National Center for Cultural Competence
Georgetown University Center for Child and Human Development

Climate of the Learning Environment

Cultural and Linguistic Competence Checklist for MCH Training Programs

Overview and Purpose

The U.S. Department of Human Services, Health Resources and Services Administration (HRSA) Maternal and Child Health (MCH) Training Program funds public and private nonprofit institutions of higher learning that provide education and training to those working in maternal and child health professions. A major objective of the MCH Training Program is to *support trainees, faculty, continuing education, and technical assistance to train the next generation of leaders in maternal and child health*. The program places emphasis on interdisciplinary, family-centered, culturally competent care with a population-focused, public health approach.

In support of this objective, the National Center for Cultural Competence (NCCC), with input from an expert MCH faculty workgroup, developed a set of checklists to assess cultural and linguistic competence within the MCH Training Program. Each checklist addresses a different aspect of the infrastructure, function, policy, and practice of training programs. The checklists are not designed to measure the cultural and linguistic competence of a given program; rather, they provide a structure for discussion and self-examination to facilitate programmatic and organizational change. The themes for each checklist were chosen with input from the expert workgroup and include the following:

- Climate of the Learning Environment
- Curriculum
- Experiential Learning
- Research
- Community Engagement

What is Campus Climate?

The literature reveals that there are very different ways that campus climate is conceptualized and defined.[1] Some definitions ascribe campus climate solely to student perceptions and experiences.[2] Other conceptualizations make a distinction between the values, beliefs, and legacy of a university versus the day-to-day realities that students, faculty, and staff experience. The following definitions of campus climate are offered for faculty and staff to decide which is most reflective of a given MCH training program and its university setting.

Early models of campus climate focused on attitudes, perceptions, or observations.[4] A framework advanced by Hurtado and colleagues,[5-7] and expanded by Milem et al,[8-9] puts forth a multidimensional conceptualization of campus climate. This framework also presents the factors that create, sustain, or lead to change in the university or organization and ultimately its climate. While this model was developed to address issues related to racial and ethnic diversity,

Selected Definitions of Campus Climate

Campus climate is a measure—real or perceived—of the campus environment as it relates to interpersonal, academic, and professional interactions. In a healthy climate, individuals and groups generally feel welcomed, respected, and valued by the university.[3(p12)] "A healthy climate is grounded in respect for others, nurtured by dialog between those of differing perspectives, and evidenced by a pattern of civil interactions among community members."[3(p12)] A healthy climate may at times lead to discomfort, as members of the community confront uncomfortable situations in ways that lead to growth, change, and understanding.

The major features of campus climate are its (1) primary emphasis on common participant views of a wide array of organizational phenomena that allow for comparisons among groups over time, (2) focus on current patterns of beliefs and behaviors, and (3) often ephemeral or malleable character. Climate is pervasive, potentially inclusive of a broad array of organizational phenomena…[4(p8)]

The authors describe three categories of climate—the objective climate, the perceived climate, and the psychological or felt climate.[4]

BOX 1. Microaggressions

Sue defined microaggressions as: "Brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual orientation, and religious slights and insults to the target person or group."[10(p5)]

the concepts are broadly applicable to an array of cultural groups. The factors in this model are:

- **External forces** includes, but is not limited to, socio-historical and political forces such as racism, segregation in education, anti-immigrant movements, or homophobia; catastrophic events such as 9/11; or governmental policies that impact the academic institution's implementation of affirmative action, financial aid, or student loans.
- **Compositional diversity** is the number and proportion of various racial, ethnic, and cultural groups on a campus. It relates to the diversity of trainees, faculty, and administrative staff in an academic institution. This factor tends to receive the most attention in many academic institutions.
- **Historical legacy of inclusion or exclusion** is the factor that reflects historical vestiges of segregated schools and colleges, and policies that imposed quotas for admission or hiring based on such factors as race, ethnicity, gender, or religious affiliation. It involves the public perception and collective memory of why, when, and how admission and hiring policies changed in the college or university.
- **Psychological climate**, as described by Hutardo et al,[5-7] is seen as the views held by individuals about intergroup relations, how the institution responds to diversity, views on racial conflict on campus, and attitudes toward people from different backgrounds.
- **Behavioral climate** is the term that Hutardo et al[5-7] used to describe the interactions among individuals and groups of different races and ethnicities. This factor includes positive cross-racial and ethnic interactions and overt negative behaviors such as harassment and hate crimes, and microaggressions. (See Box 1.)
- **Organizational/structural dimension of climate** is reflected in how race, ethnicity, and culture are addressed in the curriculum, criteria for grading/evaluating student efforts, allocation of resources, tenure policies, admissions processes and requirements, and other structures, including the make-up of faculty search committees and admissions committees.[8]

Why is a climate that is inclusive and culturally competent important for training programs funded by the Maternal and Child Health Bureau (MCHB)?

