

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	LEC VIP Medical
2. Name of Applicant	Liberty Endoscopy Center (LEC)
3. Name of Independent Entity, including lead contact and full names of individual(s) conducting the HEIA	<p>Sachs Policy Group (SPG) – 212-827-0660</p> <ul style="list-style-type: none"> • Jaclyn Pierce, MPH jpierce@sachspolicy.com • Anita Appel, LCSW - AnitaAppel@sachspolicy.com • Maxine Legall, MSW, MBA - mlegall@sachspolicy.com <p>Qualifications:</p> <ul style="list-style-type: none"> • 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	<p>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.</p> <p>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.</p> <p>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</p>

	<p>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.</p> <p>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.</p>
5. Date the Health Equity Impact Assessment (HEIA) started	May 15, 2025
6. Date the HEIA concluded	July 28, 2025

7. Executive summary of project (250 words max)
<p>This project seeks to expand the procedures offered at Liberty Endoscopy Center (LEC), which is currently a gastrointestinal-focused ambulatory surgery center. These new procedures would include specific vascular procedures—namely, radiofrequency ablation and Varithena treatments—which are appropriately performed in a procedure room setting by a qualified surgeon.</p>
8. Executive summary of HEIA findings (500 words max)
<p>LEC seeks to expand its Article 28 license by adding minimally invasive vein treatments—radiofrequency and Varithena ablations—to its lower Manhattan site, which already performs endoscopy services. Our assessment determined that older adults and women will be the primary beneficiaries. Both groups face higher risks for chronic venous disease: prevalence climbs with age, complications such as thrombosis and ulcers are more common among seniors, and pregnancy-related physiologic changes make varicose veins disproportionately frequent in women. Physicians confirmed that these demographics are highly prevalent in their current vein caseloads.</p> <p>By co-locating vein care within an already licensed ambulatory surgery center, the project can open rapid, high-quality access to safe, sterile procedures without disrupting existing services, immediately expanding appointment availability for nearby residents. Afternoon scheduling of vein cases after morning endoscopies maximizes shared staff and space, while the outpatient setting offers older adults and busy women convenient, same-day treatments that avoid hospital fees and overnight stays. Coupled with existing referral networks, this integration supports seamless continuity of care, earlier intervention, and reduced</p>

complications—ultimately narrowing treatment gaps and easing cost, time, and mobility burdens for these medically underserved groups. Interpreter services, including American Sign Language and multilingual personnel, are already in place, and the center remains fully ADA compliant. Interviews with surgeons, staff, the local health department, and community partners, plus an English- and Spanish-language survey, consistently supported the project.

To maximize impact, we recommend that LEC pursue several actions. First, forge partnerships with women’s health providers—OB-GYN practices, Planned Parenthood—to streamline referrals and host virtual education sessions on venous disease. Second, collaborate with senior centers and long-term-care operators to publicize the service and coordinate transportation. Third, leverage existing ties with Federally Qualified Health Centers and community partners to reach broader underserved populations. Fourth, reassure current gastroenterology patients that their care experience and clinical team remain unchanged. Fifth, sustain open dialogue with staff, patients, and referral partners to monitor integration and capture feedback. Finally, develop vein-specific quality metrics, such as thirty-day occlusion, re-intervention, and ulcer-free survival—stratified by demographic factors to track equity outcomes.

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

We analyzed utilization data from the Applicant, census data for the service area, academic literature, information obtained from interviews with center staff and external stakeholders, and information obtained from a community survey. We were not able to access market share information for other similar service providers in the area.

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

We expect the Applicant's proposal to add vein procedures to its operating certificate to primarily impact older adults and women because these groups are more at risk for chronic venous conditions and are therefore more likely to need procedures such as radiofrequency ablation and Varithena ablation. These minimally invasive procedures "have revolutionized varicose vein treatment, offering high success rates and quicker recovery compared to traditional surgery."¹ The physicians that will be performing the vein procedures confirmed that while varicose veins and related complications are a common problem affecting a significant portion of the population, older adults and women are frequent patients due to their unique risk factors outlined below.

