DEVELOPING A BLUEPRINT FOR CULTURAL COMPETENCE EDUCATION AT PENN

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This article describes the structure, process, and outcomes of developing a blueprint for integration of cultural competence education into the curriculum at the University of Pennsylvania, School of Nursing. The overarching framework of Kotter (1995) on leading change and organizational transformation was used as a guide for evaluation of faculty efforts. Within the setting of a research-intensive university, the process consisted of implementing a series of action steps which included appointment of a Director of Diversity Affairs, selection of a Master Teachers Taskforce on Cultural Diversity as catalysts for change; conduction of intensive faculty development programs, dissemination of information about cultural competence education, and use of innovative teaching approaches and student participation in curriculum activities. In addition, a Blueprint for Integration of Cultural Competence in the Curriculum (BICCC) was developed and used as the instrument for faculty surveys for 2 consecutive academic years. Faculty survey findings showed a substantial increase in the number of courses integrating cultural competence content in the programs of study. Successful outcomes of the Penn initiative were due to administrative and faculty support, utilization of a Director of Diversity Affairs, innovative work of the Master Teachers Taskforce on Cultural Diversity, faculty development initiatives, and development of the BICCC as a guiding framework for identifying areas of needed curricular change. (Index words: Cultural competence education; Faculty development; Curriculum transformation; Blueprint for Integration of Cultural Competence in the Curriculum) J Prof Nurs 24:136–42, 2008. © 2008 Elsevier Inc. All rights reserved.

INTEGRATION OF CULTURAL competence into nursing curricula is a daunting challenge, albeit a moral imperative for faculty. The need for education of culturally competent nurses for the 21st century is due to a number of emerging trends. These include the changing demographics in America (RAND, 2004), underrepresentation of minorities in nursing and other health professions (Sullivan, 2004), compelling evidence of disparities in health care (Smedley, Stith, & Nelson, 2003), and the recommendations from the Office of Minority Health (1999) for use of Culturally and Linguistically Appropriate Service (CLAS) as standards for care (U.S. Department of Health and Human Services Office of Minority Health, 1991).

Education of professional nurses about the dimensions of cultural competence requires administrative support and a critical mass of faculty who are committed to curriculum transformation throughout the planning and implementation process. The notion of cultural competence is defined as a process of

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developing knowledge, skill, and sensitivity about the cultural uniqueness of the client within the context of individual, family, or organizational systems (Betancourt, Green, & Carrillo 2003, Campinha-Bacote, 2002, Giger & Davidhizar, 2004). To achieve optimal levels of health, providers must develop requisite cognitive, affective, and psychomotor core competencies to bridge the provider–patient cultural gap within the context of the clinical setting.

The purpose of this article is to present the strategic plan and outcomes of the curriculum efforts of faculty and administrators to develop a blueprint for cultural competence education. More specifically, it addresses the framework and process for curriculum transformation with use of a series of eight action steps and describes the use of the *Blueprint for Integration of Cultural Competence in the Curriculum* (BICCC) as a teaching guide and evaluative tool for faculty and students.

**Background**

A number of scholars have developed cross-cultural models as organizing frameworks for addressing cultural competence. The publications of Campinha-Bacote (2002), Purnell and Paulanka (2003), Giger and Davidhizar (2004), as well as the seminal work of Spector (2004) and Leininger and Mcfarland (2002) have shaped the debate on matters of cultural competence in nursing and health care. For many years, nursing schools have used a variety of strategies for incorporating aspects of cross-cultural nursing in programs of study. Such activities include graduate programs in cross-cultural nursing, master’s degrees or specialties in international and cross-cultural nursing, use of required courses related to cultural health and diversity for undergraduate and graduate students, international cultural immersion experiences, and distance learning initiatives (Lipson & DeSantis, 2007). For a number of years, a variety of interdisciplinary continuing education programs have been offered to health professionals.

