Cultural and Linguistic Physician Competency (CLC) Workgroup Update

Members of the Workgroup
Jorge Carreon, MD, CLC Chair
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The Medical Board of California (Board) has held CLC workgroup meetings to facilitate the implementation of legislation addressing cultural and linguistic competency of physicians in California. This document provides a quick overview of the CLC and where we are at currently with this program.

Assembly Bill 801 (Diaz; Chap. 510, Stats. of 2003) added Business and Professions Code section 2198, The Cultural and Linguistic Competency of Physicians Act of 2003. This law is operated by local medical societies of the California Medical Association (CMA) and is monitored by the Board. The Board has the responsibility to convene a workgroup including, but not limited to, representatives of affected patient populations, medical societies engaged in program delivery, and community clinics.

The **goal** of this workgroup is to perform the following functions:

1. Evaluate the progress made in the achievement of the intent of B&P Section 2198.
2. Determine the means by which achievement of the intent of 2198 can be enhanced.
3. Evaluate the reasonableness and the consistency of the standards developed by those entities delivering the program.
4. Determine and recommend the credit to be given to participants who successfully completed the identified programs. Factors to be considered in this determination should include, at a minimum, compliance with requirements for continuing medical education (CME) and eligibility for increased rates of reimbursement under Medi-Cal, the Healthy Families Program, and health maintenance organization contracts.

Funding:

Funding shall be provided by fees charged to physicians who elect to take these educational classes and any other funds that local medical societies may secure for this purpose.

Definition of "Cultural and Linguistic Competency":

Per Business and Professions Code Section 2198.1, CLC means cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment. This includes, but is not limited to, the following:

- Direct communication in the patient-client primary language
- Understanding and applying the roles that culture, ethnicity, and race play in diagnosis, treatment, and clinical care
- Awareness of how the healthcare providers and patients attitudes, values, and beliefs influence and impact professional and patient relations.

Additional Legislation:

Assembly Bill 1195 (Coto; Chap. 514, Stats. of 2005) amended Business and Professions Code section 2190.1. It requires all continuing medical education courses (CME) to contain curriculum that includes cultural and linguistic competency in the practice of medicine. California-based CME providers planning courses within the State of California must comply with this law.

In 2006, the Institute for Medical Quality (IMQ) was awarded a grant by the California Endowment to provide technical assistance and other resources to providers of CME to effectively integrate CLC into the planning, development, and implementation of courses and materials offered to physicians in California. The second two-year grant, ending in late August 2010, funds a full-time Project Administrator, Sheryl Horowitz, dedicated to the IMQ CLC program. Priorities of this position are to work directly with CME providers and community experts to inform and facilitate the sharing of best practices.

The IMQ CLC Program services include outreach efforts such as CLC Regional Workshops, one-on-one technical assistance with CME programs in person, by phone, or email, and the Annual IMQ/CMA CME Provider Conference.

Here are some examples of frequently asked questions about AB 1195:

Does AB 1195 require a certain number of curriculum hours of Continuing Medical Education dedicated to Cultural and Linguistic Competency?
No. There are not a specific number of hours, but all CME activities after July 1, 2006 should include Cultural and Linguistic Competency in their curriculum.

Does AB 1195 affect all CME activities?
No. The following educational activities are exempt: activities solely dedicated to research, other activities that do not contain patient care components, and activities offered by providers not located in California.

How do we show compliance with AB 1195?
IMQ expects each provider to make a good-faith effort to comply with the law. Program planning documentation should show evidence of efforts both to assess the need for CLC education as well as to meaningfully address these needs in CME activities. Standards for AB 1195 compliance have been approved by the IMQ/CMA CME Committee and Board of Directors. Please download a copy at http://www.cmanet.org/upload/AB1195_standards07.doc

Is there a specific list of populations that our organization should target for improving Cultural and Linguistic Competency in CME curriculum?
No. Studies have shown that certain populations experience significant health disparities and disease burden. Unequal access to care and services as a result of language barriers and cultural differences can lead to poorer overall health status. Cultural competence, however, implies the ability to adapt and reinvent according to a changing environment (including demographics, socio-economics, literacy levels, and acculturation), and the expressed needs of the surrounding community.

Will IMQ provide AB 1195 related templates of speaker requirements, policies, or other materials for us to use to comply?
IMQ will provide resources to assist CME providers in drafting policies and other relevant materials specific to identified provider needs. There is no "one-size-fits-all" solution to complying with AB 1195. In fact, the spirit of AB 1195 promotes variation in how CME providers will target their education strategies.

