

STATE OF NEW YORK

8360

IN SENATE

May 19, 2020

Introduced by Sen. SANDERS -- read twice and ordered printed, and when printed to be committed to the Committee on Health

AN ACT in relation to requiring the New York state department of health to collect and report certain data concerning COVID-19

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

- 1 Section 1. Short title. This act shall be known and may be cited as
2 the "equitable data collection and disclosure on COVID-19 act".
- 3 § 2. Findings. (a) The World Health Organization (WHO) declared
4 COVID-19 a "public health emergency of international concern" on January
5 30, 2020. By late March 2020, there have been over 470,000 confirmed
6 cases of, and 20,000 deaths associated with, COVID-19 worldwide.
- 7 (b) In the United States, cases of COVID-19 have quickly surpassed
8 those across the world, and as of April 12, 2020, over 500,000 cases and
9 20,000 deaths have been reported in the United States alone.
- 10 (c) Reports have shown racial inequities in COVID-19 testing and
11 treatment, specifically in communities of color and in Limited English
12 Proficient (LEP) communities.
- 13 (d) The burden of morbidity and mortality in the United States has
14 historically fallen disproportionately on marginalized communities,
15 those who suffer the most from great public health needs and are the
16 most medically underserved.
- 17 (e) Historically, structures and systems, such as racism, ableism and
18 class oppression, have rendered affected individuals more vulnerable to
19 inequities and have prevented people from achieving their optimal health
20 even when there is not a crisis of pandemic proportions.
- 21 (f) Significant differences in access to health care, specifically to
22 primary health care providers, health care information, and greater
23 perceived discrimination in health care place communities of color,
24 individuals with disabilities, and LEP individuals at greater risk of
25 receiving delayed, and perhaps poorer, health care.
- 26 (g) Communities of color experience higher rates of chronic disease
27 and disabilities, such as diabetes, hypertension, and asthma, than non-

EXPLANATION--Matter in italics (underscored) is new; matter in brackets
[-] is old law to be omitted.

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1 Hispanic White communities, which predisposes them to greater risk of
2 complications and mortality should they contract COVID-19.

3 (h) Such communities are made even more vulnerable to the uncertainty
4 of the preparation, response, and events surrounding the pandemic public
5 health crisis, COVID-19. For instance, in the recent past, multiple
6 epidemiologic studies and reviews have reported higher rates of hospi-
7 talization due to the 2009 H1N1 pandemic among the poor, individuals
8 with disabilities and preexisting conditions, those living in impover-
9 ished neighborhoods, and individuals of color and ethnic backgrounds in
10 the United States. These findings highlight the urgency to adapt the
11 COVID-19 response to monitor and act on these inequities via data
12 collection and research by race and ethnicity.

13 (i) Research experts recognize that there are underlying differences
14 in illness and death when each of these factors are examined through
15 socioeconomic and racial or ethnic lenses. These socially determinant
16 factors of health accelerate disease and degradation.

17 (j) Without clear understanding of how COVID-19 impacts marginalized
18 racial and ethnic communities, there will be exacerbated risk of endan-
19 gering the most historically vulnerable of our nation.

20 (k) The consequences of misunderstanding the racial and ethnic impact
21 of COVID-19 extends beyond communities of color such that it would
22 impact all.

23 (l) Race and ethnicity are valuable research and practice variables
24 when used and interpreted appropriately. Health data collected on
25 patients by race and ethnicity will boost and more efficiently direct
26 critical resources and inform risk communication development in
27 languages and at appropriate health literacy levels, which resonate with
28 historically vulnerable communities of color.

29 (m) The dearth of racially and ethnically disaggregated data reflect-
30 ing the health of communities of color underlies the challenges of a
31 fully informed public health response.

32 (n) Without collecting race and ethnicity data associated with COVID-
33 19 testing, hospitalizations, morbidities, and mortalities, as well as
34 publicly disclosing it, communities of color will remain at greater risk
35 of disease and death.

36 § 3. Emergency funding for state data collection on the racial,
37 ethnic, and other demographic disparities of COVID-19. Funding shall be
38 appropriated from the general fund to conduct or support data collection
39 on the racial, ethnic, and other demographic implications of COVID-19 in
40 New York state, including support to assist in the capacity building for
41 state and local public health departments to collect and transmit
42 racial, ethnic, and other demographic data to the relevant state depart-
43 ment of health agencies.

44 § 4. COVID-19 data collection and disclosure. (a) Data collection. The
45 commissioner of health, shall make publicly available on the depart-
46 ment's website of the data collected across all surveillance systems
47 relating to COVID-19, disaggregated by race, ethnicity, sex, age, prima-
48 ry language, socioeconomic status, disability status, and county,
49 including the following:

50 (1) data related to all COVID-19 testing, including the number of
51 individuals tested and the number of tests that were positive;

52 (2) data related to treatment for COVID-19, including hospitalizations
53 and intensive care unit admissions; and

54 (3) data related to COVID-19 outcomes, including total fatalities and
55 case fatality rates, expressed as the proportion of individuals who were
56 infected with COVID-19 and died from the virus.

1 (b) Timeline. The data made available under this section shall be
2 updated daily throughout the public health emergency.

3 (c) Privacy. In publishing data under this section, the commissioner
4 of health shall take all necessary steps to protect the privacy of indi-
5 viduals whose information is included in such data, including, but not
6 limited to:

7 (1) complying with privacy protections provided under the regulations
8 promulgated under the federal Health Insurance Portability and Account-
9 ability Act of 1996; and

10 (2) protections from all inappropriate internal use by an entity that
11 collects, stores, or receives data, including use of such data in deter-
12 minations of eligibility or continued eligibility in health plans, and
13 from inappropriate uses.

