Building Diverse and Inclusive Communities in Academic Health Centers

2008 Forum on Emerging Issues
Harry Gibbs, Robert C. Like and Jeannette E. South-Paul
Acknowledgments

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and the

UNIVERSITY of COLORADO DENVER

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2008 ELAM Forum on Emerging Issues

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Advancing Women’s Leadership in Academic Medicine: An Overview of the ELAM Program

ELAM Overview
Founded in 1995, ELAM is the only in-depth national program that focuses on preparing senior women faculty at academic health centers (AHCs) to move into positions of institutional leadership where they can make positive change. ELAM is a core program of the Institute for Women’s Health and Leadership (IWHL) at Drexel University College of Medicine. Together, ELAM and the IWHL continue the long legacy of advancing women in medicine that began in 1850 with the founding of the Female Medical College of Pennsylvania, the nation’s first women’s medical school and predecessor of today’s Drexel College of Medicine.

ELAM’s year-long part-time fellowship program mixes traditional executive seminars and workshops on topics pertinent to AHC management, with group and individual projects aimed at developing personal leadership. Throughout the year, there are opportunities to meet with nationally recognized leaders in academic medicine, health care, government and industry and to interact with peers from different disciplines and institutions. The program year culminates in a 1½ day Forum, when the Fellows, their Deans, and other invited guests gather with top experts to explore a new methodology or strategy for addressing a timely issue facing AHC leadership.

Recognition of ELAM’s importance and the leadership potential of its graduates is evidenced in the following statistics: nearly 90% of U.S. medical schools and 50% of U.S. dental schools have sponsored ELAM Fellows. ELAM participants now hold senior posts (Department Chair or higher) at close to 100 U.S. academic institutions, including 10 deanships.

ELAM Recognition and Support
ELAM has been honored in every facet of its work. In higher education, it has received the American Council on Education’s Office of Women in Higher Education Network Leadership Award; in medicine, the Association of American Medical Colleges’ Women in Medicine Leadership Development Award; and in dentistry, the Dr. Edward B. Shils Entrepreneurial Education Fund Award.

Because of its pre-eminence in the field of women’s leadership education, ELAM received a five-year grant in 2001 from The Robert Wood Johnson Foundation to conduct an in-depth evaluation of the program’s effectiveness and develop theory about educating women for leadership. Additional funding for this research project was provided by the Mayo Medical School and Mayo Clinic Rochester, the University of Michigan, Vanderbilt University, Wright State University, and the Jessie Ball duPont Fund.

ELAM is supported by program fees, grants, gifts, and in-kind contributions from ELAM classes, foundations, corporations, and individual donors, notably Patricia Kind, who established partial endowment for the program in memory of her mother, Mrs. Hedwig Pfaltz van Ameringen. ELAM also receives contributions from the ELAM Alliance, a consortium of independent consultants working in academic medicine and higher education committed to the advancement and success of women in leadership positions, and from the Society for Executive Leadership in Academic Medicine (SELAM International). SELAM, founded in 1998 by ELAM alumnae, is committed to the advancement and promotion of women to executive positions in academic health professions through programs that enhance professional development and provide networking and mentoring opportunities.
The ELAM Program’s Forum on Emerging Issues
The Forum on Emerging Issues is the capstone event of the ELAM spring session, when Fellows are joined by senior delegates from their home institutions, most often the Deans, along with invited guests (see Appendix A for list of this year’s participants). Each year, the ELAM Forum explores an innovative concept or methodology that has direct application to leading and managing an academic health center. The Forum’s interactive format enables participants to explore potential applications of the new concept in a collegial and creative environment.

Past Forum Topics

Positive Deviance (2007)
Positive Deviance differs from traditional “needs based” or problem-solving approaches; rather, it seeks to mobilize the organizational community to identify and amplify positive problem-solving practices that already exist. Led by Jerry and Monique Sternin, who first developed the approach 10 years ago to address the problem of malnutrition in Vietnam. Underwritten by the University of Alabama at Birmingham School of Medicine and West Virginia University School of Medicine.

Tapping the Full Power of the Alpha Leader (2006)
Working from the belief that the greatest leadership influence is leveraged through openness to feedback and commitment to transparent communication, facilitators Kate Ludeman and Eddie Erlandson of Worth Ethic offered techniques for moving the “Sludge” out of interactions and communications in order to move to “Results.” Underwritten by the University of Iowa Carver College of Medicine, the University of Medicine and Dentistry of New Jersey/New Jersey Medical School, and the University of Ottawa Faculty of Medicine.

Transformational Philanthropy (2005)
Participants explored effective ways for attracting and cultivating individual donors to support their institutional mission and vision and help transform their organizations. Led by fundraising expert Karen E. Osborne, President of The Osborne Group, Inc. Underwritten by the University of Texas M.D. Anderson Cancer Center.

Uncovering and Overturning the ‘Immunity to Change’: Personal Learning and Professional Development (2004)
Looking first at themselves and then at their organizations, participants identified “Core Contradictions” that impede work commitments or aspirations. Led by Harvard’s Meehan Professor of Adult Learning and Professional Development, Robert Kegan, an award-winning psychologist, teacher, and co-author of How the Way We Talk Can Change the Way We Work. Underwritten by the University of Texas Medical Branch at Galveston.

Energizing Change in Organizations: An Introduction to Appreciative Inquiry (2003)
Participants learned how to improve their own leadership and facilitate organizational change using the methods of Appreciative Inquiry. Led by Penelope R. Williamson, Associate Professor of Medicine at Johns Hopkins University School of Medicine, and Anthony L. Suchman, Practicing Internist and Organizational Consultant, participants explored strategies for building more relationship-centered, inclusive, collaborative organizational systems that focus on institutional strengths rather than problems. Underwritten by the University of Utah School of Medicine.
Building the Leadership Engine for Academic Health Centers (2002)
Led by Noel M. Tichy, Professor of Organizational Behavior and Human Resource Management at the University of Michigan Business School and Director of its Global Leadership Program. Dr. Tichy and participants explored how to develop effective leaders and winning organizations. Dr. Tichy’s scholarship and research focus on global leadership, strategic human resource management, organizational change and career development. He led participants through a series of exercises and reflections on how to develop effective leaders and winning organizations. Underwritten by the University of Michigan’s Medical School, School of Dentistry, and Office of the Provost.

Innovative Thinking and Creativity Tools to Improve Academic Health Centers (2001)
Paul Plsek, an internationally recognized consultant on improvement and innovation for today’s complex organizations and developer of the concept of DirectedCreativity™, introduced participants to a variety of creativity tools to promote innovative thinking and problem solving at AHCs. Underwritten by the University of Michigan’s Medical School, School of Dentistry, and Office of the Provost.

The tool of the Balanced Scorecard for strategy and performance measurement efforts was applied in the academic health center setting. Led by Stephen Rimar, a recognized leader in the application of the Balanced Scorecard approach to academic medicine and then Vice-Chairman of the Department of Anesthesiology and Medical Director of the Faculty Practice Plan at the Yale University School of Medicine. Underwritten by the Colgate-Palmolive Company.

Using an innovative model specially designed for ELAM that focused on academic health centers, participants built on the scenario-planning concepts explored in the 1998 Forum. Guided by Bruce Gresh, who designed the simulation, participants played out the effects of implementing management decisions in a complex system. Underwritten by the Colgate-Palmolive Company.

