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

	behavioral health providers, child welfare agencies, and providers that support individuals with intellectual and developmental disabilities. The SPG HEIA team is deeply passionate about improving the health care delivery system, especially for underserved populations. The team is unwavering in its commitment to promoting equity through rigorous research, insightful consulting, and strategic advisory work.
5. Date the Health Equity Impact Assessment (HEIA) started	August 6, 2025
6. Date the HEIA concluded	October 14, 2025

7. Executive summary of project (250 words max)

The Wartburg Home of the Evangelical Lutheran Church ("Wartburg") has been providing services to the Westchester community since 1866 and opened its first senior housing building in 1897. Currently, Wartburg provides senior residential and health care services across the care continuum on its 34-acre campus. Services include an independent living program, affordable senior housing, assisted living facilities, a discrete memory care center, social and medical adult day services, and rehabilitation facilities for dementia care, palliative and hospice care, and spiritual care.

The Waltemade building on Wartburg's campus has served as a 160-bed skilled nursing facility (SNF) building since 1995. However, the building is not currently compliant with the American Disabilities Act, has seen a drastic reduction in occupancy since the COVID-19 pandemic, and is currently empty. Meanwhile, the waiting list for affordable senior housing in Mount Vernon (the closest metropolitan area to Wartburg) is 3-5 years.

Average monthly occupancy rates for skilled nursing beds in 2023:

January	56%
February	57%
March	55%
April	51%
May	49%
June	48%
July	50%
August	46%

September	44%
October	43%
November	41%
December	40%

In response to the urgent need for affordable senior housing in the local community and the reduced demand for skilled nursing beds, Wartburg intends to decertify Waltemade's 160 certified skilled nursing beds in order to transition the building into 102 affordable housing units for older adults 62 years or older.

The units will be rented at below the Area Median Income (AMI), with a proposed split as follows:

# Units	Rented at
30	30% of AMI
22	50% of AMI
30	60% of AMI
20	80% of AMI

The Wartburg campus will retain all other services, including the 50 skilled nursing beds within the rehabilitation building on campus.

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

This Health Equity Impact Assessment (HEIA) utilized data from the census, academic and gray literature, and interviews with leadership, staff, a campus resident, community-based organizations, and referral partners.

The HEIA found that while some community partners were concerned about the loss of certified skilled nursing facility (SNF) beds at the facility and long-term care options for low-income individuals covered by Medicaid, the majority highlighted that there are many SNFs still in operation in the area. Referral partners said that they do not have difficulty finding placements for individuals needing skilled nursing care – even after Waltemade stopped accepting new admissions.

Over the past two years, residents were slowly transitioned out of the Waltemade building into levels of care consistent with their clinical needs and preferences. No residents were required to leave the Wartburg campus as a result of this project, although some residents requested to transfer to an external facility.

Stakeholders emphasized the urgent need for affordable housing in the region, particularly for older, low-income individuals and individuals who are racial and ethnic minorities. It is expected that this project, while reducing the number of skilled nursing beds in the area, will ultimately have a positive impact on health

equity in the region. Safe, stable housing is an essential component to healthy aging, and Wartburg has demonstrated a strong commitment to using this project to create an equitable environment for housing and health care access for underserved populations in the area.

A current resident of on-campus affordable housing expressed strong appreciation for the safety, cleanliness, and supportive community of on-campus life. In addition, they noted the importance and positive presence of maintenance staff who can help with the needs of older residents (e.g., installing showerheads, changing lightbulbs) – enabling them to age gracefully in place.

The overarching recommendations of this HEIA are:

- Integrate health and wellness programs such as resident education initiatives, primary care, preventive health, pharmacy, behavioral health, nutrition services, and referral pathways to local partners.
- Strengthen accessibility for non-English-speaking community members by implementing multilingual outreach and communication, hiring bilingual staff, expanding interpretation capacity, and providing cultural competency training for staff.
- Establish regular resident engagement mechanisms, including resident surveys, feedback channels, and resident advisory councils.
- Create a health equity and community impact committee to advise on marketing, admissions, data collection, and evaluation processes for the new housing units.

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_wartburg.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
- People with disabilities
- Older adults
- People who are eligible for or receive public health benefits

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

   We utilized data from the Applicant, U.S. Census data for the community/service area, New York State Department of Health nursing home census data, academic literature, and interviews with leadership, staff, residents, family members, community-based organizations, and referral partners.

   In our geographic analysis and scoping tables, we included the zip codes indicated in Table 1. The facility is located in Westchester County and the majority of zip codes in the service area are located in Westchester County. Mount Vernon is the closest metropolitan area to the Applicant.

