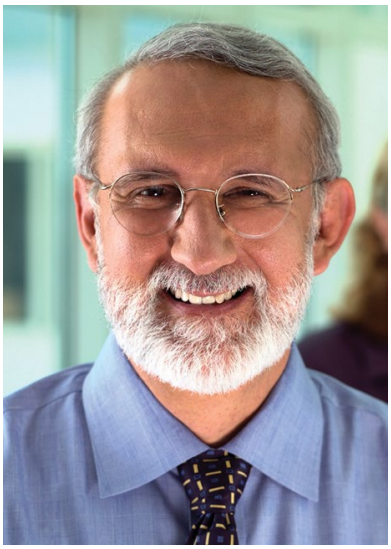

Sergio Aguilar-Gaxiola, MD, PhD is Professor of Clinical Internal Medicine, School of Medicine, University of California, Davis. He is the Founding Director of the Center for Reducing Health Disparities at UC Davis Health and the Director of the Community Engagement Program of the UCD Clinical Translational Science Center (CTSC). He is a past member of the National Advisory Mental Health Council (NAMHC), National Institute of Mental Health (NIMH). He is Past Chair of the Board of Directors of Mental Health America (MHA; formerly the National Mental Health Association) and Past President of the Board of Directors of National Alliance on Mental Illness (NAMI) California. He was a member of the California Future Health Workforce Commission's Technical Advisory Committee and co-chair of the Behavioral Health Subcommittee and a past member of the California Department of Public Health Office of Health Equity's Advisory Committee. He is currently a member of the National Advisory Council of the Substance Abuse and Mental Health Administration (SAMHSA) - Center for Mental Health Services (CMHS), and board member of the California Health Care Foundation, Physicians for a Health California, and the Public Health Institute. On October 2020, he was appointed by the CA Department of Public Health to the California COVID-19 Vaccine Drafting Guidelines Workgroup with the charge of drafting guidelines for the prioritization of supplies of available COVID-19 vaccines. He is a national and international expert on health and mental health comorbidities on diverse populations. Over the last 25 years, he has held several World Health Organization (WHO) and Pan American Health Organization (PAHO) advisory board and consulting appointments and is currently a member of the Executive Committee of WHO's World Mental Health Survey Consortium (WMH) and its Coordinator for Latin America overseeing population-based national surveys of Mexico, Colombia, Peru, and Argentina, a regional survey of Brazil, and two surveys of the city of Medellín, Colombia.

Dr. Aguilar-Gaxiola's applied research program has focused on identifying unmet mental health needs and associated risk and protective factors to better understand and meet population mental health needs and achieve equity in health and mental health

disparities in underserved populations. He is also very active translating health, mental health and substance abuse research knowledge into practical information that is of public health value to consumers, service administrators, and policy makers. He is the on-site principal investigator of and conducted the Mexican American Prevalence and Services Survey (MAPSS) – the second largest mental health study done in the U.S. on Mexican Americans funded by NIMH and the largest population-based comprehensive study done on farmworkers' mental health, which also included Mixtecos. In the MAPSS study, he identified the most prevalent health and mental health disorders in the Mexican-origin population in California's Fresno County and reported that the rate of disorders increases the longer the individual resides in the U.S and demonstrated that children of immigrants have even greater rates of mental disorders. From the results of this study, he and his team developed a model of service delivery that increased access to mental health services among the Central Valley's low-income, underserved, rural populations. He is a Multiple Principal Investigator (MPI) on two National Institute of Health-funded projects: ÓRALE COVID-19! project (a part of the NIH-RADx-UP national initiative) and the UC Davis STOP COVID-19 CA (a part of the NIH-CEAL national initiative). He is also the Principal Investigator of a FEMA-funded project through the CA Department of Public Health's Office of Health Equity and the on-site Principal Investigator of a CDC funded project. All four of the COVID-19 funded projects are focusing primarily on farmworkers and their families, immigrants, and other underserved populations.

