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	Construct a 21 bed ICU unit
2. Name of Applicant	Mount Sinai Queens
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	Sachs Policy Group (SPG) – 212-827-0660 • Aisha King, MPH - aking@sachspolicy.com • Anita Appel, LCSW - AnitaAppel@sachspolicy.com • Maxine Legall, MSW, MBA - mlegall@sachspolicy.com Qualifications: • Health equity – 6 years • Anti-racism – 6 years • Community engagement – 25+ years • Health care access and delivery – 10+ years
4. Description of the Independent Entity's qualifications	The Health Equity Impact Assessment (HEIA) Team at Sachs Policy Group (SPG) is a diverse and experienced group dedicated to addressing health disparities and promoting equitable access to care. The team comprises experts with extensive backgrounds in health policy, population health, data analysis, community engagement, and anti-racism. They are committed to understanding and improving how social, environmental, and policy factors impact health equity, particularly for historically marginalized communities. The team collaborates with a wide range of health care organizations, government agencies, and communities to provide strategic support with an overarching goal of advancing diversity, equity, and inclusion. Their work encompasses research and evaluation of health programs and initiatives, stakeholder engagement, policy analysis, and development of mitigation and monitoring strategies. In particular, the team has experience analyzing policy proposals that impact medically underserved groups, such as Medicaid programs serving low-income individuals and maternal health initiatives that aim to reduce pre- and post-partum health disparities. They are dedicated to supporting organizations that serve vulnerable populations, including safety net hospitals, community health centers, long-term care organizations,

	behavioral health providers, child welfare agencies, and providers that support individuals with intellectual and developmental disabilities. The SPG HEIA team is deeply passionate about improving the health care delivery system, especially for underserved populations. The team is unwavering in its commitment to promoting equity through rigorous research, insightful consulting, and strategic advisory work.
5. Date the Health Equity Impact Assessment (HEIA) started	November 11, 2025
6. Date the HEIA concluded	January 30, 2026

7. Executive summary of project (250 words max)
Mount Sinai Queens (MSQ) is a 228-bed acute care hospital located at 25-10 30th Avenue Astoria, NY. The Intensive Care Unit (ICU) at MSQ is an eight-bed closed unit that cares for adult patients with severe and/or life-threatening illnesses and injuries. Patients are admitted from the Emergency Department (ED) and other areas of the hospital, including complex surgeries. The ICU is staffed by interventionists, physician assistants, and nurses, who also run the Rapid Response and Difficult Airway Response Teams for the entire hospital. They address stroke codes, cardiac arrests, and sterile bedside procedures such as central venous catheters for the whole hospitals. Patient need for ICU beds at MSQ has increased steadily in recent years, causing overflow to other units and hospitals. In 2023, MSQ transferred approximately 120 patients requiring ICU care to other facilities. With significant financial and political support from a variety of public, private, and community sources, MSQ is seeking approval to create a new ICU unit and increase the number of ICU beds from 8 to 21 beds. The renovated ICU will include private rooms for all critical care patients, allowing clinicians to provide treatment in safer, more private conditions. Being able to keep severely ill patients at MSQ will improve continuity of care, keep them closer to home, and reduce ambulance expenses. In addition, the expanded ICU will allow the hospital to increase the number of staff trained to provide critical care, which will have a positive impact hospital-wide.
8. Executive summary of HEIA findings (500 words max)

Background research for this HEIA included analyzing and collating utilization data provided by the Applicant, census data for the community/service area, and relevant academic literature. For the meaningful engagement portion of the HEIA, we interviewed twenty-one stakeholders, including four patients, five community leaders, four representatives from the New York City Department of Health and Mental Hygiene, and nine clinical staff and leaders.

This HEIA finds that the ICU renovation and expansion will positively impact the entire community of western Queens. Medically underserved populations who will be most impacted include: low-income individuals, people from racial and ethnic minority groups, immigrants, older adults, people with disabilities, people with prevalent diseases and/or conditions, people who receive public health benefits, people without any or adequate health insurance, other people who are unable to obtain healthcare, people seeking asylum, and people experiencing homelessness/ living in shelters.

All stakeholders engaged as part of this assessment were supportive of the project and felt that it was beneficial for staff, patients, and the broader community. The primary benefits associated with the project include:

- Improved access to critical care in the local community, reducing diversions and transfers to external hospitals
- Reduced infection rates that may occur from shared rooms
- Improved hospital throughput, including reduction of bottlenecks, reduced time between ED and ICU admission, and reduced ED boarding
- Improved clinical outcomes for critically ill patients, patient satisfaction, staff morale, and staff retention

Minimal concerns were raised. Stakeholders mentioned potential disruption due to construction noises and possible issues recruiting enough staff within the anticipated time frame. However, all stakeholders expressed confidence in hospital leadership and believed that they will take the necessary steps to minimizing any disruption and recruit sufficient numbers of appropriately trained staff.

The Independent Entity recommends that the Applicant work with clinical staff to ensure the new space meets all of the clinical and emotional needs of patients and staff and continue plans to minimize any potential disruption to patient care or access to care. They should prioritize training and onboarding new staff, leveraging the expertise and leadership capabilities of current ICU staff.

Existing metrics, (e.g., patient outcomes, mortality, readmission, infection rates, time from ED to ICU admission, length of stay) should be disaggregated by race/ethnicity, preferred language, housing status, insurance type, and any other relevant demographics to identify potential disparities in access to care among medically underserved groups and ensure equitable access to care in the expanded unit. The Applicant should additionally collect data on and monitor any differences in patient outcomes prior to and after the expansion.

SECTION B: ASSESSMENT

For all questions in Section B, please include sources, data, and information referenced whenever possible. If the Independent Entity determines a question is not applicable to the project, write N/A and provide justification.

STEP 1 – SCOPING

1. **Demographics of service area: Complete the "Scoping Table Sheets 1 and 2" in the document "HEIA Data Tables". Refer to the Instructions for more guidance about what each Scoping Table Sheet requires.**

   Please see attached spreadsheet titled "heia_data_tables_MSQ_ICU.xlsx"

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

- Low-income people
- Racial and ethnic minorities
- Immigrants
- Women
- 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
- Other people who are unable to obtain health care
- People with unstable housing conditions (e.g., experiencing homelessness/ living in shelters)
- Asylum seekers

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

   The Independent Entity analyzed utilization data provided by the Applicant, census data for the community/service area, academic literature, and information obtained from interviews with leadership, staff, patients, and community leaders.