Table 1. Applicant Service Area

ZIP Code	County	Primary Area
10530	Westchester	Hartsdale
10550	Westchester	Mount Vernon
10552	Westchester	Mount Vernon
10553	Westchester	Mount Vernon
10605	Westchester	White Plains
10701	Westchester	Yonkers
10704	Westchester	Yonkers
10707	Westchester	Tuckahoe
10708	Westchester	Bronxville
10709	Westchester	Eastchester
10801	Westchester	New Rochelle
10805	Westchester	New Rochelle
10030	New York (Manhattan)	Harlem
10462	Bronx	Parkchester
10464	Bronx	City Island
10470	Bronx	Woodlawn
10471	Bronx	Riverdale
11106	Queens	Astoria

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

Nursing homes, or skilled nursing facilities (SNFs), provide vital 24/7 care, including skilled nursing, short-term rehabilitation, and long-term residential care for individuals needing assistance with activities of daily living (ADLs). Based on the Service Area and services provided, it is expected that the decertification of 160 skilled nursing beds at Wartburg will primarily impact older adults, individuals who are racial/ethnic minorities, immigrants, people with disabilities, and low-income individuals who rely on public health benefits. While the availability of skilled nursing care at Wartburg will be reduced, there is a robust network of SNFs in the surrounding area. In this context, the medically underserved groups that may be affected by this project are highlighted below.

Older Adults

The prevalence of older adults (65 years or older) is approximately 19% in Westchester County and 17% in the Applicant's service area.[1] Mount Vernon experienced a 25% increase in the 65 and older population over the past 5 years, reaching 18% according to the latest Census. Nationally, the elderly population is projected to more than double over the next 40 years - and the number of individuals over 85 is expected to quadruple.[2,3]

Although SNFs serve individuals of all ages, approximately 82% of SNF residents are over the age of 65.[4] The Department of Health and Human Services estimates that over half of Americans turning 65 need long-term services and supports.[5]

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

In Westchester County and the Applicant's service area, an estimated 9% of families live below the poverty level, lower than the statewide average of 10%.[1] However, poverty levels vary widely across the Applicant's service area, from less than 2% in some zip codes to 28% in one zip code area in the Bronx. In Mount Vernon, an estimated 14% of individuals live below the poverty line – a statistic that jumps to 21% among seniors (65 years and older).[6] Across the Applicant's service area, median household income ranges from $42,000 to over

[1] U.S. Census Bureau. (2023). *data.census.gov* [Data portal]. https://data.census.gov/
[2] U.S. Census Bureau. (2023, May). *2020 Census: The United States' older population grew.* https://www.census.gov/library/stories/2023/05/2020-census-united-states-older-population-grew.html
[3] Urban Institute. (n.d.). *The U.S. population is aging.* https://www.urban.org/policy-centers/cross-center-initiatives/program-retirement-policy/projects/data-warehouse/what-future-holds/us-population-aging
[4] National Center for Health Statistics. (2024). *Overview of post-acute and long-term care providers and services users in the United States, 2020* (National Health Statistics Reports No. 208). Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/data/nhsr/nhsr208.pdf
[5] New York State Senate. (2021). *Long-term care workforce hearing report 2021.* https://www.nysenate.gov/sites/default/files/article/attachment/long-term_care_workforce_hearing_report_2021.pdf
[6] Census Reporter. (n.d.). *Mount Vernon, NY (city) profile.* U.S. Census Bureau, American Community Survey 2019–2023 5-year estimates. Retrieved October 7, 2025, from https://censusreporter.org/profiles/16000US3649121-mount-vernon-ny/

$175,00, highlighting income inequality across the region. Community leaders frequently mentioned the high cost of housing in Westchester as compared to average incomes. Approximately 24% of individuals in the county are enrolled in Medicaid, which is also the primary payer (70%) for skilled nursing services in New York.[7]

Racial and ethnic minorities and immigrants

The Applicant's service area is diverse with a long history of race-based inequities in health care and housing. Table 2 shows the racial and ethnic identities of individuals living in Westchester county, Mount Vernon, and NYS.

Table 2. Race & Ethnicity

	Westchester County	Mount Vernon	NYS
Non-Hispanic Black	13%	62%	14%
Non-Hispanic White	49%	12%	53%
Asian	6%	1%	9%
Hispanic	28%	21%	20%

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

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

Evidence indicates that the proportion of minority residents in nursing homes is increasing rapidly, in part due to unequal access to home and community-based alternatives among persons of color.[8,9,10] Increasing the availability of affordable senior housing in areas where a significant proportion of the population is BIPOC may help alleviate this disparity.

