

Chapter III.

Strategy Development Sessions

STRATEGY DEVELOPMENT SESSIONS
OCTOBER 27-28, 1995

I. Goals and Objectives of the Strategy Development Sessions:

Goal: To discuss and reach a consensus on recommendations to change medical education curricula to include women's health and cultural competence.

II. Objectives:

- 1) To use key questions, as appropriate, and other questions that arise from the group to develop policy recommendations to change medical education.
- 2) To develop at least three specific short-term policy recommendations with implementation strategies for each.
- 3) To target these recommendations to the following key players:
 - a. Federal Government
 - b. State Governments
 - c. Medical Schools
 - d. Residency and Fellowship Programs
 - e. Health Professional Associations
 - f. Foundations
 - g. Medical Board Exam Organizations
 - h. Licensing/Accreditation Bodies
- 4) To have a group discussion and come to a consensus on the three short-term high priority policy recommendations.

III. Approach:

Based on their areas of expertise and to also ensure balance and diversity, the conference attendees (speakers and audience) will be assigned to participate in strategy sessions that will develop recommendations which will focus on key players influencing medical education. Strategy session assignments are included in the conference binder behind the tab "Conference Agenda".

The strategy sessions will begin on Friday evening with a plenary at 7:00 p.m. to establish the ground rules. The work groups will then meet from 7:15 p.m. to 8:30 p.m. and the following morning after the plenary session. A facilitator and a note taker will be provided.

The following questions will be used to facilitate brainstorming by the participants for the strategy sessions:

- 1) What is the current situation and need, internal and external, to change curricula to include cultural competence and women's health curricula within medical education teaching institutions?
- 2) What can be done to promote the inclusion of cultural competence and women's health curricula in medical education by the key players?
- 3) What administrative policies should be developed to support the integration of women's health and cultural competency into medical education curricula in the institution?
- 4) What mechanisms can be supported by this entity (i.e., Medical Schools, Health Professional Associations, Federal Government, etc.) to increase discussion and implementation of new innovative medical education curricula?
- 5) What programs can be developed to increase the number of women and minorities in medical education faculty and leadership positions in your institution?
- 6) What funding mechanism should be used to accomplish innovative curricula development?
- 7) What research or research programs, that stimulate new knowledge regarding women's health or cultural competency curricula, can be supported by the institution?
- 8) How can a interdisciplinary approach to integration of women's health and cultural competency in medical education curricula be supported by this institution?

At the end of the strategy sessions, each group will develop three short-term high priority policy recommendations, including specific strategies, to promote curricular change within medical teaching institutions for the inclusion of cultural competence and women's health curricula.

IV. Report-Outs:

Each group facilitator will be required to report the top three short-term policy recommendations to the whole body. These reports will be presented following lunch on Saturday.

Strategy Development Sessions: Federal Government

Marcy L. Gross
Agency for Health Care Policy and Research
Department of Health and Human Services
Rockville, Maryland

Recommendations:

1. Develop a national dissemination strategy for cultural competence and women's health curricula through the National Women's Health Information Clearinghouse that is being developed by the Office on Women's Health and by sponsoring a 2nd Annual National Conference.
2. Sponsor curriculum demonstration projects in such areas such as telemedicine.
3. Foster community-based education through various mechanisms (e.g., research grants, videos, Americorps, international projects).

Presentation

Our agency has several recommendations to enhance the study of women's health and the development of cultural competency. However, in order to encompass the concept of lifetime learning, we have broadened our mandate. We do not want to solely focus on medical school development, so our recommendations go beyond medical school curricula.

First, we would like to build upon the work of local community based organizations. I have visited the Latin American Youth Center in Washington D.C. From this and other experiences, it was clear that people were starting from scratch in building programs. They were doing it *de novo*.

The federal government has sponsored a host of curriculum development projects upon which we can build. We and other federal agencies can extend grants to foster innovation at the community level. Many community-based organizations have clinics and health care programs. Physicians can learn from direct contact with the health problems that patients experience in these environments.

