Dear Colleague

COVID-19 Updates

New York City Department of Health and Mental Hygiene

Health Inequities and COVID-19

June 21-27, 2020

Mary Eliza Mahoney, first African-American licensed nurse in the United States, 1879.
Image courtesy of The New York Public Library, Digital Collections.

Inside This Newsletter

Updated Data and Guidance

Visit the New York City (NYC) Department of Health and Mental Hygiene's COVID-19 Provider webpage for the latest health alerts, testing information, provider webinars and guidance for specific patient populations. The COVID-19 Health Care Facilities webpage has guidance for inpatient, outpatient, long-term care, and other settings. The COVID-19 data webpage is updated daily and includes counts and per capita rates of COVID-19 by ZIP code of residence, with case, hospitalization and death rates stratified by age, sex, race/ethnicity, poverty and borough.

NYC Guidance

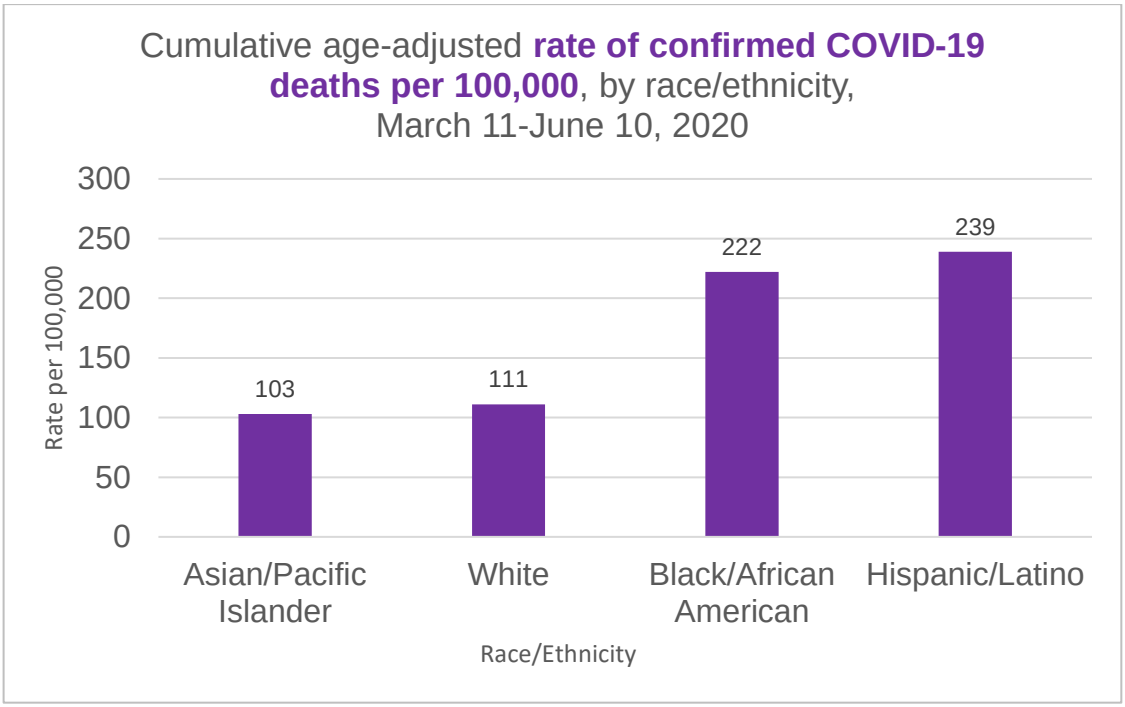
- Health Alert #19: Help Prevent Heat-Related Illness and Death Among Heat-Vulnerable People During the COVID-19 Pandemic (June 10)
- Health Alert #18: COVID-19 Test and Trace Operations Begin in New York City (June 2)

Stay Up to Date

- Sign up to receive NYC Health Alerts.
- Join the City Health Information network to receive this newsletter by email.
- Register for the bi-weekly NYC Health Department COVID-19 Provider Webinar.

