Committee on Hospitals

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**The Council of the City of New York**

**COMMITTEE REPORT OF THE HUMAN SERVICES DIVISION**

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**COMMITTEE ON HOSPITALS**

Hon. Carlina Rivera*, Chair*

**September 18, 2019**

**Oversight – The Delivery of Culturally Competent & Equitable**

**Health Care Services in New York City Hospitals**

**RESOULTION NO. 512:** By Council Members Rosenthal, Rivera, Ayala, Reynoso, Lander and Cornegy

**TITLE:** Resolution calling on New York State to require medical schools to train all students about “implicit bias”

1. **Introduction**

On September 18, 2019, the Committee on Hospitals, chaired by Council Member Carlina Rivera, will hold an oversight hearing on The Delivery of Culturally Competent & Equitable Health Care Services in New York City Hospitals. During the hearing, the Committee will explore disparities in health care delivery and the impacts on health outcomes. The Committee will hear a resolution calling on New York State to require medical students to receive implicit bias training. New York City’s Health + Hospitals Corporation (H+H), advocacy groups, and other interested parties are expected to testify.

1. **Background**

*Cultural Competence and Health Equity*

According to the Commonwealth Fund, cultural competence is the ability of systems to provide care to patients with diverse values, beliefs, and behaviors.[[1]](#footnote-1) Culture has been defined as “an integrated pattern of learned beliefs and behaviors that can be shared among groups [and] includes thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs.”[[2]](#footnote-2) Culture is shaped by multiple influences, including race, ethnicity, nationality, language, gender, socioeconomic status, physical and mental ability, sexual orientation, and occupation, among other factors.[[3]](#footnote-3)

To provide culturally competent health care, delivery of care must be tailored to meet patients’ social, cultural, and linguistic needs.[[4]](#footnote-4) A culturally competent health care system can help eliminate health disparities and inequities.[[5]](#footnote-5) Health inequity is defined as a specific type of health inequality that denotes an unjust difference in health, such as when health differences are preventable or unnecessary, and when individuals face an unfair amount of health risks because of one or more of their identities.[[6]](#footnote-6) Culturally competent health care can ultimately help improve health outcomes and quality of care for all individuals, regardless of age, race, ability/disability, income, gender, and sexual orientation.[[7]](#footnote-7)

Health inequities are pervasive in the American health care system. In the United States, Black people are 40 percent more likely to have high blood pressure and 30 percent more likely to die from heart disease than other groups.[[8]](#footnote-8) The prevalence of diagnosed diabetes is twice as high in Mexican-American and Puerto Ricans populations than in the non-Hispanic White population.[[9]](#footnote-9) Native Americans have the highest rates of diagnosed diabetes, with a prevalence rate of about fifteen percent in the adult population.[[10]](#footnote-10)

Studies have also shown the individuals who identify as lesbians have more barriers and are not screened for cervical cancer as often as heterosexual women, even though there are higher rates of cervical cancer in the lesbian population.[[11]](#footnote-11) Transgender and gender non-conforming (TGNC) individuals are more likely to experience discrimination, marginalization, and poor physical and mental health outcomes, which can result in a variety of physical and mental health conditions.[[12]](#footnote-12) When surveyed by The National Center for Transgender Equality, TGNC respondents rated their health as “poor” or “fair” at a rate 4 percent higher than the U.S. general population, and were experiencing serious psychological distress at a rate almost 8 times the rate of the U.S. population.[[13]](#footnote-13) Further, the TGNC community is exposed to physical and psychological dangers from forced conversion therapy, from societal pressure to “de-transition,”[[14]](#footnote-14)and from external physical and sexual violence toward the community.[[15]](#footnote-15)

