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NEW YORK CITY COUNCIL

OVERSIGHT: THE DELIVERY OF CULTURALLY COMPETENT & EQUITABLE HEALTH CARE SERVICES IN NEW YORK CITY HOSPITALS

COMMITTEE ON HOSPITALS

SEPTEMBER 18, 2019

Good afternoon Chairperson Rivera and members of the Committee on Hospitals. I am Matilde Roman, Chief Diversity and Inclusion Officer at NYC Health + Hospitals (Health + Hospitals), and I am joined by Dr. Machelle Allen, Senior Vice President and Chief Medical Officer of Health + Hospitals. On behalf of Health + Hospitals' CEO, Dr. Mitchell Katz, thank you for the opportunity to testify before you to discuss "the delivery of culturally competent and equitable health care services" and the programs and initiatives at Health + Hospitals that ensure we provide culturally responsive health care.

Health + Hospitals is *the* safety net for the uninsured and underserved in New York City, providing health care services to one million New Yorkers each year -- 375,000 of whom are uninsured. Our mission is to provide care to everyone, regardless of ability to pay, immigration status, gender identity, disability, or national origin. As such, it is a crucial part of our mission to provide accessible, culturally, linguistically appropriate services to ensure full access to comprehensive and quality care for all New Yorkers.

New York City is home to over 3 million immigrant New Yorkers. Fifty percent of New Yorkers speak another language other than English at home and nearly one million New Yorkers self-identify as a person with disability. This City is also home to the largest LGBTQ community in the nation, and as such providing culturally competent and accessible care is a business imperative.

At Health + Hospitals, patients who receive care belong to many different racial and cultural backgrounds. An estimated 30% of patients served are limited English proficient, and more than 60% of patients self-identify as either Black/African American, Hispanic/ Latino, or Asian.

Health + Hospitals provision of culturally competent, equitable health services are guided by: 1) an understanding of the important role of one's culture, race, class, age, disability, gender, sexual orientation, and gender identity in interpersonal and professional encounters in health care; 2) an awareness of historical and socio-political factors such as racism, ableism, immigration patterns, and human rights violations and their impact on the health and well-being of minority populations; and 3) the value in collaborating with ethnic and racial minority community-based organizations to ensure appropriate responses to individual health needs.

Health + Hospitals is a leader in providing culturally competent and linguistically appropriate services by investing in trainings and initiatives to provide care for all that is safe, responsive and effective; addressing the health care needs of immigrant New Yorkers through the issuance of an Open Letter to reassure immigrant New Yorkers that Health + Hospitals is a safe place to receive care, and through our partnerships with LegalHealth to offer legal services. We also make available multi-lingual materials and collaborate with community-based organizations with close ties to the Latino, West African, and Asian communities to promote our initiatives, such NYC Care, which is a health care access program that guarantees low-cost and no-cost services to New Yorkers who do not qualify for or cannot afford health insurance.

This ongoing process requires periodic assessment of the cultural competency of our workforce, ongoing evaluation of the effectiveness of our diversity training programs, and formal and informal linkages with the communities that our facilities serve. I want to take a moment to highlight a few key initiatives that sets Health + Hospitals apart in providing culturally and linguistically appropriate services.

LANGUAGE ACCESS PROGRAM: Health + Hospitals offers free language services 24 hours a day, 7 days a week, 365 days a year in over 200 languages and dialects. We translate key patient documents, such as consent forms and patient education materials, into the top 13 languages requested by limited English proficient (LEP) New Yorkers. In Fiscal Year (FY) 2018, Health + Hospitals facilities received more than 1 million requests for interpretation services that yielded 13 million interpretation minutes. System wide initiatives to support communication for persons who are LEP include:

- Making available language access resources to inform the public of the availability of free language services, tools to ensure quicker access like language ID desktop displays, and 'I Speak' cards to support facilities in the delivery of language assistance services;

- Creation of a centralized database system to collect language service usage and key performance metrics to monitor for quality assurance and effectiveness; and
- Having a designated Language Access Coordinator at each facility who is responsible for overseeing the provision of language services.

LGBTQ AFFIRMING SERVICES: Health + Hospitals has and will continue to strive to provide patient centered, affirming care to lesbian, gay, bi-sexual and queer (LGBQ) and transgender and gender non-conforming (TGNC) communities. For the fourth consecutive year, all Health + Hospitals' qualifying facilities received the designation of "Leader in LGBTQ Healthcare Equality," by the Human Rights Campaign Foundation's Healthcare Equality Index. This designation demonstrates Health + Hospitals strong commitment to LGBTQ health equity through our policies, programs, and ongoing training. We also have Pride Health Centers at Metropolitan, Woodhull, Bellevue, and Gouveneur, which provide general preventive care and mental health services, as well as gender affirming care, such as hormone therapy or referrals to specialists. The Bridge Program at Spring Street offers medical, mental health and other support services to LGBTQ youth and emerging adults; and at Metropolitan Hospital, we provide gender-affirming surgery. During the past year, Health + Hospitals also launched the LGBTQ Community Engagement Initiative focused on connecting, engaging and facilitating affirming services to New York City's LGBQ and TGNC communities to improve access to affirming care.

ACCESS TO CARE FOR PEOPLE WITH DISABILITIES: Health + Hospitals is required to comply with various federal, state, and local laws requiring accessibility for all individuals with disabilities, including the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and the Affordable Care Act for new construction, major modernization projects, and barrier removal. As part of these efforts, we are also working to ensure effective communication and reasonable accommodations for individuals with disabilities, including those who are blind or have low vision, and those who are Deaf and hard-of-hearing.

Additionally, for the last several years, we have collaborated with the Independence Care System (ICS) Women's Health Program to provide competent and accessible care to women with disabilities. Thanks to the support of City Council, this important work– $2.5 million in capital funds to upgrade four facilities – Morrisania, Sydenham, Cumberland, and Woodhull; and $275,000 in discretionary funds allow Health + Hospitals to continue this important work with ICS.

RESOURCES AND TRAININGS FOR EMPLOYEES: Health + Hospitals offers system wide training on diversity and inclusion, cultural competency, LGBTQ health, unconscious bias, and interreligious awareness through distance learning, new employee orientation, annual in-service, and other in-person trainings such as grand rounds and small facilitated dialogues offered year round.

IMPROVING MATERNAL AND INFANT HEALTH: In 2018, the First Lady and the former Deputy Mayor for Health and Human Services announced New York City's first comprehensive plan to reduce maternal deaths and life threatening complications of childbirth among women of color. The five-year plan aims to eliminate disparities in New York City's maternal mortality between black and white women – where the widest disparity exists – and reducing by half the number of severe maternal morbidity events in the five boroughs. As it relates to Health + Hospitals, the plan includes enhancing maternal care at our facilities by focusing on four specific strategies: 1) simulation training to assist health providers master skills to identify and respond to the two top causes of pregnancy-related deaths for women of color; 2) new maternal care coordinators who will assist an estimated 2,000 high-risk women; 3) coordination of newborn and postpartum appointments; and 4) new practices in primary care to identify women who are planning to have a child within six to 12 months. Additionally, Health + Hospitals increased screening for maternal depression through a partnership with ThriveNYC and the New York City Department of Health and Mental Hygiene (DOHMH) to enhance screening of pregnant women and new mothers in order to promote treatment of maternal depression, and 10 of our 11 acute care facilities have earned the prestigious "Baby-Friendly" designation from the World Health Organization for promoting the highest level of care for infants through breast feeding and promoting bonding between mother and baby.

IMPLICIT BIAS TRAINING: As the largest public health system in the nation, serving perhaps the most diverse city in the country, Health + Hospitals is committed to ensuring its staff is sensitive to issues of health equity and that we are delivering truly equitable care. We have made available to staff all year two e-learning modules on the **Impact of Unconscious Bias on a Culture of Inclusion, and Diversity and Inclusion: A Business Imperative** that was developed by Interactive Business Inclusion Solutions (IBIS). Additionally, we have engaged with **Perception Institute**, a leading organization who translates innovative mind science research on race, gender, ethnic, and other identities into workable solutions, usually in the form of workshops, to reduce bias and discrimination, and promote belonging. Health + Hospitals will begin training Health + Hospitals Board of Directors and senior leadership this fall. In addition, we are working hand-in-hand with DOHMH to provide train-the-trainer implicit bias training through **Re-Birth Equity Alliance** to provide training sessions to all of the hospitals in Health + Hospitals, as well as other hospitals participating in the DOHMH Maternal Hospital Quality Improvement Network (MHQIN). The trainings will focus on improving equity in childbirth. This training will take place next month, in October.

Other facility-based programs that demonstrate our commitment to cultural competence and equity include: The **Medina Health Center** operated at Harlem Hospital, which offers quality medical services to the African community, many of whom are African immigrants and members of the Muslim community. **Llyria Clinic** at Jacobi, which provides culturally sensitive medical care to refugees from the Balkans. Elmhurst Hospital Center operates psychiatric inpatient units that address the needs of both Spanish speaking patients and Asian patients who primarily speak Cantonese, Mandarin, or Korean. Lincoln Hospital operates the **Viva Mujer (Long Live Women), Viva Los Hombres (Long Live Men) & For You, For Life! Cancer Outreach Program** that promotes public education in the areas of cancer screening, prevention, and early detection.

At Health + Hospitals, we believe all New Yorkers, regardless of disability, national origin, gender, or citizenship status deserve equitable, affordable, and accessible high quality health care. True to our mission, Health + Hospitals will continue to provide health services in a culturally responsive manner to meet the needs of the City's diverse population. Thank you for your interest and attention, and we are happy to answer any questions you may have.

New York City Council Committee on Hospitals

Oversight Hearing – Cultural Competence in the Delivery of Health Care Services
Proposed Resolution 512 – Calling for New York State to Require Medical Schools to Train all Students about Implicit Bias in Health Care
Wednesday, September 18, 2019 – 1:00 pm
New York City Hall

Testimony Provided By

Marilyn E. Saviola
Sharifa Abu-Hamda
Rosamaria Ocasio
Manyon Lyons
Michaeline Branker

Testimony of Marilyn E. Saviola

Senior Vice President of Advocacy and Women's Health, Independence Care System

Regarding Resolution 512

September 18, 2019

Thank you for the opportunity to testify today. My name is Marilyn Saviola and I am the Senior Vice President of Advocacy and the Women's Health Program at Independence Care System (ICS). ICS is a Managed Care Organization that was recently designated the first and only Health Home for people with physical disabilities in New York State. We serve just under 3000 members in four boroughs of New York City.

The issue of education on implicit bias to medical students is one of crucial importance to me and the 3000 members we represent. We are literally dying of a lack of education. Doctors are rarely taught in medical school about people with disabilities, especially those successfully living in the community. We are often seen as a failure of the medical profession because our conditions are not curable. Like many people, doctors grow up thinking people with disabilities are objects of pity or exist to provide able-bodied people with inspiration. This lack of awareness begins in in childhood and continues as new doctors enter a health care delivery system fraught with systemic issues for people with disabilities. Doctors are a powerful part of any health care dynamic and their education and advocacy is necessary to create the systemic change we believe is needed in the health care system.

Teaching medical students about implicit bias towards people with disabilities is critical to avoiding costly hospitalizations and poor health outcomes. Having a disability often co-occurs with other social disparities of health. Disability often contributes to poverty and high unemployment. People with disabilities are part of every group of underrepresented people cited in the resolution. We are disabled AND gay, transgender, people of color, women, women who give birth, older adults and people with HIV. Disability accelerates and complicates all of these situations.

There are times when a lack of knowledge about physical disabilities can have dire consequences. For example, a first line response to a diagnosis of high blood pressure is to prescribe a diuretic. This prescription is a disaster for a person that needs assistance to evacuate their bladder. A diuretic causes frequent urination.

This is a complicated situation for a wheelchair user and may require frequent transfers from their wheelchair and increase the likelihood of leaks. Both can contribute to skin breakdown in people with limited mobility. Skin breakdown or decubiti ulcers can lead to infection, costly in-home treatment, hospitalizations and, if left untreated, death.

Better-trained doctors can also make sure to practice in accessible locations. People with disabilities need accessible locations to receive medical testing and treatment. A primary care doctor with an office three steps down is inaccessible to me. Because of inaccessibility, many people with disabilities end up seeing their specialist instead of a primary care doctor. In doing this, they miss out on preventative screenings routinely done by a primary care doctor including weight and blood pressure monitoring. These conditions are regularly monitored because they can have a profoundly negative health impact. People with disabilities without routine access to primary care are not receiving the benefit of early testing, diagnosis and treatment costing. This problem costs the person with a disability the loss of their health and independence and adds millions to the cost of caring for this population.

The Americans with Disabilities Act passed in 1992, twenty-nine years ago this past July. While accessibility for people with disabilities has improved in many areas, ironically, health care remains one of the last holdouts to create true accessibility for people with disabilities. Women with disabilities in particular struggle to gain access and information to very basic preventive care, like mammograms and pap smears that have been proven to save lives. The barriers women with disabilities face in trying to access health care are multiple, from architectural barriers in the built environment to inaccessible equipment like exam tables and mammography machines to attitudinal barriers. I know this from personal experience, the experiences of my friends, and the experiences of ICS's members.

You will hear today from several members of Independence Care System about their experiences in trying to access health care, including how they were denied services due to their wheelchairs;

got subpar service because their bodies did not work the way they were "supposed" to work; and were, despite being grown women, treated as asexual children, never asked about their sexual activity or reproductive health.

Change will happen by creating a network of disability competent caring professionals across the continuum of heath care. Helping medical students to learn about health disparities and diversity as a part of their education is an important step. A truly inclusive system that addresses health disparities for people with disabilities also requires innovative thinking, bold policy initiatives written with and by the community of people with disabilities and adequate funding to make real systemic change a reality.

ICS and Health+ Hospitals have formed a highly successful partnership that has made a real impact on the health care delivery system in New York City. The model we created started with access to mammograms, expanded to OB/GYN care and is now growing to include disability competent primary care. Over the past several years, this important work has been supported by City Council funds. Your continued support is vital to expand our work to provide disability competent health care to even more New Yorkers with Disabilities.

We support Resolution 512 and hope this committee will continue to push for accessible, affordable health care for people with disabilities. It is my sincere hope that you will lend your voices to this cause and invest in what must be done to safeguard the health and lives of people with disabilities in New York City.

Testimony of Sharifa Abu-Hamda
New York City Council Committee on Hospitals
Wednesday, September 18, 2019

My name is Sharifa Abu-Hamda. I have Limb Girdle Muscular Dystrophy. As someone who has struggled to find disability competent medical care for my entire life, I believe the language of Resolution 512 should be expanded to include the many health consequences that people with disabilities face because of bias against us that is baked into our healthcare system.

It is hard to believe, but the truth is that medical schools, nursing schools, and programs that train other healthcare professionals simply do not teach students about how to work with patients like me. As a result, we often can't get healthcare and are mistreated, humiliated and even injured when we try.

I have dealt with medical staff who did not know how or who refused to help me get from my wheelchair onto an exam table. For years I had to take my brother with me to help me when I tried to get gynecological care, which, as you can imagine, was deeply uncomfortable for both of us.

Some of the most striking examples of bias that I have experienced have been in situations where a facility advertised itself as disability friendly. Because of my condition, I need an accessible lift, often called a Hoyer lift, in order to get onto an exam table. At one facility that was supposed to be disability friendly, I called twice before my appointment to make sure that they had a Hoyer lift and was assured that they did. However, when I got there, they were not able to transfer me. Yes, they had the lift, but the staff had not bothered to learn how to use it. I was unable to have my exam.

In another instance when I went for an exam and the staff didn't know how to use the lift, instead of addressing their own lack of training they actually told the doctor that I had refused to be examined. And at that same facility, when I was finally examined by a doctor, she told me that it was the worst exam she had ever done. Somehow, the fact that I have a disability made her feel free to say something to me that I am sure she would never say to a patient without a disability.

For five years I lived with an extremely painful condition because I simply could not bear the way I was treated when I attempted to get what should be routine medical care. It was not until I received help from Independence Care System that I was finally able to get the surgery I desperately needed to become healthy again and pain free. That was only able to happen because ICS has trained doctors how to communicate with and care for people like me, but most medical professionals still don't have a clue.

Testimony of Rosamaria Ocasio
New York City Council Committee on Hospitals
Wednesday, September 18, 2019

My name is Rosamaria Ocasio. I am a mother and grandmother. My disabilities began in 1997 when I worked as a nurses' aide and home care aide and was injured on the job, followed by an accident in my home. I have permanent disabilities involving my back, neck, arms, legs, and foot. In some places, my bones have been fused. I can't move far without a walker and I have a lot of pain.

It is important that people with disabilities can see ourselves in Resolution 512 because we endure tremendous bias and discrimination in healthcare. These attitudes are everywhere.

For example, until I was able to get a mammogram with the help of Independence Care System, my experiences trying to get breast cancer screening were horrible. I have a very hard time getting into the position for a mammography machine. I have braces on both my legs. I can't put all of my weight on either one. I have to shift from side to side. To get a mammogram, you have to be still. You have to lean over, which with a back problem is very hard to do. And if I lean too long, I go into spasms in my upper back.

