AGL 2022

51st GLOBAL CONGRESS ON MIGS

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SYLLABUS

Panel 3: Quality Improvement and Patient Safety in Minimally Invasive and Complex Gynecologic Surgery Panel: Advancing Patient Safety Science Through Structural Processes

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Richard B. Rosenfield, MD*
Kristen J. Sasaki, MD – Speakers Bureau: AbbVie; Consultant: Aqua Therapeutics; Johnson & Johnson

Panel 3: Quality Improvement and Patient Safety in Minimally Invasive and Complex Gynecologic Surgery
Panel: Advancing Patient Safety Science Through Structural Processes

Chair: *Susan S. Khalil, MD*

Faculty: *Kristen J.Sasaki, MD, Richard B. Rosenfield, MD*

Course Description

This course will help you understand national drivers in gynecologic surgery through structural factors that shape gynecologic surgical training, value-based indicators in MIGS and complex gynecologic surgery, as well as health equity in MIGS and complex gynecologic surgery. There will also be a discussion the role of quality improvement initiatives and disparities in MIGS. The target audience for this program includes residents, fellows, faculty and program directors in minimally invasive gynecologic surgery and women's health.

Learning Objectives

At the conclusion of this course, the participants will be able to: 1) Identify drivers of structural measures in minimally invasive gynecologic and complex gynecologic surgery training; 2) Recognize national drivers for quality programs and value-based medicine; and 3) Summarize the role of health equity and QI within creation of disparities in MIGS or complex gynecologic surgery.

Course Outline

3:15 pm	Welcome, Introduction and Course Overview	S.S. Khalil
3:20 pm	Structural Drivers of Quality in Gynecologic Surgery Training	S.S. Khalil
3:35 pm	Health Equity in Minimally Invasive Gynecologic Surgery	K.J. Sasaki
3:50 pm	Value Based Medicine in Minimally Invasive Gynecologic Surgery	R.B. Rosenfield
2:55 pm	Questions & Answers	All Faculty
3:05 pm	Adjourn	

Quality Panel 2022: Structural Drivers of Quality in Gynecologic Surgical Training

Susan Khalil, MD
Associate Program Director, Fellowship in Minimally Invasive Gynecologic Surgery
Mount Sinai Hospital
New York, NY

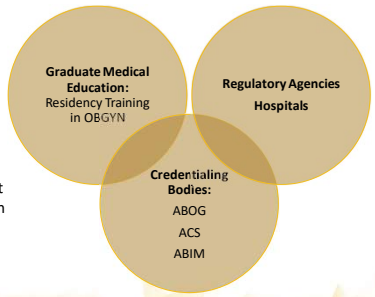
Disclosure

- Surgical Advisory Board: JNJ

Objectives

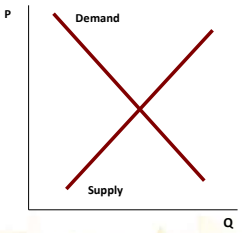
- Understand regulatory forces on surgical training in gynecology
- Differentiate quality and regulatory drivers with patient-factors that shape gynecologic surgery
- Recognize structural quality drivers in gynecologic surgical training

Static Forces:
RVUs
CPT reimbursement
Insurance allocation

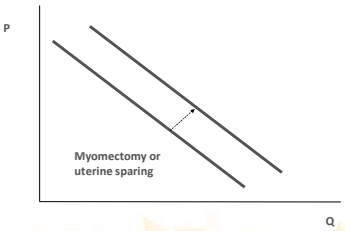


Transparent Forces: Patient-Centered Demand For Uterine Sparing Options

- Demand will increase
- Supply is unchanged
- Cost is increased
- There are regulatory factors that have greater influence than the market demand for this service