Dr. Aguilar-Gaxiola is the author of over 190 scientific publications. He is the recipient of multiple international, national, state, and local awards, including a distinguished member of the Top 10 U.S. Latino Physicians in the May 2016 issue of *Latino Leaders* Magazine. More recently, he received the Ohtli Award, the highest honor granted by the Mexican government to individuals who have dedicated their lives to improving the well-being of Mexicans, Mexican Americans, and other Latinos in the US and abroad. In October 2021, he was distinguished by the National Hispanic Science Network with the 2021 National Award of Excellence in Research by a Senior Investigator award and by the National Latino Behavioral Health Association with the 2021 Lifetime Award for the Advancement of Latino Behavioral Health.

Dr. Aguilar-Gaxiola is currently serving as co-chair of the Steering Committee of the National Academy of Medicine (NAM) Assessing Meaningful Community Engagement in Health and Health Care.

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Integrating Cultural and Linguistic Competency In Continuing Medical Education

Sergio Aguilar-Gaxiola, MD, PhD
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Director, Center for Reducing Health Disparities
UC Davis School of Medicine

February 11, 2022

UCDAVIS HEALTH | Center for Reducing Health Disparities

Medical Board of California

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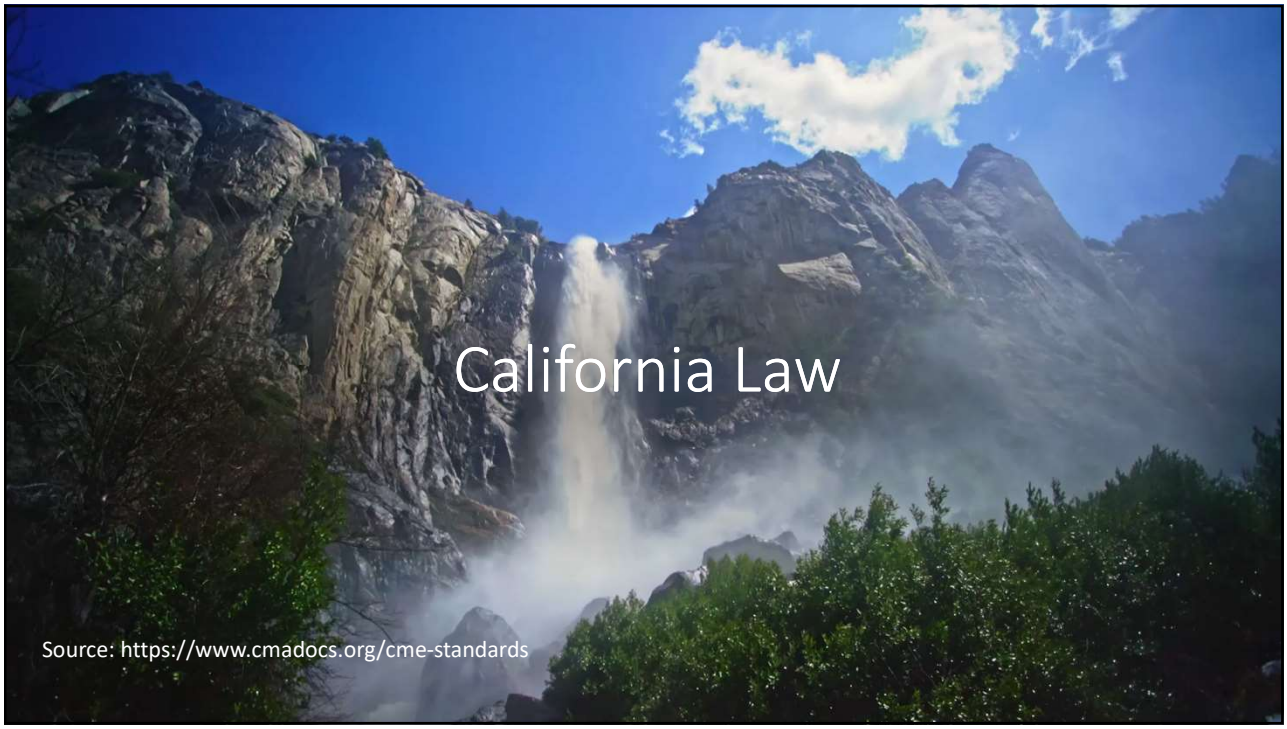
Cultural & Linguistic Competency and Implicit Bias Standards

Standards for integrating cultural and linguistic competency and implicit bias into Continuing Medical Education course for California physicians.



