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Chair Greenlick and Members of the House Health Care Committee,

I am in complete support of HB2611 requiring Cultural Competence Continuing Education for health care providers, and could not agree more with the statement "Cultural Competence is just good health care."

I second the previous testimonies, and I would like to speak briefly regarding 2 key aspects of this legislation: the need for requirement and the need for training standards.

1.The need for a requirement

Knowing how to bridge any of the many possible differences in the provider-patient relationship cannot not be optional.

- When providers in Oregon state that the population is not diverse enough to require cultural competence training, they are likely thinking only what minorities they can "see." In the following list, there are **more "invisible" than "visible" minority categories**: expressed or perceived race, color, spiritual beliefs, creed, age, tribal affiliation, national origin, immigration or refugee status, marital status, socio-economic status, veteran's status, sexual orientation, gender identity, gender expression, and gender transition, level of formal education, physical or mental disability, or medical condition.
- Providing health services that meet or exceed the standard of care to all patients is an integral aspect of **ethical practice**. Ignoring or minimizing differences, imposing the provider's worldview on the patient, and making assumptions about the patient that impact their care are against ethical practice. Just as ethical practice is not optional, nor should cultural competence be optional.
- There is a misconception that cultural competence is an **area of specialty** relevant only to providers who work primarily with minority populations. However, cultural competence is a lens that must guide all doctor-patient relationships since it is impossible to determine solely by sight or last name if someone may be member of a minority group. The specialty perspective allows for providers to opt out of addressing differences. The current "optional" policy of culturally competent care has lead to significant and documented health disparities in Oregon.

- Minority providers or majority "allies" are not "**naturally" culturally competent** and therefore all providers require training is area. All providers may be vulnerable to their own biases or blind-spots; no two people are alike nor have had the same life experiences, nor the same reactions to similar experiences and making assumptions to the contrary is part of what cultural competence educates against.
- Current health reform strongly emphasizes integrated care and multi-disciplinary teams. Another important contribution of this bill is that by including all health care professions it can foster increased cross-pollinization among health disciplines and contribute to a common set of skills across disciplines. Requiring cultural competency training will only enhance the integrated approach to heath care.

2. The need for training standards

There is a responsibility that accompanies any requirement: If it is going to be required, let's make sure it's done right.

- There is a robust body of literature that describes standards related to cultural competence, and they are typically organized into 3 categories: (1) awareness, (2) knowledge (provider and training), and (3) skills.
- Awareness includes provider self-awareness such as being able to identify own worldview and biases, to be aware of differences between self and patient, to articulate goals in their own developmental path towards cultural competency, understand own reactions to patient behavior, etc.
- Provider Knowledge includes understanding what cultural competence is and what it is not, having a base of data such as health disparities and local minority communities from which to assess whether these are relevant to a particular patient, etc.
- Training Knowledge includes trainer characteristics, and using a range of educational techniques, adequate evaluation, etc.
- Skills include being able to elicit the patient's beliefs regarding health and disease, how to avoid a judgmental stance and how to collaborate to establish patient health goals, how to access cultural competency self-assessment tools, etc.
- A poor training experience may actually negatively impact providers' attitudes towards their patients' diversity. As a result, standards have been divided into "essential" and "advanced." While all standards are considered essential, standards also need to accommodate the range of training lengths from 2 hours or 2 days. The essential ones can be included in brief trainings and across all disciplines, while the advanced include standards that could not be adequately addressed in 1 or 2 hours and may or may not apply to all disciplines.
- Training standards operationalize cultural competence training experiences in order to ensure a positive and useful experience for providers, and to maximize provider learning about implementation of cultural competency.

OHA will be able to use these standards in identifying quality educational experiences.

Finally, good health care is about **patients and providers**, not just providers. When a provider or an organization expresses the burden on them of having an additional requirement they are focusing on one aspect of the burden at the expense of "seeing" and understanding the **real burden** on a larger number of patients , e.g. related to not having adequate access to health care, and/or receiving low quality health care once they have access. This bill cannot be assessed by only considering the provider's perspective. This bill is about quality care for all, whether a patient's minority status is visible or not.

Thank you for the opportunity to testify before you today. I would be happy to answer any questions.