Health Equity Advisory Commission
Meeting Notes

Date: October 18, 2021

I. Updates

Do we want to have a phone tree? We would use this is we have something urgent to communicate to the group (cancelling meeting, public statement). Consensus: yes. Director Davis will send it out today. Please note who calls you/who you call. Please take care with others' personal contact information.

II. Discussion: Consensus building model

Davis

At our last meeting we discussed decision making and governance. We recognize that the formality of a parliamentary process may reinforce hierarchies that are harmful and perpetuate white supremacist culture.

We want to make sure we have tight documentation of our decision-making process

We may need a backup method

See resources Director Davis sent

III. Discussion: Communications standards

Gillom

Steffen shared a document that includes a shared value statement and pledge, guidelines around general conduct.

It is imperative that we have a way to communicate that keeps us streamlined, doesn't overwhelm us. There are different types of models under consensus-based decision making – "rules to the rules"

One basic tenet of a consensus model of decision making is that one cannot block action – members can object to an action, take different stances, but do not have authority to shut it down

Consensus model of decision making

1) Discussion and check for consensus.
2) Initiate second round of discussion if needed.
3) If consensus can not be reached, members may:
    a. mark that they have concerns (“I don’t block, but I want it noted that I have concerns”),
    b. reservations,
    c. non-support/stand aside.
4) If consensus is unreachable, 2/3 of the group can consent.

This document will be circulated after the meeting. We’d like to read and offer comments first. We can decide on adoption/modification next meeting.

Comments: very helpful, great work

Suggestions: add age and disability to the first line where you ID race and class, change pronouns in bullet 3? Maybe just “their”

IV. Reflections on Health Equity in VT

All

Questions in the chat to prompt discussion: What has changed? What has not changed? What does success look like for this Commission? Who have been/could be leaders? How can we engage? What pitfalls should we avoid? How has intersectionality shown itself in VT’s health systems?

Director Davis: We are here for a reason, we may have different perspectives on health/ equity/policy. Invite conversation about what all of this means to you

Monica: equity conversations have been happening over past several years. Example of pandemic – impacted across populations

(illness, interventions, etc) – think about how we communicate, who with, what structures, consider poverty, SDOH, how we respond. Daunted by enormity of conversation. Running through learning from pandemic to situate/filter self.

Kheya: seconds Monica, reflecting on specific populations we don't do a good job with. We see it in vax rates, low trust. Trans adults – need excellent healthcare. Health and mental health – we do a really bad job outreaching/educating/understanding because we are such a white state. We don't understand extended family systems.

Kirsten: VT Developmental Disabilities Council has had long standing concern for people with intellectual and/or developmental disabilities. White paper was published 7 years ago with qualitative data. People with I/DD have twice the rate of chronic disease in VT as those without. Practical barriers exist (ex: if you need things explained more slowly), enormity of barrier around attitudes toward people with I/DD (ex: exceptions to visitor policies). Ableism is unconscious. Cautious to make sure we are moving all of our groups together.

Ericka: staffs a drop-in center for folks exp homelessness and may have I/DD – everything went to phone/internet systems (health care, transportation). This is a population that is left out because of that

Annette: pandemic effects on mental health, close down of a lot of activities. Some peers are really struggling, not enough connection. Something has to be done.

Steffen: find a way to get voices of more nurses at the table. Not represented well in general discussion around health care and equity. Should have more diverse array of discussion around MH that crosscuts race. VT focuses on certain "types" of social work. We are not culturally responsive. Ex: Latinx/black family systems – can use more applicable interventions. Has to be discussion around MH treatment for queer and trans Vermonters/intersection with race. Most information/interventions are tailored to the white LGBTQ+

community. Trainings and nuance. How will HEAC intersect with other commissions so we aren't working in a silo.

Patricia: when I'm having a hard time transporting patients at the end of their ER stay, Green Mt Transit can be helpful. Having to send out many vouchers; can VT create a system for all hospitals to make sure there is a licensed professional on those transports. We are tired, broke, frazzled, on edge, leaving, there is broad inequity in pay across providers (ex: local vs traveling providers), killing morale.

Monica: picking up on themes – whole concept of health equity in health care. 1) Individuals themselves, how to support them, 2) making sure that people see themselves represented in the workforce. Create tracks for people to enter the health care field.

