ASCO Special Report

The Path to Cultural Competence</br>in Optometric Education and Practice:</br>a Timeline to Multicultural Clinical Excellence

Edwin C. Marshall, OD, MS, MPH, FAAO, FNAP

The following report is one of two reports in this edition of the journal that highlight what ASCO has achieved over the past 12 years in the areas of cultural competence and diversity. (Click here to read the other report, "Diversity in our Colleges and Schools of Optometry.")

The cornerstones of the Association's efforts have been the Diversity and Cultural Competency Committee (DCCC) and its Cultural Competency Curriculum Guidelines Subcommittee (CCCGS).

The mission of the DCCC is:

- *To enhance the possibility that students from under-represented minority groups will become interested in careers in optometry and apply to, be accepted by, and graduate from schools and colleges of optometry*
- *To encourage institutional diversity and cultural competency efforts across the nation's schools and colleges of optometry*
- *To develop national partnerships to explore and identify ways to share expertise, best practices and resources regarding diversity, recruitment and cultural competence across the spectrum of education/research/practice*

The DCCC was formed as a task force in 2005 and became a standing committee in 2011 with a vision of achieving diversity and cultural competence in optometric education and patient care. The committee has made great strides, including the development of cultural competency curriculum guidelines in 2008. The charge of the CCCGS was to facilitate and encourage implementation of the curriculum guidelines at the schools and colleges of optometry. The subcommittee met its charge and was discontinued in June 2015.

ASCO wishes to acknowledge the many contributors to the DCCC and the CCCGS, as well as those who helped to lay crucial groundwork in the Association's cultural competency and diversity efforts, all of whom have moved the needle forward in these important endeavors. Special thanks go to Edwin C. Marshall, OD, MS, MPH, FAAO, FNAP (Indiana University), who chaired the ASCO Diversity Task Force and the ASCO Cultural Competence Guidelines Work Group, Larry Davis, OD (UMSL), who chaired the DCCC over the past three years, and Barbara Fink, OD, MS, PhD (OSU), who chaired the CCCGS to implement training workshops at 18 schools and colleges of optometry.

ASCO Diversity Task Force (2006-2008)

Chair, Edwin C. Marshall, OD, MS, MPH, FAAO, FNAP (Indiana University)

Robert E. Horn, MS (PCO)

Liduvina Martinez-Gonzalez, MS (SUNY)

Sam Quintero, OD (University of Houston)

Jeffrey J. Walline, OD, PhD (OSU)

Cynthia G. Heard, OD (AAO)

Teisha Johnson, MS (ICO)

Renee Mika, OD (AOA)

Gerald Simon, OD (UAB)

Hector C. Santiago, OD, PhD (ASCO Executive Committee)

Paige Pence, BA (ASCO staff)

Enid-Mai Jones, MA, MSEd (former ASCO staff)

ASCO Cultural Competence Guidelines Work Group (2007-2008)

Chair, Edwin C. Marshall, OD, MS, MPH, FAAO, FNAP (Indiana University)

Yi Pang, OD, PhD (ICO)

Sunita Mutha, MD (Consultant, UCSF)

Barbara Fink, OD, MS, PhD (OSU)

Hector C. Santiago, OD, PhD, (Inter American University of Puerto Rico)

Priti Patel, OD (Liaison, Wal-Mart Optical Division)

Paige Pence, BA (ASCO staff)

Enid-Mai Jones, MA, MSEd (former ASCO staff)

Cultural Competency Curriculum Guidelines Subcommittee (2014-2015)

Chair, Gary Chu, OD, MPH (NECO)

Past Chair, Barbara Fink, OD, MS, PhD (OSU)

Angel Novel-Simmons, OD (USML)

Hector Santiago, OD, PhD (IAUPR)

Wendy Stone, OD (ICO)

Carol Brubaker (ASCO staff liaison)

Diversity and Cultural Competency Committee (2017-2018)

Chair, Andrew Buzzelli, OD, MS (KYCO)

Past Chair, Larry Davis, OD (UMSL)

Gary Chu, OD, MPH (NECO)

Keshia Elder, OD (UABSO)

Lillian Kalaczinski, OD (MCO)

Carrie Lebowitz, OD (SCO)

Ruth Shoge, OD (Salus/PCO)

Carol Brubaker (ASCO staff liaison)

As you read this report, it is important to keep in mind that achievement and maintenance of cultural competency and diversity are continuous journeys. As such, the report serves as a signpost as we continue on this road.

