AGENDA

Equity, Diversity and Inclusion Committee

Meeting Date
April 12, 2021

Time
10:30 A.M.

Location
Virtual / Board Room (532)

CALL TO ORDER	Feniosky Pena-Mora
ADOPTION OF MINUTES JANARY 11, 2021	Feniosky Pena-Mora
FY20 AFFILIATE & EMPLOYEE WORKFORCE DATA	Matilde Roman
EQUITY & ACCESS REPORT OUT	Natalia Cineas Nichola Davis
OLD BUSINESS	
NEW BUSINESS	
ADJOURNMENT	

Equity, Diversity and Inclusion Committee Virtual Meeting – January 11, 2021
As Reported by: Helen Arteaga Landaverde
Committee Members Present: Helen Arteaga Landaverde, José Pagán, Mitchell Katz – joined at 11:33, Feniosky Pena- Mora,

CALL TO ORDER

The meeting of the Equity, Diversity and Inclusion Committee of the NYC Health + Hospitals' Board of was called to order at 11:20 a.m. Upon motion made and duly second the minutes of the March 12, 2020 meeting was unanimously approved.

OFFICE OF DIVERSITY UPDATE

The Chief Diversity and Inclusion Officer, Matilde Roman, highlighted a few of the organization's diversity and inclusion milestones.

- Since the announcement of the Equity and Access Council in June, the Council has been building the groundwork. There were a series of dialogues and listening sessions held for employees over the summer to discuss the topic of bias and racism in the aftermath of Georg Floyd that again amplified the reality of systemic racial inequalities in our country.
- Ms. Roman shared that the unconscious bias learning element was integrated into new employee orientation and annual in-service training.
- From July 2020 through the end of 2020, over 25,000 trainings were completed on different diversity and inclusion topics that include interreligious awareness, introduction to unconscious bias, LGBTQ affirming services, and health literacy. In addition, the following virtual workshops were launched: (1) Having Essential Conversations, (2) How to be an Inclusive Colleague, and (3) How to be an Upstander.
- Ms. Roman also reported that the Office of Population Health and Behavioral Health host ECHO learning sessions aimed at improving awareness and knowledge on the impact and intersectionality of social determinants, held two series focused on structural racism, stigma, and trauma, and the second on LGBTQ health equity.
- In August, the Human Rights Campaign published the 2020 Healthcare Equality Index, and announced that all 23 qualifying sites within the System received the designation "Leader in LGBTQ Healthcare Equality" for the fifth consecutive year.

WORKFORCE DATA FOR FISCAL YEAR 2020

Ms. Roman, shared workforce data for fiscal year 2020. During the reporting cycle, there were 41,494 employees, and the data was segmented to reflect direct service jobs titles such as nursing, medical residents, employee physicians, social workers, and clerical associates. It also included administrative and leadership roles. The data excluded affiliate staff, which was planned to be presented at the next committee meeting. Ms. Roman reported that there were approximately 6,500 affiliate staff, of which fifty eight percent (58%) identified as minority and fifty five percent (55%) identified as women. Fifty six percent (56%) of affiliate physicians identified as either Black/African American, Asian, Hispanic/Latino, American Indian or Alaskan Native, or marked two or more races. In addition, forty three percent (43%) of affiliate physicians identified as women. Ms. Roman then walked the Committee through the employee data related to race, ethnicity and gender. The employee data showed that overall NYC Health + Hospitals has been successful in ensuring workforce diversity, and highlighted the nursing titles, medical residents and employee physician data that illustrated this fact.

José Pagán, Chair of the Board of Directors, asked whether NYC Health + Hospitals compares employee data with other Systems, or with City population data to understand if we are on the right path. Ms. Roman replied that there has been some preliminary analysis made that indicates that the System is on the right path. The data is analyzed to determine if there is workforce underrepresentation, similar to how vendor workforce representation is analyzed and found no underrepresentation. Also mentioned, that the Equity and Access Council will be critical in this work and making more efforts in comparing data. Ms. Roman also shared the leadership racial, ethnic and gender breakdown, and reiterated the continued commitment to look for opportunities to improve workforce diversity. Feniosky Pena-Mora, Board Member, congratulated NYC Health + Hospitals on their diversity and inclusion efforts. The Committee Chair, Helen Arteaga Landaverde, also expressed an appreciation for the progress made.

Dr. Pagán asked if we could share information about recruitment efforts. The Vice President for Human Resources, Yvette Villanueva, shared some high-level insights of the System’s recruitment strategy that includes expanding our reach to professional associations and organizations, use of ethnic media, and leveraging our internal networks to maximize touchpoints with as many diverse qualified candidates that can be considered, especially in leadership positions. Ms. Villanueva also mentioned investments in professional staff

development of our diverse talent to foster growth, and to mentor them for future succession planning purposes.