Language and immigration status are also significant barriers to health care access. Approximately a quarter of Westchester County residents were born outside of the U.S., and more than half of these individuals come from Latin

[7] United Hospital Fund. (n.d.). *Medicaid enrollment by county.* Retrieved October 14, 2025, from https://uhfnyc.org/our-work/initiatives/medicaid-institute/dashboards/mi-current-enrollment/#Medicaid%20Enrollment%20by%20County

[8] Feng, Z., Fennell, M. L., Tyler, D. A., Clark, M., & Mor, V. (2011). Growth of racial and ethnic minorities in U.S. nursing homes driven by demographics and possible disparities in options. *Health Affairs, 30*(7), 1358–1365. https://doi.org/10.1377/hlthaff.2011.0126

[9] Li, Y., & Cai, X. (2018). Disparities in nursing home use and quality among African American, Hispanic, and White Medicare residents with Alzheimer's disease and related dementias. *Journal of Aging and Health, 30*(8), 1371–1389. https://doi.org/10.1177/0898264318767778

[10] Smith, D., Chai, E., & Temkin-Greener, H. (2020). Racial/ethnic disparities in nursing home end-of-life care: A systematic review. *Journal of the American Medical Directors Association, 21*(10), 1445–1450. https://doi.org/10.1016/j.jamda.2020.05.026

America. About 54,000 people living in Westchester, or 5% of the county's population, are undocumented. Having undocumented status can severely limit access to health care for a variety of reasons, from fear of high costs due to lack of health insurance to fear of deportation when accessing in-person medical services. However, as undocumented individuals are generally not seen in Medicaid-funded SNFs, it is unlikely that there will be an actual impact on this population. With regard to language; Nearly 20% of Westchester County residents speak Spanish at home, and a quarter of Spanish-speakers do not speak English well. Nearly 4% of County residents speak an Asian or Pacific Island language at home, and 15% of these individuals do not speak English well. Availability of services, care, and information in an appropriate language is of utmost importance in health care access.

Individuals with disabilities

Although statistics on disability vary widely by definition and measurement, the American Community Survey reports that the percent of the population living with a disability is 13.4% in the Applicant's service area and 10% in Westchester County.[1] Disabilities are more common among adults 65 years or older; approximately 2 in 5 adults in this group have a disability.[11] In New York State, 41.4% of individuals 65 years or older have at least one disability. Disability is also higher among racial and ethnic minorities and individuals living in poverty, indicating intersectional challenges.[12]

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

The tables below outline the utilization of skilled nursing and short-term rehabilitation services at Wartburg across medically underserved groups. The demographics of individuals accessing skilled nursing and rehabilitation services at Wartburg are not expected to change as a result of this project.

Table 3. Race/Ethnicity

Race	% of SNF Residents
Non-Hispanic White	69.8%
Non-Hispanic Black	25.6%
Other Race	4.7%

Table 4. Age

[11] Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. (n.d.). *Disability and Health Data System (DHDS).* Retrieved March 20, 2025, from https://dhds.cdc.gov

[12] Okoro, C. A., Hollis, N. D., Cyrus, A. C., & Griffin-Blake, S. (2018). Prevalence of disabilities and health care access by disability status and type among adults—United States, 2016. *MMWR Morbidity and Mortality Weekly Report, 67*, 882–887. https://doi.org/10.15585/mmwr.mm6732a3

Age	% of SNF Residents
55-59 years	2.3%
60-64 years	0.0%
65-74 years	4.7%
75-84 years	32.6%
85+	60.5%

Table 5. Payor Mix

Payor	% of SNF Residents
Medicaid	20.9%
Medicare Part A	69.8%
HMO/ Managed Care	7.0%
Self-pay/ Private	2.3%

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

Table 6 shows the SNFs in the Applicant's service area, including the number of beds and occupancy rates in either September or August 2025. Six out of the 15 SNFs are not-for-profit and the rest are LLCs, Business Corporations, or Partnerships. All are Medicaid and Medicare certified. There are additional SNFs available in Yonkers, Manhattan, Queens, and Upstate NY (not shown).

Table 6. Nursing Homes in the Applicant's Service Area[13]

Facility Name	City	Zip Code	County	Occupancy Rate	Total Beds
Glen Island Center for Nursing and Rehabilitation	New Rochelle	10805	Westchester	95%	182
Hudson Hill Center for Rehabilitation and Nursing	Yonkers	10701	Westchester	86%	315
Westchester Center for Rehabilitation & Nursing	Mount Vernon	10550	Westchester	97%	240
Sutton Park Center for Nursing and Rehabilitation	New Rochelle	10801	Westchester	94%	160
Yonkers Center for Rehabilitation and Nursing	Yonkers	10701	Westchester	91%	200
Park Gardens Rehabilitation & Nursing Center LLC	Riverdale	10471	Bronx	96%	200
Dumont Center for Rehabilitation and Nursing Care	New Rochelle	10805	Westchester	95%	196
Adira at Riverside Rehabilitation and Nursing	Yonkers	10701	Westchester	89%	120
Bayberry Nursing Home	New Rochelle	10805	Westchester	90%	60
United Hebrew Geriatric Center	New Rochelle	10805	Westchester	56%	294
Hebrew Home for the Aged at Riverdale	Bronx	10471	Bronx	60%	607
Methodist Home for Nursing and Rehabilitation	Bronx	10471	Bronx	90%	120
Rebekah Rehab and Extended Care Center	Bronx	10462	Bronx	96%	213