ASCO Special Report:

The Path to Cultural Competence in Optometric Education and Practice: a Timeline to Multicultural Clinical Excellence

Edwin C. Marshall, OD, MS, MPH, FAAO, FNAP

The U.S. population is becoming increasingly more diverse in terms of its racial, ethnic, cultural and linguistic characteristics, and these characteristics are becoming increasingly more relevant to understanding patient behavior and delivering quality health care. However, the healthcare workforce has not grown to mirror the diversity of the population, and its ability to respond to the needs of diverse patients has become more challenging. Low provider diversity and the potential for consequent challenges are especially relevant to optometry, where the workforce is considerably less diverse than the general population and optometry student enrollment – particularly for African American and Hispanic students – is not suggestive of significant change in the near future **(Table 1)**.

TABLE 1
Percent Race and Ethnicity of the U.S. Population and Optometry Workforce

	Population Estimate 2015[a]	Optometrists 2011-2015[b]	Optometry Students	
			Enrolled 2015-2016[c]	Graduates 2015[c]
American Indian and Alaska Native	0.9	NR	0.6	0.4
Asian	6.6	14.3	29.6	30.9
Black or African American	15.1	1.9	2.8	3.7
Native Hawaiian and Other Pacific Islander	0.2	NR	0.2	0.5
White	74.7	81.6	57.3	57.4
Two or More Races	2.5	1.9	2.3	1.8
Other/Unknown	NR		7.1	5.3
Total Race (Non-Hispanic)	100.0	99.7	99.9	100.0
Hispanic or Latino	17.6	3.9	5.6	4.6
Non-Hispanic or Latino	82.4	96.1	94.4	95.4
Total Racial/Ethnic	100.0	100.0	100.0	100.0

NR = not reported

a. U.S. Census Bureau. Annual Estimates of the Resident Population by Sex, Race, and Hispanic Origin for the United States, States, and Counties: April 1, 2010 to July 1, 2015. Accessed Nov. 18, 2016. Available from: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
b. U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. Sex, Race, and Ethnic Diversity of U.S. Health Occupations (2011-2015), Rockville, MD; 2017. Accessed Oct. 5, 2017. Available from: https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/diversityushealthoccupations.pdf.
c. Association of Schools and Colleges of Optometry. Annual Student Data Report: 2015-2016 Student Data Report. Accessed Oct. 6, 2017. Available from: https://www.optometriceducation.org/wp-content/uploads/2017/05/ASCO-StuData-Report-15-16-5-9-17-2.pdf.
Table 1. Click to enlarge

The case for increasing diversity in the healthcare workforce has been adequately documented by the U.S. Department of Health and Human Services,[1] the Institute of Medicine (IOM),[2] and the Sullivan Commission on Diversity in the Healthcare Workforce.[3] While workforce diversity is an important element in meeting the needs of a diverse population and eliminating racial and ethnic disparities in health and health care, diversity alone does not necessarily imply competency in the workforce's ability to understand and react effectively to the healthcare challenges of a culturally diverse population.

Culture is not a singular attribute, but a composite of demographics, value systems and learned behaviors that can create multiple cultural identities. According to Cross et al., it "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."[4] Culture has become an important variable in the delivery of quality health care. A failure to recognize and address its relevance to health care can lead to a poor quality of care. Cultural beliefs, customs, values, attitudes, perspectives, expectations, preferences, experiences, assumptions, fears and practices across diverse populations help form and influence variations in health understanding and behavior. Factors ranging from effective communication and engagement to issues of trust and compliance to decision-making and overall satisfaction can be positively or negatively impacted by the intercultural dynamics within the patient-provider encounter.[5]