Health Inequities During COVID-19

NYC data show disproportionate impacts of COVID-19-related morbidity and mortality among Black and Latino New Yorkers in comparison to their White and Asian counterparts. As of June 18, 2020, 22,199 COVID-19-related deaths were reported in NYC. The age-adjusted rate of death is approximately twice as high among Black and Latino New Yorkers than among White and Asian New Yorkers. While robust data are lacking to statistically assess the impact of COVID-19 among immigrants and people who are undocumented, indigenous, living in poverty, transgender or gender non-binary, lesbian, gay or bisexual, it is widely recognized that these groups also tend to experience health inequities.



Disparities in health outcomes are perpetuated by systemic racism that assigns value and opportunities based on race and ethnicity and prevents communities of color from having equal opportunities for health and well-being. This includes *structural racism* and *racial bias. Structural racism* refers to the factors that determine the environments in which we live, work and play, and is enacted through policies and enforcement on people of color that in turn reinforce discriminatory beliefs, values and distribution of resources (Bailey 2017). *Racial bias* is the conscious or unconscious attitudes or stereotypes that affect an individual's understanding, treatment and actions towards people from specific groups.

Intersecting systems of oppression around race, ethnicity, class, immigration, gender and gender identity, and sexual orientation can amplify the effects of each individual factor, putting affected individuals at even greater risk of poor health outcomes. Furthermore, chronic stress on people due to racist structures can lead to chronic health conditions (Duru 2012; Mays 2018). These chronic and underlying health issues can in turn lead to an increased risk of other diseases, including severe COVID-19.

Advancing Health Equity During COVID-19

Disparities in health outcomes, as seen in NYC's data, reflect the lack of opportunities for people to achieve optimal health and are rooted in inequitable social structures. *Health equity* occurs when no one is kept from reaching their highest level of health due to social position or their social identities. The COVID-19 pandemic highlights the extent of racial and ethnic inequities in NYC and presents an opportunity to address those inequities through public health and health care interventions. Key to addressing systems of inequity are partnerships with providers who serve Black and Latino communities, who can take part in this initiative alongside efforts from the NYC Health Department. The NYC Health Department has taken the following actions to assist in this effort:

1. Data Reporting to Identify Inequities

The NYC Health Department's COVID-19 data webpage publishes daily updated rates of COVID-19 cases, hospitalizations and deaths by age, race/ethnicity, underlying conditions, borough, and neighborhood poverty level. Geospatial and race/ethnicity data identify neighborhoods and populations most affected by COVID-19 and where more equitable distribution of resources is needed.

NYC Health + Hospitals' Test & Trace Corps has begun collecting the race/ethnicity and gender identity/sexual orientation of people diagnosed with COVID-19 in ongoing efforts to identify disproportionately affected populations.

2. Multilingual Messaging to the Public

The NYC Health Department translates key patient materials into 26 languages commonly used across NYC. Visit the NYC Health Department COVID-19 webpage for waiting room posters and patient education materials.

3. Telehealth Resources to Increase Access to Care

The NYC Health Department's NYC REACH program is a free membership organization offering telehealth implementation support to private practices, community health centers, health systems and pharmacies. NYC REACH assists members with health information technology, primary care workflows, medication therapy management, chronic disease self-management, the referral process and other quality improvement projects.

The weekly webinar series Telehealth During the Public Health Emergency: Training for Practices covers regulations for telehealth, reimbursement, best practices and workflows for implementing telehealth, strategies to enhance patient buy-in for telehealth services and resources for business assistance.

NYC REACH provides additional support for member practices servicing neighborhoods disproportionately affected by COVID-19. NYC Care Calls assists providers with patient outreach, known as "COVID Health Calls." Bilingual staff inform patients about services available at your practice and general information about COVID-19. Bilingual staff also assess needs and provide resources for medications, food, housing, health care access and mental health.

NYC REACH technical assistance and call center support for patient outreach is available during the COVID-19 emergency for members and non-members. Visit NYC REACH or email nycreach@health.nyc.gov to learn more.

4. Access to Care for All Immigrants

Providers should assure patients that in NYC it is safe to seek care if they are ill. Testing and treatment services for COVID-19 will NOT be considered under the public charge rule in NYC. Remind patients that anyone seeking care at NYC Health + Hospitals facilities will be provided care regardless of immigration status or ability to pay. NYC Health + Hospitals also provide low-income residents and immigrants with health insurance enrollment assistance.

