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On behalf of the Health Equity Advisory Commission

House Committee on Health Care

Vermont Health Equity Advisory Commission

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Vermont Health Equity Advisory Commission

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Executive Summary

Act 33 of 2021 established the Health Equity Advisory Commission (HEAC), a 29-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 Commission is presently chaired by the Executive Director of the Vermont Racial Justice Alliance. The Vice-Chair is the Department of Mental Health Director of Trauma Prevention and Resilience Development. The Commission will submit an annual report to the Senate Committee on Health and Welfare and the House Committees on Health Care and Human Services with findings and recommendations for legislative action on or before January 15, 2023.
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Act 33 of 2021, Section 5; Report; Continuing Education, compels 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 has met one to two times each month and engaged in an array of meetings across seven working committees. Throughout the course of deliberations, the magnitude of the task at hand has become increasingly clear. We know that an understanding and acknowledgement of the realities of health disparities resulting from the harmful systems of systemic racism, ableism, and homophobia/transphobia are essential in the work of earnestly addressing health equity. We also understand that the upstream and downstream effects of social determinants of health increase the complexity of the implementation of mitigation strategies exponentially. It is for this reason that we suggest that the legislature strongly consider a whole-of-government approach to addressing equity in state government to ensure transformation.

Though this report targets largely training and education, HEAC's approach is data-driven and programmatic and targets true transformation. Some of the recommendations related to systems include the creation of a Health Equity Program across all systems of state government to better serve Vermonters receiving services; a Health Equity Fund to ensure ongoing financial support for the work related to ongoing health equity programs; and legislation requiring base health equity training and education for employees, contractors, grant recipients, and licensed/certified professionals who work in health-related fields.

Licensing and workforce development recommendations include the creation of a Health Equity Telehealth Program specifically to provide access to a broader selection of providers who possess the cultural competency and humility required to provide appropriate care to marginalized communities. Recommendations in this area also included leveraging current community support groups to provide services to marginalized populations through the creating of grants.

Continuing education and training recommendations include creating standardized baseline awareness training on the origins, impact and mitigation approaches to addressing the harmful systems of ableism, homophobia/transphobia, and systemic racism. A programmatic and continuous Training and Education Program (with Standards) is also proposed. Language access recommendations include the idea of developing more (and more consistent) plain-language and accessible documentation.

Conclusion

The HEAC is appreciative of the legislative commitment to addressing the harmful systems of ableism, homophobia/transphobia, and systemic racism which consistently produce adversely disparate health inequities. The HEAC welcomes the engagement of committee members, the House Committee on Health Care, the Senate Committee on Health and Welfare or a Joint Health Committee in moving forward. The legislature's involvement is critically important as the HEAC carries out its legislatively mandated duties including but not limited to the creation of the Office of Health Equity.

The success of the work of the HEAC is greatly dependent on the involvement of the legislative committees of jurisdiction. It is the hope of the HEAC that the legislature continues to be an active partner throughout this important phase of the implementation process. The report is robust and includes many more recommendations. The HEAC encourages the Committees to read the report through and give careful and thorough consideration to these recommendations which form the backbone of the work emerging from the HEAC. The HEAC stands ready to provide any clarification or additional detail regarding this report.

Respectfully,

Vermont Health Equity Advisory Commission

Introduction

Pursuant to Act 33 of 2021, this report will focus on Health Equity Advisory Commission (HEAC) “recommendations for improving cultural competency and cultural humility and antiracism in Vermont’s healthcare system through initial training, continuing education requirements, and investments.”

HEAC’s Preliminary Report – Feb 2022

Report submitted to the Legislature [\[link\]](#)

In its preliminary report to the Vermont State legislature in February 2022, the Health Equity Advisory Commission (HEAC or “the Commission”) noted dozens of opportunities for further exploration of inequities in health care delivery. This preliminary report highlights the fact that much of the necessary exploration of health inequities must happen outside of the healthcare industry. That is, the factors contributing to health inequity and poor health outcomes often originate in sectors that appear to be unrelated to health altogether. These seemingly unrelated factors include housing, transportation, education, worker support, the criminal and juvenile justice system, and other areas representing the social determinants of health. As the state of Vermont continues to seek ways to address health inequity, it is imperative that there be representation from these various sectors to ensure that emerging health equity programs include them. It is even more imperative that there be adequate representation from the community to ensure a community-based approach to addressing health equity.

