



**Connecticut Academy
of Family Physicians**

Statement concerning

Senate Bill 655 – An Act Concerning Cultural Competency Instructions for Physicians

Public Health Committee

February 11, 2009

This statement is being submitted on behalf of the members of the Connecticut Academy of Family Physicians on Senate Bill 655 – An Act Concerning Cultural Competency Instructions for Physicians.

While we feel that cultural competency for physicians, and actually all professionals, is a worthy goal, we do not feel the need to mandate it. First, cultural competency is already being taught in most medical schools which have a defined curriculum based on the needs of its medical students. Second, family physicians have numerous resources, courses and educational opportunities at our disposal through the American Academy of Family Physicians, as well as the American Medical Association. These resources, courses and education each take into account the differing medical specialties and cultures that competency is being sought for.

Family physicians, like all physicians, routinely engage in cultural competency training because it enables us to better serve our patients. When we engage in such training many times we do so because of the area that we practice in, a growing population within our patient base, our specialty, etc. Our concern is that a mandate would actually have the effect of diminishing the more specific types of cultural competency that we need and desire to serve our particular

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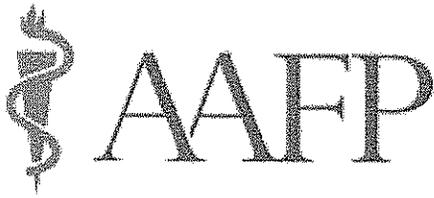
patients. Once a physician is mandated to participate in a particular type of cultural training, it will have the possible effect of diminishing their ability to get more practice specific training that they actually need. We feel that the teaching of cultural competency should be left to the professionals who are in the field and best able to continue to change the curriculum to the needs and demands of its physicians and patients.

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Principles for Improving Cultural Proficiency and Care to Minority and Medically-Underserved Communities (Position Paper)

1. Introduction: Importance of Improving Cultural Proficiency in the Delivery of Health Services

Cultural proficiency and linguistic competence are widely recognized as fundamental aspects of quality in health care—especially for diverse patient populations—and as essential strategies for reducing disparities by improving access, utilization, and quality of care.¹ The National Standards on Culturally and Linguistically Appropriate Services (CLAS) under the direction of the Department of Health and Human Services' Office of Minority Health mandate attention to cultural proficiency and language access to recipients of federal funds. Additionally, the Office for Civil Rights' Title VI of the Civil Rights Act of 1964; Limited English Proficiency Policy Guidance for Recipients of Federal Financial Assistance prohibits discrimination against national origin as it affects limited English proficient (LEP) persons.

The Joint Principles of the Patient-Centered Medical Home state that “care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.”

- The American Academy of Family Physicians (AAFP) is committed to ensuring high quality of care and patient safety by promoting access for limited English proficient (LEP) patients, cultural proficiency, expanded health workforce diversity, and reduced health disparities in the provision of medical care to our nation's LEP and racial/ethnic medically-underserved populations. Cultural proficiency is a necessary component for patient safety and adherence. All persons, regardless of race, ethnicity or primary language deserve access to high quality health services.
- Cultural proficiency is defined as a set of congruent behaviors, attitudes and policies that come together in a system, agency or among health professionals that enables work in cross-cultural situations. A culturally proficient organization values diversity; conducts cultural self-assessments; is conscious of and manages the dynamics of difference; institutionalizes cultural knowledge; and adapts services to fit the cultural diversity of the community it serves.

2. Organizing Principles

Physician Education

According to the Association of American Medical Colleges (AAMC), it is imperative that health care professionals are educated on issues of culture because of the growing diversity in the U.S. population and the strong evidence of racial and ethnic disparities in health care.² In 2000, the Liaison Committee on Medical

Education (LCME) introduced two standards about cultural competence that inspired medical schools to introduce cultural competence education into the undergraduate curriculum. The Tool for Assessing Cultural Competence Training (TACCT) is a self-administered assessment tool that can be used by medical schools to examine all components of the entire medical school curriculum.