Planning, Learning and Rehearsing the Future for Academic Health Centers: Success in the Face of... (1998)
Introduced scenario planning methodology. Led by Paul Batalden, Director, Health Care Improvement Leadership Development, Center for Evaluative Clinical Sciences, Dartmouth Medical School. Underwritten by a grant from the Josiah Macy, Jr. Foundation.

Peter Senge’s Five Disciplines was applied to academic health center systems.

Academic Medical Centers 2010: An Organizational Odyssey (1996)
Using future search methodology, this Forum explored the optimal governance structures and leadership styles that will be essential for the future.

* Note: Titles listed above are as of the dates each topic was presented.
The 2008 ELAM Forum on “Building Diverse and Inclusive Communities in Academic Health Centers” was unique in: the expertise and experience of the three faculty facilitators; the broad focus; and wealth of resources that were provided to participants.

**Faculty**

The Forum faculty team members were all senior-level academicians who hold senior- or executive-level positions in their institutions. For this Forum, we selected faculty who possess not only credentials and experience in diversity education, but have deep experience in leading academic health center operations.

**Harry Gibbs, M.D.**

Dr. Gibbs is Vice President for Institutional Diversity at the University of Texas M.D. Anderson Cancer Center. He has designed, developed, and produced workshops and seminars, both internal and multi-center, focused on minority faculty and staff development. His work includes diversity initiatives for organizational advancement, mentoring, and cross-cultural communications. He is the Chairman of the Diversity Council and the Affirmative Action Officer at M.D. Anderson Cancer Center in Houston, Texas.

**Robert Like, M.D., M.S.**

Dr. Like is Professor and Director of the Center for Healthy Families and Cultural Diversity in the Department of Family Medicine at the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School. Dr. Like is nationally known for his work in the area of cultural competency and health professions education. He has received a variety of awards including the 2004 Distinguished Service in the Health Field Award from the National Association of Medical Minority Educators, and is a 2004 and 2007 Pfizer/American Academy of Family Physicians Foundation Visiting Professor in Family Medicine.

**Jeannette South-Paul, M.D.**

Dr. South-Paul is Andrew W. Mathieson Professor and Chair of the Department of Family Medicine at the University of Pittsburgh School of Medicine. She has been actively involved in cultural diversity activities for more than 15 years, serving on committees in the Association of American Medical Colleges (AAMC) and the American Academy of Family Physicians (AAFP).
Forum Topics
An unusually wide range of issues involved in building diverse and inclusive communities were presented over a day and half of the Forum, using slides, table and plenary discussions, and videos. The topics included: organizational culture, considerations in conducting research in a multicultural setting, addressing racial and ethnic disparities and the role of the medical profession, and how to become a culturally competent academic health center.

HEALTHCARE ORGANIZATIONAL CULTURE
Harry Gibbs, M.D., provided an overview of the role of culture and leadership in creating an environment of inclusion and the importance of organizational culture in serving as a “critical lens for diversity, inclusion and cultural competency.” He presented a description of culture and healthcare organizational culture:

“Culture is the totality of socially transmitted behavioral patterns, arts, beliefs, values, customs, lifeways, and all other products of human work and thought characteristics of a population of people that guide their worldview and decision-making.”

“Health care organizational culture has a profound effect on the capacity as well as the commitment to provide culturally competent care.”

Purnell and Paulanka, Transcultural Health Care (ref: slides of Dr. Gibbs)

He posited that the organizational culture of healthcare is a unique and complex one regardless of whether the approaches to care follow non-profit or for-profit models. Some aspects that contribute to its uniqueness are: elaborate system of beliefs, pervasive technology, conflict between reliance on technology and humanism, social license to actually invade body and mind, and government-sanctioned authority to exclude “non-accepted” beliefs, practices and practitioners. As a result of its complexity and uniqueness:

“The health care industry as a culture occupies a special place in society, quite different from the culture of its patients, regardless of their ethnicity or social class. The industry is essentially mechanical, technical, financial, and actuarial, whereas its patients are none of these”

Lonner and Mayeno, LY 2000 (ref: slides of Dr. Gibbs)

Therefore the healthcare organizational culture creates a “power struggle” or tension between providers and patients where patients may have little control over choice of plan or provider and choices may vary with cultural determinants (see Table I).
What are the conditions for organizational change (specifically in the realm of cultural competence)? (See sidebar.) Gibbs suggested focusing the change effort on the 45% of the workforce who, research shows, are in the group that initiates change, those who agree immediately with the change, and those who agree when they see a positive indication from the change. He also referred to The Spiral Dynamics Model, (described later in the report on page 17), an organizational culture assessment tool that M.D. Anderson Cancer Center has found particularly useful in documenting evolution along the continuum of increasing cultural competence.

The leader’s role is to provide the necessary commitment and support for the change; otherwise, according to John Kotter in Leading Change, efforts will wither, from the start, or later or become unsustainable for lack of a champion. When the leadership is invested in creating an inclusive environment where individuals are committed to attaining cultural competence, then there will be more authenticity in outward behaviors reflecting individual intentions systemically throughout the organization.

Table I – Cultural Determinants

<table>
<thead>
<tr>
<th>Cultural Determinants (we tend to focus on those that 100% involve us)</th>
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</thead>
<tbody>
<tr>
<td>Languages</td>
</tr>
<tr>
<td>Religious orientation</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Patriarchal</td>
</tr>
<tr>
<td>Family</td>
</tr>
<tr>
<td>Medical center culture</td>
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<tr>
<td>Nationality</td>
</tr>
<tr>
<td>Race</td>
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</tbody>
</table>

CULTURAL AND OTHER CONSIDERATIONS IN CONDUCTING RESEARCH IN MULTI-CULTURAL SETTINGS

Jeannette South-Paul, M.D., presented provocative issues that increasingly face AHCs as they are encouraged by governments and funding agencies to expand clinical services and to consider the relevance of race and ethnicity in clinical trials and other types of community interventions. The first is the notion of cultural and linguistic competence:

“...a set of congruent behaviors, knowledge, attitudes and policies that come together in a system, organization or among professionals that enables effective work in cross-cultural situations”.

Cross, Basron, Dennis and Isaacs, Study conducted at the National Center for Cultural Competence, Georgetown University 1989
Dr. South-Paul deemed the foremost critical skill to be “cultural humility” -- commitment to: lifelong self-evaluation and self-critique, understanding and redressing the power imbalance in the patient-physician dynamic, and developing mutually beneficial partnerships with communities on behalf of individuals and defined populations (Tervalon M, Murray-Garcia J. Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education. *Journal of Health Care for the Poor and Underserved* 1998; 9(2):117-124.) The considerable resources provided by the North American Primary Care Research Group were highlighted (http://www.napcrgr.org/responsible.research.pdf) and the importance of a Community Research Advisory Board also was cited (Cappon P, Parboosingh J, et al. “Social Accountability A Vision for Canadian Medical Schools”. *Health Canada*, Ottawa, Ontario © Her Majesty the Queen in Right of Canada, represented by the Minister of Public Works and Government Services Canada, 2001).

“Responsible, culturally competent research is participatory research.” It requires changing the view of the community as a problem to be solved with multiple needs that must be addressed (drop-outs, welfare recipients, gangs) to an assets-based view of clients having individual and collective gifts and talents (businesses, income, cultural groups).