In its deliberations, the Commission has repeatedly returned to the adage “nothing about us without us,” because when policy decisions and budget allocations are made by people in positions of prominence and authority, it is easy for the voices of impacted communities to be ignored or drowned out. For this reason, the Commission reiterates one of its central points from the preliminary report: that while we acknowledge the efforts to include community voices in our deliberations, we insist that more must be done to expand public participation (Health Equity Advisory Commission 2022). The Commission commits to using lessons learned this last year to construct a strategy to increase community involvement, which is imperative in public health and healthcare policy decisions, as well as in other social and economic policy decisions that drive health inequities. Health is implicated in all policy decisions, even when it is not readily apparent. As discussed in its preliminary report, the HEAC meets as a full body every two to four weeks. HEAC members also participate on five subcommittees to facilitate more in-depth discussions. Although the HEAC has chosen to break into subgroups, each committee is keenly aware of the overlap between subject areas. For example, an understanding of the contributing factors to the social determinants of health has bearing on how broadly equity training should be applied. How the equity training should occur can have an effect on licensing and education requirements. Each choice links to another to create a synergistic whole.

Public policy plays a central role in establishing who benefits, and who does not benefit, from health care and public health initiatives. A truism often cited in health reform efforts attributed variously to Dr. Paul Batalden, Dr. Don Berwick, and W. Edwards Deming says, “Every system is perfectly designed to get the results it gets.” (Carr 2008) In other words, disparate outcomes are not an oversight but a direct result of systemic racism, ableism, and homophobia/transphobia. In the United States, a history of systemic institutional bias means that the people disproportionately affected by socioeconomic factors

tend to be people of color, people with disabilities, and/or LGBTQIA+ people. It is important to keep in mind the intersectional identities of every person. For example, being part of the LGBTQIA+ community is not mutually exclusive from being a person of color. People with multiple marginalized identity factors tend to experience more stressors and greater health disparities because of their minoritized status (Denato, 2012). Dismantling these constructs requires comprehensive and programmatic approach to systemic change. The recommendations in this report are intentionally broad, even while remaining within the areas of training and professional development. They include not only professional development, but issues related to workforce diversity, recruitment and retention, and individual and organizational performance evaluation.

Programmatic Approach to Systemic Change

While the October 2022 HEAC report is focused on training, continuing education requirements, and investments, it is presented through a programmatic lens because a programmatic approach is essential to achieve a sustainable transformation to achieve health equity in Vermont. Any earnest Statewide effort to achieve impactful and sustainable health equity must be implemented programmatically with full buy-in. This means that the primary scope of the Health Equity Program must be State of Vermont employees. The Health Equity Program must first and foremost be adequately funded to ensure its success. The program executive must be thoughtfully positioned within the State government to ensure effectiveness. Though the funding and placement of the Health Equity Office are beyond the scope of this report, we stress the importance of planning all health equity training and education within the context of a larger health equity program.

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 Analysis of existing and emerging policies as well as 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.

Training and Education Program

Target Audience for Training and Education

The Commission deliberated concepts on the health equity training and education of numerous demographics including State employees, credentialed (and other health care) professionals, other credentialed professionals, and the Health Equity Advisory Commission.

State Employees

The Commission found there to be a wide range of training available and ongoing for all state employees. These trainings include topics such as Diversity, Inclusion, Equity, Implicit Bias and more and cover a broad range of material. This "training" is not standardized and State leaders' decision in introducing any given option is highly discretionary.

Credentialed Health Professionals (and other health professionals)

Some of the Commission's discussions focused on the need to ensure healthcare professionals receive training as a part of their continuing professional education. Our discussions included the Office of Professional Regulation and the University of Vermont Network. It is clear that as we consider requirements surrounding the mandate on health equity continuing professional education, we must look to other health related professions (currently non credentialed) and determine strategies to ensure their inclusion.

Other credentialed professionals

As we understand the implications of the social determinants of health's tremendous impact on disparate health outcomes, Commission discussions have emerged on non-health credentialed professions. The work ahead involves the continued coordination with the Office of Professional Regulation and other professional oversight entities within the State as we determine health equity education requirements for all credentialed professionals.

