

1 H.210

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

9 Referred to Committee on

10 Date:

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

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

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

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

2 Sec. 1. FINDINGS.

3 The General Assembly finds that:

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

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

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

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

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

13 (D) significantly more likely to have depression;

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

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

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

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

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

14 (C) While there are not statistically significant differences in the rates
15 of preexisting conditions, such as diabetes, lung disease, and cardiovascular
16 disease, among White and non-White Vermonters, there are disparities in the
17 rates of pre-existing conditions among Vermonters testing positive for COVID-
18 19. The preexisting conditions rate among COVID-19 cases is 19.4 percent
19 for non-White Vermonters and 12.1 percent for White Vermonters. This
20 suggests that non-White Vermonters are at higher risk of exposure to COVID-
21 19 due to their type of employment and living arrangements. Thirty-six

1 ~~percent of non-White Vermonters had household contact with a confirmed case~~
2 ~~of COVID-19, as compared to only 20 percent of White Vermonters.~~

3 ~~(D) Adults with a disability are:~~

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

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

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

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

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

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

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

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

20 ~~(I) nearly twice as likely to have ever had cancer than adults without~~
21 ~~a disability,~~

1 ~~(D) statistically more likely to have had skin cancer than adults with~~
2 ~~no disability;~~

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

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

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

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

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

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

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

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

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

21 ~~(U) Adults who are LGBTQ are.~~

- 1 ~~(A) three times as likely to report seriously considering suicide~~
2 ~~compared to non-LGBTQ adults;~~
- 3 ~~(B) statistically more likely to delay care due to cost than non-~~
4 ~~LGBTQ adults;~~
- 5 ~~(C) statistically more likely to report poor mental health in the last~~
6 ~~month than non-LGBTQ adults;~~
- 7 ~~(D) statistically more likely to report a disability than non-LGBTQ~~
8 ~~adults;~~
- 9 ~~(E) statistically more likely to have asthma than non-LGBTQ adults;~~
- 10 ~~(F) significantly more likely to have depression than non-LGBTQ~~
11 ~~adults; and~~
- 12 ~~(G) significantly more likely to have been worried about having~~
13 ~~enough food in the past year when compared to non-LGBTQ adults.~~
- 14 ~~(7) According to Vermonters who experience health inequities, they:~~
- 15 ~~(A) face discrimination, prejudice, and racism that is often invisible~~
16 ~~to others;~~
- 17 ~~(B) do not trust and feel misunderstood by “the system”;~~
- 18 ~~(C) do not feel valued, included, or safe;~~
- 19 ~~(D) feel like services are not designed to support them;~~
- 20 ~~(E) feel a lack of agency over their health and their own lives, and~~

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

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

7 (A) Just 21 percent of Black Vermonters own their own homes
8 whereas 72 percent of White Vermonters own their own home. Nationally,
9 41 percent of Black Americans own their own home.

10 (B) The median household income of Black Vermonters is
11 \$41,533.00 while the median household income of White Vermonters is
12 \$58,244.00.

13 (C) In 2018, 23.8 percent of Black Vermonters were living in poverty
14 while 10.7 percent of White Vermonters lived in poverty. In addition,
15 57 percent of Black Vermonters earned less than 80 percent of Vermont's
16 median income while 43 percent of White Vermonters earned less than
17 80 percent of Vermont's median income.

18 (D) About one in two non-White Vermonters experience "housing
19 problems," which is defined as homes that lack complete kitchen facilities or
20 plumbing, overcrowded homes, or households paying more than 50 percent of

1 income towards rent, mortgage payments, and utilities. One in three

2 Vermonters experience “housing problems.”

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

7 Sec. 2. LEGISLATIVE INTENT AND PURPOSE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 CHAPTER 6. HEALTH EQUITY

13 § 251. DEFINITIONS

14 As used in this chapter:

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

20 (A) awareness and acknowledgement of the health care
21 professional’s own culture,

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

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

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

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

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

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

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

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

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

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

18 § 252. OFFICE OF HEALTH EQUITY

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

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

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

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

11 (B) publishing data reports documenting health disparities;

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

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

18 (E) conducting State-level strategic planning to eliminate health
19 inequities.

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

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

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

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

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

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

1 ~~health care access, utilization, treatment decisions, quality, and outcomes~~

2 among individuals who are Black, Indigenous, and Persons of Color;

3 individuals who are LGBTQ; and individuals with disabilities; and

4 (L) developing curricula and the provision of continuing education

5 courses to teach cultural competency in the practice of medicine.

6 (2) The Office may:

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

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

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

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

20 (c)(1) The Office shall be administered by a Director of Health Equity,
21 who shall be appointed by the Commissioner of Health and serve at the

1 pleasure of the Commissioner until the appointment of the Director's
2 successor.

