

ASCO
GUIDELINES FOR CULTURALLY COMPETENT
EYE AND VISION CARE

**AN ADAPTATION OF BEST PRACTICES FROM THE SCHOOLS, COLLEGES,
ORGANIZATIONS, AND ASSOCIATIONS OF THE HEALTH PROFESSIONS**

DIVERSITY TASK FORCE
ASSOCIATION OF SCHOOLS AND COLLEGES OF OPTOMETRY

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PREFACE

“I have always felt that the action most worth watching is not at the center of things but where edges meet. I like shorelines, weather fronts, international borders. There are interesting frictions and incongruities in these places, and often, if you stand at the point of tangency, you can see both sides better than if you were in the middle of either one. This is especially true, I think, when the apposition is cultural.”

The Spirit Catches You and You Fall Down
Anne Fadiman, 1998

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. In concert with ASCO’s mission of diversity and multiculturalism, the ASCO Diversity Task Force functions to assist the schools and colleges of optometry in institutionalizing diversity and multiculturalism as core values in optometric education, training, and practice.

Assisting the schools and colleges of optometry in the preparation of optometric clinicians who will be clinically ready to address the vision and eye care needs of a multicultural and global community is within the mission of the Diversity Task Force. To specifically address cultural competence as a multicultural and global issue, the Task Force established the Cultural Competence Guidelines Work Group. The Work Group was charged with the task of developing guidelines to help promote a culturally competent system of health care.

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)

The *ASCO Guidelines for Culturally Competent Eye and Vision Care* have been adapted from materials previously developed and tested by other entities and disciplines. Much of the content comes from the following primary resources: *Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals* by The California Endowment; *Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies* from the University of California, San Francisco Center for the Health Professions; *Cultural Competence Education for Medical Students* from the Association of American Medical Colleges; and the *Tool for Assessing Cultural Competence Training* (TACCT) developed by the Association of American Medical Colleges.

The ASCO Diversity Task Force is very appreciative of the financial support from Wal-Mart for the planning and preparation of these guidelines and for the direct assistance of the Director of Professional Services, Dr. Priti Patel. The Task Force is also very appreciative of the guidance and services provided by Dr. Sunita Mutha, Associate Professor in the Department of Medicine and Program Director at the Center for the Health Professions at the University of California, San Francisco.

INTRODUCTION

There is clear evidence of large disparities in health access and status across race/ethnic groups within the U.S. population – a serious situation that calls for focused attention to the health care needs of these groups and the factors that are affecting their levels of care. The result of these circumstances is a call for educating health care professionals in the attitudes, knowledge and skills necessary for providing quality care to a diverse population – a nexus of practice patterns and attributes that has come to be known as cultural competence. The need for this type of education is seen to be important in the basic, formal education of health care professionals and in continuing education for professionals already in practice.

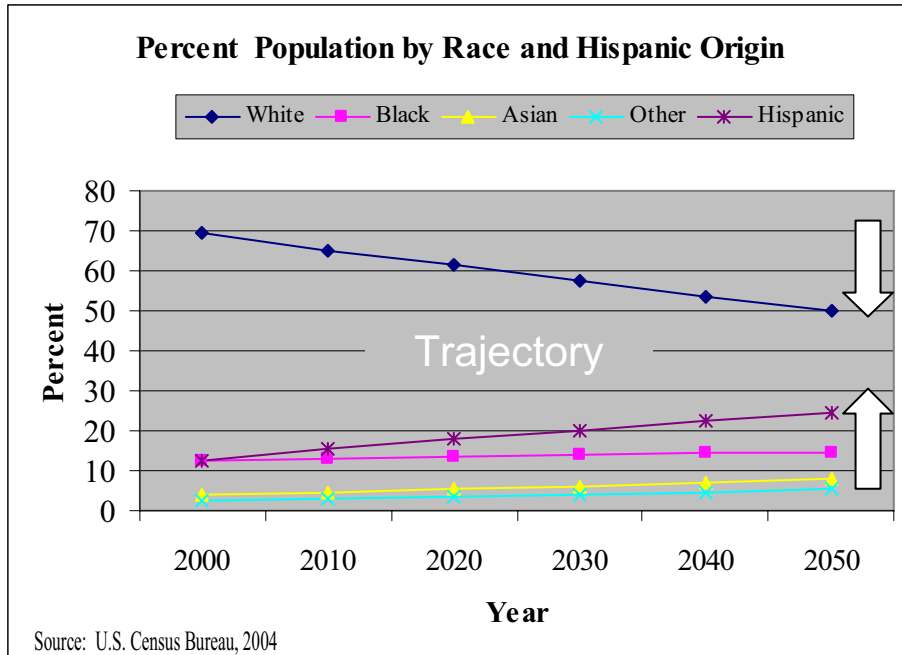
*Principles and Recommended Standards for
Cultural Competence Education of Health Care Professionals
The California Endowment, 2003*

The *ASCO Guidelines for Culturally Competent Eye and Vision Care* are based on existing models within the health professions that show promise for optometry. Application of the guidelines should assist the schools and colleges of optometry in documenting institutional objectives for developing culturally competent practice, identifying points of curricular intervention, and assessing the performance and outcomes of the intervention. It is important that the curricular content of the guidelines be viewed not as a stand-alone, add-on course to the existing curriculum, but as an approach to cultural awareness and sensitivity evidenced throughout the educational experience.

The National Center for Cultural Competence (NCCC) at Georgetown University identified six reasons to support the incorporation of cultural competence into organizational policy: 1) respond to current and projected demographic changes in the United States; 2) eliminate long-standing disparities in the health status of people of diverse racial, ethnic and cultural backgrounds; 3) improve the quality of services and health outcomes; 4) meet legislative, regulatory and accreditation mandates; 5) gain a competitive edge in the market place; and 6) decrease the likelihood of liability/malpractice claims (Georgetown University, 2008).

Projected Population of the United States by Race and Hispanic Origin, 2000 to 2050						
	Percent of Total Population by Race and Hispanic Origin					
	2000	2010	2020	2030	2040	2050
White alone, not Hispanic	69.4	65.1	61.3	57.5	53.7	50.1
Black alone	12.7	13.1	13.5	13.9	14.3	14.6
Asian alone	3.8	4.6	5.4	6.2	7.1	8.0
All other races*	2.5	3.0	3.5	4.1	4.7	5.3
Hispanic (of any race)	12.6	15.5	17.8	20.1	22.3	24.4
*Includes American Indian and Alaska Native alone, Native Hawaiian and Other Pacific Islander alone, and Two or More Races						
Source: U.S. Census Bureau, 2004						

It is commonly understood that our global society is on a constant trajectory of increasing geographic, economic, religious, racial, ethnic, cultural, and linguistic diversity and that, “our success as a nation hinges on how we meet the challenges diversity poses, while capitalizing on the strengths it provides” (Betancourt, 2003). According to data from the U.S. Census Bureau, 14 million households in the U.S. contain people who speak one of the 311 languages other than English – from Abnaki to Zuni – spoken in the U.S. (U.S. Census Bureau, 2008). The Census also informs us that about 1 in 3 U.S. residents is a minority and more than 300 U.S. counties are “majority-minority” counties, with nearly 1 out of 10 counties having a population that is more than 50% minority.



A global society, characterized by the one in which we live and work, requires a culturally competent workforce to meet the demands of culturally diverse populations. The Bureau of Health Professions links health professions diversity to health outcomes with the proposition that increased diversity in the health professions contributes to more patient-provider concordance, more effective patient-provider communication and trust, improved access to care and use of services, improved quality of care, and improved health outcomes (U.S. Department of Health and Human Services, 2006). However, diversity alone does not necessarily imply or guarantee that the workforce is able to respond appropriately to the health care needs of a multicultural society. “One size fits all” and “building it and they will come” are no longer appropriate constructs for addressing the needs of a 21st century society (Wilson-Stronks et al., 2008). Following the path of business and other health professions, optometry must take measures to ensure its competence to serve a multicultural population. In a 2006 editorial in *Optometric Education*, Hoppe commented that optometric “educators will need to make sure that our graduates have the skills required to serve a variety of cultures that may differ from their own” (Hoppe, 2006).

Cultural differences between patients and optometrists can affect patient-provider interactions and decision-making regarding the appropriateness of care, which can lead to disparate processes and outcomes (Betancourt et al., 2003; Betancourt et al., 2002). People from different racial, ethnic, and cultural backgrounds are disproportionately burdened with systemic and ocular morbidity.

Glaucoma, diabetic eye disease, hypertensive retinopathy, and uncorrected refractive error are unnecessarily more prevalent in some populations than in others. The elimination of racial and ethnic disparities in health is one of the overarching goals of *Healthy People 2010*, and a culturally competent health care workforce is vital to the attainment of the *Healthy People 2010* disparity goal (U.S. Department of Health and Human Services, 2000).

Cultural competence is directly linked to the Institute of Medicine's six principles of health care quality. Safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity are mediated through culturally competent providers and a culturally competent health care system. *Patient-centered* care ("providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions") and *equitable* care ("providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status") are particularly relevant to discussions of cultural competence (Institute of Medicine, 2001). Being respectful and responsive to patient preferences, needs, and values and providing care of equal quality irrespective of patient characteristics are the benchmarks of culturally competent health care. However, safe, effective, timely, and efficient care is an equally recognized byproduct of culturally competent care.

RATIONALE

It seems commonsensical that the study of patients in all their varieties would be found throughout the medical curriculum: How does one take care of patients without knowing the social and cultural contexts from which they come or without knowing the complex interplay of patients’ values and beliefs with their conceptions of health and illness?

Wear, 2003

Clinicians aren’t shielded from diversity, as patients present varied perspectives, values, beliefs, and behaviors regarding health and well-being.

Betancourt, 2003

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. A patient’s cultural beliefs regarding health, wellness, disease, diagnosis, treatment, and/or the role of health care providers can interfere with the biomedical concepts and constructs of ethnocentric Western medicine. According to the U.S. Office of Minority Health, “the provider and the patient each bring their individual learned patterns of language and culture to the health care experience which must be transcended to achieve equal access and quality health care” (U.S. Department of Health and Human Services, 2008). Knowledge of the health-related beliefs and practices of diverse populations is an important adjunct to clinical knowledge as it enhances the patient-optometrist experience and provides greater opportunity for improving the quality of clinical care and patient outcomes. This is in addition to its positive impact on such management concerns as the mitigation of malpractice risk from misinformation, the growth of market share from patient satisfaction, and the nuances of performance-based reimbursement.

Why Optometrists Need Education and Training in Cultural Competence
<ul style="list-style-type: none"> • Quality of care/clinical outcomes <ul style="list-style-type: none"> ○ Patient-centered care/patient compliance ○ Healthy People 2010/elimination of health care disparities • Practice management <ul style="list-style-type: none"> ○ Demographic changes ○ Market share/competitive edge ○ Patient satisfaction ○ Performance-based reimbursement ○ Licensing/certification requirements ○ Risk management/malpractice/informed consent • Benchmarking <ul style="list-style-type: none"> ○ Accreditation standards for other health professions

Cultural competence provides health care providers with the requisite attitudes, knowledge, and skills to obtain the necessary information to make timely and appropriate diagnoses. It facilitates the development of treatment plans that are more readily followed by the patient and supported by family members, reduces delays in seeking care and receiving appropriate use of health care services, enhances overall communication and positive clinical interaction between patients and providers, and fosters compatibility between biomedical and cultural health practices. Cultural competence, very importantly, helps health care providers challenge the uncertainty of their assumptions and understand how cultural variations in perspectives, values, beliefs, and behaviors affect cultural variations in “patient recognition of symptoms, thresholds for seeking care, ability to communicate symptoms to a provider who understands their meaning, ability to understand the prescribed management strategy, expectations of care (including preferences for or against diagnostic and therapeutic procedures), and adherence to preventive measures and medications” (Betancourt, 2003).