Several barriers contribute to interference with community research. One is historic distrust of the healthcare system exemplified by the 40-year Tuskegee syphilis study. The community also experiences its own stressors (for example, family, unemployment, educational and healthcare problems). Dr. South-Paul referred to studies by The Commonwealth Fund’s 2001 Health Care Quality Survey that demonstrated minorities face greater difficulty communicating with their physicians. Hispanics and African Americans were most likely to feel they were treated with disrespect (because of lack of ability to pay, race, lack of ability to speak English). Other barriers include the fact that some diverse communities have not benefited from the research they participated in; that different values, spiritual, social, and cultural beliefs prevent participation; and finally that funders of research do not follow principles of participatory research and have little or no training in the area (Goode T, Harrison N. Policy Brief 3: Cultural Competence, in Primary Health Care Partnerships for a Research Agenda. National Center for Cultural Competence. Georgetown University, Summer, 2000).

An example of community participation is the CRAB (Community Research Advisory Board) at the University of Pittsburgh, a vision of Stephen B. Thomas, Ph.D., Director of the Center for Minority Health (CMH). About 40 people are on the board and about 20 of them meet monthly. The group includes: CMH faculty, staff and individuals from academic, health related and community settings and other stakeholders such as patients, clergy, retailers, law enforcement, community organizations, and government. Participants are enrolled from broader places: community health centers, churches, schools, health fairs.

addition, Dr. South-Paul added two additional commandments based on her experience. Participatory research results in service learning and more practical clinical trials. A new field is developing for studying outcomes based on practical clinical trials. One dynamic in participatory research is how to facilitate mutual valuation of the contributions of the participants.

**The Ten Commandments of Community Based Research**

+ Two

1. Thou shalt not define, design nor commit community research without consulting with the community!
2. As ye value outcomes, so shall ye value processes!
3. When faced with a choice between community objectives and the satisfaction of intellectual curiosity, thou shalt hold community objectives to be the higher good!
4. Thou shalt not covet the community’s data!
5. Thou shalt not commit analysis of community data without community input!
6. Thou shalt not bear false witness to or about members of the community!
7. Thou shalt not release community research findings before the community is consulted (premature exposition)!
8. Thou shalt train and hire community people to perform community research functions!
9. Thou shalt not violate confidentiality!
10. Thou shalt freely confess thyself to be biased and thine hypotheses and methodologies so likewise!

**Plus two from Dr. South-Paul**

11. Thou shalt know and respect the culture of the community you are studying!
12. Thou shalt know that the community is the expert on its culture and consult it first!
Small groups of Forum participants then outlined barriers that dissuade some ethnic groups’ participation in clinical trials and diminish patient-oriented interactions and community involvement (Table II). Groups also listed strategies some AHCs are using to enhance community-based participatory research and the impact on the traditional research process and reward system in AHCs (Table III).

### Table II – Barriers to Conducting Clinical Trials in the Community

<table>
<thead>
<tr>
<th>1.</th>
<th>Barriers to participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Financial.</td>
</tr>
<tr>
<td>b.</td>
<td>Assuming Medicare drives everything (e.g. nursing, public health).</td>
</tr>
<tr>
<td>c.</td>
<td>HIPAA.</td>
</tr>
<tr>
<td>d.</td>
<td>Academic view of “good” and “bad science.”</td>
</tr>
<tr>
<td>e.</td>
<td>Organization structure.</td>
</tr>
<tr>
<td>2.</td>
<td>Children</td>
</tr>
<tr>
<td>a.</td>
<td>Under-represented, understudied and underfunded.</td>
</tr>
<tr>
<td>3.</td>
<td>Communities</td>
</tr>
<tr>
<td>a.</td>
<td>Are diverse: Considering them as one unit results in ineffective interventions and evaluations using the current model.</td>
</tr>
<tr>
<td>b.</td>
<td>Expect you to meet clinical needs, not just research needs: How best to meet their needs with limited resources? (e.g. Tertiary care medical center tend not to focus on major issues of concern to rural inhabitants [primary care]).</td>
</tr>
<tr>
<td>c.</td>
<td>Require a trust-based relationship: This requires time, and respect for the community time table.</td>
</tr>
<tr>
<td>d.</td>
<td>Are often multiple communities: (e.g. The term “Latino” includes multiple communities.)</td>
</tr>
<tr>
<td>4.</td>
<td>Community Care Providers</td>
</tr>
<tr>
<td>a.</td>
<td>May perpetuate barriers to care at academic health centers.</td>
</tr>
<tr>
<td>b.</td>
<td>Memory of something that didn’t go well lasts a long time.</td>
</tr>
<tr>
<td>c.</td>
<td>Can be seen as competitors.</td>
</tr>
<tr>
<td>5.</td>
<td>Continuum of Research Infrastructure/Flexibility</td>
</tr>
<tr>
<td>a.</td>
<td>What researcher or structure can assume a new focus? For example, if research focus is diabetes and the community is concerned with violence, what is appropriate infrastructure to provide that flexibility?</td>
</tr>
<tr>
<td>6.</td>
<td>Disclosure</td>
</tr>
<tr>
<td>a.</td>
<td>We cannot tell community results before prohibition-disclosure requirements.</td>
</tr>
<tr>
<td>7.</td>
<td>Innovation/Technology</td>
</tr>
<tr>
<td>a.</td>
<td>Need for new methods to evaluate impact and respond to refined processes identified during study implementation.</td>
</tr>
<tr>
<td>b.</td>
<td>Technology application, e.g. telemedicine.</td>
</tr>
<tr>
<td>8.</td>
<td>Relationships and Relationship-building</td>
</tr>
<tr>
<td>a.</td>
<td>Past history of problematic relationships between community and school.</td>
</tr>
<tr>
<td>b.</td>
<td>To establish relationships: need time and need resources.</td>
</tr>
<tr>
<td>c.</td>
<td>Institution needs to support and value community relationships.</td>
</tr>
<tr>
<td>d.</td>
<td>Relationship develops with individual, not institution, and may be lost easily</td>
</tr>
<tr>
<td>e.</td>
<td>Identifying the right people who represent the community; identifying the champion; identifying who “speak for” communities and also for the academic health center; must be very cautious not to alienate parts of the community.</td>
</tr>
</tbody>
</table>
**Participating in Community Research – Opportunities**

1. **Change Attitude/Approach**
   - a. The community is the guide rather than the AHC.
   - b. The definition of community may not be what you initially thought.
   - c. It will take time and timing belongs to the community.
   - d. Immediate response is required to develop a trust-based relationship.

2. **Find Common Goals**
   - a. Begin with survey of needs and barriers for community to complete.
   - b. Necessary to find common goals in order to successfully carry out. The question may not be the primary goal for the community, yet the researcher may successfully complete the study because the community’s goal is being addressed.
   - c. Need University person – engaged in community research and development.

3. **Build Community Relationships**
   - a. Establish trust prior to making proposal.
   - b. Need to keep coming back to the community. Build a relationship over time.
   - c. Community Involvement – ask the recent additions to communities (Bosnians, Africans) what they need.
   - d. Establish relationship BEFORE you need to do research project.

4. **Communicate with the Community**
   - a. We (Emory) do extensive research to determine what types of informational communications are most effective given the demographics of Atlanta. We have found face to face communications are best for African American females, whereas slick on line information is the only type that attracts the young (Millennial(s)). Hence tailor the communications to the group. Ensure you’ll share data prior to publishing.
   - b. Media.
     1) If we know about press, we can prepare for patients better, adjust website in advance.
     2) Can use good stories to provide local information.
   - c. Utilize community participatory process to develop, refine and confirm the research questions that matter and the interventions that are feasible.