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

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

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

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

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

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

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

1 ~~(C) a strong understanding of health inequities and disparities in~~
2 ~~Vermont.~~

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

10 ~~(e) The Office is authorized to seek the assistance and avail itself of the~~
11 ~~services of employees of any State agency, department, board, bureau, or~~
12 ~~commission as it may require and as may be available to it for its purposes.~~

13 ~~All State agencies, departments, boards, bureaus, or commissions are~~
14 ~~authorized and directed to cooperate with the Office of Health Equity, to the~~
15 ~~extent consistent with law.~~

16 § 253. HEALTH EQUITY ADVISORY COMMISSION

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

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

- 1 ~~(A) the Director of Health Equity established pursuant to section 252~~
2 ~~of this title;~~
- 3 ~~(B) the Commissioner of Health or designee;~~
- 4 ~~(C) the Commissioner of Mental Health or designee;~~
- 5 ~~(D) the Commissioner of Disabilities, Aging, and Independent~~
6 ~~Living or designee;~~
- 7 ~~(E) the Commissioner of Vermont Health Access or designee;~~
- 8 ~~(F) the Commissioner for Children and Families or designee;~~
- 9 ~~(G) the Commissioner of Housing and Community Development or~~
10 ~~designee;~~
- 11 ~~(H) the Commissioner of Economic Development or designee;~~
- 12 ~~(I) the Chief Performance Officer or designee;~~
- 13 ~~(J) a member, appointed by the Racial Justice Alliance;~~
- 14 ~~(K) a member, appointed by the Rutland Area NAACP;~~
- 15 ~~(L) a member, appointed by the Association of Africans Living in~~
16 ~~Vermont;~~
- 17 ~~(M) a member, appointed by the Windham County Vermont NAACP;~~
- 18 ~~(N) a member, appointed by the Pride Center of Vermont;~~
- 19 ~~(O) a member, appointed by Outright Vermont;~~
- 20 ~~(P) a member, appointed by Migrant Justice;~~
- 21 ~~(Q) a member, appointed by Out in the Open,~~

1 ~~(P) a member, appointed by Another Way Community Center;~~

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

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

4 Living;

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

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

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

8 Missiquoi;

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

10 (Y) a member, appointed by the Vermont Commission on Native

11 American Affairs;

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

13 (AA) a member, appointed by Vermont Federation of Families for

14 Children's Mental Health.

15 (2) The term of office of each appointed member shall be three years,

16 but of the members first appointed, three shall be appointed for a term of one

17 year, four shall be appointed for a term of two years, and 10 shall be appointed

18 for a term of three years. Members shall hold office for the term of their

19 appointments and until their successors have been appointed. All vacancies

20 shall be filled for the balance of the unexpired term in the same manner as the

21 original appointment. Members are eligible for reappointment.

1 ~~(a) Powers and duties. The Advisory Commission shall:~~

2 ~~(1) review and make recommendations to the Office of Health Equity~~

3 ~~on any rules or policies proposed by the Office;~~

4 ~~(2) conduct statewide hearings on issues of concern to the health~~

5 ~~interests of individuals who are Black, Indigenous, and Persons of Color;~~

6 ~~individuals who are LGBTQ; and individuals with disabilities;~~

7 ~~(3) review, monitor, and advise all State agencies regarding the impact~~

8 ~~of current and emerging State policies, procedures, practices, laws, and rules~~

9 ~~on the health of individuals who are Black, Indigenous, and Persons of Color;~~

10 ~~individuals who are LGBTQ; and individuals with disabilities;~~

11 ~~(4) identify and examine the limitations and problems associated with~~

12 ~~existing laws, rules, programs, and services related to the health status of~~

13 ~~individuals who are Black, Indigenous, and Persons of Color; individuals who~~

14 ~~are LGBTQ; and individuals with disabilities;~~

15 ~~(5) advise the Office of Health Equity on the awarding of grants and the~~

16 ~~development of programs and services required pursuant to this chapter;~~

17 ~~(6) advise the Office of Health Equity on the needs, priorities,~~

18 ~~programs, and policies relating to the health of individuals who are Black,~~

19 ~~Indigenous, and Persons of Color; individuals who are LGBTQ; and~~

20 ~~individuals with disabilities, and~~

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

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

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

9 (f) Meetings.

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

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

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

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

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

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

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

13 § 254. GRANTS IN PROMOTION OF HEALTH EQUITY

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

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

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

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

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

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

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

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

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

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

1 ~~(A) The purpose and objectives of the grant proposal and~~
2 ~~identification of the particular disparity that the project plans to address,~~
3 ~~including one or more of the following areas:~~
4 ~~(i) decreasing health disparities for Vermonters who are Black,~~
5 ~~Indigenous, and Persons of Color;~~
6 ~~(ii) decreasing health disparities for individuals who are LGBTQ;~~
7 ~~(iii) decreasing health disparities for individuals with disabilities;~~
8 ~~and~~
9 ~~(iv) improving social determinants of health, such as housing,~~
10 ~~employment, safety, freedom from discrimination, and food access, as outlined~~
11 ~~by the Centers for Disease Control and Prevention’s “Tools for Putting Social~~
12 ~~Determinants of Health into Action”;~~
13 ~~(B) identification and relevance of the target community;~~
14 ~~(C) methods for obtaining baseline health status data and assessment~~
15 ~~of community health needs;~~
16 ~~(D) mechanisms for mobilizing community resources and gaining~~
17 ~~local commitment;~~
18 ~~(E) mechanisms and strategies for evaluating the project’s objectives,~~
19 ~~procedures, and outcomes; and~~
20 ~~(F) a proposed work plan, including a timeline for implementing the~~
21 ~~project.~~

