The impact of multicultural education course on therapist cultural competence

Gemma Cosky Saxon

University of North Dakota

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The Impact of Multicultural Education Course on Therapist Cultural Competence

by

Gemma Cosky Saxon, MOTS

Advisor: LaVonne Fox, OTR/L, PhD

A Scholarly Project
Submitted to the Occupational Therapy Department
of the
University of North Dakota
in partial fulfillment of the requirements
for the degree of
Master’s of Occupational Therapy

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Approval Page

This Scholarly Project Paper, submitted by Gemma Cosky Saxon in partial fulfillment of the requirement for the Degree of Master’s of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

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Faculty Advisor

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Date
Title: The Impact of Multicultural Education Course on Therapist Cultural Competence

Department: Occupational Therapy

Degree: Master’s of Occupational Therapy

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I would like to thank my nuclear family and extended family for all the support and encouragement throughout my entire educational experience. I am so blessed to have a family that not only valued education, but also encouraged me to be a strong independent young woman. I would not be were I am today without you guys and do not know if I could have done this journey without everyone.

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ABSTRACT

"The need for culturally skilled occupational therapists (OTs) has been documented for years" (Wittman & Velde, 2002). In 2009, Cherry, Kitchens, Nicholson, Soden, Tomkiewicz, Kedia & Shah found that 32.8% of their respondents did not know about the demand for culturally competent occupational therapy (OT) services and cultural factors that could influence a client's occupational performance. Of this group 55-85% rated themselves as having limited awareness.

The purpose of this proposed study was to assess the effectiveness of the University of North Dakota (UND) OT multicultural course in preparing graduates toward cultural competence. The assessment was then compared to the literature to identify gaps in the course’s preparation of OT graduates. A retrospective, causal non-experimental survey design was used to gather data to answer the research question. A multi-dimensional survey was created and distributed. An online survey allowed the researcher to reach a wide range of potential participants that met the inclusion criteria. The survey allowed the researcher to identify key strengths and weaknesses within the OT 451 course and learn about the general attitudes of the participants who took the course. The University of North Dakota Occupational Therapy Alumni from graduating classes 2009-2013 were surveyed to evaluate the effectiveness of the OT 451 course in preparing students to become culturally competent practitioners.

The results of the research provide evidence that the course OT 451: Multicultural Competency in Occupational Therapy does provide effective education on cultural competency. The use of interactive activities and multiple teaching strategies is beneficial in the learning
process. The results of this study have a significant benefit for the UND OT department to be able to identify activities and teaching strategies that enable cultural competency growth and generalization. This will strengthen the students learning. It is believed that the UND OT students will enter the workforce able to more implement culturally sensitive interventions. It will contribute to the literature on the effective and ineffective strategies and activities for a more systematic teaching of cultural competence.

There are also limited consistent research outcomes related to developing or measuring cultural competence knowledge for occupational therapy students and clinicians. It is anticipated that the results of this study will add to the emergent body of literature intended to identify and improve the educational preparation of occupational therapy students toward becoming more culturally competent.
CHAPTER I

Introduction

According to the U.S. Census Bureau the nation’s population will be more ethnically and racially diverse by 2050 (U.S. Department of Health and Human Services Centers for Disease Control and Prevention, 2013). Progression toward this is already significant and its impact is easily observable in healthcare. In the midst of this growing ethnic and racial diversity has been a consistent and growing issue; health disparities (Center for Disease Control and Prevention, 2013). Health disparities refer to differences between groups of people. These differences can affect how frequently a disease affects a group, how many people get sick, or how often the disease causes death (The National Institute of Health, 2015 ¶1, http://www.nlm.nih.gov/medlineplus/healthdisparities.html). “Prejudice and discrimination can be sources of acute and chronic stress which have been linked to conditions such as cardiovascular disease and alcohol abuse. Discrimination can restrict the educational, employment, economic, residential and partner choices of individuals…. Environmental influences from industry, toxic waste disposal sites, and other geographic aspects linked with poverty and minority status can result in serious disadvantages to low SES and racial and ethnic groups' health” (National Institutes of Health, n.d.).