Mr. Pena-Mora asked about the official programs for leadership development. Natalia Cineas, the Chief Nurse Executive, shared that leadership development is part of the 2021 nursing plan that is currently being developed. Also mentioned was the clinical leadership fellowship program as another concrete example. Ms. Villanueva also mentioned that the System is also developing a mentorship program for finance, which is expected to launch in February. Mr. Pena-Mora inquired about programs specific to hospital administrators. Ms. Villanueva replied that the System had the American Essential Hospitals fellowship program, which allowed sponsored employees to participate in professional development training that included performing a project for the System. As a result of the pandemic, these efforts have been put on hold and other initiatives have been delayed, but the System is committed to continue to support these and other programs in the future.

Follow-up: Mr. Peña-Mora request a briefing to get a better understanding on the System wide mentorship programs.

EQUITY AND ACCESS COUNCIL REPORT OUT

The Co-Chairs of the Equity and Access Council, Dr. Nichola Davis and Natalia Cineas, reported out to the Committee on the progress made. Dr. Davis shared that since the official launch of the Equity and Access Council ("the Council"), the Council has focused on developing the structure and assessing the needs of facilities engaged in equity initiatives.

The goal of the Council is to provide strategic direction for developing programs and initiatives aimed at eliminating barriers, institutional and structural inequities, and improving the health and well-being of vulnerable and marginalized populations.

Dr. Davis shared the four pillars in the charter that will drive the activities for the Council that include evaluation and metrics and how to better use data to measure progress, workforce diversity to enhance efforts to attract diverse talent and mentorship opportunities, workforce inclusion to promote inclusive practices, and equity of care aimed at reducing racial and social inequities. The activities may include review of institutional policies that may have equity implications, creating a mechanism for system wide response to current events or disparities in outcomes related to equity. There is also

interest in identifying additional projects that are related to the priority areas within the charter.

Council members will serve in an advisory and oversight role on projects agreed to in advance. Each project will be driven by an equity workgroup, comprised of five to seven interested employees selected from across facilities as well as a Council member. Each workgroup will have two project leads, and tasked to develop work plans and timelines to meet the project's goals and outcomes.

The responses from the equity and access survey that facilities were asked to complete will be instrumental in learning about innovative clinical programs, community initiatives, or other types of equity work that is ongoing at the facilities, and help identify employees interested in working with the Council to advance this work.

The feedback from the employee voices session were also useful as we learned that employees are interested in more forums that allow for dialogue and implicit bias trainings. Employees were pleased that leadership had moved forward with these sessions and provided them with the opportunity to participate, and wanted to see a continued leadership commitment on the issue. We also learned that there were many employees interested in helping the Council to move the work forward and participate in the equity workgroups.

Next steps are to complete the analysis to define the projects, and identify the employees to participate in the workgroups. Once the workgroups have been established, we plan to host an orientation session and then begin developing the workplans, and release system wide communication to inform the system at large.

Mr. Pena-Mora stated that he liked the idea of getting staff voices and concerns for consideration and asked if there was a process for evaluating activities and metrics to measure impact. Natalia Cineas, Senior Vice President and Chief Nurse Executive, responded by saying that the Council planned to have report outs for all workgroups to track the progress of each project. Dr. Davis mentioned that where possible, we are establishing baseline data to know how we are improving, and the Council is working with the Chief Data Officer to ensure alignment with the system wide dashboards and diversity and inclusion metrics. The Committee members expressed interest in seeing the data and receiving reports from the Council on the progress being made.

MWBE PROGRAM AND POLICY UPDATE

Keith Tallbe, Senior Counsel, provided the MWBE program and policy update. Mr. Tallbe provided an overview and history, shared recent data and accomplishments, and outlined next steps for the MWBE program.

Mr. Tallbe provided background on the 1988 NYS legislation, which was intended as a fundamental tool to set goals on State contracts. NYC Health + Hospitals has participated in the program for many years. In 2017, the System formalized and adopted a new procurement policy, which established three key MWBE procurement tools. We are now allowed to conduct MWBE only solicitations, included an MWBE as a quantitative scoring in all solicitations, and able to make discretionary purchases with MWBE businesses on contracts less than one million dollars.

In 2017, the System began tracking contracted spend with vendors certified as diverse by New York State, New York City, as well as other MWBE certifications. Supply Chain Services, who is responsible for the procurement of all good and services for the System, was able to place controls on all procurement processes, including MWBE requirements. Those tools include, ensuring all contracts are not approved without an MWBE certification or waiver, and all service contracts over one million dollars be reviewed by the System's Contract Review Committee.

