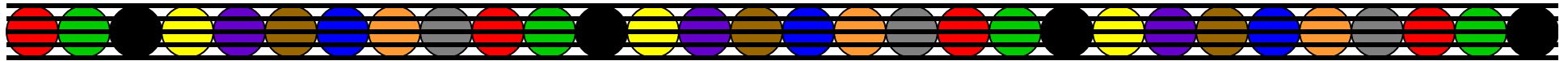# ASCO GUIDELINES FOR CULTURALLY COMPETENT EYE AND VISION CARE
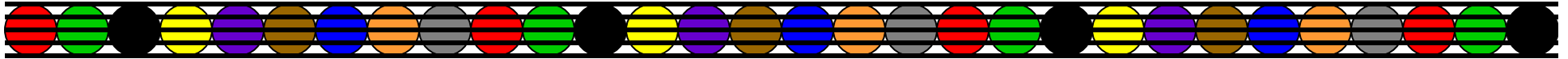
AN ADAPTATION OF BEST PRACTICES FROM THE SCHOOLS, COLLEGES, ORGANIZATIONS, AND ASSOCIATIONS OF THE HEALTH PROFESSIONS

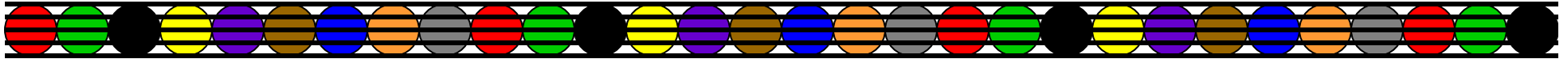# ASCO GUIDELINES FOR CULTURALLY COMPETENT EYE AND VISION CARE

- Introduction
- Rationale
- Vision
- Definitions
- Guiding Principles

- Curricular Philosophy
- Curricular Integration
- Training Methods
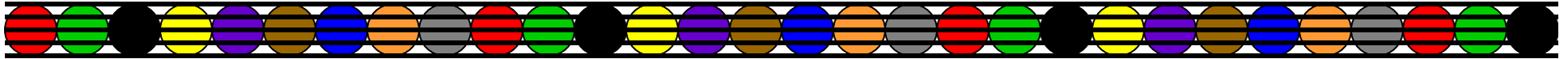- Program Assessment
- Conclusion

Introduction

- 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.
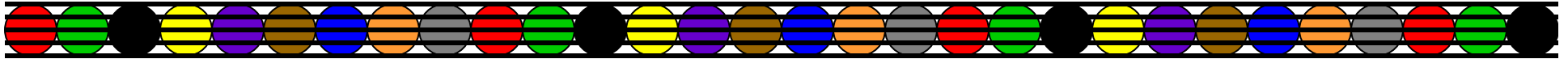
Introduction

- Purpose of the Guidelines:
  - determine institutional objectives for developing culturally competent optometric care
  - identify points of curricular intervention
  - assess the performance and outcomes of interventions

Introduction

- Reasons to Incorporate Cultural Competence into Organizational Policy (Georgetown University, 2000)
  - respond to demographic changes in U.S.
  - eliminate health disparities
  - improve quality of services and health outcomes
  - meet legislative, regulatory, and accreditation mandates
  - gain competitive edge in the market place
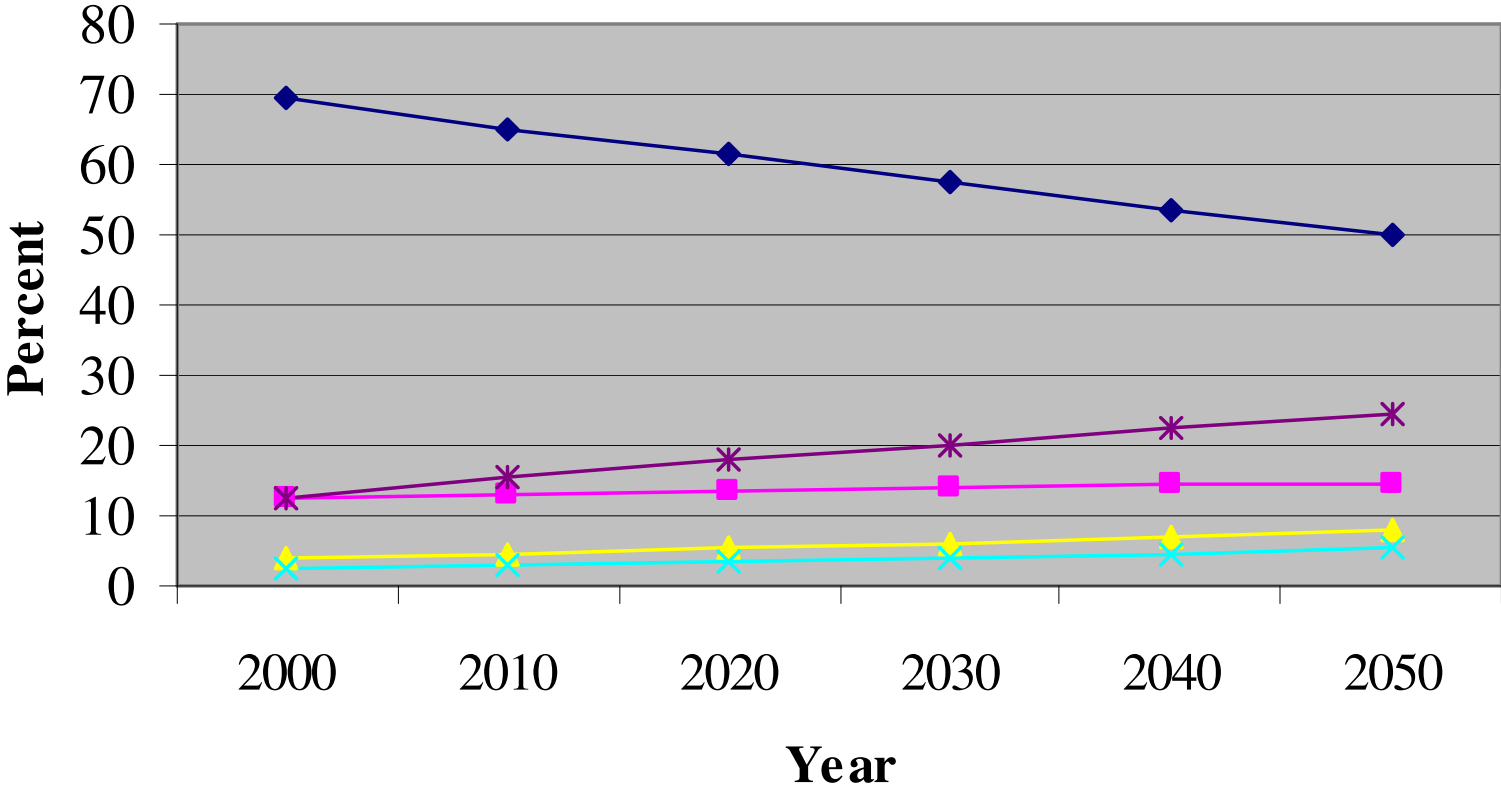 - decrease likelihood of liability/malpractice claims