The Health Equity Advisory Commission

There is a natural tendency for those who do the work of equity to often make the mistake of overlooking the work that must be done internally to the "working" group. Training and Education on health equity, specifically matters relating to root causes and impacts of these harmful ideals and systems of ableism, homophobia, and systemic racism is a must for the Commission. The Commission will bring in external assistance for this work and establish some ongoing procedures and protocols to ensure that this work is ongoing and impactful.

Training Priorities

The Commission has engaged in extensive discussions on training and education to drive systemic transformation. There is consensus that some of the existing training and education are actively harmful because they present misconceptions and inaccuracies that perpetuate stereotypes. As a result of our findings the Commission has focused on naming the systemic issues, creating standardized, continuous, and ongoing training and education curricula for all State employee levels; and ensuring that State contractors are also trained. Though these trainings will be targeted to specific demographics within state government, there must be a consistent thread that connects all of the statewide training. It is also important that the interconnectedness of the trainings is highlighted so as not to silo and isolate areas that must be emphasized for their intersectionality.

Commission Focus

"Naming" the Systemic Issues

It is imperative that the naming of systemic issues, their origins and impact undergird the training and education component of the Health Equity Program. Clarity is critical in discussing systemic barriers. Many are already challenged with understanding the concepts related to systems outcomes. Some struggle with understanding impacts that they themselves may not completely experience. In its effort to "name" the issues, the Commission has found that any training should involve discussions on the root causes, impacts, and elimination of systemic racism, ableism, and homophobia/transphobia.

Creating standardized, continuous, and ongoing training and education curricula for all State employee levels

Many existing trainings being offered statewide are ineffective, inconsistent, or delivered on a one-time basis. In addition to being more consistent, training and education should be role-appropriate. Many trainings are not tailored to the trainees' organizational roles, given an individual's department or grade. This can often create additional challenges given the difficulty of challenging discussions in the presence of management. It also may fail to adequately equip those in sensitive, high impact, high discretion positions within an organization. Equity-related training for State employees and for members of institutions and sectors that affect health outcomes and inequities should reflect the employees' position within the institution. Further, there should be tailored training for roles and offices with specialized or sensitive duties, such as the Attorney General's Office, the Human Rights Commission, the Office of Racial Equity, and others. By focusing on consistent and ongoing training the State can ensure all employees understand their role in furthering systemic change. In addition, it is important to note that base-level training must be accomplished to ensure a common level of understanding statewide. Trainings that are role-specific or office/program specific should follow once base-level training is received. This will enable a broad-reaching yet highly effective approach.

Ensuring that State Contractors are Trained

Contractors comprise an enormous number of the folks doing the work of the State daily. The Commission has been in discussion surrounding possible approaches to ensuring that contractors are held to and protected by the same health equity standard as State employees. Discussions continue the prospect of incorporating a health equity program clause into all State contracts.

Programmatic Framework

Health Equity Training and education in a programmatic framing and systematic approach has led the Commission to consider the leveraging the existing Statewide infrastructure and work underway. The Commission has been discussing leveraging the work of the *Health in All Policies* Initiative to ensure a systems wide approach to the implementation of a Health Equity Program. We have also engaged in a robust overview and discussion of Medicaid, given its expansive reach and financial implications.

The HEAC views that ongoing work of the Office of Racial Equity as relevant, given the programmatic nature of its duties and responsibilities (3 V.S.A. § 5003) and specific requirements to "develop and conduct training for agencies and departments regarding the nature and scope of systemic racism and the institutionalized nature of race-based bias."

Licensing and Professions

One important way to improve cultural competency in Vermont's healthcare system is to ensure representation from more cultures among Vermont's healthcare system workers. The Commission has identified several factors that can help or hinder such representation:

- Defining and expanding the professions: Identifying which professions are included in our assessment of who is a "healthcare system worker," and
- Dismantling barriers to entry: The academic, financial, and regulatory inequities that make it harder for people from marginalized communities to enter healthcare professions.