To decrease that gap and optimize patient outcome health providers must be culturally competent when working with individuals from different ethnic backgrounds (Center for Disease Control and Prevention, 2013). The necessity of this is seen in the changes of standards across all healthcare professions and accrediting bodies.
The culture of an individual influences their beliefs about health, illness, disease, healing and the delivery of service (i.e. compliance, meaningful occupations/outcome of therapy, recovery time, etc.). The healthcare provider brings their individual influences about their beliefs about health, illness, disease, healing and the delivery of service to every interaction they have with anyone else. So when a provider and a client meet there are varying beliefs that can collide or collaborate. The collision of these results in the healthcare disparities gap.

According to Murden, Norman, Ross, Sturdivant, Dedia, & Shah (2008), cultural competences is now an essential element in the standard of care and is emphasized among educational objectives in the occupational therapy practice framework. To address the need for cultural competence, the University of North Dakota Occupational Therapy Department implemented a required course into the curriculum; OT 451 Multicultural Competency in Occupational Therapy (OT). The goal of the course is to train/educate the students in becoming culturally skilled OT’s in order to meet the need of culturally competent skilled OTs in the workforce. Literature found that students who receive cultural competency training/education have an improved ability to generalize that knowledge in the workforce. Though, literature lacks evidence of specific training/education techniques in preparing students to be culturally competent practitioners.

Statement of the Problem

"The need for culturally skilled occupational therapists (OTs) has been documented for years" (Wittman & Velde, 2002). In 2009, Cherry, Kitchens, Nicholson, Soden, Tomkiewicz, Kedia & Shah found that 32.8% of their respondents did not know about the demand for culturally competent occupational therapy (OT) services and cultural factors that could influence
a client's occupational performance. Of this group 55-85% rated themselves as having limited awareness.

Purpose of the Study

The purpose of this proposed study was to assess the effectiveness of the University of North Dakota (UND) OT multicultural course in preparing graduates toward cultural competence. The assessment was then compared to the literature to identify gaps in the course’s preparation of OT graduates.

Theoretical Framework

The research process, design and development of the survey are based on Knowles Andragogy Theory. Knowles made four assumptions about adults as learners: (1) Adults are self-directed learners, (2) learning occurs when reflecting on past experiences and is related to something the learner already knows, (3) readiness to learn is oriented to the development tasks of social roles and (4) learning is person centered and problem centered (Bastable & Dart, 2011). Adult educational experiences should enhance personal growth make it easier for adults to adapt to internal and external changes until the end of life (Boggs, 1981).

Research Question

The purpose of this study was to assess the effectiveness of the University of North Dakota (UND) Occupational Therapy Multicultural course (OT 451) in preparing graduates toward cultural competence. The second adjoining question: how effective do graduates feel the University of North Dakota’s Occupational Therapy Multicultural course (OT 451) was preparing graduates toward cultural competence?
Research Design

A retrospective, causal non-experimental survey design was used to gather data to answer the research question. A multi-dimensional survey was created and distributed. An online survey allowed the researcher to reach a wide range of potential participants that met the inclusion criteria. The survey allowed the researcher to identify key strengths and weaknesses within the OT 451 course and learn about the general attitudes of the participants who took the course. The University of North Dakota Occupational Therapy Alumni from graduating classes 2009-2013 were surveyed to evaluate the effectiveness of the OT 451 course in preparing students to become culturally competent practitioners.

The participants completed the survey that included the following constructs: (1) participant demographics and work information; (2) if the course met the course objectives for the participants; (3) the value of the course activities and teaching strategies; (4) the participants’ assessment of their confidence in regard to cultural competency; (5) the participants’ perspective on the national and global issues regarding the importance of cultural factors; and (6) the participants’ understanding of the cultural competency preparation of their colleagues in comparison to their preparation will be included.