California Law

- Business and Professions (B&P) Code Section 2190.1 requires the California Medical Association (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)

Source: https://www.cmadocs.org/cme-standards

Business and Professions (B & P) Code Section 2190.1

Assembly Bill 1195
Cultural and Linguistic Competency (CLC)

Assembly Bill 241
Implicit Bias (IB)

Source: https://www.cmadocs.org/cme-standards

Standards

Each standard applies to both AB 1195 (CLC) and AB 241 (IB), unless otherwise noted

1) **WEBSITE LINK**
   - + Provide link on website or other means to make AB 1195 and AB 241 legislation accessible to planners, faculty and speakers

2) **DEFINITION**
   - + Present definition of CLC and IB to planners, faculty and speakers

3) **RESOURCES**
   - + Direct or otherwise make CLC and IB educational resources available to planners, faculty and speakers

Source: https://www.cmadocs.org/cme-standards

Standards (cont.)

4) PATIENT POPULATIONS (CLC ONLY)

+ Reflect on the patient populations impacted by the provider's CME program to best determine how cultural/linguistic factors should be addressed, and communicate to planners, faculty and speakers

5) DISPARITIES (IB)

+ Reflect on disparities in care affecting the patient populations impacted by the provider's CME program, and the role IB plays in these disparities, 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 as impacting the provider's patient populations and disparities potentially caused or exacerbated

*Activities exempted from including CLC or IB content by the state law must be documented

Source: https://www.cmadocs.org/cme-standards

Assembly Bill 1195 Cultural & Linguistic Competency

Attitudes | Knowledge | Skills

Effective care for patients from diverse cultures, groups, communities

Source: https://www.cmadocs.org/cme-standards

Assembly Bill 241 Implicit Bias

Attitudes and internalized stereotypes

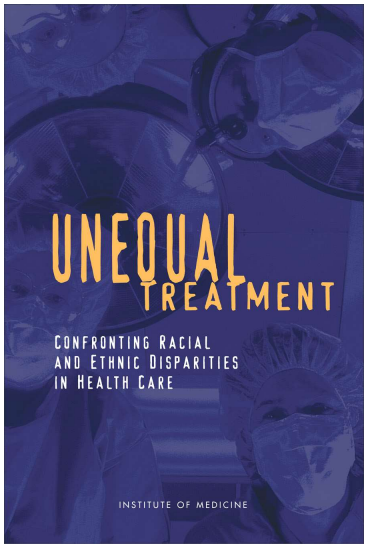
unconsciously affect

Perceptions | Actions | Decisions

contribute to **unequal treatment**, based on

Race, ethnicity | Gender identity, sexual orientation | Age, ability, other characteristics

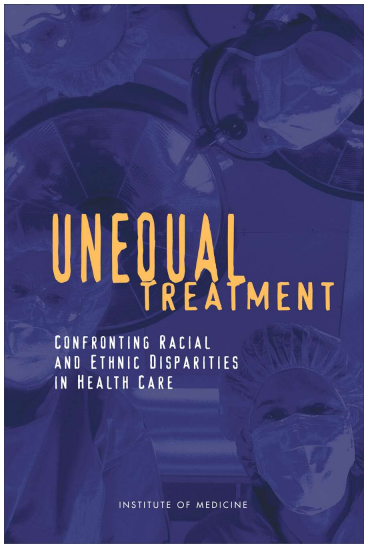
Disparities in Quality of Health Care



- In 2002, the Institute of Medicine published *Unequal Treatment* which compiled research demonstrating substantial racial and ethnic variation in **quality** of health care.
- It brought healthcare disparities to the attention of the nation, placing the issue on the forefront of the nation's health policy agenda.