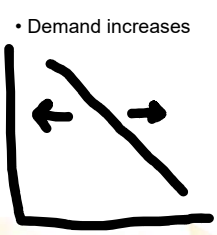


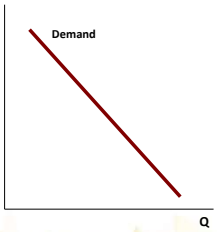
Patient-Centered Surgical Care: Uterine Sparing Demand Increases



Patient Forces: The Demand Curve Shift

- Demand increases





Myomectomy within Public Payor Systems

Myomectomy	$5,000
Blood units	$300-2300
OR staff: anesthesia, RN, scrub tech, environmental, regulatory	Variable- OR hour- $1000/hr and avg LOS 2-3 hrs: 2-3000
OR Tray maintenance: central sterile staff, machinery, regulatory standards maintenance	Variable
OR disposables	Variable: suture $13/suture x 20 used: $260
Hemostatic agents	$13-$400
Adhesion barriers	$40-60
Use of perfusionists: optional	Variable if onsite or offsite
OR facility maintenance	Variable- NYC zip code adjustments
Hospital bed	Variable
Lab testing	Variable

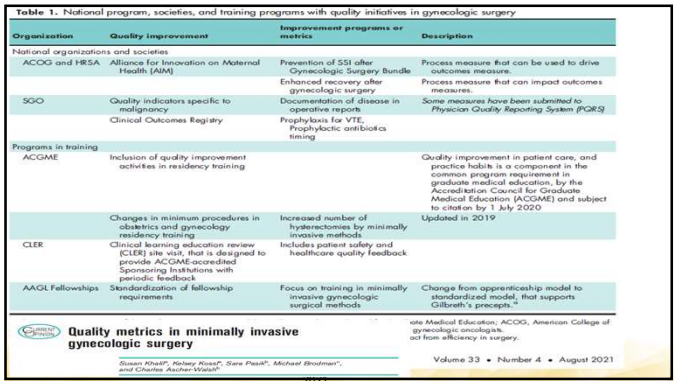


Table 1. National program, societies, and training programs with quality initiatives in gynecologic surgery

Organization	Quality improvement	Improvement programs or metrics	Description
National organizations and societies			
ACOG and HRSA	Alliance for Innovation on Maternal Health (AIM)	Prevention of SSI after Gynecologic Surgery Bundle	Process measure that can be used to drive outcomes measure.
		Enhanced recovery after gynecologic surgery	Process measure that can impact outcomes measures.
SGO	Quality indicators specific to malignancy	Documentation of disease in operative reports	*Some measures have been submitted to Physician Quality Reporting System (PQRS)*
	Clinical Outcomes Registry	Prophylaxis for VTE, Prophylactic antibiotics timing	
Programs in training			
ACGME	Inclusion of quality improvement activities in residency training		Quality improvement in patient care, and practice habits is a component in the common program requirement in graduate medical education, by the Accreditation Council for Graduate Medical Education (ACGME) and subject to citation by 1 July 2020
	Changes in minimum procedures in obstetrics and gynecology residency training	Increased number of hysterectomies by minimally invasive methods	Updated in 2019
CLER	Clinical learning education review (CLER) site visit, that is designed to provide ACGME-accredited Sponsoring Institutions with periodic feedback	Includes patient safety and healthcare quality feedback	
AAGL Fellowships	Standardization of fellowship requirements	Focus on training in minimally invasive gynecologic surgical methods	Change from apprenticeship model to standardized model, that supports Gilbreth's precepts.[4]

Quality metrics in minimally invasive gynecologic surgery

Susan Khalil, Kelsey Kosel*, Sara Pauli*, Michael Brodman*, and Charles Ascher-Walsh**

ote Medical Education; ACOG, American College of gynecologic oncologists.
act from efficiency in surgery.