The same inequities exist in New York City. Although White women in New York City have higher rates of breast cancer diagnoses than black women, at about 133 vs. 99 per 100,000 respectively, black women are more likely to die from breast cancer.[[16]](#footnote-16) The difference in diagnoses and death rates likely results from Black New Yorkers having the lowest rates of early diagnosis for both breast and cervical cancer.[[17]](#footnote-17) Although colorectal diagnosis and deaths have decreased since 1994, Black men and women in New York City are still more likely to die from this type of cancer.[[18]](#footnote-18) Furthermore, colorectal cancer mortality rates correlate with wealth disparities. New Yorkers living in the poorest areas are more likely to die from colorectal cancer than those from the richest areas, with a death rate of about 26 vs. 19 per 100,000 respectively.[[19]](#footnote-19) This display of wealth disparity is greatest in the Asian population, with a gap in the rate of death of 51 percent between communities with the highest wealth and those with the lowest.[[20]](#footnote-20) Following the Black population, Hispanic New Yorkers have the second highest rate of death due to colorectal, breast, and cervical cancers.[[21]](#footnote-21) Diabetes is another health concern that disproportionately affects minority communities. Regardless of the poverty level of the neighborhoods in which they live, Black, Latinx, and Asian/Pacific Islander populations have higher rates of diabetes than White populations.[[22]](#footnote-22)

The health outcomes of pregnant people and their children also display terrible rates of inequity. Recent data suggests Black mothers in NYC are 12 times more likely to die from pregnancy-related causes than White mothers.[[23]](#footnote-23) From 2006 to 2010, residents of the Bronx had the highest pregnancy-related mortality ratio with 26.0 deaths per 100,000 live births, followed by Brooklyn with 25.7, Queens with 24.6, Staten Island with 17.4 and Manhattan with 13.9.[[24]](#footnote-24) Furthermore, government data suggests that Black infants are more than twice as likely to die as White infants; 11.3 per 1,000 Black babies, compared with 4.9 per 1,000 white babies, a racial disparity that is actually greater than in 1850, 15 years before slavery was abolished in the U.S. [[25]](#footnote-25) Research points to race, rather than educational attainment or income level of the patient, as the cause of such discrepancies. [[26]](#footnote-26) In fact, a Black woman with an advanced degree is more likely to lose her baby than a White woman with less than an eighth-grade education.[[27]](#footnote-27)

In New York City, many TGNC individuals may avoid healthcare services because of discrimination or previous negative experiences.[[28]](#footnote-28) Those who do access healthcare services may avoid discussing gender with providers or have difficulty finding providers who adequately understand their social and health concerns.[[29]](#footnote-29) They also have less access to health insurance, according to a survey of 359 people within the LGBTQ/TGNC community by the City Comptroller’s office.[[30]](#footnote-30) In addition to the TGNC population, those with disabilities tend to face health care accessibility issues.[[31]](#footnote-31) Almost 1 million New Yorkers, or roughly 11.2 percent of the city’s population, have disclosed that they are living with a disability.[[32]](#footnote-32) Inadequate access to care causes preventable health conditions, which contributes to people with disabilities experiencing worse health status than people without disabilities.[[33]](#footnote-33) In 2014, 44.4 percent of New Yorkers with disabilities rated their health as fair or poor, compared to only 9.1 percent of those without disabilities.[[34]](#footnote-34) Additionally, those with disabilities likely require greater health services than those without disabilities.

Individuals with Limited English Proficiency (LEP) may face increased barriers to accessing health care.[[35]](#footnote-35) Immigrants disproportionately have LEP, meaning they “speak English less than ‘very well,’”[[36]](#footnote-36) compared to the general population.[[37]](#footnote-37) The American Medical Association’s Journal of Ethics reports that individuals with LEP experience high rates of medical errors, have worse clinical outcomes, and receive lower quality of care by other metrics than their English-speaking counterparts.[[38]](#footnote-38) Research has also found that having parents with LEP is associated with worse health outcomes among children.[[39]](#footnote-39)

            These inequities impact New Yorkers and their health. In New York City, approximately 49 percent of all immigrants have LEP, including nearly 63 percent of undocumented immigrants.[[40]](#footnote-40) H+H serves many of the city’s uninsured, including those that are ineligible for health insurance, i.e. the undocumented. Only 69 percent of non-citizen New Yorkers have health insurance compared to 94 percent of those who are U.S.-born, and only 42 percent of undocumented immigrants have health insurance.[[41]](#footnote-41)

Nearly 41 percent of all foreign-born New Yorkers who speak a language other than English at home speak Spanish,[[42]](#footnote-42) and more than 80 percent of people who are Latinx ages five and older report speaking Spanish at home.[[43]](#footnote-43) English proficiency among those who are Latinx is associated with improved health literacy and more positive interactions with health care providers.[[44]](#footnote-44) Among Latinx adults, 67 percent report their health as “excellent,” “very good,” or “good,” compared with 81 percent of non-Latinx adults.[[45]](#footnote-45)

Conversely, in 2017, the New York State Department of Health (NYSDOH) issued a report suggesting that when pooling all people who report English as a second language (ESL), the ESL population had equal or better preventative care and health outcomes when compared to the non-ESL population.[[46]](#footnote-46) However, this data groups ESL individuals of different backgrounds into a single category.