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

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

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

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

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

17 § 255. DATA RESPONSIVE TO HEALTH EQUITY INQUIRIES

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

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

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

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

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

16 § 1400. RENEWAL OF LICENSE; CONTINUING MEDICAL

17 EDUCATION

18 * * *

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

1 ~~effect for the renewal of licenses to practice medicine expiring after August~~
2 31, 2014. The Board shall require a minimum of ~~10~~ 12 hours of continuing
3 medical education by rule, of which two hours shall include cultural
4 competency in the practice of medicine. The training provided by the
5 continuing medical education shall be designed to ~~assure~~ ensure that the
6 licensee has updated his or her knowledge and skills in his or her own
7 specialties and also has kept abreast of advances in other fields for which
8 patient referrals may be appropriate. The Board shall require evidence of
9 current professional competency in recognizing the need for timely appropriate
10 consultations and referrals to ~~assure~~ ensure fully informed patient choice of
11 treatment options, including treatments such as those offered by hospice,
12 palliative care, and pain management services.

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

18 (A) awareness and acknowledgement of the health care
19 professional’s own culture;

20 (B) utilization of cultural information to establish therapeutic
21 relationships,

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

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

5 * * *

6 Sec. 5. EFFECTIVE DATE

7 ~~This act shall take effect on July 1, 2021.~~

Sec. 1. FINDINGS

The General Assembly finds that:

(1) The Department of Health's 2018 State Health Assessment indicates that Vermont residents experience barriers to the equal enjoyment of good health based on race and ethnicity, sexual orientation, gender identity, and disability status.

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

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

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

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

~~*(D) significantly more likely to have depression,*~~

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

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

~~(3) According to the Department of Mental Health’s analysis entitled “Race Data VPCH Admissions,” which reviewed patients admitted from May 1, 2019 to April 30, 2020, Non-White Vermonters are disproportionately represented in the highest level of involuntary hospitalization. At the Vermont Psychiatric Care Hospital, 15 percent of the patients are non-White.~~

~~(4)(A) Non-White Vermonters have also been disproportionately affected by COVID-19. According to a data brief published on the Department of Health’s website in December 2020, entitled “COVID-19 among Vermonters who are Black, Indigenous, and People of Color (BIPOC),” nearly one in every five COVID-19 cases in Vermont are among Black, Indigenous, and Persons of Color even though these Vermonters make up approximately six percent of Vermont’s population. According to that same data brief, the incidence rate for non-White Vermonters is 74.2 versus 26.2 for White Vermonters. The incidence rate for Black Vermonters is 225.7; the incidence rate for Asian Vermonters is 61; the incidence rate for Hispanic Vermonters is 41.7; and the incidence rate for other races is 20.5. Non-White Vermonters are also at a higher risk for more serious outcomes, such as hospitalization.~~

~~(B) According to the Department of Health's December 2020 data brief, COVID-19 cases among non-White Vermonters tend to be younger than for White Vermonters. The average age of persons testing positive for COVID-19 is 33 among non-White Vermonters, whereas the average age is 46 among White Vermonters.~~

~~(C) While, according to the Department of Health's 2018 Behavior Risk Factor Surveillance System, there are not statistically significant differences in the rates of preexisting conditions, such as diabetes, lung disease, and cardiovascular disease, among White and non-White Vermonters, the Vermont Department of Health's December 2020 data brief indicates that there are disparities in the rates of preexisting conditions among Vermonters testing positive for COVID-19. As stated in that data brief, the preexisting conditions rate among COVID-19 cases is 19.4 percent for non-White Vermonters and 12.1 percent for White Vermonters. According to the same December 2020 data brief, this suggests that non-White Vermonters are at higher risk of exposure to COVID-19 due to their type of employment and living arrangements. Thirty-six percent of non-White Vermonters had household contact with a confirmed case of COVID-19, as compared to only 20 percent of White Vermonters as stated in the Department of Health's December 2020 data brief.~~

~~(5) According to the 2018 Vermont Behavioral Risk Factor Surveillance System Report, adults with a disability are:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) According to the 2018 Vermont Behavior Risk Factor Surveillance System Report, adults who are LGBTQ are:

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

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

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

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

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

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

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

(7) LGBTQ youths, according to Vermont's 2019 Youth Risk Behavior Survey, are:

(A) four times more likely to purposefully hurt themselves in the preceding 12 months and four times more likely to make a suicide plan in the preceding 12 months than cisgender, heterosexual peers,

~~(B) five times more likely to have attempted suicide in the preceding 12 months than cisgender, heterosexual peers;~~

~~(C) over three times more likely to experience unwanted sexual contact as compared to cisgender, heterosexual peers;~~

~~(D) twice as likely to experience bullying during the preceding month and significantly more likely to skip school due to safety concerns at or on their way to or from school as compared to cisgender, heterosexual peers;~~

~~(E) nearly three times more likely to experience housing insecurity as compared to cisgender, heterosexual peers;~~

~~(F) twice as likely to face food insecurity as compared to cisgender, heterosexual peers; and~~