Two, we feel that although there is a fair amount of work going on in the women's health side, there needs to be more development on cultural competency of curriculums. Further, we thought that the National Women's Health Information Clearing House, which is being developed by the Office on Women's Health, would be an ideal place to lead the convening of a second meeting like this one. We would like to work with the Office of Minority Health and the Office on Women's Health in this regard.

We suggest that an additional day be added to such a meeting to allow the Office of

Minority Health, the Office on Women's Health and the Health Resources and Services Administration (HRSA) and other partners to gather as much information about the curricula actually being used in various schools around the country. This could be followed by a full day for a hands-on exchange of information. Small groups could examine and discuss the curricula and talk and think about how to adapt them for their local use.

The third recommendation is to have the Federal government sponsor curricula development efforts. We think that agencies such as HRSA and the Veteran's Administration could incorporate funding preferences in existing grant programs. This could allow preferences to be given to curricula that include women's health issues as a part of criteria for the funding of medical training. These preferences would be given for undergraduate, residency or continuing education activities that address women's health and cultural competency. There are also some agencies, particularly Department of Defense (DOD) and the Office of Minority Health, in which new curriculum development efforts could be sponsored.

We would also like to see attention given to continuing medical education. These projects could fall under the auspices of a new, alternative type of curricula development that have not received much attention. We see the potential for telemedicine to be a major innovative vehicle for curriculum development. We suggest a specific strategy where an interdepartmental team could work with Vice-President Al Gore's telecommunications initiative. We envision the development of a short curricula aimed at physicians and other providers, which would be broadcast to medical centers around the country. Vice-President Gore previously did this on the reinventing government initiative. These activities could be followed by local community-oriented discussions.

We need to break out of our old molds in communicating these concepts. We think that linking with student groups could be a good starting point. We could go a step further by having students teach the faculty about things they have learned from their rotations in the community. The Federal government could help foster this effort. This could be a kind of Americorps project, where we could search for other funding sources. We could also develop international linkages.

Strategy Development Sessions: State Government

Julia P. Fortier

Resources for Cross Cultural Health Care

Silver Spring, Maryland

Recommendations:

1. Raise awareness (e.g., establish statewide task forces for curricula, policy makers, health professionals, and consumers.)
2. Work to tithe the 3rd party payers in a state to fund curriculum that is directed to achieve quality outcomes.
3. Establish incentives for diverse students (e.g., funding preferences for training for diverse populations).

Presentation

This workshop discussed the crosscutting issues that have had an impact on what state government can do in the areas of cultural competence and women's health. Changes in federal funding have had a great impact on how a state delivers health services. The shift from federal categorical grants to block grants has expanded state responsibilities for the delivery of health care. Changes in Medicare and Medicaid also affect how states deliver health services. These changes provide opportunities for the growth of women's health and cultural competence.

Both public and private medical teaching institutions are under financial pressure. How will this affect the development of women's health and cultural competence curricula? These programs could be cut back at a time when the need for them is greatest. This can be prevented if policy makers, health professionals, providers, medical educators and consumers understand the importance of women's health and cultural competence.

State policy makers need to develop financial incentives for third party payers to participate in women's health and cultural competence programs. All participants will need a piece of the pie as an inducement. Funds could be distributed under existing state block grants.

We believe that incentives at the state level should be provided to medical colleges to create or expand women's health and cultural competence programs. Additional dollars could be made available to programs that meet the needs of diverse populations. These dollars could be used to support and expand curriculum development, scholarships, and continuing education for physicians, nurses and health professionals and licensing.

Strategy Development Sessions: Medical Schools

Billy R. Ballard, D.D.S., M.D.
The University of Texas Medical Branch
Galveston, Texas
and
Julius Mallette, M.D.
East Carolina University - School of Medicine
Greenville, North Carolina

Presentation

Our recommendations to achieve advances in women's health and cultural competency curricula in medical schools include:

Curriculum Development

- 1) Women's health and cultural competence should be a part of the formal curriculum for all health and medical education and training.
- 2) Each institution should conduct a formal curriculum assessment to determine how best to implement additions to existing training.
- 3) Institutional assessment should be a part of a national curriculum evaluation conducted at the Federal level.
- 4) Innovative curriculum models need to be implemented and formally evaluated. This will tell us about the impact of curriculum changes on medical training.

