue, New York, NY 10016	20	New York
Metropolitan Hospital Center	1901 First Avenue, New York, NY 10029	19	New York
New York-Presbyterian Hospital - New York Weill Cornell Center	525 East 68th Street, New York, NY 10021	3	New York
New York-Presbyterian Hospital - Columbia Presbyterian Center	622 West 168th Street, New York, NY 10032	3	New York
Mount Sinai West	1000 10th Avenue, New York, NY 10019	22	New York
Mount Sinai - Behavioral Health Center	45 Rivington Street, New York, NY 10002	26	New York
Flushing Hospital Medical Center	45th Avenue & Parsons Blvd, Flushing, NY 11355	30	Queens
St Johns Episcopal Hospital So Shore	327 Beach 19th Street, Far Rockaway, NY 11691	32	Queens
Staten Island University Hospital Prince's Bay	375 Seguine Avenue, Staten Island, NY 10309	44	Richmond
Richmond University Medical Center	355 Bard Avenue, Staten Island, NY 10310	7	Richmond

Sample Provider Notification

(Hospital Letterhead)

Month Date, 2025

Dear Provider:

We are writing to inform you of an important update regarding health care services at Kings County Hospital Center (KCHC, the "Hospital"). In our continuing efforts to meet the needs of our community in an evolving health care environment, the Hospital closed its 30-bed Chemical Dependence – Detoxification ('detox") unit in 2020 and transitioned substance use services towards outpatient treatment. The Hospital has submitted an application to the New York State Department of Health to convert the 30 detox beds to 25 medical/surgical beds in order to better meet the changing needs of our patients. The change will be effective on or around DATE.

Closure of the detox beds at KCHC was consistent with a paradigm shift in the treatment of substance use disorders away from inpatient care and toward outpatient services, including Medicated Assisted Treatment (MAT). For those still in need of inpatient detox services, the closest hospital to KCHC with detox beds is Interfaith Medical Center (IMC), located 2.2 miles away at 1545 Atlantic Avenue in Brooklyn.

If you have any questions or concerns regarding substance use treatment programs at KCHC, please contact our clinic front desk at 718-245-4878. In addition, our Opioid Treatment Program can be reached directly at 718-245-2621.

Very Truly Yours,

NAME
TITLE

Appendix C

Financial Statements

Appendix D

Operating Certificate

Facility Id. 1301
Certificate No. 7001016H

State of New York

Department of Health

Office of Primary Care and Health Systems Management

OPERATING CERTIFICATE

Effective Date: 12/30/2019

Expiration Date: NONE

Certified Beds - Total	**624**
Chemical Dependence - Detoxification	30
Coronary Care	8
Intensive Care	32
Maternity	30
Medical / Surgical	246
Neonatal Continuing Care	10
Neonatal Intensive Care	10
Neonatal Intermediate Care	10
Pediatric	28
Pediatric ICU	7
Physical Medicine and Rehabilitation	23
Psychiatric	190

Hospital

Kings County Hospital Center
451 Clarkson Avenue
Brooklyn, New York 11203

Operator: New York City Health and Hospital Corporation
Operator Class: Public Municipality

Has been granted this Operating Certificate pursuant to Article 28 of the Public Health Law for the service(s) specified.

AIDS Center	Ambulance	Ambulatory Surgery - Multi Specialty	Audiology O/P	Cardiac Catheterization - Adult Diagnostic
Cardiac Catheterization - Electrophysiology (EP)	Certified Mental Health Services O/P	Chemical Dependence - Detoxification	Chemical Dependence - Rehabilitation O/P	Chemical Dependence - Withdrawal O/P
Clinical Laboratory Service	Comprehensive Psychiatric Emergency Program	Coronary Care	Dental O/P	Emergency Department
Intensive Care	Level III Perinatal Care	Lithotripsy	Maternity	Medical Services - Other Medical Specialties
Medical Services - Primary Care	Medical Social Services	Medical/Surgical	Methadone Maintenance O/P	Neonatal Continuing Care
Neonatal Intensive Care	Neonatal Intermediate Care	Nuclear Medicine - Diagnostic	Nuclear Medicine - Therapeutic	Pediatric
Pediatric Intensive Care	Physical Medical Rehabilitation	Primary Stroke Center	Psychiatric	Radiology - Diagnostic
Radiology-Therapeutic	Renal Dialysis - Acute	Renal Dialysis - Chronic (26)	Respiratory Care	SAFE Center
Therapy - Occupational O/P	Therapy - Physical O/P	Therapy - Speech Language Pathology	Therapy - Vocational Rehabilitation O/P	

20200203

Deputy Commissioner, Office of Primary Care and Health Systems Management

This certificate must be conspicuously displayed on the premises.

Facsimile

Commissioner

Limited Review Application

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

Schedule LRA 2

Total Project Cost

ITEM	ESTIMATED PROJECT COST	
1.1 Land Acquisition *(attach documentation)*	$	
1.2 Building Acquisition	$	
	1.1-1.2 Subtotal:	$0
2.1 New Construction	$	
2.2 Renovation and Demolition	$	
2.3 Site Development	$	
2.4 Temporary Power	$	
	2.1-2.4 Subtotal:	$0
3.1 Design Contingency	$	$0
3.2 Construction Contingency	$	$0
	3.1-3.2 Subtotal:	$0
4.1 Fixed Equipment (NIC) - Refer to Schedule LRA 2 for equipment quote.	$	
4.2 Planning Consultant Fees	$	
4.3 Architect/Engineering Fees (incl. computer installation, design, etc.)	$	
4.4 Construction Manager Fees	$	
4.5 Capitalized Licensing Fees	$	
4.6 Health Information Technology Costs	$	
4.6.1 Computer Installation, Design, etc.	$	
4.6.2 Consultant, Construction Manager Fees, etc.	$	
4.6.3 Software Licensing, Support Fees	$	
4.6.4 Computer Hardware/Software Fees	$	
4.7 Other Project Fees (Consultant, etc.)	$	
	4.1-4.7 Subtotal:	$0
5.1 Moveable Equipment - Please refer to Schedule LRA 2 Attachment.	$	$397,413
6.1 Total Basic Cost of Construction	**$**	**$397,413**
7.1 Financing Costs (points, fees, etc.)	$	
7.2 Interim Interest Expense - Total Interest on Construction Loan: Amount @ % for months	$	
7.3 Application Fee	$	$1,000
8.1 Estimated Total Project Cost (Total 6.1 - 7.3)	**$**	**$398,413**

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

Construction Start Date: N/A

Construction Completion Date: N/A

KINGS COUNTY HOSPITAL CENTER

SCHEDULE LRA 2 ATTACHMENT

EQUIPMENT INFORMATION

EQUIPMENT LIST

Qty	Description	Manufacturer	Model	Unit Cost	Ext.Cost
3	Pump, Suction/Aspirator, General, Portable	Armstrong Medical Industries	SSCOR DUET (AE-6975)	$ 1,194.00	$ 3,582.00
28	Bed, Electric	Hillrom - Bed & Stretcher Group	VersaCare Air [VC755] w/AIR Surface, Scale & PPM	$ 9,480.96	$ 265,466.88
28	Bracket, Monitor, Wall	GCX Corporation	19" Seismic Chan. w/VHM for Philips MP&MX Series	$ 818.40	$ 22,915.20
28	Compression Unit, Extremity Pump, Intermittent	Medline Industries Inc.	Vaso-Force DVT Pump (MDS600)	$ 1,160.40	$ 32,491.20
14	Disposal, Sharps, Wall Mount	Stericycle	Bio Systems C-03RES-0203-OC	$ 102.00	$ 1,428.00
28	Flowmeter, Oxygen	Precision Medical	Chrome (0-15 lpm, DISS Female)	$ 48.00	$ 1,344.00
28	Flowmeter, Air	Precision Medical	Chrome (0-15 lpm, DISS Female)	$ 60.00	$ 1,680.00
1	Monitor, Physiologic, Bedside	Philips Healthcare - Monitoring Systems	Intellivue MX800	$ 33,759.60	$ 33,759.60
1	Cart, Procedure, Resuscitation	Armstrong Medical Industries	PBL-AR-30 Premier Aluminum Breakaway 6-Dwr (Red)	$ 1,986.00	$ 1,986.00
28	Dispenser, Glove, Triple Box	Omnimed, Inc	305302 Stainless Steel	$ 48.00	$ 1,344.00
28	Dispenser, Personal Protection, Wall Mount, Recessed	Bowman Dispensers	RE101-0012 Semi-Recessed	$ 1,122.00	$ 31,416.00

$ 397,412.88

Limited Review Application

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

Schedule LRA 3

Proposed Plan for Project Financing

A. LEASE ☐

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

A complete copy of each proposed lease must be submitted.

Attachment # _____

ITEM	COST AS IF PURCHASED	
	$	
	$	
	$	
	$	
	$	

B. CASH ☒

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

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

Attachment # Schedule LRA 3 Attachment

Accumulated Funds	$	$398,413
Sale of Existing Assets*	$	
Other – (i.e. gifts, grants, **etc.)	$	
TOTAL CASH	$	$398,413

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

Attachment # N/A

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

Attachment # N/A

C. DEBT FINANCING ☐

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

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

Attachment # _____

Principal	$	
Interest Rate		
Term		
Pay-out Period		
Type *		

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

KINGS COUNTY HOSPITAL CENTER

SCHEDULE LRA 3 ATTACHMENT

FINANCIAL STATEMENTS

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)

Basic Financial Statements and Supplemental Schedules

June 30, 2024

(With Independent Auditors' Report in Accordance with Government Auditing Standards Thereon)

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)

Table of Contents

KPMG LLP
345 Park Avenue
New York, NY 10154-0102

Independent Auditors Report

The Board of Directors
New York City Health and Hospitals Corporation:

Report on the Audit of the Financial Statements

Opinions

We have audited the financial statements of the business-type activities and the discretely presented component unit of the New York City Health and Hospital's Corporation (the Corporation), a discretely presented component unit of the City of New York, as of and for the year ended June 30, 2024, and the related notes to the financial statements, which collectively comprise the Corporation's basic financial statements for the year then ended as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the discretely presented component unit of the Corporation, as of June 30, 2024, and the respective changes in financial position and, where applicable, cash flows thereof for the year then ended in accordance with U.S. generally accepted accounting principles.

Basis for Opinions

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Corporation and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions. The financial statements of MetroPlus Health, Plan, Inc, a discretely presented component unit, and HHC Insurance Company, Inc., a blended component unit, were not audited in accordance with Government Auditing Standards.

