

SENATE No. 1388

The Commonwealth of Massachusetts

PRESENTED BY:

Joanne M. Comerford

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act establishing health equity at all levels in government.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
<i>Joanne M. Comerford</i>	<i>Hampshire, Franklin and Worcester</i>	
<i>Kay Khan</i>	<i>11th Middlesex</i>	<i>3/4/2021</i>
<i>Rebecca L. Rausch</i>	<i>Norfolk, Bristol and Middlesex</i>	<i>3/8/2021</i>
<i>Michael O. Moore</i>	<i>Second Worcester</i>	<i>3/9/2021</i>
<i>Adam G. Hinds</i>	<i>Berkshire, Hampshire, Franklin and Hampden</i>	<i>4/20/2021</i>
<i>Julian Cyr</i>	<i>Cape and Islands</i>	<i>5/10/2021</i>

SENATE No. 1388

By Ms. Comerford, a petition (accompanied by bill, Senate, No. 1388) of Joanne M. Comerford, Kay Khan, Rebecca L. Rausch and Michael O. Moore for legislation to establish health equity at all levels in government. Public Health.

The Commonwealth of Massachusetts

**In the One Hundred and Ninety-Second General Court
(2021-2022)**

An Act establishing health equity at all levels in government.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. Chapter 3 of the General Laws is hereby amended by inserting after section
2 38C the following section:-

3 Section 38D. (a) As used in this section the following words shall, unless the context
4 clearly requires otherwise, have the following meanings:-

5 “Contracted institution”, the academic institution selected by the department of public
6 health.

7 “Determinants of equity”, social, economic, geographic, political, and physical
8 environmental conditions that lead to the creation of a fair and just society.

9 “Health disparities”, differences in health status among distinct segments of the
10 population, including differences that occur by gender, age, race or ethnicity, sexual orientation,

11 gender identity, education or income, disability or functional impairment, or geographic location,
12 or the combination of any of these factors.

13 “Health equity”, efforts to ensure that everyone has a fair and just opportunity to be as
14 healthy as possible. This requires removing obstacles to health such as poverty, discrimination,
15 and their consequences, including powerlessness and lack of access to good jobs with fair pay,
16 quality education and housing, safe environments, and health care. For the purposes of
17 measurement, health equity means reducing and ultimately eliminating disparities in health and
18 its determinants that adversely affect excluded or marginalized groups.

19 “Health equity principles”, principles that facilitate the realization of health equity for all
20 people in the commonwealth, including, but not limited to:

21 (i) the incorporation of health equity considerations into decision-making in all sectors,
22 levels, and policies;

23 (ii) the meaningful involvement of all people with respect to the development,
24 implementation and enforcement of laws, regulations and policies that affect health equity; and

25 (iii) the equitable distribution of resources, benefits and burdens, with special attention to
26 equity across geographic regions of the commonwealth and impacts on populations that have
27 experienced marginalization or oppression.

28 “Health inequities”, disparities in health, or the factors that shape health, that are systemic
29 and avoidable and, therefore, considered unjust or unfair.

30 “Initiative”, the health equity at all levels in government initiative.

31 “Populations that have experienced marginalization or oppression”, communities that
32 include, but are not limited to, women; Black, Indigenous, and People of Color; minority ethnic
33 groups; low-income individuals and families; individuals who are incarcerated and those who
34 have been incarcerated; individuals experiencing homelessness; individuals with disabilities;
35 individuals with mental health conditions; children, youth and young adults; seniors; immigrants
36 and refugees; individuals who are limited-English proficient; lesbian, gay, bisexual,
37 transgender/gender non-conforming, queer, intersex, and agender/asexual/ally communities; and
38 environmental justice populations, as defined in section 62 of chapter 30, or combinations of
39 these populations.

40 “Social determinants of health”, the conditions in the environments where people are
41 born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and
42 quality-of-life outcomes and risks, including, but not limited to, economic stability, education
43 access and quality, health care access and quality, neighborhood and built environment, and
44 social and community context.

45 “State agencies”, the executive offices of administration and finance, education, energy
46 and environmental affairs, health and human services, housing and economic development, labor
47 and workforce development, public safety and security, technology services and security, the
48 department of transportation and other departments, commissions, offices, boards, divisions,
49 institutions or other agencies of the executive department that the governor may from time to
50 time designate.

