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

Documenting the Implementation of Cultural and Linguistic Competence: A Guide for Maternal and Child Health Bureau Funded Training Programs

Training programs funded by the Division of Maternal and Child Health (MCH) Workforce Development of the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration, U.S. Department of Health and Human Services, may be called upon to document their efforts related to cultural and linguistic competence in the implementation of their grant activities. This guide is designed to provide suggested approaches that can be used for grant proposals, progress reports, and site visits to document these efforts or to document progress over time. The guide's structure is based on the areas addressed in site visits to Leadership in Neurodevelopmental Disabilities (LEND) programs; however, the suggested approaches to documentation can be used by all types of training programs.

Curricula

Consider presenting information on the extent to which your training program's curriculum addresses the following areas.

- Content related to cultural and linguistic competence is integrated throughout the curricula and is not limited to a stand-alone or separate module or topic.
- Curricula are reviewed and updated to include the most current thinking and evidence on such topics as cultural and linguistic competence, health and health care disparities, disproportionality in educational settings, the role of culture in the social determinants of health, and inequities that are relevant to disciplinary practice.
- Curricula address 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 for linguistic competence;
  - Title VI and legal requirements for ensuring language access in health care, mental health care, and primary and secondary education;
  - The *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care*; https://www.thinkculturalhealth.hhs.gov/Content/clas.asp
  - leadership for cultural and linguistic competence in health, education, and human services settings;
  - culturally defined values, belief systems, and practices about disability;
  - the impact of cultural belief and practices on diagnostic evaluation, services, and supports (from the perspectives of both those who receive and those who provide such services);
  - 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, mental health care, and other social and educational services.
- Curricula development and delivery involve racially, ethnically, and culturally diverse youth and adults and their families impacted by MCH services, and community members.
- Curricula are evaluated to assess trainees' perceptions of how courses and the program enhanced their knowledge and skills related to cultural and linguistic competence.

Clinical Preparation

Consider presenting information describing the extent to which clinical preparation in your training program addresses the following areas.

- Clinical experiences prepare trainees to engage, provide services and supports, and conduct research in culturally and linguistically diverse communities.
- Clinical experiences offer trainees opportunities to apply their knowledge and skills with diverse populations and in diverse settings based on such factors as:
  - geography (urban, suburban, rural, frontier, tribal, territorial);
  - race;
  - ethnicity;
  - language;
  - gender;
  - age;
  - spirituality/religiosity/faith beliefs;
  - disability;
  - immigrant or refugee status;
  - educational and literacy levels;
  - health literacy levels;
  - sexual orientation (lesbian, gay, bisexual, transgender, and questioning [LGBTQ]), and gender identity and expression;
  - socioeconomic status or class; or
  - affiliation or service in the U.S. military.
- Clinical supervision provides instruction on practice adaptations that are responsive to the cultural and linguistic characteristics of a given population such as the capacity to:
  - choose appropriate screening and evaluation tools;
  - address family values and beliefs in recommended interventions;
  - engage extended family or community members whom the family includes on their decision-making team;
  - address language, literacy, health literacy, or disability-related communication preferences and needs in clinical interactions; and
  - work with interpreters effectively (e.g., sign language and languages other than English).
- Clinical supervision both models and teaches trainees how appropriate sections of the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* apply to each student's disciplinary practice and to interprofessional practice. https://www.thinkculturalhealth.hhs.gov/Content/clas.asp
  - Clinical experiences address how "isms," bias, stereotyping, and discrimination can manifest in clinical settings.

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- Clinical experiences teach trainees how to address and respond to bias, stereotyping, discrimination, and other "isms" in clinical settings.
- Clinical experiences provide trainees with structured opportunities for self-reflection and feedback from faculty, preceptors, peers, families, and youth about cross-cultural experiences.

Family Involvement

Consider presenting information on the extent to which your training program's approach to family involvement integrates principles and practices of cultural and linguistic competence. This information may include, but is not limited to, the following areas.

- Family involvement activities engage families that are diverse based on such factors as:
  - geography (urban, suburban, rural, frontier, tribal, territorial);
  - race;
  - ethnicity;
  - language;
  - gender;
  - age;
  - spirituality/religiosity/faith beliefs;
  - disability;
  - immigrant or refugee status;
  - educational and literacy levels;
  - health literacy levels;
  - sexual orientation (LGBTQ), and gender identity and expression;
  - socioeconomic status or class; or
  - affiliation or service in the U.S. military.
- Family involvement activities provide supports for families that enable them to participate fully such as:
  - interpreters provided for languages other than English;
  - translation of written materials into languages other than English;
  - information provided in ways that take into account:
    - literacy and health literacy levels,
    - disability-related needs,
    - personal and culturally based preferences for receiving information; and
  - Sign language interpreters.
- Family involvement activities structure meetings or other participatory opportunities to:
  - take into account cultural values and beliefs about behavior in public situations;
  - address power differentials among members of the group; and
  - respond to and manage communication differences among group members.

Cultural Competence

Consider presenting information on your training program's overall approach to addressing cultural and linguistic competence that may address the following areas.

- The training program has clearly articulated definitions and conceptual frameworks for cultural competence and linguistic competence.
- The training program has structures that support cultural and linguistic competence and serve as resources for program faculty and trainees (e.g., committee, work group, or task force and mentorships, lecture series, or grand rounds).

