CALIFORNIA MEDICAL ASSOCIATION

Continuing Medical Education Standards

Cultural & Linguistic Competency and Implicit Bias

April 20, 2021

CMA

Introductions

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Agenda

- Welcome
- Introductions
- Background
- Public Comment Period
- CLC & IB Definitions & Standards
- Feedback
- Adjournment

CMA CME

- CMA CME is the ACCME recognized accreditor for the state of California
- CMA accredits 200+ organizations that provide CME in the state of California, under the Recognition of the Accreditation Council for Continuing Medical Education's (ACCME)
- CMA has been delegated the authority to create these standards for all CA providers by the Medical Board of California

California Law

- Business and Professions (B&P) Code Section 2190.1 requires CMA to develop standards for cultural and linguistic competency (CLC) and implicit bias (IB) for inclusion in continuing medical education (CME) activities.
- The CLC and IB standards are codified into B&P 2190.1 from the following legislation:
  - Assembly Bill (AB) 1195 (Coto, Statute of 2005)
  - AB 241 (Kamlager-Dove, Statute of 2019)

Medical Board of California (MBC)

- The California Business & Professions Code includes among the Medical Board's responsibilities the administration of a continuing education program
    - Authorizes the MBC to accept educational activities that meet its content standards (which now include the implicit bias & CLC training) and are accredited by CMA or the ACCME (§§ 2004(i); 2190; 2190.1(g))
- MBC's delegation of authority to CMA-CME provides the necessary authority to create the standards it deems necessary to ensure compliance with its accreditation standards, including standards relating to the implementation of cultural and linguistic competency and implicit bias training (§2190.1(b)(1)&(d)(1))

Business and Professions Code 2190.1

(a) The continuing medical education standards of Section 2190 may be met by educational activities that meet the standards of the board and that serve to maintain, develop, or increase the knowledge, skills, and professional performance that a physician and surgeon uses to provide care, or to improve the quality of care provided to patients. These may include, but are 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 or a course offered by a continuing medical education provider that is not located in this state is 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 update these standards, as needed, 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, including, as appropriate, information pertinent to the appropriate treatment of, and provision of care to, the lesbian, gay, bisexual, transgender, and intersex communities.

Business and Professions Code 2190.1 (cont)

(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) (1) On and after January 1, 2022, all continuing medical education courses shall contain curriculum that includes the understanding of implicit bias.

(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 or a course offered by a continuing medical education provider that is not located in this state is not required to contain curriculum that includes implicit bias in the practice of medicine.

(3) Associations that accredit continuing medical education courses shall develop standards before January 1, 2022, for compliance with the requirements of paragraph (1). The associations may update these standards, as needed, in conjunction with an advisory group established by the association that has expertise in the understanding of implicit bias.

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

(1) Examples of how implicit bias affects perceptions and treatment decisions of physicians and surgeons, leading to disparities in health outcomes.

(2) Strategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, or other characteristics.

(f) 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.

(g) 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.

Requirements and Exceptions

- B&P 2190.1 governs California CME provider organizations.
- California CME provider organizations accredited by CMA CME or ACCME will be required to meet these standards as of January 1, 2022.
- The following are exempted from AB 1195 and AB 241 in their CME activities:
  - a CME course dedicated solely to research or other issues that does not include a direct patient care component
  - a course offered by a CME provider that is not located in California

