



**MEMBERS OF THE  
WORKGROUP**

*Hedy Chang  
Shelton Duruisseau, Ph.D.*

**CULTURAL AND  
LINGUISTIC PHYSICIAN  
COMPETENCY PROGRAM  
WORKGROUP MEETING**

*Action may be taken on any  
item listed on the agenda.*

**September 25, 2007**

Medical Board of California  
Greg Gorges Conference Room  
1424 Howe Avenue  
Sacramento, CA 95825

**AGENDA**

10:00 a.m. – 1 p.m. (or until completion of business)

If a quorum of the Board is present, members of the Board who are not members of the Workgroup may attend only as observers.

1. Call to Order/Roll Call
2. Web Site Presentation Regarding Cultural and Linguistic Physician Competency Incorporation into Continuing Medical Education Courses (AB 1195, Coto, Ch. 514, Stats 2005) – Alecia Robinson, Institute for Medical Quality
3. Cultural and Linguistic Competency Educational Course Demonstration
4. Presentation: Providing Quality Health Care with CLAS – UC Davis School of Medicine, Center for Reducing Health Disparities – Sergio A. Aguilar-Gaxiola, M.D., Ph.D. and Hendry Ton, M.D.
5. Identification of Future Workgroup Goals
6. Development of Workgroup Action Plan
7. Schedule of and Agenda Items for Future Meetings
8. Public Comment on Items not on the Agenda
9. Adjournment

*The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.*

*NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications in order to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting Billie Baldo at (916) 263-2365 or sending a written request to Ms. Baldo at the Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825. Requests for further information should be directed to the same address and telephone number.*

*Meetings of the Cultural and Linguistic Physician Competency Workgroup are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Workgroup, but the Facilitator may apportion available time among those who wish to speak.*

\*\*\*\*\*

*For additional information, contact the Licensing Program at (916) 263-2382.*

Incorporating Cultural and Linguistic Competency into CME - Microsoft Internet Explorer provided by Jim, your Network Guy

http://www.imq.org/clc\_index.html

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Incorporating Cultural a... X Southwest Airlines Paymen... from: Ontario Inter Airport,...

Workshop Resources Contact Home

## IMQ CLC Resources

Incorporating Cultural and Linguistic Competency into CME

### Welcome!

The IMQ Cultural and Linguistic Competency Program offers technical assistance on 42 CFR 1195 compliance. These resources are available to existing CME providers and those interested in offering CME.

[IMQ Cultural and Linguistic Competency Program](#)

### CLC Program Staff

Meet [Asia Robinson](#), the Project Administrator for the IMQ CLC Program. Her express purpose at IMQ is to ensure provision of appropriate technical assistance to California based CME providers and others interested in CME.

### Recent News & Updates

- April 13th**  
CLC Regional Workshops in San Francisco and Los Angeles. [View...](#)
- May 11th**  
IMQ held its Annual CME Provider Conference on May 11, 2007. [View...](#)
- July 20th**  
Event Full! Thank you, Mercy Medical Center, Merced! We will hold our July 20th CLC Regional Workshop in Merced. Expect to participate in CLC issues relevant to the Central Valley Region. [More...](#)
- October 5th**  
New Workshop! The date for the [Sacramento](#) CLC Regional Workshop has just been announced.

assistance to California-based CME providers and others interested in CME. October 5th  
New Workshop! The date for the [Sacramento CLC Regional Workshop](#) has just been announced.

**Choose CLC resources according to...**

your role in the CME community. Whether you are a CME coordinator, a CME Committee Chair, or a prospective CME provider, feel free to utilize these tools on cultural and linguistic competency.

1. [Professionalism](#)
2. [Cultural and Linguistic Competency](#)
3. [Cultural and Linguistic Competency](#)
4. [Cultural and Linguistic Competency](#)
5. [Cultural and Linguistic Competency](#)
6. [National Resource Agency for Health Professions Education](#)
7. [State and Regional Resources](#)
8. [Resources for Hospital-based CME Programs](#)
9. [Resources for Organization sponsored CME Programs](#)



# CLC Resources

Examples of CME on CLC

[Workshop Synopses](#) [Contact](#) [Home](#)

- [Cultural and Linguistic Competency in the Workplace](#)
- [Cultural and Linguistic Competency in the Classroom](#)
- [Cultural and Linguistic Competency in the Community](#)
- [Cultural and Linguistic Competency in the Home](#)
- [Cultural and Linguistic Competency in the Workplace](#)

- [Cultural and Linguistic Competency in the Workplace](#)
- [Cultural and Linguistic Competency in the Classroom](#)
- [Cultural and Linguistic Competency in the Community](#)
- [Cultural and Linguistic Competency in the Home](#)
- [Cultural and Linguistic Competency in the Workplace](#)





AMERICAN ACADEMY OF FAMILY PHYSICIANS

# CME Center

SEARCH

[Advanced Search](#)

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- [CLINICAL & RESEARCH](#)
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- [POLICY & ADVOCACY](#)
- [CAREERS](#)

Home Page > CME Center > Self-study CME > Quality Care for Diverse Populations Video

## SELF-STUDY CME

- ▶ [Quality Care for Diverse Populations Video](#)
- ▶ [AAFP Courses - Self-study Materials](#)
- ▶ [Americans in Motion](#)
- ▶ [AFP Online Quiz](#)
- ▶ [FPM Quiz](#)
- ▶ [AFP Monographs](#)
- ▶ [Case Studies](#)
- ▶ [DVD: CME Videos](#)
- ▶ [Clinical Procedures](#)
- ▶ [CME Bulletins](#)
- ▶ [Home Study](#)
- ▶ [METRIC](#)
- ▶ [Topics in the News](#)
- ▶ [Video CME Online](#)

## Quality Care for Diverse Populations Video

Quality Care for Diverse Populations is a Web-based training program developed by the American Academy of Family Physicians to assist physicians and other health care professionals in becoming more culturally proficient in the provision of care to their patients. The program includes five video vignettes depicting simulated physician-patient visits in an office setting as a means to explore ethnic and sociocultural issues found in today's diverse health care environment.

- [Printer-friendly version](#)
- [Email this page](#)

### Learning Objectives

- Understand how to work collaboratively with medical interpreters;
- Recognize why and when cultural factors related to obesity may be a barrier to doctor-patient communication and patient compliance;
- Identify specific health-based information concerning gay, lesbian, bisexual and transgender (GLBT) populations, including health risks, health disparities and strategies for improvement;
- Identify major stressors related to the process of immigration and

**MEMBERS**  
[Log In](#)

**MY ACADEMY:**

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- More

**QUESTIONS?**  
CME Production  
[Send E-mail](#)  
800-274-2237 ext 6537

Get the credit you deserve

**EASY PAY**

Quality Interactions - Microsoft Internet Explorer provided by Jim, your Network Guy

http://www.qualityinteractions.org/

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Quality Interactions Southwest Airlines Paymen... from: Ontario Inter Airport,...

# QUALITY INTERACTIONS®

A Patient-Based Approach to Cross-Cultural Care

- Home
- Cultural Competence
- Product Overview
- Success Stories
- Demo
- Press & Literature
- About Us



Quality Interactions—An innovative CME-accredited cultural competency training program for physicians, nurses and health care professionals.

[Learn more about Quality Interactions](#)

[Cultural Competence in Healthcare](#)

## NEWS

**February 6, 2007**  
 Manhattan Cross Cultural Group and Cook Ross, Inc. Align to Provide Comprehensive Cultural Competence Solutions [More >](#)

**November 17, 2006**  
 Aetna Launches Tools to Improve Cross-cultural Awareness, Communication Among Health Care

## PRODUCT OVERVIEW

**New!! Quality Interactions introduces new program for all employees in health care organizations!**

[Read more >](#)

Quality Interactions is the first e-learning program on cultural

## SUCCESS STORIES

Thousands of physicians and nurses have been successfully trained with the Quality Interactions e-learning program. Health care providers from around the country have found the program to be a comprehensive, engaging, and worthwhile experience.

[Find out more](#) about the success stories of organizations who used the



# A Physician's Practical Guide to Culturally Competent Care

Portal Home Course Home Earn Credit

## Course Login

**Returning Users**  
Forgot Password?

User Name   
Password

**Go**

## New User?

Registration is open to physicians, nurses, pharmacists, and all health care professionals.

**Register**

Registered users may request the DVD supplement to this program.