Denial of the existence and/or importance of cultural conflicts can create challenges for both health care professionals and their patients. In the absence of cultural competence, clinical knowledge and skills, while necessary, may be insufficient to provide quality health care to populations with cultures not common to the optometrist. Clinical uncertainty from a lack of patient-provider concordance (i.e., sociocultural differences between patient and provider) can adversely affect patient expectation, communication/understanding/interpretation, participation, trust, compliance, satisfaction, and the subsequent outcomes of the clinical care encounter, including the exacerbation of racial, ethnic, and cultural disparities in health (Smedley et al., 2003; Wear, 2003). For example, the lack of language concordance can lead to misunderstandings which adversely affect compliance with a prescribed regimen in the treatment of glaucoma.

Cultural Competence versus Cultural Incompetence	
Cultural Competence	Cultural Incompetence
Clearer channels of communication	Higher possibility for patient/provider misunderstanding/miscommunication
More positive patient/provider interaction	Greater opportunity for patient/provider discordance
Greater patient/family investment in care plan	Greater likelihood of patient distrust, dissatisfaction, and reduced compliance
More timely and appropriate care	Less likelihood of awareness and appreciation of the cultural influence on health and illness
Reconciliation of Western biomedical and traditional cultural health practices	Greater likelihood of provider uncertainty and cultural stereotyping
Less provider uncertainty and greater familiarity with sociocultural determinants of health	Less probability for positively impacting health disparities
Improved patient compliance	

A culturally insensitive optometrist may not understand a patient’s culturally-based belief that Western medicine is "too strong," or that chronic disease is a Western concept and medications are only for acute relief. Misunderstandings about medicinal philosophies could affect patient compliance, particularly with maintenance dosing for a chronic illness like glaucoma. A culturally incompetent optometrist may not understand why a patient may not discuss symptoms of an illness for fear that such a discussion would cause the illness to occur, or why a patient

cannot make timely clinical care decisions in the absence of family members, or why a patient distrusts the optometrist who does not wear a white coat, or why a patient perceives a lack of seriousness about his illness when the optometrist smiles frequently, or why the patient discontinues treatment that conflicts with the perceived spiritual etiology of the illness.

Biomedical and Sociocultural Constructs of Perceived Illness	
Biomedical Etiologies	Sociocultural Etiologies
Physical trauma/fracture	Evil spirits/bewitching/aire
Bacterial/viral/fungal infection	Spiritual imbalance
Genetics	Loss of soul/susto/mal de ojo
Cancer	God's will
Elevated blood pressure/blood sugar	Cold (bad air)
Congenital defect	Punishment

Such a lack of understanding can perpetuate unconscious bias and lead to racial and cultural stereotyping and the failed application of culturally-sensitive care. The failure to recognize and appreciate cultural differences between patients and optometrists affects interpersonal communication, trust, and the subsequent behavior of both patient and optometrist (Betancourt et al., 2002). To be more exact, “without understanding the fundamental nature of culture and the integrity of differing belief systems, the risk of conflict and its negative impact on health outcomes is inevitable” (Kagawa-Singer and Kassim-Lakha, 2003).

Biomedical and Sociocultural Constructs of Treatment	
Biomedical Interventions	Sociocultural Interventions
Drug therapy	Prayer/meditation
Psychotherapy	Acupuncture
Physical therapy	Herbal therapy
Surgery	Coining

Under the assumption that differences may exist with regard to perceptions about the cause and/or nature of disease and expectations for treatment, integration of the cultures of the clinician, the patient and/or family, and the health care institution can transform a discordant clinical environment into one that is necessary for effective cross-cultural communication and interaction (Kagawa-Singer and Kassim-Lakha, 2003). The ability to understand, appreciate, and respect the importance of the multi-directional partnership of clinical communication is integral to the delivery of high quality and efficient health care.

Tervalon offers the following responses to the simple question of “Why learn about the impact of culture in health and health care delivery?” (Tervalon, 2003):

- The ever-changing demographic patterns in the United States.
- Literature indicating negative health outcomes when culture is dismissed as an influencing factor in health.

- The use of complementary and alternative medicine by large numbers of patients.
- Evidence that increasing provider education about culture in health can contribute to reducing racial and ethnic differentials in health outcomes.
- Adherence to mandates requiring that providers be knowledgeable about the applications of culture in health and health care delivery.

Betancourt identified three major factors that led to the emergence of cultural competence in medical education: 1) the deeming of cross-cultural education as critical to preparing providers to meet the health needs of the growing, diverse population; 2) the hypothesis that cultural competence education could improve provider–patient communication and help eliminate the pervasive racial/ethnic disparities in medical care; and 3) the adoption by accreditation bodies for medical training of standards that require cross-cultural curricula as part of medical education (Betancourt, 2003). The National Board of Medical Examiners is moving towards a “focus on cultural competency skill as one requirement for passing licensing exams” (Crandall et al., 2003).

Medicine, dentistry, nursing, and pharmacy have introduced the concepts of culturally competent education and training into their professional and continuing education curricula. The Association of American Medical Colleges (AAMC) believes that “with the ever-increasing diversity of the population of the United States and strong evidence of racial and ethnic disparities in health care, it is critically important that health care professionals are educated specifically to address issues of culture in an effective manner” (Association of American Medical Colleges, 2005). To facilitate the introduction of cultural competence education into the medical curriculum, the Liaison Committee on Medical Education (the accrediting authority for medical education programs leading to the M.D. degree in the U.S. and Canada) introduced the following standards for cultural competence: “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” and “medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery” (Association of American Medical Colleges, 2005).

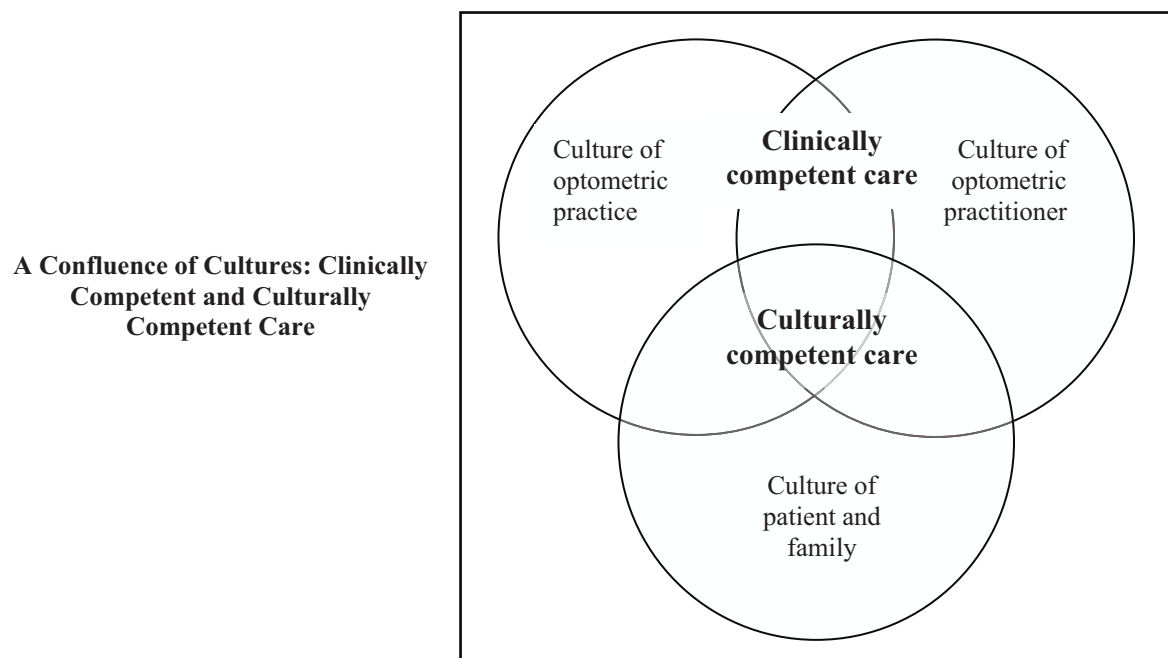
As part of the program requirements for resident training, the Accreditation Council on Graduate Medical Education approved a set of six general competencies. The competencies apply to core specialties and subspecialties (e.g., ophthalmology) and are reviewed during accreditation site visits. Included among the general competencies are two that relate directly to cultural competence (Accreditation Council on Graduate Medical Education):

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

The American Pharmacists Association’s release of *Essentials of Cultural Competence in Pharmacy Practice*, the profession’s first book on cultural competence, provides pharmacists and student pharmacists with the knowledge to deliver pharmaceutical care that accommodates the needs, beliefs, and health practices of all patients (American Pharmacists Association, 2008). Several states have enacted legislation requiring cultural competence training for physicians to receive or renew their medical license. The Office Minority Health sponsored Web site, *Think*

Cultural Health: Bridging the Health Care Gap through Cultural Competency Continuing Education Programs (<http://www.thinkculturalhealth.org/>), monitors and reports state cultural competency legislation activity via an interactive national map (U.S. Department of Health and Human Services, 2008b).

The optometric profession realizes that “ethnic diversity should be of particular interest to health care providers because of the inherent complexities in the delivery of care due to both language and cultural factors” and that “culture and linguistics play a critical role in how optometrists deliver care and how patients perceive and receive the care they are rendered” (Freeman, 2008; Intercultural Sensitivity: Educating Educators Research Group, 2006). However, optometry has been slow to embrace a curriculum of formal education and training in cultural competence. It has been stated that “cultural competency represents a new frontier for optometry” (Intercultural Sensitivity: Educating Educators Research Group, 2006). A 2004 survey of the Chief Academic Officers of the schools and colleges of optometry in the U.S. and Puerto Rico revealed that “much more is needed to bring the issue of cultural competence to the forefront of optometric education” (Lambrechts, et al., 2006).



As with the older medical school curricular paradigm, “students tended to learn that the proper stance of a physician [optometrist] is one of social neutrality – classless, raceless, genderless, cultureless, as well as class-blind, color-blind and so on” (Beagan, 2003). It is not the intent of these guidelines to imply that optometry students or optometrists consciously interject prejudices into the clinical encounter. Prejudices exist primarily unconsciously as a consequence of uncertainty about the interplay of cultures in clinical care and decision-making, such that optometrists may exhibit “unconscious incompetence” in failing to recognize a lack of understanding or miscommunication between patient and provider (Crandall et al., 2003).

As a primary health care profession that provides the majority of vision care services to the U.S. population, optometry must assume a more aggressive posture toward incorporating cultural competence education and training throughout the four years of the professional degree

curriculum and within post-graduate continuing education. Undiagnosed and untreated sight-threatening morbidities, such as glaucoma, diabetic eye disease, cataract, age-related macular degeneration, and uncorrected refractive errors, lead to vision impairment, blindness, and a reduced quality of life. Unresolved ocular morbidity also creates a visual environment in which educational opportunities are compromised and occupational opportunities are limited. 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.