Assumptions

It was assumed that the participants would provide truthful responses to the survey items because it was anonymous and voluntary. The validity of the participant’s responses cannot be guaranteed.
Delimitation:

There were not an equal number of participants from each graduating class surveyed, which can limit the study’s outcomes. There were 7.8% (n=4) of the participants who rated the learning activity as N/A to their learning experience, which were identified as missing data. The surveys were comprised of close-ended questions to enhance management of the data and allow for statistical analysis but there were also several open-ended questions present. The study was limited to a five year window of graduates. Lastly, the course objectives remained the same during the sample period but the activities were adjusted or changed during that period so not all participants had equal opportunity to engage in all of the same learning experiences.

Importance of Study

The results of this study has a significant benefit for the UND OT department to be able to identify activities and teaching strategies that enable cultural competency growth and generalization. This will strengthen the students learning. It is believed that the UND OT students will enter the workforce able to more implement culturally sensitive interventions. It will contribute to the literature on the effective and ineffective strategies and activities for a more systematic teaching of cultural competence.

There are also limited consistent research outcomes related to developing or measuring cultural competence knowledge for occupational therapy students and clinicians. It is anticipated that the results of this study will add to the emergent body of literature intended to identify and improve the educational preparation of occupational therapy students toward becoming more culturally competent.
Definition of Terms

The following definitions are essential to understanding cultural competence, healthcare disparities and culture. For purposes of this study the following definitions are provided to ensure the reader has a uniformed understanding of the perspective of the researcher.

1. Culture: “Culture has been defined as an integrated pattern of learned beliefs and behaviors that can be shared among groups. It includes thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs” (Betancourt, Green & Carrillo, 2002, p.1).

2. Cultural Competence: A complex know-action grounded in critical reflection and action, which the health care professional draws upon to provide culturally safe, congruent, and effective care in partnership with individuals, families, and communities living health experiences, and which takes into account the social and political dimensions of care (Garneau & Pepin, 2014, p. 4).

3. Cultural humility: the willingness to admit what a person does not know and be flexible and humble in interactions with others, recognizing the importance of self-reflection and lifelong learning (Bonder & Martin, 2013). The ability to demonstrate cultural humility and reflection is essential for both the clinician as well as the academician.

4. Ethnocentrism: is a way an individual thinks and assumes that their way of thinking and acting is naturally superior to another individual’s beliefs (Bucher & Butcher, 2010). This thought process has led to practitioners becoming culturally incompetent within practice.

5. Health Disparities: “A type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systematically experienced greater social or economic obstacles to health. These
obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. Other characteristics include cognitive, sensory, or physical disability” (U.S. Department of Health and Human Services, Healthy People 2020 Draft. 2009).

6. Occupational Justice: occupational justices as; justice related to opportunities and resources required for occupational participation sufficient to satisfy personal needs and full citizenship” (Christiansen & Townsend, 2004, p. 278).

Summary

Chapter 1 provided an introduction to the literature and the purposes of this study, the study design and sample, research questions, assumptions, delimitations and definitions. Chapter II provides a more detailed examination of the literature that was introduced in Chapter I with emphasis on: culture and cultural competence; standards for academic preparation for occupational therapists; barriers that interfere with gaining this cultural competence and best practice teaching strategies to develop culturally competent practitioners.
CHAPTER II

Literature Review

The U.S. Census Bureau reports that the nation’s population will be more ethnically and racially diverse by 2050 (U.S. Department of Health and Human Services Centers for Disease Control and Prevention, 2013). In conjunction with these statistics, the health disparities gap is also growing (Center for Disease Control and Prevention, 2013). To decrease that gap and optimize patient outcome health providers must be culturally competent when working with individuals from different ethnic backgrounds (Center for Disease Control and Prevention, 2013).