Current key issues in cultural competence education in curriculum design focus on faculty development and evaluation of teaching effectiveness. Other issues center on resolution of content integration including individual courses versus integrated curriculum, maintenance of the integrative curriculum, and funding (Lipson & DeSantis, 2007). Thus, the development of the “best practice model” for integration of culture competence in the curriculum has not been established and remains a challenge for faculty and administrators.

**Framework for Curriculum Transformation**

Diffusion of an idea throughout an organization occurs within the context of the organizational structure, mission, institutional values, and the team leading the change. An authority on organizational leadership, Harvard Professor John P. Kotter (1995) outlined the *Eight Steps for Transformation of Your Organization* as a guiding framework for generating change and successful achievement of desired outcomes in the competitive world of business. The key components of the process are addressed in Box 1.

As a consultant for large and small corporations, Kotter (1995) elaborates on the realities and pitfalls of failure to achieve desired outcomes. Some of these problems include (a) lack of clarity to articulate and communicate a clear vision coupled with a sense of urgency and passion, (b) failure to assemble a creative taskforce of key leaders, (c) inability to remove negative stakeholders who undermine the process and are resistant to change, and (d) unrealistic belief that change occurs quickly. Thus, the leadership group must recognize and accept the perceived slow pace of progress during the change process. If critical steps are skipped or ignored, successful outcomes and acceptance of the innovation will not occur. Given the characteristics of academic institutions, the processes essential for organizational change provide an appropriate framework for addressing curriculum transformation related to cultural competence education.

**Academic Structure and Mission**

Embracing the notion of cultural competence education is rooted in the philosophy of the university and the School of Nursing. Opened in 1751, the University of Pennsylvania is located in Philadelphia, the birthplace of America and symbolic of the idea of democracy. Penn continues to embrace the spirit of its founder, Benjamin Franklin—pragmatist, public citizen, scientist, statesman, and maverick in nonsectarian education in Colonial America (Isaacson, 2004). Franklin’s philosophy focused on “service to mankind, country, friends and family” (Isaacson, 2004 p. 24). In her October, 2004 inaugural address, President Guttmann highlighted the Penn Compact to describe the mission of the university in the 21st century and outlined the need to increase access for the education of talented students, integrate knowledge, and engage communities locally and globally (Guttmann, 2004).

The mission of the School of Nursing is consistent with Franklin’s vision and that of the university. As a research-intensive university, teaching remains a core value. In the 2003 to 2008 strategic plan, the first goal of
faculty was to increase diversity and cultural competence throughout the research, education, and practice agenda of the School of Nursing. After discussion through curriculum committees and given the plethora of courses taught at the university, the faculty chose to use an integrated rather than a single-course option for cultural competence education.

Matters of diversity and culture are embedded in the school’s history. In terms of continuing education, the highly successful Biennial Black Health conference was launched in 1981 and continued as a signature event for two decades. The 1993 appointment of a senior fellow in Cultural Diversity helped to establish a “Seminar Series on Culture” at Penn School of Nursing. The subsequent formation of a Diversity Committee served as a forum for students, faculty, and staff to discuss issues of tolerance in the workplace environment. During the October 2002 faculty retreat, members of the Diversity Committee defined and described the dimensions of diversity in health as an integral aspect of the tripartite mission of the school.

**Process of Advancing Curriculum Transformation**

Over a period of 5 years, the following action steps were implemented to address the targeted goal of integration of cultural competence education throughout the curriculum. With the strong support of administration and faculty, eight action steps are described.