Introduction

- Demographic Changes in U.S.
  - increasing geographic, economic, religious, racial, ethnic, cultural, and linguistic diversity
  - 311 languages other than English in 14 million U.S. households
  - 1 in 3 U.S. residents is a minority
  - 1 in 10 counties >50% minority
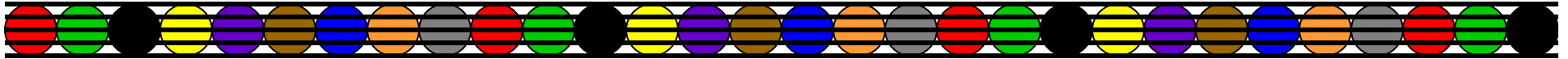
Percent Population by Race and Hispanic Origin

Legend: ◆ White ■ Black ▲ Asian ✕ Other ✳ Hispanic

Y-axis: Percent (0, 10, 20, 30, 40, 50, 60, 70, 80)

X-axis: Year (2000, 2010, 2020, 2030, 2040, 2050)
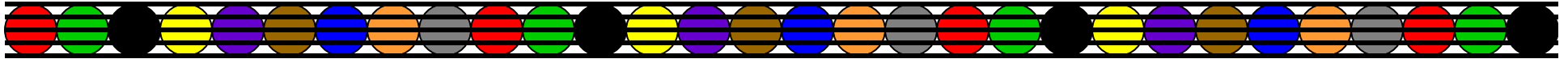
Source: U.S. Census Bureau, 2004

Introduction

- Diversity in the health professions contributes to:
  - patient-provider concordance
  - patient-provider communication and trust
  - access to health care
  - use of health care services
  - quality of health care
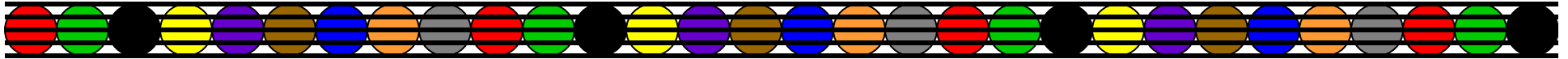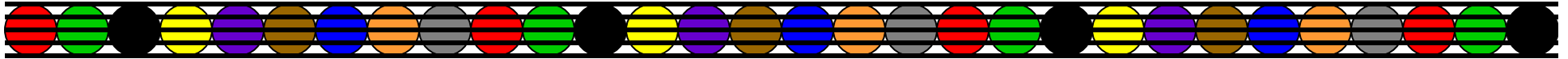 - improved health outcomes

Introduction

- Institute of Medicine's Six Principles of Health Care Quality (2001)
  - safety
  - effectiveness
  - patient-centeredness

    "providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions"
  - timeliness
  - efficiency
  - equity

    "providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status"

Rationale

- 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.
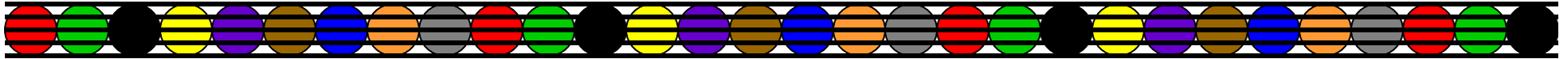
Rationale

- Improved Quality of Care with Cultural Competence
  - obtain necessary information
  - make timely and appropriate diagnoses
  - develop treatment plans that are followed by the patient and supported by family members
  - reduce delays in seeking care
  - make appropriate use of health care services
  - enhance communication and positive interaction between patients and providers
  - foster compatibility between biomedical and cultural health practices

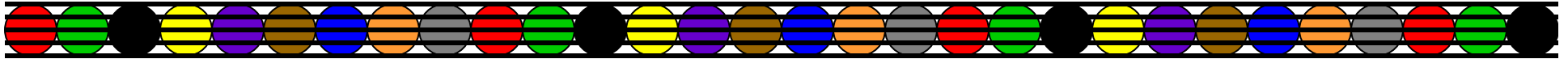# Why Optometrists Need Education and Training in Cultural Competence

- Quality of care/clinical outcomes
  - Patient-centered care/patient compliance
  - Healthy People 2010/elimination of health care disparities
- Practice management
  - Demographic changes
  - Market share/competitive edge
  - Patient satisfaction
  - Performance-based reimbursement
  - Licensing/certification requirements
  - Risk management/malpractice/informed consent
- Benchmarking
  - Accreditation standards for other health professions

Rationale

- Cultural Competence Helps Health Care Providers
  - Challenge their assumptions
  - Understand how cultural variations influence
    - recognition of symptoms
    - thresholds for seeking care
    - ability to communicate symptoms
    - ability to understand management strategy
    - expectations of care
    - adherence to preventive measures
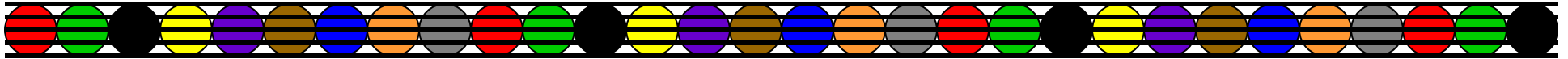 - Prevent racial/cultural stereotyping

Rationale

- **Cultural Competence**
  - Clearer channels of communication
  - More positive patient/provider
  - interaction
  - Greater patient/family investment in
  - care plan
  - More timely and appropriate care
  - Reconciliation of Western biomedical
  - and traditional cultural health practices
  - Less provider uncertainty and greater
  - familiarity with sociocultural
  - determinants of health
  - Improved patient compliance

- **Cultural Incompetence**
  - Higher possibility for patient/provider
  - misunderstanding/miscommunication
  - Greater opportunity for patient/provider
  - discordance
  - Greater likelihood of patient distrust,
  - dissatisfaction, and reduced compliance
  - Less likelihood of awareness and
  - appreciation of the cultural influence on
  - health and illness
  - Greater likelihood of provider
  - uncertainty and cultural stereotyping
  - Less probability for positively
  - impacting health disparities

Rationale

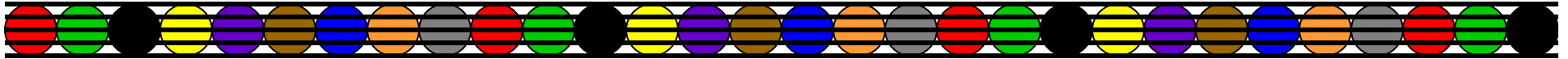Biomedical and Sociocultural Constructs of Perceived Illness

Biomedical Etiologies

Physical trauma/fracture

Bacterial/viral/fungal infection

Genetics

Cancer

Elevated blood pressure/blood sugar

Congenital defect

Sociocultural Etiologies

Evil spirits/bewitching/aire

Spiritual imbalance

Loss of soul/susto/mal de ojo

God's will

Cold (bad air)

