CITY COUNCIL
CITY OF NEW YORK

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TRANSCRIPT OF THE MINUTES

Of the

COMMITTEE ON HOSPITALS

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HELD AT: Committee Room – City Hall

B E F O R E: CARLINA RIVERA
Chairperson

COUNCIL MEMBERS: Diana Ayala
Mathieu Eugene
Mark Levine
Alan N. Maisel
Francisco P. Moya
Antonio Reynoso

A P P E A R A N C E S (CONTINUED)

Matilde Roman, Chief Diversity and Inclusion Officer, New York City Health and Hospitals Appearing for Dr. Mitchell Katz, CEO NYC Health and Hospitals

Dr. Machelle Allen, Senior Vice President and Chief Medical Officer, New York City Health and Hospitals

Dr. Wendy Wilcox, Chief of OBGYN at Kings County Hospital & Clinical System Wade Ford (sic) Women's Health

Marilyn Saviola, Senior Vice President for Advocacy and Women's Health, Independent Care System, ICS

Mandy Martin, Person with Disability

Rosa Maria Ocasio, Person with Disability

Dr. Carla Boutin Foster, Associate Dean, Office of Diversity, Education and Research at SUNY Downstate Health Center

Dr. Cristina Gonzalez, Physician & Scientist

Tara Cortez, Executive Director and a Professor, Hartford Institute for Geriatric Nursing, Geriatric arm of New York University, Rory Meyers College of Nursing

Conner Fox, Student, Icahn School of Medicine at Mount Sinai

Rachel Wilkinson, Student, Icahn School of Medicine at Mount Sinai

Art Forbuck, Student, Icahn School of Medicine at Mount Sinai

Andrea Bowen, Principal of Public Affairs Consulting

Sacha Panapa

Heidi Siegfried, Health Policy Director Center for Independence of the Disabled in New York

Eric Gayle, Family physician and Senior Medical Director, Institute for Family Health

Kate Steinle, Associate Vice President of Clinical Services & Director of the Transgender Health Services, Planned Parenthood of New York, City

Christopher Schuyler, Senior Staff Attorney, Disability Justice Program, New York Lawyers for the Public Interest

[sound check] [pause[] [background comments] [gavel]

CHAIRPERSON RIVERA: Good afternoon everyone. Thank you for attending today's hearing. I'm Council Member Carlina Rivera. I am Chair of the committee on Hospitals, and I'd like to start off by acknowledging my colleagues and fellow members of the committee, Council Member Reynoso, Council Member Moya, Council Member Ayala, Council Member Levine and Council Member Rosenthal. Today the committee will examine the importance of culturally competent healthcare in our healthcare system helping to address the health disparities and inequities the persist in our city. The inequitable roots of our healthcare system stretch back to the incorporation of racist ideologies and subsequent faulty data and medical testing, and still impacts the way we perceive pain, health and wellbeing of people. These particularly ugly histories are important to acknowledge and understand if we hope to create a future that is more equitable and just for all. For example in the 19th Century faulty medical testing performed by white male doctors sought to justify slavery through so-called scientific evidence such as

proving that people who are black, at the time slaves have lesser lung capacity and, therefore, needed to do more labor to help improve their lungs. This socially informed medicine continued into the 20th Century particularly in Europe, but also in America where Eugenics and ethnically based experimentation was utilized to justify racism, anti-semitism and genocidal behavior. Throughout history individuals with disabilities have been institutionalized, isolated, experimented on, and in many cases abused all based on scientific and medical evidence that today we would find horrific and unconscionable. Though many—though these may feel like anachronistic tales from a bygone era, the truth is that our medical school, healthcare and scientific institutions still perpetuate great inequities and have more work to do to educate and ensure true cultural competency. Nationally, black people are 40% more likely to have high blood pressure, and 30% more likely to die from heart disease than others. The prevalence of diagnosed diabetes is twice as high in Mexican-American and Puerto Rican populations than in the non-Hispanic white populations. Individuals with limited English proficiency experience high

rates of medical errors, have worse clinical outcomes and receive lower quality of care by other metrics than their English speaking counterparts. Studies have shown that individuals who identify as Lesbians are not screened for cervical cancer as often as heterosexual women even though there are higher rates of cervical cancer in the Lesbian population. Transgender and gender non-conforming 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. Adults with disabilities are four times more likely to report their health to be fair or poor than people with no disabilities, and adults with disabilities are less likely to receive needed medical care because of the cost of care. Of course, race, poverty, disability, gender, gender expression, and other identities can be intersectional. So, inequities can impact a single individual in many, many ways. The same inequities exist in New York City. Black New Yorkers have the lowest rates of early diagnosis for both breast and cervical cancer. Black women are more likely to die from breast cancer than white women

even though white women in New York City have higher rates of breast cancer diagnosis than black women. Black pregnant people are 12 times more likely to die due to pregnancy related causes than white pregnant people. Although colorectal diagnosis and deaths have decreased since 1994, black men and women in New York City are more likely to dies from this type of cancer. Furthermore, Colorectal Cancer mortality illustrates wealth disparities. New Yorkers living in the poorest areas are more likely to die from colorectal cancer than those from the richest areas. This display of wealth disparity it greatest in the Asian population with a gap in mortality rate of 51% between wealthier and poorer areas. Diabetes is another health concern that disproportionately affects minority communities. Regardless of the poverty level of the neighborhood, black. Latinos and Asian Pacific Island populations have higher rates of diabetes than white populations. Furthermore, a survey of 359 people within the LGBTQ TGNCNB community by City Comptroller's office reveal that those who are transgender, gender non-conforming and/or gender non-binary are more likely to have less access to health insurance. People with disabilities

experience worse health status than people without disabilities partly due to inadequate access to care, which causes preventable health conditions. In 2014, 44.4% of New Yorkers with disabilities rated their health as fair or poor compared to only 9.1% of those without disabilities. While the causes of these inequitable health outcomes are complex, culturally competent healthcare can play an important role in helping to address negative health outcomes. Recognizing this H&H, Health and Hospitals has made investments in training in language services to improve their delivery of culturally competent and linguistically appropriate services. H&H provides culturally competent training for all new staff as well as periodic ongoing trainings, and I look forward to hearing more about these trainings today. In 2016 H&H released a plan to enhance equitable care which outlined their commitment to provide each individual patient with a positive experience and to raise the bar on equitable care. The report speaks to the importance of addressing health inequities and calls on healthcare staff to understand, take into account and incorporate cultural differences and social determinants of health into their practice.

While there is still a lot of work to be done, H&H has been recognized for these investments. This year 23 of H&H's patient care locations across all five boroughs received the designation leader in LGBTQ healthcare equality from the Human Rights Campaign Foundation, and it was the fourth consecutive year that H&H received this designation. In addition to these discussions today we will hear Resolution 512 sponsored by Council Member Rosenthal, which calls on New York State to require medical schools to train all students about implicit bias. Unlike explicit bias where consciously held beliefs influence the way a person evaluates or behaves toward a certain group, implicit bias results from unconscious attitudes or stereotypes. Implicit bias training helps provide— helps providers better understand the population they serve by helping clinicians begin—become aware of their own biases. Our medical education system must incorporate meaningful and robust education on implicit bias as well as health and equity and the racist, misogynistic and overall bias underpinnings of our medical school system. I look forward to hearing testimony regarding this very important issue, and I thank you all again for being here

today. I would like to ask Council Member Rosenthal to make remarks on her resolution.

COUNCIL MEMBER ROSENTHAL: Thank you so much, Chair Rivera. I really appreciate your convening this hearing. The—the—this resolution stems from a hearing that that the Committee on Women and Gender Equity had last year regarding maternal mortality morbidity in New York City, and while I commend the city's Department of Health for being every day conscious of the reality that black women die at rate eight times higher than white women regardless of socio-economic status during childbirth. There is so much more work to be done. They the Department of Health has been studying this issue for over a decade, and I do commend them for that, but—so this--this resolution stems from that hearing and what we—the—what we learned about at our hearing was this systematic discrimination that is engrained into our society has, of course, this terrible affect on anyone who's—who is not a white male, and Hannah Nikole Jones in her 1619 project, of course, made all of the systemic racism and explained it in every different area of our life so clearly. As the chair mentioned, you know, this point about

slavery is okay. Physicians validated slavery based on the fact that a black person's lungs would be better served working in the fields similarly that a black person's skin was so thick that—that whippings would be tolerable. Given what we know now, it's imperative that all of us strive to change our society from where it is now to where we need to be. One way is by training our medical providers who had previously been taught myths in order to justify slavery. We need to train them that that is not only no longer true, but people must be aware of how it affects them in their day to day medical practice. Of course, this all similarly applies to anyone who is considered other, who has been marginalized in our society. In hospitals in particular we must be training not only our physicians, but all of those who volunteer who greet people who walk in the door, who are nurses in any way take care of someone walking in the door. I so appreciate the chair for having a hearing on this topic for including my resolution, and I look forward to hearing from the Administration who I know is working diligently to reverse the—the scourge that is racism in New York City. So thank you.

CHAIRPERSON RIVERA: Thank you, Council Member Rosenthal. I going to have Counsel swear you in.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee and to respond honestly to Council Member questions?

MATILDE ROMAN: I do. Thank you Chairman—Chairperson Rivera, and Good afternoon Chairperson Rivera, and members of the Committee on Hospitals. I am Matilde Roman, Chief Diversity and Inclusion Officer at New York City Health and Hospitals and I'm joined by Dr. Machelle Allen, Senior Vice President and Chief Medical Officer. On behalf of Health and Hospitals CEO Dr. Mitchell Katz, thank you for the opportunity to testify before you to discuss the delivery of Culturally competent end equitable healthcare services and the programs and initiatives at Health and Hospitals to provide culturally responsive healthcare. Health and Hospitals is a safety net for the uninsured and under-served in New York providing healthcare services to 1.1 million New Yorkers each year, 3080 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 prove accessible, culturally and linguistically appropriate services to ensure full access to comprehensive and quality care for all New Yorkers. New York City is home to over three million immigrant New Yorkers. Fifty percent of New Yorkers speak a 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 and 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 and Hospitals' provision of culturally competent equitable health services are guided by an understanding of the important role of one's culture, race, class, age, gender, sexual orientation and gender identity in interpersonal and

professional encounters in Healthcare, and awareness of historical and socio-political factors such as racism, ableism, immigration patterns and human rights violations, and their import—and the impact on the health and wellbeing of minority populations, and the value in collaborating with ethnic and racial minority community based organizations to ensure appropriate responses to individual health needs. Health and Hospitals is a leader in providing culturally competent and linguistically appropriate services, by investing in training and initiatives to provide care for all that is safe, responsive and effective. Addressing the healthcare needs of immigrant New Yorkers through the issuance of an open letter to reassure immigrant New Yorkers that Health and Hospitals is a safe place to receive care, and through our partnerships with Legal Health 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 out initiatives such as NYC Care, which is a healthcare 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 culturally competency of our workforce, ongoing evaluations of the effectiveness of our diversity training programs [pause] I was just making sure. This ongoing process requires periodic assessment of cultural competency of our workforce, ongoing evaluation of the effectiveness of our Diversity Training Programs and formal—and informal linkages with communities that our facilities serve. I want to take a moment to highlight a few key initiatives that set New York City Health and Hospitals apart in providing culturally and linguistically appropriate services. So, with respect to language access, Health and Hospitals offers free language services 24 hours a day, 7 days a week year round 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 New Yorkers. in Fiscal Year 2018, Health and Hospitals facilities received more than one million requests for interpretation services that yielded that 13 million interpretations minutes. Systemwide initiatives to support communication for

person who are limited English proficient include making available language access resources to inform the public of the availability of free language services, tools to ensure quicker access to language ID desktop displace and I-Speak card to support facilities in the delivery of language assistant services. Creating a centralize 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 is also very important for us , and at Health and Hospitals we will continue to strive to provide patient centered affirming care to Lesbian, Gay, Bisexual, and Queer and Transgender and Gender Non-Conforming communities For the fourth consecutive year, all qualifying facilities within the health system received the designation of leader and LGBTQ healthcare equality by the Human Rights Campaign. This designation demonstrates Health and 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 Gouverneur, 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, and in the past year, due to the support of the City Council Health and Hospitals has launched an LGBTQ community engagement initiative focused on connecting, engaging and facility—and facilitating affirming services to New York City's LGBQ/TGNC communities to improve access to affirming care. Access to Care for Individuals With Disabilities: Health and Hospitals is required to comply with various federal, state and local laws requiring accessibility for individuals with disabilities including the Americans with Disabilities Act, the Rehabilitation Act, and the Affordable Care Act among others. We also implement programs to ensure access to effective communication for individuals with disabilities including those who are blind or have low vision and who are guests for hard of hearing.

