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Cultural Competency Observation Tool

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Intercultural Competency Observation Tool

Observer: _____ **Student:** _____ **Date:** _____

Directions: Underline behaviors observed in each row and column. Score each row 1-5. Total Score: _____/50

Communication Elements	5 Mastery Patient Centered Intercultural Care	4 Proficient Patient Centered Intercultural Care	3 Beginning Intercultural Provider Centered Clinically Competent Care	2 Novice Task Centered Deficient Care	1 Incompetent Intercultural Care	Score 1 – 5
Greeting and connecting with the patient	Greeting and connecting clearly demonstrated adapted to the patient's response. Initial remarks revealing or soliciting personal knowledge of the patient & promoting patient comfort.	Greeting and connecting demonstrated. Attention mostly on patient.	Smiles, uses Pt's name, if return visit-demonstrates recognition of pt. Attention fluctuates between patient, computer, and chart.	Addresses the reason of the visit but without connecting with the patient.	No initial remarks of a warm personal nature. Most of attention focused on charts, computers instead of patient.	
Establishing the focus, reasons for visit	Reason for visit clearly established. Allows Pt. to express initial concerns w/o interrupting, elicits complete problem list at early part of visit.	Reason for visit established. Employs open-ended questions. Interrupts rarely, elicits complete problem list by middle part of visit.	Mixture of open and closed-ended questions. Interrupts occasionally, elicits complete problem list by end of visit.	Asks mostly closed ended questions. Interrupts frequently, elicits partial problem list during visit.	Relies on leading and closed ended questions; significant concerns or questions go unanswered or only appear at the end of the visit. Does not elicit problem list during visit.	
Seeking to understand the patient's explanatory model	Uses sequenced questioning calibrated to the patient's response to elicit the meaning that the Pt ascribes to their symptoms within their cultural context. Uses Pt's questions to explore their explanatory model.	Makes effort to elicit patient's deeper understanding of any symptoms or disease process.	Explores obvious discrepancies between provider and Pt. understanding of symptoms.	Elicits symptoms, but does not explore the meaning these have to the patient	Does not recognize or acknowledge emergence of explanatory model (How the patient understands/ explains their health, illness, and symptoms; and expectation from the visit.). Many questions go unanswered.	
Sharing information	Pt. understanding / feasibility actively solicited, communicates Dx/Tx options, tactful blending of biopsychosocial, self-management promoted	Education done in accessible language, Questions elicited and answered.	Explains Dx/Tx in accessible language. Questions elicited but not fully answered.	Patient questions not elicited and/or not fully answered.	Uses only medical jargon, no info is given and no check on Pt. understanding. Questions not elicited or answered.	
Negotiating agreement	Elicits reaction, confirms feasibility and "buy in," adjusts plan to conform w/ Pt./family preferences, resources and limitations. Actively problem solves differences in understanding.	Engages Pt/Family in management of condition.	Partially explores Family/Pt. reaction to acceptance of Dx/Tx options.	Pt./Family Rxn to Dx/Tx options not explored.	Makes no attempt to elicit Pt/Family reaction or acceptance of Dx/Tx options.	
Providing closure	All final questions are answered satisfactorily. Follow up plans are clear and have been agreed upon by all parties.	Checks understanding of plan and follow up. Asks "anything else?"	Plan is summarized, F/U plans described.	Patient initiates significant new issues at closing and some issues remain unresolved.	Plan not summarized. Major issues remained unresolved or unclear.	
Language	Fluently conducted in patient's language appropriate to their apparent educational level. If interpreter is used, it is effective, with attention focused on patient and not interpreter.	Communication geared to patient's education and language and communication is free of obvious errors.	Communication is effective but limited. Provider gives limited information, speaks to interpreter rather than the Pt, or does not fully explain terms, but communication is free of obvious errors.	Some misinterpretations or misunderstanding by patient, provider, or interpreter.	Communication is ineffective. Provider and Pt. speak different language. No interpreter used if it is needed or is used inappropriately.	
Non-verbal behavior, promoting comfort	Nonverbal behavior demonstrates empathy and positive regard. Positioning, tone, eye contact, touch, and changes in line of questioning mirror Pt. nonverbal cues to promote patient comfort.	Nonverbal behavior promotes comfort; eye contact & body posture mirrors patient most of the time.	Nonverbal behavior, eye contact & body posture mirror patient some of the time.	Body posture and eye contact do not mirror patient nonverbal behavior.	Body posture and eye contact do not mirror patient nonverbal behavior. Discomfort or mismatch evident on the part of Pt. or provider.	
Culture-laden health issues (e.g., pain, depression, disability)	Evidence-based care provided and skillfully explained to the Pt and negotiated within the Pt's cultural context. Pt understanding and collaboration solicited.	Explores culture-laden health issues through H&P and provides evidence-based care.	Culture-laden health issues addressed in a limited fashion.	Culture-laden health issues that appear to have importance to the patient are avoided, dismissed, or unaddressed.	Provider's explanatory model as indicated by comments about the condition (e.g. depression, pain) is not evidence-based. Significant culture-laden health issues are dismissed or avoided.	
Professional Regard	Sensitive issues handled adroitly within a therapeutic framework of unconditional positive regard, maintaining a focus on what provider and Pt agree is the best interest of the Pt.	Affable, engaged and provides support. Demonstrates unconditional positive regard.	Provides some effort or support to alleviate discomfort and unease.	Disconnected, but not adversarial. Misses opportunities or provides minimal support.	Provider is dismissive, avoidant, uncomfortable or hostile toward the patient. Provides no support.	

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Pt Race/Ethnicity		Pt. Gender		Pt Age group		Pt Type		Visit Type	
African-American		Female		Infant (0-2)		New		Acute	
Haitian		Male		Child (3-12)		Established		Chronic	
English-Speaking Caribbean		Transgender		Adolescent (12-17)				Preventive	
Spanish-Speaking Caribbean				Young Adult (18-21)				Mental Health	
Mexican-Central American				Adult (21-40)				Disability	
South American				Middle-aged (41-65)				Pain mgmt	
Non-Latino Caucasian				Elder (>65)				Behavioral	
Asian/Pacific Island								Mixed	
Native American								Other	
Other									

Remarks:

This observational assessment rubric includes rating of the elements of patient centered communication defined in the Kalamazoo Consensus Statement regarding patient centered communication. The group identified seven essential sets of communication tasks: “(1) build the doctor-patient relationship; (2) open the discussion; (3) gather information; (4) understand the patient's perspective; (5) share information; (6) reach agreement on problems and plans; and (7) provide closure.” These are all included within the rating system. These are augmented with sections that highlight factors that emerged in our observations specific to intercultural communication such as language and interpreters, nonverbal communication, mental and social issues with a large cultural overlay (mental health, pain, and disability). In addition, the tool incorporates issues of the medical context such as professional competence and professional regard. The rubric is informed by the developmental model of intercultural sensitivity and Dreyfus’s phenomenology of skill acquisition with skill levels progressing through the stages: novice, beginner, competence, proficient, mastery. This tool equates level 5 with mastery of effective intercultural, patient centered, evidence-based health care. Level 4 is proficient. Level 3 is medically competent but only advanced beginner level with regard to intercultural patient centered communication. Level 2 defines novice performance that is excessively focused on tasks or deficient in basic expectations. Level 1 reflects incompetent or negligent performance.