Punishment

Rationale

Biomedical and Sociocultural Constructs of Treatment
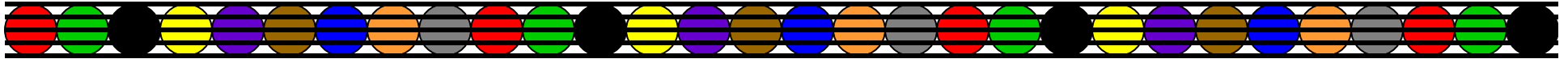
Biomedical Interventions

Drug therapy

Psychotherapy

Physical therapy

Surgery

Sociocultural Interventions

Prayer/meditation

Acupuncture

Herbal therapy

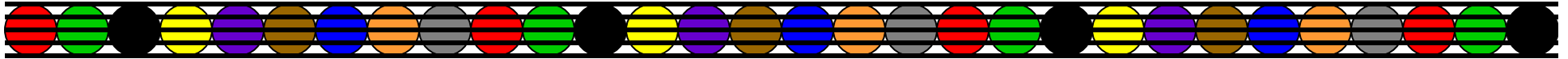Coining

Rationale

- Why learn about the impact of culture in health and health care delivery? (Tervalon, 2003)
    - ever-changing demographic patterns in the U.S.
    - negative health outcomes when culture is dismissed
    - use of complementary and alternative medicine by large numbers of patients
    - reduction of racial and ethnic differentials in health outcomes
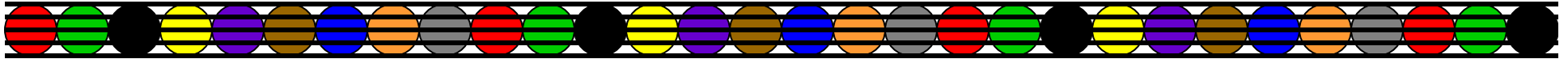   - mandates require application of culture in health care

Rationale
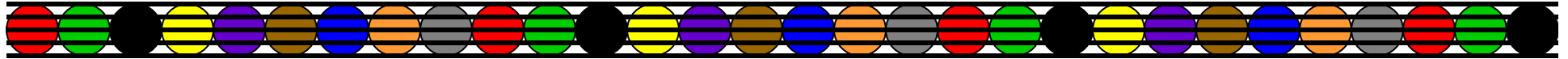
- Cultural Competence in Medical Education (Betancourt, 2003)
  - critical to preparing providers to meet the health need of growing diverse populations
  - improves provider-patient communication and eliminate racial-ethnic disparities in medical care
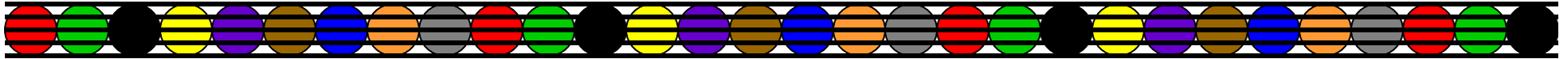 - cross-cultural curricula required by accreditation bodies

Rationale

- Cultural Competency Requirements in Medicine (Association of American Medical colleges, 2005)
  - "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."
  - "Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery."

Rationale

- Cultural Competency in Medical Resident Training (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.
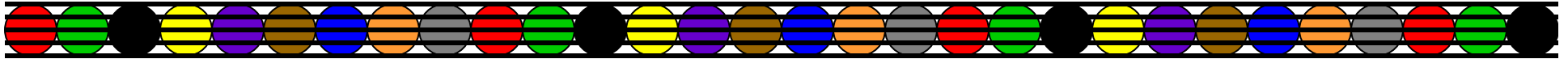
Rationale

- Cultural Competency in Pharmacy

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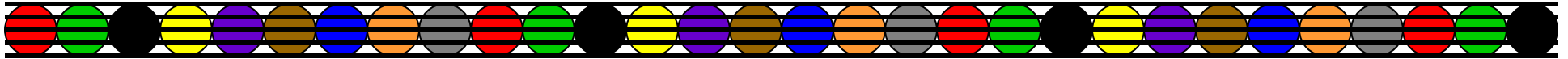
Rationale

- State Cultural Competency Legislative Activity

  Think Cultural Health: Bridging the Health Care Gap through Cultural Competency Continuing Education Programs
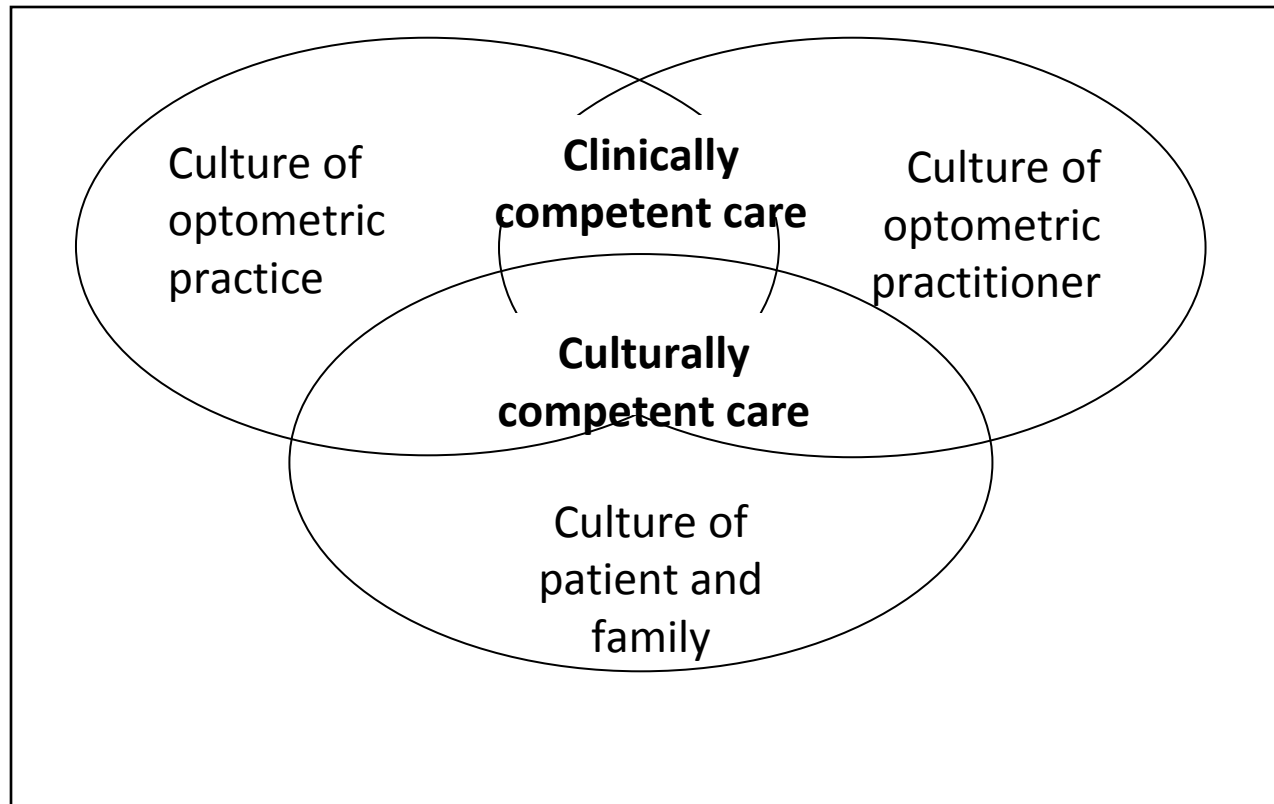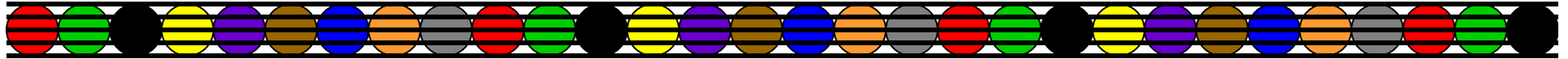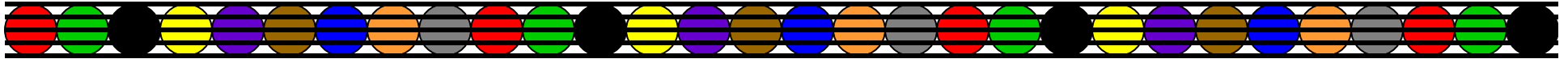
  http://www.thinkculturalhealth.org