Additionally, for the last several years we've had strong collaboration within this care system, Woman's Health Program to provide competent and accessible care to women with disabilities. This important work was supported by City Council funds, $2.5 million in capital funds to upgrade four facilities: Morrisania, Sydenham, Cumberland and Woodhull and $275,000 in discretionary funds, which will allow Health and Hospitals to continue its work with ICS. We also provide resources and training for our employees. Health and Hospitals offers system wide training on diversity and inclusion, cultural competency, LGBTQ health, unconscious bias and inter-religious awareness through distance learning, new employee orientation, annual in-service and other in-person training such ground rounds and small facilitative dialogues offered year round. Improving maternal and infant health is also a top priority. 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 disparities exist and reducing by half the number of several maternal morbidity events in the five boroughs. For Health and Hospitals the plan includes enhancing maternal care at our facilities by focusing on four specific strategies. The first one is simulation training to assist health providers, master skills to identify and respond to the top two causes of pregnancy and related deaths for women of color. The second is new maternal care coordinators who will assist an estimated 2,000 high risk women. The third is coordination of new born and post-partum appointments, and lastly, new practices in primary care to identify women who are planning to have a child within 6 to 12 months. Additionally, Health and Hospitals increased screening for maternal depression through a partnership with ThriveNYC and DOHMH to enhance screening of pregnant women and new mothers in order to promote treatment of maternal depressions, and we're happy to announces that 10 of our acute care facilities have earned the prestigious baby friendly designation from the World Health Organization for promoting the highest level of care for infants,

their breast feeding and promoting bonding between mother and baby. We also have Implicit Bias Training. As the largest public health system in the nation serving perhaps the most diverse city in the country, Health and Hospitals is committed to ensuring its staff is sensitive to the issues of health equity and that we are delivering truly equitable care. We've issued two new E-learning modules. One is entitled Impact of Unconscious Bias on Cultural Inclusion and the second Diversity and Inclusion of Business Imperative. 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 and Hospitals will begin training Health and Hospitals' Board of Directors and senior leaders this fall. Moreover, we are working with DOHMH to provide Train the Trainer Implicit Bias Training through Rebirth Equity Alliance to provide training sessions across Health and Hospitals as well as other hospitals participating in the DOHMH Maternal Hospital Quality Improvement Network. The

trainings will focus on improving equity in childbirth and this training will take place next month in October. I also want to highlight a number of culturally competent—competent—competency programs specific at facilities such as 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. The Leera (sic) Clinic at Jacobi, which provides culturally sensitive medical care to refugees from the Balkans; Amherst Hospital, that operates the psychiatric in-patient units that address the needs of both Spanish speaking patients and Asian patients who primarily speak Catonese, Mandarin and Korean, and Lincoln Hospital operates the [foreign language] Long Live Women and [foreign language] Long Live Men, Cancer Outreach Programs that promotes public education in the area of cancer screening prevention and early detection. [sirens] In conclusion, at New York City Health and Hospitals we believe all New Yorkers regardless of the disability, national origin, gender, or citizenship status deserves equitable, affordable care of the highest quality and true to our mission Health and

Hospitals will continue to provide health services in a culturally responsive manner to meet the needs of the city's divers population. I thank you for your interest and attention, and we're happy to answer any questions that you may have at this time.

CHAIRPERSON RIVERA: Great. Thank you. I just want to acknowledge that we were joined by Council Member Mathieu Eugene, and we've joined by Council Member Alan Maisel. So, I want to ask a couple of question s about some of the things you mention in your testimony. So, we'll go right into the Implicit Bias Training piece, and it seems just by kind of what I've heard that you are working on a number of training sessions and—and workshops. I think what you call workable solutions and that you really are trying to address some of the issues that I pointed out in my testimony and that you just see every single day considering the very diverse population that we have. You mentioned here that we have made available to staff all year two E-learning modules, and that you're also working with the Perception Institute on workable solutions usually in the form of workshops. So, which one of these trainings—are any of them mandatory?

MATILDE ROMAN: So, currently we're working at integrating. So our trainings that are mandatory are in our New Employee Orientation programs and our annual in-service, and in these--

CHAIRPERSON RIVERA: [interposing] The second please?

MATILDE ROMAN: Annual In-Service. So all employees have to take annually a suite of training content and that's mandatory, but part of the strategy for Health and Hospitals is really to thread and integrate many of these key components into the training. So we have stand-alone trainings such as the one we mentioned, but we also look for opportunities to augment and supplement existing training so that at any point where individuals are exposed to training they also are able to partake in culturally competent best practices and other topics related to diversity and inclusion. So, the goal would be that we're—the hope is to integrate many of this content to help support learning on an ongoing basis.

CHAIRPERSON RIVERA: I know that we're going to hear from a lot of and many institutions that train some of our doctors, and I believe in New

York City is probably top in the nation in terms of training our medical students, but what I'm hearing is that—so you have a new employee orientation and an annual in-service training that is a suite of trainings, correct? So, are any of those specifically addressing culturally competency and implicit bias and are they mandatory? I just want to make sure I understand.

MATILDE ROMAN: Thank you for that question. So, in the new employee orientation is offered system level. That's available to all employees, new employees. We also have new employee orientation at the facility level. We embed these training components into those training suites so they happen. They're blended training so there's live sessions as well as E-learning, and so we integrate components of our work in the diversity inclusion space to include that. We also have stand-alone trainings. The one I mentioned was the unconscious bias and diversity inclusion, business imperative. Those are stand-alone trainings that individuals can access year round and we enroll individuals in an ongoing basis so that they can also avail themselves of that training as well. The

Perception Institute is a training that is being offered now for senior level staff as well as—and cabinet members, and—and so I would defer to Dr. Allen to elaborate on this one.

CHAIRPERSON RIVERA: I just want to make sure we swear the—the panel in. Did we swear you in?

DR. MACHELLE ALLEN: [off mic] No, I'll introduce and then you can.

CHAIRPERSON RIVERA: Yeah, I would love to. Whoever. I would love to talk to all of you if it's appropriate.

DR. MACHELLE ALLEN: So, I'm Dr. Michelle Allen, Chief Medical Officer of the Health and Hospital system.

DR. WENDY WILCOX: I'm Dr. Wendy Wilcox. I'm a Chief of OBGYN at Kings County Hospital as well as the Clinical System Wade Ford (sic) Women's Health.

LEGAL COUNSEL: Do you affirm to tell the truth, the whole truth and nothing but the truth in your testimony before this committee and to respond honestly to Council Member questions?

DR. MACHELLE ALLEN: Yes.

LEGAL COUNSEL: Thank you.

DR. MACHELLE ALLEN: So you asked about implicit—the perception training that we're offering in for implicit bias.

CHAIRPERSON RIVERA: And let me give you a little more information. So, what I want to know is what is the curriculum like? If it's not mandatory , if it's optional I hear that some things are mandatory in the new employee training, and I imagine that you cover cultural competency. Just given alone the diverse population that we serve and the languages that are spoken inside of your facilities. What I—what I'm trying to get to is whether or not some of these trainings are, in fact, mandatory for any of the employees. You have a—you have many, many employees. What percent of them are actually trained in cultural competency and/or implicit bias and I realized there are many titles for what we imagine is the same curriculum because what we also will ask in a minute is for those people that have taken the training whether or not they're mandatory or even the optional ones, what are the outcomes like? Are you tracking those outcomes facility wide, but also one-on-one?

DR. MACHELLE ALLEN: So, I'm going to divide the question or responses into two. So, Matilde shared with you what we're doing for our staff, which is our entire staff. What Dr. Wilcox will speak to is what we're doing for Maternal Child Health staff, and we're also collaborating with DOHMH with an implicit bias training as well. So, what I'd like to do is first describe what you asked with the curriculum what be covered and the logistics of the training, and what we're doing with implicit—with perceptions. We're starting at the very senior level with the Board of Directors and the senior cabinet and do you want to take it from there?

MATILDE ROMAN: And after they receive their training this fall, we have a plan to roll it out to the 11 acute care facilities to train the leadership both clinical, executive level, administration, nursing, department heads as well as a cross section of the staff including front line staff and learners.

MATILDE ROMAN: So, at the moment the concept is to cover everybody.

CHAIRPERSON RIVERA: The concept. So, right now how many are trained?

MATILDE ROMAN: We're beginning in October and November. October for the senior cabinet and November for the Board of Directors and once we have educated the senior leaders because it's really imperative that we lead a model of behavior and really implicit bias is so subtle and insid—insidious that none of us know or aware of. So, we would really like to make everybody aware of their own judgmental assumptions or decisions that they make, and we really want to start at the very senior level with the Board of Directors and get their buy-in and support to spread. After we do the senior leaders then October, Senior Cabinet; November Board of Directors and then rollout of the senior leadership of each facility and then spread down from there. So, it will probably be a nine-month process to do the entire system. Our focus is maternal child health, but the rest are going to be looking at all of our staff. Building from Human Resources we have online training, which is tracked, and I don't know if you want to speak to the tracking and—

MATILDE ROMAN: Yes, so all our trainings whether they're in person or through distance learning are tracked through our learning management

system and so, you know, we can count how many at each facility have taken our—any—any training.

CHAIRPERSON RIVERA: So, you're—you're tracking who is going to be receiving the training, correct? Because from what I understand you're launching October/November and you're starting at the top--

MATILDE ROMAN: Yes.

CHAIRPERSON RIVERA: --and you have a nine-month timeline to train every single person employed by Health and Hospitals. Is that correct?

MATILDE ROMAN: Nine months? About nine months, yeah.

DR. MACHELLE ALLEN: Just a point of correction. The nine months is going to be for board members, senior leaders across our eleven acute facilities with the intent in nine months to also enroll additional front patient-facing staff and direct care providers in our eleven acute facilities. I think that is something that's manageable in the nine-month period.

CHAIRPERSON RIVERA: Ultimately, I think everyone here and I imagine that people from your Administration and from H&H are going to stay for the

entire duration of the hearing in order to hear the testimony of some of the people in this room who are consumers and advocates, and they're going to be sharing some very personal experiences is that every single person in the facility should be trained on cultural competence and implicit bias. I mean your visit starts at reception. You know, you're interaction with a custodian or with a physician's assistant or a nurse's assistant there are so many people that work inside of your 11 acute facilities and the Gotham Network that we want to make sure that you have the support that you need and that you have a real plan because you also mentioned in your testimony your focus on maternal mortality and there was an announcement by the First Lady in 2018, and that—that was a five-year plan.

MATILDE ROMAN: Right.

CHAIRPERSON RIVERA: How far along are you in the plan? Are you tracking outcomes? Are you—are you set on that timeline? I'm try to—I really want to grasp and I want the people in this room and the public to know exactly how we're looking at healthcare and how we're focusing on this, which is leading to some horrific outcomes in this city not

just nationwide not just in the forest areas, but I have I—I read aloud some alarming statistics that no matter where you live sometimes it is just the color of your skin or the first language that you speak at home that is attributing to some really, really terrible outcomes for some of our patients and that is unacceptable.