Source: "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care", IOM, 2002

Health Disparities: Findings



- Racial and ethnic disparities exist across a wide range of:
  - disease areas
  - clinical services
  - clinical settings
- **Underrepresented minorities receive lower-quality health care**
- **Disparities are associated with higher mortality**

Source: "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care", IOM, 2002

Cultural & Linguistic Competency Training

Culture Counts!

Culture influences:

- How consumers/patients communicate and manifest their symptoms
- Their style of coping
- Their family and community support
- **Their willingness to seek treatment and the provider-patient interaction**

Source: Culture, Race, and Ethnicity: A Supplement to Mental Health. A Report of the Surgeon General, 2001.

Cultural & Linguistic Competency Training

Cultural Competence

"A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and consumers and enables that system, agency or those professionals and consumers to work effectively in cross-cultural situations."

Cultural competence is a developmental process – one that occurs over time.

Source: Cross, Bazron, Dennis & Isaacs, 1989

Cultural & Linguistic Competency Training

Language also Counts!

- Language is the core medium for the communication, creation, and transmission of culture

Source: Guarnaccia, et al., 1998; p. 424

Cultural & Linguistic Competency Training

Communication as Cause of Harm

Common root causes	Up to 2004	2005
- Communication	65%	68%
- Orientation/training	57%	28%
- Patient assessment	42%	52%
- Staffing	22%	12%
- Availability of information	20%	26%

Source: Schyve, 2007

The Joint Commission

Most Frequently Identified Root Causes of Sentinel Events Reviewed by the Joint Commission

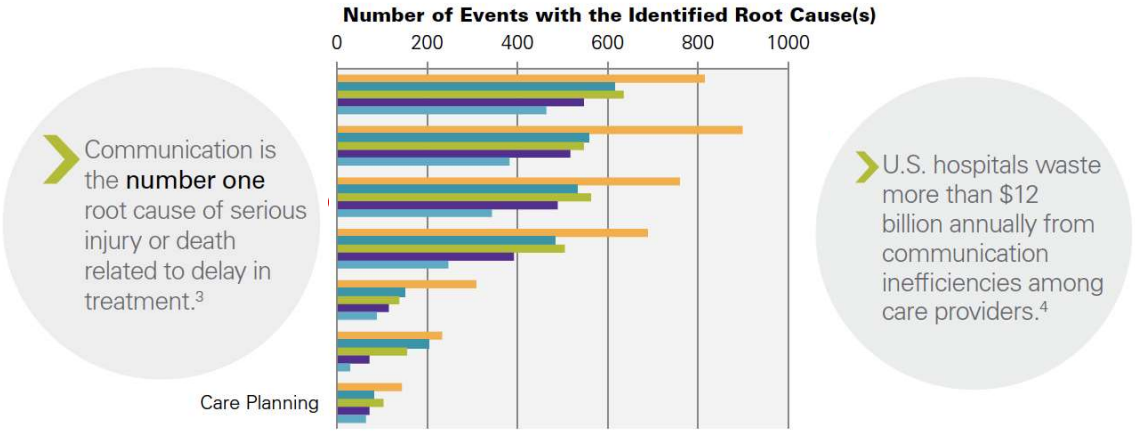


Figure 1. Root causes of sentinel events as reported to The Joint Commission from 2011 through the first half of 2015[3]

Source: Spok, 2017

Implicit Bias

- Refers to attitudes, stereotypes, or opinions that we possess and that unconsciously affect our understanding, actions, and decisions
- Social stereotypes about certain groups of people that individuals form outside their own conscious awareness (Fiske & Taylor, 1991; Valian, 1998)
- All of us hold unconscious beliefs about various social and identity groups
- Stems from our tendency to organize social worlds by categorizing

Source: Salazar, 2016

Implicit Bias

- Compelling body of scientific evidence shows unconscious bias pervasively influences (Wright, AAMC 2010)
  - Daily interactions (microagressions)
  - Hiring
  - Evaluation
  - Patient care

Health inequities are ubiquitous

Why does it matter?