Climate is identified in the literature as a key to successful recruitment and retention of underrepresented trainees and faculty in MCH-related professions.

(Note: Whenever the term underrepresented *is used in this document, it refers specifically to those individuals from racial and ethnic groups underrepresented in MCH training programs and professions.)*

The literature reports that poor climate in academic settings has been linked to alienation, poor integration, poor academic performance, and problems with academic, personal, and emotional adjustment for racially and ethnically diverse students.[11-12] These factors play a role in poor retention of trainees and faculty as well. Poor integration of trainees and faculty from underrepresented racial and ethnic groups is in part related to the power dynamics between the dominant culture (based on race, ethnicity, gender, etc.) in the academic institution or MCH Training Program and those trainees and faculty who are not from that culture.[13] The organizational and structural dimensions of climate in academic institutions and training programs are typically based on cultural values, preferred ways of learning, and educational goals of the dominant group. Too often, trainees and faculty from racial and ethnic groups other than non-Hispanic White are expected to leave their cultural identities at home in order to pursue and succeed in educational and career goals.[14] Culture informs the perceptions and definitions of "success." Thus, admissions standards and processes, grading and degree completion requirements, and tenure and promotion criteria may all reflect the dominant culture's values and practices. They also create a cultural disconnect for trainees and faculty who are not from the dominant culture in the university and/or the MCH Training Program. Teaching methods reflect a cultural perspective as well and may not be effective for trainees from all backgrounds.

Recruitment and retention of underrepresented trainees and faculty are critical to addressing persistent racial and ethnic health and health care disparities for MCH populations. Research reports the following about Underrepresented Minority (URM) health professionals:

- "URM health professionals, particularly physicians, disproportionately serve minority and other medically underserved populations;
- minority patients tend to receive better interpersonal care from practitioners of their own race or ethnicity, particularly in primary care and mental health settings; and
- non-English-speaking patients experience better interpersonal care, greater medical comprehension, and greater likelihood of keeping follow-up appointments when they see a language-concordant practitioner, particularly in mental health care."[15(p3)]

Yet the racial and ethnic diversity of the current workforce required to address the broad array of preferences and needs of MCH populations is limited. For example, reports indicate that:

- 83.2% of registered nurses are non-Hispanic White;[16] and
- 54.5% of physicians and surgeons are non-Hispanic White, 12.2% are Asian, 4.9% are Hispanic, 3.5% are Black, and .16% are American Indian/Alaskan Native (AI/AN).[17]

There is a similar lack of racial and ethnic diversity in other disciplines needed to address the needs of MCH populations, such as physical therapists, dentists, psychologists, social workers, psychiatrists, and school psychologists.[15,18-19]

There remains a need to increase the number of trainees and faculty from racial and ethnic groups underrepresented in MCHB-funded training programs and in the workforce. On the basis of data from the MCHB Discretionary Grant Information System (DGIS) (https://mchdata.hrsa.gov/dgisreports/PerfMeasure) in 2010, faculty in these training programs were 86.3% White, 5.3% Black, 4.8% Asian, .5% AI/AN, .3% Native Hawaiian or other Pacific Islander, and .8% were more than one race. In that year, 5% of faculty were Hispanic or Latino. Trainees in MCH training programs

reflected somewhat greater diversity with, on average, 22% non-White (note that this includes Asian trainees, who may not be an underrepresented group in some training programs and institutions) and 7.6% Hispanic trainees in 2010.

Climate is linked to improved performance and development of cross-cultural knowledge and skills for all trainees.

Research demonstrates the link between climate and educational outcomes, both for minority and for majority students.[9] Teachable moments that grow from tensions and difficulties in interactions between groups and individuals can lead to reflection and personal growth. Building upon these experiences enables trainees and faculty to develop enhanced levels of cultural awareness and a set of skills for cross-cultural interactions. When the climate does not have ways to address those tensions, it can fester and lead to negative outcomes. These outcomes can be poor retention of racially, ethnically, and culturally diverse trainees and faculty *and* lost opportunities for all trainees and faculty to learn and grow. *All* trainees prosper and flourish academically when the climate is positive, respectful, and nurturing for everyone.

The role of cultural competence in enhancing campus climate:

- Raises cultural awareness among trainees, faculty, and staff;
- Increases knowledge and skills among trainees, faculty, and staff to interact positively with people from cultures than other than their own;
- Increases knowledge and skills to recognize and manage cross-cultural conflicts;
- Defines and describes approaches to mitigate the effects of bias, prejudice, stereotyping, discrimination, homophobia, racism, and other "isms";
- Helps instill a sense of social justice to advocate and address inequities within the university climate; and
- Integrates such content in curricula, coursework, teaching methodologies, research, and community engagement.