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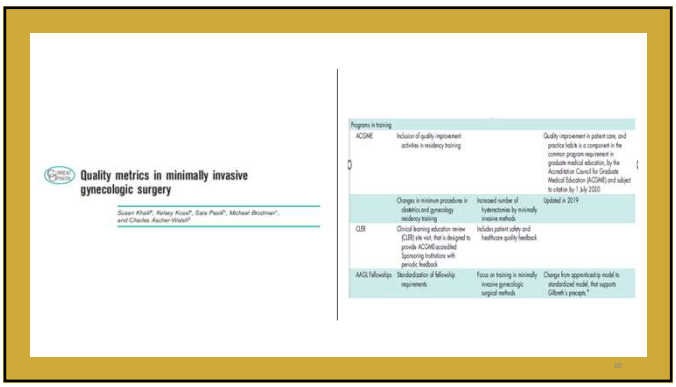


High Surgeon and Hospital Volume, and Selective Referral

- High-volume surgeons and institutions have been associated with improved outcomes measures.

  Wright et al. reviewed key studies that demonstrate this finding for benign hysterectomy.

  Vaginal and laparoscopic hysterectomies performed by high-volume surgeons were associated with decreased complications

The Impact of Fellowship Training On Outcomes Measures

- A systematic review by Johnston et al. evaluating 23 studies across various subspecialties (not including gynecologic surgery) showed:
  - improved mortality and complication rates at institutions affiliated with a fellowship training program.
- Select subspecialties demonstrated similar findings comparing surgeons with and without fellowship training

The Impact of Fellowship Training On Outcomes Measures

Selective referral to a high-volume hospital is supported by multiple studies showing:

- Improved mortality rates when high-risk procedures were concentrated to a smaller number of hospitals over time

The Impact of Fellowship Training On Outcomes Measures

- Gynecologic surgery for benign indications:
- Retrospective data demonstrated mixed results
- Observational study of Medicare beneficiaries by Burke et al. showed that:
- Major teaching hospitals were associated with lower mortality rates for common medical conditions and select high-risk surgical procedures

Residency Surgical Minimum Requirements: Gynecology

Abdominal hysterectomy	15
Vaginal hysterectomy	15
Laparoscopic hysterectomy	15
Total hysterectomy (includes abdominal, vaginal, and laparoscopic hysterectomies)	85
Incontinence and pelvic floor procedure (excludes cystoscopy)	25
Cystoscopy	10
Laparoscopy	60
Hysteroscopy	40
Abortion	20
Transvaginal ultrasound	50
Surgery for invasive cancer	25

Case Log Information: Obstetrics and Gynecology
Review Committee for Obstetrics and Gynecology

While residents can log any active CPT code in the ACGME Case Log System, only some CPT codes for obstetrics and gynecology are "tracked" in Case Logs. Of the tracked CPT codes, a subset are "mapped" to a required minimum (i.e., give credit towards a minimum category). The CPT code information in the Case Log System indicates if the code is tracked, and if tracked, which minimum category(ies) will receive credit. Examples:

- CPT code tracked in the Case Log System **and** credit given to a minimum category:

Code	Description	Area	Type
			TRACKED IN CASE LOG
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care **Min Cat:** CDEL CREDIT GIVEN TO A MINIMUM CATEGORY	Cesarean Deliveries	Cesarean delivery only

Case Log Information: Obstetrics and Gynecology
Review Committee for Obstetrics and Gynecology

Fellowship Surgical Requirements: AAGL Programs

FMIGS CASE MINIMUMS

Case Type		Minimum Case Number
Hysteroscopy	Non-Global Endometrial Ablation	25
	Myomectomy	
	Polypectomy	
	Lysis of adhesions	
	Septum/isthmocele resection	
	Office-Based	15
Laparoscopy	Myomectomy	15
	Adnexal Surgery	35
	Retroperitoneal Dissection	35
	Adhesiolysis	30
	Endometriosis Surgery (Stage III and IV)	35
Minimally Invasive Hysterectomy	Laparoscopic Hysterectomy +/- BSO	110
	Robotic Hysterectomy +/- BSO	
	LAVH +/- BSO	
	*Vaginal Hysterectomy +/- BSO	
Cystoscopy	Diagnostic or operative	15

* While no minimum number is required, programs must ensure competency.

