H.210

Introduced by Representatives Cina of Burlington, Brady of Williston, Burrows of West Windsor, Christie of Hartford, Colburn of Burlington, Colston of Winooski, Cordes of Lincoln, Donahue of Northfield, Houghton of Essex, James of Manchester, Lippert of Hinesburg, Morris of Springfield, Mulvaney-Stanak of Burlington, Pugh of South Burlington, Small of Winooski, Surprenant of Barnard, and Vyhovsky of Essex

Referred to Committee on

Date:

Subject: Health care; equity; race; ethnicity; sexual orientation; gender identity; persons with disabilities

Statement of purpose of bill as introduced: This bill proposes to: (1) establish the Office of Health Equity; (2) establish the Health Equity Advisory Commission; (3) issue grants for the promotion of health equity; (4) collect data to better understand health disparities in Vermont; and (5) require an additional two hours of continuing medical education on cultural competency in the practice of medicine.

An act relating to addressing disparities and promoting equity in the health care system

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. FINDINGS

The General Assembly finds that:

(1) Research and experience demonstrate that Vermont residents experience barriers to the equal enjoyment of good health based on race and ethnicity, sexual orientation, gender identity, and disability status.

(2) According to the 2018 Vermont Department of Health's Behavioral Risk Factor Surveillance System report, non-White Vermonters are:

(A) statistically less likely to have a personal doctor;

(B) statistically more likely to report poor mental health;

(C) more than twice as likely to report rarely or never getting the necessary emotional and support;

(D) significantly more likely to have depression;

(E) significantly more likely to have been worried about having enough food in the past year; and

(F) significantly more likely to report no physical activity during leisure time.

(3) Non-White Vermonters are disproportionately represented in the highest level of involuntary hospitalization. At the Vermont Psychiatric Care Hospital, 15 percent of the patients are non-White.

(4)(A) Non-White Vermonters have also been disproportionately affected by COVID-19. Nearly one in every five COVID-19 cases in Vermont are among non-White Vermonters even though non-White Vermonters make up approximately six percent of Vermont's population. The incidence rate for non-White Vermonters is 74.2 versus 26.2 for White Vermonters. The incidence rate for Black Vermonters is 225.7; the incidence rate for Asian Vermonters is 61; the incidence rate for Hispanic Vermonters is 41.7; and the incidence rate for other races is 20.5. Non-White Vermonters are also at a higher risk for more serious outcomes, such as hospitalization.

(B) COVID-19 cases among non-White Vermonters tend to be younger than for White Vermonters. The average age of persons testing positive for COVID-19 is 33 among non-White Vermonters, whereas the average age is 46 among White Vermonters.

(C) While there are not statistically significant differences in the rates of preexisting conditions, such as diabetes, lung disease, and cardiovascular disease, among White and non-White Vermonters, there are disparities in the rates of pre-existing conditions among Vermonters testing positive for COVID-19. The preexisting conditions rate among COVID-19 cases is 19.4 percent for non-White Vermonters and 12.1 percent for White Vermonters. This suggests that non-White Vermonters are at higher risk of exposure to COVID-19 due to their type of employment and living

arrangements. Thirty-six percent of non-White Vermonters had household contact with a confirmed case of COVID-19, as compared to only 20 percent of White Vermonters.

(5) Adults with a disability are:

(A) five times as likely to consider suicide than adults with no disability;

(B) eight times more likely to report fair or poor health than adults with no disability;

(C) statistically more likely to delay care due to cost than adults with no disability;

(D) seven times more likely to report poor physical health than adults with no disability;

(E) statistically more likely to report poor mental health in the last month than adults with no disability;

(F) more than twice as likely to report rarely or never getting the necessary emotional support as compared to White adults with no disability;

(G) statistically more likely to report having arthritis than adults with no disability;

(H) statistically more likely to have asthma than adults with no disability;

(I) nearly twice as likely to have ever had cancer than adults without a disability;

(J) statistically more likely to have had skin cancer than adults with no disability;

(K) three times more likely to report having cardiovascular disease than adults with no disability;

(L) five times more likely to report having chronic obstructive pulmonary disease than Vermonters with no disability;

(M) significantly more likely to have depression than adults with no disability;

(N) three times as likely to report having diabetes than those with no disability;

(O) significantly more likely to report having hypertension than those with no disability;

(P) statistically more likely to report having kidney disease than adults with no disabilities;

(Q) significantly more likely to have been worried about having enough food in the past year when compared to adults with no disability;

(R) more than three times as likely to report housing insecurity in the past year than adults with no disability; and

(S) significantly more likely to report no physical activity during leisure time than adults with no disability.

