

Medical Leadership Council Meeting: November 2005 (Long Summary)

Ending Health Disparities: California Health Care Leaders Work Together on Solutions

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EXECUTIVE SUMMARY

Meeting together since 2002 as the Medical Leadership Council on Language Access, leaders of several California medical societies, health systems, health plans, and advocacy organizations have made great strides in increasing language access for Limited English Proficient patients. Backed by a growing body of research that shows health care quality is at stake, and learning more about funding, policy and technology, Council members are improving access to interpretation and translation services.

At its November 2005 meeting, the group voted to broaden its attention to health disparities, and changed its name to The California Endowment's Medical Leadership Council on Cultural Proficiency. Speakers at this meeting provided Council members with the latest thinking on cultural competence in health systems, updates on language access projects, a summary of challenges and opportunities to create a more ethnically and racially diverse workforce, and reports on new legislation supporting language access in California.

NEW FOCUS: MEDICAL LEADERSHIP COUNCIL ADDRESSES HEALTH DISPARITIES

Several physician and health care organizations in California have agreed to work together to find ways to end health care disparities. Convened by The California

Endowment, a private, statewide foundation, more than 28 organizations will meet as the Medical Leadership Council on Cultural Proficiency over the next two years to educate, build capacity and engage their memberships on issues of racial and ethnic health disparities.

“Our work is historic,” said Robert Ross, MD, president and CEO of The California Endowment at the Council’s November 17, 2005 meeting in Oakland. “We’re leveraging the expertise of health care leaders - in medical societies, advocacy organizations, health plans and health systems - to solve a critical element of the nation’s health care crisis.”

The Institute of Medicine in 2002 issued a report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, highlighting research showing that patients from racial and ethnic minorities in the United States are less likely to receive even routine medical procedures and experience a lower quality of health services overall.

Most of the participating organizations have been meeting together since 2002 as the Medical Leadership Council on Language Access, exploring policy, funding, human resources and technology to better meet the needs of patients with Limited English Proficiency (LEP). Realizing the larger context of health disparities, member organizations voted at their November meeting to expand the Council’s scope of work beginning in 2006.

“Together we’ve made great strides in awareness and services for language access,” said Leonard Fromer, MD, past president of the California Academy of Family Physicians (CAFP), which serves as the lead administrative organization for the Medical Leadership Council, along with its Foundation. “Now, while continuing that work, we’ll bring the same urgency and responsibility to eliminating health care disparities.”

Dr. Ross underscored Council-related accomplishments over the past few years, including new continuing medical education programs on language access provided by the California Academy of Family Physicians, American College of Obstetrics and Gynecology, American College of Emergency Physicians, and California Latino Medical Association. He also highlighted the Alameda-Contra Costa County Medical Association Collaborative – working on language access with other health care organizations throughout the county. And he pointed out that Kaiser Permanente, Catholic Healthcare West, Scripps, Sutter and St. Joseph’s health systems all now have language access initiatives in place.

“Building this awareness, these relationships and trust has made this work possible and will help us keep moving forward,” he said.

A FRAMEWORK FOR CULTURALLY COMPETENT HEALTH SYSTEMS

The California Endowment, a foundation dedicated to improving health and health care in California, has a particular interest in health care for underserved populations and is a leader in improving language access. At the November Council meeting, Ignatius Bau, the program director for work on culturally competent health systems, outlined the foundation's framework for achieving such competence.

Working with grantees, The California Endowment plans to accomplish its mission - "to expand access to affordable, quality health care for underserved individuals and communities and to promote fundamental improvements in the health status of all Californians" – by focusing on three goals:

- Providing access to affordable, quality health care;
- Achieving cultural competence in health care, including increasing workforce diversity; and
- Creating healthier communities, including ending health disparities.

Federal Initiatives

Bau provided a summary of federal initiatives shaping this work.

