The spirit and the letter of the law
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IMQ CME provider conference
May 12, 2006

Assembly Bill No. 1195

In 2006, the People of the State of California passed Assembly Bill No. 1195 requiring that continuing medical education courses, except as specified, include curriculum in the subjects of cultural and linguistic competency in the practice of medicine, as defined.
Cultural Competency

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.

Including:

- linguistic skills
- cultural information to establish therapeutic relationships
- cultural data in diagnosis and treatment
- cultural and ethnic data to the process of clinical care

California Assembly Bill Number 1195 amending Division 2, Chapter 5, Article 10, Section §2190.1 of the Business and Professions Code. (2005).

Linguistic Competency

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.

California Assembly Bill Number 1195 amending Division 2, Chapter 5, Article 10, Section §2190.1 of the Business and Professions Code. (2005).
AB 1195-the spirit of the law

- America is becoming more culturally diverse
- And more linguistically diverse
- And there are differences in health outcomes based on cultural and linguistic differences

Health and Health Care Disparities: A National Problem

Facts . . .

As our society increasingly becomes racially and ethnically diverse, health care professionals need to acknowledge the cultural diversity of their patients.

A wealth of studies have shown that disparities clearly exist in the health care of racially and ethnically diverse populations.

Even after adjustment for insurance status and income, populations of color tend to have less access to health care and lower-quality health care than the white population.

Unequal access to care and services as a result of language barriers, and cultural differences can lead to poorer overall health status.
To Improve Quality of Care and Ensure Patient Safety

- Quality of care and patient safety can be hindered because of bias and prejudice.
- Quality of care and patient safety can be hindered because of communication, language, or cultural barriers.

Definition of Terms

- The term "populations of color" includes Black or African American, Asian, Native Hawaiian or other Pacific Islander, Hispanic or Latino, American Indian or Alaska Native, and other racial/ethnic groups.
- The term "minority" falsely suggests a homogeneous groups of nonwhites. The reality is extraordinary diversity both within and among minority groups. . .” (Herbert W. Nickens, “The Health Status of Minority Populations in the United States,” Western Journal of Medicine, vol. 155, no. 1 (July 1991), pp. 27-32.
- The term “health disparity” means a difference in health status between a defined portion of the population and the majority. Disparities can exist because of socioeconomic status, age, geographic area, gender, race or ethnicity, language, customs and other cultural factors, disability or special health need.
- This discussion focuses on racial, ethnic and Language related health disparities.
It is estimated that by 2030, minority Americans will constitute more than 40 percent of the total US population. The most prominent growth rates are expected in the Hispanic, Asian American, and Other populations.¹

Changing U.S. Demographics

2000 LEP* Population Groups

- Spanish: 13.1
- Other Indo-European Languages: 3.4
- Asian & Pacific Island Languages**: 3.6
- All Other Languages: 0.6

* Based on 2000 U.S. Census Bureau summary. Number in millions.
** Limited-English Proficient.
*** Asian, Native Hawaiian or Other Pacific Islander


Language Diversity

- A minimum of 329 languages are currently spoken by residents of the United States.¹

- In some US cities, less than 60 percent of the overall population speaks English.¹

¹U.S. Bureau of the Census, Population Division, Education and Social Stratification Branch, 1990 Census of Population
U.S. Demographics

The Face of America - 2000

- **Whites**: 71%
- **A/I**: 4%
- **Blacks**: 12%
- **Hispanic**: 12%
- **API**: 1%

The Face of America by 2050

- **Whites**: 52%
- **A/I**: 1%
- **Blacks**: 14%
- **Hispanic**: 25%
- **API**: 8%

The Hispanic pop increased by more than 50 percent (57.9) since 1990, from 22.4 million in 1990 to 35.3 million in 2000, compared with an increase of 13.2% for total US pop.

Source: U.S. Census Bureau 2000

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U.S. Census 2000 Language Demographics - Top 10

- **Spanish or Spanish Creole**: 28,101,052 (73%)
- **Chinese (all spoken dialects)**: 2,022,143 (5%)
- **Russian**: 706,242
- **Korean**: 894,063
- **Italian**: 1,008,370
- **Vietnamese**: 1,009,627
- **Tagalog**: 1,224,241
- **German**: 1,383,442
- **French (incl. Patois, Cajun)**: 1,643,838
- **Polish**: 667,414

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Changing Demographics

California Demographics / Measured in Millions of Californians

San Francisco

- English: 54%
- Chinese: 18%
- Spanish: 12%
- Tagalog: 4%
- Russian: 2%
- Vietnamese: 1%
- French: 1%
- Japanese: 1%

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Why Should We Care?