**Action Step 1: Appointment of a Director of Diversity Affairs**

The aggressive agenda on diversity and cultural competence began with the appointment of Afaf Meleis as Dean of the School of Nursing, an advocate of diversity, cultural competence, and globalization in health care. During the first year of her tenure, the Dean appointed a Director of Diversity Affairs, who would be responsible to develop and implement (a) a cultural competence educational initiative, (b) a proactive framework for recruitment and retention of students and faculty, and (c) strategies for facilitating a more caring and zero-tolerance environment for diversity at the School. As a faculty member, this individual also served as chairperson of the Biannual Black Health Conference and cochairperson of the Diversity Committee along with an Associate Professor of Nursing. With regard to curriculum, the specific challenges were to:

- ensure that cultural competence was integrated throughout the educational programs of study at the School;
- enrich faculty development programs as a targeted goal of the Diversity Committee;
- work with curriculum committees to continue the process of developing, monitoring, and measuring outcomes of integrative efforts; and
- generate periodic progress reports for faculty, the Dean, administrative leadership groups, and the Provost of the university.

**Action Step 2: Selection of the Master Teachers Taskforce on Cultural Diversity**

During the first year, the Director of Diversity Affairs presented lectures in targeted courses with emphasis on concepts of cultural competence, contemporary issues facing health care providers, and challenges in delivering culturally competent care. With collaboration from the director of the undergraduate program, meetings were held with faculty who were course directors examining course outlines in undergraduate courses. An initial baseline review showed that aspects of cultural competence were addressed in some courses but that there was a need to incorporate cultural competence in many other courses. At the end of the year, the dean established an ad hoc Master Teachers Taskforce on Cultural Diversity. The specific charge to the task force was to develop a blueprint for cultural competence integration, monitor curriculum change, serve as a resource and disseminate information about cultural competence to faculty and clinical educators, and communicate with all constituents about the goals and activities of the task force.

The Director of Diversity Affairs and a professor of nursing served as cochairs of the Master Teachers Taskforce on Cultural Diversity. The task force consisted of an influential group of faculty representing undergraduate and graduate programs and with considerable expertise in their specialty, teaching experience and curriculum activities. The group held a variety of academic appointments which included assistant, associate and full professors, program directors, clinical educators, and student representatives. At the end of the academic year, each member of the task force was financially compensated for their work with a bonus.

**Action Step 3: Implementation of an Intensive Faculty Development Program**

The combined efforts of the Diversity Committee, the Master Teachers Taskforce on Cultural Diversity, and the Center for Professional Development helped to launch an intensive faculty development program during a 5-year period. A variety of activities consisted of lectures, orientations for new faculty, in-service teacher education programs, workshops, and conferences. The highly successful Seminar Series on Diversity and Cultural Competence, consisting of 35 lectures, helped to advance the discourse on multiculturalism in health care. It addressed themes of race, ethnicity, class, and the health of high-risk populations. It provided a forum for discussions about cultural competence within the framework of institutional, system, or clinical scenarios. An interdisciplinary cadre of visiting lecturers from academia, government, and the private sector, as well as university faculty, participated in the series. In partnership with the university, one annual major event, the Annual Martin Luther King Commemorative Symposium on Social Change focused on highly sensitive matters of race, racism, or race-related health care concerns.
New faculty/clinical educator orientation and in-service education programs focused on teaching methods of cultural competence education. In partnership with the Center for Professional Development, several workshops titled, “Cultural Competency for Clinicians” provided practitioners in the region the opportunity to attend continuing education workshops. A national event, the Summit on American Indian Health Care titled, “Bridging the Cultural Canyon: Strategies to Reduce Health Inequities for American Indians” was a highly successful event attended by faculty, students, and community persons (Lipman & Watts, 2006). As a community outreach initiative, this interdisciplinary summit was co-sponsored by the Penn Schools of Nursing and Medicine and the tribal host, the Lenape Nation of Pennsylvania.

The annual Summer Nursing Research Institute (SNRI), sponsored by the Center for Health Disparities Research, provided a forum to address the state of culturally appropriate research strategies for pre- and post-doctoral students examining aspects of health disparities research. The SNRI also launched a new initiative titled, the Penn Health Science Summer Scholars Program which was targeted for undergraduate and graduate students. The purpose of the program was to narrow gaps in health disparities that currently exist between American citizens of different ethnic and racial origins by fostering the intellectual and professional development of health science scholars. Students were exposed to research in which culturally appropriate interventions have been designed to promote health and reduce the risk of disease. In addition, they studied the influence that culture, race, and ethnicity exert within the client system, health care system, and society, and the impact these have on health and illness.

