

## **ASCO GUIDELINES FOR CULTURALLY COMPETENT EYE AND VISION CARE**

- I. Introduction
  - A. The Association of Schools and Colleges of Optometry (ASCO) and its member institutions have embraced the concepts of diversity and multiculturalism in optometric education and in the profession.
  - B. Purpose of the Guidelines:
    1. determine institutional objectives for developing culturally competent optometric care
    2. identify points of curricular intervention
    3. assess the performance and outcomes of interventions
  - C. Reasons to Incorporate Cultural Competence into Organizational Policy (Georgetown University, 2000)
    1. respond to demographic changes in U.S.
    2. eliminate health disparities
    3. improve quality of services and health outcomes
    4. meet legislative, regulatory, and accreditation mandates
    5. gain competitive edge in the market place
    6. decrease likelihood of liability/malpractice claims
  - D. Demographic Changes in U.S.
    1. increasing geographic, economic, religious, racial, ethnic, cultural, and linguistic diversity
    2. 311 languages other than English in 14 million U.S. households
    3. 1 in 3 U.S. residents is a minority
    4. 1 in 10 counties >50% minority
  - E. Diversity in the health professions contributes to:
    1. patient-provider concordance
    2. patient-provider communication and trust
    3. access to health care
    4. use of health care services
    5. quality of health care
    6. improved health outcomes
  - F. Institute of Medicine's Six Principles of Health Care Quality (2001)
    1. safety

2. effectiveness
3. patient-centeredness  
“providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions”
4. timeliness
5. efficiency
6. equity  
“providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status”

## II. Rationale

- A. It is a clinical necessity that optometrists possess the patient-centered attitudes, knowledge, and skills necessary to competently serve a diverse community with its spectrum of education, experiences, beliefs, values, customs, preferences, fears, and expectations that impact the interpersonal interactions of clinical care.
- B. Improved Quality of Care with Cultural Competence
  1. obtain necessary information
  2. make timely and appropriate diagnoses
  3. develop treatment plans that are followed by the patient and supported by family members
  4. reduce delays in seeking care
  5. make appropriate use of health care services
  6. enhance communication and positive interaction between patients and providers
  7. foster compatibility between biomedical and cultural health practices
- C. Cultural Competence Helps Health Care Providers
  1. challenge assumptions
  2. understand how cultural variations influence
    - a. recognition of symptoms
    - b. thresholds for seeking care
    - c. ability to communicate symptoms
    - d. ability to understand management strategy
    - e. expectations of care
    - f. adherence to preventive measures
  3. Prevent racial and cultural stereotyping and unconscious bias

- D. Cultural Competence versus Cultural Incompetence
- Insert table
- E. Biomedical and Sociocultural Constructs of Perceived Illness
- Insert table
- F. Biomedical and Sociocultural Constructs of Treatment
- Insert table
- G. Why learn about the impact of culture in health and health care delivery? (Tervalon, 2003)
1. ever-changing demographic patterns in the U.S.
  2. negative health outcomes when culture is dismissed
  3. use of complementary and alternative medicine by large numbers of patients
  4. reduction of racial and ethnic differentials in health outcomes
  5. mandates require application of culture in health care
- H. Cultural Competence in Medical Education (Betancourt, 2003)
1. critical to preparing providers to meet the health need of growing diverse populations
  2. improves provider-patient communication and eliminate racial-ethnic disparities in medical care
  3. cross-cultural curricula required by accreditation bodies
- I. Cultural Competency Requirements in Medicine (Association of American Medical colleges, 2005)
1. "The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments."
  2. "Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery."
- J. Cultural Competency in Medical Resident Training (Accreditation Council on Graduate Medical Education)

1. communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.
2. sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

K.. Cultural Competency in Pharmacy

*Essentials of Cultural Competence in Pharmacy Practice* (American Pharmacists Association, 2008)

L. State Cultural Competency Legislative Activity

*Think Cultural Health: Bridging the Health Care Gap through Cultural Competency Continuing Education Programs*

<http://www.thinkculturalhealth.org>

M. Need for Cultural Competence in Optometry

Racial and ethnic minorities frequently are at increased risk for vision and ocular morbidity, and the lack of access to culturally competent eye and vision care affects the daily living, personal advancement, and future opportunities for those at greatest risk.

