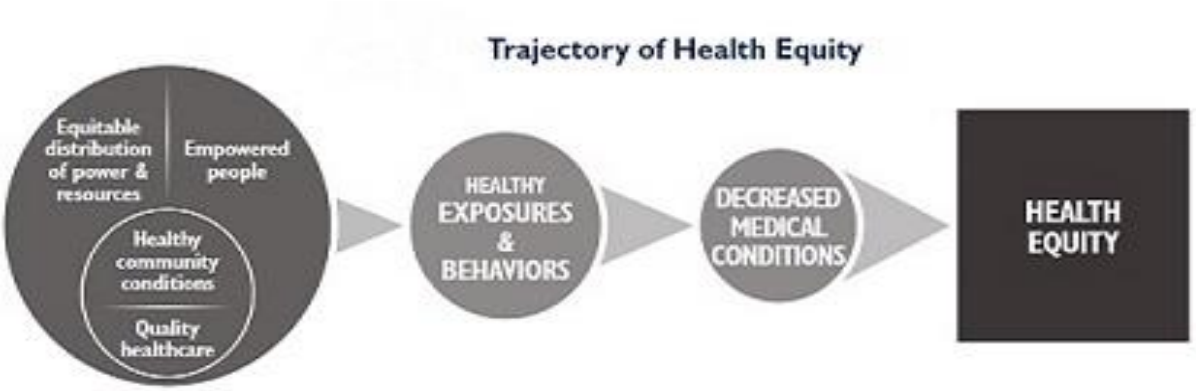
Health Equity



Advisory Commission

Annual Report
February 15, 2023

PREPARED BY:
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On behalf of the Health Equity Advisory Commission

SUBMITTED TO THE GENERAL ASSEMBLY
Senate Committee on Health and Welfare
House Committee on Health Care
House Committee on Human Services

VERMONT

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HB Lozito - Out in the Open

Abel Luna - Migrant Justice

Carol McGranahan - Commission on Native American Affairs

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Executive Summary

Act 33, 2021 (18 V.S.A. § 252) established the Health Equity Advisory Commission (HEAC), a 30-member team of state staff, advocacy organizations, and community members focused on expanding equity in public health and healthcare delivery. The Commission's purpose is to:

- "Promote health equity and eradicate health disparities among Vermonters, including particularly those who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ+; and individuals with disabilities;"
- "Amplify the voices of impacted communities regarding decisions made by the state that impact health equity, whether in the provision of health care services or as the result of social determinants of health;"
- "Provide strategic guidance on the development of the Office of Health Equity, including recommendations on the structure, responsibilities, and jurisdiction of such an office;"

The HEAC is chaired by the Executive Director of the Vermont Racial Justice Alliance. The Vice-Chair is the Department of Mental Health (DMH) Director of Trauma Prevention and Resilience Development. The Commission has met one to two times each month since October 2021 and engaged in an array of meetings across seven working committees.

18 V.S.A. § 252 (e) requires the HEAC to submit an annual report to the Senate Committee on Health and Welfare and to the House Committees on Health Care and Human Services with "it's findings and any recommendations for legislative action." The *HEAC Preliminary Report*[1] was submitted February 7, 2022. The Preliminary Report offers insight into the Commissions' initial impressions of systemic health inequities and thoughts for further exploration. The C*ontinuing Education Report*, submitted November 1, 2022, provided recommendations for improving cultural competency, cultural humility and antiracism in Vermont's health care system through initial training, continuing education requirements, and investments.

Overview of findings and recommendations contained in this report

This report outlines findings and recommendations for legislative and other actions required for the continued work of the HEAC and the implementation of the Office of Health Equity. Some of the recommendations and analysis are related to budget requirements of the HEAC and Office of Health Equity and provide responses to questions posed to the HEAC surrounding data and policy.

The HEAC offers a total of 37 recommendations including General Findings (including concepts like a whole of government approach to addressing equity); the Office of Racial Equity; statewide Policies and Programs; Funding and Grants; Training and Education (revisited from last report); and Data Collection. There is also a section of this report that provides a discussion and recommendations on the use of the terms "White" and "Non-white" in data collection and disaggregation.

[1] Full link text: https://aoa.vermont.gov/sites/aoa/files/HEAC%20Report%201%20-%20Preliminary%20Findings%20on%20Health%20Equity%20in%20Vermont.pdf

The baseline budget request for the Health Equity Advisory Commission is **$1,570,000.00.** The requested appropriation would support continued HEAC operations and the initial implementation of the Office of Racial Equity.

Conclusion

The HEAC is appreciative of the legislative commitment to addressing the harmful systems of oppression, including ableism, homophobia/transphobia, and systemic racism which consistently produce adverse and disparate health outcomes. The HEAC welcomes the engagement of at-large committee members, the House Committee on Health Care, House Human Services and Senate Health and Welfare as partners in this ongoing work.

Introduction

This is the Annual Report of the Health Equity Advisory Commission (HEAC).

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" (*Act 33*, 2021).

The HEAC is a 30-member Commission of state staff, advocacy organizations, and community members created to:

- "promote health equity and eradicate health disparities among Vermonters, including particularly those who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ+; and individuals with disabilities; "and
- "amplify the voices of impacted communities regarding decisions made by the State that impact health equity, whether in the provision of health care services or as the result of social determinants of health;" and
- "provide strategic guidance on the development of the Office of Health Equity, including recommendations on the structure, responsibilities, and jurisdiction of such an office" (*Act 33*, 2021).

