

UCSHC
SCHOOL OF MEDICINE
CULTURAL COMPETENCE AND DIVERSITY CURRICULUM
VERSION 6.0
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Director: Angela Sauaia, MD, PhD

Committee Members:

Gwyn Barley
Lilia Cervantes
Imran K. Choudhry
Sonya Erickson
Genaro Fernandez
Stacy Fischer
Candace Fleming
David Gaspar
Gretchen Guiton
Oswaldo A. Grenardo
Jackie Glover
Robin Harvan
Gwendolyn Hill
Carol Hodgson
Mary Anne Johnston
Steven Lowenstein
Regina Kilkenny
Angela Sauaia
Virginia Sarapura
Deb Seymour
Lena Sorensen

General Recommendations of the 2004 Committee

- The cultural competence curriculum (CCC) will be organized through a website that will outline the core curriculum, provide information and course work to the students, serve to unify the CCC throughout the 4 years, and track students progress and learning on the CCC's topics.
- The CCC should have at least one immersion experience to help bring together the teachings of the CCC curriculum and allow students to practice and demonstrate the content, frameworks, and skills that they have learned.
- As much as possible nontraditional formats of teaching and assessment should be utilized in the CCC. Lectures and multiple choices testing as away of conveying and assessing content should be minimized, with maximization of participant problem focused learning with direct observational assessment.
- It will be essential for the CCC to achieve its mission that there also be faculty development and training on cultural competence and diversity. Faculty will need to possess the knowledge and skills to appropriately treat all patient populations and model this for the medical students. This faculty development process should also include efforts to increase diversity among the faculty.

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Section I: Overall Mission

The mission of the cultural competence curriculum (CCC) is to ensure that medical students and faculty develop knowledge, skills and behaviors with respect to the great diversity of the human condition. During their lifelong practice of medicine, graduating physicians will possess evolving knowledge of the similarities and differences between oneself and others. This includes the values, ways of life, abilities, beliefs, and opportunities that influence every aspect of how people relate to each other. Graduating physicians will be equipped with clinically applicable knowledge and skills that allow them to navigate and successfully interface with all patient populations. This knowledge, and these skills, will be brought to bear with each patient encounter, each program plan, each research protocol, and each information exchange with colleagues.

Section II: Domains, learning objectives and correlation with ACGME competencies

The cultural competence and diversity curriculum (CCDC) cannot be an add-on to the present medical school curriculum. If issues such as culture, professionalism, and ethics are presented separately from other content areas, they risk becoming de-emphasized as fringe elements or of marginal importance. The intent of a cultural competence curriculum is to enhance the patient-physician interaction and assure that students have the knowledge, skills, and attitudes that allow them to work effectively with patients and their families, as well as with other members of the medical community.¹

Health care professionals must be educated to avoid stereotyping, but to also be aware of normative cultural values that can affect informed consent and can have serious consequences.²

The committee in charge of this curriculum developed the following domains and learning objectives. Recommendations of the American Association of Medical Colleges (AAMC) project *Medical Education and Cultural Competence: A Strategy to Eliminate Racial and Ethnic Disparities in Health Care*, which produced the *Tool for Assessing Cultural Competence Training* (TACCT) based on the input of experts in cultural competence and medical education were also incorporated.

The domains are correlated to the ACGME competencies defined by the ACGME Outcome Project as follows³:

- a. **Patient Care (PC)** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
- b. **Medical Knowledge (K)** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
- c. **Practice-Based Learning and Improvement (PLI)** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
- d. **Interpersonal and Communication Skills (IC)** that result in effective information exchange and teaming with patients, their families, and other health professionals
- e. **Professionalism (P)**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
- f. **Systems-Based Practice (SP)**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system

¹Medical Education and Cultural Competence: A Strategy to Eliminate Racial and Ethnic Disparities in Health Care, Supported by The Commonwealth Fund

Project Director: Deborah Danoff, M.D., Associate Vice President

Division of Medical Education, Association of American Medical Colleges

² Paasche-Orlow, M. The Ethics of Cultural Competence. *Academic Medicine* vol. 79, no. 4, April 2004, pp. 347-350.

³ Minimum Program Requirements Language, *Approved by the ACGME, September 28, 1999*

For each domain, we present initially a list of contents followed by a list of learning objectives and its correlation with the ACGME competencies.