MATILDE ROMAN: So our maternal, morbidity and mortality plan is actually a five-prong plan as you mentioned, and thank you for that question. It's something that's very close to our heart and very passionate and committed to implementing. We have—or we—as you've heard in the testimony there are five prongs one of which is simulation training to train all the obstetricians around the two leading causes of death, which is cardiac arrest during labor as well as post-partum hemorrhage. To date we've trained 60% of all our maternal child health staff, and the goal is by December 100%. We also have placed in primary care a pregnancy intention question. So, if you look at maternal morbidity and mortality often it's those women who access care late who have not been in primary care, and have not had the opportunity to

their chronic medical conditions actually addressed and controlled. So, starting in the—for those patients who are in primary care clinic with chronic medical conditions to ask every woman of—with deductitve (sic) age who is in the Primary Care Clinic are they planning a pregnancy within the next year? If they are planning a pregnancy within the next year referring them to a Lead clinic with the intent to really fine tune their Diabetes, their hypertension, the pulmonary hypertension, et cetera. If they're not planning a pregnancy within—and this has already been implemented. It sits in our electronic medical record. So if a woman has chronic diet—chronic Diabetes or chronic hypertension and she's not planning pregnancy to make sure she gets to her gynecologist to have effective birth control. So, we want women who are planning on becoming pregnant to be their healthiest and best control in terms of their chronic conditions, and those who are not planning to make sure they have effective contraception. We also have another prong, which providing—is standing up at Maternal Medical Hall very similar to what we have in Primary Clinic, Primary Care Clinic. So, that we're enhancing our

social support systems within the clinic and building our—through the outreach workers and our connections with our community based organizations understanding that a lot of complications with pregnancy we can't treat in the office within their conditions, access to food, access to babysitters, transportation, et cetera that impact the outcome of a pregnancy. You also mentioned simulation. Another fact is about 40% of prenatal patients actually do not follow up with their postpartum visit, but they, in fact, keep their pediatric visits so we're co-locating and coordination the postpartum visit with the well baby visit. Queens is our model for that. They actually have two models for that. One is absolute colocation in the Saturday clinic or the evening clinic when they actually have the ability and resources to do that or they have sequential visits that there's a pediatric visit followed up by a postpartum visit on the same day. So that's what we've initiated to date.

CHAIRPERSON RIVERA: I'm glad that you mentioned the community based organizations and specifically in know that you are working. You mentioned in the testimony with ICS on really making

sure that there is true and equitable access for people with disabilities. When you're working with community based organizations, how do you find them? Because I think, you know, what you mentioned is that people aren't seeking care as early as they should with something as serious as pregnancy. So, with these community based organizations, how—how are you kind of finding them, and how are you working with them, and—and the other reason why I ask is because we have a very toxic anti-immigrant administration in Washington that is day after day putting forward proposals that is scaring our immigrant communities and some of our poorest New Yorkers from entering public trusted spaces including our hospitals. So, if it's hard to get them in the door, and they weren't seeking the early treatment and—and support to begin with, what are you doing to make sure that you are constantly working with the trusted non-profits in the—in these neighborhoods to—to make sure that that outreach is—is-is 100%?

DR. WILCOX: Chairperson, can I ask a clarifying question.

CHAIRPERSON RIVERA: Sure.

DR. WILCOX: Is it specific to the maternal women or is it much more broader, your—your scope of questioning?

CHAIRPERSON RIVERA: I actually would like to hear about both. I think that maternal mortality is—is—those—those rates continue to be I think what is—it's just shameful in terms of our reputation and—and they have this—this hearing that Council Member Rosenthal mentioned, but we know that as—as much as we're trying, we're still failing our black and brown mothers and—and—and parents and families, and it honestly we—we—when we mention socio-economic factors, it is true, but I can't help but—but come back to the thought of when someone as rich and famous as Serena Williams isn't heard, you know we have a problem, right? She can't even access the care that she needs, and this is not the average person. So, when people come to me and they say, you know, I'm afraid. I'm unenrolling in benefits. I want to make sure that whether you're pregnant or not or whether you want to start a family that is your own choice that people have trusted CBOs that they're going to. And so I guess my question is regardless of the sector of care, regardless of whether it's

getting pregnant or treatment for your diabetes, how are you finding these community based organizations and how are you working with them?

MATILDE ROMAN: So, we've actually started in Brooklyn working with the three other obstetrical hospitals in Brooklyn, and brought a consortium of community based organizations together to meet with us recognizing particular challenges in Central Brooklyn. We met with LaRay Brown and other hospital leaders, Kings County, City Downstate Brookdale and invited the community leaders Lou Gosy Moses joined us, midwives from the community joined us, doulos from the community joined us and we started to actually work out a plan how to move forward to improve access of women in the community who are fearful of coming to the big house hospital that are actually going to the community providers, and we wanted to start there in Brooklyn to build those connections with the community's support using doulos and midwives to help us engage with the citizens of Brooklyn.

CHAIRPERSON RIVERA: Well, that's excellent and I—I know we had a hearing recently talking about the importance of doulos, and I'm very

interested in holding a hearing on-on midwives and their work and how we can redefine who midwives are because I don't think it's just—it's not just female right? These are TGNCNB individuals. So, does H&H have any permanent staff who are charged with overseeing these trainings, make sure that people are not just getting the trainings, but they know that some of those E modules are available and is there any incentive to—to get people to take these trainings? I wan to believe that every person working in a hospital wants to take these trainings, but I also know that we have a lot going on, and we want to make sure that we're holding the entire employee system accountable.

DR. WILCOX: That's a great question. Thank you for that. So we have within Health and Hospitals the Chief Learning Officer for the system, and their team is really investing in building training to support capacity building of staff, and I work closely with Chief Learning Officer and their team, Dr. Allen, and all the other clinical leads work closely with the Chief Learning Officer to really ensure that we are providing up-to-date best practices and building the skills and competencies of

our workforce. So, thank you for that because we actually have a dedicated team assists—that works across the system to support learning and development.

CHAIRPERSON RIVERA: How large is the team? I'm sorry if I'm---

DR. WILCOX: Oh, I don't know the exact number, but it's a—it's a sizable team. They have training facilitators. They have support content—content with our subject that are experts. They develop in-house the—the learning management and support the learning management systems that we have, and we—they support us even with in-person live sessions that happen across the system at each facility.

CHAIRPERSON RIVERA: In November 2018 we held a hearing on TGNCNB Healthcare Services, and we heard from a lot of amazing advocates and the work that that they were doing, and we had as I guess I would say a big budget win in 2019 to make sure that we sure that we had healthcare navigators for this community. So, since then H&H launched 14 unique training opportunities for staff that relate to creating affirming environments for TGNC, people,

patients, families, employees and we have here the number 6—16,264 unique staff had taken at least one of these trainings. Now, I don't know what the numbers are as of today but is your goal to have a 100% of the employees trained in this? I think if you have timeline?

DR. WILCOX: Thank you for the question. The good news to report is that we've added two new training modules so we have 16 unique training opportunities for staff that relates to creating affirmative environments for TGNC people, and to date we have trained upwards of over 20,000 unique staff on one or more trainings that gets us approximately 60% and our goal really as I had stated earlier is to really integrate training on cultural competency LGBTQ affirming services in a way that everyone has access and is exposed to this content year round. We don't want to look at this as one-offs because we believe that it's really important to continue providing and reinforcing best practices throughout the year.

CHAIRPERSON RIVERA: How do you handle complaints about cultural insensitivity?

DR. WILCOX: So complaints in general are—are managed and handled via in accordance with federal regulation. At each facility we have patient/guest relation teams that's mission really is to serve as advocates for patients, and manage complaints and so the—the projected—the way that complaints are received is that patients will connect with the patient representative. Most complaints are resolved as quickly as possible, but within 24 hours. For instances where they may be a more complex or require more time. By federal regulation we have to acknowledge and respond to the patient within seven days.

CHAIRPERSON RIVERA: How do you track , and analyze them?

DR. WILCOX: They are tracked. They are all tracked, and they go through our QA on a quarterly basis.

CHAIRPERSON RIVERA: And so does—as you gather this data, there is someone there to analyze them to see how you could refine and improve the trainings and some of the care that you're providing?

DR. WILCOX: Absolutely, and most of the complaints that we receive are really service related

issues such as like I haven't seen my doctor, and so that's something that's quickly triaged within a matter of hours. So, if there is a patient who wants to see their doctor, they would speak to the Patient Relations Office and the—the Patient Relations rep would then connect the patient with their physician and the matter is resolved. So many of the complains that we do receive from our patients are things that we can manage and resolve and in a very quick period of time.

CHAIRPERSON RIVERA: You said that most of the complaints you said are service related.

DR. WILCOX: Uh-hm.

CHAIRPERSON RIVERA: How many complaints do you typically receive?

DR. WILCOX: I don't have a specific number, but I know that the vast majority of the complaints that we receive are service related, and are resolved rather quickly. They're resolved within 24 hours, but I don't have any specific numbers for you at this time.

CHAIRPERSON RIVERA: And you can absolutely break them down to better tailor some of the trainings?

DR. WILCOX: I haven't been able to analyze it to that level of detail but—but I do understand is that many of the complaints we receive are something that we are able to resolve quickly and with very little effort by our patients.

CHAIRPERSON RIVERA: And how are patients informed of their rights, and how to complain in the grievance process?

DR. WILCOX: That's a great. So, we have posted in our inconspicuous locations across our like waiting areas the list of the—list of patient relation contact information. I also serve as the Supervise Coordinator for Patient Services for the system,, and so they can directly connect with our office, but if people don't feel comfortable in submitting a grievance or a complaint within Health and Hospitals, we also have listed the U.S. Department of Health and Human Services Office of Civil Rights, and their process for receiving complaints, which can be by telephone, via email or by completing the form that you downloaded, and so we have based on regulations have to post this, and it's available to patients.

CHAIRPERSON RIVERA: When you mentioned the service related complaints, would a person's spoke language ever cause a delay in receiving care?

MATILDE ROMAN: So for the system, we monitor language services through my office. So, I am the bassist owner for Language Service across the system. We monitor daily our connection times, our wait times any quality issues. We have monitoring and audiences in place that allow our end users, which is our providers to provide us with real time feedback, and we get that immediately, and so really it's an opportunity for us to always evaluate and assess the effectiveness of language services because that is a top priority for us because it speaks directly to quality and safety of our patients.

CHAIRPERSON RIVERA: So when you sit down with a patient and you're doing an intake for example, do you ask—do you collect data on racial or ethnic groups? Do you ask people if they have a disability? What kind of personal information is collected?

MATILDE ROMAN: Demographic is—demographic information is collected at point of intake. We have race, ethnicity. We collect and if

an interpreter is needed and the language in which interpretation services is required, and that's how we connect individuals with services, and we have a variety of different methods in how we deliver assistant services to our patients to ensure—because it's—it's not a one size fits all approach, and so we ask the question, you know, what is the preferred method of communicating with your doctor or your nurse?

CHAIRPERSON RIVERA: Do you ask if they have a disability.

MATILDE ROMAN: We do and we have in our demographic information fields that allow for us to annotate that on the record.

CHAIRPERSON RIVERA: And you mentioned you are trying to use this data to inform the quality of care you're providing, correct?

MATILDE ROMAN: Correct and as—as and as you know, we are slowly migrating into our new electronic medical record and that we hope to have fully phased in by the end of Calendar year 2019, and the goal for us would be is that as we have all our facilities and using the same electronic medical record, and we continue forward in training staff on

using the new electronic medical record that we're—we are going to strengthen the demographic information that's going to be able to inform prevention intervention, and our practices within our healthcare delivery.

CHAIRPERSON RIVERA: No, it's exciting the—for anyone that doesn't know, the electronic medical record is epic. It's going to be officially live in all of the facilities by December 8th I think.

MATILDE ROMAN: December.