18 V.S.A. § 252 (e) outlines HEAC reporting responsibilities, requiring the submission of an Annual Report to the Senate Committee on Health and Welfare and to the House Committees on Health Care and Human Services with "its findings and any recommendations for legislative action." Act 33, 2021 Sec. 6 outlines additional reporting requirements as indicated below:

- budget recommendations for continuation of HEAC work in fiscal year 2023; and
- budget recommendations for funding of the Office of Health Equity; and
- recommendations on appropriate inclusive terms to replace the term "non-White" in 18 V.S.A. chapter 6; and
- recommendation on disaggregating data categories and tabulations beyond non-White and White in accordance with 18 V.S.A. § 253 (a); and
- recommendations for most effectively utilizing funding received by the state pursuant to the American Rescue Plan Act of 2021, Pub. L. No 117-2 in a manner that promotes health and

achieves health equity by eliminating avoidable unjust disparities in health on the basis of race, ethnicity, disability, or LGBTQ status.

18 V.S.A. § 252 (c) empowers and assigns the HEAC the following duties in the corresponding sections (emphasis added by the Commission in bold text):

(1) provide guidance on the development of the Office of Health Equity, **which shall be established based on the Advisory Commission's recommendations not later than January 1, 2023;** and
(2) provide advice and make recommendations to the Office of Health Equity **once established**; and
(3) 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; and
(4) advise the Department of Health and General Assembly on any funding decisions relating to eliminating health disparities and promoting health equity, including the distribution of federal monies related to COVID-19; and
(5) to the extent funds are available for the purpose, distribute 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; and
(6) advise the General Assembly on efforts to improve cultural competency, cultural humility, and antiracism in the health care system through training and continuing education requirements for health care providers and other clinical professionals.

Highlights of some of our key findings and recommendations from previously submitted reports include:

- Whole-of-government approach to addressing equity across state government to ensure transformation.
- Funding for operations of a statewide Office of Health Equity.
- Funding for ongoing work within local communities specific for promotion of health equity.
- Health equity training and education for state employees, contractors, grant recipients.
- Health equity training and education for and licensed/certified professionals who work in health-related fields.

General Findings

Whole of Government Approach

Any serious attempt towards health equity must be endeavored with an understanding of the persistent nature of the disparate outcomes across all Social Determinants of Health. The empirical quantitative data representing inequities in health outcomes is undeniable and well-articulated in the enabling statute of the HEAC (*Act 33*, 2021). We know that the harmful systems of oppression, including ableism, homophobia/transphobia, and systemic racism consistently produce adverse health inequities (Yearby et. al, 2022; Hoffman et. al, 2011; National Center for Health Statistics, 2020). We also understand that these disparate outcomes are manifested in housing, education, employment, economic development, transportation and the criminal and juvenile justice system. These Social Determinants of Health directly

impact overall health outcomes to a greater extent than the provision of individual medical care (Solar & Irwin, 2010). This is why the Office of Health Equity was envisioned and the implementation of such office requires a whole of government approach to ensure its success.

The life-altering impact of the compounded adverse outcomes of interconnected Social Determinants of Health demand an aggressive whole of government equity agenda. The Commission has engaged in extensive discussions surrounding the need for a whole of government agenda to advancing equity. This comprehensive approach must start with an Executive Order Policy Statement that the state government will pursue a comprehensive approach to advancing equity for all, including people of color, people with disabilities, members of the LGBTQ+ community and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. The policy statement must also mandate that:

1. Affirmatively advancing equity is the responsibility of the whole of our government; and
2. All departments and agencies must address inequities in their existing and emerging policies and programs.

A federal Executive Order currently in affect states, "Our Nation deserves an ambitious whole-of-government equity agenda that matches the scale of the opportunities and challenges that we face."

It further states that it is the policy of the Administration that "the Federal Government should pursue a comprehensive approach to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Affirmatively advancing equity, civil rights, racial justice, and equal opportunity is the responsibility of the whole of our government. Because advancing equity requires a systematic approach to embedding fairness in decision-making processes, **executive departments and agencies (agencies) must recognize and work to redress inequities in their policies and programs that serve as barriers to equal opportunity."** This Executive Order could serve as a model for the administration in developing a whole of government approach in advancing equity[2]

Programmatic Approach

Equity must be realized in the healthcare system and within all Social Determinants of Health if true health equity is to be achieved in Vermont. This will first require a standardized programmatic approach, applying an equity framework to programming across all systems of state government. This proposed **statewide program** will require a centralized program authority and prioritization, cooperation, and the close coordination of all state agencies to ensure transformational outcomes. Success of such a statewide program requires a unified effort on policy, training, data collection and more. A coordinated effort of this magnitude necessitates a whole government approach, requiring an executive mandate that drives equity as a primary goal, and equivalent appropriations to support those efforts.

[2] **Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government** - https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/

A programmatic approach is essential to attaining sufficient transformation to achieve and maintain health equity in Vermont. Any earnest Statewide effort to achieve impactful and sustainable health equity must be implemented with support and participation at all levels. Once implemented, the Office of Health Equity should create and manage the Health Equity Program. The Health Equity Program must be adequately funded to ensure its success. The program must be thoughtfully implemented within State government to ensure agency, shared responsibility and effectiveness. All equity training and education must be within the context of this larger Health Equity Program.

Framework

We know that any programmatic approach to health equity transformation requires the implementation of policy reflecting the values of fairness and diversity. The policy must include expectations and consequences for non-compliance. Data collection is important for establishing baselines, measuring progress, and informing mitigation and other strategic decisions. Equity Impact Analyses of existing and emerging policies as well as the review of hiring and appointment processes are important aspects of a programmatic approach. Finally, state commitment to health equity must be included in individual and departmental performance reviews to ensure accountability to the transformational process. Further discussion on this programmatic approach will be addressed in the Commission's future reports.