Other Matter

As part of our audit of the 2024 financial statements, we also audited the adjustments described in Note 1(r) that were applied to restate the net position (deficit) as of June 30, 2023. The Corporation's previously issued financial statements were audited, before the restatement described in Note1(r), by other auditors. In our opinion, such adjustments are appropriate and have been properly applied.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with U.S. generally accepted accounting principles, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Corporation's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditors Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and Government Auditing Standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and Government Auditing Standards, we:

Exercise professional judgment and maintain professional skepticism throughout the audit.

Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.

Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Corporation's internal control. Accordingly, no such opinion is expressed.

Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.

Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Corporation's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Required Supplementary Information

U.S. generally accepted accounting principles require that the management discussion and analysis, schedule of NYC Health + Hospitals' contributions NYCERS Pension Plan, schedule of NYC Health + Hospitals' proportionate share of the net pension liability NYCERS Pension Plan, and schedule of NYC Health + Hospitals' changes in total OPEB liability and related ratios be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with GAAS, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management s responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by Government Auditing Standards

In accordance with Government Auditing Standards, we have also issued our report dated October 22, 2024, on our consideration of the Corporation's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Corporation's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with Government Auditing Standards in considering the Corporation's internal control over financial reporting and compliance.

KPMG LLP

New York, New York
October 22, 2024

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of The City of New York)

Management's Discussion and Analysis (Unaudited)

Summary of Statements of Net Position

Years ended June 30, 2024 and 2023

(In thousands)

See accompanying notes to management's discussion and analysis.

[redacted]

	Business-type Activities – HHC	Activities – HHC (as restated)
[redacted]		

See accompanying notes to management's discussion and analysis.

[redacted]

(Continued)

[redacted]

[redacted]

[redacted]

Land and land improvements	$ [redacted]
Buildings and leasehold improvements	
Equipment	
Construction in progress	
Total capital assets, net of accumulated depreciation	$

[redacted]

- [redacted]
- [redacted]
- [redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Lease assets
Subscription IT assets

Total

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]

[redacted]

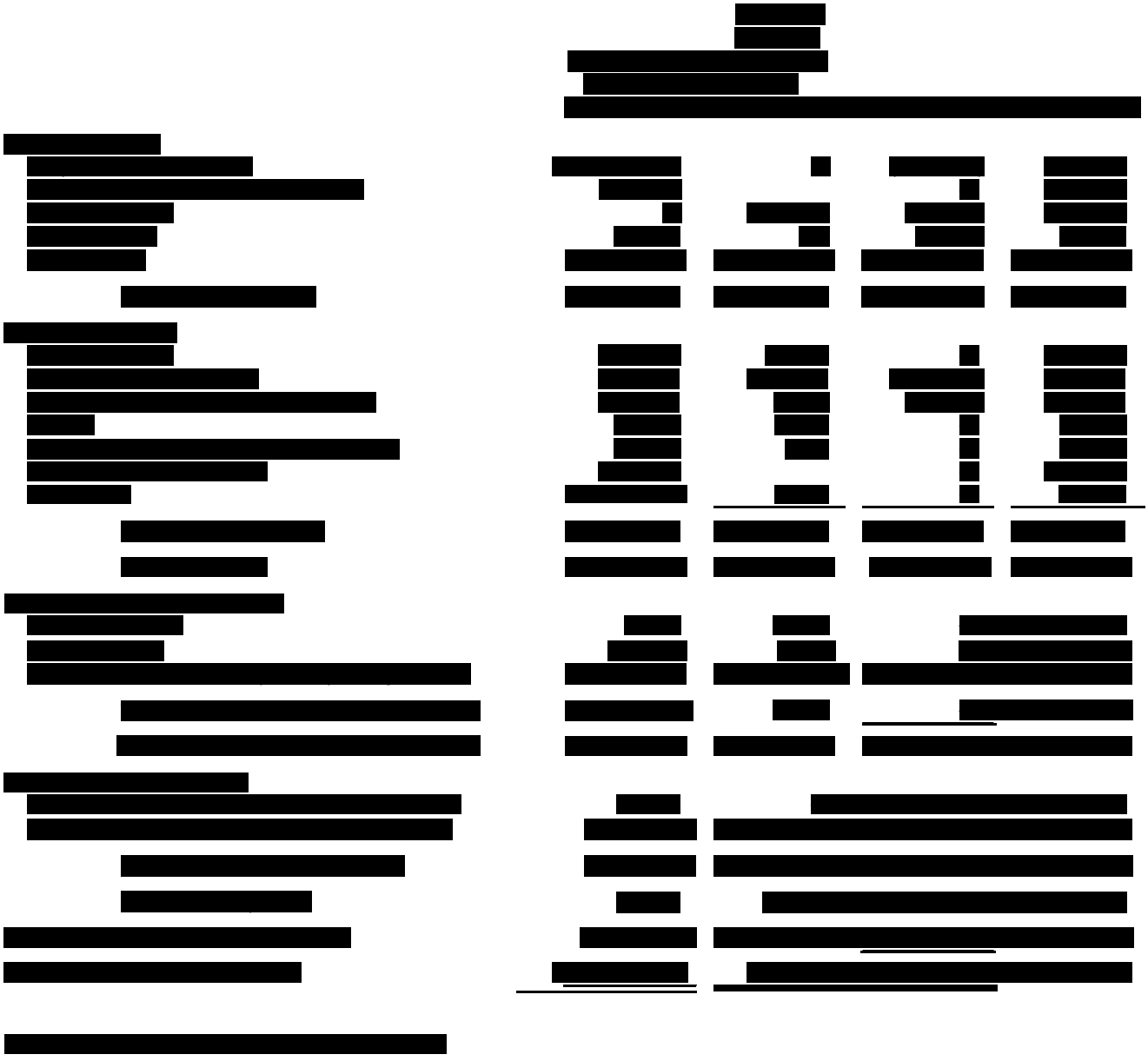
[redacted]

[redacted]

[redacted]				
[redacted]	$ [redacted]	[redacted]		[redacted]
[redacted]	[redacted]	[redacted]		[redacted]
[redacted]	[redacted]		[redacted]	[redacted]
[redacted]		[redacted]	[redacted]	[redacted]
[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]			[redacted]
[redacted]	[redacted]			[redacted]
[redacted]	[redacted]			[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]				
[redacted]	[redacted]	29,093	[redacted]	
[redacted]	[redacted]	3,499	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	
[redacted]				
[redacted]				
[redacted]	$ [redacted]		[redacted]	[redacted]
[redacted]	37,336	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]		[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]				
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]		[redacted]	
[redacted]		[redacted]	[redacted]	[redacted]
	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]				
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]				
[redacted]	[redacted]		[redacted]	
[redacted]	[redacted]		[redacted]	
[redacted]	[redacted]		[redacted]	
[redacted]		[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	
	[redacted]	[redacted]	[redacted]	

[redacted]

[redacted]



[redacted]

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of The City of New York)

Statement of Cash Flows

Year ended June 30, 2024

(In thousands)

	Business-type activities – HHC
[redacted]	

(Continued)

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of The City of New York)

Statement of Cash Flows

Year ended June 30, 2024

(In thousands)

	Business-type activities – HHC
[redacted]	

[redacted]

- [redacted]
- [redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]

(Continued)

[redacted]

[redacted]

(Continued)

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

(Continued)

[redacted]

- [redacted]
- [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

(Continued)

[redacted]

Land improvements	2 to 45 years
Buildings and leasehold improvements	5 to 70 years
Equipment	2 to 30 years

[redacted]

(Continued)

[redacted]

(Continued)

[redacted]

[redacted]

(Continued)

[redacted]

(Continued)

[redacted]

[redacted]

[redacted]

Charges foregone, based on established rates	$	[redacted]
Estimated expenses incurred to provide charity care		

[redacted]

[redacted]

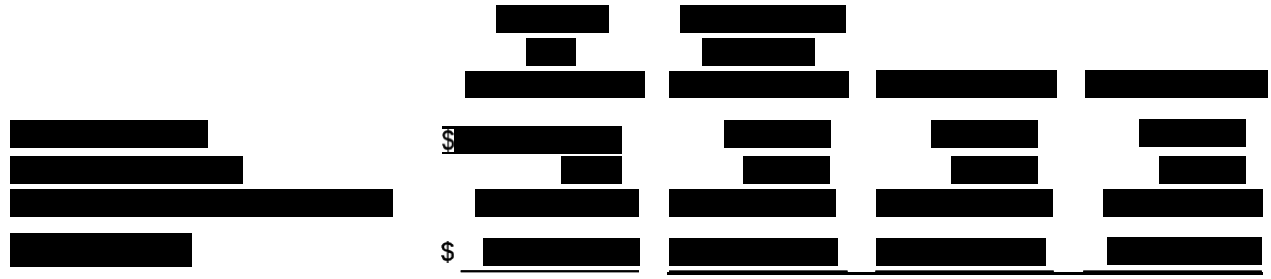
[redacted]

[redacted]

(Continued)

[redacted]

[redacted]



[redacted]

(Continued)

[redacted]

(Continued)

[redacted]

	Fair value	Level 1	Level 2
Cash and U.S. Treasury bills	$ 1[redacted]	[redacted]	1[redacted]

[redacted]

(Continued)

[redacted]

(Continued)

[redacted]

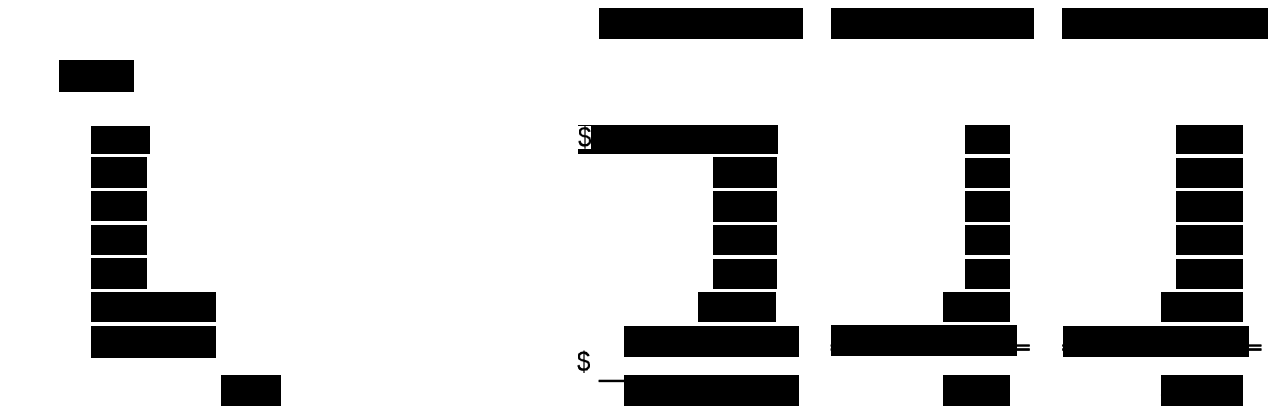
	[redacted]	[redacted]	[redacted]
[redacted]			
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]		[redacted]
	$ 335,578	[redacted]	[redacted]

