Education Grand Rounds

University of Oklahoma Health Sciences Center

Connecting Cultural Competence Education to Outcomes: "We Make the Road by Walking"*

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Cell phones and pagers should be turned to silent or off. Thank you!

*Horton M, Freire P, Gaventa J. We Make the Road by Walking: Conversations on Education and Social Change. Temple University Press; Reprint edition, August 1991

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Organizing Thoughts for Educators

1. Consider practical aspects & challenges to implementing and evaluating cultural competency curriculum.
2. Determine authentic educational and assessment strategies…"best practices?"
3. Discuss what *is* meaningful assessment.
4. Identify meaningful assessments strategies for implementation within curriculum.

Question

What are the most appropriate benchmark metrics and assessment methods for connecting cultural competence education to outcomes within nursing, pharmacy, allied health, dentistry, medicine, physician assistant and public health disciplines?

Fundamental Assumptions

- Each of us has our own set of cultural lenses & biases that frames how we view our world.
- "Our similarities have never caused us serious problems." (Donna Stringer)
- There are ethical & legal considerations underlying education for cultural sensitivity/ humility – those will not be addressed.

Why is Cultural Competency Important?

Goal for Health Professions Education

Help learners acquire the A, K, S necessary (and gives them the confidence) to effectively care for diverse patients and patients from vulnerable groups (age, gender, sexual identity, religion, ability, SES, race, ethnicity).

"Cultural competence also focuses its attention on population-specific issues including:

- health-related beliefs and cultural values (the socioeconomic perspective),
- disease prevalence (the epidemiological perspective),
- and treatment efficacy (the outcome perspective)."

http://erc.msh.org/mainpage.cfm?file=2.1.htm&module=provider&language=English

Results of Medical Ethnocentrism

- Poor patient communication
  - Patient refusal to communicate beliefs and behaviors for fear of a negative reaction.
  - Significant information for patient care may not be obtained.
  - Providers use own beliefs/cultural lens (bias) that may be incorrect.

IMPACT?

Poor communication = Poor patient care outcomes/health inequities/ disparities

Legal Landmarks

- Federal and State Law
  - Title VI of the Civil Right Act of 1964
  - CLAS Standards (2000) (Enhanced Standards announced April 24, 2013)
  - CME required in 6 states; 5 pending

Accreditation Standards

- LCME
  - Curricular content (ED-21, ED 22)
  - Faculty/student diversity (IS-16)
  - Diversity among qualified applicants (MS-8)
- ACGME Milestones
  - PROF-3 Demonstrates humanism and cultural proficiency
  - SBP-3 Advocates for individual and community health
  - C-1 Develops meaningful, therapeutic relationships with patients and families
  - C -2 Communicates effectively with patients, families, and the public

Accreditation Standards

- 4th Edition of ARC-PA
  - B1.06 – The curriculum must include instruction to prepare students to provide medical care to patients from diverse population.

Accreditation Standards

Baccalaureate nursing education – 5 Competencies:

1. Apply knowledge of social and cultural factors that affect nursing and health care across multiple contexts.
2. Use relevant data sources and best evidence in providing culturally competent care.
3. Promote achievement of safe and quality outcomes of care for diverse populations.
4. Advocate for social justice, including commitment to the health of vulnerable populations and the elimination of health disparities.
5. Participates in continuous cultural competence development.

Good Business

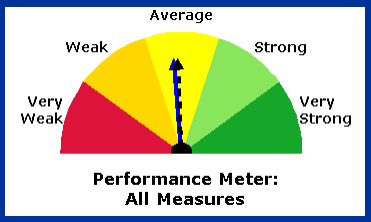
- Business Imperative – "enhancing quality of care, expanding markets, maximizing retention rates, customizing care & containing costs…" (Kaiser Permamente)

Reporting of Evidence - examples

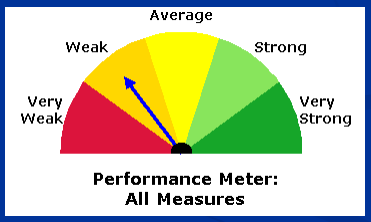
- IOM Report – Unequal Treatment: Confronting Racial and Ethnic Disparities (2003)
- National Healthcare Disparities Report (AHRQ, 2010)
- Link between interpretive services and medical errors
  - Flores G, et al. Errors in medical interpretation and their potential clinical consequences. Pediatrics 2003; 111:6-14.
  - Gany F et al. The impact of medical interpretation method on time and errors. J Gen Intern Med 2007; 22 (S2): 319-323.

AHRQ Dashboard on Health Care Quality
Compared to All States
Overall Health Care Quality

North Carolina



Oklahoma



http://statesnapshots.ahrq.gov/snaps10/map.jsp?menuId=2&state=

It's a human right!

It's the right thing to do.

Practical Concerns

Practical Aspects & Challenges

1. Do you integrate the content into existing curricular activities or develop a stand-alone experience for students?
2. Who needs to be engaged in the planning process?
3. What level of cultural competency (sensitivity, humility) are desired? What theory will you use?

Practical Aspects & Challenges

4. What type of learning experiences are needed (Attitudes, Knowledge, Skills)?
5. What kind of resources will you need for these learning experiences?
6. What type of assessment of students' learning should be designed and implemented?