**Action Step 4: Dissemination of Information About Cultural Competence Education**

As shown in Figure 1, the task force members served on a number of school committees and provided updated information on the work of the Master Teacher Taskforce on Cultural Diversity. With the establishment of several subcommittees, the members of the task force examined the literature on cultural competence education, participated in faculty orientation activities, gave presentations, helped to fine-tune surveys, collected quantitative and qualitative data on faculty and students, and facilitated Web site development.

The School’s Internet diversity Web site, titled “Diversity as a Driving Force” (www.nursing.upenn.edu/diversity), was developed providing an overarching framework for a comprehensive diversity agenda and serves as a core value of the tripartite mission of the school with emphasis on education, research, and practice. It highlights faculty, students, staff, and the workforce environment at the School of Nursing.

The Master Teachers Taskforce on Cultural Diversity also launched a successful Intranet Web site to serve as an internal resource for faculty and educators. Thus, faculty have the opportunity to access information on school documents, faculty and student survey reports, conference announcements, and links to cultural competence education opportunities to assist in teaching methods and strategies for teaching in the classroom and clinical setting.

**Action Step 5: Use of Innovative Teaching Approaches**

The challenge in teaching about the complexity of cultural competence requires learning about the interconnected domains of knowledge, affective learning, and skill acquisition on matters of culture health and illness. The use of 4- to 5-min clinical vignettes or “trigger films” that depict multicultural clinical encounters served as an excellent resource for faculty (Cross, Walsh Brennan, Cotter, & Watts, 2008; Cuellar, Walsh Brennan, Vito, & de Leon Siantz, 2008). The 16 individual films have been designated for specific courses in the undergraduate and graduate program and are used following a preparatory discussion of the issues (Kaiser Permanente & Multimedia Library, 2002). Following the film, there are debriefing and analysis of the scenario with identification of alternative actions by the health professionals portrayed in the film.

The advantages in using these vignettes as powerful adjuncts to learning are to provide the opportunity for students to analyze complex clinical scenarios, engage in critical thinking, and become cognizant of cultural issues as an integral aspect of clinical decision making. A facilitator’s guide provides organization of the content as well as objectives, time frame for content, ideas for discussion (objectives, reflection, interpretation, and decisional), and handouts for students to have for the class.

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**Figure 1.** A graphic depiction of communication by the Master Teachers Taskforce on Cultural Diversity.
Specific instructions are given to faculty to foster group discussion and interactions about culturally sensitive clinical encounters. Other teaching strategies used to incorporate culturally competent teaching strategies are available (Cuellar et al., 2008).

**Action Step 6: Student Participation in Curriculum Activities**

Following a Penn tradition, students serve as active participants on school committees, including the Master Teachers Taskforce on Cultural Diversity. To get a better understanding of student’s insights into education on cultural competence in the undergraduate and masters programs, questionnaires were distributed to ask students if cultural competence was covered in the curriculum, the strengths and weakness in the curriculum related to the content, and how it was taught. The doctoral students on the task force conducted focus groups at the undergraduate, master’s, and doctoral levels to determine students’ perceptions about integration of cultural competence research in their program of studies. Titled *Caring for Patients Not Like You*, these data enriched the information obtained in student surveys. Permission from the institutional review board for any surveys or focus groups was obtained. A number of recommendations were made including layering of content of cultural competence building on basic to more complex, the need for faculty to seize a “teachable moment” rather than avoid uncomfortable topics, and to address the issues of complexity of culturally congruent research. Results of the qualitative data were discussed in undergraduate and graduate curriculum committees and posted on the Intranet for faculty to review.

