

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

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

8 Sec. 2. LEGISLATIVE INTENT AND PURPOSE

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

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

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

18 (3) Structural racism, defined as the laws, policies, institutional
19 practices, cultural representations, and other societal norms that often work
20 together to deny equal opportunity, has resulted in health disparities among
21 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, but
4 also social determinants of health, including the environment, the physical
5 structure of communities, nutrition and food options, educational attainment,
6 employment, race, ethnicity, sex, geography, language preferences, immigrant
7 or citizen status, sexual orientation, gender identity, and socioeconomic status,
8 that directly and indirectly affect the health, health care, and wellness of
9 individuals and communities.

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

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

20 (7) Definitions of racial categories and identities can be difficult to agree
21 upon, as they often create hierarchies and comparisons that center whiteness,

1 prioritize one group or identity over another, or fail to recognize historical
2 inequities and oppression. Definitions also shift over time as broader cultural
3 norms change. While potentially problematic, in order to align with data
4 collection standards and create consistency, this bill does use the term “non-
5 White” as defined in 18 V.S.A. § 251 and also seeks to create new definitions
6 that better reflect racial and ethnic identities and categories pursuant to Sec. 6
7 of this act.

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

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

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

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

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

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

19 CHAPTER 6. HEALTH EQUITY

20 § 251. DEFINITIONS

21 As used in this chapter:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15 § 252. HEALTH EQUITY ADVISORY COMMISSION

16 (a) Creation. There is created the Health Equity Advisory Commission to
17 promote health equity and eradicate health disparities among Vermonters,
18 including particularly those who are Black, Indigenous, and Persons of Color;
19 individuals who are LGBTQ; and individuals with disabilities. The Advisory
20 Commission shall amplify the voices of impacted communities regarding
21 decisions made by the State that impact health equity, whether in the provision

1 of health care services or as the result of social determinants of health. The
2 Advisory Commission shall also provide strategic guidance on the
3 development of the Office of Health Equity, including recommendations on the
4 structure, responsibilities, and jurisdiction of such an office.

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

7 (A) the Executive Director of Racial Equity established pursuant to
8 3 V.S.A. § 5001 or designee;

9 (B) the Commissioner of Health or designee;

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

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

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

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

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

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

18 (I) the Chief Performance Officer or designee;

19 (J) the Chief Prevention Officer or designee;

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

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

- 1 (M) a member, appointed by the Association of Africans Living in
2 Vermont;
- 3 (N) a member, appointed by the Windham County Vermont NAACP;
4 (O) a member, appointed by the Pride Center of Vermont;
5 (P) a member, appointed by Outright Vermont;
6 (Q) a member, appointed by Migrant Justice;
7 (R) a member, appointed by Out in the Open;
8 (S) a member, appointed by Another Way Community Center;
9 (T) a member, appointed by Vermont Psychiatric Survivors;
10 (U) a member, appointed by the Vermont Center for Independent
11 Living;
- 12 (V) a member, appointed by the Elnu Abenaki Tribe;
13 (W) a member, appointed by the Nulhegan Abenaki Tribe;
14 (X) a member, appointed by the Koasek Traditional Nation of
15 Missiquoi;
- 16 (Y) a member, appointed by the Abenaki Nation of Missiquoi;
17 (Z) a member, appointed by the Vermont Commission on Native
18 American Affairs;
- 19 (AA) a member, appointed by Green Mountain Self-Advocates;
20 (BB) a member, appointed by the Vermont Developmental
21 Disabilities Council;

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

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

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

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

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

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

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

3 (C) how the Office shall be staffed;

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

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

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

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

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

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

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

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

19 (3) review, monitor, and advise all State agencies regarding the impact
20 of current and emerging State policies, procedures, practices, laws, and rules

1 on the health of individuals who are Black, Indigenous, and Persons of Color;
2 individuals who are LGBTQ; and individuals with disabilities;

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

7 (5) advise the Department of Health and General Assembly on any
8 funding decisions relating to eliminating health disparities and promoting
9 health equity, including the distribution of federal monies related to COVID-
10 19;

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

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

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

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

10 (f) Meetings.

11 (1) The Executive Director of Racial Equity or designee shall call the
12 first meeting of the Advisory Commission to occur on or before September 1,
13 2021.

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

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

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

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

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

11 § 253. DATA RESPONSIVE TO HEALTH EQUITY INQUIRIES

12 (a) Each State agency, department, board, or commission that collects
13 health-related, individual data shall include in its data collection health equity
14 data disaggregated by race, ethnicity, gender identity, age, primary language,
15 socioeconomic status, disability, and sexual orientation. Data related to race
16 and ethnicity shall use separate collection categories and tabulations,
17 disaggregated beyond non-White and White, in accordance with the
18 recommendation made by the Executive Director of Racial Equity, in
19 consultation with the Advisory Commission.

20 (b)(1) The Department of Health shall systematically analyze such health
21 equity data using the smallest appropriate units of analysis feasible to detect

1 racial and ethnic disparities, as well as disparities along the lines of primary
2 language, sex, disability status, sexual orientation, gender identity, and
3 socioeconomic status, and report the results of such analysis on the
4 Department’s website periodically, but not less than biannually. The
5 Department’s analysis shall be used to measure over time the impact of actions
6 taken to reduce health disparities in Vermont. The data informing the
7 Department’s analysis shall be made available to the public in accordance with
8 State and federal law.

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

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

14 § 5003. DUTIES OF EXECUTIVE DIRECTOR OF RACIAL EQUITY

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

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

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

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

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

13 * * *

14 Sec. 5. REPORT; CONTINUING EDUCATION

15 On or before October 1, 2022, the Health Equity Advisory Commission
16 established pursuant to 18 V.S.A. § 252, in consultation with licensing boards,
17 professional organizations, and providers of all health care and clinical
18 professions, shall submit a written report to the House Committee on Health
19 Care and to the Senate Committee on Health and Welfare with its
20 recommendations for improving cultural competency and cultural humility and

1 antiracism in Vermont’s health care system through initial training, continuing
2 education requirements, and investments.

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

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

9 (1) budget recommendations for continuation of its work in fiscal year
10 2023, if necessary, and for the funding of the Office of Health Equity;

11 (2) recommendations on:

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

14 (B) disaggregating data categories and tabulations beyond non-White
15 and White in accordance with 18 V.S.A. § 233(a); and

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

1 Sec. 7. EFFECTIVE DATE

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

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9 (Committee vote: _____)

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Senator _____

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FOR THE COMMITTEE