Since Supply Chain Services assumed responsibility for the MWBE program in 2017, the program has increased year-over-year utilization. The historic average utilization prior to 2017 was four percent (4%). In 2018, we had five percent (5%) utilization, in 2019 seven percent (7%), and for 2020 we are at sixteen percent (16%), with a year-to-date at eighteen percent (18%). A breakdown of this past fiscal year total contract spend that is directly with vendors is $110,349,387 and approximately $19,261,875 with subcontractors. This amount excludes exempt or waived spend $813,789,805. There are 154 diverse vendors that the System conducts business with.

Thirty two percent (32%) of the spend is exclusively New York City certified vendors, twenty five percent (25%) are dual certified between the city and state, twenty five percent (25%) with New York State, eight percent (8%) with the Women Business Enterprise National Council, and six percent (6%) with the National Minority Supplier Diversity Council, which are the two main private, not-for-profit certifying agencies. The remaining four percent (4%) are other. Mr. Tallbe noted that there is an overrepresentation of non-minority

women, which is consistent with the rest of the City and State's outcomes, and commonly referred to as a disparity within the disparity. The System is working to address this on a case-by-case basis on all procurements.

Mr. Tallbe walked the Committee through Supply Chain's 2020 accomplishments, which includes contracts with a New York City WBE for PPE purchases in response to COVID that resulted in $90 million in spend. Supply Chain also contracted for pharmacy inventory management for a total contract value of $76 million, with sixty two percent (62%) of subcontracting goals that included an award to a WBE for $47 million. There was a system wide environmental services management company with a contract value of $121 million, with a thirty percent (30%) goal on the contract representing an award of $16 million. These contracts are renewed contracts that previously did not have any goals, which we deem a significant success. Mr. Tallbe also shared that the System also conducted their first large, closed pool solicitation, for MWBE businesses only. This resulted in a $12 million-dollar award to a dual certified Hispanic and women owned vendor new to the System. Another closed pool solicitation for advertising for the Test and Trace Program resulted in an $11.5 million-dollar award to five minority and women owned businesses. Metro plus is also leveraging those contracts.

Supply Chain is also working closely with EITS to move from a transactional approach for all the System's internet cabling to a contracted approach with one vendor that has a thirty percent (30%) goal with two MWBE vendors. In addition, the System issued a Request for Proposals (RFP) that contracted with construction management firms awarding approximately thirty different MWBEs vendors under that RFP.

Mr. Tallbe shared an outline of the proposed policy which sets a similar framework for other municipal MWBE programs with a legal basis for contract goal setting based on the New York State and New York City disparity studies. The policy incorporates tools from our procurement procedure with closed pool solicitations, discretionary purchases, and quantitative scoring. The policy will allow for goal setting on all contracts at both the System and contract level, and provide for vendor compliance to ensure MWBE goals. Controls will be instituted in the near future that include payment confirmation to subcontractors, and penalties for vendors who are non-responsive, which may include agreement termination and assessing liquidated damages.

The policy will also include the vendor diversity program aimed at developing an education and outreach component and additional key components to support MWBE businesses interested in doing business with the System. There will be a mechanism for tracking and reporting. In addition, the System will set goals for diverse hiring when contracting with vendors that will hire on our behalf to perform services under an agreement. This will support the goal of ensuring the workforce the vendor hires is diverse. Mr. Tallbe concluded his presentation by offering a high-level overview of key next steps that included formalizing the policy, creating a manual, and dashboards to be used to measure progress and to forecast.

Mr. Pena-Mora asked how the System would be working to reach some of the subgroups that are underrepresented within MWBE contracting, mainly black and Hispanic businesses. Mr. Tallbe replied that there is currently a plan in place that entails review of each procurement on a case-by-case basis when overrepresentation is discovered. In the future, we will also review to find opportunities against the availability and set disaggregated goals for each procurement, which will lead to better compliance with prime vendors. Mr. Pena-Mora requested that the strategy be explored and memorialized for the record.

Mr. Pena-Mora mentioned the Comptroller's grade report, where it showed no spend for NYC Health + Hospitals, and asked what steps were being taken to correct the record. Mr. Tallbe replied that only a portion of the System's spend moves through the Comptroller's Office, which is mainly capital purchases funded by the City. The majority of the System's spend and capital items funded through other sources does not go through the Comptroller's Office, and the Comptroller's report only shows spend that flows through them. Mr. Tallbe shared that all data is reported to the City directly.

Danielle DiBari, Senior Vice President for Business Operations, responded to a question clarifying that she has assumed the role of the MWBE diversity officer, which is distinct from the Chief Diversity and Inclusion Officer, who is Matilde Roman. Ms. DiBari mentioned that this separation is typical in big organizations in the nation today, and shared that her office works in partnership with the Office of Diversity and Inclusion.

Follow up: Mr. Peña-Mora asked how the new policy will be integrated into operating procedure 100-05 and requested a briefing for an in-depth understanding OP 100-05.