[redacted]

(Continued)

[redacted]

[redacted]



(Continued)

[redacted]

	Principal	Interest	Total
Year:			
2025	$ 444	—	444
Total	$ 444	—	444

[redacted]

(Continued)

[redacted]

(Continued)

[redacted]

(Continued)

[redacted]

(Continued)

[redacted]

(Continued)

[redacted]

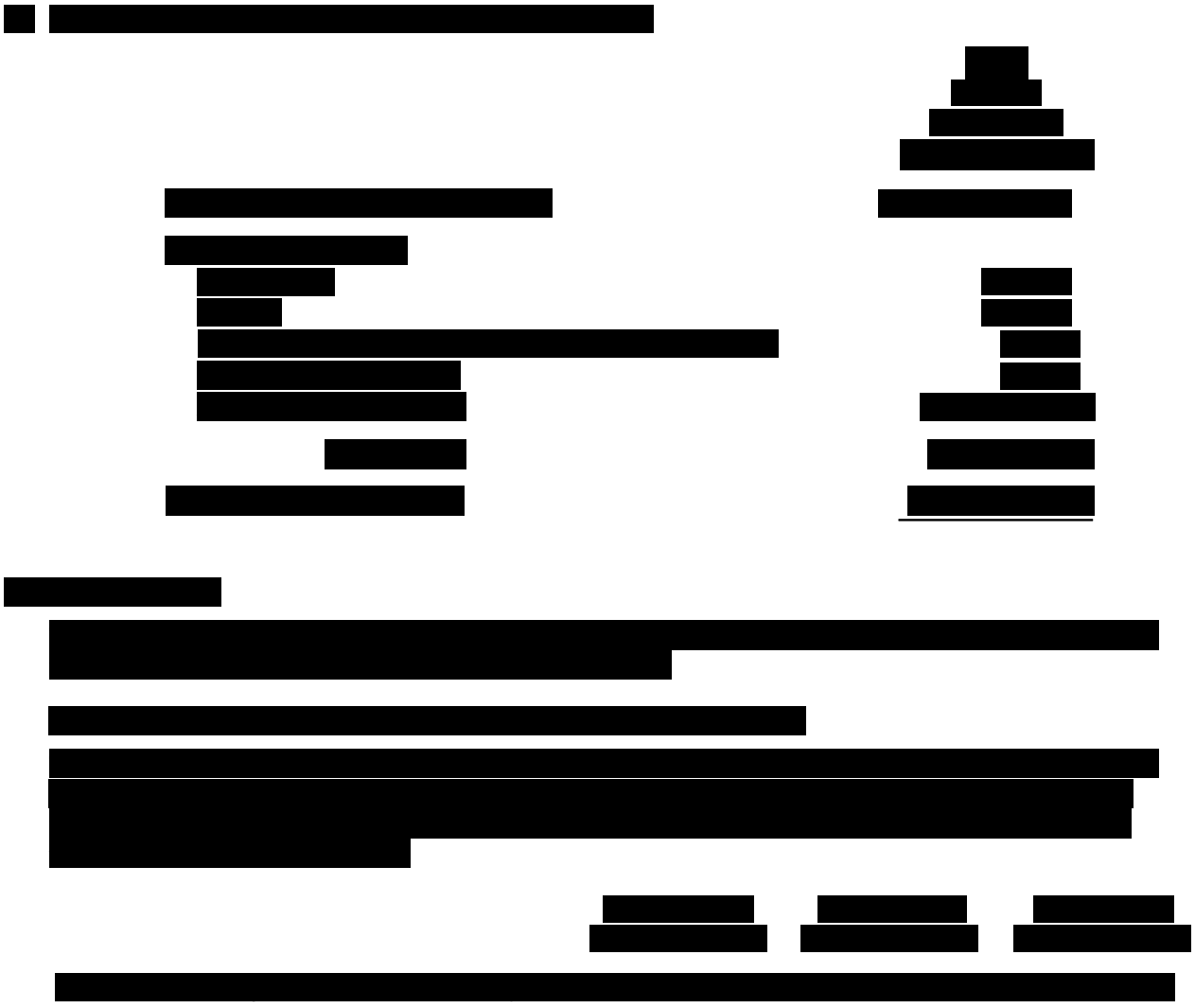
(Continued)

[redacted]

(Continued)

[redacted]

(Continued)



(Continued)

[redacted]

(Continued)

[redacted]

(Continued)

[redacted]

(Continued)

[redacted]

(Continued)

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]”

[redacted]

[redacted]

[redacted]

[redacted]

(Continued)

[redacted]

(Continued)

[redacted]

Medicaid	48 %
[redacted]	[redacted]
HARP	8
[redacted]	[redacted]
Medicare	4
[redacted]	[redacted]
[redacted]	[redacted]
	100 %

** Included in "Others" are MetroPlusHealth Gold, CHP, QHP, Small Business Health Options Programs ("SHOP"), GoldCare, and MAP*

[redacted]

[redacted]

(Continued)

[redacted]

Line of business	Target percentages of premium
[redacted]	
Essential Plan	91
HARP	91
CHP	88.
D-SNP	88.
Medicaid	87.
GoldCare Plan	86.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

[redacted]

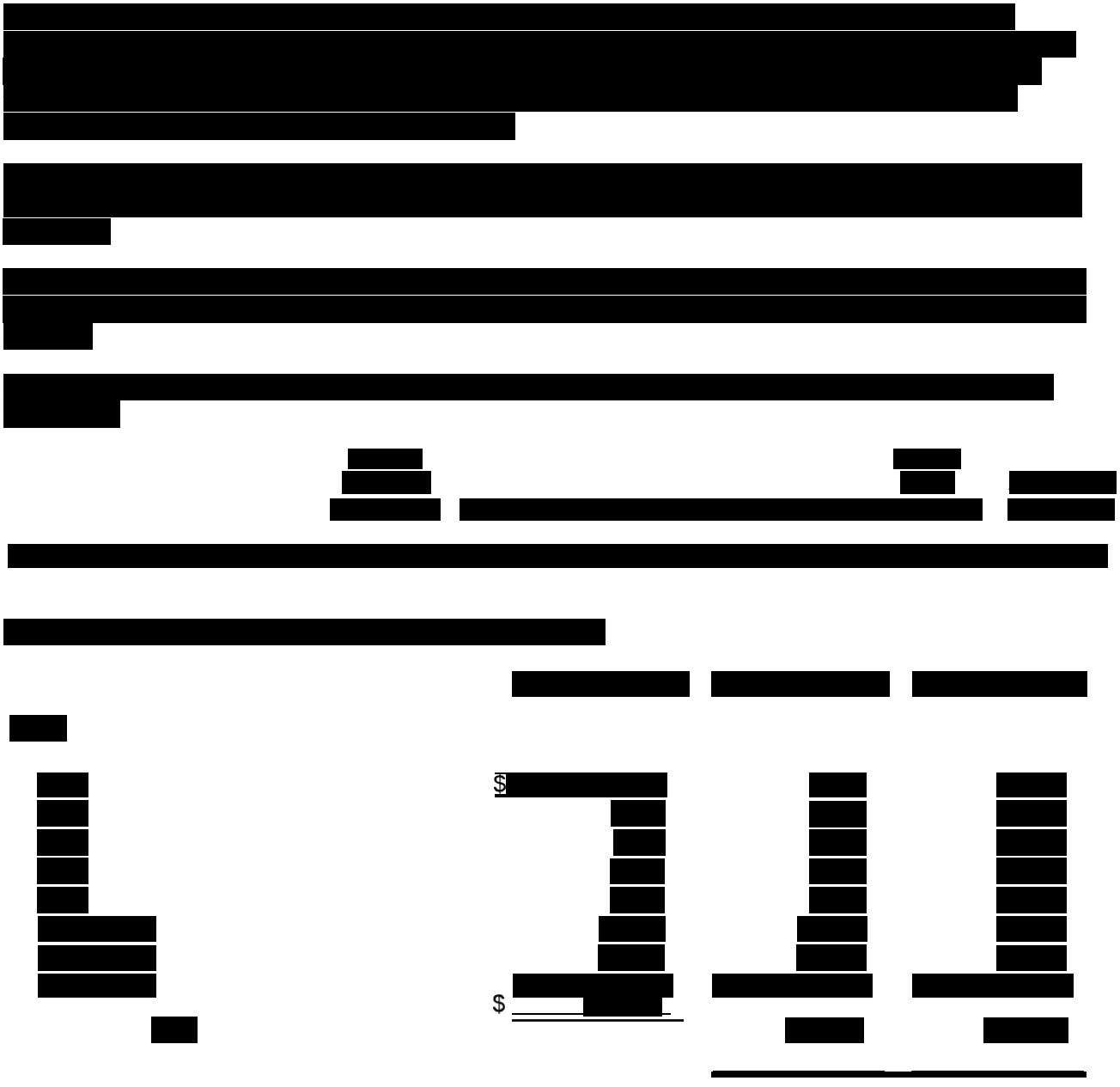
(Continued)

[redacted]

(Continued)

[redacted]

(Continued)



(Continued)

[redacted]

(Continued)

[redacted]

- [redacted]
- [redacted]
- [redacted]

[redacted]

[redacted]