5. **Find Community Champions and/or Advocates**
   - a. ID community participants.
     1) Work through an existent “channel” in low income housing.
     2) Identify a population and its leaders.
   - b. Community participation in all aspects. Not just research in building of a center. Representatives serve as conduit of the community and have an investment in the community.
   - c. For pre-determined disease, specific studies (i.e. Atlanta’s HIV vaccine trial) we go to specific advocacy groups rather than community at large and they in turn serve as intermediaries to communities. Examples of these groups are AIDS Atlanta, Sister Love, and Gay and Lesbian Groups.

6. **Discover and Enhance Community Assets**
   - a. Enhance community through the process (provide training for involved members that allow them to advance their own positions/education).
   - b. Large long-term network in rural communities; screening connections with local resources.
   - c. “Centers for Independent Living” are available in many areas who serve as “the community home” for persons with disabilities.

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**Table III– Strategies to Increase Community Participation in Research Trials**

<table>
<thead>
<tr>
<th>Number</th>
<th>Phase</th>
<th>Description</th>
</tr>
</thead>
<tbody>
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<td>2</td>
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<table>
<thead>
<tr>
<th>7.</th>
<th>Academic Adaptations</th>
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<tbody>
<tr>
<td>a.</td>
<td>Redefine/change criteria for promotion and tenure that reflect CBPR (Community Based Participatory Research) principles. Make criteria explicit.</td>
</tr>
<tr>
<td>b.</td>
<td>Student outreach projects-teach them to be in community (e.g. Specific medical education program focusing on the Latino Community by recruiting medical students and faculty who want to focus on care to this community).</td>
</tr>
<tr>
<td>c.</td>
<td>Read successful CTSA Applications.</td>
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<tr>
<th>8.</th>
<th>IRB Adaptations</th>
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<tbody>
<tr>
<td>b.</td>
<td>IRB’s need to understand the 10 Commandments of Participatory Research.</td>
</tr>
<tr>
<td>d.</td>
<td>What you should focus on in this method is data, not instruments.</td>
</tr>
<tr>
<td>e.</td>
<td>Conduct qualitative research as well as quantitative research.</td>
</tr>
<tr>
<td>f.</td>
<td>Remember that process and product are inextricably linked.</td>
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<thead>
<tr>
<th>9.</th>
<th>Academic Networks</th>
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<tbody>
<tr>
<td>a.</td>
<td>Community-based Schools must partner with large institutions.</td>
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<tr>
<td>b.</td>
<td>Develop large regional consortium for community-based research involving community medical schools.</td>
</tr>
<tr>
<td>c.</td>
<td>Isolated Academic Medical Centers-develop outreach with rural or inner urban Medical Centers (AHEC program).</td>
</tr>
<tr>
<td>d.</td>
<td>Having Community Partners.</td>
</tr>
<tr>
<td></td>
<td>2) Practice based research networks.</td>
</tr>
<tr>
<td></td>
<td>3) Large institutions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10.</th>
<th>What Worked Well</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>UCLA</td>
</tr>
<tr>
<td></td>
<td>1) Robert Wood Johnson Scholars Program.</td>
</tr>
<tr>
<td></td>
<td>2) School Systems-Family Health Clinic in a MS.</td>
</tr>
<tr>
<td></td>
<td>3) Med Students are docs for kids in juvenile health system.</td>
</tr>
<tr>
<td>b.</td>
<td>UNC</td>
</tr>
<tr>
<td></td>
<td>1) AHEC-40 years.</td>
</tr>
<tr>
<td></td>
<td>2) Family Practice Network Case for Community focused research.</td>
</tr>
<tr>
<td></td>
<td>3) AHEC’s (9 centers) education, clinical research.</td>
</tr>
<tr>
<td></td>
<td>4) Community based practice for med students.</td>
</tr>
<tr>
<td></td>
<td>5) SPH efforts out in the community.</td>
</tr>
<tr>
<td>c.</td>
<td>Louisville</td>
</tr>
<tr>
<td></td>
<td>1) Community representation on board of directors.</td>
</tr>
<tr>
<td></td>
<td>2) When building new buildings, always have community reps on their board.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11.</th>
<th>Technology</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Telemedicine</td>
</tr>
</tbody>
</table>

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**Need to value community engaged research in same way we value NIH-funded research when promotion and tenure are considered.**
Questions and answers triggered by the video

There was lively response and reactions of ELAM participants to videos about various aspects of cultural competency in health care education and delivery and how they could be used. These included:

- Viewing diversity as positive rather than focusing on the numbers.
- Need to consider white males – that do not fit the mold of white male heterosexual stereotype.
- Celebrate all dimensions of diversity in one month as opposed to separate holidays.
- Consider preventive action rather than solving problems as they arise.
- As new people come into the organization, assign mentors who understand the organization, career ladders, etc.
- Couple the trigger tapes with personal stories for greatest impact.
- Make incremental movements and celebrate movements toward that culture of inclusion rather than focusing on major organizational change initiatives.
- Create a business case for diversity, comparing the cost if one chooses to ignore creating a culture of diversity (for example, the turn over costs 16M /yr at MDACC).
- How does the institution deal with patient bias toward caregivers? Make clear that the organization is inclusive.
- Make outreach to the community to familiarize them with the organization and have the organization know who is in the community.
- Sensitize faculty and staff with regards to community issues.
- Vignettes seem so blatant...and yet insensitivities still occur that are similar to the vignettes presented.
- Educate young people about their micro-inequities so they are better prepared.
  
  E.g. the words might be OK but the tone may be condescending.

One film illustrated cultural issues with a U.S. medical school starting a school abroad. A take-home message was the importance of framing the inquiry. (e.g. asking “What do you understand?” “What do you need?” “What are your concerns?” – rather than – “What are your questions?”)

Films Shown

*Hold Your Breath* from Stanford University depicts Mohammad Kochi who fled Afghanistan in 1979 to settle in CA but then develops an aggressive life-threatening cancer. Concerns about his care arise because of lack of cultural understanding as well as language and communication barriers. The video illustrated non-effective tactics: developing cultural competency for each culture. It is more effective to develop health literacy by creating feedback loops to check for understanding.

In *Worlds Apart*, African American Robert Philips, Stanford, CA who had end stage renal disease presented his experience with the racial inequities that kept him on the waiting list longer than Euro-American transplant patients. Questions raised by participants included: What would they say on watching film? Were the family members involved in the editing?
AFFIRMATIVE ACTION

Dr. South-Paul then presented highlights of legislation that had major impact on underrepresented minority enrollment and advancement at academic health care centers (Table IV).