CHAIRPERSON RIVERA: I knew it was the 7th or 8th. It's on my calendar.

MATILDE ROMAN: So there's a lot of training and learning that needs to happen, but we believe that it—as we have integrated into the standard electronic medical record that our data is going to get stronger, and that data is going to inform our work better.

CHAIRPERSON RIVERA: And—and that's great because I know you had three different systems, and they weren't talking to each other and every hospital was using something else. So, this is streamlined and it sounds like it's—it's going to be I guess an

unintended epic, right? [laughter] So, the—the--the data that you're collecting right now and you're—you know, you're using it to inform the services that you provide. Do you—I just want to make sure that-that—that you're refining some of your services, right, that you're using it to make sure that if you receive a population that speaks a certain language, which clearly you need to find a doctor or a nurse or an interpreter 24 hours a day that speaks that language, or if you noticed that people with disabilities have heard that the services at Morrisania are outstanding, and they continue to come to your facility because they both advocate for some of those changes, but you're making sure that it is some of the—the best equipment, the—the best services that they can receive. Can you give a couple of examples of how use some of this data that you're tracking to measure and then improve outcomes?

MATILDE ROMAN: So, I could speak with respect to language services, and how—how we track. Language use informs us and new and emerging languages within specific geographic locations in which we're providing services, and then we work closely with our vendors to help source interpreters

to fill the need. I know that in our work with ICS they have been instrumental in identifying opportunities for improvement, and we have been working closely with them to retrofit a number of our exam rooms, and out diagnostic areas in order for us to create greater improvement for women who have mobility issues. So those are some-some—two-two quick examples of the work, but I think the data says one thing, and I think part of the—the larger story for us is that, you know, we are engaged with the community in ways that that inform that we're doing well, and where we still need to improve and—and so that's something that happens ongoing. Dr. Katz meets regularly with communities. So that he can himself listen to their concerns and challenges, and so we're very much open to really understanding how as a system we can do better.

CHAIRPERSON RIVERA: Alright, I believe that you all very earnest in your approach to this, and I—I—I think my—my one kind of question and I'm—I want to make sure again that I understand that you continue to make sure that in your new employee orientation, and your annual in-service meetings that people receive culturally competent—cultural

competency training as well as implicit bias information materials resources. Correct? That you're working on a fuller more comprehensive plan that will launch this fall in which you're starting at the top and hoping to at some point down the line train every single person in your facility. Is that correct?

MATILDE ROMAN: Yes.

CHAIRPERSON RIVERA: Everyone, right? From reception to the aids to the doctors? Maybe not by tomorrow, but at some point, right?

MATILDE ROMAN: That is the goal. The goal is that at—at the point of entry to the point of discharge that people are receiving affirming competent care throughout the continuum of care. We've trained hospital police on LGBTQ sensitivity. We are training clerical staff on how to ask those related questions that are respectful. We are training our community health workers on health literacy and cultural competency. We have in-service cultural competency components embedded. We have also—also in our in-service and it is true to say and I'm—and I have high confidence in saying to you that it's our goal is to always make sure that on an

ongoing basis that our staff are receiving culturally competent training.

DR. MACHELLE ALLEN: And just to add to that Chairman Rivera, as we're building curriculum that are not specifically about implicit bias, so as we're building curriculum and simulation should we just—show a post-partum hemorrhage, that implicit bias is included and embedded in our academic courses as well.

CHAIRPERSON RIVERA: And I just want to add that I think you would have the support of the medical community if you, you know, go on record and say that these—these trainings they should be mandatory that they should not be optional, that it is far too late in the game, and we're far too long in history with—with things that we have to acknowledge that we've done. We've done them unjustly and we really have to correct so much in—in delivering what is a basic human right. I—I just want to thank you. I know that, um, I've asked you a lot of questions about why isn't it mandatory and why is this optional or why isn't this up and running. I realize it takes a ton of coordination, but I want to just thank you for being here. There are many

hospitals with fare more resources that H&H who decided to not attend this hearing and I don't believe Greater New York they will be in attendance today to deliver their testimony and I know for a fact that they have far more of a better capacity considering the patient population that you're serving. So, I want to thank you for answering as honestly as possible and for all your work and dedication and I really want to stress that you and your team stick around as long as possible because we're going to hear from some amazing people, and thank you so much for your testimony.

MATILDE ROMAN: Thank you, Chairperson.

DR. MACHELLE ALLEN: Thank you for inviting us. Thank you for addressing this topic. It's paramount for us. It's excruciatingly important. We see it every day in every service. So, I just want to thank you personally for holding this hearing.

CHAIRPERSON RIVERA: Thank you. We are going to call up Marilyn Saviola, Claire Abanante (sp?) Rosa Maria Ocasio and Makaley Brink—Brinker, and you can feel free to correct me on the names. So, I have my name mispronounced all the time, and I'm

sensitive to that. [pause] And Minion Lyons also. [pause] No apology necessary. Don't worry about it. I just want everyone to be as comfortable as possible, and if you need anything you just let us know.

MARILYN SAVIOLA: Okay, can you hear me. [background comments] Alright, my name is Marilyn Saviola, and I am Senior Vice President for Advocacy In Women's Health at ICS and I am honored to be at this hearing. I want to start by thanking Casa for calling me here, and our staff and the work they've done with us. Thank you. There are a lot of things I want to skip in my testimony, but a lot because I want to respond to some things with the agency. I want to begin with saying that we have an excellent relationship with them, and we started with Women's with people with disabilities in 2007, and we got a grant, but I think that you knew that with my--from my background and my life and my peers, friends and colleagues for some membership that people are not getting women's healthcare specifically a mammogram. When those were new, and then I found mammogram then for myself getting a mammogram or picture Rosie someone who has trouble with balance, and on that and

so we all went out and challenged it. It took—so we got duress when the culmination to—to—I think if I addressed the barriers that prevent women with physical disabilities from getting mammograms or other screenings, and if—if we're not oncologists, we're not a breast service and we're not radiology. That's what I'll say, but we are really competent as an organization, and it's good to down there. We are-excuse me a second. So, we got the demand so we had to apply it in the department site in the breast cancer screening that would work with us, and, um, it's running that. It took us 5-12 months in New York City to find one facility that would work with us. Either one we would go it's got your egress and inaccessible because you couldn't get in the building then. You couldn't get in the examining room where the machine is. That bucket (sic) that you put your breast in didn't go down low enough to accommodate someone sitting in a wheelchair or someone who had the machine or like nor the disability competent training, and I knew and I'm concerned about how much money they would lose because they are only reimbursed for a 15 units (sic) really to get breast cancer screening. I had lost a dear friend who had

breast cancer, and some of the polls (sic) they had before you get a mammogram, and screened mammogram on that. I'm sure the workers said its in her mouth (sic) not her breast. She had unfortunately died a very painful death all because there was accessible for the patient was in there. We found that there is a—there's a department that works with people with disabilities and for a lot of these services you need to be—you need to be in the application of it in the community wise or parents or mothers where we work—we raise children just like anybody else with any illness that it's compounded by a physical disability, and it's like that and so it's rough for people with disabilities. Okay, thank you. [pause] I said that the care for people with disabilities is very segmented. It's just this up until after a few years when I got my primary care from my neurologist. She questioned me about my disability. She knew what she had to look for. Many of us became disabled as children so some of these patients are in their 40s because they have no one else who would take them. You can talk to me for—about the incidents. There are incidents of death and something in breast cancer. There is not a higher incidence of breast

cancer within the population of people with disabilities, women with disability, but there is— there the clients work on the death rate or the mortality rate. You know, but it's…well, the obvious reason is that places are not accessible and so they don't know where to go, and the danger is that people with disability are not given aggressive treatment the way an able bodied woman would. For someone that's a value judgment that someone is likely not be happy for it, and now we see these losses of life. They suffer more and have to have a cultural mammogram so they can be comfortable like comfortable and maybe have one from that perspective. [pause] Oh, what happens when someone like me who is like myself goes to a doctor, or-or maybe like someone like myself testifies at a hearing with the Department of Health. I'm their biggest nightmare because they know they're going to see it all behind me. It's high-end costs (sic). It's a population of people with disabilities at high-end so there is obviously staff are the ones are the ones who are last, and nothing in this area exists, and the one thing we missed in that 1997 (sic) we started this program and we found partners first at Columbia, but it was at the

Columbia Center. It was that Forsyth that worked with us, and then we moved again with Juniper (sic) up to the Harlem Breast Center, but we couldn't get into the—in age. We had many different meetings, different people and we went up to Lincoln Hospital because of they were starting to bring new radiology, and for the mammography they thought the machines were better. So, we went up and reviewed them and we surveyed that. We went and—and we talked to people and they were trying—they set up a meeting, ICS set up one and talked about why I was new was this, and after getting again like three or four times, which it had not developed and it was still a little new, and as soon they thought about as to the money it would cost. So, you're in our presentation, and—and usually it's cheap radiology is that I saw it and the Woman's Health Program for breast cancer radiology. But this time, there is also the Chief of the department that came out, it's the Chief of the Managed Care and it's the Chief Medical Officer, and she ended up in the room, and she said, you know, I'm—I'm really upset. This is—here I am. I'm a primary care doctor, and there is a white elephant in this room, and the elephant is why your only looking

at a woman's breast. Why don't you look at—at her whole body? I don't think you try that, and so we told her we realized that we were, but the best thing that happened to us because she referred us to Morrissania and that's the –that's the treatment center, which is our first entry and we said they really welcomed us. They said you could really help train us because we don't—we do this, but we don't do it a lot. (sic) I think we would rather do this. So they—and we do trainings on disability health industry, and there was some sensitivity. Where there is a sensitivity. It's in all of us in my women's health area who are providers and who have more contact with patient care, and it's a long journey and it's done, and we actually did make a video with H&H. That I would say that was in 2010 or 2011, which was supposed to be news. It's, um, only—I've taken it for four years. (sic) We didn't like the video. They didn't like the video. The people in the video didn't like the video. So, we didn't get very far. It's something we need to revisit, and the other thing is now about is to go into primary care with Health and Hospitals, H&H, and with Ken Long (sic) We would have—within his staff to, um, get this

done. Right now we have five sites with H&H that are disability accessible—disability friendly. They are not ADA accessible because we don't have the money to do that, but you're using that if you make simple changes enough. You know, to follow the standards for accessibility, which is all that as they renovate and become more and more accessible, and that was the thing against it. The other thing is—is to realize that, um, like so just noise to that doctors aren't taught about. I mean I think that there is some training at medical schools, but it's an elective that one might take after class that becomes from mutual (sic) from that that we do. So, I, you know, we have the commitment to help at H&H to move ahead, and start primary care, which is the next step because that is where the money saving costs are. That's where if we give the people with disabilities the primary shots (sic) you know, and the minor shots. Like a person under their primary care doctor. They go to see their neurologist who doesn't have, you know that kind of upset New Yorkers usually. So, we have to deal with that within our--

CHAIRPERSON RIVERA: Well, I—I was going to mention that it—it speaks to a lot of the work

that you have been doing. I mean they specifically mentioned the Independence Care System, you know, in their testimony, and—and all of the work I guess collaboratively that you've been able to—to accomplish, all of the things you've been accomplish and—and for me I—I—you answered a lot of my questions in your—in your testimony in terms of your perspective and your experience, and I think that we all agree and why the honor is mine to hold this hearing and to have you talk a little bit about personal experience and-and how long you've been working at this issue. Is that right? We do not want cultural competency training or implicit bias classes to be an elective. It's—it's—that's non-negotiable. That's not where we're at and we have—we have a long way to go. So, I know that you have a number of other—other advocates with you correct?

MARILYN SAVIOLA: Correct.

CHAIRPERSON RIVERA: And thank you so much.