Life After Residency and Fellowship

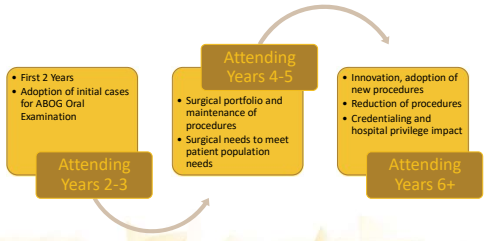
Early-Phase:
Adopt cases that may become lifelong

Mid-Phase:
Continue with cases initially adopted

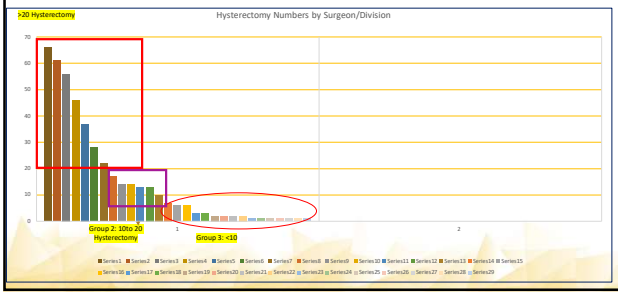
Work towards independence

Beyond:
Hospital credentialing

Minimum volumes



Which Group Are you In?



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Wright JD. The volume-outcome paradigm for gynecologic surgery: clinical and policy implications. Clin Obstet Gynecol 2020; 63:252–265.

Ruiz MP, Chen L, Hou JY, et al. Outcomes of hysterectomy performed by very low-volume surgeons. Obstet Gynecol 2018; 131:981–990.

Wallenstein MR, Ananth CV, Kim JH, et al. Effect of surgical volume on outcomes for laparoscopic hysterectomy for benign indications. Obstet Gynecol 2012; 119:709–716.

Johnston MJ, Singh P, Pucher PH, et al. Systematic review with meta-analysis of the impact of surgical fellowship training on patient outcomes. Br J Surg 2015; 102:1156–1166.

McDonnell RM, Hollingworth JL, Chivers P, et al. Advanced training of gynecologic surgeons and incidence of intraoperative complications after total laparoscopic hysterectomy: a retrospective study of more than 2000 cases at a single institution. J Minim Invasive Gynecol 2018; 25:810–815.

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Burke LG, Frakt AB, Khullar D, et al. Association between teaching status and mortality in US hospitals. JAMA 2017; 317:2105–2113.

Andiman SE, Xu X, Boyce JM, et al. Decreased surgical site infection rate in hysterectomy: effect of a gynecology-specific bundle. Obstet Gynecol 2018; 131:991–999.

Scheib SA, Thomassee M, Kenner JL. Enhanced recovery after surgery in gynecology: a review of the literature. J Minim Invasive Gynecol 2019; 26:327–343.

Thank you!

Questions/Comments--

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Health Equity in Minimally Invasive Gynecologic Surgery

Kirsten J. Sasaki, MD FACOG
Advanced Gynecologic Surgery Institute

Disclosure

- Financial disclosures
  - Speakers Bureau: Abbvie
  - Consultant: Aqua Therapeutics, Johnson & Johnson

Objectives

- List known predictors of peri-operative outcomes
- Describe racial and insurance status differences in rate of MIH (minimally invasive hysterectomy) versus AH (abdominal hysterectomy)
- Classify predictors of peri-operative complications after MIH

Health Equity

- "Health equity is achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." "
- "Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment"

Centers for Disease Control. Health Equity. Cdc.gov https://www.cdc.gov/chronicdisease/healthequity/index.htm Accessed Aug 31, 2022