[Help / FAQs](#)

## Course Information

**A Physician's Practical Guide to Culturally Competent Care** is a continuing medical education activity:

*This continuing medical education activity is jointly sponsored by CME-Med, Inc.*



## Why Culturally Competent Care?

[e-mail a colleague](#)

With the increasing diversity of the United States' population, physicians are more and more likely to encounter situations that require the delivery of culturally competent care, access to a vast array of language services, and supportive healthcare organizations.

**Register today to start earning up to 9 free CME credits (Physicians), 9 CNE credits (Nurses) or 9 contact hours (0.9 CEUs) (Pharmacists) while exploring engaging cases and learning about cultural competency in health care.**

Below you may view case highlights from this website:

## Case Highlights



**Cultural Fact**  
Within 50 years, nearly half of the



# CLC Resources

By Physician Specialty

[Workshop Synopses](#) [Contact](#) [Home](#)

- [Allergy/Immunology](#)
- [Anesthesiology](#)
- [Cardiovascular Medicine](#)
- [Emergency Medicine](#)
- [Family Medicine](#)
- [Internal Medicine](#)
- [Neurology](#)
- [Nuclear Medicine](#)
- [Obstetrics and Gynecology](#)
- [Ophthalmology](#)
- [Orthopedics](#)

- [Pediatrics](#)
- [Podiatry](#)
- [Psychiatry](#)
- [Sports Medicine and Rehabilitation](#)
- [Endocrinology](#)
- [Geriatric Medicine](#)
- [Hematology](#)
- [Infectious Diseases](#)
- [Intensive Care Medicine](#)
- [Laboratory Medicine](#)
- [Neurology](#)
- [Oncology](#)
- [Radiology](#)
- [Surgery](#)
- [Urology](#)





# CLC Resources

By Health Risks, Diseases, Illness

[Workshop Synopses](#) [Contact](#) [Home](#)

- [Introduction](#)
- [Introduction to CLC](#)
- [CLC](#)
- [CLC in the Workplace](#)
- [CLC in the Community](#)
- [CLC in the Home](#)
- [CLC in the Classroom](#)
- [CLC in the Hospital](#)
- [CLC in the Office](#)

- [CLC in the Workplace](#)
- [CLC in the Community](#)
- [CLC in the Home](#)
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- [CLC in the Community](#)
- [CLC in the Home](#)
- [CLC in the Classroom](#)
- [CLC in the Hospital](#)
- [CLC in the Office](#)







# CLC Resources

By Patient Population

[Workshop Synopset](#) [Contact](#) [Home](#)

- [Introduction](#)
- [Cultural Competency](#)
- [Cultural Awareness](#)
- [Cultural Sensitivity](#)
- [Cultural Proficiency](#)
- [Cultural Humility](#)
- [Cultural Intelligence](#)

- [Cultural Competency](#)
- [Cultural Awareness](#)
- [Cultural Sensitivity](#)
- [Cultural Proficiency](#)
- [Cultural Humility](#)
- [Cultural Intelligence](#)





Internet Explorer browser interface showing the address bar with the URL <http://www.imq.org/national.html>. The menu bar includes File, Edit, View, Favorites, Tools, and Help. The toolbar contains a search box with the Google logo, navigation buttons (Go, Back, Forward, Stop, Reload), and utility buttons (Bookmarks, 33 blocked, Check, AutoLink). The status bar at the bottom shows the current page title "Incorporating Cultural a...", the active window "Southwest Airlines Paymen...", and other browser controls like Home, Print, Page, Tools, and Help.



# CLC Resources

National CLC Resources

[Workshop Outcomes](#)   [Links & Downloads](#)   [Contact](#)

## National CLC resources

[National Center for Cultural Competence](#)  
[National Center for Cultural Competence](#)

### HRSA Bureau of Health Professionals - Programs to Increase Diversity

- [HRSA Bureau of Health Professionals - Programs to Increase Diversity](#)
- [HRSA Bureau of Health Professionals - Programs to Increase Diversity](#)
- [HRSA Bureau of Health Professionals - Programs to Increase Diversity](#)
- [HRSA Bureau of Health Professionals - Programs to Increase Diversity](#)
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[HRSA Bureau of Health Professionals - Programs to Increase Diversity](#)





# CLC Resources

CLC Workshop: April 13, 2007

[IMQ Home](#) [Links & Downloads](#) [Contact](#)

## Synopsis of April 13, 2007 CLC Workshop

"CULTURAL & LINGUISTIC COMPETENCY IN CME: WHERE DO WE BEGIN?"

Carol Havens, MD and Alecia Robinson, MPH, MCP

The initial CLC Regional Workshop was successful, and 11 providers out of 23 expressed their comments in the post workshop survey. Overall satisfaction was high.

Approximately 64% of participants agreed or strongly agreed that session content addressed "...challenges and other AB 1195 issues as they relate" to their own programs. (27% answered "somewhat agree"). 90% of attendees also mentioned that as a result of attending this session, they were very likely or likely to contact the IMQ CLC Program for technical assistance in the future. 72% of attendees commented that they were very likely or likely to change their practices in their CME program after learning AB 1195 implementation skills during the workshop.

Other behavioral changes included, "Set up a meeting of physicians and pertinent individuals in the organization to further develop and implement CLC program in the hospital", "Will check existing activities to see if we already have incorporated CLC aspects...and work with my committee to brainstorm ways to incorporate new CLC information", and "Present the program with an emphasis on CLC in part of the presentation".

- *Definitions of cultural and linguistic competency*
- *Overview of cultural and linguistic competency in CME*
- *Activity specific "how-to" for addressing CLC in CME*
- *Available CLC resources*

PARTICIPANT COMMENTS & QUESTIONS

*What are workshop participants doing in their programs to integrate CLC into CME?*

1. Adding books on CLC and navigating cultural relationships to their staff library.
2. Medical staff recognized that witnessing and respecting the self efficacy and cultural identity among clinicians (of color) improves overall morale.
3. Approached new funding sources for cultural outreach in osteoporosis prevention and treatment.

*What can be done differently?*

1. One prospective CME provider raised the issue of how important it is to collect sound data in conjunction with training on racism in a hospital or organization.
2. One attendee recommended using California demographics to plan CME activities according to service area cultural differences.
3. A provider suggested CLC training across the professional life course of clinicians.
4. A participant spoke of peer to peer sharing of "Cool ideas...give your 5 best examples of CLC in CME".
5. Suggestions were made to have a "CLC in CME" webinar, a "CLC in CME" list-serv, and a web-based "CLC in CME" group (i.e., yahoo groups).
6. A workshop participant recommended that we provide CLC Pre/Post questions at the CLC workshops.

**WWW.IMQ.ORG/CLC\_INDEX.H  
TML**

# Cultural Competence in Healthcare

Presentation for:  
The Medical Board of California



*University HealthSystem Consortium*

**hccs**  
Experts in Healthcare Learning

# About HCCS



- HCCS develops, delivers and maintains on-line compliance and quality improvement training for the healthcare industry, with specific focus on hospitals, health plans, and other healthcare institutions
- HCCS also identifies and markets the “best-of-breed” training on topics from 3rd party vendors
- HCCS is working with the University Health System Consortium (97 academic medical centers) to offer UHC Cultural Competency courses to healthcare organizations outside their membership

# About HCCS



- **Since 1998**
- **Focused exclusively on healthcare compliance, competency and quality improvement**
- **High quality expert content**
- **Healthcare LMS**
- **Experienced**
  - **600 Clients**
  - **Over 1,200,000 Registered Users**
  - **2,500,000 training hours**
  - **96% average completion rate**

# Team of Experts

- **Geri-Ann Galanti**, PhD, faculty member UCLA School of Medicine, and dual appointments at Cal State University's School of Nursing and Department of Anthropology, Author of *Caring for Patients from Different Cultures*
- **Jacqueline Voigt**, MSSA, Manager of the Cultural Competency Division, at the University of Michigan Health System
- **Mechelle Callen**, MBA, SPHR, Director The Wishard Institute for Employee Development, Wishard Health Services
- **Cezanne Garcia**, MPH, CHES, Associate Director, Patient and Family Centered Care and Education Services, University of Washington Medical Center
- **Cathy Krsek**, RN, MSN, MBA, Director, Operational Benchmarking & Nursing Leadership, UHC