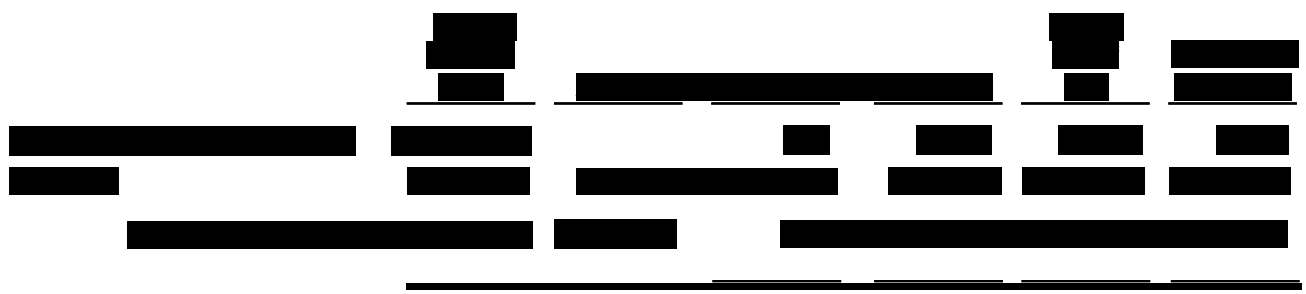
[redacted]

[redacted]

[redacted]

[redacted]

[redacted]



[redacted]

[redacted]

(Continued)

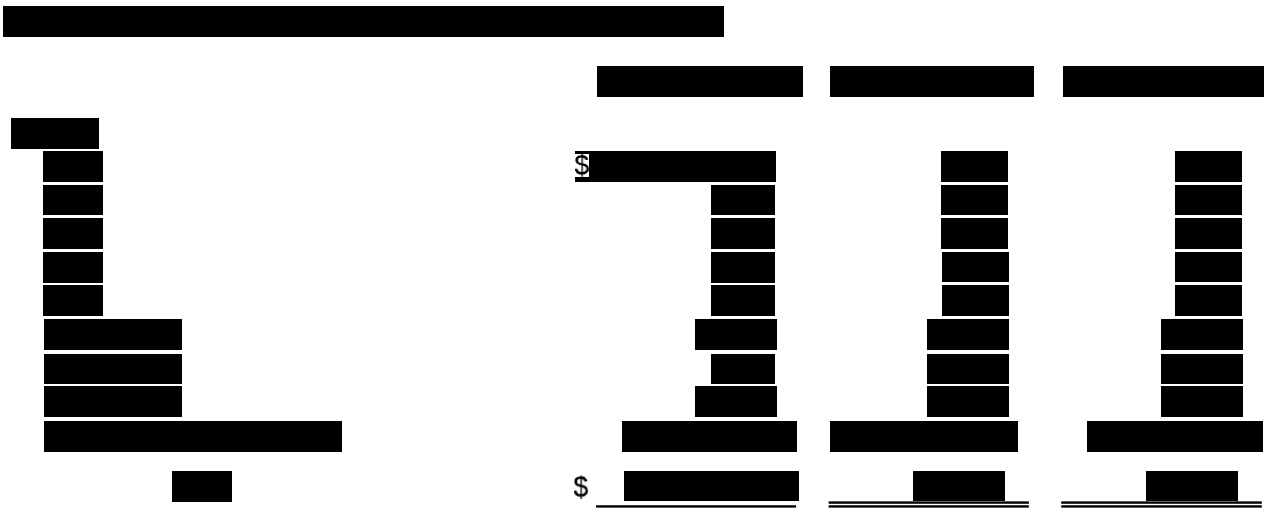
[redacted]

[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	$ 23,130	[redacted]	[redacted]

[redacted]

(Continued)

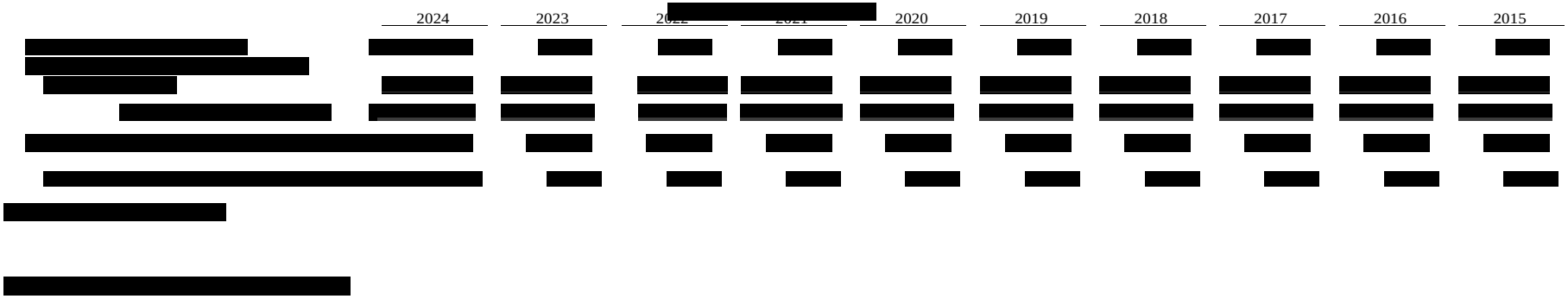
[redacted]



[redacted]

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)

[redacted]



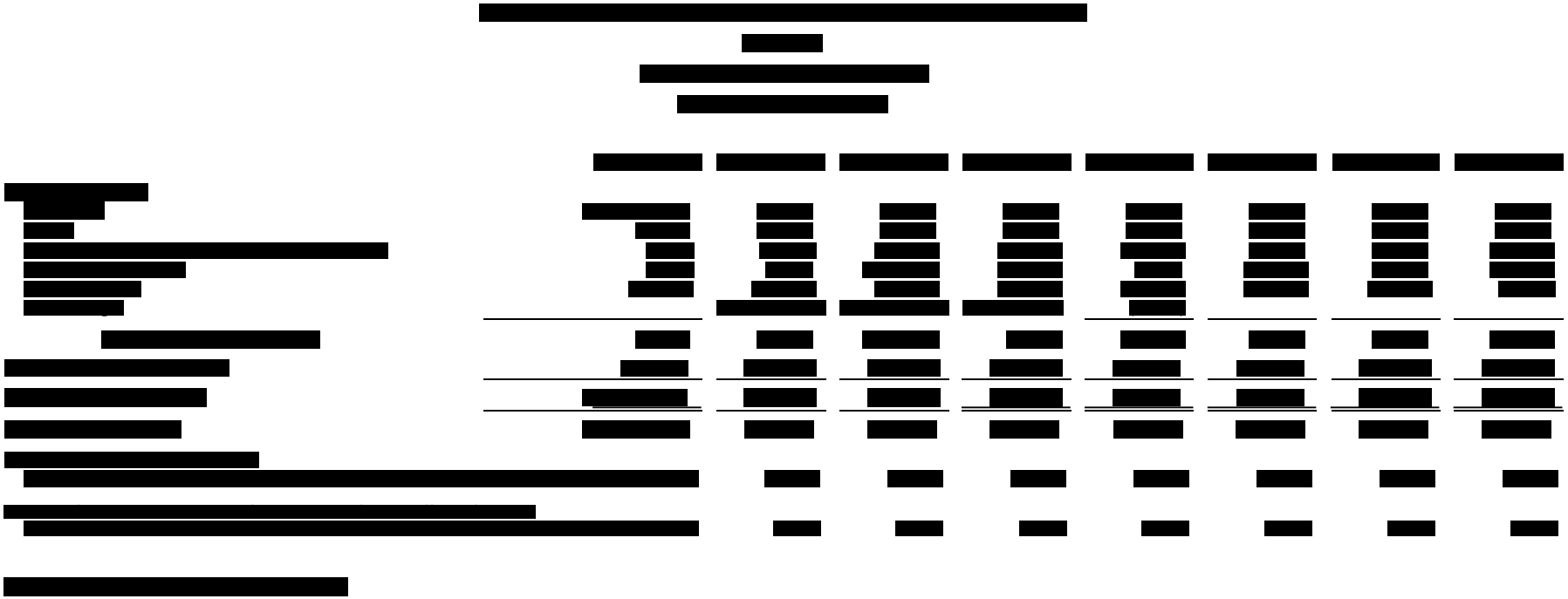
[redacted]

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)

[redacted]

See accompanying independent auditors' report.

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
(A Component Unit of the City of New York)



[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

KPMG

[redacted]

[redacted]

[redacted]’s Response to Findings

[redacted]’s response [redacted]

[redacted]

[redacted] entity’s [redacted]

KPMG LLP

[redacted]

[redacted]

Schedule LRA 4/Schedule 7
CON Forms Regarding
Environmental issues

Contents:

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

2.14	Will the project affect any threatened or endangered plants or animal species?	☐	x
2.15	Will the project result in a major adverse effect on air quality?	☐	x
2.16	Will the project have a major effect on visual character of the community or scenic views or vistas known to be important to the community?	☐	x
2.17	Will the project result in major traffic problems or have a major effect on existing transportation systems?	☐	x
2.18	Will the project regularly cause objectionable odors, noise, glare, vibration, or electrical disturbance as a result of the project's operation?	☐	x
2.19	Will the project have any adverse impact on health or safety?	☐	x
2.20	Will the project affect the existing community by directly causing a growth in permanent population of more than five percent over a one-year period or have a major negative effect on the character of the community or neighborhood?	☐	x
2.21	Is the project wholly or partially within, or is it contiguous to any facility or site listed on the National Register of Historic Places, or any historic building, structure, or site, or prehistoric site, that has been proposed by the Committee on the Registers for consideration by the New York State Board on Historic Preservation for recommendation to the State Historic Officer for nomination for inclusion in said National Register?	☐	x
2.22	Will the project cause a beneficial or adverse effect on property listed on the National or State Register of Historic Places or on property which is determined to be eligible for listing on the State Register of Historic Places by the Commissioner of Parks, Recreation, and Historic Preservation?	☐	x
2.23	Is this project within the Coastal Zone as defined in Executive Law, Article 42? If Yes, please complete Part IV.	☐	x
Part III.		**Yes**	**No**
3.1	Are there any other state or local agencies involved in approval of the project? If so, fill in Contact Information to Question 3.1 below.	☐	x
	Agency Name:		
	Contact Name:		
	Address:		
	State and Zip Code:		
	E-Mail Address:		
	Phone Number:		
	Agency Name:		
	Contact Name:		
	Address:		
	State and Zip Code:		
	E-Mail Address:		
	Phone Number:		
	Agency Name:		
	Contact Name:		

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

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

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

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

FEMA **Elevation Certificate** and Instructions

Limited Review Application

Schedule LRA 5

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

Space & Construction Cost Distribution

☐ New

☐ Alteration

LOCATION			Code and Functional Category Description	Functional Gross SF	Construction Cost per SF	Total Construction Cost	(ALT) Scope of Work
Bldg. No.	Floor No.	Sect. No.					
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
			Not Applicable -				
			no construction				
			required for this				
			project.				
			Total Construction		**#DIV/0!**		