Managing Institutional Change

- 1) Medical school administrators should take an active role in leading their institutions to include cultural competency and women's health in their curricula.
- 2) The Office of Minority Health and the Office on Women's Health and other agencies should provide information and resources to medical administrators who are working to change their institutions.
- 3) Each institution should have a plan for change. This plan should include:
 - a) Recruitment of new faculty
 - b) Recruitment of new students.
 - c) Development of community involvement.
 - d) Development and maintenance of adequate resources for the transition to the new curriculum.
 - e) Creating institution wide assessment and evaluation tools.

Resource Development

- 1) Develop a plan and then go after the money to fund institutional change.
- 2) The Office of Minority Health and the Office on Women's Health and other federal agencies need to develop a database on available resources to fund institutional change.
- 3) Data on state and local funding sources needs to be developed.

Strategy Development Sessions: Residency and Fellowship Programs

Saralyn Mark, M.D.

PHS Office on Women's Health

Washington, District of Columbia

and

Debbie Jackson

The Council on Graduate Medical Education, HRSA

Rockville, Maryland

Recommendations:

1. Establish minimum competencies for training of primary care and specialty physicians in the area of women's health and cultural competency. Utilize the support of women and minority offices of medical societies.
2. Incorporate women's health and cultural competence into all disciplines and in all levels of graduate medical education. The OWH and OMH should convene a meeting of specialty boards to develop recommendations for medical education regulatory bodies.
3. Establishment of curricula should be done through the following:
 - a. Establish pilot programs for women's health within academic medicine such as Centers of Excellence and fellowship programs;
 - b. Develop approaches to train physicians to be culturally competent.
 - c. Seek out the possibility of funding from managed care organizations.

Presentation

There has been an inaccurate dichotomy in the thinking concerning the development of women's health curricula. Should we have separate residency, or fellowship tracks? Should women's health be integrated throughout medical school curricula? The tenor of our discussion should not be either/or. We want to reach some type of consensus that insures the main streaming of women's health so everyone develops skills in these areas.

What we have here is an opportunity for all of us to speak about what we have been exposed to, what we see, what we envision, what we would like to see happen. This session is a sounding board. The process during this session will be that each of us is going to create a list of things that we view as most important in women's health training right now and we will then discuss it. Many of you have thought about the issues related to women's health for some time. For others, these issues are new. The important point is to learn from each other. There are no right and wrong answers.

However, before we do this, let's hear from Debra Jackson, a staff member from the Health

Resources and Services Administration, the Council on Graduate Medical Education.

Presentation

Debbie Jackson, the Council on Graduate Medical Education (COGME)

In my life before the Public Health Service, I was the internal medicine staff member of the Accreditation Council on Graduate Medical Education. Accreditation is often seen as a lever to get programs instituted and recognized. I think its helpful to see what the situation is in terms of getting programs certified.

When I started at the ACGME in the early 1980's, there were no accredited internal medicine residency programs. I was brought on board to set up the mechanisms to get programs recognized. There have been specialty programs since the 1930's and 40's, including cardiology and gastroenterology. But some programs have taken decades to go through the processes. Others have seemingly been recognized almost overnight.

When I came on board, geriatrics' efforts to receive accreditation were being discussed. Some of the pleas of its advocates fell on deaf ears until the politics of its situation were right and its advocacy groups were strong. I think that's important for women to recognize because though the content area is what defines a group, it is not all that is important.

However, the content area must be clear. Women's health curricula have been generated by different bodies that encompass what I think is the spirit of what we're talking about. The American Medical Women's Association has their curriculum. The National Academy of Women's Health Medical Education has put together a list of competencies. The councils on internal medicine have a list of competencies in women's health.

What has to happen is that a board recognizes a field of knowledge. Then the programs in the field are reviewed and considered for accreditation. The fields of family practice and internal medicine to achieve certification navigated this course. Before that time, there's just a lot of talk, a lot of wishful thinking concerning these fields. So those of you who want certification for women's health must develop a strategy and an understanding of what you're up against. You will need to clearly define your content area and then ally yourselves with other programs and key individuals that can help you.