Table IV – Selected Affirmative Action Legislation

<table>
<thead>
<tr>
<th>Year</th>
<th>Agent</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td>John F. Kennedy</td>
<td>Executive Order (EO) 10925: first used the term affirmative action (AA) to ensure equal treatment regardless of race, religion, color, sex or national origin.</td>
</tr>
<tr>
<td>1964</td>
<td>Lyndon B. Johnson</td>
<td>Landmark Civil rights Act of 1964: Prevented discrimination by large employers (over 15 employees) regardless of government contract status. EEOC established.</td>
</tr>
<tr>
<td>1978</td>
<td>Supreme Court</td>
<td>U of CA vs. Bakke upheld use of race as one factor for admission of qualified applicants. Unlawful: SOM’s practice of setting aside 18/100 seats for disadvantaged.</td>
</tr>
<tr>
<td>1995</td>
<td>Bill Clinton</td>
<td>Reviewed affirmative action guidelines and declared support: “mend it, don’t end it.”</td>
</tr>
<tr>
<td>1995</td>
<td>Regents of UC</td>
<td>University of CA voted to end affirmative action programs at all University of California Campuses. In 1998, ban resulted in 61% drop in African Am, Latino and Native Americans at Berkeley and 36% drop at UCLA.</td>
</tr>
<tr>
<td>1995</td>
<td>Voters</td>
<td>CA Prop 209: Abolished all public sector affirmative action programs in the state (employment, education, contracting).</td>
</tr>
<tr>
<td>1997</td>
<td>Student Plaintiffs</td>
<td>Lawsuits filed against University of Washington Law school use of affirmative action policies in admission standards.</td>
</tr>
<tr>
<td>1998</td>
<td>Voters</td>
<td>Voters in Washington passed Initiative 200 banning affirmative action policies in education, public contracting and hiring.</td>
</tr>
<tr>
<td>2000</td>
<td>FL Legislature</td>
<td>Passed One Florida Plan banning Affirmative Action. It also included the Top 20% plan guaranteeing the top 20% admission into the University of Florida system.</td>
</tr>
<tr>
<td>2001</td>
<td>California</td>
<td>Adopted plan for top 12.5% of students entry into the State university system.</td>
</tr>
<tr>
<td>2002</td>
<td>6th Circuit Ct</td>
<td>Grutter vs. Bollinger upheld use of race as one of many factors in admission to University of Michigan Law School.</td>
</tr>
<tr>
<td>2003</td>
<td>Supreme Court</td>
<td>Grutter vs. Bollinger upheld use of race because narrowly defined, served compelling interest, flexible and took a holistic view of each applicant.</td>
</tr>
<tr>
<td>2003</td>
<td>Supreme Court</td>
<td>Gratz vs. Bollinger - Rejected: granting points based on race/ethnicity for admission to school of Literature, Science and Arts was rigid. No review of applicant’s file.</td>
</tr>
</tbody>
</table>

(*Wilcher, SJ, Wilcher Global, LLC and former Executive Director of Americans for a Fair Chance)

There are trends toward anti-affirmative action policies. In 2006, the Michigan Civil Rights Initiative (MCRI) coalition passed an amendment to the state constitution banning consideration to individuals or groups based on race, gender, color, ethnicity or national origin for public employment, education or contracting purposes. Ward Connerly (political activist and entrepreneur) is spearheading anti-affirmative action programs in targeted states: Colorado, Arizona, Missouri Oklahoma and possibly South Dakota or Nebraska. However, Jordan Cohen, M.D., AAMC's president emeritus, documents the need for diversity among faculty, physicians, students and managers of healthcare to improve medical education and research, to care for underserved populations and because it makes business sense (Cohen, J. The Consequences of Premature Abandonment of Affirmative Action in Medical School Admissions. JAMA 2003; 289(9) 1143-1149). Without mandated programs in higher education to ensure such diversity, underserved minority representation falls.
Robert C. Like, M.D., M.S., provided an overview of the research that documents health/healthcare disparities, contributing factors, and what medical professionals can do.

In the area of cardiovascular care, for example, out of 81 studies conducted between 1984 and 2001, 68 found evidence of racial/ethnic difference in care, 11 found no difference, and two found minorities more likely than whites to receive appropriate care. Social determinants (socioeconomic status, class, and education), access to care (for example, insurance or geographic location) and the provision of health care (through the individual medical encounter and/or the health system itself) can lead to disparities in health (Kaiser Family Foundation’s Racial/Ethnic Differences in Cardiac Care: The Weight of the Evidence (see: http://www.kff.org/uninsured/20021009c-index.cfm).

More minorities (African Americans, Asians, Latinos and Native Americans) are uninsured compared to non-Latino whites, (Kaiser Commission on Medicaid and the Uninsured, Health Insurance Coverage in America, 2001, updated 2003) with higher mortality rates among African Americans across all age groups (Kaiser Family Foundation, 2003).

The causes of health care disparities can be found at the level of the patient, the health care system, the practice, and the physician. Communication is critical to the practice of medicine; but “isms,” trust, stereotypes and biases need to be examined, understood and eliminated since they interfere with effective communication. RESPECT (a mnemonic for Respect, Explanatory model, Sociocultural context, Power, Empathy, Concerns and fears, Therapeutic alliance) is an educational model to improve cross-cultural communication and therapeutic encounters with patients from diverse backgrounds.
Dr. Like provided a list of selected resources for more information on minority health and health disparities:

http://health.nih.gov/search.asp/26  
http://ncmhd.nih.gov  
http://www.hhs-stat.net/omh/index.htm  
http://www.ahrq.gov/research/minorix.htm  
http://www.rwjf.org  
http://cmwf.org  
http://www.cdc.gov/omhd/AMH/AMH.htm

Systemic cultural competence: “The ability of systems to provide care to patients with diverse values, beliefs and behaviors including tailoring delivery of care to meet patients’ social, cultural and linguistic needs. The ultimate goal if a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background or English proficiency.”

The Commonwealth Fund, 2002

**BECOMING A CULTURALLY COMPETENT AHC**

Dr. Like discussed a variety of organizational and educational interventions that are useful in increasing the cultural competency of AHCs. He noted the importance of identifying which curriculum – explicit, implicit/hidden, or null/absent – is being transformed. He also highlighted several initiatives for cultural competency education and patient-centered care (Table V). In addition, he provided a Cultural Competence Assessment Exercise for use in AHCs (see page 18).

**Table V – Selected Cultural Competency Education and Patient/Family Centered Care Initiatives**

<table>
<thead>
<tr>
<th>Cultural Competency and Patient-Family Centered Care Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>▶ Picker Institute (<a href="http://www.pickerinstitute.org">www.pickerinstitute.org</a>)</td>
</tr>
<tr>
<td>▶ Planetree Health Alliance (<a href="http://www.planetree.org">www.planetree.org</a>)</td>
</tr>
<tr>
<td>▶ Institute for Family-Centered Care (<a href="http://www.familycenteredcare.org">www.familycenteredcare.org</a>)</td>
</tr>
<tr>
<td>▶ California Endowment second language and cultural competency training (<a href="http://www.calendow.org">www.calendow.org</a>)</td>
</tr>
<tr>
<td>▶ Association of American Medical Colleges Tool for Assessing Cultural Competency, TACCT (<a href="http://www.aamc.org/tacct">www.aamc.org/tacct</a>)</td>
</tr>
<tr>
<td>▶ Georgetown National Center for Cultural Competence (<a href="http://www.georgetown.edu/research/gucchd/nccc">www.georgetown.edu/research/gucchd/nccc</a>)</td>
</tr>
<tr>
<td>▶ NHLBI-funded consortium for multi-cultural education (<a href="http://culturalmeded.stanford.edu">http://culturalmeded.stanford.edu</a>)</td>
</tr>
<tr>
<td>▶ HRSA cultural and linguistic competence education conducted through their centers of excellence (<a href="http://www.hrsa.gov/culturalcompetence/curriculumguide">www.hrsa.gov/culturalcompetence/curriculumguide</a>)</td>
</tr>
</tbody>
</table>
The following exercise was adapted by Robert C. Like, MD, MS, Center for Healthy Families and Cultural Diversity, Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School.