"The need for culturally skilled occupational therapists (OTs) has been documented for years" (Wittman & Velde, 2002). In 2009, Cherry, Kitchens, Nicholson, Soden, Tomkiewicz, Kedia & Shah found that 32.8% of their respondents did not know about the demand for culturally competent occupational therapy (OT) services and cultural factors that could influence a client's occupational performance. Of this group 55-85% rated themselves as having limited awareness. According to Murden, Norman, Ross, Sturdivant, Dedia, & Shah (2008), cultural competences is now an essential element in the standard of care and cultural aspects are clearly highlighted in the 2014 Occupational Therapy Practice Framework: Domain & Process 3rd Edition. Based upon the need for culturally skilled OT’s the University of North Dakota had implemented a required course into the curriculum; OT 451 Multicultural Competency in OT in 2004. In 2009 the course became one of the University’s Essential Studies courses.
The literature review explored: 1. the definition of culture and cultural competence; 2. the American Occupational Therapy Associations’ view on cultural competence; 3. the Accreditation Council for Occupational Therapy Education (ACOTE) standards for academic preparation for occupational therapists; 4. barriers that interfere with gaining this cultural competence and; 5. best practice teaching strategies to develop culturally competent practitioners. The literature review culminates in a summary that provides a rationale to study the effectiveness of the University of North Dakota (UND) OT multicultural course in preparing graduates toward cultural competence.

Culture

Culture is very complex because of its fluidity for each individual. It involves multiple components such as language, thoughts, customs, personal identification, beliefs, actions and values that influence an individual’s beliefs and behaviors. It can be shaped by nationality, ethnicity, race, and gender, but it can also extend to socioeconomic status, physical and mental ability, sexual orientation, and occupation among other component (Carpenter-Song, Nordquest, Schwallie, & Longhofer, 2007). These components further influence individuals’ beliefs about health, illness, disease, healing and the delivery of service (i.e. compliance, meaningful occupations/outcome of therapy, recovery time, etc.).

Within the literature there are many definitions of culture. For purposes of this research study the following definition is used:

“Culture has been defined as an integrated pattern of learned beliefs and behaviors that can be shared among groups. It includes thoughts, styles of communicating,
ways of interacting, views on roles and relationships, values, practices, and customs” (Betancourt, Green & Carrillo, 2002, p.1).

It is evident in an individuals’ behavior, which reflects the integration of multiple influences. The context can determine the effect of a cultural response to different situations (Bonder & Martin, 2013). The various definitions reflect the complexity and challenge in defining and measuring cultural competence.

**Cultural Competence**

According to the literature, the concept of cultural competence has been accepted within the medical profession as a fundamental factor of health care and health care education (Capell, Dean, & Veenstra, 2014; Delgado, Ness, Ferguson, Engstrom, Gannon, & Gillett, 2014; Murden, Norman, Ross, Sturdivant, Dedia, & Shah, 2008; Noble, Nuszen, Rom, & Noble, 2014;). Garneau & Pepin (2014) looked at a variety of theories, perspectives, and models related to culture to develop a constructivist definition of cultural competence:

A complex know-act grounded in critical reflection and action, which the health care professional draws upon to provide culturally safe, congruent, and effective care in partnership with individuals, families, and communities living health experiences, and which takes into account the social and political dimensions of care (Garneau & Pepin, 2014, p. 4).

The American Occupational Therapy Association (2014) defines cultural competence as the following:
As a journey, rather than an end. It refers to the process of actively developing and practicing appropriate, relevant, and sensitive strategies and skills in interacting with culturally different persons.

Carpenter-Song, Nordquest, Schwallie, & Longhofer (2007) define cultural competence as “the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs.”