Rationale

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

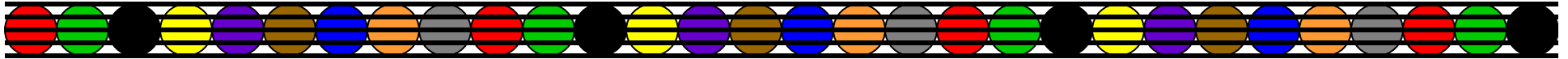# A Confluence of Cultures: Clinically Competent and Culturally Competent Care

Culture of optometric practice

Clinically competent care

Culture of optometric practitioner

Culturally competent care
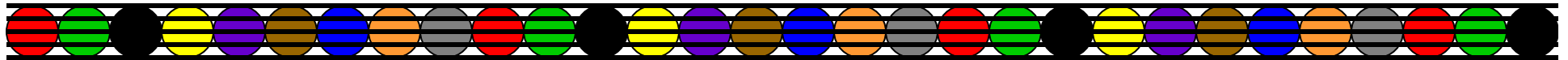
Culture of patient and family

Rationale

- ## Linguistic Competence
  - National Standards on Culturally and Linguistically Appropriate Services (CLAS) developed by the Office of Minority Health.
  - Most are guidelines recommended by OMH for adoption by federal and state accrediting agencies.

Rationale

- ## Linguistic Competence
  - ### 14 CLAS standards
    - Culturally Competent Care (Standards 1-3)
    - Language Access Services (Standards 4-7)
    - These are mandates, federal requirements for all recipients of federal funds.
    - Organizational Supports for Cultural Competence (Standards 8-14)

CLAS Standards 1-3

| 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.	

CLAS Standards 4-7
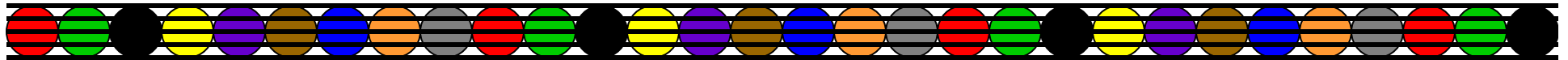
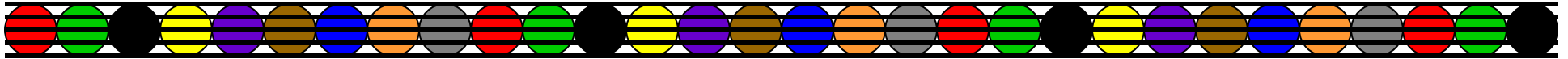|	
4	Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5	Health care organizations 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.

CLAS Standards 8-11

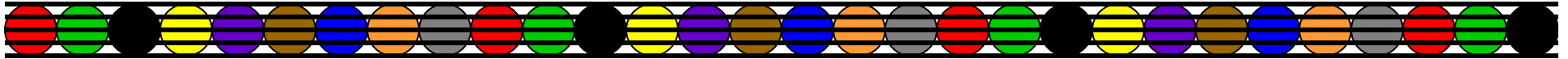|	
8	Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9	Health care organizations should conduct 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.

CLAS Standards 12-14
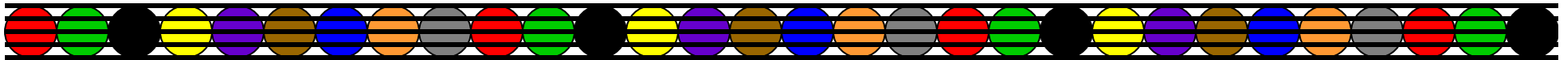
12	Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13	Health care organizations should 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.

Effects of Cultural Competence Training on Health Care Providers

| Attitudes	- 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

Effects of Cultural Competence Training on Health Care Providers

Knowledge	• Impact of culture on patient-provider encounter • How provider ignorance adversely impacts patients • Knowledge of disease burdens across populations • Knowledge of traditional cultural practices

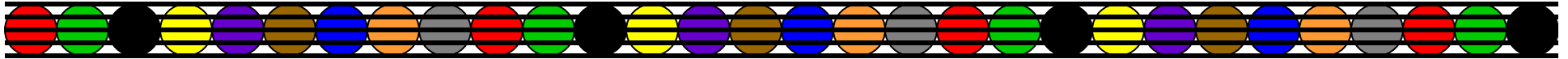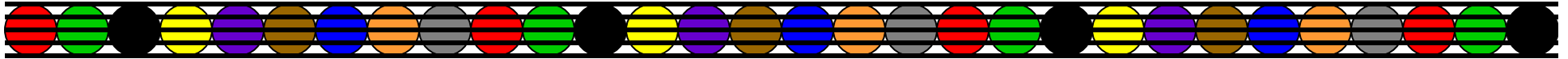# Effects of Cultural Competence Training on Health Care Providers
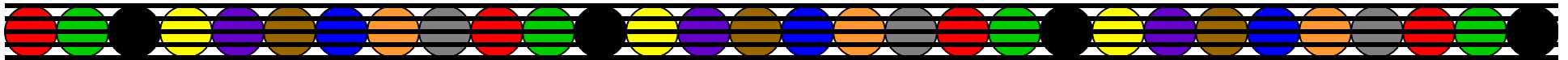
| Skills	- Communication - Interviewing non-English-speaking patients - Community-based education - Social interactions with peers of different races and ethnicities - Enhanced ability to conduct behavioral analyses and treatment plans

Vision

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

Vision

- Mission
  - 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.

