Comments on 4th draft of Health Equity Continuing Education Rules

WAC Section	Comment Received	Department of Health Response
246-12-700	Add "members of" before "secretary professions or board and commission professions"	Accepted this recommendation.
246-12-700	Add "those terms are" before defined in WAC 246-12-710.	Accepted this recommendation.
246-12-710	Modify definition of "health equity" to the following: "Health equity" means all people have the same opportunities and equal access in order to attain their full health potential regardless of the color of their skin, ancestry, ethnicity, level of education, gender identity, sexual orientation, age, religion, socioeconomic status, the job they have, the neighborhood they live in, or their ability status.	Accepted this recommendation, but will still need to go through internal review due to this being a department definition.
246-12-720	With the changes in this WAC section, I would recommend retitling it to: "Health Equity Continuing Education Training Minimum Hours."	Accepted this recommendation.
246-12-720(1)	As I reviewed the language in subsection (1), it didn't seem to fit within this WAC. If you want to give professions the ability to set additional training standards, that language needs to be placed in WAC 246-12-730. Because of this, I believe this subsection should be deleted.	Accepted this recommendation. We are still discussing ways to incorporate this comment.
246-12-720(1)	While WAC 246-12-700 was modified to clarify that these rules apply to all professions with a continuing education requirement, this subsection was limited to the Secretary professions. I don't believe that was the intent.	Accepted this recommendation.
246-12-720(2)	Members of secretary and board and commission professions must complete a minimum of 2 hours in health equity continuing education training every four years, unless a secretary or board and commission professions ~~specify~~	Accepted similar recommendation. We are still discussing ways to incorporate this comment.

	specifies a different number of hours in rule.	
246-12-720(2)	In considering how best to amend subsection (2)—now subsection (1)—to include all health care professionals, it seemed easiest to use the definition for "health care professional."	Accepted this recommendation. We are still discussing ways to incorporate this comment.
246-12-720(2)	In addition, in creating an option for a higher number of hours, it seemed easiest to refer to "rule-making authorities" as those words are used in the underlying legislation (RCW 43.70.613(1).	Accepted this recommendation. We are still discussing ways to incorporate this comment.
246-12-730(1)	The draft rules now require that the training must include at least three of the topics listed in subsection (1). I believe this change could be seen in conflict with the underlying statute. The statute was very open-ended, and you reference it in subsection (2). These rules, as written, do not sync with that intent. While you could assert that the same problem existed previously, requiring three topics in any health equity CE training is much more restrictive. I defer to your AAG or other Department of Health counsel for a review of this issue.	- Topics come from what individuals identified during listening sessions. ESSB 5229 directed the department to engage with individuals with lived experience with health inequities and racism in the health care system - These are minimum standards. Professions can increase the number of hours.
246-12-730(1)	I included language that allows rule-making authorities to exceed minimum standards. This is the WAC section where this language belongs, not WAC 246-12-720. Suggest adding "The relevant rulemaking authorities may ste tandards that exceed minimum standards."	Accepted this recommendation. We are still discussing ways to incorporate this comment.
246-12-730(4)(a)	Add "in-person or virtual" before "online continuing education training"	Accepted this recommendation.
246-12-730(4)(b)	Suggest the following edits: A document provided at the end of an in-person or virtual continuing education training that attests ~~that the health care professional attended~~ attendance at the training	Accepted this recommendation.

General Comments

Comment Received	Department of Health Response
We believe that 2 hours every year should be the minimum standard across all healthcare professions, regardless of the total amount of CE hours required. Two hours every 4 years seems like a "check the box" situation and won't provide the depth & up to date knowledge needed, as research and best practice in cultural attunement/DEI is constantly evolving. Providers serve incredibly diverse populations and should be expected to keep up. Cultural attunement and DEI could be integrated with other important training topics within the same CE to provide a gold standard of integration; i.e. the equity perspective ought to be integrated into every aspect of care inasmuch as inequity is not experienced as a separate thing apart from other aspects of care.	This is one of two positions, that 2 hours is more than enough, or that it is not enough training. This will need to be discussed at the next rules workshop.
"While we understand that these have been adopted from the UW DEI trainings, these are individual aspects of training, and we believe it is also important to specifically address institutional racism and oppression and the ethical mandate upon institutions to address systemic racism and oppression."	We must be careful that our rulemaking does not limit valid trainings from meeting standards. It is also important that we make sure that professionals are provided with the correct tools to address inequities in the health system. We will add this as a topic of discussion at our next workshop.
"Strongly recommends that the DoH prioritize trainings and content created and led by people of color and others who hold marginalized identities and that trainers be compensated for their labor."	We will bring this to the next rules workshop and discuss how BIPOC and other marginalized communities can be prioritized and compensated for their labor.
We engage in a lot of equity training in my workplace. It would be nice if this equity training was able to fulfill new equity training requirements.	At this time, there is nothing in rule that does not make this possible, but professions may require that training is provided by a certain entity. This rule requires that a professional meets the minimum standards written in rule.
A basic human right is the right to sexuality yet it is not a required subject to be taught for any of our caregivers in long term care and it should as it is a social justice and health equity subject. How can teams of paid supports also legally and legitimately navigate issues of sexuality and disability rights as well as sexuality for those who are intellectually and developmentally diverse without a basic foundation? We cannot assume that caregivers have them, in fact, we can pretty much assume they will not. So, we have a whole bunch of people who are sexually frustrated who then act out behaviorally.	These courses seem to be covered in the proposed training topics, and a professional can specialize in these topics. I would need to also seek legal advice concerning the scope of this ask, although it could fit into health equity training, the training is specifically for sexuality and socialization training.