[13] New York State Department of Health. (n.d.). *Nursing home profiles.* Retrieved October 1, 2025, from https://profiles.health.ny.gov/nursing_home/

Elizabeth Seton Children's Center	Yonkers	10701	Westchester	100%	169

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

   The number of available nursing beds and the occupancy rates for nursing homes in the Applicant's service area are outlined above. The Nursing Home Profiles were last updated by the NYS DOH on September 23, 2025. At that time, there were 3,286 certified skilled nursing home beds in the Applicant's service area. The Applicant currently manages 6.4% of skilled nursing home beds in the service area. After the decertification of 160 beds, the Applicant will manage 1.5% of skilled nursing home beds in the service area.

8. **Summarize the performance of the Applicant in meeting its obligations, if any, under Public Health Law § 2807-k (General Hospital Indigent Care Pool) and federal regulations requiring the provision of uncompensated care, community services, and/or access by minorities and people with disabilities to programs receiving federal financial assistance. Will these obligations be affected by implementation of the project? If yes, please describe.**

   N/A

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

   As the building will be converted into housing units, no physician or professional staffing issues are expected to result from the project.

   Waltemade residents were transitioned gradually over two years into other facilities on or off campus, short-term rehabilitation, assisted living, or specialized memory care. Workforce impact from the closure was limited, as most staff were reassigned on campus or chose to retire. A limited number of staff chose to leave voluntarily and some Certified Nursing Assistants and Environmental/Food Service employees were let go.

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

    In 2018, a Plaintiff filed a purported class action in the U.S. District Court for the Southern District of New York alleging that www.wartburg.org was not fully accessible to individuals with disabilities in violation of Title III of the Americans with Disabilities Act of 1990, the New York State Civil Rights Law, the New York State and New York City Human Rights Laws. The case was later settled.

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

The Berkemeier Living Center, a market-rate Assisted Living facility built for specialized memory care, opened in May 2024. Berkemeier has been successfully increasing occupancy, demonstrating need for this level of care. Although it is too soon to describe any long-term outcomes of the project, it is expected that older individuals and individuals with disabilities who require intensive memory care will see benefits from the project.

The current project meets a distinct but equally pressing need in the area – affordable housing. The Applicant's ultimate goal is to promote independence and healthy aging for all individuals by building a national model for creative aging, lifelong learning, integrated care, housing, and community services. The organizational vision emphasizes aging in place, flexibility, and quality of life across the continuum.

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**

Stakeholders indicated that the repurposing of Waltemade into affordable senior housing reflects the changing needs of the community. In the years during and since the COVID-19 pandemic, the occupancy rate of skilled nursing beds at Wartburg has been decreasing steadily. Additionally, like many SNFs that primarily serve Medicaid beneficiaries, the Applicant has faced financial and operational challenges due to rising costs, workforce shortages, and reimbursement obstacles. Lastly, the Waltemade building is 25 years old and not ADA-compliant, highlighting the need for renovations.

By transforming Waltemade into affordable senior housing, the Applicant intends to provide a vital service to the local community. There has been a notable increase in the proportion of older individuals nationally and in NYS who desire and are able to live independently with minimal support. Simultaneously, the severe shortage of affordable housing in the region disproportionally affects groups that are also medically underserved.

Stakeholders emphasized that there is a robust network of SNFs in the Applicant's service area, and referral partners indicated that taking Waltemade

offline has not created difficulty placing individuals in SNFs locally. As such, the decertification of the 160 skilled nursing beds in Waltemade is not expected to have a significant negative impact on access to skilled nursing care in the region. Notably, the Applicant is retaining 50 certified beds in the rehabilitation unit on campus. Most of these beds are used for short-term rehabilitation services, but there are a limited number of long-term patients.

For older adults, people with low incomes or who qualify for public health benefits, BIPOC communities, and individuals with disabilities, this project will improve access to health care and improve equity as follows:

Improve Access to Services and Health care

- On-campus proximity: All residents will benefit from direct access to health care services on campus, including rehabilitation services and potential future primary care clinics. The proximity to services will reduce transportation barriers – which are a particular concern for older individuals, individuals with low incomes, and people with disabilities – and ensures continuity of care in a familiar environment.
- Supportive environment and resource navigation: Staff can actively inform residents about available services and assist them in connecting to these services, addressing gaps in digital literacy and ensuring that older adults can access the care they need.
- Financial flexibility: Lower rent burdens mean more financial flexibility to afford necessary health care.