Helen Arteaga Landaverde asked if there was old business or new business. Hearing none, she thanked the EDI Committee, NYC Health + Hospitals staff and board members for their time and adjourned the meeting at 12:25 p.m.

HAL: mar

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Equity, Diversity and Inclusion Committee

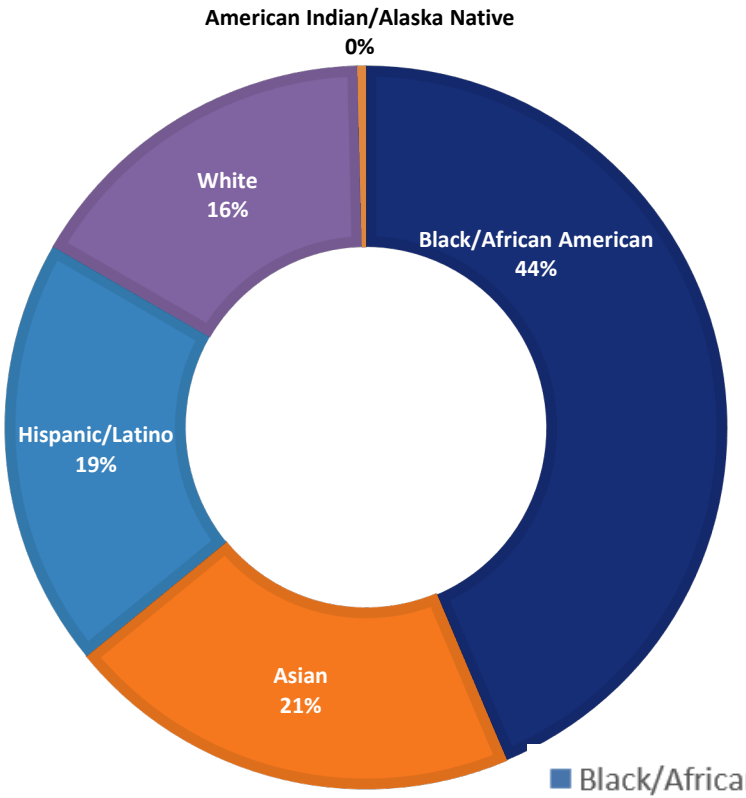
April 12, 2021

DIVERSITY & INCLUSION

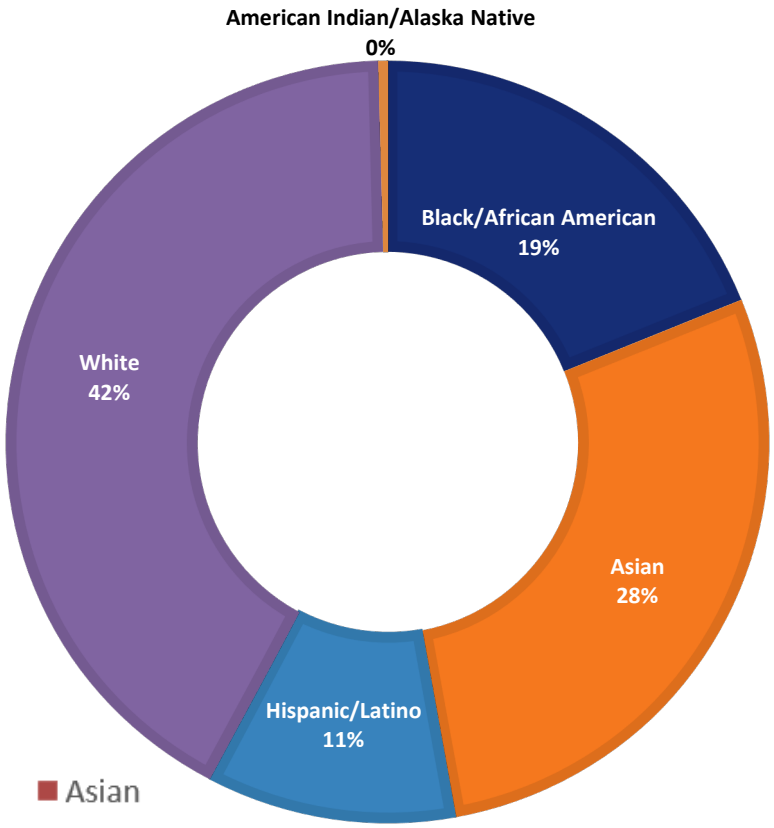
FY20 Affiliate & Employee Workforce Data