Domain I: Cultural Competence— Rationale, Context and Definition

- A. Definitions of race, ethnicity, culture, sexual orientation and disability
- B. Definition and understanding of the importance of cultural competence
- C. Understand how cultural issues affect health and health care quality, cost; the consequences of cultural issues
- D. History of racism and prejudice in health care
- E. Racism/prejudice: internal, personally mediated and institutionalized
- F. Diversity in the health care professions
- G. Self-assessment, reflection, and self-awareness of own culture, assumptions, stereotypes, biases and prejudices

Learning objectives:

1. Define race, ethnicity, culture, sexual orientation, and disability and identify how they affect health and health care quality, cost and consequences (K)
2. Discuss the implications of race, ethnicity, and culture in the context of the medical encounter (PC, P)
3. Describe important examples of racism and prejudice in the history of health care(K)
4. Value diversity in health care professions and propose and/or collaborate with ways to improve recruitment and retention of minority health care professionals(P, IC)
5. Use self-assessment tools and self-reflective writing to describe their own cultural background, cultural beliefs and how they affect themselves and the care they provide (PC, IC)

Domain II: Cultural Competence— Family and Community

- A. Definitions and culturally defined role in health care of family, community, institution
- B. The importance of family, community, and institution in health and health care
- C. Patient/family-centered vs. physician-centered care: emphasis on patients'/families' healing traditions and beliefs [e.g., ethno-medical healers]
- D. Institutional cultural issues
- E. Self-assessment of the culture, values and biases of their own family, community and institutions (including their medical school)

Learning objectives:

1. Define family, community and institution (K) and Recognize the influence of family, community and institution in health and health care(K)
2. Elicit information from patient in context of family-centered care defining the roles of patient, family and community in the specific medical situation and use the information in medical decision making and care planning (PC, IC, P)

3. Use assessment tools and self-reflective writing to describe their family, community and institution cultural background, values and biases and how they affect themselves and the care they provide(IC,PC,SP,P)

Domain III: The Impact of Discrimination and Stereotyping in Health Care

- A. Definition and history of bias, stereotyping, discrimination, and racism, including limited access to health care and education
- B. Effects of stereotyping on medical decision-making
- C. Processes to report and legal consequences of racism, prejudice and discrimination in health care

Learning objectives:

1. Describe impact of bias, stereotyping, discrimination, and racism on clinical decision-making and recognize providers' potential for biases and stereotyping in a clinical encounter(P, PC, IC)(P)
2. Describe patterns of health care disparities that can result from health care provider bias and discrimination (K)
3. Use self-assessment tools and reflective writing to identify their own stereotypes and biases that may affect clinical encounters and identify strategies to manage them(PC, IC, P)
4. List and describe existing processes to report and legal consequences of racism, prejudice and discrimination in health care(P, K)

Domain IV: Health Disparities

- A. Epidemiology of health and health care disparities (race and ethnic groups, literacy in English and in other languages, disability, sexual orientation, disability)
- B. Genetics, race and ethnicity
- C. Social determinants of health and factors underlying health care disparities—access, socioeconomic, environment, institutional, health policy, racial/ethnic, literacy, language, immigration
- D. Health care delivery system, health care safety nets and health disparities (SP)
- E. Cultural preferences versus cultural disparities
- F. Health disparities in research and how it affects current medical evidence (PLI)
- G. Eliminating health disparities: existing initiatives, health policies, barriers and the role of individuals and communities, including the role of community-participatory models
- H. Advocacy, health policy and political action
- I. Community immersion experience

Learning objectives:

1. Define areas of health disparities in incidence, mortality, morbidity, risk factors by ethnic groups, sexual orientation and disabilities(K) utilizing resources such as Healthy People 2010, Institute of Medicine Report "Unequal Treatment", Physicians for Human Rights Report "The Right to Equal Treatment" (K)
2. Discuss the link between genetics, race, ethnicity and implications for health disparities(K)