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

The MSQ ICU cares for adult patients with severe and/or life-threatening illnesses and injuries, including patients recovering from complex surgeries, bariatric procedures, open-abdominal wounds, vascular emergencies, cardiac angioplasties, and neurologic emergencies. The ICU team works across the hospital with experts from palliative care, social work, chaplaincy, physical therapy, speech therapy, and nutrition, to provide the best possible care. They also run the rapid response team for the entire hospital. The ICU itself is a closed unit consisting of eight beds in 6 rooms; 2 rooms each have 2 beds. The current project proposes creating an entirely new ICU unit on a separate, currently empty floor of the hospital. The new ICU will consist of 21 ICU beds in 21 much larger private rooms. The new space will accommodate much-needed storage, a waiting room, a procedure room, and a staff break room.

The expansion of the ICU would impact all medically underserved populations in the Applicant's services area. Among the most impacted will be: low-income individuals, people from racial and ethnic minority groups, immigrants, older adults, people with disabilities, people with prevalent diseases and/or conditions, people who receive public health benefits, people without any or adequate health insurance, other people who are unable to obtain healthcare, people seeking asylum, and people experiencing homelessness/ living in shelters. Outlined below are service-area demographics and the clinical and access needs for these groups.

For the purpose of this service area analysis, we are using data from Queens County, NY. As of the 2020 Decennial Census, there were 2,405,464 individuals living in Queens County. Unless otherwise noted, statistics reported below are from the most recent Census (ACS 2024 1-year).

Individuals with low incomes, who are eligible for or receive public health benefits, and/or who do not have health insurance

	New York State	Queens County
Median household income	$ 85,820	$ 85,273 ↓
Poverty rate	14.0%	13.3% ↓
% Public health insurance	26.1%	30.0% ↑
% Without health care coverage	5.0%	7.4% ↑

The poverty rate in Queens is slightly lower than that of NYS (13.3% vs. 14%). This includes 15% of children under the age of 18, 12% of individuals aged 18-64, and nearly 17% of those aged 65 or above. However, a larger proportion of Queens residents are without health care coverage as compared to NYS (7.4% vs. 5%). In November 2025, more than 3.9 million individuals in NYC were enrolled in Medicaid, or about 57% of total NYS Medicaid enrollment.[1] More than a million individuals enrolled in Medicaid lived in Queens.

[1] New York State Department of Health. (2025). *Medicaid enrollment by resident county.* Retrieved from https://www.health.ny.gov/health_care/medicaid/enrollment/docs/by_resident_co/current_month.htm

There are 21 New York City Housing Authority (NYCHA) public housing developments in Queens, including 15,348 apartments and 29,530 residents.[2] The developments closest to the Applicant include QueensBridge, Ravenswood, and Astoria Houses. QueensBridge is the nation's largest public housing complex and is comprised of 26 buildings with more than 3,000 units.

Access to ICU beds is an equity issue. Nationally, lower income communities are less likely to have ICU beds than higher income communities, while at the same time low-income communities are more likely to see higher prevalence of chronic medical conditions associated with increased need for ICU-level care.[3] Additionally, people without health insurance are less likely to have access to routine primary care, which can lead to delayed detection of chronic illness, rapid disease progression upon detection, increased risk of needing ICU-level care, and premature mortality.[4]

Increasing the number of ICU beds to meet the current and anticipated need for care will allow individuals with low incomes, who are eligible for or receive public health benefits, and those who do not have health insurance to access appropriate levels of care for their clinical needs.

People with unstable housing conditions, including asylum seekers

As of December 2025, more than 100,000 individuals were living in shelters across NYC. Thousands more are unsheltered at any given time, although there is no reliable estimate of this data, and more than 200,000 individuals are estimated to be 'doubled up,' or living with friends or family.[5] In 2022, there was a steep increase in the number of individuals living in Department of Homeless Services (DHS) shelters due to the influx of individuals from other nations arriving directly in NYC seeking asylum or being bussed in from Texas. In 2024, there were more than 64,000 asylum seekers living in city-run emergency shelters, more than 30% of whom resided in Queens. Northwest Queens, where the Applicant is located, has one of the higher concentrations of emergency shelters in NYC. Community District 1, where the Applicant is located, hosted 20 Department of Homeless Services (DHS) shelters specifically for asylum seekers. Several stakeholders confirmed that the proximity of the Applicant to the LaGuardia Airport and local shelters has meant that people with unstable housing conditions and new arrivals frequently seek care at MSQ. A report from NYC show that among 530 asylum seekers who were unstably housed in 2023, 63% experienced hazardous events during migration (e.g., physical/sexual

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[2] New York City Housing Authority. (2025, January). *NYCHA fact sheet* (Release January 2025) [PDF]. NYC.gov. https://www.nyc.gov/assets/nycha/downloads/pdf/NYCHA_Fact_Sheet.pdf

[3] Shaw, K. M., Theis, K. A., Self-Brown, S., Roblin, D. W., & Barker, L. (2016). *Chronic disease disparities by county economic status and metropolitan classification, Behavioral Risk Factor Surveillance System, 2013. Preventing Chronic Disease, 13*, 160088. https://doi.org/10.5888/pcd13.160088

[4] Brooks, E. L., Preis, S. R., Hwang, S. J., et al. (2010). *Health insurance and cardiovascular disease risk factors. The American Journal of Medicine, 123*(8), 741–747. https://doi.org/10.1016/j.amjmed.2010.02.013

[5] Coalition for the Homeless. (2025). *How many people are homeless in NYC altogether?* https://www.coalitionforthehomeless.org/how-many-total-people-are-homeless-in-nyc/

assault, kidnappings, extortion, injuries, illnesses).[6] Other studies have shown that major depression and posttraumatic stress disorder are present in more than 40% of refugees and asylum seekers who experience violence.[7] Individuals who are incarcerated or detained face additional risks of infectious diseases in overcrowded facilities.[8]

For myriad reasons, people experiencing homelessness, and even more so unsheltered individuals, have higher rates of chronic disease, serious mental illness, and substance abuse than housed individuals.[9,10] Structural barriers to accessing alternative forms of care contribute to high usage of EDs and hospital-based care among individuals experiencing homelessness.[11] In some cases (e.g. injury), people experiencing homelessness are more likely to be admitted to the hospital than housed individuals.[12] The most common reasons for hospitalizations for patients with housing instability are mental, behavioral, and neurodevelopmental disorders, injury, and circulatory system diseases.[13] Having housing instability has also been associated with longer lengths of hospital stay and increased likelihood of hospital readmission as compared to individuals with stable housing conditions.[14] ED usage and long lengths of stay lead to steep healthcare costs.