5. Free Hotel Stays to Prevent COVID-19 Transmission

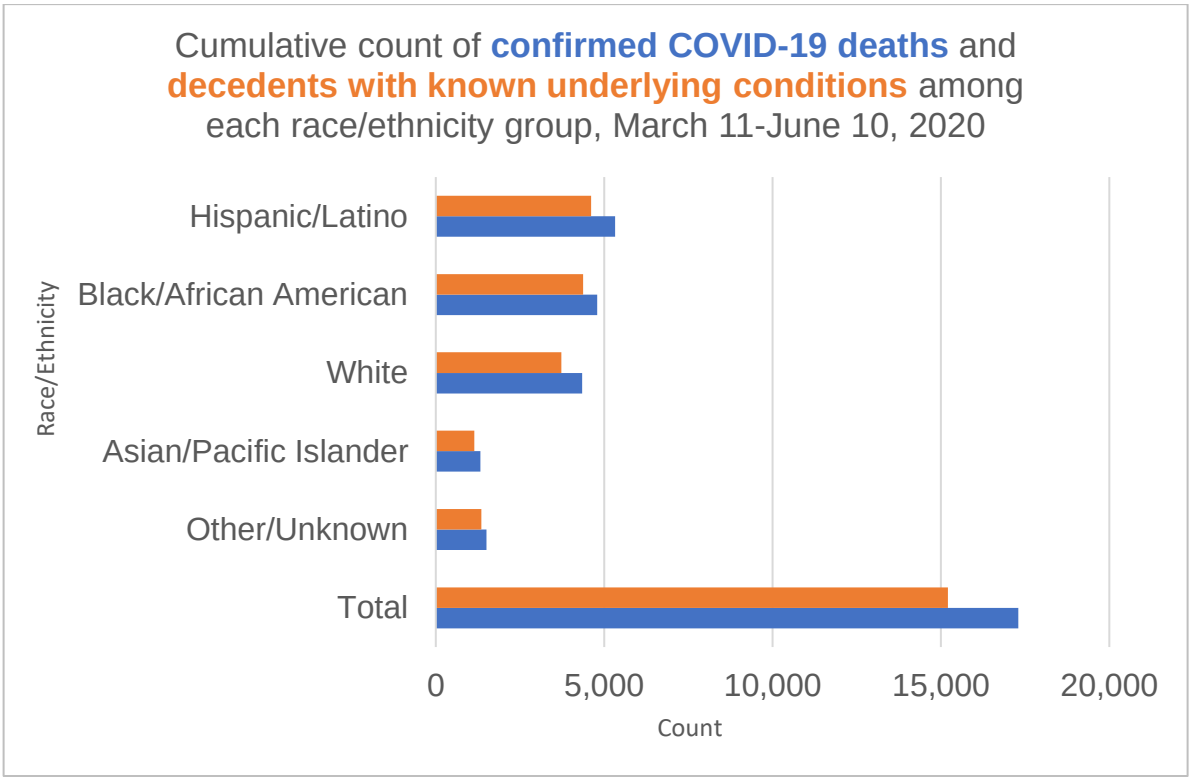
NYC Health + Hospitals is offering a free hotel referral program for individuals who have or may have COVID-19 and do not have a place to safely isolate or quarantine. Providers can refer patients for hoteling services or patients can self-enroll. This program is also available to health care workers and medical volunteers.

How Providers Can Address Health Inequities

1. Attend to High-Risk Patients

Several underlying, chronic health conditions may put patients at an increased risk of severe COVID-19. These conditions include lung disease, moderate to severe asthma, heart disease, a weakened immune system, obesity, diabetes, kidney disease, liver disease and cancer.

Black and Latino people are more likely to have conditions that can exacerbate COVID-19 illness. Health conditions such as obesity, asthma, cancer and hypertension often result from environmental factors, including living in food deserts or neighborhoods with poor air quality, reflecting a history of housing segregation and other forms of institutionalized racism (Colen 2018). For instance, the Bronx, the NYC borough with the highest proportion of Black and Latino residents, has the highest rates of poverty, the lowest levels of educational attainment, and the highest rates of morbidity and mortality related to COVID-19 (Wadhera 2020).