Identifying cultural competence as "the knowledge, skills, attitudes, and behavior required of a practitioner to provide optimal health care services to persons from a wide range of cultural and ethnic

backgrounds," Cohen and colleagues state that, "health care providers must have a firm understanding of how and why different belief systems, cultural biases, ethnic origins, family structures, and a host of other culturally determined factors influence the manner in which people experience illness, adhere to medical advice, and respond to treatment."[6] Cohen also affirms that "such differences are real and translate into real differences in the outcomes of care." For example, implicit or unconscious bias (unconscious stereotyping) may influence provider expectations and the type of questions asked during case history, which in turn could lead to incomplete diagnoses and inadequate treatment decisions.[7]

Betancourt et al. state "the goal of cultural competence is to create a health care system and workforce that are capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency."[8] To do so, healthcare providers must be able to reconcile their personal and professional values and cultural assumptions against those of their patients and tailor care that is consistent with their patients' needs, expectations and preferences.[9,10] Applying the knowledge and skills necessary to understand and appreciate the cultural needs, beliefs and practices of patients fosters relationships that minimize opportunities for miscommunication, misunderstanding, misinterpretation, distrust and dissatisfaction and improve opportunities for patient compliance, optimal outcomes and quality healthcare experiences.

Cultural Competency in Clinical Practice and Health Professions Education

Clinical practice

The cultural competency discussion has never been more important than today as the healthcare professions look to redefine excellence in the context of a diverse and multicultural society. In 2000, the U.S. Office of Minority Health (OMH) published the National Standards for Culturally and Linguistically Appropriate Services in Health Care (National CLAS Standards) to help reduce healthcare access and service inequities created by cultural and linguistic barriers.[11] Four years later the OMH launched a self-directed, e-learning CME/CE credit experience with A Physician's Practical Guide to Culturally Competent Care. The guide, the National CLAS Standards, and other resources to assist healthcare professionals with the knowledge, skills, attitude and awareness to care for patients regardless of their cultural or linguistic background were placed on the OMH's "Think Cultural Health" website (https://www.thinkculturalhealth.hhs.gov/) for access by physicians and other healthcare professionals.

In Crossing the Quality Chasm: A New Health System for the 21st Century, the IOM identified specific aims for the 21st century healthcare system. Included among IOM's specific aims were providing "care that is respectful of and responsive to individual patient preferences, needs, and values" (patient-centered care) and "care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status" (equitable care).[12] With a finding that "cultural awareness and cultural competence are essential skills for providing quality health care to a diverse patient population," the New Jersey legislature made New Jersey the first state to make cultural competency training a condition of physician licensure by the State Board of Medical Examiners: "The public interest in providing quality health care to all segments of society dictates the need for a formal requirement that medical professionals be trained in the provision of culturally competent health care as a condition of licensure to practice medicine in New Jersey."[13] The 2005 legislation also required persons who received a diploma from a New Jersey college of medicine prior to the effective date of the legislation to document completion of cultural competency training to the satisfaction of the board as a condition of re-licensure.

Health professions education

A 1991 position paper adopted by the American Nurses Association (ANA) Board of Directors stated that "ethnocentric approaches to nursing practice are ineffective in meeting health and nursing needs of

diverse cultural groups" and called for all nursing curricula to include "pertinent information about diverse health care beliefs, values, and practices" to demonstrate that "cultural beliefs and practices are as integral to the nursing process as are physical and psycho-social factors."[14] The Society of Teachers of Family Medicine (STFM) was one of the early adopters of core curriculum guidelines to promote culturally sensitive and competent health care.[15] The 1996 guidelines included the attitudes, knowledge and skills considered to be important to the delivery of high-quality primary care with the belief that "a deeper understanding of the sociocultural background of patients, their families, and the environments in which they live" and an appreciation of "how one's own cultural values, assumptions, and beliefs influence the provision of clinical care" are necessary for such care to be "meaningful, acceptable, accessible, effective, and cost-efficient."[15]

The Liaison Committee on Medical Education (LCME), recognized by the U.S. Department of Education as the accrediting authority for programs leading to the MD degree, established cultural competence standards in 2000.[16] LCME standard 7.6 requires:[17] "The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process; and the medical curriculum include instruction regarding:

- The manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments
- The basic principles of culturally competent health care
- The recognition and development of solutions for health care disparities
- The importance of meeting the health care needs of medically underserved populations
- The development of core professional attributes (e.g., altruism, accountability) needed to provide effective care in a multidimensional and diverse society"

By the 2003-2004 academic year, almost 51% of U.S. residency programs included cultural competence training.[18] In 2004, the Health Resources and Services Administration (HRSA) published Cultural Competency in Medical Education: A Guidebook for Schools to assist medical schools in integrating cultural competency through institutional tailoring of a suggested curriculum and application of strategies to "sell" the curriculum and prepare faculty to teach cultural competency.[19] To further expand the role of cultural competence education for medical students, the Association of American Medical Colleges (AAMC) published Cultural Competence Education. In the 2005 monograph the AAMC endorsed the importance of healthcare professionals being "educated specifically to address issues of culture in an effective manner."[16] In addition to the licensure requirement, the 2005 New Jersey legislation also requires instruction and training in cultural competency to be included in the curricula of each of the state's medical schools: "Completion of cultural competency instruction . . . shall be required as a condition of receiving a diploma from a college of medicine in this State."[13] The legislation directs medical schools to provide classroom instruction, workshops or other educational programs, including continuing education credit, "developed in consultation with the Association of American Medical Colleges or another nationally recognized organization which reviews medical school curricula." The Indiana University School of Medicine, the largest medical school in the United States, offers programs to engage faculty, staff and learners in dialogues about important medicine and healthcare issues facing diverse populations. The school also offers cultural competence workshops on a variety of topics, such as cultural differences and mistrust, intercultural communication, diversity, health disparities and implicit bias.

In 2006, the Association of Schools of Public Health set forth a baseline of skills in the domain of diversity and culture that MPH students should master prior to graduation.[20] Following up five years later, the Interprofessional Education Collaborative – consisting of the American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Dental Education Association, Association of American Medical Colleges, and

the Association of Schools of Public Health – published the 2011 Core Competencies for Interprofessional Collaborative Practice. The collaborative called for health professions education programs to “embrace the cultural diversity and individual differences that characterize patients, populations, and the health care team” as a core interprofessional competency in the learning process.[21] The next year an expert panel convened by the Association of American Medical Colleges and the Association of Schools of Public Health reported out a second set of joint educational recommendations that would help prepare students for successful practice. With the goal of embedding cultural competence in medical and public health education and practice, the expert panel identified cultural competencies common to medical and public health students across the three domains of knowledge (cognitive competencies), skills (practice competencies) and attitude (values/beliefs competencies).[22]

The Path to Culturally Competent Eye and Vision Care

The National Academies of Sciences, Engineering, and Medicine (NASEM) believes “including training in culturally competency in all medical, optometric, allied health, and public health educational programs could be an effective strategy for improving health system quality across all specialties and professions.”[23] One of the earliest efforts to address the needs of culturally and linguistically diverse patients in eye and vision care came via the National Eye Institute (NEI). Responding to a 1988 congressional directive, the NEI launched in 1991 a national partnership with public and private organizations – the National Eye Health Education Program – to collaborate on creating culturally and linguistically appropriate, evidence-based resources for eyecare professionals to use in caring for culturally and linguistically diverse patients at higher risk for eye disease and vision loss (https://nei.nih.gov/nehep). Almost a decade and a half later in 2004, the Association of Schools and Colleges of Optometry (ASCO) developed “A Road Map for Diversity in Optometric Education and the Profession.” The road map called for the schools and colleges of optometry to “create, foster, and maintain an institutional climate that welcomes and embraces diversity” by conducting multicultural symposia and developing cultural competence/cultural communication seminars for faculty and staff.[24]