Community Participation

Two-thirds of the HEAC are members of communities across Vermont, many representing organizations that support, serve or advocate for individuals who are currently experiencing inequity in our health care system. Unfortunately, attendance from many of the organizations identified in statute has waned, and it has become increasingly difficult to get a representative quorum at any given meeting or committee meeting.

One serious inhibitor seems to be the actual or perceived limitations of the current per-diem reimbursement in 32 V.S.A. §1010. The policy only allows for a payment of fifty dollars per day for meetings and activities attended. The state must ensure that these laws are updated to reflect current market rates based on cost of living and inflation rates. Additionally, clear guidance must be provided to all members appointed to Boards and Commissions statewide relative to filing for peridium as per 32 V.S.A. §1010. 18 V.S.A. 32, §252 (h) is misleading in suggesting that payments can only be made for the attendance of meetings.

Boards and Commissions have served at the pleasure of elected officials in Vermont for centuries. Historically those appointed to Boards and Commissions have been those more able to participate economically and have typically represented the status quo. Only over the recent years have significant numbers of Boards and Commissions been convened to rectify social and racial inequities in the pursuit of justice. By design, these Boards and Commissions have increasingly called for the participation of members representing marginalized communities – people less likely to participate without sufficient economic offset. ***The prospect of community involvement is dramatically reduced in the absence of a strong per-diem policy.***

Another possible barrier to attendance is related to the timing of meetings and the work of the Commission. Significant challenges exist for community members to take time from their normal work

and responsibilities to attend these meetings. This frequently results in the majority of participants in many meetings being state employees.

Continuous community involvement and engagement are crucial in the planning and implementation of a statewide health equity program. Many approaches to health and wellness originated in Black and Indigenous cultures (Fleming, 2020; Reid, 2022). Impacted communities have the answers to many of the challenges that they face in health and wellness but lack sufficient resources to make them a reality. Emerging from these communities are various approaches such as affinity groups, peer-to-peer counseling, support groups, and ideas on creating training curricula for various healthcare professionals by and for impacted groups.

Impacted community members are also best positioned to conduct listening sessions and surveys to acquire the qualitative and quantitative data needed to advance their own health and wellness. Communities are empowered when they have space and support to self-advocate and implement programs that are important to them. That empowerment enables those most impacted to serve their communities and receive the support they believe they require in a manner of their choosing. Service provided must expand far beyond basic health care provision into areas of youth services, housing, education, employment, and economic development. These community-oriented programs and services have historically been delivered inefficiently, ineffectively, or sometimes not at all. Creating or extending such services is a transformative, preventative approach that positively addresses the health and wellness of impacted communities, an approach that strengthens the whole of society (Blackwell, 2017).

As state and community partners advance more “equity in all policies” efforts, they have grown increasingly aware of the need for clear and reliable communication with impacted community partners. Rather than assessing and prescribing, now is the time for listening and responding with transformative action. Community partners report feeling ignored when they offer up recommendations that are not acted upon. Consequently, community partners are reluctant to continue to participate in traditional forums. As a result, these community engagement approaches have often failed impacted communities.

Often criteria for receiving federal funds includes the requirement to ensure the engagement of marginalized communities. Unfortunately, open meeting laws, parliamentary meeting procedures, and processes like “executive sessions” often hinder the participation of impacted communities, preventing them from engaging in thoughtful discussions and providing constructive input into the policies most impacting their lives.

Listening to impacted communities and allowing them to prioritize the most effective methods of support will improve health equity while uplifting historically and currently marginalized communities. Creating new methods of engagement and increasing transparency in decision making processes will create a trauma responsive, healing centered focus that will enable these communities to be involved in the process. One of the HEAC’s intentions while addressing health equity is to ensure that impacted communities have the ability inform this incredibly important process. The ability to make meaningful progress in this work is significantly hindered without the participation and input of those of those most impacted by the current inequitable systems.

The Commission continues to examine the barriers to broader participation as well as what approaches could be implemented to increase and sustain the ability of impacted communities to engage in these critical efforts.

Administrative Support

18 V.S.A. §252, assigns administrative, legal and technical assistance for the HEAC to the Agency of Administration at the request of the Executive Director of Racial Equity. This model cannot sufficiently sustain the ongoing operations of the Commission. The already overburdened Office of Racial Equity has provided support based on its available capacity. The Executive Assistant to the Secretary of the Agency of Administration is ladened in her role supporting multiple executives on a full-time basis. Full staffing of the HEAC Is required to ensure success.

The Commission intended to utilize contracted support to assist in formulating recommendations for this report but were unable to do so due to tight timelines and the transition in Commission leadership. The Commission will continue to explore the idea of a consultant to support the efforts of the HEAC. Further details on staffing can be found in the Budget section of this report.