My experience was terrible because the mammography technicians didn't understand my condition, didn't ask appropriate questions, and basically let me know that I was a burden to them. They made a lot of assumptions. They assumed I was unwilling to cooperate, when all I was doing was trying to accommodate my body so it wouldn't hurt so much. They were impatient and would rush me and, as a result, for years I had to worry because I could not get a valid mammogram. The results always came back inconclusive. That is not good medical care. And I know that it's a direct result of bias because ever since ICS helped me find disability competent doctors who actually treat me as an individual and work with me and my condition, I have been able to get proper breast cancer screening.

Testimony of Manyon Lyons
New York City Council Committee on Hospitals
Wednesday, September 18, 2019

My name is Manyon Lyons. I want to explain why it is very important to include people with disabilities in Resolution 512.

I've had cerebral palsy since birth. The main symptom for me is severe spasticity. Because of my disability, I've had a lot of bad experiences in trying to get health care. Some of this has to do with physical barriers. I've been to doctors' offices that didn't have an adjustable exam table. I had to struggle to get out of my wheelchair and climb onto the table—which is not a safe thing for me to have to do.

However, a lot of the problems have to do with bias against people like me. I have very often not been treated equally by medical professionals because of my disability.

For example, when I brought my aide with me into a doctor's office, the doctor would talk to the aide instead of talking to me. They'd look at her and say, to her, about me, "How is she feeling? Why is she here?" It was so insulting.

When I was pregnant with my son, a social worker asked me why I would want to keep the baby. My sister-in-law was with me and she got really upset, but I said: "I thank God that my mother kept me. No matter what, I will keep my baby."

Then one time I went to a neighborhood clinic for my prenatal care. They referred me right away to a hospital and to a high-risk doctor just because I use a wheelchair. They did this without even asking me what I wanted. I was pregnant, I would have wanted to go to the local clinic but no one had a conversation with me about what I preferred. After a few visits, the high-risk doctor said I didn't have high blood pressure or swelling in my legs. I was healthy and I didn't need high risk care.

If things don't change, what happened to a really close friend of mine will happen to other women. She had a disability and she developed breast cancer but by the time she found out, it had gone too far. Nobody should have to die from a late diagnosis because the medical profession doesn't think your life matters much because you have a disability. But too often, that's just the way it is.

I'm here today because I want things to be different and teaching doctors about bias against people with disabilities is an important step that needs to be taken.

Testimony of Michaeline Branker
New York City Council Committee on Hospitals
Wednesday, September 18, 2019

I am a Registered Nurse and a Certified Nurse Midwife. I have a spinal cord injury, which happened in 1993, as the result of surgery gone wrong.

After I became disabled I applied for a job as a school nurse, which I was completely qualified for. However, the nurse who I would have been working with at that school called the district area supervisor to stay that she didn't believe I would be able to perform in the job because of my disability.

Even after I went in for a trial at the school and demonstrated that I was fully able to carry out the responsibilities of that job, I was not hired due to my disability.

At first, it was incredible to me that I would be discriminated against in this way by another nurse, but in retrospect, I should not have been surprised because, as a medical professional myself, and someone who spent my career in the medical field, I am all too aware of the bias that people with disabilities face when seeking healthcare.

I am here today to urge the council to rewrite Resolution 512 to broadly and specifically include people with disabilities. In fact, in my opinion, it should be aimed not only at medical school students, but to those in nursing schools and other programs that train medical assistants, technicians, even medical receptionists and other office staff.

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Testimony of the Hartford Institute for Geriatric Nursing (HIGN)
before
The New York City Council Committee on Hospitals

September 18, 2019

Good Afternoon Chairperson Rivera and all Council Members present. My name is Dr. Tara A. Cortes and I am Executive Director for The Hartford Institute for Geriatric Nursing (HIGN), the geriatric arm of the New York University (NYU) Rory Meyers College of Nursing. Thank you for the opportunity to testify today and share my expertise on the topic of healthcare service delivery and outcomes among urban populations.

Access to affordable, quality and timely health care contributes to efficient and effective health care. Improved access to good primary care can contribute to the prevention of chronic diseases, better management of existing chronic diseases and earlier detection of health issues. Offering people access to affordable, even free, primary care eliminates the concern of economic insecurity. There are several reasons that are barriers to accessible healthcare.

27.5M people in the United States or 8.5% of the population went without health insurance in 2018. That is an increase of 1.9M people from the previous year. This is usually considered the first barrier to receiving quality healthcare. Others do not access health services because of language barriers, insensitivity to cultural differences, high cost deductibles or immigration status. These people most often receive their primary care in the city's emergency rooms where they go when they have a health issue. This inappropriate use of the healthcare system is not only costly, but also does not provide people with the care needed to decrease the incidence or mitigate the impact of chronic disease. It results in poorer health outcomes, lower quality of life and higher mortality rates.

However, access to quality clinical care is not the only determinant of better health outcomes. The County Health Rankings developed by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation look at multiple factors that contribute to the health and health equity of a community. These factors, known as determinants of health, have shown that **clinical care**, including access to and quality of that care, only **contributes 20%** to length of life and quality of life in a community. **Social economic factors** which are characterized by where people are born, grow, live, work and age and defined by education, employment and income **contribute 40%.** **Health behaviors** defined by activity, nutrition, smoking and sexual health contribute 30% and the **physical environment** - air and water quality and housing - **contributes 10%**. In New York in 2019, the Bronx is ranked #62 in health outcomes, the lowest in the entire state. New York is #5, Queens is #8, Kings is #17 and Richmond is #28.

From the Affordable Care Act, a model of primary care emerged which requires providers to integrate social supports into their care. This model, the Patient-Centered Medical Home, has become the model for primary care services across most of the New York City Federally Qualified Health Centers (FQHCs) and H+H practices. This designation by the federal government creates a higher level of reimbursement and gives provider incentives for addressing patients' socio-economic needs, which account for 40% of the influence on health outcomes.

Health behaviors which account for 30% of the influence on health outcomes are actions individuals take to affect their health. They include actions such as eating well, being physically active and avoiding actions which increase the risk of disease such as smoking, excessive alcohol intake and risky sexual behavior. For example, poor nutrition and lack of exercise are associated with a higher risk of cardio vascular disease, type 2 diabetes and obesity. Tobacco use is associated with cardiovascular disease, cancer and poor pregnancy outcomes. Excessive alcohol is associated with injuries, certain cancers and liver disease.

To improve health outcomes and reduce the high cost of disease treatment there must be a multifaceted approach. Increased access to primary care is one way, and using the medical home model for care makes the assessment and intervention of socio-economic factors part of the primary care paradigm. It must be noted that not everyone has the means and resources to make healthy decisions. Since health behaviors account for 30% of health outcomes they must be addressed.

The Hartford Institute for Geriatric Nursing at NYU Meyers College of Nursing has implemented an initiative in the Bronx in partnership with RAIN and JASA to increase health literacy and impact health outcomes for older adults in the Bronx. Using community-based volunteers to ensure cultural competency, we have educated almost 200 volunteers who have held nearly 300 classes and educate nearly 5000 older adults on such topics as exercise, nutrition, stress management, sexuality, oral health, opioid uses and misuse, and management of chronic diseases – asthma, heart disease, and dementia. When surveyed between one and 3 months after completing the education 79% of the seniors say they have changed their behavior and 75% say the feel their health has improved. One participant said "I finally know how to talk to my doctor about my asthma symptoms."

In summary, improving population health requires more than just addressing health care cost and access. Risk behaviors such as poor food choices or sedentary lifestyles, and social/economic/physical conditions such as food insecurity and housing, whose combined impact on health outcomes exceeds that of clinical care by 4:1, also need to be addressed.

Thank you for the opportunity to testify. We welcome any additional questions the Committees may have. (Please contact Konstantine Tettonis, NYU Government Affairs, kt1249@nyu.edu)

Cristina M. Gonzalez M.D., M.Ed.

I would like to write in support of the resolution regarding implicit bias training in medical schools. By way of background, I am a physician scientist extramurally funded by the National Institutes of Health. Clinically, I care for hospitalized patients in Bronx, NY, often teaching medical students and residents. I am also an associate professor of medicine at Albert Einstein College of Medicine. My singular research focus is designing, implementing, and evaluating interventions related to implicit bias recognition and management. The ultimate goal of my research program is to optimize the outcomes of the patient-physician dyad. I have designed interventions across the spectrum of physician training and practice- starting as early as the first week of medical school. To inform the design of these innovations I conducted three in-depth qualitative studies to explore patient, student, and faculty perspectives on implicit bias in the clinical encounter, as well as participating in and facilitating instruction, respectively. Conducting this research has provided me with unique insights and expertise; my purpose is to help inform the development of the resolution. Thank you for this opportunity. Much of my written testimony is taken from grants and manuscripts I have previously written:

Implicit, or unconscious, bias may contribute to health disparities via two distinct aspects of clinical practice behaviors: communication patterns and medical decision-making.[1] Medical students, like everyone, possess implicit biases.[1,2] Left unexamined, these biases and prejudices may lead to health disparities in their medical practice.[3-10] Well-designed implicit bias training with appropriate mitigation strategies could lead to a reduction in health disparities and improvements in patient/provider communication and medical decision-making.[10] Raising knowledge and awareness of implicit bias without instruction that leads to such skill development, however can have negative consequences, such as social distancing.[11] In our previous work, students expressed their desire to move beyond knowledge and recognition of implicit bias to skill development.[12] To date, most curricula on implicit biases involve one session.[13-19] In addition, extant explorations of learner reactions to implicit bias training suggest that a single session may not be adequate for learners to transition from resistance to acceptance of implicit bias.[15,16]

Single sessions have demonstrated student resistance to growth in strategy development to address implicit bias in oneself: Resistance has been demonstrated as a reduction in humanistic strategies,[15] persistence of suppression strategies,[15] and maintenance of pre-existing beliefs about bias.[18] In our explorations of faculty experiences with implicit bias instruction, some reported feeling overwhelmed by student resistance.[20] Our research into student perspectives also highlight the need for training of faculty, as faculty facilitators can "make or break" a session, impacting students' engagement in any future instruction.[21] Finally, faculty themselves are willing to facilitate this instruction, but face internal and external obstacles to perceived success, all of which are addressable through faculty development programs and realignment of institutional priorities.[20]

Given our previous research and existing evidence, we advocate for multiple sessions to not only raise awareness of implicit bias, but to allow for skill development and practice in order to mitigate the influence of bias on clinical practice behaviors. Our research into patient perspectives highlighted targets for curriculum interventions and opportunities to restore the patient-provider encounter. Implicit bias education should strive to empower not only medical students, but all health professionals with the skills to recognize and address implicit bias both in their own and in witnessed clinical encounters (such as working in teams). To foster continued engagement in skill development, we suggest instruction should include assessments that are based on relevant patient outcomes. My team and I just received funding from the National Institutes of Health (NIH) to design and validate simulations and patient-oriented outcome metrics. These novel simulations and metrics will help advance the field and facilitate evaluation of future innovations, thereby guiding efforts to enhance the outcomes of the patient-provider dyad and contribute to delivering excellent, equitable care for all of our patients.

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N Y L P I

JUSTICE THROUGH
COMMUNITY POWER

Testimony of Christopher Schuyler, Senior Staff Attorney
New York Lawyers for the Public Interest, Disability Justice Program
To the New York City Council, Hospitals Committee
Regarding Resolution 512 Calling on New York State to Require Medical Schools to Train All Students about "Implicit Bias" (September 18, 2019)

Patients with disabilities experience greater barriers to health care than patients without disabilities. Among the reasons for this disparity are the implicit biases held by medical providers. Training medical students in identifying implicit bias, as called for in Resolution 512, is a critical step to elevate the quality of medical care available for patients with disabilities.

Good afternoon. My name is Christopher Schuyler and I am a Senior Staff Attorney with the Disability Justice Program of New York Lawyers for the Public Interest (NYLPI).

I. Patients with disabilities face myriad barriers to medical care

People with disabilities experience greater barriers to health care than people without disabilities.[1] Generally speaking, "people with disabilities are 2.5 times more likely to have unmet health care needs than their non-disabled peers and are more likely to suffer from a terminal condition that may have been detected earlier through disease prevention screening."[2] Particularly affected, however, by the disparity in access are women with disabilities, especially in the area of cancer screening.[3] To give a sense of numbers, 61.4% of women with disabilities reported having mammograms while 74.4% of women without disabilities received this test.[4] For pap tests, 64.6% of women with disabilities received pap tests compared to 82.5% of women without disabilities.[5] Such significant lack of access to critical services leads to poorer health outcomes for women with disabilities, including higher mortality rates.[6]

It is also suggested that racial minorities with disabilities experience disproportionate barriers to health care. While "relatively little is known about the health status of individuals with disabilities who are also members of racial or ethnic minorities [], reports from the CDC on the health status of people living with disabilities along racial lines show that people of color present with poorer health at a higher frequency than Caucasians, and racial and ethnic minorities have historically been and continue to be disproportionately impacted by health disparities.[7] Inaccessibility to health care affects people with disabilities on every level of their lives: socially, psychologically, physically, and economically.[8]

II. Negative impact of structural-environmental barriers to medical care for patients with disabilities

There are two primary causes for the disparity in health care faced by persons with disabilities: structural-environmental barriers and process barriers.[9] Structural-environmental barriers include types of services offered, accessibility of provider offices and diagnostic equipment, and insurance coverage.[10] Process barriers include medical provider implicit bias and their lack of knowledge in treating minority patients.[11] We strongly support the fact that Resolution 512 addresses process barriers, as "[c]onscious and unconscious biases held by health care providers are another underlying aspect of identified barriers to health care access for people with disabilities as well as other marginalized groups, such as racial and ethnic minorities. Negative stereotypes held by health care providers translate into lower quality and fewer services provided as well as contributing to poorer health outcomes for these groups of people."[12] However, Resolution 512 makes no mention of the equally critical structural-environmental barriers, notwithstanding the fact that such barriers present significant and continuing impediments to receiving appropriate health care.[13] We urge the immediate addition of language acknowledging and condemning such structural-environmental barriers.

III. Training medical students to recognize bias will improve medical access for people with disabilities

Adding implicit bias trainings to medical school curriculums will, first and foremost, start a valuable discussion about treating patients with disabilities. Simply bringing awareness to medical providers about the challenges people with disabilities face in accessing health care is significant, as:

> physicians have not received training on the fundamental aspects of working with people with disabilities. In a 2007 survey of primary care physicians, 91% of them revealed that they had never received training on how to serve people with intellectual or developmental disabilities. According to a national study of physicians, only 2.6% of respondents demonstrated specific awareness of the ADA [(Americans with Disabilities Act)]. Another survey of more than 500 physicians revealed that nearly 20% of respondents were unaware of the ADA and more than 45% did not know about its architectural requirements. Moreover, less than a quarter of the respondents had received any training on

> physical disability issues in medical school, and only slightly more than a third had received any kind of training on disability during their residency. However, nearly three quarters of the physicians surveyed acknowledged a need for training on these issues.[14]

Such trainings will also lead to increased awareness of medical equipment and procedures for people with disabilities. There is a significant correlation between knowledge about accessibility and the provision of accessible equipment in health care clinics. Yet, in one study only 46% of health care administrators in clinical practices knew that accessible equipment existed, and only 25.4% were able to describe accessible equipment. While 44% of administrators had considered purchasing accessible equipment at some point, only 22% knew of the federal tax credit program that assists businesses in complying with the legal mandates to do so.[15]

Moreover, open discussion of implicit bias at medical schools will encourage future medical providers to publicly identify as people with disabilities. Medical professionals are hesitant to identify as people with disabilities for fear of stigma and damaging their career prospects.[16] Having bias training in the curriculum will set the stage for medical professionals to identify as people with disabilities, and in turn, take a larger role in advocating for medical access issues concerning disability.

Trainings on implicit bias will also increase "disability literacy," or making one's language, knowledge, and interactions reflective of understanding disability experiences and disability etiquette.[17] Increasing the level of disability literacy among medical providers in turn will lessen the barriers to medical access for people with disabilities.

IV. Recommendations

NYLPI respectfully requests that the NYCC Hospitals Committee modify Resolution 512 as follows:

- Add people with disabilities to the list of "traditionally marginalized communities" in the first paragraph.
- Add a paragraph summarizing the statistical disparities faced by people with disabilities, with an emphasis on structural environmental barriers, as set forth above.
- Mandate training regarding removal of structural-environmental barriers.

V. Conclusion

Thank you for the opportunity to testify about these key issues affecting appropriate medical care to patients with disabilities. Please feel free to contact me to discuss further.

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About New York Lawyers for the Public Interest
For over 40 years, NYLPI has been a leading civil rights and legal services advocate for New Yorkers marginalized by race, poverty, disability, and immigration status. Through our community lawyering model, we bridge the gap between traditional civil legal services and civil rights, building strength and capacity for both individual solutions and long-term impact. Our work integrates the power of individual representation, impact litigation, organizing, and policy campaigns. Guided by the priorities of our communities, we strive to achieve equality of opportunity and self-determination for people with disabilities, create equal access to health care, ensure immigrant opportunity, secure environmental justice for low-income communities of color, and strengthen local nonprofits.