Definitions of Culture
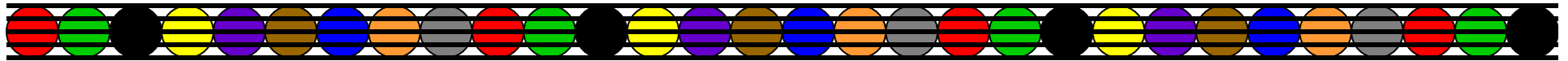# and Cultural Competence
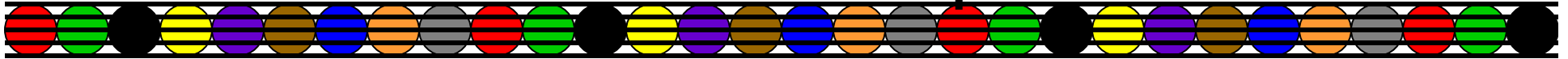
- Culture
  - Culture is a set of learned and shared beliefs and values that are applied to social interactions and to the interpretation of experiences (Mutha et al., 2002).
  - Culture includes: race, ethnicity, socioeconomic status, religion, gender, age, nationality, sexual orientation, education, language, occupation, and disability (Betancourt, 2003).
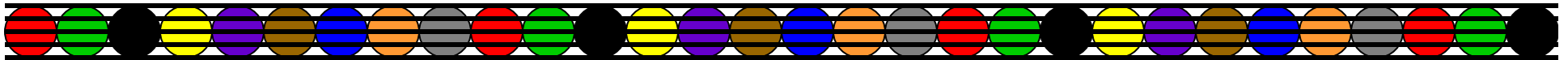
Definitions of Cultural Competence
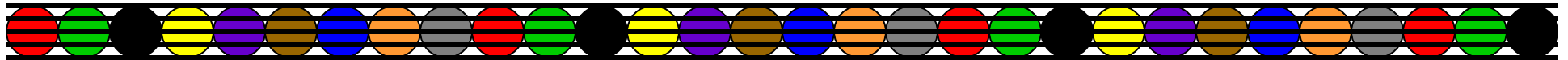
- Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals that enables that system, agency, or those professionals to work effectively in cross-cultural situations. Culture implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Competence implies having the capacity to function in a particular way: the capacity to function within the context of culturally-integrated patterns of human behavior as defined by the group (Cross, Bazron, Dennis and Issacs,1989).
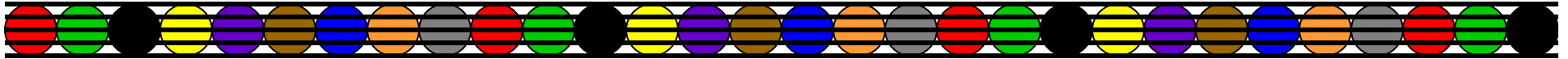
Definitions of Cultural Competence

- ## Cultural Competence in Health Care
  - Cultural competence is a set of skills, knowledge and attitudes, which enhance a clinician's 1) understanding of and respect for patients' values, beliefs and expectations; 2) awareness of one's own assumptions and value system in addition to those of the U.S. medical system; and 3) ability to adapt care to be congruent with the patient's expectations and preference (Mutha et al., 2002).

Definitions of Cultural Competence

- ## Cultural Competence in Health Care
  - The nexus of practice patterns and attributes—the attitudes, knowledge, and skills necessary for providing quality care to a diverse population (The California Endowment, 2003).
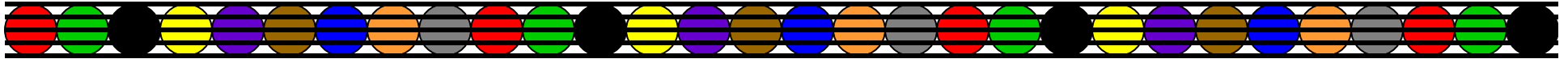
Definitions of Cultural Competence

- ## Cultural Competence in 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).
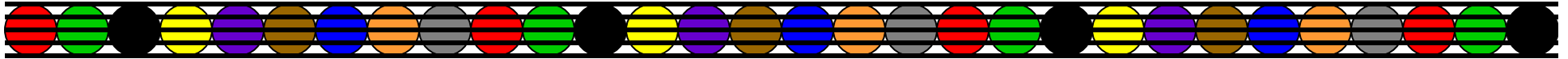
Definitions of Cultural Competence

- ## Cultural Competence in Health Care
  - Being respectful and responsive to patient preferences, needs, and values and providing care of equal quality irrespective of patient characteristics are benchmarks of culturally competent health care.
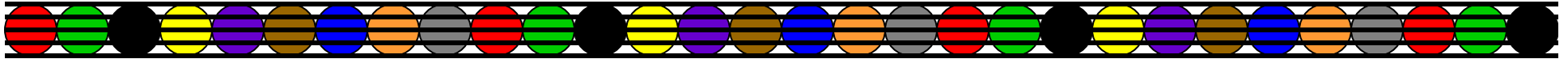
Guiding Principles

- ASCO has embraced the guiding principles for development of standards adopted by the California Endowment.
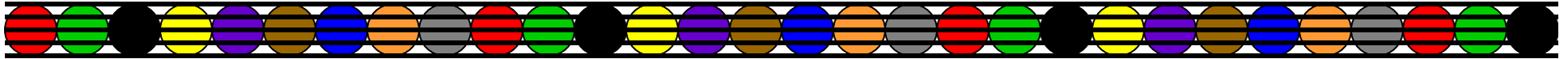
Guiding Principles

- The guiding principles help structure:
    - what should be taught
    - when it should be taught
    - how it should be taught
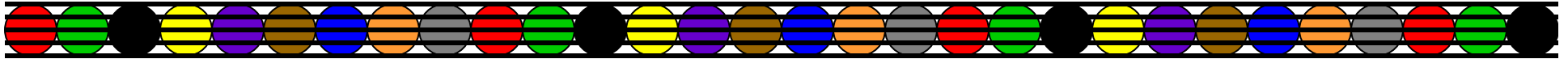   - who should teach it

12 Guiding Principles

- Principle #1: Goals of Cultural Competence Training
  - self awareness and receptivity to diverse patient populations
  - clinical excellence and alliances with patients
  - reduction of health care disparities, improved quality and cost-effective care
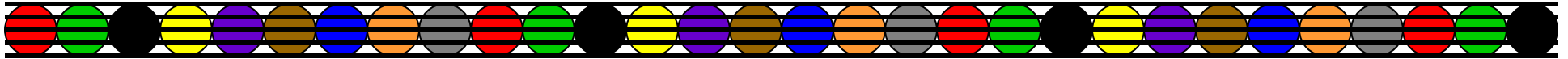
12 Guiding Principles

- Principle #2: Definition of Diversity
  - Trainings should provide a broad and inclusive definition of cultural and population diversity, including consideration of race, ethnicity, class, age, gender, sexual orientation, disability, language, religion, and other indices of difference.
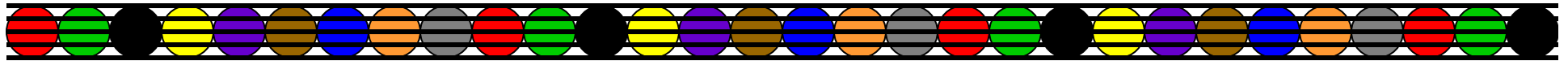
12 Guiding Principles

- Principle #3: Trainings Should Be Developmental
  - Institutional Development

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

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

    Programs and student learning should be regularly evaluated.