# *Cultural Competence in Health Care*



## *African American Culture*



# Learning Objectives

- Cite several questions to ask to elicit cultural information.
- Explain strategies for providing culturally appropriate medical and nursing care.
- Describe several tools for increasing patient trust and compliance.
- Recognize the difference between a stereotype and a generalization and know how to apply generalizations without stereotyping.
- Explain the impact of racism and prejudice on medical care and a patient's experience in medical contexts.
- Explain the effects of cultural values and beliefs (world view) on behavior.
- Recognize the difference between traditional treatments and abuse.
- Explain strategies for dealing with difficult family members.
- Recognize items of religious or spiritual significance and treat them with respect

# Sample Screen Shots

(training uses flash animation)

Cultural Competence in Health Care - Windows Internet Explorer

http://hlp.hccs.com/organizations/org00000202/courses/00000012/aa727/Presentations/pres-out30.html

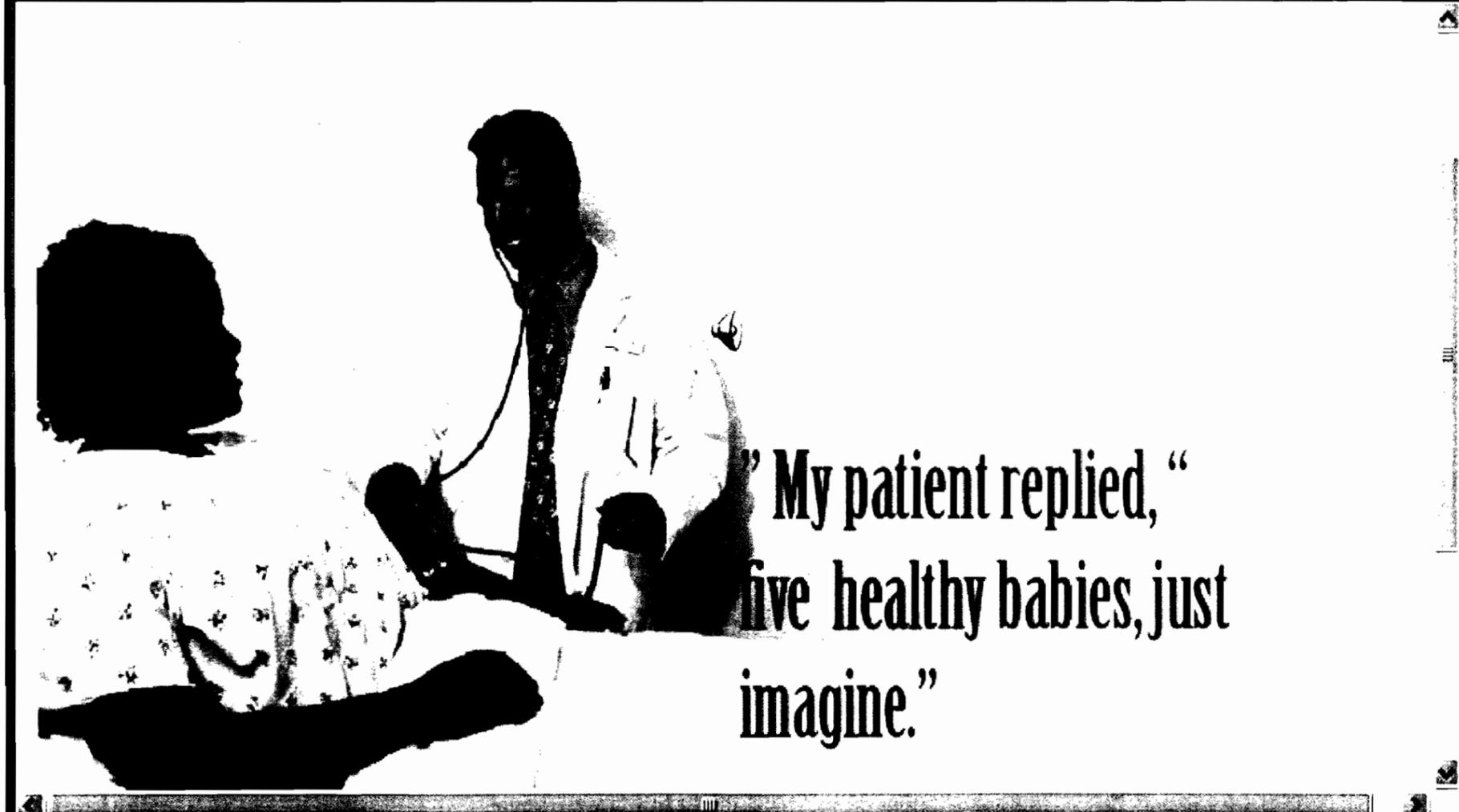
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☆ ☆ Home Page Tools ?



As I finished the examination,  
I said, "Both you and the baby  
are perfectly healthy, Carla."

Done Internet 100%



” My patient replied, “  
five healthy babies, just  
imagine.”

Cultural Competence in Health Care - Windows Internet Explorer

<http://hlp.hccs.com/organizations/org000000202/courses/00000012/aa727/Presentations/pres-out30.html>

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☆ ☆ Home RSS Print Page Tools



This seemed to me the appropriate time to ask my next question, which was whether my patient had considered having her tubes tied after delivering the baby.

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Cultural Competence in Health Care - Windows Internet Explorer

http://hlp.hccs.com/organizations/org00000202/courses/00000012/aa727/Presentations/pres-out30.html

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☆ ☆ Home Page Tools ?

Instead of answering,  
she began to get very angry  
and accused me of racism.



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Cultural Competence in Health Care / African American - Windows Internet Explorer

http://hlp.hccs.com/organizations/org00000202/courses/00000012/aa727/AAQC1a/index.html

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Cultural Competence in Health Care / African American Start



# Case Summary

A Caucasian doctor completes a prenatal exam for Othella Carter, a, 43-year old African American patient

The doctor addresses the patient by her first name telling her she and her baby are healthy

In response, the patient states: "Five healthy babies, just imagine"

The doctor interprets this as an opportunity to discuss future family plans and asks Mrs. Carter about 'having her tubes tied'

Instead of answering, the patient gets very angry and accuses the doctor of racism

### Coaching Corner

[How can I avoid the perception of discrimination?](#)

[How might trust issues manifest themselves in the health care setting?](#)

[Are there trust issues specific to African American patients?](#)

### Resources

[Establishing Meaningful Dialogue](#)

[Generalizing or Stereotyping?](#)

[Additional Resources](#)

[Soliciting Patient Information](#)

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Ask the Expert - Windows Internet Explorer

http://hip.hccs.com/organizations/org00000202/courses/00000012/aa727/AfricanAmAsk/main-out575-0.html

UHC LEARNING EXCHANGE

Glossary | Help | Exit

**Ask the Expert**

**Question**

How can I avoid the perception of discrimination?

**Answer**

  
Gen-Ana Collins, Ph.D.

Treat patients with respect. Address each adult patient by title and last name, unless told to call them by their first name. If you are running late, apologize and explain the reason. Think about how your words or actions might be perceived. Also, when you do patient teaching, it is important to explain things clearly without sounding condescending. (This will come through largely in your tone of voice.) Avoid phrases like, "Let me put this in words you can understand..."

**Select a Follow-up Question**

- [Are there trust issues specific to African American patients?](#)
- [How do African Americans feel about donating organs?](#)
- [How might trust issues manifest themselves in the health care setting?](#)
- [Are there terms I should avoid?](#)
- [Do all cultures have the same orientation to time?](#)
- [What are African American beliefs about blood and how can they be confused with blood pressure?](#)
- [What are customs for birth and pregnancy?](#)

**Additional Information**

[Print all Questions and Responses](#)

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Coaching Corner

How can I avoid the perception of discrimination?

How might trust issues manifest themselves in the health care setting?

Are there trust issues specific to African American patients?

Resources

Establishing Meaningful Dialogue

Generalizing or Stereotyping?

Additional Resources

Soliciting Patient Information

Select a Choice Below

Why would the patient have perceived this as a racist question?

- (Click a choice below)*
- She may distrust the medical community based on historical treatment of Africans American in the medical community.
- She is aware of racial disparities in health care and is afraid of being mistreated.
- As an African American woman, it is likely that she has experienced both subtle and overt forms of racism her entire life, and her radar is highly attuned to it.

**Select a Choice Below**

**Why would the patient have perceived this as a racist question?**

She may distrust the medical community based on historical treatment of African American in the medical community.