Global Demographic Data
Race / Ethnicity Comparison

Employee Workforce



Affiliate Workforce

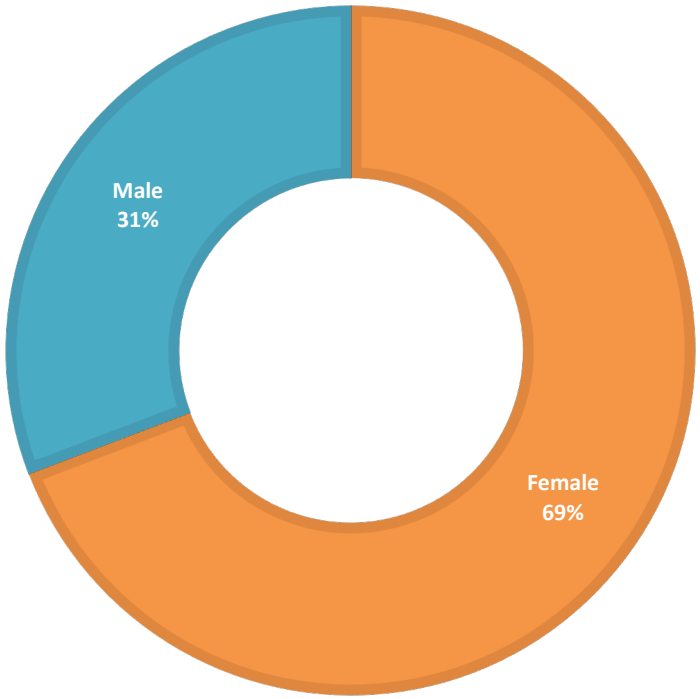


Black/African American
Asian
Hispanic/Latino
White
American Indian/Alaska Native

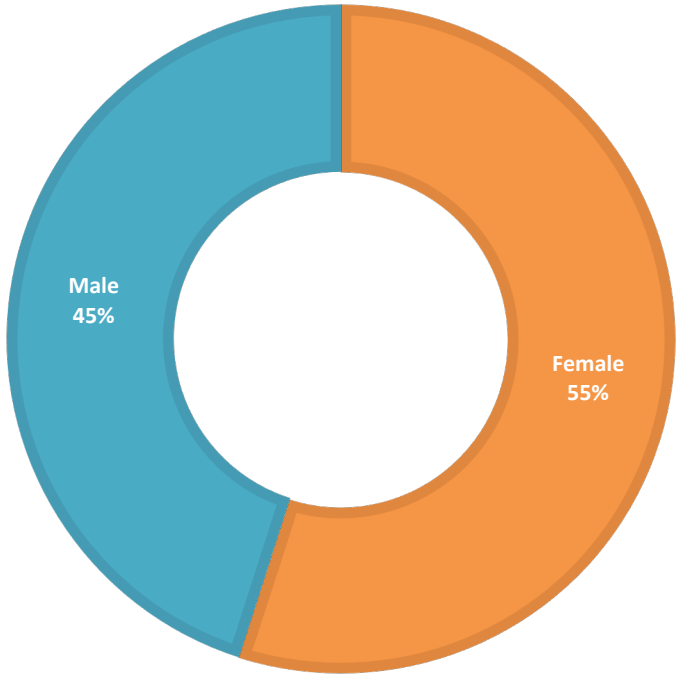
Employees at NYC Health + Hospitals: N=41,494 (FY 20 Data: July 1, 2019- June 30, 2020)
Affiliate Organizations: N=6,503 (Comprises of 1,550 Mount Sinai, 1,958 NYU, 2,927 PAGNY, and 68 SUNY staff on active status in 2020.)

Global Demographic Data
Gender Comparison

Employee Workforce



Affiliate Workforce



Male Female

Employees at NYC Health + Hospitals: N=41,494 (FY 20 Data: July 1, 2019- June 30, 2020)
Affiliate Organizations: N=6,503 (Comprises of 1,550 Mount Sinai, 1,958 NYU, 2,927 PAGNY, and 68 SUNY staff on active status in 2020.)

Equity & Access Council Report Out

Nichola Davis, M.D.
Vice President, Chief of Population Officer

Natalia Cineas, DNP, RN, NEA-BC
Sr. Vice President, Chief Nurse Executive

Equity & Access Council

The Equity and Access Council provides strategic direction for the development of programs and initiatives aimed at eliminating barriers, institutional and structural inequities, and improve the health and well-being of segregated and marginalized communities.

Council Members

- Natalia Cineas, RN, NEA-BC (Co-Chair)
- Nichola Davis, MD (Co-Chair)
- Louis Hart, MD
- Justin List, MD
- Matilde Roman, Esq.

Equity & Access Framework

- Each project will be driven by Equity Work Groups (EWG), comprised of approximately 5-7 members, and guided by 2 project leads to drive goals and outcomes in each area of focus.

- EWG members will be tasked to develop a work plan, metrics and a timeline for each approved project.

- Council members will offer the EWGs guidance and serve an advisory and oversight capacity for the projects to champion the work and be accountable for their progress/success.

Internal Process Milestones

- Completed recruitment of Workgroup members.
- Developed Workgroup Profiles: Membership, Roles, Scope of Work, Objectives.
- Conducted additional facility surveys to learn about current facility work and engage workgroup members.

