

1 TO THE HONORABLE SENATE:

2 The Committee on Health and Welfare to which was referred House Bill  
3 No. 210 entitled “An act relating to addressing disparities and promoting  
4 equity in the health care system” respectfully reports that it has considered the  
5 same and recommends that the Senate propose to the House that the bill be  
6 amended by striking out all after the enacting clause and inserting in lieu  
7 thereof the following:

8 Sec. 1. FINDINGS

9 The General Assembly finds that:

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

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

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

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

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

20 (D) significantly more likely to have depression;

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

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

5           (3) According to the Department of Mental Health’s analysis entitled  
6           “Race Data VPCH Admissions,” which reviewed patients admitted from May  
7           1, 2019 to April 30, 2020, Non-White Vermonters are disproportionately  
8           represented in the highest level of involuntary hospitalization. At the Vermont  
9           Psychiatric Care Hospital, 15 percent of the patients are non-White.

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

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

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

- 1           (5) According to the 2018 Vermont Behavioral Risk Factor Surveillance  
2           System Report, adults with a disability are:
- 3                   (A) five times as likely to consider suicide than adults with no  
4           disability;
- 5                   (B) eight times more likely to report fair or poor health than adults  
6           with no disability;
- 7                   (C) statistically more likely to delay care due to cost than adults with  
8           no disability;
- 9                   (D) seven times more likely to report poor physical health than adults  
10           with no disability;
- 11                  (E) statistically more likely to report poor mental health in the past  
12           month than adults with no disability;
- 13                  (F) more than twice as likely to report rarely or never getting the  
14           necessary emotional support as compared to White adults with no disability;
- 15                  (G) statistically more likely to report having arthritis than adults with  
16           no disability;
- 17                  (H) statistically more likely to have asthma than adults with no  
18           disability;
- 19                  (I) nearly twice as likely to have ever had cancer than adults without  
20           a disability;

1           (J) 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 those  
12          with no disability;

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

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.

1           (6) According to the 2018 Vermont Behavior Risk Factor Surveillance

2           System Report, adults who are LGBTQ are:

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

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

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

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

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

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

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

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

18                   (A) four times more likely to purposefully hurt themselves in the  
19          preceding 12 months and four times more likely to make a suicide plan in the

20          preceding 12 months than cisgender, heterosexual peers;

1           (B) five times more likely to have attempted suicide in the preceding  
2           12 months than cisgender, heterosexual peers;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



1 of Vermont’s median income, while 43 percent of White Vermonters earned  
2 less than 80 percent of Vermont’s median income.

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

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

16 (10) Vermont’s role in the eugenics movement, including the State’s  
17 1931 sterilization law, and its impacts on individuals who are Black,  
18 Indigenous, and Persons of Color; individuals who are LGBTQ; and  
19 individuals with disabilities is an example of past injustice in the health care  
20 system that continues to impact members of these communities in the present  
21 day.

1       Sec. 2. LEGISLATIVE INTENT AND PURPOSE

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

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

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

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

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

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

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

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

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

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” means acquiring both humility and 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;

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

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

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

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

20           (4) “Health equity data” means demographic data, including, but not  
21 limited to, race, ethnicity, primary language, age, gender, socioeconomic

1 position, sexual orientation, disability, homelessness, or geographic data that  
2 can be used to track health equity.

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

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

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

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

1 conditions that are associated with lower capacity to fully participate in  
2 society.

3 § 252. HEALTH EQUITY ADVISORY COMMISSION

4 (a) Creation. There is created the Health Equity Advisory Commission to  
5 promote health equity and eradicate health disparities among Vermonters,  
6 including particularly those who are Black, Indigenous, and Persons of Color;  
7 individuals who are LGBTQ; and individuals with disabilities. The Advisory  
8 Commission shall amplify the voices of impacted communities regarding  
9 decisions made by the State that impact health equity, whether in the provision  
10 of health care services or as the result of social determinants of health. The  
11 Advisory Commission shall also provide strategic guidance on the  
12 development of the Office of Health Equity, including recommendations on the  
13 structure, responsibilities, and jurisdiction of such an office.