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[1] Independence Care System & New York Lawyers for the Public Interest ("ICS & NYLPI"),
Breaking down barriers, breaking the silence: Making health care accessible for women with disabilities (2012), p. 1. Available at: https://www.nylpi.org/images/FE/chain234siteType8/site203/client/breakingbarriers.pdf. *See also*, ICS & NYLPI, at 1.

[2] Onyeabor, Sunny. (2015). Addressing Health Disparities at the Intersection of Disability, Race, and Ethnicity: the Need for Culturally and Linguistically Appropriate Training for Healthcare Professionals. Journal for Racial and Ethnic Health Disparities. 3. 10.1007/s40615-015-0140-9.

[3] Yee, S., et al., Compounded disparities: Health equity at the intersection of disability, race, and ethnicity, The National Academies of Sciences, Engineering, and Medicine (2016). *See also*, ICS & NYLPI, *supra* at 1.

[4] Altman, B. M., & Bernstein, A., Disability and health in the United States (2008), 2001-2005.

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[6] ICS & NYLPI, at 1.

[7] Onyeabor.

[8] ICS & NYLPI, at 5. *See also*, Neri, M. T., & Kroll, T., Understanding the consequences of access barriers to health care: experiences of adults with disabilities. Disability and Rehabilitation, 25(2) (2003), 85-96. Available at doi:10.1080/0963828021000007941, "Social consequences have to do with one's relationships, social role, and social participation. Psychological consequences often involve depression, frustration, and stress along with experiences of stigma. Physical consequences may lead to a deterioration in one's health due to limited or skipped diagnostic and health screening procedures and related limitations in activities of daily living. Economic consequences involve potential lost wages, financial strain, and additional health service expenditures one has to undertake. With regards to independence, barriers to health care access can lead to a greater dependency on others than individuals would require otherwise."

[9] Kroll, T., Jones, G. C., Kehn, M., & Neri, M. T., (Barriers and strategies affecting the utilisation of primary preventive services for people with physical disabilities: a qualitative inquiry, Health & Social Care in the Community, 14(4) 2006), 284-293. Available at: doi:doi:10.1111/j.1365-2524.2006.00613.x. *See also*, ADA National Network, Health Care Access and the ADA: An ADA Knowledge Translation Center Research Brief (2019). Available at: https://adata.org/publication/health-care-access-and-ada. This report finds that the challenges faced by people with disabilities can be categorized as [margins] environmental, attitudinal, and policy barriers.

[10] *Id.*

[11] Kroll, *et al.*

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[12] ADA National Network, *supra* note 8. *See also*, Yee, et al and ICS & NYLPI at 7, 15. Research shows that bias and misinformation, including stereotypes, negatively affect the quality of care patients with disabilities receive.

[13] ICS & NYLPI at 5.

[14] ICS & NYLPI, at 7 (internal citations omitted).

[15] Pharr, J., Accessible medical equipment for patients with disabilities in primary care clinics: Why is it lacking? Disability and Health Journal, 6(2) (2013), 124-132. Available at: doi:https://doi.org/10.1016/j.dhjo.2012.11.002.

[16] Steinberg, A. G., Iezzoni, L. I., Conill, A., & Stineman, M., (Reasonable accommodations for medical faculty with disabilities. JAMA, 288(24) 2002), 3147-3154. Available at: doi:10.1001/jama.288.24.3147. *See also*, Matt, S. B., Nurses with Disabilities: Self-Reported Experiences as Hospital Employees, Qualitative Health Research, 18(11) (2008), 1524-1535. Available at: doi:10.1177/1049732308325295.

[17] Yee. *et al.* (2016).

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Planned Parenthood of New York City
Mandatory Implicit Bias Training in all New York State Medical Schools
Res. 0512-2018
September 18, 2019

Good afternoon, my name is Kate Steinle and I am the Associate Vice President of Clinical Services and Director of Transgender Health Services at Planned Parenthood of New York City (PPNYC). Thank you to the Chair of the Committee on Hospitals, Councilmember Carlina Rivera, as well as Councilmembers Levine, Ayala, Moya, Reynoso, Euguene and Maisel, and Speaker Johnson for convening this hearing. Planned Parenthood of New York City acknowledges the importance of cultural competency within health care and I am pleased to submit testimony at today's hearing.

For over 100 years, Planned Parenthood has been a leading provider of reproductive and sexual health services in New York City. We are a trusted name in health care because of our commitment to comprehensive, inclusive and confidential care. At PPNYC we have provided Gender Affirming Therapy to over 650 patients since the service's inception in 2016 and believe that high quality health care is a human right, regardless of gender identity, sexual orientation, race or income. Due to our commitment to provide the best possible care to all individuals, we support Reso. 0512-2018, which calls on New York State to establish a medical school curriculum that requires training and understanding of implicit bias.

Historically, lesbian, gay, bisexual (LGB), transgender and gender non-conforming (TGNC) individuals have experienced inadequate access to care; this disparity still persists today. In the 2011 National Transgender Discrimination Survey, the largest survey of transgender individuals to date, 28% of individuals reported having been harassed by medical providers because of their transgender identity, while 19% reported that they were refused medical care because of their transgender identity.[1] These findings confirm widespread systemic and societal discrimination against transgender individuals, especially within healthcare settings, and exemplify the need for a medical school curriculum that includes implicit bias training that considers all aspects of an individual's identity.

Presently, medical school curricula throughout New York State is not comprehensive. According to the Association of American Medical Colleges, medical students in the United States are taught the impacts of stereotyping, racial biases, and gender related assumptions and how these personal shortcomings affect patient care and access to care.[2] This curriculum, though beginning to address implicit bias, does not take into account the biases and prejudices that health care professionals may have towards LGB and TGNC populations nor do they address a provider's lack of confidence in their ability to provide care for LGBTQ

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[1] http://www.transequality.org/issues/national-transgender-discrimination-survey

[2] https://www.aamc.org/download/54338/data/

individuals the result of which leads to incomplete sexual and medical histories and the harboring of bias towards LGBTQ patients' preferred sexual practices.[3]

As a sexual and reproductive health care organization, PPNYC has actively addressed the disparities mentioned above and taken steps to create a welcoming environment for all our clients, including LGB and TGNC individuals. These efforts include revising our protocols and interactions with patients to create a more inclusive and welcoming environment for our patients.

At any PPNYC health center, a patient is asked their pronouns and affirming name at the front desk, during their very first interaction with any PPNYC health care professional. This policy was implemented to capture this information as early as possible and to ensure that all staff who the patient interacts with afterward that initial interaction are familiar with the patient's identity and is addressing them accordingly.

Our health care professionals are trained and equipped with information about the differences between sex, sexual orientation, gender, and gender identity, informing the manner in which they interact with our clients in order to reinforce the respectful environment upon which we operate. We believe that by using appropriate terminology, such as "transgender" or "cisgender", we avoid alienating any individual or group of individuals and incorrectly normalizing any one identity.

We also endeavor to meet our patients where they are to ensure that we are equipped with information to appropriately treat, and support patients that experience health disparities. As such, PPNYC adopted practices to obtaining an accurate medical and sexual history for each of our clients, including asking them sexual orientation and gender identity (SOGI) questions and restructured sexual behavior and risk evaluation questions to make these sometimes awkward conversations with providers regarding preferred sexual behavior free of assumptions and stereotypes.

PPNYC's work is informed by the understanding of sexual orientation, gender identity, gender and sex, however, we also believe that it is imperative to acknowledge the way that these experiences intersect with race and ethnicity. Historically, health care providers have not done much proactive work around racial equity, other than identify this as an area for improvement. While there has been some increased conversations about how PPNYC can provide culturally, racially and ethnically appropriate care, we are far from having eliminated these biases in our own practice and care.

PPNYC is committed to providing equitable access to all of our patients, but in order for all providers to work towards equity, New York State must commit to a standard of education and training for our health care professionals, including medical students, that is reflective of all aspects of identity and how bias manifests itself in a healthcare setting. Implicit bias trainings, rooted in understanding systemic inequities and structural racism, will help health care organizations like PPNYC, continue to do the very necessary work of providing sexual and reproductive services that understand the impacts of race and ethnicity.

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[3] https://www.ncbi.nlm.nih.gov/pubmed/30800981

The health care industry has a long history of treating certain groups of people and behaviors as "normal" while alienating others. This has resulted in generations of mistrust in, and mistreatment by medical providers. When we look towards strengthening our communities, it is imperative that access to culturally competent health care is easily accessible for all.

PPNYC is confident that if implemented, a mandatory implicit bias training, would inform health care professionals about implicit bias and its effects, ultimately resulting in a better understanding of how prejudice undermines equitable care and how to actively deconstruct notions that jeopardize access to care. Reso. 0512-2018 and the development of state-wide standards will improve the quality of care throughout New York State.

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Center for Independence of the Disabled, NY

Testimony to the New York City Council Committee on Hospitals'

Oversight - Cultural Competence in the Delivery of Health Care Services.

September 18, 2019

Testimony By:
Heidi Siegfried, Esq.
Director of Health Policy
Center for Independence of the Disabled

This testimony is submitted on behalf of Center for Independence of the Disabled, New York (CIDNY), a non-profit organization founded in 1978. CIDNY's goal is to ensure full integration, independence and equal opportunity for all people with disabilities by removing barriers to full participation in the community. CIDNY helps consumers understand, enroll in and use private and public health programs and access the care they need.

CIDNY whole heartedly endorses Reso No. 512 calling on New York State to require medical schools to train all students about "implicit bias" and would urge that it include an exploration of attitudes towards people all types of disabilities including visual, hearing, ambulatory, cognitive, self-care, and independent living disabilities, which may affect the way they provide care to their patients.

People with disabilities report being treated unfairly at practitioner offices because of their disabilities. They report negative attitudes and lack of knowledge about treating people with their disabilities.

Physicians receiving training on disability issues are in the minority. Lack of knowledge or disability-related education is consistent with other reports finding inadequate preparedness to provide health services to people with disabilities.

The HHS – Advisory Committee on Minority Health said in July 2011 that "By every measure, persons with disabilities disproportionately and inequitably experience morbidity and mortality associated with unmet health care needs in every sphere. Disability has been recognized as a bona fide disparities population. People with disabilities are more likely to experience difficulties or delays in getting the health care they need and are more likely to not have had an annual dental visit not have had a mammogram in the past 2 years and not have had a pap test within the past 3 years

A complex interaction of factors influence health status and health outcomes for people with disabilities, These include the limited enforcement of the nondiscrimination, accessibility, accommodation, policy modification, and communication that are required by the Americans with Disabilities Act and the lack of provider education and training, the lack of disability literacy, stigma and stereotypes.

To learn more about consumer experiences with health plan networks, CIDNY's project New Yorkers for Accessible Health Coverage (NYFAHC) and its partner organizations—Public Policy and Education Fund, Raising Women's Voices for the health care we need, New York Immigration Coalition, and Metro New York Health Care for All—conducted seven consumer listening sessions around the state between August 23, 2017 and February 1, 2018. Participants in the listening sessions included a range of ages and diverse races, ethnicities, and disabilities (called "mixed consumers" below), but three specialized sessions were held for Spanish speakers, women, and LGBTQ individuals.

In addition to looking at appointment availability, office locations, and hours, we did ask about non-clinical competencies.

Low income people and people of color expressed concerns with practitioners that had insufficient sensitivity to their life situations and the issues they faced. One participant, Lauren, said that some practitioners did not take the complaints of pain by black women like herself seriously enough. Lauren also said that at least one practitioner made a real difference for her economically because the practitioner, unlike others, recommended lower cost alternatives to drugs they prescribed.

Participants in the LGBTQ listening session spoke about the difficulty they experienced finding providers who are sensitive and understanding of their health needs as LGBTQ individuals. A number of participants have had experiences where they believed their provider was not respectful of their gender identity or expression or sexual orientation.

People with disabilities reported problems with inaccessible providers and providers that did not understand the need to accommodate their disability. They reported that providers would refuse to treat them, even for a common condition, because of their disability.

Our recommendation was that New York should establish a work group that includes all relevant stakeholders with the responsibility of recommending cultural competency standards for provider networks in New York State. Some consumers will have better health outcomes when their providers are culturally competent. Cultural competence in the broadest sense involves understanding of and respect for a person's culture and self-identity including their race, ethnicity, religion, gender, gender expression, sexual orientation, age, disability, and socio-economic statuses. There are greatly varying trainings, courses, and certifications to help providers deliver culturally competent care and we thought that a stakeholder workgroup should be created with the responsibility of recommending standards, including trainings, to ensure that all providers are culturally competent.

Certainly a requirement that medical schools train all students about "implicit bias" would go a long way to helping providers deliver culturally competent care.

At CIDNY we also see this as part of a civil rights framework. Section 1557 of the Affordable Care Act prohibits discrimination in health care programs on the basis of race, color, national origin, sex, sex stereotypes, gender identity, age, or disability. Providers who are not aware of "implicit bias" may wind up discriminating in their delivery of care in violation of this statute, the Americans with Disabilities Act and other civil rights laws. The ADA, in particular, is a little different from most civil rights statutes that require "equal treatment" in that it requires "accommodation" to ensure that a person with a disability can benefit from the health program or services to the same extent as their non-disabled peers. Implicit bias training could really help providers understand and fulfill their responsibility to accommodate people with disabilities.

Thank you for consideration of our comments. For further information, please contact Heidi Siegfried, CIDNY's Health Policy Director, at 646.442.4147 or hsiegfried@cidny.org.

September 18, 2019

Hearing of the Committee on Hospitals
New York City Council
September 18, 2019

Resolution No. 512

Eric Gayle MD
Neil Calman MD
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Esteemed Members of the New York City Council:

My name is Eric Gayle. I am a Family Physician and Senior Medical Director for the Institute for Family Health. I am speaking to you on behalf of the Institute for Family Health, a network of 35 Federally Qualified Health Centers that was founded by Dr. Neil Calman who still serves as its President and CEO. Dr. Calman is in Washington DC today, seeking continued funding for our programs with no Federal budget yet passed for the coming year which starts in just two weeks.

Thank you for inviting me to testify on Resolution 512, which would require the training of all medical students in implicit bias. I strongly support this resolution but as you will see, I believe it must be coupled with other requirements for it to achieve its desired goal – that goal being to assure that all people receive the full range of compassionate, high-quality services that they need and that all people who come to hospitals in New York City are provided that care on an equal basis regardless of race, ethnicity, language, gender, or source of payment.

Last year, the Institute for Family Health served over 116,000 patients in over 650,000 visits – primary care, oral healthcare and behavioral healthcare. Of the patients we serve, over 50% identify as Black or Hispanic/Latino and over 18% are best served in a language other than English. Only 30% of our patients have private insurance. We also provide services to populations requiring specialized medical services, such as through the Ryan White HIV/AIDS program. Around 4,000 students were served at our School Based Health Centers and 1,000 patients were served at our satellite sites in homeless shelters. This is all to say we serve a diverse group of patients from all walks of life.

In addition to the care we provide to patients, we are deeply committed to training and educating the next generation of clinicians. We run two family medicine residency programs in New York City and one in the Mid-Hudson region graduating about 23 residents each year. Our fellowships include those in nurse practice, addiction medicine, integrative family medicine, women's health and clinical research. Our Institute trains medical students as well - mostly from Mount Sinai but also at least 200 students from NYU and Einstein in our free clinics in the Bronx and Manhattan.

Implicit Bias Training is Necessary but Not Sufficient

All of us have grown up with biases that have the potential of influencing our clinical decisions, and for clinicians these biases are potentially harmful to their patients. Implicit bias training for medical students is the first step in addressing personalized and internalized forms of racism and other biases in healthcare.

There is much evidence in medicine supporting this. In a 12-week longitudinal study, participants of a multi-faceted prejudice habit-breaking intervention experienced reductions in implicit race bias and increased concern about discrimination, and personal awareness of bias [i].

Another study measured implicit bias against African Americans in medical students in their first year then again in their fourth year and showed that participating in a formal curriculum significantly decreased implicit bias. The study suggests that just the act of taking a Black-White Implicit Association Test predicted a decrease in implicit bias [ii]. Implementing an implicit bias curriculum and debriefing session in preclinical years changed outcomes in implicit bias associated tests [iii].

In addition to these promising outcomes, implicit bias training with clinicians has the ability to improve patient satisfaction and experience. Research is developing to measure training impact on clinical outcomes [iv]. In our own program, a NY State sponsored fellow in our Empire State Research Program, Ivonne McLean, is implementing a longitudinal training program for family medicine residents to measure persistant bias, the impact of a longitudinal curriculum, and ways to measure patient clinical outcomes.

Suggestions to improve Res. No. 512

So let me now make some suggestion for improving Resolution 512. First, it currently only applies to medical students. Implicit bias trainings should include the entire clinical team and training people in interdisciplinary teams has many other advantages. Second, before training students, the faculty must be trained. Attitudes are formed and reinforced by cultural factors. In one study, hearing negative comments from attending physicians or residents about African American patients was a statistically significant predictor of increased implicit bias [ii]. In addition, we need to encourage ongoing trainings with continued discussion to supplement the proposed initial training. An advisory group should be established to determine what the minimum training requirements should be. I don't believe a one-hour lecture in a classroom setting or an online training will have the desired impact.