12 Guiding Principles

- Principle #4: Attitudes, Knowledge, Skills
  - Cultural competence training is best organized around enhancing providers' attitudes, knowledge, and skills and attention to the interaction of these three factors is important at every level of the training.
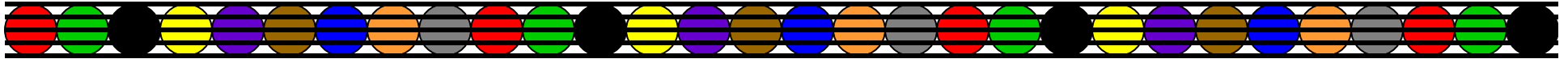
12 Guiding Principles

- Principle #5: Focus on Communication
  - Focus on tools and concepts that will improve communication and development of therapeutic alliances with patients.
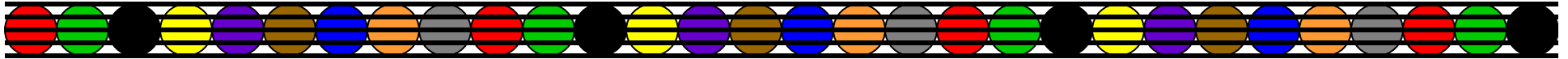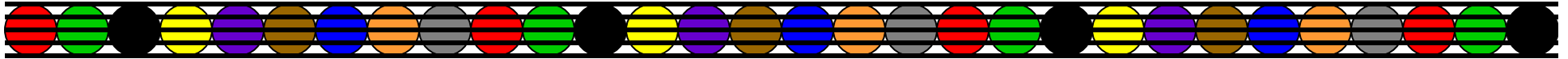
12 Guiding Principles

- Principle #6: Incorporation throughout Curriculum
  - Cultural competence training is best integrated into numerous courses, symposia and experiential, clinical, evaluation, and practicum activities as they occur throughout an educational curriculum.
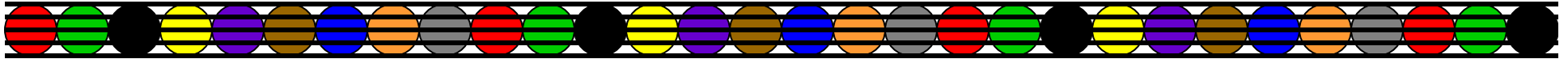
12 Guiding Principles

- Principle #7: Institutionalization of Cultural Competence Education
  - Include cultural competence issues throughout curriculum and training.
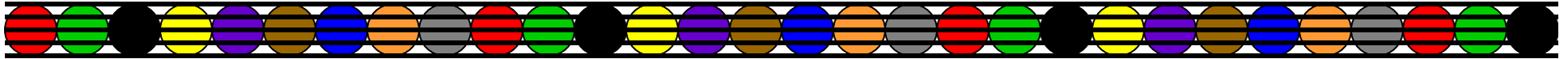
12 Guiding Principles

- Principle #8: Interdisciplinary Framework
  - Draw from numerous fields to provide cultural competence education.
- Principle #9: Respect Needs of Learners
- Principle #10: Context of Policy and Educational Guidelines
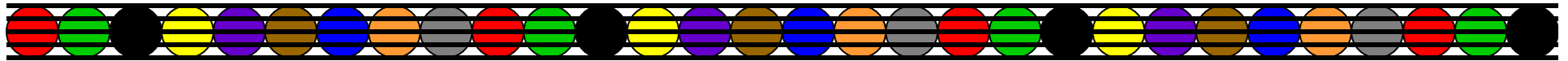
12 Guiding Principles

- Principle #11: Involve People from Diverse Backgrounds
  - in the design, implementation, and evaluation of cultural competence curricula.
- Principle #12: Safe, Non-judgmental, Supportive Environment
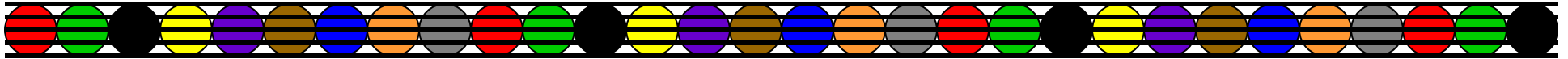
Curricular Philosophy

- Steps in Teaching Cultural Competency
  - prepare clinicians to understand and respect values, beliefs, and expectations of their patients
  - help clinicians apply attitudes, knowledge, and sills to patient encounters
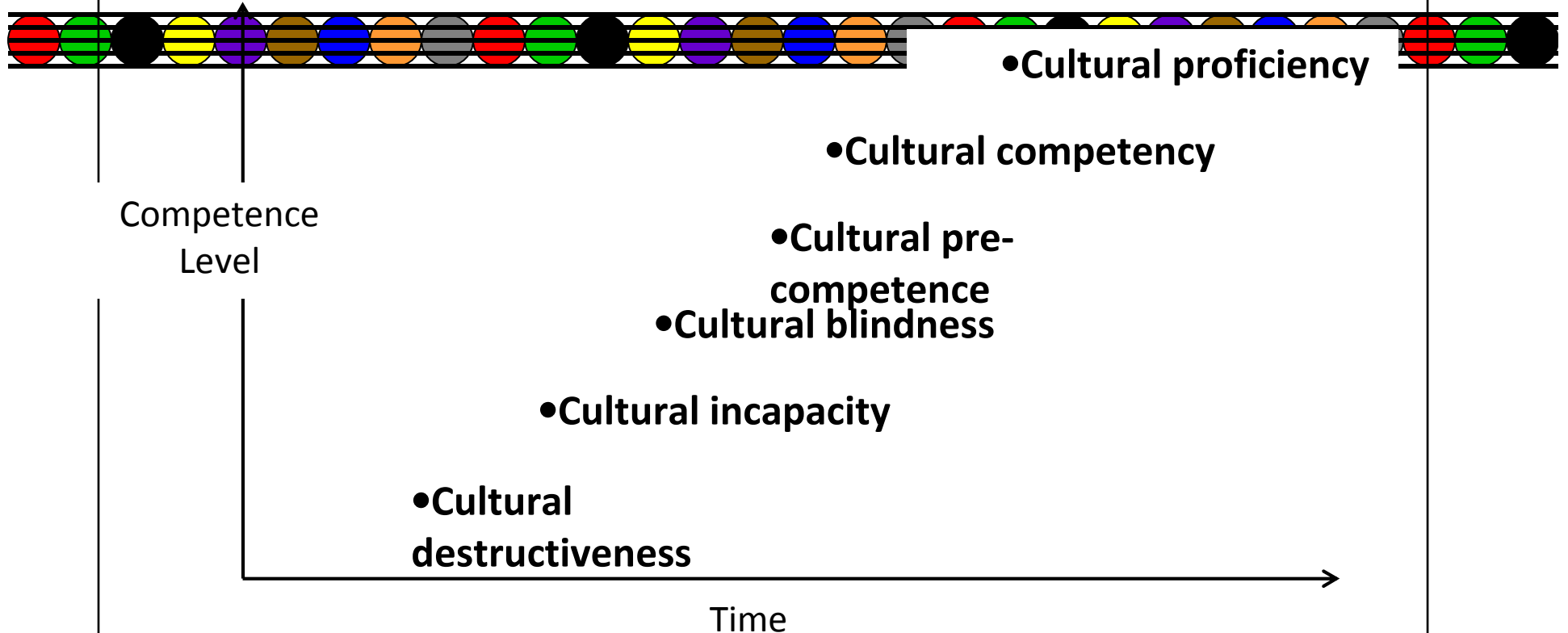
Curricular Philosophy

