STATE SENATOR
CHARLETA B. TAVARES
15TH DISTRICT

Sponsor Testimony
Presented by: Senator Charleta B. Tavares
Senate Bill 16
Health, Human Services, & Medicaid Committee
Senator Dave Burke, Chair
Tuesday March 7, 2017

Chairman Burke, Vice-Chair Beagle, and members of the Health and Human Services Committee; I appreciate you scheduling Senate Bill 16 and your interest in hearing testimony on this important issue. Senate Bill 16 requires healthcare professionals to complete cultural competency training in order to receive or renew their license, certification or registration by the appropriate state board. Healthcare professionals will have to submit evidence to the board which they report to demonstrating that they have completed training in cultural competence according to the standards set by their respective boards.

According to The U.S. Department of Health and Human Services Office of Minority Affairs, culture is defined as integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Competency in serving diverse cultures implies having the capacity to function effectively as an individual and an organization with regards to the cultural beliefs, behaviors and needs presented by consumers and their communities.

Cultural Competency has become recognized as an integral component of healthcare because of its relevance in treating patients and eliminating health disparities among racial, ethnic and

cultural communities. A significant aspect of communication between the provider and the patient includes conversations and the respect that is demonstrated for their culture, language and beliefs. It is critical that patients and healthcare providers are able to effectively communicate with one another in order for the best care to be provided. Research from the Health Policy Institute of Ohio indicates that African Americans and Hispanics are more likely than Caucasians to feel they have been treated disrespectfully during a health care visit - spoken to rudely, talked down to, or ignored. Compared to Caucasians, African Americans, Hispanics, and Asian Americans are more likely to report that their doctor did not listen to everything they said, they did not fully understand their doctor, or they had questions during the visit that they did not ask. This type of miscommunication can be fatal.

Examples of health disparities among racial and ethnic minority populations include following diseases:

Cancer

- African Americans have the highest mortality rates of any racial group for all sites/ types of cancer, with African Americans males having 33% higher cancer mortality rates compared to White males The cancer death rate for African Americans is 35 percent higher than the rate for whites.[1]
- Hispanics have higher rates of cervical, gallbladder, and stomach cancer than whites.[1]
- The prostate cancer mortality rate for African American males in Ohio was more than twice the rate among non-Hispanic White males.[1]

Cardiovascular Disease

[1] Ohio Statewide Health Disparities Collaborative "http://www.ohiohealthdisparitiescollaborative.org/wp-content/uploads/2014/01/Health-Disparities-African-American-men.pdf"

- According to the CDC Health Disparities and Inquities Report, Coronary Heart Disease was among African Americans more than any other racial or ethnic group. The rate of premature death was higher among blacks than their white counterparts.[2]

Diabetes/Kidneys

- Diabetes prevalence of African Americans males in Ohio was 6.6% compared to 3.7% among White males.[3]
- African Americans are 2.6 to 5.6 times more likely to suffer from kidney disease due to their diabetes.[3]
- African Americans are 2.7 times more likely to suffer from lower-limb amputations.[3]

This data only represents a few of the health complications that are more prevalent among diverse populations in our country and state. What also must be considered is that socioeconomic status, income and education impact cultural norms and behavior, what we refer to as the social determinates of health. Studies show that these factors are associated with the higher rate of heart disease in minority populations.

Healthcare providers need to be equipped with the skills to serve the state's diverse populations which are continuing to increase. In Ohio racial and ethnic minorities represent a little over 15% of the population.[4] African Americans account for 12.2 % and Asians 1.9 %.[4] The Hispanic population in Ohio grew 40.2% between 2000 and 2008, and now accounts for 3.4 % of the state's total population.[4] In addition, there are regional differences. For example African Americans account for 51.6% of the population in Cleveland.[4] According to the federal Office of Refugee Resettlement, Columbus is host to the second-largest Somali community. Available estimates for the total Somali population in the county vary however, the population is

[2] CDC Health Disparities and Inequalities Report — United States, 2013 "https://www.cdc.gov/mmwr/pdf/other/su6203.pdf"
[3] Ohio Statewide Health Disparities Collaborative "http://www.ohiohealthdisparitiescollaborative.org/wp-content/uploads/2014/01/Health-Disparities-African-American-men.pdf"
[4] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF

somewhere between 15,000 – 40,000. Furthermore, with more than 60 languages spoken in Ohio it is increasingly important to be culturally and linguistically competent in order to better serve our state's residents.

To address this issue the U.S. Department of Health and Human Services established the National Standards on Culturally and Linguistically Appropriate Services (CLAS) aimed at assisting healthcare organizations in making their services culturally and linguistically accessible. CLAS themes are separated into the following areas: Culturally Competent Care, Language Access Services and Organizational Supports for Cultural Competence. While some of the standards serve as recommendations and guidelines others are mandated for recipients of Federal funds. Six states have required cultural competency as a part of their continuing medical education: California, Connecticut, New Jersey, New Mexico, Oregon, and Washington.[5]

Ohio has made notable strides in becoming more culturally competent. Senate Bill 206 in the 130th General Assembly required the Medicaid Director to implement a system that encourages Medicaid providers to provide services in a culturally and linguistically appropriate manner. Senate Bill 332 of the 131st General Assembly required each state board shall annually provide its licensees or certificate holders with a list of continuing education courses and experiential learning opportunities addressing cultural competency in health care treatment. While these efforts are certainly a step in the right direction, we still have work to do if we want to eliminate health disparities. In order to achieve health equity we must eliminate barriers that prevent individuals from receiving quality care. Requiring cultural competency training is an opportunity to assist healthcare providers in gaining the knowledge needed to successfully serve patients from all backgrounds and eliminate health disparities among all Ohioans.

[5] https://www.thinkculturalhealth.hhs.gov/clas/clas-tracking-map

Chairman Burke and members of the Committee, I appreciate your attention to this issue and I respectfully request your favorable consideration and passage of Senate Bill 16. Thank you and I am happy to respond to questions from the committee.