MANDY MARTIN: Good morning and God bless you. My name is Mandy Martin and I've had—and I want to explain why it is very important to include people with disability in the Resolution 51—512. I've had

Cerebral Palsy since birth. My main—my main systems for is severe spasticity. Because of my disability I've had a lot of bad experience in trying get healthcare. Some of this is due to the physical barriers. I've been—I've-I've been to doctors' office and have not—okay and have not been able to get on adjustable table. I have struggled to get out of my chair and climb on a table, which is not safe—which is not a safe thing for me to do. However, a lot of the problem is the bias against people like me. I have very—I have been very—no, I have very badly treated [background comments] by medical professionals because of my disability. For example, I—when I was brought into the doctor's office, the doctor would often talk to my aid instead of me. Let me give an example. They would look at her and say: How is she doing? Why is she here? That's insulting. Do I sound—do I look or sound like I can't speak for myself. You never know—you don't know me, but just looking at me do I really look like I can't speak for myself? Okay, when I was pregnant with my son—that's another story—the social work asked me: Why do you want to keep your baby? My first pregnancy, my only pregnancy, thank you, Jesus. My

sister-in-law was listening and she was up—she was very upset. I had to more calm her down than me. Thank God. I said my mother kept me. So, why wouldn't I keep my baby? Then one time I went to the neighborhood clinic—the neighborhood clinic for my—for my pregnancy, and they referred right away to a high-ris clinic and not to a hospital just because they saw the wheelchair. They asked—they-they didn't ask me or didn't investigate did I have high blood pressure or were my feet swollen. So, I went to another hospital, and then—then at the high risk—at the high risk clinic for pregnancy the doctor said: Why are you here? I didn't have high pressure or my feet weren't swollen, they—again, they just looked at my wheelchair. Okay, if this have—if this doesn't change—if this doesn't change, what will happen? If things like this don't change, what will happen to people like me. What happened to a very close friend of mine, she was—she also had a disability, and she developed breast cancer, but by the time they found out, it was too late and she passed away. No one should have to die from a late diagnosis or by a medical professional. Don't they thing that—that your matters just because you have a disability, but

too often it's just the way it is. I'm here today because I want things—I want things to be very different and teach doctors about not to have bias against people with disabilities. It's important—that is why it is important to take these steps. Thank you for listening to my testimony.

CHAIRPERSON RIVERA: Thank you. [pause]

ROSA MARIA OCASIO: Good afternoon. My name is Rosa Maria Ocasio. I am a mother and grandmother with disability. My disabilities began in 1997 when I was working as nurse's aid and also a home care aid. I was injured on the job followed by another accident in my home. I have permanent disabilities involving my neck, my back, my arm, my legs, my foot and in some cases my bones are fused together. I can't move far without a walker, and I have a lot of pain, constant pain that is just there. 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—I'm having trouble holding it up. I'm sorry. My experiences trying to get a

breast cancer screening were horrible. I have a very hard time getting into position for the mammogram machine. I wear braces on both of my legs. I can't put all of my weight on either one of then and I have to shift from side to side. To get a mammogram I have to be still, and I also have to lean over, which is was bad problem. It's very hard to do, and if I do so for a long time, I go into back spasm in my lower back and allow me to add I have also had RSD to my left hand. I have, you know, I'm getting nervous.

CHAIRPERSON RIVERA: It's okay.

ROSA MARIA OCASIO: I also have an extension--

CHAIRPERSON RIVERA: Don't get nervous, okay?

ROSA MARIA OCASIO: --I also have an extension at a 45 degree angle to my right forearm. The experiences was so terrible because of the mammography technicians didn't understand my condition. They didn't ask appropriate questions and basically to let me know that I was a burden to them. I've even called on—what is the word that I could give. Incompliable (sic) Yeah, they assumed I was unwilling to cooperate when all I was trying to do

was trying to accommodate my body so it wouldn't hurt so much. They were very 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 a good medical care, and I know that it is a direct result of bias [background comments] because ever since ICS, Independent Care System helped me with finding a disability competent doctors who actually treat me as an individual and work with me and my condition I've been able to get the proper breast cancer screening.

CHAIRPERSON RIVERA: Thank you.

Good afternoon. My name is Michelin Branker. I'm a registered nurse and a certified nurse midwife. I have a spinal cord injury, which happened in 1993 as a result of surgery gone wrong. After I became disabled, I applied to a job as a school nurse, which I was completely qualified for. However, the nurse who I would have been working with at the school called the district area supervisor to say that she didn't believe I would be able to perform in the job because of my disability. Even after I went for a trial at the school in the administrative 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'm all to aware of the bias that people with disabilities face in seeing health care. I'm there today to urge the Council to rewrite the 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. Thank you.

CHAIRPERSON RIVERA: Thank you, and I want to let you know that this is exactly why we have hearings to let you know that we take this feedback seriously, and your recommendations to heart, and that the Resolution and its language right now is—is not final, and is open to amendment, and so I want to thank you for making those suggestions very, very

much and thank you to all of you for sharing your personal experience.

FEMALE SPEAKER: Hi. Thank you very much. I appreciate your time and I really appreciate this resolution. As you see, this is very personal for all of us for implicit bias training. I'm going to read the testimony of Dr. Carla Boutin Foster who is the Associate Dean, Office of Diversity, Education and Research at SUNY Downstate Health Center. She works very closely with us and she's very interested in changing curriculum for physicians to include implicit bias. Thank you for your commitment to promoting health equity. I write to you as the daughter of a Haitian-American man that by training was a physician and researcher. About 10 years ago my then 70-year-old father developed painless hematuria, blood in the 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 my dad the latest clinical therapies, one who would also be able to put him at ease while communicating with him. We were fortunate enough 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 a math teacher. I was glad to have found a physician who knew that my father enjoyed walking across the Brooklyn Bridge, but was not limited because of his sever 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 was not the same for everyone. I can recall a story of a health advocate who went to get a mammogram and was told you people—people in a wheelchair cannot be treated here. I also recall a family friend who said when he went to the doctor 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 work to be done. Several medical schools have integrated elements into their curriculum that introduce students to health disparities, health inequities, social determinants and, cultural competencies and unconscious bias. As our population becomes increasingly diverse there's an even greater urge for integrating these dimensions of professionalism into medical school curriculum. Future physicians must be able to attend—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 cultural influences healthcare and outcomes. There is a need to move beyond safe discussions about cultural competence and disparities and create safe spaces where these 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 towards developing a more diverse and culturally competent workforce. Thank you.

CHAIRPERSON RIVERA: Thank you so much, and thank you for assisting us today. I just wanted to make sure did we hear from Sharisa?

FEMALE SPEAKER: I'm sorry. Sharisa at the last minute could not make it.

CHAIRPERSON RIVERA: That's okay. We—we sill submit her testimony for the record though.

FEMALE SPEAKER: Thank you.

CHAIRPERSON RIVERA: Okay. Well, thank you for—for reading that. Coming from someone or people who have experience in the field who also are facing receiving care and for all of your advocacy, we—we-again, we're open to recommendations on how we make this the strongest resolution possible because we have every intention of continuing this conversation and lobbying our colleagues in Albany who have a lot of say over what we can do to improve just our health system overall, public or private. So thank you very much for your testimony.

FEMALE SPEAKER: Thank you.

CHAIRPERSON RIVERA: I'm going to call up Sasha Penapa, Dr. Tara Cortez, Christina Gonzalez. I have three Students, Connor Fox, Rachel Willingson, and Alec Feuerbach, [background comments] I also have Andrea Bowan here. I want to make sure we can fit you all. I'm sorry if I just called up the whole room. [background comments/pause] So for all of you that are standing, they're getting your chairs right now, and I appreciate the kind of—I know some people have to go, and I want to be respectful of everyone's time. How are we doing? One more—one more chair. Okay. Yeah. Who would like to—do you want to start? Okay.

DR. CRISTINA GONZALEZ: Thank you. Hi. I'm Dr. Cristina Gonzalez. I am a physician and a scientist, and my singular focus of research is on designing, implementing and evaluating interventions and implicit bias recognition in management. I have prepared a short written testimony with a lot of references and, of course, I have a lot to say based on the excellent testimony and advocacy from the previous people. Did you want me just to stick to this or-

CHAIRPERSON RIVERA: Honestly, it's up to you. Within just a couple of minutes you can-you can read, you can hit a couple of important points if you'd like or cover things that maybe you don't felt were underlined. It's really up to you. Just know this will be submitted for the record and anything else that you say.

DR. CRISTINA GONZALEZ: Oh, perfect. Now, I'll say other things.

CHAIRPERSON RIVERA: Okay.

DR. CRISTINA GONZALEZ: And so briefly, I want to applaud your work on writing this resolution and addressing the problem of implicit bias and I think that there are opportunities for implicit bias, education or training and across the spectrum of training and practice and I want to emphasize the, um, importance of what our colleagues said in the previous testimony regarding the training all the way through from front desk all the way to whoever checks you out, and parking attendants. I mean we've built the model and based it actually on patient perspectives my team and I on how they perceive bias, and so sometimes I asked for myself. I as a physician may make an assumption and say the wrong thing or do

the wrong thing, but I also may be asking standard questions that we teach our medical students to asked that based on the level of experience of perhaps being covertly accused of things like asking you if you smoke because I was taught to ask about these multiple risk factors. They may be, you know, put off by that, and in training students and—and beyond to realize the perspective, taking the importance and to the lived experience of the patient and to have worked on that taking it personally. Patients have talked about being snubbed at the front desk and then seeing the physician, and so they may be in a different place mentally than I would assume they were based on perhaps my intentions, and so looking at beyond the health conditions and the and the Resolution, which I imagine wasn't meant to be all encompassing. Just something as simple as verbal dominance and non—non-verbal behavior such as interpersonal distance and safe touch are—have been directly related to implicit bias tested and fit by physicians, and in addition to the decision making related to life saving procedures, medications, going to the count (sic) during a heart attack and so there are many existing programs. I have developed

electives and thank you for saying that because once the science is worked out, you do need attend the science sometimes in the full audience as a medical education researcher. You need to pilot it, do the innovation, make sure it works and roll it out to the broad audience as you will never change policy on the outcomes of the self-selected volunteers, right, who are wonderful for electives, and so we've done extensive work on patient, student and faculty perspectives, and I just want to say that if there's a way in the Resolution to sort of where you're trying to contribute to—to the knowledge base to move beyond one training because there are unintended consequences of raising awareness. So, if you raise awareness and you stop, which is often what you can do in one session, making aware of your own implicit bias there are data to support that. There are subsequent negative effects such as social avoidance, right, because good people with good intentions who realize they may be biased against groups they don't want to consciously be biased against without skill development may actually withdraw and then—and—and avoid encounter and they shorten visits even with—with patients, and given to actually skill

development and that outcomes you mentioned tracking if we can push the field and each other to move beyond how many people took the course or took a session to actual patient oriented outcomes right including communication, including decision making, which can be measured and tracked. We have an age funding right to—to work on validating outcome metrics because people will no matter how good their intentions are, are unlikely to engage in multiple sessions if they don't have any evidence that they're effective, and we don't have any outcomes to strive for, and so I'm available for any discussions or for anything that might be helpful. This has been a singular professional passion, and I think you for the opportunity.

CHAIRPERSON RIVERA: Thank you, thank you.