Based upon these definitions it can easily be seen that cultural competence is a lifelong reflective process that involves delivering services with an understanding of the individual’s cultural beliefs and values. For purposes of the course and study, aspects from all three definitions were chosen to clarify cultural competency at the individual and system level resulting in the following key components of cultural competence (Carpenter-Song, Nordquest, Schwallie, & Longhofer, 2007):

1. Understanding the communities being served;
2. Understanding the sociocultural influences on individual patients’ health beliefs and behaviors;
3. Understanding how these factors interact with the health care system and how it might prevent the client from obtaining quality health care and;
4. Devising strategies to reduce and monitor potential barriers through interventions.

The health outcome of an individual will be greater if the health provider delivers culturally competent care.

“Research has shown that provider-patient communication is linked to patient satisfaction, adherence to medical instructions, and health outcomes. Thus, poorer
health outcomes may result when sociocultural differences between patients and providers are not reconciled in the clinical encounter. Ultimately, these barriers do not apply only to minority groups but may simply be more pronounced in these cases. Finally, two landmark Institute of Medicine (IOM) reports—*Crossing the Quality Chasm* and *Unequal Treatment*—highlight the importance of patient-centered care and cultural competence in improving quality and eliminating racial/ethnic health care disparities.” Betancourt, J. R., Green, A.R., Carrillo, J.E. & Park, E.R. (2005).

The individual will have felt the healthcare provider understood their perspective and culture. With different beliefs being held by different cultures it is essential for healthcare practitioners to be aware of the differences of the client and families and tailor to their need (Lehman, 2009).

Taking all of the information into consideration, the next step was to identify the OT professions strategic approach to developing cultural competence for students and clinicians. So an essential part of the development of the multicultural course at the University of North Dakota was to identify what occupational therapy professional resources, literature, research and standards were identified regarding cultural competence. The initial step in this process begun with the American Occupational Therapy Association (AOTA)

**American Occupational Therapy Association**

AOTA is the national professional association for occupational therapists. It was established in 1917 to address occupational therapy students and practitioners concerns regarding the quality of occupational therapy services. The mission of AOTA is to
advance “the quality, availability, use, and support of occupational therapy through
standard-setting, advocacy, education and research on behavior of its members and the
public” (American Occupational Therapy Association, 2014,

AOTA’s approach to diversity, over the decades, has varied considerably. In
1986-1987, AOTA developed the minority affairs program. In 1991 the name was
changed to the Multicultural Affairs Program (MAP). The program was quite active
during the early to mid-90s when Shirley Wells was at the helm. It had a significant focus
on increasing minority awareness in and of the profession as well as minority
recruitment. One example was an invitation letter inviting individuals to participate in a
Multicultural Affairs Coalition meeting and to also take part in a diversity forum. By
1995 Wells was inviting networks and organizations of diverse OT groups to participate
in a Multicultural Coalition meeting, a Multicultural Exchange, a Multicultural Affairs
Booth and a Unity Through Diversity Reception. Wells was also identifying
Multicultural State Liaisons to bring the program goals of (MAP) to the state level. One
approach that MAP presented was the production of a career awareness poster and
brochure to promote name recognition, create an awareness of career opportunities,
promote early thinking about the future, and show parents that OT is a way to help
themselves and their community. It was designed to target diverse youths age 10-13 and
their parents.

In a 1995 Memorandum, Wells identified the focus on the Multicultural Affairs
Program to include:
1. promoting and supporting a diverse and inclusive professional environment and community;

2. enhancing the awareness of, appreciation of, respect for, sensitivity to, and integration of differences throughout the association and profession; and

3. addressing the specific needs, concerns, and issues of practitioners and students from culturally diverse backgrounds.

OT was working toward making occupational therapy a more diverse and inclusive profession and in reality was ahead of its time when looking at all of the medical and health professions.