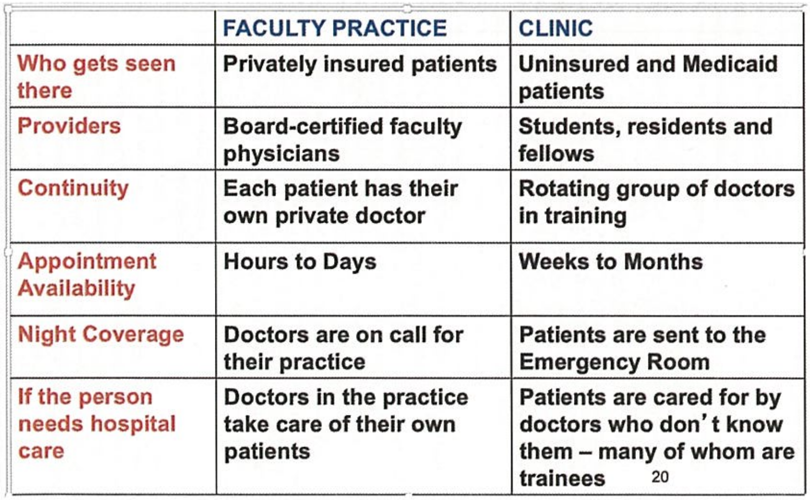
Res. No. 512 does not address structural and institutionalized racism:

More important than anything I have said so far is that Resolution 512 does not even touch the main issue in the delivery of racially and ethnically biased care and that is structural racism in the manner in which medical care is paid for and in the way our hospital system is structured in New York City. Teaching about implicit bias in an environment that does not treat all patients equally negates any possible beneficial impact of implicit bias training. It says "Do what I say and not what I do."

There are many components to the systematic structural racism in our healthcare system in New York City. It starts with a State that pays far less for care under Medicaid, where underrepresented minorities are 66% of the population compared to Medicare where the population is only 32% minority [v] [vi]. We have created a reimbursement system that values healthcare for the elderly more than it values healthcare for the poor in a reality where those who reach age 65 to collect Medicare are disproportionately white.

Second, people covered by Medicaid or Medicaid managed care and the uninsured are relegated to clinics within our academic medical centers and are rarely accepted into the faculty practices which are run by their affiliated medical schools. Because these clinics are intentionally underresourced by the institutions who sponsor them, what results are long, sometimes infinitely long, waits for care by specialists. In fact, many of these patients end up in the public hospital system which is then adversely affected economically by serving patients who are uninsured or insured mostly by Medicaid.

A study we published based on secret shopper phone calls and interviews with patients and doctors outlined the disparities that are documented in Table 1 [vii].



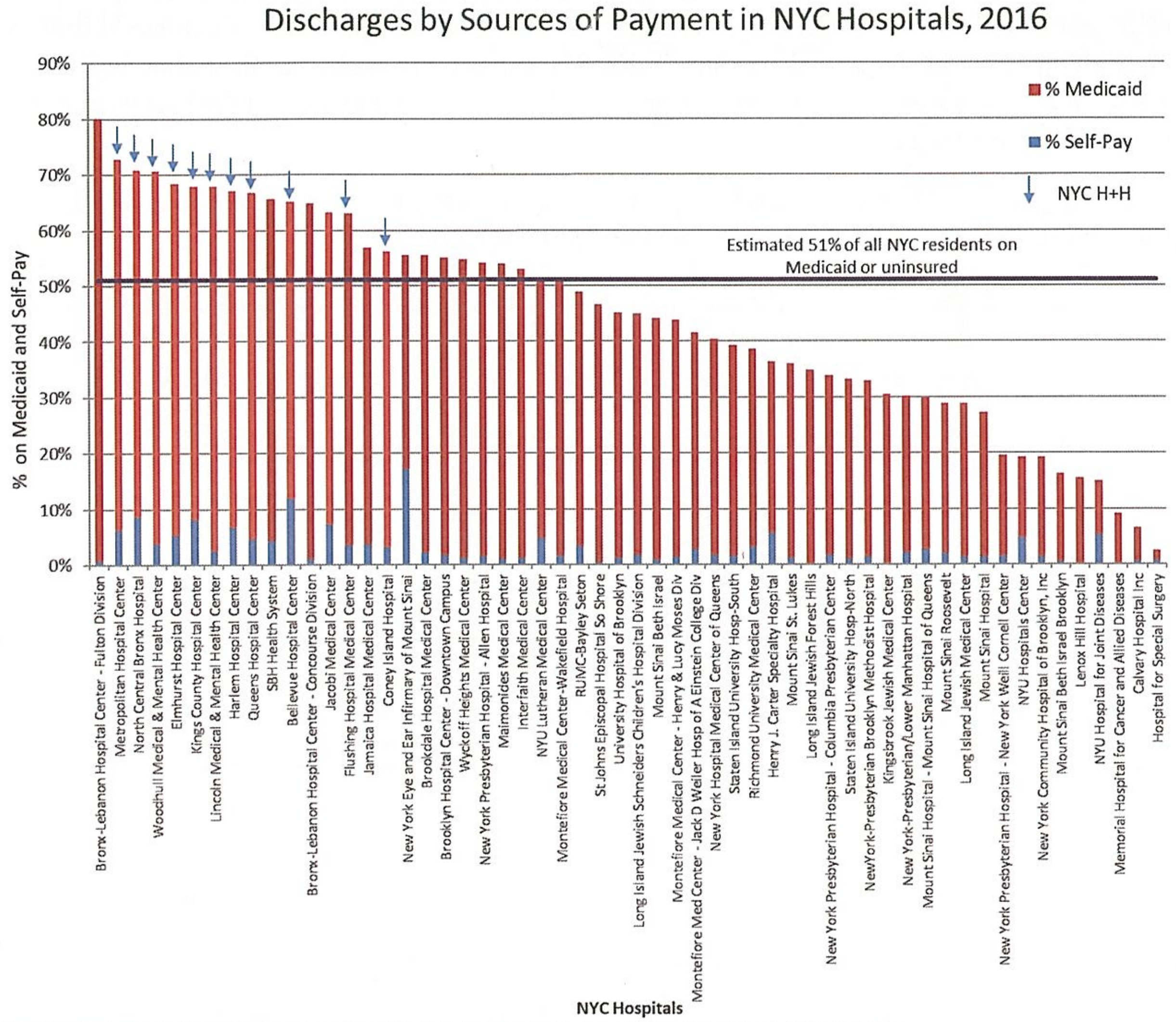
	FACULTY PRACTICE	**CLINIC**
Who gets seen there	**Privately insured patients**	**Uninsured and Medicaid patients**
Providers	**Board-certified faculty physicians**	**Students, residents and fellows**
Continuity	**Each patient has their own private doctor**	**Rotating group of doctors in training**
Appointment Availability	**Hours to Days**	**Weeks to Months**
Night Coverage	**Doctors are on call for their practice**	**Patients are sent to the Emergency Room**
If the person needs hospital care	**Doctors in the practice take care of their own patients**	**Patients are cared for by doctors who don't know them – many of whom are trainees** [20]

Table 1

Despite the fact that faculty practices in the Academic Health Centers do not, for the major part, accept patients covered by Medicaid, NY State formulas specifically perpetuate the inequities by not fully reimbursing public hospitals for care to patients who are underinsured or uninsured while still providing indigent care funding to non-profit hospitals with substantial net incomes (profits) which underserves vulnerable people [viii]. Public hospitals are being the first and hardest hit as the Federal disproportionate hospital funding pool (DSH funding) begins to decrease, during a time when fewer individuals are getting health insurance.

Our studies, using publicly available, hospital reported data demonstrate clearly that only a few of the private non-profit hospitals in New York City serve a population of patients covered by Medicaid and the uninsured that reperesent the distribution of these patients in New York City. In other words, knowing that the underinsured and uninsured suffer worse healthcare and worse health outcomes, the majority of these institutions continue to underserve these needy New Yorkers [ix].

Figure 1 below demonstrates this and shows the percentage of hospital discharges from each hospital as reported to NY State.



Data retrieved from NYS DOH SPARCS Database, NYS DOH DSRIP Database, U.S. Census ACS, Accessed October 2018

Figure 1

From the above figure, it should be clear that the vast majority of patients seen in the public hospital system are covered by Medicaid or are uninsured while the private hospitals largely underserve this population. This, coupled with the separation of patients by the voluntary hospitals into those who have commercial insurance from those covered by Medicaid creates defacto discrimination based on race due to the maldistribution of commercial insurance by race noted above. Students rightly experience this as discrimination by the institution itself and any training in implicit bias will be tainted by their lived experience in training in these institutions.

I will end by saying that this is all remediable and there are laws and regulations in place already that should be able to limit these practices but which are not enforced. One example is the New York State Hospital Patient Bill of Rights, which states that patients have a right to receive treatment without discrimination as to source of payment [x]. Here in New York City, the Public Accomodations Law defines hospitals and medical offices as places of public accommodation, among other facilities, but needs to cite differential access by source of payment or insurance as a form of discrimination [xi]. By accurately identifying the faculty practices of academic medical centers accurately as functions of the hospital itself, even Title VI of the Civil Rights Act can be used to help correct inequities in places of treatment.

In conclusion we support the mandatory implicit bias training of medical students but these must be coupled with structural reforms to correct the racism and the discrimination by source of payment that has long plagued our healthcare system. While I applaud the New York City Council for this resolution and their commitment to addressing health disparities, I also implore you to look further into the structures and system that institutionalize racism in healthcare here in New York City.

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[xi] N.Y.C. Admin. Code §§ 8 -101.

Additional Resources

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Hearing of the Committee on Hospitals
New York City Council
September 18, 2019
Resolution No. 512

Conner Fox, MD 2020
Alec Feuerbach, MD 2020
Rachel Wilkinson, MD 2021
James Blum, MD 2021
Zina Huxley-Reicher, MD 2020
Akila Pai, MD 2021
Michelle Tong, MD 2022

Esteemed Members of the New York City Council:

Thank you for having us. My name is Conner Fox, and I am joined today by Rachel Wilkinson and Alec Feuerbach. We are students at the Icahn School of Medicine at Mount Sinai.

We appreciate the opportunity to offer testimony on Resolution 512, as to how mandatory implicit bias training will benefit students in New York State medical schools, as well as the patients we serve. As students at an institution that already has implemented an implicit bias curriculum for the past several years, we would like to offer our perspectives on the tremendous value of this type of education, in addition to discussing ways in which medical schools and hospitals could do even more to address racism and bias in healthcare.

The Icahn School of Medicine at Mount Sinai has sought to be a leader in vocally and intentionally addressing racism and bias in our medical school curriculum. In 2018, our school launched a Racism and Bias Initiative, with the goal of eradicating racism and bias completely from the environment and education at Mount Sinai. Part of the initiative is expanding the two year longitudinal racism and bias curriculum that students have during their pre-clinical years.

I use the word "pre-clinical" to describe medical education that takes place in the classroom, typically in the first two years of medical school, before medical students begin clinical education rotating through various hospital and clinic settings. I make this distinction between pre-clinical and clinical education in order to highlight the stark contrast between what we learn in our pre-clinical racism and bias curriculum, versus what we learn during hands-on clinical training.

As a fourth year student at Sinai, I was in one of the first classes of students to complete the pre-clinical racism and bias curriculum, which was developed with the help of students just a few years ahead of me. The curriculum, which takes place in a series of classes throughout the first two years, covers instances of historical racism like the Tuskegee experiments, unpacks the inherent racism in current clinical guidelines that categorize patients on the basis of race, and challenges students to confront their own implicit biases. This curriculum helped prepare me to be an effective and compassionate provider to medically underserved or marginalized patients, and has equipped me to make serious efforts to reduce the inequities present in today's healthcare landscape. Such curricula are hugely helpful in empowering the next generation of physicians to address social injustices in medicine, and should indeed be required at all New York State medical schools.

However, a pre-clinical implicit bias curriculum alone is not sufficient. Even if all medical students are trained to be aware of their implicit biases, little will change if these same students learn to practice medicine in institutions and systems that are not designed to treat patients equally. This is an issue faced by medical schools in New York City and across the United States.

What students learn from clinical training in a biased system is often referred to as the "hidden curriculum" of medical school. This curriculum teaches medical students that the lives of some patients are more valuable than others, and that those "others" -- typically people of color, patients that don't speak English, patients with undocumented immigration status, or other marginalized patients -- are to be valued primarily for training opportunities that they provide. One major driver of this hidden curriculum is the fact that in many healthcare settings patients are routinely separated on the basis of socioeconomic status.

For example, in New York State, and especially in New York City, many hospitals commonly separate patients insured with Medicaid from patients with private insurance or Medicare, a practice we refer to as "segregated care." This segregation can take a variety of forms -- patients can be seen in separate sites, in the same site at different times, and at the same time but by different providers. Most commonly, patients with Medicaid are seen by a rotating cast of residents in one clinic while privately insured patients are seen by dedicated attending physicians in another. Much of clinical training for medical students and residents occurs in the context of providing care to patients who are not privately insured.

This practice of separating patients based on insurance yields defacto racial segregation because in New York State, people of color are twice as likely to be insured by Medicaid compared to white patients. This separation within the health system is one of the key reasons that non-white patients have less access to care and continuity in their care compared to white patients. Rather than undoing or dismantling the socioeconomic factors that disadvantage the health of these patients, our hospital systems reiterate and reinforce them in the very structure by which we deliver care and in how we train the next generation of physicians. Unfortunately, there is very little anti-racism and bias training provided during the clinical phase of training to equip students to address these systemic inequities.

Despite this, students at Mount Sinai have advocated for changes to this system for the past several years. In 2018, we began surveying clinical-year students on how this segregated system impacts their education. The results from the fall of 2018 showed that 40 percent of respondents witnessed one or more incidents of segregated care within their first three months of clinical rotations *(response rate = 54%)*; a 2019 end-of-year survey of all students at the school showed that 58 percent of respondents believed segregated care negatively affected their education, and 80 percent of respondents believed these differences in care may lead to worse health outcomes *(response rate = 65%)*. These experiences ranged from seeing patients with private insurance admitted to more comfortable inpatient units, to a lack of adequate attending supervision when working with patients covered by Medicaid, to being allowed to participate only in births with women covered by Medicaid.

From our survey, we have compiled a few of the quotes that illustrate the pervasiveness of these differences in care and the damage they have on patients and trainees.

As one student wrote, *"It truly feels like every single aspect of patient care -- from the way physicians and ancillary staff speak about patients, speak to patients, formulate treatment plans for patients, teach medical students to treat patients and so on -- is different based on patient insurance status."*

Another student wrote: *"[This system is] perpetuating biases in our generation of doctors by training them in an environment that inherently prejudices you against poor people of color."*

A third student wrote: "*[I] repeatedly heard residents comment about how much more relaxed they felt treating poorer medicaid patients, how if mistakes happened it didn't matter as much."*

A fourth student: "*This system affects every aspect of patient care, so therefore also affects every aspect of learning . . . It was SO blatant, so ingrained into resident/attending culture, and so entrenched in language used on the wards, that no one even seemed to realize how messed up it was."*

A fifth student: *"Because we do so much observing and imitating third year; we have heightened ability to notice it but also to subconsciously internalize and mimic certain aspects of these behaviors"*

And a sixth student: *"[It] makes me feel sort of disappointed to be a doctor but also feel sort of powerless to do anything about it."*

Further student accounts can be found in our addendum.

Though these accounts were collected at Mount Sinai, our correspondences with students at other medical schools suggest that these comments reflect the experiences of students at medical schools across the city. They underscore that the way that students are educated in New York's medical schools and the way the patients are treated in New York's hospitals are inextricably linked. Training in a biased system will inevitably engender bias among trainees.

While implicit bias training across all stages of training and at all medical schools in New York State will equip medical students with tools to consider and address their own biases, such measures will not be as impactful if they are directly contradicted by what medical students are taught during their clinical education. We, as students, are in support of a mandate that all New York State medical students receive implicit bias training, but we implore our legislators to take further action to address the structural racism and bias inherent in how New York State delivers healthcare. While health care systems may ultimately determine clinic staffing and student rotations, city and state policies can play a significant role in determining what type of patients are seen where. For example, health care systems in New York State are often limited in providing care to publicly insured patients only in hospital spaces that qualify for maximum Medicaid reimbursement, thereby setting the conditions for patients to be seen in separate clinics solely based on their insurance status. By addressing these and other barriers, we can start to construct a healthcare system free of systemic racism and bias. Only in such a system can we train medical students to treat patients equitably and without prejudice.

Addendum

The comments below are responses of clinical-year medical students who were asked to anonymously report instances where they witnessed segregation of patients by insurance status or differential education based on insurance status, how they believe it affected their education, and how it affected them personally. The responses included below were selected for pertinence to Resolution 512 and are not a comprehensive sample of all responses; some comments are from the same respondent, but answer different questions. These reflect the views and experiences of individuals, and we unfortunately cannot in each instance point to exactly where or when these incidents occurred. These comments are not edited for grammar, but a small number of comments are edited for clarity, with edits appearing in [brackets], and for pertinence, with omissions marked by ellipses.