1. If new construction is involved, is it "freestanding"? ***N/A*** Yes ☐ No ☐

2. (Check where applicable) The facilities to be affected by this project are located in a:

■ Dense Urban Area ☐ Other Metropolitan or Suburban Area ☐ Rural Area

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

☐ Alteration Construction Report Number of pages _____

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

(Rev. 7/7/2010

Schedule 6
Architectural/Engineering Submission

Contents:

New York State Department of Health Certificate of Need Application

Schedule 6

Architectural Submission Requirements for Contingent Approval and Contingency Satisfaction

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

Instructions

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

Architecture/Engineering Narrative

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

Project Description	
Schedule 6 submission date: 2/14/2025	Revised Schedule 6 submission date: Click to enter a date.
Does this project amend or supersede prior CON approvals or a pending application? Choose an item. If so, what is the original CON number? Click here to enter text.	
Intent/Purpose: The purpose of this project is to convert 25 chemical dependence-detoxification beds to 25 medical/surgical beds. There is no construction proposed for this project.	
Site Location: 451 Clarkson Avenue, Brooklyn, New York, 11203	

Brief description of current facility, including facility type: Existing hospital Chemical Dependence – Detoxification beds.	
Brief description of proposed facility: The existing 2nd floor patient care unit will be transitioned into a medical/surgical unit comprised of 11 Double Bedrooms and 3 Single Bedrooms (including an isolation room).	
Location of proposed project space(s) within the building. Note occupancy type for each occupied space. The proposed project is located on the 2nd floor within the existing healthcare occupancy type.	
Indicate if mixed occupancies, multiple occupancies and or separated occupancies. Describe the required smoke and fire separations between occupancies: Two-hour fire smoke occupancy separation between existing healthcare and business occupancies.	
If this is an existing facility, is it currently a licensed Article 28 facility?	Yes
Is the project space being converted from a non-Article 28 space to an Article 28 space?	No
Relationship of spaces conforming with Article 28 space and non-Article 28 space: N/A	
List exceptions to the NYSDOH referenced standards. If requesting an exception, note each on the Architecture/Engineering Certification form under item #3. N/A	
Does the project involve heating, ventilating, air conditioning, plumbing, electrical, water supply, and fire protection systems that involve modification or alteration of clinical space, services or equipment such as operating rooms, treatment, procedure rooms, and intensive care, cardiac care , other special care units (such as airborne infection isolation rooms and protective environment rooms), laboratories and special procedure rooms, patient or resident rooms and or other spaces used by residents of residential health care facilities on a daily basis? If so, please describe below. No changes to the existing building system.	No
Provide brief description of the existing building systems within the proposed space and overall building systems, including HVAC systems, electrical, plumbing, etc. No changes to the existing building system.	
Describe scope of work involved in building system upgrades and or replacements, HVAC systems, electrical, Sprinkler, etc. No changes to the existing building system.	
Describe existing and or new work for fire detection, alarm, and communication systems: Standpipe system, Fire alarm system, Sprinkler system	
If a hospital or nursing home located in a flood zone, provide a FEMA BFE Certificate from www.fema.gov, and describe the work to mitigate damage and maintain operations during a flood event. No.	
Does the project contain imaging equipment used for diagnostic or treatment purposes? If yes, describe the equipment to be provided and or replaced. Ensure physicist's letter of certification and report are submitted. Click here to enter text.	
Does the project comply with ADA? If no, list all areas of noncompliance. No construction modification to existing facility.	
Other pertinent information: N/A	

Project Work Area	**Response**
Type of Work - N/A – no construction proposed for this project	Choose an item.
Square footages of existing areas, existing floor and or existing building.	2nd floor existing healthcare occupancy: 11,093 sf; 2nd floor existing business occupancy: 24,938sf.
Square footages of the proposed work area or areas. Provide the aggregate sum of the work areas.	8,400sf

Does the work area exceed more than 50% of the smoke compartment, floor or building? No construction work involved in this project.	Choose an item.
Sprinkler protection per NFPA 101 Life Safety Code	Sprinklered throughout
Construction Type per NFPA 101 Life Safety Code and NFPA 220	Type I (443)
Building Height	111 feet
Building Number of Stories	7
Which edition of FGI is being used for this project?	2018 Edition of FGI
Is the proposed work area located in a basement or underground building?	Grade Level
Is the proposed work area within a windowless space or building?	No
Is the building a high-rise?	Yes
If a high-rise, does the building have a generator?	Yes
What is the Occupancy Classification per NFPA 101 Life Safety Code?	Chapter 18 New Health Care Occupancy
Are there other occupancy classifications that are adjacent to or within this facility? If yes, what are the occupancies and identify these on the plans. Business occupancy	Yes
Will the project construction be phased? If yes, how many phases and what is the duration for each phase? Click here to enter text.	No
Does the project contain shell space? If yes, describe proposed shell space and identify Article 28 and non-Article 28 shell space on the plans. Click here to enter text.	No
Will spaces be temporarily relocated during the construction of this project? If yes, where will the temporary space be? Click here to enter text.	No
Does the temporary space meet the current DOH referenced standards? If no, describe in detail how the space does not comply. Click here to enter text.	Not Applicable
Is there a companion CON associated with the project or temporary space? If so, provide the associated CON number. Click here to enter text.	Not Applicable
Will spaces be permanently relocated to allow the construction of this project? If yes, where will this space be? Click here to enter text.	Not Applicable
Changes in bed capacity? If yes, enumerate the existing and proposed bed capacities. Click here to enter text.	No Change
Changes in the number of occupants? If yes, what is the new number of occupants? Click here to enter text.	Not Applicable
Does the facility have an Essential Electrical System (EES)? If yes, which EES Type? Click here to enter text.	Yes
If an existing EES Type 1, does it meet NFPA 99 -2012 standards?	Yes
Does the existing EES system have the capacity for the additional electrical loads? Click here to enter text.	Yes
Does the project involve Operating Room alterations, renovations, or rehabilitation? If yes, provide brief description. Click here to enter text.	No
Does the project involve Bulk Oxygen Systems? If yes, provide brief description. Click here to enter text.	No
If existing, does the Bulk Oxygen System have the capacity for additional loads without bringing in additional supplemental systems?	Yes
Does the project involve a pool?	No

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

KINGS COUNTY HOSPITAL CENTER

SCHEDULE LRA 6 ATTACHMENT

ARCHITECTURAL INFORMATION

SELF-CERTIFICATION FORM FOR ARCHITECTS AND ENGINEERS

Date: 2/24/25
CON Number: To be assigned
Facility Name: Kings County Hospital Center
Facility ID Number: PFI 1301
Facility Address: 451 Clarkson Avenue, Brooklyn (Kings County), New York 11203

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

I hereby certify that:

1. I have been retained by the above-named facility, to provide services related to the design and preparation of construction documents and specifications for the aforementioned construction project, and, as applicable, to make periodic visits to the site during construction, and perform such other required services to familiarize myself with the general progress, quality and conformance of the work.

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

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

   a. ☒ 712 (Standards of Construction for General Hospital Facilities)
   b. _ 713 (Standards of Construction for Nursing Home Facilities)
   c. _ 714 (Standards of Construction for Adult Day Health Care Program Facilities)
   d. _ 715 (Standards of Construction for Freestanding Ambulatory Care Facilities)
   e. __ 716 (Standards of Construction for Rehabilitation Facilities)
   f. _ 717 (Standards of Construction for New Hospice Facilities and Units)

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

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

6. I have reviewed and acknowledged the Supplemental Self-Certification Eligibility Checklist Page 4 of this document and evaluated and determined this project does meet the prerequisite requirements for Self-Certification. I understand and agree, if the project is deemed by NYSDOH not meeting the criteria allowable for self-certification, I will be required to be resubmit the project documents for an AER review.

   This self-certification is being submitted to facilitate the Architectural CON process and is in lieu of a plan review. It is understood that an electronic copy of final Construction Documents on CD, meeting the requirements of DSG-05 must be submitted to PMU for all projects, including limited, administrative, full review, self-certification and reviews performed and completed by DASNY, prior to construction.

Project Name: Kings County Hospital Center

Location: 451 Clarkson Avenue, Brooklyn (Kings County), NY 11203
Description: Convert 25 Chemical Dependence - Detoxification beds to 25 Medical/Surgical beds

Signature of NYS Licensed Architect/Engineer

PAUL DRAGO

Name of Architect/Engineer (Print)

022980-1

Professional New York State License Number

NK Architects - 233 Broadway, Suite 2150, New York, NY 10279

Business Street Address, City, State, Zip Code

Architectural or Engineering Professional Stamp

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

2/14/2025 — Date

GEOFFREY Gorousingh — Name (Print)

Dr. of Capital Budgets — Title

Signature of Applicant

Notary signing required for the applicant

STATE OF NEW YORK)
) SS:
County of Kings)

On the 14 day of February 2025 before me personally appeared Geoffrey Gorousingh to me known, who being by me duly sworn, did depose and say that he/she is the Director of Capital Budgets of Governor's ... , the facility described herein which executed the foregoing instrument; and that he/she signed his/her name thereto by order of the governing authority of said facility.