(6) Adults who are LGBTQ are:

(A) three times as likely to report seriously considering suicide compared to non-LGBTQ adults;

(B) statistically more likely to delay care due to cost than non-LGBTQ adults;

(C) statistically more likely to report poor mental health in the last month than non-LGBTQ adults;

(D) statistically more likely to report a disability than non-LGBTQ adults;

(E) statistically more likely to have asthma than non-LGBTQ adults;

(F) significantly more likely to have depression than non-LGBTQ adults; and

(G) significantly more likely to have been worried about having enough food in the past year when compared to non-LGBTQ adults.

(7) According to Vermonters who experience health inequities, they:

(A) face discrimination, prejudice, and racism that is often invisible to others;

(B) do not trust and feel misunderstood by "the system";

(C) do not feel valued, included, or safe;

(D) feel like services are not designed to support them;

(E) feel a lack of agency over their health and their own lives; and

(F) believe this takes place because our society has been structured to maintain a status quo that provides them with unequal opportunities.

(8) Social determinants of health are underlying, contributing factors of the foregoing health inequities. That is, disparities in social determinants of health contribute to health inequities. Disparities in the social determinants of health exist in Vermont. For example:

(A) Just 21 percent of Black Vermonters own their own homes whereas 72 percent of White Vermonters own their own home. Nationally, 41 percent of Black Americans own their own home.

(B) The median household income of Black Vermonters is $41,533.00 while the median household income of White Vermonters is $58,244.00.

(C) In 2018, 23.8 percent of Black Vermonters were living in poverty while 10.7 percent of White Vermonters lived in poverty. In addition, 57 percent of Black Vermonters earned less than 80 percent of Vermont's median income while 43 percent of White Vermonters earned less than 80 percent of Vermont's median income.

(D) About one in two non-White Vermonters experience "housing problems," which is defined as homes that lack complete kitchen facilities or

plumbing; overcrowded homes; or households paying more than 30 percent of income towards rent, mortgage payments, and utilities. One in three Vermonters experience "housing problems."

(E) Black Vermonters are overrepresented among Vermonters experiencing homelessness. While Black Vermonters make up about one percent of Vermont's population, they make up six percent of Vermonters experiencing homelessness.

Sec. 2. LEGISLATIVE INTENT AND PURPOSE

(a) It is the intent of the General Assembly to promote health and achieve health equity by eliminating avoidable and unjust disparities in health through a systemic and comprehensive approach that addresses social, economic, and environmental factors that influence health. To this end, the General Assembly believes that:

(1) Equal opportunity is a fundamental principle of American democracy.

(2) Equal enjoyment of the highest attainable standard of health is a human right and a priority of the State.

(3) Structural racism, defined as the laws, policies, institutional practices, cultural representations, and other societal norms that often work together to deny equal opportunity, has resulted in health disparities among Vermonters. Great social costs arise from these inequities, including threats to

economic development, democracy, and the social health of the State of Vermont.

(4) Health disparities are a function of not only access to health care, but also social determinants of health, including the environment, the physical structure of communities, nutrition and food options, educational attainment, the physical structure of communities, employment, race, ethnicity, sex, geography, language preferences, immigrant or citizen status, sexual orientation, gender identity, and socioeconomic status, that directly and indirectly affect the health, health care, and wellness of individuals and communities.

(5) Efforts to improve health in the Unites States have traditionally looked to the health care system as the key driver of health and health outcomes. However, there has been increased recognition that improving health and achieving health equity will require broader approaches that address factors that influence health.

(6) Health equity is the attainment of the highest level of health for all people. Health equity can be achieved only by eliminating the preventable differences in the health of one group over another as the result of factors such as race, sexual orientation, gender, disability, age, socioeconomic status, or geographic location.