Recommendations:

1. **Undertake whole of government approach to addressing equity in the state; and**
2. **Develop and implement an equity framework to be applied to systems and programming across state government; and**
3. **Examine and update the existing per-diem structure for community participation on Boards and Commission; and**
4. **Include sufficient budget for the HEAC to offset the community facility rentals and participant stipends; and**
5. **Engage community in public spaces in communities across the state; and**
6. **Budget for dedicated administrative and legal support to sustain HEAC operations; and**
7. **Carry forward funding for contracted support for the HEAC until such time as it is expended fully; and**
8. **Amend 18 V.S.A. § 252 (h)to establish an hourly rate of compensation for Board members of $50.00, with a cap of 15 hours per month, per member to be compensated at this rate for Board meetings, special meetings, sub-committees and working groups.**

Office of Health Equity

18 V.S.A. § 252 (c) (1) directs the HEAC to "provide guidance on the development of the Office of Health Equity, which shall be established **not later than January 1, 2023.**" These responsibilities include recommendations on:

- the structure, responsibilities, and jurisdiction of the Office; and
- whether the Office shall be independent and, if not, in which State agency or department it shall be situated; and
- how the Office shall be staffed; and
- the populations served and specific issues addressed by the Office; and

- the duties of the Office, including how grant funds shall be managed and distributed; and
- the time frame and necessary steps to establish the Office.

18 V.S.A. § 252 (c) (2) directs the HEAC to "provide advice and make recommendations to the Office of Health Equity **once established**" including input on:

- any rules or policies proposed by the Office; and
- the awarding of grants and the development of programs and services; and
- 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
- any other issue on which the Office of Health Equity requests assistance from the Advisory Commission.

Barriers:

1) **The enabling statute does not specify the agency responsible for the creation of the Office of Health Equity.**
2) **There are no specific appropriations allocated to fund the creation of the Office of Health Equity.**

Absent an agency designated to house the Office of Health Equity and absent specific appropriations, the HEAC has defaulted to ongoing discussions with the Vermont Department of Health (VDH) (18 V.S.A. § 252 (c) (2)).

Through a recent CDC grant, VDH has established an *Office of Health Equity Integration (OHEI) within the VDH Commissioner's Office.* The Vision of the Office of Health Equity Integration is "A transformed public health system that is just and equitable." Its Mission is to 'Collectively reimagine and rebuild public health systems that have historically prevented individuals and communities in Vermont from living their healthiest lives.' OHEI includes a Community Engagement Team that focuses on priority populations including: LGBTQIA+ people, unhoused Vermonters, Indigenous communities, folks with Disabilities and BIPOC/Global Majority. There are also a group of Health Equity Leads/Liaisons who support VDH's Divisions and programs in integrating health equity practices into their daily work. OHEI also oversees many community partner grants that support organizations doing health and racial equity work in their communities. OHEI uses a systems approach to addressing the root causes of health inequities, and intentionally 'leads with race.'

The HEAC has engaged in discussions with OHEI with the goal of understanding the intended nature of the newly formed Office of Health Equity Integration and what if any relationship it could have to the statutorily mandated Office of Health Equity. The HEAC has invited the Director of the Office of Health Equity Integration to be a member-at-large of the Commission alongside an existing VDH representative. Consultation as outlined above will continue **until such time as the Office of Health Equity is formally established.**

The commission has engaged in numerous discussions on where the Office of Health Equity should be located within state government. Throughout these discussions various options have been considered, ranging from placing the Office inside of VDH to creating a fully independent Office of Health Equity.

Through deliberation in the Social Determinants of Health / Policy Committee and the Full Commission, the HEAC has established that the powers, duties, functions and reporting requirements as outlined in the H.210, 2021 as introduced **should serve as a guide in the development and placement of the Office of Health Equity.** The Office of Health Equity will be responsible for health equity program coordination across all state agencies. The Office's powers will enable it to "avail itself of the services of employees of any state agency, department, board, bureau, or commission as it may require." Reporting requirements are to the Governor and committees of jurisdiction in the General Assembly. A list of the recommended powers, duties, functions and reporting requirements can be found in Appendix 1 of this report. Increasingly, various committees and the full Commission have discussed that wherever the Office of Health Equity is placed in state government, it must take into account the Office's powers, duties, functions and reporting requirements. These conversations continue. The Commission and VDH understand that the Office of Health Equity will coexist and/or interoperate with the Office of Health Equity Integration.

Recommendations:

1. **Adopt the scope of responsibility for the Office of Health Equity provided by the HEAC; and**
2. **Provide guidance on the positioning of the Office of Health Equity within state government; and**
3. **Establish an appropriation to fund the Office of Health Equity administratively and operationally.**

Statewide Policies and Programs

Pursuant to 18 V.S.A. § 252 (c) (3) and (4) the HEAC has sweeping responsibility to review and provide recommendations on statewide policies and programs. This will require cooperation and accountability across state agencies at unprecedented levels.

One approach that has the potential to support our ongoing work is to overlay equity programming with the Health in all Policies Initiative which operates across state government now. Introducing an expanded health *equity* in all policies lens would ensure review of policies across state government not only for health impact but also to address health impacts specifically for those populations who historically see health disparities.

Recommendations:

1. **Redesignate the Health in All Policies Initiative to "Health Equity in All Policies"; and**
2. **Relaunch Health in All Policies initiative, to facilitate a seamless expansion of health equity policy initiative statewide.**

Funding and Grants

Funding

Pursuant to 18 V.S.A. § 252 (c) (5), recommendations for funding decisions relating to eliminating health disparities and promoting health equity, including the distribution of federal monies related to COVID-19 are as follows:

Grants

18 V.S.A. § 252 (c) (6) calls of the HEAC to distribute grants that stimulate the development of community-based and neighborhood-based projects that will improve health outcomes of individuals who are Black, Indigenous, and Persons of Color; individuals who are LBGBTQ; and individuals with disabilities. There were insufficient appropriations for the HEAC to carry out this responsibility.