Improving access to care among high-need patients is essential, and expanding the ICU will allow the Applicant to treat all patients at the appropriate level of care, including individuals experiencing homelessness. In particular, it will benefit patients to be treated close to their housing situation, whatever that might be, and their families who might be living in shelters nearby. For asylum-seekers with unclear legal status, being treated in a familiar space can lessen fear of deportation and enable family members to visit. Stakeholders emphasized that people who are undocumented and/or who do not have legal status feel much more comfortable receiving care at the Applicant than at hospitals in Manhattan, and that being transferred to or having family visit at a Manhattan location would be a significant barrier to accessing care. It is highly beneficial for individuals,

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[6] Olivo-Freites, C., Miguez-Arosemena, P., Henao-Martínez, A., Suarez, J. A., Franco-Paredes, C., Edelman, D., Olivo-Freites, C., Marquez, J., Plazola, C., Leschly, K., Leschly, J., Gundacker, N., & Mohareb, A. M. (2025). *Health hazards of migration in people seeking asylum in New York City, 2023. American Journal of Public Health, 115*(10), 1691–1699. https://doi.org/10.2105/AJPH.2025.308065

[7] Tamblyn, J. M., Calderon, A. J., Combs, S., & O'Brien, M. M. (2011). *Patients from abroad becoming patients in everyday practice: Torture survivors in primary care. Journal of Immigrant and Minority Health, 13*(4), 798–801. https://doi.org/10.1007/s10903-010-9429-2

[8] Lo, N. C., Nyathi, S., Chapman, L. A. C., et al. (2021). *Influenza, varicella, and mumps outbreaks in U.S. migrant detention centers. JAMA, 325*(2), 180–182. https://doi.org/10.1001/jama.2020.20539

[9] Richards, J., & Kuhn, R. (2023). *Unsheltered homelessness and health: A literature review. AJPM Focus, 2*(1), 100043. https://doi.org/10.1016/j.focus.2022.100043

[10] Chimowitz, H., & Ruege, A. (2023, September 25). *The costs and harms of homelessness: A learning brief examining the costs borne by individuals, communities, systems, and society.* Community Solutions. https://community.solutions/research-posts/the-costs-and-harms-of-homelessness/

[11] Ku, B. S., Fields, J. M., Santana, A., Wasserman, D., Borman, L., & Scott, K. C. (2014). *The urban homeless: Super-users of the emergency department. Population Health Management, 17*(6), 366–371. https://doi.org/10.1089/pop.2013.0118

[12] Silver, C. M., Thomas, A. C., Reddy, S., Sullivan, G. A., Plevin, R. E., Kanzaria, H. K., & Stey, A. M. (2023). *Injury patterns and hospital admission after trauma among people experiencing homelessness. JAMA Network Open, 6*(6), e2320862. https://doi.org/10.1001/jamanetworkopen.2023.20862

[13] Rollings, K. A., Kunnath, N., Ryus, C. R., Janke, A. T., & Ibrahim, A. M. (2022). *Association of coded housing instability and hospitalization in the US. JAMA Network Open, 5*(11), e2241951. https://doi.org/10.1001/jamanetworkopen.2022.41951

[14] Silver, C. M., Thomas, A. C., Reddy, S., Kirkendoll, S., Nathens, A. B., Issa, N., Patel, P. P., Plevin, R. E., Kanzaria, H. K., & Stey, A. M. (2024). *Morbidity and length of stay after injury among people experiencing homelessness in North America. JAMA Network Open, 7*(2), e240795. https://doi.org/10.1001/jamanetworkopen.2024.0795

particularly those who are in vulnerable situations, to be able to be treated in their community near their families and continue to build stability.

Racial and ethnic minorities and people from immigrant communities

	New York	Queens County
White	54.3%	25%% ↓
Black/African American	14.2%	17.1% ↑
Asian	9.5%	26.5% ↑
American Indian and Alaska Native	0.6%	0.8% ↑
Hispanic/Latino	20.2%	28.5% ↑
Foreign born	23.3%	47.5% ↑
Speak language other than English at home	31.6%	56.1% ↑

Queens is one of the most racially, ethnically, culturally, and linguistically diverse counties in the US. More than 17% of the population identifies as Black/African American and 28.5% identify as Hispanic/Latino. Nearly half of those living in Queens were born outside of the U.S., and more than 56% speak a language other than English at home. The most commonly spoken language other than English is Spanish, with a quarter of Queens residents speaking Spanish at home. This is followed by other Indo-European languages (15%) and Asian and Pacific Islander languages (15.7%). Local stakeholders identified several key racial/ethnic minority and immigrant populations in the area and languages spoken. Notable groups include the Bengali community, the Greek community, and Arab communities.

There are well-documented racial and ethnic disparities in critical illness outcomes in the US.[15] People from racially or ethnically minoritized groups are more likely to experience low-quality care across many metrics, including being more likely to die during hospitalization and within the year following a hospitalization.[16] These disparities have been partially explained by variation in hospital or ICU quality in areas where more racial/ethnic minority groups live, but recently researchers have begun to investigate the possible role of individual-level or systemic factors that may influence differing outcomes.[17,18] Structural and social determinants of health contribute to individuals with racial or ethnic minority identities being at greater risk of developing critical illness, facing higher rates of chronic disease, having decreased access to preventive care, and being

[15] Hauschildt, K. E., Thornton, J. D., Brown, C., Hope, A. A., Jain, S., Valley, T. S., Aslakson, R. A., Carlton, E. F., Iwashyna, T. J., Mikkelsen, M. E., Boen, C., Dzeng, E., Falvey, J., George, N., Hotchkin, D., Khandelwal, N., Khatri, U. G., McPeake, J., Nadig, N. R., ... Ashana, D. C. (2025). *A research agenda to mitigate racial and ethnic disparities in U.S. critical care medicine: An official American Thoracic Society research statement. American Journal of Respiratory and Critical Care Medicine, 211*(12), 2268–2288. https://doi.org/10.1164/rccm.202509-2229ST