Advisory Council

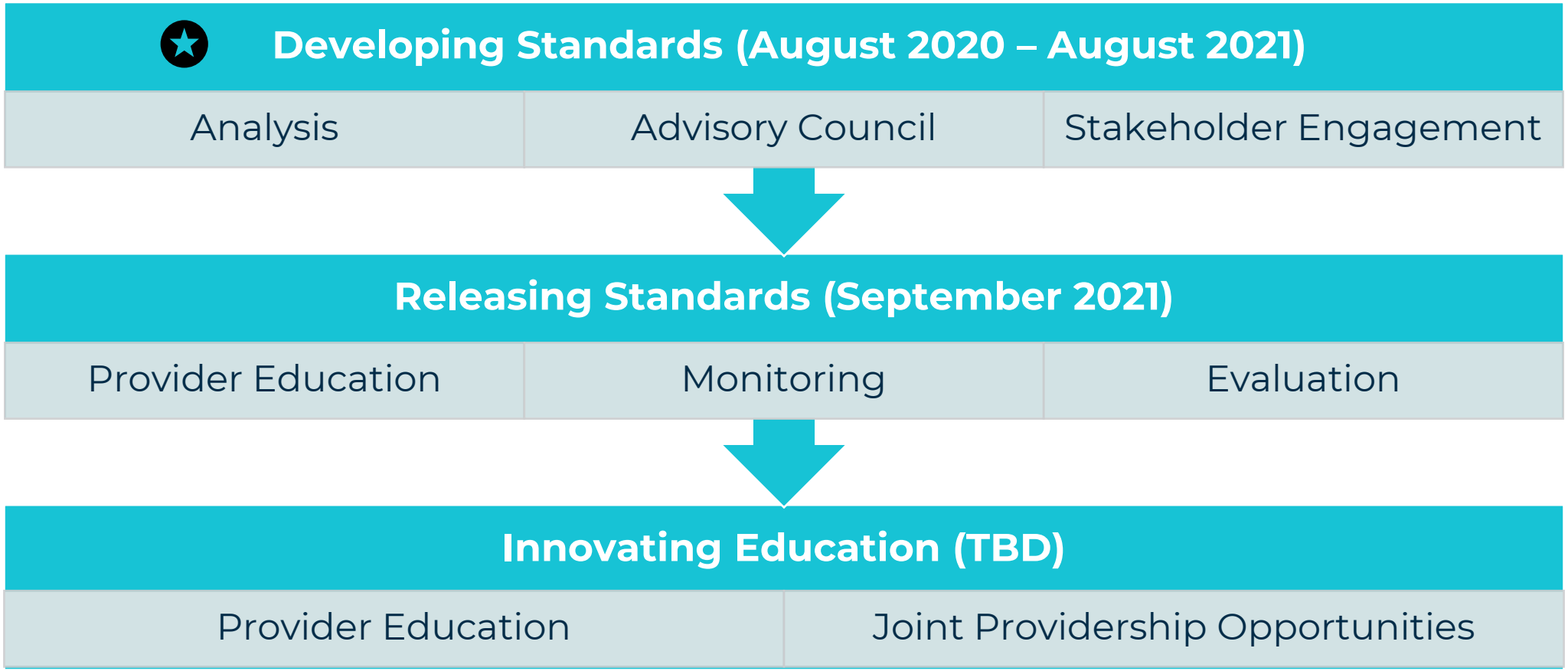
- Kristin Jensen, M.D., Palo Alto VA Health Care System
- Kavitha Jayachandran, M.D., Department of Medicine, The Permanente Medical Group
- Kristin E. Fontes, M.D., FAAEM, FACEP, Santa Barbara Cottage Hospital
- Judy Hyle, CME Consultants
- Margaret Juarez, M.D., San Gabriel Women's Health Inc
- Michele Ruiz, BiasSync
- Kiran Savage-Sangwan, California Pan-Ethnic Health Network
- Nancy Wongvipat Kalev, Health Net

Guiding Principles

We will…

- Follow statutory intent & language
- Draft standards that matter
- Draft standards that are achievable by all CME programs
- Collaborate with provider organizations to support implementation
- Secure feedback from stakeholders (e.g., patients, families & caregivers)

Roadmap



Public Comment Timelines & Strategy

Timeline	Activity
April 5-May 5, 2021	Public Comment Period
April 21, 2021	Advisory Council Meeting
May 6-26, 2021	Feedback Analyses
May 26, 2021	Advisory Council Meeting
August/September 2021	Release Standards
August 1 to December 31, 2021	Provider Education
January 1, 2022	Standards are Effective

Cultural and Linguistic Competency Definition

Ability and readiness of health care providers and health organizations to humbly and respectfully demonstrate, effectively communicate, and tailor delivery of care to patients with diverse values, beliefs, identities, and behaviors, in order to meet patients' social, cultural, and linguistic needs as it relates to patient health.

Implicit Bias Definition

The attitudes, stereotypes, and feelings, either positive or negative, that affect our understanding, actions, and decisions without conscious knowledge or control. Implicit bias is a universal phenomenon. When negative, implicit bias often contributes to unequal treatment and disparities in diagnosis, treatment decisions, levels of care, and health care outcomes of people based on race, ethnicity, gender identity, sexual orientation, age, disability, and other characteristics.