Brandon M Rivera
Notary Public State of New York
No. 01RI6415838
Commision Expires 03/29/2025

(Notary)

Project Eligibility Checklist for Architectural/Engineering Self-Certification			
	Does the project include any of the following?	YES If Yes, project is not eligible for Self-Certification and is required to be submitted for an AER review.	NO
1.	Is a waiver or exceptions required?		X
2.	Will the project costs exceed $15,000,000.00 (fifteen million dollars)?		X
3.	Is Bulk Oxygen /Medical Gas Storage associated with this project? Examples of Bulk Oxygen /Medical Gas Storage projects include but not limited to the following:		
	a. Hyperbaric Chambers		
	b. Bulk Systems include Nitrous Oxide System and Oxygen System: Definitions as defined below:		
	Bulk Nitrous Oxide System. An assembly of equipment as described in the definition of bulk oxygen system that has a storage capacity of more than 3,200 lb (1,452 kg) [approximately 28,000 fu (793 m3) (NTP)l of nitrous oxide. (PIP)irround		X
	Bulk Oxygen System* An assembly of equipment such as oxygen storage containers, pressure regulators, pressure relief devices, vaporizers, manifolds, and interconnecting piping that has a storage capacity of more than 20,000 fu (566 m3) of oxygen (NTP) including unconnected reserves on hand at the site. The bulk oxygen system terminates at the point where oxygen at service pressure first enters the sunnlv line. **(PIP)**		
4.	**Will** this project have Locked or Secured Units? Examples of Locked or Secured Units include but not limited to the following:		
	a. Observation Units for behavioral health in EDs.		
	b. Behavioral health located within inpatient settings.		X
	c. Nursing Homes or other facilities with Dementia Units that are locked.		
	d. Corrections and Detention Facilities located in Hospitals, Ambulatory Health Care Occupancies and Business Occupancies where healthcare is provided.		
5.	Will this project involve construction of new procedure rooms, new operating rooms, renovations and or alterations to existing procedure rooms and or operating rooms, including modifications made to existing support systems, including, but not limited to heating, cooling, plumbing, electrical systems, medical gas systems, fire detection and fire protection systems, located in hospitals and existing ambulatory surgery centers? Examples, include but not limited to the following.		X
	a. Endoscopy Procedure Rooms		
	b. Procedure Rooms		
	c. Operating Rooms		
	d. Interventional Imaging i. Located in procedure rooms ii. Located in operating rooms		
6.	Is this a project requiring construction that is required to comply with New Ambulatory Health Care Occupancies as indicated in Chapter 20 of NFPA 101, 2012 edition requirements? Examples, include but not limited to the following:		X
	a. New Ambulatory Surgery Center		
	b. Endoscopy Centers and or Other Procedure Rooms		
	c. Free Standing Emergency Departments providing Definitive Care.		
7.	Is this project intended to provide Ventilator units for patients located in nursing homes?		X
8.	Does this project involve Airborne infection isolation **(All)** room?		X
9.	Does this project involve Protective environment (PE) room?		X

King County Hospital Center – R2 East Functional Program Narrative
February 07, 2025

A. Purpose of the Project

The Purpose of this project is to convert 25 Chemical Dependence – Detoxification beds to 25 Medical/Surgical beds.

B. Environment of Care

The 2nd floor patient care unit will be transitioned into a medical/surgical unit comprised of 11 Double Bedrooms and 3 Single Bedrooms (including an isolation room). The conversion of these beds within the current Chemical Dependence – Detoxification beds will provide additional medical/surgical capacity for the Hospital.

C. Layout/Operational Planning

The area included in the project is on the 2nd floor of Building "R", which is the main building on the campus. It will be a no construction of the existing Chemical Dependence – Detoxification beds unit; approximately 6,225 net square feet. The building has four existing stairs on the corners and an elevator core is centrally located.

There are several room types on the plan, and all rooms but one have the toilet room located adjacent to the headwall for patient safety. There are two patient bedrooms with Toilet/Shower Rooms are accessible and the public toilet is also accessible.

There is one Medical/Surgical Nurse Station on the unit. There is one Clean Supply area within unit. Two Soiled Holding, Meds and Nourishment, are also provided. There is a family space, which is adjacent to the Toilet, Meditation Room and a multipurpose room.

No construction is required for this project.

D. Architectural Space Requirements

The project area will meet the requirements of Chapter 2.2, Section 2.2-2.1 and 2.2-2.2, of the 2018 Edition of the ***Guidelines for Design and Construction of Hospitals and Outpatient Facilities*** (hereafter referred to as the "Guidelines") as follows:

2.2-2.2 Medical/Surgical Nursing Unit

2.2-2.2.2 Patient Room

2.2-2.2.2.1 Patient Rooms (R2220 to R2221) are single bedrooms. Patient Rooms () are double bedrooms.

*2.*2-2.2.2.2 & 2.2-2.5.2.2 All Medical Surgical Patient Single Bedrooms are larger than the required 120sf and Double Bedrooms are larger than the required 200sf. All Patient rooms have been designed to accommodate the needs of the clinical services provided and required minimum bed clearances are provided.

2.2-2.2.2.3 & 2.1-7.2.2.5 Each Patient Room is provided with fixed windows which meet the minimum required size.
2.2-2.2.2.4 All Patient Rooms have been designed to provide visual privacy for patients. Each double bedroom is fitted with a privacy curtain
2.2-2.2.2.5 & 2.1-2.2.5.3 Hand-washing stations are technically infeasible to be located within patient bedrooms, hand-washing stations are provided in patient toilet rooms. A hand-washing station is in the Isolation Room.
2.2-2.2.2.6 Patient Toilet Rooms meeting the requirements of 2.1-2.2.6, 2.1-2.6.5 and 2.1-8.4.3.7 are provided in each Patient Room. Each Patient Toilet Room is fitted with a hand-wash sink and toilet fixture which has a bedpan washer.
2.2-2.2.2.7 Patient bathing facilities meeting the Guidelines requirements are provided in each Patient Toilet Room.
2.2-2.2.2.8 Patient Storage is provided in each Patient Room. Each room has a patient wardrobe with a hanging rod and drawers for folded garments.

2.2-2.2.3 Patient/Family-Centered Care

2.2-2.2.3.1 Family zone support features – Space is provided for moveable seating for visitors and a recliner for the patient. A bench (which doubles as a sleeper), is provided for long-term sitting.

2.2-2.2.4 Special Patient Care Rooms

2.2-2.2.4.2 Airborne Infection Isolation (AII) **–** 1 AII rooms () meeting the requirements of 2.1-2.4.2 and 2.2-2.2.2 are provided. Anteroom is not required by the Guidelines; a hand wash sink and storage for personal protective equipment are provided in the AII room.
A separate room with a hand washing sink, toilet and shower is provided in each AII room.
2.1-2.4.2.4 AII room has been architecturally detailed to prevent the spread of infection, and to meet the Guidelines requirements.

2.2-2.2.8 Support Areas for Patient Care-General

Support spaces have been provided per the functional program. All required spaces are located on the same floor as the Unit and are readily accessible.

2.2-2.2.8, 2.2-2.5.6 & 2.1-2.6 Support Areas for Medical Surgical Nursing Units

This will be updated
2.2-2.2.6.12 & 2.1-2.6.12 House Keeping closet R2092 is provided.
2.2-2.2.6.13 All single patient bedrooms provided.

2.2-2.2.7 & 2.1-2.7 Support Areas for Staff

2.1-2.7.1 Staff Lounge R2084 is accessible from the unit.
2.1-2.7.2 A centrally located unisex Staff Toilet Room (R2218) with a toilet and hand wash sink is provided.
2.1-2.7.3 Lockers are provided in the staff lounge.

2.2-2.2.10 Support Areas for Patients, Families and Visitors

2.2-2.2.10.1 Family Lounge Room R2204 is provided on the floor.
2.2-2.2.10.2 Toilet Room (R2216) with a hand wash station is provided and is readily accessible to Multipurpose Room (R2205).
2.2-2.2.10.4 Meditation Room (R2217) is provided, dedicated to support meditation, bereavement or prayer.

NYC HEATH + HOSPITALS KINGS COUNTY HOSPITAL CENTER

	SPACE NAME	NET AREA OF SPACE	NO OF SPACES	TOTAL NET AREA	NO. OF PER	EQUIPMENT, FURNITURE & REMARKS
1.1	Nurse Station	368	1	368		
1.2	Meeting Room	189	1	189		
1.3	Activity Room	79	1	79		
1.4	Single Bedroom	171	2	341		
	Patient Toilet Room	48	2	96		
1.5	Double Bedroom	228	11	2,510		
	Patient Toilet Room	25	11	275		
1.6	Isolation Room	169	1	169		
	Patient Toilet Room	48	1	48		
1.8	Staff Restroom	36	1	36		
1.9	Public Toilet	77	1	77		
1.10	Equipment Holding	130	2	260		
1.11	Program Room	206	1	206		
1.12	Linen	40	1	40		
1.13	Medication	80	1	80		
1.14	Exam Room	168	1	168		
1.15	Family and Visitor	393	1	393		
1.16	Multipurpose Room	255	1	255		
1.17	Dining Room	378	1	378		
1.18	Nourishment	64	1	64		
1.19	Soiled Utility Room	114	1	114		
1.20	Clean Supply Room	79	1	79		
	l Subtotal :		**Gross SF:**	**6,225**	**0**	

Total Departmental Net Square Feet	**6,225**
Grossing Factor	**29%**
Ciculation/Construction SF	**1,805**
TOTAL DEPARTMENTAL GROSS AREA SUBTOTAL	**8,030**

Total Available Area: 3,040

Limited Review Application

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

Schedule LRA 7

Proposed Operating Budget

Budget	Current Year	First Year (Projected)	Third Year (Projected)
Revenues			
Service Revenue			
Grants Funds			
Foundation			
Other			
Fees			
Other Income			
(1) Total Revenues	N/A	$0	$0
Expenses			
Salaries and Wage Expense		$3,236,940	$3,236,940
Employee Benefits		$1,294,776	$1,294,776
Professional Fees			
Medical & Surgical Supplies		$200,000	$200,000
Non-Medical Equipment			
Purchased Services			
Other Direct Expense			
Utilities Expense			
Interest Expense			
Rent Expense			
Depreciation Expense			
Other Expenses			
(2) Total Expense	$0	$4,731,716	$4,731,716
Net Total - (1-2)	N/A	-$4,731,716	-$4,731,716

Note: The table above reflects only incremental expenses for the proposed new 25 med/surg beds. The applicant is projecting no additional revenue as a result of this project. The proposed 25 med/surg beds will primarily be used to decant patients in the Emergency Department who have been admitted but were previously unable to be moved to an inpatient bed immediately after admission due to lack of available med/surg capacity.

Limited Review Application

Schedule LRA 7

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

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

Patient Days ☐ Patient Discharges ☐ **Not Applicable: Outpatient services only**

Inpatient Services Source of Revenue		Total Current Year			First Year Incremental			Third Year Incremental		
		Patient Days or discharges	Net Revenue*		Patient Days or discharges	Net Revenue*		Patient Days or discharges	Net Revenue*	
			%	Dollars ($)		%	Dollars-($)		%	Dollars-($)
Commercial	**Fee for Service**									
	Managed Care									
Medicare	**Fee for Service**									
	Managed Care									
Medicaid	**Fee for Service**									
	Managed Care									
Private Pay										
OASAS										
OMH										
Charity Care										
Bad Debt										
All Other										
Total		N/A	N/A	N/A	0	0.0%	$0	0	0.0%	$0

Note: The applicant is projecting no additional revenue as a result of this project. The proposed 25 medical/surgical beds will primarily be used to decant patients in the Emergency Department who have been admitted but were previously unable to be moved to an inpatient beds immediately after admission due to lack of available med/surg capacity.