~~(G) twice as likely to report having a physical disability, long-term health problem, emotional problem, or learning disability as compared to cisgender, heterosexual peers.~~

~~(8) According to Preliminary Data from the 2018 State Health Assessment presented to the House Committee on Health Care by the Department of Health in January 2018, Vermonters who experience health inequities report that they:~~

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

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

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

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

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

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

~~(9) Vermont's 2018 State Health Assessment indicates that social determinants of health are underlying, contributing factors of the foregoing health inequities. That is, disparities in social determinants of health contribute to health inequities. Disparities in the social determinants of health exist in Vermont. For example:~~

~~(A) According to the Vermont Housing Finance Agency, just 21 percent of Black Vermonters own their own homes, whereas 72 percent of White Vermonters own their own home. Nationally, 41 percent of Black Americans own their own home.~~

~~(B) According to the Vermont Housing Finance Agency, the median household income of Black Vermonters is \$41,533.00, while the median household income of White Vermonters is \$58,244.00.~~

~~(C) According to the U.S. Census Bureau, in 2018, 23.8 percent of Black Vermonters were living in poverty, while 10.7 percent of White Vermonters lived in poverty. In addition, according to the Vermont Housing Finance Agency, 57 percent of Black Vermonters earned less than 80 percent of~~

~~Vermont's median income, while 43 percent of White Vermonters earned less than 80 percent of Vermont's median income.~~

~~(D) According to the Vermont Housing Finance Agency, about one in two non-White Vermonters experience "housing problems," which is defined by the U.S. Department of Housing and Urban Development as homes that lack complete kitchen facilities or plumbing; overcrowded homes; or households paying more than 30 percent of income towards rent, mortgage payments, and utilities. One in three Vermonters experience "housing problems."~~

~~(E) According to the Vermont Coalition to End Homelessness and Chittenden County Homeless Alliance's 2020 Point-in-Time Count, Black Vermonters are overrepresented among Vermonters experiencing homelessness. While Black Vermonters make up about one percent of Vermont's population, they make up six percent of Vermonters experiencing homelessness.~~

~~(10) Vermont's role in the eugenics movement, including the State's 1931 sterilization law, and its impacts on individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities is an example of past injustice in the health care system that continues to impact members of these communities in the present day.~~

~~Sec. 2. LEGISLATIVE INTENT AND PURPOSE~~

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

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

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

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

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

~~that directly and indirectly affect the health, health care, and wellness of individuals and communities.~~

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

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

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

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

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

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

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

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

~~CHAPTER 6. HEALTH EQUITY~~

~~§ 251. DEFINITIONS~~

~~As used in this chapter:~~

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

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

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

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

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

~~(2) “Health disparity” means differences that exist among specific population groups in the United States in attaining individuals’ full health~~

~~potential that can be measured by differences in incidence, prevalence, mortality, burden of disease, and other adverse health conditions.~~

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

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

~~(5) “LGBTQ” means Vermonters who identify as lesbian, gay, bisexual, transgender, queer, or questioning.~~

~~(6) “Non-White” means Black, Indigenous, and Persons of Color. It is not intended to reflect self-identity, but rather how people are categorized in the racial system on which discrimination has been historically based in the United States and how Vermont typically disaggregates data solely by White and non-White.~~

~~(7) “Race and ethnicity” mean the categories for classifying individuals that have been created by prevailing social perceptions, historical policies, and~~

~~practices. Race and ethnicity include how individuals perceive themselves and how individuals are perceived by others.~~

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

~~§ 252. HEALTH EQUITY ADVISORY COMMISSION~~

~~(a) Creation. There is created the Health Equity Advisory Commission 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. The Advisory Commission shall 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. The Advisory Commission shall also provide strategic guidance on the development~~

~~of an Office of Health Equity, including recommendations on the structure
responsibilities, and jurisdiction of such an office.~~

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

~~(A) the Executive Director of Racial Equity established pursuant to
3 V.S.A. § 5001 or designee, who shall serve as chair;~~

~~(B) the Commissioner of Health or designee;~~

~~(C) the Commissioner of Mental Health or designee;~~

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

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

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

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

~~(H) the Commissioner of Economic Development or designee;~~

~~(I) the Chief Performance Officer or designee;~~

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

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

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

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

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

~~(O) a member, appointed by Outright Vermont;~~

~~(P) a member, appointed by Migrant Justice;~~

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

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

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

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

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

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

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

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

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

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

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

~~(BB) any other members at large that the Advisory Commission deems necessary to appoint to carry out the functions of this section, including ensuring equitable representation and a balance between impacted~~

~~communities, and that health care provider perspectives are represented, based on a majority vote of the members.~~

~~(2) The term of office of each appointed member shall be three years, with the exception that members at large shall each have a term of one year. Of the members first appointed, who are not designated as at-large members, four shall be appointed for a term of one year, four shall be appointed for a term of two years, and 10 shall be appointed for a term of three years. Members shall hold office for the term of their appointments and until their successors have been appointed. All vacancies shall be filled for the balance of the unexpired term in the same manner as the original appointment. Members are eligible for reappointment.~~