■ The training program has processes to address faculty or student experiences or observations of bias, prejudice, discrimination, stereotyping, or the "isms" within the:
  • program,
  • department,
  • college or university, or
  • affiliated experiential/clinical learning setting.
■ The training program conducts self-assessment processes for cultural and linguistic competence.

Diversity

Consider presenting information on the extent to which your training program addresses recruitment and retention of racially and ethnically diverse trainees and faculty who are underrepresented in MCH training programs. This information may include, but is not limited to:

■ The training program has recruitment approaches to increase the number of trainees from underrepresented groups including, but not limited to, the following:
  • considers life experiences relevant to the trainee's area of study as part of admission or program acceptance standards; and
  • has a program admissions committee that is racially, ethnically, and culturally diverse.
■ The training program has approaches that enhance the retention of trainees from underrepresented groups including, but not limited to, the following:
  • identifies resources to provide stipends or other financial support for trainees who are disproportionately impacted by poverty or low income;
  • keeps abreast of issues affecting the climate of the learning environment, not only the training program, but other related entities such as the academic departments, the university, off-campus clinical settings, etc.;
  • supports faculty to:
    – address differences in preferred ways of learning,
    – demonstrate skills that draw upon the diverse cultural experiences of trainees (e.g., valuing collaborative vs. independent approaches to coursework, graphical vs. verbal demonstration of knowledge); and
  • provides faculty development on advising and mentoring trainees and junior faculty from racial, ethnic, or cultural groups different from their own.
■ The training program has approaches to enhance the racial and ethnic diversity of faculty including, but not limited to, the following:
  • Strives for program faculty who are representative of the diverse racial, ethnic, and cultural groups in the United States or geographic area served by the training program.
  • Supports and advocates for faculty tenure evaluations that value:
    – research on cultural and linguistic competence, health and mental health disparities, and health and mental health equity;
    – active and meaningful approaches to community engagement related to MCH populations; and
    – successful recruitment, retention, and mentoring of trainees from racial and ethnic groups underrepresented in MCH.
■ The training program tracks and routinely updates data on the demographic make-up of the state, region, or localities and their implications for those populations and communities served by the program.

Title V/Community Collaboration

Consider presenting information on the extent to which your training program addresses culturally and linguistically competent approaches to community engagement. This may include, but is not limited to, the following.

- Community engagement is guided by defined values and guiding principles.
- Formal policy and procedures assure that communities are both valued and engaged as essential allies in achieving programmatic goals.
- Faculty and trainees are prepared and supported to engage communities using culturally and linguistically competent approaches such as the capacity to:
  - demonstrate respect for the traditions and practices of local cultural communities;
  - use strategies to learn about communities before being assigned to a community setting;
  - know the demographics of the population in the service area, and track the changes over time;
  - ensure that structures and practices are in place to share knowledge about local communities with new trainees, faculty, staff, and volunteers;
  - value and engage in mutual learning with community members; and
  - provide interpretation and translation services as required to ensure meaningful community access and participation.
- Community engagement efforts demonstrate solid ties and partnerships with community organizations (e.g., social service agencies, merchants, faith-based organizations, recreation programs, ethnic-specific advocacy organizations, civic and neighborhood organizations, social justice organizations).
- Program faculty cultivate and nurture good working relationships with leaders of diverse cultural communities in the service area.
- Community engagement activities are designed to ensure that communities economically benefit from collaboration.

Faculty

Consider presenting the information on the extent to which your training program supports faculty in achieving cultural and linguistic competence. This may involve the following efforts.

- Faculty development opportunities include how to:
  - integrate cultural and linguistic competence into courses, clinical experiences, and other learning opportunities effectively.
  - address interpersonal conflict that may arise in the discussion of culture, diversity, cultural and linguistic competence, and other topics such as health and health care disparities and inequities, the concept of privilege, and the "isms."
  - embed culturally and linguistically competent approaches in the conduct of research.
- Search committees elicit information about, and consider awareness, knowledge, and skills in cultural and linguistic competence in the recruitment of program faculty.
- Mentoring and other professional development are offered for faculty who want to pursue an in-depth academic focus on components of cultural and linguistic competence, diversity and inclusion, health disparities, and health equity.
- Faculty members are encouraged to partner with other universities and colleges that have expertise in cultural and linguistic competence.
- Faculty members receive fiscal support to participate in conferences and other professional development forums to increase their capacity to address cultural and linguistic competence in the training program.

- Faculty convene forums to share insights, research, and experiences in embedding cultural and linguistic competence in all aspects of the training program.
- Faculty evaluation processes include criteria on cultural and linguistic competence and/or other areas relevant to the training program (e.g., health disparities, health equity).

Key Definitions

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.[1]

Community Outreach: Community outreach is the donation of time or resources to benefit a community or its institutions such as nonprofit, civic, or community-based organizations in an effort to improve the quality of life for community residents,[2] especially as an act of charity or goodwill.

Community Engagement: Community engagement is "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people."[3]

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.[4,5]

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.[6]

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."[7]

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.[8] 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.[7]

Healthcare Disparities: Healthcare 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.[8,9] Disparities in health care are reflected in discrimination in care and care settings and differences in insurance, access, quality, and services provided.[10]

"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.[11]

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.[12]

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.[13] 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.[14]

Stereotype: A stereotype is a cognitive structure that contains the perceiver's knowledge, beliefs, and expectations about a human group.[13] 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.[13] 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."[15(p814)]

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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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