- Access
- Comprehension
- Quality
- Satisfaction
- Cost

Access

- Spanish-speaking Latinos less likely to have physician visits, flu shots, or mammograms than English speaking Latinos or non-Latino whites. (Fiscella 2002)
- Children whose parents speak Spanish less likely to have usual source of care than English speaking Latinos or non-Latino whites. (Weinick 2000)
- Spanish speakers who could not communicate with their physicians less likely to be discharged from the ER with a follow-up appointment. (Sarver 2000)
Evidence of Disparate Health Outcomes:
Language

- In a national survey, children whose parents responded in English were 2.6 times more likely to have a usual source of care than those whose parents responded in Spanish. (Am J Pub Health 2000, 90-1771-4)

- Patients who experienced a language barrier during the medical encounter were significantly less likely to be discharged from the ER with a follow-up appointment than other patients. (JGIM 1999, 14:82-87)

- Disparities between LEP and non-LEP patients in colorectal screening and flu shots decreased after implementation of an interpreter services program. (JGIM 2001, 16: 468-74)

Comprehension

- Spanish speakers less likely to be discharged from the ER with an understanding of their medications, special instructions, and plans for follow-up care. (Crane 1997)

- Spanish-speaking Latinos more likely to report problems with communication than English-speaking Latinos. (Commonwealth Fund Health Care Quality Survey 2002)

- Spanish speakers who needed but didn't receive an interpreter were at much higher risk for not understanding discharge medications. (Andrulis 2002)
Cost

- Pediatric patients with a language barrier had higher charges ($38) and longer stays (20 min) than those without language barriers. (Hampers 1999)

- Pediatric patients who needed, but didn't receive, a professional interpreter had higher test costs and were the most likely to be admitted to the hospital (compared to patients who could speak directly with their doctors, and patients who had a trained interpreter). (Hampers 2002)

Evidence of Disparate Health Outcomes: Language

- Pediatric patients whose families were assessed to have a "language barrier" with the physician had higher charges ($38) and longer stays (20 minutes) than those without language barriers. (Peds 1999, 103(6):1253-1256)

- A 22-year-old non-English-speaking man in Miami was awarded a lifetime settlement of $71 million as a result of a missed stroke. The ER staff assumed his mother's use of the word "intoxicado" meant he had a drug overdose. (Med Econ 1984, June:289-92)

- A pregnant Spanish-speaking woman was seen in a Chicago ER for pre-term bleeding. Another patient was used to interpret; she left the ER believing her pregnancy was on track. Two months later, wondering why her baby had not grown, she again sought care. On reviewing her medical records, it was discovered that the woman had in fact lost her baby that night in the ER. (J Healthcare Poor Underserved 1998, 9:S80-100)
Satisfaction

- Patients whose primary language was not English were significantly less likely to want to return to same ER for future care. (Carrasquillo 1999)

- Patients who needed but didn’t receive an interpreter in the ER were less satisfied with the care they received, as well as less satisfied with their physician. (Baker 1998)

Quality

- Speaking a primary language other than English (or Spanish) was an independent predictor of patient-reported drug complications. (Ghandi 2000)

- Spanish-speaking patients were less likely to receive standard of care (prompt surgery) in cholecystitis. (Diehl 1993)
Evidence of Disparate Health Outcomes: Racial and Ethnic Variation

- Nulliparous Somali women were more likely to have a cesarean delivery than black and white women (control group limited to Washington state). Among all women who had cesarean deliveries, Somali women more commonly had cesarean deliveries associated with fetal distress and failed induction of labor. (Am J Obstet Gynecol. 2005 Aug;193(2):475-82)

- Puerto Rican children had the highest prevalence of lifetime asthma (26 percent) and recent asthma attacks (12 percent), compared with non-Hispanic black children (16 percent and 7 percent, respectively), non-Hispanic white children (13 percent and 6 percent, respectively), and Mexican children (10 percent and 4 percent, respectively). (Pediatrics. 2006 Jan;117(1):43-53)

- Overall rates of sexually transmitted disease infection were highest in Black Caribbean men and women (2176 and 1899 per 100,000 population per year) and lowest in white men and women (119 and 139 per 100,000 per year) when compared among whites, Black African, and Black Caribbean (control group limited to east London). (Sex Transm Infect. 2004 Oct;80(5):379-85)

Evidence of Disparate Health Outcomes: Racial and Ethnic Variation

- Alaskan Natives experience the highest rates of colon and rectal cancers of any racial or ethnic group in the U.S. (Institute of Medicine, 1999b)

- Korean Americans have the highest rates of stomach cancer (48.9 per 100,000 population) among U.S. males, followed by Japanese Americans (30.5 per 100,000 population). (Institute of Medicine, 1999b)

- Vietnamese American women experience the highest incidence of cervical cancer in the U.S., at rates nearly six times higher than that of white women. (Institute of Medicine, 1999b)
Evidence of Disparate Health Outcomes:
Race

A Recent NCQA Study of Health Plans... 