Understand the history of structural racism and its impact on health outcomes and avoid blaming patients for any chronic conditions they have. Communicate concern to your patients with chronic conditions about the factors that might put them at higher risk and take special consideration to educate them on COVID-19 prevention. Advise patients with severe symptoms due to any condition to promptly seek medical care. Patients should be advised to immediately call 911 or visit the nearest emergency room if they exhibit severe symptoms, including difficulty breathing, signs of stroke or heart attack, or newly altered mental status. Recognize symptoms consistent with the newly recognized multi-system inflammatory syndrome in children (MIS-C) associated with COVID-19, and educate parents and caregivers on when to seek care.

2. Help Patients Isolate or Quarantine Safely

Living conditions such as overcrowded housing place people at an increased risk of exposure to COVID-19 by undermining their ability to isolate safely. Multigenerational households compromise the safety of older people (especially those aged 65 years or older), who are also at greater risk for severe disease from COVID-19. Black and Latino people are more likely to live in crowded housing and in congregate living facilities, such as shelters and correctional facilities (Ross 2020; Centers for Disease Control and Prevention 2020). Ask patients about their living conditions and if they can safely isolate if they are ill with COVID-19 or need to quarantine after a

possible exposure. Educate patients about NYC's free hoteling program for COVID-19 patients who are unable to safely isolate or quarantine at home.

3. Support Essential Workers

The sacrifices of the COVID-19 pandemic's frontline workers stretch beyond those working in health care. Many Black and Latino New Yorkers work in the service industry, which includes restaurant and food delivery workers, ride-share drivers, transit workers, grocery workers, postal workers and janitors. These jobs often do not allow people to stay at home, thus placing them at an increased risk of SARS-CoV-2 exposure.

Black and Latino New Yorkers comprise the majority of the essential workforce in NYC (NYC Comptroller 2020). Be mindful of patients' occupations when assessing them for possible COVID-19 or when counseling them about COVID-19 prevention. Ask patients about their occupation, where they work, how they commute to work and what protections employers are making available to them. Ask to what extent physical distancing and face covering rules are being followed in the workplace. Provide comprehensive prevention education to those at highest risk of exposure due to their occupation, such as proper face covering, hand washing, sneeze and cough etiquette and cleaning and disinfecting shared spaces, to help protect both work colleagues and vulnerable household members. Encourage patients to call you if they experience symptoms of COVID-19.

Be mindful that people in these occupations are often at a higher risk of job loss. Remind patients that many workers are entitled to sick leave for COVID-19 and they should not experience job loss for remaining home while ill. Additionally, patients can call 311 to access NYC's Worker Protection Hotline and to learn more about NYC labor laws.

4. Reach Out to Immigrants and Undocumented New Yorkers

COVID-19 has exacerbated many barriers to care for immigrants and undocumented people. Immigrant New Yorkers might not seek care due to lack of insurance or fear of immigration enforcement (NYC Health Department 2020; Duncan 2020; Ross 2020). The intersection of immigrant experience with racial and socio-economic inequities can particularly affect access to care. Immigrants in the Bronx, for instance, represent the majority of essential workers, placing them at increased risk of SARS-CoV-2 exposure (Ross 2020). Consider these factors when assessing disease burden on immigrant patients. Reach out to immigrant patients and assure them they can safely seek care in NYC for COVID-19.

5. Collect Accurate and Comprehensive Demographic Data

Collect comprehensive patient demographic data to allow NYC to understand which communities are most affected by COVID-19, including information on race/ethnicity, gender identity and sexual orientation. Asking the following questions will improve our public health response; it can also foster connectedness and build trust with your patients.

Race and Ethnicity

It is important to avoid making assumptions about a person's race or ethnicity based on the way they may look, speak, their name, religious affiliation or country of origin. To accurately capture information about a patient's ethnicity and race, use the following questions:

1. Do you consider yourself to be Hispanic or Latino?
    - ☐ Hispanic/Latino
    - ☐ Non-Hispanic/Non-Latino
    - ☐ Declines to answer
    - ☐ Unknown (no information available)

2. Do you identify with one or more of the following races? You can describe yourself as more than one.
    - ☐ White
    - ☐ Black or African American
    - ☐ Asian
    - ☐ Native American or Alaskan Native
    - ☐ Native Hawaiian or Pacific Islander
    - ☐ Other race: _____
    - ☐ Does not identify with any race
    - ☐ Declines to answer
    - ☐ Unknown (no information available)

Gender Identity and Sexual Orientation

The traditional question on gender, "Are you male or female?" assumes a gender binary, does not account for the fluidity of gender, and denies many people's lived experience. Instead, use a two-step question that asks a patient about their *gender identity* (how they see themself and live their life) and their *sex assigned at birth.* This approach allows you to recognize and respect patients who are transgender or are gender non-binary (those who do not identify as either female or male), and to avoid making inaccurate assumptions about their gender identity. While these

assumptions and biases might be subconscious, they are forms of discrimination that can harm patient care.