**Action Step 7: Development of a BICCC**

Nurse scholars have been highly successful in the development of a myriad of theoretical and conceptual models of cultural diversity and various dimensions of transcultural nursing. With regard to medical education, an expert panel of the Association of American Medical Colleges (AAMC, 2005) has made substantial advancements in the integration of cultural competence in the curriculum. The *Tool for Assessing Cultural Competence Training* (TACCT) is a detailed instrument targeted for evaluating culture competence in undergraduate medical school curricula (AAMC, 2005). The 67-item TACCT contains five domains, each addressing specific areas of learning related to knowledge, attitudes, and skill acquisition. Emphasis is placed on bridging the physician–patient cultural gap during the clinical encounters. In discussing the advantages of using the TACCT, Betancourt (2007) points out: “It is not perfect. It has a very large list of teaching objectives that allows medical schools to use it as an environmental scan and a blueprint for building their curriculum” (p. 258).

Given the need to measure outcomes for culture competence education at the School of Nursing, the Master Teachers Taskforce on Cultural Diversity developed a 31-item BICCC. The blueprint contains selected items derived from the TACCT with the addition of items specific to nursing education research and practice. It also contains the three major components of the teaching for assessment of knowledge (20 items), skills (5 items), and attitudes (6 items) (Cuellar et al., 2008). Permission to use the TACCT was granted to the School of Nursing.

The emphasis on the education and development of culturally competent practitioners was a major priority of the task force. The BICCC was targeted for students and faculty teaching in undergraduate and master’s programs. More specifically, it was used for (a) guidelines for teaching, (b) faculty surveys, and (c) student surveys. Thus, faculty had guidelines for teaching cultural competence education and were surveyed on the inclusion of this content in their teaching. In addition, students had the opportunity to report their perceptions about incorporation of this material in their programs of study based on the same criteria.

**Action Step 8: Surveys of Faculty and Clinical Educators**

Given the work of the task force to disseminate information about cultural competence education, faculty surveys were conducted for 2 consecutive academic years to determine if faculty infused cultural competence content in their courses. Using the BICCC survey as a measurement tool, faculty were asked to identify content of cultural competence in the courses they taught. As shown in Table 1, a summary of faculty surveys for each item on the BICCC shows the number of courses and the change in the number of courses which incorporated aspects of cultural competence education. An increase of teaching cultural competence was positive in both undergraduate and graduate programs. Using the BICCC for faculty surveys, data showed that a large percentage of content was taught and often duplicated across courses; however, several areas of cultural competence education were not addressed. Little or no change was identified in discussions of theoretical formulations related to culture, nursing and health, review or discussion of clinical studies focusing on health disparities research, and opportunities for skill development with special populations. These outcomes provide definitive information that faculty/clinical educators who are engaged in the process of educating students about matters of cultural competence can use to become better educators. The BICCC faculty survey will be useful to monitor changes over time throughout undergraduate and graduate programs in determining curriculum transformation.

**Outcomes of the Blueprint Initiative**

The challenge continues for faculty and administrators to determine the best practice model of curriculum transformation for inclusion of cultural competence education. Using the framework of Kotter (1995) for
understanding the fundamental processes and outcomes of organizational change, this article addresses the strategic efforts of faculty at the University of Pennsylvania, School of Nursing to establish a blueprint for cultural competence education. The definitive outcome of faculty surveys showed that concepts of cultural competence were taught in the knowledge, skill, and attitude domains of the BICCC. The action steps identified in this article clearly contributed to the success of establishing a blueprint for cultural