[16] McGowan, S. K., Sarigiannis, K. A., Fox, S. C., Gottlieb, M. A., & Chen, E. (2022). *Racial disparities in ICU outcomes: A systematic review. Critical Care Medicine, 50*(1), 1–20. https://doi.org/10.1097/CCM.0000000000005269

[17] Hasnain-Wynia, R., Baker, D. W., Nerenz, D., Feinglass, J., Beal, A. C., & Landrum, M. B. (2007). *Disparities in health care are driven by where minority patients seek care: Examination of the Hospital Quality Alliance measures. Archives of Internal Medicine, 167*(12), 1233–1239. https://doi.org/10.1001/archinte.167.12.1233

[18] Tukpah, A. M., Moll, M., & Gay, E. (2021). *COVID-19 racial and ethnic inequities in acute care and critical illness survivorship. Annals of the American Thoracic Society, 18*(1), 23–25. https://doi.org/10.1513/AnnalsATS.202005-549VP

more likely to experience chronic stress of social marginalization.[19]

The proposed addition of ICU beds and creation of a new, expanded ICU unit is likely to improve care outcomes for individuals living in the local community, particularly those who are more comfortable receiving care near their friends, families, and homes. The positive impact is likely to be particularly felt by immigrant communities and those who do not speak English well, who may find it more difficult to navigate other complex medical systems and whose families may experience challenges visiting them if they are transferred.

Older Adults

Age Group	New York State	Queens County
65+	18.9%	19.1% ↑

Queens has a similar proportion of individuals over the age of 65 to NYS (around 19%). ICU staff indicated that significant proportion of their patients are older, including nursing home patients, although they do see younger/middle aged patients with certain conditions (e.g. myocardial infarction). Older individuals typically require more inpatient services than younger individuals, as incidence of chronic health problems increases starting in mid-life.[20]

Older adults and their spouses may face significant barriers navigating new healthcare systems, telehealth and digital health platforms, and transferring to Manhattan. Fear of being transferred could result in delayed care-seeking, difficulty attending follow-up appointments, and complications coordinating transfers between facilities - concerns that are particularly acute for older individuals living alone without caregiver support. Expanding ICU services at the Applicant will positively impact older individuals by making it more likely that they can receive care in a more intimate setting in their own community, near their homes, families, and communities.

People with disabilities and/or prevalent infectious disease or condition[21]

	New York State	Queens County
% Living with disability	13.5%	12.8%

Nearly 13% of individuals in Queens are living with a disability. The most common disability is difficulty with independent living (6.8%). People with disabilities face barriers to accessing health care services due to physical accessibility issues, transportation limitations, communication challenges

[19] Doshi, R. P., Aseltine, R. H., Sabina, A. B., & Graham, G. N. (2017). *Racial and ethnic disparities in preventable hospitalizations for chronic disease: Prevalence and risk factors. Journal of Racial and Ethnic Health Disparities, 4*(6), 1100–1106. https://doi.org/10.1007/s40615-017-0342-3

[20] Huguet, N., Hodes, T., Liu, S., Marino, M., Schmidt, T. D., Voss, R. W., Peak, K. D., & Quiñones, A. R. (2023). *Impact of health insurance patterns on chronic health conditions among older patients*. Journal of the American Board of Family Medicine, 36(5), 839–850. https://doi.org/10.3122/jabfm.2023.230106R1

[21] U.S. Census Bureau. (2024). https://data.census.gov/profile/Queens_County,_New_York?g=050XX00US36081#health

(particularly for individuals with hearing or cognitive impairments), and a lack of providers trained in disability-sensitive care. Populations with disabilities, infectious diseases, and chronic conditions are at increased risk for needing intensive healthcare services, and having a chronic condition is a leading cause of death in the US.[22] Clinical staff noted that ICU patients have highly complex medical needs and often have comorbid conditions such as COPD, respiratory failure, heart failure, stroke, and/or sepsis caused by infection or urinary tract infections.

Individuals with cognitive impairments or mobility limitations may experience greater difficulty in navigating complex healthcare systems, leading to delayed or inadequate treatment. Therefore, these individuals are likely to be positively impacted by the ICU expansion, increased access to necessary services, and reduced likelihood of having to transfer to hospital in Manhattan.

Women

	New York State	Queens County
Cisgender women as % of total population	51.2%	51.1%

The ICU may improve outcomes among women with cardiac and stroke emergencies, who face lower survival rates from out-of-hospital events compared to men. [23] In urgent clinical cases, transportation from Queens to Manhattan can mean the difference between life and death. This proposed project, therefore, may reduce gender disparities in outcomes and recovery. Additionally, women are more likely to be the primary caregivers in their families and may face barriers accessing care due to caregiving responsibilities, transportation limitations, and financial constraints. Increasing available services may therefore reduce logistic and financial burdens for this population and the whole community.

All groups

People belonging to medically underserved groups often have intersectional identities and can experience multifaceted barriers to accessing care. We anticipate that all individuals will be positively impacted by the increased ICU capacity of this local community hospital.

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?**

[22] Hacker, K. (2024). *The burden of chronic disease. Mayo Clinic Proceedings: Innovations, Quality & Outcomes, 8*(1), 112–119. https://doi.org/10.1016/j.mayocpiqo.2023.08.005

[23] Mody, P., Pandey, A., Slutsky, A. S., Segar, M. W., Kiss, A., Dorian, P., Parsons, J., ... Morrison, L. (2021). Gender-based differences in outcomes among resuscitated patients with out-of-hospital cardiac arrest. *Circulation, 143*(7), 641-649. https://doi.org/10.1161/CIRCULATIONAHA.120.050427

The tables below describe the available data about the Applicant's patient population in 2024.