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

~~(1) provide preliminary guidance on the development of an Office of Health Equity and make recommendations on the structure, responsibilities, and jurisdiction of such an office, including:~~

~~(A) whether the Office shall be independent, and if not, in which State agency or department it shall be situated;~~

~~(B) how the Office shall be staffed;~~

~~(C) the populations served and specific issues addressed by the Office.~~

~~(D) the duties of the Office, including how grant funds shall be managed and distributed; and~~

~~(E) the time frame and necessary steps to establish the Office,~~

~~(1) provide guidance on the development of the Office of Health Equity, which shall be established based on the Advisory Commission's recommendations as soon as fiscally practicable to do so, including guidance on:~~

~~(A) the structure, responsibilities, and jurisdiction of the Office;~~

~~(B) whether the Office shall be independent and, if not, in which State agency or department it shall be situated;~~

~~(C) how the Office shall be staffed;~~

~~(D) the populations served and specific issues addressed by the Office;~~

~~(E) the duties of the Office, including how grant funds shall be managed and distributed; and~~

~~(F) the time frame and necessary steps to establish the Office;~~

~~(2) provide advice and make recommendations to the Office of Health Equity once established, including input on:~~

~~(A) any rules or policies proposed by the Office;~~

~~(B) the awarding of grants and the development of programs and services,~~

~~(C) the needs, priorities, programs, and policies relating to the health of individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities; and~~

~~(D) any other issue on which the Office of Health Equity requests assistance from the Advisory Commission;~~

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

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

~~(5) advise the Department of Health on any funding decisions relating to eliminating health disparities and promoting health equity, including the distribution of federal monies related to COVID-19;~~

~~(6) to the extent funds are available for the purpose, distribute grants that stimulate the development of community-based and neighborhood-based projects that will improve the health outcomes of individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities, and~~

~~(57) advise the General Assembly on efforts to improve cultural competency and antiracism in the health care system through training and continuing education requirements for health care providers and other clinical professionals.~~

~~(d) Assistance. The Advisory Commission shall have the administrative, legal, and technical assistance of the Agency of Administration at the request of the Executive Director of Racial Equity.~~

~~(e) Report. Annually, on or before January 15, the Advisory Commission shall submit a written report to the Senate Committee on Health and Welfare and to the House Committees on Health Care and on Human Services with its findings and any recommendations for legislative action. The Advisory Commission is encouraged to base recommendations on the data collected and analysis completed pursuant to section 253 of this title.~~

~~(f) Meetings.~~

~~(1) The Executive Director of Racial Equity or designee shall call the first meeting of the Advisory Commission to occur on or before September 1, 2021.~~

~~(2) The Advisory Commission shall meet at least bimonthly and when requested by either the Chair or by any eight appointed members.~~

~~(3) Nine public members of the Advisory Commission shall constitute a quorum for the transaction of business.~~

~~(2) The Advisory Commission shall select a chair and vice chair at its first meeting and annually thereafter.~~

~~(3) The Advisory Commission shall adopt procedures to govern its proceedings, including voting procedures and how the staggered terms shall be apportioned among members.~~

~~(4) All meetings of the Advisory Commission and any subcommittees of the Advisory Commission shall be open to the public with opportunities for public comment provided on a regular basis.~~

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

~~(h) Compensation and reimbursement. Appointed members of the Advisory Commission shall be entitled to per diem compensation and reimbursement of expenses as permitted under 32 V.S.A. § 1010 for meetings as deemed appropriate by the Advisory Commission within the appropriation provided. These payments shall be made from monies appropriated to the Agency of Administration.~~

§ 253. DATA RESPONSIVE TO HEALTH EQUITY INQUIRIES

~~(a) Each State agency, department, board, or commission that collects health-related, individual data shall include in its data collection health equity~~

~~data disaggregated by race, ethnicity, gender identity, age, primary language, socioeconomic status, disability, and sexual orientation. Data related to race and ethnicity shall use separate collection categories and tabulations, disaggregated beyond non-White and White, in accordance with the recommendation made by the Executive Director of Racial Equity, in consultation with the Advisory Commission.~~

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

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

~~Sec. 4-3 V.S.A. § 5003 is amended to read:~~

~~§ 5003. DUTIES OF EXECUTIVE DIRECTOR OF RACIAL EQUITY~~

~~(a) The Executive Director of Racial Equity (Director) shall work with the agencies and departments to implement a program of continuing coordination and improvement of activities in State government in order to combat systemic racial disparities and measure progress toward fair and impartial governance, including:~~

~~(1) overseeing a comprehensive organizational review to identify systemic racism in each of the three branches of State government and inventory systems in place that engender racial disparities;~~

~~(2) managing and overseeing the statewide collection of race-based data to determine the nature and scope of racial discrimination within all systems of State government; ~~and~~~~

~~(3) developing a model fairness and diversity policy and reviewing and making recommendations regarding the fairness and diversity policies held by all State government systems; and~~

~~(4) temporarily overseeing ~~and chairing~~ the establishment of the Health Equity Advisory Commission established pursuant to 18 V.S.A. § 252 until an Office of Health Equity is established.~~