(b) The purpose of this act is to eliminate disparities in health status based on race, ethnicity, disability, and LGBTQ status by:

(1) establishing better and more consistent collection and access to data;

(2) enhancing the full range of available and accessible culturally appropriate health care and public services across Vermont;

(3) ensuring the early and equitable inclusion of Vermonters who experience health inequities because of race, ethnicity, disability, and LGBTQ status in efforts to eliminate such inequities; and

(4) addressing social determinants of health, particularly social, economic, and environmental factors that influence health.

Sec. 3. 18 V.S.A. chapter 6 is added to read:

CHAPTER 6. HEALTH EQUITY

§ 251. DEFINTIONS

As used in this chapter:

(1) "Cultural competency in the practice of medicine" means a set of integrated attitudes, knowledge, and skills that enables a health care professional to care effectively for patients from cultures, groups, and communities other than that of the health care professional. At a minimum, cultural competency should include the following:

(A) awareness and acknowledgement of the health care professional's own culture;

(B) utilization of cultural information to establish therapeutic relationships;

(C) eliciting and incorporating pertinent cultural data in diagnosis and treatment; and

(D) understanding and applying cultural and ethnic data to the process of clinical care.

(2) "Health disparity" means differences that exist among specific population groups in the United States in attaining individuals' full health potential that can be measured by differences in incidence, prevalence, mortality, burden of disease, and other adverse health conditions.

(3) "Health equity" means all people have a fair and just opportunity to be healthy, especially those who have experienced socioeconomic disadvantage, historical injustice, and other avoidable systemic inequalities that are often associated with the social categories of race, gender, ethnicity, social position, sexual orientation, and disability.

(4) "Health equity data" means demographic data, including, but not limited to, race, ethnicity, primary language, age, gender, socioeconomic position, sexual orientation, disability, homelessness, or geographic data that can be used to track health equity.

(5) "Non-White" means Black, Indigenous, and People of Color. It is not intended to reflect self-identity, but rather how people are categorized in

the racial caste system on which discrimination has been historically based in the United States and how Vermont typically disaggregates data solely by White and non-White.

(6) "Race and ethnicity" mean the categories for classifying individuals that have been created by prevailing social perceptions, historical policies, and practices. Race and ethnicity include how individuals perceive themselves and how individuals are perceived by others.

(7) "Social determinants of health" are the conditions in the environments where people are born, live, learn, work, play, worship, and age, such as poverty, income and wealth inequality, racism, and sex discrimination, that affect a wide range of health, functioning, and quality-of-life outcomes and risks. They can be grouped into five domains: economic stability; education access and quality; health care access and quality; neighborhood and built environment; and social and community context. Social determinants of health are systematic, interconnected, cumulative, and intergenerational conditions that are associated with lower capacity to fully participate in society.

§ 252. OFFICE OF HEALTH EQUITY

(a) There is created the Office of Health Equity within the Department of Health to advise the Commissioner of Health, Governor, and General Assembly on matters of health equity affecting Vermonters. The Office shall

serve in a coordinating, educating, and capacity-building role for State and local public health programs and community-based organizations that promote health equity in Vermont by implementing strategies tailored to address the varying complex causes of health disparities, including the economic, physical, and social environment. The Office shall work collaboratively within the Department and with affected stakeholders to set priorities, collect and disseminate data, and align resources within the Department and across other State agencies.

(b)(1) The Office has the following powers, duties, and functions:

(A) leading and coordinating the Department's health equity efforts;

(B) publishing data reports documenting health disparities;

(C) providing education to the public on health equity, health disparities, and social determinants of health;

(D) building capacity within communities to offer or expand public health programs to better meet the needs of individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities;

(E) conducting State-level strategic planning to eliminate health inequities;

(F) providing technical assistance to the Department of Health in carrying out its programs and to public health agencies, community-based organizations, and communities in the State;

(G) coordinating and staffing the Health Equity Advisory Commission established pursuant to section 253 of this title;

(H) building collaborative partnerships with communities to identify and promote health equity strategies;

(I) providing grants to community-based organizations to conduct special research, demonstration, and evaluation projects that support individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities and to support ongoing community-based projects that are designed to reduce or eliminate health disparities in Vermont;

(J) developing a statewide plan for increasing the number of individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities in the health care profession, including recommendations for the financing mechanisms and recruitment strategies necessary to carry out the plan;

(K) working collaboratively with the University of Vermont's College of Medicine and other health care professional training programs to develop courses that are designed to address the problem of disparities in

health care access, utilization, treatment decisions, quality, and outcomes among individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities; and

(L) developing curricula and the provision of continuing education courses to teach cultural competency in the practice of medicine.