51 (b) The department of public health shall contract with an academic institution to provide
52 health equity assessments of bills before the general court. The department shall select the

53 contracted institution on the basis of expertise in health equity, expertise in public health,
54 program capacity and such other criteria that the department determines are necessary. The
55 department shall provide adequate funding to ensure that the contracted institution shall have
56 adequate capacity to complete assessments. Each contract shall last for a duration of 5 years.

57 (c) The contracted institution shall conduct a health equity assessment for a bill upon
58 request of a committee of the general court having jurisdiction, the committee on ways and
59 means of either branch, or a member of the general court. The contracted institution may decline
60 a request for a health equity assessment if the bill is unrelated to health equity or if producing an
61 assessment would not be feasible while operating within its available resources. A committee of
62 the general court having jurisdiction and the senate and house committees on ways and means
63 may consider any health equity assessment that has been produced when deciding whether to
64 report a bill favorably.

65 (d) The contracted institution shall conduct a health equity assessment for all bills
66 referred by a committee of the general court having jurisdiction. Committees of the general court
67 shall refer all bills under their jurisdiction that the house or senate chair of the committee, the
68 speaker of the house of representatives, the president of the senate, the minority leader of the
69 house of representatives or the minority leader of the senate determines is likely to have a
70 significant impact on health equity or is likely to have a fiscal impact of more than \$50 million.
71 The contracted institution may decline a referral for a health equity assessment if the bill is
72 unrelated to health equity or if producing an assessment would not be feasible while operating
73 within its available resources. A committee of the general court having jurisdiction and the
74 senate and house committees on ways and means shall consider any health equity assessment
75 that has been produced when deciding whether to report a bill favorably.

76 (e) (1) Health equity assessments shall be conducted in accordance with health equity
77 principles. Health equity assessments shall include, at a minimum and to the extent that
78 information is available, an analysis of whether the proposed policy is likely to promote or
79 undermine health equity in the commonwealth.

80 (2) Health equity assessments may consider:

81 (i) direct impacts on health disparities, health inequities, the social determinants of health,
82 and the determinants of equity, with special attention to impacts on populations that have
83 experienced marginalization or oppression;

84 (ii) the quality and relevance of studies to evaluate said impacts;

85 (iii) the availability of measures that would minimize any anticipated adverse health
86 equity consequences;

87 (iv) the existence of adverse short-term and long-term health equity consequences that
88 cannot be avoided should the proposed policy be enacted;

89 (ii) the availability of reasonable alternatives to the proposed policy; and

90 (iii) the impact of the proposed policy on factors that include, but are not limited to:

91 (A) income security, including, but not limited to, adequate wages, relevant tax policies,
92 and paid leave;

93 (B) food security and nutrition, including, but not limited to, food assistance program
94 eligibility and enrollment, assessments of food access and rates of access to unhealthy food and
95 beverages;

96 (C) child development, education, and literacy rates, including, but not limited to,
97 opportunities for early childhood development and parenting support, rates of graduation
98 compared to dropout rates, college attainment and adult literacy;

99 (D) housing, including, but not limited to, access to affordable, safe and healthy housing;
100 housing near parks and with access to healthy foods; and housing that incorporates universal
101 design and visitability features;

102 (E) environmental quality, including, but not limited to, exposure to toxins in the air,
103 water and soil;

104 (F) accessible built environments that promote health and safety, including, but not
105 limited to, mixed-used land; active transportation such as improved pedestrian, bicycle and
106 automobile safety; parks and green space; and healthy school siting;

107 (G) health care, including, but not limited to, accessible chronic disease management
108 programs, access to affordable, high-quality health and behavioral health care, assessment of the
109 healthcare workforce, and workforce diversity;

110 (H) prevention efforts, including, but not limited to, community-based education and
111 availability of preventive services;

112 (I) assessing ongoing discrimination and minority stressors against individuals and
113 groups in populations that have experienced marginalization or oppression based upon race,
114 gender, gender identity, gender expression, ethnicity, marital status, language, sexual orientation,
115 disability, and other factors, including, but not limited to, discrimination that is based upon bias
116 and negative attitudes of health professionals and providers;

117 (J) neighborhood safety and collective efficacy, including, but not limited to, rates of
118 violence, increases or decreases in community cohesion, and collaborative efforts to improve the
119 health and well-being of the community;

120 (K) culturally appropriate and competent services and training in all sectors, including,
121 but not limited to, training to eliminate bias, discrimination and mistreatment of persons in
122 populations that have experienced marginalization or oppression;

123 (L) linguistically appropriate and competent services and training in all sectors,
124 including, but not limited to, the availability of information in alternative formats such as large
125 font, braille and American Sign Language; and

126 (M) accessible, affordable and appropriate mental health services.