~~Sec. 5. REPORT; CONTINUING EDUCATION~~

~~*On or before October 1, 2022, the Health Equity Advisory Commission established pursuant to 18 V.S.A. § 252, in consultation with licensing boards, professional organizations, and providers of all health care and clinical professions, shall 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 antiracism in Vermont's health care system through initial training, continuing education requirements, and investments.*~~

~~Sec. 6. APPROPRIATION~~

~~*(a) In fiscal year 2022, \$180,000.00 is appropriated to the Agency of Administration from the General Fund for use by the Executive Director of Racial Equity in carrying out the provisions of this act.*~~

~~*(b) It is the intent of the General Assembly that similar appropriations be made in future fiscal years until an Office of Healthy Equity is established.*~~

~~Sec. 6. REPORT; FISCAL YEAR 2023 BUDGET RECOMMENDATIONS~~

~~*As part of the annual report that shall be submitted by the Health Equity Advisory Commission pursuant to 18 V.S.A. § 252(e), the Advisory Commission shall include budget recommendations for continuation of its work in fiscal year 2023, if necessary.*~~

~~Sec. 7. EFFECTIVE DATE~~

~~This act shall take effect on July 1, 2021.~~

Sec. 1. FINDINGS

The General Assembly finds that:

(1) The Department of Health's 2018 State Health Assessment indicates that Vermont residents experience barriers to the equal enjoyment of good health based on race and ethnicity, sexual orientation, gender identity, and disability status.

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

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

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

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

(D) significantly more likely to have depression;

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

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

(3) According to the Department of Mental Health's analysis entitled "Race Data VPCH Admissions," which reviewed patients admitted from May 1, 2019 to April 30, 2020, Non-White Vermonters are disproportionately

represented in the highest level of involuntary hospitalization. At the Vermont Psychiatric Care Hospital, 15 percent of the patients are non-White.

(4)(A) Non-White Vermonters have also been disproportionately affected by COVID-19. According to a data brief published on the Department of Health's website in December 2020, entitled "COVID-19 among Vermonters who are Black, Indigenous, and People of Color (BIPOC)," nearly one in every five COVID-19 cases in Vermont are among Black, Indigenous, and Persons of Color even though these Vermonters make up approximately six percent of Vermont's population. According to that same data brief, the incidence rate for non-White Vermonters is 74.2 versus 26.2 for White Vermonters. The incidence rate for Black Vermonters is 225.7; the incidence rate for Asian Vermonters is 61; the incidence rate for Hispanic Vermonters is 41.7; and the incidence rate for other races is 20.5. Non-White Vermonters are also at a higher risk for more serious outcomes, such as hospitalization.

(B) According to the Department of Health's December 2020 data brief, COVID-19 cases among non-White Vermonters tend to be younger than for White Vermonters. The average age of persons testing positive for COVID-19 is 33 among non-White Vermonters, whereas the average age is 46 among White Vermonters.

(C) While, according to the Department of Health's 2018 Behavior Risk Factor Surveillance System, there are not statistically significant

differences in the rates of preexisting conditions, such as diabetes, lung disease, and cardiovascular disease, among White and non-White Vermonters, the Vermont Department of Health's December 2020 data brief indicates that there are disparities in the rates of preexisting conditions among Vermonters testing positive for COVID-19. As stated in that data brief, the preexisting conditions rate among COVID-19 cases is 19.4 percent for non-White Vermonters and 12.1 percent for White Vermonters. According to the same December 2020 data brief, this suggests that non-White Vermonters are at higher risk of exposure to COVID-19 due to their type of employment and living arrangements. Thirty-six percent of non-White Vermonters had household contact with a confirmed case of COVID-19, as compared to only 20 percent of White Vermonters as stated in the Department of Health's December 2020 data brief.

(5) According to the 2018 Vermont Behavioral Risk Factor Surveillance System Report, adults with a disability are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

disability;

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

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

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

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

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

(6) According to the 2018 Vermont Behavior Risk Factor Surveillance System Report, adults who are LGBTQ are:

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

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

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

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

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

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

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

(7) LGBTQ youths, according to Vermont's 2019 Youth Risk Behavior Survey, are:

(A) four times more likely to purposefully hurt themselves in the preceding 12 months and four times more likely to make a suicide plan in the preceding 12 months than cisgender, heterosexual peers;

(B) five times more likely to have attempted suicide in the preceding 12 months than cisgender, heterosexual peers;

(C) over three times more likely to experience unwanted sexual contact as compared to cisgender, heterosexual peers;

(D) twice as likely to experience bullying during the preceding month and significantly more likely to skip school due to safety concerns at or on their way to or from school as compared to cisgender, heterosexual peers;

(E) nearly three times more likely to experience housing insecurity as compared to cisgender, heterosexual peers;

(F) twice as likely to face food insecurity as compared to cisgender, heterosexual peers; and

(G) twice as likely to report having a physical disability, long-term health problem, emotional problem, or learning disability as compared to cisgender, heterosexual peers.