Age

Age group	% of Patients
0-19 years	5.3%
20-64 years	60.7%
65+ years	34.0%

Sex

Sex	% of Patients
Female	44.4%
Male	55.6%

Race

Race	% of Patients
White	26.7%
Black or African American	11.4%
American Indian and Alaska Native	0.2%
Asian	4.2%
Native Hawaiian and Other Pacific Islander	0.1%
Some other race	57.5%

Ethnicity

Ethnicity	% of Patients
Hispanic/Latino (any race)	44.9%
Not Hispanic/Latino	55.1%

Payor Mix

Payor	% of Patients
Child/Family Health	0.8%
Commercial/Indemnity	3.1%
Exchanges/Essential Plan 1-2	5.6%
HMO Contract	9.1%
Medicaid	4.4%
Medicaid HMO/Essential Plan 3-4	27.9%
Medicare	10.1%
Medicare HMO	22.4%
No Fault	0.4%
Other	1.0%
PPO Contract	9.5%
Self-Pay	5.0%
Workers Comp	0.9%

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

The following are hospitals with intensive care beds in Queens County and their distance from the Applicant.

Hospital Name	Number of ICU Beds	Distance from Mount Sinai Queens
Elmhurst Hospital Center	20	3.2 mi
New York- Presbyterian/ Queens	68	5.8 mi
Flushing Hospital Medical Center	12	6.9 mi
Long Island Jewish Forest Hills	28	8.1 mi
Queens Hospital Center	16	9.2 mi
Jamaica Hospital Medical Center.	8	10 mi
Long Island Jewish Medical Center	62	15mi
Mount Sinai Queens	8	--
St. John's Episcopal Hospital So Shore	8	20 mi

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

Hospital Name	# ICU Beds (current)	Market Share (current)	# ICU Beds (projected)	Market Share (projected)
Elmhurst Hospital Center	20	9%	20	8%
New York- Presbyterian/ Queens	68	30%	68	28%
Flushing Hospital Medical Center	12	5%	12	5%
Long Island Jewish Forest Hills	28	12%	28	12%
Queens Hospital Center	16	7%	16	7%
Jamaica Hospital Medical Center.	8	3%	8	3%
Long Island Jewish Medical Center	62	27%	62	26%
Mount Sinai Queens	8	3%	21	9%
St. John's Episcopal Hospital So Shore	8	3%	8	3%
TOTAL	230		243	

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.

The hospital is subject to federal and New York State charity care requirements. Under the revised NYS Financial Assistance Program (effective 10/1/2024), the organization has updated its policies to expand eligibility and strengthen protections for uninsured and underinsured patients. These changes ensure compliant, accessible financial assistance for patients with limited ability to pay. Key updates included:

- Revised FAP, signage, and systems to reflect new income guidelines and Medicare-based pricing for charity care.
- Expanded zero-charge eligibility to patients up to 200% of the FPL and creation of a new program for underinsured patients whose medical debt exceeds 10% of income.
- Updated collection practices, patient statements, and required credit-card waiver notices.
- New financial agreement forms and enhanced reporting under IRS Form 990.[24]

These obligations will not be affected by implementation of the project.

9. **Are there any physician and professional staffing issues related to the project or any anticipated staffing issues that might result from implementation of project? If yes, please describe.**

No. The hospital plans to add ICU staff to the new facility to provide optimal critical care and to accommodate the increase in bed count. The additional ICU capacity will allow the Applicant to maintain optimal staffing units, including hiring more intensivists to staff the facility.

The Applicant states that *Hiring will follow established Mount Sinai workforce planning processes, with continued use of cross-training and internal mobility where appropriate to ensure safe staffing ratios are always maintained.*

Leadership and staff indicated that many nurses working in other units at the hospital would like to work in the ICU, and that they do not anticipate issues filling the new ICU-based roles. ICU leadership mentioned that they have a 1% turnover rate, and that the only vacancies typically come from retirees. The new unit is expected to improve staff retention further, as the current unit is so small as to be uncomfortable to work in. Some staff mentioned that there might be difficulties filling roles or backfilling roles for staff transferring to work in the new ICU, but they also emphasized confidence that the hospital will do everything they can to fill all vacancies.

[24] Mount Sinai Health System. (n.d.). *Financial assistance*. https://www.mountsinai.org/about/financial-assistance

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

    There are no civil rights access complaints against MSQ.

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.**

    MSQ recently opened their new Crescent Building practices, which consist of an express care and pharmacy, cardiac practices, and multispecialty offerings such as Rheumatology, Endocrinology, Physical Therapy, Rehab, Gastroenterology and Hematology/Oncology. The ICU expansion is part of a broader effort to bring more complex care to the borough of Queens and is needed to meet current critical care needs.

STEP 2 – POTENTIAL IMPACTS

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

    The expansion and improvement of the ICU will improve access and health equity and reduce disparities for the medically underserved populations identified above in the following ways:

    1. Improved access to critical care and essential services
    Expanded ICU capacity directly addresses an unmet need in the local community. Stakeholders described the current 8-bed ICU as operating at or near 100% capacity, which results in ED boarding, overflow into step-down units, and transfers to Manhattan hospitals. Expanding the ICU to 21 units will improve access to services in the following ways:

    - Patients who require ICU level care will be more likely to be treated in their local community
    - Patients will be admitted more quickly from the ED to ICU, hopefully leading to shorter waiting times, reduced boarding, reduced clinically unsafe delays, improved patient experience, and shorter hospital stays
    - Throughput will improve throughout the hospital, and diversions and bottlenecks will be reduced.
    - Specialty services (e.g., cardiac catheterization, stroke care, and renal replacement therapy) will be delivered more efficiently

    For medically underserved residents (e.g., older adults, individuals without insurance, low-income households, and patients with limited family support),

keeping care local is critical. Stakeholders emphasized that being transferred to Manhattan creates hardship for patients, delays family involvement, and in some cases leads patients to refuse care altogether. Stakeholders also highlighted emotional strain, logistical barriers, and reduced visitation when loved ones are transferred.

The expansion will also reduce the need to move critically ill patients between units (e.g., between step-down and ICU) and improve safety and clinical continuity. This is particularly important for patients with complex chronic conditions (e.g., diabetes, COPD, stroke) who are overrepresented among medically underserved populations. The expansion will also allow patients recovering from surgery in the Post-Anesthesia Care Unit (PACU) to move to the ICU more quickly, improving care outcomes and likely reducing their overall length of stay.

Lastly, this project is in alignment with community growth and changing health needs. Community members highlighted the rapid growth of the community due to rezoning and new construction, and clinical staff noted increasing severity and younger age of ICU patients due to cardiac and stroke emergencies.