127 (3) Health equity assessments shall be based on the best available empirical information
128 and professional assumptions available to the contracted institution within the time required for
129 completing the assessment. Health equity assessments shall be nonpartisan, informational in
130 nature and shall not provide any recommendation on the reporting of the bill by the committee
131 having jurisdiction.

132 (4) The contracted institution may limit the number of health equity assessments it
133 produces to retain quality while operating within its available resources.

134 (f) For each health equity assessment, the contracted institution shall accept public
135 comment for no less than 20 days. The contracted institution shall consult with relevant state
136 agencies and community organizations and may hold public hearings.

137 The contracted institution shall conduct all public hearings and opportunities for public
138 comment in accordance with health equity principles. The contracted institution shall implement
139 additional measures to improve public participation by populations that have experienced
140 marginalization or oppression. Such measures shall include, as appropriate:

141 (i) making public notices and other key documents available in English and any other
142 language spoken by a significant number of individuals who are limited-English proficient;

143 (ii) providing translation services at public meetings;

144 (iii) requiring public meetings be held in accessible locations that are near public
145 transportation; and

146 (iv) providing appropriate information about the assessment procedure for the bill.

147 The contracted institution shall file the health equity assessment with the clerks of the
148 house of representatives and the senate and the requesting party or committee having jurisdiction
149 within 30 days of the request or referral. The speaker of the house of representatives or the
150 president of the senate may extend the deadline for filing a health impact assessment on a major
151 and complicated bill for a period of not more than 30 days.

152 (g) Joint committees of the general court and the house and senate committees on ways
153 and means when reporting on bills referred to them shall include any health equity assessment
154 that has been produced. If the contracted institution fails to file the health equity assessment
155 within 30 days, or within 60 days if an extension applies, said committees may report on bills
156 referred to them without including a health equity assessment.

157 (h) Every 2 years on or before the final day of each legislative session, the contracted
158 institution shall issue a report that provides an overview of the health equity assessments
159 prepared during the session. The contracted institution shall file the report with the clerks of the
160 house of representatives and the senate and the chairs of the house and senate committees on
161 ways and means.

162 (i) The contracted institution shall testify at hearings when requested by a committee of
163 the general court. The contracted institution may provide training to the general court on health
164 equity, health disparities, and the social determinants of health.

165 SECTION 2. The first sentence of section 17 of chapter 6 of the General Laws is hereby
166 amended by inserting after the words “office of the child advocate,” the following words:- , the
167 health equity at all levels in government initiative.

168 SECTION 3. Chapter 6 of the General Laws is hereby amended by adding after section
169 219 the following section:-

170 Section 220. (a) As used in this section the following words shall, unless the context
171 clearly requires otherwise, have the following meanings:-

172 “Contracted institution”, the academic institution selected by the department of public
173 health.

174 “Determinants of equity”, social, economic, geographic, political, and physical
175 environmental conditions that lead to the creation of a fair and just society.

176 “Health disparities”, differences in health status among distinct segments of the
177 population, including differences that occur by gender, age, race or ethnicity, sexual orientation,

178 gender identity, education or income, disability or functional impairment, or geographic location,
179 or the combination of any of these factors.

180 “Health equity”, efforts to ensure that everyone has a fair and just opportunity to be as
181 healthy as possible. This requires removing obstacles to health such as poverty, discrimination,
182 and their consequences, including powerlessness and lack of access to good jobs with fair pay,
183 quality education and housing, safe environments, and health care. For the purposes of
184 measurement, health equity means reducing and ultimately eliminating disparities in health and
185 its determinants that adversely affect excluded or marginalized groups.