Draft Standards (Required)

- **Each draft standard complies with AB 1195 (CLC) and AB 241 (IB), unless otherwise noted.**

1) WEBSITE LINK

✚ Provide link on website to AB 1195 and AB 241 legislation that is accessible to planners, faculty and speakers

2) DEFINITION

✚ Present definition of CLC and IB to planners, faculty and speakers

3) RESOURCES

✚ Make CLC and IB educational resources available to planners, faculty and speakers

4) PATIENT POPULATIONS (CLC ONLY)

✚ Identify provider's patient populations; determine how cultural/linguistic factors should be addressed (i.e., data, surveys, research, etc); and communicate to planners, faculty and speakers

Draft Standards (Contd)

5) DISPARITIES (IB)

+ Identify disparities in care for provider's patient populations (i.e., data, surveys, research, etc); the role IB plays in this; and communicate to planners, faculty and speakers

6) DIVERSITY

+ Include diverse planners, faculty and/or patient representatives in the activity planning process

7) INCORPORATE

+ Incorporate educational components to address factors identified in #4 and #5

8) NO RELEVANCE

Activities with no applicable CLC or relevant IB content must be documented

Best Practices: CME Activities

- 1) DEVELOP EVALUATION + Develop CLC or IB-specific evaluation questions related to CLC factors or disparities in care and IB identified in standard #4
- 2) FOLLOW-UP + Follow-up on evaluation after 3 – 6 months
- 3) DATA + Provide data on specific under-represented groups and topics of CME activity to learners
- 4) IMPACT + Conduct an annual, standalone CME activity on cultural and linguistic inequities or IB, as it related to health care, including information on how CLC or IB impacts access to care and health outcomes DRAFT CMC CLC & IB STANDARDS Page 2 of 2 (Rev. 04/03/21) cmadocs.org/cme-standards C ONTA CT US cmestandards@cmadocs.org
- 5) PATIENT REPRESENTATIVES + Include patient representatitves in CME activity
- 6) LEARNING OBJECTIVE + Identify at least one learning objective, related to CLC or IB in all applicable activities

Best Practices: Program/Organization

- 1) PARTICIPATE + Participate in your organization's Equity, Diversity and Inclusion (EDI) efforts
- 2) CONTRIBUTE (CLC) + Contribute to the identification of personal, interpersonal, institutional, structural and cultural barriers to health equity
- 3) CONTRIBUTE (IB) + Contribute to the identification of previous or current unconscious biases and misinformation and their impact on health outcomes
- 4) PROVIDE INFORMATION ON CULTURAL IDENTITY + Provide information about cultural identity across diverse communities with an emphasis on racial or ethnic groups and disparities within health care
- 5) PROVIDE INFORMATION ON COMMUNICATING + Provide information about communicating more effectively across identities, including racial, ethnic, religious and gender
- 6) ADOPT PERSPECTIVES + Adopt perspectives of diverse, local constituency groups and experts on racial, identity, cultural and provider relations in the community and impact on health outcomes

Adherence

- CMA currently exploring adherence to standards that are meaningful, relevant and not burdensome

FAQ

- What if I'm accredited by ACCME?
  - Providers accredited by ACCME will still need to adhere to these standards to be compliant with CA law.
- Is this for all activities?
  - Yes, this is for all activities that include a direct patient care component
- How does this work for an RSS?
  - An RSS is considered a single activity, and CLC/IB must be included in at least one session

