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

Curriculum

Cultural and Linguistic Competence Checklist for MCH Training Programs

Overview and Purpose

The U.S. Department of Health and 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 MCH Training 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

Why ensure that values, principles, and practices of cultural and linguistic competence are embedded in the curriculum of MCH-funded training leadership programs?

1. **Preparing leaders.** It is the responsibility of MCH leadership training programs to ensure that program graduates have the foundation necessary to work within a variety of professional settings and to contribute to the health and well-being of our Nation's diverse populations, including those that are most vulnerable. One of the MCH Core Leadership Competencies focuses on cultural competence.[1] Achieving cultural *and* linguistic competence requires strong and informed leadership to spur the necessary changes within systems, organizations, and practice. Curriculum within training programs should foster leaders who have the commitment, energy, knowledge, and skills to do the difficult work of (a) advancing and sustaining cultural and linguistic competence; (b) addressing health and health care disparities; and (c) promoting health and mental health equity.[2]

2. **Professional accreditation standards for training and education.** Many professional associations that accredit MCH disciplines have established standards and require that curricula address cultural and linguistic competence. Moreover, consensus within the health professions emphasizes that specific knowledge and skills are required to respond to the health and behavioral health interests and needs of diverse populations in the United States, its territories, and tribal communities. The promulgation of these standards was in part recognition of the lack of adequate attention to and inclusion of content that addresses the role of culture and language in health and health care.[3-6]
3. **Demonstrated impact of education on cultural and linguistic competence.** Numerous studies have provided the evidence to support the efficacy of cultural and linguistic competence education for health care providers and public health professionals. Studies have demonstrated positive impact on health care provider knowledge, attitudes, and skills as well as the satisfaction of patients who interact with those providers.[7] Like other professional competencies expected of MCH leaders, cultural and linguistic competence requires direct instruction. Current research indicates that this set of competencies can be developed through educational interventions.[8]

Challenges to embedding principles of cultural and linguistic competence in the curriculum of MCH-funded training leadership programs.

1. **Faculty may not have the skills and comfort to include this content in coursework.** The introduction of content related to cultural and linguistic competence in professional curricula is a relatively recent phenomenon. Some MCH faculty may have neither this content in their discipline-specific academic training nor the opportunity to observe effective models of delivering such content. It may be necessary for MCH training programs to provide faculty development to ensure the inclusion of cultural and linguistic competence in all aspects of curricula development, implementation, and evaluation. Such efforts will require intentionality on the part of both programs and faculty to embrace new knowledge and skills and to make the investment of time and resources necessary to enhance faculty capacity in cultural and linguistic competence.
2. **Curricula for health professions training programs are "chock-full" of required** content. Including additional courses, modules, and lessons dedicated solely to cultural competence and linguistic competence is both challenging and not likely to assure that trainees develop a full understanding of their relationship to all areas of study. In some programs, cultural and linguistic competence is relegated to one course or part of one course across a multi-year educational experience. Thus, the challenge for MCH training programs is how to embed this content across all courses within the curriculum.

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.[9]

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.[10,11]

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.[12]

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.[13]

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.[14]

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.[15] 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.[14]

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.[16,17] Disparities in health care are reflected in discrimination in care and care settings and differences in insurance, access, quality, and services provided.[18]

"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.[19]

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.[20]

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.[21] 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.[21]

Privilege: Privilege is defined as a right or immunity granted as a peculiar benefit, advantage, or favor, such as a right or immunity attached specifically to a position or an office or the advantage that wealthy and powerful people have over other people in a society.[22] One characteristic of privilege is that those who have it are not aware of their advantage and rather see others as having challenges or deficiencies.[23] "Although different privileges bestow certain common characteristics (membership in the norm, the ability to choose whether to object to the power system, and the invisibility of its benefit), the form of a privilege may vary according to the

power relationship that produces it. Male privilege and heterosexual privilege result from the gender hierarchy. Class privilege derives from an economic, wealth-based hierarchy."[24(p17)]

Stereotype: A stereotype is a cognitive structure that contains the perceiver's knowledge, beliefs, and expectations about a human group.[25] 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.[25] 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."[26(p814)]

Checklist to Facilitate the Integration of Cultural and Linguistic Competence Into the Curriculum

Approaches to integrating cultural and linguistic competence into the curriculum should reflect the most effective approaches to curriculum design and innovation. As with any new curriculum development it will be important for faculty to:

- Examine their implicit beliefs about cultural and linguistic competence as reflected in the curricular design and delivery;
- Identify student learning outcomes specific to cultural and linguistic competence;
- Use concepts and models from the educational literature to devise teaching approaches that align with those learning outcomes; and
- Create a range of feedback mechanisms (including students and other faculty) to evaluate new curricular content and approaches and use that feedback in ongoing improvement of the design.[27]

This checklist is designed to assist programs and their faculty in embedding values and guiding principles of cultural and linguistic competence in all aspects of curricula and in creating the policies, structures, and practices to sustain these efforts. The checklist is (a) designed to address the challenges to achieving this goal; and (b) based on the principle that cultural and linguistic competence content is infused throughout all courses and curricular components. The National Center for Cultural Competence (NCCC) acknowledges that some MCH training programs may not have full control over all curricular components of their programs.