186 “Health equity principles”, principles that facilitate the realization of health equity for all
187 people in the commonwealth, including, but not limited to:

188 (i) the incorporation of health equity considerations into decision-making in all sectors,
189 levels, and policies;

190 (ii) the meaningful involvement of all people with respect to the development,
191 implementation and enforcement of laws, regulations and policies that affect health equity; and

192 (iii) the equitable distribution of resources, benefits and burdens, with special attention to
193 equity across geographic regions of the commonwealth and impacts on populations that have
194 experienced marginalization or oppression.

195 “Health inequities”, disparities in health, or the factors that shape health, that are systemic
196 and avoidable and, therefore, considered unjust or unfair.

197 “Initiative”, the health equity at all levels in government initiative.

198 “Populations that have experienced marginalization or oppression”, communities that
199 include, but are not limited to, women; Black, Indigenous, and People of Color; minority ethnic
200 groups; low-income individuals and families; individuals who are incarcerated and those who
201 have been incarcerated; individuals experiencing homelessness; individuals with disabilities;
202 individuals with mental health conditions; children, youth and young adults; seniors; immigrants
203 and refugees; individuals who are limited-English proficient; lesbian, gay, bisexual,
204 transgender/gender non-conforming, queer, intersex, and agender/asexual/ally communities; and
205 environmental justice populations, as defined in section 62 of chapter 30, or combinations of
206 these populations.

207 “Social determinants of health”, the conditions in the environments where people are
208 born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and
209 quality-of-life outcomes and risks, including, but not limited to, economic stability, education
210 access and quality, health care access and quality, neighborhood and built environment, and
211 social and community context.

212 “State agencies”, the executive offices of administration and finance, education, energy
213 and environmental affairs, health and human services, housing and economic development, labor
214 and workforce development, public safety and security, technology services and security, the
215 department of transportation and other departments, commissions, offices, boards, divisions,
216 institutions or other agencies of the executive department that the governor may from time to
217 time designate.

218 (b) The commonwealth recognizes racism as a public health crisis. Health is an outcome
219 of a wide range of factors, many of which lie outside the activities of the health sector and

220 require a shared responsibility and an integrated and sustained policy response across
221 government.

222 (c) There shall be a health equity at all levels in government initiative. The governor shall
223 appoint the director of the initiative. The initiative may utilize data, staff and expertise from the
224 department of public health. Nothing in this section shall be construed to limit or interfere with
225 the office of health equity's duties under section 16AA of chapter 6.

226 In all of its work, the initiative shall act in accordance with health equity principles and
227 shall seek to address racism as a public health crisis.

228 The initiative shall:

229 (1) in consultation with the interagency task force and oversight board, establish a
230 comprehensive, cross-sectoral strategic plan to eliminate health disparities and inequities,
231 provided, that:

232 (i) the initiative shall publish the plan on its website;

233 (ii) the initiative shall accept public comment on the plan for no less than 30 days and
234 shall hold not less than 2 public hearings;

235 (iii) the initiative shall update the strategic plan not less than every 2 years;

236 (iv) the plan shall address the following key factors as they relate to health disparities and
237 inequities:

238 (A) income security, including, but not limited to, adequate wages, relevant tax policies,
239 and paid leave;

240 (B) food security and nutrition, including, but not limited to, food assistance program
241 eligibility and enrollment, assessments of food access and rates of access to unhealthy food and
242 beverages;

243 (C) child development, education, and literacy rates, including, but not limited to,
244 opportunities for early childhood development and parenting support, rates of graduation
245 compared to dropout rates, college attainment and adult literacy;

246 (D) housing, including, but not limited to, access to affordable, safe and healthy housing;
247 housing near parks and with access to healthy foods; and housing that incorporates universal
248 design and visitability features;

249 (E) environmental quality, including, but not limited to, exposure to toxins in the air,
250 water and soil;

251 (F) accessible built environments that promote health and safety, including, but not
252 limited to, mixed-used land; active transportation such as improved pedestrian, bicycle and
253 automobile safety; parks and green space; and healthy school siting;

254 (G) health care, including, but not limited to, accessible chronic disease management
255 programs, access to affordable, high-quality health and behavioral health care, assessment of the
256 healthcare workforce, and workforce diversity;