(8) According to Preliminary Data from the 2018 State Health Assessment presented to the House Committee on Health Care by the Department of Health in January 2018, Vermonters who experience health inequities report that they:

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

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

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

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

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

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

(9) Vermont’s 2018 State Health Assessment indicates that social determinants of health are underlying, contributing factors of the foregoing health inequities. That is, disparities in social determinants of health contribute to health inequities. Disparities in the social determinants of health exist in Vermont. For example:

(A) According to the Vermont Housing Finance Agency, just 21

percent of Black Vermonters own their own homes, whereas 72 percent of White Vermonters own their own home. Nationally, 41 percent of Black Americans own their own home.

(B) According to the Vermont Housing Finance Agency, the median household income of Black Vermonters is \$41,533.00, while the median household income of White Vermonters is \$58,244.00.

(C) According to the U.S. Census Bureau, in 2018, 23.8 percent of Black Vermonters were living in poverty, while 10.7 percent of White Vermonters lived in poverty. In addition, according to the Vermont Housing Finance Agency, 57 percent of Black Vermonters earned less than 80 percent of Vermont's median income, while 43 percent of White Vermonters earned less than 80 percent of Vermont's median income.

(D) According to the Vermont Housing Finance Agency, about one in two non-White Vermonters experience "housing problems," which is defined by the U.S. Department of Housing and Urban Development as homes that lack complete kitchen facilities or plumbing; overcrowded homes; or households paying more than 30 percent of income towards rent, mortgage payments, and utilities. One in three Vermonters experience "housing problems."

(E) According to the Vermont Coalition to End Homelessness and Chittenden County Homeless Alliance's 2020 Point-in-Time Count, Black

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

(10) According to the Indian Health Service, "[t]he American Indian and Alaska Native people have long experienced lower health status when compared with other Americans," including a life expectancy among American Indian and Alaska Native people born today that is 5.5 years less than the U.S. all races population.

(11) As outlined in 2021 J.R.H. 2, Vermont's "State-sanctioned eugenics policies targeted Vermonters of Native American Indian heritage, including French-Indian and Abenaki families, and persons of mixed ethnicity and of French-Canadian heritage, as well as the poor and persons with disabilities, among others." These policies, including the State's 1931 sterilization law, are examples of past injustices in the health care system that continue to impact members of these communities in present day.

Sec. 2. LEGISLATIVE INTENT AND PURPOSE

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

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

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

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

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

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

address factors that influence health.

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

(7) Definitions of racial categories and identities can be difficult to agree upon, as they often create hierarchies and comparisons that center whiteness, prioritize one group or identity over another, or fail to recognize historical inequities and oppression. Definitions also shift over time as broader cultural norms change. While potentially problematic, in order to align with data collection standards and create consistency, this bill does use the term “non-White” as defined in 18 V.S.A. § 251 and also seeks to create new definitions that better reflect racial and ethnic identities and categories pursuant to Sec. 6 of this act.

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

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

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

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

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

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

CHAPTER 6. HEALTH EQUITY

§ 251. DEFINITIONS

As used in this chapter:

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

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

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

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

(D) understanding and applying cultural and ethnic data to the

process of clinical care; and

(E) the ability to recognize the importance of communication, language fluency, and interpretation in the provision of health care services and assist with access to interpretation and appropriate communication services.

(2) “Cultural humility” means the ability to maintain an interpersonal stance that is other-oriented, or open to the other, in relation to aspects of cultural identity that are most important to the client or patient.

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

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

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

(6) “LGBTQ” means Vermonters who identify as lesbian, gay, bisexual, transgender, queer, or questioning.

(7) “Non-White” means Black, Indigenous, and Persons of Color. It is not intended to reflect self-identity, but rather how people are categorized in the racial system on which discrimination has been historically based in the United States and how Vermont typically disaggregates data solely by White and non-White.

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

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

§ 252. HEALTH EQUITY ADVISORY COMMISSION

(a) Creation. There is created the Health Equity Advisory Commission 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. The Advisory Commission shall 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. The Advisory Commission shall also provide strategic guidance on the development of the Office of Health Equity, including recommendations on the structure, responsibilities, and jurisdiction of such an office.

(b) Membership.

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

(A) the Executive Director of Racial Equity established pursuant to 3 V.S.A. § 5001 or designee;

(B) the Commissioner of Health or designee;

(C) the Commissioner of Mental Health or designee;

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

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

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

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

(H) the Commissioner of Economic Development or designee;

(I) the Chief Performance Officer or designee;

(J) the Chief Prevention Officer or designee;

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

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

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

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

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

(P) a member, appointed by Outright Vermont;

(Q) a member, appointed by Migrant Justice;

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

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

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

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

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

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

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

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

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

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

(BB) a member, appointed by the Vermont Developmental Disabilities Council;

(CC) a member, appointed by Vermont Federation of Families for Children's Mental Health; and

(DD) any other members at large that the Advisory Commission deems necessary to appoint to carry out the functions of this section, including ensuring equitable representation and a balance between impacted communities, and that health care provider perspectives are represented, based on a majority vote of the members.