We do have other states in the USA who have mandated sexuality and socialization classes for their healthcare/caregiving workers. NM's office of behavioral supports has even gotten these services written into their DD Waiver for both consumer and supports to be trained in separate trainings! This is an important health equity topic! Please make sure that this is included in the discussion.	DSHS maintains authority for those working in nursing homes but has been participating to expand training. I will discuss this with the workshop group.
I believe it should be a REQUIREMENT to provide an easy-to-understand MATRIX and checklist to allow for easier compliance and avoid un-intended confusion and missed deadlines EVERY TIME there is an update to these requirements	We do not want to create unforeseen burdens through requiring more documentation. With that said, we will speak to program managers for each respective program, as well as share in our workshop.
In regards to the draft health equity CE regulations currently presented for review, I would like to request that the following be included: "Health Equity CE shall be provided to the individual licensee either free-of-charge (for programs developed by the Department of Health) or no more than 5% of the licensee's license renewal fee if provided by any other approved entity." In the past health care licensees have had to bear the brunt of the cost of mandatory continuing education costs such as programs for HIV and Suicide Prevention. In the case of Suicide Prevention a few of these programs were presented at exorbitant cost to the licensee (due to the paucity of providers of said CE). It is my feeling that these programs need to be no- to low-cost given that many licensees, such as home care aides or pharmacy/medical assistants, currently are paid at just above minimum wage and that the cost of this type of CE, especially since it seems to be set up to recur every 4 years, presents a huge burden to those licensees (especially if one includes retired licensees), potentially being an equity issue in and of itself.	The legislation requires that we identify at least one free training that meets the minimum standards. Each profession has their own fee requirements, that are reviewed based on many factors, such as number of individuals credentialed, legal and program costs, ect. Putting a blanket statement may make it much more difficult to implement. We agree that programs need to be no to low cost and have begun looking at starting and median wages in each profession throughout the Washington State. The bill itself says that training must be completed once every four years, and we are unable to make rules that conflict with that training. Each profession may decide to require more training every four years.
I truly find it hard to believe that there are enough health practitioners out there excluding any patient or refusing treatment based on the criteria cited in this rule to necessitate the implementation of such a rule. Especially in the current "hyper aware and hyper litigious" state of our society. I could be wrong, but it seems that this rule is not needed. Especially if there is to be an "education requirement" tied to it. Maybe if	The bill has been passed by legislators, and as a result, the department will need to write rules surrounding the training.