*Federal, State, and Local Action*

Section 1557 of the Affordable Care Act prohibits health programs or facilities that receive federal funds from discriminating based on race, color, national origin, age, disability or sex.[[47]](#footnote-47) However, recently the Trump Administration has tried to roll back some of these protections,[[48]](#footnote-48) potentially harming members of the TGNC community, individuals seeking abortion care, individuals with LEP, and others.[[49]](#footnote-49) New York State, in turn, has strengthened protections for individuals seeking medical care, including those who are transgender[[50]](#footnote-50) and women/pregnant people.[[51]](#footnote-51) Those with disabilities have additional protections. Under Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, New York State (NYS) Human Rights Law, and regulations promulgated under the New York State Public Health law, facilities have legal responsibilities to ensure that individuals with disabilities have full and equal access to programs and services.[[52]](#footnote-52) An individual with a disability must have access to the same health care services that someone without a disability receives.[[53]](#footnote-53)

New York State also has a Patients’ Bill of Rights, which clearly outlines that a patient in a hospital in New York State has the right to receive treatment without discrimination as to race, color, religion, sex, gender identity, national origin, disability, sexual orientation, age or source of payment.[[54]](#footnote-54) New York City’s Department of Health and Mental Hygiene has also implemented a Center for Health Equity which works to ensure that every New Yorker, regardless of where they live, has the opportunity to lead their healthiest lives.[[55]](#footnote-55)

In addition, the U.S. Department of Health and Human Services has an Office of Minority Health (OMH), which was created in 1986 as a result of the Secretary's Task Force Report on Black and Minority Health.[[56]](#footnote-56) OMH works to develop and promote policies, programs, and practices to achieve health equity, and funds demonstration programs at the regional, state, and local level that contribute to health policy.[[57]](#footnote-57) It also improves data collection, fosters research and evaluation, and performs other activities to address health inequity.[[58]](#footnote-58)

*Center for Linguistic and Cultural Competency in Health Care*

Within OMH is the Center for Linguistic and Cultural Competency in Health Care, which was created to address the health needs of populations with LEP.[[59]](#footnote-59) OMH, alongside federal and nonfederal partners across the country, developed National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards).[[60]](#footnote-60) The National CLAS Standards aim to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities.[[61]](#footnote-61) Their principle standard is to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.[[62]](#footnote-62) OMH also developed a framework and toolkit to guide health care organizations’ efforts in evaluating their implementation of the National CLAS Standards.[[63]](#footnote-63) Federal and State laws prohibit national origin discrimination against individuals with LEP when they are provided health care services, and New York State also has specific protections for individuals with LEP that require language interpreters in hospital settings.[[64]](#footnote-64)  The NYSDOH included implementation of the National CLAS Standards as a part of its long-range planning in their *Prevention Agenda 2013-2017: New York State’s Health Improvement Plan*, and has acted in line with the Standards in a variety of ways, including provider trainings, assessments of health plans, and surveys.[[65]](#footnote-65)

*H+H and Cultural Competency*

In 2011, the New York City Council Committees on Civil Rights and Health held a hearing about H+H’s cultural competency.[[66]](#footnote-66) During the hearing, H+H spoke about their investments in training and services and their delivery of culturally competent and linguistically appropriate services.[[67]](#footnote-67) H+H discussed their cultural competency training for all new staff as well as periodic ongoing trainings, and their language services.[[68]](#footnote-68) In Fiscal Year 2011, H+H facilities provided interpretation services in response to more than 600,000 language interpretation requests in more than 160 languages, and, between FY 09 and FY 11, these figures grew to more than 1.5 million language interpretation requests at an estimated cost of more than $10.4 million.[[69]](#footnote-69)