The Vermont Department of Health (VDH) was able to re-distribute ARPA and CDC money in the form of Health Equity Grants. Those grants have significantly energized communities to prioritize and address health equity. The HEAC requests immediate and sustainable funding of this policy to enable our ability to satisfy our statutory mandate to distribute grants that stimulate the development of community-based and neighborhood-based projects that will improve health outcomes of individuals who are Black, Indigenous, and Persons of Color; individuals who are LBGBTQ; and individuals with disabilities. marginalized communities.

HEAC and Office of Health Equity Budget

The baseline budget for the Health Equity Advisory Commission is **$1,570,000.00.** The requested appropriation would support continued HEAC operations and Office of Racial Equity support. It is more fully detailed below:

SFY'24 HEAC requests that it continues to receive administrative support from Office of Racial Equity. This support would primarily include the hiring and support for one full-time staff person who would be fully dedicated to supporting the Commission's work in SFY'24 and beyond. The position, hired by the Commission with support from Office of Racial Equity would have duties including, but not limited to, assisting the Commission, conducting and memorializing Board meetings, actions and ongoing work, and coordinating with the Office of the Secretary of Administration to ensure compliance with Vermont's Open Meeting and records retention laws, as well as the Commission's other legal, financial and regulatory obligations. The full time, dedicated admin staff member would be located in the Office of Racial Equity **(120K).**

In SFY'24, the Commission, with the support of the Office of Racial Equity, the hired admin support and **a hired consultant,** will develop a scope of work and implement the first phase of preparatory work pursuant to 18 V.S.A. § 252 (c) (3) and (4). In this work the HEAC will operationalize the ongoing statutorily mandated work of examining the limitations and problems associated with existing laws, rules, programs, and services and reviewing and monitoring, and advising all State agencies regarding the impact of current state policies, procedures. Laws, and rules all they pertain to the health and health status of Black, Indigenous, and Persons of Color; individuals who are LBGBTQ; and individuals with

disabilities The next phase of the Commission's work under this recommendation would be to evaluate baseline data, identify opportunities, and establish priorities for action under its statutory powers and duties including but not limited to examining the limitations of policies and programs and advising all State agencies regarding the impact of current State policies. The operationalization of the HEAC will include the funding of the grant-making apparatus, as outlined in the above-mentioned grant program. Partial funding is requested as a part of this appropriation request. **(Consultant, 160K; Community and Neighborhood Grants, 750K)**

The Commission will also engage in public education and outreach related to the work of the Commission, explicitly including outreach to community members from historically marginalized and disadvantaged communities. The HEAC will always conduct its work in a manner that maximizes access for community members, providing travel vouchers, food, and childcare where necessary to accommodate participation, as well as fair market compensation for community members who might be asked to serve on more formal sub-committees and who would otherwise not be able to participate. **(90K)**

The Commission with support from Office of Racial Equity, will hire an Executive Director ("ED"), who would have duties including, but not limited to, directing the Office of Health Equity (OHE), representing the OHE in external affairs, and facilitating meetings, decision-making, program implementation, budgeting and accounting, etc. The ED would then hire two managers for program implementation. **(450K)**

Budget Overview

HEAC Governance, Staffing and Administration	$120,000.00
Assessment of State Policies and Programs (Consulting)	$160,000.00
Community-based and Neighborhood-based Grants	$750,000.00
HEAC Compensation and Community Engagement and Facility Expenses	$90,000.00
Office Of Health Equity Initial Staffing, Overhead and Indirect Expenses (ED and 2 Managers)	$450,000.00
Total	**$1,570,000.00**

ARAP Fund Utilization

Act 33, 2021, Section 6 (3), calls on the HEAC to "provide recommendations for most effectively utilizing funding received by the State pursuant to the American Rescue Plan Act of 2021, Pub. L. No. 117-2 **in a manner that promotes health and achieves health equity by eliminating avoidable and unjust disparities in health** on the basis of race, ethnicity, disability, or LGBTQ status."

Though the Commission was unable to address this request throughout the course of our work to date, we are mindful of the statewide deliberations surrounding the distribution of these funds and request

that we be permitted to offer some recommendations under the cover of a follow-on report or within the course of a committee discussion.

As the disposition of these funds is contemplated, it is our hope that policy makers remain ever mindful of the original intent of these funds and the systemically inequitable manner in which a the majority of these funds have been distributed. It is our hope that consideration would be given to programs and services designed to address the inequitable outcomes that are a constant in the lives of Black, Indigenous, and Persons of Color; individuals who are LBGBTQ; and individuals with disabilities.

Recommendations:

1. **Establish an HEAC grant fund to HEAC to fund and administer grants for community-based and neighborhood-based projects that improve health outcomes for impacted communities as prescribed in 18 V.S.A. § 252 (c) (6); and**
2. **Approve appropriation for the operationalization of the HEAC; and**
3. **Approve appropriation for HEAC community engagement; and**
4. **Approve appropriation for the implementation of the Office of Health Equity; and**
5. **Support community-based programs targeted at achieving health equity by eliminating avoidable unjust disparities in health on the basis of race, ethnicity, disability, or LGBTQ status: and**
6. **Accept follow-on report or committee testimony on ARPA Fund distribution.**

Training and Continuing Education

Training Priorities

Act 33 of 2021, Section 5; Report; Continuing Education, compelled the HEAC, in consultation with licensing boards, professional organizations, and providers of health care and clinical professions to "submit a written report to the House Committee on Health Care and to the Senate Committee on Health and Welfare with its recommendations for improving cultural competency and cultural humility and antiracism in Vermont health care system through initial training, continuing education requirements, and investments." The HEAC Report on Continuing Education was submitted on October 31, 2022.