Defining the Professions and Roles

Often, discussions around “healthcare professionals” tend to revolve around doctors, nurses, hospital administrators, and medical specialists. Less frequently, these discussions also include dentists and mental health professionals. Still more rarely do these conversations incorporate non-licensed workers. Because of the narrow scope of the dialogue around healthcare professionals, policymakers and advocates often neglect other professionals who impact individual and community health outcomes. For example, patients interact with more than just doctors and nurses when visiting hospitals. They encounter reception staff, schedulers, billing specialists, insurance providers, drivers, custodial staff, and other patients as well. In fact, there are many opportunities to improve cultural competency, cultural humility, and anti-racism practices for all healthcare workers in the healthcare delivery process:

- **Community health workers:** community health workers are a critical lifeline to people across the state. They come from varied backgrounds and work to build trust in communities through outreach, education, and peer support. Community health workers are often rendered invisible in discussions around public health professionals, largely due to the perception that they are not “essential” workers. However, community health workers are often the initial point of contact for community members who otherwise would not choose to engage with public health or healthcare delivery systems. Community health workers build trust and a local presence that bridges traditionally defined health providers and the communities they might not otherwise be able to reach.
- **Law enforcement:** In acute or emergency medical situations, law enforcement are often present at the scene because of the procedural link between dispatching medical assistance workers and dispatching police. As noted in the Commission's preliminary report, the close ties between medical intervention and police intervention have created tremendous harm, particularly in communities of color, low-income communities, the Deaf and disability community, and the LGBTQIA+ community. According to a recent report on best practices for antiracist mental health crisis response, “exposure to police violence is an independent risk factor for subsequent mental illness, and those suffering from untreated mental illness are 16 times more likely to be killed during police confrontations than other civilians.” (Mubarak 2022). It is the Commission’s intention to make recommendations in a future report about ways to untether law enforcement from health systems to improve outcomes for individuals and communities. Nevertheless, the current common practice of dispatching law enforcement alongside medical personnel means that law enforcement officers are often directly engaged with people experiencing physical or mental health events. Further, law enforcement officers are often the first responders on the scene during physical or mental health events. The expectation for law enforcement officers to respond to physical or mental health events places a large burden of responsibility on officers to be adept at recognizing a health crisis before or during its occurrence. Officers must be trained on how to address a physical or mental health crisis from a public health perspective instead of a criminalizing perspective (Mubarak 2022).
- **Paramedics:** Paramedics, Emergency Medical Technicians (EMTs), and other first responders are an important and early link in the chain of healthcare professionals. Like law enforcement officers, they are often directly engaged with people experiencing physical or mental health

events. First responders must navigate the complex chain of decisions on how to assist a patient whether they are on site at a well-resourced hospital facility or on the scene in a community. Because they are often mobile, paramedics and other first responders are required to navigate health events while conducting patient transport. Their role in patient transportation adds a layer of logistical complexity to the treatment protocol necessary to address the health event as it unfolds.

- **Direct support providers and home care providers:** Like community health workers, direct support providers are often rendered invisible in conversations about healthcare professionals because they are less commonly seen in medical facilities. However, many direct support and home care providers are members of vulnerable populations, especially women of color (Gleason and Miller 2021). Holding an equity lens to the issues of workforce retention and training must include consideration for the identities of the people providing health care services and the unique challenges they face as both patients and providers.
- **People who interact with patients during transport to long-term care facilities or hospice facilities:** This group includes drivers, operators of specialized equipment like Hoyer lifts or accessible vans, and others.
- **Peer Supports:** Peers play a critical, recognized role in many community-based healthcare settings. Peer support can aid in increasing health equity and lower barriers. Peer workers are individuals with lived experience who are willing to provide support to others undergoing similar experiences. It is important to identify peer supports as both sources and recipients of cultural competency training opportunities. Peers with lived experience of health inequities can provide insight into health equity concerns to inform the systemic change recommended by the HEAC (Ho et. al 2022, Watson, Staton & Gastala 2022, Eliacin et. al 2022).
- **Policymakers, including Legislators, members of State Boards and Commissions, and Executive Branch employees such as the Office of Professional Regulation:** Despite not usually appearing in healthcare settings, policymakers are among the most influential people when it comes to impacting health outcomes. Policymakers set the legal and regulatory frameworks in which all healthcare delivery happens. They decide where funding is directed, who should be regulated, how they should be disciplined for misconduct, and much more. In fact, policymakers don't even have to be making decisions about healthcare to impact a community's health outcomes: a local board vote on where to place oil and gas refineries could lead to a spike in the rate of child asthma among Black families decades later (Fleischman and Franklin 2017). Even the Health Equity Advisory Commission itself must be continually educated about the upstream and downstream contributors to health inequity for the Commission to be effective at its work.