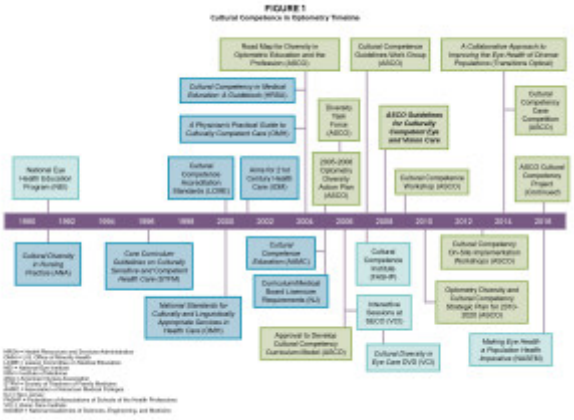


Figure 1. Click to enlarge

In March of 2005, Vistakon hosted at its headquarters in Jacksonville a meeting of the newly formed ASCO Diversity Task Force. The meeting was an adjunct to Vistakon’s diversity training agenda and included representatives from ASCO, the American Optometric Association (AOA), the National Optometric Association (NOA), the American Academy of Optometry (AAO) and the National Optometric Student Association (NOSA). The participants explored mechanisms for implementing the objectives and approaches outlined in the ASCO diversity road map. The outcome of the meeting was the 2005-2006 ASCO Diversity Action Plan, which was approved by the ASCO Board of Directors at its June meeting.

The diversity action plan was based on the diversity road map and represented the next step in ASCO’s

diversity initiative. The objective of the plan was to make diversity and multiculturalism core values within the academic culture of the ASCO schools and colleges of optometry.[25] Key components of the plan included the incorporation of diversity and cultural competency in the mission, goals and objectives of member institutions and the development of a cultural competency curriculum. The plan also included a focus on increased student diversity, realizing that students at more diverse schools tend to have higher self-assessments of cultural competence and are better prepared to address the needs of a multicultural population.[26]

On the practice side, the Vision Care Institute (VCI) – a Johnson & Johnson Company – provided an educational grant to SECO in 2006 in support of a continuing education program on cultural competency for conference attendees. Professional actors staged a series of theatrical sketches to illustrate the interpersonal faux pas from cultural blindness in a mock optometric office. The interactive sessions at the 2006 conference in Atlanta portrayed how certain conscious and unconscious actions could be influenced by cultural differences and how they might impact clinical care. The “Cultural Diversity in Eye Care” session was videotaped and released as a DVD by the VCI in 2007.[27]

ASCO Guidelines for Culturally Competent Eye and Vision Care

In concert with the ASCO Road Map for Diversity in Optometric Education and the Profession, the Diversity Task Force requested approval from the ASCO Board to proceed with the Diversity Action Plan’s recommendation to develop a cultural competency curriculum for implementation by the schools and colleges of optometry. The ASCO Board of Directors approved the task force’s request in June 2006. The approval to develop a “cultural competency curriculum model” came with the understanding that external funding would be required to support the process. The task force prepared and submitted a proposal for funding to Walmart’s Optical Division, an ASCO Corporate Contributor that expressed interest in supporting ASCO’s diversity initiatives. The proposal stressed the importance of a culturally competent optometric workforce in meeting the quality of care demands of a diverse society. Walmart approved the task force’s request with a grant for $70,000 over two years (2007-2008). The funding was split into two phases. Phase 1 funding supported the convening of a group of experts to develop the cultural competency curriculum model; phase 2 funding supported a training workshop on the cultural competency curriculum for faculty and administrators.

Phase 1

In January 2007, the chair of the ASCO Diversity Task Force, the ASCO Director of Student Affairs, and a faculty member from the UAB School of Optometry, along with representatives from allopathic medicine, osteopathic medicine, dentistry, pharmacy, nursing, veterinary medicine, allied health, public health and physician assistant education participated in the four-day Cultural Competence in Health Professions Education Institute sponsored by the Federation of Associations of Schools of the Health Professions (FASHP). The institute was designed to promote leadership and continuous improvement of cultural competence education in health professions institutions. It consisted of interactive exercises, clinical cases and vignettes that focused on the knowledge, attitudes, behaviors and skills necessary for integrating cultural competence education into the curricula of the health professions schools. The sessions were facilitated by faculty from the University of California, San Francisco, and the UCSF Center for the Health Professions. The facilitators introduced the Tool for Assessing Cultural Competence Training (TACCT). TACCT is a self-administered assessment tool that can be used to identify areas in the curriculum where aspects of culturally competent care are currently taught, as well as identify gaps where specific aspects of culturally competent care are missing from the curriculum.[28] The tool was developed by the AAMC to assist medical schools in meeting the LCME accreditation standards for integrating cultural competence training into the curriculum.[8]