DR. TARA CORTEZ: Good afternoon Chairperson Rivera and Council Members present. My name is Dr. Tara Cortez and I'm Executive Director and a Professor at the Hartford Institute for Geriatric Nursing, which is the geriatric arm of New York University, Rory Meyers College of Nursing. Thank You for the opportunity to testify today and

share my expertise in the topic of healthcare service delivery and outcomes among urban populations. Access to afford quality and timely healthcare contributes to efficient and effective healthcare. 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, but there are several reasons that are barriers to accessible healthcare, and the first one that is usually thought of is people who do not have access to health insurance, and this affects all—all people including those who are our marginalized population such as those who with that—who are part of the racism, those who are disabled and those in the LGBTQ community. Twenty-seven and a half million people in the United States or 8.5% of the population went without health insurance in 2018. The number is slowly rising. That's an increase of 1.9 people from the previous year. Others do no have access to health services because of language barriers, insensitive to cult—insensitivity to cultural differences or immigration status. We saw a very interesting and fascinating picture. It's tough to follow the first panel because

they were so compelling. 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 incidents of or mitigate the impact of chronic disease. It results in poor health outcomes, lower quality of life and a higher mortality rate. The hard things (sic) , too, for geriatric nursing is develop two online alerting modules for the Arch Care Workforce Improvement organization to address cultural diversity and competency in healthcare. That one is to address the professionals and the second one was—was specifically designed for home health aids and CNAs. 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. Those 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 the 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 physical environment, air quality, water quality and housing contributes 10%. In New York in 2019, the Bronx is ranked number 62 in health outcomes. That is the lowest in the entire state. New York County is number 5, Queens is number 8, Kings is number 17 and Richmond is number 28. Health behaviors are—account for 30% of the influence on our health outcomes and actions people take to effect their health. So, this is something that that could be intervened. There could be an intervention for health behaviors that's maybe low-hanging fruit. It includes action such as eating well, being physically active and avoiding actions, which increase the risk of disease such as smoking, excessive alcohol intake and risking sexual behavior. For example, poor nutrition and lack of exercise are associated with a higher risk of cardiovascular disease, Type 2 Diabetes and obesity. Tobacco use is associated with

cardiovascular disease, cancer and poor pregnancy outcomes. Excessive alcohol intake is associated with injuries, certain cancers and liver disease as well as poor pregnancy outcomes. So, health behavior certainly also a factor in maternal and children outcomes of—of maternity health. The Hartford Institute for Geriatric Nursing believes that to achieve good health outcomes we need to break down the doors, the four walls of the hospital system and extend care across the continuum to include community resources and recognize those as a partner in healthcare. Those communities are the culturally sensitive resources for people who live in them. Hartford Institute for Geriatric Nursing has implemented an initiative in the Bronx in partnership with two community based organizations Rain and JASA to increase health literacy and impact health outcomes for older adults in the Bronx. Using community based volunteers, peer-to-peer education to ensure cultural competency we have educated almost 200 volunteers who have held nearly 300 classes and educated nearly 5,000 older adults on such topics as exercise, nutrition, stress management, sexuality, oral health, opioid uses, misuse and management of

chronic diseases, asthma, heart disease, and dementia. When surveyed between one and three months after completing this education, 79% of the seniors say they changed their behaviors and 75% said they- they feel their health has improved. One participant said: Oh, my gosh, you saved my life and when we asked her why she said I never knew how to talk to my doctor, and from the class I learned how to talk to my doctor, and I was on the wrong asthma medication. He has changed my medication and now I feel so much better. In summary, improving population health requires more than just addressing healthcare access and cost. Risk behavior such as poor food choices or sedentary lifestyles and socio-economic physical conditions such as food insecurity and housing whose combined impact on health outcomes exceeds that of clinical care by 4 to 1 also needs to be addressed. I would recommend that those be included in the resolution. Thank you for the opportunity to testify. We welcome any additional questions the committee may have.

CHAIRPERSON RIVERA: I just have a question because I'm wondering here. You said risk

behaviors. You said something should be included in the language for the resolution. Can you--?

DR. TARA CORTEZ: I mean the other determinants of health meaning socio-economic, the health behaviors as well as physical environment.

CHAIRPERSON RIVERA: That should be included in the resolution to improve implicit bias training in some of our medical training institutions.

DR. TARA CORTEZ: Yes because those are-- health—healthy babies are very often culturally driven.

CHAIRPERSON RIVERA: If you could just talk into the mic. Understood, but do you—do you not think that curriculum is—is covered into, and especially if—let's say we have New York students.

DR. TARA CORTEZ: Uh-hm.

CHAIRPERSON RIVERA: --and this is a very, very diverse city, and I mentioned some statistics and some demographics and how people are suffering in—from certain epidemics more than others and so I—you want that language the social determinants of health to be included in the

curriculum in some of our schools. Is it not included?

DR. TARA CORTEZ: It's beginning to be trickling in, but it's not universally included. I—I not every curriculum is including a comprehensive social determinants of health particularly looking at how do we change those aspects of healthcare. We still focus primarily in-in nursing education and I think still in medical education. We focus primarily on clinical care, and as important as it is, and as important as that is to a particular discipline, it takes the whole healthcare team. It's interprofessional team. So, I—we still don't have interprofessional education embedded into our systems. We still teach in silos. Until we can really embed interprofessional education and cross over so that who does take care of—of some of the social determinates of health. It's social workers, it's occupational therapists who address things in the environment. So, it needs to be an interprofessional approach, and I think that we need to be more clear on that in the resolution that it's more than just access to clinical care, but it's access to care that incorporates these concepts.

CHAIRPERSON RIVERA: Well, do you agree that medical schools should be training students more competently in implicit bias? Yes or no?

DR. TARA CORTEZ: Yes, I do but I also think our work force because I think what happens to a lot of students they get into a workforce that doesn't—doesn't practice what they—what is now being taught because of them grew up in an age when this was part of the curriculum. They enter that workforce, which is not focused on that. So, unless we educate the workforce about these things so that people coming out of schools with this knowledge are in a workforce that understands what they're talking about, and embrace it and encompass it into their practice, we won't make the change.

CHAIRPERSON RIVERA: I'm sure I'll have some follow-up questions for that, and I have your contact information in the testimony. Thank you.

CONNER FOX: Esteemed members of the New York City Council thank you for having us. My name is Conner Fox and I'm joined today by Rachel Wilkinson and Art Forbuck. We're 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 has already implemented an implicit bias curriculum over the past several years, we'd 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. Our school has sought to be a leader and 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 curriculum on racism and bias that students have during their pre-clinical years. I use the word preclinical to describe medical education that takes place in the classroom typically in the first two years in 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 horlight—highlight the stark contrast between what we learn in our pre-clinical, racism and biased curriculum versus what we learn hands-on during clinical training. As the 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 is developed with the help of students just a few years ahead of me. The curriculum restricts—placed in a series of classes throughout the first two years tells instances of historical racism like the Tuskegee experiments and practicing 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 has helped prepare me to being an effective and compassionate provider to medically underserved or marginalized patients and has equipped me to make serious efforts to reduce inequities present in today's healthcare landscape. Such curricula are hugely helpful in 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 created by medical schools in New York City and across the United States.

ART FORBUCK: So, 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 who are typically people of color, patients who don't speak English, patients with undocumented immigration status, or other marginalized patients are to be valued primarily as training opportunity—for the training opportunities that they provide. One major driver of this hidden curriculum during medical school is the fact that in many healthcare settings patients are routinely separated on the basis of their socio-economic status. For example, in New York State and especially here in New York City many hospital

systems commonly separate patients insured with Medicaid from patients with private insurance or Medicare. The practice that we are referring to as segregated care. This segregation can take a variety of forms. Patients can be seen in separate sites. They can be seen in the same site, but at different times, and they can be seen at the same time, but by different providers. Most commonly patients with Medicaid or patients that are uninsured are seen by a rotating cast of residents in one clinic while privately and Medicare insured patients are seen by dedicating attending—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 and her being seen in those resident clinics. This practice of separating patients based on insurance yields de facto racial segregation because here in New York State people of color are twice as likely to be insured by Medicare 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. So rather than undoing

or dismantling the socio-economic factors that disadvantaged 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 also very little anti-racism and bias training provided during the clinical phase of training to equip students to address these systemic inequities. In light of this, student at Mount Sinai have advocated for changes to the system for the past several years. In 2018, we began serving clinical year students on how this segregated system impacts their education. The results from the fall of 2018 showed that 40% of respondents witnessed one or more incidents of segregated care within their first three months of clinical rotations. A 2019 end of year survey of all student at the school showed that 58% of respondents believed segregated care negatively affected their education, and 80% of respondents believed these differences in care may lead to worse health outcomes. Now these experiences range from seeing patients with private insurance admitted to more comfortable in-patient 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 that were covered by Medicaid and seen in the resident clinic.

RACHEL WILKINSON: From our survey we have compiled a few of the quotes that illustrate the pervasiveness of these differences in care and how they damage our 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 and teach medical students to treat patients 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 poor Medicaid patient, how if mistakes happened, it didn't matter as much. A fourth student: This affects every aspect of patient care. So, therefore, it also affects every aspect of learning. It was so blatant so engrained as a resident and attending culture and

so entrenched in the language used on the wards, but no one even seems to realize how messed up it was. A fifth student: Because we do so much observing and imitating third year, we have a heightened ability to notice that, 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 it also feels sort of powerless to do anything about it. Further student can be found in my addendum. As these accounts were collected at Mount Sinai, our correspondence says with students at every medical school suggests that these comments reflect experience of the students at medical schools across the city. We underscore that the way those 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 amongst trainee. 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 as they are directly contradictive by what medical students are taught

during their education. We as students are therefore in support of the 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 and how New York State delivers healthcare. While healthcare systems may ultimately determine clinic staffing as student rotations, city and state policies can play a significant role in determining what types of patients are seen where. For example, healthcare systems New York State are often limited in providing care to publicly insured patients only in hospital spaces that quality 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, and only in such a system can we train medical students to treat patients equitably and without prejudice.

CHAIRPERSON RIVERA: Thank you so much and—and thank you for bringing up insurance based discrimination. It's—it's—it's kind of astounding I

feel like how little we talk about it, or that it should be brought up more often. How has the school responded to—to these, to this report, to—to this—this data collection, and-and do you have counterparts in other medical schools that are really trying to compile this type of information?

CONNER FOX: I guess regarding the second question first, we have been in contact with other students at other schools, and have communicated with—with them and have heard anecdotally that they experienced similar sorts of things, but I don't think that anywhere else they have taken these exact same efforts. In terms of how the school has responded they have started a what they call an equity task force that is trying to address these matters. Some of the issue have—that we have encountered in trying to push for integration of clinical spaces has as far as we as students understand—understand things, it's been I guess a barrier towards integration has been physical space and the fact that the hospital is trying to get maximum Medicaid reimbursement by seeing Medicaid patients in hospital spaces as defined by Article 28, and they are then seeing the amount of Medicaid

insured patients in spaces that do not meet Article 28 requirements for full reimbursement. So, even though the state law is sort of enabling segregation even if it's not explicitly doing—saying anything about it.

CHAIRPERSON RIVERA: So, they put together a Heathy Equity Task Force kind of based on these. I'm going to follow up with them and I'd be interested to know their format and kind of their—their goals and I guess I have you all to thank for it. I think it's incredibly important, and—and thank you for your testimony.

CONNER FOX: Thank you.

CHAIRPERSON RIVERA: I guess you're up Andy.