3. Define areas of differences in access to and quality of health care in prevention, preventive, primary and specialty care including the difference between cultural preferences and true disparities(K)
4. Describe factors such as access, literacy, language socioeconomic, historical, political, environmental, and institutional that impact health and underlie health and healthcare disparities(K)
5. Discuss public health programs and health insurance coverage for various populations (including legal immigrants and undocumented individuals) and demonstrate skills to search and use existing organizations serving as health care safety nets and other community resources (SP)
6. Discuss barriers and existing initiatives to eliminate health disparities (CDC REACH, etc) (SP)
7. Critically appraise the literature as it relates to health disparities, including systems issues and quality in health care, and sources of selection bias (sex, gender, age, race, ethnicity, socioeconomic status, access to care, study setting, etc.)(PLI)
8. Develop a proposal for a community-based health intervention using a community-participatory model (SP)
9. Describe the role of advocacy in health care and propose an advocacy initiative (e.g., informing legislation, taking political action, describing the process for approaching representatives) (SP)
10. Describe their community immersion experience and use reflective writing to describe the effect it had on themselves(K, PC, IC, SP)

Domain V: Cross-cultural Clinical Skills

- A. Patients'/families' healing traditions, values and beliefs [e.g., ethno-medical healers]
- B. Knowledge, respect, and validation of differing values, cultures, and beliefs, including sexual orientation, gender, age, race, ethnicity, disability and class
- C. Curiosity, empathy, and respect in patient care
- D. Dealing with hostility/discomfort as a result of cultural discord
- E. Eliciting a culturally sensitive and valid social and medical history, including eliciting information about sexual orientation
- F. Communication, interaction, and interviewing skills including modifications necessary to accommodate disease and disability
- G. Understanding language barriers and working with interpreters
- H. Culturally sensitive physical exam
- I. Negotiating and problem-solving skills
- J. Diagnosis, management, and patient-adherence skills leading to patient compliance

Learning objectives:

1. Describe common health beliefs, values and traditions in the community they serve (K, PC)
2. Describe and effectively uses models of effective cross-cultural communication, assessment, and negotiation (BELIEF, LEARN, etc) (PC, IC)
3. Use and adapt communication skills (history taking, interview, consent form, decision making, patient education and care planning) to assess and accommodate different education/literacy levels (including strategies to assess literacy level), other languages and disabilities (PC, IC)
4. Identify when an interpreter is needed, describe his/her functions, and collaborate with interpreter effectively to perform a history and physical exam (PC, IC)
5. Obtain a culture, social, and medical history, including a patient's health beliefs, and model of their illness (PC, IC)
6. Demonstrate skills that build trust by addressing contextual factors (e.g. culture, ethnicity, gender, language/literacy, socioeconomic class, spirituality/religion, age, sexual orientation, disability) (PC, IC)
7. Explore diverse views on significant life events such as birth, illness, death and disability in diverse cultural contexts (PC, IC)
8. Demonstrate respectful and culturally sensitive techniques to insure patient's comfort while obtaining an accurate physical exam to address: modesty, cultural values and beliefs, disability (PC, IC, P)
9. Assess patient understanding of his/her condition and instructions for care and enhance adherence, including collaboration with family, community and traditional community healers (PC, IC, P)
10. Use reflective writing to assess where they are in the cultural competency continuum, their feelings regarding their medical encounters, the utility of the tools they learned and their plan for their own life-long, continuous development in the area of cultural competence (PC, IC, P)

Section III: Format and Integration of thread curriculum

o I. Curriculum

Funding for the CCDC is provided by a grant from the Colorado Trust from December 2005 to November of 2010. The CCDC is woven through the entire medical program. It vigorously fight stereotyping of ethnic groups, emphasizing that each individual is unique. The CCDC is not segregated in separate workshops or seminars, but fully integrated to courses and clerkships.

The CCDC addresses all three levels of racism: institutionalized, personal-mediated and internalized.⁴ As part of these concepts, we emphasize self knowledge and self acceptance with a progressive framework, as follows:

- Phase I: Self-discovery and self-acceptance of one's own culture, values, prejudices and biases
- Phase II: Knowledge of the culture, values and biases of our community and institutions
- Phase III: Cross-cultural skills and patient/community advocacy

The students will be exposed to the following cross cultural communication models:

- Kleinman's questions (Kleinman et al, 1978)
- LEARN (Berlin & Fowkes, 1983)
- BATHE (Stuart & Leibermann, 1993)
- ESFT (Betancourt et al., 1999)
- Eliciting patient information & negotiating (Carrillo et al, 1999)
- ETHNIC (Levin et al, 2000)
- Model for cultural competency in health care (Flores, G, 2000)
- Review of systems domains of the social context (Green et al, 2002)
- BELIEF (Dobbie et al, 2003)
- **Teaching Methods**
 - Small groups, PBL with case studies
 - Debates
 - Panels (community, advocates, legislators)
 - Interactive seminars and workshops
 - Standardized patients
 - Videos (Color of Fear, KP series, etc.)
 - Books (e.g., The spirit catches and you fall down by A. Fadiman, Infections and Inequalities by P. Farmer, Pedagogy of the Oppressed by P. Freire, etc.)
 - Reports (Institute of Medicine Unequal treatment; Physicians for Human Rights The right to equal treatment, Healthy People 2010)

⁴ Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health.* 2000 Aug;90(8):1212-5; Kendall F. *Understanding White Privilege* (free access at <http://northonline.sccd.ctc.edu/beginnings/Kendall.htm>)

- Integration:

Integration is following the below described process:

The CCC committee convened in December 2004 refined the CCC learning objectives using previous work by a cultural competence/ diversity committee and the AAMC TACTT as a basis. A modified Delphi process was used to achieve consensus on how to integrate the objectives in each medical school year. The final iteration is included as Appendix 1.

In addition, the directors of the threads (CCC, Medicine and Society, Ethics and Evidence-based Medicine) are working together to approach the integration process. The individual thread committees will define the learning objectives of each thread as well as their potential integration into blocks. The thread directors will meet (as a group or using a representative) with each block director to work on how to integrate the thread objectives into the block sessions.

- **Narrative Medicine in the CCDC (led by Stacy Fischer, MD)**

“Despite medicine’s recent dazzling technological progress in diagnosing and treating illnesses, physicians sometimes lack the capacities to recognize the plights of their patients, to extend empathy toward those who suffer, and to join honestly and courageously with patients in their illnesses.”
Rita Charon, MD, PhD

Narrative Medicine has four domains that naturally engage cultural competence :

- Patient-Physician: Empathic engagement
- Physician-Self: Reflection
- Physician-Colleagues: Profession
- Physician-Society: Culture

Narrative Medicine will be integrated into the CCDC as follows:

- Year 1
 - Human Body - "Cadaver as a First Patient"
 - Foundations of Doctoring - Reflect on their own cultural background, beliefs and biases
- Year 2
 - Nervous System: Reflect on their personality type and how they relate to others
 - Foundations of Doctoring: Reflect on the culture/ biases of their community and institution
 - Cross-cultural skills reflection initiated
- Year 3
 - Clerkships
 - Reflect on their own, their family’s, the community’s, and institution’s culture and biases
 - Cross-cultural skills reflection continued
 - Hidden Curriculum - narrative of a case that challenged their bias, beliefs, and/or cultural views in a case involving a woman in the patient or caretaker role
- Year 4

- AHEC experience - Reflect on their community immersion experience

Each student will have by the end of the medical program a portfolio of the several narratives. The format and operations for this portfolio are under development (May 2006).

Section IV: Faculty Development

• Faculty Development (led by Gwen Hill)

The goal of our faculty development training is to prepare culturally competent faculty who will:

- Demonstrate an evolving understanding of their own self-awareness and biases and how these can affect the provision of health care
- Demonstrate an understanding of the manner in which people of diverse cultures, histories, and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments
- Demonstrate an understanding of the terms *cultural competency* and *culturally competent healthcare* as well as related terms, such as *culture*, *race*, *ethnicity*, associated with discussions of cultural competence and health disparities
- Demonstrate an understanding of health disparities in the U.S. and Colorado and the role cultural competence plays in addressing and reducing health disparities
- Demonstrate an understanding of the new curriculum and specifically the cultural competency and diversity thread
- Demonstrate knowledge and communication skills to provide culturally competent care
- Teach, in didactic and clinical settings, the knowledge and communication skills necessary to provide culturally competent care
- Demonstrate skills to discuss sensitive issues with students in a manner that encourages open communication and promotes development of students' self awareness, cultural awareness and sensitivity, communication skills, and ultimately cultural competence

Three modalities of teaching are under development: a 4-hour workshop, an 8-hour workshop and an online course developed by the Office of Minority Health (USDHHS) and available at <https://cccm.thinkculturalhealth.org>.