**How could the physician have handled the situation in a more culturally sensitive manner?**

*(Click a choice below)*

Rather than addressing her by her first name, he could have used her last name and title.

Rather than directly asking if she wants a tubal ligation, he might tell her that he is concerned about the increased risks of pregnancy for women in their forties and give her more information so she can make an informed choice.

Rather than directly asking if she wants a tubal ligation, he should ask a more general question, like, 'Are you planning on having more children?'

**Resources**

- [Establishing Meaningful Dialogue](#)
- [Generalizing or Stereotyping?](#)
- [Additional Resources](#)
- [Soliciting Patient Information](#)

Cultural Competence in Health Care / African American - Windows Internet Explorer

http://hlp.hccs.com/organizations/org00000202/courses/00000012/aa727/AAQC1a/index.html

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Cultural Competence in Health Care / African American Start

### The Result of Your Selections

Good. Your insight about the potential root of the patient's perception is correct and by showing concern for her health, you would be taking a productive step toward insuring she does not jump to the conclusion that the physician is being racist.

### Feedback on Your Performance

- **Your response. She may distrust the medical community.** Yes. From 1932-1972, the U.S. Public Health Service conducted an experiment on African American men. Known as the Tuskegee Experiment, for the Alabama county where it occurred, nearly 400 African American men with syphilis were purposely left untreated in order to observe the effects of the disease. Data was to be collected from their autopsies. Add to that the growing evidence of racial disparities in health care. For example, according to the Agency for health care Research and Quality, African Americans are 13 percent less likely to undergo coronary angioplasty and one-third less likely to undergo bypass surgery than are whites. African American with HIV infection are less likely to be on antiretroviral therapy, less likely to receive prophylaxis for pneumocystis pneumonia, and less likely to be receiving protease inhibitors than other persons with HIV. It is no wonder that many African Americans have little trust for medical institutions.
- **Your response: Rather than directly asking if she wants a tubal ligation, he might tell her that he is concerned about the increased risks of pregnancy for women in their forties and give her more information so she can make an informed choice.** This is generally a good approach, however, be aware that her religious beliefs could conflict with this approach. Many African Americans are very religious and believe that their health and all other related outcomes are in Gods hands.

done Internet 100%

Cultural Competence in Health Care - Windows Internet Explorer

http://hlp.hccs.com/organizations/org00000202/courses/00000012/as727/Presentations/pres-out43.html

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Glossary | help | Exit

Cultural Competence in Health Care / Case 1 Summary Case 1 Summary

### Key Take-Aways

- Numerous studies have shown that racial disparities in medicine do exist.
- Racism and discrimination are unfortunate realities in our country.
- Given the above facts, many African Americans are attuned to words and actions that can be perceived as racist and discriminatory, even if they are not intended as such.
- Culturally competent health care providers, aware of these facts, will make every effort not to say or do things that can be interpreted as racist. For example, show respect for patients by using their last name, and finding out what the *patient* wants, rather than making assumptions. This is good practice for all patients, not just African Americans.
- When you make a statement that offends a patient, whether or not you intended it in the way it was interpreted, apologize. It is the first step in rebuilding trust.

Click on the Clipboard to Review All of the Questions and Responses from Case



Internet 100%

Cultural Competence in Health Care - Windows Internet Explorer

http://hlp.hccs.com/organizations/org00000202/courses/00000012/aa727/Presentations/pres-out85.html

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Now, complete the Mastery Test below. You must finish it to complete the course.

### African American Cultural Competence

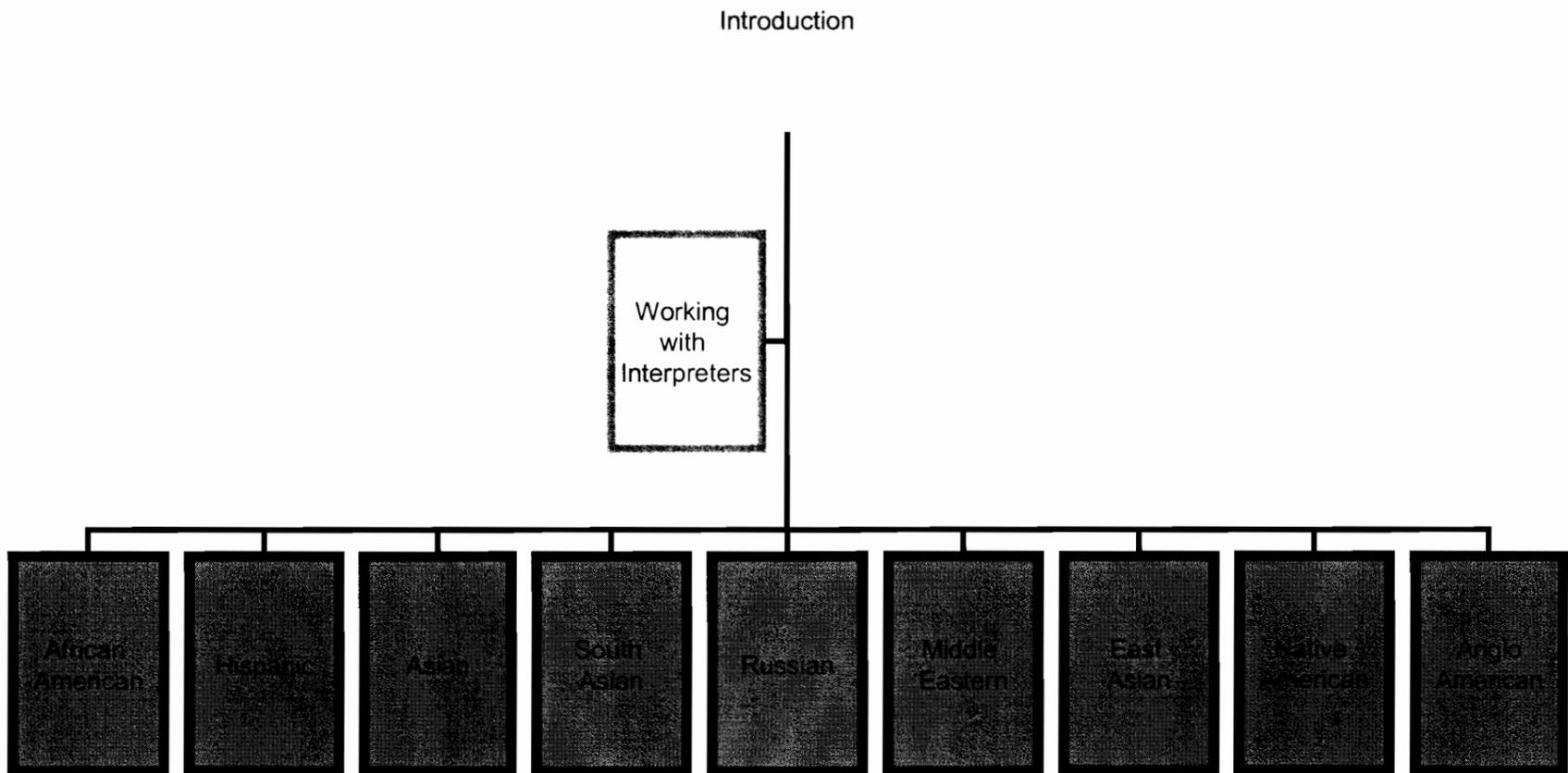
Question 1 of 5: Point Value 10

People with which time orientation are more likely to utilize preventive health care measures?

