Identification of Future Workgroup Goals

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).

1. 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.[128]

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 pushthis 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.*[171]

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.[62]

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.[172] 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.[44] 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.[173] 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.[43] 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.[128] 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.

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.