For several of the groups listed above, there are few or no licensure requirements to serve in the role. Creating a education requirement based on role rather than further certification or licensure is recommended by the Commission.

Barriers to Entry to the Profession(s)

Inter-state Licensure Transferability

With a population of just under 650,000 people, Vermont is one of the smaller U.S. states (Vermont Department of Health 2022). It also has the third highest median age of all the U.S. states (Duffin 2022). These two data points reveal one of the challenges the state faces: maintaining and eventually growing its population, specifically its worker population. Additional data indicates that 92.5% of Vermont residents are White, while only 60% of the U.S. population is White (Vermont Racial Justice Alliance 2021). The state's unique population characteristics mean that Vermont will need to diversify its racial and ethnic demographics if it hopes to grow the workforce. The current cultural climate around race and support infrastructure are not sustainably retaining Vermonters of color (Flynn 2022).

As long-time professionals in healthcare settings exit the workforce, Vermont needs a commensurate influx of people entering the workforce to maintain a reliable and consistent pool of practitioners. Further, it is imperative to combat the history of systemic racism and other forms of discrimination in healthcare provider education by recruiting healthcare providers with lived experience of health inequities through their personal identity factors such as race, ethnicity, gender identity, sexual orientation, and disability status (Stein 2021). Workforce retention is not just the work of healthcare institutions.; For healthcare institutions to attract and retain workers, certain wrap around supports also need to be in place for those workers. Basic infrastructural supports include affordable and appropriate housing, adequate transportation options, safe and quality schools in their neighborhoods, access to telecommunications connectivity and broadband internet, and a safe and welcoming community. Many of these supports are outside the control of healthcare institutions and their administrators. Therefore, recruitment of residents to the state and recruitment of healthcare workers requires specific, intentional action from leaders and impacted communities in nearly every sector.

Even when all these supports are present, there may be another barrier that prevents successful recruitment of a healthcare worker from outside the state: license reciprocity. The Commission recognizes that many U.S. states have worked hard to coordinate their licensure requirements for numerous professions to create some uniformity and compatibility for professionals to practice their trade in different states. Despite these efforts, there are still shortcomings preventing prospective Vermonters from practicing their work in Vermont.

Vermont's licensed health professionals are regulated through the Secretary of State's Office of Professional Regulation. The Office's oversight system is complex, and many of its rules exist precisely to provide that inter-state licensure compatibility with other states who have mirror regulations. It is worth exploring whether the complexity of inter-state licensure requirements is contributing to workforce shortages in Vermont, and if so, how the state can adjust its licensure requirements to permit more qualified professionals to practice their trade in Vermont. The Office of Professional Regulation has already done some of the work of reducing barriers to entry into health professions by reassessing its foreign credentialing rules to find ways to allow more transferability of professional credentials obtained outside the U.S. The Commission encourages the Office to continue that work and to expand its inquiry to account for practitioners who wish to come to Vermont from other U.S. states.

Because of the complexity of the Office of Professional Regulation's work, it may not be clear to the average person how to learn more about the regulatory system for a given profession or how to interact with the Office. The Office of Professional Regulation also receives and investigates complaints made by members of the public against licensed professionals in the state. In addition to the educational materials the Secretary of State has made available to the public, the Commission recommends

conducting more proactive outreach to residents and visitors of Vermont to educate the public about how to make a complaint and what relief that process can provide. The Office of Professional Regulation's proactive outreach must be accessible to people living with disabilities and linguistically accessible to people in Vermont whose spoken language is not English, including Deaf community members.

