

**The Power of Partnership:
Meeting Today’s MCH Challenges through Partnerships
MCH Training Program**

**Cultural and Linguistic Competency in Curricula and Training Workgroup
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I. Introduction

Denise Sofka and Clare Dunne introduced the Cultural and Linguistic Competency workgroup. The goal of this workgroup was to address the Action Strategies of the National MCH Training Strategic Plan to “Build Diversity and Cultural Competence” (Goal 2) and “Develop MCH Leaders” (Goal 4). Concrete examples of curricula and training—approaches, strategies, and methodologies—that incorporate values, principles and practices of cultural and linguistic competence were showcased. The interactive sessions included (1) a presentation of curricula enhancement series in two formats (web-based and print), focusing on public health in a multicultural environment; (2) case studies in pediatric care that address culture and language; (3) a facilitated discussion and opportunities to share and learn strategies, as well as a discussion of challenges and barriers encountered in incorporating cultural and linguistic competence into curricula and training; and ended with (4) workgroup recommendations to MCHB.

Tawara Goode introduced the Curriculum Enhancement Module Series, developed by the National Center for Cultural Competence (NCCC) through a cooperative agreement with the Division of Research, Training and Education (DRTE), Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services. The goal of the series is to increase the capacity of DRTE-funded programs to incorporate principles and practices of cultural and linguistic competence into all aspects of their leadership training. The curricula enhancement series centers on four key content areas:

- Cultural awareness
- Cultural self-assessment
- Process of inquiry—communicating in a multicultural environment
- Public health in a multicultural environment

The curricula enhancement module series is designed to:

- Assist faculty in incorporating the four key content areas into existing curricula that are important to cultural and linguistic competence in public health;
- Provide a set of defined areas of knowledge, skills, and awareness related to each core content area;
- Offer relevant materials, articles, publications, and other multimedia resources for each core content area; and
- Provide faculty with instructional and self-discovery strategies.

It is also available online in pdf and word formats at <http://www.ncccurricula.info>

II. Defining Cultural Competence

The definition developed by the National Center for Cultural Competence in 2001 is as follows “an integrated pattern of human behavior which includes but is not limited to thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships and expected behaviors of a racial, ethnic, religious, social or political group; the ability to transmit the above to succeeding generations; dynamic in nature.”

Cultural competence has to be achieved at both the organizational level and the practitioner level.

The organizational level is made up of five elements. To be culturally competent, the organization must (1) value diversity, (2) conduct cultural self-assessment, (3) manage the dynamics of difference, (4) institutionalize cultural knowledge, and (5) adapt to diversity by utilizing policies, values, structures, and service. Ms. Goode explained that one example of how an institution can practice cultural competence is to evaluate how faculty, staff, and practitioners interact culturally.

The practitioner level is also made up of five levels. These levels are (1) acknowledging cultural differences, (2) understanding your own culture, (3) engaging in self-assessment, (4) acquiring cultural knowledge and skills, and (5) viewing behavior within a cultural context.

There are essential elements in a culturally competent system. All levels in the system must be impacted and must be seen in all levels within an organization. These levels must be seen in policy-making, administration, practice/service delivery, the consumer/family, and the community. All levels must be evident in the attitudes, structures, policies, and service within the institution. According to Ms. Goode, institutions, for example, can demonstrate cultural competence by providing policies and procedures in different languages. This can be achieved by providing consent forms in the cultural language spoken by particular individuals. It has been

documented that patient care improves when services are provided in patient's language. She said that this is important for institutions because consent forms are being signed and people do not know what they are signing. Another example where cultural competency can be improved is to stop the practice of using children as interpreters for their families.

Information can be given in writing, through audiovisual aids, and by explanation. Ask patients how they prefer information to be shared. Giving care to different cultures is a complex issue, but institutions must be capable of doing so.

Main Points of Ms. Goode's Presentation:

- For organizations to become culturally competent, they must have a clearly defined curriculum.
- Institutions can depend on the use of the Internet for materials such as modules to assist with cultural competence. One set of modules that can be used is the Curricula Enhancement Module Series developed by the NCCC.
- Institutions must begin where they are and move forward with the process using the module as a guide in helping them to achieve cultural competence.

III. Public Health in a Multicultural Environment

Jeff Oxendine, from the University of California Berkeley, School of Public Health and author of the module "Public Health in a Multicultural Environment" presented an overview of this module. He discussed eight key points on the role of public health in a multicultural environment and the implications for MCHB training programs.

1. Compelling forces and rationale: In this area, he listed changing demographics, health status and disparities, public health workforce, the call for strengthening curricula and competency, research, economics, social inequities and justice, legal and regulatory compliance and quality of care service.
2. Programs must respond and strengthen capabilities to succeed in a multicultural environment.
3. Apply frameworks for public health and cultural and linguistic competency.
4. Infuse into all aspects of program.
5. Take advantage of the many opportunities to build on your assets.
6. Realize that the process requires leadership commitment and change.
7. The journey takes patience and perseverance.
8. Use the power of partnership to advance.

Mr. Oxendine explained that people's cultures affect how they respond to disease. Some important ways that culture influences health are:

- Individual preferences affect traditional and nontraditional approaches to health.
- Patients must overcome personal experiences of biases with health organizations.
- Leaders and professionals from culturally and linguistically diverse groups are underrepresented.

- Cultural perspectives influence how programs are designed and implemented.
- Populations respond to programs differently. What works with one group, neighborhood, or population may not work in another setting (National Center for Cultural Competence).

He said that public health must meet the challenge of identifying and diagnosing problems in the community and developing policies and plans to deal with cultural problems. In doing so, institutions have to evaluate the doctor-patient interaction, health disparities, minority populations, and racial/ethnic disparities.