2. Improved health equity for underserved populations

The Applicant serves populations that have been historically disadvantaged by geography, language, and income. Stakeholders indicated that the service area houses large numbers of older adults aging in place, residents of NYCHA developments and local shelters, immigrant communities including undocumented individuals, and community members with limited English proficiency across dozens of languages. The ICU expansion will improve health equity by ensuring that these populations can access the same level of critical care locally that other populations can access elsewhere. Rather than relying on transfers, which are more difficult for families and patients without a car, legal status, strong English-speaking capacity, or strong advocacy, the project increases availability of high-level services within the community.

Additionally, increasing the availability of much needed services in the community will reduce reliance on patient self-advocacy – which may be difficult for patients who are unhoused, undocumented, older, or not comfortable speaking English. Families are more likely to remain involved if care is provided locally, which is better for family wellbeing and patient recovery, and helps foster shared decision-making. Social work, palliative care, and care coordination teams can also work more efficiently with patients and families already known to them.

Keeping care locally allows patients to remain in a familiar environment where staff are familiar with the community's cultural, linguistic, and social needs. This includes established interpreter services, culturally sensitive practices around end-of-life care, and trusted relationships with local religious and community institutions.

3. Reduction of health disparities

Early intervention reduces delays in life-threatening conditions, and the expanded ICU will reduce delays caused by waiting for appropriate beds or arranging inter-facility transfers, enable faster delivery of evidence-based critical care, and improve outcomes for conditions that disproportionately impact low-income and minority populations. One stakeholder highlighted the case of an individual who died during transfer to Manhattan.

The new ICU design, which will include single-occupancy rooms with large windows, should lead to lower risk of complications and infections. Clinical staff noted challenges in infection risk, managing isolation, and conducting bedside procedures safely in the current unit. The project is expected to reduce risk of infection caused by shared rooms, allow for greater privacy, dignity, and comfort during critical illness and end-of-life care, and lead to safer working conditions for staff. The current ICU is very cramped. While staff provide the best possible care under current conditions, having more space to move around in patients' rooms and hallways will allow for increased safety for patients, families, and staff. The project is also expected to reduce health disparities by freeing up telemetry beds for patients who need routine monitoring.

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.**

Negative health equity impacts:

- Construction could lead to disturbances in care, including for vulnerable patient populations. Disruptions to unit locations, elevator access, and circulation patterns could disproportionately burden older adults, patients with mobility limitations, and individuals with limited English proficiency. However, the Applicant has developed significant mitigation strategies to communicate any changes proactively, including comprehensive signage, staff assistance protocols, and proactive communication.
- There may be staffing pressures during the ramp-up phase of the project. Careful workforce planning is necessary, and already underway by the hospital, in order to ensure that the new unit is staffed appropriately to be able to utilize the new space fully.

Positive health equity impacts:

- The expansion reinforces the institution's role as a community anchor, signaling sustained commitment to local health needs. Institutional stability and trust is particularly important for populations who may delay care due to transfer concerns, prior negative healthcare experiences, or immigration-related fears.
- The improved infrastructure of the new unit will address essential workforce needs by creating a dedicated staff break room, and storage space for staff's personal items. This will improve working conditions,

morale, and retention for staff who want to remain close to their critically ill patients but need adequate working conditions.

- The bigger space will expand the possibilities for training medical students and residents. Clinical leaders noted that the hospital has growing institutional recognition as a high-quality academic training site. By expanding training opportunities, the hospital can increase the number of specialists trained in critical care management.
- The improved physical environment should have positive therapeutic impacts. The new unit will have increased square footage for patient rooms, waiting areas, and the floor in general. Additionally, natural lighting and panoramic views of the NYC skyline should contribute to a more peaceful environment and improved patient and family wellbeing.
- Single-patient rooms and a dedicated family conference space will improve privacy and dignity, particularly during end-of-life care. Staff reported that spatial constraints in the current unit sometimes necessitate critical family discussions and grieving in shared environments, which can be distressing.
- Having all critical-care patients in one place will facilitates multidisciplinary care coordination, including timely social work and palliative care consultation. Right now, it can be complicated or time consuming for social workers to find all of their patients if they are distributed across the hospital or transferred to another facility. Having all ICU patients in one place will help social workers identify patients and locate family members more quickly.
- A bigger ICU will attract more specialty services, which is better for everyone, as the services available on-site will increase and improve.

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.**

    - **2024 Free Care/Charity Care:** 24,450 visits totaling $37,718,313
    - **2024 Below Cost Care:** 6,242 visits totaling $2,854,230

    The amount of indigent care is not expected to significantly change if the project is implemented, although it may slightly increase as the project expands capacity to treat more patients.

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.**

    Most patients take the subway, drive, hire a taxi, or walk to the facility. Patients in critical condition arrive by ambulance to the ED. The Applicant is a 5-minute walk from the 30 Av N/W subway stop and there is a Q18 bus stop at the hospital

entrance. The hospital has a parking lot available for a fee, and there is street parking available in the neighborhood. Transportation is not expected to change if the project is implemented.

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

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

6. **Describe how implementation of the project will impact the facility's delivery of maternal health care services and comprehensive reproductive health care services, as that term is used in Public Health Law § 2599-aa, including contraception, sterility procedures, and abortion. How will the project impact the availability and provision of reproductive and maternal health care services in the service area? How will the Applicant mitigate any potential disruptions in service availability?**

   N/A

Meaningful Engagement

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

   New York City Department of Health and Mental Hygiene (NYC DOHMH)

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

   Yes. The Independent Entity met with representatives from the NYC DOHMH and they provided a statement.

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

   Please see attached spreadsheet titled "heia_data_tables_MSQ_ICU.xlsx"

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

    All residents of Queens, and particularly those living in Astoria and Long Island City, will be positively affected by this project. The expansion of the ICU will improve access to ICU-level care and increase the availability of specialized

services for everyone living in the area. It will reduce the need for patients to be transferred to Manhattan hospitals, which can cause significant burden for patients and families. All stakeholders were supportive of the project, and their feedback directly informed our reporting on how the project will improve access to quality care.

There were no major concerns about the expansion. Some staff requested to be included in decisions on design features of the new space, although other staff noted that they were included in planning and design of the new space. One stakeholder mentioned the importance of securing sufficient funding and that additional costs are always incurred in construction projects. However, they also noted that the hospital has significant political and community support and did not anticipate this would be a problem for the completion of the project. Several staff noted the importance of hiring new staff early and taking the time to onboard them properly. This was not presented as a concern, but rather a suggestion.