N. Linguistic Competence

1. National Standards on Culturally and Linguistically Appropriate Services (CLAS) developed by the Office of Minority Health.
2. Most are guidelines recommended by OMH for adoption by federal and state accrediting agencies.
3. 14 standards
  - a. Culturally Competent Care (Standards 1-3)
  - b. Language Access Services (Standards 4-7)  
These are mandates, federal requirements for all recipients of federal funds.
  - c. Organizational Supports for Cultural Competence (Standards 8-14)

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O. Effect of Cultural Competence training on Health Care Providers

Insert Table.

III. Vision

A. All ASCO member institutions will be culturally competent in eye and vision care.

B. Mission

1. Promote a competent system of eye and vision care that acknowledges and incorporates the importance of culture, the cultural strengths associated with people and communities, and the assessment of cross-cultural relations.
2. Promote better understanding of strategies on how to serve diverse populations.
3. Foster the development of the attitudes, knowledge, and skills needed to be culturally competent.
4. Facilitate the clinical readiness of optometry faculty, students, and staff to respond to the health-related cultural needs of a diverse society.
5. Reduce access, systemic, and provider-based barriers that foster racial and ethnic disparities in health.

IV. Definitions of Culture and Cultural Competence

A. Culture

1. Culture is a set of learned and shared beliefs and values that are applied to social interactions and to the interpretation of experiences (Mutha et al., 2002).
2. Culture includes: race, ethnicity, socioeconomic status, religion, gender, age, nationality, sexual orientation, education, language, occupation, and disability (Betancourt, 2003).

B. Cultural Competence

1. Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals that enables that system, agency, or those professionals to work effectively in cross-

cultural situations. Culture implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Competence implies having the capacity to function in a particular way: the capacity to function within the context of culturally-integrated patterns of human behavior as defined by the group (Cross, Bazron, Dennis and Issacs,1989).

## 2. Cultural Competence in Health Care

- a. Cultural competence is a set of skills, knowledge and attitudes, which enhance a clinician's 1) understanding of and respect for patients' values, beliefs and expectations; 2) awareness of one's own assumptions and value system in addition to those of the U.S. medical system; and 3) ability to adapt care to be congruent with the patient's expectations and preference (Mutha et al., 2002).
- b. The nexus of practice patterns and attributes—the attitudes, knowledge, and skills necessary for providing quality care to a diverse population (The California Endowment, 2003).
- c. Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs (Betancourt et al., 2002).
- d. Being respectful and responsive to patient preferences, needs, and values and providing care of equal quality irrespective of patient characteristics are benchmarks of culturally competent health care.

## V. Guiding Principles

- A. ASCO has embraced the guiding principles for development of standards adopted by the California Endowment.
- B. The guiding principles help structure:
  1. what should be taught
  2. when it should be taught
  3. how it should be taught

4. who should teach it

## C. Twelve Principles

1. Goals of Cultural Competence Training

- a. self awareness and receptivity to diverse patient populations
- b. clinical excellence and alliances with patients
- c. reduction of health care disparities, improved quality and cost-effective care

2. Definition of Diversity

Trainings should provide a broad and inclusive definition of cultural and population diversity, including consideration of race, ethnicity, class, age, gender, sexual orientation, disability, language, religion, and other indices of difference.

3. Trainings Should Be Developmental

- a. Institutional Development

more complex and integrated attention to cultural issues in later stages of professional education.

- b. Individual Development

become progressively more sophisticated in understanding the complexities of diversity and culture.

- c. Evaluation and Feedback

Programs and student learning should be regularly evaluated.

4. Attitudes, Knowledge, Skills

Cultural competence training is best organized around enhancing providers' attitudes, knowledge, and skills and attention to the interaction of these three factors is important at every level of the training.