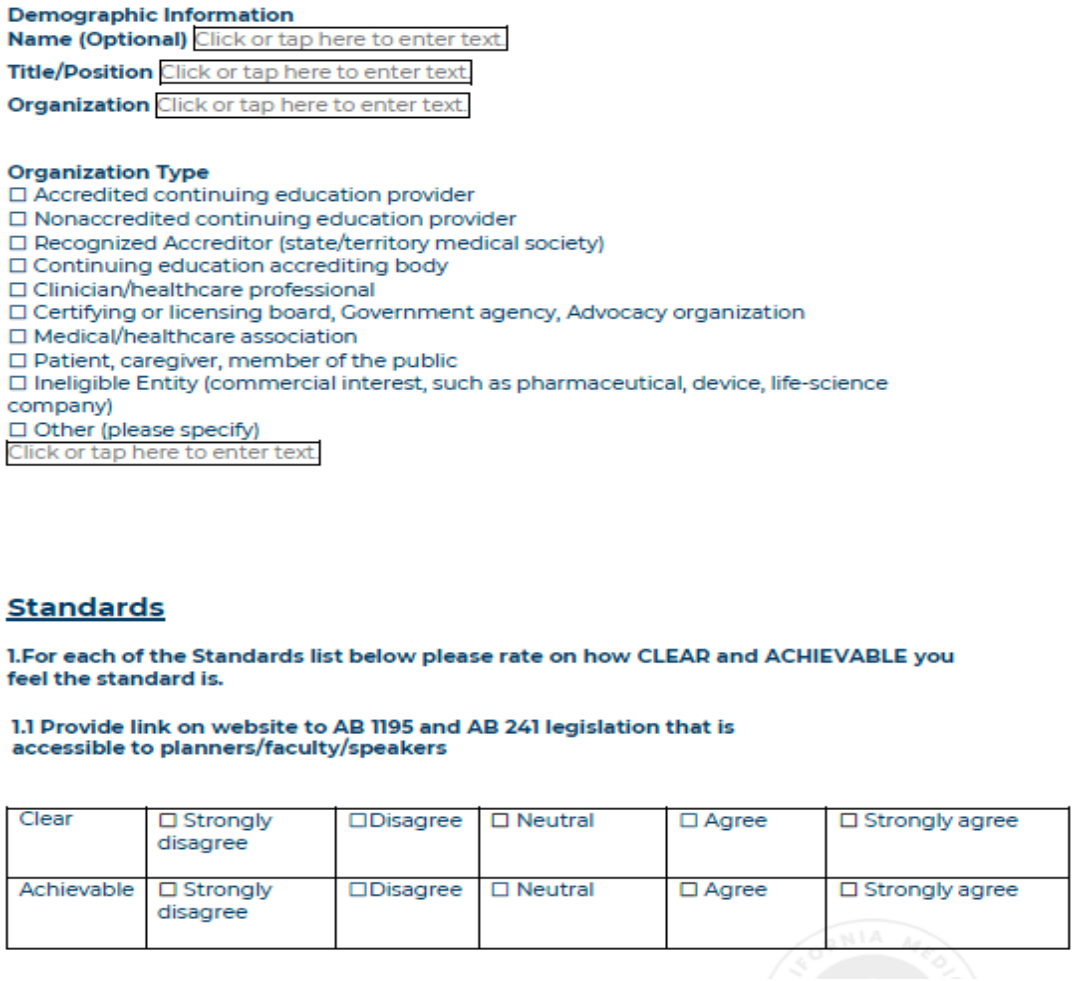
FAQ (Contd)

- How will this affect my accreditation?
  - Adherence with the law is separate from your accreditation decision
- How will you document adherence?
  - CMA is currently exploring adherence to standards that are meaningful, relevant and not burdensome

Providing Public Comment

- There are multiple venues for providing comment. These include:
  - Completing the online survey (preferred approach)
  - Completing a fillable document
  - Sending an email to: CMEStandards@cmadocs.org
  - Sending a letter to:

    California Medical Association
    CME Standards Public Comment
    1201 K Street, Suite 800
    Sacramento, CA 95814



Demographic Information
Name (Optional) Click or tap here to enter text.
Title/Position Click or tap here to enter text.
Organization Click or tap here to enter text.

Organization Type
☐ Accredited continuing education provider
☐ Nonaccredited continuing education provider
☐ Recognized Accreditor (state/territory medical society)
☐ Continuing education accrediting body
☐ Clinician/healthcare professional
☐ Certifying or licensing board, Government agency, Advocacy organization
☐ Medical/healthcare association
☐ Patient, caregiver, member of the public
☐ Ineligible Entity (commercial interest, such as pharmaceutical, device, life-science company)
☐ Other (please specify)
Click or tap here to enter text.

Standards

1.For each of the Standards list below please rate on how CLEAR and ACHIEVABLE you feel the standard is.

1.1 Provide link on website to AB 1195 and AB 241 legislation that is accessible to planners/faculty/speakers

Clear	☐ Strongly disagree	☐Disagree	☐ Neutral	☐ Agree	☐ Strongly agree
Achievable	☐ Strongly disagree	☐Disagree	☐ Neutral	☐ Agree	☐ Strongly agree

Next Steps

- Feedback will be discussed with Advisory Council, CMA committees, and ACCME
- Final standards will be released in the late summer/early fall
- Be on the lookout for education regarding the implementation of the standards in late summer/early fall

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Thank You

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