ANDREA BOWEN: Thank you Chair Rivera for, um, um the opportunity to provide testimony today. Thank you for your consistent amazing work in supporting our marginalized communities in public hospitals, and I want to give a shout-out to Council Member Rosenthal for this number—Resolution Number 512. So, my name is Andrea Bowen. I am principal of Public Affairs Consulting. I'm speaking on my own behalf today even though I generally work with

several organizations that work with transgender and non-conforming and non-binary people. I'm just speaking off [laughter] the testimony that—So, first, I want to thank—start by thanking you and your many colleagues, but you really led the charge on getting funding for the LGBTQ Health Outreach workers at H&H. it's really exciting to see those implemented, and I guess I just wanted to emphasize a couple of things moving on forward from that baselined funding, which was just again making sure that there is as much advertising as possible that they exist, and that they can like really spread the word that TGNCNB folks can get quality care in the H&H system, and as word spreads about these positions that their numbers expand commensurate with need. I think that H&H is still keeping it at about three folks who are doing the, um, this work with the LGBTQ community outreach workers, but the baselined funding I would imagine would make it more possible for expansion moving forward. When it comes to I guess issues directly related to the oversight function of this hearing, I just—I don't know if this is possible, but as some of the testimonies that were provided by TGNCNB community members over the last year could be—I mean

put on the record for this one. I don't know if that's doable, but I'd love to make the ask. I mentioned in hearings where they take place. I hope it--

CHAIRPERSON RIVERA: You're permitted. You could--

ANDREA BOWEN: Okay, cool. I only—I mean I only have my own but there were like a lot of people who testified on this. So, um, so hopefully that was all coherent. As regards promotion of implicit bias training, um, so I'm totally in favor of that so long as it's high quality and effective and by that I mean it should involve the—implicit bias trainings obviously should involve the community input process using experienced curriculum developer and trainer, include a pilot study, a series of refinements. It's on page 2. Sorry. I'm kind of jumping around. Just to make sure that like there's a clear theory of change, that the theory of change evidenced based, and that the actions taken by the trainer that the attitudes and behavior of the trainees towards marginalized communities in question, and, of course, like this kind of training from my understanding works best when it's put together someone who has,

you know, stature in the field with their training. So, we would want this to be like a trustworthy authority in the field of clinical practice as well as like the like field of competencies pertinent to the marginalized communities that their trainings are focusing on. Am I coherent so far?

CHAIRPERSON RIVERA: Yes, and you.

ANDREA BOWEN: Swell.

CHAIRPERSON RIVERA: --you're providing us with a redlined version, which is always helpful.

ANDREA BOWEN: Okay, not too much. [laughter]

CHAIRPERSON RIVERA: Oh, no.

ANDREA BOWEN: As an example of like a really-this is not implicit bias, but it's something that was done by the city that I think was a really cool model, and I think was actually effective. SO, DOHMH did a TGNCNB training curriculum for these actual health clinics, and so these develop learning and allowed the clinicians to crack this anti-bias techniques that they learned by working with paid practice patients from the TGNCNB community, and it speaking to the direct skill—skill and about my work and my colleague mentioned earlier. So the practice

patients were there to make sure the clinicians could actually like practice using their right pronouns and practice using affirming practices and it's a model that really should be incorporated more widely and I put that language also in the redlined version. So implicit bias is important to root out, but we also wanted to make sure that like we're focusing on the skills aspect so that they practice affirming skills is also followed through on. So, I added that to the rest of the language and thank you so much for everything that you do.

CHAIRPERSON RIVERA: thank you. Thank you for your testimony.

SACHA PANAPA: Hello. Good morning or good afternoon. My name is Sacha Panapa. Thank you for the opportunity to speak today, and my role is a little bit different than everyone here. I am here as a person who experienced discrimination and bias at one of the local hospitals here nine months ago. I was hit by a car and while I was walking across the street and SUV ran the red light and hit me, and I flew about 40 to 50 feet, and I was brought to the hospital. I was at the hospital for 12 hours and while there nobody provided me with someone with

excellence. I shattered my wrist. I had a concussion and I injured both my knees and I had language access to no medical care what was wrong and disabilities and injuries the prevalence, and I bring—while I was there maybe about five or six times I asked for a patient advocate because my background is providing medical training to hospitals on disability centers in another state. And in this hospital I asked five times for a patient advocate. Nobody called, nobody came, nobody helped me and nobody gave an interpreter My sister ended up becoming my interpreter at the hospital and that was not her role, and he role was she was supposed to take care of me, and make sure that I survived, and the nurse at the hospital in one of the patient waiting rooms, asked her to leave. My sister would explain her she's deaf. She can't hear. She can't sign. She shattered her dominant hand, and the nurse threatened to call the police. My sister left the room. The same nurse privately put on her computer what is a $900 video game console. So that is bias that you couldn't value patient's language access to their trauma, to their accident, to whatever they're experiencing. Deaf people are people. We are surviving clients. We are delivering

babies. We have cancer. We have taken care of sick children and families. We are people, and that bias is not acceptable. So, as I'm listening to everyone talking about their biases and their trainings and their clinical, and I think that's great, but one of the biggest components of that training and that curriculum needs to be how do you execute that. Who do you contact at your hospital? Who is the patient advocate? What are the resources at the hospital? Did that nurse know? Did the frontline staff know? Did my doctor know? And even leaving the hospitals and that 12 hours no. Who did know how to respond to me. Where are the resources? Who is the patient that they get and this is a city hospital, and they're trying to do a tremendous amount of work for people of color, people who injured, people who are disabled. I believe that we're talking about and they're doing amazing work, but it's not amazing if we can't access it. So, I'm here to say that this is my story and I hope that going forward when they do hopefully pass there that part of that curriculum and that bias includes the actual implementation of what are you going to do when somebody is there and you have the patient in front of you, and I'm not quite

sure how to support that. I'm not quite sure how to address their needs because of my bias or the lack of information from all of that, and that's it. Thank you.

CHAIRPERSON RIVERA: Thank you for your testimony. As I—your story is—is important well, that you felt comfortable enough to share it with us, but also because you're clearly someone I would say who is informed as to their rights. You asked five times correct--

SACHA PANAPA: Yes.

CHAIRPERSON RIVERA: --for assistance and you did you not receive it.

SACHA PANAPA: So, I did not receive assistance yes.

CHAIRPERSON RIVERA: So, for those who don't know how to ask for help, and for when someone finally gets the message, and they can't support you in the way that you need, who do they call? These are all concerns that we're trying to raise today, and I—I want to make sure that as we have this conversation why your story in particular is so important is because you are an advocate and you know how to navaigate the system from what it sounds like

based on your professional experience, and I want to make surd that we're not putting 100% of the onus on patients. So thank you. Thank you so much.

SACHA PANAPA: Can I add something?

CHAIRPERSON RIVERA: Absolutely.

SACHA PANAPA: In New York City alone there are 250,000 deaf and hard of hearing people. . So, it would be nice to know the cost of medical school or the hospitals here what are their resources? How are they tracking their best efforts and they best practice to meet the needs of all of these deaf people that have access to no medical census.

CHAIRPERSON RIVERA: Correct and—and we—we plan to continue asking H&H and every hospital quite frankly and health clinics citywide how they plan to implement what I think is a better plan because I—I always say a disability or however you characterize your limitation, that's a minority group that anyone can join. So think you. Heidi Siegfried, Juan Pinto, Eric Gayle and Christopher Sharler. Oh, and also Kate Stinely. [background comments] Kate. Sorry. Hi, Kate. [pause]

I do and there's a light. Oh, now it's red. That's good, thought right? [laughter]

CHAIRPERSON RIVERA: Red is good.

HEIDI SIEGFRIED: [laughter] I would say it's great. Okay, so, um, I'm Heidi Siegfried. I'm the Health Policy Director at Center for Independence of the Disabled in New York, which is a non-profit organization with the goal of ensuring full integration, independence and equal opportunity for all people with disabilities by removing barriers to full practice patient in the community, and we help people—we have a lot of programs, but we help people understand and roll in and use their private and public health coverage and also to access to care they need. So, we definitely endorse Resolution 512 calling on New York State to require medical schools to train all students about implicit bias, and we would urge that it would include an exploration of attitudes towards people with all types of disabilities so that would include mobility impairments but also visual, hearing, ambulatory, cognitive, self-care, independent living and these are all the American Community Survey ways of characterizing disability and-and identifying it and

counting it. So, anyway, people with disabilities do report being treated unfairly, and I think we've heard—heard some of that today, and they report negative attitudes and lack of knowledge about treating people with disabilities. Physicians receive training on disability issues. It's really—it doesn't happen that often and the lack of knowledge our disability related education is consistent with other reports finding inadequate preparedness to provide health services to people with disabilities. A complex interaction of factors influences health status and health outcomes for people with disabilities and these include the limited enforcement of non-discrimination, accessibility, accommodation, policy modification and communications that are required by the ADA 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 we conducted a series of focus groups with the Public Policy Education Fund, Raising Women's Choices for the Health Care we Need, New York Immigration Coalition and Metro New York Healthcare for All in 2017 and 2018, and we had, you know, a

wide range of people in our focus groups in terms of race, ethnicity, disability, immigration status. We conducted specialized sessions with Spanish speakers, women and LGBTQ people, and we asked people—we were, of course, looking at network adequacy. So, we were looking a point and availability and office locations and hours and, but we did ask people about non-clinical competency and what their experience was in healthcare, and some people and people of color did express concerns with practitioners that had insufficient sensitivity to their life situations, the issues that they faced. One participant that we profiled for our report said that some practitioners did not take the complaints of pain by black women like herself seriously enough, and she said that at least one practitioner made a real difference for her economically because this practitioner unlike others recommended lower cost alternatives to the drugs they had prescribed. Participants in the LGBTQ listening sessions 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 is not respectful of the

their gender identify or express or sexual orientation, and we all included one story in our report that, you know, a physician who was unfamiliar with—with prep and—and, you know, and then having to talk about it, and explain, you know, what it is and why you, you know, and what your sexual orientation is was just, I mean it was really a horrible experience to—to learn about malpractice at U.S. Preventative Services Task Force, you know, A & B recommendation that you don't even have to have a co-pay for. [laughs] This doctor didn't even know about it. So, yeah, and then, of course, people with disabilities report inaccessible providers and all that. So, our recommendation in our report was that New York should establish—see, we don't feel that we have the expertise to really, you know, say exactly what should happen, but that there—there should be a work group that includes all the relevant stakeholders with the responsibility of recommending cultural competency standards for provider networks, and certainly, you know, consumers have better health outcomes when providers are culturally competent, and we think of cultural competence in the broadest sense involving and understanding of and respect for a

person's culture and orientation, age, disability and socio-economic status. So, there's a lot of trainings and courses and certifications, and we thought stakeholder work group should be created with the responsibility of—of recommending standards including trainings to ensure that all providers are—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. So, Section 1557, which has not been repealed, and cannot be repealed as long as we have a Democratic House, of the Affordable Care Act prohibits discrimination in healthcare programs on the basis of race, color, national origin, sex, sex stereotypes, gender identity, age or disability, and providers who are not aware of their implicit bias—bias may actually wind up discriminating in the delivery of care in violation of this statute, the Americans with Disabilities Act and other civil rights laws. So, the ADA in particular is a little different from most civil rights laws in that it—you know most civil rights laws require equal treatment,

but with the—with the Americans with Disabilities Act requires accommodations. You have to sort of like vary your policies and practices to ensure that a person with a disability can benefit from the health program or services to the same extent as a non-disabled person. So, imply--implicit bias training would really help providers to understand and fulfill their responsibility to accommodate people with disabilities. So, we really appreciate this resolution and wholeheartedly endorse it, and we thank you for the consideration of our comments.

CHAIRPERSON RIVERA: Thank you.

DR. ERIC GAYLE: Esteemed members of the 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. Neal Calman who still serves as its President and CEO. Dr. Calman is in Washington, D.C. today seeking continued funding for our programs with no federal budget yet passed for the coming year, which it's—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 health, behavioral health. 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 of our—4,000 students were served at our school based health centers, and 1,000 patients were served at our satellite sites in homeless centers. 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 education the next generation of commissions. We run two family medics and residency programs in New York City and one in the Mid-Hudson region graduating about 22 residents each year. Our fellowships include those in nurse practitioner, addiction medicine, integrated 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 three clinics in the Bronx and Manhattan. Implicit bias training is necessary, but is not enough, but it's 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 the a 12-week longitudinal study participants of a multi-facet—faceted prejudice have a break and intervention, experience reductions in implicit race-based—race bias and increased concern

about discrimination and personal awareness of bias. Another study measured implicit bias against African-Americans and medical students in their first year, then again in their fourth year, and showed that participating in a former curriculum significantly decreased implicit bias. This study suggests that just the act of taking a black-whit implicit association test predicted a decrease in implicit bias. Implementing an implicit bias curriculum and the briefing session in pre-clinical years changed outcomes in implicit bias associated tests. 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. In our own program a New York State sponsored fellow in our Empire State Research Program Dr. Yvonne McClellan is implementing a longitudinal training program for family medicine residents to measure persistent bias impacted by longitudinal curriculum and the ways to measure patient clinical outcomes. Suggestions to improve Resolution 512. Let me now make some suggestions for improving Resolution 512. First, it currently only applied to

medical students. Implicit bias training should include the entire clinical team and training people in interdisciplinary teams has man y 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. In addition, we need to encourage ongoing trainings with continued discussion in addition to the proposed initial trainings. 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. 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 equitably biased care and that is structural racism in the manner in which medical care is paid for and in way— 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 race—structural racism in our healthcare system in New York City. It starts with a state that pays for—pays far less for care under Medicaid or under-represented minorities as 66% of the population compared to Medicare where the population is only 30%--32% minority. We have created a reimbursement system that values healthcare for the elderly more than it values healthcare for the poor, and a reality where those who are—who reach age 65 to collect Medicare are disproportionately white. Second, people covered by Medicaid or Medicaid Managed Care and has uninsured or—and 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 under-resourced by the institutions who respond to 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.

