



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

Experiential Learning

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 training and education 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 and Collaboration

Addressing cultural and linguistic competence within the context of experiential learning in MCH requires training programs to: (a) select and adopt an experiential learning model; (b) determine how values and principles of cultural and linguistic competence map to those of the experiential learning model; (c) establish supporting policies and practices within the program or department, including faculty development; (d) prepare and support trainees in their placement settings; and (e) monitor and evaluate experiential learning settings. The Experiential Learning Checklist is designed to assist MCH training programs in assuring cultural and linguistic competence in experiential learning opportunities for students. Experiential learning experiences may include, but are not limited to, classroom sessions, clinical practica, peer-to-peer models, community engagement, and the conduct of research. These experiences may take place within the training program or in other settings.

Definitions and a Useful Model of Experiential Learning

There are myriad definitions of experiential learning in the literature. While each definition differs depending on the discipline and intended audience, there is a common thread that links them. All describe experiential learning as involving learning-by-doing, real-life and practical experiences, and knowledge gained by true experience. Selected conceptualizations and definitions follow.

“Experiential learning exists when a personally responsible participant cognitively, affectively, and behaviorally processes knowledge, skills, and/or attitudes in a learning situation characterized by a high level of active involvement.”^{1(p25)}

“At the core of experiential learning is action. Rather than merely thinking about abstract concepts, learning-by-doing involves a direct encounter with the phenomenon being studied. It utilizes actual experience with the phenomenon to validate a theory or concept. Several authors suggest that ideas cannot be separate from experience; they must be connected to the learners’ lives in order for learning to occur.”^{2(p25)}

Experiential learning is described as learning activities that directly engage the learner in the phenomenon being studied and provide opportunities for reflection on those experiences.³ Kolb and Kolb⁴ provide a useful model that delineates four elements of experiential learning. This learning model involves an integrated cycle of activities that include:

- (1) concrete experience,
- (2) abstract conceptualization,
- (3) reflective observation, and
- (4) active experimentation.

The learning process, according to the Kolb model, is best understood as a spiral or cycle. The learner will experience each of the activities again and again in a process that is responsive to both what is being learned and the setting within which the learning takes place.⁴

“Learning is the process whereby knowledge is created through the transformation of experience.”⁵

Why ensure that experiential learning opportunities for trainees funded by the Maternal and Child Health Bureau (MCHB) integrate cultural and linguistic competence?

1. Accreditation standards for MCH professional training programs require that trainees in those programs learn to practice their discipline in a culturally and linguistically competent manner.⁶⁻¹⁴ the standards state that discipline-specific knowledge and skills must be included in applied learning settings. Given the large role of experiential learning in professional education, MCH training programs must: (a) clearly define the role of cultural and linguistic competence; (b) delineate the associated knowledge base and skill sets; and (c) intentionally select settings that provide an appropriate and conducive environment, or support such settings in an effort to advance and sustain cultural and linguistic competence.
2. Student exposure to serving culturally and linguistically diverse and underserved populations can increase their likelihood of wanting to serve them in practice.¹⁵⁻¹⁷ Thus, MCH training programs can enhance experiential learning by intentionally seeking sites that provide trainees experiences with diverse populations.
3. MCH faculty members have a responsibility to prepare future leaders to:
 - incorporate cultural and linguistic competence into their professions;
 - observe and advocate for the cultural and linguistic competence of organizations where they work;
 - have the skills to address bias and discrimination in organizations where they work;
 - work with and serve racially and ethnically diverse populations; and
 - Know the role of cultural and linguistic competence in addressing health and health care disparities.
4. MCHB-funded training programs must have the capacity to support trainees who encounter policies, practices, and attitudes that do not

demonstrate cultural and linguistic competence in organizations in which they receive experiential training. Or these programs must also have the capacity to support trainees who encounter policies, practices, and attitudes that reflect bias and discrimination toward the populations served, trainees, and employees. Trainees are often at a distinct disadvantage in these situations because of power differentials and valid concerns about alienating those upon whom they depend in the experiential learning setting. MCH training programs have a responsibility to both prepare and support trainees who encounter these circumstances and to address these issues with appropriate personnel in the experiential learning setting. When necessary, these issues may need to be addressed with policymakers within the setting. MCH programs are responsible for finding alternative experiential learning settings for their trainees if such circumstances persist.