Kheya: We need to be very careful that we're not tokenizing. How we treat our health care professionals. We expect a lot, we get little in return. How are we compensating people? MH gets kicked into the corner until we're screaming. We should connect with the MH Integration workgroup.

Isaac: VRJA working on a survey, will attempt to gauge what the problem is. We don't have the luxury in VT to see providers who look like us – there are so few Black doctors in VT. Will forward survey.

Thato: What Ericka was sharing mirrors the experience of lots of New Americans.

Andrea: Value community health work over formal degrees. How do we address harm caused to providers of color? Insurance gaps for Medicaid/Medicare.

Patricia: Re: tokenization - I'm the only black nurse in my facility. Sometimes when you're the only POC in certain situations, you're called upon a lot. It doesn't bother me. Personal story about being subjected to abuse repeatedly by a patient. Maybe we should do targeted hiring (specialized marketing) to POC providers. (Don't

always sell VT with “mountain sports”) What makes VT welcoming to POC? We don’t meet the benchmark.

Lucy: preK-8 at her school, everyone is susceptible. Frustrating trying to balance if someone is exposed in the family, what do we do? Not sure how they can do rapid tests. MH of teachers – they have to be remote at a given moment, it’s overwhelming.

Steffen: we should focus on licensures, where are people are being licensed who would be attracted to VT? NH, MA, RI have much more diverse licensure representation. Would like to have a predominant research methodology that we stick and hold to. Need strong data.

Thato: reflecting on similar experiences with refugee community, access to health care is limited. We have improved in terms of language access, there is still lack of cultural understanding in MH/health settings for former refugees. Must understand their walk of trauma. Understand how people view MH and what they perceive as healing. We are a white state, hard to work in any healthcare setting to find anyone who looks like me. Foster talent, support with scholarships, so they can maintain living in VT. Engage universities to be socially responsible.

X: a lot of us talking about health, HEAC brings in leaders and comm members who are upstream (housing, transportation). Can people afford to live here. If we talk about health, we have to talk about all social determinants of health (SDOH)

Kheya: What about native healing practices? How do people think about healing?

Joanne: We do need to change the perspective of health care – they don’t see someone’s culture as part of their wellness. It’s not two separate issues.

HB: Connections among healthcare and other carceral systems. If we have access to funding, how are we lessening harm. We all want positive health outcomes. Safe use sites – providing them in the

state, how are we weaving in harm reduction. Decriminalize sex work. Queer and trans people – left out of any data collection re: COVID. Food insecurity. Basic access to health care for queer and trans people. Want this Commission to use the power that we have for swift action. People are not ok.

V. Public Comment

No comments.

VI. Review/Preview

Davis

Director Davis: what to cover at next meeting? This is the tip of the iceberg. Other committees/councils/etc have been looking at these issues. Upstream factors. Facilities, funding, employment, what equity means for practitioners and professionals. Diversify profession and make it so practitioners are not being harmed. Opportunities for recent graduates, focus on generational equity.

Shape our thinking to what we're being asked to do. Equity doesn't always conform to the process. Report due to leg on Jan 15th – written report with findings, recommendations for legislative action. Consider, be prepared to comment on: What are anticipated data needs to write report? Who do we consult with? What do we need to get/do/hear to put this report together?

Kirsten: what are other Commissions doing. Report circulating on workforce development. Is Director Davis in the position to think about where there are other important entities/work to get on our radar?

Director Davis: was hosting quarterly meetings, haven't convened in a while, will reconvene, place where we can understand what we're all working on.

Monica: 3 months is a short span of time to be thoughtful and put forth recommendations. Is it reasonable to imagine asking for an

extension/submit report that is introductory? Don't want to shortchange the work for the deadline.

Director Davis: yes, could ask for more time. Worth a conversation with larger group. We will meet week of 11/1. Help me craft next agenda.

Kirsten: Let's look at what we've discussed and break out into topics to do deeper dives (workforce, etc)

Monica: common baseline in terms of data/information. Create a cache of all relevant data. May need to parse out certain populations, but generally guard against that.

Need a common repository for data, documents. Could we put together a SharePoint site?

Action items: **Director Davis** will send phone tree, grounding doc that Steffen drafted, calendar invite for next meeting. **Monica will** send Director Davis the Workforce Development report that was referenced. **Steffen and Kheya** will collaborate to pull together themes from these notes, distill today's reflection into topic areas to group our thinking.

Minutes submitted by: Sara Chesbrough

Minutes approved by: XR Davis