Studying State Legislation of Cultural and Linguistic Competence

Studying state-level strategies to address health and mental health disparities through cultural and linguistic competency training and licensure

SUMMARY

An emergent body of evidence and consensus among many in the health and mental health care community concludes that cultural competence and linguistic competence are key approaches in efforts to reduce health disparities and improve quality of care. Some states have either introduced or enacted legislation requiring cultural and/or linguistic competence for health care professionals as a policy imperative to address disparities.

Researchers at the National Center for Cultural Competence at Georgetown University analyzed efforts by 14 states to integrate cultural and/or linguistic competence into curricula, continuing education and licensure requirements for health and mental health care professionals.

Key Findings

- Legislative champions who were knowledgeable about health disparities and cultural competence—and who possessed the skills to address attitudinal barriers and build needed coalitions and collaborations—were more successful in shepherding legislation to enactment.

- States that introduced or passed legislation:
  - Had more laws on the books with mandates related to health
  - Were more likely to have Democratic than Republican legislatures and governors
  - Were more likely to have legislators who worked at least two-thirds time

- Barriers to passage of legislation included:
  - A sole legislator sponsoring bills without the support of consumer advocates, health care stakeholders, and fellow legislators
— Bias and lack of awareness of health disparities among some legislators who associated the need for cultural and linguistic competence with undocumented immigration

— State medical societies, institutions of higher education, and professional associations that viewed the legislation as an intrusion on professional authority

**Funding**

The Robert Wood Johnson Foundation (RWJF) supported the project from January 2007 through September 2008 with a solicited grant of $254,146.

**THE PROBLEM**

The divisions of race, ethnicity and culture in the United States are sharply reflected in the health and mental health status of its residents. The 2005 National Healthcare Disparities report issued by the Agency for Healthcare Research and Quality concluded that "racial, ethnic, and socioeconomic disparities are national problems that affect health care at all points in the process, at all sites of care, and for all medical conditions—in fact, disparities are pervasive in our health care system and ethnic minority groups in the U.S."

The political will to eliminate health disparities has grown over the past decade. In addition to efforts at the national level, some states have enacted state legislation to address disparities and promote health equity, while others have used non-legislative approaches. Developing cultural and linguistic competence among providers has emerged as a key approach in both national and state initiatives.

Although research is still in the early stages, emerging evidence suggests that culturally and linguistically competent health care is associated with:

- Increased use of screening and greater adherence to treatment protocols and medication regimens by patients
- More effective patient-provider communication and increased patient satisfaction with care
- Enhanced cultural knowledge and skills among providers
Cultural and Linguistic Competence Defined

According to the National Center for Cultural Competence at Georgetown University, Washington:

"Cultural competence requires that organizations:

- "Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.
- "Have the capacity to:
  — value diversity,
  — conduct self-assessment,
  — manage the dynamics of difference,
  — acquire and institutionalize cultural knowledge and
  — adapt to diversity and the cultural contexts of the communities they serve.
- "Incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.

"Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum.

"Linguistic competence is the capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing. Linguistic competency requires organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity." Click here for a full definition.

CONTEXT

RWJF's Quality/Equality approach had four major components, each representing significant investments and multiple partners.

Aligning Forces for Quality

Aligning Forces for Quality is the core strategy of the Foundation's longstanding commitment to improve the quality of health care that Americans receive. Through this
national initiative, RWJF is working to lift the overall quality of health and health care in targeted communities across the country.

**Transparency**

While performance measurement and public reporting in quality have become more common, we need far greater collaboration at the federal and local levels to standardize measurement and reporting activities and create measures that are more meaningful to patients, providers and others.

**Measuring Progress**

RWJF is devoting a substantial portion of our portfolio to research, tracking and evaluation. Some of this work will involve:

- Using the Foundation's existing research investments to assess more purposefully progress in the communities engaged in *Aligning Forces for Quality*
- Issuing targeted solicitations to the field to garner ideas for new interventions and tools to help spur the pace of quality change and transformation

**Communications**

The team is designing and executing communications activities and support at multiple levels.

- Local communities, for example, might require different types of targeted assistance with messaging, advocacy and engagement.
- At the national level, the Quality/Equality team is actively sharing the stories and lessons learned from its regional work.

The project described in this report aimed to inform RWJF’s strategic planning by analyzing state legislative efforts to increase cultural and linguistic competence among health care providers.