11. **How has the Independent Entity's engagement of community members informed the Health Equity Impact Assessment about who will benefit as well as who will be burdened from the project?**

As part of our stakeholder engagement process, the Independent Entity interviewed leadership and staff across MSQ, patients, community leaders, and NYC DOHMH. These conversations provided important qualitative insights that highlighted the importance of the hospital to the community and to medically underserved populations in the area. Stakeholders shared their experiences with the hospital and the current ICU from clinical, administrative, and personal perspectives. Semi-structured interview guides were carefully developed to ensure that stakeholders had the opportunity to raise questions and concerns about the project, provide feedback, and share their thoughts on the potential impact of the proposed project.

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

SPG's stakeholder engagement process included a comprehensive outreach strategy to a diverse set of stakeholders. Nineteen interviews with twenty-one stakeholders were conducted as part of this assessment, including five with patients and family members with firsthand experience in the ICU. Only one stakeholder did not respond to our request for interview. We believe that all relevant medically underserved groups, or representatives who could speak to their experience, were represented in the meaningful engagement portion of the HEIA. We spoke with individuals, community leaders, and staff from a variety of racial, ethnic, linguistic, and cultural backgrounds. We spoke with representatives from the Boys and Girls Club of Queens, Astoria Queen's Sharing and Caring, and the Queens Gazette. Several patients we spoke with were also community leaders and were able to speak not only to their own personal experience but also that of their community members. Engaged staff included ICU and stepdown

nurses, the Associate Director of Critical Care Nursing, the ICU Nurse Manager, the Associate Director of the Emergency Department, the Director of Social Work, a hospitalist, and the Director of Critical Care.

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?**

Per the Applicant's Policy, "Mount Sinai Health System recognizes the right of every patient to receive medical information in their preferred language and is committed to provide interpretation services, free of charge, to patients with Limited English Proficiency (LEP) and/or their families as necessary for effective communication in the delivery and understanding of medical care. Multilingual signage indicating that interpretation services are available and provided free of charge to the patient/family member is displayed in a variety of formats (wall poster, digital signage, self-standing cardboard chart) at main entrances, lobbies, emergency rooms, admission, inpatient units, and ambulatory settings."

Staff are responsible for identifying and recording patients' preferred language, as well as determining the need for phone, video remote, and/or face-to-face interpretation. Detailed policies and procedures outline circumstances in which each format of interpretation is to be used. Qualified medical interpreters are available for over-the-phone interpretation services in more than 200 languages and video remote interpretation services in 35 languages. The use of ad-hoc interpreters (family, friends, minors) is not recommended except in very specific circumstances and must be documented clearly in the patient's medical record.

Applicant policies additionally outline measures to ensure effective communication with patients with speech, hearing, or visual impairments. Qualified Sign Language interpreters are available for in person ASL or other Sign Language interpretation, and tactile interpreters are available for Deaf-blind individuals. A variety of assistive devices are available, such as clear masks, videophones, and large-type forms.

Staff noted the lengths that the Applicant goes to ensure that all patients have adequate translation or interpretation services available to them, including hiring support staff to facilitate conversation with a patient who was mute and deaf. Community leaders indicated that communication across languages is sufficiently managed at the hospital. One community leader noted that some older individuals in the community occasionally have difficulties communicating their

needs and understanding healthcare providers at the hospital. Having a patient navigator that is available to help these individuals may be helpful.

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

   The Independent Entity believes that the Applicant is taking appropriate steps to meet the needs of medically underserved groups. In addition, we recommend that the Applicant:

   - Continue to actively seek out and consider clinical staff feedback on ICU plans – including but not limited to on final touches in patient room design and decoration.
   - Continue to take proactive steps to ensure that the project does not disrupt patient care or access to care.
   - Prioritize training and onboarding new staff, leveraging the leadership capabilities of current ICU staff.
   - Ensure that the planned website is publicized, consistently updated on project status, and available in multiple languages.

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

   The Applicant has proactively communicated their plans in the following ways:

   - Press releases announced $6 million in state funding for a new and expanded ICU, communicated the planned expansion, highlighted rationale for the project, and explained benefits.
   - Local media coverage in the Queens Gazette, Queens Daily Eagle, and other outlets described additional funding from local sources (e.g., state senator Gianaris and the hospital itself), described the estimated cost (~25 million), and emphasized community benefit.
   - Elected officials Senator Gianaris and Borough President Richards publicly declared support for the project at press conferences, public events, and quotes in media and hospital releases.
   - Internal announcements were shared with staff during leadership rounds, department meetings and staff town halls. Announcements emphasized improvement to patient flow, reduced ICU overcrowding, and new clinical capabilities. Staff were also informed about anticipated operational changes to the ICU.
   - Community groups were informed of the proposed change, including at Community Board meetings, Hospital Advisory board meetings, and facility walkthroughs with community leaders and elected officials.

- Written notice in the form of capital project summaries was shared with public officials (e.g., Borough President Richards, City Council), including details on funding contributions.
- Online content was posted on Mount Sinai's newsroom site, Health Systems blogs, and local news websites.

The Applicant also has a well-formulated communication plan that will be enacted after approval of the project:

- Staff (clinical and non-clinical) will be proactively informed about construction timeline updates, operational changes, staffing plans, new equipment, patient flow impacts, and who to contact with questions. Communication will conducted through a variety of formats, including but not limited to department huddles, posters, and short video updates.
- Patients and families will be informed about what the expansion means for quality care, how the work will affect visiting, including noise and construction timing, and clear instructions on who to contact with concerns. Communication will be conducted through patient-facing letters, flyers, and FAQ sheets, informational notifications, digital signage, and a website.
- Community and external partners (neighborhood residents, community boards, elected officials, local media) will be informed about the timeline for construction milestones, community impact (more beds, less transfers, better access), funding progress or announcements, partnerships (state/city support), and benefits to underserved communities. This will include press releases, briefing packets for officials, annual or semi-annual community board presentations, hospital blog/website updates, and social media announcements.
- Donors will be informed about what their funds will support, visible impact and patient stories, and opportunities for naming or sponsorship via emails, letters, foundation events, tours, and one-page impact reports.