Email: Like@umdnj.edu
Website: http://www2.umdnj.edu/fmedweb/chfcd/index.htm

CULTURAL COMPETENCE ASSESSMENT EXERCISE:
ACADEMIC MEDICAL CENTERS

1. Describe the culturally diverse faculty, learners, administration, and staff in your academic medical center

2. Describe the culturally diverse populations served by your academic medical center

3. Describe barriers you have encountered in:
   A. Teaching about culturally diverse populations
   B. Providing clinical care to culturally diverse populations
   C. Engaging in research with culturally diverse populations

4. Discuss any challenges you have had working with:
   A. Faculty/Learners/Administrators/Staff of Culturally Diverse Backgrounds
   B. Patients/Families of Culturally Diverse Backgrounds
   C. Community Organizations and Advocacy Groups Representing People of Culturally Diverse Backgrounds

5. Describe any cross-cultural success stories and why they occurred:
   A. Predoctoral and Postdoctoral Educational Programs
   B. Clinical Care Programs
   C. Research Programs
   D. Community Service Programs

6. Describe academic medical center policies and procedures developed, and strategies and resources used to increase organizational cultural competence

7. Discuss how your academic medical center is addressing the Office of Minority Health’s National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care.

8. Identify areas where key internal and external stakeholders can collaborate to improve education, clinical care, and research involving culturally diverse populations

Adapted and expanded with modifications from the work of:
   James L. Mason
   JLM & Associates
   Portland, Oregon 1994

Please do not duplicate, circulate, or quote from without permission of the author.
Several continuums for organizational cultural competence were presented:

- “No talk and no walk” → “talking the talk” → “walking the talk” → “talking and walking”
- Inaction → symbolic action and initial organization → formalized internal action → patient and staff cultural diversity initiatives → culturally diverse learning organizations (Andrulis, http://erc.msh.org/provider/Andrulis.pdf)

Another approach to organizational change in the direction of cultural competence is Appreciative Inquiry (AI). This approach focuses on conversational inquiry to define what are people’s best experiences in a topic (such as diversity) and then to create a dynamic and compelling positive future vision for the organization. AI has been used to foster:

- Inclusiveness in residency programs and hospitals: http://meded.iusm.iu.edu/resources/rcciinfo.htm

See the Appreciative Inquiry website at the University of Virginia for additional resources: http://appreciativeinquiry.virginia.edu/.
The Forum faculty and participants identified several instruments and models that are available to understand where an organization is along the diversity spectrum.

### Table VI – Resources for Multicultural Assessment

<table>
<thead>
<tr>
<th>MULTICULTURAL AUDIT RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Spiral Dynamics model. This model has seven stages, each of which is created from lessons learned in the previous stage, problems created by previous stage solutions, and new realities. MDACC has worked extensively on adapting this approach for assessing the organizational cultural climate, and its changes with various interventions to move an organization from an individualistic “me” culture to a more inclusive “we” culture. (Beck, D, Cowan C. Spiral Dynamics: Mastering Values, Leadership and Change. UK. Blackwell Publishing, 1996)</td>
</tr>
<tr>
<td>o 10 typical lenses through which people see the world;</td>
</tr>
<tr>
<td>o four organizational types (intolerant → tolerant → valuing → inclusive) and how the 10 lenses act in each (p.183-187);</td>
</tr>
<tr>
<td>o human resources management systems typical under each lens (p.211-214);</td>
</tr>
<tr>
<td>o an 11th lens (“One song, many voices”) (p.172-181).</td>
</tr>
<tr>
<td>o scorecard initiative experience of 14 California higher education institutions;</td>
</tr>
<tr>
<td>o framework of four dimensions (access, retention, institutional receptivity, and excellence).</td>
</tr>
<tr>
<td>Dismantling Racism Resource Book: For Organizations Striving to Become Multi-Cultural Anti-Racist Organizations. Western States Center, 1705 Wallace Street, Durham, NC, 919-490-4448 – pp. 42-52</td>
</tr>
<tr>
<td>o details four organizational types (all White club → token or affirmative action organization → multi-cultural organization → anti-racist organization)</td>
</tr>
<tr>
<td>o details how each organizational type will deal with: power and pay; location; members; decision-making; budget; money source; to whom accountable; culture; programs, etc.</td>
</tr>
</tbody>
</table>
Catalyst.org has developed a business case for building a diverse inclusive workforce, and has several short manuals outlining suggested approaches and strategies (Table VII).

**Table VII – Suggested Approaches and Strategies**

<table>
<thead>
<tr>
<th>Title</th>
<th>Source</th>
<th>Month of Pub</th>
<th>Year of Pub</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buying Power</td>
<td>Quick Takes</td>
<td>May</td>
<td>2008</td>
</tr>
<tr>
<td>LGBT Inclusion – Understanding the Challenges by David Megathlin</td>
<td>Making Change</td>
<td>May</td>
<td>2007</td>
</tr>
<tr>
<td>Creating a Business-Aligned Diversity Scorecard</td>
<td>Making Change</td>
<td>January</td>
<td>2005</td>
</tr>
<tr>
<td>Georgia-Pacific Corporation – Bridging Cultures, Leveraging Differences</td>
<td>D&amp;I Practices</td>
<td>January</td>
<td>2005</td>
</tr>
<tr>
<td>The Bottom Line: Connecting Corporate Performance and Gender Diversity</td>
<td>Research Reports</td>
<td>January</td>
<td>2004</td>
</tr>
<tr>
<td>Becoming A Diversity Champion</td>
<td>Making Change</td>
<td>January</td>
<td>2002</td>
</tr>
<tr>
<td>Creating a Business Case for Diversity</td>
<td>Making Change</td>
<td>January</td>
<td>2002</td>
</tr>
<tr>
<td>Developing a Diversity Recruitment Strategy</td>
<td>Making Change</td>
<td>January</td>
<td>2002</td>
</tr>
<tr>
<td>Moving Women of Color Up the Ladder</td>
<td>Making Change</td>
<td>January</td>
<td>2002</td>
</tr>
<tr>
<td>Tackling Resistance to Diversity Efforts</td>
<td>Making Change</td>
<td>January</td>
<td>2002</td>
</tr>
<tr>
<td>Tapping Women for Global Assignments</td>
<td>Making Change</td>
<td>January</td>
<td>2002</td>
</tr>
<tr>
<td>Using Metrics to Support Workplace Diversity</td>
<td>Making Change</td>
<td>January</td>
<td>2002</td>
</tr>
<tr>
<td>Advancing Women in Law Firms</td>
<td>Making Change</td>
<td>January</td>
<td>2001</td>
</tr>
<tr>
<td>Assessing Your Work Environment</td>
<td>Making Change</td>
<td>January</td>
<td>2001</td>
</tr>
</tbody>
</table>
SUMMARY CONSIDERATIONS
The Forum faculty left the group to consider these on-going challenges to achieving cultural competency.