<table>
<thead>
<tr>
<th>Teaching Areas</th>
<th>Undergraduate Courses (Number)</th>
<th>Master's Courses (Number)</th>
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<tbody>
<tr>
<td></td>
<td>Change</td>
<td>Change</td>
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<tr>
<td>A. Knowledge (Concepts, issues, clinical decision making, and research)</td>
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<tr>
<td>i. Key concepts</td>
<td></td>
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<tr>
<td>1. Definitions of diversity</td>
<td>1 8 +7 (0.88)</td>
<td>1 4 +3 (0.75)</td>
</tr>
<tr>
<td>2. Analysis of social constructs (ethnicity, race, culture, gender, etc.)</td>
<td>2 6 +4 (0.66)</td>
<td>1 3 +2 (0.67)</td>
</tr>
<tr>
<td>3. Definitions of cultural competence (individual, system, and organizational)</td>
<td>2 7 +5 (0.71)</td>
<td>2 7 +5 (0.71)</td>
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<tr>
<td>4. History of health care discrimination—societal and professional</td>
<td>3 6 +3 (0.50)</td>
<td>2 6 +4 (0.67)</td>
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<tr>
<td>ii. Issues on health disparities</td>
<td></td>
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<tr>
<td>5. Group history, health status, and epidemiology of minority groups</td>
<td>0 8 +8 (100)</td>
<td>3 8 +5 (0.63)</td>
</tr>
<tr>
<td>6. Biophysiological determinants of health and illness with minority groups</td>
<td>5 12 +7 (0.58)</td>
<td>3 5 +2 (0.40)</td>
</tr>
<tr>
<td>7. Social determinants of health—impacts of race, culture, health status, employment, etc.</td>
<td>2 9 +7 (0.78)</td>
<td>1 8 +7 (0.88)</td>
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<tr>
<td>B. Skill</td>
<td></td>
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<tr>
<td>21. Conduct self assessment of biases and stereotypes about “the other”</td>
<td>2 7 +5 (0.71)</td>
<td>0 0 0</td>
</tr>
<tr>
<td>22. Complete cultural health heritage history—cultural beliefs and behaviors</td>
<td>1 4 +3 (0.75)</td>
<td>0 1 +1 (1.00)</td>
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<tr>
<td>23. Elicit cross-cultural health history which includes the patient's health beliefs</td>
<td>2 4 +2 (0.50)</td>
<td>3 14 +11 (0.79)</td>
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<tr>
<td>24. Facilitate cross-cultural collaboration in the community</td>
<td>1 3 +2 (0.67)</td>
<td>1 8 +7 (0.88)</td>
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<tr>
<td>25. Identify level of cultural competency development with special populations</td>
<td>1 3 +2 (0.67)</td>
<td>6 6 0 (00)</td>
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<tr>
<td>C. Attitude/Awareness</td>
<td></td>
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<tr>
<td>26. Self-awareness of values, cultures, beliefs, and biases</td>
<td>2 11 +9 (0.82)</td>
<td>0 6 6 (1.00)</td>
</tr>
<tr>
<td>27. Strategies for reducing bias and stereotyping about others</td>
<td>0 9 +9 (1.00)</td>
<td>0 3 +3 (1.00)</td>
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<tr>
<td>28. Awareness of the challenges with cross-cultural communication</td>
<td>0 9 +9 (1.00)</td>
<td>0 8 +8 (1.00)</td>
</tr>
<tr>
<td>29. Comfort level with cross-cultural clinical encounters</td>
<td>4 7 +3 (0.43)</td>
<td>0 8 +8 (1.00)</td>
</tr>
<tr>
<td>30. Recognition of the historical impact of racism and discrimination in health care</td>
<td>1 7 +6 (0.86)</td>
<td>0 0 0</td>
</tr>
<tr>
<td>31. Demonstrate respect during the clinical encounter</td>
<td>0 2 +2 (1.00)</td>
<td>0 4 +4 (1.00)</td>
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* Areas of deficiency.
competence education. Kotter's notion of successful transformation of an organization including clarifying the vision, establishing a leadership group, and identifying some short-term successes, were successful in this endeavor. In terms of long-term goals, the Master Teachers Taskforce on Cultural Diversity recommends that faculty build on the blueprint. The blueprint allowed future planning to (a) address areas of deficiency in cultural competence content as identified in faculty surveys, (b) use student-facilitated focus groups to capture qualitative data on culture competence education, and (c) facilitate use of the BICCC for concurrent surveys of faculty and students.

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