As a preliminary step in the process of developing a cultural competency curriculum model, the ASCO

Diversity Task Force sought to educate and get early buy-in to its cultural competence initiative from key decision-makers at the schools and colleges of optometry and other constituencies within the optometric profession. The task force called upon the ASCO presidents, deans and chief academic officers to employ the AAMC Tool for Assessing Cultural Competence Training to conduct an internal assessment of their institution's level of knowledge, attitudes and skills in the five domains identified as necessary for cultural competence education: 1) cultural competence rationale, context and definition; 2) key aspects of cultural competence; 3) impact of stereotyping on medical decision-making; 4) health disparities and factors influencing health; and 5) cross-cultural clinical skills.[28] The task force chair presented the deans and presidents with the assessment findings at the March 2007 ASCO Board meeting. Less than 50% of the institutions responded to the assessment request, but many of those that did respond indicated a less than formal approach to cultural competence education. The task force chair also presented the rationale and development/implementation strategy for the cultural competence curriculum model. The presentation reinforced the curricular emphasis on culture – not race or ethnicity – as a quality-of-care issue.

The March presentation to the ASCO Board was followed by a similar presentation in June to the chief academic officers. Between the March and June presentations the task force decided to change the focus of the project from a "cultural competency curriculum model" to the less intrusive "cultural competence guidelines." The presentation was repeated again in September at a meeting of the clinic directors to further advance the case for formalizing an approach to cultural competence education in optometry. During the same year, the AOA Optometry 2020 Summit reinforced the call for cultural competence in clinical practice. As a "preferred future," the AOA reported optometrists and their staff should possess the knowledge, skills, and attitude to serve patients of different ethnicities, native languages, age, gender, religious, and cultural backgrounds.[29] The business case for workforce diversity and cultural competency in the ophthalmic community was also an agenda topic at the AOA Ophthalmic Council retreat in September.

For the next year the ASCO Diversity Task Force worked to develop a set of cultural competence education and training guidelines that could be integrated across the four-year curriculum of the ASCO institutions. The task force convened a Cultural Competence Guidelines Work Group comprised of the task force chair and one other task force member, the ASCO student affairs director, and four invited outside members, including two optometry faculty members with curriculum expertise, an outside content expert from the University of California, San Francisco, and the Director of Professional Relations for the Walmart Optical Division. The work group met for the first time in August, 2007 in a two-day workshop in Rockville, Maryland to: 1) define cultural competence in the context of comprehensive health care; and 2) identify key reasons why cultural competence training is essential to the optometric curriculum. The work group collected, reviewed, and assimilated best practices of cultural competence education into guidelines that would fit the needs of optometric education and practice. It drew upon the resources provided by the UCSF Center for the Health Professions, The California Endowment, the Association of American Medical Colleges, and the U.S. Office of Minority Health.

The guidelines were based on models previously developed and tested by other health disciplines and designed with the objective of providing a curricular platform from which to better prepare optometric clinicians to address the eye and vision health needs of a multicultural and global community. More specifically, the guidelines were designed 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

The final draft of the proposed curriculum guidelines was presented to the ASCO Board of Directors at its June 2008 meeting. The ASCO Board formally approved the ASCO Guidelines for Culturally Competent Eye and Vision Care[30] and posted the 53-page document on its website (https://www.opted.org/). ASCO's adoption of the guidelines brought optometric education into line with other health professions – particularly medicine, pharmacy, nursing, and public health – who understood early on the relationship of cultural competency to quality care. Components of the ASCO cultural competency guidelines project have been shared at meetings of the American Academy of Optometry and the World Congress on Optometric Education.