Older Adults

Approximately 16% of individuals in the Applicant's service area are over the age of 60, compared to 24% statewide.² New York currently has the 4th largest population of older adults in the country, with the aging population continuing to increase.³ The prevalence of venous disease and varicose veins increases with age.^{4,5} Older adults are also at greater risk for complications related to varicose veins, such as venous thrombosis or ulcers.^{6,7} Varicose veins are an increasingly frequent cause of discomfort and decreased

¹ Fayyaz, F., Vaghani, V., Ekhtor, C., Abdullah, M., Alsubari, R. A., Daher, O. A., Bakht, D., Batat, H., Arif, H., Bellegarde, S. B., Bisharat, P., & Faizullah, M. (2024). Advancements in varicose vein treatment: Anatomy, pathophysiology, minimally invasive techniques, sclerotherapy, patient satisfaction, and future directions. *Cureus*, 16(1), e51990. <https://doi.org/10.7759/cureus.51990>

² U.S. Census Bureau. (2023). *2022 American Community Survey 5-Year Estimates: Data Profiles* [Data set]. Retrieved June 30, 2025, from <https://www.census.gov/acs/www/data/data-tables-and-tools/data-profiles/2022/>

³ New York State Department of Health, Office of Aging and Long Term Care, & New York State Office for the Aging. (2025, June 30). *New York State master plan for aging: Final report*.

<https://planforaging.ny.gov/system/files/documents/2025/06/mpa-final-report-6.30.25.pdf>

⁴ Beebe-Dimmer, J. L., Pfeifer, J. R., Engle, J. S., & Schottenfeld, D. (2005). The epidemiology of chronic venous insufficiency and varicose veins. *Annals of Epidemiology*, 15(3), 175–184. <https://doi.org/10.1016/j.annepidem.2004.05.015>

⁵ Eberhardt, R. T., & Raffetto, J. D. (2014). Chronic venous insufficiency. *Circulation*, 130(4), 333–346. <https://doi.org/10.1161/CIRCULATIONAHA.113.006898>

⁶ Mok, Y., Ballew, S. H., Kucharska-Newton, A., Butler, K., Henke, P., Lutsey, P. L., Salameh, M., Hoogeveen, R. C., Ballantyne, C. M., Selvin, E., & Matsushita, K. (2025). Demographic and clinical risk factors of developing clinically recognized varicose veins in older adults. *American Journal of Preventive Medicine*, 68(4), 674–681. <https://doi.org/10.1016/j.amepre.2024.12.009>

⁷ Attaran, R. R., & Carr, J. G. (2022). Chronic venous disease of the lower extremities: A state-of-the-art review. *Journal of the Society for Cardiovascular Angiography & Interventions*, 2(1), Article 100538. <https://doi.org/10.1016/j.jscai.2022.100538>

quality of life with age, but surgical treatment can be more effective than conservative management.⁸ As a result, older adults may be more in need of additional access points for low acuity vein procedures in the service area.

Women

Approximately 52% of individuals in the Applicant's service area are female, compared to 51% statewide.² Most studies indicate that varicose veins present more commonly in women compared with men.^{5,5,9} Pregnancy is a major contributory factor in the increased incidence of varicose veins in women and is also considered a risk factor for chronic venous insufficiency.⁴ As a result, women may be more in need of additional access points for low acuity vein procedures in the service area.

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?

Tables 1 and 2 below outline the age and gender distribution of current patients at the facility. Since services at LEC are currently limited to endoscopic procedures, we expect the demographics of the patient population to change slightly. Because the outlined risk factors are most common in older adults and women, introducing vein procedures will likely boost the facility's overall service volume—especially from these two groups.