The report largely targets opportunities for training and education, suggesting some specific components of that education that could be most impactful. HEAC recommends considering the issue programmatically to ensure true transformation. Some of the **recommendations** that are related to systems include:

Recommendations:

1. **Create a Health Equity Program across all systems of state government; and**
2. **Establish of a Health Equity Fund to ensure ongoing financial support for the work related to health equity programs; and**

3. **Require baseline health equity training and education for all state employees, contractors, grant recipients; and**
4. **Require baseline health equity training and education for and licensed/certified professionals who work in health-related fields; and**
5. **Create a Health Equity Telehealth Program to specifically provide access to a broader selection of providers who possess the cultural competency and humility required to provide appropriate services; and**
6. **Leverage community support groups to provide services to marginalized populations through grant creation; and**
7. **Create standardized baseline awareness training on the origins, impact and mitigation approaches to addressing the harmful systems of ableism, homophobia/transphobia, and systemic racism; and**
8. **Create a programmatic and continuous Training and Education Program (with Standards); and**
9. **Develop more (and more consistent) plain-language and accessible documentation; and**
10. **Review the full report previously submitted.**

Data Collection

The state has prioritized collecting and disaggregating data due to the adverse disparate outcomes resulting from systemic racism, ablism, and homophobia/transphobia. Therefore, a subcommittee of the HEAC was created to focus on health equity data. At the subcommittee's meeting on April 22, 2022, it adopted the following scope of work.

The Data subcommittee of the Health Equity Advisory Commission (HEAC) will lead the Commission's use and interpretation of data in support of the mission to promote health equity and eradicate health disparities among Vermonters, including those who are Black, Indigenous, and Persons of Color, individuals who are LGBTQ, and individuals with disabilities. The subcommittee may provide guidance to the Commission related to data including recommendations about:

- data collection and methodology; and
- the use, sharing, and reporting of health equity data; and
- education/training about the meaning and use of health equity data; and
- or other topics as identified by the HEAC.

During this first year of deliberations, the subcommittee conducted its discussions at a high level, focusing on principles of data collection and the challenges to achieving a clear understanding of health inequities posed by current data infrastructure.

The HEAC Subcommittee on Data reviewed and adopted a working set of principles to help guide their understanding of quality data collection and management:

1. **Data should be up to date**: Data are collected and made available in a timely fashion to accurately reflect current conditions.
2. **Data should be comprehensive**: Data are collected and available for all social determinants of health and able to be disaggregated as appropriate.
3. **Data should be secured**: Data are safeguarded and controlled.
4. **Data should be findable**: Curated data can be easily found.

5. **Data should be accessible**: Data are available to those that need it in an understandable format.
6. **Data should be clean**: Data are continually checked for errors, such as incomplete entries and duplicates to facilitate analysis.
7. **Data should be anonymous**: Data should not be used in a way that would lead to the unwanted identification of an individual.
8. **Data should be consistent**: Data are the same in terms of meaning as well as representation across different data sources. Data are also able to be plotted over time as a means of creating baselines.
9. **Data should be useful**: Data can answer meaningful questions, leading to insights which drive action to improve results and outcomes.
10. **Data should be trustworthy**: Data, and the systems that support it, garner trust and have a positive reputation.
11. **Data should be shared**: Data are fully and openly shared for appropriate purposes in accordance with relevant laws and policies.
12. **Data should be as unbiased as possible**: Bias within data collection, processing and reporting should be counteracted.
13. **Data should be participatory**: Data governance norms, principles, policies, rules and practices are developed in an open and fully participatory manner.
14. **Data should be integrated**: Data is integrated into formal accountability mechanisms and decision-making processes.

Selected resources related to racial equity in data integration are available in the "Additional Supporting Resources" section of the HEAC Continuing Education Report. [3]

The HEAC DATA Subcommittee understands its work to be closely intertwined with work undertaken by the Vermont Department of Health pursuant to 18 V.S.A. §253, as well as broader efforts by VDH to develop guidelines for the collection of health equity data.

18 V.S.A. §253 charges "each State agency, department, board, or commission that collects health-related, individual data" to include in its data collection "health equity data disaggregated by race, ethnicity, gender identity, age, primary language, socioeconomic status, disability, and sexual orientation." VDH is further charged with the systemic analysis of "such health equity data using the smallest appropriate units of analysis feasible to detect racial and ethnic disparities, as well as disparities along the line of primary language, sex, disability status, sexual orientation, gender identity, and socioeconomic status and report the results of such analysis on the Department's website periodically, but not less than biannually." In addition, the Department is to submit report containing the results of this analysis to legislative committees of jurisdiction, which it has done.[1]

The HEAC notes that in its Health Equity Data report (January 16. 2023), VDH stated that it "faced staffing challenges which limited the health equity data analysis required by 18 V.S.A. § 253." This was due to the fact that the lead data analyst position for this work was only filled for half of 2022. The

[3] Full link text:
https://aoa.vermont.gov/sites/aoa/files/InfoReportReleases/HEAC_Report_on_Continuing_Education_10-31-2022.pdf

HEAC and its Data subcommittee were similarly impacted in that this analyst was helping to support their discussions.