(2) The term of office of each appointed member shall be three years, with the exception that members at large shall each have a term of one year. Of the members first appointed, who are not designated as at-large members, ten shall be appointed for a term of one year, ten shall be appointed for a term of two years, and nine shall be appointed for a term of three years. Members shall hold office for the term of their appointments and until their successors

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

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

(1) provide guidance on the development of the Office of Health Equity, which shall be established based on the Advisory Commission's recommendations not later than January 1, 2023, including on:

(A) the structure, responsibilities, and jurisdiction of the Office;

(B) whether the Office shall be independent and, if not, in which State agency or department it shall be situated;

(C) how the Office shall be staffed;

(D) the populations served and specific issues addressed by the Office;

(E) the duties of the Office, including how grant funds shall be managed and distributed; and

(F) the time frame and necessary steps to establish the Office;

(2) provide advice and make recommendations to the Office of Health Equity once established, including input on:

(A) any rules or policies proposed by the Office;

(B) the awarding of grants and the development of programs and services;

(C) the needs, priorities, programs, and policies relating to the health of individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and individuals with disabilities; and

(D) any other issue on which the Office of Health Equity requests assistance from the Advisory Commission;

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

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

(5) advise the Department of Health and General Assembly on any funding decisions relating to eliminating health disparities and promoting health equity, including the distribution of federal monies related to COVID-19;

(6) to the extent funds are available for the purpose, distribute grants that stimulate the development of community-based and neighborhood-based projects that will improve the health outcomes of individuals who are Black, Indigenous, and Persons of Color; individuals who are LGBTQ; and

individuals with disabilities; and

(7) advise the General Assembly on efforts to improve cultural competency, cultural humility, and antiracism in the health care system through training and continuing education requirements for health care providers and other clinical professionals.

(d) Assistance. The Advisory Commission shall have the administrative, legal, and technical assistance of the Agency of Administration at the request of the Executive Director of Racial Equity.

(e) Report. Annually, on or before January 15, the Advisory Commission shall submit a written report to the Senate Committee on Health and Welfare and to the House Committees on Health Care and on Human Services with its findings and any recommendations for legislative action. The Advisory Commission is encouraged to base recommendations on the data collected and analysis completed pursuant to section 253 of this title.

(f) Meetings.

(1) The Executive Director of Racial Equity or designee shall call the first meeting of the Advisory Commission to occur on or before September 1, 2021.

(2) The Advisory Commission shall select a chair and vice chair at its first meeting and annually thereafter.

(3) The Advisory Commission shall adopt procedures to govern its

proceedings, including voting procedures and how the staggered terms shall be apportioned among members.

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

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

(h) Compensation and reimbursement. Appointed members of the Advisory Commission shall be entitled to per diem compensation and reimbursement of expenses as permitted under 32 V.S.A. § 1010 for meetings as deemed appropriate by the Advisory Commission within the appropriation provided. These payments shall be made from monies appropriated to the Agency of Administration.

§ 253. DATA RESPONSIVE TO HEALTH EQUITY INQUIRIES

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

disaggregated beyond non-White and White, in accordance with the recommendation made by the Executive Director of Racial Equity, in consultation with the Advisory Commission.

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

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

Sec. 4. 3 V.S.A. § 5003 is amended to read:

§ 5003. DUTIES OF EXECUTIVE DIRECTOR OF RACIAL EQUITY

(a) The Executive Director of Racial Equity (Director) shall work with the agencies and departments to implement a program of continuing coordination

and improvement of activities in State government in order to combat systemic racial disparities and measure progress toward fair and impartial governance, including:

(1) overseeing a comprehensive organizational review to identify systemic racism in each of the three branches of State government and inventory systems in place that engender racial disparities;

(2) managing and overseeing the statewide collection of race-based data to determine the nature and scope of racial discrimination within all systems of State government; and

(3) developing a model fairness and diversity policy and reviewing and making recommendations regarding the fairness and diversity policies held by all State government systems; and

(4) temporarily overseeing the establishment of the Health Equity Advisory Commission established pursuant to 18 V.S.A. § 252 until the Office of Health Equity is established.

* * *

Sec. 5. REPORT; CONTINUING EDUCATION

On or before October 1, 2022, the Health Equity Advisory Commission established pursuant to 18 V.S.A. § 252, in consultation with licensing boards, professional organizations, and providers of all health care and clinical professions, shall 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's health care system through initial training, continuing education requirements, and investments.

*Sec. 6. REPORT; FISCAL YEAR 2023 BUDGET RECOMMENDATIONS;
INCLUSIVE DEFINITIONS; AMERICAN RESCUE PLAN ACT
FUNDING*

As part of the annual report that shall be submitted by the Health Equity Advisory Commission pursuant to 18 V.S.A. § 252(e), the Advisory Commission shall include:

(1) budget recommendations for continuation of its work in fiscal year 2023, if necessary, and for the funding of the Office of Health Equity;

(2) recommendations on:

(A) appropriate and inclusive terms to replace the term "non-White" in 18 V.S.A. chapter 6; and

(B) disaggregating data categories and tabulations beyond non-White and White in accordance with 18 V.S.A. § 253(a); and

(3) recommendations for most effectively utilizing funding received by the State pursuant to the American Rescue Plan Act of 2021, Pub. L. No. 117-2 in a manner that promotes health and achieves health equity by eliminating avoidable and unjust disparities in health on the basis of race, ethnicity,

disability, or LGBTQ status.

Sec. 7. EFFECTIVE DATE

This act shall take effect on July 1, 2021.