Discussion

Speaker 1: One of our options might be following the lead of geriatrics. It seems to make sense considering what happened to the field of emergency medicine. Emergency medicine developed just because a few physicians decided that they wanted to do it separately, differently and better. They formed an organization and just did it. They also found enough people to follow them.

Speaker 2: The same can be said of sports medicine. My husband is an orthopedist at UCLA. He specializes in sports medicine. I was trained as a family practitioner and my

department chair started a sports medicine fellowship before family practitioners got accredited as a subspecialty of family medicine. He expanded the sports medicine fellowship and now they have their own accreditation requirements and examinations. People are spraining their ankles and they're doing hundreds of thousands of dollars worth of studies to see whether high-top sneakers increase the support of the ankle versus low-top sneakers. Compare this to the seriousness of women's health issues. The priorities of our medical institutions are wrong if women's health is not as important as sports medicine. What's important to me is to make sure that women get better care.

Speaker 3: We're all going to have to give up some special turf in order to better serve women. The system has to change because of the way it was instituted. It doesn't serve women's purposes. Yes, we're going to have to collaborate. But really what does it take to delivery comprehensive services to women? We have to put that above being a better OB/GYN, internist, or family medical practitioner because women's health combines all three. If any one of those three medical specialties served women well by themselves, we wouldn't be having this discussion.

Question

There are two things that hit me as an obstetrician. First I didn't hear any mention today of obstetrical problems. Now, I'm not sure how you can talk about women's health care and eliminate obstetrics and all its problems from a discussion of women's health curriculum. There also has been no discussion about the gynecological aspects of women's care. We heard information from an internal medicine and family practice point of view, but nothing from the point of view of obstetrics.

Answer

Let me explain how that happened. The presentations were selected through the submission of abstracts. We did not receive any abstracts for this session from the areas of obstetrics and gynecology.

Question

What is the best way to integrate women's health curricula?

Answer

There really isn't an ideal group out there. I think what we're hearing and what probably everybody agrees with, is that the development of women's health curricula has to be a joint venture. Now we're discussing whether it's better to form a joint venture integrating existing departments, or a joint venture puffing together a new department.

I think the first thing we have to understand is there is no group out there that can do it all. We have to work together. So we either have to work together, or neither ACGME nor any other accrediting body will recognize us.

I think to start a new fellowship or a new discipline is very difficult in times when funding is scarce. Right now, in most universities, it's impossible- so I don't think we have much of a choice but to integrate with other programs. It is an economic issue.

Question

At what level do you see integrating women's health curricula?

Answer

Speaker 1: That should be the focus of our discussion in each of our institutions. In some institutions, we will need to take different approaches. We have a primary care model in our institution. We've taken the model of the obstetrician and gynecologist and built on that. Our program was endorsed by the ACGME, which listed sixty requirements that had to be taught in order to qualify. We have a program in women's health, but it is within primary care medicine. The next steps are to develop a women's health initiative in internal medicine, pediatrics, OB/GYN and family medicine.

Speaker 2: We built our program through a joint effort between family practice, internal medicine, and others. We took the route of becoming a multidisciplinary group. We hired internists and family doctors and others. It's much easier to do it that way.

Speaker 3: I think we heard today is that it's at a mid-management level where most of these things work, or don't work. After the mid-management does the work, then go to the chairman with the product and usually you will succeed. If you go to the chairman first, you will have problems. But if you go to the chairman with a product that makes sense and that has been working, you'll usually be able to sell it.

Question

What do you call the program?

Answer

It's the Fort Worth Affiliated Program. The group is called Obstetrics and Gynecology Consultants at the Southwest. It's a group that contracts. We're different. We're a private group that contracts with the county hospital to supply services.

Question

How would you like to see women's health organized within the medical school environment?

Discussion

Speaker 1: My wish list would be the incorporation of women's health throughout the standard curriculum throughout medical education.

Speaker 2: We're talking about graduate medical education. Are you talking about integrating existing disciplines as they are right now? Basically, there's a separate residency, a separate fellowship, or and other separate components. Are you talking about integrating women's health throughout this framework?

Speaker 3: Let's integrate women's health and cultural competence for all existing residency programs.

Speaker 4: We're into either/or again. Let's integrate women's health and also have a fellowship.