Use the recommended two-step approach to ask both about gender and sex assigned at birth:

1. How do you identify your gender? Do you identify as:
   - ☐ Woman
   - ☐ Man
   - ☐ Transgender woman
   - ☐ Transgender man
   - ☐ Non-binary or genderqueer person*
   - ☐ Gender identity not listed: _____

2. What sex were you assigned at birth?
   - ☐ Female
   - ☐ Male
   - ☐ Neither female nor male

*Queer is sometimes used as an inclusive term for people whose identity, presentation, or sexual practices resist societal expectations. Historically derogatory, "queer" is now used by many LGBTQ people as a political term and, by some, as an individual identity.

People who identify as lesbian, gay, bisexual or who are questioning their gender also face many forms of discrimination and social stress that can cause disproportionate health outcomes. Stressors such as experiencing discrimination, internalized homophobia, and ameliorative coping processes are drivers of mental health issues among LGBQ populations, including substance use disorders, affective disorders, and suicide (Meyer 2003). The allostatic load or “wear and tear” that chronic stress exacts on the brain and body can result in metabolic, cardiovascular, endocrine and autonomic dysregulation (Mays 2018). Results of related chronic health conditions can place individuals at increased risk of severe COVID-19. Routine questions about sexual orientation during health care visits allow patients to discuss how their sexuality may affect their health and help document health burdens facing their communities, including illness related to COVID-19.

6. Understand Implicit Bias

Implicit bias is the subtle or unconscious attitudes directed towards other groups of people that can affect our understanding, actions and decisions in an unintentional way. Health care providers, like the population at large, are subject to these biases, which may affect delivery of care. Studies have shown that providers may spend less time listening to Black or Latino patients than White patients during clinical interactions or be more restrictive in their prescribing practices and recommended medical interventions (DeAngelis 2019; The Joint Commission 2016; Green 2007).

Implicit bias might have a role to play in the disproportionate outcomes of COVID-19. These biases could lead providers to be less likely to offer COVID-19 testing to symptomatic or concerned patients who are Black or Latino, or influence decisions on life-prolonging measures (Rubix Life Sciences 2020; Milam 2020). While Black and Latino providers tend to demonstrate lower levels of implicit bias overall, these biases can impact providers of all ethnicities, as they are heavily ingrained in American society (Hall 2015). Inequities in care contribute to a deep-seated history of medical mistrust among Black and Latino communities, requiring additional efforts by providers to cultivate trust with their patients (Armstrong 2007).

To address and mitigate the impact of implicit bias in your practice:

- Become aware of your own biases. Go to Project Implicit online to take a free implicit bias test.
- Be aware of your own stress levels and how stress might amplify bias. Take steps to reduce stress throughout your day.
- Embrace humility and display a readiness to learn about your patients, especially when it comes to their cultures and identities.
- Reframe your interactions with patients as interactions between equals. Create space for patients to have agency over their health and health care decisions. Be collaborative and transparent in decision making.
- Practice evidence-based medicine and use checklists where they have been shown to prevent biased clinical decision making (e.g., computerized tools to determine risk-appropriate venous thromboembolism prophylaxis) (Lau 2015).
- Speak up to combat bias in observed interactions.

Learn more about how to promote equitable care by reducing the impacts of implicit bias.

7. Improve Language Access

In uncertain times, accessible, accurate and credible information provides patients with a sense of empowerment and comfort. Patients with limited English proficiency might feel shame or stigma and be fearful to speak up if they do not understand information presented to them. Providers

should take special consideration for patients with limited English proficiency, including (U.S. Department of Health and Human Services 2020):

- "Teach Back" by asking your patients to explain to you in their own terms the health information communicated to them.
- Contract with service providers for language access through multiple types of media (e.g., telephone, video remote interpreting).
- Provide documents in multiple languages and in multiple locations, including at providers' initial point of contact.
- Appoint staff to coordinate language services and disseminate language service resources to all staff.
- Use plain language and ask open-ended questions. Be mindful of tone, pace, and volume and be aware of existing power dynamics.