Table 1. Age

Age	% of Patients
Under 18	0%
18-34	35%
35-49	39%
50-64	20%
65+	6%

Table 2. Gender

Gender	% of Patients
Male	46%

⁸ Chen, H., Reames, B., & Wakefield, T. W. (2017). Management of chronic venous disease and varicose veins in the elderly. In R. Chaer (Ed.), *Vascular disease in older adults: A comprehensive clinical guide* (pp. 95–111). Springer. https://doi.org/10.1007/978-3-319-29285-4_5

⁹ Eberhardt, R. T., & Raffetto, J. D. (2014). Chronic venous insufficiency. *Circulation*, 130(4), 333–346. <https://doi.org/10.1161/CIRCULATIONAHA.113.006898>

Female	54%
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6. What is the availability of similar services or care at other facilities in or near the Applicant's service area?

Clinical facilities in Manhattan that offer outpatient vein procedures such as sclerotherapy, laser treatment, radiofrequency ablation, or Varithena ablation and their distance from the Applicant's site are outlined in Table 3 below.

Table 3. Manhattan-Based Outpatient Centers Providing Vein Procedures

Provider	Location	Distance from LEC
Liberty Endoscopy Center (LEC)	156 William St., NY, NY 10038	-
Vein Treatment Clinic – Financial District	156 William St., NY, NY 10038	0 miles
NYP Lower Manhattan Hospital – Vein Center	156 William St., NY, NY 10038	0 miles
Advanced Varicose Vein Treatments – Downtown	111 John St., NY, NY 10038	~0.2 miles
USA Vein Clinics – Lower Manhattan	122 Fulton St., NY, NY 10038	~0.2 miles
Northwell Health Vein Center (Union Square)	95 University Pl., NY, NY 10003	~1.8 miles
Manhattan Dermatology – Union Square	55 W. 17 th St., NY, NY 10011	~2 miles
USA Vein Clinics – Chelsea	314 W. 23 rd St., NY, NY 10011	~2.5 miles
NYU Langone Vein Center	530 First Ave, NY, NY 10016	~2.8 miles
Manhattan MedSpa Sclerotherapy Clinic	220 Madison Ave, NY, NY 10016	~2.9 miles
New York Vein Treatment Center	30 Park Ave, NY, NY 10016	~3 miles
Vein Treatment Clinic – Midtown	290 Madison Ave, NY, NY 10017	~3.1 miles
Advanced Varicose Vein Treatments – Midtown	369 Lexington Ave, NY, NY 10016	~3.1 miles
Manhattan Dermatology – Midtown	56 W. 45 th St., NY, NY 10036	~3.5 miles
USA Vein Clinics – Lenox Hill	1153 1 st Ave, NY, NY 10065	~4 miles
Metro Vein Centers – Midtown	111 East 57 th St., NY, NY 10022	~4.2 miles
Fox Vein Care	1041 Third Ave, NY, NY 10065	~4.3 miles

Columbia Vein Program – Midtown	51 West 51 st St., NY, NY 10019	~4.3 miles
Mount Sinai West Vascular	425 West 59 th St., NY, NY 10019	~4.3 miles
The Vein Treatment Center	910 Fifth Ave, NY, NY 10021	~4.8 miles
USA Vein Clinics – 1st Ave	1974 First Ave, NY, NY 10029	~5 miles
Vein Treatment Clinic – Upper East Side	1111 Park Ave, NY, NY 10128	~5.5 miles
Manhattan Dermatology Specialists	983 Park Ave, NY, NY 10028	~5.5 miles
Shulman Vein and Laser Center	1165 Park Ave, NY, NY 10128	~5.8 miles
USA Vein Clinics – Harlem	262 W. 145 th St., NY, NY 10039	~7 miles
Mount Sinai Hospital Vascular Surgery	1190 Fifth Ave, NY, NY 10028	~6.3 miles
Mount Sinai Morningside Vascular	111 Amsterdam Ave, NY, NY 10025	~7 miles
USA Vein Clinics – Dyckman	155 Dyckman St., NY, NY 10040	~9 miles
USA Vein Clinics – Washington Heights (St. Nicholas)	1264 St. Nicholas Ave, NY, NY 10033	~9.4 miles
USA Vein Clinics – Washington Heights (Broadway)	4159 Broadway, NY, NY 10033	~10.1 miles
Columbia Vein Program – Uptown	161 Fort Washington Ave, NY, NY 10032	~10.1 miles

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

We were not able to obtain outpatient data specific to each of the practices above to adequately measure the market share.