(2) The Office may:

(A) hire personnel as the Director of Health Equity, in consultation with the Commissioner of Health, deems necessary;

(B) apply for and accept any grant of money from the federal government, private foundations, or other sources, which may be available for programs related to the health of individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities;

(C) serve as the designated State agency for receipt of federal funds specifically designated for programs that support individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities; and

(D) enter into contracts with individuals, organizations, and institutions necessary for the performance of its duties under this chapter.

(c)(1) The Office shall be administered by a Director of Health Equity, who shall be appointed by the Commissioner of Health and serve at the pleasure of the Commissioner until the appointment of the Director's successor.

(2) The Director of Health Equity shall have the following experience, skills, knowledge, and qualifications:

(A) lived experience of oppression or discrimination, or both, based on race, ethnicity, perceived mental condition, or LGBTQ or disability status, or any combination thereof;

(B) demonstrated experience addressing inequities in a range of political and professional environments;

(C) experience in equity advocacy or systems change efforts, including experience working in or with individuals who are Black, Indigenous, or Persons of Color; individuals who are LGBTQ; or individuals with disabilities;

(D) experience measuring and monitoring program evaluation activities and working in multidisciplinary partnerships;

(E) demonstrated success in the administration of community, education, or social justice programs that focus, in part, on the elimination of structural racism, including at least two years in a managerial, supervisory, or program administration capacity;

(F) a strong understanding of the root causes of inequities and the social determinants of health and capacity to educate others; and

(G) a strong understanding of health inequities and disparities in Vermont.

(d) Annually, on or before September 30, the Office shall submit a report to the Governor, the Senate Committee on Health and Welfare, and the House Committees on Health Care on Human Services regarding the activities of the Office. The report shall address the projects and services developed and funded by the Office and the health inequities that the grant funds are intended to ameliorate. The report shall include any recommendations for administrative or legislative action that the Director deems appropriate.

(e) The Office is authorized to seek the assistance and avail itself of the services of employees of any State agency, department, board, bureau, or commission as it may require and as may be available to it for its purposes. All State agencies, departments, boards, bureaus, or commissions are authorized and directed to cooperate with the Office of Health Equity, to the extent consistent with law.

§ 253. HEALTH EQUITY ADVISORY COMMISSION

(a) Creation. There is created the Health Equity Advisory Commission to monitor health equity issues throughout Vermont and provide the Office of Health Equity with recommendations and guidance.

(b)(1) Membership. The Advisory Commission shall be composed of the following members:

(A) the Director of Health Equity established pursuant to section 252 of this title;

(B) the Commissioner of Health or designee;

(C) the Commissioner of Mental Health or designee;

(D) the Commissioner of Disabilities, Aging, and Independent Living or designee;

(E) the Commissioner of Vermont Health Access or designee;

(F) the Commissioner for Children and Families or designee;

(G) the Commissioner of Housing and Community Development or designee;

(H) the Commissioner of Economic Development or designee;

(I) the Chief Performance Officer or designee;

(J) a member, appointed by the Racial Justice Alliance;

(K) a member, appointed by the Rutland Area NAACP;

(L) a member, appointed by the Association of Africans Living in Vermont;

(M) a member, appointed by the Windham County Vermont NAACP;

(N) a member, appointed by the Pride Center of Vermont;

(O) a member, appointed by Outright Vermont;

(P) a member, appointed by Migrant Justice;

(Q) a member, appointed by Out in the Open;

(R) a member, appointed by Another Way Community Center;

(S) a member, appointed by Vermont Psychiatric Survivors;

(T) a member, appointed by the Vermont Center for Independent Living;

(U) a member, appointed by the Elnu Abenaki Tribe;

(V) a member, appointed by the Nulhegan Abenaki Tribe;

(W) a member, appointed by the Koasek Traditional Nation of Missiquoi;

(X) a member, appointed by the Abenaki Nation of Missiquoi;

(Y) a member, appointed by the Vermont Commission on Native American Affairs;

(Z) a member, appointed by Green Mountain Self-Advocates; and

(AA) a member, appointed by Vermont Federation of Families for Children's Mental Health.