Predictors of Clinical Outcomes

- Patient and Disease ("Fixed")
  - Age
  - Body Mass Index (BMI)[2]
  - Previous Surgery [1]
  - Co-morbidities[1]
  - Indications for Surgery (Malignancy, Endometriosis, Uterine fibroids[2])
- Extrinsic ("Adjustable")
  - Route of Surgery (Laparotomy)[1]
  - Surgeon Training
  - Surgeon Volume [3, 4]
  - Hospital/Surgical center Volume [4]

[1]DeLong A, Shirreff L, Murji A et al. Individualized assessment of risk of complications after benign hysterectomy. JMIG 2022, 29:
[2] Driessen S, Sandberg E, la Chapelle F et al. Case-Mix variables and predictors for outcomes of laparoscopic hysterectomy: a systematic review. JMIG 2016;23:317-30.
3 Ruiz M, Chen L, Hou J et al. Outcomes of hysterectomy performed by very low-volume surgeons. Obstet Gynecol 2018;131 (6):981-90.
4 Mehta A, Xu t, Hutfless S et al. Patient, surgeon, and hospital disparities associated with benign hysterectomy approach and perioperative complications. Am J Obstet Gynecol 2017;216:497.e1-10.

Additional "Fixed" Variables

- Race
- Geography
  - Urban/Suburban/Rural
  - Northeast/Midwest/South/West
- Insurance Status
- Education
- Employment
- Income
- Housing
- Language
- Reliance on Public Services

Race and Route of Inpatient Hysterectomy

- Bougie et al (2019)
- 114,719 benign, elective hysterectomies Nationwide Inpatient Sample 2009-2013
- Rate of MIH versus AH
  - Black versus White: OR 0.33 (0.32-0.36), Adjusted* OR 0.55 (0.52-0.59)

- *Adjusted for income, primary payer, hospital location, teaching status

Race and Route of Inpatient and Outpatient Hysterectomy

- Traylor (2020) retrospective analysis benign hysterectomies IL (2016-2018)
  - N=42,945 hysterectomies (75% MIH, 25% AH)
  - Non-Hispanic black MIH vs AH versus non-Hispanic White
    - aOR 0.53(0.47-0.60)
  - Hospital volume:
    - Treated at High volume MIH hospitals: Non-Hispanic Blacks (25.7%) vs. Non-Hispanic whites (60%)

Race and Route of Hysterectomy- Universal Insurance

- Ranjit (2017) (n=33,015)
  - Retrospective Analysis TLH, TVH, versus AH
  - TRICARE (universal insurance coverage)
  - TLH vs. AH
    - Black RR .51 (.48-.63), *ARR .63 (.48-.69)
    - Asian RR .53 (.45-.63), *ARR .69 (.58-.83)
  - TVH vs. AH
    - Black RR .40 (.37-.43), *ARR .63 (.58-.69)
    - Asian RR .61 (.52-.71), *ARR .71 (.60-.84)

*Adjusted for age, rank, service type, marital status, region, indication for surgery(fibroids, endometriosis), system of care and year of surgery

Ranjit A, Sharma M, Romano A et al. Does universal insurance mitigate racial differences in minimally invasive hysterectomy? JMIG 2017. 24:790-6.

Race and Route of Hysterectomy for Uterine fibroids

- Rate of MIH for uterine fibroids (n=20,133)
  - Ko et al (2020)
  - National Surgical Quality Improvement Program (NSQIP) database
    - 2014-2017
  - AH vs. MIH (vs. white women)
    - Black: OR* 2.22 (2.07-2.38)
    - Hispanic: OR* 1.76 (1.58-1.96)
    - Asian: OR *1.33 (1.16-1.53)

- Adjusted for patient demographics, medical and surgical history, gynecologic factors (uterine weight, parity) and surgical variables (prior surgery, additional procedures)

Ko J, Suh C, Huang H et al. Association of race/ethnicity with surgical route and perioperative outcomes of hysterectomy for leiomyomas. JMIG 2021,28:1403-10