Despite these limitations, the HEAC has adopted, and recommends for statewide adoption, the following:

Recommendations:

1. **As referenced in 18 V.S.A. §253, "health-related individual data" should be understood broadly to include data regarding the social determinants of health, including but not limited to housing, employment, education, economic services, incarceration, and involvement with the Department of Children and Families; and**
2. **Data should be disaggregated by race, ethnicity, gender identity, age, primary language, socioeconomic status, disability, and sexual orientation; and**
3. **The State must adopt a uniform strategy of data collection, disaggregation, and analysis to aid in addressing the causes and impact of disparate outcomes in health and in the social determinants of health; and**
4. **Key metrics must be selected based upon areas thought to be most impactful. These data should be disaggregated by race, ethnicity, gender identity, age, primary language, socioeconomic status, disability, and sexual orientation. For an example of such key metrics, see the Agency of Human Services Performance Score Cards.[4]; and**
5. **To be effective, the HEAC must have access to expertise in data systems and analysis, including but not limited to two full-time positions within the Office of Health Equity.**

[1] Health Equity Data, 2023 Report to the Legislature, https://pdf.live/edit?url=https%3A%2F%2Flegislature.vermont.gov%2Fassets%2FLegislative-Reports%2FEquityData_LegReport_2023.Final.pdf&source=f&installDate=070622

White and Non-white Terms and Data Categories

One of the charges for the Commission is to create a common definition of terminology to be used by the State of Vermont and to recommend how data should be collected and grouped.

We acknowledge the current practice of using the term non-white is harmful. However, after beginning discussion and analysis of this charge, the Commission realized that this work is already ongoing through different agencies and divisions. Some examples of this include:

- The VDH received an upcoming CDC infrastructure grant which includes funding for data modernization; and
- The Agency of Transportation is exploring how to collect data for its Transportation Equity Framework project; and
- The Division of Racial Justice Statistics within the Office of Racial Equity has been charged with functioning as a repository for demographic information related to racial disparities in criminal justice system; and

[4] Full link text:https://humanservices.vermont.gov/our-impact/performance-scorecards

- Agencies and Departments such as DMH, Department for Children and Families (DCF), and Agency of Education (AOE) are exploring methods to better collect, share, and use data in a meaningful manner; and
- The Judiciary Diversity, Equity, and Inclusion (DEI) Commission has a Data Subcommittee which is working to determine standards for collecting race and ethnicity data within the Vermont Judiciary systems.

In order to better understand what Vermonters need to achieve health equity, we must first be able to collect, analyze, and use data to drive systemic change and break down barriers. Dividing data by the terms white and non-white does not allow us to understand how specific groups may be faring. Combining the data of all "non-white" people dilutes the statistical effects of discrimination and inequity that may be experienced to a different degree of severity or intensity by different groups of people within the catchall of "non-white" (Bratter & Gorman, 2011; Yi et. al 2022). Health disparities and associated inequities will only be eliminated if we are able to gather detailed, high-quality data that reflects the various groups who reside in Vermont. We need to ensure a cohesive approach to this work to ensure that it is effective and impactful.

An issue that should also be noted includes federal data reporting guidelines. Often data is required to be collected in a manner that does not allow for uniformity or disaggregation. Different federal agencies have differing requirements and must meet diverse statutory requirements. Two federal statutes that impede the use of complete disaggregation in data collection are the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Family Educational Rights and Privacy Act (FERPA). The protections enshrined in these statutes prohibit disaggregation in circumstances where privacy concerns could arise.

In order to better understand the charge laid upon this commission and recommend definitions and changes, an analysis of the types of data, data policy, and an exploration of different technology and data gathering systems may be necessary.

Recommendation:

1. **A statewide policy on the collection of social demographic data, including race, ethnicity, gender identity, sexual orientation, primary language, and disability status: and**
2. **Research of relevant federal policy; and**
3. **Consultation with lawyers versed in data policy.**

Recommendations

General Findings

1. Undertake whole of government approach to addressing equity in the state; and
2. Develop and implement an equity framework to be applied to systems and programming across state government; and
3. Examine and update the existing per-diem structure for community participation on Boards and Commission; and
4. Include sufficient budget for the HEAC to offset the community facility rentals and participant stipends; and
5. Engage community in public spaces in communities across the state; and
6. Budget for dedicated administrative and legal support to sustain HEAC operations; and
7. Carry forward funding for contracted support for the HEAC until such time as it is expended fully; and
8. Amend 18 V.S.A. § 252 (h)to establish an hourly rate of compensation for Board members of $50.00, with a cap of 15 hours per month, per member to be compensated at this rate for Board meetings, special meetings, sub-committees and working groups.

Office of Health Equity

9. Adopt the scope of responsibility for the Office of Health Equity provided by the HEAC; and
10. Provide guidance on the positioning of the Office of Health Equity within state government; and
11. Establish an appropriation to fund the Office of Health Equity administratively and operationally.

Statewide Policies and Programs

12. Redesignate the Health in All Policies Initiative to “Health Equity in All Policies”; and
13. Relaunch Health in All Policies initiative, to facilitate a seamless expansion of health equity policy initiative statewide

Funding and Grants

14. Establish an HEAC grant fund to HEAC to fund and administer grants for community-based and neighborhood-based projects that improve health outcomes for impacted communities as prescribed in 18 V.S.A. § 252 (c) (6); and
15. Approve appropriation for the operationalization of the HEAC; and
16. Approve appropriation for HEAC community engagement; and
17. Approve appropriation for the implementation of the Office of Health Equity; and
18. Deploy ARPA funding to support community-based programs targeted at achieving health equity by eliminating avoidable unjust disparities in health on the basis of race, ethnicity, disability, or LGBTQ status: and
19. Accept follow-on report or committee testimony on ARPA Fund distribution.