Equity & Access Drivers

1. Build a robust data infrastructure to create disease-specific queries that incorporate race, ethnicity, language and other social identity categories to identify health inequities.

2. Improve the accuracy and reliability of the collection of race, ethnicity, language, sexual orientation, gender identity, and disability demographic values in support of the System's ongoing efforts to improve health care delivery and health care outcomes.

3. Establish Inclusion Groups to connect, collaborate and support career growth for physicians from under-represented groups.

4. Evaluate and, where appropriate, replace race-based algorithms in medical care.

Accomplishments/Milestones

Equity of Care

- Vaccine Communication Workgroup focused on improving vaccination rates.
- Removal of some race-based algorithms in medical care.

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Equity of Care

MEDICAL ERACISM – ENDING RACE BASED eGFR

CONTEXT

- When calculating a patient's kidney function (GFR), we often use a set of calculations based on various factors to estimate their glomerular filtration rate or eGFR
- Traditionally, these risk factors include serum creatinine, age, sex and **race (Black vs. non-Black)**
- The equation reports out two values. For Black patients it increases the estimated GFR by 16-21% to account for their "increased muscle mass", though no robust scientific evidence exists to support this claim
- **The unintended consequence is to assert and propagate a biological cause for Black bodies being different from all non-Black bodies, a popular eugenicist view**

CONTRIBUTING FACTORS

- ❑ African Americans have a **3x** and Hispanics **1.5x higher risk** of developing kidney failure than White Americans[1]
- ❑ By having higher eGFRs, Black patients might have delayed referral to specialty services, dialysis and transplantation

KEY TAKEAWAYS

- ❑ The inclusion of race is fraught with bias and has lasting deleterious implications for our Black patients. **For a multitude of social and scientific reasons, the Nephrology workgroup feels strongly that the inclusion of subjective race (a social construct) as an objective (biologic) proxy for creatinine generation / clearance in the biomedical environment does not meet the scientific rigor required at NYC Health + Hospitals for our diagnostic screening tools.**

PLANS FOR CORRECTIVE ACTION

- ❑ Lab Services - Standardize all eGFR calculations to use CKD-EPI eGFR(Cr) where results will be reported without race adjustment based on serum creatinine, age, sex, and is normalized to 1.73m2 body surface area
- ❑ Epic – Work to ensure raced based eGFR is no longer reported out as 2 different values to our clinicians and patients
- ❑ **Approved by Nephrology Workgroup, IM Council, ICU & OB/GYN leadership, Quality & Safety, Medical & Professional Affairs, Equity & Access Council, Clinical Lab Council, CMO Council**

1. https://www.kidney.org/news/establishing-task-force-to-reassess-inclusion-race-diagnosing-kidney-diseases

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Medical Eracism – Stop Race-Based VBAC Counseling

Context:

+ Clinicians may use a risk tool – known as **V**aginal **B**irth **A**fter **C**esarean-section (**VBAC**) calculators – to estimate the risk and likely success of a trial of labor for a vaginal delivery after an earlier C-section in a prior pregnancy.
+ Formulated in 2007, the VBAC calculation includes risk factors, such as age, BMI, and clinical history of delivery. These algorithms also consider whether the patient is of **Black race** or **Hispanic ethnicity**. For **Black women** it decreases the estimated success rate of vaginal deliveries by **67%** and for **Hispanic women** by **68%**.
+ The functional consequence is to insinuate a biological cause for Black & Hispanic women's bodies being fundamentally different from a "normal" body. This reinforces the false idea that race itself is a biologically significant risk factor for illness and minimizes the real effects of racism and health inequity on minoritized people.

Contributing Factors:

- Black women remain **3x – 4x** more likely to die from pregnancy-related causes than White women in America.[1]
- While both the clinician and patient decide together whether a TOLAC or elective CS should be performed, the decision to pursue either may be influenced by medical bias.

Key Takeaways:

- **The Women's Health Council feels strongly that the inclusion of race as an objective proxy for a patient's VBAC complication risk calculation does not meet the scientific rigor required at NYC Health + Hospitals for our diagnostic screening tools.**
- **The Women's Health Council applauds NYC Health + Hospitals clinicians for forgoing the use of the race-based VBAC calculators in their VBAC counseling**. Additionally, the American College of Obstetricians & Gynecologists also stresses that individual complications must be assessed on a case-by-case basis.

Plans for Further Action:

- We must continue to eliminate health inequities from within Women's Health in the United States. A key first step is identifying how implicit biases affect the way we view, interact with and counsel our patients. De-implementation of race-based clinical calculators in favor of more equitable approaches that address both women's social determinants of health (e.g. insurance type, zip code, low income, racism) and their biological clinical measures (e.g. prior labor course, age, BMI).
- This is evidenced in NYC H+H's Cesarean-section rates below the NY state average **(19%, vs. 22.9%)** and successful VBAC rates greater than the NY state average **(19%, vs. 13.3%)**. NYC Health + Hospitals remains committed to using the most empirically-relevant information to inform our diagnostic screening tools.