The IMQ CLC Program sponsors a website resource which houses general and specialized CLC data, journal articles, assessment tools, and CME on cultural and linguistic competency.

The IMQ CLC Program Web site is structured to address the variety of needs for CME program staff. Physicians can access CLC resources by their specialty, or select information specific to a patient population or disease state. CME coordinators may share examples of CME on CLC with their CME committees for planning purposes. Prospective CME providers may find national and state resources useful as they prepare for accreditation. Other features of the IMQ CLC Program Web site include synopses of CLC workshops and information about upcoming events. Please visit the IMQ CLC Program CLC Website at http://www.img.org/?page_id=2307 for more information.

CLC Workgroup Chronology:

2003:	CLC of Physicians Act of 2003 established
2006:	CLC became a required component of CME courses
Nov/Dec 2005:	Hedy Chang (Chairperson), Shelton Duruisseau, and Cesar Aristeiguieta appointed as work group members
Dec 2005:	The Board held CLC Workgroup meeting
June 2006	The Board held CLC Workgroup meeting
Sept. 2006	The Board held CLC Workgroup meeting
Oct. 2006	The Board held CLC Workgroup meeting
Feb. 2007	Board staff met with Board member Hedy (Chairperson of CLC work group) and Board member Dorene Dominguez to discuss next work group opportunity/topics.
Sept. 2007	The Board held CLC Workgroup meeting
Summer 2009	New Workgroup members appointed: Jorge Carreon, M.D. as Chair, Shelton Duruisseau, Ph.D. and Barbara Yaroslavsky

Business and Professions Code
Division 2 – Healing Arts, Chapter 5 – Medicine
Article 10.5 – Cultural and Linguistic Competency of Physicians
Sections 2198 and 2198.1

Section 2198 – Citation of article; Competency program established

2198. (a) This article shall be known and may be cited as the Cultural and Linguistic Competency of Physicians Act of 2003. The cultural and linguistic physician competency program is hereby established and shall be operated by local medical societies of the California Medical Association and shall be monitored by the Division of Licensing.

(b) This program shall be a voluntary program for all interested physicians. As a primary objective, the program shall consist of educational classes which shall be designed to teach physicians the following:

(1) A foreign language at the level of proficiency that initially improves their ability to communicate with non-English speaking patients.

(2) A foreign language at the level of proficiency that eventually enables direct communication with the non-English speaking patients.

(3) Cultural beliefs and practices that may impact patient health care practices and allow physicians to incorporate this knowledge in the diagnosis and treatment of patients who are not from the predominate culture in California.

(c) The program shall operate through local medical societies and shall be developed to address the ethnic language minority groups of interest to local medical societies.

(d) In dealing with Spanish language and cultural practices of Mexican immigrant communities, the cultural and linguistic training program shall be developed with direct input from physician groups in Mexico who serve the same immigrant population in Mexico. A similar approach may be used for any of the languages and cultures that are taught by the program or appropriate ethnic medical societies may be consulted for the development of these programs.

(e) Training programs shall be based and developed on the established knowledge of providers already serving target populations and shall be formulated in collaboration with the California Medical Association, the Division of Licensing, and other California-based ethnic medical societies.

(f) Programs shall include standards that identify the degree of competency for participants who successfully complete independent parts of the course of instruction.

(g) Programs shall seek accreditation by the Accreditation Council for Continuing Medical Education.

(h) The Division of Licensing shall convene a workgroup including, but not limited to, representatives of affected patient populations, medical societies engaged in program delivery, and community clinics to perform the following functions:

(1) Evaluation of the progress made in the achievement of the intent of this article.

(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.

Factors to be considered in this determination shall include, at a minimum, compliance with requirements for continuing medical education and eligibility for increased rates of reimbursement under Medi-Cal, the Healthy Families Program, and health maintenance organization contracts.

(i) Funding shall be provided by fees charged to physicians who elect to take these educational classes and any other funds that local medical societies may secure for this purpose.

(j) A survey for language minority patients shall be developed and distributed by local medical societies, to measure the degree of satisfaction with physicians who have taken the educational classes on cultural and linguistic competency provided under this section.
Local medical societies shall also develop an evaluation survey for physicians to assess the quality of educational or training programs on cultural and linguistic competency. This information shall be shared with the workgroup established by the Division of Licensing.