1. Repeatedly heard residents comment about how much more relaxed they felt treating poorer medicaid patients, how if mistakes happened it didn't matter as much, among other reasons.
2. The way it was presented though, made it seem like it was the norm in healthcare. To be honest didn't concern me to the degree it should have until third year when it became clearer the difference in treatment and attention--at the very least respect shown to patients both to their faces and behind doors--that existed between patients with private v. public medicaid.
3. I'm shocked how medical providers can be OK with this system. It is against the morals we are taught as medical students and inherently forces us to treat certain patients with substandard care. If I could [choose] all over again, I would much rather choose to train in a system that treats everyone, regardless of insurance status the same.
4. This system affects every aspect of patient care, so therefore also affects every aspect of learning . . . It was SO blatant, so ingrained into resident/attending culture, and so entrenched in language used on the wards, that no one even seemed to realize how messed up it was.
5. In the outpatient setting in particular, I feel as if Medicaid patients become our learning tools while the private patients just have us as observers in the corner. This is unfair to

patients who may not feel as if they can express a desire to have the medical student leave the room or just observe.

6. This is incredibly concerning to me because it shows how our institution, at the end of the day, chooses to prioritize profit over patient care. It also worries me to think about how it is perpetuating biases in our generation of doctors by training them in an environment that inherently prejudices you against poor people of color. It made me feel like the institution of medicine and the institution of Mount Sinai does not exist for people like me, and it made me feel incredibly disenfranchised.
7. This has been apparent even when I was visiting as a pre-med student shadowing and noting the Madison Ave and 5th Ave entrances. It's very concerning to me. I didn't realize the profound depth of racism and elitism still alive and well in many medical institutions until attending medical school here
8. I learned about the segregation of care just prior to matriculating at Mount Sinai. But knowing about it is different from actually experiencing it. It certainly has been concerning to me, as although the patients with medicare/medicaid may not always receive substandard care, they receive DIFFERENT care than the commercially insured patients. They see different providers (often younger, less experienced providers), it is harder for them to access certain medications and services (and accordingly, doctors have to spend more time on the phone approving those med/services for them), and often they have different socioeconomic circumstances that provide unique challenges to their care that their commercially insured counterparts don't have. As a student, I often felt that I was directed toward the medicare/medicaid patients, and discouraged from the privately insured patients, like I was less of a liability with certain patients or something. Overall, it was a disturbing experience to be a part of.
9. It is upsetting but i feel somewhat powerless
10. I can't believe how ignorant the residents and attendings were to these obvious differences in care provision, and that was the most startling and concerning to me. It was incredible (not in a good way) that I basically only participated in the deliveries of black and brown babies . . . Perhaps the residents are too busy to really question how biased their training is, but it definitely made me, as a student of color, feel very uncomfortable during the rotation.
11. It feels shitty, it makes you very cynical because of how intractable these things are
12. The way in which I was asked to interact with the patients was a large difference, and I was always told to sometimes avoid working with private insurance patients.
13. Less of one concrete example but more of an implicit understanding of the clinical team that patients at Elmhurst would not be explained a diagnosis and set of options but rather just assigned to surgery. Contrast at Sinai, where generally insured/upper SES [socioeconomic status] patients received longer visits, increased attentiveness, and markedly increased explanation + decision-making capacity
14. I think this ultimately detracted [from my education]. While it is true that I was able to do more in the resident clinic, I wasn't given as much supervision and instruction in proper technique etc. Also being educated in a system that is segregated in this way begins the process of implanting these biases and conditioning me to think that this is okay and how medicine should be practiced.

15. I just felt more cautious around the patients who were in the "nicer" wings of the hospital and noticed that my attendings/residents spoke to these patients in a "nicer" tone and were more accommodating and reassuring overall. They spent more time explaining their diagnoses, which they didn't do with patients without insurance
16. Because its so implicit + insidious, it is very easy to seep unconsciously into your behavioral patterns/set of assumptions especially as we are developing our clinical styles + behaviors on the wards.
17. It was a disturbing balance between enhancement (we did indeed get to "practice" things) and detraction (it was painful knowing we had exploited a population for our own education)
18. At FPA [faculty practice associates - private and Medicare practice] I was not allowed to enter the room until the physician had gone in to see the patient and specifically ask if they were open to having me see them. At IMA [internal medicine associates - Medicaid practice], I would enter the room with the physician and would be present when the physician asked if the patient was open to having me seen them.
19. At IMA [internal medicine associates - Medicaid practice] the patients were almost never warned that they would be seen by a medical student, while at FPA [faculty practice associates - private and Medicare practice] each patient was asked if they were ok with me even being present in the room. Also the care flow differs significantly between those two sites. At IMA the patient would be called for vitals, then sent to the waiting room, then called into an exam room and be seen by a provider, then sent back to the waiting room, then called for blood draw. At FPA each patient would simply be directed to an exam room, vitalized there, be seen by a provider there, and then a phlebotomist would come there to draw blood. The FPA process is a lot more efficient and pleasant for the patients.
20. Assumptions were made that patients really weren't smart enough to understand what was going on with them
21. Rich patients had a lot more patience from the team that would not otherwise be offered to [a] patient
22. A physician brought a group of students into the nursery to demonstrate the newborn physical exam. When asked which baby was available to examine, the nurse responded, 'You mean a 'division' baby, right?' Using the euphemism for publicly insured patients. Implying that only publicly insured babies should be examined by students
23. I felt that I was encouraged to do more procedures / get more involved in deliveries for patients that did not have private insurance.
24. I was encouraged to introduce myself to all 'service' patients, typically those with medicaid, to try to be part of their deliveries. However, I was often discouraged from talking to or taking part in the care of privately insured patients. There were, of course, exceptions to this but it was pretty striking.
25. Patients of low SES [socioeconomic status] spoken about in a more negative light, greater blame placed on patients
26. It changes how you view patients and how you are taught to analyze and assess patients. It also feels weird to be taught context dependent medicine.

27. My attending gave me a lecture about how important it is to show donors that they're 'worth it' by going the extra mile for them. I think we're pretty clearly being taught that some people are more worthy patients than others
28. It was also awkward and borderline unethical how the non-private patients were treated, based on how little autonomy they had
29. Because we do so much observing and imitating third year; we have heightened ability to notice it but also to subconsciously internalize and mimic certain aspects of these behaviors
30. Practicing in an environment where patients are separated on the basis of insurance status aka race teaches us that some patients are more or less deserving of care.
31. I felt that the risks of educating a medical student (learning procedures, etc) were disproportionately placed on patients who did not have private insurance, who anecdotally were more likely to be patients of color, non english speaking, or low income
32. Makes me less motivated to want to stay in this field.
33. Institutional racism makes me less passionate and contributes to burnout.
34. Sets segregated care as a norm of the profession.
35. Just made me feel shitty / jaded / disappointed
36. Made me sad and feel jaded about the healthcare system
37. Makes me feel sort of disappointed to be a doctor but also feel sort of powerless to do anything about it
38. It is disturbing to realize how explicitly the system values lives differently.
39. I felt that it was not fair for learning opportunities to be heavily sourced from patients with public insurance.
40. It makes me sad and feel like I'm a part of something bad
41. Changed my view of medicine. I don't always feel that people have the best intention when caring for patients. Makes me feel frustrated and burnt out by the system.
42. It's depressing particularly in the context of a newborn to think that in the first hours of life, some babies are thought of by the care team as different than others based only on their insurance status.

September 16, 2019

Thank you for taking the time to read this letter, and for your commitment to promoting health equity. I write to you as the daughter of a Haitian-American man, though by training, I am a physician and a researcher.

About 10 years ago, my then 70-year-old father developed painless hematuria (blood in his urine). As a physician and researcher, I immediately knew the diagnosis. As a daughter, I was terrified. My father did not like going to the doctor because he feared hearing bad news.

I found it ironic my father's fear of hearing bad news turned out to be real when he was diagnosed with prostate cancer. But this only reinforces the importance of regular doctor visits.

As a physician, I knew I needed to find a doctor who would offer my dad the latest clinical therapies, and one who would also be able to put him at ease while communicating with him. We were fortunate to find someone whose bedside manner immediately put my dad at ease because he understood my father's fears.

I was blessed that we found a physician who was interested in the fact that he was Haitian, one who knew that he lived in Brooklyn, who spoke to him about the construction of the Brooklyn Bridge because he knew that my father was an engineer and math teacher.

I was glad to have found a physician who knew that my father enjoyed walking across the Brooklyn Bridge but now was limited because of his severe osteoarthritis. I was grateful for the physician who recognized my father's tremendous anxiety and would utter a few words in Creole just to bring a little levity to an often-heavy discussion. **Of note, this physician was not Haitian**.

While my dad's experience was positive; sadly, it is not the same for everyone. I can recall the story of a health advocate who went to get a mammogram and was told "You people (people in a wheel chair) can't be treated here." I also recall a family friend who said he went to the doctor and was referred to as "you people". These types of responses make it all the more difficult for people to WANT to see doctors. There is so much more work to be done.

Several medical schools have integrated elements in their curriculum that introduce students to health disparities, health inequities, social determinants, cultural competency, and unconscious bias. As our population becomes increasingly diverse, there is an even greater need for integrating these dimensions of professionalism into the medical school curriculum.

Future physicians must be able to understand how to effectively communicate with patients in a way that reaffirms their values, physicians must be able to recognize and respond to their own unconscious biases, and future physicians must appreciate how culture influences healthcare and outcomes. There is a need to move beyond 'safe' discussions about cultural competence and disparities and create safe spaces where students openly discuss racism, bias, and discrimination, and more importantly, how these concerns affect the inadequate quality of healthcare that is often associated with traditionally underserved communities.

I am hopeful that these discussions will move academic health centers, community organizations, and city council leaders to work collaboratively toward developing a more diverse and culturally-competent workforce.

Thank you,

Carla Boutin-Foster, MD
Francois Boutin's Daughter

Community
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New York

FOR THE RECORD

September 18, 2019

Testimony by Juan Pinzon, Director of Health Services at the Community Service Society of New York

Hearing on Oversight - Cultural Competence in the Delivery of Health Care Services: before the New York City Council RE: Res 512 - Calling on New York State to require medical schools to train all students about "implicit bias".

For 175 years, CSS has been an unwavering voice for low- and moderate-income New Yorkers. Our health programs help New Yorkers enroll into health insurance coverage, find health care if they are ineligible or cannot afford coverage, and help them use their coverage or otherwise access the health care system. We do this through a live answer helpline and through our partnerships with over 50 community-based organizations throughout New York State. Annually, CSS and its partners serve over 100,000 New Yorkers—many of whom are New Yorkers of color.

Thank you for the opportunity to comment on Resolution 512, which asks New York State to require training on implicit bias during medical school. Disparities in health outcomes kill New Yorkers every year and make life harder, and more painful for others. These disparities are so serious that life expectancy is lower for Black New Yorkers in many parts of the state than for White New Yorkers. In Manhattan, Black New Yorkers have a life expectancy that is ten years lowers than White New Yorkers (76.8 years compared to 86.9).[1] Disparities start before birth: 12 percent of Black infants born in New York State have a low-birth weight compared to only 7 percent of White infants, setting the stage for life-long complications.[2] Black infants born in Manhattan die before turning 1 over three times as often as White infants.[3] Child mortality rates (death between the ages of 1 and 18) are also twice as high or higher for Black children as for White children in many parts of New York. Many of these statistics are even worse outside of New York City – racial disparities in infant and child mortality are especially severe in Upstate counties like Albany, Erie, Monroe, and Niagara.[4]

New York State has made progress on some of the causes of these disparities. For example, New York's enthusiastic implementation of the Affordable Care Act and subsequent reductions in the number of people without insurance has proven to reduce health disparities between different racial and ethnic groups.[5] Education, income, and insurance coverage are

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[1] County Health Rankings, "Life Expectancy 2015-2017," available at https://www.countyhealthrankings.org/app/new-york/2019/measure/outcomes/147/data

[2] County Health Rankings, "Difference in Health Outcomes within States by Place and Racial/Ethnic Groups: 2019 New York Report," https://www.countyhealthrankings.org/reports/state-reports/2019-new-york-report.

[3] https://www.countyhealthrankings.org/app/new-york/2019/measure/outcomes/129/data?sort=sc-0

[4] https://www.countyhealthrankings.org/app/new-york/2019/measure/outcomes/128/data?sort=sc-0

[5] Laurie McGinley, "ACA linked to reduced racial disparities, earlier diagnosis and treatment in cancer care," The Washington Post, June 2, 2019, https://www.washingtonpost.com/health/2019/06/02/aca-linked-reduced-racial-disparities-earlier-diagnosis-treatment-cancer-care/.

almost always associated with better health outcomes. However, racial and ethnic disparities in health outcomes persist even when comparing people of similar incomes, insurance coverage, and education levels.[6]

There is no question that bias, explicit and implicit, is one cause of those disparities.[7] Healthcare providers are not less likely than the wider population to exhibit bias. The most pernicious aspect of implicit bias is that it changes the behavior of people who do not believe consciously in racist ideas but who have been affected in ways they may not understand by the racism endemic in American culture. The same holds true for bias against people based on gender, sexuality, socio-economic status, mental illness, weight, disability, and other characteristics.

Bias can cause healthcare providers to spend less time with patients, listen less carefully to patients, and miss important information leading to incorrect treatment. A recent literature review examining the care decisions made by healthcare providers who demonstrated high levels of implicit bias in tests found differences in diagnoses, treatment recommendations, the number of questions the provider asked the patient, and the number of tests ordered.[8] In patient stories about bias, a common complaint is that their most obvious characteristics narrow their providers ability to see or understand their symptoms clearly. For example, patients may complain of going to their medical provider for straightforward health problems – for example, flu symptoms or food poisoning - but being unable to get their provider to focus on anything besides their weight, a previously diagnosed mental illness, their physical disability, or their gender transition. Patients perceive providers' implicit biases even when the provider does not, and the more experiences patients have of biased providers the more likely they are to distrust medical professionals throughout their lives.[9]

Overt training in the existence of racial health disparities and the role that implicit bias plays in producing those outcomes is a way to address the problem. In a study published in the Journal of General Internal Medicine, researchers found that discussing implicit bias in formal curricula was associated with a significant decrease in implicit bias at the end of medical school. [10] Activities with the biggest impacts included taking a seminar or workshop on minority health, a seminar or workshop on cultural competency in healthcare, and taking a test of their own implicit bias as part of their coursework. When made aware of the vast differences in health

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[6] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. "Communities in Action: Pathways to Health Equity." Washington (DC): National Academies Press (US); 2017 Jan 11. 2, The State of Health Disparities in the United States. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425844/

[7] Chloe Fitzgerald and Samia Hurst, "Implicit bias in healthcare professionals: a systematic review," BMC Medical Ethics, 18, Vol. 18:19 (2017), https://bmcmedethics.biomedcentral.com/articles/10.1186/s12910-017-0179-8.

[8] Ibid.

[9] Tori DeAngelis, "How does implicit bias by physicians affect patients' health care," American Psychological Association, March 2019, https://www.apa.org/monitor/2019/03/ce-corner.

[10] Michelle van Ryn et al., "Medical School Experiences Associated with Change in Implicit Racial Bias Among 3,547 Students: A Medical Student CHANGES Study Report," Journal of General Internal Medicine, Vol. 30 (12): 1748-1756, December 2015, https://link.springer.com/article/10.1007/s11606-015-3447-7.

outcomes between different groups and of the differences in healthcare provided, students were able to overcome those biases and treat patients more equally.

CSS therefore supports Resolution 512. Requiring such training in all of New York's medical schools could have a meaningful impact on the lives of New Yorkers and is worth the investment it will take to achieve.

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Committee on Hospitals
Carlina Rivera, Chair

Oversight – The Delivery of Culturally Competent & Equitable Health Care Services in New York City Hospitals
And Res. No. 512
Testimony of Andrea Bowen
Principal, Bowen Public Affairs Consulting

September 18, 2019

Thank you, Chair Rivera, for the opportunity to provide testimony today, and thank you, Council Member Rosenthal, for your Res. No. 512. My name is Andrea Bowen, and I'm the principal of Bowen Public Affairs Consulting. I work with several organizations that work with and are led by transgender, gender non-conforming, and non-binary (TGNCNB) people, and I am a transgender woman myself. Today, I am writing today on behalf of my own firm, Bowen Public Affairs Consulting, based on my own experience and outreach to experts in the field.

I want to start by thanking you, Chair Rivera, and—extending into the Committee on Hospitals, and sponsors of Res. No. 512—Council Members Ayala, Dromm, Levine, Moya, Reynoso, and Rosenthal for your outstanding advocacy for the baselined funding of what are officially known as LGBTQ Community Outreach Workers, the Health and Hospitals employees who have specific knowledge on TGNCNB issues, have been doing outreach to the community, and are acting as point people around trainings and advocacy. These workers are a great addition to ensuring that NYC's public hospitals are affirming of TGNCNB people, and my main asks are:

- that there be as much advertising as possible that these LGBTQ Outreach Workers exist and are here to ensure the TGNCNB community can get quality care in the H+H system,

- and as word spreads about them, that their numbers can expand commensurate with need.

  The baselined funding you fought for should ideally make that more possible.