Not Applicable - inpatient services only.

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

Total of Inpatient and Outpatient Services			**N/A**			**$0**			**$0**

	Title of Attachment	Filename of Attachment
1. In an attachment, provide the basis and supporting calculations for all revenues by payor.	Based on the actual experience of the Hospital for its existing medical/surgical beds.	N/A
2. In an attachment, provide the basis for charity care.		N/A

* Net Deductions from Revenue

Limited Review Application

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

Schedule LRA 8

Staffing

Staffing Categories	Number of FTEs to the Nearest Tenth		
	Current Year	First Year of implementation	Third Year of implementation
Health Providers:**			
Physician		6.00	6.00
Physician Assistant/Nurse Practitioner		12.00	12.00
Assistant Director of Nursing		3.00	3.00
Head Nurse/Assistant Head Nurse		2.00	2.00
Staff Nurses		22.00	22.00
Creative Arts Therapist		2.00	2.00
Support Staff*:**			
Case Manager/Case Worker		4.00	4.00
Social Worker		2.00	2.00
Patient Care Associate		15.00	15.00
Behavioral Health Associate		6.00	6.00
Clerical Associate		2.00	2.00
Transporter		1.00	1.00
Environmental Services		3.80	3.80
Food Service Associate		1.50	1.50
Total Number of Employees	N/A	82.30	82.30

* Last complete year prior to submitting application.

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

*** All other staff.

Describe how the number and mix of staff were determined:

The table above reflects total staffing for the new 25-bed medical/surgical unit only. The staffing was based on the applicant's current staffing for its existing medical/surgical beds.

PLEASE COMPLETE THE FOLLOWING:

1. Are staff paid and on payroll?	**Yes.**
2. Provide copies of contracts for any independent contractor.	**Not Applicable.**
3. Please attach the Medical Doctors C.V.	**Please refer to Schedule LRA 8 Attachment.**
4. Is this facility affiliated with any other facilities? (If yes, please describe affiliation and/or agreement.)	**Yes - refer to Network Statement under Schedule LRA 8 Attachment.**

KINGS COUNTY HOSPITAL CENTER

SCHEDULE LRA 8 ATTACHMENT

MEDICAL DIRECTOR CURRICULUM VITAE

NETWORK STATEMENT

RAJESH VERMA, M.D., FAAEM

rajesh.verma@nychhc.org

Results-driven Chief Medical Officer (CMO) with extensive experience in managing physicians and clinical operations within healthcare organizations. Proven track record of ensuring adherence to safety standards and healthcare regulations while continuously seeking ways to enhance clinical services. Skilled in updating staff on the latest healthcare regulations and developing comprehensive training programs for new physicians. Demonstrated expertise in financial management through effective development and oversight of clinical facilities budgets. Committed to fostering a culture of safety, quality, and innovation in healthcare delivery. Board certified in emergency medicine with nearly 25 years of leading the safe, effective, and efficient delivery of emergency care in high-volume, fast-paced hospitals including two Level 1 trauma centers.

EDUCATION

NEW YORK MEDICAL COLLEGE 1993
Doctorate of Medicine (MD)

NEW YORK UNIVERSITY 1986
Bachelor of Arts (BA) in Chemistry

RESIDENCY & INTERNSHIP

BETH ISRAEL MEDICAL CENTER 1994 – 1997
Resident, Department of Emergency Medicine
- Chief Resident, 1996-1997

BETH ISRAEL MEDICAL CENTER 1993 – 1994
Intern, Department of Internal Medicine

LICENSURE

Licensed MD in the State of New York

PROFESSIONAL EXPERIENCE

KINGS COUNTY HOSPITAL – BROOKLYN, NY **January 2023 – Present**

Chief Medical Officer

Under direction of the Executive Director, plans, organizes, supervises and controls medical and health care services including primary medical and dental care, diagnostic and therapeutic services, medical staff and support services, education, and other health related services in a health care facility or for overall corporate programs for medical affairs and professional services.

- Serve as the Chief Medical Officer and advisor to the Executive Director, addressing issues related to facility administration and medical staff that impact clinical departments.
- Direct and coordinate clinical functions through department chairpersons/Chiefs, ensuring effective staffing and quality medical care for inpatients, outpatients, and emergency services.
- Initiate and lead efforts to deliver high-quality patient care by planning, directing, and coordinating clinical operations.
- Collaborate with organized medical staff and committees to ensure compliance with Medical Staff bylaws, healthcare facility policies, regulatory standards, and Joint Commission requirements.
- Coordinate the appointment, re-appointment, and delineation of clinical privileges for medical staff and

independent practitioners, ensuring adherence to relevant rules and regulations.
- Oversee medical Staff Office functions, including monitoring medical staff files and profiles based on Quality Improvement, Risk Management, and Patient Relations findings.
- Ensure that graduate programs operated in compliance with ACGME standards and that they meet the clinical service needs of the healthcare facility.
- Act as a liaison between the Executive Director and affiliation administration, managing contract matters related to clinical policy, staffing, and education.
- Oversee clinical research activities, ensuring adherence to H+H policies and procedures and that all projects receive necessary approvals.
- Coordinate multidisciplinary program planning, development, implementation, and evaluation.
- Participate in the strategic planning process, including annual budget development for expenses, revenue, and capital.
- Advocate for community health needs, representing the healthcare facility and medical staff in community engagements to improve public health outcomes.
- Recommend allocation of affiliation contract funds based on organizational needs and priorities.
- Conduct performance appraisals for Chiefs/Directors of Service in consultation with the Executive Director and affiliation administration.
- Collaborate with the Executive Director to periodically conduct comprehensive evaluations of clinical services and support functions, with evaluations not occurring less than every five years.

KINGS COUNTY HOSPITAL – BROOKLYN, NY **August 2018 – December 2022**

Chief, Department of Emergency Medicine

Ensure delivery of safe and efficient patient care, while improving patient experience in this Level 1 trauma center's Emergency Department. Lead medical staff of over 70 medical doctors, 8 physician assistants, and 2 nurse practitioners to treat about 140K patients yearly. Partner with Director of Nursing and Assistant Directors of ED on special projects. Oversee a well-established and the largest emergency medicine residency program in United States with 98 residents. Additionally, provide oversite of 9 fellowship programs within emergency medicine department.

- **Recruited 18 emergency medicine board eligible/certified physicians** within the first year of coming onboard.
- **Instituted Admission Guidelines** to ensure proper placement of admitted patients to appropriate in-patient services.
- **Improved the front flow metrics** including left without being seen by implementing vertical flow and physician in triage.
- **Organized and implemented yearly attending and leadership retreats** to discuss mission and vision of the Emergency Department. This venue has served to engage the attending staff and boost morale.
- **Created and implemented a robust surge plan** for the ED during the COVID-19 pandemic.
- **Designed and opened 12-bed observation unit** managed by the Emergency Department.
- **Created the first Clinical Forensic Medicine Fellowship** which offers clinical forensic science to emergency medicine practitioners. The goal of this fellowship is to develop leaders and elevate skills in the identification, prevention, and advocacy of trauma patients.
- **Created the first Emergency Medicine Administration Fellowship** which provides all of the necessary elements to develop future leaders in Emergency Medicine.

GOHEALTH/ NORTHWELL HEALTH – NASSAU, NY **February 2017 – June 2018**

Regional Director, Nassau County Urgent Cares

Managed operations of all urgent cares in Nassau County. This included 11 centers with a provider staff consisting of physicians and physician assistants. Day to day operations included taking calls from physician assistants to help manage the cases clinically and troubleshoot any patient complaints/issues in real time. Participated in meetings with leadership from other counties to contribute to citywide projects.

HARLEM HOSPITAL CENTER – NEW YORK, NY **October 2014 – February 2017**

Chair, Department of Emergency Medicine

Ensured delivery of safe and efficient patient care, while improving patient experience in this Level 1 trauma center's Emergency Department. Lead medical staff of 18 medical doctors, 12 physician assistants, and 3 nurse practitioners for adult ED. Partnered with Director of Nursing and Associate Director of ED on special projects.

Provided guidance and oversight for emergency medicine residents rotating from Metropolitan Hospital EM Residency Program. Additionally, supervised trauma training rotation for EM residents from Coney Island Hospital EM Residency Program.

- **Established Harlem's first Simulation Fellowship Program** and the largest in New York with 11 hospitals participating. Hired Director of Simulation Fellowship Program and obtained first fellow, an ER trained resident, in July 2015.
- **Lowered patient wait times, treat and release times, and dwell times,** resulting in increased patient satisfaction, by launching dedicated Urgent Care service that reduced volume in main ED by about 25%.
- **Initiated development of EM Residency Program.** Formed residency planning committee, selected and appointed a committee chair, and obtained hospital administration approval to implement program.
- **Filled all open MD and PA positions in first 12 months** by recruiting 10 EM board eligible/certified physicians and two physician assistants. Expanded staff with two additional nurse practitioners.
- **Improved all ED patient flow metrics** by redesigning department to include 24/7 fast-track area and reconfiguring staffing schedule to match patient surge times.

NORTH BRONX HEALTHCARE NETWORK – BRONX, NY **July 2008 – September 2014**

Director, North Central Bronx Hospital Department of Emergency Medicine

Led staff of 12 physicians and 12 physician assistants to treat approximately 55K patients each year at North Central Bronx Hospital and additional patients at sister hospital, Jacobi Medical Center. Directed all emergency department operations to ensure safe and efficient delivery of patient care. Collaborated with nurse director to assure nursing staff supported mission of emergency medicine.

- **Reduced overall treat and release times by approximately 40%** from 5+ hours to 3 by creating fast track area within the department to examine all ESI-5 patients.
- **Played vital role in nearly 75% decrease in ED dwell times for admitted patients** by collaborating with admitting, internal medicine, and nursing to address all contributing factors.
- **Accelerated triage process** by leveraging LEAN methodology to create triage cells for adult, pediatric, and psychiatric patients.

NORTH BRONX HEALTHCARE NETWORK – BRONX, NY **July 1998 – June 2008**

Associate Director, Department of Emergency Medicine

Promoted from Attending Physician and Quality Assurance Coordinator (July 1998 – June 2000).

