**Health and Human Services Committee**

**Senator Dave Burke, Chair**

**Tuesday, June 5, 2018**

**Proponent Testimony**

**Senate Bill 16**

**Angela Dawson, Ohio Commission on Minority Health**

Chairwoman Burke, Ranking Minority Member Tavares, and members of the Medicaid, Health and Human Services Committee; my name is Angela Cornelius Dawson and I serve as the Executive Director of the Ohio Commission on Minority Health. I appreciate the opportunity to provide proponent testimony for Senate Bill 16.

Senate Bill 16 requires healthcare professionals to complete instruction in cultural competency in order to receive or renew their license, certification or registration by the appropriate state board.

In 2010, Ohio became the first state in the nation to adopt a cultural competency definition: “Cultural Competency is a constant learning process that builds knowledge, awareness, skills and capacity to identify and respect the unique beliefs, values, customs, languages, abilities and traditions of all Ohioans in order to develop policies to promote effective programs and services.”

According to the Cultural and Linguistic Accountability Standards, cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. Culture refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

The National Standards for Culturally and Linguistically Appropriate Services were developed by the HHS Office of Minority Health in 2000 and updated in 2013. The National CLAS Standards include a collective set of mandates and guidelines that inform, guide and facilitate both required and recommended practices related to culturally and linguistically appropriate health services.

The National Standards on Culturally and Linguistically Appropriate Services (CLAS) are aimed at assisting healthcare organizations in making their services culturally and linguistically accessible. Examples of other states who have required cultural competency as a part of their continuing medical education are California, Connecticut, New Jersey, New Mexico and Washington.

These states recognize that the business case for culturally and linguistically appropriate services help health care organizations’ bottom line and improve health outcomes. Likewise, accrediting bodies such as The Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance have established accreditation standards that focus on improving communication, cultural competency, patient-centered care, and the provision of language assistance services. Additionally, based on the study conducted by The Joint Center for Political and Economic Studies, the elimination of health disparities for minorities would have reduced direct medical care expenditures by $230 billion between the years 2003 and 2006.

Moreover, research also shows that good communication helps avoid cases of malpractice due to diagnostic and treatment errors, which can cost millions of dollars in liability or malpractice claims. Culturally and linguistically appropriate services can reduce the possibility of such errors.

By tailoring services to an individual's culture and language preference, health professionals can help bring about positive health outcomes for diverse populations. The provision of health care services that are respectful of and responsive to the health beliefs, practices and needs of diverse patients can help improve compliance and adherence to health care professionals recommendations.

The pursuit of health equity must remain at the forefront of our efforts, with the goal of respectful quality healthcare being the focus of our healthcare systems. The goal of health equity must include efforts to eliminate barriers to quality care. Ohio can capitalize on ways in which healthcare systems can meet diverse patient needs and reduce health disparities.

According to the National Institute of Health, providers of health information or health care, must be aware of the influence culture has on belief systems surrounding health, healing, wellness, illness, disease, and delivery of health services. The concept of cultural competency has a positive effect on patient care delivery by enabling providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients. Cultural competency is critical to reducing health disparities and improving access to high-quality health care that is respectful of and responsive to the needs of diverse patients.

A recent report from the National Institutes of Health, states, “…that when developed and implemented as a framework, cultural competence enables systems, agencies and groups of professionals to function effectively and to understand the needs of groups accessing health information and health care.” The percentage of Americans who are racial and ethnic minorities and who speak a primary language other than English continues to grow rapidly. Organizations are seeking ways to meet the challenges of serving diverse communities and provide high quality services and care.

The American College of Physicians released an update to its policy paper, "Racial and Ethnic Disparities in Health Care." It calls for the healthcare system to adapt to meet the needs of an increasingly multicultural patient base. Recommendations specified that healthcare professionals need to acknowledge the cultural, informational, and linguistic needs of their patients as our society increasingly becomes more racially and ethnically diverse. Cultural competency is recognized as an integral component of healthcare services delivery due to its relevance in treating patients and eliminating health disparities among racial, ethnic and cultural communities.

With growing concerns about health inequities and the need for health care systems to reach increasingly diverse patient populations, cultural competence has become more and more a matter of local, state and national concern.

According 2017 Census data, racial and ethnic diversity in Ohio now accounts for over 21% of the states total population:

* African Americans account for 12.8%, and
* Asians American Pacific Islanders - 2.2% with
* Native American/American Indians accounting for less than 1%.
* Two or more races, 2.20%
* From 2000 to 2008, the Hispanic population increased by 40.2% and now accounts for 3.7% of the state’s total population
* Columbus, Ohio is host to the second largest Somali community in the country.