Closely related to cultural competence is linguistic competence. The U.S. Office of Minority Health (OMH) believes that culture and language may influence: 1) health, healing, and wellness belief systems; 2) how illness, disease, and their causes are perceived; 3) the behaviors of patients who are seeking health care and their attitudes toward health care providers; and 4) the delivery of services by the provider who looks at the world through his or her own limited set of values, which can compromise access for patients from other cultures (U.S. Department of Health and Human Services, 2008). In a 2008 editorial, Freeman alerted optometrists to “the distinct possibility that at some point in our optometric careers we may be faced with the awkward inability to clearly communicate important information about the care and treatment of an ocular pathology that might not be complied with, or information about vision rehabilitation, or aspects of behavioral vision that might be misconstrued” (Freeman, 2008).

The Office of Minority Health has developed a set of principles and activities referred to as the National Standards on Culturally and Linguistically Appropriate Services (CLAS). While directed primarily at health care organizations, the 14 CLAS standards have relevance and application to individual health care providers, who are “encouraged to use the standards to make their practices more culturally and linguistically accessible” (U.S. Department of Health and Human Services, 2008). The CLAS Standards are organized by the Office of Minority Health into three themes: Culturally Competent Care (Standards 1-3); Language Access Services (Standards 4-7); and Organizational Supports for Cultural Competence (Standards 8-14). Four of the CLAS Standards (Standards 4-7) are mandates, in that they exist as federal requirements for all recipients of federal funds. Of the remaining ten standards, all except one (Standard 14) represent guidelines recommended by OMH for adoption as mandates by federal, state, and national accrediting agencies. Standard 14 is a recommendation suggested by OMH for voluntary adoption by health care organizations.

Theme	CLAS Standards		Type
Culturally Competent Care	1	Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.	Guidelines
	2	Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.	
	3	Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.	

Language Access Services	4	Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.	Mandates
	5	Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.	
	6	Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).	
	7	Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.	
Organizational Supports for Cultural Competence	8	Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.	Guidelines
	9	Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.	
	10	Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.	
	11	Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.	
	12	Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.	
	13	Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.	
	14	Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.	Recommendation

Beach conducted a systematic review and analysis of the literature and found evidence that cultural competence training impacts the attitudes, knowledge, skills, and behaviors of health care providers and the satisfaction of patients (Beach, 2005). Findings indicated that cultural competence training has a positive impact on such concepts as providers’ knowledge of how culture affects the patient-provider encounter or how cultural incompetence can negatively affect patients. Evaluations of cultural competence training seminars and workshops held at several schools and colleges of optometry indicate similar findings – that is, positive changes in the levels of knowledge, awareness, beliefs, and behaviors of optometric faculty, staff, and students (Fink, 2006; Intercultural Sensitivity: Educating Educators Research Group, 2006). The conclusion by Beach that cultural competence training positively impacts the “intermediate outcomes” of provider attitudes, knowledge, skills, and behaviors suggests that the training intervention would “ultimately impact patient outcomes” (Beach, 2005).

Effect of Cultural Competence Training on Health Care Providers*	
Attitudes	<ul style="list-style-type: none"> • Confidence in knowledge and skills related to African American, Asian, Latino, and Native American patients • Attitudes toward community health issues • Interest in learning about patient and family backgrounds
Knowledge	<ul style="list-style-type: none"> • Impact of culture on patient-provider encounter • How provider ignorance adversely impacts patients • Knowledge of disease burdens across populations • Knowledge of traditional cultural practices
Skills	<ul style="list-style-type: none"> • Communication • Interviewing non-English-speaking patients • Community-based education • Social interactions with peers of different races and ethnicities • Enhanced ability to conduct behavioral analyses and treatment plans
*Source: Beach MC, Price EG, Gary TL. Cultural competence: a systematic review of health care provider educational interventions. <i>Med Care</i> 2005; 43:356-373	

It is imperative that optometrists and optometry students understand and respond with sensitivity to the needs and preferences that culturally and linguistically different individuals bring to the eye care system because culture and language are vital factors in how health services are rendered and received. (Jenkins, 2006)

VISION

The delivery of high-quality primary health care that is meaningful, acceptable, accessible, effective, and cost efficient requires a deeper understanding of the sociocultural background of patients, their families, and the environments in which they live. It is also critical to become more aware of how one's own cultural values, assumptions, and beliefs influence the provision of clinical care and are shaped by social relationships and the contexts in which we work and live.

Society of Teachers of Family Medicine
Like et al., 1996

It is the vision of the ASCO Cultural Competence Guidelines Work Group and Diversity Task Force that all ASCO member institutions will be culturally competent in eye and vision care.

The mission of the *ASCO Guidelines for Culturally Competent Eye and Vision Care* is to:

- 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.
- Promote better understanding of strategies on how to serve diverse populations.
- Foster the development of the attitudes, knowledge, and skills needed to be culturally competent.
- Facilitate the clinical readiness of optometry faculty, students, and staff to respond to the health-related cultural needs of a diverse society.
- Reduce access, systemic, and provider-based barriers that foster racial and ethnic disparities in health.

DEFINITION OF CULTURE AND CULTURAL COMPETENCE

Culture is a set of learned and shared beliefs and values that are applied to social interactions and to the interpretation of experiences.

Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies
Mutha et al., 2002

Culture affects our view of the world and the values we apply to that view. Cultural perspectives are shaped by many factors, including socioeconomic status, religion, gender, age, nationality, sexual orientation, education, language, occupation, disability, as well as race and ethnicity; consequently, we all reflect multicultural perspectives that include more than race and ethnicity and which help influence our values, belief systems, and behaviors (Betancourt, 2003; Betancourt et al., 2002).

Based on the work of Cross (Cross et al., 1989), the National Center for Cultural Competence (Georgetown University, 2008) adopted a conceptual framework of cultural competence that requires organizations and their personnel to: 1) have a defined set of values and principles; 2) demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally; and 3) 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.

A shared understanding of what is meant by the term “cultural competence” is most important to an understanding of the academic and practical aspects of cultural competence education and training. There are many definitions of cultural competence, but probably the one most frequently cited or from which others are mostly derived is the one provided by Cross, Bazron, Dennis and Issacs in 1989 (Cross et al., 1989):

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.

Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies provides an alternative definition that more directly applies to health care (Mutha et al., 2002):

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.

GUIDING PRINCIPLES

These [principles] seemed to implicitly guide the development of the specific standards regarding cultural competence, including what should be taught, when it should be taught, how it should be taught and who should teach it.

*Principles and Recommended Standards for
Cultural Competence Education of Health Care Professionals
The California Endowment, 2003*

The ASCO Diversity Task Force embraces the “guiding principles” for developing specific standards regarding cultural competence adopted by the California Endowment. The guiding principles help structure “what should be taught, when it should be taught, how it should be taught and who should teach it” (The California Endowment, 2003):

1. The goals of cultural competence training should be: 1) increased self awareness and receptivity to diverse patient populations on the part of health care professionals; 2) clinical excellence and strong therapeutic alliances with patients; and 3) reduction of health care disparities through improved quality and cost-effective care for all populations.
2. In all trainings there should be 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. Training efforts should be developmental, in terms of the institution and the individual. Institutions may start out simply in their inclusion of cultural competency training as a specific area of study, but are expected to build in more complex, integrated, and in-depth attention to cultural issues in later stages of professional education. Trainees should be expected to become progressively more sophisticated in understanding the complexities of diversity and culture as they relate to patient populations and health care. Both instructional programs and student learning should be regularly evaluated in order to provide feedback to the on-going development of educational programs.
4. 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. It is important to recognize the extensive preexisting knowledge and skill base of health care professionals and to seek to promote cultural competence within this context.
5. While factual information is important, educators should focus on process-oriented tools and concepts that will serve the practitioner well in communicating and developing therapeutic alliances with all types of patients.
6. Cultural competence training is best integrated into numerous courses, symposia and experiential, clinical, evaluation, and practicum activities as they occur throughout an educational curriculum. Attention may need to be directed to faculty, staff, and administrative development in cultural competence in order to effect this integration.

7. Cultural competence education should be institutionalized within a school or college so that when curriculum or training is planned or changed, appropriate cultural competence issues can be included.
8. Cultural competence education is best achieved within an interdisciplinary framework and context, drawing upon the numerous fields that contribute to skill and knowledge in the field.
9. Education and training should be respectful of the needs, the practice contexts, and the levels of receptivity of the learners.
10. Education in cultural competence should be congruent with and, where possible, framed in the context of existing policy and educational guidelines of professional accreditation and practice organizations.
11. Wherever possible, diverse patients, community representatives, consumers, and advocates should participate as resources in the design, implementation, and evaluation of cultural competence curricula.
12. Cultural competence education should take place in a safe, non-judgmental, supportive environment. Schools and colleges must be settings that are conducive to functioning in a culturally competent way and visibly support the goals of culturally competent care.

The ASCO Diversity Task Force suggests that the guiding principles articulated by The California Endowment and listed above be part of the cultural fabric of the cultural competence education and training within the schools and colleges of optometry.

CURRICULAR PHILOSOPHY

While the content and subject matter of cultural competence training/education are extremely varied, they generally fall into three general categories: Attitudes, Knowledge and Skills. Each of these areas is supportive of the other two. Like a three-legged stool, the structure would fail if one “leg” were missing. Most importantly, the knowledge and skills related to cultural competence in health care would be seriously reduced in effectiveness if a committed consciousness and receptive attitude did not underlie their use. From a practical standpoint, these three content areas are applicable in the education of all professional health care disciplines and are useful at any stage of the developmental learning process.

*Principles and Recommended Standards for
Cultural Competence Education of Health Care Professionals
The California Endowment, 2003*

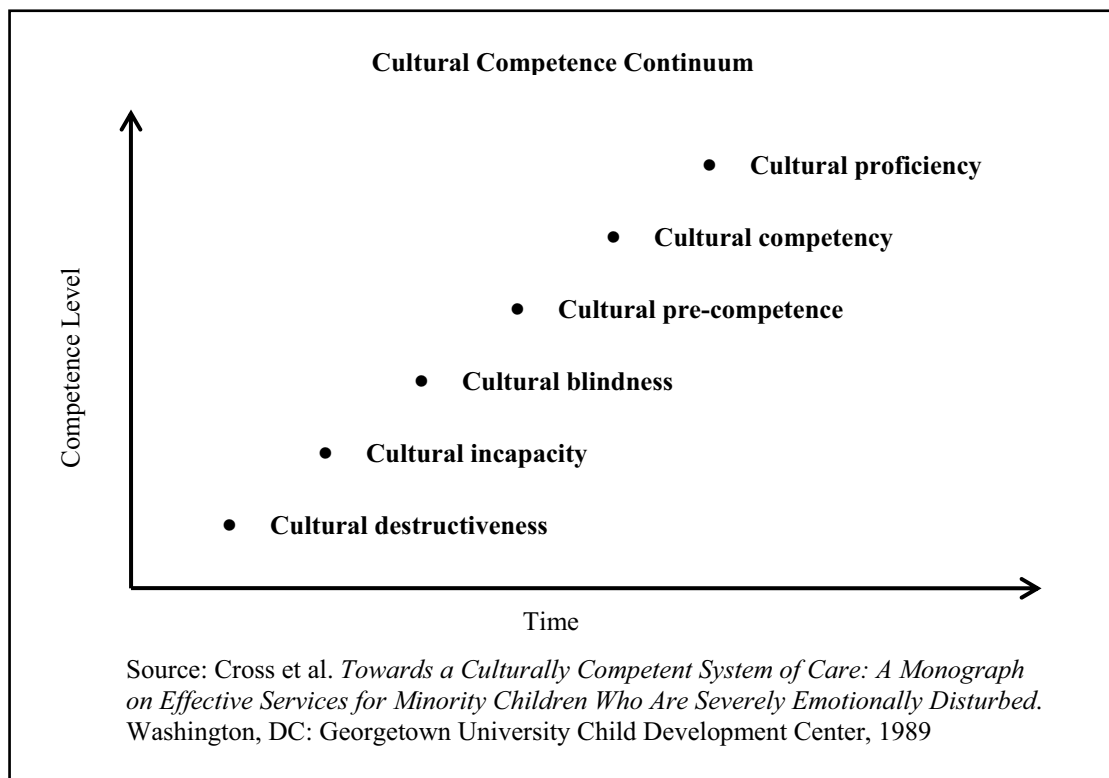
Teaching cultural competency centers on two primary challenges: 1) preparing clinicians to understand and respect the values, beliefs, and expectations of their patients; and 2) helping clinicians apply the requisite attitudes, knowledge, and skills to each patient encounter to achieve improved clinical outcomes (Mutha et al., 2002). The National Center for Cultural Competence affirms that in order to provide culturally competent quality health care in a globally diverse society it is critical that health care providers have an understanding of the: 1) beliefs, values, traditions, and practices of a culture; 2) culturally-defined, health-related needs of individuals, families, and communities; 3) culturally-based belief systems of the etiology of illness and disease and those related to health and healing; and 4) attitudes toward seeking help from health care providers (Georgetown University, 2008). However, before a cultural competence curriculum can be implemented, the Association of American Medical Colleges notes that certain institutional requirements must be met (Association of American Medical Colleges, 2005):