- Disparities in Quality of Care for Medicare managed care participants
  - Regional differences

- Disparities in Language Access
  (Contact NLCP if interested in results)

Source: HEDIS and CAHPS Analysis Results, NCQA 2005

Cholesterol Screening and Control – Acute Cardiac Events

Source: HEDIS and CAHPS Analysis Results, NCQA 2005
Follow Up After Mental Health Hospitalization (30 Days)

Source: HEDIS and CAHPS Analysis Results, NCQA 2005

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Beta Blocker & Blood Pressure

Source: HEDIS and CAHPS Analysis Results, NCQA 2005

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Breast Cancer Screening

![Breast Cancer Screening Graph]

Source: HEDIS and CAHPS Analysis Results, NCQA 2005

Magnitude of Racial Disparity Differs

<table>
<thead>
<tr>
<th>Condition</th>
<th>W-B Diff in Adjusted Rate</th>
<th>Improvement for Blacks</th>
<th>Improvement for Whites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer Screening</td>
<td>1.2</td>
<td>2.8</td>
<td>0.0</td>
</tr>
<tr>
<td>Diabetes HbA1c screen</td>
<td>3.8</td>
<td>13.9</td>
<td>10.9</td>
</tr>
<tr>
<td>Diabetes LDL screen</td>
<td>3.8</td>
<td>26.9</td>
<td>21.5</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>5.3</td>
<td>14.6</td>
<td>14.4</td>
</tr>
<tr>
<td>Beta Blocker after Heart Attack</td>
<td>5.7</td>
<td>10.3</td>
<td>11.6</td>
</tr>
<tr>
<td>Diabetes LDL control &lt;130</td>
<td>9.0</td>
<td>28.6</td>
<td>25.5</td>
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<tr>
<td>Poor HbA1c control</td>
<td>8.4</td>
<td>12.2</td>
<td>14.8</td>
</tr>
<tr>
<td>Cardiac event: Chol Screening</td>
<td>11.5</td>
<td>24.3</td>
<td>23.5</td>
</tr>
<tr>
<td>Cardiac event: Chol Control</td>
<td>15.8</td>
<td>22.3</td>
<td>22.5</td>
</tr>
<tr>
<td>Depress Med Mgmt Acute Phase</td>
<td>11.0</td>
<td>9.4</td>
<td>7.6</td>
</tr>
<tr>
<td>Depress Med Mgmt Cont Phase</td>
<td>13.8</td>
<td>6.4</td>
<td>6.4</td>
</tr>
<tr>
<td>Follow Up after MH Hosp</td>
<td>12.0</td>
<td>7.0</td>
<td>2.3</td>
</tr>
</tbody>
</table>

Source: HEDIS and CAHPS Analysis Results, NCQA 2005
AB 1195-the letter of the law

- Every CME activity must contain elements of cultural and/or linguistic competency
- A CME activity can be:
  - Single activity with single session
  - Single activity with multiple sessions during same time period
  - RSCs—an activity with multiple sessions occurring over time
  - An enduring material

Compliance-when?

- All activities planned after July 1, 2006
Compliance-what content?

- All CME activities with a patient care component

- EXEMPT activities
  - Activities solely dedicated to research
  - Other activities which do not contain patient care components (such as leadership)
  - Activities offered by providers not located in California

Compliance-what?

- Single activity, single session
  - Elements incorporated into session

- Single activity, multiple sessions
  - Single session dedicated to cultural and linguistic issues
  - CL incorporated into multiple sessions

- RSCs
  - As above, but may need several sessions dedicated to CL

- Enduring materials
  - Must be incorporated into activity
Compliance-how?

- In content
  - Incorporated into sessions as differences in incidence, diagnosis, management, prognosis, etc
  - Linguistic/cultural issues specific to topic
  - As dedicated sessions, general approach to diversity, appropriate use of interpreters, overview of health disparities
- As supporting documents
  - Websites, handouts, reference cards, patient education, tapes/CDs/handbooks, local resources

Compliance-how to document

- On application/planning form for CME credit
- On accreditation application
  - How are you assuring compliance with AB 1195?
  - Show examples
  - Good faith effort to comply
Summary

- Providing culturally competent and linguistically appropriate care is the right thing to do
- Incorporating education about these issues into CME activities is now mandated
- There are resources to help accomplish this

Thanks

- Kaiser Permanente national diversity department
- California Academy of Family Physicians
AB 1195-resources

- www.imq.org
- www.familydocs.org/multicultural_health.php