Phase 2

In the year following adoption of the guidelines, the chief academic officers of the schools and colleges of optometry (or a designee), members of the ASCO Diversity Task Force and Cultural Competence Guidelines Work Group, and a few other guests were invited to attend the ASCO Cultural Competence Workshop that was held in Ft. Lauderdale in May prior to the 2009 ARVO meeting. Travel, lodging and meal expenses for the invitees were covered by the Walmart grant. Nearly all U.S. schools and colleges of optometry were represented. As expected, there was a wide range in interest and experience among the 33 participants, with some appearing more ready than others to take a lead in the next phase of the process. The two-day train-the-trainer workshop was facilitated by Sunita Mutha, MD, FACP, director of the Healthforce Center at UCSF (formerly the Center for the Health Professions) at the University of California, San Francisco. Dr. Mutha was the lead author of Toward Culturally Competent Care: A Toolbox for Teaching Communication Strategies[10] and the content expert for the Cultural Competence Guidelines Work Group.

The Cultural Competence Workshop was designed to equip participants with the tools necessary to integrate cultural competence content into the optometric curriculum. With the guidelines as a resource, the workshop featured interactive presentations and training activities to help participants acquire the knowledge and skills necessary to design coursework that could assist students in becoming culturally competent providers of eye and vision care to diverse populations. The program started with identifying the pedagogic and logistic challenges associated with adding content to the curriculum. The facilitator framed the imperative for culturally competent care and reflected on how cultural values influence encounters with others. She discussed the dimensions of culture that impact interpersonal relationships, communication, and the differences that may exist between health professionals' and patients' perceptions of health, illness and healing practices. Participants examined tools for bridging cultural differences with patients, discussed the essential components of a cultural competency training curriculum, and identified strategies for integrating cultural content into the curriculum. Workshop participants were expected to apply their training by convening meetings of their respective faculty during the summer and fall to discuss and develop institution-specific implementation plans.

The guidelines work group chair presented a post-workshop review to the ASCO Board at its June 2009 meeting. Participant evaluations indicated that more than 80% agreed or strongly agreed with the workshop objectives and the workshop itself was given a high rating for content value. With the guidelines in place and the train-the-trainer workshop done, the guidelines work group had completed its charge. Also, with diversity firmly instilled as a major ASCO priority and in recognition of the need for continuing efforts to promote cultural competence, the ASCO Executive Committee voted to transform the Diversity Task Force into the Diversity and Cultural Competency Committee (2011). The charge to the new standing committee included encouraging the Accreditation Council on Optometric Education (ACOE) to include institutional diversity and cultural competence as an ACOE accreditation standard. A

new Cultural Competency Curriculum Guidelines Subcommittee was formed and charged with the continuing task of encouraging and facilitating implementation of the guidelines at all ASCO member institutions. Responding to a follow-up survey with the 2009 train-the-trainer workshop participants, the subcommittee prepared a summary text of the guidelines and a PowerPoint presentation for online access at the ASCO website.

Phase 3

The third phase of the ASCO cultural competency guidelines project was initiated in 2011 with the support of a second grant from Walmart. Phase 3 focused on the use of new strategies for implementing the guidelines at the institutional level with consideration of the unique needs and challenges of each institution. A Cultural Competency Guidelines Workshop Planning Group was formed to develop a program that could assist faculty with school-specific plans for integrating the guidelines into the activities and curriculum of the individual schools and colleges of optometry. The on-site Cultural Competency Curriculum Guidelines Implementation Workshops commenced in 2013 with seven schools participating the first year. The guidelines subcommittee chair met with the clinic directors and administrators at their 2014 fall meeting to stimulate greater interest in the on-site workshops. Two more institutions participated the second year (2014), five more in the third year (2015) and two more in the fourth year (2016). With two more institutions scheduled to participate in 2017, a total of 18 of the 23 ASCO institutions have or will have participated during the first five years in which the implementation workshops have been offered.

As a complement to the ASCO Guidelines for Culturally Competent Eye and Vision Care and following a recommendation from the Diversity and Cultural Competency Committee, ASCO introduced the Cultural Competency Case Study Competition for Optometry Students and Residents as a new ASCO award and resource. The competition, which was conducted in 2014 and 2015, was sponsored by the Diversity and Cultural Competency Committee with funding from the Walmart Optical Division. It served as a student-engaged tool for exploring and developing insight into aspects of culturally competent eye and vision care. The authors of the winning entries received a financial award of $2,500. The seven best case studies from the two years were published and made available on the ASCO website as a downloadable compendium of Case Studies in Cultural Competency[31] to help educate students on patient-centered attitudes, knowledge and skills leading to cultural awareness and competence.