Race and Referral to Specialist

- Schneyer 2022 (Cases 2015-2020)
- Retrospective cohort study- Quaternary Care academic hospital
- Hysterectomy or Myomectomy for uterine fibroids (n=1311)
  - Rates MIS- 94.7% MIGS, 44.2% Ob/Gyn specialists, 46.8% Gyn Onc
  - Procedure by MIGS specialist:
    - White 59.8%
    - Black 44%
    - Hispanic 45.7%

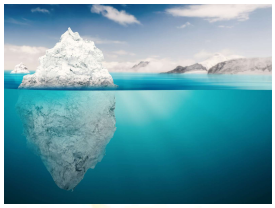
Insurance and Route of Hysterectomy

- Price (2017)
- Cross-sectional study 3 hospitals within academic university health system in Philadelphia
- 1746 benign hysterectomies
  - MIH versus AH: Medicaid *OR 0.59 (0.38-0.90) versus private insurance

*Adjusted age, BMI, income quartile, obstetrical and surgical history, uterine weight, income, insurance status

Price J, Zimmerman L, Koelper N et al. Social determinants of access to minimally invasive hysterectomy: reevaluating the relationship between race and route of hysterectomy for benign disease. Am J Obstet Gynecol 2017;217:572.e1-10.

What are the implications of this disparity?



Peri-operative Outcomes

- Pepin (2021)
  - 3441 LH for benign indications at one hospital system
  - 2009-2017
  - Initial Predictors Complication:
    - Non-White Race * OR 1.97 (1.34-2.1)
    - Higher BMI
    - Lower median income
    - History of laparotomy * OR 1.69 (1.26-2.28)
    - Surgeon Volume
    - Higher Uterine weight * OR 1.003 (1.002-1.004)
    - Indication for surgery (Pain/endo and Uterine fibroids)
      - * remained significant after multivariable logistic regression

Pepin K, Cook F, Maghsoudlou P et al. Risk-prediction model for patients undergoing laparoscopic hysterectomy. JMIG 2021. 28:1751-8.

Peri-Operative Outcomes

- Bougie (2019)- NIS elective benign hysterectomy
- N=114,719 from 2009-2013
- Inpatient Complications
  - Black versus White women
    - OR 1.13 (1.04-1.24), aOR* 1.03 (0.93-1.13)
      - *Adjusted for age, income, primary payer, hospital location/teaching status, comorbidity index, route of surgery
    - LH: OR 1.11 (0.88-1.40)
  - Hispanic versus White women
    - OR 0.89 (0.80-0.98)

Bougie O, Singh S, Chen I et al. Relationship between race/ethnicity and hysterectomy outcomes for benign gynecologic conditions. JMIG 2019;25:456-62.

Peri-Operative Outcomes

- Ko et al (2020), n=18,123
- NSQIP database (2014-2017)
- 30 day complication rate
  - Black vs. White
    - AH OR* 1.54 (1.31-1.80)
    - VH OR*1.65 (1.02-2.68)
    - LH OR* 1.37 (1.13-1.66)
  - Asian vs. White: OR* 1.51 (1.10-2.07)
- Readmission within 30 days
  - Black vs. White
    - AH OR 1.44* (1.07-1.94)
    - LH OR 1.45* (1.06-1.99)

- *adjusted for age, BMI, co-morbidities, parity, uterine weight, endometriosis, PID, previous surgeries

Ko J, Suh C, Huang H et al. Association of race/ethnicity with surgical route and perioperative outcomes of hysterectomy for leiomyomas. JMIG 2021;28:1403-10

Peri-Operative Outcomes

- Pepin 2020- Risk prediction model using NSQIP Database
- Benign LH 2014-2017, n=33,123
  - 7 Variables associated with increased odds complication
    - History of Laparotomy 21%
    - Age 2%/year of life
    - BMI: 0.2%/unit of BMI
    - Parity: 7%/delivery
    - Race: black (34%), Other race (18%) versus white
    - ASA Score 31-172%
    - Predicted uterine weight

Pepin K, Cook E, Cohen S. Risk of complication at the time of laparoscopic hysterectomy: a prediction model built from the national surgical quality improvement program database. Am J Obstet Gynecol 2020;223:555.e1-7.