14 (d) Consultation with Indian tribes. The department of health shall
15 consult with Indian tribes and confer with urban Indian organizations on
16 data collection and reporting.

17 (f) Report; public. No later than 60 days after the date on which the
18 commissioner of health certifies that the public health emergency
19 related to COVID-19 has ended, a summary of the final statistics related
20 to COVID-19 shall be made public.

21 (g) Report; legislature. No later than 60 days after the date on which
22 the commissioner certifies that the public health emergency related to
23 COVID-19 has ended, the department of health shall compile and submit to
24 the senate committee on health, the senate committee on finance, the
25 assembly committee on ways and means and the assembly committee on
26 health a preliminary report:

27 (1) describing the testing, hospitalization, mortality rates, and
28 preferred language of patients associated with COVID-19 by race and
29 ethnicity; and

30 (2) proposing evidenced-based response strategies to safeguard the
31 health of such communities in future pandemics.

32 § 5. Commission on ensuring health equity during the COVID-19 public
33 health emergency. (a) Establishment. No later than 30 days after the
34 effective date of this act, the commissioner of health shall establish a
35 commission, to be known as the "Commission on Ensuring Health Equity
36 During the COVID-19 Public Health Emergency" (referred to in this
37 section as the "Commission") to provide clear and robust guidance on how
38 to improve the collection, analysis, and use of demographic data in
39 responding to future waves of the coronavirus.

40 (b) Membership and chairperson. (1) The Commission shall have 17
41 members which shall consist of:

42 (A) the commissioner of the department of health;

43 (B) the secretary of state;

44 (C) the commissioner of homeland security and emergency services;

45 (D) the director of the office of minority health and health dispari-
46 ties prevention;

47 (E) the director of the office of emergency management;

48 (F) the director of the office of mental health;

49 (G) three members appointed by the temporary president of the senate;
50 one member appointed by the senate minority leader; three members
51 appointed by the speaker of the assembly and one member appointed by the
52 assembly minority leader; and

53 (H) racially and ethnically diverse representation from at least three
54 independent experts with knowledge or field experience with racial and
55 ethnic disparities in public health appointed by the commissioner of
56 health.

1 (2) The commissioner of the department of health shall serve as the
2 chairperson of the Commission.

3 (c) Duties. The Commission shall:

4 (1) examine barriers to collecting, analyzing, and using demographic
5 data;

6 (2) determine how to best use such data to promote health equity
7 across the state and reduce racial, Tribal, and other demographic
8 disparities in COVID-19 prevalence and outcomes;

9 (3) gather available data related to COVID-19 treatment of individuals
10 with disabilities, including denial of treatment for pre-existing condi-
11 tions, removal or denial of disability related equipment, including
12 ventilators and CPAP, and data on completion of DNR orders, and identify
13 barriers in obtaining accurate and timely data related to COVID-19
14 treatment of such individuals;

15 (4) solicit input from public health officials, community-connected
16 organizations, health care providers, state and local agency officials,
17 and other experts on barriers to, and best practices for, collecting
18 demographic data; and

19 (5) recommend policy changes that the data indicates are necessary to
20 reduce disparities.

21 (d) Report. No later than 60 days after the effective date of this
22 act, and every 180 days thereafter until the commissioner certifies that
23 the public health emergency related to COVID-19 has ended, the Commis-
24 sion shall submit a written report of its findings and recommendations
25 to the governor and the legislature and post such report on the depart-
26 ment of health's website. Such reports shall contain information
27 concerning:

28 (1) how to enhance state, local, and Tribal capacity to conduct public
29 health research on COVID-19, with a focus on expanded capacity to
30 analyze data on disparities correlated with race, ethnicity, income,
31 sex, age, disability status, specific geographic areas, and other rele-
32 vant demographic characteristics, and an analysis of what demographic
33 data is currently being collected about COVID-19, the accuracy of that
34 data and any gaps, how this data is currently being used to inform
35 efforts to combat COVID-19, and what resources are needed to supplement
36 existing public health data collection;

37 (2) how to collect, process, and disclose to the public the data
38 described in paragraph one of this subdivision in a way that maintains
39 individual privacy while helping direct the state and local response to
40 the virus;

41 (3) how to improve demographic data collection related to COVID-19 in
42 the short- and long-term, including how to continue to grow and value
43 the Tribal sovereignty of data and information concerning Tribal commu-
44 nities;

45 (4) to the extent possible, a preliminary analysis of racial and other
46 demographic disparities in COVID-19 mortality, including an analysis of
47 comorbidities and case fatality rates;

48 (5) to the extent possible, a preliminary analysis of sex, gender,
49 sexual orientation, and gender identity disparities in COVID-19 treat-
50 ment and mortality;

51 (6) an analysis of COVID-19 treatment of individuals with disabili-
52 ties, including equity of access to treatment and equipment and inter-
53 sections of disability status with other demographic factors, including
54 race, and recommendations for how to improve transparency and equity of
55 treatment for such individuals during the COVID-19 public health emer-
56 gency and future emergencies;

1 (7) how to support the state, local, and Tribal communities in order
2 to eliminate barriers to COVID-19 testing and treatment; and
3 (8) to the extent possible, a preliminary analysis of state policies
4 that disparately exacerbate the COVID-19 impact, and recommendations to
5 improve racial and other demographic disparities in health outcomes.
6 § 6. This act shall take effect immediately.