I ask that testimonies from TGNCNB community members who spoke at previous hearings be reviewed by committee staff and added to the record of this hearing to inform future actions to improve services for the TGNCNB community, and that includes:

- the November 26, 2018 hearing on "Access to Transgender and Gender Nonconforming-friendly Health Services," held by the Committees on Hospitals and Health;
- the budget testimonies held on March 18, 2019 (for the Committee on Health) and March 25, 2019 (for the Committee on Hospitals).

As regards promotion of implicit bias training, I recommend that the resolution and any further action the Council takes toward reducing implicit bias using training modalities assures that the training provided is of high quality and is effective. If trainings are created by a government agency or agencies, they should involve a community input process and use an experienced curriculum developer and trainer, include a pilot study, and a series of refinements to assure it is effective in changing the attitudes and behavior of the target audience. Any training should also be of sufficient length and seriousness to effect change.

If the trainings are selected from existing curricula or by hiring an external trainer, government agencies implementing the training should assure that the training has:

- a theory of change that illustrates how the actions taken by the trainer affect the attitudes and behavior of the trainees towards marginalized patients and clients,

- evidence that the training is effective in improving attitudes and behavior towards marginalized people;
- And a plan to adapt the training to the specific audiences in the hospitals in which it is implemented.

The trainings, regardless of whether they are designed or contracted, should be delivered by a figure considered by the audience of the training to be a trustworthy authority in the field of clinical practice as well as in the field of competencies pertinent to the marginalized communities that the trainings focus on.

An example of the first process, in which a department created its own training using experienced curriculum developers, trainers, and piloting can be found in the TGNCNB training for the DOHMH's sexual health clinics. This training used adult learning theory and allowed clinicians to practice the anti-bias techniques they learned by working with paid practice patients from the TGNCNB community. The practice patients were available to make sure the clinicians' skills were commensurate with affirming practices. This is a model that should be incorporated more widely, and mentioned in the resolution. Implicit bias is important to root out, but it is also vital and inherently practical to ensure that the literal actions of clinicians are in line with affirming practices.

In other words, Council should support use of a training that is effective at reducing bias and improving clinical practice and is proven to do so.

I have included a redlined version of Res. No. 512, attached to this testimony, that incorporates these suggestions.

Thank you for your time and consideration, and I look forward to talking with you further about this important work. You can contact me at andy@bowenpublicaffairs.com, or (917) 765-3014.

Res. No. 512

Resolution calling on New York State to require medical schools to train all students about "implicit bias".

By Council Members Rosenthal, Rivera, Ayala, Reynoso, Lander, Cornegy and Dromm

Whereas, In recent years, the health care community has shifted its focus to further address health inequity and its impact on individuals from traditionally marginalized communities, including people of color, people who are lesbian, gay, bisexual, transgender, queer/questioning, and/or gender non-conforming (LGBTQ/TGNC), and those who are female; and

Whereas, According to Cornell University, implicit bias is defined as an unconscious, unintentional bias that, unlike explicit bias, exists when an individual does not have direct control or understanding of their perceptions and motivations; and

Whereas, Research has shown that people have implicit attitudes towards many different topics, such as race, gender, age, disability, and sexual orientation, and several general patterns of bias have repeatedly been shown in the research, such as socially-dominant groups often having implicit bias against subordinate groups; and

Whereas, Research shows that racial disparities can have an impact on a person's health outcomes and care in New York City, which is illustrated by the City's maternal mortality and morbidity rates; and

Whereas, Statistics show that about 30 women in the City die each year of a pregnancy-related cause and approximately 3,000 women “almost die” or experience morbidity during childbirth; and

Whereas, Black, non-Latina women are the most likely to experience maternal mortality or maternal morbidity; and

Whereas, According to the Brookings Institution, childbirth-related deaths disproportionately affect Black women, regardless of their income or education; and

Whereas, There are many other examples of health inequities potentially resulting from implicit bias; and

Whereas, National surveys of individuals who are transgender reveal that one-third of those who saw a health care provider had at least one negative experience related to being transgender, and nearly one-quarter reported that they did not seek the health care they needed due to fear of being mistreated as a transgender person; and

Whereas, According to the Gay Men’s Health Crisis, despite the declining rate of new infections per year, New York leads the nation in the number of new HIV cases, and 20% of people do not know they are infected; and

Whereas, In 2016, 77 percent of new HIV diagnoses and AIDS-related deaths in NYC were among African Americans and Hispanics; and

Whereas, As of now, not all medical students in the state of New York receive implicit bias training, which could hamper the goal of health equity for all; and

Whereas, All implicit bias trainings must include an explicit bias component, because medical professionals may also possess explicit biases which can result in the harm of a patient; and

Whereas, all implicit bias trainings should be effective and of high quality; and

Whereas if trainings are created by a government agency or agencies, they should involve a community input process and use an experienced curriculum developer and trainer, include a pilot study, and a series of refinements to assure it is effective in changing the attitudes and behavior of the target audience; and

Whereas any training should also be of sufficient length and seriousness to effect change; and

Whereas if the trainings are selected from existing curricula or by hiring an external trainer, government agencies implementing the training should assure that the training has:

- a theory of change that illustrates how the actions taken by the trainer affect the attitudes and behavior of the trainees towards marginalized patients and clients,
- evidence that the training is effective in improving attitudes and behavior towards marginalized people;
- And a plan to adapt the training to the specific audiences in the hospitals in which it is implemented.

Whereas the trainings, regardless of whether they are designed or contracted, should be delivered by a figure considered by the audience of the training to be a trustworthy authority in the field of clinical practice as well as in the field of competencies pertinent to the marginalized communities that the trainings focus on;

Whereas an example of the first process, in which a department created its own training using experienced curriculum developers, trainers, and piloting can be found in the TGNCNB training for the DOHMH's sexual health clinics. This training used adult learning theory and allowed clinicians to practice the anti-bias techniques they learned by working with paid practice patients from the TGNCNB community. The practice patients were available to make sure the clinicians' skills were commensurate with affirming practices. This is a model that should be incorporated more widely, and mentioned in the resolution. Implicit bias is important to root out, but it is also vital and inherently practical to ensure that the literal actions of clinicians are in line with affirming practices.

Whereas, It is critical to have well-trained and culturally competent providers who are educated about implicit bias to ensure the fairer treatment of all individuals, and to ensure medical outcomes are not skewed because of bias, whether implicit or explicit; now, therefore, be it

Resolved, The Council of the City of New York calls on New York State to require medical schools to train all students about "implicit bias"

GREATER NEW YORK HOSPITAL ASSOCIATION
555 WEST 57TH STREET, NEW YORK, NY 10019 • T (212) 246-7100 • F (212) 262-6350 • WWW.GNYHA.ORG • PRESIDENT, KENNETH E. RASKE

September
Eighteen
2019

Council Member Carlina Rivera
Chair, Committee on Hospitals
New York City Council
250 Broadway, Suite 1808
New York, NY 10007

RE: Statement for Hearing: "The Delivery of Culturally Competent & Equitable Health Care Services in New York City Hospitals."

Dear Council Member Rivera:

Thank you for the opportunity to submit a statement on behalf of the Greater New York Hospital Association (GNYHA), which represents more than 140 public and not-for-profit hospitals and health systems in New York State—the majority in New York City. GNYHA is proud to serve New York City's hospitals and health systems, which take their responsibility to provide respectful, high-quality care to everyone who walks through their doors very seriously.

My statement covers GNYHA's and our members' work on culturally competent care, including maternal and child health, language access, and Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) services.

Cultural Competency
Hospitals include cultural competency training as part of new staff orientation and build it into ongoing training requirements. Hospitals are also increasingly finding innovative ways to help their staff understand each institution's culture and expectations of respect for every patient. These include special programs that celebrate different cultures, programs that share and celebrate hospitals' LGBTQ+ policies, the establishment of diversity councils and employee resource groups, and special programs that provide an opportunity to discuss racism and implicit bias.

GNYHA supports these initiatives by convening members to discuss and share best practices in cultural diversity. Most recently, GNYHA—under a grant from the New York State Department of Health (DOH) and with supplemental GNYHA funding—provided cultural competence training to almost 2,000 frontline staff and managers, mostly from New York City hospitals. In addition to basic cultural competence, the training covered implicit bias and respect for LGBTQ+ and disabled patients. We are now working to convert this training into a “train the trainer” model that can be shared with the membership.

GNYHA also took the lead in drafting several recommendations to DOH on how to reduce maternal mortality, including a recommendation to design and implement—with State funding—implicit bias training for maternal health care providers. The State is now working on implementing this training on a pilot basis. We will continue to work with the State on this issue as the pilot is rolled out.

Hospital Language Access

All hospitals in New York State are required to have language access programs that address the language needs of patients who present to the hospital. Hospitals have policies and protocols in place, and designated staff to coordinate hospital activities, including process improvement to address any issues that may arise. GNYHA supports these activities by convening hospital coordinators to share best practices and challenges, and to collaborate with State and national experts in the field. Language access is a continuing priority for GNYHA members, and we will continue to offer them a forum to discuss these issues and share best practices.

LGBTQ+-Friendly Care

Many New York City hospitals and health systems are national leaders in LGBTQ+ care, and many have LGBTQ+ centers whose mission is to ensure that policies and practice are in place to provide quality care to LGBTQ+ patients. The Human Rights Campaign (HRC) has recognized many hospitals and health systems across New York City as leaders in LGBTQ+ care as part of HRC’s Health Equity Index. The index reviews hospital policies and practices across many domains, including non-discrimination and staff training, patient benefits and support, employee benefits and policies, and transgender care.

Just as we do with language access, GNYHA has long worked with our member hospitals to identify and share best practices in LGBTQ+ care. Today, the very day of this hearing, GNYHA convened members to discuss best practices on the collection and use of sexual orientation and gender identity patient data. Many of our members are quite advanced in working on these issues and serve as faculty for the programs that GNYHA convenes. GNYHA and its members are committed to continuously improving LGBTQ+ care.

Conclusion

GNYHA and its entire membership are strongly committed to ensuring that hospitals provide culturally competent care. We appreciate the City Council’s interest in this issue and look forward to working together to serve New York City’ diverse population.

If you have any questions, please contact Andrew Title (atitle@gnyha.org) or David Labdon (dlabdon@gnyha.org).

Sincerely,

Lloyd C. Bishop

Lloyd C. Bishop
Senior Vice President
Community Health, Diversity, and Health Equity

September 16, 2019

Thank you for taking the time to read this letter, and for your commitment to promoting health equity. I write to you as the daughter of a Haitian-American man, though by training, I am a physician and a researcher.

About 10 years ago, my then 70-year-old father developed painless hematuria (blood in his urine). As a physician and researcher, I immediately knew the diagnosis. As a daughter, I was terrified. My father did not like going to the doctor because he feared hearing bad news.

I found it ironic my father's fear of hearing bad news turned out to be real when he was diagnosed with prostate cancer. But this only reinforces the importance of regular doctor visits.

As a physician, I knew I needed to find a doctor who would offer my dad the latest clinical therapies, and one who would also be able to put him at ease while communicating with him. We were fortunate to find someone whose bedside manner immediately put my dad at ease because he understood my father's fears.

I was blessed that we found a physician who was interested in the fact that he was Haitian, one who knew that he lived in Brooklyn, who spoke to him about the construction of the Brooklyn Bridge because he knew that my father was an engineer and math teacher.

I was glad to have found a physician who knew that my father enjoyed walking across the Brooklyn Bridge but now was limited because of his severe osteoarthritis. I was grateful for the physician who recognized my father's tremendous anxiety and would utter a few words in Creole just to bring a little levity to an often-heavy discussion. **<u>Of note, this physician was not Haitian</u>**.

While my dad's experience was positive; sadly, it is not the same for everyone. I can recall the story of a health advocate who went to get a mammogram and was told "You people (people in a wheel chair) can't be treated here." I also recall a family friend who said he went to the doctor and was referred to as "you people". These types of responses make it all the more difficult for people to WANT to see doctors. There is so much more work to be done.

Several medical schools have integrated elements in their curriculum that introduce students to health disparities, health inequities, social determinants, cultural competency, and unconscious bias. As our population becomes increasingly diverse, there is an even greater need for integrating these dimensions of professionalism into the medical school curriculum.

Future physicians must be able to understand how to effectively communicate with patients in a way that reaffirms their values, physicians must be able to recognize and respond to their own unconscious biases, and future physicians must appreciate how culture influences healthcare and outcomes. There is a need to move beyond ‘safe’ discussions about cultural competence and disparities and create safe spaces where students openly discuss racism, bias, and discrimination, and more importantly, how these concerns affect the inadequate quality of healthcare that is often associated with traditionally underserved communities.

I am hopeful that these discussions will move academic health centers, community organizations, and city council leaders to work collaboratively toward developing a more diverse and culturally-competent workforce.

Thank you,

Carla Boutin-Foster, MD
Francois Boutin’s Daughter

Community
Healthcare Network

Oversight – Cultural Competence in the Delivery of Healthcare Services
Res512 – Calling on NYS to require medical schools to train all students about “implicit bias”

Hearing before the New York City Council Committee on Hospitals
Testimony of Dorothy Farley, VP of Behavioral Health, Social Services, & Care Coordination
Wednesday, September 18, 2019

Thank you Chairwoman Rivera and members of the Committee on Hospitals for the opportunity to speak this afternoon. My name is Dorothy Farley and I am the Vice President of Behavioral Health, Social Services, and Care Coordination at Community Healthcare Network (CHN). CHN is a non-profit network of 14 Federally Qualified Health Centers (FQHCs), including two school-based health centers and a fleet of medical mobile vans. We provide high-quality primary care, dental, behavioral health, and social services to over 85,000 New Yorkers annually throughout Manhattan, Queens, Brooklyn, and the Bronx. We turn no one away.

CHN's mission is grounded in the belief that all individuals have the right to comprehensive and culturally-responsive care. As part of this mission, we have taken considerable lengths to ensure that patients receive healthcare services in an environment that is inclusive and accepting of all identities.

In 2017, CHN implemented a Diversity & Inclusion Taskforce, with the goal of creating an organizational culture that values diversity, enables individuals to work to their full potential in a safe and respectful environment, and embraces future demographic changes reflected among CHN's patients and staff. As part of this effort, CHN has committed to continuously improving its organizational composition, human resource strategies, and marketing and communication efforts to reflect and underscore the value of diversity in the delivery of healthcare.

These policies are woven into CHN's ongoing training and education initiatives, including new employee education, de-escalation training, and management/hiring training, as well as discussions around trauma-informed care and social determinants of health. These trainings are not just offered to patient-facing staff, but all CHN personnel, including board members and executive management. Our efforts also include a deliberate approach to interdisciplinary, team-based care – including patients as active participants – and a hard look at CHN's electronic health record system to ensure that patient identities are accurately reflected – and validated – in both documentation and practice.

These initiatives are not without justification. In 2017, researchers found that less than half of medical students felt adequately prepared to practice by their fourth year of medical school – particularly among diverse populations. Failure to address these challenges at the outset of clinical education may have deleterious effects upon delivery of care – especially as medical schools instruct students to expedite care by making at-a-glance diagnoses. This is further exacerbated among providers whose clinical environments perpetuate biased decision-making.

There is a wealth of research showing that implicit bias in medicine may lead to worse outcomes among marginalized communities, including communities of color, LGBTQ+ populations, and individuals with disabilities. These populations are particularly vulnerable to snap judgements that may lead to worse treatment for chronic pain, maternal health, and/or mental illness – among other issues. While research linking cultural competence training to better health outcomes is limited, anecdotal evidence suggests that incorporating cultural competency and implicit bias training into medical curricula and employee education may yield better patient-provider relationships, greater engagement in care, and improved health among underserved communities.

While CHN maintains room for improvement, our deliberate approach to diversity and inclusion has helped create an organizational culture in which staff are increasingly cognizant of the risks of implicit bias and are constantly taking steps to create a more inclusive and validating environment of care for individuals of all backgrounds and experiences.

We firmly support the City’s efforts to address systemic bias in medicine, and are committed to working with the Council and Administration to improve delivery of healthcare for all New Yorkers. Thank you for the opportunity to speak today.

NYLPI
JUSTICE THROUGH
COMMUNITY POWER

Testimony of Christopher Schuyler, Senior Staff Attorney
New York Lawyers for the Public Interest, Disability Justice Program
To the New York City Council, Hospitals Committee
Regarding Resolution 512 Calling on New York State to Require Medical Schools to Train All Students about "Implicit Bias" (September 18, 2019)

Patients with disabilities experience greater barriers to health care than patients without disabilities. Among the reasons for this disparity are the implicit biases held by medical providers. Training medical students in identifying implicit bias, as called for in Resolution 512, is a critical step to elevate the quality of medical care available for patients with disabilities.

Good afternoon. My name is Christopher Schuyler and I am a Senior Staff Attorney with the Disability Justice Program of New York Lawyers for the Public Interest (NYLPI).