Institute of Medicine (IOM): Recommendations from four IOM reports:

- *To Err is Human (1999)*, addressing the need to improve patient safety¹
- *Crossing the Quality Chasm (2001)*, addressing the need to improve healthcare quality²
- *Unequal Treatment (2002)*, addressing the need to reduce health disparities³
- *Compelling Interest (2004)*, addressing the need to diversify the health workforce⁴

Department of Health and Human Services (DHHS): In the federal *Healthy People 2010* plan DHHS established two goals: to increase the quality and years of life for people in the United States, and to eliminate health disparities among various segments of the population.⁵

DHHS also published *National Standards for Culturally and Linguistically Appropriate Services in Health Care (2001)*.⁶

Agency for Healthcare Research and Quality (AHRQ): Aligned with the *Healthy People 2010* plan, AHRQ now monitors disparities (see the 2004 National Healthcare

Disparities Report)⁷ as well as quality (see the 2004 National Healthcare Quality Report).⁸

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO):

Beginning in January 2006, the Joint Commission requires hospitals and other accredited health care organizations to collect information on patients' language and communications needs. (California enacted a similar requirement for health facilities and primary care clinics, Assembly Bill 800-Yee, effective January 1, 2006.)⁹

In explaining the need for this revision to the Information Management standard, JACHO said that "Research shows that differences in language and culture can have major impacts on the quality and safety of care and that disparities in health services and outcomes are associated with race, ethnicity and language."¹⁰

JCAHO also is conducting a 30-month study, begun in January 2004, *Hospitals, Language, and Culture: A Snapshot of the Nation*, funded by The California Endowment, to gather data on a sample of hospitals to assess their capacity to address issues of language and culture that impact the quality and safety of patient care.¹¹

Endowment Strategies

Bau also outlined four strategies The California Endowment is pursuing to reach its goal of increased cultural competence in California's health systems. These strategies are:

- Policy change
- Education and training of health professionals
- Quality improvements in health systems, plans, and providers
- Engagement of patients/consumers

One focus of this work is creating a more diverse health workforce to serve the underserved. Recommended improvements include increasing incentives for health care professionals to serve in underserved areas; developing education and career ladders for health care professionals in underserved areas; recruiting more minority faculty in medical, nursing, dentistry and allied health professional schools; increasing academic and social support for under-represented minority students in health professions schools; increasing financial aid; creating effective high school pipelines to encourage under-represented minority students to enter the health professions; and better integrating internationally trained health professionals.

Another focus of The California Endowment's work is ensuring equal access for all patients regardless of language. Recommended improvements include expanding and better enforcing legal requirements for language access; requiring health systems to include language access as a quality measure; developing and diffusing technological innovations for providing language access; ensuring sufficient, qualified human resources to provide language access; recognizing trained interpreters as important health professionals; increasing patient advocacy and patient awareness of language access rights and availability; and ensuring that language access services are adequately financed.

Bau highlighted an interpreter videoconferencing project by Alameda County Medical Center and San Francisco General Hospital as a good example of developing and diffusing technology innovations.

He also described the language access toolkit developed by the California Academy of Family Physicians (CAFP) as "a great model of what can be done working with providers and physicians." *Addressing Language Access Issues in Your Practice*, funded by The California Endowment, has been the basis of CME courses for 600 physicians across California and has been highly rated by attendees. Follow-up activities include both systems issues - how to find out who is LEP, assessing staff language competence, finding out if a medical group pays for telephone interpreters, and doctor-patient communication – paying more attention to the patient than to an interpreter, taking more time between sentences, and using teach-back techniques.

To order copies of the kit, which includes a publication, CD/DVD, and speaker's notes, or to download a PDF copy for printing, contact CAFP.¹²

Bau also recognized the National Council on Interpreting in Health Care (NCIHC) for its October 2005 release of the *National Standards of Practice for Interpreters in Health Care*, the first such standards for medical interpreting professionals in the United States. This work was funded by The California Endowment and The Commonwealth Fund to set national standards of practice for interpreters.¹³

The California Endowment is working with New California Media¹⁴ to reach health care consumers through ethnic media outlets in their primary languages to inform them of their rights and ways to achieve language access in health care.