Financial Costs

As with almost all professional pursuits, there are significant costs associated with becoming educated and credentialed in a healthcare profession. First, decades of research have confirmed that the people most likely to succeed in higher education are those who have experienced the most housing stability, food access, educational nurturing, and other consistent supports throughout their formative years (Espinosa 2019). Already, socioeconomic factors outside of their control disadvantage young people who are experiencing food insecurity, housing insecurity, physical or emotional abuse, or lack of accommodations in school settings. There are many systemic factors that contribute to these occurrences. For example, workplace discrimination might lead to unemployment. Unemployment might lead to eviction for nonpayment of rent. Eviction might lead to overcrowding in a shared household, which may strain the household budget and create food insecurity for those affected. Discrimination in one sector can have a cascading negative impact on the success of a young person even before that person decides what career to pursue.

Second, the cost of higher education in the US has ballooned over the last four decades. Since 1980, the Consumer Price Index for all items has risen by 236%. Over the same period, college tuition and fees have risen 1200% (Bhutada, 2021). Further, these discrepancies in costs are not sustainable by wage earnings in the US. According to the Pew Research Center, in real terms, average hourly earnings peaked more than 45 years ago: The \$4.03-an-hour rate recorded in January 1973 had the same purchasing power that \$23.68 would today." (Desilver, 2018) These metrics make it clear that education is largely unattainable for many people in the U.S. due to its high financial cost. The high cost of education shuts out people who are more likely to experience economic strain, which in the United States tend to be people of color, people living with disabilities, members of the LGBTQIA+ community, and people in the line of intergenerational poverty.

Exclusion from Educational Programs

Discrimination in academia might be excluding potential students at the undergraduate, graduate, and technical certification levels. Citing research in the *AMA Journal of Ethics*, the Harvard Law School Project on Disability reports that "both ableism in medical schools' admissions processes and expectations set by technical standards for the physician workforce can perpetuate historical patterns of exclusion in healthcare settings...Patients with disabilities receive substandard health care and have unequal access to health care services and barriers for persons with disabilities to enter the medical profession will undermine commendable disability awareness efforts for clinicians" (Stein 2021). The ableism experienced by people with disabilities in educational settings is often a precursor to the ableism and discrimination people with disabilities face in employment (Stein 2021). Recommendations made by Vermont Center for Independent Living (VCIL) in their 2021 report titled *Our Time is now* should be considered (https://vcil.org/wp-content/uploads/2022/06/VCIL_2021_Report_VF_sm.pdf).

Logistics, Infrastructure, and the Built Environment

Sometimes, being enrolled in a school program is not the problem. For some, the logistical challenges of being able to join the class can be a barrier. Transportation and connectivity play key roles in student exclusion from educational programs, particularly over the course of the COVID-19 pandemic when students were routinely asked to adjust to fluctuations between in-person, remote, and hybrid learning patterns (Building Bright Futures 2020). With Vermont's high need for access to broadband and sparse public transit options, it is important for the state to incorporate infrastructural concerns in its plans to grow and diversify the state's healthcare workforce.

Vermont has an opportunity to increase access to healthcare professions through tools such as language access for professionals. Language access can help expand the healthcare workforce to reduce backlogs and speed up access to treatment for patients, especially for those who experience long waits to see mental health wellness workers. It is also imperative that we consider different treatment models that incorporate cultural needs that have long been ignored, including Indigenous healing practices and other cultural and spiritual considerations (Office of Minority Health, 2013). Expanding our definitions of acceptable treatment models must include providing adequate resource allocations for group support services or similar options that allow multicultural healthcare workers to connect with the communities they serve.

Defining the Population, Culture, and Approach

Care Models

In the public narrative around health care and wellness, there is often a narrow focus on individual care and individual responsibility for one's own health. The Commission urges the legislature and others in decision making roles to think of healthcare as community care, and to consider ways to improve health equity using a broader systems approach in addition to an individual-focused approach. A broad systems-wide approach includes addressing/eliminating structural and systemic barriers to health and health care that harm people from historically and currently marginalized communities.

Community Support

Continuous community involvement and engagement are crucial in the planning and implementation of a statewide health equity program. Many non-Western approaches to health and wellness originated in Black and Indigenous cultures. For example, the often-cited Hierarchy of Needs created by psychologist Abraham Maslow in 1943 was originally developed based Maslow's experiences living with Indigenous Siksika (Blackfoot) tribes in 1938 (Ravilochan, 2021). 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 have come various approaches such as affinity groups, peer-to-peer counseling, support groups, and ideas on creating training curriculum for various healthcare professionals by and for impacted communities. 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. Community empowerment enables those most impacted to serve their communities and receive the support that they believe they require in a manner of their choosing. Services provided must expand far beyond basic health services into areas of youth services, housing, education, employment, and economic development. Extending and creating these community-oriented programs and services that historically have been delivered inefficiently or ineffectively, or

sometimes not at all, is a transformative approach that positively addresses the health and wellness of impacted communities, thereby strengthening the whole of society (Blackwell 2017).