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.

There are no staffing issues anticipated related to the project. The facility will be bringing on a new vascular surgeon to complete the vein procedures onsite. The vascular surgeon currently performs these procedures within VIP Medical Group, which is located within the same building as LEC and is where the consultations for all procedures will take place. Existing support staff, such as nurses and technicians, will be trained to support the surgeon during the procedures.

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

No

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.

No

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**

By offering low acuity vein procedures at the existing endoscopy clinic, the project will create an additional outpatient option in lower Manhattan – expanding patient choice of both provider and location. Enhancements to access include:

- 1. Co-Location benefits:** The clinic already holds an Article 28 license for sterile outpatient procedures and meets all relevant clinical and regulatory requirements and standards. There are no capital changes required, and only minimal equipment

and staff training will be necessary. This will result in a rapid start-up of services and more immediate appointment availability for neighborhood residents.

2. **Complementary scheduling and shared staff:** According to staff and other experts in the field, endoscopy procedures typically take place in the early morning due to the preparation requirements, allowing for afternoon blocks to be dedicated to vein procedures. This maximizes the facility's current space and staffing while ensuring no disruption to existing patients and services. Operations staff confirmed that LEC currently has the physical space and staff capacity to accommodate new patients.
3. **Ambulatory setting:** Low acuity procedures, such as radiofrequency ablation, provided in an ambulatory setting rather than in the hospital can be both convenient and cost-effective.¹⁰ Research shows that vein treatment procedures performed in an outpatient setting demonstrate comparable results to those obtained in a conventional operating theater, with particularly benefits for individuals over age 65 who can better tolerate outpatient procedures compared to hospitalization.¹¹ Studies also shows that most patients – including women juggling family or work – seeking treatment for varicose veins prefer local anesthetic therapy and single visit treatment options compared to surgery.¹²
4. **Continuity of care:** Given that LEC has existing gastrointestinal services and referral partnerships with primary care providers, the project may improve continuity of care and access to other services for patients newly seen at the clinic for vein procedures. Cross-disciplinary case conferences and warm hand-offs reduce fragmented care, shorten wait times for ancillary services, and improve adherence to follow-up—ultimately lowering the risk of ulceration, infection, and emergency department use.

For women, the improved access to same-day procedures in an outpatient setting with flexible scheduling may improve convenience and help with childcare constraints or other time limitations. For older adults, the outpatient model avoids an overnight stay in a hospital setting and the local community access can minimize transportation barriers for mobility-limited seniors. For both populations, earlier intervention can reduce the likelihood of advanced skin changes, increased discomfort, ulcers, and other complications that disproportionately affect women and older adults. Collectively, this

¹⁰ Gohel, M. S., Epstein, D. M., & Davies, A. H. (2010). Cost-effectiveness of traditional and endovenous treatments for varicose veins. *British Journal of Surgery*, 97(12), 1815–1823. <https://doi.org/10.1002/bjs.7256>

¹¹ Varetto, G., Gibello, L., Frola, E., Trevisan, A., Trucco, A., Contessa, L., & Rispoli, P. (2018). Day surgery versus outpatient setting for endovenous laser ablation treatment: A prospective cohort study. *International Journal of Surgery*, 51, 180–183. <https://doi.org/10.1016/j.ijsu.2018.01.039>

¹² Shepherd, A. C., Gohel, M. S., Lim, C. S., Hamish, M., & Davies, A. H. (2010). The treatment of varicose veins: An investigation of patient preferences and expectations. *Phlebology*, 25(2), 54–65. <https://doi.org/10.1258/phleb.2009.009008>

project can help close treatment gaps for women and older adults, bringing low acuity vein care close to home while easing cost, time, and mobility burdens.