I. Patients with disabilities face myriad barriers to medical care

People with disabilities experience greater barriers to health care than people without disabilities.[1] Generally speaking, "people with disabilities are 2.5 times more likely to have unmet health care needs than their non-disabled peers and are more likely to suffer from a terminal condition that may have been detected earlier through disease prevention screening."[2] Particularly affected, however, by the disparity in access are women with disabilities, especially in the area of cancer screening.[3] To give a sense of numbers, 61.4% of women with disabilities reported having mammograms while 74.4% of women without disabilities received this test.[4] For pap tests, 64.6% of women with disabilities received pap tests compared to 82.5% of women without disabilities.[5] Such significant lack of access to critical services leads to poorer health outcomes for women with disabilities, including higher mortality rates.[6]

It is also suggested that racial minorities with disabilities experience disproportionate barriers to health care. While "relatively little is known about the health status of individuals with disabilities who are also members of racial or ethnic minorities [], reports from the CDC on the health status of people living with disabilities along racial lines show that people of color present with poorer health at a higher frequency than Caucasians, and racial and ethnic minorities have historically been and continue to be disproportionately impacted by health disparities.[7] Inaccessibility to health care affects people with disabilities on every level of their lives: socially, psychologically, physically, and economically.[8]

II. Negative impact of structural-environmental barriers to medical care for patients with disabilities

There are two primary causes for the disparity in health care faced by persons with disabilities: structural-environmental barriers and process barriers.[9] Structural-environmental barriers include types of services offered, accessibility of provider offices and diagnostic equipment, and insurance coverage.[10] Process barriers include medical provider implicit bias and their lack of knowledge in treating minority patients.[11] We strongly support the fact that Resolution 512 addresses process barriers, as "[c]onscious and unconscious biases held by health care providers are another underlying aspect of identified barriers to health care access for people with disabilities as well as other marginalized groups, such as racial and ethnic minorities. Negative stereotypes held by health care providers translate into lower quality and fewer services provided as well as contributing to poorer health outcomes for these groups of people."[12] However, Resolution 512 makes no mention of the equally critical structural-environmental barriers, notwithstanding the fact that such barriers present significant and continuing impediments to receiving appropriate health care.[13] We urge the immediate addition of language acknowledging and condemning such structural-environmental barriers.

III. Training medical students to recognize bias will improve medical access for people with disabilities

Adding implicit bias trainings to medical school curriculums will, first and foremost, start a valuable discussion about treating patients with disabilities. Simply bringing awareness to medical providers about the challenges people with disabilities face in accessing health care is significant, as:

> physicians have not received training on the fundamental aspects of working with people with disabilities. In a 2007 survey of primary care physicians, 91% of them revealed that they had never received training on how to serve people with intellectual or developmental disabilities. According to a national study of physicians, only 2.6% of respondents demonstrated specific awareness of the ADA [(Americans with Disabilities Act)]. Another survey of more than 500 physicians revealed that nearly 20% of respondents were unaware of the ADA and more than 45% did not know about its architectural requirements. Moreover, less than a quarter of the respondents had received any training on

> physical disability issues in medical school, and only slightly more than a third had received any kind of training on disability during their residency. However, nearly three quarters of the physicians surveyed acknowledged a need for training on these issues.[14]

Such trainings will also lead to increased awareness of medical equipment and procedures for people with disabilities. There is a significant correlation between knowledge about accessibility and the provision of accessible equipment in health care clinics. Yet, in one study only 46% of health care administrators in clinical practices knew that accessible equipment existed, and only 25.4% were able to describe accessible equipment. While 44% of administrators had considered purchasing accessible equipment at some point, only 22% knew of the federal tax credit program that assists businesses in complying with the legal mandates to do so.[15]

Moreover, open discussion of implicit bias at medical schools will encourage future medical providers to publicly identify as people with disabilities. Medical professionals are hesitant to identify as people with disabilities for fear of stigma and damaging their career prospects.[16] Having bias training in the curriculum will set the stage for medical professionals to identify as people with disabilities, and in turn, take a larger role in advocating for medical access issues concerning disability.

Trainings on implicit bias will also increase "disability literacy," or making one's language, knowledge, and interactions reflective of understanding disability experiences and disability etiquette.[17] Increasing the level of disability literacy among medical providers in turn will lessen the barriers to medical access for people with disabilities.

IV. Recommendations

NYLPI respectfully requests that the NYCC Hospitals Committee modify Resolution 512 as follows:

- Add people with disabilities to the list of "traditionally marginalized communities" in the first paragraph.
- Add a paragraph summarizing the statistical disparities faced by people with disabilities, with an emphasis on structural environmental barriers, as set forth above.
- Mandate training regarding removal of structural-environmental barriers.

V. Conclusion

Thank you for the opportunity to testify about these key issues affecting appropriate medical care to patients with disabilities. Please feel free to contact me to discuss further.

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About New York Lawyers for the Public Interest
For over 40 years, NYLPI has been a leading civil rights and legal services advocate for New Yorkers marginalized by race, poverty, disability, and immigration status. Through our community lawyering model, we bridge the gap between traditional civil legal services and civil rights, building strength and capacity for both individual solutions and long-term impact. Our work integrates the power of individual representation, impact litigation, organizing, and policy campaigns. Guided by the priorities of our communities, we strive to achieve equality of opportunity and self-determination for people with disabilities, create equal access to health care, ensure immigrant opportunity, secure environmental justice for low-income communities of color, and strengthen local nonprofits.

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[1] Independence Care System & New York Lawyers for the Public Interest ("ICS & NYLPI"),
Breaking down barriers, breaking the silence: Making health care accessible for women with disabilities (2012), p. 1. Available at: https://www.nylpi.org/images/FE/chain234siteType8/site203/client/breakingbarriers.pdf. *See also*, ICS & NYLPI, at 1.

[2] Onyeabor, Sunny. (2015). Addressing Health Disparities at the Intersection of Disability, Race, and Ethnicity: the Need for Culturally and Linguistically Appropriate Training for Healthcare Professionals. Journal for Racial and Ethnic Health Disparities. 3. 10.1007/s40615-015-0140-9.

[3] Yee, S., et al., Compounded disparities: Health equity at the intersection of disability, race, and ethnicity, The National Academies of Sciences, Engineering, and Medicine (2016). *See also*, ICS & NYLPI, *supra* at 1.

[4] Altman, B. M., & Bernstein, A., Disability and health in the United States (2008), 2001-2005.

[5] Mudrick, N. R., & Schwartz, M. A., Health care under the ADA: A vision or a mirage? Disability and Health Journal, 3(4) (2010), 233-239. Available at: doi:https://doi.org/10.1016/j.dhjo.2010.07.002.

[6] ICS & NYLPI, at 1.

[7] Onyeabor.

[8] ICS & NYLPI, at 5. *See also*, Neri, M. T., & Kroll, T., Understanding the consequences of access barriers to health care: experiences of adults with disabilities. Disability and Rehabilitation, 25(2) (2003), 85-96. Available at doi:10.1080/0963828021000007941, "Social consequences have to do with one's relationships, social role, and social participation. Psychological consequences often involve depression, frustration, and stress along with experiences of stigma. Physical consequences may lead to a deterioration in one's health due to limited or skipped diagnostic and health screening procedures and related limitations in activities of daily living. Economic consequences involve potential lost wages, financial strain, and additional health service expenditures one has to undertake. With regards to independence, barriers to health care access can lead to a greater dependency on others than individuals would require otherwise."

[9] Kroll, T., Jones, G. C., Kehn, M., & Neri, M. T., (Barriers and strategies affecting the utilisation of primary preventive services for people with physical disabilities: a qualitative inquiry, Health & Social Care in the Community, 14(4) 2006), 284-293. Available at: doi:doi:10.1111/j.1365-2524.2006.00613.x. *See also*, ADA National Network, Health Care Access and the ADA: An ADA Knowledge Translation Center Research Brief (2019). Available at: https://adata.org/publication/health-care-access-and-ada. This report finds that the challenges faced by people with disabilities can be categorized as [margins] environmental, attitudinal, and policy barriers.

[10] *Id.*

[11] Kroll, *et al.*

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[12] ADA National Network, *supra* note 8. *See also*, Yee, et al and ICS & NYLPI at 7, 15. Research shows that bias and misinformation, including stereotypes, negatively affect the quality of care patients with disabilities receive.

[13] ICS & NYLPI at 5.

[14] ICS & NYLPI, at 7 (internal citations omitted).

[15] Pharr, J., Accessible medical equipment for patients with disabilities in primary care clinics: Why is it lacking? Disability and Health Journal, 6(2) (2013), 124-132. Available at: doi:https://doi.org/10.1016/j.dhjo.2012.11.002.

[16] Steinberg, A. G., Iezzoni, L. I., Conill, A., & Stineman, M., (Reasonable accommodations for medical faculty with disabilities. JAMA, 288(24) 2002), 3147-3154. Available at: doi:10.1001/jama.288.24.3147. *See also*, Matt, S. B., Nurses with Disabilities: Self-Reported Experiences as Hospital Employees, Qualitative Health Research, 18(11) (2008), 1524-1535. Available at: doi:10.1177/1049732308325295.

[17] Yee. *et al.* (2016).

amsny
The Voice of Medical Education

Testimony of:

Jo Wiederhorn, President & CEO
Associated Medical Schools of New York
(AMSNY)

Resolution 0512-2018:

Training Medical School Students on “Implicit Bias”
A Hearing of
the Committee on Hospitals
New York City Council

September 18, 2019 1:00 pm

250 Broadway, 14th Floor Committee Room, New York

Good afternoon, Chairwoman Rivera and other distinguished members of the committee. Thank you for this opportunity to testify on Resolution 0512-2018: *Resolution calling on New York State to require medical schools to train all students about "implicit bias."*

My name is Jo Wiederhorn, President & CEO of the Associated Medical Schools of New York (AMSNY), the consortium of the 17 public and private medical schools in New York State, eight of which are located within New York City's five boroughs. AMSNY works in partnership with its members to promote high-quality and cost-efficient health care by ensuring that New York State's medical schools provide outstanding medical education, patient care and biomedical research.

AMSNY and its member institutions believe strongly in a multifaceted approach to decreasing implicit and explicit bias and increasing cultural awareness and cultural competency. In fact, New York's medical schools began integrating bias training as part of their curricula more than five years ago. This mandated training takes many forms and is provided to students, faculty and admissions committees within the schools.

These training courses were not added due to a mandate from the State, but because New York's medical schools have been committed to educating and training a diverse physician workforce for more than three decades. Indeed, it has long been a core part of AMSNY's mission and a major focus of our programming.

According to the SUNY Albany Center for Health Workforce Studies, while African American/Blacks and Latino/Hispanics make up 31 percent of the New York State population, they accounted for approximately 12 percent of the state's physician workforce between 2011 and 2015. Increasing racial and ethnic diversity among health professionals is important because evidence shows that diversity is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction as well as better educational experiences for health professions students. As such, increasing the number of physicians from communities underrepresented in medicine (URIM) practicing in the state is vital to the health of New Yorkers.

Implicit & Explicit Bias Curriculum

Of New York State's 17 medical schools, 15 provided detailed responses to a survey about implicit and explicit bias in their curricula.

- 100 percent responded that bias is taught as part of the curriculum
- 92 percent indicated that both implicit and explicit bias are taught

- 93 percent stated that it is integrated throughout their curriculum

The topics that are covered are wide-ranging. For example:

- Barriers to LGBTQ
- Bias and Stereotyping
- Health Equity, Unconscious Bias and Vulnerable Populations
- Microagressions
- Principals of Cultural Competency
- Self-Recognition of Implicit Bias
- Use of Interpreters

In most medical schools, these concepts are integrated into coursework as well as in independent small group learning sessions, via lectures and workshops and through simulated patient settings. Examples of the courses include:

- Foundations of Clinical Medicine
- Transitions to Clerkships
- Population Health
- Small Group Doctoring Labs

In addition, 86 percent of the respondents said they mandate bias training for their faculty and fifty percent say their admissions' committees go through implicit and explicit bias training.

AMSNY does not believe a mandate is necessary. As our survey results clearly demonstrate, New York State's medical schools already take the need for implicit and explicit bias training very seriously and have had training integrated in their curricula for some time. Moreover, our medical schools have been nationally recognized for their initiatives to expand the pipeline of students from educationally and economically underrepresented communities.

AMSNY's Diversity in Medicine Program

Since 1985, AMSNY has supported a broad range of pipeline programs across the state that have expanded the pool of underrepresented students pursuing careers in health and medicine. The goal of these programs is to provide academic enrichment and support to students from educationally and/or economically underserved backgrounds. These programs provide an opportunity that most participants would not have otherwise had due to significant cultural and/or financial barriers.

AMSNY's Diversity in Medicine Programs (DiMP) have by all metrics been extremely successful. There are six initiatives within the DiMP, including four post-baccalaureate programs (three of which lead to Master's degrees) that provide guaranteed acceptance at the New York medical school that referred the students. Additionally, the DiMP funds an academic learning center at the CUNY School of Medicine's seven-year BS/MD program and a City College of New York program that develops students' interest in careers in the health sciences by pairing junior and senior undergraduate students with federally funded researchers. During the 2018-2019 academic year, the outcomes were as follows:

Post-baccalaureate Program at the Jacobs School of Medicine and Biomedical Sciences at University at Buffalo SUNY:

- 91 percent of the students who entered the program matriculated into medical school

Post Baccalaureate Master's Degrees Programs at New York Medical College, Renaissance School of Medicine at Stony Brook SUNY, and Upstate Medical University:

- 100 percent of the students who entered these programs matriculated into medical school

City College of New York Pathways to Careers in Medicine and Research:

- 100 percent presented their research at a scientific conference

Learning Resource Center at the CUNY College of Medicine:

- 98 percent would recommend the Pre-Matriculation program to incoming classes
- 96 percent rated peer tutoring effective
- 97 percent rated academic workshops effective

AMSNY Diversity in Medicine Scholarship Program

In order to meet the growing demand for primary care and specialty physicians, while simultaneously addressing the need to improve access in underserved communities, AMSNY launched the Diversity in Medicine Scholarship Program in 2017. AMSNY recently selected the third cohort of scholarship awardees for the 2019-2020 academic year. Scholarship recipients are New York State students who have graduated from one of the AMSNY post-baccalaureate programs and commit to working in underserved areas of New York for at least two years after their medical training. This scholarship program puts diverse physicians in the areas of highest need in New York State.

Conclusion

AMSNY is keenly aware that an individual's well-being entails more than physical health. One must also consider the biopsychosocial environment in which an individual is living. Medical students must of course learn to diagnose and treat patients and recognize the social and environmental determinants of health. Medical students must also learn how their own histories influence their understanding of the patients they treat. This is vitally important in order to provide true patient-centered care. As you can see, New York's medical schools are leaders in both teaching implicit and explicit bias and in developing the next generations of physicians who more closely resemble the populations they will treat.

I must, however, conclude with a plea. The stress placed on medical students is considerable and, at times, overwhelming. It is not unusual for a school that admits a class of 150 students to have more than 5,000 applicants. Once admitted, the pace of learning and the competition is fierce. As technology progresses, and our ability to diagnose and treat improves almost exponentially, more and more material is added to existing curricula. Moreover, the weight and scores of licensing exams exerts a strong influence on where and in which specialties students will be able to pursue. And finally, medical school debt – which currently hovers around $200,000 – weighs heavily on students.

Medical schools are accredited and governed by the Liaison Committee for Medical Education (LCME). The LCME mandates the contents of curricula and establishes the accreditation standards which all US medical schools must comply. Current LCME standards require bias training and have for many years included significant benchmarks for diversity and inclusion.

I respectfully request that we work together to address future concerns about the contents of medical education. Indeed, there are several points during medical education, training and licensure that may be appropriate for interventions aimed at improving health outcomes for all New Yorkers.

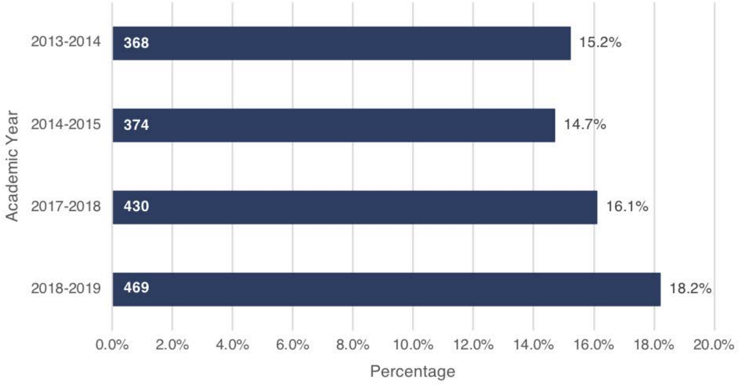
Thank you. I will be happy to answer any questions.

