Testimony for the House Finance
Subcommittee on Health and Human Services
From The Ohio Psychological Association
November 16, 2017

The Ohio Psychological Association is pleased to offer Proponent Testimony on SB 332. Our Association represents psychologists and graduate students around Ohio, many of whom treat young families, expectant mothers and women with postpartum depression as well as drug-addicted babies and their mothers in specialized hospital-based programs.

Psychologists know the emotional devastation that occurs when an infant dies. The Infant Mortality Commission and SB 332 wisely recommend additional screening for mothers both pre and post pregnancy. This step identifies mothers who need treatment for mental illness, which is known factor in poor maternal care that can contribute to infant mortality. Untreated postpartum depression, at its worse, can lead to psychosis. Caught early, it can be treated quickly and successfully. Having a regular health care provider contributes to adherence to appropriate prevention and treatment procedures. Providers need to be trained and ready to assist women in a culturally competent manner that leads to on-going trust and confidence in their providers. SB 332 would help with this concern.

Medicaid Managed Care Organizations and Ohio Department of Medicaid reported that during community meetings residents recommended a healthcare system that prepares culturally competent providers.

Research has shown that there is a disparity in Medicine for racial, ethnic, and sexual minorities. The World Health Organization found that African Americans are systematically undertreated for pain in relation to white Americans.[1] Research has also shown that these disparities can be linked to provider bias. Gonzalez, Kim, and Marantz found that a physician may vary treatment services for different patients.[2]

These discrepancies are thought to be the result of implicit bias, and can contribute to health gaps. Hoffman, Trawalter, and Oliver did a study on bias in medical students, and concluded that biases originate from false beliefs regarding race and medicine.[3] More specifically, results revealed that a number of white medical students and residents hold false beliefs about biological differences between African American and white Americans. For example, many students believe that African American skin is thicker, that their blood coagulates

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[1] Cleeland CS, Gonin R, Baez L, Loehrer P, Pandya KJ*(1997) Pain and treatment of pain in minority patients with cancer. The Eastern Cooperative Oncology Group Minority Outpatient Pain Study. Ann Intern Med 127(9):813–816*

[2] Gonzalez, C. M., Kim, M. Y., & Marantz, P. R. (2014). Implicit bias and its relation to health disparities: A teaching program and survey of medical students. *Teaching and learning in medicine*, *26*(1), 64-71.

[3] Hoffman, K. M., Trawalter, S., Axt, J. R., & Oliver, M. N. (2016). Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *Proceedings of the National Academy of Sciences*, 201516047.

more quickly, and that they are more likely to abuse medication. These false beliefs could affect how they assess and treat pain in black patients. In the Hoffman study, medical students were not able to properly assess the magnitude of pain in African American patients due to their false beliefs. Another study, done by Anderson, Greene, and Payne gave medical students and residents mock patients along with false and accurate beliefs regarding medical differences between African Americans and white Americans.[4] The medical students and residents were then instructed to come up with treatment recommendations. They found that half of the sample believed at least one false belief, and those who endorsed a false belief were more likely to report lower pain ratings for black patients. They were also less accurate in the treatment recommendations for black patients than white patients. However, white medical students and residents who did not endorse false beliefs did not show the same bias.

Early meta-analysis shows a positive relationship between cultural competency training and improved patient outcomes.[5] After considering these studies, it is a safe assumption that other health care professionals may also have biases that can impact their care treatment. OPA has worked hard to provide many continued education courses on diversity and multicultural competency. We support SB 332 and its recommendation for extensive training opportunities for providers.

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[4] Anderson KO, Green, Payne (2009) Racial and ethnic disparities in pain: Causes and consequences of unequal care. *J Pain,* 10(12), 1187–1204.

[5] Lie, D. A., Lee-Rey, E., Gomez, A., Bereknyei, S., & Braddock III, C. H. (2011). Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research. *Journal of general internal medicine*, *26*(3), 317-325.