Speaker 5: Are you saying a separate women's health residency and integrate women's health through all existing disciplines?

Speaker 6: I would like to see more of a focus on preventive care in women's wellness, with a training focus on community-based ambulatory care.

Speaker 7: I would like a strong component of women's health in primary care training. All primary care providers should be trained in women's health and fellowship.

Speaker 3: I stand by integrating women's health into residency programs. I might be swayed to go with a fellowship if I knew who was going to own it. But you will still have the same turf war with fellowship that we have right now.

Speaker 8: I would like to have a separate discipline in women's health. I think the residency would be the best place to put it because it would give it a light of its own. We could stop all the dancing we've been doing trying to fit it into existing specialties. So I think you've got to go with a residency and integration back into the system.

Speaker 9: My answer would be an across the board minimum competency for medical and health professionals taking care of women.

Speaker 10: I don't think anybody ever argues that there shouldn't be history; there shouldn't be clinical science, biology, or English. So I think we have to be able to bring the same openness and breadth to a discussion of women's health. We're stuck with the fact that we happen to have internal medicine, OB/GYN and family practice. That's what exists now in reality. We're going to need to evolve all three towards a comprehensive practice of women's health.

The fact that we're all working and focusing on women will define eventually how we all professionally relate to each other's fields of practice. It is in some respects premature to say what's the best route. I think we must not get into this discussion because it really limits how we view the road to serving women better.

Strategy Development Sessions: Health Professional Associations

Wendy Rivers, M.D.
George Washington University Medical Center
Washington, District of Columbia

Recommendations:

1. In terms of health professional associations, the following should be done:
 - a. Promote women and minorities,
 - b. Decrease the barriers to reach high levels of management, and
 - c. Implement programs throughout the organization, not as a separate track.
2. Establish curricula through the organizations such as CME programs for practicing physicians and faculty development seminars.
3. Establish formal liaisons with medical schools and residency programs for student grant, scholarship, and mentorship programs.

Presentation

There are several key medical associations that influence policies concerning women's health. They are the Women's Medical Association of New York City, the Ambulatory Pediatric Association, the Society of Family Medicine and the Society of Internal Medicine. Most people join these organizations after they have completed their formal training, usually after medical school and the completion of their residency. The advantage of working through organizations is that, historically, they have lobbied Federal and state government influenced public policy debates and made policy recommendations. They have established funding sources and are involved in accreditation and faculty development. They also develop continuing medical education (CME) accreditation programs and establish faculty development seminars.

Almost every physician belongs to one or more of these and other professional associations. We can also use some of their resources and make presentations at their meetings that incorporate information on women's health and cultural competence.

Our first policy recommendation is that changes need to be made internally within these professional organizations. There is a culture in health professional organizations that needs to be changed. Associations must accept responsibility for promoting women and minorities to leadership roles. They must also eliminate the barriers that prevent women and people of color from reaching executive, management and administrative positions within these organizations.

These associations have traditionally been involved in residency and medical education. These associations need to identify people who have an interest in women's health and/or medicine that focuses on minority populations. These medical practitioners need should be assisted in reaching their goals and objectives. This cannot occur if women's health and culturally diverse medical practice is isolated from the mainstream practices of these organizations.

We recommend developing curricula in women's health and cultural competence throughout these associations for students, other health professionals, residents, faculty and administrators. These curricula should include both wellness and illness-based training models. They should incorporate morbidity, co-morbidity and mortality of specific populations. As important is the inclusion of community values, beliefs and attitudes.

Strategy Development Sessions: Foundations

Debra Delgado
The Annie E. Casey Foundation
Baltimore, Maryland
and
Leilani Doty, Ph.D.
University of Florida
Gainesville, Florida

Recommendations:

1. Establish a National Advisory Council for funding of model curricula in women's health and cultural competence.
2. Establish a national grants program for medical training institutions to develop curricula models in the areas of cultural competence and women's health.
3. Fund community based organization projects that create ongoing measurements for accountability.

Presentation

Our present healthcare delivery system does not work for women and culturally diverse people. In the United States today, there is no comprehensive national leadership center or advisory council. There are few models in the country that comprehensively address the issues of attitudes, skills, practices and behaviors of academic practitioners regarding cultural sensitivity and competence and women's health. Programs must shift from a disease focus to become more people-focused and responsive.