257 (H) prevention efforts, including, but not limited to, community-based education and
258 availability of preventive services;

259 (I) assessing ongoing discrimination and minority stressors against individuals and
260 groups in populations that have experienced marginalization or oppression based upon race,

261 gender, gender identity, gender expression, ethnicity, marital status, language, sexual orientation,
262 disability, and other factors, including, but not limited to, discrimination that is based upon bias
263 and negative attitudes of health professionals and providers;

264 (J) neighborhood safety and collective efficacy, including, but not limited to, rates of
265 violence, increases or decreases in community cohesion, and collaborative efforts to improve the
266 health and well-being of the community;

267 (K) culturally appropriate and competent services and training in all sectors, including,
268 but not limited to, training to eliminate bias, discrimination and mistreatment of persons in
269 populations that have experienced marginalization or oppression;

270 (L) linguistically appropriate and competent services and training in all sectors,
271 including, but not limited to, the availability of information in alternative formats such as large
272 font, braille and American Sign Language; and

273 (M) accessible, affordable and appropriate mental health services.

274 (2) in partnership with the interagency task force, develop shared health equity metrics
275 for use by all state agencies;

276 (3) collect and analyze data from state agencies and other sources, and publish analyses
277 on its website;

278 (4) publish evidence-based, evidence-informed, and community-based information on
279 health equity, health inequities, health disparities, social determinants of health, determinants of
280 equity and the effect on populations that have experienced marginalization or oppression on its
281 website;

282 (5) provide technical assistance to local boards of health and other local agencies that
283 address the social determinants of health;

284 (6) provide training and technical assistance to state agency officials and staff;

285 (7) assist state agencies with self-audits and informal review of policies, projects, rules
286 and regulations;

287 (8) upon request from a state agency, provide health equity assessments of policies,
288 projects, rules and regulations, provided, that health equity assessments be conducted in
289 accordance with health equity principles and shall include, at a minimum and to the extent that
290 information is available, an analysis of whether the proposed policy is likely to promote or
291 undermine health equity in the commonwealth and may consider:

292 (i) direct impacts on health disparities, health inequities, the social determinants of health,
293 and the determinants of equity, with special attention to impacts on populations that have
294 experienced marginalization or oppression;

295 (ii) the quality and relevance of studies to evaluate said impacts;

296 (iii) the availability of measures that would minimize any anticipated adverse health
297 equity consequences;

298 (iv) the existence of adverse short-term and long-term health equity consequences that
299 cannot be avoided should the proposed policy be enacted;

300 (v) the availability of reasonable alternatives to the proposed policy; and

301 (vi) the impact of the proposed policy on factors that include, but are not limited to, the
302 factors in subclause (iv) of clause (1).

303 (9) upon request from a state agency, advise on development of health equity strategic
304 plans or emergency plans;

305 (10) consult with and provide information to the interagency task force, oversight board,
306 and department of public health when appropriate;

307 (11) issue reports and hold public hearings on the state of health equity in the
308 commonwealth and on special health equity needs; and

309 (12) testify at hearings when requested by a committee of the general court.

310 The initiative shall conduct all public hearings and opportunities for public comment in
311 accordance with health equity principles. The initiative shall implement additional measures to
312 improve public participation by populations that have experienced marginalization or oppression.

313 Such measures shall include, as appropriate:

314 (i) making public notices and other key documents available in English and any other
315 language spoken by a significant number of individuals who are limited-English proficient;

316 (ii) providing translation services at public meetings;

317 (iii) requiring public meetings be held in accessible locations that are near public
318 transportation; and

319 (iv) providing appropriate information about the assessment procedure for the bill.

320 (d) The initiative shall convene an interagency task force to facilitate collaboration
321 between the state agencies. The task force shall consist of the governor; the secretary of each of
322 the state agencies or a designee, provided, that the secretary shall attend at least one meeting of
323 the task force each year; the director of the initiative; the commissioner of public health; and
324 additional members designated by the governor. The director of the initiative and the
325 commissioner of public health shall serve as co-chairs of the task force. The task force shall meet
326 not less than quarterly and at other times at the discretion of the chairs.