- How do we generate interest, deal with resistance and inertia, and support the desire to become more culturally competent? And remember that cultural competency includes more than ethnicity – it also includes disability, sexual orientation, and other differences that may be visibly “hidden.”
- How do we measure “cultural competence” and “cultural humility”?
- How do we evaluate the effectiveness of clinical cultural competency educational programs?
- How do we deal with “hot button” and “cold button” issues, and prevent “burnout”?
- How do we partner with communities in developing, implementing, and assessing the impact of cultural competency training?
- How do we provide high quality cultural competency training within a budget?
- How can you effectively measure/make the business case for becoming more culturally competent?
- How do we identify and reward groups/leaders who would champion change?
- How do we find or take advantage of opportunities, and/overcome the discomfort to start the conversation around culture?
- How do we maintain the energy and commitment to engage in transformational activities?
Final Thoughts from ELAM participants on Institutionalization Steps to Becoming Culturally Competent Organizations
Daily Actions

• Remember that opposition and challenges are regular occurrence

Top Driven - Core Value (UAB)

• Check for equity and diversity
• Provide half-day diversity training in orientation for everyone
• Educate and change Search Committees. Have deans sign off on every search committee member
• Bring community members on as members

Education

• Explore student’s perspective
• Develop a pipeline – go back to high school, health science academy at schools of medicine, consider AAMC. Recognize that training more MDs will not fix color disparities; need to increase diversity of other health care professionals
• Aspiring Doctors Program – hypothesis driven projects (AAMC)
• Make cultural competency part of the curriculum and patient-clinician relationship

Community

• Centralized multicultural (Medical, Educational, Research, Clinical) staff
• Remember grape vine is its own community. African Americans in silos, need to break down.
• Diversity is better solution especially in ambulatory, chronic continuity of care, nursing patient relationship-UMDNJ)
• Build trust with community we serve (pay attention to social determinants of health e.g. class geography)

Staffing/Recruitment

• Avoid exploiting minority faculty (results in racial fatigue. For example, University of Alabama limits minority from serving on more than two search committees per year.)
• Focus on social class differences when recruiting
• Focus on raising awareness among current staff who would improve recruitment
The 2008 ELAM Forum on Emerging Issues
Appendices

A. List of 2008 Forum Participants.................................Page 25
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C. Culturally Competent Health Care References........Page 33
D. Best and Promising Practices........................................Page 44
### The 2008 ELAM Forum on Emerging Issues
#### Deans & Designees

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Karen Antman *</td>
<td>Boston University School of Medicine</td>
</tr>
<tr>
<td>Edward Benz *</td>
<td>Harvard Medical School Dana-Farber Cancer Institute</td>
</tr>
<tr>
<td>David Bjorkman * #</td>
<td>University of Utah School of Medicine</td>
</tr>
<tr>
<td>John Daly *</td>
<td>Temple University School of Medicine</td>
</tr>
<tr>
<td>Peter Densen #</td>
<td>University of Iowa Roy J. and Lucille A. Carver College of Medicine</td>
</tr>
<tr>
<td>Thomas Deutsch *</td>
<td>Rush Medical College of Rush University</td>
</tr>
<tr>
<td>Cam Enarson * #</td>
<td>Creighton University School of Medicine</td>
</tr>
<tr>
<td>Howard Federoff * #</td>
<td>Georgetown University School of Medicine</td>
</tr>
<tr>
<td>Joseph Flaherty * #</td>
<td>University of Illinois at Chicago College of Medicine</td>
</tr>
<tr>
<td>Steven Gabbe * #</td>
<td>Vanderbilt University School of Medicine</td>
</tr>
<tr>
<td>Antonio Gotto *</td>
<td>Cornell University Weill Cornell Medical College</td>
</tr>
<tr>
<td>William Green *</td>
<td>Dartmouth Medical School</td>
</tr>
<tr>
<td>Jeffrey Griffith</td>
<td>University of New Mexico School of Medicine</td>
</tr>
<tr>
<td>Margaret Gyetko #</td>
<td>University of Michigan Medical School</td>
</tr>
<tr>
<td>Marc Hahn *</td>
<td>University of North Texas Health Science Center</td>
</tr>
<tr>
<td>Edward Halperin *</td>
<td>University of Louisveille School of Medicine</td>
</tr>
<tr>
<td>William Henrich *</td>
<td>University of Texas Medical School at San Antonio</td>
</tr>
<tr>
<td>Carol Herbert *</td>
<td>University of Western Ontario Schulich School of Medicine and Dentistry</td>
</tr>
<tr>
<td>Richard Homan * #</td>
<td>Drexel University College of Medicine</td>
</tr>
<tr>
<td>Sharon Hostler * #</td>
<td>University of Virginia School of Medicine</td>
</tr>
<tr>
<td>Keith Joiner * #</td>
<td>University of Arizona College of Medicine Arizona Health Sciences Center</td>
</tr>
<tr>
<td>Richard Krugman * FORUM Co-sponsor</td>
<td>University of Colorado Denver School of Medicine</td>
</tr>
</tbody>
</table>

* Denotes Dean
# Denotes Sustaining Member
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Boston University School of Public Health

Frederick Morin *  
University of Vermont College of Medicine

Lois Nora *  
Northeastern Ohio Universities College of Medicine

Rodney Parry *  
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* Denotes Dean
# Denotes Sustaining Member
## The 2008 ELAM Forum on Emerging Issues

### Invited Guests

<table>
<thead>
<tr>
<th>Name</th>
<th>Title &amp; Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ralph Altiere</td>
<td>FORUM Co-sponsor, University of Colorado Denver School of Pharmacy</td>
</tr>
<tr>
<td>David Bachrach</td>
<td>+, The Physician Executive's Coach, Inc.</td>
</tr>
<tr>
<td>Sue Duckles</td>
<td>FORUM Co-sponsor, University of California, Irvine</td>
</tr>
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<td>Sharon Hull</td>
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<tr>
<td>Jesse Joad</td>
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<td>Ana López</td>
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<td>Ana Maria López</td>
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<td>Debra Perina</td>
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<td>Andrea Pozez</td>
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Dani Zander
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Note: Institutions listed are as of April 2008.
The 2008 ELAM Forum on Emerging Issues
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**Required Reading**

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**Recommended Reading**

- AAMC: Focus on Affirmative Action. Web site includes links to information about AAMC Amicus Brief supporting University of Michigan’s use of race and ethnicity as one factor in its admissions policy to promote diversity. [http://www.aamc.org/diversity/focuson.htm](http://www.aamc.org/diversity/focuson.htm)


Videos (shown during the Forum)

• Hold Your Breath by Maren Grainger-Monsen, MD and Julia Haslett (www.fanlight.com)

• Through the Patient’s Eyes, Volume I, Hospital Care. The Picker Institute, 1998 http://www.pickerinstitute.org


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Culturally Competent Health Care: Selected References

The following list of references was compiled by Robert C. Like, MD, MS, Center for Healthy Families and Cultural Diversity, Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School.

Email: Like@umdnj.edu
Website: http://www2.umdnj.edu/fmedweb/chfcd/index.htm

**Medical Education -- General**

- Transforming the Face of Health Professions Through Cultural & Linguistic Competence Education: The Role of the HRSA Centers of Excellence [http://www.hrsa.gov/culturalcompetence/curriculumguide](http://www.hrsa.gov/culturalcompetence/curriculumguide)


- Achieving Diversity in Dentistry and Medicine [http://www.amsa.org/addm/index.cfm#eth](http://www.amsa.org/addm/index.cfm#eth)

- Accreditation Council for Graduate Medical Education. ACGME Outcome Project [http://www.acgme.org/Outcome](http://www.acgme.org/Outcome)


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• Shapiro J, Hollingshead J, Morrison EH. Primary Care Resident, Faculty, and Patient Views of Barriers to Cultural Competence, and the Skills Needed to Overcome Them," Medical Education 2002; 36:749-759.

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**Internal Medicine**


• Carrillo JE, Green AR, Betancourt JR. "Cross-Cultural Primary Care: A Patient-Based Approach," *Annals of Internal Medicine* 1999; 130:829-834.