1. https://doi.org/10.1016/j.whi.2019.04.007

Workforce Diversity

- “Black Men in White Coats” community screening and panel discussion – documentary focused on the devastating and disproportionately low rates of Black male physicians in the US.

- Physician Diversity Initiative aimed at improving diversity of physician workforce. These efforts involve a strategic alliance with affiliate organizations to build a sustainable plan for recruitment and retention of a provider workforce that better reflects the patient population at H+H affiliated hospitals.

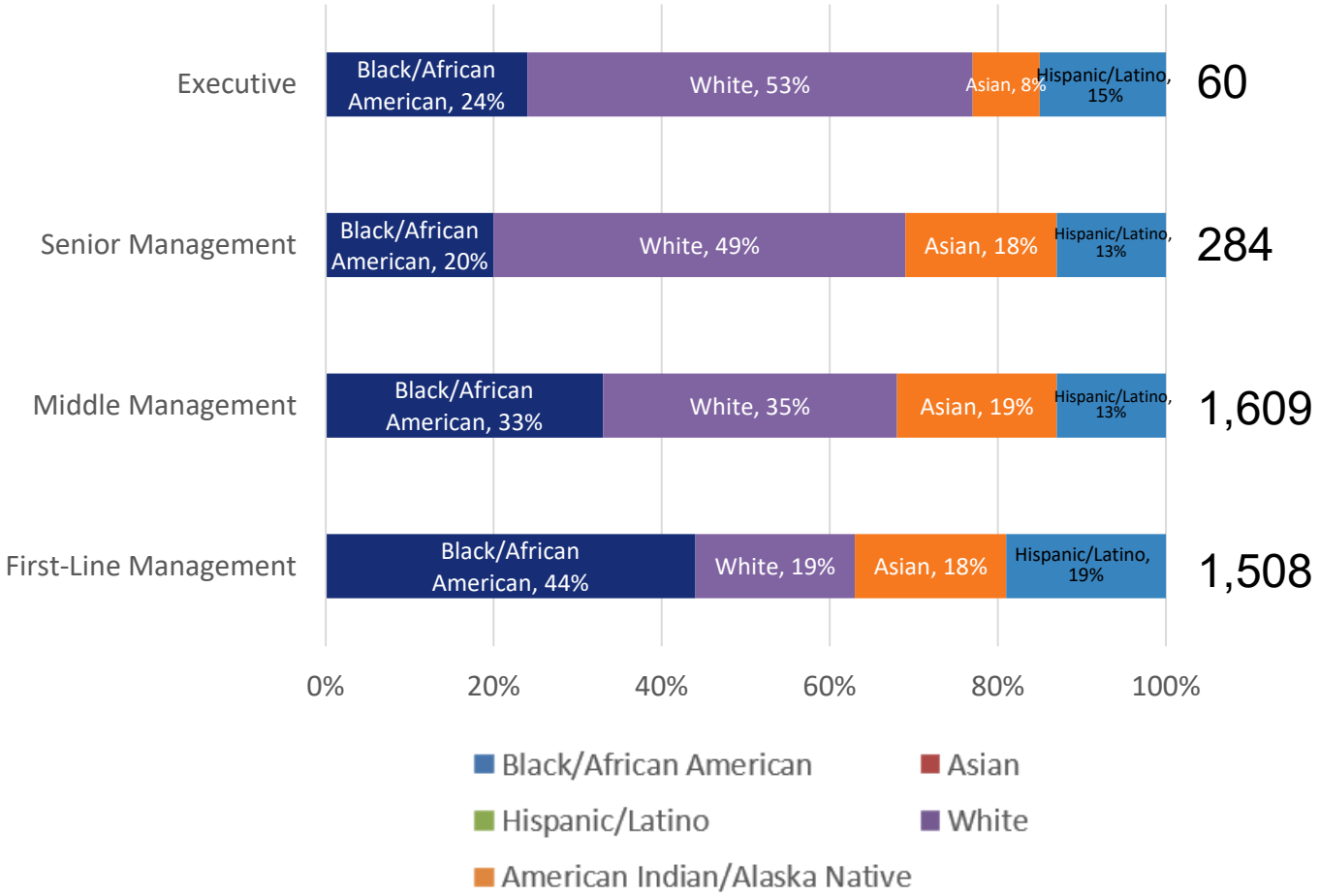
Diversity by the Numbers

Diversity in senior management

Modern Healthcare asked the 20 largest health systems to provide the **percentage of their senior management who are ethnic or racial minorities**