327 The task force shall: (i) identify barriers to and opportunities for coordination across
328 sectors and between state agencies; (ii) consider best practices used by other jurisdictions and
329 state agencies; (iii) in partnership with the initiative, develop shared health equity metrics for use
330 by all state agencies; and (iv) facilitate data sharing between state agencies and the initiative.

331 (e) The initiative shall convene an oversight board to provide accountability and
332 community perspectives. The initiative shall regularly consult with and provide information as
333 requested by the oversight board.

334 The oversight board shall consist of the director of the initiative; the commissioner of
335 public health or designee; the executive director of the health policy commission or designee; the
336 house chair and the senate chair of the committee on racial equity, civil rights and inclusion or
337 their designees; and 27 additional members, 1 of whom shall represent the Massachusetts Public
338 Health Association; 1 of whom shall represent Health Care for All; 1 of whom shall represent the
339 Western Massachusetts Health Equity Network; 1 of whom shall represent the Springfield Faith-
340 Based Health Alliance; 1 of whom shall represent the Boston branch of the National Association
341 for the Advancement of Colored People New England Area Conference; 1 of whom shall

342 represent the Men of Color Health Awareness project; 1 of whom shall represent the
343 Massachusetts Senior Action Council; 1 of whom shall represent City Life/Vida Urbana; 1 of
344 whom shall represent the Massachusetts Communities Action Network; 1 of whom shall
345 represent the Disability Policy Consortium Inc.; 1 of whom shall represent public sector service
346 industry unions, chosen by the director of the initiative; 1 of whom shall represent the Boston
347 Public Health Commission; 1 of whom shall represent the Massachusetts League of Community
348 Health Centers, Inc.; 1 of whom shall represent the Springfield health department; 1 of whom
349 shall represent a health department in a rural community, chosen by the director of the initiative;
350 1 of whom shall represent Cape Cod and the southeastern region of the commonwealth, chosen
351 by the director of the initiative; 1 of whom shall represent the Boston Alliance of Gay, Lesbian,
352 Bisexual and Transgender Youth; 1 of whom shall represent the commission on Indian affairs; 1
353 of whom shall represent Lawyers for Civil Rights, Inc.; 1 of whom shall represent Neighbor to
354 Neighbor Massachusetts Education Fund; 1 of whom shall represent Rosie's Place; 1 of whom
355 shall represent Families for Justice as Healing, Inc.; 1 of whom shall represent the National
356 Alliance on Mental Illness of Massachusetts, Inc.; and 4 persons from populations that have
357 experienced marginalization or oppression, 1 of whom shall be appointed by the speaker of the
358 house of representatives, 1 of whom shall be appointed by the president of the senate, 1 of whom
359 shall be appointed by the chair of the Black and Latino Caucus and 1 of whom shall be appointed
360 by the chair of the Asian-American Caucus.

361 The board shall annually elect 1 of its members to serve as chair. The representatives of
362 nongovernmental organizations shall serve staggered terms of 3 years. Vacancies of unexpired
363 terms shall be filled within 60 days by the appropriate appointing authority. The oversight board
364 shall meet not less than quarterly and at other times at the discretion of the chair.

365 The board shall (i) advise the initiative and task force; (ii) recommend shared health
366 equity metrics for selection by the initiative and the task force; (iii) set goals and benchmarks for
367 the initiative; (iv) hold public listening and oversight sessions; (v) issue annual reports; and (vi)
368 issue special reports identifying topics related to health equity in the commonwealth.

369 The board shall conduct all public listening and oversight sessions in accordance with
370 health equity principles. The board shall implement additional measures to improve public
371 participation by populations that have experienced marginalization or oppression. Such measures
372 shall include, as appropriate:

373 (i) making public notices and other key documents available in English and any other
374 language spoken by a significant number of individuals who are limited-English proficient;

375 (ii) providing translation services at public meetings;

376 (iii) requiring public meetings be held in accessible locations that are near public
377 transportation; and

378 (iv) providing appropriate information about the assessment procedure for the bill.

379 (f) The initiative and the oversight board shall evaluate health equity strategic plans
380 submitted by the state agencies in accordance with health equity principles. The initiative shall
381 publish the health equity strategic plan of each state agency on its website. The initiative shall
382 accept public comment on each health equity strategic plan for no less than 30 days and may
383 hold public hearings. The initiative, in consultation with the oversight board, shall issue an
384 approval or disapproval of the health equity strategic plan no later than 30 days following the
385 completion of the public comment period.