**Geriatrics**

• Achieving Diversity in Dentistry and Medicine (ADDM), Ethnogeriatric Curricular Guidelines for Medical and Dental Schools, American Medical Student Association Foundation, November 2005 [http://www.amsafoundation.org/pdf/EthnogeriatricCurriculum.pdf](http://www.amsafoundation.org/pdf/EthnogeriatricCurriculum.pdf)

• Cultural Competency for Health Professionals in Geriatric Care. Western Reserve Geriatric Education Center [http://www.nethealthinc.com/cultural/index.asp](http://www.nethealthinc.com/cultural/index.asp)
• Ethnogeriatrics. Developed by Fred Kobylarz, MD, MPH, Florida State University College of Medicine -- [http://med.fsu.edu/geriatrics/ethnogeriatric](http://med.fsu.edu/geriatrics/ethnogeriatric). Available also at the Portal of Geriatric Online Education (POGOe) -- [http://www.pogoe.org/px/login.cfm](http://www.pogoe.org/px/login.cfm)


**Obstetrics and Gynecology**


**Psychiatry/Psychology Health/Social Work**


**Nursing**


Pharmacy

Dentistry


Occupational Therapy/Rehabilitation


Public Health

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Selected “Best and Promising Practices” - Cultural Competency

The following list of references was compiled by Robert C. Like, MD, MS, Center for Healthy Families and Cultural Diversity, Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School.

Email: Like@umdnj.edu
Website: http://www2.umdnj.edu/fmedweb/chfcd/index.htm

Health Care Policy


Hospitals, Ambulatory Care, and Public Health Settings

- HRSA Cultural Competence Website http://www.hrsa.gov/culturalcompetence/
California Endowment - Exploring Organizational Development & Capacity in Cultural Competence: Building Knowledge and Practice Series Monograph Series

- Multicultural Organizational Development: A Resource for Health Equity
- Cultural Competency in Capacity Building

Commonwealth Fund – The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality
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National Initiative for Children’s Healthcare Quality (NICHQ), Improving Cultural Competency in Children’s Health Care: Expanding Perspectives http://www.nichq.org/NR/rdonlyres/5B534B7B-0C38-4ACD-8996-EBB0C4CB2245/0/NICHQ_CulturalCompetencyFINAL.pdf

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- “Cultural Competence Works: Using Cultural Competence to Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements”
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• Hablamos Juntos: Improving Patient-Provider Communication for Latinos
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  [The latter 2 reports can be obtained at www.cmwf.org or www.healthlaw.org]

Health Literacy
• AMA/AMA Foundation’s Health Literacy toolkits, videos, partnerships http://www.ama-assn.org/ama/pub/category/8115.html
• Office of the Surgeon General: Improving Health Literacy http://www.surgeongeneral.gov/publichealthpriorities.html#literacy
• Institute of Medicine Health Literacy website http://www.aed.org/ToolsandPublications/iom
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• AHRQ Health Literacy and Cultural Competency Website
  http://www.ahrq.gov/browse/hlitix.html
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• National Institute for Literacy http://www.nifl.gov/nifl/webcasts/20040803/webcast08-03.html
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  http://www.mlanet.org/resources/healthlit
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  http://www.hsph.harvard.edu/healthliteracy

**Movies, Videos, and CD-ROM Resources**

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- The Kaiser Permanente/California Endowment Clinical Cultural Competency Video Series. In 2000, Kaiser Permanente, with funding from The California Endowment, embarked on a project to create “trigger” videos as teaching tools for training health care professionals in cultural competence. The Project Director was Jean Gilbert, PhD, a medical anthropologist, and Jo Ann Lesser, Producer, a media specialist. Directing were Rod Gerber and Lisa Beezely Lipman, of the
Kaiser Permanente C.A.R.E. Actors. These now completed videos comprise three sets, each with accompanying facilitator’s guide and contextual materials. Each set costs $35.00 or $105 for all 20. The scenarios are from eight to fourteen minutes long. The actors, all professionals living in Los Angeles, are highly diverse in age, gender, ethnicity, and race. The videos have won many prizes at various international film and video festivals (Send order to: Gus Gaona, Kaiser Permanente, National Media Communications: Media Distribution, 825 Colorado Ave., Suite 300, Los Angeles, CA 90041; Phone: 323-259-4776).

- **Quality Care for Diverse Populations.** Video/CD-ROM/Facilitator's Guide, Contributors: K. Bullock, L.G. Epstein, E.L. Lewis, R.C. Like, J.E. South Paul, C. Stroebel, et al.) This educational program includes five video vignettes depicting simulated physician-patient visits in an office setting as a means to explore ethnic and sociocultural issues found in today's diverse health care environment. Produced by the American Academy of Family Physicians (AAFP), with partial funding by the Bureau of Primary Health Care, Health Resources and Services Administration, June 2002. (Available from the American Academy of Family Physicians, AAFP Order Dept., 11400 Tomahawk Creek Parkway, Leawood, KS 66211; Phone (800)-944-0000; Fax (913)-906-6075; [http://www.aafp.org/x13887.xml](http://www.aafp.org/x13887.xml)).

- **Community Voices: Exploring Cross-Cultural Care Through Cancer.** Video and Facilitator's Guide by Jennie Greene, MS & Kim Newell, MD (Available from the Harvard Center for Cancer Prevention, Harvard School of Public Health, 665 Huntington Avenue, Bldg 2, Rm 105, Boston, MA 02115; Phone (617) 432-0038; Fax: (617)-432-1722; [hccp@hsph.harvard.edu](mailto:hccp@hsph.harvard.edu), or Fanlight Productions, [www.fanlight.com](http://www.fanlight.com)).

- **Worlds Apart. A Four-Part Series on Cross-Cultural Healthcare.** By Maren Grainger-Monsen, MD, and Julia Haslett, Stanford University, Center for Biomedical Ethics (available from Fanlight Productions, [www.fanlight.com](http://www.fanlight.com))

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- **The Culture of Emotions: A Cultural Competence and Diversity Training Program.** Harriet Koskoff, Producer/Co-Coordinator, 415 Noe Street, #5, San Francisco, CA 94114; Phone 415-864-0927; Fax 415-621-8969 (Available from Fanlight Productions, [www.fanlight.com](http://www.fanlight.com)).

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- MD Advantage Insurance Company of New Jersey. Cultural Competency: A Risk Management Agenda for Change. Accredited by UMDNJ Center for Continuing Outreach and Education.
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- Communicating Through Health Care Interpreters. Medical Directions – The Virtual Lecture Hall and Rush University Medical Center.
- Culture and Health Care: An E-Learning Course (based on Cultural Sensitivity: A Guidebook for Physicians and HealthCare) Doctors in Touch (DIT)
  [http://www.doctorsintouch.com/courses_for_CME_credit.htm](http://www.doctorsintouch.com/courses_for_CME_credit.htm)
- Cultural Competency Challenge CD-ROM Educational Program (AAOS Product #02735).
  American Academy of Orthopaedic Surgeons, 6300 North River Road, Rosemont, IL 60018-4262.
  [www.aaos.org/challenge](http://www.aaos.org/challenge)
- Cross-Cultural Health Care: Case Studies. Pediatric Pulmonary Centers: A Collaborative Web Site of the MCH Training Network. [http://www.dcs.wisc.edu/pda/online/cc-cases.htm](http://www.dcs.wisc.edu/pda/online/cc-cases.htm)
- Measuring Health Disparities, Interactive CD-ROM. John Lynch, PhD, and Sam Harper, PhD, McGill University. Produced by the Michigan Public Health Training Center (MPHTC) [http://measuringhealthdisparities.org](http://measuringhealthdisparities.org)

**Curricular Materials**