Cultural & Linguistic Competency in CME

CME Essentials Workshop
Los Angeles, CA
December 3 & 4, 2013

Why CLC Matters

- >95 million people with literacy levels below what is needed to understand information (e.g. how often to take medicine)
- Most frequently cited root causes of sentinel events are language barriers, cultural differences, low health literacy (The Joint Commission)
- 49% patients with limited English proficiency (LEP) experience adverse events involving physical harm compared to 30% for English speaking patients
Assembly Bill No. 1195

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

IMQ/CMA REVISED CLC POLICY

Element 3.2.1 The provider must be in compliance with all California State laws regarding continuing medical education, including Assembly Bill 1195, effective July 1, 2006. Provider meets or exceeds minimum requirements of AB 1195 by the following:

- Determine for each planned CME activity with a clinical care focus, if there are cultural or linguistic health disparities relevant to the targeted physician learners and/or their patient community. If no relevant cultural or linguistic health or health care disparities are identified, this should be documented.

- When a relevant cultural or linguistic health disparity is identified, generate at least one educational component to address the specific need(s) related to the educational activity.

Note: In compliance with California law, relevant Cultural and Linguistic disparities need to be addressed in one or more sessions within a Regularly Scheduled Series (RSS).

Effective September 1, 2013
The Spirit of the Law

- America is culturally and linguistically diverse
- Our healthcare system relies on transmitting complex information efficiently, clearly, effectively
  - >95 million people with literacy levels below what is needed to understand information (e.g. how often to take medicine)
- There are real variations in health outcomes based on cultural and linguistic differences
  - Most frequently cited root causes of sentinel events are language barriers, cultural differences, low health literacy
  - 49% patients with limited English proficiency (LEP) experience adverse events involving physical harm compared to 30% for English speaking patients

(The Joint Commission)

Cultural & Linguistic Factors

Consider dimensions beyond race, ethnicity and language!
Some CLC Considerations...

- Does the evidence show any health disparities associated with the “topic” (i.e., diagnosis, disease, treatment)?
- Do the identified health disparities relate to the patient population cared for by the target audience for this topic?
- Do the disparities relate to the professional practice gap for the activity you are planning?
- Are there underlying educational need(s) related to the health disparity?

Exercise: Group Discussion

› Choose a recent clinically-focused CME activity you are planning and discuss:
  - How you identified CLC health disparities related to the patients and/or target audience?
  - How you incorporated (or could have incorporated) CLC into the activity?
  - What sources you used or could have used to research CLC disparities?
Q: What exactly has changed in the CLC requirement?

A: These are the changes made during the past year:

Clarified that consideration of CLC is required ONLY if the activity applies to clinically-focused, patient-care-related CME activities

Eliminated requirement to:
- Incorporate CLC intent in your mission statement
- Measure how physicians plan to (or have addressed) CLC in their professional practice (unless it’s the PPG/need addressed by the activity)
- Address CLC in the Accreditation with Commendation criteria

Q: Do we still need to include a CLC component when planning our activities?

A: Maybe. When an activity focuses on clinical care, consider whether there is a relevant CLC discrepancy that contributes to the identified performance gap(s) (Criterion 2).
Q: Can we leave the decision to faculty to decide about including CLC?

A: No. CME planners must determine if Cultural and Linguistic disparities exist for each activity and if they are relevant to either the physician learners and/or their patients.

Q: What do we do if we can’t find CLC-related disparities, or determine the disparities aren’t relevant to this activity?

A: For CME activity with clinical, patient-care focus, planners may decide: no CLC disparity exists or it exists but is not relevant to the gap/needs/target audience. Planners document what was indentified, discussed or researched (e.g., sources) and/or conclusions leading to decision
Q: What documentation is required to demonstrate compliance that a relevant cultural or linguistic disparity was identified and addressed within an activity?

A: Multiple ways to show a CLC disparity was addressed. For example, identify disparity on the activity planning form and put copies of slide(s)/materials in activity file.

CLC Tips and Tools

Some useful resources:

- Agency for Healthcare Research and Quality (AHRQ) website to research CLC-related gaps and needs: www.ahrq.gov
  - Example: Closing the Quality Gap: Quality Improvement Interventions to Address Health Disparities: Evidence Report

- ACCME video interviews (Education section) website: Addressing Health Care Disparities with CME Sonja Boone, MD, Director of Physician Health and Healthcare Disparities, American Medical Association and ACCME Chief Executive Murray Kopelow, M.D.