Section 2198.1 – "Cultural and linguistic competency" defined

2198.1. For purposes of this article, "cultural and linguistic competency" means cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment, including, but not limited to, the following:

(a) Direct communication in the patient-client primary language.

(b) Understanding and applying the roles that culture, ethnicity, and race play in diagnosis, treatment, and clinical care.

(c) Awareness of how the health care providers and patients attitudes, values, and beliefs influence and impact professional and patient relations.

Business and Professions Code
Division 2 – Healing Arts, Chapter 5 – Medicine
Article 10 – Continuing Medical Education
Sections 2190 through 2196.5

Section 2190.1 – Educational activities meeting standards (Relevant cultural and linguistic competency provisions highlighted)

2190.1. (a) The continuing medical education standards of Section 2190 may be met by educational activities that meet the standards of the Division of Licensing and serve to maintain, develop, or increase the knowledge, skills, and professional performance that a physician and surgeon uses to provide care, or improve the quality of care provided for patients, including, but not limited to, educational activities that meet any of the following criteria:

(1) Have a scientific or clinical content with a direct bearing on the quality or cost-effective provision of patient care, community or public health, or preventive medicine.

(2) Concern quality assurance or improvement, risk management, health facility standards, or the legal aspects of clinical medicine.

(3) Concern bioethics or professional ethics.

(4) Are designed to improve the physician-patient relationship.

(b) (1) On and after July 1, 2006, all continuing medical education courses shall contain curriculum that includes cultural and linguistic competency in the practice of medicine.

(2) Notwithstanding the provisions of paragraph (1), a continuing medical education course dedicated solely to research or other issues that does not include a direct patient care component and a course offered by a continuing medical education provider that is not located in this state are not required to contain curriculum that includes cultural and linguistic competency in the practice of medicine.

(3) Associations that accredit continuing medical education courses shall develop standards before July 1, 2006, for compliance with the requirements of paragraph (1). The associations may develop these standards in conjunction with an advisory group that has expertise in cultural and linguistic competency issues.

(4) A physician and surgeon who completes a continuing education course meeting the standards developed pursuant to paragraph (3) satisfies the continuing education requirement for cultural and linguistic competency.

(c) In order to satisfy the requirements of subdivision (b), continuing medical education courses shall address at least one or a combination of the following:

(1) Cultural competency. For the purposes of this section, "cultural competency" means a set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities. At a minimum, cultural competency is recommended to include the following:

(A) Applying linguistic skills to communicate effectively with the target population.

(B) Utilizing cultural information to establish therapeutic relationships.

(C) Eliciting and incorporating pertinent cultural data in diagnosis and treatment.

(D) Understanding and applying cultural and ethnic data to the process of clinical care.

(2) Linguistic competency. For the purposes of this section, "linguistic competency" means the ability of a physician and surgeon to provide patients who do not speak English or who have limited ability to speak English, direct communication in the patient's primary language.

(3) A review and explanation of relevant federal and state laws and regulations regarding linguistic access, including, but not limited to, the federal Civil Rights Act (42 U.S.C. Sec. 1981, et seq.), Executive Order 13166 of August 11, 2000, of the President of the United States, and the Dymally-Alatorre Bilingual Services Act (Chapter 17.5 (commencing with Section 7290) of Division 7 of Title 1 of the Government Code).

(d) Notwithstanding subdivision (a), educational activities that are not directed toward the practice of medicine, or are directed primarily toward the business aspects of medical practice, including, but not limited to, medical office management, billing and coding, and marketing shall not be deemed to meet the continuing medical education standards for licensed physicians and surgeons.

(e) Educational activities that meet the content standards set forth in this section and are accredited by the California Medical Association or the Accreditation Council for Continuing Medical Education may be deemed by the Division of Licensing to meet its continuing medical education standards.

Cultural and Linguistic Proficiency for practicing physicians

IN THE BEGINNING THERE WAS A BILL...

In the beginning:
Cultural and Linguistic Competency Act of 2003

§ 2198. COMPETENCY PROGRAM ESTABLISHED.