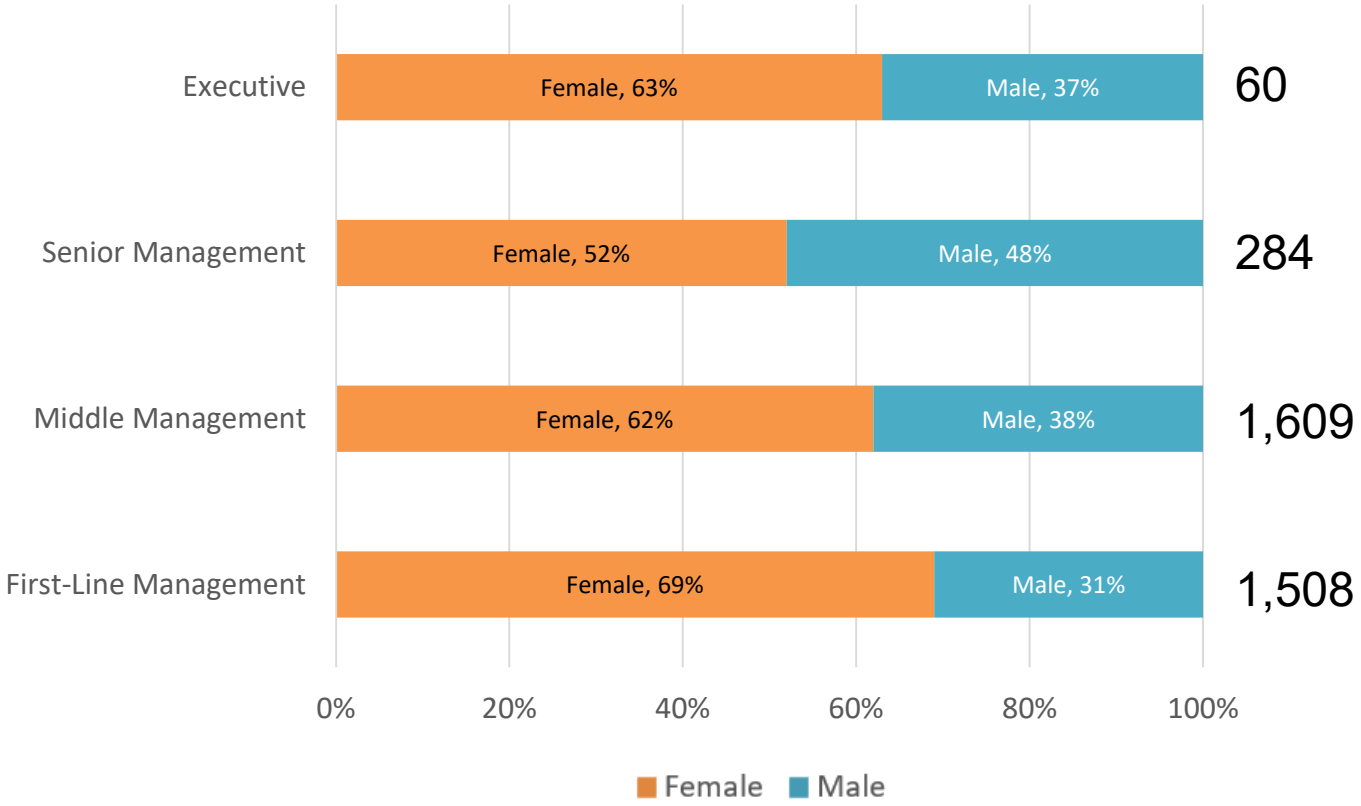
System	Percentage
AdventHealth	19%
Advocate Aurora Health	16%
Ascension	17%
Baylor Scott & White Health	17%
Cleveland Clinic Health System	13%
CommonSpirit Health	43%
Community Health Systems	10%
HCA Healthcare	25%
Kaiser Permanente	27%
Mass General Brigham	Did not participate
Mayo Clinic Health System	19%
NYC Health & Hospitals	**46%**
Northwell Health	13%
Providence	40%
Sutter Health	25%
Tenet Healthcare Corp.	Did not participate
Trinity Health	20%
Universal Health Services	Did not participate
University of California Health System	10%
UPMC	Declined
Median of all participants	**19%**

Race / Ethnicity – All Leadership



N=3,461
FY 2020 Data (July 1, 2019 – June 30, 2020)

Gender – All Leadership



N=3,461
FY 2020 Data (July 1, 2019 – June 30, 2020)

Accomplishments Continued . . .

Inclusion

- Started to establish Inclusion Workgroups
  - Black Female Physician Group

Evaluation

- Convene multidisciplinary data team to streamline how REaLD/SOGI data is collected and analyzed

Next Steps

- Convene the Equity Workgroups.
- Develop work plans (with timelines).
- Establish success metrics for each workgroup.