386 Upon declaration of a public health emergency, the initiative or the governor may direct
387 state agencies to submit emergency health equity strategic plans to address an emergency health
388 equity need. The initiative or the governor may specify the form and substance of emergency
389 health equity strategic plans. The initiative shall publish the emergency health equity strategic
390 plan of each state agency on its website. The initiative shall accept public comment on each
391 emergency health equity strategic plan for no less than 7 days and may hold public hearings. The
392 initiative, in consultation with the oversight board, shall issue an approval or disapproval of the
393 emergency health equity strategic plan no later than 7 days following the completion of the
394 public comment period.

395 (g) The initiative may conduct audits of state agency policies, projects, rules and
396 regulations at its discretion.

397 SECTION 4. The first sentence of subsection (c) of section 16AA of chapter 6A of the
398 General Laws is hereby amended by inserting, after the word “office” the following words:- in
399 partnership with the health equity at all levels in government initiative.

400 SECTION 5. Chapter 30 of the General Laws is hereby amended by adding after section
401 65 the following section:-

402 Section 66. (a) As used in this section the following words shall, unless the context
403 clearly requires otherwise, have the following meanings:-

404 “Contracted institution”, the academic institution selected by the department of public
405 health.

406 “Determinants of equity”, social, economic, geographic, political, and physical
407 environmental conditions that lead to the creation of a fair and just society.

408 “Health disparities”, differences in health status among distinct segments of the
409 population, including differences that occur by gender, age, race or ethnicity, sexual orientation,
410 gender identity, education or income, disability or functional impairment, or geographic location,
411 or the combination of any of these factors.

412 “Health equity”, efforts to ensure that everyone has a fair and just opportunity to be as
413 healthy as possible. This requires removing obstacles to health such as poverty, discrimination,
414 and their consequences, including powerlessness and lack of access to good jobs with fair pay,
415 quality education and housing, safe environments, and health care. For the purposes of
416 measurement, health equity means reducing and ultimately eliminating disparities in health and
417 its determinants that adversely affect excluded or marginalized groups.

418 “Health equity principles”, principles that facilitate the realization of health equity for all
419 people in the commonwealth, including, but not limited to:

420 (i) the incorporation of health equity considerations into decision-making in all sectors,
421 levels, and policies;

422 (ii) the meaningful involvement of all people with respect to the development,
423 implementation and enforcement of laws, regulations and policies that affect health equity; and

424 (iii) the equitable distribution of resources, benefits and burdens, with special attention to
425 equity across geographic regions of the commonwealth and impacts on populations that have
426 experienced marginalization or oppression.

427 “Health inequities”, disparities in health, or the factors that shape health, that are systemic
428 and avoidable and, therefore, considered unjust or unfair.

429 “Initiative”, the health equity at all levels in government initiative.

430 “Populations that have experienced marginalization or oppression”, communities that
431 include, but are not limited to, women; Black, Indigenous, and People of Color; minority ethnic
432 groups; low-income individuals and families; individuals who are incarcerated and those who
433 have been incarcerated; individuals experiencing homelessness; individuals with disabilities;
434 individuals with mental health conditions; children, youth and young adults; seniors; immigrants
435 and refugees; individuals who are limited-English proficient; lesbian, gay, bisexual,
436 transgender/gender non-conforming, queer, intersex, and agender/asexual/ally communities; and
437 environmental justice populations, as defined in section 62 of chapter 30, or combinations of
438 these populations.

439 “Social determinants of health”, the conditions in the environments where people are
440 born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and
441 quality-of-life outcomes and risks, including, but not limited to, economic stability, education
442 access and quality, health care access and quality, neighborhood and built environment, and
443 social and community context.

444 “State agencies”, the executive offices of administration and finance, education, energy
445 and environmental affairs, health and human services, housing and economic development, labor
446 and workforce development, public safety and security, technology services and security, the
447 department of transportation and other departments, commissions, offices, boards, divisions,

448 institutions or other agencies of the executive department that the governor may from time to
449 time designate.