The foundation also is working with medical schools, residency programs, hospitals and health systems to ensure that language access, health care disparities, and cultural competence are part of physician education and training. "Providers need to go beyond just providing language access to best serve their patients," Bau said.

CURRENT LANGUAGE ACCESS INITIATIVES

“The improvements you make to work with the most vulnerable patients will improve the care you deliver to all your patients,” said Alice Hm Chen, MD, MPH, in her presentation to the Medical Leadership Council. “If you look at health outcomes for Limited English Proficient and low-health-literacy patients, language access is somewhat of a sentinel event.”

Chen, medical director at the General Medicine Clinic at San Francisco General Hospital, provided updates on various national, state and local language access projects.

National Quality Forum

The National Quality Forum (NQF) is a membership organization of physician societies, healthcare systems, health plans, accrediting bodies, employers, purchasers and governmental agencies. Its goal is to develop and implement national standards for measurement and public reporting of healthcare quality data and then publish and disseminate consensus reports.

In September NQF released a report, *Improving Use of Prescription Medications: A National Action Plan*,¹⁵ which underscores the risks for LEP patients. The report encourages providers to ask all patients to bring medications to physician office visits and keep an up-to-date list; offer all written prescription medication information in foreign languages and large print; use the “teach back” method with medications; and provide language assistance options for patients such as telephone interpreters or bilingual pharmacists.

This year NQF also released *Improving Patient Safety Through Informed Consent for Patients with Limited Literacy*,¹⁶ a report emphasizing the benefits of using the “teach-back” method for the informed consent process, which shows benefits particularly for Limited English Proficiency and low-health-literacy patients.

National Initiative for Children’s Healthcare Quality (NICHQ)

NICHQ emphasizes quality improvement in pediatric care through collaboratives, the spread of innovation and best practices, and advocacy work. NICHQ has addressed asthma, ADHD, obesity, epilepsy, foster care, access/flow, medical home, and more.

A current project, the *Improving Cultural Competency in Children’s Health Care*¹⁷, funded by The California Endowment, is exploring ways to integrate cultural competency

into the quality improvement framework with a focus on process and outcome measures. The project promotes the integration into ongoing disease and condition specific collaboratives, and a cultural competency assessment is now part of the standard change package.

Hospitals: JCAHO

In addition to the JCAHO projects mentioned above, Chen also explained the study, *Understanding Adverse Events in Minority Patients with Limited English Proficiency*,¹⁸ which is investigating adverse events and “near misses” due to patient-provider communication problems related to language barriers, to identify potential preventive strategies, and to inform policy on language services in the context of patient safety.

California Public Hospitals Projects

Dr. Chen also described some of the work occurring in public hospitals in California. The *University of California, San Francisco Center for the Health Professions and California Association of Public Hospitals Safety Net Institute* are implementing a joint initiative: The LEAD Program: Leadership, Education, Accountability, and Dissemination. This two-year project will work with four public hospitals each year, focusing on organizational change to integrate culturally and linguistically competent care into their healthcare systems. The first cohort of four hospitals have implemented the following:

Contra Costa Medical Center: Improving access to prenatal care for Latinas using a promotora model. Plan to increase patient satisfaction by identifying needs of Latina women through focus groups and interviews. Will provide cultural competency trainings for staff.

Los Angeles County Hospital and University of Southern California: Increasing quality of interpreter services through interpreter trainings of bilingual staff: initial 40 hour training followed by ongoing meetings. Providing material support to interpreters (medical dictionaries, point-to cards, language posters, dual handset phones). Training frontline and mid-level managers on the importance of cultural and linguistic issues. Conducting an in-depth pilot with Department of Radiology.

