TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred House Bill No. 210 entitled "An act relating to addressing disparities and promoting equity in the health care system" respectfully reports that it has considered the same and recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

The General Assembly finds that:

(1) Research and experience demonstrate 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 Vermont 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) 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. Nearly one in every five COVID-19 cases in Vermont are among Black, Indigenous, and People of Color even though these Vermonters make up approximately six percent of Vermont's population. 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) 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 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, there are disparities in the

rates of pre-existing conditions among Vermonters testing positive for COVID-19. The preexisting conditions rate among COVID-19 cases is 19.4 percent for non-White Vermonters and 12.1 percent for White Vermonters. 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.

(5) 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 last 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 disabilities;

(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) 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 last 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 youth, 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 Vermonters who experience health inequities, 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) 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) 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) The median household income of Black Vermonters is $41,533.00 while the median household income of White Vermonters is $58,244.00.

(C) In 2018, 23.8 percent of Black Vermonters were living in poverty while 10.7 percent of White Vermonters lived in poverty. In addition,

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) About one in two non-White Vermonters experience "housing problems," which is defined 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) 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.

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, the physical structure of communities, 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. DEFINTIONS

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 People 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.

(8) "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; and

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

(2) The term of office of each appointed member shall be three years, but of the members first appointed, 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 is 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;

(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 Committee;

(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; and

(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; and

(5) 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 the 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.

(f) Meetings.

(1) The Executive Director of Racial Equity or designee shall call the first meeting of the Advisory Committee 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.

(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 not more than six meetings annually. 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 Committee.

(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 data 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 Health Equity Advisory Commission established pursuant to 18 V.S.A. § 252 until an Office of Health Equity is established.

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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. 7. EFFECTIVE DATE

This act shall take effect on July 1, 2021.

(Committee vote: _____)

_____

Representative _____

FOR THE COMMITTEE