Everyone deserves a fair chance to lead a healthy life. No one should be denied this chance because of who they are or their socioeconomic opportunities.

Is it possible to advance health equity in historically underserved populations?

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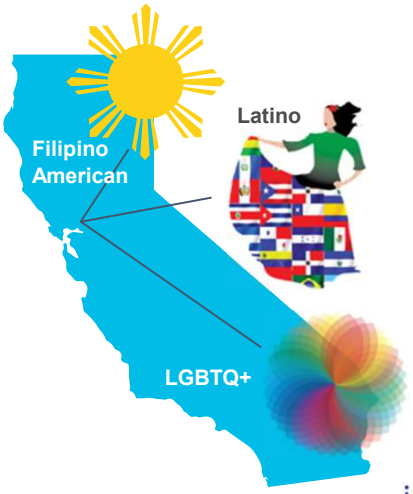
Interdisciplinary Collaboration and Cultural Transformation Model (ICCTM)

2016 - 2021

5

YEARS

- 5-year multi-phase MHSA Innovation Project
- Focused on three priority underserved populations in Solano County
- Anchored in the nationally recognized **Culturally and Linguistically Appropriate Services (CLAS) Standards**
- **First project of its kind combining the CLAS Standards with community engagement**



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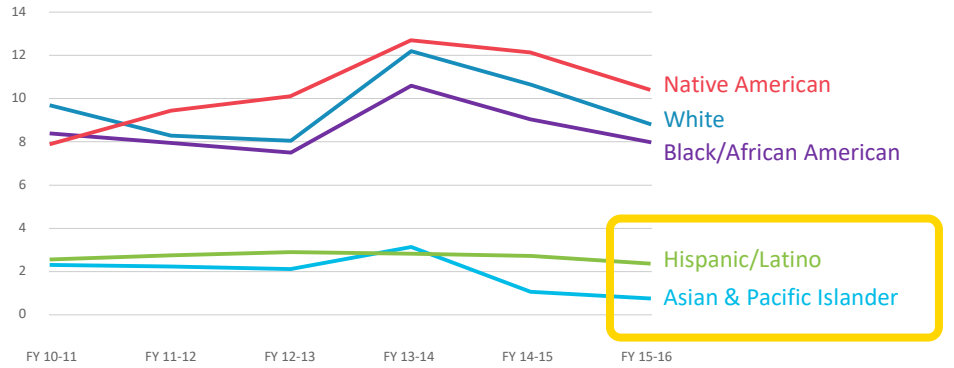
Solano County Mental Health Plan Service Penetration Rates by Race/Ethnic Group



Hispanics and Asians had much lower Mental Health Penetration Rates than other groups

Note: Penetration rates are calculated by dividing the number of beneficiaries receiving SMHS by the number of Medi-Cal eligible beneficiaries.
Source: External Quality Review Organization (EQRO) and Solano County Behavioral Health

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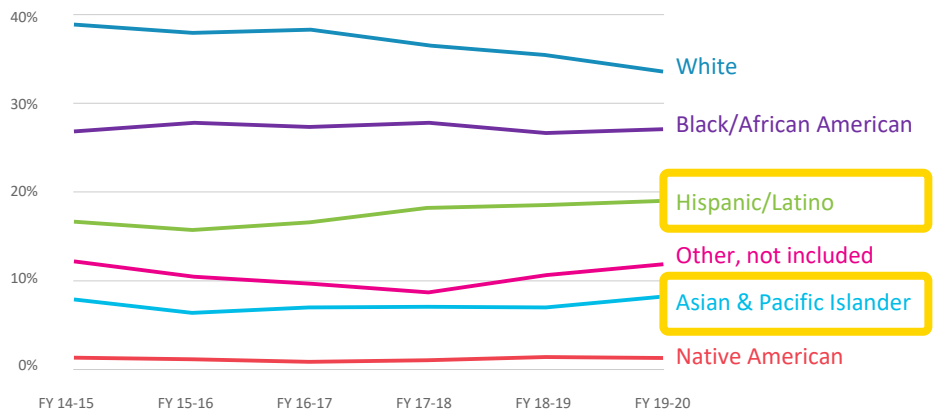
ICCTM Outcomes - Utilization of Solano County MHP Services by Race/Ethnic Group