Equity Resources

Racial Equity Tools: COVID-19 - Racial Equity & Social Justice Resources

Vital Talk COVID-Ready Communication Playbook: Communication skills for bridging inequity

Centers for Disease Control and Prevention, COVID-19: Communication Toolkit for Migrants, Refugees, and Other Limited-English-Proficient Populations

Selected Publications

Rodriguez JA, Clark CR, Bates DW. Digital health equity as a necessity in the 21st century cures act era. *JAMA*. 2020;323(23):2381-2382.

This viewpoint discusses inequities in broadband access and digital health literacy in the United States and proposes policies and actions to bring equity to patient-facing digital health tools in the context of the Health Information Technology's Cures Act.

Openshaw JJ, Travassos MA. COVID-19 outbreaks in U.S. immigrant detention centers: the urgent need to adopt CDC guidelines for prevention and evaluation. *Clin Infect Dis*. Published online May 31, 2020.

Despite several outbreaks of COVID-19 in federal immigrant detention centers, Department of Homeland Security (DHS) policies continue to differ from CDC guidelines for detention facilities,

including around social distancing. Adoption of CDC guidelines by DHS has the potential to protect and save the lives of the most vulnerable populations.

Roberton T, Carter ED, Chou VB. Early estimates of the indirect effects of the COVID-19 pandemic on maternal and child mortality in low-income and middle-income countries: a modelling study. *Lancet Glob Health*. 2020;8(7):e901-e908.

Potential disruptions to routine health care and food access could lead to devastating increases in child and maternal deaths. The most severe scenario would result in an additional 1,157,000 child deaths and 56,700 additional maternal deaths.

Williams DR, Cooper LA. COVID-19 and health equity—a new kind of "herd immunity." Published online May 11, 2020.

This editorial urges the development of a new kind of "herd immunity" by protecting people across all social groups from negative social determinants of health to combat racial/ethnic disparities in health.

Shah GH, Shankar P, Schwind JS, Sittaramane V. The detrimental impact of the COVID-19 crisis on health equity and social determinants of health. *J Public Health Manag Prac*. 26(4):317-319.

This commentary discusses how the COVID-19 pandemic has been worsened by poverty, structural racial injustice, inability to treat underlying chronic conditions due to increased health care burden and clinic closures, patients' lack of access to critically needed health care, food insecurity, and job/income losses.

Subbaraman N. How to address the coronavirus's outsized toll on people of colour. *Nature*. Published online May 18, 2020.

Better data on COVID-19 incidence, increased testing and improved preparedness among hospitals serving at-risk populations are key to erasing inequalities.

Saini A. Stereotype threats. *Lancet*. Published online May 23, 2020.

Demographic differences socially recognized, while important for identifying disparities in health outcomes, often do not have biological significance and may reinforce damaging myths about biological differences between groups. Care is needed to avoid conclusions that may reinforce social stereotypes rather than recognize how differential findings may be socially determined. Therefore, if

race is to be used as a research variable or diagnostic tool, the reasons why need to be clearly articulated and justified.

Page KR, Venkataramani M, Beyrer C, Polk S. Undocumented U.S. immigrants and COVID-19. *N Eng J Med*. 382:e62.

The public charge rule, in effect as of February 24, 2020, states that "aliens are inadmissible to the United States if they are unable to care for themselves without becoming public charges." As the COVID-19 pandemic places new economic strains on immigrant communities, many fear deportation if they enroll in government assistance programs or seek health care services. Policy changes are needed to support immigrant communities and help contain the spread COVID-19.

Alang S, McAlpine DD, Hardeman R. Police brutality and mistrust in medical institutions. *J Racial Ethn Health Disparities*. Published online January 27, 2020.

Findings from a cross-sectional survey of adults living in urban areas that investigated the relationship between police brutality and medical mistrust and assessed whether it varies by race. Groups that have negative experiences with police are more likely to mistrust the medical system, controlling for sociodemographic, health status and health care access. Blacks/African Americans, Hispanics/Latinx, and Native Americans had higher levels of mistrust than Whites.