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?**

Disparities in healthcare access occur across factors including but not limited to race and ethnicity, socioeconomic status, age, geography, language, gender, disability status, and citizenship status. Many individuals experience disparities across multiple dimensions. Disadvantaged and marginalized populations experience disproportionately high rates of infection, hospitalization, and death, often driven by social determinants of health and systemic and/or structural barriers to equitable access to services and care. As these populations are overrepresented among hospitalized patients, shortage of ICU beds disproportionately impacts these groups. Patients are also more likely to seek care in the areas where they live, and the Applicant's patient population reflects the diversity of the local community – including individuals who immigrated to the US, individuals who don't speak English well, and individuals and families living in shelters or affordable housing units. This project directly reduces systemic

barriers to equitable access to care by increasing access to ICU care in western Queens for all individuals living in the area.

STEP 4 – MONITORING

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

   The following existing mechanisms can be leveraged to monitor the potential impacts of the project: patient outcomes, mortality rates, hospital-acquired infection rates (e.g., CLABSI and CAUTI), readmission rates, length of stay, patient experience and satisfaction scores, sepsis rates, catheter rates, census and throughput in the ED (e.g., time to discharge or admit), admission time from ED or other hospital unit to ICU, diversions, and staff compliance with safety and quality standards. The annual employee engagement survey can also be leveraged to ensure that staff perspectives are considered.

2. **What new mechanisms or measures can be created or put in place by the Applicant to ensure that the Applicant addresses the findings of the HEIA?**

   The following mechanisms and measures could be implemented to ensure continuous monitoring and responsiveness to HEIA findings:

   - Solicit ongoing feedback from patients and staff about the new ICU unit, both in the design phase and in early implementation. This may include asking the office of patient experience to engage relevant stakeholders about the changes, particularly during implementation of the project. For staff, leadership could additionally leverage all-staff meetings to collaboratively identify priorities for clinical staff in the design of the new unit, and once it is complete, to identify any emerging challenges and proposed solutions.
   - Disaggregate existing metrics, including those identified in the previous question, by race/ethnicity, preferred language, housing status, and insurance type to identify potential disparities in access to care among medically underserved groups and ensure equitable access to care in the expanded unit.

   These mechanisms should enable the Applicant to ensure equitable access to the new unit and appropriate care levels. They will also be able to identify and address any unintended negative consequences of the project in a timely and data-driven manner.

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, (Mount Sinai Queens), attest that I have reviewed the Health Equity Impact Assessment for the (Construct a 21 bed ICU unit) that has been prepared by the Independent Entity, (Sachs Policy Group).

Cameron R. Hernandez

Name

President and COO

Title

Signature

2/2/26

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)

Mount Sinai Queens will mitigate the potential negative health equity impacts identified in the Health Equity Impact Assessment through deliberate planning, phased implementation, and continuous monitoring to ensure that medically underserved and vulnerable populations maintain equitable access to safe, high-quality inpatient and critical care services throughout the ICU build-out.

To mitigate potential disruptions associated with construction activities, including temporary impacts to unit locations, elevator access, and internal circulation patterns, the Applicant will implement a construction management and patient flow plan designed to minimize disruptions to inpatient care. Clear, highly visible, and multilingual signage will be deployed throughout affected areas, and designated staff assistance protocols will be implemented to support patient transport and wayfinding. Clinical and support

staff will be trained to proactively identify patients requiring additional assistance and ensure safe, timely movement throughout the facility.

Construction phasing will be coordinated to preserve uninterrupted ICU operations and maintain appropriate separation between patient care areas and construction zones. The Applicant will closely monitor patient flow, transport times, and elevator access to ensure that critical care service and ancillary support are not adversely affected. Any temporary operational adjustments will be communicated in advance to clinical teams to support continuity of care and patient safety.

To address potential staffing pressures during the ICU ramp-up phase, Mount Sinai Queens has initiated workforce planning efforts to ensure that the expanded ICU space is appropriately staffed prior to activation. Recruitment and onboarding plans for critical care nurses and support staff will align with projected patient volumes and acuity. The Applicant will utilize a phased activation approach to bring ICU beds online in a manner that supports safe staffing ratios, care quality, and staff sustainability. Up-training and orientation programs will be implemented as needed to ensure staff readiness and continuity of care, while minimizing reliance on temporary staffing resources.

Throughout the construction and activation phases, Mount Sinai Queens will monitor key operational and equity-related indicators, including ICU access, patient outcomes, and care delivery performance, to identify and address any unintended impacts on medically underserved populations. Findings will inform ongoing adjustments to mitigation strategies to ensure compliance with CON requirements and the Applicant's commitment to advancing health equity.

Through these measures, Mount Sinai Queens will mitigate potential negative impacts identified in the Health Equity Impact Assessment and ensure that the ICU build-out enhances, rather than impedes, equitable access to critical care services for the diverse communities it serves.

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.

APPENDIX

Anna Kril
23-55 21st Street
Astoria, NY 11105

December 16, 2025

Aisha King
Mount Sinai Queens – Health Equity Impact Assessment (HEIA)
60 E. 42nd Street, Suite 1762
New York, NY 10165

To Whom It May Concern,

As a member of the community and a two-time breast cancer survivor, I am writing to express my strong support for the expansion of the Intensive Care Unit at Mount Sinai Queens. During my own health challenges, I often had to travel to receive the level of critical care I needed. I know firsthand how stressful and exhausting it can be for patients and families to travel long distances during medical emergencies, especially when every minute truly matters. Having such critical services available locally can make an immeasurable difference in both outcomes and peace of mind.

Mount Sinai Queens holds a special place in our community, and expanding the ICU will ensure that patients who are critically ill can receive advanced, lifesaving care close to home. Access to care locally not only improves medical outcomes but also allows families to remain nearby, providing essential emotional support that is a critical part of the healing process. For patients facing serious illness, knowing that high-quality care is accessible within their community can provide reassurance, reduce anxiety, and allow families to focus on supporting their loved ones during difficult times.

This expansion represents more than a construction project, it is a meaningful investment in the health, safety, and resilience of our community. It strengthens our healthcare system, improves access to lifesaving services, and ensures that Mount Sinai Queens is better prepared to meet both current and future healthcare needs.

From my personal perspective, I wholeheartedly support this initiative. I am confident that it will have a lasting, positive impact on the patients and families who rely on Mount Sinai Queens, offering them critical medical care, comfort, and peace of mind during times of serious illness.

Sincerely,

Anna Kril

Anna Kril