- present- time orientation
- clock time
- future time orientation

Done Internet 100%

# Curriculum Map



## More Information

Request pricing information or a private demo: [info@hccs.com](mailto:info@hccs.com)

Learn more about HCCS courseware: <http://www.hccs.com>

## Next Steps?

DHHS Office of Minority Health  
State Partnership Grant Program to  
Improve Minority Health

**Providing Quality Health Care  
with CLAS:**

A Curriculum for Culturally and Linguistically  
Appropriate Services

**A Partnership Between:**

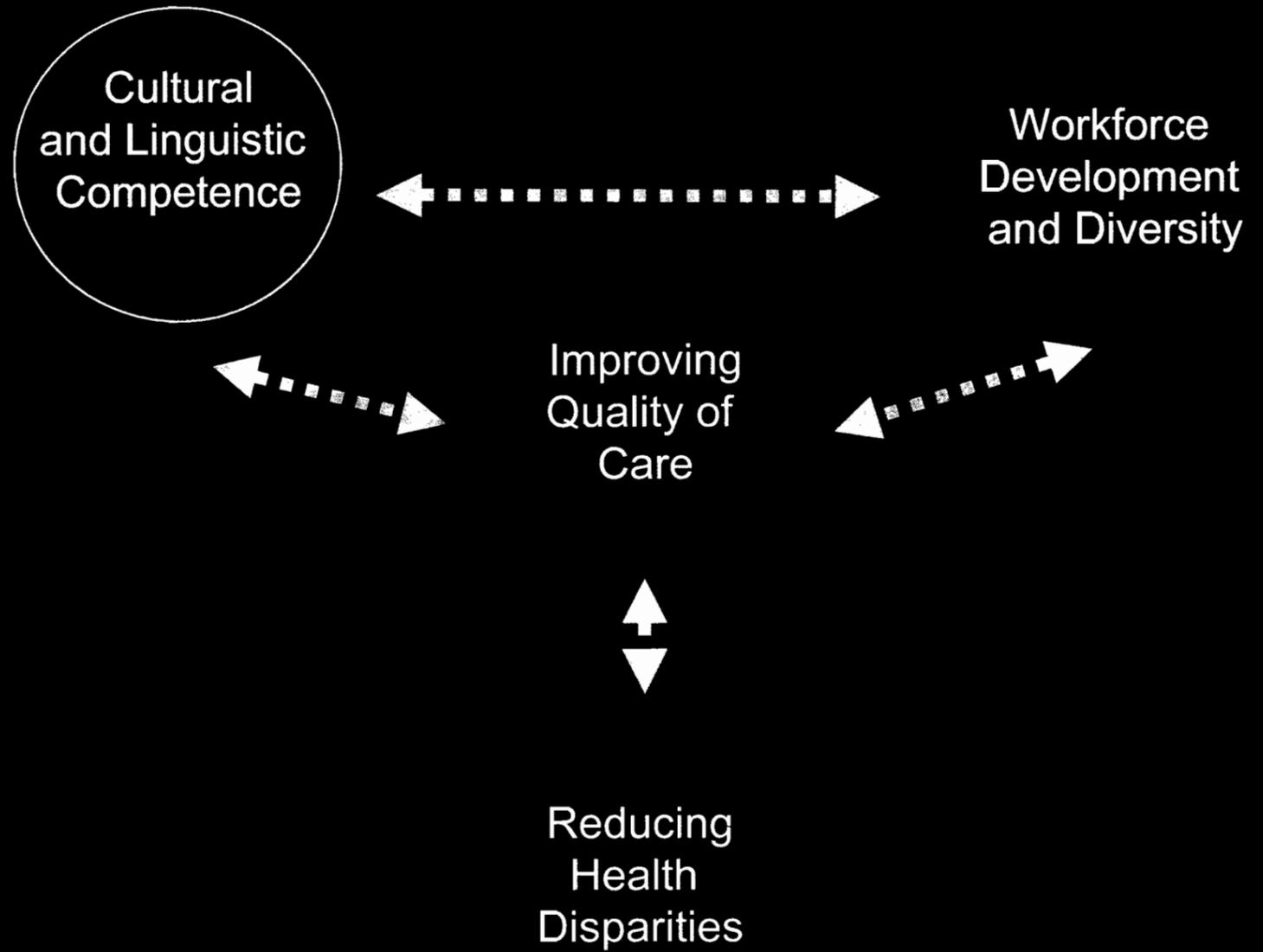
CDHS, Office of Multicultural Health

UCDHS Center for Reducing Health Disparities



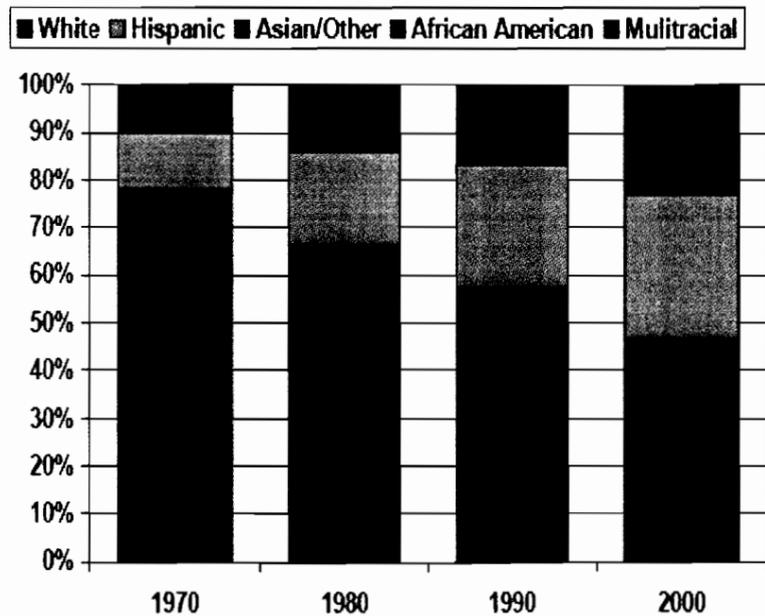
**UCDAVIS**  
*HEALTH SYSTEM*

# Demographic Changes



## California's Population by Race and Ethnicity

**Figure 2**  
**Racial/Ethnic Composition of California's Population, 1970-2000**

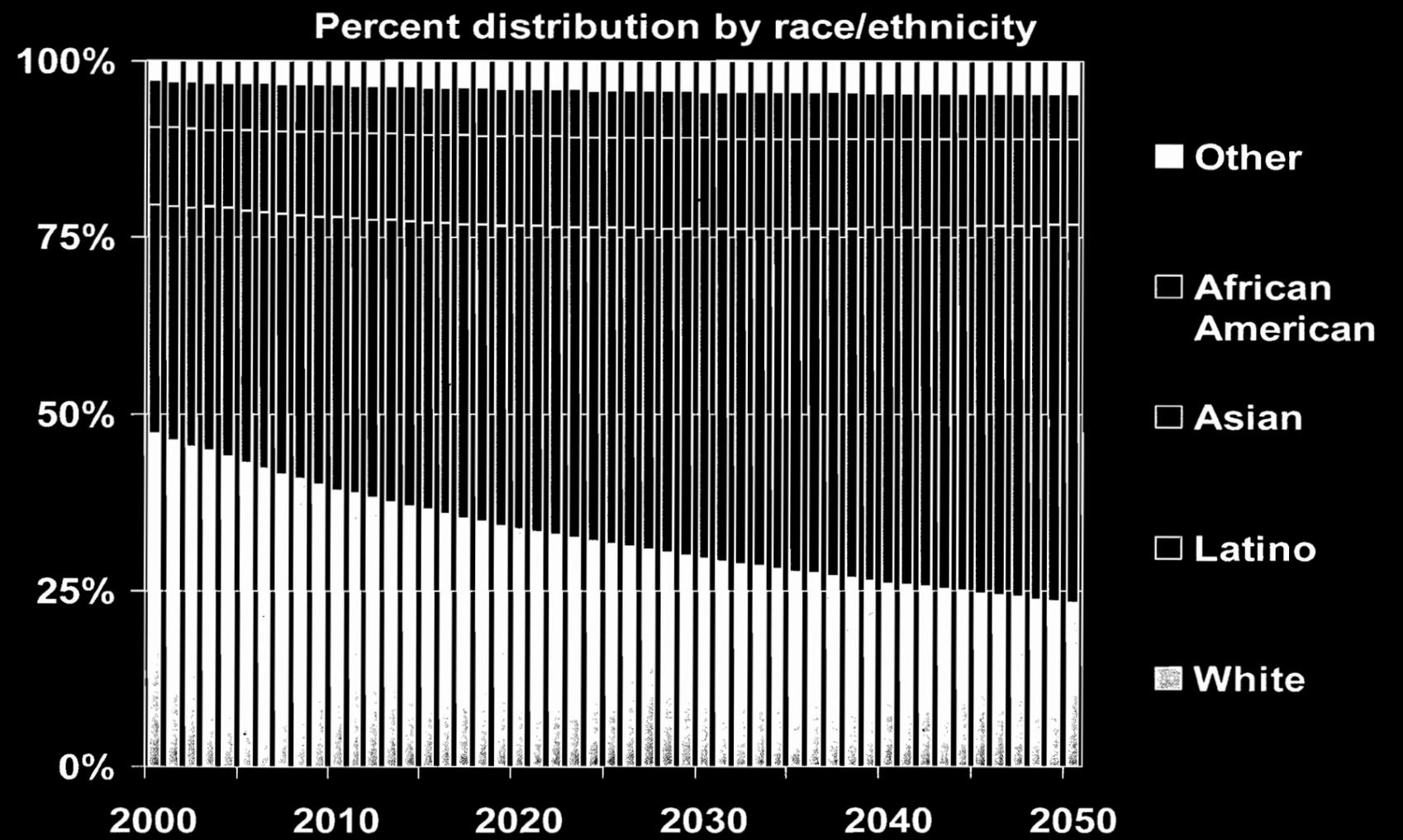


Source: Decennial censuses

- California leads the nation in diversity.
- As such, the state is challenged with a substantial leadership role in designing and maintaining services that achieve cultural and linguistic competency.