(2) The term of office of each appointed member shall be three years, but of the members first appointed, three shall be appointed for a term of one year, four shall be appointed for a term of two years, and 10 shall be appointed for a term of three years. Members shall hold office for the term of their

appointments and until their successors have been appointed. All vacancies shall be filled for the balance of the unexpired term in the same manner as the original appointment. Members are eligible for reappointment.

(c) Powers and duties. The Advisory Commission shall:

(1) review and make recommendations to the Office of Health Equity on any rules or policies proposed by the Office;

(2) conduct statewide hearings on issues of concern to the health interests of individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities;

(3) review, monitor, and advise all State agencies regarding the impact of current and emerging State policies, procedures, practices, laws, and rules on the health of individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities;

(4) identify and examine the limitations and problems associated with existing laws, rules, programs, and services related to the health status of individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities;

(5) advise the Office of Health Equity on the awarding of grants and the development of programs and services required pursuant to this chapter;

(6) advise the Office of Health Equity on the needs, priorities, programs, and policies relating to the health of individuals who are Black, Indigenous,

and Persons of Color; individuals who are LGBTQ; and individuals with disabilities; and

(7) provide any other assistance to the Office of Health Equity as may be requested by the Director of Health Equity.

(d) Assistance. The Advisory Commission shall have the administrative and technical assistance of the Office of Health Equity.

(e) Report. Annually, on or before January 15, the Advisory Commission shall submit a written report to the Senate Committee on Health and Welfare and to the House Committees on Health Care and on Human Services with its findings and any recommendations for legislative action.

(f) Meetings.

(1) The Director of Health Equity shall call the first meeting of the Advisory Committee to occur on or before September 1, 2021.

(2) Annually, the Advisory Commission shall select a chair and vice chair from among its appointed members. The Advisory Commission may select a secretary who need not be a member of the Advisory Commission.

(3) The Advisory Commission shall meet at least bimonthly and when requested by either the Chair or Vice Chair or by any eight appointed members.

(4) Nine public members of the Advisory Commission shall constitute a quorum for the transaction of business.

(5) All meetings of the Advisory Commission and any subcommittees of the Advisory Commission shall be open to the public with opportunities for public comment provided on a regular basis.

(g) Acceptance of grants and other contributions. The Advisory Commission may accept from any governmental department or agency, public or private body, or any other source grants or contributions to be used in carrying out its responsibilities under this chapter.

(h) Compensation and reimbursement. Appointed members of the Advisory Commission shall be entitled to per diem compensation and reimbursement of expenses as permitted under 32 V.S.A. § 1010 for not more than six meetings annually. These payments shall be made from monies appropriated to the Department of Health.

§ 254. GRANTS IN PROMOTION OF HEALTH EQUITY

(a) It is the intent of the General Assembly to provide grants that stimulate the development of community-based and neighborhood-based projects that will improve the health outcomes of individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities.

(b) The grants described in subsection (a) of this section shall be administered by the Office of Health Equity established pursuant to section 252 of this title. The Office of Health Equity shall:

(1) publicize the availability of grants and establish an application process for submitting a grant proposal;

(2) provide technical assistance and training, as requested, including convening meetings for grant recipients throughout the State to promote best practices;

(3) develop uniform data reporting requirements for the purpose of evaluating the performance of grant recipients and measuring improved health outcomes;

(4) develop a monitoring process to evaluate progress toward meeting grant objectives; and

(5) coordinate with existing community-based programs at the State and local levels to avoid duplication of effort and promote consistency.

(c)(1) Any individual, entity, or organization within the State of Vermont may apply for a grant pursuant to this section and serve as the lead agency to administer and coordinate project activities within the State. An individual, entity, or organization awarded a grant may develop community partnerships necessary to implement the grant.