Jo Wiederhorn
President & CEO

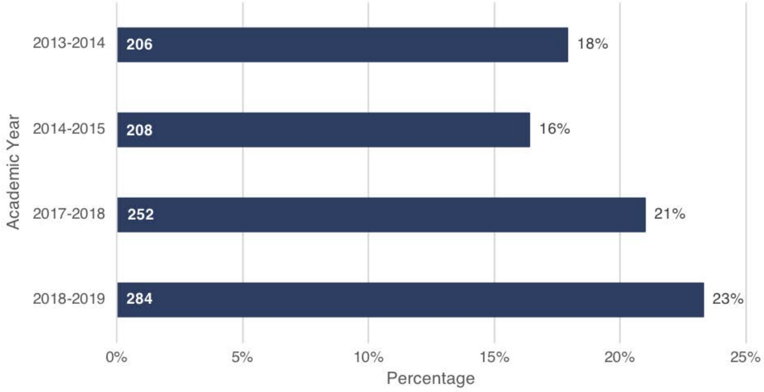
Addressing Bias in Medical Education

Under-represented in Medicine (URIM) Medical Students

URIM Students in the Entering 1st- Year Class in New York State Medical Schools



URIM Students in the Entering 1st- Year Class in NYC Medical Schools



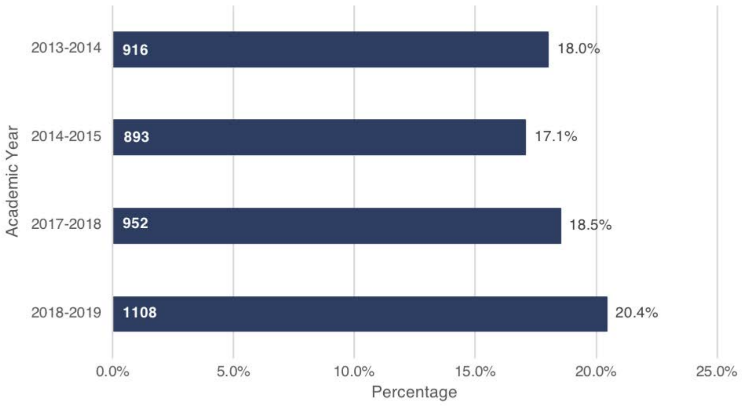
100%

of respondents have integrated bias training in their curriculum

(Data From 2019 Survey)

50% address cultural competence in tandem with bias training

URIM Students Enrolled in New York City Medical Schools



Student instruction and learning through:

- small groups
- clinical and pre-clinical training
- lectures
- workshops
- simulated patient settings

Topics of study for bias training and instruction include:

- ➡ self-recognition of implicit bias
- ➡ health equity and social determinants of health
- ➡ diversity and culturally responsive care
- ➡ implicit bias regarding sex trafficking
- ➡ impact of implicit bias in cardiovascular disease

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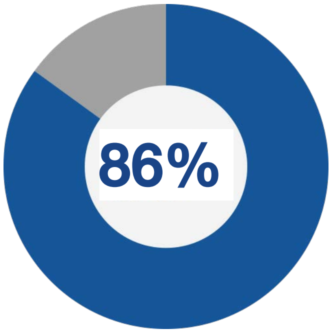
Faculty, Admissions, and Staff Bias Training



of respondents report that their faculty undergo bias training

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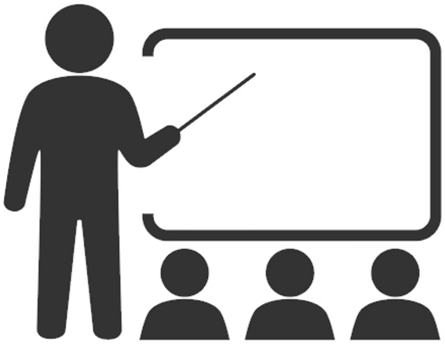
64% of respondents report that their **admission committees** undergo cultural bias training; of those, 77% mandate it

57% of respondents report that staff training is annual or biannual

Faculty bias training includes:

- online modules
- lectures
- interactive large and small groups
- virtual reality experiences
- interactive case discussions
- seminars
- workshops



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Associated Medical Schools of New York
Diversity in Medicine Program
2018 – 2019 Program Outcomes Data

Post-Baccalaureate Program

School	Percent of students who completed program and matriculated into medical school
Jacobs School of Medicine & Biomedical Sciences, the University at Buffalo, SUNY	91%

Post-Baccalaureate Masters Degree Programs

School	Program Degree	Percent of students who completed program and matriculated into medical school
New York Medical College	Masters of Science (MS) Degree in Interdisciplinary Medical Sciences	100%
Renaissance School of Medicine at Stony Brook University	Masters of Science (MS) Degree in Physiology and Biophysics	100%
SUNY Upstate Medical University	Masters of Science (MS) Degree in Medical Technology	100%

Post-Baccalaureate Student Demographics	Black/ African American		Hispanic/ Latino	
	Male	Female	Male	Female
	18%	33%	27%	21%

Other Diversity in Medicine Pipeline Programs

School	Program	Outcomes (percent of participating students)
CUNY School of Medicine	Learning Resource Center	➢ 98% of students who participated in the Pre-Matriculation Program would recommend the program to incoming classes ➢ 96% rated peer tutoring effective ➢ 97% rated academic workshops effective
City College of New York	Pathways to Careers in Medicine and Research	➢ 100% presented their research at a scientific conference

AMSNY's Diversity in Medicine programs are supported through the New York State Department of Health.

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DIVERSITY IN MEDICINE

AMSNY supports programs across the educational continuum to expand the pool of students choosing careers in medicine and other health professions. The programs are supported through a grant from the State Department of Health, with additional financial assistance from the medical schools. In 2019, AMSNY's Diversity in Medicine Programs were recognized by the Insight into Diversity Inspiring Programs in STEM Award.

POST-BACCALAUREATE & MASTER'S DEGREE PROGRAMS

The programs provide coursework, financial assistance, mentoring and comprehensive support services to students recommended by participating medical schools. Students are referred through wholistic admissions processes and offered conditional acceptance to medical school.

94%

of students who completed the Master's Degree programs have entered medical school

(DATA FROM 2008-2017)

MASTER'S DEGREE PROGRAMS

MS in Interdisciplinary Medical Sciences
New York Medical College

MS in Physiology and Biophysics
Stony Brook University School of Medicine

MS in Medical Technology
SUNY Upstate Medical University

> *"The preparation and training provided by AMSNY's Medical Scholars Master's Program enabled me to feel confident and handle the rigorous demands of medical school."*
>
> **DR. SAMANTHA JONES**
> Assistant Professor of Emergency Medicine, SUNY Upstate Medical University, alumna, SUNY Upstate Medical Scholars Program

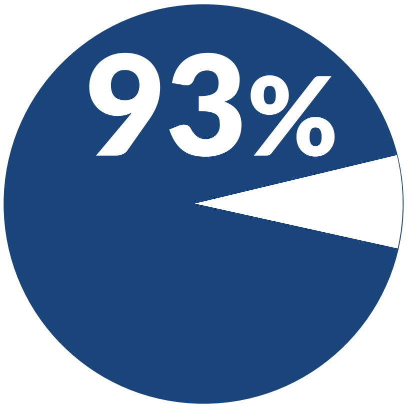
POST-BACCALAUREATE PROGRAM

Jacobs School of Medicine & Biomedical Sciences, University at Buffalo, SUNY

482 students have participated since the program's creation in 1991

(DATA FROM 1991-2017)

> *"If I didn't have this opportunity, I probably wouldn't be a doctor today. About 90% of my patients are Hispanic. For them to come and see me is a big relief. I speak their language. I know their culture."*
>
> **DR. JAIME NIETO**
> Chief of Neurologic Surgery, New York-Presbyterian/Queens, alumnus, University at Buffalo Post-Baccalaureate



of students who entered the Post-Baccalaureate Program entered medical school

85%	of students who matriculated into medical school graduated
48%	of MD graduates went into primary care residencies
62%	stayed in New York for residencies

(DATA FROM 1991-2017)

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DIVERSITY IN MEDICINE

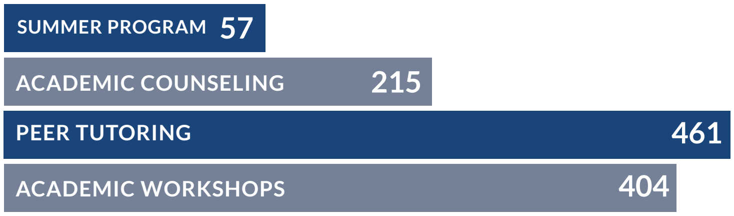
In addition to the post-baccalaureate programs, AMSNY's diversity in medicine initiative targets students in high school and college.

LEARNING RESOURCE CENTER

CUNY School of Medicine

The Learning Resource Center provides academic resources, skills, mentorship and support that assist CUNY medical students in pursuing their joint BS/MD degrees.

# of medical students that utilized:

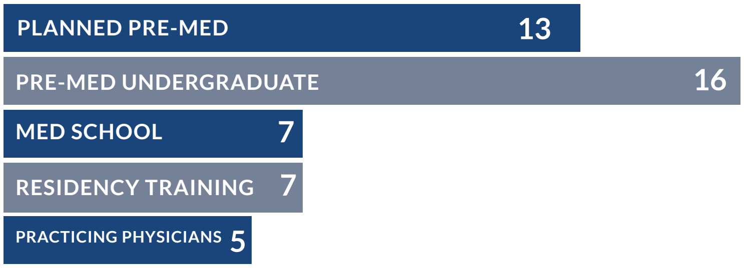


PHYSICIAN CAREER PREP PROGRAM

Staten Island University Hospital Northwell Health

The program provides academic support, workshops, clinical shadowing and research opportunities to encourage high school students to pursue careers in medicine and health.

118 students



(DATA UP THROUGH 2017)

DIVERSITY IN MEDICINE SCHOLARSHIP PROGRAM

Started in 2017-2018, this scholarship program aims to address the gap in physician diversity. The full tuition scholarship helps medical students from backgrounds underrepresented in medicine by eliminating the financial barrier to medical school enrollment.

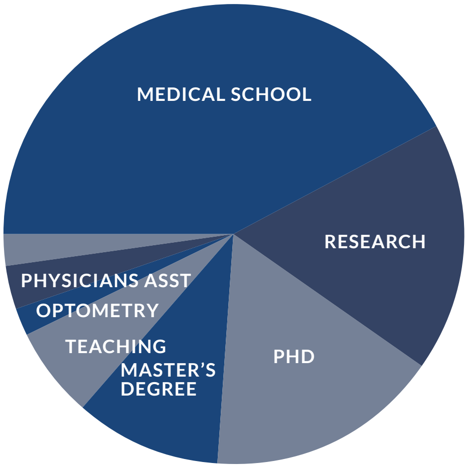
- 10 initial scholarship recipients, 40 students when fully funded
- Students from medical schools throughout New York State
- Scholarship pegged to SUNY tuition
- Up to 4 year service committment in an underserved area of NYS

PATHWAYS TO CAREERS IN MEDICINE AND RESEARCH

City College of New York

Students are mentored by National Institutes of Health (NIH) researchers, who help them develop and conduct independent research projects. At the conclusion of the program, research projects are presented locally and nationally.

(DATA FROM 2008-2017; TRACKING DATA FROM 59 STUDENTS)



137 students

> *"At different times in my life, when I'd felt unsure of my potential, AMSNY's programs provided enrichment opportunities for me to learn and grow professionally."*
>
> **DR. MAURICE SELBY**
>
> Emergency Medicine Resident, SUNY Downstate Medical Center, alumnus, Physician Career Prep Program at Staten Island University Hospital Northwell Health and Pathways to Careers in Medicine Program at CCNY

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MEDICAL EDUCATION IN NEW YORK STATE

17 PUBLIC AND PRIVATE MEDICAL SCHOOLS IN NEW YORK STATE

In the 2017-2018 academic year, New York State medical schools enrolled

10,684

students

15.4% of students are underrepresented in medicine

Spending by medical schools and teaching hospitals contributes **$54.01B**, or **$2,745.33** per state resident, and **544,979** jobs to **New York State's** economy

Medical schools and teaching hospitals added

23,765 total research jobs

in New York State

In 2018, the National Institutes of Health awarded $2.6 billion to research institutions in New York State,

61% of which funded groundbreaking science at our academic medical centers

There was an **11% increase in enrollment** at New York State medical schools from 2008 to 2017

Sources: Center for Health Workforce Studies, School of Public Health, University of Albany, State University of New York, The Health Care Workforce in New York (2018); Association of American Medical Colleges, Applicants and Matriculants Data by School, State of Legal Residence, and Sex, 2017-2018; American Association of Colleges of Osteopathic Medicine, AACOMAS Applicant Pool Profile (2017) American Association of Medical Colleges, Economic Impact of AAMC Medical Schools and Teaching Hospitals (2015-2016) National Institutes of Health (2017)

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ABOUT US

Albany Medical College

Albert Einstein College of Medicine CUNY School of Medicine

Columbia University Vagelos College of Physicians and Surgeons

Icahn School of Medicine at Mount Sinai

Jacobs School of Medicine and Biomedical Sciences, University at Buffalo, SUNY

New York Institute of Technology College of Osteopathic Medicine

New York Medical College

New York University Long Island School of Medicine

New York University School of Medicine

SUNY Downstate Medical Center SUNY Upstate Medical University

Renaissance School of Medicine at Stony Brook University

Touro College of Osteopathic Medicine

University of Rochester School of Medicine and Dentistry

Weill Cornell Medicine

Zucker School of Medicine at Hofstra/Northwell

The Associated Medical Schools of New York (AMSNY) is the consortium of the 17 public and private medical schools throughout New York State. AMSNY's mission is to be the voice of medical education in New York State, advancing biomedical research, diversity in medical school and the physician workforce, and high quality, cost-efficient patient care.

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I intend to appear and speak on Int. No. ________ Res. No. 512

☒ in favor ☐ in opposition

Date: ________

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Name: ERIC GAYLE, M.D.

Address: 2006 Madison Avenue

I represent: The Institute for Family Health

Address: 2006 Madison Avenue 10035

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Appearance Card

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☒ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Greg Waltman

Address: ________

I represent: G-One-Quantum

Address: ________

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Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. 512

☐ in favor ☐ in opposition

Date: 9/18/19

(PLEASE PRINT)

Name: Andrea Bower

Address: 147 S Oxford St Apt 1D 11217

I represent: Bower Public Affairs Consulting

Address: see above Need to leave at 3 - sorry!!

Please complete this card and return to the Sergeant-at-Arms

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Appearance Card

I intend to appear and speak on Int. No. ______ Res. No. ______

☒ in favor ☐ in opposition

Date: 9/18/19

(PLEASE PRINT)

Name: Kate Steinle

Address: 26 Bleecker St

I represent: Planned Parenthood of NYC

Address: ______

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☐ in favor ☐ in opposition

Date: 9/18

(PLEASE PRINT)

Name: Dr. Tara A Cortes

Address: 665 Broadway

I represent: ~~[illegible]~~ NYU

Address: 665 Broadway

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Appearance Card

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☒ in favor ☐ in opposition

Date: ______

(PLEASE PRINT)

Name: Cristina González

Address: ~~[illegible]~~ 1825 EastChester Road Bronx NY 10461

I represent: Physician Perspective - Einstein

Address: (Same)

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Date: ________

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Name: Manyon Lyons

Address: 145 East 126th nyc, ny

I represent: myself

Address:

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Appearance Card

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☒ in favor ☐ in opposition

Date: 09.18.19

(PLEASE PRINT)

Name: HEIDI SIEGFRIED

Address: 841 BROADWAY, SUITE 301

I represent: CIDNY

Address: 841 BROADWAY. 301

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Appearance Card

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☒ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: JUAN C PINZON

Address: ________

I represent: Community Service Society

Address: 633 3rd Ave, 10FL, NY 10017

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Appearance Card

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Date: September 18, 2019

(PLEASE PRINT)

Name: Rosamaria Ocasio

Address: 1664 Popham Ave Bronx, NY 10453

I represent: myself

Address:

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☑ in favor ☐ in opposition

Date: September 18, 2019

(PLEASE PRINT)

Name: Marilyn Saviola

Address: 175 Willoughby St Brooklyn, NY 11201

I represent: myself

Address:

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☑ in favor ☐ in opposition

Date:

(PLEASE PRINT)

Name: Claire Abenente

Address: 215 West 78th St nyc, ny 10024

I represent: Dr. Carla Boutin-Foster

Address: SUNY Downstate

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☑ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Michaeline Branker

Address: 125 Father Zieser Pl Bronx, NY 10468

I represent: ________

Address: ________

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☑ in favor ☐ in opposition

Date: 9/18/19

(PLEASE PRINT)

Name: Conner Fox, Rachel Wilkinson, Alec Feuerbach

Address: 50 E 98th St, New York, NY 10029

I represent: Students at Mount Sinai

Address: ________

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Appearance Card

I intend to appear and speak on Int. No. ________ Res. No. ________

☐ in favor ☐ in opposition

Date: ________

(PLEASE PRINT)

Name: Sasha Ponappa

Address: ________

I represent: ________

Address: ________

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Appearance Card

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☐ in favor ☐ in opposition

Date: September 18, 2019

(PLEASE PRINT)

Name: Matilde Roman, Chief Diversity & Inclusion Officer

Address:

I represent: Health + Hospitals

Address:

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☐ in favor ☐ in opposition

Date: September 18, 2019

(PLEASE PRINT)

Name: Dr. Wendy Wilcox, Chief of Obstetrics + Gynecology, Kings County Hospital

Address:

I represent: Health + Hospitals

Address:

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☐ in favor ☐ in opposition

Date: September 18, 2019

(PLEASE PRINT)

Name: Dr. Machelle Allen, Senior VP + Chief Medical Officer, H+H

Address:

I represent: Health + Hospitals

Address:

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Appearance Card

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☐ in favor ☐ in opposition

Date: 9/18/19

(PLEASE PRINT)

Name: Christopher Schuyler

Address:

I represent: New York Lawyers for Public Interest

Address: 151 W. 30th Street, 11th Floor

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