1. **SHALL BE OPERATED BY LOCAL MEDICAL SOCIETIES OF THE CALIFORNIA MEDICAL ASSOCIATION AND**
2. **SHALL BE MONITORED BY THE DIVISION OF LICENSING**

ORIGINALLY DESIGNED AS A VOLUNTARY PROGRAM OF EDUCATIONAL CLASSES TO TEACH PHYSICIANS :

1. **Foreign Languages**
2. **"Cultural Beliefs And Practices That May Impact Patient Health Care Practices And Allow Physicians To Incorporate This Knowledge In The Diagnosis And Treatment Of Patients Who Are Not From The Predominate Culture In California"**

Cultural and Linguistic Competency Act of 2003

- The Division of Licensing shall convene a workgroup including but not limited to:
  - Representatives of affected patient populations
  - Medical societies engaged in program delivery
  - Community clinics
- Functions of the workgroup include:
  - Evaluation of the progress made in the achievement of the intent of this article and ways to enhance this.
  - Evaluation of the reasonableness and consistency of the standards developed by entities delivering the program and of the credit given.

Cultural and Linguistic Competency Act of 2003 Workgroup functions (cont)

- Funding shall be provided by fees charged to physicians for educational classes and other funds local medical societies may secure for this purpose
- A survey for language minority patients shall be developed and distributed by local medical societies to measure satisfaction of physicians who have taken the educational classes on CLC provided.
  - Local medical societies shall also develop an evaluation survey to assess the quality of educational or training programs on CLC.
  - This information is to be shared with the Division of Licensing

Cultural and Linguistic Competency Workgroup

MEETINGS:

PRE-DISCUSSION: JUNE 2006
INITIAL MEETING: OCTOBER 2006
JUNE 2007
SEPTEMBER 2007

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2008 STRATEGIC PLAN GOALS 2008-2010

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MAY 2010

Bill No: AB1195 summary

REQUIRES ALL CONTINUING MEDICAL EDUCATION COURSES, UNLESS EXEMPTED, TO CONTAIN CURRICULUM PERTAINING TO CULTURAL AND LINGUISTIC COMPETENCY IN THE PRACTICE OF MEDICINE BY JULY 1,2006.

Bill No: AB1195

Arguments presented in support of the bill

- **Cultural and linguistic competency skills are essential for providing quality health care to California's diverse patient population.**
- **Instruction in cultural and linguistic competency will help address the problems of racial, ethnic, linguistic, and gender-based disparities in medical treatment.**
- **Because health care providers frequently do not understand unique cultural beliefs about health care that consumers hold, and do not consider culture when developing a treatment plan, many consumers are given treatment regimes that they will not follow. (Finding from 2003 Task Force on Culturally and Linguistically Competent Physicians and Dentists)**

Bill No: AB1195

CME courses shall address at least one of the following:

1) **Proficiency in attitudes knowledge or skills that enables the physician or organization to care effectively for patients from diverse cultures, groups and communities: e.g.**
   a) **Communicating in ways that patients understand.**
   b) **Forming therapeutic relationships with the patient.**
   c) **Eliciting and incorporating pertinent personal data in dx and tx.**
   d) **Understanding and applying relevant personalized data to the process of clinical care.**
2) **Accommodation of patients who are LEP or are not fluent in English with communication in language they will understand.**

That was 2006

WHAT HAPPENED NEXT?

1. CME PROVIDERS DEVELOPED PLANS
2. LARGER HEALTH CARE SYSTEMS IMPLEMENTED PROGRAMS (E.G. KAISER, SUTTER, UCSF)
3. MANY LOOKED AROUND FOR GUIDANCE AND ANSWERS

IMQ Cultural and Linguistic Competency Program (CLC)

***THE CALIFORNIA ENDOWMENT* FUNDED THE INSTITUTE FOR MEDICAL QUALITY TO CREATE A PROGRAM THAT WOULD ASSIST CME PROVIDERS WITH INCORPORATION OF CLC INTO CME ACTIVITIES**

IMQ Cultural and Linguistic Competency Program (CLC)

9/2006- 9/2008

GUIDELINES WERE DEVELOPED BY CME COMMITTEE: ALIGNED WITH ACCME CRITERIA FOR ADULT LEARNERS

PROVIDERS RECEIVED ASSISTANCE WITH INTERPRETATION OF AB1195- DEFINITIONS AND IDENTIFICATION OF RELEVANT RESOURCES

CME EVALUATION: DOCUMENTATION OF GOOD FAITH EFFORT

Program Results:

9/2006 - 9/2008

- 425 + provider requests for individualized technical assistance
- 63,000 hits to CLC program website with resources (88% from main IMQ webpage)
- ~350 providers receive regular program updates
- 9 regional workshops (~180 CME providers)
- 2 statewide CME provider conferences featuring a CLC plenary and breakout sessions. (500 + attending)
  - Awards were given for effective CLC integration

Status check 2008

1. CME PROVIDERS ARE STILL NOT COMFORTABLE WITH HOW CULTURAL AND LINGUISTIC ISSUES (CLC) FIT WITHIN CME
2. PHYSICIAN EDUCATORS DO NOT SEE THE RELEVANCE OF CLC FOR THEIR TOPICS & DISCIPLINES
3. PHYSICIAN LEARNERS DO NOT UNDERSTAND CLC AS A PRIORITY FOR THEIR PRACTICE

Further outreach

IN 2008 CALIFORNIA ENDOWMENT FUNDED IMQ/CLC PROGRAM TO:

1. **CONTINUE WORKING WITH CME PROVIDERS TO INTEGRATE CLC INTO CME**
2. **OUTREACH TO PHYSICIANS WHO MAY NOT BE AWARE OF THE CLC INITIATIVE AND RESOURCES**

Clarification: Why is AB1195 important

Physicians practitioners

- Patients and physicians are from diverse backgrounds
- Health disparities exist in California and are not disappearing.
- Effective communication is key to the therapeutic process and outcomes

Physician learners

- Cultural communication (including language and literacy) are not consistently taught in medical school.
- Physicians are unaware of the range and sources of health disparities and their involvement.
- Physician-patient relationships are not formally considered within the clinical encounter.

New CLC standard in CME

Announced: 06/09

Compliance Assessed: 01/10

- AB1195 mandated that the CME accrediting agencies (ACCME and IMQ/CMA) develop standards for compliance.
- Initially CME providers were asked to "show examples" of how they were complying with AB1195 and to demonstrate "good faith efforts"
- In 2009 paralleling the ACCME paradigm shift to a more formal adult learning model, a CLC standard was developed.

This legislation brings attention to aspects of patient care that may not have received sufficient consideration in the past, but are in fact directly aligned with the general goals of continuing medical education, i.e. to maintain, develop, or increase the knowledge, skills, and professional performance that a physician and surgeon uses to provide care, or improve the quality of care provided for patients.

The goal is to:

- **Highlight the importance of cultural and linguistic understanding in the professional development of MDs and to determine if physicians/surgeons can improve in areas where there are known gaps and to evaluate the impact of those changes i.e. to determine if health inequities can be decreased.**

- **Embed cultural and linguistic elements into the natural process flow of CME activity development and outcomes.**

New CLC standard in CME

To assure that cultural and linguistic understanding is effectively integrated into physician education the CME provider will:

a) **Acknowledge within their CME mission statement the importance of culture and communication for delivering effective health care and establish a commitment to educate physicians to deliver culturally and linguistically appropriate care.**

b) **Assess for each planned CME activity any evidence of health disparities that have been linked to cultural or linguistically related practice gaps found within the relevant physician learners/patient community. If no cultural or linguistic health or health care disparities or practice gaps are identified, this should be documented.**

c) **Generate at least one educational component for each activity that addresses a specific need underlying the identified cultural/linguistic competency-based quality gap.**

d) **Incorporate appropriate assessment tools for each cultural/linguistic component, and evaluate any changes/improvements that occur as a result.**

Challenges Ahead

1. GETTING BEYOND AB1195 IN CME-
2. BRINGING EVERYONE ON BOARD-
3. BRIDGING THE GAPS-
4. IS IT WORKING? EVALUATING EFFORTS

Getting beyond AB1195 in CME-

letter vs. spirit

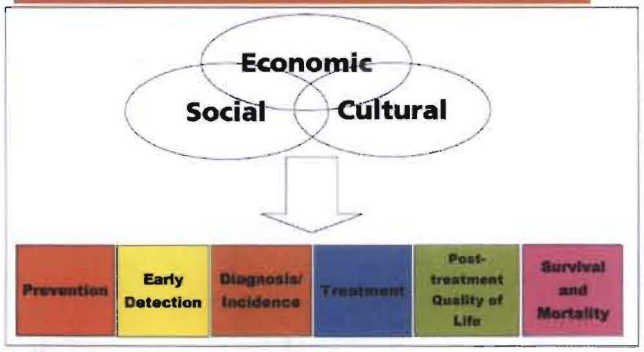


FIGURE 1 Factors That Influence Social Disparities.
Source: Adapted from Freeman, HP[3] and Institute of Medicine.[7]