- The curriculum must have the institutional support of the leadership, faculty, and students.
- Institutional and community resources must be committed to the curriculum.
- Community leaders must be sought out and involved in designing the curriculum and providing feedback.
- The institution and its faculty need to commit to providing integrated educational interventions appropriate to the level of the learner.
- A cultural competence curriculum must have a clearly defined evaluation process that includes accountability and evaluation (e.g., evidence of a planning process to assure appropriate inclusion of material throughout the curriculum, details on curriculum process and content, specific student feedback, and consideration of outcomes assessment).

There is no quick fix, recipe, or cookbook to attaining cultural competence. Although examples of cultural norms, expectations, practices, etc. are provided for illustrative purposes, no one example or set of examples can be entirely descriptive of any culture. Cultural competence is a process that evolves over time with the demonstration of various levels of awareness,

knowledge, and skills. The NCCC framework requires that the above concepts be embedded in all aspects of policy making, administration, practice, and service. Cross acknowledged that the path to cultural competence exists as a continuum, with several stages of development (Cross et al., 1989):

1. Cultural destructiveness (attitudes, policies, and practices that are destructive to cultures and individuals within the culture).
2. Cultural incapacity (the system or agencies do not intentionally seek to be culturally destructive, but lack the capacity to help minority clients or communities so that the system remains extremely biased).
3. Cultural blindness (the system and its agencies provide services with the express philosophy of being unbiased).
4. Cultural pre-competence (the agency realizes its weaknesses in serving minorities and attempts to improve some aspect of their services to a specific population).
5. Cultural competency (agencies are characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority populations).
6. Cultural proficiency (agencies seek to add to the knowledge base of culturally competent practice by conducting research, developing new therapeutic approaches based on culture, and publishing and disseminating the results of demonstration projects).



The goal of cultural competence education and training is to provide the knowledge and skills that cultivate the attitudes and practice that promote the clinician's understanding of and respect for patients' values, beliefs, and expectations; awareness of one's own assumptions and value system; and ability to adapt care to be congruent with the patient's expectations and preference (Mutha et al., 2002).

The California Endowment's *Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals* describes the inter-relational aspects of attitudes, knowledge, and skills as follows (The California Endowment, 2003):

A. ATTITUDES:

- Lifelong commitment to learning and self-evaluation through an ability to recognize and question one's own assumptions, biases, stereotypes, and responses.
- Open-mindedness and respect for all patients, including those who differ socially or culturally.
- Patient and family-centered care with the understanding that effective therapeutic alliances may be construed differently across patients and cultures.
- Commitment to equal quality care for all.
- Identification and elimination of barriers to patient access and use of services within practice environments.

B. KNOWLEDGE

- Self-awareness of internalized beliefs, values, norms, stereotypes, and biases; how ethnocentrism operates in all cultures; and how the possibility of ethnocentrism in one's own thinking may influence interaction with patients.
- Understanding of the concept of culture (that all people operate within multiple cultures) and the connections between worldview, beliefs, norms, and behaviors related to health, illness, and care-seeking in different populations and how one's own cultures, including the cultures of biomedicine, inform perceptions and behaviors.
- Knowledge of local and national demographics with attention to specific populations, immigration, and changing demographics and implications for one's current and future professional practice.
- Knowledge of legal, regulatory, and accreditation issues which address cultural and linguistic issues in health care, including the U.S. Department of Health and Human Services (DHHS) position on civil rights and language access, federal and state cultural competence contract requirements for publicly funded health care, state legislation around the provision of language services and culturally sensitive health care, and the DHHS National Standards on Culturally and Linguistically Appropriate Services (CLAS).
- Knowledge of cultural and linguistic policy or standards espoused by one's professional associations (e.g., Association of Schools and Colleges of Optometry, American

Optometric Association) and understanding of how cultural competence fits into the goals of professional education.

- Knowledge of the kinds and degrees of disparities in health status, health care access, and use of preventive strategies across racial, ethnic, gender, and other discrete population groups in the United States and how class, racial and ethnic discrimination, social and structural variables, including the structure of health care, contribute to these disparities.
- Exploration of family structure and dynamics, health beliefs, behaviors, and health practices demonstrated in different cultures and population groups, especially those in the local areas of service.
- Understanding of the concept of medical pluralism – the concurrent use of both traditional and biomedical systems of care – and familiarity with the kinds of healers and healing traditions within one’s communities of practice or those frequently associated with one’s specialty field (*improved understanding of traditional practices does not mean endorsing them, but it can lead to improved provider-patient or provider-family interaction*).
- Understanding of within-group variation, including class and acculturation, and how inferences from probabilistic, group-level generalizations to individual cases can lead to stereotyping and associated clinical risks (*a “recipe” approach to cultural and clinical descriptions of groups should be rigorously avoided*).
- Evaluation and understanding of emergent data in genome research and ethnopharmacology and their implications and potential use in enhancing the quality of care for specific racial and ethnic groups.
- Knowledge of epidemiology and limitations of epidemiological information among specific populations, nationally and within one’s local areas, and use this knowledge in patient assessment, health promotion, and other aspects of care.
- Knowledge of the dangers of attempting to care for a patient whose language one does not understand well and the problems associated with the use of family members, friends, or unskilled interpreters.
- Knowledge of cross-cultural variations in verbal and non-verbal communication and etiquette and techniques for recovering if one discovers that a cultural norm was inadvertently breached.
- Awareness of available resources, such as bibliographies, Websites, case studies, and community contacts and resources, to expand one’s knowledge and education around cultural issues while engaging in professional practice.

C. SKILLS

- Ability to assess one’s responses, biases, and cultural preconceptions on an ongoing basis.
- Ability to elicit patients’ social, family, and medical histories, including patients’ health beliefs, practices, and explanatory models; foster positive therapeutic alliances with diverse patients; and assess patients’ expectations around levels of interactive formality with providers while valuing and incorporating the patients’ beliefs and understanding

into diagnosis, treatment options, and preventive health care where possible and negotiating conflicting patient/provider perspectives when necessary.

- Ability to access, interact, and collaborate with diverse local communities for the purpose of understanding their traditional or group-specific health care practices and needs and tailoring effective outreach, prevention, and educational programs and materials.
- Ability to assess patients' language skills as they relate to their ability to communicate fully with the practitioner and staff and to their understanding of written instructions, prescriptions, and educational materials (*while language and literacy issues may be particularly important in working with limited English speakers, they should be considered in relating to all patients*).
- Ability to realistically assess one's proficiency in languages other than English and acquisition of the skills for effective use of interpreters, including working with an untrained interpreter, a trained interpreter, and telephone interpreting.
- Ability to access translated written materials through one's organizations (e.g., American Optometric Association, National Eye Institute, National Eye Health Education Program) and commercial resources, including computer programs and Web-based resources.
- Ability to retrieve data concerning cultural issues in health care, population data, and epidemiological information on the Web.

The Center for the Health Professions, in *Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies*, suggests a 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.
5. Apply – discuss how the concepts learned from the exercise can be applied to clinical settings and personal or professional experiences.

As an applied example of the above concepts, an important skill in the assessment of optometric patients is the ability to appropriately query the patient with regard to their medical history for diagnostic and therapeutic purposes. It can be said, therefore, that the clinician's role is to: 1) thoughtfully and respectfully elicit information from the patient alone or in partnership with interpreters; 2) skillfully utilize social and cultural profiles when interviewing patients; and 3) consider how the cultural beliefs of the patient will be incorporated into the provider's decision-making processes when negotiating treatment and referral plans with patients and families (Tervalon, 2003).

CURRICULAR INTEGRATION

“While our clinical population . . . has a great deal of cultural diversity, with a large volume of African American and Hispanic patients in particular, we do not specifically address training in any of the areas that are mentioned in the survey. We discuss some of the issues informally during patient care but that is all.”

ASCO School/College A

“. . . doesn’t have any formal diversity curriculum, however, we do have a very diverse student body and an even more diverse patient population, so we welcome the Task Force developing a curriculum.”

ASCO School/College B

“I have had numerous faculty members share that they found the survey to be eye-opening and they will be re-evaluating their individual course curricula as a result of the experience in the future. So, even at this entry level stage of the project we found the process useful and enlightening.”

ASCO School/College C

TOOL FOR ASSESSING CULTURAL COMPETENCE TRAINING (TACCT)

The Tool for Assessing Cultural Competence Training (TACCT) was developed by the Association of American Medical Colleges to provide a framework for assisting medical schools in their efforts to integrate cultural competence training into their curricula and assess the culturally appropriate content of their curricula (Association of American Medical Colleges, 2005). It is a self-administered assessment tool that can be used to identify curricular areas where culturally competent content currently exists and where appropriate content is missing.

The TACCT consists of two parts: “domains” and “specific components.” Domains consider the components of the cultural competence curriculum and allow monitoring of curricular content (where teaching is occurring). Domains apply and should be assessed relative to every course in the preclinical and clinical curricula. Specific components

Tool for Assessing Cultural Competence Training (TACCT)
(a). Domains (Overview)

Name: _____
 Course Name/Curriculum Year/Type of Course: _____
 Institution and Date Completed: _____

		Pre-Clinical Course Names																				
		1	2	3	4	5	6	7	8	9	10											
Domain I	Beliefs, Customs, and Culture	A. Definition of cultural competence																				
		B. Definitions of race, ethnicity and culture																				
		C. Clinicians' self assessment and reflection																				
		D. Epidemiology of population health																				
		E. Patients' healing traditions and systems																				
Domain II	Essays on Cultural Competence	A. Institutional cultural issues																				
		B. History of the patient																				
		C. Effects of stereotyping																				
Domain III	Understanding the Impact of Stereotyping on Medical Decision-Making	A. History of stereotyping																				
		B. Bias, discrimination, and racism																				
		C. Effects of stereotyping																				
Domain IV	Health Disparities and Factors Affecting Health	A. History of health-care discrimination																				
		B. Epidemiology of health-care disparities																				
		C. Factors underlying health-care disparities																				
		D. Demographic patterns of disparities																				
		E. Collaborating with communities																				
Domain V	Care-Cultural Clinical Skills	A. Offering relief, culture, and beliefs																				
		B. Dealing with hostility/abuse																				
		C. Taking a social and medical history																				
		D. Communication skills																				
		E. Working with interpreters																				
		F. Negotiating and problem-solving skills																				
		G. Diagnose and patient-adherence skills																				

provide for the identification of education for detailed attitudes, knowledge, and skills (what learning objectives are being met). Each of the five domains has specific attitudes (A), knowledge (K), and skills (S) and to be taught and evaluated.