Definitions and Key Concepts

Bias: Bias is a preference or an inclination, especially one that inhibits impartial judgment. Bias is a natural tendency among all humans; however, it becomes a concern when it interferes with how we make fair decisions.[20]

Discrimination: Discrimination is differential behavior or conduct of one person or group toward another person or group that is based on individual prejudice or societal norms that have institutionalized prejudicial attitudes.[21-22]

Cultural Competence: Cultural competence requires that organizations:

- have a congruent, defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally;
- have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to the diversity and cultural contexts of communities they serve; and
- incorporate the above into all aspects of policymaking, administration, practice, and service delivery and systematically involve consumers, key stakeholders, and communities.

Cultural competence is a developmental process that evolves over an extended period of time. Individuals, organizations, and systems are at various levels of awareness, knowledge, and skills along the cultural competence continuum.[23]

Cultural Diversity: The term *cultural diversity* is used to describe differences in ethnic or racial classification and self-identification, tribal or clan affiliation, nationality, language, age, gender, sexual orientation, gender identity or expression, socioeconomic status, education, religion, spirituality, physical and intellectual abilities, personal appearance, and other factors that distinguish one group or individual from another.[24]

Disparity: Disparity, as used within the context of health care, reflects more than numbers—not just differences in prevalence rates or morbidity and mortality rates. A disparity can be thought of as "A chain of events signified by a difference in: the environment, access to, utilization of, and quality of care, health status, or a particular health outcome that deserves scrutiny."[25]

Health Disparity: Health disparity represents a type of systemic difference in the prevalence, morbidity, disease burden, mortality of a disease, or illness of one social group as compared with another as a function of underlying social advantage or disadvantage.[26] A health disparity is also defined as a particular type of health difference that is closely linked with social or economic disadvantage. Such disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; mental health; cognitive, sensory, or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion.[25]

Health Care Disparities: Health care disparities are the types of differences between groups in which health care treatment, services, or outcomes vary in a way that is unjustified by the underlying need or preference of the patient who is associated with membership in a social group. The measure of the differences is usually by comparison with the dominant population group or the population as a whole. The differences may be quantified by differences in race, ethnicity, language spoken, socioeconomic status, disability, national origin, sexual orientation, or other social attribute marginalized by society. These differences are reflected in service system attributes.[27-28] Disparities in health care are reflected in discrimination in care and care settings and differences in insurance, access, quality, and services provided.[29]

"isms": The "isms" is a catch-all term used to refer to a range of attitudes and behaviors that involve perceived superiority, oppression, and discrimination based on such factors as race, national origin, ethnicity, language, social class, disability, gender, and sexual orientation and identity.[30]

Linguistic Competence: The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse groups including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing. Linguistic competency requires organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations served. The organization must have policies, structures, practices, procedures, and dedicated resources to support this capacity.[31]

Prejudice: Prejudice is an explicit, known, conscious, and usually pejorative judgment or attitude toward a group. Prejudice is beliefs and attitudes that people know they hold and can control deliberately and strategically.[32] Such biases can result in prejudice. However, people have conscious access to their explicit biases and are able to monitor and control them to mitigate the impact of those biases on their behavior.[32]

Stereotype: A stereotype is a cognitive structure that contains the perceiver's knowledge, beliefs, and expectations about a human group.[33] Stereotypes are reflected in the preconceptions that one person has about another based on group membership. Stereotypes are normal strategies that humans use to process and store information in an efficient manner.[33] A stereotype is "a widely held image of a group of people through which individuals are perceived or the application of an attitude set based on the group or class to which the person belongs."[34(p814)]

Checklist to Facilitate the Integration of Cultural and Linguistic Competence into the Climate of the Learning Environment

The following checklist is offered for consideration with the understanding that some academic climate factors within MCH training programs are affected by the climate of the institutions in which they exist. Checklist items are designed to address: (1) areas in which programs can have control; and (2) the potential role MCH training programs can assume to improve the climate within their broader institutions.

Interpersonal Dimensions of Climate

"Interpersonal dimensions of climate" refers to the values, beliefs, attitudes, and behaviors of individuals within the program. Interpersonal dimensions involve how the program promotes understanding, respect, and positive interactions among individuals who differ based on an array of factors, such as race, ethnicity, nationality, language, age, gender, sexual orientation, gender identity or expression, socioeconomic status, education, religion, spirituality, or physical and intellectual abilities.