Source: Johnson, California's Demographic Future, Public Policy Institute of California, 2003

# California's Projected Population by Race and Ethnicity



Source: Hayes, 2006

## Health Disparities: Findings

### UNEQUAL TREATMENT

CONFRONTING RACIAL  
AND ETHNIC DISPARITIES  
IN HEALTH CARE

INSTITUTE OF MEDICINE

- Racial and ethnic disparities exist across a wide range of
  - disease areas
  - clinical services
  - clinical settings
- Minorities receive lower-quality health care
- Associated with higher mortality among minorities

Source: "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care", IOM, 2002

# The National Healthcare Disparities 2006 Report

## National Healthcare Disparities Report



### Access to Care:

- Most disparities in access to care experienced by AA (3/5), Asians (3/5), and AI/ANs (4/5) were improving;
- Most disparities experienced by Hispanics (4/5) and by poor people (3/5)

## Recommendations from the IOM's Unequal Treatment

- Increase awareness of racial/ethnic disparities in health care;
- Collect patient data by race/ethnicity;
- Include measures of racial and ethnic disparities in performance measurement;
- Promote the use of interpretation services;
- Increase diversity of the health care workforce;
- Integrate cross-cultural education into the training of all current and future health professionals.

Source: Smedley, Stith, & Nelson, Eds. (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington: National Academies Press.

## Rationale for Culturally and Linguistically Competent Health Care

- Responding to demographic changes;
- Eliminating disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds;
- Improving the quality of services and outcomes;
- Meeting legislative, regulatory, and accreditation mandates;
- Gaining a competitive edge in the marketplace;
- Decreasing the likelihood of liability/malpractice claims.

Source: Cohen E, Goode T. Policy Brief 1: Rationale for cultural competence in primary health care. Georgetown University Child Development Center, The National Center for Cultural Competence. Washington, D.C., 1999.

## Legislation

**California: “Continuing education: cultural and linguistic competency”**  
**AB 1195—California Business and Professions Code. Ch. 5,**  
**Article 10, § 2190.1 (2005), effective July 1, 2006**  
[www.healthlaw.org/library.cfm?fa=download&resourceID=78947&print](http://www.healthlaw.org/library.cfm?fa=download&resourceID=78947&print) -

**New Jersey: “Requires Physician Cultural Competency  
Training as a Condition of Licensure”**  
Senate Bill 144, signed into law March 23, 2005  
<http://www.njleg.state.nj.us>

**Washington State: “Requiring Multicultural Education  
for Health Professionals”**  
2006 Senate Bill 6194S, signed into law March 27 , 2006  
<http://www.washingtonvotes.org/2006-SB-6194>

## How Can A Program/Agency Become Culturally Competent

- Eight essential elements contribute to a health system or agency's ability to become more culturally competent;
- Each of these elements must function at every level of the system, i.e., policy, administration, practices and advocacy.

Source: Cohen & Goode, National Center for Cultural Competence, 1999

## How Can A Program/Agency Become Culturally Competent

### **The System/Agency:**

1. Should conduct needs assessments for service planning purposes;
2. Must value diversity;
3. Should have the capacity for cultural self-assessment;
4. Should be conscious of the dynamics inherent when cultures interact;

Source: Cross, TL, Bazron, BJ Dennis, KW and Isaacs MR, Towards a Culturally Competent System of Care, Child and Adolescent Service System program (CASSP) Technical Assistance Center, Georgetown University Child Development Center, Washington, D.C., 1989.

## How Can A Program/Agency Become Culturally Competent

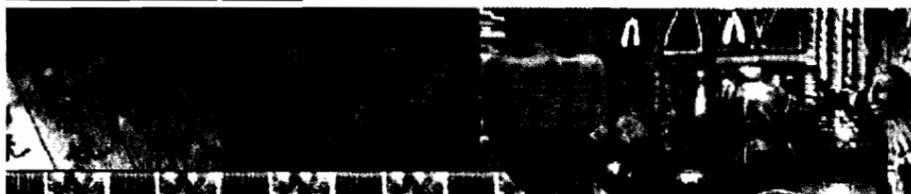
### **The System/Agency:**

5. Should institutionalize cultural knowledge;
6. Should develop adaptations to diversity when necessary;
7. Should separate the effects of poverty and geographic location from cultural values;
8. Should be on guard against the creation of stereotypes in its efforts to be culturally competent.

Source: Cross, TL, Bazron, BJ Dennis, KW and Isaacs MR, Towards a Culturally Competent System of Care, Child and Adolescent Service System program (CASSP) Technical Assistance Center, Georgetown University Child Development Center, Washington, D.C., 1989.



U.S. Department of Health and Human Services, OPHS  
Office of Minority Health



**National Standards for  
Culturally and Linguistically  
Appropriate Services in  
Health Care**

**FINAL REPORT**



March 2001  
Washington, D.C.

## Culturally and Linguistically Appropriate Services (CLAS) Standards

- A response to public and private providers, organizations, and government agencies for culturally and linguistically appropriate standards in the provision of health care;
- Emphasizes the importance of cultural and linguistic competence in health care;
- Developed 14 standards which define key concepts and issues, and discussion of critical implementation issues.

Source: Office of Minority Health, U.S. Department of Health and Human Services. (2000). National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. Federal Register, 65(247), 80865-80879.  
<http://www.omhrc.gov/clas/finalcultural1a.htm>

## CLAS Standards Themes

The 14 Standards are organized by three themes:

- Culturally Competent Care
  - Standards 1-3
- Language Access Services
  - Standards 4-7
- Organizational Supports
  - Standards 8-14

Funded Project:  
OMH State Partnership Grant Program  
to Improve Minority Health

**Purpose:**

- A national strategy to facilitate the improvement of minority health and elimination of health disparities through the development of partnerships with established state and territorial offices of minority health.

**A Partnership between:**

- CDHS, Office of Multicultural Health
- UCDHS Center for Reducing Health Disparities

# CLAS Standards Project Organizational Chart

Cultural and Linguistic  
Competence Content  
Advisory Task Force

1. Matthew Mock
2. Mario Hernandez
3. Tawara Goode
4. Guadalupe Pacheco
5. Ken Martinez
6. Annelle Primm
7. Mayra Endriga
8. Peter Guarnaccia
9. DJ Ida
10. Rachel Guerrero
11. Robert Like
12. William Vega
13. Anthony Dekker

Hendry Ton, M.D., MS  
CRHD  
Education Director

Erik Fernandez, M.D., MPH  
CLAS Project  
Evaluator

Marbella Sala  
CRHD  
Operations Manager

Daniel Steinhart  
CRHD  
CLAS Project Coordinator

# Cultural Competency Toolkit Curriculum Development Project

## Goals:

- Develop, implement, and evaluate a training curriculum for health service agencies and organizations based on the *Culturally and Linguistically Appropriate Services (CLAS) standards*.
- Disseminate and provide technical assistance in an effort to improve health service outcomes for minority populations .

# CLAS Implementation

## **Mission Statement:**

To implement, integrate and evaluate cultural and language competence across health systems to:

- Create a culturally and linguistically competent organization;
- Improve access to care;
- Enhance quality of care and outcomes;
- Maximize patient satisfaction and retention;
- Reduce health disparities.

## Curricular Approach

- Participant-centered, strength-based;
- Emphasizes collaborative effort;
- Facilitates deeper understanding and creative solutions;
- Allows for integration of CLAS standards into the organization's infrastructure, mission, and values.