- Concepts that Health Care Practitioners Must Understand (Georgetown University, 2008):
  - beliefs, values, traditions, and practices of a culture
  - culturally-defined, health related needs
  - culturally-based belief system concerned with etiology of disease, health, and healing
  - attitudes toward seeking help from health care providers

Curricular Philosophy

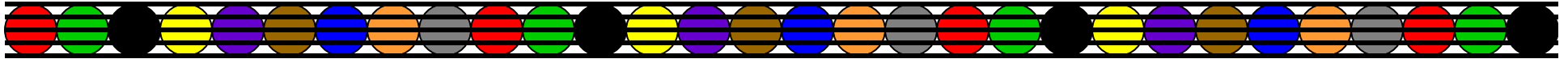- Stages of Development of Cultural Competence (Cross et al., 1989)

Cultural Competence Continuum

Competence Level

•**Cultural proficiency**

•**Cultural competency**

•**Cultural pre-competence**

•**Cultural blindness**

•**Cultural incapacity**

•**Cultural destructiveness**

Time

Source: Cross et al. *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. Washington, DC: Georgetown University Child Development Center, 1989
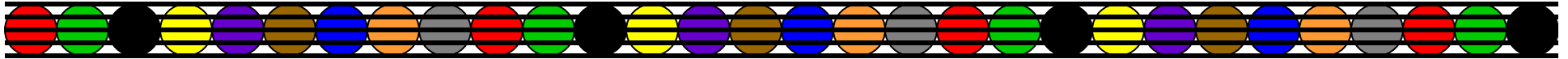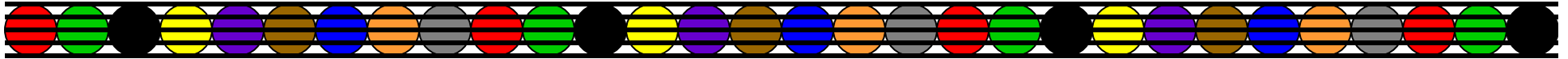
Curricular Philosophy

- Goals of Cultural Competence Education
  - provide knowledge and skills
  - cultivate attitudes and practices
  - promote understanding of and respect for patients' values, beliefs, and expectations
  - improve awareness of clinicians' assumptions and value systems
  - model ability to adapt care to patient's expectations and preference
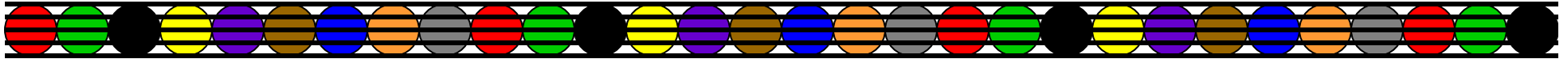
Curricular Philosophy

- Attitudes Assessment
  - self-evaluation of assumptions, biases, stereotypes, responses
  - open-mindedness and respect
  - patient and family-centered care
  - equal quality care for all
  - identify and eliminate barriers to access to health care
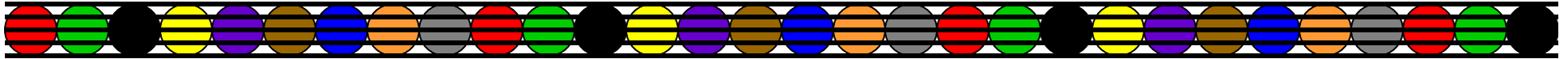
Curricular Philosophy

- Knowledge
  - ethnocentricism and how it impacts interactions with patients
  - culture impacts perception and behavior
  - changing demographics
  - legal, regulatory, and accreditation issues
  - cultural and linguistic policy or standards
  - health care disparities
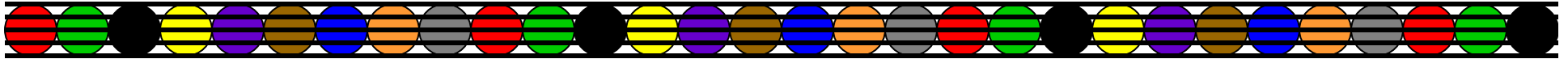
Curricular Philosophy

- Knowledge
  - health practices of different cultures
  - medical pluralism
  - within-group variations and acculturation
  - implications of genome research and ethnopmarmacology
  - epidemiology
  - linguistic barriers and impact on health care
  - cross-cultural variations in verbal and non-verbal communication
  - available resources on cultural issues
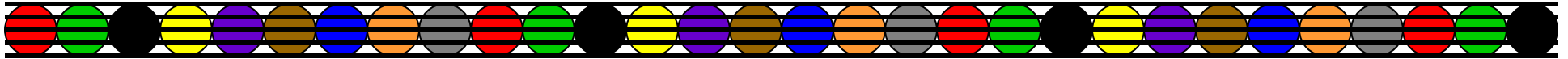
Curricular Philosophy

- Skills
  - assessment of responses, biases, and cultural preconceptions
  - patient history
  - outreach
  - assessment of patients' language skills
  - use of interpreters
  - use of translated written materials
  - use of resources and data
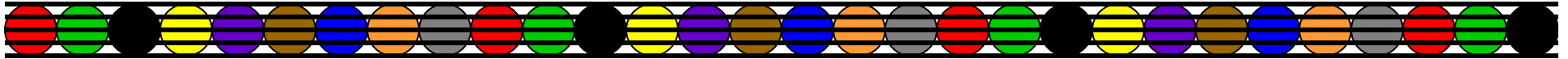
Curricular Philosophy

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

    Use lectures and other didactic approaches.
  - Experience

    Engage learners in exercises that demonstrate the points made in the didactic presentations.
  - Identify

    Solicit learners' responses to what they experienced and felt.
  - Reflect

    Ask learners to process what they experience and link experience to ideas presented in didactic presentation and learning objectives.