In order to have a positive impact on the interpersonal dimensions of climate within our MCH Training Program, we:

- ☐ Ensure that faculty, staff, and trainees understand and describe the value of diversity within the program, within the profession, and in MCH leadership;
- ☐ Articulate and demonstrate the value of diversity through modeling respect for cultural beliefs and practices;
- ☐ Ensure diversity of thought, perspectives, and voices in formal and informal discussions and classroom interactions;
- ☐ Provide opportunities for safe and respectful discussions of issues such as:
  - how cultural differences impact interactions within the program
  - historical exclusion and/or marginalization of groups based on race, ethnicity, gender, disability, sexual orientation, gender identity or expression, or other cultural factors within both the program and the university
  - current political, social, or legal issues that impact the experiences of trainees and faculty within the program; and
- ☐ Provide activities and processes to promote positive cross-cultural interactions during which trainees, faculty, and staff share perspectives and learn from one another.

In some instances, overt behaviors that reflect prejudice, stereotyping, bias, and outright hostility toward individuals or groups within the program or the broader university negatively impact the climate. In order to address such overt behaviors within our MCH Training Program, we:

- ☐ Provide a structured process for discussing the impact of the "isms" within the program, university, and larger society;
- ☐ Recognize the impact of conscious and unconscious biases and use approaches to address them;
- ☐ Communicate to all trainees, faculty, and staff (in both verbal and written format) that bias, stereotyping, discrimination, and the "isms" are not tolerated in the program and university;
- ☐ Inform all trainees, faculty, and staff of university or organizational policies for reporting harassment, discrimination, and hate crimes;
- ☐ Have program procedures and processes to respond to reports of harassment, discrimination, and hate crimes experienced or witnessed by program trainees, faculty, or staff; and

Checklist to Facilitate the Integration of Cultural and Linguistic Competence into the Climate of the Learning Environment

☐ Provide a forum for all trainees, faculty, and staff to learn about microaggressions and the impact on:
- individuals within the program
- the health and well-being of diverse populations.

Organizational and Structural Dimensions of Climate

"Organizational and structural dimensions of climate" refers to policies, structures, and practices within the MCH Training Program. It includes how courses and didactic activities support diversity and create a welcoming and respectful environment in which all trainees and faculty can flourish and be recognized for their success.

In order to embed cultural competence in the organizational and structural dimensions of climate in our MCH Training Program, we:

☐ Strive for program faculty whose demographic make-up is culturally diverse (i.e., race, ethnicity, and disability, who are individuals with lived experience such as community members and families of children with special health care needs);

☐ Support and advocate for faculty tenure evaluations that value:
- research on cultural and linguistic competence and on health and mental health disparities and inequities
- active and meaningful approaches to community engagement related to MCH populations;

☐ Consider life experiences relevant to the trainee's area of study as part of admission or program acceptance standards;

☐ Have a program admissions committee that is racially, ethnically, and culturally diverse;

☐ Consider how stipends or other financial support promotes the inclusion of trainees from diverse racial, ethnic, and cultural backgrounds;

☐ Design coursework that offers multiple ways to demonstrate knowledge and skills that are consonant with the cultures of diverse trainees;

☐ Support faculty use of multiple teaching modalities that address differences in preferred ways of learning;

☐ Have grading standards that reflect definitions of success that incorporate multiple cultural perspectives (e.g., valuing collaborative vs. independent approaches to coursework, visual vs. verbal demonstration of knowledge);

☐ Present the topics of health and health care disparities and inequities within the contexts of:
- historical experiences of diverse populations
- current political realities impacting diverse communities
- social determinants of health;

☐ Present information about inequities and disparities in ways that do not stigmatize diverse populations and groups;

☐ Include content on the concept of privilege (i.e., race, ethnicity, gender, or ability) and the relative disadvantage of those who are not members of the privileged groups;

☐ Provide structured approaches to build skills of faculty to advise and mentor trainees from racial, ethnic, or cultural groups other than their own; and

☐ Discourage the practice of asking a single member of a particular racial, ethnic, or cultural group to represent the perspectives of all members of that group in class discussions, committee meetings, etc.

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About the National Center for Cultural Competence

The National Center for Cultural Competence (NCCC) provides national leadership and contributes to the body of knowledge on cultural and linguistic competency within systems and organizations. Major emphasis is placed on translating evidence into policy and practice for programs and personnel concerned with health and mental health care delivery, administration, education and advocacy. The NCCC is a component of the Georgetown University Center for Child and Human Development and is housed within the Department of Pediatrics of the Georgetown University Medical Center.

The NCCC provides training, technical assistance, and consultation, contributes to knowledge through publications and research, creates tools and resources to support health and mental health care providers and systems, supports leaders to promote and sustain cultural and linguistic competency, and collaborates with an extensive network of private and public entities to advance the implementation of these concepts. The NCCC provides services to local, state, federal, and international governmental agencies, family and advocacy support organizations, local hospitals and health centers, health care systems, health plans, mental health systems, universities, quality improvement organizations, national professional associations, and foundations.

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