Unfortunately MAP was closed in 1998 due to restructuring and financial changes at AOTA. Several duties were assigned to remaining AOTA staff and volunteer members. Aspects of the MAP remained but several key functions did not remain such as the: 1) state liaisons, 2) Unity Through Diversity Reception, 3) data regarding diversity for the Multicultural Networks and most significantly, 4) a key department or program that centralized everything related to diversity in one place. Why is the history of MAP significant? It relates considerably to AOTA’s Centennial Vision and their varied systematic strategic approach to preparing occupational therapists to effectively work with diversity.

Centennial Vision

In 2006, AOTA’s Centennial Vision was approved by the Representative Assembly (RA) which states:

"We envision that occupational therapy is a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society's occupational needs" (AOTA)
The Centennial Vision was designed to be a road map for the profession’s future and to commemorate AOTA’s 100th anniversary in 2017. Academia plays a significant role in meeting this vision statement as the entrance point to preparing for future clinicians.

An area pertinent to this study is the focus on … *globally connected and diverse workforce meeting society’s occupational needs*. The first aspect, *globally connected*, seems to indicate that the profession will expand through helping other nations gain an understanding of how the profession can help meet their occupational needs. The second aspect focuses on expanding the *diversity of the OT workforce*. This could be in relation to the significant shifts in demographics currently within the U.S and continued shifts predicted for the future. Based on a 2012 Census Bureau release the U.S. population continues becoming more racially and ethnically diverse.

According the Academic Programs Annual Data Report (2014) 82% of students are Caucasian. So the profession has two focus areas; 1. ensure preparation of an OT workforce toward cultural competency due to its continued high homogeneity and 2. recruit and retain more diverse students so it more effectively mirrors the diversity changes occurring in our society. An aspect of preparing OT’s was evident in the OT academic standards, presented later, that require OT programs to meet. Another document, designed to be used in preparing OT students but also at the clinician level, is the Occupational therapy Practice Framework: Domain & Process, 3rd Edition (2014). This document is often referred to as the Framework in the profession.
**Framework**

The Framework is an AOTA official document that is intended to summarize the central concepts of occupational therapy practice and to guide occupational therapy practice. The Framework is an essential aspect of any academic curriculum as well as practicing clinicians. It has two main sections: 1. the domain which presents the professions scope of knowledge and expertise and 2. the process which describes what actions OTs take when providing services. Under the domain section there are several aspects which include occupations, client factors, performance skills, performance patterns and context and environment. These domains are of equal value and together they interact to affect the client’s occupational identity, health, well-being, and participation in life (AJOT, 2014, pg. S4). Process focuses on the evaluation, intervention and targeted outcomes of the areas under the domain.

Diversity, within the client population OT serves, is clearly presented under client factors. Client factors include values, beliefs and spirituality. Performance patterns are also clearly cognizant of diversity with the OT looking at personal habits, routines, rituals, roles as well as group or population routines, rituals and roles. The Framework also has the therapist look at the context and environment that surrounding the client in which the client’s daily occupations occur. The contexts are cultural, personal, temporal and virtual and the environments are physical and social. Social demands need to also be considered regarding the social environment and virtual and cultural contexts. The Framework guides the therapist to make sure the assessment, intervention and outcomes align with the client’s goals, values, beliefs and needs as well as perceived utility.
It is unknown the extent to which OT students and OT clinicians take into consideration the client factors, performance patterns, contexts and environments from the clients diverse background versus the OT’s own perspective. It is assumed that since it is an official document that OT’s are focused on all areas of the document. The ability for the OT to effectively take these areas into consideration strengthens his or her ability to be more culturally competent and makes therapy much more client centered. When reviewing OT literature in a larger context there are very few articles that truly lend themselves to highlighting or teaching OT students and professionals how to apply these areas when assessing for or implementing services. The Blueprint for Entry Level Education does address some of these aspects and gives a little more specifics on how to apply the information to the client/therapist interaction.