TACCT Domains:

- Preclinical/clinical
 1. Rationale, context, and definition
 2. Key aspects of cultural competence
 3. Understanding the impact of stereotyping on medical decision-making
 4. Health disparities and factors influencing health
 5. Cross-cultural clinical skills

TACCT specific components:

- Attitudes
- Knowledge
- Skills

The following outline details the content of each domain and the respective attitudes, knowledge, and skills to be taught and assessed within each domain (Association of American Medical Colleges, 2005):

TACCT DOMAIN I: CULTURAL COMPETENCE – RATIONALE, CONTEXT, AND DEFINITION

- A. Definition and understanding of the importance of cultural competence; how cultural issues affect health and health care quality and cost; and, the consequences of cultural issues.
- B. Definitions of race, ethnicity, and culture, including the culture of medicine.
- C. Clinicians' self-assessment, reflection, and self-awareness of own culture, assumptions, stereotypes, biases.

At the end of optometry school, students will be able to:

- A1. Describe their own cultural background and biases.
- A2. Value the importance of the link between effective communication and quality care.
- A3. Value the importance of diversity in health care and address the challenges and opportunities it poses.
- K1. Define – in contemporary terms – race, ethnicity, and culture, and their implications in health care.
- K2. Identify how these factors – race, ethnicity, and culture – affect health and health-care quality, cost, and consequences.

- K3. Identify patterns of national data on health, health care disparities, and quality of health care.
- K4. Describe national health data in a worldwide immigration context.
- S1. Discuss race, ethnicity, and culture in the context of the medical interview and health care.
- S2. Use self-assessment tools, asking: What is my culture? What are my assumptions/stereotypes/biases?
- S3. Use *Healthy People 2010* and other resources to make concrete the epidemiology of health care disparities.

TACCT DOMAIN II: KEY ASPECTS OF CULTURAL COMPETENCE

- A. Epidemiology of population health.
- B. Patient/family-centered vs. physician-centered care: emphasis on patients'/families' healing traditions and beliefs (for example, ethno-medical healers).
- C. Institutional cultural issues.
- D. Information on the history of the patient and his/her community of people.

At the end of optometry school, students will be able to:

- A1. Exhibit comfort when conversing with patients/colleagues about cultural issues.
- A2. Ask questions and listen to patients discuss their health beliefs in a nonjudgmental manner.
- A3. Value the importance of social determinants and community factors on health and strive to address them.
- A4. Value the importance of curiosity, empathy, and respect in patient care.
- K1. Describe historical models of common health beliefs and health belief models (for example, illness in the context of "hot and cold," Galen and other cultures).
- K2. Recognize patients'/families' healing traditions and beliefs, including ethno-medical beliefs.
- K3. Describe common challenges in cross-cultural communication (for example, trust, and style).
- K4. Demonstrate basic knowledge of epidemiology and biostatistics.
- K5. Describe factors that contribute to variability in population health.
- S1. Outline a framework to assess communities according to population health criteria, social mores, cultural beliefs, and needs.
- S2. Ask questions to elicit patient preferences and respond appropriately to patient feedback about key cross-cultural issues. Elicit additional information about ethno-medical conditions and ethno-medical healers.
- S3. Elicit information from patient in context of family-centered care.

- S4. Collaborate with communities to address community needs.
- S5. Recognize and describe institutional cultural issues.

TACCT DOMAIN III: UNDERSTANDING THE IMPACT OF STEREOTYPING ON HEALTH CARE DECISION-MAKING

- A. History of stereotyping, including limited access to health care and education.
- B. Bias, stereotyping, discrimination, and racism.
- C. Effects of stereotyping on medical decision-making.

At the end of optometry school, students will be able to:

- A1. Identify their own stereotypes and biases that may affect clinical encounters.
- A2. Recognize how provider biases impact the quality of health care.
- A3. Describe/model potential ways to address bias in the clinical setting.
- A4. Recognize importance of bias and stereotyping on clinical decision-making.
- A5. Recognize need to address personal susceptibility to bias and stereotyping.
- K1. Describe social cognitive factors and impact of race/ethnicity, culture, and class on clinical decision-making.
- K2. Identify how physician bias and stereotyping can affect interaction with patients, families, communities, and other members of the health care team.
- K3. Recognize physicians' own potential for biases and unavoidable stereotyping in a clinical encounter.
- K4. Describe the inherent power imbalance between physician and patient and how it affects the clinical encounter.
- K5. Describe patterns of health care disparities that can result, at least in part, from provider's bias.
- K6. Describe strategies for partnering with community activists to eliminate racism and other bias from health care.
- S1. Demonstrate strategies to assess, manage, and reduce bias and its effects in the clinical encounter.
- S2. Describe strategies for reducing provider's own biases.
- S3. Demonstrate strategies for addressing bias and stereotyping in others.
- S4. Engage in reflection about their own cultural beliefs and practices.
- S5. Use reflective practices in patient care.
- S6. Gather and use local data as examples of *Healthy People 2010*.

TACCT DOMAIN IV: HEALTH DISPARITIES AND FACTORS INFLUENCING HEALTH

- A. History of health care design and discrimination.

- B. Epidemiology of specific health and health care disparities.
- C. Factors underlying health and health care disparities – access, socioeconomic, environment, institutional, racial/ethnic.
- D. Demographic patterns of health care disparities, both local and national.
- E. Collaborating with communities to eliminate disparities – through community experiences.

At the end of optometry school, students will be able to:

- A1. Recognize the existence of disparities that are amenable to intervention.
- A2. Realize the historical impact of racism and discrimination on health and health care.
- A3. Value eliminating disparities.
- K1. Describe factors other than bio-medical – such as access, historical, political, environmental, and institutional – that impact health and underlie health and health care disparities.
- K2. Discuss social determinants on health including, but not limited to, the impact of education, culture, socioeconomic status, housing, and employment.
- K3. Describe systemic and medical-encounter issues, including communication, clinical decision-making and patient preferences.
- K4. Identify and discuss key areas of disparities described in *Healthy People 2010* and the Institute of Medicine’s report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*.
- K5. Describe important elements involved in community-based experiences.
- K6. Discuss barriers to eliminating health disparities.
- S1. Critically appraise the literature as it relates to health disparities, including systems issues and quality in health care.
- S2. Describe methods to identify key community leaders.
- S3. Develop a proposal for a community-based health intervention.
- S4. Actively strategize ways to counteract bias in clinical practice.

TACCT DOMAIN V: CROSS-CULTURAL CLINICAL SKILLS

- A. Knowledge, respect, and validation of differing values, cultures, and beliefs, including sexual orientation, gender, age, race, ethnicity, and class.
- B. Dealing with hostility/discomfort as a result of cultural discord.
- C. Eliciting a culturally valid social and medical history.
- D. Communication, interaction, and interviewing skills.
- E. Understanding language barriers and working with interpreters.
- F. Negotiating and problem-solving skills.

G. Diagnosis, management, and patient-adherence skills leading to patient compliance.

At the end of optometry school, students will be able to:

- A1. Demonstrate respect for a patient's cultural and health beliefs.
- A2. Acknowledge their own biases and the potential impact they have on the quality of health care.
- K1. Identify questions about health practices and beliefs that might be important in a specific local community.
- K2. Describe models of effective cross-cultural communication, assessment, and negotiation.
- K3. Understand models for physician-patient negotiation.
- K4. Describe the functions of an interpreter.
- K5. List effective ways of working with an interpreter.
- K6. List ways to enhance patient adherence by collaborating with traditional and other community healers.
- S1. Elicit a culture, social, and medical history, including a patient's health beliefs and model of their illness.
- S2. Use negotiating and problem-solving skills in shared decision-making with a patient.
- S3. Identify when an interpreter is needed and collaborate with interpreter effectively.
- S4. Assess and enhance patient adherence based on the patient's explanatory model.
- S5. Recognize and manage the impact of bias, class, and power on the clinical encounter.

Evaluation grids are used to assess all required courses within the preclinical and clinical components of the curriculum (the full grids can be downloaded from the AAMC Website at <http://www.aamc.org/meded/tacct/start.htm>). The domains grid is used to provide an overall “blueprint” (e.g., absence of content material); whereas, the specific components grid (attitudes, knowledge, skills) is used to provide a more detailed analysis of educational objectives (e.g., quality of curricular content). The TACCT does not make recommendations for the number of credit hours of instruction for the individual or collective domain or the total cultural competence curriculum.

A preliminary survey of the schools and colleges of optometry, conducted in 2007 by the ASCO Diversity Task Force with 41% of the schools and colleges responding, indicated that the TACCT Domains and Skills were most prevalent in the curricular content of clinical science courses, public health courses, and clinic and least prevalent in orientation and biomedical science courses. The attitudes, knowledge, and skills (specific components) reported most frequently as included in the 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; and 7) elicit a culture, social, and medical history.

Domains Most Prevalent in Curricula of ASCO Institutions as Reported on TACCT Survey, 2007			
TACCT Domains		Preclinical	Clinical
Rationale, Context, and Definitions	Definition of cultural competence		
	Definitions of race, ethnicity, and culture	X	
	Clinician's self-assessment and reflection		
Key Aspects of Cultural Competence	Epidemiology of population health	X	X
	Patient's healing traditions and systems		
	Institutional cultural issues	X	
	History of the patient	X	X
Understanding the Impact of Stereotyping on Medical Decision-Making	History of stereotyping		
	Bias, discrimination, and racism		
	Effects of stereotyping		
Health Disparities and Factors Influencing Health	History of health care discrimination		
	Epidemiology of health care disparities		
	Factors underlying health care disparities		
	Demographic patterns of disparities		
	Collaborating with communities		
Cross-Cultural Clinical Skills	Differing values, cultures, and beliefs	X	X
	Dealing with hostility/discomfort	X	X
	Eliciting a social and medical history	X	X
	Communication skills	X	X
	Working with interpreters	X	X
	Negotiating and problem-solving skills	X	X
	Diagnosis and patient-adherence skills	X	X

To further guide the development of cultural competence curricula and the comparison of program components across curricula, Dolhun et al. created a tool that could complement the TACCT in the integration and assessment of culturally appropriate content into optometric curricula (Dolhun et al., 2003). The tool defined eight areas of cultural competence education content:

1. General concepts of culture (culture, individual culture, group culture).
2. Racism (racism and stereotyping).
3. Doctor-patient interactions (trust and relationship).
4. Language (meaning of words, non-verbal communication, use of interpreters, coping with language barriers).
5. Specific cultural content (epidemiology, patient expectations and preferences, traditions and beliefs, family role, spirituality and religion).
6. Access issues (transportation, insurance status, immigration/migration).
7. Socioeconomic status (SES).
8. Gender roles and sexuality.

TRAINING METHODS

Cultural competence is a relatively new field and is being taught in a variety of settings and venues, from formal professional school curricula to stand-alone workshops and conferences. Though the content areas are complex and many of the subjects to be covered are sensitive, the subject must compete with others in crowded curricula of professional schools or in time-limited workshops or training modules. Students and educators are varied in their receptivity, sophistication and educational background. Thus, careful selection of educational approaches is critical.