someone has a complaint filed against them based on behavior that warrants an education in that area it makes sense. But to require all health care practitioners to take even more time away from work, family, etc. to be "educated" on something that is not a problem for them is just another reason health care professionals grow weary of the oversight imposed on them.	The department must create rules surrounding health equity continuing education.
As I was reading under the subsection of 1 that there is nothing specifically identifying socioeconomic status or religion identifying as groups to be specifically for CEUS. I am wondering if there is reason for this? In the past disabilities has also been covered in this area also is this not being considered (wheelchair bound individuals, ADA individuals, hearing impaired, etc)? I am concern with religion being left out with the increase in hate crimes with religious implications with places of worship. Also, how an individual dresses can be viewed as different based on religious beliefs and how this can be a factor and many medical and mental health modalities. How is the specialist or trainer being verified as being known to be a specialist or a trainer in this field? This has been a hot topic within the field that unless you are from the minority group that your not a specialist in this area or can't speak in this area?	We have added a topic to the original five that expands to include groups that were inadvertently left out/not addressed previously. Each topic can be specialized to focus on different areas of health inequity. We are encouraging further discussion on the addition of the new topic. We did not want the language to be too narrow for the trainer. Instead, material reference in training must be relevant and trainers must have experience in providing health equity training, which includes those with both lived experience or specialists.
(several comments) Difficult for some health care professionals to afford to pay for continuing education.	We will be identifying a free training that meets the minimum standards that we put into place.
(several comments) Health equity CE courses are not needed	The law has already been passed and as a result, the department will need to write rules surrounding the training.
The every 4 year requirement could be changed to 6 year to be the same as the Ethics CE requirement Ethics and Health Equity have equal importance for professional conduct.	Current legislation says every 4 years. Due to that, we are not able to require training every 6 years.
I'm hoping you can provide some clarification on the change in recent draft of the health equity continuing education rules in section 246-12-730 (1), where the rule shifted from requiring the training to include "at least one of the following topics" to "at least three of the following topics."	The shift is a response to numerous comments to increase the number of required hours for CE. We also got push NOT to increase the minimum hour. As a result, we increased the minimum amount of core training topics that must be met during the training so that individuals can receive training that requires more topic

	minimums, while leaving the CE hour amount the same. Many of the comments are uncertain that professionals will at minimum build a base of health equity knowledge and application with a 2-hour CE requirement and a requirement to only cover one topic. We are hoping to not only receive comments about this language and proposed change, as well as have some conversation at our next workshop surrounding this portion.
The legislation seems to be designed to mandate continuing education for health care providers to be aware of "structural" health inequalities/racism, and reflect on this. Further, they will be evaluated on their "ability to apply health equity concepts into practice." Briefly, all of us live in (and provide services in) an environment of limited resources. Legislation of this sort advocates creating special privileges in that environment of limitations-- If successful, it will give priority for limited services to members of the special group to the detriment of those not in the special group. Over the long run, these new institutional biases, however well-meaning, will create resentment and increase disadvantage for members of the groups they are trying to help. Training based on the failed ideas of "structural inequality" and "structural racism" (likely of French philosophers such as Jacques Derrida) will provide no practical tools for the healthcare provider. If mandated, such training will contribute to the de-legitimization of regulatory authority in healthcare. If put into practice by a healthcare provider, these principles will harm the groups they are meant to help. There are already laws on the books that prevent bias based on race, religion and gender. Everyone who works in healthcare is well aware of them and is already doing everything they can to administer limited public healthcare services as equitably as possible. If the results are less than satisfactory, find a way to increase funding for the neglected services, or possibly provide the Pharmacy Association with the authority to canvas charitable organizations for such funding	The law has already been passed and as a result, the department will need to write rules surrounding the training.

Providers of such courses can offer them to health care professionals, but they should not be mandated--Especially not if such mandates take the place of other, already-mandated CE (Section 2, Page 2, lines 12-13).	
I am wondering if there can also be some expanded culture and race education be considered in what is added into the education. So much focus is on some primary communities and many are forgotten or we are needed more in-depth on the communities. An example is a primary training that is covered is: Some examples: 1) African American/ Black community yet there is very little covered on how there is differences between those the identify as African of Jamaican yet identify as Black and are "lumped" into this group/ community. 2) There is also a need for more with a wide differences of knowing differences with Latin X communities such as how Central American communities have differences from South American and the Caribbean communities can identify as both Latin X or even as other community. 3) Finding trainings that covered more populations such as those from some of the other Cultures/ Races. Asian communities are widely present and live within Washington state yet there are very few training opportunities and would be great learning opportunities with having client from these communities. Also, with having many families who also adopt individuals from these communities which would be useful. 4) Very few training cover those that are mixed race or mixed culture and how to address those concerns. Another concern is the limited where information/ education can be added to consider culture and race outside of skin tone/ color. Currently much of the culture and race issues address the culture/ race issues when skin tone/ color is presence yet it is important to know when culture issues are present and influence the mental health. Examples of this to consider: 1) Currently Ukrainians or Russians yet these are not populations that are typically covered and are considered as "white" yet with now high number of Ukrainian immigrants be welcomed into the US this will be increasing. 2) I have had a high number of individuals that were born and raised in Germany. They then came to the US. I have had to do my own research on this population. This is important to keep in mind the need that there are	The added topic does cover the communities mentioned, but we do not dictate more in-depth topics. Language, Economic Status, and Access were something we heard about in our listening sessions. Although we believed we captured these in our broader topics, we will hold more discussion about our topics in our upcoming rules workshop.

numerous different because they have “white skin” does not mean that living current in US means that more information is not necessary or understanding their culture/ would not be important.	