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.

For women and older adults, and others who are at greater risk of varicose veins and related conditions (e.g., those with genetic risk factors), an unintended positive health equity benefit that might occur as a result of this project is that it will divert low acuity vein cases from higher need settings, such as hospital operating rooms, freeing those rooms for higher acuity and more emergent procedures.

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

The current amount of indigent care provided by the Applicant is outlined below. As the number of total services provided at the center will increase, the overall amount of indigent care may also increase. However, the proportion of uncompensated/charity care compared to compensated care is likely to remain the same as the demographics of the population served is not expected to change significantly. Additionally, the Applicant will maintain its commitment to broad community services and the provision of charity care in compliance with New York State regulations for ambulatory surgery services. This will be achieved through the Applicant's charity care policy and commitment to providing a volume of at least 2% in charity care cases annually, partnerships with local Federally Qualified Health Centers (FQHCs), and contractual agreements with Medicaid managed care plans. The Applicant currently has partnerships with eight NYC-based FQHCs and is in contract with five Medicaid managed care plans.

Charity Care:

- 2023 – 43 cases, \$86,000
- 2024 – 20 cases, \$40,000
- 2025 through 6/6 – 7 cases, \$14,000

Write Offs for Uncompensated Care:

- 2023 – 16 patients, \$15,764.73
- 2024 – 10 patients, \$4,486.51
- 2025 through May – 5 patients, \$3,200.81

Bad Debt Write Offs:

- 2023 86 patients, \$5,044.69
- 2024 – 168 patients, \$24,645.29

- 2025 through May – 87 patients, \$9,159.91

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 facility is accessible via several public transportation options:

Subway:

- Fulton Street Station (A/C, J/Z, 4/5 lines) is an approximately 1-minute walk
- Cortlandt Street Station (R/W line) is an approximately 4-minute walk
- World Trade Center (E line) is an approximately 7-minute walk

Bus:

- M15 Local & M15 Select Bus Service (SBS)
- M103
- M9
- M55

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

The facility is currently compliant with all ADA accessibility requirements.

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 (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 spoke with DOHMH on July 17, 2025 and they provided a statement for inclusion in the assessment (see Meaningful Engagement tables for the full statement). DOHMH did not have any serious concerns with the project and encouraged the facility to leverage existing partnerships and monitor marketing and referrals to ensure equitable access.

DOHMH had questions regarding scheduling availability, staff capacity, consultations, staff training, and charity care. In response to these questions, LEC clarified that first availability for appointments is at 7am, allowing for morning appointments. There are 4 procedure rooms, and frequently only 3 are in use, ensuring adequate capacity for vein procedures to take place in both the morning and afternoon timeframes. For both staff and physical space, the facility reported that it is not at capacity and can comfortably meet the expected demand. For staff training, staff will observe cases at the vascular surgeons existing office within VIP Medical (156 William Street, Suite 302, New York, NY 10038), which is in the same building as LEC. Trainings will be scheduled around current operational needs to ensure sufficient staffing is maintained. When a patient is scheduled – either insured or uninsured – the LEC and VIP Medical billing and financial teams will meet to discuss any upfront fees. For insured patients, this would include copays for the total cost of care. In the event a patient is receiving care pro bono, this will be clearly discussed upfront and agreed upon by both teams. The facility will never surprise bill patients.

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_LEC.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?

The stakeholders most affected by this proposed project are individuals who suffer from varicose veins and related conditions or complications, such as pain, ulcers, chronic

venous disease/insufficiency, and deep vein thrombosis. None of the stakeholders interviewed or surveyed as part of this assessment expressed any concern related to the project. All interviewees were supportive of the project, with most indicating that the new service line would fit in seamlessly within the center’s existing care model and philosophy.