CHAIRPERSON RIVERA: Dr. Gayle, if you could just wrap up. Everything is going to be submitted for the record, and I want to thank you for your recommendations because you also brought up insurance based discrimination, which I think is incredibly important, and hopefully, we'll discuss single payers soon, but anyway so if you could just wrap up your comments to make sure that we can get through this.

DR. ERIC GAYLE: Sure.

CHAIRPERSON RIVERA: Thank you so much.

DR. ERIC GAYLE: So, I will end by saying that this remedial are there are laws and regulations in place already that should be able to limit these practices for 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 a source of payment. Here in New York City the Public Accommodations 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. By accurately identifying the faculty practices of academic medical centers accurately as functions of the hospital itself, even Title 6 of the Civil Rights Act can be used to help correct inequities in place of treatment. In conclusion, we support mandatory implicit bias training of medical students, but these must be coupled with structural reforms to correct racism and discrimination by source of payment, and long plagued our healthcare system. While I applaud the New York City Council for this resolution, and the commitment to address—addressing health disparities I also implore you to look further into structures and system that institution—institution as racism in healthcare here in New York City. Thank you.

CHAIRPERSON RIVERA: Thank you so much.

KATE STEINLE: Hi. My name is Kate Steinle, and I'm the Associate Vice President of Clinical Services and the Director of the Transgender Health Services at Planned Parenthood of New York, City. Thank you to Chair Rivera as well as the committee for convening this hearing. Planned Parenthood of New York City acknowledges the

importance of cultural competency within healthcare, and I'm pleased to submit testimony in support of Resolution 512. For over 100 years Planned Parenthood ahs been a leading provider of reproductive and sexual health services in New York City. We're a trusted name in healthcare and believe that high quality healthcare is a human right regardless of gender identity, sexual orientation, race or income. Historically lesbian, gay, bisexual, transgender and gender non-conforming individuals have experienced inadequate access to care. This disparity till persists today. In a 2011 National Transgender Discrimination Survey, 28% or 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. These findings confirmed widespread systemic and societal discrimination against transgender individuals within healthcare settings and exemplify the need for medical school curriculum that includes implicit bias related to all aspects of an individual's identity. Persently, 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. This curriculum does not take into account the biases of and prejudices that healthcare professional may have towards LGBNTGNC patient populations, nor do they address the harboring of bias towards LGBTQ patient sexual practices. As a sexual and reproductive healthcare organization, PPNYC has actively addressed the disparity—disparities mentioned above and taken steps to create a welcoming environment for our patients. These efforts include revising our protocols and interactions with patients to create a more inclusive environment. 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 healthcare professional. This policy was implemented to ensure that all staff are familiar with a patient's identity and are addressing them accordingly. Our healthcare professionals are trained and equipped with information about the differences between sex, sexual orientation, gender, gender identity informing manner in which they interact with our patients. We believe by using appropriate terminology such as transgender

or cisgender we avoid alienating any individual or group of individuals and 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---and support patients that experience health disparities. As such, PPNYC has adopted policies to obtaining accurate medical and sexual history for each of our patients including asking them sexual orientation and gender identity questions and restructured sexual behavior and risk evaluation questions, to have conversations about sexual behavior free from assumptions and stereotypes. The healthcare industry has a long history of treating certain groups of people and behaviors as normal while alienating others. This has resulted in generations of mistrusting, and mistreatment by our medical providers. When we look towards strengthening our communities, it's imperative that access to culturally competent healthcare is easily accessible to all. PPNYC is confident that if implemented correctly, then mandatory bias training will result in a better understanding. The power of prejudice undermines equitable care, and how

healthcare providers can actively deconstruct notions that jeopardize access to care. Reso 512 and the development of statewide standards will improve the quality of care throughout New York State. Thank you.

CHAIRPERSON RIVERA: Okay.

CHRISTOPHER SCHUYLER: Good afternoon. My name is Christopher Schuyler. I'm a senior Staff Attorney at New York Lawyers for the Public Interest, the Disability Justice Program. I'm—I'm a person who stutters. Patients with disabilities experience critical barriers to healthcare than patients without disabilities. Among the reasons for this disparity are the implicit biases held by medical providers. Training of medical students have identified implicit bias as a call formalization (sic) is a critical step to elevate the quality of care that meant—the quality of medical care available for patients with disabilities such as having one. Patients with disabilities face myriad barriers to medical care. Generally speaking, people with disabilities are 2-1/2 times more likely to have unmet healthcare needs than their non-disabled peers, and more likely to suffer from a terminal condition that may affect—that

may have been detected earlier the disease prevention screening. Particularly affected, however, by—by the disparity in access are women with disabilities especially in the area of cancer screening. To give a sense of the numbers 61% of women with disabilities reported having mammograms while 74% of women without a disability will receive this test. For PAP tests 65% of women with disabilities received PAP tests compared to 83% of women without disabilities Such a significant lack of access to critical services leads to poor health outcomes for women with disabilities including higher mortality rates. It is also suggested that the racial minorities with disabilities experience disproportionate barriers to healthcare. While relatively little is known about the health status of individuals with disabilities, were 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 poor health at a higher frequency than Caucasians, and racial and ethnic minorities. In racial and ethnic minorities have historically been and continue to be disproportionately impacted by health disparities.

Inaccessibility to healthcare affects people with disabilities on every level o their lives, socially, psychologically, physically and economically. Section Heading 2: Negative Impact of Structural and Environmental Barriers to Medical Care for Patients with Disabilities. There are two primary causes for that disparity in healthcare faced by persons with disabilities. Structural environmental barriers and process barriers. Structural environmental barriers include types of services offered, accessibility of provider offices and diagnosing it-diagnostic equipment and insurance coverage. Process barriers include medical provider, implicit bias and the lack of knowledge in treating patients with disabilities. We strongly support the fact that—that Resolution 512 addresses process barriers as conscious and unconscious biases held by healthcare providers are another underlying aspect of identified barriers to healthcare access for people with disabilities as well as other marginalized groups especially as racial and ethnic minorities. Many stereotypes held by healthcare providers translate into lower quality and fewer services provided as those contributing to poor health—health outcomes for these groups of

people. However, Resolution 512 makes no mention of equally critical structural environmental barriers notwithstanding the fact that such barriers present significant and continuing impediments to receiving appropriate healthcare. We urge the-the immediate addition of language acknowledging and condemning such structural environmental barriers. Section Heading 3: Training Medical School Students to Recognize What 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 healthcare is significant as physicians have not received training the fundamental aspects of working with people with disabilities. In a 2007 survey of primary care physicians, 91% of the revealed that they had never receive 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 Americans with Disabilities

Act. Another survey of more than 500 physicians revealed that the nearly 20% of respondents were unaware of the ADA and more than 40—45% did not know about its architectural requirements. Moreover, less than a quarter of the respondents had received any training in physical disability issues in medical school [background comments] and only slightly more than a third have received any kind of training on disability during their residency. However, three-quarters of physicians surveyed acknowledged the need for training on those issues. Such trainings will—will also lead to increased awareness of medical equipment and procedures available for people with disabilities. There is a significant correlation between knowledge about accessibility and the provision that accessible equipment in healthcare clinics. Yet, in one study only 46% of healthcare administrators and clinical practices knew that accessible equipment existed and only 25% were able to—to describe accessible equipment. While 44% of administrators have considered purchasing accessible equipment at some point, only 22% knew the Federal Tax Credit Program that assists businesses in complying with their legal mandates to do so.

Moreover, open discussion about 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—for fear of stigma and damaging with their career prospects. 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—will also increase disability literacy when making one's language knowledge and interactions reflective of understanding disability experiences and disability etiquette. Increasing the level of disability literacy among medical providers in turn will lessen the barriers to medical access for people with disabilities. Section Heading 4: Recommendations. New York Lawyers for the Public Interest respectfully requests that the New York City Council Hospitals Committee to modify Resolution 512 as follows: Add people with disabilities to the list of traditionally marginalized communities in the first paragraph, and our 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. In conclusion, thank you for the opportunity to testify today about these key issues affecting appropriate medical care for people with disabilities. I would be pleased for you to contact me and look forward to discussing this further.

CHAIRPERSON RIVERA: Thank you so much everyone. Thank you for your recommendations. Changes to the Reso itself are totally a possibility, and I don't think I've ever seen a resolution with this much response to how can improve the language itself, which I think speaks volumes for how important it is. So thank you. Thank you to all of you. I do have one last addition. So, it's—so I thank you. Thank you to the panel. I want to make sure you get a chance to go. Thank you. Greg Waltman. [pause]

GREG WALTMAN: Good afternoon. My name is Greg Waltman. I represent G-1 Quantum Clean Energy Company. Councilman Rivera and General Counsel, nice to see you. Just adding to the conversation around

disability and the way the city allocates funds to help those that need more assistance, you know, we've been going around quite some time now with solutions, contractual solutions on the solar wall, different types of applications, Quantum, Traxson. You're, you know, although the conversation and dialogue is somewhat constructive, when I'm here it seems that there is no follow through, and when we build upon implicit bias what is the difference between implicit bias and censorship as it relates to people with disabilities? Because for value it seems like okay well, we don't like the dialogue or the narrative or the solutions so we're just going to parse it out and sensor it, which is inherently implicit bias. So, when someone is presenting a superior course of action in the Council and the Council like yourself takes it into consideration, but then out—outside of the Council where extenuating value factors play into the Council's ability are limited, it becomes somewhat frustrating. It must be—to be, you know, execute or—or have to execute these types of dialogues with the public, but when in reality there are other types of fiscal solutions that are more constructive and productive. So, I—I was just

building upon that so with the hope that, you know, as we progress forward and the Green New Deal scams and those types of things are parsed and broken down and these value narratives are further broken down an the Mayor has more time now that he's not running for President that we can actually bring these solutions to fruition and actually reach the type of outcomes so we can fill the gaps and budgetary concerns so people with disabilities get the funds they need and people that aren't disabled aren't forced onto disability. Thank you.

CHAIRPERSON RIVERA: Thank you so much. Any more—any other members of the public that wish to testify today? Seeing none, I just want to thank everyone who stuck with us, and thank you for your testimony. I think we all agree conclusively that mandatory implicit bias training is absolutely necessary, but only if it's coupled with structural reforms, but only if it's coupled with having the conversation about racism and discrimination that takes place inside our facilities and even the lack of conversation inside of our schools. So institutionalized racism is real. We're hoping that we can move forward with a constructive dialogue that

allows us to make sure that everybody has equitable access, and so with that, I'm going to adjourn this hearing. Thank you so much. [gavel]

C E R T I F I C A T E

World Wide Dictation certifies that the foregoing transcript is a true and accurate record of the proceedings. We further certify that there is no relation to any of the parties to this action by blood or marriage, and that there is interest in the outcome of this matter.

Date September 23, 2019