San Joaquin Medical Center: Hiring three staff interpreters in Spanish. Language line rates negotiated at 75% discount. Supplying hardware – telephones, speakerphones, dual handsets, videoconferencing equipment. Training front line staff on how to identify which patients need interpreters, and how to access interpreter services.

San Mateo Medical Center: Focusing on Emergency Department as high impact site. Formalized policies and procedures; tools. Increasing quality of interpretation through medical interpreter trainings for bilingual staff. Improving use of interpreters through trainings for medical providers on why and how to work with medical interpreters. Reinforced with institution-wide cultural competency trainings.

Other activities at public hospitals include:

Alameda County Hospital Summit: A report, *State of Hospital Language Assistance Services in Alameda County*, was published by Board of Supervisors in September 2004. The Board convened a Hospital Summit held October 2005 on next steps, sharing promising practices, and developing joint hospital initiatives around written materials, videoconference medical interpreting, bulk purchasing and improving quality of phone services.

San Joaquin General Hospital: Remote Voice Videoconference Medical Interpreting. San Joaquin General Hospital has hired three interpreters and established a collaborative with other public hospitals to share interpreters. When San Joaquin is not using them, two other hospitals (San Mateo and Contra Costa County) can work with them remotely via telephone or videoconference.

OPPORTUNITIES TO INCREASE HEALTHCARE WORKFORCE DIVERSITY

Three of the biggest challenges in U.S. healthcare are meeting the needs of a rapidly increasing population, an increasingly diverse population, and an aging population, according to presenter Ed O'Neil, PhD, MPA, FAAN, professor, Family Medicine, Community Medicine and Dental Health; director, Center for the Health Professions, University of California, San Francisco; and partner, Health Work Force Solutions, LLC. The overall U.S. population is expected to increase by 42% by 2050, he said.

The nature of health care services also is changing, and we will be focusing more heavily on treating chronic conditions, and on using new care management technologies resulting from new combinations of information technology and biotechnology.

Greater degrees of health care system integration and cost-containment will be necessary, he said, and patient satisfaction and provider and system performance will be more closely monitored and more widely reported in a model where consumers have more access to information and more power to choose.

The vacancy rate for health care professionals – including RNs, LVNs, lab technicians, radiology technicians, and respiratory technicians – is twice the rate for similarly trained professionals outside healthcare, O’Neil said. Costs are estimated at \$5 billion a year for RN turnover and \$5 billion a year for allied health turnover.

As health care experts struggle to find ways to recruit and retain more health care professionals in general, they also must find ways to increase the number of historically under-represented minorities in these fields, he advised. All health professional job categories, including allied health, which is the most diverse, are still over-represented by Caucasians.

Training capacity for most health professions is insufficient, he said, and it’s declining in some professions. The shortfall for allied health workers nationwide will range between 1.5 million and 3 million workers by 2020. The nursing profession will be short about 800,000 people.

In dentistry, the ratio of dentists to overall population is expected to decline as well. In addition, most dentists are not trained or sufficiently encouraged to work with populations like inner-city communities where dental disease is epidemic.

In medicine, medical school enrollment stopped growing in the late 1980s. By 1996, there were 25 percent more residency program slots than there were applicants from U.S. medical schools, so remaining slots were filled by international medical graduates. There’s a movement now to increase the number of medical students to fill residency slots, O’Neil said, but such growth begs the question of whether more of these slots should be allotted to primary care instead of specialties.

Challenges facing medicine include: the growing need for new MDs in relevant specialties as the population ages; the need to focus training programs on diverse participants and patient populations, underserved communities, and aging populations; the need for new practice models in primary care; and the need for new incentives and models for integrating primary and specialty care.

O’Neil’s recommendations include: reducing costs and time to training; changing regulations to allow innovation in education and training; aggressively engaging underrepresented minorities; moving beyond the traditional separation of education and practice to integrate training, resources, research and service; creating new practice models that are evidence-based, more attractive to professionals, and more effective; creating new care pathways which leverage emergent technology to move care out of traditional settings; and creating new ways of integrating educational competencies across traditional professional boundaries.