As the 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. Local and state governments often tend to assess and prescribe, ignoring the ideas of community partners. Now more than ever is a time for listening and responding with transformative action. Community partners report feeling ignored when they offer up ideas and thus, become reluctant to continue participation in traditional forums. These traditional community engagement approaches have and continue to fail impacted communities.

Open meeting laws, parliamentary meeting procedures, and meeting executive sessions have not and do not provide the spaces that impacted communities need to conduct thoughtful discussions and provide constructive input in the systems impacting their lives. In fact, federal mandates require that the State include impacted communities as a condition for receiving related federal funding. 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.

Recommendations

Systems Coordination

- Consider whether and how to coordinate systems among the “helping professions.” In making this decision, account for the possibility that systems coordination may be overwhelming to those we wish to serve. For example, information-sharing between care settings might seem like a positive step towards care coordination. However, it may at times be unnecessary and may allow institutions to collect, hold, and share too much information in ways that do not necessarily help in treatment (Allen 2022). For more information, see the “Additional Supporting Resources” section entitled “Data Integration and Racial Equity”.
- **A base level Health Equity Program should be created and used across all systems to better serve Vermonters receiving services. The HEAC, in consultation with impacted community leaders and equity industry associations should be responsible for program creation, training the trainers, and creating a system to monitor compliance.**
- All State agencies should coordinate their equity efforts where appropriate to maximize resources and funds.
- More community voices must be identified at every stage of decision-making on public health matters. Community members must be respected as “experts” and less reliance should be placed on health corporations and government (Organizing Engagement, 2022). For more information on empowering community members, see the “Additional Supporting Resources” section entitled “Outreach and Engagement”.
- Organizational policies, procedures, manuals, and documents should be reviewed for instances where harmful systems of ableism, homophobia/transphobia, and systemic racism consistently produce adversely disparate health inequities. For more information, see the “Additional Supporting Resources” section entitled “Outreach and Engagement”.

- **A Health Equity Fund should be created to ensure ongoing financial support for the work related to ongoing Health Equity Programs.**
- **State legislation should require a base Health Equity Training and Education Program for State employees, contractors, grant recipients, and licensed/certified professionals who work in health-related fields.**
- Expand the Office of Racial Equity's Equity Program Model to apply to other marginalized groups.
 - Data collection activities should baseline the program, measure program impact and inform future mitigation strategies (including training)
 - Policies must communicate the State's values and expectations concerning fairness and diversity and mandate training.
 - Training must include policy awareness and origins, impact and mitigation approaches to addressing the harmful systems of ableism, homophobia/transphobia, and systemic racism.

Licensing + Workforce Development

- Modify licensing exams for all professions for whom licensing exams are required to include more questions about health equity, inclusion, and accessibility.
- Create more access to peer support providers trained in health equity. Peer supports have been clinically proven to improve patient outcomes in many settings (Ho et. al 2022, Watson, Staton & Gastala 2022, Eliacin et. al 2022). In order to make effective recommendations, the HEAC will continue to visit this topic to create further recommendations in upcoming reports.
- Recruit more, better, and differently by paying for prospective workers' travel and moving expenses, and by providing onboarding and educational materials in more languages.
- In order to recruit a more diverse section of health care providers, consider specifically the ways in which professionals can serve in under-saturated practice areas, such as group support in mental health services and among rural populations. The HEAC will be cataloging any existing programs to better understand where holes may exist to provide effective recommendations to the legislature.
- **Create a Health Equity Telehealth Program specifically to provide access to a broader selection of providers who possess the cultural competency and humility required to provide the appropriate care to marginalized communities. This Health Equity Telehealth Program could leverage Act 107, 2022, An act relating to telehealth licensure and registration and to provisional licensure for professions regulated by the Office of Professional Regulation.**
- The Office of Professional Regulation should review the relevant inter-state licensure requirements to ensure that out-of-state telehealth providers are held to the same standards of health equity training as Vermont-based providers.
- **Leverage current community support groups to provide services to marginalized populations through the creating of grants overseen by the HEAC.**
- Create a model of reimbursement or insurance coverage requirements for alternative therapies such as reiki, herbalism, Chinese medicine and other nonwestern approaches.

