Implementing California’s Mandate for Cultural Competence Training of 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”
2006 modification: 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

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

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

What happened next?

1. Some 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 (IMQ) 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 Accreditation: Documentation of good faith effort
CLC Program Implementation Data:

9/2006 - 9/2010

- Over 500 provider requests for individualized technical assistance
- 21 regional workshops (~570 CME providers)
- 4 statewide CME provider conferences featuring a CLC plenary and breakout sessions. (1000+ attending)
  - Awards given for effective CLC integration
- Yearly Training for Accreditation Surveyors in hospitals, ambulatory centers, and jails

Status check 2008

1. CME providers were not comfortable with how to fit cultural and linguistic issues (CLC) within CME
2. Physician educators did not see the relevance of CLC for their topics & disciplines
3. Physician learners did not see CLC as a priority within their practices
Stepping Back- New Approach

- Why are we doing this?
  - making the connection with Health Disparities
- What do health disparities look like?

Medicare managed care enrollees with inadequate health literacy had higher (all cause) mortality than those with adequate or marginal health literacy. (N=3260)


Where’s the Data?

Many physicians are
- Unaware of the range of health disparities.
- Convinced they treat all patients the same.
- Not collecting data that would confirm or dispute their assessment.
What’s the Data?
Expanding the vision of culture

- not just ethnicity, gender or age. It is all of these and more.

- not esoteric – not about the “other” – it involves the physician, coworkers and requires self examination.

- not just about things and attributes, but about how we think and make sense of the world.

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

Don’t tell me I’m incompetent!
Getting Beyond the C word

- The term cultural competency is an ongoing burden to the goal of teaching cross-cultural communication and eliminating health disparities.
  - Allow physicians to use their own definitions e.g. “the art of medicine”

- Mainstream CLC
  - CLC is often in a silo. When considered as non-clinical, it is secondary to medical issues.
  - This is all about communication. Language, culture, and literacy are essential to forming therapeutic relationships that contribute to clinical outcomes.
Getting beyond the C Word

Focus on the goal of delivering equitable care to all patients not on fulfilling a legal mandate or satisfying a requirement for accreditation.

Connect these goals with physician professional values. e.g. AMA principles of medical ethics
- 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.

Reposition CLC within the context of patient-provider communication to fully integrate into the clinical process.

New CLC standard in CME

AB1195 mandated that the CME accrediting agencies develop standards for compliance.

- Announced: 06/09
- Compliance Assessed: 01/10

Parallels the ACCME paradigm shift to a more formal adult learning model.

Embeds cultural and linguistic elements into the natural process flow of CME activity development and outcomes.

Focuses on known practice gaps that contribute to health disparities and determine if physicians/surgeons can improve in these areas and evaluate any impact of those changes (i.e. health inequities decrease).
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.

Integrating cultural and linguistic issues in CME Activities:

- Review topic and identified needs
- Faculty awareness of associated health disparities or gaps in cultural or linguistic proficiencies
- National level data for health disparities
- Search local sources for disparities or gaps in CLC that are associated with these disparities
- Develop an educational component around CLC (e.g. increase awareness, change behavior)
- Evaluate the impact of the educational exercise
- Report lack of findings
Promising Strategies

- **Bring it home**: Connecting providers with local (county level) data sets that can reveal disparities - CHIS

- **Keep it simple**: Small incremental steps from awareness to adopting new behaviors. Provide tools and mnemonics.

- **Keep it going**: Using repetition and continuing exposure. A moderated E-forum helped keep information in the forefront.

- **Make it real**: needs assessments—with actual examples from local settings, in house complaints, quality improvement data, HCAHPS reports.

- **Physicians are people too**: listening and empathizing. Using physician blogs to elicit underlying fears and biases.

How are we doing?

Database results-- TBI
Challenges Ahead

1. Taking a systems approach to the role of CLC in delivering effective care to avoid losing out to competing priorities in the new Health Reform environment.
2. Bringing all physicians on board and not creating an us and them environment.
3. Determining ways to collect and use patient data within CME to evaluate physician efforts.

Systems approach
CLC is integrated into patient care
Models: the Patient Centered Medical Home
**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.

**CME landscape is changing and providers are constrained by economic realities.**

**Evaluation**

How to determine effectiveness?

Data collection is essential to health disparity efforts.

- 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”