All survey respondents were either supportive of the project or felt neutral about it. One respondent questioned how the center intends to adjust the facility or hire staff that are well versed in vein procedures, given their current focus on gastroenterology. No other concerns regarding the project were voiced by survey respondents.

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 conducted one-on-one interviews with vascular surgeons, employees, partners, and associations. We also distributed a community survey that was available in both English and Spanish and open for three weeks. Although the survey was prominently displayed in the facility and staff actively encouraged participation, the response rate remained low. Our stakeholder and community engagement complemented our data analysis by providing qualitative insights into the medically underserved populations that may be impacted.

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 a diverse set of stakeholders from which we sought feedback for the assessment. As part of this effort, we conducted 7 interviews with staff, referral and community partners, and the local health department and received 4 responses to our survey from patients, family members, and employees.

The demographics of the survey respondents are outlined below:

Table 1. Race/Ethnicity

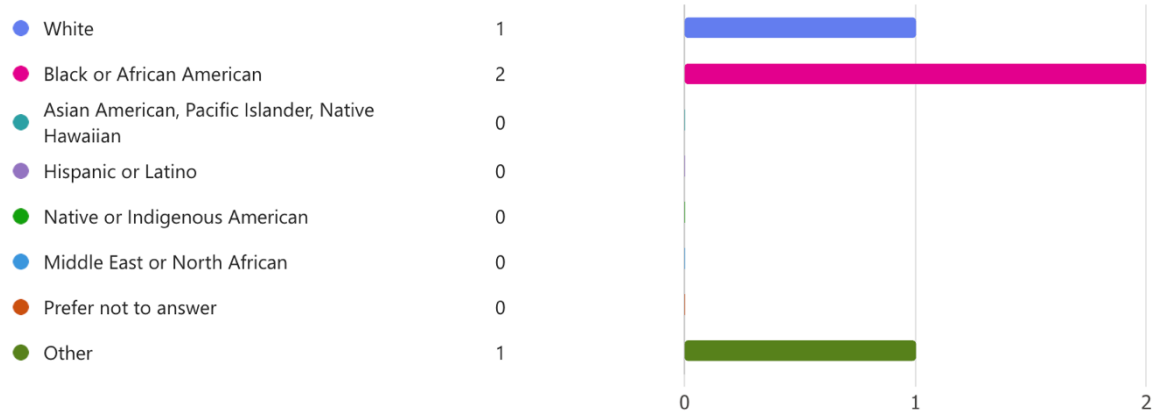


Table 2. Gender



Table 3. Insurance Coverage

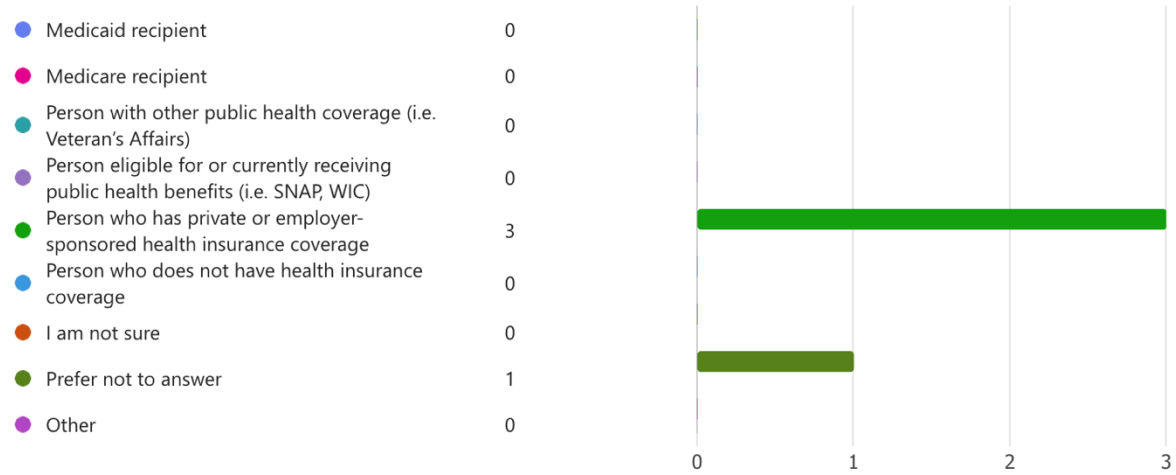
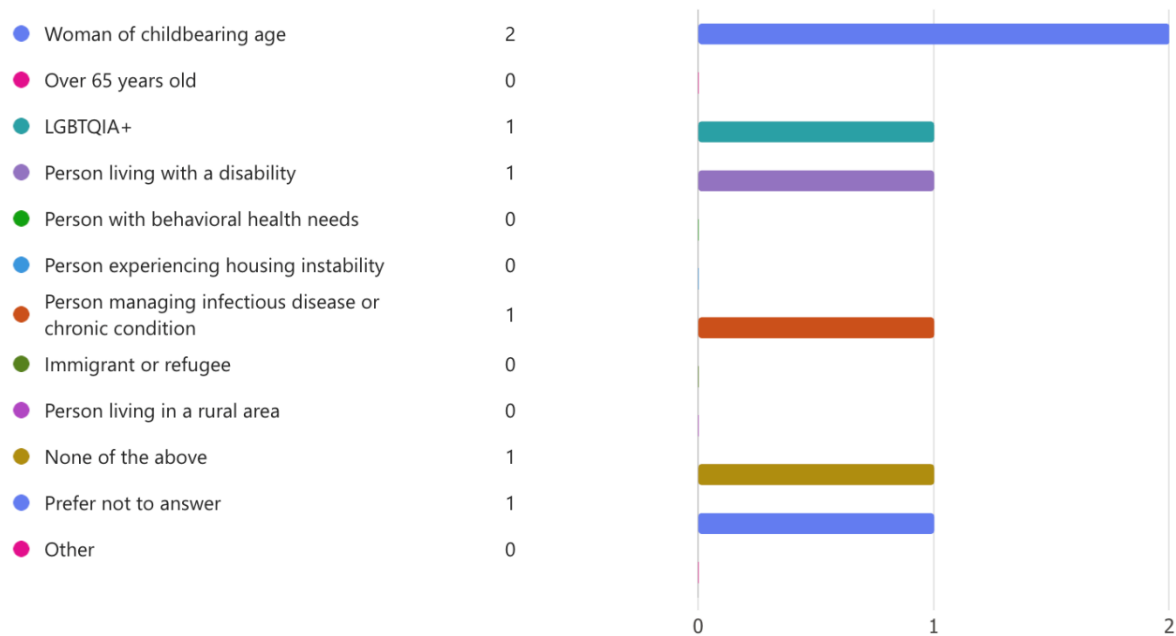


Table 4. Other Demographics



We attempted to reach as many organizations/individuals/groups as possible that represent the medically underserved groups impacted by the project. While we believe that we received adequate feedback from a diverse group of stakeholders, we recognize that certain individuals/populations may have faced barriers to participation. For example, most opportunities for participation were delivered via electronic means (i.e., online survey), potentially limiting participation for those with limited access to the Internet/electronic equipment. However, we believe that the medically underserved groups impacted by the project were adequately represented by the individuals from whom we received feedback during the stakeholder engagement process.

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 has an interpreter service that is used to support individuals who speak other languages or who require American Sign Language (ASL) services. Some of the clinical and administrative staff are also bi- or tri-lingual.

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

To ensure awareness of the services and seamless referral pathways for women, the Applicant should explore partnerships with women’s health and social service providers, such as OB-GYN practices, WIC sites, birthing centers, and Planned Parenthood sites. The Applicant could also consider hosting virtual “lunch-and-learn” webinars on venous diseases for women’s health advocacy groups and organizations.