Continuing Training and Education

- **Create standardized baseline awareness training on origins, impact and mitigation approaches to addressing the harmful systems of ableism, homophobia/transphobia, and systemic racism. (HEAC, in consultation with leaders from impacted communities and equity industry associations).**

- Create a statewide mandate on equity to ensure Equity Training and Education is amongst the highest of priorities and essential for professional development. Not a check-box or administrative sign-off.
- **Health Equity Training and Education Program should be programmatic and ongoing (and include Standards). It should ensure that all employees understand their role in furthering systemic change. This training and education should also be role-based and created in conjunction with impacted community leaders and equity professional associations.**
- Create legislation that requires additional professions other than those who provide direct care services to also receive training in Health Equity. This should include billing staff, paramedics, receptionists, schedulers, social workers, peer supports and anyone else who plays a significant role in patient experiences or outcomes.
 - o Areas for training should include the topics of LGBTQIA+ communities, understanding disability, cultural humility, systemic racism, bias, and other areas mentioned by this report.
 - o Create specific community-based trainings in collaboration with professional and community voices.
 - o The HEAC should vet and maintain an accessible menu of these trainings for interested parties to access.
- Communicate the urgency and priority of education against homophobia/transphobia, ableism, and systemic racism alongside existing trainings that are already heavily weighted, such as Equal Opportunity gender-related anti-bias trainings and sexual harassment prevention trainings.
- Create a defined protocol for how to address instances of harassment or discrimination in healthcare settings, especially racial discrimination. To practice anti-racism in meaningful ways, healthcare institutions and other impactful sectors must insist on living out a shared set of values and committing to upholding them.
 - o Implementing the cultural changes to dismantle systemic racism includes having a robust and effective discipline policy for perpetrators of discrimination and/or harassment, providing socio-emotional support for those who experience discrimination or harassment, and implementing or updating the staff and patient codes of conduct to reflect shared values.
 - o Ensure adequate resourcing to include time and finances for training the healthcare delivery workforce and expanded definitions of healthcare workers, including a robust community health workforce to meet people where they are at.
 - o Create a programmatic training co-operative that is available at no cost to ensure access for all which is managed by the HEAC
 - o Rather than mandating training, the legislature should consider the option of providing some benefits for engaging in this training such as a tax credit.
- Creation of culturally sensitive training on alternatives to medical model - i.e., Reiki, massage, acupuncture, shamans, naturopaths and others.

Language Access

- **Develop more (and more consistent) plain-language and accessible documentation. For more information on plain language, see the “Additional Supporting Resources” section entitled “Language Access”.**

- Provide more opportunities for timely and seamless ASL and other language translation and interpretation services.
- Increase Medicaid reimbursement for interpreting services. Recruiting and retaining interpretation and translation staff is vital to support the growing linguistic diversity of Vermont residents and visitors. Community feedback to the Office of Racial Equity indicates that the current level of Medicaid reimbursement for interpretation services is too low to equitably pay highly trained, essential medical interpreters for their services (Davis 2022). Patient health outcomes are worse when patients who speak languages other than English do not have access to trained interpretation service providers in healthcare settings (Flores et. al 2012, Green, A. R., & Nze, C. 2017).

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Additional Supporting Resources:

Data Systems Integration and Racial Equity

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State of Vermont Office of Racial Equity Language Access documents

[1] Summary document from community feedback sessions held by ORE and [2] Forthcoming resulting proposal.

State of Vermont Resources

Act No. 186 An act relating to reporting on population-level outcomes and indicators and on program-level performance measures., Pub. L. No. 3 V.S.A. § 2311, Legislature.Vermont.Gov (2014). <https://legislature.vermont.gov/Documents/2014/Docs/ACTS/ACT186/ACT186%20As%20Enacted.pdf>

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