There is a lack of support and funding for a comprehensive mechanism to provide leadership and coordination. We do not have sufficient resources for design, development implementation, and information dissemination. In order to promote health and well being among all members of our national and local communities, and to ensure the stability of the healthcare system, our group would like to propose the following recommendations.

First, foundations should design a national advisory council with representatives from women, diverse organizations, and professional groups. This council will be charged with developing an accountability mechanism that measures outcomes and disseminates progress and results. This group should also have additional resources so it can fund programs in women's health and culture competence. We also suggest providing funds and funding opportunities at the grass roots level. Many people here are on the firing line in organizations that address the needs of patients and that help students learn how to work with patients. We believe that creative ways to fund these community-based programs should be developed so they incorporate women's health and culture competence curricula. There also needs to be ongoing outcomes measurement so that projects, programs, initiatives are piloted, evaluated and revised.

Strategy Development Sessions: Medical Board Exam Organization

Lila Wallis, M.D.
Cornell University Medical Center
New York, New York

Recommendations:

1. OWH and OMH should establish a Task Force to review content and to suggest new questions for medical board exams.
2. All boards should recruit individuals as members of the committees from national women's and minority medical groups.
3. Board should have prerequisites to demonstrate speciality characteristics.

Presentation:

Our group was dedicated to seeing how the medical board examination can participate in this great revolution. There was a consensus that we are talking about incorporating women's health into medical board examinations.

We are not talking about a new speciality and a new board in women's health and cultural competency. So, we all agreed that the policies should be directed to all allopathic and osteopathic boards including national and medical speciality boards.

A letter should be sent to the American Board of Medical Specialties that:

- ◆ Recommends the formation of task forces co-sponsored by the Office of Women's Health (OWH), Office of Minority Health (OMH). They will work with existing boards to review the content outlined in existing questions and revise and develop new questions in the areas of women's and minority health.

- ◆ Recommends that all boards recruit individuals sensitive and versed in women's health and cultural competency as members of their committees and make use of academic and professional organizations which can be advocates of women's and minority health, including the National Academy of Women's Health Medical Education (NAWHME), the Health Resources Services Administration, (HRSA), Office of Maternal and Child Health, which has developed competencies in minority health, the National Osteopathic Women's Physician Association (NOWPA), Society of Black Academic Surgeons, Association of Women Surgeons, Women in Cardiothoracic Surgery and National Council on Women's Health.
- Recommends that each board include among its pre-requisites for any specialty board demonstration speciality-approved skills in women's and minority health.

Strategy Development Sessions: Licensing and Accreditation Bodies

P. Daniel Hunt, M.D.
University of Washington School of Medicine
Seattle, Washington

Presentation

We are not going to change our entire organizations over night. We have to adjust our strategies to fit reality. When attempting organizational change, we need to develop A *Must Change List*.

One of the *must change items* should be a shared mission statement that faculty and administration participate in the development of and buy into. That statement should include verbiage like: "All instruction should stress a requirement that students be concerned with the total medical needs of their patients and the effect on their health of their social and cultural circumstances." A similar "gender-based biology" mission statement should be added for women's health. If these statements are a part of the overall mission statement of the medical institution, their administrations and outside accreditation bodies will be able to monitor the development of curriculum content and evaluate progress.

Questions should be added to survey instruments and questionnaires used during accreditation monitoring. Questionnaire results often appear in an institutions annual report. These processes formalize the importance of women's health and cultural competence to the overall medical school curriculum.

We recommend two questions be added to medical school questionnaires. The first: Is there a process in place for students to learn and practice cultural competence in a medical setting? The second: Is there a process in place for students to learn and practice gender-based biology?

The final recommendation we have is for licensing bodies. As licensing bodies experiment with different types of standardized methods to test for skills, we strongly recommend that cultural-based competency be included, since it is difficult to test this area with multiple-choice questions. We also recommend to the Federation of Licensing Boards that state licensing boards continue to require at least 10 credits for gender-based biology and to develop requirements for learning cultural competency.