Improve Health Equity

- Housing stability: Housing stability is a key component of health. Stable housing can uplift mental health and allows individuals to maintain hygiene, manage chronic conditions, prepare nutritious food, and connect with the community.
- Autonomy and dignity: Affordable, supportive housing empowers individuals to live independently, countering systemic inequities often faced by individuals with disabilities and older individuals who may need structural support (e.g., railings) that they might not otherwise have the financial means to afford. Structural and maintenance support allows individuals to age gracefully in place, setting them up for success and reducing potential for falls. Many seniors enter SNFs prematurely due to lack of affordable housing or means to pay for Assisted Living; independent housing options help maintain health, autonomy, and community connections.
- Community integration: Social programs and shared spaces foster inclusion, reducing isolation and promoting well-being. This can also help create social cohesion among the community at large, as visiting families may have increased opportunities for meeting community members they might otherwise not interact with.

- Economic mobility: Reduced housing costs free up familial resources for health care, education, and other needs, breaking intergenerational cycles of poverty.

Reduce Health Disparities

- Access to preventive care: Being in a stable and supportive environment that is close to health care services will ensure timely preventive care and reduce disparities in emergency response.
- Community partnerships: By expanding the non-clinical campus population, the Applicant will have an increased incentive to partner with local hospitals and organizations to offer primary care and other specialty services on campus – both for residents and the broader community. These kinds of partnerships have the potential to reduce health disparities both among residents and the local community.

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

Unintended negative impacts may include:

- Reduced access to highly rated skilled nursing care in Westchester County. The decertification of Waltemade skilled nursing beds could reduce access to highly rated skilled nursing services for individuals with complex medical needs, especially for those on Medicaid who may not be able to afford alternative care. This could burden individuals and/or families if they are not able to access a SNF of their choice or in their vicinity. However, most stakeholders believe that SNF capacity in Westchester County is sufficient to meet current and future demand. Leadership and external stakeholders highlighted the importance of policy shifts to establish sustainable funding mechanisms for elder care to 1) avoid strain on emergency departments and 2) ensure that high-quality and non-profit SNFs can remain open and financially sustainable.

Unintended positive impacts may include:

- Relieved pressure on affordable housing. The planned housing units could help alleviate demand for affordable housing in the community for young and middle-aged working individuals by providing increased places for older individuals.
- Increased sense of community. The introduction of more than 100 affordable housing units on campus may increase the sense of community across the campus, and certainly for individuals who move into the new building. Residents of the affordable housing building already on campus talked about the increased opportunity for socializing that living on campus has brought them, from daily morning coffee with their neighbors to community barbeque events. The new building may also encourage family

members and other community members to become more familiar with the Wartburg campus and increase a sense community in the area.

- Increased social activities and health care services. The introduction of a new group of individuals who are able to live independently may lead to increased incentive and ability to hold social events and activities across campus. It may also encourage the development and implementation of more collaborative programming with existing and new partners.
- Increased visibility in the broader community. This project will increase visibility of Wartburg in the local community and highlight the full range of services available. This visibility may foster increased trust and engagement from community members who were previously unfamiliar with the campus.

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

   N/A

4. **Describe the access by public or private transportation, including Applicant-sponsored transportation services, to the Applicant's service(s) or care if the project is implemented.**

   The most common way to access Wartburg is by car, as the campus is a 7-minute drive from the metropolitan area of Mount Vernon. However, there are local bus stops near campus, and the Pelham Metro-North stop is an 8-minute drive from campus. This project will not affect the availability of public, private, or Applicant-sponsored transportation services. However, transportation will be a concern for residents, who will need reliable transportation to routine health care appointments off campus. Suggestions are included below.

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

   The project will reduce architectural barriers for people with mobility impairments by renovating the Waltemade building to be ADA-compliant and with structural supports appropriate for an older population.

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.'**

   Westchester County Department of Health

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

   The local health department did not provide information for this HEIA. However, the Applicant has worked closely with the local health department on this project and received a significant amount of financial support for the project from key government partners such as the City of Mount Vernon, Westchester County, and New York State.

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

   Please refer to attached spreadsheet titled "heia_data_tables_wartburg.xlsx

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

    Former residents of Waltemade and future residents of the new affordable housing units will be the most affected by this project. As noted above, all Waltemade residents moved from the building over the past two years. The majority of residents relocated to other buildings on campus, although some chose to move to external facilities. No residents were obliged to move off campus if they wished to stay on campus.

    No stakeholders expressed significant concern about the project's impact on former residents, although some noted that staff morale dipped during the transition. Most stakeholders highlighted that there are many SNFs close by, but some were concerned about reduced access to long-term care options that accept Medicaid.

    Across the board, all stakeholders were in favor of the project and highlighted the need for affordable housing – particularly for seniors – in the area.

    Potential challenges such as contractor delays, labor shortages, and material supply chains, were identified. One stakeholder indicated concern about parking

availability, and one stakeholder indicated concern that lack of onsite medical services may leave gaps for higher-acuity residents.