To reach and serve older adults, the Applicant can collaborate with senior centers, home health agencies, and long-term care providers to publicize the new vein care options and arrange transportation or ambulette services where needed. Communication and appointment reminders should meet the needs and preferences of older adults, including phone calls/mail instead of email/text as necessary.

The Applicant can draw on its proven track record in community outreach – especially its partnerships with FQHCs and the Citywide Colorectal Cancer Control Coalition (C5) – to ensure these services reach underserved populations more broadly. The Applicant can also leverage its existing relationships with primary care providers and OB-GYN practices to support access to colonoscopy screenings.

Finally, the Applicant should proactively reassure current gastroenterology patients that their care experience – and the clinical team providing it – will remain unchanged.

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

The Applicant should maintain open communication with staff, current and prospective patients, and referral sources to confirm the new services integrate smoothly into existing workflows and meet everyone’s needs. Once approved, the Applicant intends to alert its physician and FQHC partners about the availability of the new services and to put it on their website so that the community is aware. These steps will keep all stakeholders informed, engaged, and empowered to shape the service as it grows.

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?

The project may address systemic barriers to care such as:

1. High Cost of Care: By providing services in a community-based setting, patients may experience reduced cost of care as compared to hospital inpatient or outpatient settings that may include facility fees and other costs.

2. Administrative Hurdles: The new access point in lower Manhattan may improve wait times and scheduling bottlenecks while providing additional appointment options for patients.

3. Transportation and Mobility Issues: A community-based clinic accessible by subway/bus can reduce transportation barriers, particularly for older adults and other populations that need to rely on public transportation or caregivers for medical trips.

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 currently analyzes patient outcomes and experience using clinical data and Press Ganey surveys. The Applicant also conducts risk assessments for infections and falls. The new patient population accessing vein procedures will be added to these standardized assessments.

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

The Applicant should partner with the vascular surgeons to develop appropriate clinical quality and safety metrics specific to the new procedures, such as 30-day vein occlusion rates, reintervention rates, and ulcer-free survival rates. Metrics should be stratified by age, sex, race/ethnicity, insurance type, and interpreter use to monitor health equity impact. Additional measures should be considered related to implementation, staff engagement, and workflows to ensure smooth integration and operation of the new services.

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

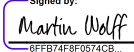
I, (Liberty Endoscopy Center), attest that I have reviewed the Health Equity Impact Assessment for the (LEC VIP Medical) that has been prepared by the Independent Entity, (Sachs Policy Group).

Martin Wolff, MD

Name

President

Title

Signed by:

6FFB74F8F0574CB

Signature

7/31/2025

Date

II. Mitigation Plan

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

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

Liberty Endoscopy Center recognizes its responsibility to ensure that the addition of vein procedures does not create or exacerbate barriers to care for medically underserved groups. The Center has an established Uncompensated Care Policy and partnerships with federally funded clinics, which will continue to mitigate potential negative health and/or financial impacts for patients who are unable to pay for services.

Under its policy, Liberty Endoscopy Center is committed to providing uncompensated care to individuals who have received services and can substantiate their inability to pay. The Center follows a structured and equitable process to support patients facing financial hardship. The Center's existing outreach program works closely with local providers to provide affordable care to underserved residents of the Center's primary service area. Patients are not excluded from the policy based on ability to pay. The Center provides charity care at no cost to patients without insurance who are unable to pay and utilizes a sliding fee scale for those with insurance who experience financial hardship.

The Center also provides uncompensated care as part of its charity care program. The Center has initiated discussions with state funded vascular outreach programs to expand its impact. Through existing and forthcoming agreements with local federally funded clinics the Center ensures access for uninsured and underinsured patients within underserved communities.

Liberty Endoscopy Center anticipates that the implementation of vein procedures will not disproportionately impact medically underserved groups. By integrating the uncompensated care policy and additional targeted outreach programs into the operational planning for the vein service line, Liberty Endoscopy Center will continue to uphold its mission of equitable and inclusive care delivery, addressing social determinants of health and reducing barriers for vulnerable populations.