**THE PROJECT**

Researchers at the *National Center for Cultural Competence* identified 14 states that had either introduced or enacted legislation mandating the integration of cultural and/or linguistic competence into curricula, continuing education and licensure requirements for health and mental health care professionals as of January 2007.

California, New Jersey and Washington had enacted mandatory legislation. Other states enacted voluntary legislation, and some states proposed but did not enact legislation.

See the *Appendix*.  

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RWJF Program Results Report – Studying State Legislation of Cultural and Linguistic Competence
The National Center for Cultural Competence is part of the Georgetown University Center for Child and Human Development in Washington Tawara D. Goode, MA, directs the National Center for Cultural Competence and also co-directed this project with Suzanne M. Bronheim, PhD.

The National Center contracted with Joanne Fuccello, MSW, LCSW, an expert in policy analysis related to health issues, to consult in designing and executing the project.

**Methodology**

Goode and colleagues:

- Collected data for each of the 14 states describing its racial/ethnic composition, areas in which health disparities existed, the political party of the governor and legislature, minority representation in the legislature and the level of regulatory activity in health care. They also gathered limited data regarding the political and policy environments of the remaining 36 states in the United States.

- Analyzed transcripts of public hearings and copies of proposed and final regulations in states that enacted legislation.

- Interviewed by telephone 49 key individuals in 12 of the 14 states, including legislators or staff, governors' staff, academic researchers, and representatives from hospitals, medical societies, advocacy groups, state health commissions and policy institutes.

- Interview topics included the person's role in the legislation, contributing factors and barriers to passage, the policy and political environment in the state at that time, the impact of the legislation and future directions in the state related to health disparities including follow-up activities in states where legislation was introduced but not passed.

Researchers examined steps in the policymaking process employed by the 14 states through the lens of two frameworks:

- John Kingdon's rational decision-making framework, which holds that there is a "policy window" through which issues surface and are acted upon. Three policy streams converge to open the window: problem identification/recognition, policy proposals/debates, and political processes. When the window opens, an opportunity for change is provided.

- Charles Lindblom's "Science of Muddling Through" framework, which holds that key players most often adjust policy at the margins, absent a structured and rational sequence of activities, by using "rule of thumb" approaches and shortcuts. In Lindblom's view, policymaking is reactive, characterized by limited information-processing and often involves reactive policy design in response to a crises.
RESULTS

Goode submitted a report to RWJF in November 2008: *State-Level Strategies to Address Health and Mental Health Disparities Through Cultural and Linguistic Competency Training and Licensure: An Environmental Scan of Factors Related to Legislative and Regulatory Actions in States*. The report includes a discussion of the project methodology, overall findings, state profiles, conclusions and implications. See the Bibliography for details.

FINDINGS

Goode presented the following findings in the November 2008 report to RWJF:

- **States with high rates of racial, ethnic and linguistic diversity were the first to introduce bills requiring cultural competency training for health care providers.**

- **Legislative "champions" who were knowledgeable about health disparities and cultural competence—and possessed the skills to address attitudinal barriers and build coalitions—were more likely to shepherd legislation to successful enactment.**

- **Most states that introduced or enacted legislation:**
  - Had more laws on the books with mandates related to health than other states.
  - Had both houses of the legislature and the governor's office under Democratic control.
  - Had legislators that worked at least two-thirds time, with equivalent levels of staff support.

- **Interviewees identified factors that characterized legislative efforts in their own states:**
  - States that consistently used strategies to build coalitions and involve the executive branch had the most positive outcomes.
  - Learning about activities in other states provided a catalyst for action by some states.
  - Barriers to the passage of legislation included:
    - A sole legislator sponsoring bills without the support of consumer advocates, health care stakeholders, and fellow legislators
    - Bias and lack of awareness of health disparities among some legislators who associated the need for cultural and linguistic competence with undocumented immigration
• State medical societies, institutions of higher education, and professional associations that viewed the legislation as an intrusion on professional authority

• Legislative leadership did not perceive legislation requiring cultural competence to address health disparities as a significant issue

• Few states ranked highly on the Kingdon model scale.
  — California, New Mexico and Washington ranked high on the Kingdon policy window model scale in that they devoted time to identifying the problem, proposing alternatives and involving stakeholders in the political process. These states also passed legislation mandating or allowing integration of cultural and/or linguistic competence into curricula, continuing education and licensure requirements for health and mental health care professionals. State rankings for either the Kingdon or Lindblom policy frameworks were measured by coding various policy activities that took place in each studied state and categorizing them as representing features of each model.
  — Massachusetts, Maryland and New Jersey, which also passed legislation mandating or allowing integration of cultural and/or linguistic competence, used processes which were a hybrid of the Kingdon and Lindblom models.
  — The Colorado Legislature passed legislation mandating cultural competency training as a requirement for physician licensure in the state; however, the law was subsequently vetoed by the governor.