Limitations

- Retrospective
- Data: Billing, Nationwide Databases
- Only capturing subset of population

Areas of “Equity” in MIGS

- Specific Health Care Systems
- Schneyer (2022)
  - Minimally invasive myomectomy (MIM):
    - Black vs. White OR 0.30 (0.19-0.47), aOR* 0.61 (0.35-1.05)
  - Total complications
    - Black vs. White OR 1.84 (1.31-2.59), aOR* 1.28 (0.88-1.86)
- *Adjusted age, BMI, ASA class, parity, prior surgery, insurance type, pre-op anemia, specimen weight and myomas removed

Areas of “Equity” in MIGS

- Price (2017)
  - 1746 Hysterectomies in Philadelphia
  - MIH vs. AH
    - Black aOR* 0.82 (0.61-1.10)
    - Hispanic aOR* 0.59 (0.38-0.90)
- *Adjusted age, BMI, income quartile, obstetrical and surgical history, uterine weight, income, insurance status

Areas of “Equity” in MIGS

- Fakas (2022), n=1628
- Retrospective Cohort Study 7 hospitals + 4 ambulatory surgery centers within academic health system
  - Hysterectomy or Myomectomy for Abnormal uterine bleeding
- Higher SVI- Higher proportion non-Hispanic black and other multiracial backgrounds, non-English speaking, Medicaid insured
- Odds Laparotomy
  - Hysterectomy Q4 aOR* 0.90 (0.51-1.58)
  - Myomectomy Q4 aOR* 1.10 (0.69-1.75)
    - *Adjusted: Age, race, ethnicity, marital status, education, language, BMI, previous uterine surgery, type of facility

Fakas S, Lu A, Shahni D et al. Social vulnerability index and surgical management of abnormal uterine bleeding in reproductive-age women. JMIG 2022, 00:1-6.

Why these differences exist?

- Access to care
  - Insurance
  - Socioeconomic Status
- Referral to Subspecialists- especially with more challenging pathology
  - Medical Literacy
  - Hospital System/Location

Take Home Points

- Difference in Rates of MIH and Peri-operative Complications
  - Race
  - Insurance Status
  - Income

References

- Bougie O, Singh S, Chen I et al. Relationship between race/ethnicity and hysterectomy outcomes for benign gynecologic conditions. JMIG 2019;25:456-62.
- DeLong A, Shirreff L, Murji A et al. Individualized assessment of risk of complications after benign hysterectomy. JMIG 2022, 29:
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Questions


AAGL 2022
51st GLOBAL CONGRESS ON MIGS
December 1-4, 2022 | Aurora, CO | congress.aagl.org
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Value Based Healthcare in Gyn

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Disclosure

"**I have no financial relationships to disclose**"

Objectives

- Define Value Based Healthcare
- Identify Key Components of Value
- Explain the Importance of Value Based Care
- Reveal the Opportunity for Improvement in Healthcare Delivery

WHAT IS VALUE BASED HEALTHCARE?

- Reduced Cost
- Improved Outcomes
- Better Patient Experience
- TRIPLE AIM

- QUADRUPLE AIM – BETTER PHYSICIAN EXPERIENCE

The AAGL dilemma

- "We need new codes for Endometriosis Excision"
  - Ergo, we want better compensation for what we do

- Economic impossibility
  - Static or Reduced Funds
  - Growing Patient Population
  - Inflation
  - Cost of Goods
  - Cost of Staffing

Value Based Healthcare

- MUST provide a solution

- HOW?
  - Decrease cost of surgery
    - Most expensive component of Surgery in Venue of Service
    - Close behind is cost of COMPLICATIONS
    - The Robot is only part of a much bigger economic discussion
  - Improve Quality of Outcomes
    - Registry
    - Track outcomes (bariatrics, cardiac)
    - Shift cases to higher volume surgeons

HOW?

