HOUSE BILL REPORT
ESSB 5229

As Passed House - Amended:
March 24, 2021

Title: An act relating to health equity continuing education for health care professionals.

Brief Description: Concerning health equity continuing education for health care professionals.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Randall, Das, Keiser, Lovelett, Nobles, Wilson, C., Dhingra, Hasegawa, Kuderer, Nguyen and Stanford).

Brief History:
Committee Activity:
Health Care & Wellness: 3/15/21, 3/17/21 [DPA].
Floor Activity:
Passed House: 3/24/21, 57-41.

Brief Summary of Engrossed Substitute Bill
(As Amended By House)

- Requires disciplining authorities to adopt rules requiring health equity continuing education.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 12 members: Representatives Cody, Chair; Bateman, Vice Chair; Caldier, Assistant Ranking Minority Member; Bronoske, Davis, Harris, Macri, Maycumber, Riccelli, Simmons, Stonier and Tharinger.

Minority Report: Without recommendation. Signed by 2 members: Representatives Schmick, Ranking Minority Member; Ybarra.

Staff: Jim Morishima (786-7191).

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Background:

The Department of Health, in consultation with health profession disciplining authorities, must establish a multicultural health awareness and education program to raise awareness and educate health professionals on the knowledge, attitudes, and practice skills necessary to care for diverse populations to achieve a greater understanding of the relationship between culture and health. Disciplining authorities with the authority to offer continuing education may provide training in the dynamics of providing culturally competent, multicultural health care to diverse populations. A disciplining authority may require that instructors of continuing education or continuing competency programs integrate multicultural health into their curricula when it is appropriate to the subject matter. A disciplining authority may defray costs by authorizing a fee to be charged for participants or materials relating to any sponsored program.

Summary of Amended Bill:

By January 1, 2024, the disciplining authority for each health profession subject to continuing education requirements must adopt rules requiring a licensee to complete health equity continuing education training at least once every four years. The continuing education may be taken in addition to other continuing education requirements, unless the disciplining authority finds that the course fulfills existing requirements, in which case the training may be in lieu of existing requirements.

By July 1, 2023, the Secretary of Health (Secretary) and other disciplining authorities must work collaboratively to provide information to licensees about available courses. When developing this information, the Secretary and disciplining authorities must consult patients or communities with lived experience of health inequities or racism in the health care system and relevant professional organizations. The information must include an option that is free of charge. It is not required that the courses be included in the information in order to fulfill the health equity continuing education requirement.

By January 1, 2023, the Department of Health (DOH) must adopt model rules establishing the minimum standards for health equity continuing education programs. The rules must be adopted in consultation with disciplining authorities, patients or communities with lived experience of health inequities or racism in the health care system, and relevant professional organizations. The minimum standards must include instruction on skills to address structural factors that manifest as health inequities, such as bias, racism, and poverty. The skills must include individual-level and system-level intervention and self-reflection to assess how the licensee's social position can influence the licensee's relationship with patients and their communities. The skills must also enable a health care professional to effectively care for patients from diverse cultures, groups, and communities, varying in race, ethnicity, gender identity, sexuality, religion, age, ability, socioeconomic status, and other categories of identity. The courses must assess the licensee's ability to apply health equity concepts into practice.

Course topics may include:

- strategies for recognizing patterns of health care disparities on an individual, institutional, and structural level and eliminating factors that influence them;
- intercultural communication skills training, including how to work effectively with an interpreter and how communication styles differ across cultures;
- implicit bias training to identify strategies to reduce bias during assessment and diagnosis;
- methods for addressing the emotional well-being of children and youth of diverse backgrounds;
- ensuring equity and anti-racism in care delivery pertaining to medical developments and emerging therapies;
- structural competency training addressing recognizing the structures that shape clinical interactions, developing an extra-clinical language of structure, rearticulating "cultural" formations in structural terms, observing and imagining structural interventions, and developing structural humility; and
- cultural safety training.

"Structural competency" is defined as a shift in medical education away from pedagogic approaches to stigma and inequalities that emphasize cross-cultural understandings of individual patients, toward attention to forces that influence health outcomes at levels above individual interactions. Structural competency reviews existing structural approaches to stigma and health inequities developed outside of medicine and proposes changes to United States medical education that will infuse clinical training with a structural focus.

"Cultural safety" is defined as an examination by health care professionals of themselves and the potential impact of their own culture on clinical interactions and health care service delivery. This requires individual health care professionals and health care organizations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures, and characteristics that may affect the quality of care provided. In doing so, cultural safety encompasses a critical consciousness where health care professionals and health care organizations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires health care professionals and their associated health care organizations to influence health care to reduce bias and achieve equity within the workforce and working environment.

The authority of a disciplining authority to provide training in multicultural health, to require instructors integrate multicultural health into curricula, and to authorize a fee, is eliminated.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) Many Washingtonians who are people of color have experienced challenges navigating the health care system. The COVID-19 pandemic has highlighted and exacerbated these disparities. Persons of color experience disproportionate outcomes from COVID-19, maternal mortality, diabetes, and asthma. This is true regardless of insurance coverage. The current system is built on rocky ground and this bill gives providers the tools to understand the broken system and how to fix it. Physicians have traditionally opposed mandated education, but recognize that this is an exception and a chance to address inequities. Physicians hold influence in their communities and have a responsibility to patients and the profession to help disband health inequities rooted in society and institutions. This bill gives each profession the flexibility to implement this requirement in a way that is appropriate for the profession. The bill will allow providers to be knowledgeable about cultural sensitivities, patterns of disparities, and bias, all of which affect patient outcomes. Understanding social determinants of health such as race, ethnicity, sexuality, and socioeconomic status will help providers be better equipped to develop patient relationships and comprehensive, culturally humble health care plans. This bill focuses on all health care, including behavioral health. It is important to make the health care workforce more diverse, but it is also important to give training to existing professionals to effectively serve patients. Systemic inequities need to be examined. This is not an add-on, but a core competency. This is only one piece of the solution.

(Opposed) This bill seems to focus on the responsibilities of the professionals, but health outcomes have a lot to do with individual responsibility too. It is unclear how the state will know when this education is actually affecting the change the bill wants to address. It is unclear whether this training will go against a provider's conscience or religious beliefs. The cultural and religious beliefs of providers should be protected. This bill lacks a definition of structural humility.

Persons Testifying: (In support) Senator Randall, prime sponsor; Alex Wehinger and Katina Rue, Washington State Medical Association; Laurie Lippold, Partners for Our Children; and Bob Cooper, National Association of Social Workers Washington Chapter.

(Opposed) Sarah Davenport-Smith, Family Policy Institute of Washington.

Persons Signed In To Testify But Not Testifying: None.