5. Focus on Communication

tools and concepts that will improve communication and development of therapeutic alliances with patients.

6. Incorporation throughout Curriculum

Cultural competence training is best integrated into numerous courses, symposia and experiential, clinical, evaluation, and practicum activities as they occur throughout an educational curriculum.

7. Institutionalization of Cultural Competence Education

Include cultural competence issues throughout curriculum and training.

8. Interdisciplinary Framework

Draw from numerous fields to provide cultural competence education.

9. Respect Needs of Learners

10. Context of Policy and Educational Guidelines

11. Involve People from Diverse Backgrounds

in the design, implementation, and evaluation of cultural competence curricula.

12. Safe, Non-judgmental, Supportive Environment

VI. Curricular Philosophy

A. Steps in Teaching Cultural Competency

1. prepare clinicians to understand and respect values, beliefs, and expectations of their patients
2. help clinicians apply attitudes, knowledge, and skills to patient encounters

B. Concepts that Health Care Practitioners Must Understand (Georgetown University, 2008):

1. beliefs, values, traditions, and practices of a culture
2. culturally-defined, health related needs



3. culturally-based belief system concerned with etiology of disease, health, and healing
  4. attitudes toward seeking help from health care providers
- C. Institutional Requirements for Implementing Cultural Competence Curriculum (Association of American Medical Colleges, 2005)
1. Institutional Support of leadership, faculty, and students
  2. resources committed to the curriculum
  3. community leaders involved in designing and providing feedback
  4. integrated educational interventions appropriate to the level of the learner
  5. evaluation process
- D. Stages of Development of Cultural Competence (Cross et al., 1989)
- Figure
- E. Goals of Cultural Competence Education
1. provide knowledge and skills
  2. cultivate attitudes and practices
  3. promote understanding of and respect for patients' values, beliefs, and expectations
  4. improve awareness of clinicians' assumptions and value systems
  5. model ability to adapt care to patient's expectations and preference
- F. Attitudes Assessment
1. self-evaluation of assumptions, biases, stereotypes, responses
  2. open-mindedness and respect
  3. patient and family-centered care
  4. equal quality care for all
  - g. identify and eliminate barriers to access to health care
- G. Knowledge
1. ethnocentrism and how it impacts interactions with patients
  2. culture impacts perception and behavior
  3. changing demographics
  4. legal, regulatory, and accreditation issues
  5. cultural and linguistic policy or standards

6. health care disparities
7. health practices of different cultures
8. medical pluralism
9. within-group variations and acculturation
10. implications of genome research and ethnopharmacology
11. epidemiology
12. linguistic barriers and impact on health care
13. cross-cultural variations in verbal and non-verbal communication
14. available resources on cultural issues

#### H. Skills

1. Assessment of responses, biases, and cultural preconceptions
2. patient history
3. outreach
4. assessment of patients' language skills
5. use of interpreters
6. use of translated written materials
7. use of resources and data

#### I. Five-Step Sequence of Curricular Engagement (Mutha et al., 2002)

1. Inform  
  
Use lectures and other didactic approaches.
2. Experience  
  
Engage learners in exercises that demonstrate the points made in the didactic presentations.
3. Identify  
  
Solicit learners' responses to what they experienced and felt.
4. Reflect  
  
Ask learners to process what they experience and link experience to ideas presented in didactic presentation and learning objectives.

### VII. Curricular Integration

#### A. Tool for Assessing Cultural Competence Training (TACCT)

(Association of American Medical Colleges, 2005)

1. TACCT Domains (components of the cultural competence curriculum)
  - a. Cultural Competence: Rationale, Context, and Definition
  - b. Key Aspects of Cultural Competence
  - c. Understanding the Impact of Stereotyping on Health Care Decision-making
  - d. Health Disparities and Factors Influencing Health
  - e. Cross-cultural Clinical Skills
2. TACCT Specific Components

These are the list of attitudes, knowledge, and skills that are taught and evaluated.