Utilization increased from 14.9% to 17.4% for Latinos and from 6.3% to 6.8% for Asians

Consumers Served also increased for both groups: 16.9% for Latinos and 7.9% for Asians

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ICCTM Outcomes

Comparison of calls to Access Line requesting services from FY 2014/15 to FY 2019/20

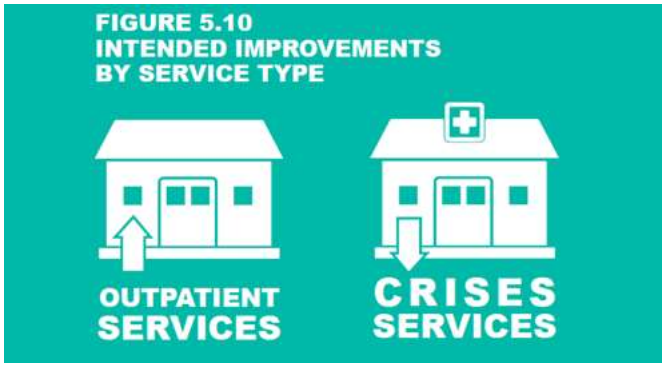
1.5-fold increase in Asian-American callers to the Access Line.

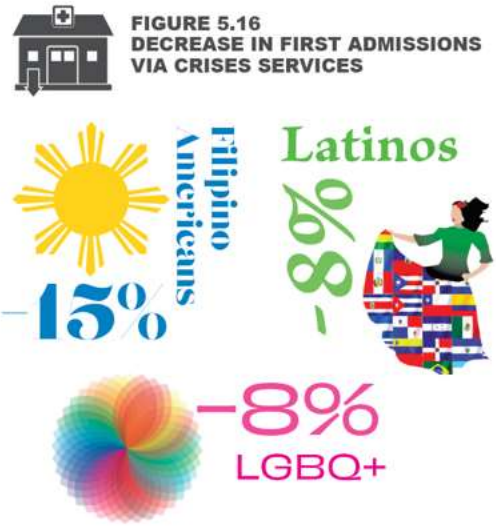
1.5-fold increase in Latino Access Line callers

Five-fold increase of callers who identified as a gender other than "male" or "female"

Seven-fold increase of callers who identified their sexual orientation as something other than "heterosexual"

ICCTM Outcomes





Recommendations

To ensure culturally and linguistically competent quality of care for all patients with limited English proficiency (LEP) or no proficiency in health care:

- **Recognize the importance of accurate communication between providers and patients**
- **Identify the language needs of all patients**
- **Provide qualified medical interpretation and linguistically appropriate services** that can prevent miscommunications and prevent costly medical errors and lawsuits
- **Provide free interpreting services**
- **Refrain from using families and friends as interpreters and prohibit the use of minors** as well

Unrealistic Assumptions about Cultural and Linguistic Competency

- It can remedy all disparities in treatment
- It is easily dispensed in short training sessions
- Patient outcomes can be improved without disturbing "business as usual" such as patient management routines of health providers
- It won't cost much money
- It satisfies the ethical requirement for responsiveness to diversity

Keeping it Alive!

- Cultural and linguistic competence must fit healthcare organizational priorities even while it seeks to change them
- Must not attach ourselves solely to the vehicle of "cultural competence" but **to the goal of improving quality of care and health outcomes**

Source: Vega, 2005

Acknowledgments

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