*Principles and Recommended Standards for
Cultural Competence Education of Health Care Professionals
The California Endowment, 2003*

TEACHING

Teaching methods across the curriculum include case studies, didactic lectures, clinical experiences, workshops, interactive/participatory activities, role playing, mentoring, group discussions, internships, service learning projects, language training, and cultural immersion site visits/programs (Beach et al., 2005; Crandall et al., 2003; Dolhun et al., 2003). The schools and colleges of optometry routinely employ the cultural immersion approach with student rotations through clinics that exist in and/or serve primarily patients from diverse backgrounds, such as health centers in ethnocentric neighborhoods or clinics outside of the country (e.g., Mexico, China). “Immersion in culture and language is an effective means of learning about oneself and about another culture,” but it is not the singular answer nor should it be the sole approach to increasing the cultural competence of optometry students, faculty, and graduates (Crampton et al., 2003). Sending students, faculty and/or staff to culturally diverse sites without sufficient preparation can lead to a “cultural mismatch” and suboptimal care (Intercultural Sensitivity: Educating Educators Research Group, 2006).

The California Endowment’s *Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals* proposes the following approaches to cultural competence education and training (The California Endowment, 2003):

1. Achieving cultural competence is an incremental process and cultural competence education and training methods should be suited to the level, needs, and learning styles of optometry students.
2. Cultural competence training should be developmental – a step-by-step process, increasing in complexity as students acquire the ability to apply the understandings and skills in a variety of situations and settings (*no brief or one-time training can meet these criteria appropriately*).
3. Cultural competence education is best achieved through a diverse set of training strategies (e.g., lectures, in-depth and interactive exercises and discussions, case study analysis, genograms, journal keeping, selected readings, Web-based learning and data gathering, videos, CD ROMs, DVDs, and simulations).
4. The most important learning opportunities should come through experiential learning, ranging from role plays with feedback to working with diverse patients and getting

hands-on experience in community settings where care is delivered to diverse patient populations.

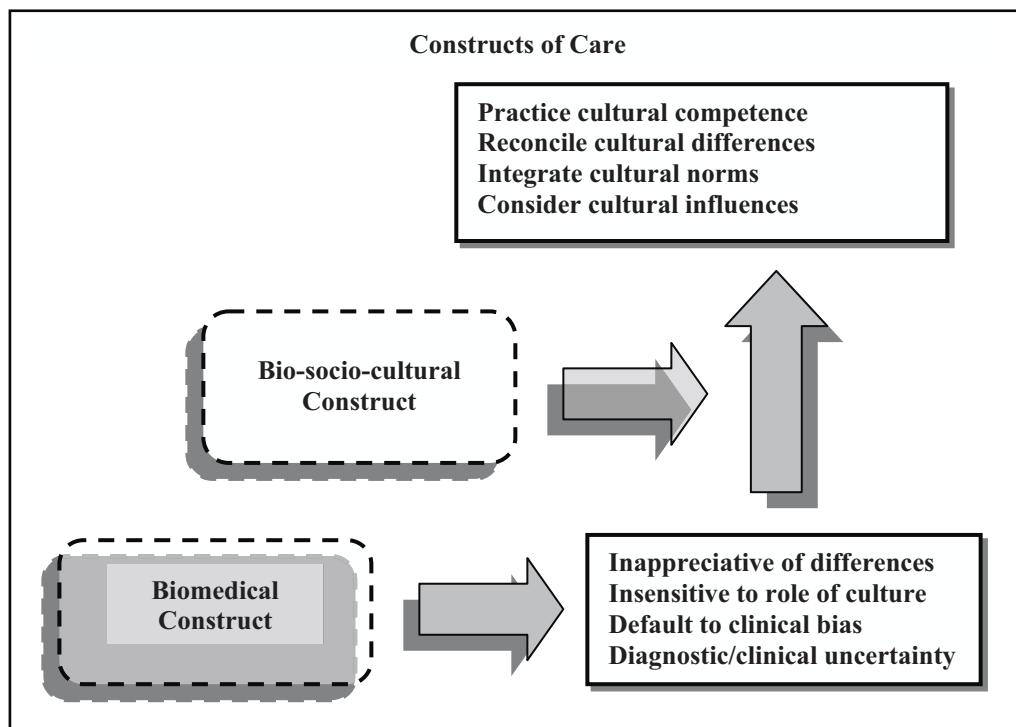
5. Cultural competence education should not be confined to one course or workshop, but should be integrated into many curricular offerings and educational activities, such as case discussions, grand rounds, symposia, clinical rotations, preceptorships, continuing education courses, and conferences.
6. Cultural competence training may best be accomplished by an interdisciplinary, multicultural team (community members and indigenous healers as informants, lecturers and training team members) and should bring together information from different backgrounds and perspectives as it relates to patient care and health care settings.
7. Faculty should articulate the attitudes engendered by cultural competency and model cultural competency attitudes, knowledge, and skills so that students can learn by example.

It has been suggested that “schools and colleges of optometry can encourage cultural competency in their students, faculty, and staff by conducting workshops; incorporating inclusion dialogue in their mission statements and policy and procedure manuals; establishing a curriculum that interweaves cultural competency training in didactic and clinical courses; encouraging and supporting research that focuses on multicultural eye health and cultural and linguistic competency; and fostering an environment that values multicultural students, faculty and staff” (Jenkins, 2006). Jenkins outlined eight factors necessary for incorporating cultural and linguistic competence into optometric education and training (Jenkins, 2006):

1. Solid and authentic institutional commitment.
2. Resource commitment.
3. Willingness to change policies and practices.
4. Administration and faculty champions.
5. Shared vision and “buy in” from faculty, staff, and students.
6. Community engagement, involvement, and collaboration.
7. Safe and supportive environment for discussion and change.
8. Patience, persistence, and realistic expectations.

A key aspect of cultural competence education and training is to provide students with the opportunity for self-reflection and assessment “to examine and understand their own multifaceted cultural identities, their perspectives and views on the culture of biomedicine, and the ways in which these elements may influence their attitudes and behaviors in health care settings” (Tervalon, 2003). Student self-assessment can involve several learning processes for students as they: 1) acknowledge and describe their own multicultural identities and those of peers, patients, and communities; 2) describe how these cultural identities, along with the culture of biomedicine, influence their health belief systems; 3) identify the sources of potential conflict and compatibility that arise from these influences in health care settings; 4) identify potential or actual sources of bias, prejudice, and discrimination that arise from their lived experiences; 5) remediate identified limitations through anti-bias, anti-isms training with a focus pertinent to

health care; and 6) utilize these self-reflection tools and skills in their lifelong work (Tervalon, 2003).



Irrespective of cultural norms, each person is a unique blend of culture, experience, and personality. It is, therefore, essential to understand two other important concepts: 1) understanding the culture of a patient does not necessarily prevent patient-provider conflict over values, health-related beliefs, or practices, but provides a reference for the non-judgmental reconciliation of differences; and 2) culture is not “homogeneous,” “monolithic,” or “static” (Kagawa-Singer and Kassim-Lakha, 2003):

For example, a case presentation routinely includes a racial designation, such as “a 65-year-old Chinese male presents with chest pain.” What information does “Chinese” convey? This man could have been born in Hong Kong, be a college professor who speaks five languages including English, and lives six months of the year in the United States and six months in Hong Kong. This man could also be a monolingual Chinese gentleman, born in the United States, unmarried, and living alone in Chinatown in New York, with little education and very poor. Lack of accountability for these differences perpetuates stereotypical evaluations and diverts the clinician from accurately assessing the strengths of and potential conflicts with individual patients and their families.

Similar to the above example, it is important to understand that a Chinese, Filipino, or Mexican patient may or may not share the cultural belief that the bad news of a poor prognosis should be given first to the family for it to decide how much, if anything, should be told to the patient; or that a patient who avoids eye contact may do so due to a lack of interest, depression, embarrassment, respect, or to prevent the theft of his soul (Galanti, 2000).

COMMUNICATION MODELS

Different approaches to cross-cultural communication have been developed and used as models for teaching and practicing effective communication skills. The EYECARE (Evaluate, Yield, Explore, Communicate, Acknowledge, Reevaluate, and Execute) model is the only one specifically designed to “give optometric institutions, organizations, and practitioners a template for incorporating cultural competence into their prospective areas of eye care delivery while adhering to the CLAS standards” (Jenkins, 2006). The following models (except the RESPECT and EYECARE models) for effective cross-cultural communication and negotiation were compiled by the Association of American Medical Colleges in its *Cultural Competence Education for Medical Students* (Association of American Medical Colleges, 2005):

Models	Sources
<p><u>BATHE</u> Background (What is going on in your life?) Affect (How do you feel about what is going on?) Trouble (What troubles you most?) Handling (How are you handling that?) Empathy (This must be very difficult for you)</p>	<p>Stuart, MR, Leibermann JR. <i>The Fifteen Minute Hour: Applied Psychotherapy for the Primary Care Physician</i>. New York: Praeger, 1993.</p>
<p><u>BELIEF</u> Beliefs about health (What caused your illness/ problem?) Explanation (Why did it happen at this time?) Learn (Help me to understand your belief/opinion) Impact (How is this illness/problem impacting your life?) Empathy (This must be very difficult for you) Feelings (How are you feeling about it?)</p>	<p>Dobbie AE, Medrano M, Tysinger J, Olney C. The BELIEF instrument: a preclinical teaching tool to elicit patients’ health beliefs. <i>Family Medicine</i> 2003; 35:316-319.</p>
<p><u>Eliciting Patient Information and Negotiating</u> Identify core cross-cultural issues Explore the meaning of the illness Determine the social context Engage in negotiation</p>	<p>Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: a patient-based approach. <i>Ann Intern Med</i> 1999; 130(10):829-834.</p>
<p><u>ESFT model for communication and compliance</u> Explanatory model Social risk for noncompliance Fears and concerns about the medication Therapeutic contracting and playback</p>	<p>Betancourt JR, Carrillo JE, Green AR. Hypertension in multicultural and minority populations: linking communication to compliance. <i>Curr Hypertens Rep</i> 1999; 1(6):482-488.</p>

<p><u>ETHNIC</u> Explanation (How do you explain your illness?) Treatment (What treatment have you tried?) Healers (Have you sought any advice from folk healers?) Negotiate (mutually acceptable options) Intervention (agreed on) Collaboration (with patient, family, and healers)</p>	<p>Levin SJ, Like RC, Gottlieb JE. ETHNIC: A framework for culturally competent ethical practice. <i>Patient Care</i> 2000; 34 (9):188-189.</p>
<p><u>Kleinman’s questions</u> What do you think has caused your problem? Why do you think it started when it did? What do you think your sickness does to you? How severe is your sickness? Will it have a short or long course? What kind of treatment do you think you should receive? What are the most important results you hope to receive from this treatment? What are the chief problems your sickness has caused for you? What do you fear most about your sickness?</p>	<p>Kleinman A, Eisenberg L, Good B. Culture, Illness, and Care: Clinical lessons from anthropologic and cross-cultural research. <i>Annals of Internal Medicine</i> 1978; 88:251-258.</p>
<p><u>LEARN</u> Listen with sympathy and understanding to the patient’s perception of the problem Explain your perceptions of the problem Acknowledge and discuss the differences and similarities Recommend treatment Negotiate treatment</p>	<p>Berlin EA, Fowkes WC. A teaching framework for cross-cultural health care. <i>The Western Journal of Medicine</i> 1983; 139:934-938.</p>
<p><u>Model for Cultural Competency in Health Care</u> Normative cultural values Language issues Folk illnesses Patient/parent beliefs Provider practices</p>	<p>Flores G. Culture and the patient-physician relationship: Achieving cultural competency in health care. <i>J Pediatr</i> 2000; 136:14-23.</p>
<p><u>“Review of Systems” domains of the Social Context</u> Social stressors and support network Change of environment Life control Literacy</p>	<p>Green AR, Betancourt JR, Carrillo JE. Integrating social factors into cross-cultural medical education. <i>Acad Med</i> 2002; 77(3):193-197.</p>