B. Survey of Schools and Colleges of Optometry

The attitudes, knowledge, and skills (specific components) reported most frequently as included in the optometric curricula were

1. discuss race and culture in the medical interview
2. ask questions to elicit patient preferences
3. listen non-judgmentally to health beliefs
4. value curiosity, empathy, and respect
5. describe factors that impact health
6. describe systemic and medical encounter issues
7. elicit a culture, social, and medical history

C. Eight Areas of Cultural competence Education (Dolhun et al, 2003)

1. general concepts of culture
2. racism and stereotyping
3. doctor-patient interactions and trust
4. language  
meaning of words, non-verbal communication, ;use of interpreters, language barriers)
5. cultural content  
epidemiology, patient expectations and references, traditions and beliefs, family role, spirituality and religion
6. access issues  
transportation, insurance, immigration
7. socioeconomic status
8. gender roles and sexuality

## VIII. Training Methods

### A. Teaching

#### 1. Methods

- a. case studies
- b. didactic lectures
- c. clinical experiences
- d. workshops
- e. interactive-participatory activities
- f. role-playing
- g. monitoring
- h. group discussions
- i. internships
- j. service learning projects
- k. language training
- l. cultural immersion programs

#### 2. Approaches to Cultural Competence Education and Training (The California Endowment, 2003)

- a. methods suited to level, needs, and learning styles of students
- b. step-by-step process
- c. diverse set of training strategies
- d. include experiential learning
- e. not confined to one course of workshop; integrated into many curricular offerings
- f. interdisciplinary multicultural team
- g. faculty should model attitudes, knowledge, skills

### B. Communication Models

1. BATHE = background, affect trouble, handling, empathy
2. BELIEF = beliefs about health, explanation, learn, impact, empathy, feelings
3. ESFT = explanatory model, social risk for noncompliance, fears and concerns about the medication, therapeutic contracting and playback
4. ETHNIC = explanation, treatment, healers, negotiate, intervention, collaboration
5. Kleinman's questions
6. LEARN = listen, explain, acknowledge, recommend, negotiate

7. Flores Model = normative cultural values, language issues, folk illnesses, patient beliefs, provider practices
8. review of systems = social stressors and support network, environment, life control, literacy
9. RESPECT = respect, explanatory, social and spiritual, power, empathy, concerns, trust
10. EYECARE = evaluate, yield, explore, communicate, acknowledge, reevaluate, execute

C. Exercises

1. Sample Self-Awareness Exercises (NCBI)
  - a. Introductions
  - b. Up/Down
  - c. Paired Introductions
  - d. First Thoughts
  - e. Internalized Oppression
  - f. Caucuses
  - g. Stereotypes
2. *Cultural Diversity in Eye Care* DVD by the Vision Care Institute
3. *A Physician's Practical Guide to Culturally Competent Care*  
Web Site: <http://www.thinkculturalhealth.org>
4. Common Ethnic Stereotypes
5. Student Assessment for Self-Awareness

IX. Program Assessment

- A. California Endowment Standards for Assessing Mastery of Cultural Competence Attitudes, Knowledge, and Skills
  1. variety of techniques
  2. demonstration through role play, case study analysis, observed interactions
  3. opportunities for student self-assessment
  4. evaluation of usefulness of training
  5. difficult to test competencies and effect on patient satisfaction with clinical encounters

Insert Table

X. Conclusion

A. Optometry 2020 Preferred Futures (American Optometric Association, 2007)

Preferred Future: All patients receive culturally competent care by their optometrist and staff; optometrists and staff have the knowledge, skills, and attitude to serve patients of different ethnicities, native languages, age and gender, religions, and cultural backgrounds; and optometrists and/or staff provide care in multiple languages and/or provide interpretation services.

B. It is hoped that each of the ASCO member institutions will embrace the *ASCO Guidelines for Culturally Competent Eye and Vision Care* and integrate them into their optometric curricula and clinical training programs.