Additionally, the federal CLAS standards ask that “health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.”

- Medical societies and health professional associations should work with their members to educate them about cultural proficiency, health disparities among racial/ethnic medically underserved populations, and the impact on health outcomes of limited English proficiency. These organizations should link to available information, training, and other resources so that health professionals may continually improve access to quality care and reduce health and health care disparities.
- Health professionals should be aware of, and sensitive to, the cultural and ethnic diversity of patients they serve so they can develop and implement best practices such as providing interpreter services and culturally proficient care in their offices. Health professionals should be aware of the connection between good cross-cultural communication and ensuring patient safety.
- The Office for Civil Rights should disseminate information and provide technical assistance about best practices in the provision of culturally, ethnically, and linguistically sensitive care delivery.

Workforce

Landmark reports, such as *Missing Persons: Minorities in the Health Professions*,³ *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*,⁴ and *In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce*⁵ provide clear evidence of the growing need for diversity in the physician workforce to serve an increasingly multicultural U.S. population. Additionally, the Future of Family Medicine recommendations include “a comprehensive family medicine career development program and other strategies will be implemented to recruit and train a culturally diverse family physician workforce that meets the needs of the evolving US population for integrated health care for whole people, families, and communities.”

- The AAFP should advocate for the federal government to encourage the racial, ethnic, religious, and linguistic diversity of the health care workforce to reflect the needs of the population.
- Medical and other health professional schools should increase efforts to recruit and retain minority faculty and promote minority faculty into leadership positions.
- Cultural proficiency training should be incorporated into medical schools and residency education in every specialty and should be available as part of the continuing professional development of health professionals.
- To meet the needs of LEP patients, the federal government should provide incentives for the development of a trained interpreter workforce.
- Medical school admissions policies should reflect the importance of increasing the representation of underrepresented minority students and encourage the use of “pipeline” recruitment programs.

Language Access

More than 23 million Americans speak English less than “very well” and thus have LEP.⁶ Clear documentation exists regarding how the lack of language services creates a barrier to and decreases the quality of health care for limited English persons.⁷⁻¹⁰

- Language assistance services, including, but not limited to, qualified bilingual health professionals, trained health care interpreters, telephonic and video language services, translated or in-language

written materials, and translated or in-language signage, are an essential element of delivering culturally proficient care in all settings, particularly to LEP and racial/ethnic medically-underserved communities.

- Any language access requirements placed on health professionals must recognize the logistical difficulties in the provision of interpreter services for unusual or rarely encountered languages and in urgent and emergent situations, and provide exemptions and additional assistance for these situations, as appropriate.
- National, state, regional, and local systems of language assistance service should take into account the limited capabilities and resources of health plans, hospitals, clinics, health departments, medical groups, physician practices, and other health professionals. To the extent possible, there should be efforts to collaborate, coordinate, and centralize the provision of language assistance services to increase efficiencies and minimize costs and administrative burdens to health professionals.
- Payment for interpreter services in both publicly- and privately-funded health care systems must be the responsibility of the insuring or purchasing entity.

Research and Data Collection

Standardized data collection would allow researchers to disentangle factors associated with health care disparities. The current national commitment to reduce health disparities may be compromised without more research on measurement quality. For example, self-report measures are required for research on disparities in the United States, although such measures are developed primarily in mainstream samples, and must be appropriate when applied in culturally and ethnically diverse groups.¹¹

- Health insurers and health care plans should be encouraged to collect and/or report socio-cultural health information (e.g., patient race and ethnicity, including subpopulations, primary language, etc.) to assist physician offices, while respecting the individual privacy of patients. This data collection shall not be delegated to the treating physician without an explicit paid, contractual agreement.
- Culturally and ethnically diverse populations be fully represented as appropriate in clinical studies supported by both private and public sector funds. Encourage researchers from minority communities to conduct research and clinical trials.
- Diseases and conditions disproportionately affecting LEP and racial and ethnic medically-underserved populations should be adequately investigated. Research on specific populations should be conducted to document health issues and successful interventions. This research goal can be accomplished through the Institutional Review Board process and through research done by Practice-Based Research Networks.