**Blueprint for Entry Level Education (AOTA, 2010)**

“The purpose of the Blueprint for Entry-Level Education was to identify the content knowledge that occupational therapists and occupational therapy assistants should receive in their educational programs” (AOTA, 2015, http://www.aota.org/Education-Careers/Educators/Future.aspx). The Blueprint was developed as a curriculum content guide designed to ensure educational programs are preparing future practioners, educators, scientists and entrepreneurs for the 21st century in the profession (pg. 1). It can “offer guidance to educators in designing curriculum content that will prepare students for a changing society in which occupational therapy’s unique contributions are so critical to foster the health and participation of those they serve” (pg. 1).
The Blueprint does address cultural issues throughout the various sections. In Section II *Environment-Centered Factors*, it has a specific focus on the cultural environment with concepts identified as individual vs. population vs. institution. In Section IV *Professional and Interpersonal Factors* culture is again identified as a primary topic with the concepts of: diversity, cultural sensitivity, health beliefs and practices and non-traditional, alternative and complementary health practices presented.

Based on this researcher’s perspective, the Blueprint is a guide so it contains suggestions and recommendations. “It is not the intent of the Blueprint to provide details about how or what to teach different levels of occupational therapy. The key concepts …offer guidance to educators in designing curriculum content that will prepare students for a changing society in which occupational therapy’s unique contributions are so critical to foster the health and participation of those they serve” (AOTA, 2010, p. 1).

Academic programs are not required to implement any aspect of the guide. The professions accrediting body determine the requirements for an academic curriculum.

**Accreditation Council for Occupational Therapy Education (ACOTE)**

Occupational Therapy academic programs are accredited by AOTA’s Accreditation Council for Occupational Therapy Education. “ACOTE currently accredits over 340 occupational therapy and occupational therapy assistant educational programs in the United States and its territories” (ACOTE, 2014, p.1). ACOTE’s Accreditation Manual (2013, p. 3) indicates that the specific purposes of the ACOTE accreditation process are:

1. to encourage continuous self-analysis and improvement of the occupational therapy educational program by representatives of the institution’s administrative
staff, teaching faculty, students, governing body, and other appropriate constituencies, with the ultimate aim of assuring students of quality education in this profession and assuring patients of appropriate occupational therapy care.

2. to determine whether the occupational therapy educational program meets the appropriate approved educational standards.

3. to encourage faculty to anticipate and accommodate new trends and developments in the practice of occupational therapy that should be incorporated into the educational process.

4. to assure the educational community, the general public, and other agencies or organizations that the program has both clearly defined and appropriate objectives, maintains conditions under which these objectives can reasonably be expected to be achieved, appears to be accomplishing them substantially, and can be expected to continue to do so.

One method of meeting these purposes is through established ACOTE standards. The Standards establish the critical requirements necessary to prepare individuals to become entry-level occupational therapists or occupational therapy assistants. The section B standards are the standards related to curriculum content requirements. These content requirements are tied to expected student outcomes (ACOTE Standards and Interpretive Guide pg. 18). It is the responsibility of the Faculty to develop learning activities and methods of evaluation to document how the students have met these outcomes. For purposes of this study the accreditation standards for a master’s degree level educational program that more directly relate to culture and cultural competency are identified in the following:
### Cultural and Cultural Competency Standards