The most common concern was about how to make the process for selecting residents as equitable as possible, beyond income restrictions. Stakeholders emphasized the following:

- Marketing and outreach must deliberately reach diverse groups, particularly those with language or technological barriers.
- The application process must ensure cultural, linguistic, and socioeconomic inclusivity to ensure the housing serves a truly diverse population.
- Priority should go to long-term county residents who are invested in the community.
- The importance of considering residents' independence levels, access to transportation, social activities, and on-site staff support such as a building manager to help with coordination and accessibility.

Additional suggestions have been integrated into Step 3, Question 2: *What specific changes are suggested so the project better meets the needs of each medically underserved group*.

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

As part of our stakeholder engagement, we interviewed internal stakeholders, including leadership, staff, and a resident of the affordable housing building on campus. External to the organization, we interviewed referral partners and community leaders.

Our stakeholder and community engagement complemented our data analysis by providing qualitative insights into the medically underserved populations that could be impacted by this project. This engagement also helped identify specific needs and challenges faced by these individuals and informed strategies for how the organization can effectively support them if the project is implemented.

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

SPG's stakeholder engagement process involved developing a comprehensive outreach strategy to community-based organizations, staff, providers, and community members from whom we sought feedback for the assessment. As part of this effort, we conducted 7 interviews with staff and leadership, one interview with a resident, and 10 interviews with external stakeholders, including community leaders and local health care providers. We believe that relevant stakeholders participated in meaningful engagement.

STEP 3 – MITIGATION

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

    The Applicant is committed to ensuring effective communication with all communities, including non-English-speaking populations and individuals with disabilities. All outreach materials will be available in both English and Spanish, and the Applicant's website will offer translation into additional languages to accommodate diverse linguistic needs. Recruitment for the project will adhere to state protocols, including public advertising and oversight by the Homes and Community Renewal agency. To ensure fairness and transparency, a third-party firm will manage the application, interview, and vetting process.

    The Independent Entity advises the Applicant to leverage its existing relationships with local organizations, faith-based groups, and referral partners, such as the Rotary Club, Lions Club, city programs, local colleges, and federally qualified health care centers, to disseminate information through trusted community channels. Additionally, all printed and digital communications should adhere to ADA standards, including providing large-print formats, braille, and screen-reader-compatible digital content to ensure accessibility for individuals with speech, hearing, or visual impairments.

    Partnership with community-based organizations and faith-based groups can foster trust and reach underserved populations. Hosting town halls and soliciting community feedback in multiple formats - such as telephonic/audio and in-person sessions – can help ensure that all voices are heard. In addition to Spanish, it is suggested that French Creole be prioritized in outreach efforts, as significant gaps exist in serving communities that speak this language. To further amplify the project's impact, a joint communication campaign with the Westchester Community Health Center is suggested. A joint campaign would highlight the Applicant's housing and support services alongside the Health Center's primary care offerings, while increasing the likelihood of reaching a diverse group individuals who could benefit from affordable housing.

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

    We recommend the following specific changes:

    - **Strengthen existing partnerships and develop new partnerships with local health care providers to provide essential supports for new residents.** Several local providers indicated interest in increased

partnership and recommended provision of wraparound health care services on the Wartburg campus. This may include integrating basic medical support, primary care, geriatric care, a limited urgent care outpost, and/or behavioral health care services on campus. It is also recommended that the Applicant leverage these partnerships to ensure that residents have access to transportation to necessary medical services off campus as needed. Specifically, leaders from the Montefiore Health System and Westchester Community Health Center indicated interest in partnering with the Applicant to provide additional services and transportation for current and future residents.

- **Maintain transparent communication.** Transparent and proactive communication, as has been done thus far, will be key to successful implementation of the project. We recommend that the Applicant continue to be open and proactively communicate with local partners and current campus residents about any upcoming changes.
- **Hire staff and/or volunteers fluent in prevalent community languages.** Hiring staff who are reflective of the local community can help ensure that residents feel comfortable on campus and are able to communicate with staff and learn about available services. Bilingual or multilingual staff can also assist with inquiries about the affordable housing units and provide guidance for new residents who do not speak English fluently.
- **Offer educational and socialization programs for residents:** Lectures on fall prevention, mobility, lifting, and transferring can help prevent avoidable negative health outcomes. Campus activities can emphasize socialization and community integration, particularly as residents are getting used to being on campus. In addition, the new building should be designed with community in mind; Common areas should include some spaces large enough for group activities and some small enough for intimate gatherings.
- **Strengthen communication tools.** Some residents have hearing difficulties, and stakeholders indicated that additional technology and/or tools are needed for the hearing impaired in order to improve participation in meetings and presentations.
- **Develop a concrete, transparent plan for selection process.** Many stakeholders indicated that they would like more information on the selection process, and that it should be equitable, transparent, and ensure that the diversity of the local population is reflected. The high need for affordable housing in the area means that there will be high demand for the new units, and that significant care must be taken in developing an equitable process – beyond income requirements – to select new residents.
- **Anti-Bias and Cultural and Linguistic Training:** Ongoing anti-bias and cultural competency training for staff, contractors, and partners will

help ensure equitable treatment for all residents. Training on interpretation services may also be applicable.