Cultural Competence:

Theoretical Considerations?

Cultural Attitudes

- Humility
- Empathy
- Curiosity
- Awareness of and consideration for outside influences on patients
- Respect
- Sensitivity
- Beliefs

*Betancourt JR. Cross-cultural medical education: conceptual approaches and frameworks for evaluation. *Acad Med.* Jun 2003;78(6):560-569.

Cultural Knowledge (Knows/Knows How)

- Effective Communication Skills that elicit the patient's
  - Perspective (PPI)
  - Health Beliefs
  - Health Literacy
- Mechanistic/Diagnostic Reasoning – including relevant psychosocial mechanisms

Cultural Skill (Shows)

- Elicit patients' explanatory models [PPI]& agendas (effective communication skills)
- Identify & negotiate communication styles
- Assess decision-making preferences (role of family)
- Determine perception of biomedicine and Integrative Medicine (health beliefs, health literacy)
- Recognize gender issues

(Betancourt JR., 2003)

Developmental Phases of Cultural Competency

(Theoretical Models) - Howell's 5 Levels

1. Unconscious Incompetence
2. Conscious Incompetence
3. Conscious Competence
4. Unconscious Competence
5. Unconscious Supercompetence

Howell WS. The empathic communicator. Bellmont, CA: Wadsworth, Inc; 1982.

Bennett's 6 stages

1. Denial
2. Defense
3. Minimization
4. Acceptance
5. Adaptation
6. Integration

Bennett MJ. Towards ethnorelativism: a developmental model of intercultural sensitivity. In: Paige RM, ed. Education for the intercultural experience. 2nd ed. Yarmouth, ME: Intercultural Press; 1993:21-71.

Culhane-Pera's adaptation of Bennett

1. No insight about the influence of culture on medical care
2. Minimal emphasis on culture in medical setting
3. Acceptance of the role of cultural beliefs, values, & behaviors on health, disease, and treatment
4. Incorporation of cultural awareness into daily practice
5. Integration of attention to culture into all areas of professional life

Culhane-Pera KA, et al. A curriculum for multicultural education in family medicine. Fam Med. 1997;29(10):719-723.

Cross Model of Cultural Competence (Terry Cross, 1988)

1. Cultural Destructiveness
2. Cultural Incapacity
3. Cultural Blindness
4. Cultural Pre-Competence
5. Basic Cultural Competence
6. Advanced Cultural Competence/Cultural Proficiency

Howell (1982)	Bennett (1993)	Culhane-Pera (1997)	Cross (1988)
Unconscious Incompetence	Denial	No insight about the influence of culture on medical care	Cultural Destructiveness
Conscious Incompetence	Defense/Minimization	Minimal emphasis on culture in medical setting	Cultural Incapacity/Cultural Blindness
Conscious Competence	Acceptance	Acceptance of the role of cultural beliefs, values, & behaviors on health, disease, and treatment	Cultural Pre-Competence
Unconscious Competence	Adaptation	Incorporation of cultural awareness into daily practice	Basic Cultural Competence
Unconscious Super-competence	Integration	Integration of attention to culture into all areas of professional life	Cultural Proficiency

Educational Methods and Outcomes Assessment

ASK: Educational Strategies

- Lecture/Discussion
- Interprofessional sessions (medicine/health care industry as culture)
- Self-assessment (Implicit Association Tests)
- Spirituality components w/in courses
- Required pre-reading w/small group discussion
- Story Telling – Use of Student, Patient Narratives
- Diversity training and other skill development workshops
- Essay on students' cultural backgrounds
- Simulations/Role Plays
- Reflective journals (Narrative)
- Standardized Patient Assessments (Formative)
- Panel discussions
- PBL cases (other Inquiry-Based Learning Models)
- In-depth interviews with clients
- Self-directed learning projects
- Movie nights/Readers' Theater: Pizza and a Play/Ethnic Food Lunches
- Patient Assignment (Home and Clinic Visits)
- Field Trips

Outcomes Assessment

- Pre/Post Attitude Surveys
- Reflective journals
- SP Assessment
- Panel discussions
- PBL cases
- In-depth interviews with clients
- 360 Assessment
- MCQs/exams
- Self-directed learning projects
- Clinical performance exams
- Patient Satisfaction
- Home Visits Documentation
- Portfolios

Outcomes Assessment

- Attitudes
  - surveys, self-assessments (IATs), videotapes, write-up of encounters with patients (narrative), journals, case discussions, patient advocate
- Knowledge
  - pretest-posttest, videotaped encounters with patients, patient write-ups, PBL case discussions
- Skills
  - videotapes encounters with patients/interpreters, SDL projects, OSCEs, SP Assessment/Clinical Performance Exams

What's Meaningful Evidence?

Meaningful Evidence?

- TACCT—curriculum mapping tool
  - https://www.aamc.org/initiatives/tacct/
- Graduation questionnaires
- Outcomes of Simulations (OSCE, SPA, CPX)
- Patient satisfaction
- Changes in institutional systems (PCMHs)
- Changes in National/State Policies
- Health Outcomes

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