- Commercial Insurance plans and Hospitals are now beholden to price transparency laws
  - 600% CMS for DRG basis
  - Versus ASC/HOPD
  - 1/3rd of the US population part of ERISA plans
- "But I work for a large integrated health system"
  - Open eyes to M and A deals
  - P/E aggregators

Why do I care?

- You will see patients soon being redirected away from expensive care to those who are disrupting the curve
- AAGL and others have an opportunity to support advanced training via mentorship and fellowship
- Higher reimbursement comes from increasing the cash reserves and then redistributing the reimbursement via bundles
  - This will not happen in the RVU model
  - Ship has sailed
- ACOG is not motivated to pull cases away from general OB/Gyns

The new era of private equity

- Practice aggregators
- 51% at 2-4x EBITDA
- Push volume, upcoding, longer hours, new tech
- Sell at 8-10x EBITDA
- "show me the money"

references

- https://www.cms.gov/healthplan-price-transparency
- https://www.cms.gov/hospital-price-transparency

CULTURAL AND LINGUISTIC COMPETENCY & IMPLICIT BIAS

The California Medical Association (CMA) announced new standards for Cultural Linguistic Competency and Implicit Bias in CME. The goal of the standards is to support the role of accredited CME in advancing diversity, health equity, and inclusion in healthcare. These standards are relevant to ACCME-accredited, CMA-accredited, and jointly accredited providers located in California. AAGL is ACCME-accredited and headquartered in California.

CMA developed the standards in response to California legislation (Business and Professions (B&P) Code Section 2190.1), which directs CMA to draft a set of standards for the inclusion of cultural and linguistic competency (CLC) and implicit bias (IB) in accredited CME.

The standards are intended to support CME providers in meeting the expectations of the legislation. CME provider organizations physically located in California and accredited by CMA CME or ACCME, as well as jointly accredited providers whose target audience includes physicians, are expected to meet these expectations beginning January 1, 2022. AAGL has been proactively adopting processes that meet and often exceed the required expectations of the legislation.

CMA CME offers a variety of resources and tools to help providers meet the standards and successfully incorporate CLC & IB into their CME activities, including FAQ, definitions, a planning worksheet, and best practices. These resources are available on the CLC and IB standards page on the CMA website.

Important Definitions:

Cultural and Linguistic Competency (CLC) – The ability and readiness of health care providers and 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 social, cultural and linguistic needs as they relate to patient health.

Implicit Bias (IB) – 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.

Diversity – Having many different forms, types or ideas; showing variety. Demographic diversity can mean a group composed of people of different genders, races/ethnicities, cultures, religions, physical abilities, sexual orientations or preferences, ages, etc.

Direct links to AB1195 (CLC), AB241 (IB), and the B&P Code 2190.1:

Bill Text – AB-1195 Continuing education: cultural and linguistic competency.
Bill Text – AB-241 Implicit bias: continuing education: requirements.
Business and Professions (B&P) Code Section 2190.1

CLC & IB Online Resources:

Diversity-Wheel-as-used-at-Johns-Hopkins-University-12.png (850×839) (researchgate.net)
Cultural Competence In Health and Human Services | NPIN (cdc.gov)
Cultural Competency – The Office of Minority Health (hhs.gov)
Implicit Bias, Microaggressions, and Stereotypes Resources | NEA
Unconscious Bias Resources | diversity.ucsf.edu
Act, Communicating, Implicit Bias (racialequitytools.org)
https://kirwaninstitute.osu.edu/implicit-bias-training
https://www.uptodate.com/contents/racial-and-ethnic-disparities-in-obstetric-and-gynecologic-care-and-role-of-implicitbiases
https://www.contemporaryobgyn.net/view/overcoming-racism-and-unconscious-bias-in-ob-gyn
https://pubmed.ncbi.nlm.nih.gov/34016820/