## Participants

- 15-20 individuals in leadership positions;
- Commitment to design and implement projects incorporating CLAS standards
- Take ownership and lead the organization to full integration of the CLAS standards

## Leadership Support

- Endorsement of CLAS as operational philosophy—a way of doing business
- System-wide marketing of CLAS Project
- Support for participation
- Attendance by leadership

## Four Modules

1. Overview and Foundation
2. CLAS in Context; Project Development
3. System Change and CLAS
4. Project Evaluation and Implementation

## Maintaining Momentum

- Hold monthly meetings
- Develop plan
- Identify and solve challenges
- Share successful strategies
- Ownership of the CLAS Project

# CLAS Implementation Evaluation Model

## Benchmarks

- Participant:
  - Knowledge, Skills, Attitudes regarding health disparities and CLAS
- Organizational:
  - Level of implementation of each of the 14 Standards

## Outcomes

- Participant:
  - Knowledge, Skills, Attitudes regarding health disparities and CLAS
  - Ability to develop and implement CLAS-based improvement projects
- Organizational:
  - Level of implementation of each of the 14 Standards

## Summary

- Working knowledge of CLAS standards;
- Practical plan for implementation of CLAS standards;
- Effective coordination for maximal effect.

# Evaluation

## Course Evaluation

Overall Quality of Curriculum 3.5 out of 4

11 out of 14 participants would recommend curriculum to colleagues

Response Rate: 78%

## Evaluation: Knowledge

### Improvements in Knowledge (self reported)

Can better describe CLAS standards (100%)

More familiar with strategies for implementation (91%)

Greater awareness of CLAS based projects in system (100%)

Response Rate: 61%

## Evaluation: Attitudes

After course, participants strongly agreed that:	Improvement
CLAS standards are important to healthcare	2.5x
CLAS standards are possible to implement	1.7x
Implementing CLAS standards can reduce health disparities	2.7x

# Evaluation: Skills and Strategies

Case Study

Identification of Future Workgroup Goals

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- A) Business and Professions Code Section 2198(h) - The Division of Licensing shall convene a workgroup including, but not limited to, representatives of affected patient populations, medical societies engaged in program deliver, and community clinics to perform the following functions:
  - (1) Evaluation of the progress made in the achievement of the intent of this act.
  - (2) Determination of the means by which achievement of the intent of this article can be enhanced.
  - (3) Evaluation of the reasonableness and the consistency of the standards developed by those entities delivering the program.
  - (4) Determination and recommendation of the credit to be given to participants who successfully complete the identified programs.
  
- B) Review The California Endowment Report recommendations related to Business and Professions Code section 2198 (AB 801).

## **I. RECOMMENDATIONS THAT PERTAIN TO BOTH AB 801 AND AB 1195**

### *Recommendation #1: Create a Task Force as an Advisory Body for the Implementation of AB 801 and AB 1195*

A key lesson from the evolution of the New Jersey cultural competency mandate relates to process. According to interviewees, the New Jersey legislation (S144) represented the culmination of a series of events that were designed to increase buy-in among stakeholders, from community members to the Governor's office. They shared that the implementation process for S144 will continue along this path. They outlined that a critical next step in New Jersey is that the State Board of Medical Examiners, which is responsible for interpreting the legislation, is creating an advisory Task Force. The Task Force will include in-state experts who know the state "ecosystem" and are familiar with the literature and best practices to provide guidance to strategies moving forward.

The Medical Board of California should also consider the creation of a Task Force to serve in an advisory capacity for the implementation of both AB 801 and AB 1195, as they are intrinsically linked and could be operationalized in a way that maximizes synergies between their common legislative intent - to improve physician cultural and linguistic competency thereby improving patient access to quality care. For example, as called for in AB 1195, the cultural and linguistic competency curriculum development process could put forth cross-cutting introductory modules that alert physicians of additional specific CME courses focused on cultural and linguistic competency. These modules could also include components that evaluate current physician competency/proficiency levels and assess physician interest in courses, thereby guiding the developmental process of additional CME-based cultural competency and second language training courses. These ideas are fleshed out in more detail later in this report. However they are presented here to illustrate how a common Task Force could approach the operationalization of both pieces of legislation.

This Task Force could include those with expertise on cultural competency and with second language training (maybe as subcommittees or working groups), balancing those with curriculum development expertise with those who possess experience in administering CME accredited programs. It may also consider including representatives that served on the California Department of Consumer Affairs and the California Department of Health Services AB 2394 Task Force on Culturally and Linguistically Competent Physicians and Dentists, for their experience in considering the promotion of linguistic and cultural courses as part of continuing education requirements. Or if, as recommended in the AB 2394 Task Force Final Report to the Legislature, this Task Force has continued, efforts should be made to collaborate and jointly address the common issues underlying all three enacted bills.<sup>128</sup>

The Task Force's purpose could be to help the Medical Board of California to consider the merits of the various recommendations outlined in this report, as well as to put forth other viable strategies to advance the development of voluntary cultural competency and second language CME training opportunities, and curriculum content that cuts across California's CME courses. They might also be called upon to provide guidance as to how to increase support for CME-based physician cultural competency and second language training in California. This might

*Recommendation #3: Support Cultural Competency and/or Second Language Training Inclusion in Medical School Application Criteria and Accreditation Requirements*

While AB 801 and AB 1195 focus on CME-based training, many interviewees argued that cultural competency and language skills are better learned earlier in the medical training process. According to interviewees, the Medical Board of California has the authority to push this agenda through its licensing authority over CME, an action that helps reinforce the underlying intent of these legislative acts – to improve physician cultural competency and second language skills. Although supervision of medical school CME programs have been delegated to accrediting bodies, the Medical Board can include additional requirements and/or voluntary preferences. It could make cultural competency and/or second language training “optional, but preferred criteria” to medical school applications for CME accreditation. It could also support the creation of second language learning curriculum requirements for medical school and residency program accreditation (e.g., that language courses be made available).

TCE and the Medical Board of California could begin by engaging the AAMC on the subject. The issue of second language training already appears to be on the AAMC’s radar – it has a mini-workshop discussion planned for its November 2005 annual meeting entitled *Enhancing Cultural Competence by Training Medical Students as Interpreters*.<sup>171</sup>

*Recommendation #4: Tie Second Language and Cultural Competency CME Training to the Practice-Based, Performance Improvement Trend in CME*

The new trend toward practice-based, performance improvement focused CME opens the door for the promotion of cultural competency training, and may help physicians recognize language access issues associated with their practice. Various associations, including the AAFP and the AMA, are developing CME credit bearing practice-based assessment instruments (e.g., the AAFP Metric). TCE and the Medical Board of California might consider working with those developing these assessment instruments to determine how to ensure that cultural competency and language access issues are adequately addressed in the context of physician practice-based assessment and follow-up action plans. This might take the form of funding pilot, practice-based, performance improvement CME efforts with physician associations to infuse cultural and linguistic competency analysis within physician practice review. Funding along these lines might help build physician understanding of at least two of the major domains where cultural competency is critical: at the clinical and organizational levels. The Lewin Group’s framework and indicators for organizational cultural competence assessment (commissioned by HRSA) may find application in this type of approach.<sup>62</sup>

State QIO’s and university CME providers in Alabama and Mississippi have also developed model partnerships to support quality improvement focused, practice-based initiatives. These collaborations have resulted in the creation of practice-focused CME tailored to individual physician needs.<sup>172</sup> TCE and the Medical Board of California might encourage similar collaborations in California focused on improving the cultural and linguistic competency of physicians. If practice-based performance improvement CME is the wave of the future, building partnerships along these lines will be extremely important.

Perhaps these curricular offerings could be made available to practitioners for CME credit through their offices of continuing education.

- b) *Offer CME credit for training programs that teach physicians to work more effectively with interpreters.* In addition to pairing these programs with second language training, they could be offered and promoted independently for CME credit. A number of training programs along these lines exist, including those offered by health plans and community clinics. These trainings can provide physicians with basic orientation to the concepts of second language learning, including the potential for harm associated with false fluency. TCE might fund the modification of several model programs to a CME credit bearing, physician friendly format (e.g., modular, provided in several sessions). The models could then be assessed and their replication potential explored.
- c) *Increase bilingual physician access to existing interpreter training as a means to strengthen their second language learning (not become or replace interpreters).* A number of interviewees suggested that rather than reinventing the wheel, existing second language trainings, such as interpreter programs, should be made more accessible to physicians. Bilingual physicians could participate to enhance their second language learning, improve their language “humility” (i.e., understanding the potential for serious consequences resulting from patient-provider miscommunication), and strengthen their skills in working effectively with interpreters. Some bilingual physicians already participate in this capacity in interpreter trainings, including L.A. Care Health Plan’s offering. This program already provides participating physicians with CME credit. According to a representative of its Cultural and Linguistic Services Department, it could also be modified from its current form into a more physician friendly format.<sup>44</sup> If programs like these were better promoted and offered as a CME alternative, it would both increase bilingual physicians’ access to second language training, and improve their understanding of the importance of positive communication between physicians and interpreters – that having both speak a second language may help to correct interpreter errors as well as clinician false fluency errors. TCE could fund model trainings that are modified to be more accessible and user friendly to bilingual physicians and provided for CME credit.