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

   Interviewees indicated that the Applicant has been successful and proactive in engaging and consulting stakeholders on the project. Monthly town halls meetings, barbeques, and other tools have been used to engage staff and local stakeholders from the planning of the project and throughout the transition process.

   As the project progresses, the Applicant can continue to partner with community-based organizations, academic partners, referral partners, and faith-based groups to hold town halls with community members and solicit community feedback in multiple formats (telephonic, in-person, online surveys). In addition, the Applicant should consult the residents of current affordable housing units to ensure success for the future building. In all engagement, the Applicant should consider technological barriers such as literacy levels, language preferences, and the need for technological support. Outreach should be tailored in such a way to meet all community members' levels of understanding.

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?**

   Increasing Access to Stable, Affordable Housing. The project is designed to address the critical shortage of affordable housing in the community, particularly for low-income individuals, older adults, and marginalized populations who face systemic barriers to secure and stable housing. By repurposing Waltemade into income-based affordable housing, the project ensures that vulnerable populations will have increased access to safe, accessible, and financially sustainable housing options. Stakeholders emphasized the safety of campus and the positive impact of access to green space.

   Expanding Access to Supportive Housing and Services. The project goes beyond traditional affordable housing by integrating supportive services that address the holistic needs of residents, particularly older adults and individuals with disabilities. This approach will help reduce systemic barriers that often prevent vulnerable populations from accessing stable housing and necessary care. For example, all housing units and shared spaces will be ADA-Compliant with accessible design features.

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 Applicant has several existing mechanisms and measures in place that can be leveraged to monitor the potential impacts of the project. Monthly town halls and management meetings can be used to monitor staff morale, implementation issues, and emerging needs among staff and residents. Existing social work systems at Wartburg track admissions, discharges, and transitions to community settings, including counseling and home resource connections; these could serve as baseline monitoring tools for resident stability and outcomes. Patient surveys can be used to monitor resident satisfaction and track any issues that may emerge. In addition, ESHAI (Essential Supportive Housing and Assistance Initiative) will offer support for the first five years of the project, providing a built-in reporting structure for resident outcomes.

In addition to internal mechanisms, external partnerships can be leveraged to assess potential impacts of the project. Sarah Lawrence College and Iona School of Health Sciences already partner with the Applicant for clinical placements and student research; these institutions could support evaluation and metrics related to cultural competency, resident health and campus engagement, and community benefit. Partnerships with Westchester Community Health Center (FQHC), Montefiore Mt. Vernon, and Burke Rehabilitation could encourage data-sharing and patient referral systems to track health care utilization and access-related outcomes among residents. Finally, existing relationships with faith-based organizations, Rotaries, and local civic groups (e.g., Knights of Columbus, Sisters of Divine Compassion) create informal yet consistent feedback loops to assess project perception, accessibility, and unmet community needs.

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

We encourage the Applicant to implement a comprehensive evaluation strategy of the project, including:

- **Health Equity and Community Impact Committee.** Establish a multidisciplinary committee to ensure equitable admissions strategies and successful integration of residents on campus, while anticipating and addressing ongoing needs. Membership should include leadership, residents, staff representatives, and community partners.
- **Resident surveys to track satisfaction.** Implement regular resident surveys to assess ongoing satisfaction, well-being, and service access. Early surveys should evaluate satisfaction and safety, accessibility and usability of spaces, integration with campus programs, access to transportation, and barriers experienced by non-English speakers or residents with disabilities.
- **Collect and analyze equity-focused data.** Gather and analyze demographic and socioeconomic data - such as age, race, ethnicity, income, and insurance status - to ensure that residents reflect the diversity of the surrounding community. Use this data to identify and address potential disparities over time.
- **Maintain and Strengthen Community Partnerships.** Develop

transportation and access pilot program(s) with existing partnerships (e.g., Burke Rehabilitation and/or Westchester Community Health Center). Collaborate with local health care systems to track referrals, preventive health participation, behavioral health access, and other wellness outcomes.

By systematically implementing these strategies, the Applicant can effectively monitor and address potential health equity impacts, ensuring that the project enhances access to quality care and housing for all individuals.

STEP 5 – DISSEMINATION

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

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

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

SECTION C. ACKNOWLEDGEMENT AND MITIGATION PLAN

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

I. Acknowledgement

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

_____

Name

_____

Title

_____

Signature

_____

Date

II. Mitigation Plan

If the project is approved, how has or will the Applicant mitigate any potential negative impacts to medically underserved groups identified in the Health Equity Impact Assessment? (1000 words max)

Please note: this narrative must be made available to the public and posted conspicuously on the Applicant's website until a decision on the application has been made.