<p><u>RESPECT</u></p> <p>Respect: show respect for the patient verbally and non-verbally</p> <p>Explanatory: elicit the patient’s explanatory model of health</p> <p>Social and Spiritual: elicit the patient’s social and spiritual beliefs that may help the patient cope with his illness or may conflict with medical regimens</p> <p>Power: share the power with the patient</p> <p>Empathy: demonstrate empathy for the patient</p> <p>Concerns: what underlying concerns and fears does the patient have</p> <p>Trust: assess the patient’s level of trust and improve it if needed</p>	<p>Boston Medical Center. RESPECT Model. Diversity Curriculum Task Force, Department of Medicine. Presented at the 2001 Society of General Internal Medicine. Reprinted in Bigby J, ed. <i>Cross-Cultural Medicine</i>. Philadelphia: American College of Physicians-American Society of Internal Medicine, 2003.</p>
<p><u>EYECARE</u></p> <p>Evaluate the beliefs, biases, prejudices, and assumptions of organizations, teaching institutions, professionals, students, and employees</p> <p>Yield to and surrender all preconceived prejudices and biases toward different cultures</p> <p>Explore a cultural group’s health-related beliefs and values to understand their world view</p> <p>Communicate and assess patients’ communication styles to learn about cultural-specific cues that are used</p> <p>Acknowledge and accept that traditional Western medicine and alternative or folk medicine can co-exist</p> <p>Reevaluate and restructure current policies, procedures, vision statements, and mission statements to be more inclusive and respectful of all cultures</p> <p>Execute a proactive, culturally sensitive plan for addressing health care issues in culturally diverse communities</p>	<p>Jenkins LB. Cultural competency and optometric education. <i>Optometric Educ</i> 2006; 31(3):79-83.</p>

SAMPLE SELF-AWARENESS EXERCISES

Self-awareness helps people to understand why they feel what they feel and why they behave as they behave. Every person possesses cultural beliefs and attitudes that influence interpersonal interactions. As people are able to recognize the influence of their personal experiences and cultural backgrounds on their values and beliefs, they become more open to understanding the same process in others who present as being different from them.

Learning objectives

Completion of this self-awareness exercise should enable the student to:

1. Become aware of the similarities and differences among people.

2. Identify what we think of different groups and that prejudices can be experienced due to membership in various groups.
3. Look at stereotypes that we have learned about groups other than the ones to which we belong.
4. Look at less-than-positive feelings that people have about some of the groups to which they belong.
5. Think about different ways people have experienced discrimination and to begin to think about how to end discrimination.
6. Define stereotypes and explain the negative impact they can have.
7. Describe the difference between a stereotype and a generalization.

Exercises

The following exercises provide opportunities for participants to examine their personal perspectives around issues of diversity. Some of the exercises are modeled after those used in the National Coalition Building Institute (NCBI) workshop, “Building Community by Welcoming Diversity,” conducted at The Ohio State University College of Optometry (National Coalition Building Institute, 2008; Fink, 2006).

1. Introductions

The workshop begins with introductions. Participants are asked to stand up (if they are able to) and state their name, their position, and something special about themselves (such as a hobby, favorite fruit, or favorite color). Facilitators then present the two workshop working agreements: 1) participants may share with the whole group information only for themselves (and not for partners from working in pairs); and 2) participants may not repeat outside of the workshop any information that individuals share. Facilitators ask for a show of hands from all participants to demonstrate acceptance of these two agreements.

2. Up/Down Exercise

The first exercise of the workshop is called “Up/Down.” The purpose of this exercise is to demonstrate the similarities and differences among the people in the group. People either stand or raise their hand when the facilitator calls out the name of a group to which they belong. Everyone applauds them. Groups that are mentioned include: birth order (oldest child, middle child, youngest child, only child, twin); place of birth; ethnic/cultural groups (e.g., German, Russian, African or black); religion; economic background (had enough, more than enough, or less than enough when growing up); age (in 10-year increments); and gender. Some fun categories, such as “chocolate-lovers,” might be used, and participants are asked for additional categories. After facilitators go through several groups for each category, they ask, “Which group did I leave out?” Sexual orientation is also used as a category for the up/down exercises; however, it is introduced by mentioning that some people who identify as gay, lesbian, bisexual, or transgender (GLBT) might not want to stand, and that is okay. The facilitators ask for people to stand who have friends, family, or other

people they care about who are GLBT. The up/downs continue with disabilities and private identities, such as alcoholic or victim of sexual abuse.

3. Paired Introductions

This exercise involves working in pairs. Participants introduce themselves to their partners by sharing all the groups to which they belong, such as “I am white, blonde, German-Irish, American, female, heterosexual, Catholic, middle class, middle-aged, married, working mother, associate professor.” The purpose of this exercise is to identify that we think about some of these groups more than others; however, every group is important in thinking about welcoming diversity. Also, prejudices can be experienced because of membership in each of the groups.

4. First Thoughts

The purpose of this exercise is to look at stereotypes that we have learned about groups other than the ones to which we belong. The facilitators draw a picture of a record on the flip charts, and participants are invited to suggest all the influences that make up a person’s record. These include: parents, other relatives; peers; friends; teachers; colleagues; religious leaders; media (movies, newspapers, television, etc.); political leaders and so forth. These records, including prejudices, surface when a person is feeling threatened. It is emphasized that people are more than their records.

Prior to beginning this exercise, there is a discussion about taking risks and making mistakes. Few people really enjoy making mistakes, and many are not very forgiving in allowing others to make mistakes about their groups. In order for the First Thoughts exercise to work, people must be willing to make mistakes about other groups. The facilitators have the participants shout, “I love taking risks. I love making mistakes!” They then have participants shout, “I welcome you to take risks and make mistakes about me and my group!”

Each participant selects a new partner. They choose a group to which neither of them belongs. For example, if both partners are male, they might select the group “female.” The group could be more specific, such as “African-American working mothers.” One partner mentions the name of the group, as well as variations on the name (such as “women,” “females,” “girls,” “chicks,” “ladies,” “mothers,” “wives,” and so forth), varying the tone of voice each time the group name is stated. The other partner says the first uncensored thing that pops into his/her mind. After about 10 variations of this, the partners switch and repeat the exercise. Participants might find themselves censoring their first thoughts, and sometimes their minds might go blank. They might realize that they really don’t know a lot about the group they have selected – or that many of their first thought are stereotypes of that group. After both partners complete the exercise, participants are invited to share their first thoughts with the full group, reminding them to share only for themselves and not for their partners. Participants who are members of the group selected for the first thoughts exercise are then invited to share their feelings on hearing the first thoughts. Participants should not become defensive, feel guilty, or feel uncomfortable with this exercise, and they are reminded that they are more than their records.

5. Internalized Oppression

The purpose of this exercise is to look at less-than-positive feelings that people have about some of the groups to which they belong. This is called internalized oppression, and it can be the result of discrimination and taking stereotypes out against members of our own groups. Participants select a new partner. They select a group to which both of them belong. Using finger pointing, emotion, and body language, participants are invited to express what they cannot stand about that group. For example, “What I can’t stand about you working mothers is that you don’t take care of your children and you aren’t committed to your careers.” Some people find this exercise to be more difficult than the First Thoughts exercise; however, some people find it very easy to come up with things they cannot tolerate about their own groups. Some people are taught never to talk about negative feelings towards their own groups in public. This exercise should teach participants that many of the things we do not like about our own groups are the results of internalization of what people from outside our groups have said about us. It identifies stereotypes and struggles of each group.

6. Caucuses

The purpose of the caucuses exercise is to have participants think about different ways people have experienced discrimination and to begin to think about how to end discrimination. People are invited to think about groups to which they belong that have experienced some form of discrimination. The facilitators record groups on a flip chart. The list of possible caucuses might include: women; Catholics; GLBT; black; single parents; over sixty; short; and so forth. Participants are asked to select a caucus to which they belong, and the number of participants interested in each caucus is recorded to determine the final caucuses.

Participants meet with other members of their caucus. There should be at least two people for each caucus. Facilitators might pair with individuals in order to represent groups or issues that should be addressed at the workshop. Caucuses are provided with a marker and newsprint to record their answers to the following question: “What do you never again want people to say, think, or do toward your group?” After several minutes, each caucus presents its responses to the full group. Following the presentations, there is a full-group discussion about what people learned from the caucuses.

7. Stereotypes

Generalizations are often used to summarize cultural beliefs and practices. This exercise will help participants understand the difference between a stereotype and a generalization. Participants will begin to consider some of their own stereotypes and to recognize the negative impact they can have on clinical care.

- a. Explain that this exercise will focus on stereotypes and the negative effects they can have. Explain that during this exercise participants will be asked to share their responses with others, if they feel comfortable doing so.
- b. Explain the difference between a stereotype and a generalization. Think of a generalization as a starting point. It points to common trends, but more information is needed to determine whether a statement is appropriate to an

individual. A stereotype is an ending point; no attempt is made to learn if an individual fits the statement. Give the following example:

Mexicans have large families. If I meet Rosa, a Mexican woman, and I say to myself, “Rosa is Mexican; she must have a large family,” I am stereotyping her. But if I think, “Mexicans often have large families; I wonder if Rosa does,” I am making a generalization.

- c. Ask participants to write down their own stereotypes, or ones they have heard, about optometrists or other health care professionals in the U.S. After a couple of minutes, ask participants to contribute items from their lists while you chart them in front of the group.
- d. Mention that stereotyping is a natural human tendency – we all label people – but that it can be very harmful. Ask participants for an example of how it can be harmful.
- e. Have participants complete the “Common Ethnic Stereotypes” handout (see below) that was developed from a 1999 survey conducted by the Henry J. Kaiser Family.
- f. After the participants have completed the handout, start the discussion by asking the participants how they felt as they filled out the worksheet. Begin by discussing consumers’ views of what health professional believe. What are participant’s thoughts about the impact of these stereotypes on health care? Continue on to the list of stereotypes held by health professionals. What are the possible effects of these beliefs on health care? Ask participants to consider:

How do stereotypes shape the care that is provided in your work setting?

What can you do to lessen the harmful effects of stereotypes?

- g. End the discussion by briefly summarizing what was learned.

8. Cultural Diversity in Eye Care DVD

The Vision Care Institute, LLC has produced an instructional DVD on *Cultural Diversity in Eye Care* that provides a series of vignettes to highlight “key practice techniques for creating bonds with culturally diverse patients” (The Vision Care Institute, 2007):

As today’s global environment brings more culturally diverse patients into optometry practices, eye doctors and their staff members need to be prepared to serve their wide-ranging needs. Cultural Diversity in Eye Care provides real-life examples of how to interact with various cultural backgrounds from the moment patients enter an office.

The DVD, which was filmed at the Southern Educational Congress of Optometry, discusses methods by which eye care providers can begin to immediately enhance their service capabilities for patients from diverse backgrounds. The DVD helps emphasize how patient-optometrist interactions within optometric practice may be impacted by sociocultural differences (e.g., use of the patient’s first name, patient-

provider eye contact, role of family in clinical decision-making, use of traditional remedies and their potential contraindication to Western medicine, provider assumptions about patient's ability to pay for/afford services, mixed gender interactions, spirituality/religion, appreciation of pain, and perceptions of illness). *Cultural Diversity in Eye Care* is available from the Vision Care Institute, LLC as a practical companion to the *ASCO Guidelines for Culturally Competent Eye and Vision Care*.