For more information, see recent studies, including the Robert Wood Johnson-funded *Frontline Workforce Development: Promoting Partnerships and Emerging Practices in Health and Health Care* by Health Workforce Solutions¹⁹ and the *Health Workforce Tracking Collaborative*, funded by The California Wellness Foundation, The California Endowment and the California HealthCare Foundation, at the UCSF Center for the Health Professions.²⁰

LEGISLATIVE PROPOSALS FOR LANGUAGE ACCESS

Legislators throughout the state are advancing policy proposals that meet the language and healthcare needs of their constituents. Several bills passed in 2005, and at least one is pending for 2006. Tom Riley, director of government affairs for the California Academy of Family Physicians, presented an overview of policy proposals increasing language access in California. They include:

- Assembly Bill (AB) 327-De La Torre: Establishing a funding source for a loan repayment program for physicians practicing in medically underserved areas; passed in 2005.
- AB 982-Firebaugh: Establishing a definition of a “Medi-Cal threshold language” for purposes of individuals eligible for loan repayment under the Dental and Medical Corps Programs; passed in 2005.
- AB 800-Yee: Requiring health facilities and primary care clinics to list a patient’s principal spoken language on the patient’s health records; passed in 2005.
- AB 1195-Coto: Requiring that continuing medical education courses contain curriculum that includes cultural and linguistic competency; passed in 2005.
- AB 775-Yee: Prohibiting the use of children as interpreters in most situations; pending.
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In addition, regulations are expected imminently to implement Senate Bill 853-Escutia: Requiring the Department of Managed Health Care to adopt regulations establishing standards and requirements to provide commercial health plan enrollees with access to language assistance

More information on bills, including full text, is available on the Web.²¹

FOOTNOTES

- 1 www.iom.edu/Object.File/Master/4/117/0.pdf
- 2 www.iom.edu/report.asp?id=5432
- 3 www.iom.edu/report.asp?id=4475
- 4 www.iom.edu/report.asp?id=18287
- 5 www.healthypeople.gov
- 6 www.omhrc.gov/cultural
- 7 www.qualitytools.ahrq.gov/disparitiesreport
- 8 www.qualitytools.ahrq.gov/qualityreport
- 9 www.democrats.assembly.ca.gov/members/a12/press/p122005090.htm
- 10 www.jcaho.org/about+us/news+letters/jcahonline/jo_05_05.htm.
- 11 www.jcaho.org/about%2Bus/hlc/home.htm
- 12 www.familydocs.org/toolkits.php or call 415/345-8667
- 13 www.ncihc.org/sop.htm
- 14 www.newamericamedia.org
- 15 www.qualityforum.org/txMedUseBEACH09-28-05.pdf
- 16 www.psnet.ahrq.gov/resource.aspx?resourceID=2685
- 17 www.nichq.org/NICHQ/Programs/CollaborativeLearning/CulturalCompetency2005.htm
- 18 www.academyhealth.org/2005/ppt/divi.ppt#274,1
- 19 www.healthws.com
- 20 www.futurehealth.ucsf.edu/hwtc.html

²¹ www.aroundthecapitol.com/bills

ADDITIONAL RESOURCES

- The California Endowment – Publications on language access, healthcare disparities, culturally competent health systems, and increasing workforce diversity: www.calendow.org/reference/index.stm
- Medical Leadership Council on Language Access - Public Policy Principles: http://www.familydocs.org/assets/Multicultural_Health/Medical_Leadership_Council/mlc_FINAL_w_endorsements.doc
- Medical Leadership Council on Language Access - Summary of 2002-2004 Meetings: http://www.familydocs.org/assets/Multicultural_Health/Medical_Leadership_Council/MLC_Summary_Report_11-02-04.pdf
- Medical Leadership Council on Cultural Proficiency – Charter: www.familydocs.org/medical_leadership_council.php