(2) Applicants shall submit grant proposals to the Office of Health Equity for review.

(3) A grant proposal shall include each of the following elements:

(A) The purpose and objectives of the grant proposal and identification of the particular disparity that the project plans to address, including one or more of the following areas:

(i) decreasing health disparities for Vermonters who are Black, Indigenous, and Persons of Color;

(ii) decreasing health disparities for individuals who are LGBTQ;

(iii) decreasing health disparities for individuals with disabilities; and

(iv) improving social determinants of health, such as housing, employment, safety, freedom from discrimination, and food access, as outlined by the Centers for Disease Control and Prevention's "Tools for Putting Social Determinants of Health into Action";

(B) identification and relevance of the target community;

(C) methods for obtaining baseline health status data and assessment of community health needs;

(D) mechanisms for mobilizing community resources and gaining local commitment;

(E) mechanisms and strategies for evaluating the project's objectives, procedures, and outcomes; and

(F) a proposed work plan, including a timeline for implementing the project.

(d) The Office of Health Equity shall give priority in awarding grants to proposals that:

(A) demonstrate broad-based local support and commitment from individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities, such as agreements to participate in the program, letters of endorsement, letters of commitment, or other forms of support;

(B) address the multi-dimensional ways individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities experience disparities, such as projects that target Black individuals who are also disabled or that target Indigenous persons who are also LGBTQ;

(C) demonstrate a commitment to quality in all aspects of project administration and implementation; and

(D) incorporate approaches to achieve sustainable reductions in disparities.

§ 255. DATA RESPONSIVE TO HEALTH EQUITY INQUIRIES

(a) Each State agency, department, board, or commission that collects health-related, individual data shall include in its data collection health equity data disaggregated by race, ethnicity, gender identity, age, primary language, socioeconomic status, disability, and sexual orientation. Data related to race

and ethnicity shall use separate collection categories and tabulations in accordance with the recommendation made by the Director of Health Equity, in consultation with the Advisory Committee.

(b)(1) The Department of Health shall systematically analyze such health equity data using the smallest appropriate units of analysis feasible to detect racial and ethnic disparities, as well as disparities along the lines of primary language, sex, disability status, sexual orientation, gender identity, socioeconomic status, and report the results of such analysis on the Department's website periodically, but not less than biannually. The data shall be made available to the public in accordance with State and federal law.

(2) Annually, on or before January 15, the Department shall submit a report containing the results of the analysis conducted pursuant to subdivision (1) of this subsection to the Senate Committee on Health and Welfare and to the House Committees on Health Care and on Human Services.

Sec. 4. 26 V.S.A. § 1400(b) is amended to read:

§ 1400. RENEWAL OF LICENSE; CONTINUING MEDICAL EDUCATION

* * *

(b)(1) A licensee for renewal of an active license to practice medicine shall have completed continuing medical education that shall meet minimum criteria as established by rule, by the Board, by August 31, 2012 and that shall be in

effect for the renewal of licenses to practice medicine expiring after August 31, 2014. The Board shall require a minimum of ~~10~~ 12 hours of continuing medical education by rule, of which two hours shall include cultural competency in the practice of medicine. The training provided by the continuing medical education shall be designed to ~~assure~~ ensure that the licensee has updated his or her knowledge and skills in his or her own specialties and also has kept abreast of advances in other fields for which patient referrals may be appropriate. The Board shall require evidence of current professional competence in recognizing the need for timely appropriate consultations and referrals to ~~assure~~ ensure fully informed patient choice of treatment options, including treatments such as those offered by hospice, palliative care, and pain management services.

(2) As used in this subsection (b), "cultural competency in the practice of medicine" means a set of integrated attitudes, knowledge, and skills that enables a health care professional to care effectively for patients from cultures, groups, and communities other than that of the health care professional. At a minimum, cultural competency should include the following:

(A) awareness and acknowledgement of the health care professional's own culture;

(B) utilization of cultural information to establish therapeutic relationships;

(C) eliciting and incorporating pertinent cultural data in diagnosis and treatment; and

(D) understanding and applying cultural and ethnic data to the process of clinical care.

* * *

Sec. 5. EFFECTIVE DATE

This act shall take effect on July 1, 2021.