In 2016, H+H released a *Plan to Enhance Equitable Care*, which outlined its commitment to provide each individual patient with a positive experience and to raise the bar on equitable care.[[70]](#footnote-70) The report speaks to the importance of addressing health inequities and calls on “today’s doctors, nurses, and all other clinical and administrative staff [to] understand, take into account and incorporate cultural differences and social determinants of health [into their practice], and cannot assume these characteristics will be the same for all patients.”[[71]](#footnote-71) The report also outlines five priorities: (1) an organizational assessment to obtain defined benchmarks to measure progress on their health equity agenda; (2) governance of race, ethnicity, and language data to ensure they are collecting meaningful and real data about their patients; (3) building up of organizational capacity through training, education, and enhancing recruitment strategies; (4) improvement of staff and community communication and engagement; and (5) standardization of policies and practices to ensure staff are educated and trained properly.[[72]](#footnote-72)

Furthermore, H+H has received recognition for its work, including special designations from the Human Rights Campaign.[[73]](#footnote-73) In 2019, 23 of H+H’s patient care locations, across all five boroughs, received the designation “2019 LGBTQ Healthcare Equality Leader” from the Human Rights Campaign Foundation, and it was the forth consecutive year H+H received the designation.[[74]](#footnote-74) H+H also addresses health inequity through its work as the lead entity for New York State’s largest Delivery System Reform Incentive Payment Program (DSRIP) Performing Provider System, known as OneCity Health.[[75]](#footnote-75)

1. **Implicit Bias**

*What is Implicit Bias?*

Unlike explicit bias, where consciously held beliefs influence the way a person evaluates or behaves towards a certain group, implicit bias results from unconscious attitudes or stereotypes.[[76]](#footnote-76) Implicit bias should not be confused with biases that individuals choose to withhold for social or political correctness.[[77]](#footnote-77) Harvard University started *Project Implicit* in 1998 in order to understand thoughts and feelings outside of conscious awareness.[[78]](#footnote-78) They created the Implicit Association Test (IAT) to measure the association between groups of people based on race, age, gender etc. and evaluations, such as “good” or “bad”.[[79]](#footnote-79) Through this testing, researchers found that most people have stronger positive feelings for one group over another, and these feelings are sometimes contradictory to what one consciously believes.[[80]](#footnote-80) In other words, individuals who show preference for one group over another consciously believe that they have equal preference for both groups. Their results have also shown that even members of stigmatized groups tend to show preference for the more “socially valued” group.[[81]](#footnote-81) For example, although Black people who took the test tended to have more positive implicit attitudes towards Black people than White people who took the test, Black people who took the test still showed a stronger positive bias for White people over Black people.[[82]](#footnote-82) The presence of implicit bias can result in both action and inaction and can cause harm throughout all institutional practices.[[83]](#footnote-83)

*Consequences in the Health Care Setting*

Historically, there were many assumptions about what it meant to be healthy depending on the patient’s perceived identity. [[84]](#footnote-84) For example, doctors used to firmly believe that people of color felt less pain than White people.[[85]](#footnote-85) Although this idea is no longer accepted, studies have still shown that doctors prescribe more pain medication to White people than to non-White people who present the same symptoms.[[86]](#footnote-86) The presence of implicit bias can have serious negative effects on patients’ health, including high mortality rates.[[87]](#footnote-87)

While implicit bias is not the only factor contributing to disparities in health care and health inequities, clinicians’ unconscious actions can certainly amplify the issues.[[88]](#footnote-88) This is increasingly troubling because not only do minority groups report receiving lower quality care, but they also have poorer health outcomes.[[89]](#footnote-89)

*Implicit Bias Training*

In recent years, cultural competency and implicit bias training have become a greater priority.[[90]](#footnote-90) The purpose of cultural competency and implicit bias training is to better understand the populations that one serves.[[91]](#footnote-91) Researchers do warn, however, that these trainings need to be thought through carefully, so they do not perpetuate stereotypes.[[92]](#footnote-92) The training also helps clinicians become aware of their biases as a step toward overcoming cultural conditioning.[[93]](#footnote-93) Our most vulnerable populations are suffering, and addressing biases is one step towards reducing health inequity.[[94]](#footnote-94)

1. **Conclusion**

At today’s hearing, the Committee will examine cultural competency training in New York City’s hospitals. The Committee will also consider the level and degree of training that staff receives at these facilities. Lastly, the Committee will hear from health care consumers about their experiences receiving care in New York City’s hospitals.

Res. No. 512

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

..Body

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

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, 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"

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08/03/2018

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