- **More than fulfilling a legal mandate or satisfying a requirement for accreditation, the focus should be on the goal of delivering equitable care to all patients.**
- **Physicians need to identify this initiative with the fulfillment of their professional values** e.g. AMA principles of medical ethics states that a physician shall:
  - be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
  - recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
  - support access to medical care for all people.
- **CLC needs to be repositioned within the context of patient-provider communication and fully integrated into the clinical process**

Bringing everyone on board

- **Physician culture is not uniform.**
  - **Age, ethnicity, gender, field**
  - **It includes those who will not accept non-English speaking patients to those who work uncompensated with the disenfranchised.**

Table 2. Agreement or Disagreement with Three Elements of Health Care Reform

Survey Item and Response Options	Strongly Disagree	Moderately Disagree	Moderately Agree	Strongly Agree
		percent of respondents		
Rate your degree of agreement or disagreement with the following statements:				
Addressing societal health policy issues, as important as that may be, falls outside the scope of my professional obligations as a physician.	34	44	17	5
Every physician is professionally obligated to care for the uninsured and underinsured.	10	17	35	38

This article (10.1056/NEJMp0907876) was published on September 14, 2009, and was last updated on September 18, 2009, at NEJM.org.

- **Physicians also need empathy**
- **CME landscape is changing and providers are constrained by economic realities.**

Bridging the gaps

culture writ large

Mainstreaming CLC

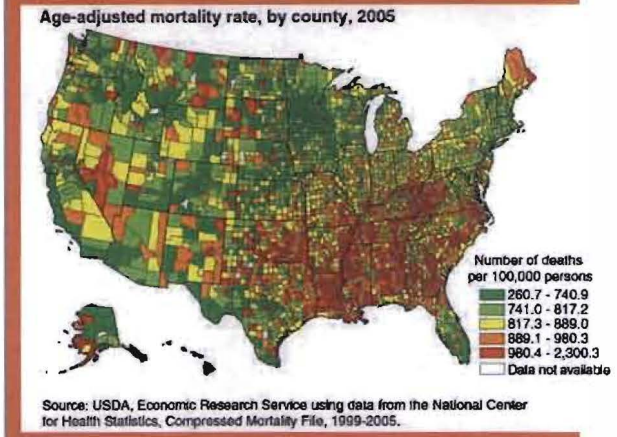
- **CLC is often siloed. Classified as non-clinical it is considered apart from main medical concerns.**
- **Culture is not just ethnicity, gender or age. It is all of these and more.**
- **Culture is not esoteric –not about the "other"–it involves the physician and requires self examination.**
- **This is <u>all</u> about communication. Language, culture, and literacy are essential to forming therapeutic relationships that contribute to clinical outcomes.**

Source: Champlain Valley Area Health Education Center, http://www.cvahec.org

Is it working?

How to determine effectiveness?

Data collection is essential to health disparity efforts.



Source: USDA, Economic Research Service using data from the National Center for Health Statistics, Compressed Mortality File, 1999-2005.

- **Interactive data is available at county and national levels. E.g. CHIS, CDC, NCI, HCUP, MEPS.**
- **IOM is promoting HIT standards in capturing cultural/linguistic patient data.**
- **Surveys are in place H-CAHPS C-CAHPS for hospitals and clinics.**
- **Awareness of these tools, along with skills and resources to implement is needed.**
- **CME activities are largely evaluated by self-report for evidence of willingness to change. These need to be coupled with patient outcome data.**

Peter Slavin
MD, CEO

Massachusetts
General Hospital

"As it relates to disparities, we need to get beyond just diagnosing the problem – we need to start treating it"

AGENDA ITEM 4

Topic ideas to generate discussion:

- Convening workgroup meetings and engaging interested parties

- Conducting Surveys :
    - Survey Type: written surveys; oral surveys; electronic surveys (internet)
    - Target Audience: physicians, patients; CME providers.
    - Survey Subject Matter: content and direction.
    - Distribution: Board quarterly newsletter; direct mail; included as a stuffer in medical license renewal; included as a stuffer in other newsletters such as California Medical Association or local Societies, etc.; electronic supplemental survey as part of a Board on line medical license renewal.

- Distributing a newsletter

- Finding out best-practices

- Encouraging meaningful participation by MBC Licensees