- **Developed and instituted ED's first peer review program** involving reviewing a sampling of each provider's charts for quality assurance; offered constructive feedback.
- **Initiated risk management case review in the Emergency Department** by joining hospital-wide risk management team.

CERTIFICATIONS

- Board Certified in Emergency Medicine
- Certified Instructor, Advanced Trauma Life Support (ATLS)
- Certified in Pediatric Advanced Life Support (PALS)
- Certified Instructor, Advanced Cardiac Life Support (ACLS)
- Certified Instructor, Basic Life Support
- Certified Sexual Assault Forensic Examiner
- Certified Team STEPPS Master Trainer

ACADEMIC TEACHING APPOINTMENTS

- SUNY Downstate Health Sciences University, Clinical Associate Professor of Emergency Medicine
- SUNY Downstate Health Sciences University, Assistant Professor of Emergency Medicine
- Columbia Medical School, Assistant Professor
- Albert Einstein Medical College, Assistant Professor for Introduction to Clinical Medicine, Course 1

AFFILIATIONS & COMMITTEES

NYC Health + Hospitals
- Chief Medical Officer Council, Member, 2023-Present
- CMO/CNO/CQO Council, Member, 2023-Present
- Chief Medical Officer/Medical Board President Council, 2023-Present
- Root Case Analysis Review Committee, Member, 2023-Present

NYC H+H/Kings County Hospital
- Community Advisory Board, Member, 2023-Present
- DMC/KCHC Joint Coordinating Committee, Member, 2023-Present
- Executive Quality Care Review Committee, Member, 2023-Present
- Executive IT Governance Committee, Member, 2023-Present
- Graduate Medical Education Committee, 2023-Present
- Health Equity Committee, Member, 2023-Present
- Hospital-Wide Quality Committee, Chair, 2023-Present
- Medical Board Committee, Executive Member, 2023-Present
- Quality Assurance Performance Improvement Board of Directors/ Governing Body Committee, Member, 2023-Present
- Root Cause Analysis Committee, Member, 2023-Present
- Senior Cabinet, Member, 2023-Present
- Hospital Flow Committee, Member, 2018-Present
- Bylaws and Credentialing Committee, 2020-2022
- President, Medical Board, 2022

Harlem Medical Associates PC
- President, 2016-2017

Harlem Hospital Center
- Medical Executive Committee, 2014-2017
- Joint Oversight Committee, 2014-2017

Physicians Affiliate Group of New York (PAGNY)
- Board Member (Observer), 2020-2022
- Human Resource Committee, 2019-2022
- Bylaws Committee, 2022
- Board Member and Secretary, 2012-2017

Albert Einstein School of Medicine
- Einstein Senate, 2011-2014

North Central Bronx Hospital
- Co-Chair, Pharmacy and Therapeutic Committee, 2011-2014
- Meaningful Use Steering Committee, 2011-2014

North Bronx Healthcare Network
- Hospital Performance Improvement Committee, 2002-2014
- Bylaws and Credentialing Committee, 2004-2014
- Pharmacy and Therapeutic Committee, 2004-2011
- New York Medical Alliance Executive Board, 2004-2011

- Vice President of New York Medical Alliance Finance Committee, 2005-2011

HONORS & AWARDS

Citation, Nassau County Office of the Executive, County Executive Laura Curran, 2020
Proclamation, New York State Senate, Senator Kevin Thomas, 2020
Davidoff Honor Society, Albert Einstein School of Medicine, 2007

SOCIETY MEMBERSHIPS

American College of Emergency Physicians, 2021 to Present
American Academy of Emergency Medicine, 1999 to Present

PUBLICATIONS

PEER REVIEWED

Felemban A., Allan S., Youssef E., **Verma R.**, Zehtabchi S. Lidocaine patch for treatment of acute localized pain in the emergency department: a systematic review and meta-analysis. Eur J Emerg Med. 2024 Jul 10. doi: 10.1097/MEJ.0000000000001158. Epub ahead of print. PMID: 38985833H.

Youssef E., Benabbas R., Choe B., Doukas D., Taitt HA., **Verma R.**, Zehtabchi S. Interventions to improve emergency department throughput and care delivery indicators: A systematic review and meta-analysis. Acad Emerg Med. 2024 Jun 3. doi: 10.1111/acem.14946. Epub ahead of print. PMID: 38826092.

Johari F., **Verma R.** Paxlovid for nonhospitalized patients with COVID-19. Academic Emergency Medicine. 2024 Mar 22.

Azad T., Pan G., **Verma R.** "Epley Maneuver (canalith repositioning) for Benign Positional Vertigo." AEMJ-20-092 – Academic Emergency Medicine.

Li J.J., Chao P., Gernsheimer, J., **Verma, R.** "Octreotide for Gastrointestinal Hemorrhage from Esophageal Varices." Academic Emergency Medicine 2019; 27(4):339-340.

Calderon Y., Cowan E., Schramm C., Stern S., Brusalis C., Iscoe M., Rahman S., **Verma R.,** Leider J. "HCV and HBV testing acceptability and knowledge among urban emergency department patients and pharmacy clients." Prev Med. 2013 Dec 29; 61C: 29-33. PMID: 2438229.

Dhuper S., Chandra A., Ahmed A., Bista S., Moghekar A., **Verma R.,** Chong C., Shim C., Cohen H., Choksi S. "Efficacy and cost comparison of bronchodilator administration between metered dose inhalers with disposable spacers and nebulizers for acute asthma treatment." The Journal of Emergency Medicine 2011; 40(3): 247- 55.

NON-PEER REVIEWED

Agenor, K., Alexander, B., Datta, P., Choe, B., **Verma, R.**, Youssef, E., 2023. Expanding the Scope of Emergency Care: The Clinical Forensic Medicine Fellowship at Kings County Hospital. NY ACEP Empire State EPIC; Vol 40:04:23, 7-8.

PRESENTATIONS

Vuppula S., Gulati G., Pinto R., Fakioglu E., Crupi R., **Verma R.,** Cervellione K., Thompson D., Liu Qing L., Susana Rapaport S. "Awareness and Knowledge of Bioterrorism Agents Among Emergency Medicine Physicians. A

cross sectional study among Emergency Medicine Physicians in New York City." Accepted at Eastern SPR and PAS annual meeting, July 24-27, 2014. Oral Presentation.

Calderon Y., Cowan E., **Verma R.,** Iscoe M., Rahman S., Rhee J., Glass L., Barbery M., Leider J. "Does the Addition of HCV Testing to a Rapid HIV Testing Program Impact HIV Test Acceptance? A Randomized Control Trial." Accepted at International Conference on Viral Hepatitis (ICVH), March 17-18, 2014. Oral Presentation.

Case Presentation at National Association of Indian Nurses of America, October 2012.

"Early centrifugation of chemistry specimens and hemolysis." Poster Presentation at Annual National ACEP Meeting in Las Vegas, NV, October 2000.

NEW YORK CITY HEALTH + HOSPITALS

New York City Health + Hospitals (H+H) is the largest public health care system in the nation. It is a network of 11 hospitals, trauma centers, neighborhood health centers, nursing homes, post-acute care centers, a home care agency and a health plan. Pertinent information regarding these hospitals is set forth below.

BRONX

1. New York City Health + Hospitals/Jacobi
   1400 Pelham Parkway South, Bronx (Bronx County), New York 10461
   (718) 918-5000
   Operating Certificate No.: 7000002H
   PFI No.: 1165

   a. New York City Health + Hospitals/North Central Bronx
      3424 Kossuth Avenue, Bronx (Bronx County), New York 10467
      (718) 519-5000
      Operating Certificate No.: 7000002H
      PFI No.: 1186
      N.B.: Pursuant to C.O.N. Project No. 191344, North Central Bronx Hospital was approved to become a division of Jacobi Medical Center (H+H/Jacobi).

2. New York City Health + Hospitals/Lincoln
   234 East 149th Street, Bronx (Bronx County), New York 10451
   (718) 579-5000
   Operating Certificate No.: 7000008H
   PFI No.: 1172

BROOKLYN

3. New York City Health + Hospitals/South Brooklyn Health
   2601 Ocean Parkway, Brooklyn (Kings County), New York 11235
   (718) 616-3000
   Operating Certificate No.: 7001009H
   PFI No.: 1294

4. New York City Health + Hospitals/Kings County
   451 Clarkson Avenue, Brooklyn (Kings County), New York 11203
   (718) 245-3131
   Operating Certificate No.: 7001016H
   PFI No.: 1301

5. New York City Health + Hospitals/Woodhull
   760 Broadway, Brooklyn (Kings County), New York 11206
   (718) 963-8000
   Operating Certificate No.: 7001045H
   PFI No.: 1692

MANHATTAN

6. New York City Health + Hospitals/Bellevue
   462 First Avenue, New York (New York County), New York 10016
   (212) 562-5555
   Operating Certificate No.: 7002001H
   PFI No.: 1438

7. New York City Health + Hospitals/Harlem
   506 Lenox Avenue, New York (New York County), New York 10037
   (212) 939-1000
   Operating Certificate No.: 7002009H
   PFI No.: 1445

8. New York City Health + Hospitals/Metropolitan
   1901 First Avenue, New York (New York County), New York 10029
   (212) 423-6262
   Operating Certificate No.: 7002021H
   PFI No.: 1454

QUEENS

9. New York City Health + Hospitals/Elmhurst
   79-01 Broadway, Elmhurst (Queens County), New York 11373
   (718) 334-2424
   Operating Certificate No.: 7003000H
   PFI No.: 1626

10. New York City Health + Hospitals/Queens
    82-70 164th Street, Jamaica (Queens County), New York 11432
    (718) 883-3000
    Operating Certificate No.: 7003007H
    PFI No.: 1633

Limited Review Application

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

Schedule LRA 10

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

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

Instructions:
"Current" Column: Mark "x" in the box only if the service currently appears on the operating certificate (OpCert) not including requested changes
"Add" Column: Mark "x" in the box this CON application seeks to add.
"Remove" Column: Mark "x" in the box this CON application seeks to decertify.
"Proposed" Column: Mark "x" in the box corresponding to all the services that will ultimately appear on the OpCert.

Category/Authorized Service	Code	Current	Add	Remove	Proposed
N/A – Please refer to Sites Tab		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

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

☐ No

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

Limited Review Application

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

Schedule LRA 12

Assurances

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

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

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

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

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

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

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

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

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

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

Date'

Signature

Sheldon P. McLeod

Name (Please Type)

Chief Executive Officer

Title (Please Type)