450 (b) State agencies shall prepare and implement health equity strategic plans every 2 years.
451 Health equity strategic plans shall be prepared and implemented in accordance with health equity
452 principles. Health equity strategic plans shall include, but not be limited to:

453 (1) a description of policy priorities, provided, that priorities shall reflect consideration of
454 regional health equity;

455 (2) a description of health equity goals to be accomplished by the state agency;

456 (3) a plan for evaluation of health equity goals, including, but not limited to, outcome
457 measures, sources of data and technical analysis;

458 (4) policies and procedures for conducting health equity assessments, including, but not
459 limited to:

460 (i) criteria for determining which policies, projects, rules and regulations shall be
461 reviewed;

462 (ii) factors that shall be considered in assessments, which may include, but not be limited
463 to:

464 (A) income security, including, but not limited to, adequate wages, relevant tax policies,
465 and paid leave;

466 (B) food security and nutrition, including, but not limited to, food assistance program
467 eligibility and enrollment, assessments of food access and rates of access to unhealthy food and
468 beverages;

469 (C) child development, education, and literacy rates, including, but not limited to,
470 opportunities for early childhood development and parenting support, rates of graduation
471 compared to dropout rates, college attainment and adult literacy;

472 (D) housing, including, but not limited to, access to affordable, safe and healthy housing;
473 housing near parks and with access to healthy foods; and housing that incorporates universal
474 design and visitability features;

475 (E) environmental quality, including, but not limited to, exposure to toxins in the air,
476 water and soil;

477 (F) accessible built environments that promote health and safety, including, but not
478 limited to, mixed-used land; active transportation such as improved pedestrian, bicycle and
479 automobile safety; parks and green space; and healthy school siting;

480 (G) health care, including, but not limited to, accessible chronic disease management
481 programs, access to affordable, high-quality health and behavioral health care, assessment of the
482 healthcare workforce, and workforce diversity;

483 (H) prevention efforts, including, but not limited to, community-based education and
484 availability of preventive services;

485 (I) assessing ongoing discrimination and minority stressors against individuals and
486 groups in populations that have experienced marginalization or oppression based upon race,

487 gender, gender identity, gender expression, ethnicity, marital status, language, sexual orientation,
488 disability, and other factors, including, but not limited to, discrimination that is based upon bias
489 and negative attitudes of health professionals and providers;

490 (J) neighborhood safety and collective efficacy, including, but not limited to, rates of
491 violence, increases or decreases in community cohesion, and collaborative efforts to improve the
492 health and well-being of the community;

493 (K) culturally appropriate and competent services and training in all sectors, including,
494 but not limited to, training to eliminate bias, discrimination and mistreatment of persons in
495 populations that have experienced marginalization or oppression;

496 (L) linguistically appropriate and competent services and training in all sectors,
497 including, but not limited to, the availability of information in alternative formats such as large
498 font, braille and American Sign Language; and

499 (M) accessible, affordable and appropriate mental health services.

500 (iii) procedures for public notice and comment or public hearings; provided, that state
501 agencies shall conduct all public hearings and opportunities for public comment in accordance
502 with health equity principles; and

503 (5) a review of progress and implementation of the agency's previous strategic plan, if
504 applicable.

505 State agencies shall submit health equity strategic plans to the initiative and the oversight
506 board for approval on or before December 31 of an odd-numbered year. If the initiative and

507 oversight board issue a disapproval of the health equity strategic plan, the state agency shall
508 submit a new plan within 30 days.

509 State agencies shall prepare and implement emergency health equity strategic plans when
510 directed by the governor or the initiative. Emergency health equity strategic plans shall include
511 such information as the governor or the initiative may specify. State agencies shall submit
512 emergency health equity strategic plans to the initiative and the oversight board for approval on
513 or before such dates as the governor or the initiative may specify. If the initiative and oversight
514 board issue a disapproval of the emergency health equity strategic plan, the state agency shall
515 submit a new emergency plan within 7 days.

516 SECTION 6. Subsection (d) of section 38D of chapter 3 of the general laws shall take
517 effect 3 years after the effective date of this act.

518 SECTION 7. Subsections (f) and (g) of section 220 of chapter 6 of the general laws shall
519 take effect 3 years after the effective date of this act.

520 SECTION 8. Subsection (b) of section 66 of chapter 30 of the general laws shall take
521 effect 3 years after the effective date of this act.