• States that had a process that adhered more closely to the Lindblom framework were less likely to pass legislation.
  — The "muddling through" process described by the Lindblom framework surfaced in the form of a sole legislator forging ahead without building coalitions, clearly identifying the problem or adequately analyzing options. When this happened, legislation did not pass.

Suggestions for RWJF

Researchers offered several implications of the study that might inform RWJF's strategic planning related to grants addressing health and mental health disparities. These included:

• **RWJF could support initiatives to help legislators advance legislation.** Some legislators understand the importance of reducing disparities but need help to understand cultural competence and how to use research in shaping and debating legislation.

• **RWJF could work with other funders of health disparities research to make the link between policy and health outcomes.** Documenting the relationship between
public policies and health outcomes would build an evidence base for legislative efforts.

- **RWJF could develop a project to track outcomes in states that passed legislation in order to derive lessons from their enactment and implementation processes.**

- **RWJF could fund further study of the role of bias and discriminatory attitudes among legislators, providers, and the public on the legislative and policy processes related to health disparities.** The study could look at the ways in which attitudes affect legislative strategies, successful approaches for addressing bias and the relationship between the level of minority representation in legislatures to legislative action on disparities.

**LESSONS LEARNED**

1. **Pair content experts with policy study experts.** In this case, the synergy between the content expertise of Center staff and the policy expertise of the contractor "exponentially enhanced the process and the product of this project." (Project Director)

2. **Develop back-up plans when seeking to interview people on topics that are controversial or sensitive.** Several people refused to be interviewed about their state's efforts to address health disparities through cultural and linguistic competence or refused to allow researchers to record the interview. In these cases, researchers sought other people to interview and agreed not to record interviews if respondents objected. (Project Director)

**AFTERWARD**

The project ended with this grant. The Center is using the lessons learned from the study in other projects that aim to support policymakers.

During the grant period RWJF changed its emphasis to focus more broadly on health care quality/equality and on community strategies to address disparities and improve care for vulnerable people.

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APPENDIX

Legislative Outcomes for the 14 States Included in the Study

As of January 2007:

- Three states—California, New Jersey and Washington—had enacted legislation mandating the integration of cultural and/or linguistic competence into curricula, continuing education and licensure requirements for health and mental health care professionals.

  - California passed Assembly Bill 1195: Continuing Education: Cultural and Linguistic Competency in October 2005. The law requires all continuing medical education courses to contain curricula pertaining to cultural and linguistic competency in the practice of medicine.

    The legislation went through several stages and reflected involvement by diverse parties including the California Medical Association, physicians, the governor's office and legislators.

    California had a history of addressing cultural and linguistic competency in private health plans, academic institutions and its Medicaid program. This law integrates cultural and linguistic competency into health care curricula, rather than specifying a one-time class or specific number of hours.

  - New Jersey passed Senate Bill 144 in March 2005 and its regulations took effect in April 2007. The law requires medical professionals to receive six hours of cultural competency training in order to receive their licenses. It also requires medical schools to provide cultural competency instruction focused on "race and gender-based disparities and medical treatment decisions."

    Passage of this law was preceded by needs assessments, reports and recommendations regarding cultural and linguistic competency that had been developed starting in 1999. Several medical and physician associations and individuals participated in public hearings that took place over the two years between the passage of the law and the regulations taking effect.

  - Washington's Engrossed Senate Bill 6194 was introduced in January 2006 and passed later that year. It requires the agency that regulates health professions to establish an "ongoing multicultural awareness and education program as part of its health professions regulation." It also requires all schools that train health professionals to offer multicultural health education by July 2008.

    The catalyst for the law was a 2004 Joint Select Committee on Health Disparities, a bicameral, bipartisan group. The legislator who chaired the committee worked
with stakeholders to create a broad base of support for the law, both inside and outside of the legislature.

- Nine states had introduced but not enacted legislation mandating the integration of cultural and/or linguistic competence into curricula, continuing education and licensure requirements for health and mental health care professionals. They were Arizona, Florida, Georgia, Illinois, Kentucky, Massachusetts, New Mexico, New York, and Ohio.

- Colorado had passed mandatory legislation that was vetoed by the governor.

- Maryland had enacted voluntary legislation.
BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Reports