According to the Pew Research Center, by 2050, the nation’s racial and ethnic mix will look quite different than it does now. Non-Hispanic whites, who made up 67% of the population in 2005, will be 47% in 2050. Hispanics will rise from 14% of the population in 2005 to 29% in 2050. Blacks were 13% of the population in 2005 and will be roughly the same proportion in 2050. Asians, who were 5% of the population in 2005, will be 9% in 2050. This rapid growth in our diversity is indicative of the importance of taking necessary policy and legislative actions to ensure our health care professionals are equipped to provide quality services that can lead to improved health outcomes. Efforts must be made to ensure that health and behavioral health care professionals are equipped to provide effective, equitable, understandable and respectful quality care and service that is responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Providers can take the first step to improve the quality of health care services given to diverse populations through cultural competency training. By learning to be more aware of their own cultural beliefs and more responsive to those of their patients, providers can think in ways they might not have before.

According to the 2016 National Healthcare Quality and Disparities Report Chartbook, Asians and Hispanics are less likely to understand their doctor and less likely to feel their doctor listened to them than African Americans and Whites. In addition, adults whose preferred language is not English are more likely than English-speaking adults to report dissatisfaction with their health care providers. African Americans and Hispanics are less likely to report confidence and trust in their specialty physician than Whites.

Health inequities in our nation are well documented, and the provision of culturally and linguistically appropriate services is one strategy to help eliminate health inequities. Over thirty years ago, then Health and Human Services Secretary Margaret Heckler’s Task Force on Black and Minority Health reported vast differences in health outcomes between racial and ethnic minorities and White populations in the US.

Over a decade later, Congress commissioned a report, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” studying the extent of racial disparities in healthcare. Their report found continued unequal treatment of minority populations in our health system.

In the United States and in Ohio, minorities experience higher rates of infant mortality, cardiovascular disease, diabetes/kidney disease, and cancer.

* African Americans have higher rates of mortality than any other racial or ethnic group for eight of the top ten causes of death.
* African Americans make up more than one third of all U.S. patients receiving dialysis for kidney failure despite representing only 13 percent of the overall U.S. population, and are nearly two times as likely to have diabetes as non-Hispanic Whites.
* In Ohio, the age-adjusted death rate for African Americans with diabetes is 77% higher than for White Ohioans.
* Latinos have higher rates of preventable diseases than non-Hispanic Whites in Ohio.
* More than 77 percent of Latino adults are overweight or obese, compared with 67.2 percent of Whites.
* Latinos are 15 percent more likely to have liver disease than non-Hispanic Whites.
* Native Americans are twice as likely to have diabetes as Whites and have disproportionately high death rates from unintentional injuries and suicide.
* Asian Americans have the highest incidence rates of liver cancer for both sexes compared with Hispanic, non-Hispanic Whites, or non-Hispanic African Americans.

The Ohio Department of Health produced the 2015 Impact of Chronic Disease Report. This report provides a comprehensive assessment of the burden and impact of chronic disease in Ohio as compared to the nation. This report includes data regarding chronic disease, incidence, prevalence and mortality, behavioral risk factors, estimated costs, and trends.

The findings of this report demonstrate the need for a coordinated approach to chronic disease prevention and health promotion due to shared causes and risk factors, similar high-need and disparate populations and comorbid conditions. Chronic Diseases are the most common, costly and preventable of all health problems in the US and Ohio.

Unfortunately, Ohio ranks among the worst in the country for cancer deaths (41st), cardiovascular deaths (37th) and diabetes (45th), which are significant cost drivers for the state. Additionally, Ohio’s 2015 infant mortality rates (IMR) reflect a 5.5 IMR for whites while the black African American Infant Mortality is nearly three times this rate at 15.1 infant deaths per 1,000 live births.

According to the Health Policy Institute of Ohio’s 2017 Health Value Dashboard report, Ohio ranks 46th for overall health value in the country, while ranking 31st for healthcare spending.

Our efforts must focus on both improving the quality of care, which includes culturally appropriate service delivery, as well as reducing costs. Senate Bill 16 cultural competency requirements are focused on improving healthcare quality.

Requiring cultural competency training creates a significant opportunity to ensure providers obtain the knowledge they need to effectively serve the diverse citizens of Ohio. Cultural competence benefits consumers, stakeholders, and communities and supports positive health outcomes.

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 for your attention am happy to respond to questions from the Committee.

Please be aware that I have a bilateral significant hearing impairment that may require you to repeat your questions. Thank you in advance for your accommodation.

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