Definitions and Key Concepts

Americans with Disabilities Act (ADA): “The ADA recognizes and protects the civil rights of people with disabilities and is modeled after earlier landmark laws prohibiting discrimination on the basis of race and gender. The ADA covers a wide range of disability, from physical conditions affecting mobility, stamina, sight, hearing, and speech to conditions such as emotional illness and learning disorders. The ADA addresses access to the workplace (title I), State and local government services (title II), and places of public accommodation and commercial facilities (title III). It also requires phone companies to provide telecommunications relay services for people who have hearing or speech impairments (title IV) and miscellaneous instructions to Federal agencies that enforce the law (title V). Regulations issued under the different titles by various Federal agencies set requirements and establish enforcement procedures. To understand and comply with the ADA, it is important to follow the appropriate regulations.” <http://www.accessboard.gov/about/laws/ADA.htm>

“Amendments to the Americans with Disabilities Act (ADA) signed into law on September 25, 2008, clarify and reiterate who is covered by the law’s

civil rights protections. The ‘ADA Amendments Act of 2008’ revises the definition of ‘disability’ to more broadly encompass impairments that substantially limit a major life activity. The amended language also states that mitigating measures, including assistive devices, auxiliary aids, accommodations, medical therapies and supplies (other than [sic] eyeglasses and contact lenses) have no bearing in determining whether a disability qualifies under the law. Changes also clarify coverage of impairments that are episodic or in remission that substantially limit a major life activity when active, such as epilepsy or post traumatic stress disorder. The amendments took effect January 1, 2009.” <http://www.access-board.gov/about/laws/ada-amendments.htm>

In experiential learning settings, the ADA can have many implications in hiring practices, physical accessibility of the setting, or how services are provided. It covers access related to communication for individuals with disabilities that is not covered under Title VI of the Civil Rights Act which addresses the needs of individuals with limited English proficiency (LEP).

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.¹⁸

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.^{19,20}

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.²¹

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.²²

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.”²³

Health Disparity: Health disparity represents a type of systemic difference in the prevalence, morbidity, disease burden, and mortality of a disease or illness of one social group as compared with another as a function of underlying social advantage or disadvantage.²⁴ 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.²³

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.^{25,26} Disparities in health care are reflected in discrimination in care and care settings and differences in insurance, access, quality, and services provided.²⁷

“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.²⁸

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 with LEP, 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.²⁹

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.³⁰ 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.³¹

Stereotype: A stereotype is a cognitive structure that contains the perceiver’s knowledge, beliefs, and expectations about a human group.³¹ 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.³¹ 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.”^{32(p814)}

Title VI of the Civil Rights Act of 1964, Sec. 601: This law ensures nondiscrimination in federally assisted programs and states that “No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” <http://www.hhs.gov/ocr/civilrights/resources/laws/index.html>

Provisions related to language access (interpreters and translated written materials):

- Service providers must take reasonable steps to provide meaningful access to their programs by persons with LEP.
68 Fed. Reg. 153 at 47322
- Providers that must provide language assistance services in order to comply with Title VI should implement policies and procedures to provide

information in appropriate languages and ensure that persons with LEP are effectively informed of, and have meaningful access to, covered programs.

68 Fed. Reg. 153 at 47320

Title VI and its implementation relate to experiential learning settings that are recipients of assistance (funding) including grant money, Medicaid and Medicare funds, etc., from the U.S. Department of Health and Human Services (HHS) including:

- hospitals, nursing homes, home health agencies, and managed care organizations;
- universities and other entities with health or social service research programs;
- state, county, and local health agencies;
- state Medicaid agencies;
- state, county, and local welfare agencies;
- programs for families, youth, and children;
- Head Start programs;
- public and private contractors, subcontractors, and vendors; and
- physicians and other providers that receive federal financial assistance from HHS.