The curriculum of the 4-hour workshop to be piloted May 17, 2006 to an audience of PBL instructors, PBL instructors, block directors (including Threads, FOD), essentials/clinical/advanced studies directors, COC faculty and ED&R faculty.

Faculty Development CULTURAL COMPETENCE and DIVERSITY CURRICULUM THREAD 4-hour Experiential Workshop

LEARNING OBJECTIVES

This session should provide participants with *preliminary* knowledge and experience in the following areas:

- an evolving understanding of their own self-awareness and biases and how these can affect the provision of health care

- an understanding of the manner in which people of diverse cultures, histories, and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments
- an understanding of the terms *cultural competency* and *culturally competent healthcare* as well as related terms, such as *culture*, *race*, *ethnicity*, associated with discussions of cultural competence and health disparities
- an understanding of health disparities in the U.S. and Colorado and the role cultural competence plays in addressing and reducing health disparities
- an understanding of the new curriculum and specifically the cultural competency and diversity thread
- knowledge and communication skills to provide culturally competent care
- teaching, in didactic and clinical settings, the knowledge and communication skills necessary to provide culturally competent care
- skills to discuss sensitive issues with students in a manner that encourages open communication and promotes development of students' self awareness, cultural awareness and sensitivity, communication skills, and ultimately cultural competence

PREREQUISITE

- Knowledge of new CU-SOM curriculum and curriculum threads, including cultural competence and diversity.

REQUIRED READINGS (prior to session)

- CU School of Medicine Cultural Competence Curriculum Overview (attached) **AND**
- Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000 Aug;90(8):1212-5 (full text access through Dennison/OVID) **AND**
- Kendall F. Understanding White Privilege (free access at <http://northonline.sccd.ctc.edu/beginnings/Kendall.htm>) **AND**
- Farmer P. *Infections and Inequalities*, Chapter 1 **OR** Fadiman A. *The Spirit Catches You and You Fall Down*

AGENDA

12:45 – 1 p.m.	Arrive/Sign In
1:00 – 1:15 p.m.	Introductions
	Health Beliefs Survey (pre)
1:15 – 1:45 p.m.	Health disparities –
	Racism and determinants of health
1:45 – 2:15 p.m.	<i>The Color of Fear</i> Part 1
2:15 – 2:30	Debriefing and Exercise
2:30 – 3:00 p.m.	<i>The Color of Fear</i> Part 2
3:00 – 3:15 p.m.	Break
3:15 – 3:45 p.m.	Debrief and discuss <i>The Color of Fear</i>
3:45 – 4:45 p.m.	Brief overview of SOM Cultural Competence Curriculum
	Cross cultural skills/Small group facilitation
4:45 – 5:00 p.m.	Health Beliefs Survey (post)
	Workshop Evaluation

- **Section V: Evaluation (led by Gretchen Guiton)**
- Evaluation Questions
 1. Does implementation on an integrated cultural competency curriculum lead to changes in students'
 - *Beliefs about the need for culturally sensitive patient care?*
 - *Skills in interacting with a patient from a different cultural background?*
 2. Does faculty participation in a cultural competency training effect students'
 - *Beliefs about the need for culturally sensitive care?*
 - *Skills in providing culturally sensitive care?*
 3. Does faculty participation in a cultural competency training effect faculty members'
 - *Knowledge and beliefs about the need for culturally sensitive patient care?*
 - *Self-reported competency in teaching about cultural competence?*
 - *Self-reported competency in providing treatment to patients from diverse backgrounds?*
 - *Behavior in their teaching practice?*
 - *Behavior in their clinical practice?*
 4. Does widespread faculty training in cultural competency alter the patient-centered nature of care settings?
- Student Instruments
 - Student BELIEF Questionnaire
 - *Questionnaire of beliefs that MD should elicit the patient's perspective & that knowledge of the patient's perspective improves care*
 - OSCE stations requiring cultural sensitivity and interpreter services
 - C³ Assessment of Patient-centeredness of Clinical Training Sites
 - *29-item measure of students' views of role models, their experiences with patients, and support for their own patient-centered actions*
- Faculty Instruments
 - Questionnaire addressing knowledge, attitudes, experience, competencies in clinical care and teaching cultural sensitivity built from:
 - Cross-Cultural Medicine Questionnaire
 - AAFM Cultural Competence Self-Assessment
 - Open-ended questions about change in skills