The Wartburg Home of the Evangelical Lutheran Church is committed to advancing health equity, ensuring that the repurposing of the Waltemade Building into affordable senior housing produces meaningful benefits for medically underserved populations, including low-income individuals, older adults, people with disabilities, racial and ethnic minorities, and individuals who receive public health benefits, while minimizing any potential negative impacts.

Wartburg recognizes that the reduction of 160 certified skilled nursing beds may raise concerns about access to long-term care for certain Medicaid-eligible residents. The following mitigation

plan outlines current strategies and will continue to ensure equitable access to care, minimize disruption, and enhance community well-being.

All residents of the Waltemade building were transitioned gradually over a two-year period to alternative levels of care consistent with their individual needs and preferences. No residents were required to leave the Wartburg campus, and many were relocated to other on-campus facilities, such as the Rehab Building, Meadowview Assisted Living or the Berkemeier Living Center for Memory Care.

Each resident received a person-centered transition plan coordinated by an interdisciplinary team consisting of social workers, medical physicians, and nursing staff while Wartburg maintained open communication with residents, families, and referral partners to ensure continuity of care, clinical oversight, and emotional support throughout the transition process.

Wartburg will retain 50 certified skilled nursing beds within its Rehab Building, ensuring continued access to post-acute rehabilitation and long-term care services for high-acuity residents. Wartburg will continue to collaborate with surrounding facilities in Westchester County and the Bronx who have sufficient skilled nursing capacity to meet demand. Wartburg will continue to collaborate with these providers to maintain referral pathways for individuals who require specialized long-term care beyond Wartburg's capacity.

The transformation of Waltemade into 102 affordable senior housing units is designed to address the region's severe housing shortage, one of the greatest social determinants of health in Westchester County. To maximize equity and accessibility, all units and common areas will be fully ADA-compliant, eliminating barriers for residents with mobility impairments. Units will be offered at multiple affordability levels (30%, 50%, 60%, and 80% of Area Median Income), ensuring access for low-income older adults. Wartburg will prioritize outreach to diverse populations, ensuring inclusive marketing and application processes that reach non-English speakers, racial and ethnic minorities, and individuals with limited digital literacy.

Wartburg's admissions and outreach processes will include partnerships with community organizations, faith-based groups, and local housing networks to ensure broad access and representation. We'll also use multilingual materials and collaboration with referral sources who serve diverse and underserved populations to ensure equity in outreach and admissions.

Recognizing that housing stability alone does not guarantee health equity, Wartburg will integrate supportive services and partnerships that bridge health and housing. Key strategies include establishing on-site wellness programming, partnering with local health centers and hospital partners to provide access to primary and behavioral health services, transportation for off-site appointments, and care coordination for residents through case management. Wartburg will maintain close collaboration with Burke Rehabilitation Hospital for on-site therapy and functional mobility support. The ability to leverage Wartburg's Adult Day Services program will promote socialization, cognitive engagement, and caregiver respite.

To ensure transparency and inclusion, Wartburg has implemented robust community engagement opportunities, including town halls, resident councils, and outreach campaigns. These forums provide ongoing opportunities for residents, staff, and local stakeholders to offer feedback on implementation and to voice concerns about potential barriers to access or service delivery. Moving forward, Wartburg will conduct annual satisfaction surveys to measure resident well-being and access to services.

Workforce transitions were handled with sensitivity and fairness. Most Waltemade staff were reassigned to other campus roles, and those unable to be retained received support through retirement pathways or job placement assistance. Wartburg remains committed to providing ongoing cultural competency and training for all staff, recruiting and retaining bilingual and multi-cultural employees and strengthening workforce development partnerships with academic institutions such as Sarah Lawrence College and New York Presbyterian Iona School of Health Sciences to foster local pipelines for nursing, social work, and support positions.

To continuously evaluate fair outcomes and mitigation effectiveness, Wartburg will build upon existing internal and external monitoring systems. Resident and staff surveys will track satisfaction, accessibility, and quality of life. Wartburg's case management tracking systems will monitor transitions, referrals, and service utilization. Partner institutions such as Sarah Lawrence College, New York Presbyterian Iona School of Health Sciences, and the Institute for Music and Neurological Function, will support research related to resident health, engagement, and social integration.

Beyond the campus, Wartburg will play an active role in addressing broader systemic barriers to health equity in Westchester County by partnering with municipal and county agencies to expand supportive housing and resources for low-income seniors and participating in county-wide partnerships focused on aging, affordable housing, and workforce development.

The Waltemade conversion represents a strategic evolution of Wartburg's mission, from institutional long-term care toward integrated, community-based models that honor independence, dignity, and inclusion. Through careful resident transition planning, equitable housing design, robust health partnerships, inclusive communication, and continuous monitoring, Wartburg has developed a comprehensive mitigation framework that not only safeguards but enhances equity for medically underserved groups.