Health Care

There is strong evidence of examples of disparate access to care and utilization of services in the literature on disparities in health care access.^{12, 13}

- The availability of, and access to, quality, affordable health services are integral to eliminating disparities among LEP and racial/ethnic medically-underserved populations.
- Public insurance programs should promote access for beneficiaries by advertising availability, providing applications and other documents in other languages, and reviewing application processes to see what barriers may exist for eligible populations.

Written Resources

- National, state and other interested stakeholders should examine the feasibility of clearinghouses for translated or in-language materials that could increase access to quality health education, medication information, and other health-related information.

Quality Assessment

- Quality indicators that measure cultural proficiency should be developed.
- A review of current quality assessment measures should be conducted to identify areas for integration of cultural proficiency measures and make appropriate recommendations.

Payment

- Payment for interpreter services in both publicly- and privately-funded health care systems must be the responsibility of the insuring or purchasing entity.
- The primary financial entity (state, insurance company, or managed care company) should contract with and pay interpreters directly unless medical groups or physicians explicitly choose to accept risk for such services in their contracts. Health professionals, including medical groups, should not unwillingly bear the burden or expense of providing interpreter services.
- There should be consideration of reimbursement of physician office bilingual staff who serves as interpreters, as long as they have been trained and assessed for linguistic competency.
- There should be consideration of compensation for bilingual physicians who would otherwise require an interpreter, provided they have been assessed for linguistic competency.

3. Policy Options

Medicaid/SHIP/Medicare

- The federal government should work with the Centers for Medicare and Medicaid Services (CMS) and the State Health Insurance Programs (SHIPs) to ensure the cultural and linguistic proficiency of their respective staffs. Materials used to detail Medicare services, in particular Medicare-covered preventive care, should meet the language and health literacy levels of the beneficiaries they serve. CMS should evaluate the materials and strategies used by SHIPs to reach the LEP and racial/ethnic populations they serve.
- The federal government should work with CMS to ensure that reliable and comprehensive data are collected and reported with regard to beneficiaries' race, ethnicity, educational level, and primary language, while respecting the individual privacy rights of beneficiaries.
- The federal government should work with CMS to ensure that any program developed by CMS that bases a payment, bonus or reward on quality measures, includes quality measures of care for minority beneficiaries.
- The federal government should seek federal matching funds for the provision of interpreter services for patients in the Medicaid and SHIP programs; state governments should also address funding issues within the workers' compensation programs.
- The AAFP should work with federal policy makers and private health insurance stakeholders to ensure that language services are a covered benefit under the Medicare program and private insurance programs.
- The AAFP should advocate for a centralized service for interpretation that can be accessed easily by physicians. Models with significant promise include those in place in Washington State and the national telephonic interpreting service in Australia. The AAFP should support a regional pilot project to test delivery models for such a service.

Managed Care/Health Plans

- Managed care/health plan organizations, including public and private Health Maintenance Organizations (HMOs), should work with physician and other health professional organizations to ensure the development, evaluation, and diffusion of curricula, training, and education programs that address cultural proficiency, medically underserved communities, and health disparities.
- Managed care/health plan organizations and health plan regulators should use cultural proficiency and the provision of high quality, easily accessed language services, as indicators of access and quality.
- Both public and private HMOs and health plans should be asked to take explicit responsibility for paying and arranging for interpreter services as a covered benefit for members with the caveat that such services are the responsibility of the primary financial entity (HMO or purchaser) and are not to

be born by fiscal intermediaries such as local medical groups or physicians and other health professionals, unless they have explicitly contracted for the provision of such interpreter services.

- Managed care/health plan organizations should negotiate with both public and private payers for adequate reimbursement or direct payment to cover the expenses of interpreter services so that they can establish services without burdening physicians.
- Private industry should be engaged by medical organizations, including the AAFP, and patient advocacy groups to consider innovative ways to provide interpreter services to both employees and the medically underserved.

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