Another new resource for eyecare practitioners also became available in 2014 with Transitions Optical's publication of A Collaborative Approach to Improving the Eye Health of Diverse Populations. The 2014 publication was an update to its 2009 roundtable discussion on Cultural and Linguistic Considerations for Vision Care. In 2016, Transitions Optical partnered with the National Optometric Association to release the educational paper Eyes on Millennials: The Most Culturally Diverse Generation that summarizes highlights from the co-sponsored "Multicultural Millennial Matters" panel presentation at the NOA convention in Chicago. The multicultural and cross-generational panel discussed eye and vision health needs through the cultural lens of minority Millennials. Transitions again partnered with the NOA in 2017 to co-sponsor the "Minority Eye Health Still Matters" panel discussion. A white paper, Why Minority Eye Health Still Matters: A Call for Current – and Future – Eyecare Professionals to be Culturally Competent, will soon be published and added to the "My Multicultural Toolkit."

All publications can be accessed from the "Cultural Connections" website via "My Multicultural Toolkit" (https://www.mymulticulturaltoolkit.com/). The toolkit also includes a variety of other resources to assist clinicians in meeting the eye and vision health needs of culturally diverse populations.

A Continuous Process

A 2014 survey found that 95% of eyecare professionals believe a good understanding of a patient's

cultural background is constructive to providing a better patient experience.[32] Furthermore, Truong et al. believe that, “Improvements in optometrist-patient relationships leading to negotiated and shared understandings of eye problems will have a positive impact on the management of ocular problems and an overall improvement in ocular health in the community.”[33] The 2016 landmark report Making Eye Health a Population Health Imperative: Vision for Tomorrow from the National Academies of Sciences, Engineering, and Medicine states, “cultural competency helps build concordance between patients and health care providers by challenging providers to think outside of their strict biomedical constructs and respond to the cultural barriers that inevitably arise because of patients’ diverse belief systems and views about health, health care and health care providers.”[23] The National Academies further reported that “the continuing development, implementation, and evaluation of cultural competence programs, training modules, and educational tools designed to improve the affective dimensions of communication and clinical behavior” can help increase patient-provider concordance, reduce implicit bias and respond to the cultural barriers that are inherent in diverse belief systems.

In parallel with the above perspectives, the ASCO Board-approved Optometry Diversity and Cultural Competency Committee Strategic Plan for 2010-2020 identifies cultural competence as a core value in optometric education and patient care.[34] The plan includes four strategic goals for institutionalizing diversity and cultural competency:

> Strategic Goal 1: Encourage each of the nation’s schools and colleges of optometry to incorporate diversity and cultural competency in its mission, goals, and objectives
>
> Strategic Goal 2: Encourage ACOE to require cultural competency education and training within the curriculum
>
> Strategic Goal 3: Reward schools and colleges who have clearly demonstrated a sustained commitment to increasing diversity and improving cultural competency
>
> Strategic Goal 4: Increase optometric faculty diversity

It was important to the ASCO Diversity Task Force for the curriculum guidelines to be viewed not as a short course or a one-time add-on to the curriculum, but as a continuous, progressive and integrated approach to blending the principles of patient-centered care with an understanding and appreciation of how diverse cultural constructs can affect the delivery of optometric services, the quality of patient experiences and the measurable success of clinical goals and outcomes. To this end, the ASCO Diversity and Cultural Competency Committee must continue to work aggressively in promoting cultural competence as a foundational step on the path to clinical excellence at the U.S. schools and colleges of optometry and as a critical quality-of-care measure for the optometric profession.

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Dr. Marshall [marshall@indiana.edu] is Professor Emeritus of Optometry and Public Health at Indiana University. He had also served as Associate Dean for Academic Affairs and Student Administration in the IU School of Optometry as well as IU Vice President for Diversity, Equity and Multicultural Affairs.

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