Programs funded by the U.S. Department of Education are also subject to Title VI regulations.

For more information, go to <http://lep.gov>

Checklist to Facilitate the Integration of Cultural and Linguistic Competency in Experiential Learning Offered By MCH Training Programs

Choosing and Monitoring Experiential Learning Settings

When choosing experiential learning settings, our MCH Training Program:

- Searches for and offers trainees opportunities to apply their knowledge and skills in settings that address communities and populations 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, and gender identity and expression;
 - socioeconomic status or class; and
 - affiliation or service in the U.S. military.

- Considers the extent to which cultural and linguistic competence is demonstrated in the following areas:
 - organizational mission and vision;
 - organizational policy;
 - programs, services, and activities conducted by the organization;
 - staff development and newcomer orientation;
 - policies and practices for individuals with LEP or who are English language learners; and
 - communication policies and practices for individuals with disabilities.

When monitoring experiential learning settings, our MCH Training Program:

- Reviews experiential learning settings, at least annually, to determine the extent to which:
 - organizational personnel have the capacity to and effectively address cultural and linguistic competence in trainee supervision;
 - the organization's programs, services, supports, and other activities incorporate culturally and linguistically competent practices; and
 - the organization complies with Title VI and language access provisions.

- Has a mechanism to elicit trainees' input routinely about the experiential learning setting to which they have been assigned to ascertain trainees' perspectives about:
 - the cultural and linguistic competence of the setting (e.g., knowledge and skills of staff, program or service delivery model, organizational values and policies, or relationships with the community); and
 - stereotyping, bias, and discrimination (e.g., directed toward the trainee or others within the setting) and if and how it was addressed.

Checklist to Facilitate the Integration of Cultural and Linguistic Competency in Experiential Learning Offered By MCH Training Programs

Preparing Trainees to Address Cultural and Linguistic Competence, Stereotyping, Bias, and Discrimination in Experiential Learning Settings

Our MCH Training Program:

- Prepares students to apply cultural and linguistic competence in their experiential learning settings by providing formal learning opportunities related to:
 - working in culturally and linguistically diverse communities;
 - history, current strengths and challenges, and cultural factors related to populations they will encounter;
 - social determinants that contribute to health and health care disparities;
 - how “isms,” bias, stereotyping, and discrimination can manifest in experiential learning settings and how to handle them, both on-site and through support from program faculty;
 - Title VI, the ADA, and other relevant federal legislation that protects the rights of those seeking or receiving services; and
 - adaptation to practice, research, or policy development to meet the cultural and linguistic characteristics of populations.

Supporting Students in Experiential Learning Settings

Our MCH Training Program:

- Supports students in raising and addressing issues related to lack of cultural and linguistic competence or incidents of bias, stereotyping, and discrimination that they may observe or experience in their placements. Examples include, but are not limited to:
 - how they are treated;
 - interactions among staff and professionals and program or community advisory boards; and
 - interactions with populations served, research subjects, or populations of focus of public health programs.
- Meets regularly with students to discuss the quality of their experiential learning placement related to:
 - adapting approaches to practice, research, or policy development to meet the cultural and linguistic needs of populations;
 - conducting community engagement activities; and
 - working with populations with:
 - LEP,
 - low or no literacy, or
 - low health literacy.
- Provides students with structured opportunities for self-reflection and feedback from faculty and peers on cross-cultural experiences.

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Suggested Citation

Goode T., Bronheim S. *Experiential learning: Cultural and linguistic competence checklist for MCH training programs*. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development; 2012.

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Funding for this Project

This checklist was developed with funding from Cooperative Agreement #U40MC00145, U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB), Division of Workforce Development (DWFD). Denise Sofka is the MCHB-DWFD project officer for the NCCC.

Acknowledgements

The NCCC is grateful for the expertise and enthusiasm of members of the MCH faculty workgroup who contributed to the Experiential Learning Checklist.

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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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