



## Oregon AFSCME Testimony in Support of HB 2011A

Dear Chair Monnes Anderson, Vice-chair Lithincum and members of the Senate Health Care Committee,

My name is Holly Copenhagen, I am an acute care physical therapist and member of AFSCME Local 328. I appreciate this opportunity to provide testimony in support of HB 2011, a bill to require cultural competency training as part of continuing education for licensed professionals in health care and other care providers.

Cultural competence is one of the primary components of building rapport with a patient. It allows providers to understand their patients on a deep, emotional level - a place where patients pull to make serious medical decisions. However, culture is also the background for what we sometimes would consider mundane, superficial decisions or habits, which of course affect a patient's ability to connect with their provider, be heard, follow through on advice and thrive. Education in cultural competency, across a wide variety of cultures, will only continue to decrease unconscious bias which can have significant negative consequences for patient care.

Without training in cultural competency a provider may not make the best decisions for the person in their care. Unconscious bias may cause a provider to assume dark spots on a baby of North African heritage's back and feet might be bruises based on the interactions with the family, noting in the medical record that the mother was submissive to the father. Cultural competency training would give the provider more perspective on the norms of that family and instead of jumping to the conclusion that the baby is bruised, understand that the spots are what is known as Mongolian Spots – birth marks caused by pigmentation that didn't make it to the top layer of the skin.

As a physical therapist, I am required to evaluate a patient's baseline and provide a structure to improve their condition. From continued discussions with patients over the years, I have come to know some cultures have a strong sense of commitment to their elderly family members. So much, in fact, they will spoon feed them or carry them from location to location, despite the patient's ability to perform these tasks. Over the years, when I need to evaluate a patient with such caring and involved family members, I take extra time to explain my role and what I need to see but I conclude my explanation with reinforcing their status quo. I thank them for the care of the patient, something such as "I need to see their ability at this time, but you are still welcome to help him during his stay here and at home." In some cases, such as after a stroke, part of regaining function can be forced use, to this a provider must also be sensitive to their normal and expected roles and explain further.

In practice, the more open and aware I have been with patients, the better response I have from my patients and family members. As a patient, when my own providers have considered more than my diagnosis, I feel respected and seen and all receiving care should expect and feel the same. Please pass HB 2011.