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

16 (A) the Executive Director of Racial Equity established pursuant to  
17 3 V.S.A. § 5001 or designee;

18 (B) the Commissioner of Health or designee;

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

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

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

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

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

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

6           (I) the Chief Performance Officer or designee;

7           (J) the Chief Prevention Officer or designee;

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

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

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

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

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

14          (P) a member, appointed by Outright Vermont;

15          (Q) a member, appointed by Migrant Justice;

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

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

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

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

20 Living;

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



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

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

3           Missiquoi;

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

5           (Z) a member, appointed by the Vermont Commission on Native

6           American Affairs;

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

8           (BB) a member, appointed by Vermont Federation of Families for

9           Children’s Mental Health; and

10           (CC) any other members at large that the Advisory Commission

11           deems necessary to appoint to carry out the functions of this section, including

12           ensuring equitable representation and a balance between impacted

13           communities, and that health care provider perspectives are represented, based

14           on a majority vote of the members.

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

16           with the exception that members at large shall each have a term of one year.

17           Of the members first appointed, who are not designated as at-large members,

18           four shall be appointed for a term of one year, four shall be appointed for a

19           term of two years, and 10 shall be appointed for a term of three years.

20           Members shall hold office for the term of their appointments and until their

21           successors have been appointed. All vacancies shall be filled for the balance

1 of the unexpired term in the same manner as the original appointment.

2 Members are eligible for reappointment.

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

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

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

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

10 (C) how the Office shall be staffed;

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

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

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

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

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

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

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

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

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

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

14          (5) advise the Department of Health and General Assembly on any  
15          funding decisions relating to eliminating health disparities and promoting  
16          health equity, including the distribution of federal monies related to COVID-  
17          19;

18          (6) to the extent funds are available for the purpose, distribute grants  
19          that stimulate the development of community-based and neighborhood-based  
20          projects that will improve the health outcomes of individuals who are Black,

1 Indigenous, and Persons of Color; individuals who are LGBTQ; and  
2 individuals with disabilities; and

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

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

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

16 (f) Meetings.

17 (1) The Executive Director of Racial Equity or designee shall call the  
18 first meeting of the Advisory Commission to occur on or before September 1,  
19 2021.

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

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

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

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

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

17           § 253. 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,  
2 disaggregated beyond non-White and White, in accordance with the  
3 recommendation made by the Executive Director of Racial Equity, in  
4 consultation with the Advisory Commission.

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

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

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

2 § 5003. DUTIES OF EXECUTIVE DIRECTOR OF RACIAL EQUITY

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

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

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

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

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

20 \* \* \*

1       Sec. 5. REPORT; CONTINUING EDUCATION

2           On or before October 1, 2022, the Health Equity Advisory Commission  
3       established pursuant to 18 V.S.A. § 252, in consultation with licensing boards,  
4       professional organizations, and providers of all health care and clinical  
5       professions, shall submit a written report to the House Committee on Health  
6       Care and to the Senate Committee on Health and Welfare with its  
7       recommendations for improving cultural competency and humility and  
8       antiracism in Vermont’s health care system through initial training, continuing  
9       education requirements, and investments.

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

11           **INCLUSIVE DEFINITIONS**

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

15           **(1)** budget recommendations for continuation of its work in fiscal year  
16       2023, if necessary;

17           **(2)** recommendations on appropriate and inclusive terms to replace the  
18       term “non-White” in 18 V.S.A. chapter 6; and

19           **(3)** recommendations for most effectively utilizing funding received by  
20       the State pursuant to the American Rescue Plan Act of 2021, Pub. L. No. 117-2  
21       in a manner that promotes health and achieves health equity by eliminating



1 avoidable and unjust disparities in health on the basis of race, ethnicity,  
2 disability, or LGBTQ status.

3 Sec. 7. EFFECTIVE DATE

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

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11 (Committee vote: \_\_\_\_\_)

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Senator \_\_\_\_\_

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FOR THE COMMITTEE