Testimony in Support of House Bill 2011 (-1 amendment)
House Committee on Health Care

Speaker of the House Tina Kotek
April 2, 2019

Chair Salinas and members of the committee, thank you for the opportunity to testify today in support of House Bill 2011 and the -1 amendment.

The underlying impetus for this bill is simple: Certain communities in Oregon face disparities in access to health care, the quality of care received, and health outcomes.

Colleagues, here are some data points to keep in mind:

- African Americans, Asian Americans, Pacific Islanders, and Latinos all reported worse access to care than their white peers in 2015, 2016 and 2017;
- Non-white patients are less likely to be prescribed pain medication, less likely to have their pain taken seriously, and less likely to feel heard by their clinician;
- In Oregon, 22 percent of transgender Oregonians reported being refused medical care; and
- In 2017, 8 of 16 CCOs regressed on their satisfaction with care metric.

Despite our gains in health care transformation and our advancements in health care technology, disparities exist and remain today. This mere fact should compel all of us to ask what more we can do and to pursue strategies to correct disparities wherever possible. Studies explicitly show how treatment adherence, decisions, and health outcomes are associated with the interpersonal aspects of care.

This bill and amendment are a piece of a broader, continued discussion about how to reduce health disparities in our state. Specifically, this bill seeks to ensure all licensed health practitioners are equipped to provide culturally appropriate health care. This bill is not a silver bullet. This bill is another needed strategy to improve provider and patient skills that have been shown to improve outcomes, like reducing provider bias and improving health literacy.

The Oregon Health Authority's (OHA) Office of Equity and Inclusion defines cultural competency as "a life-long process of examining values and beliefs, of developing and applying

an inclusive approach to health care practice in a manner that recognizes the context and complexities of provider-patient interactions and preserves the dignity of individuals, families and communities."

House Bill 2011 with the -1 amendment seeks to require cultural competency continuing education (CCCE) as a condition of licensure. Specifically, the -1 amendment:

- Allows licensing boards to retain existing CCCE requirements, where they exist, or create new credit requirements for CCCE completion in collaboration with licensees;
- Requires CCCE completion as a condition of licensure, but sets a floor of every *other* renewal period; and
- Establishes a reasonable run-up to implementation by permitting associations, provider groups, health systems, and community groups to submit or revise existing CEs in alignment with the skills identified by the OHA.

Current law requires the OHA to develop a list of continuing education opportunities, and these opportunities include, but need not be limited to (ORS 413.150):

- Courses delivered either in person or electronically;
- Experiential learning such as cultural or linguistic immersion;
- Service learning; or
- Specifically designed cultural experiences.

A forthcoming amendment will also clarify that:

- Licensing boards shall encourage, not require, participation from the OHA-approved list of CEs; and
- Licensing boards may accept CEs that are not from the OHA-approved list of CEs if the CEs adhere to the skills identified by the OHA in rule (OAR 943-090-0020(6)).

We thank the Oregon Medical Association for these suggestions and agree that this provides more flexibility in achieving our shared goal.

House Bill 2011 (with the -1 amendment and the forthcoming amendment) will provide another step toward increasing provider knowledge, changing attitudes, and expanding the skills necessary to improve health outcomes for all Oregonians. I urge your support.

Legislative History

Cultural competency is not a new topic here in the Capitol. In 2011, the Legislature sought to institute cultural competency continuing education requirements for all licensed health practitioners after numerous round tables, task forces, and special commissions charged with

tackling Oregon's racial and ethnic disparities recommended that change. A Senate bill failed that year on the House floor with a 30-30 vote.

While many supported that measure, others opposed the bill and requested the development of a common definition, a framework, and assistance in accessing CEs. Others took opposition with the mandate.

In response to this effort, the OHA established an advisory committee to develop a common definition, develop a framework for foundational and accelerated standards, and make recommendations to further the adoption of culturally competent strategies across the state. Among those recommendations was, again, the adoption of a continuing education credit at the licensure level. More than 160 providers were surveyed in the process of developing these recommendations.

Informed by this two-year process, culturally-specific organizations brought House Bill 2611 to the Legislature in 2013. As introduced, this bill would have again required CCCEs for all licensed practitioners. Provider groups asked, instead, to create a voluntary framework. The bill was subsequently amended to do just that. This framework included an advisory group within OHA to approve curriculum, establish an online registry, and allow boards enough time to create a reporting system to submit voluntary completion data to the OHA. House Bill 2611-A allowed for several years of rule making and outreach, taking full effect on January 1, 2017.

The first report to the Legislature was received in August 2018. The report showed variance in the level of CCCE completion:

- 4 of the 22 health licensing boards have self-imposed a CCCE requirement (from 4 to 6 credits per renewal);
- 13 boards allow CCCE to satisfy general CE requirements; and
- Some licensees accomplished 40 percent participation within the first six months. Others accomplished as little as 19 percent, or even lower than 11 percent.