Longer-term strategies suggested include encouraging California accredited CME providers to sponsor existing non-CME accredited training programs, addressing administrative burdens of CME accreditation, and exploring the potential for the development of new curricular offerings to be provided for CME credit. More specifically, recommendations include:

- d) *Convene accredited CME organizations, particularly medical societies and schools, with curriculum content developers, to discuss the potential for sponsorship of non-accredited programs.* Many interviewees were hesitant to explore this option for second language training, given physician false fluency concerns. However, possibilities could be explored to extend CME credit for non-accredited cultural competency trainings, such as those listed in this report. Medical societies and medical schools that have the continuing education administrative infrastructure, have access to members and alumni who they can encourage to participate. Administering these CME offerings can also help generate income, and may, for medical schools provide increased opportunities to cultivate alumni donors for longer term giving.

- Level 2 might include demonstration of ability to take a basic medical history, and explain certain conditions and symptoms.
- Level 3 might include demonstration of ability to explain risks and benefits of various treatment options, and facility with medical terminology in specialty areas.
- Level 4 might be demonstration of medical bilingual proficiency in the physician's practice area.

Certification exams that assess the proficiency of physicians at different levels of second language ability could be developed based on these standards. TCE is already working with groups, such as Kaiser Permanente and the Alameda Alliance for Health, to develop language proficiency assessment tools.<sup>173</sup> According to interviewees, some health plans are tying the development of language assessment tools to their own certification models for second language training interventions for physicians, with Kaiser Permanente advancing a multi-level rating system similar to that described above.<sup>43</sup> Their efforts will help inform more broad scale certification along these lines. The ACCME, and private and public health plans will be important partners in the development of CME-based second language training standards, programs, and marketing strategies. Health plans in particular could help create additional incentives, such as financial rewards and the opportunity for participating physicians to promote their certified second language skills in membership materials.

According to this model, the burden would be on physicians to ultimately demonstrate their second language ability according to certain certification standards. Perhaps additional incentives could be explored to encourage physician participation, including substantial CME credit for passing certification at various levels, as well as additional credits tied to recertification. This provides a basis to advocate for higher MediCal reimbursement rates for those undertaking the trainings, and maybe, if data can be presented that the programs actually improve patient-provider communication and reduce medical errors, even explore if participation could be tied to malpractice insurance incentives. To ensure industry quality controls, data could be maintained on pass rates for the various course options and made available to physicians. CME providers achieving certain pass rates among program participants could receive special acknowledgement or endorsement, thereby creating competitive incentives toward quality programming.

Exploring the potential for certification standards and examinations at multiple levels of second language training is one of the ways The California Endowment and the Medical Board of California might be able to address concerns about misplaced physician confidence in second language abilities. The program could build in outcomes measures designed to determine if programming along these lines improves patient-provider communication, reduces medical errors, and maybe even reduces the incidence of false fluency among physicians. If designed properly, physicians may be encouraged to participate as it could offer them a modicum of protection, and clarify to their patients the extent to which they can communicate in a second language.

The UCSF Center for the Health Professions recently published a paper entitled *Bilingual Proficiency Among California's Health Professionals*, written by Catherine Dower and supported by The California Endowment. This paper fleshes out many considerations in setting up language proficiency assessment and certification programs, such as the elements that might

significant analysis of what is meant by a “standard” and how this relates to providers. In its report, this group “proposed key cultural elements...to be used to develop standards” among its extensive recommendations.<sup>128</sup> As previously stated, the AB 2394 Task Force’s findings and recommendations should be more thoroughly explored before proceeding with the development of either cultural competency or second language proficiency certification or standards.

Some interviewees argued that developing separate standards or guidelines are not necessarily productive, as this language can fuel greater debate rather than focus the discussion on the intended goal, which is ultimately to improve patient care. One interviewee suggested that the Medical Board of California could develop consortia to vet the quality of programs, whereby CME providers seek a “stamp of approval.” The Medical Board could charge a fee for the review of programs to offset costs, to market endorsed programs, and to fund additional CME cultural competency opportunities, such as an annual cultural competency focused CME conference. The Medical Board’s AB 801 and AB 1195 Task Force could bring cultural competency curriculum development experts together with major CME provider stakeholders (e.g., the Society for Academic Continuing Medical Education, the Alliance for Continuing Medical Education, the Global Alliance for Medical Education) to develop the business case, as well as an outreach plan to encourage CME provider participation. As the *Opportunities* section of this scan highlights, the CME industry is big business with lots of competitors. This approach would be to help the industry to see the potential for serious revenue generation by growing the cultural competency training market.

### **3. RECOMMENDATIONS SPECIFIC TO AB 1195**

#### *Recommendation #10: Create a Technical Assistance Pool of Consultants with Cultural and Linguistic Competency Curriculum Development Experience*

The Task Force described in previous pages might also be charged with identifying and endorsing a pool of consultants with curriculum development expertise in cultural competency and second language training to help with the infusion of cultural and linguistic competency curricular content across CME courses. Many experts along these lines are listed in this paper. Others might include faculty at medical schools that have designed cultural and linguistic competency curricula. Once identified, the Task Force could issue a marketing campaign that alerts California’s CME providers (e.g., medical associations, continuing education departments in medical schools, etc.) of the passage of AB 1195, what it requires of in-state CME providers, and the availability of the technical assistance (TA) pool to assist in curriculum development. Given TCE’s experience interacting with cultural and linguistic competency curriculum developers, it might be able to help identify consultants to be considered. The Medical Board of California and its Task Force could help negotiate the nature of TA provider involvement – perhaps initially as expert advisors and eventually to identify or serve as curriculum content developers. Initially it could assist in negotiating their involvement with the CME accreditation associations, to ensure standards are developed that can then be implemented through programming. Experts might be incentivized to participate once they realize the potential long-term consultancy opportunities that their involvement creates.

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## **CONCLUSION**

The purpose of this environmental scan is to help The California Endowment and the Medical Board of California to explore the possibilities to strengthen physician second language and cultural competency training through CME activities. It outlines the current scope of program offerings, the policy context, various challenges and opportunities, and recommendations to consider. It is designed to spur future thinking and action, to determine the potential for investment in various policy and program approaches.

As the previous pages document, these are relatively uncharted waters. While countless health-focused cultural competency training programs are being developed, offerings for CME credit are limited and difficult to navigate. Medically-focused second language training for physicians is scarcer and considered quite controversial at this time. Furthermore, no state has undertaken the infusion of cultural and linguistic competency curricular content across its CME offerings related to direct patient care.

Despite these challenges, many U.S. residents face serious linguistic and cultural barriers to health care that are only likely to increase with projected demographic shifts. AB 801 and AB 1195 were enacted as measures to address the health access and quality needs of California's diverse constituencies, and the full extent of the opportunity provided by these legislative acts deserves to be fully explored. The Medical Board of California and The California Endowment can join forces on this journey, to build on the momentum that propels these issues to the forefront. Together they can spearhead exploration into how CME can be harnessed as a vehicle through which physicians can gain access to training that is transformative to their practice, and ultimately results in positive health care outcomes for diverse patients.

Development of Workgroup Action Plan

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Consider developing subgroups to implement workgroup goals for:

**Foreign Language Proficiency Programs/Classes**

- Medical schools
- Hospitals and training programs
- California Medical Association and local medical societies
- California based ethnic medical societies
- Representatives of affected patient populations
- Ethnic language minority groups
- Physician groups in Mexico

**Cultural Beliefs and Practices Programs/Classes**

- Medical schools
- Hospitals and training programs
- California Medical Association and local medical societies
- California based ethnic medical societies
- Representatives of affected patient populations
- Ethnic language minority groups
- Physician groups in Mexico