Training and Education

20. Create a Health Equity Program across all systems of state government; and
21. Establish of a Health Equity Fund to ensure ongoing financial support for the work related to health equity programs; and
22. Require baseline health equity training and education for all state employees, contractors, grant recipients; and
23. Require baseline health equity training and education for and licensed/certified professionals who work in health-related fields; and
24. Create a Health Equity Telehealth Program to specifically provide access to a broader selection of providers who possess the cultural competency and humility required to provide appropriate services; and
25. Leverage community support groups to provide services to marginalized populations through grant creation; and
26. Create standardized baseline awareness training on the origins, impact and mitigation approaches to addressing the harmful systems of ableism, homophobia/transphobia, and systemic racism; and
27. Create a programmatic and continuous Training and Education Program (with Standards); and
28. Develop more (and more consistent) plain-language and accessible documentation; and
29. Review the full report previously submitted.

Data Collection

30. As referenced in 18 V.S.A. §253, "health-related individual data" should be understood broadly to include data regarding the social determinants of health, including but not limited to housing, employment, education, economic services, incarceration, and involvement with the Department of Children and Families.
31. Data should be disaggregated by race, ethnicity, gender identity, age, primary language, socioeconomic status, disability, and sexual orientation.
32. The State must adopt a uniform strategy of data collection, disaggregation, and analysis to aid in addressing the causes and impact of disparate outcomes in health and in the social determinants of health.
33. Key metrics must be selected based upon areas thought to be most impactful. These data should be disaggregated by race, ethnicity, gender identity, age, primary language, socioeconomic status, disability, and sexual orientation. For an example of such key metrics, see the **Agency of Human Services Performance Score Cards**.[5]
34. To be effective, the HEAC must have access to expertise in data systems and analysis, including but not limited to two full-time positions within the Office of Health Equity.

White and Non-White Terms and Data Categories

35. A statewide policy on the collection of social demographic data, including race, ethnicity, gender identity, sexual orientation, primary language, and disability status: and
36. Research of relevant federal policy; and
37. Consultation with lawyers versed in data policy

[5] Full link text:https://humanservices.vermont.gov/our-impact/performance-scorecards

Appendix 1: Further Discussion of the Office of Health Equity

18 V.S.A. §252(c) calls on the Health Equity Advisory Commission to "provide guidance on the development of the Office of Health Equity" (hereafter, "the Office"). The guidance is organized in five categories, used below to organize these preliminary recommendations.

1. Structure, responsibilities, and jurisdiction of the Office, the HEAC recommends that:
    a. The Office be charged with working across State government to promote health equity and eradicate disparities in health outcomes and access to healthcare and in the social determinants that contribute to poor health among Vermonters, including particularly those who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities.
    b. The Office be 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.
    c. All State agencies, departments, boards, bureaus, or commissions be authorized and directed to cooperate with the Office of Health Equity, to the extent consistent with law.
    d. The Office be an independent instrumentality of the State of Vermont in order to facilitate the charge of working across the whole of State government.
    e. The Office be advised by the Health Equity Advisory Commission.

2. Office staffing, the HEAC recommends that:
    a. The Office be administered by a Director of Health Equity, who shall have the following experience, skills, knowledge, and qualifications.
        i. Lived experience of oppression or discrimination, or both, based on race, ethnicity, perceived mental condition, or LGBTQ or disability status, or any combination thereof.
        ii. Demonstrated experience addressing inequities in a range of political and professional environments.
        iii. 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.
        iv. Experience measuring and monitoring program evaluation activities and working in multidisciplinary partnerships.
        v. 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.

vi. A strong understanding of the root causes of inequities and the social determinants of health and capacity to educate others.
vii. A strong understanding of health inequities and disparities in Vermont.

b. Staff skills and experience:
   i. Collection and analysis of health and health-related data.
   ii. Development and implementation of training regarding the origins, impact, and mitigation approaches to addressing the harmful systems of ableism, homophobia/transphobia, and systemic racism.
   iii. Stakeholder engagement and the development, administration, and evaluation of community grants.
   iv. Policy analysis.
   v. Interagency collaboration across departments of state government

3. Populations served and specific issues addressed by the Office, the HEAC recommends:
   a. The Office shall serve Vermonters who experience disparities in health outcomes and access to healthcare and in the social determinants that contribute to poor health, including particularly those who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities.

4. Duties of the Office, including how grant funds shall be managed and distributed, the HEAC recommends:
   a. The Office shall have the following powers, duties, and functions:
      i. Leading and coordinating health equity efforts.
      ii. Publishing data reports documenting health disparities.
      iii. Providing education to the public on health equity, health disparities, and social determinants of health.
      iv. 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.
      v. Conducting State-level strategic planning to eliminate health inequities.
      vi. Providing technical assistance to health agencies and community-based organizations.
      vii. Coordinating and staffing the Health Equity Advisory Commission.
      viii. Building collaborative partnerships with communities to identify and promote health equity strategies.

ix. Providing grants to community-based organizations to 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.
x. 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.
xi. 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.
xii. Developing curricula and the provision of continuing education courses to teach cultural competency in the practice of medicine.
xiii. Administering 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 Office may:
i. Hire personnel as the Director of Health Equity shall deem necessary.
ii. 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.
iii. Serve as the designated State agency for receipt of federal funds specifically designated for health equity programs that support individuals who are Black, Indigenous, and Persons of Color, individuals who are LGBTQ, and individuals with disabilities.
iv. Enter into contracts with individuals, organizations, and institutions necessary for the performance of its duties under this chapter.

5. Regarding the time frame and necessary steps to establish the Office, the HEAC recommends:
   a. The Director of Health Equity shall be appointed by the HEAC by January 1, 2024.
   b. The Director of Health Equity shall hire staff to the extent that funds are made available to the Office by the General Assembly by July 1, 2024.

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