Support for Planning and Sustaining Curriculur Change

MCHB-funded training programs will need to create the policies, structures, and practices to plan and sustain cultural and linguistic competence in all aspects of curricula.

In order to embed cultural and linguistic competence in the curricula of our MCH Training Program, we:

- ☐ Have a process to clarify values and philosophy about cultural and linguistic competence to create a shared vision among faculty and staff.
- ☐ Have a process to review current and new curricular content to determine the extent to which that vision of cultural and linguistic competence is represented.
- ☐ Provide a process to determine faculty development needs to make and implement curricular changes.
- ☐ Create a safe environment for faculty to share challenges and learn together to deliver cultural and linguistic content in their courses effectively.

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- ☐ Include criteria in faculty performance evaluations that address the capacity to incorporate cultural and linguistic competence into teaching activities.
- ☐ Specify knowledge and skills required to design and/or implement curricula content on cultural and linguistic competence in faculty recruitment.
- ☐ Include student assessment on faculty effectiveness to incorporate cultural and linguistic competence in course evaluations.
- ☐ Include awareness, knowledge, skills, and attitudes related to cultural and linguistic competence in student evaluation and grading.

Curriculum Content

To embed cultural and linguistic competence in all aspects of curricula, our MCHB Training Program:

- ☐ Does not limit this content to a stand-alone or separate course, module, or topic.
- ☐ Reviews and updates content to include most current thinking and evidence on cultural and linguistic competence, health and health care disparities, disproportionality in educational settings, and inequities that are relevant to disciplinary practice.
- ☐ Addresses topics that include, but are not limited to:
  - definitions and conceptual frameworks of culture and multiple cultural identities;
  - definitions and frameworks of cultural competence;
  - definitions and frameworks of linguistic competence;
  - Title VI and legal requirements for ensuring language access in health care and education;
  - National Standards on Culturally and Linguistically Appropriate Services in Health and Health Care;
  - leading cultural and linguistic competence efforts in health, education, and human services settings;
  - culturally defined values, belief systems, and practices about disability;
  - the impact of cultural belief and practices on seeking diagnostic evaluation, services, and supports;
  - cultural identity at the intersection of race, ethnicity, and disability;
  - racial and ethnic disparities among people with disabilities related to health, health care, employment, housing, education, and community inclusion;
  - the historical experiences and current socio-cultural contexts of the populations that trainees will encounter;
  - concepts of privilege and advantage (based on such factors as race including "white privilege" and socioeconomic status) and their impact on population health and the life course;
  - social determinants that contribute to health and health care disparities and inequities; and
  - the role and impact of conscious and unconscious biases on health and health care.
- ☐ Involves racially, ethnically, and culturally diverse individuals from the populations of focus in planning and delivering the curriculum

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Faculty Skills and Development

Faculty may need support in developing the knowledge and skills to deliver content related to cultural and linguistic competence in their courses. In addition, faculty's capacity to convey this content is based on a set of skills that may include addressing student attitudes and comments that reflect bias and insensitivity; encouraging open dialogue about difficult issues such as inequities and the "isms"; addressing issues such as privilege; and dealing with the strong feelings and conflict that topics related to culture, inequity, and disparities may engender. MCHB-funded training programs will need to provide support to faculty to impact the delivery of curricula successfully.

In order to support the faculty in our MCHB-funded training program to embed cultural and linguistic competence in all aspects of curricula, we:

☐ Provide faculty development opportunities that address how to:

- relate values and guiding principles of cultural and linguistic competence to the general content of the courses they teach;
- integrate cultural and linguistic competence content into courses, clinical experiences, and other learning opportunities effectively; and
- effectively deal with interpersonal conflict that may arise in the discussion of cultural and linguistic competence, health and health care disparities and inequities, and the concept of privilege, and the "isms."

☐ Arrange for mentoring and other professional development supports for faculty.

☐ Encourage faculty to partner with individuals at other universities and colleges who have expertise in cultural and linguistic competence, health disparities, health equity, and explicit and implicit biases.

☐ Provide fiscal support for faculty to participate in conferences and other professional development forums to increase their capacity to address cultural and linguistic competence in interdisciplinary training programs.

☐ Convene forums to share insight, research, and experiences in embedding cultural and linguistic competence in all aspects of the MCH Training Program curriculum

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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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