The *Cultural Diversity in Eye Care* DVD consists of 14 chapters: 1) Program Introduction; 2) Reception Room Introduction; 3) Reception Room Scene; 4) Reception Room Scene Q&A; 5) African American Introduction; 6) African American Scene; 7) Dr. Derrick Artis; 8) Hispanic American Scene; 9) Dr. Héctor Santiago; 10) Asian American Scene; 11) Dr. Charissa Lee; 12) Muslim American Scene; 13) Dr. Naheed Ahmad; and 14) Panel Q&A. To supplement the video presentations, slide presentations are provided for each of the four racial, ethnic, and religious groups presented in the DVD: 1) African Americans; 2) Hispanic Americans; 3) Asian Americans; and 4) Muslim Americans. Ask the participants to view the DVD a chapter at a time. After watching a given chapter, ask participants to discuss the significant issues presented in the vignette. The slide presentations can be used to facilitate the discussion. Follow-up the vignette discussions with a participant discussion of what effect might the vignettes have on their future interactions with patients from diverse cultural backgrounds. The participants should analyze how they might have responded to the same or similar situations before and after watching the DVD. They should identify other clinically-related situations where cultural differences between the patient and the optometrist might adversely affect the patient/optometrist encounter and negatively impact quality of care.

A caution to using the DVD is not to memorize the vignettes as a composite of “facts” to pigeonhole patients into cultural categories based on stereotypical descriptions. Such a macro classification fails to consider aspects of acculturation and inter-group variability, and this superficial misunderstanding of cultural dynamics could produce the contrary or negative effect of perpetuating inappropriate cultural profiles, stereotypical attitudes, and less than optimal clinical outcomes (Betancourt et al., 2003; Taylor, 2003).

9. *A Physician's Practical Guide to Culturally Competent Care Web Site*

The Office Minority Health of the U.S. Department of Health and Human Services sponsors a Web-based series of curriculum models to promote cultural competency in health care (U.S. Department of Health and Human Services, 2008b). The interactive *Think Cultural Health: Bridging the Health Care Gap through Cultural Competency Continuing Education Programs* Web site (<http://www.thinkculturalhealth.org/>) uses case studies and provider feedback in curricula that focuses on awareness,

knowledge, and skills with information about cultural, language, and organizational issues. The free online programs include *A Physician’s Practical Guide to Culturally Competent Care*, *Culturally Competent Nursing Care: A Cornerstone of Caring*, and the *Health Care Language Services Implementation Guide*. The programs are accredited and offer continuing education credits are for physicians, physician assistants, nurse practitioners, nurses, and pharmacists.

COMMON ETHNIC STEREOTYPES

Cultural stereotypes sometimes are used as practitioner “shorthand” for the clinical and non-clinical assessment of patients. Below is a list of stereotypes that minority health care consumers believe that health care professionals hold. Have you heard patients described in this way? What might be the outcome for care if health care professionals believe these descriptions?

Stereotype	Potential Impact on Care
1. African Americans, Native Americans and some Hispanics (especially young males) are not able to pay for services.	
2. African Americans over-utilize the ER.	
3. All young African American mothers are unmarried.	
4. Asians are compliant, deferential, and non assertive.	
5. Native Americans are more likely to be drunk than ill.	

Below is a list of stereotypes that some health care professionals hold. Have you heard patients described in this way? What might be the outcome for care if health care professionals believe these descriptions?

Stereotype	Potential Impact on Care
1. Asians won’t discuss symptoms or complain.	
2. Obtaining medical history information from immigrants is impossible.	
3. Native Americans don’t show emotion.	
4. Asians won’t complete prescription drug regimens.	
5. Hispanics and African Americans won’t lose weight or eat healthy diets.	

STUDENT ASSESSMENT FOR SELF-AWARENESS

As an optometrist who will care for many different people, knowledge of yourself is very important. Please rate your degree of confidence or certainty for each of the following items, with “1” indicating no confidence and “5” indicating complete confidence.

A. About yourself, are you aware of:

- | | |
|---|-----------|
| 1. Your own cultural heritage and belief systems? | 1 2 3 4 5 |
| 2. Your own biases and limitations? | 1 2 3 4 5 |
| 3. Differences within your own cultural group? | 1 2 3 4 5 |

B. Among patients of different cultural backgrounds, Are you aware of:

- | | |
|--|-----------|
| 1. Insensitive and prejudicial treatment? | 1 2 3 4 5 |
| 2. Differences in perceived role of the optometrist? | 1 2 3 4 5 |
| 3. Traditional caring behaviors? | 1 2 3 4 5 |
| 4. Professional caring behaviors? | 1 2 3 4 5 |

C. You accept:

- | | |
|--|-----------|
| 1. Differences between cultural groups. | 1 2 3 4 5 |
| 2. Similarities between cultural groups. | 1 2 3 4 5 |
| 3. Patient’s refusal of treatments based on beliefs. | 1 2 3 4 5 |

D. You appreciate:

- | | |
|---|-----------|
| 1. Interaction with people of different cultures. | 1 2 3 4 5 |
| 2. Cultural sensitivity and awareness. | 1 2 3 4 5 |
| 3. Culture-specific optometric care. | 1 2 3 4 5 |
| 4. Patient’s worldview (philosophy of life). | 1 2 3 4 5 |

E. You recognize:

- | | |
|---|-----------|
| 1. Inadequacies in the U.S. health care system. | 1 2 3 4 5 |
| 2. Importance of home remedies and folk medicine. | 1 2 3 4 5 |
| 3. Impact of roles on health care practices. | 1 2 3 4 5 |

PROGRAM ASSESSMENT

If cultural competence is considered to be a body of knowledge and a set of skills critical to the ability of health care professionals to effectively provide quality health care to a diverse patient population, then assessment of the degree to which students actually acquire and apply the information, as with any other set of competencies, is important.

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For the cultural competence education and training program to be effective, it must be assessed at every phase and within every domain of optometric education. The California Endowment identified a series of standards for assessing the level of understanding and mastery of cultural competence attitudes, knowledge, and skills and acquired as a result of cultural competence education and training (The California Endowment, 2003):

- Evaluation should rely on a variety of qualitative and quantitative techniques (e.g., written examination, self-assessment, and evaluation of the application of attitudes, knowledge, and skills in actual practice).
- Demonstration of knowledge, processes, and skills can occur through role play, case study analysis, or observed interactions with diverse patients followed by self, peer, patient, staff, or professor feedback and evaluation.
- Opportunities should be available for student self-assessment of cultural competence knowledge and skills at various points along the educational trajectory.
- Evaluation of effectiveness and usefulness of cultural competence training by students, faculty, administrators, and patients should help improve effectiveness in developing the desired attitudes, knowledge, and skills in health care professionals.
- Efforts to test competencies in the application of cultural competence and its effect in producing increased patient satisfaction with clinical encounters and improved health status are desirable, but may not be possible within an education and training context.

Betancourt formulated the following model for assessing attitudes, knowledge, and skills using various qualitative and quantitative strategies (Association of American Medical Colleges, 2005; Betancourt, 2003):

Educational Approach Focusing On:	Evaluation Strategy
<p>ATTITUDES</p> <p>Examples:</p> <p>Has the student learned the particular importance of curiosity, empathy, and respect in cross-cultural encounters?</p> <p>Does the student exhibit these attitudes, as corroborated by evaluation?</p>	<p>Standard Surveying</p> <p>Structured Interviewing</p> <p>Self-Awareness Assessment</p> <p>Presentation of Clinical Cases</p> <p>Objective Structured Clinical Exam</p> <p>Videotaped/Audio-taped Clinical Encounter</p>
<p>KNOWLEDGE</p> <p>Examples:</p> <p>Has the student learned the key core cross-cultural issues, such as the styles of communication, mistrust/prejudice, autonomy vs. family decision-making, the role of biomedicine for the patient, traditions and customs relevant to health care, and sexual/gender issues?</p> <p>Does the student make an assessment of the key core cross-cultural issues, as corroborated by evaluation?</p>	<p>Pretest/Post-tests (multiple choice, true-false, and so on)</p> <p>Unknown Clinical Cases</p> <p>Presentation of Clinical Cases</p> <p>Objective Structured Clinical Exams (OSCEs)</p>
<p>SKILLS</p> <p>Examples:</p> <p>Has the student learned how to explore core cross-cultural issues and the explanatory model? Has the student learned how to effectively negotiate with a patient?</p> <p>Does the student explore the explanatory model and negotiate with a patient, as corroborated by evaluation?</p>	<p>Presentation of Clinical Cases</p> <p>Objective Structured Clinical Exam</p> <p>Videotaped/Audio-taped Clinical Encounter</p>

CONCLUSION

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.

Optometry 2020 Preferred Futures
American Optometric Association, 2007

Culture affects the way individuals respond to words, actions, and interactions between the patient and health care provider. Optometrists can not afford to underestimate the impact of culture on the quality of the patient-optometrist experience.

The Optometry 2020 Summits, convened by the American Optometric Association, identified 57 “Preferred Futures” as significant to the future of the optometric profession (American Optometric Association, 2007). Preferred Future 3 of Section I (Eye Care Patient/Consumer) concerned the need for culturally competent optometrists, calling for optometrists and their staff to have the attitudes, knowledge, and skills to serve patients of different ethnicities, native languages, age, gender, religions, and cultural backgrounds so that all patients receive culturally competent care by their optometrist and the optometrist’s staff. Preferred Future I-3 also calls for optometrists and their staff to be linguistically competent by providing care in multiple languages and/or providing interpretation services. In discussing the challenges that optometry will face in the future, representatives of over 20 organizations appropriately and legitimately recognized the importance of a culturally and linguistically competent optometric workforce. The task ahead is to ensure that the profession is prepared and properly positioned to address its future challenges.

The schools and colleges of optometry have the responsibility of preparing the future optometric workforce. In addition to preparing clinically competent optometrists, the schools and colleges also must prepare culturally competent optometrists with the requisite attitudes, knowledge, and skills to address the challenges presented by our global society. Cultural competence is both a quality of education and a quality of care imperative for the schools and colleges of optometry.

The Cultural Competence Guidelines Work Group of the Association of Schools and Colleges of Optometry (ASCO) Diversity Task Force, using the current literature and prevailing practices within the health professions, developed the *ASCO Guidelines for Culturally Competent Eye and Vision Care*. Although Betancourt et al. have identified three broad categories of cultural competence intervention – organizational cultural competence (e.g., diverse health care leadership and workforce), structural/systemic cultural competence (e.g., language barriers, health system design), and clinical cultural competence (e.g., cross-cultural curricula, education and training) – the ASCO guidelines relate primarily to the clinical cultural competence intervention with emphasis on interpersonal communication and awareness of the existence of cultural issues and health beliefs in all cultures (Betancourt, 2006; Betancourt et al., 2003; Betancourt et al., 2002).

The ASCO guidelines have been developed to assist the schools and colleges of optometry in promoting a culturally competent system of health care through the preparation of optometric clinicians who will be culturally competent and clinically ready to address the vision and eye care needs of a multicultural and global community.

A “culturally competent” health care system has been defined as one that acknowledges and incorporates – at all levels – the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs. A culturally competent system is also built on an awareness of the integration and interaction of health beliefs and behaviors, disease prevalence and incidence, and treatment outcomes for different patient populations.

(Betancourt et al., 2003)

The Diversity Task Force hopes 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.

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