Curricular Integration

- **Tool for Assessing Cultural Competence Training**
  - TACCT Domains (components of the cultural competence curriculum)
    - Cultural Competence: Rationale, Context, and Definition
    - Key Aspects of Cultural Competence
    - Understanding the Impact of Stereotyping on Health Care Decision-making
    - Health Disparities and Factors Influencing Health
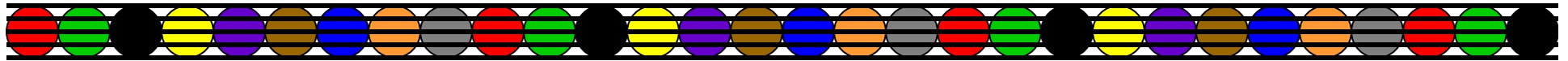   - Cross-cultural Clinical Skills

Curricular Integration

- ## TACCT Specific Components
  - ### These are the list of attitudes, knowledge, and skills that are taught and evaluated.
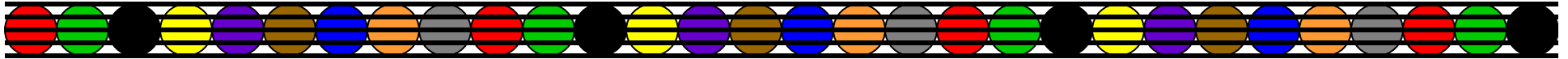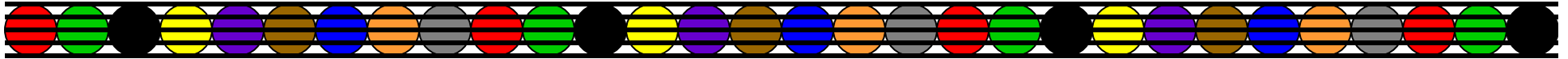
Curricular Integration

- Survey of Schools and Colleges of Optometry
  - The attitudes, knowledge, and skills (specific components) reported most frequently as included in the optometric curricula were
    - discuss race and culture in the medical interview
    - ask questions to elicit patient preferences
    - listen non-judgmentally to health beliefs
    - value curiosity, empathy, and respect
    - describe factors that impact health
    - describe systemic and medical encounter issues
    - elicit a culture, social, and medical history

Curricular Integration

- Eight Areas of Cultural competence Education (Dolhun et al, 2003)
  - general concepts of culture
  - racism and stereotyping
  - doctor-patient interactions and trust
  - language

    meaning of words, non-verbal communication, ;use of interpreters, language barriers)
  - cultural content

    epidemiology, patient expectations and references, traditions and beliefs, family role, spirituality and religion
  - access issues

    transportation, insurance, immigration
  - socioeconomic status
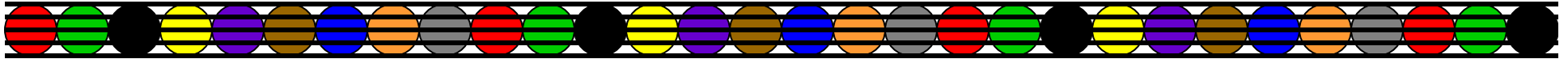 - gender roles and sexuality

Training Methods

- ## Teaching

  - ### Methods

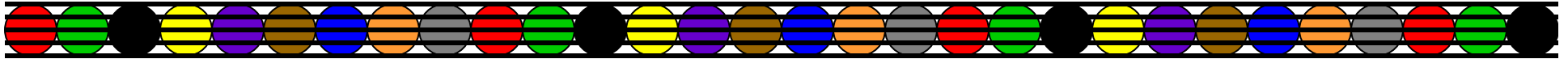 | case studies | monitoring |
    | --- | --- |
    | didactic lectures | group discussions |
    | clinical experiences | internships |
    | workshops | service learning projects |
    | interactive-participatory activities | language training |
    | role-playing | cultural immersion programs |

Training Methods

- Approaches to Cultural Competence Education and Training (The California Endowment, 2003)
  - methods suited to level, needs, and learning styles of students
  - step-by-step process
  - diverse set of training strategies
  - include experiential learning
  - not confined to one course of workshop; integrated into many curricular offerings
  - interdisciplinary multicultural team
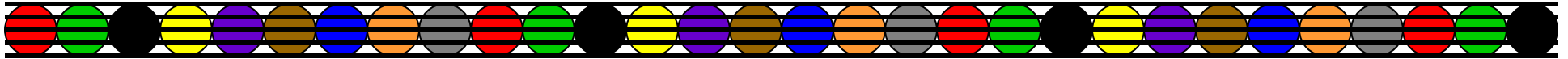 - faculty should model attitudes, knowledge, skills

Training Methods

- **Communication Models**
  - BATHE = background, affect trouble, handling, empathy
  - BELIEF = beliefs about health, explanation, learn, impact, empathy, feelings
  - ESFT = explanatory model, social risk for noncompliance, fears and concerns about the medication, therapeutic contracting and playback
  - ETHNIC = explanation, treatment, healers, negotiate, intervention, collaboration
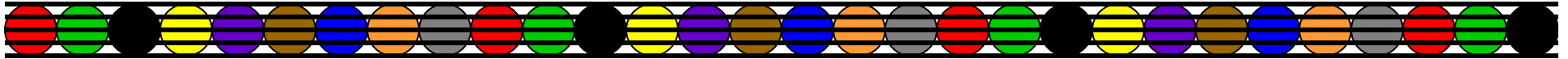 - Kleinman's questions

Training Methods

- **Communication Models**
  - LEARN = listen, explain, acknowledge, recommend, negotiate
  - Flores Model = normative cultural values, language issues, folk illnesses, patient beliefs, provider practices
  - review of systems = social stressors and support network, environment, life control, literacy
  - RESPECT = respect, explanatory, social and spiritual, power, empathy, concerns, trust
  - EYECARE = evaluate, yield, explore, communicate, acknowledge, reevaluate, execute

Training Methods

- Exercises
  - Sample Self-Awareness Exercises (NCBI)
    - Introductions
    - Up/Down
    - Paired Introductions
    - First Thoughts
    - Internalized Oppression
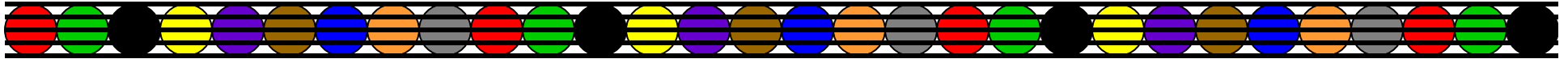   - Caucuses
    - Stereotypes

Training Methods

- Exercises
  - *Cultural Diversity in Eye* Care DVD by the Vision Care Institute
  - *A Physician's Practical Guide to Culturally Competent Care* Web Site: http://www.thinkculturalhealth.org
  - Common Ethnic Stereotypes
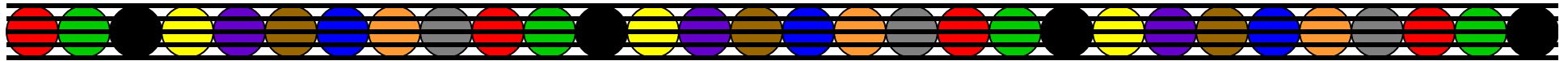 - Student Assessment for Self-Awareness
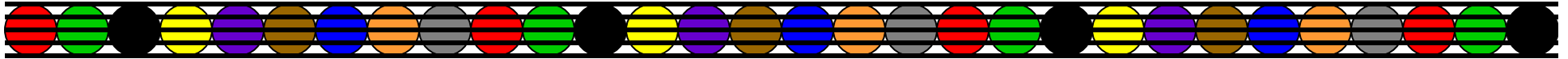
Program Assessment

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

Conclusion

- Optometry 2020 Preferred Futures (AmericanOptometric Association, 2007)
  - Preferred Future: All patients receive culturally competent care by their optometrist and staff; optometrists and staff have the knowledge, skills, and attitude to serve patients of different ethnicities, native languages, age and gender, religions, and cultural backgrounds; and optometrists and/or staff provide care in multiple languages and/or provide interpretation services.

Conclusion

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