All members of a community are affected by the poor health status of its least healthy members (Unequal Treatment, Institute of Medicine, 2002). In determining the health of people in the community, several key frameworks can be used.

One such framework is the University of California Berkeley School of Public Health’s Strategic Framework. This framework focuses on behavior, physical environment, individual, social environment, and biology. All these factors are interrelated in order to achieve access to quality health care.

Mr. Oxendine also discussed place-based factors, which are real factors that affect health. To demonstrate, he asked the participants this question: If a person wants to exercise or get fresh fruits or vegetables, where must they go? Do they feel safe? He went on to explain that demographics are important, and one must understand culturally how this affects public health. The focus on health must be on the underlining factors that affect health. The frameworks are there to be applied to public health and cultural and linguistic competency.

Main Points of Mr. Oxendine’s Presentation:

- Institutions must develop strategies and incorporate them into training programs.
- Some strategies that can be developed are strategies for curricula; evidence-based practice; research; tracking culture; interacting with communities; creating and fostering multicultural environments.
- Build awareness, skills, and knowledge = ASK, ask if you don’t know about a person’s culture.
- Use frameworks to determine the health of people in the community.
- Institutions must start where they are.
- Move from theory to practice.
- Know that change has to occur and there will be possible problems with change.
- Use linguistic competencies.
- Use partnerships to advance.

IV Day 2—Case Studies

On the second day Susan Horky from the Florida Pediatric Pulmonary Center (PPC) and Craig Becker from the Wisconsin PPC presented a Web-based interdisciplinary cultural competency

continuing education training program developed by the seven PPC's in collaboration with NCCC.

The purpose was not to teach a particular culture but to expand on customs and mores that are common in cultures. The goal is to help with self-awareness and assessment by looking at attitudes and beliefs.

Each module is developed in a case study format. The cases, which can be found on the Internet, are set up as templates. Each template consists of a homepage, lecture, case study, learning activities, resources, and a quiz. The cases that were developed focus on:

- Core concepts in cultural competence;
- Social and emotional issues of adherence;
- Interpreter services and limited English proficiency related to non-English-speaking patient and families;
- Normative values, folk health, and wellness beliefs; and
- Cultural and religious factors that affect medical decision making.

The Website is presently being set up for nursing continuing education and has yet to be pilot tested. The site will incorporate many disciplines of practice. (The Website address is not active yet.) The goal is to present core concepts that everyone can use. When a person goes to the Internet to do a case study, the templates are in place to help everyone participate in the case studies. The templates offer opportunity to engage in the teaching and learning process.

Participants suggested that these materials should be linked to the MCHB website and available to all DRTE grantees.

V. Infusing Cultural and Linguistic Competency into Interdisciplinary Training Programs: Opportunities and Challenges

Cultural and Linguistic Barriers Being Encountered by the Workgroup Participants in Their Organizations:

- Diversity in classrooms, hiring, race factors;
- Treatment of students who have very conservative values;
- Diversity assessment is needed to define the dimensions and develop focus groups and surveys;
- People have to buy into the effort to help with cultural diversity in facing the challenges;
- Who is the messenger;
- Power differential;
- Perceptions;
- Lack of recognitions and rewards for staff with cultural and linguistic competence;
- Performance evaluation with Chairs of Departments;
- Custodial staff in a hospital had major impact in terms of care-giving advice;
- Need for champions—long-term employees of the institution who have credibility and advocacy power;
- Delivery of a message must be inclusive of all cultures and gender. Programs and committees are exclusive rather than inclusive.

- Need to provide opportunities for families, the homeless, and other populations to be the “experts;”
- Physical environment (e.g., pictures on the wall);
- Need for new construction and renovation.

Ms. Goode stated we too often dance around the facts; often people do not believe that they need cultural competence. She stated that in developing cultural competence, the messenger should “match” the audience so that the message is delivered, the audience can “own” the message, and learning can take place. She stressed that the messenger is very important.

It is critical for a person to have cultural knowledge. Some cultures may not trust the physician but will trust a person within their own culture as a credible person.

Recommendations for MCHB in Regard to Dealing with Cultural/Linguistic Competency and Moving Forward:

- Surveys and questionnaires should focus on culture and less on race and ethnicity.
- Provide more information to grantees on how to evaluate cultural and linguistic competence.
- Make cultural competence a part of all competencies in organizations.
- MCHB needs to model cultural diversity within the organization.
- Acknowledge recruitment and retention challenges in some geographic locations.
- Provide opportunities for mentoring and linking with other institutions to support continued growth (e.g., leadership training, change strategy, technical assistance).
- Help organizations manage complex change: vision + skills + resources + action plan = CHANGE.
- The National MCH Training Strategic Plan should reflect the essential role of cultural and linguistic competence throughout the entire plan.
- Realize that small changes start to influence people over time.
- Include an assessment of how well MCHB is doing in implementing the program of cultural and linguistic competency.
- Consider the patient–provider public health model.
- Provide a listing of accreditation mandates and the rationale behind them.
- Frame the rationale behind cultural/linguistic competency to elicit buy-in.
- Integrate self-assessment modules in courses.
- Seek ways to integrate cultural/linguistic competency across the application.
- Establish e-mail distribution lists to initiate some discussions.
- Set up a taskforce that looks at change.
- Facilitating change within the institution takes time but one should not give up.

VI. Immediate Action

- Assure that the PPC modules are available to all DRTE training grantees.
- Market the 4 NCCC modules- “Curricular Enhancement Module Series”.
- Make MCHB guidance more specific and provide clear instructions to all reviewers.

- Evaluate proposals using the continuum of cultural and linguistic competency.
- Market the self assessment tool developed by the LEND Program.
- NCCC to develop a two page rationale for institutions to use on Cultural and linguistic competence.