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Testimony/HF 784 Section 6 Appropriation: Culturally Competent Health Care Services: to establish and support regional health clinical operated by African Americans that focus on services to African Americans and to eradicate health disparities.

Thank you, Representative Thompson and committee chair members for this opportunity.

My name is Tamiko Foster. I am a physician, board-certified in pediatrics, who has additional training in public health, health equity, and health policy. I currently work as a medical director at a national managed care company, and I am also the owner of a health and wellness company that focuses on holistic care, patient empowerment and health equity advocacy. In my 20 years of being a physician, my work has focused mainly on high-risk populations.

I strongly support the HF 784 bill Section 6 appropriation for culturally competent health care services.

There are several reasons I support this bill, but I will start with the Why. This matters because…

- **Everyone deserves the opportunity to live a fulfilled life and to feel their best while doing it.**

What:

- Culturally and linguistically appropriate services are respectful of and responsive to the health beliefs, practices and needs of diverse patients. Providing a tailored approach of health care delivery to meet patients' social, cultural and linguistic needs lead to better health outcomes. (1)

- Research has supported that patients who have access to physicians with shared racial, ethnic, or cultural backgrounds have better health outcomes. This is often referred to as patient-provider racial concordance. When considering the disparity of maternal/infant mortality alone, Black newborns die less when cared for by Black doctors. (2)

Personal story:

- Like many of my colleagues, I’ve experienced first-hand how physicians from other racial or ethnic backgrounds did not take my health concerns serious until I told them I was a physician. The color of my skin, even as a physician, acted as a barrier. My care was handled drastically differently after the revelation, and I now lead with my title in the introduction. Many of my colleagues share similar stories. However, as we also learned

from cases like Dr. Susan Moore and others, our status does not always equal appropriate care. Watching her video as she pleaded for help was a painful reminder of racism in medicine. I watched with tears as it reminded me of the last words I heard from my stepmother who pleaded on the phone with me from miles away "They won't listen to me. I'm Black, overweight, and poor. Something is not right and no one is helping me…I don't like this hospital…They don't treat me right. Please get them to help me and listen to me. Please get me out of this place; they are trying to kill me!" I urgently reached out to Black colleagues in Illinois in a desperate attempt to have her care transferred to someone she would feel more comfortable with. Someone who she could trust. She just wanted to be seen and heard. Sadly, she died 6 days later. It was then that my fight for health equity and eliminating racism in medicine was birthed.

Supporting information:

- Racism in medicine kills people and keep them sick. Structural racism is a key determinant in driving health disparities. Even when social determinants of health are addressed, African Americans continue to die and be more sick than other populations. Research has supported that patients who have access to physicians with shared racial, ethnic, or cultural backgrounds have better health outcomes.

> Racial inequalities in health care are attributable to communication barriers, which may be the result of cultural or linguistic incongruity, racial discrimination or lack of mutual trust. (3)
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> Trust is key. Studies have demonstrated increased levels of trust and communication among black patients and black doctors. Patients with black doctors were much more likely to discuss additional health problems, consider riskier procedures, and have better follow up. Patient satisfaction scores and utilization of health care services have also been reported as higher.

- In my previous role as Vice President of the Minnesota Association of Black Physicians, I became a point of contact for connecting African American community members to other African American or culturally sensitive health care providers. Over the years, current residents in Minnesota and families who are moving to the state reach out to me in the hopes of connecting with Black health care providers for their care. People are desperate to connect with someone who they feel will give them a fair chance. Someone who will listen without judgement. Someone who will understand the struggle. Of course, there is no guarantee that the relationship will be successful, in fact, there may be a chance of higher disappointment because of the expectations that may be placed on the interaction. In addition, we know that quality, compassionate, and equitable care can be provided by those of different races. I have witnessed non-Black colleagues do this passionately for years. Nevertheless, studies suggest that if given the choice, people will usually choose providers of similar racial/ethnic backgrounds.

- Lack of a diverse workforce contributes to disparities and is a barrier to providing access to such requested care. We need a healthcare workforce that reflects the patient population (5% AA doctors US, AA 13% of US population; 2.6% AA doctors MN, 7% AA MN). Support for pipelines for African American students and incentives for primary care providers to relocate to Minnesota should be instituted. Unequal allocation of power and resources make it difficult to care for those in highest need. African American physicians are more likely to serve in marginalized communities and take on higher risk patients. Reimbursement rates are typically lower for higher cost patients and providers receive less overall support There is little incentive to retain providers. Financial support and increasing patient access to the provider of their choice is critical to sustain these providers and support their efforts in advancing health equity.

I will end by restating my enthusiastic support for this bill. In addition to the moral case, health disparities costs trillions of dollars. Distribution of power, resources, and opportunities that benefit white people over other populations has cumulative and chronic adverse outcomes that not only impact health but the economy. Providing culturally competent health services for African Americans provided by African American health providers is one solution of many that will aide in the process of identifying and eliminating racism by changing systems, organizational structures, policies and practices that redistribute power to advance health equity.

Thank you for your time and consideration.

References:

1. U.S. Department of Health & Human Services Office of Minority Health. https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53. Accessed 3/2/21.

2. Greenwood BN, Hardeman RR, Huang L, Sojourner A. Physician-patient racial concordance and disparities in birthing mortality for newborns. Proc Natl Acad Sci U S A. 2020 Sep 1;117(35):21194-21200. doi: 10.1073/pnas.1913405117. Epub 2020 Aug 17. PMID: 32817561; PMCID: PMC7474610.

3. Saha, Somnath, et al. "Patient-physician racial concordance and the perceived quality and use of health care." *Archives of internal medicine* 159.9 (1999): 997-1004.