#### Table 1

<table>
<thead>
<tr>
<th>ACOTE Standards</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.1.5</td>
<td>Demonstrate an understanding of the ethical and practical considerations that affect the health and wellness needs of those who are experiencing or at risk for social injustice, occupational deprivation, and disparity in the receipt of services (pg. 18).</td>
</tr>
<tr>
<td>B.1.6</td>
<td>Demonstrate knowledge of global social issues and prevailing health and welfare needs of populations with or at risk for disabilities and chronic health conditions (pg. 19).</td>
</tr>
<tr>
<td>B.2.9</td>
<td>Express support for the quality of life, well-being, and occupation of the individual, group, or population to promote physical and mental health and prevention of injury and disease considering the context (e.g., cultural, personal, temporal, virtual) and environment (pg. 20).</td>
</tr>
<tr>
<td>B.4.2.</td>
<td>Select appropriate assessment tools on the basis of client needs, contextual factors, and psychometric properties of tests. These must be culturally relevant, based on available evidence, and incorporate use of occupation in the assessment process (pg. 21).</td>
</tr>
</tbody>
</table>
| B.4.4. | Evaluate client(s') occupational performance in activities of daily living (ADLs), instrumental activities of daily living (IADLs), education, work, play, rest, sleep, leisure, and social participation. Evaluation of occupational performance using standardized and non-standardized assessment tools includes:  
  - The occupational profile, including participation in activities that are meaningful and necessary for the client to carry out roles in home, work, and community environments.  
  - Client factors, including values, beliefs, spirituality, body functions (e.g., neuromuscular, sensory and pain, visual, perceptual, cognitive, mental) and body structures (e.g., cardiovascular, digestive, nervous, genitourinary, integumentary systems).  
  - Performance patterns (e.g., habits, routines, rituals, roles).  
  - Context (e.g., cultural, personal, temporal, virtual) and environment (e.g., physical, social).  
  - Performance skills, including motor and praxis skills, sensory–perceptual skills, emotional regulation skills, cognitive skills, and communication and social skills (pg. 21). |
| B.4.7. | Consider factors that might bias assessment results, such as culture, disability status, and situational variables related to the individual and context (pg. 22). |
| B.5.1. | Use evaluation findings based on appropriate theoretical approaches, models of practice, and frames of reference to develop occupation-based intervention plans and strategies (including goals and methods to achieve them) on the basis of the stated needs of the client as well as data gathered during the evaluation process in collaboration with the client and others. Intervention plans and strategies must be culturally relevant, reflective of current occupational therapy practice, and based on available evidence. Interventions address the following components:  
  - The occupational profile, including participation in activities that are meaningful and necessary for the client to carry out roles in home, work, and community environments.  
  - Client factors, including values, beliefs, spirituality, body functions (e.g., neuromuscular, sensory and pain, visual, perceptual, cognitive, mental) and body structures (e.g., cardiovascular, digestive, nervous, genitourinary, integumentary systems).  
  - Performance patterns (e.g., habits, routines, rituals, roles).  
  - Context (e.g., cultural, personal, temporal, virtual) and environment (e.g., physical, social).  
  - Performance skills, including motor and praxis skills, sensory–perceptual skills, emotional regulation skills, cognitive skills, and communication and social skill (pg. 23). |
| B.5.6 | Provide therapeutic use of self, including one’s personality, insights, perceptions, and judgments as part of the therapeutic process in both individual and group interaction. |
| B.5.17. | Develop and promote the use of appropriate home and community programming to support performance in the client’s natural environment and participation in all contexts relevant to the client (pg. 26). |
| B.5.23. | Grade and adapt the environment, tools, materials, occupations, and interventions to reflect the changing needs of the client, the sociocultural context, and technological advances (pg. 26). |
It is noticeable that consideration of cultural factors is part of various academic standards. Effectively taking these cultural factors into consideration in all aspects of therapy requires a certain level of competency; cultural competency. Cultural competency is not a term used within any of the OT documents presented so far, yet all of the documents refer to it indirectly. This ambiguity has an impact on preparing OT professionals, which is apparent in the study by Cherry et. al (2009) presented prior. This barrier as well as others will be presented in more detail.

**Barriers**

The literature review identified three common themes as barriers:

1. Lack of support for healthcare practitioners and educators
2. Discrimination
3. Unsystematic format/structure of cultural competence education material

(Andrulis & Brach, 2007; Dogra, Reitmanova, & Carter-Pokras, 2009; Lindsey et al., 2014; Porter & Krinsky, 2014; and Yaffa, 2014)

Each of these barriers will be explored in more detail in this section.

**Lack of support for healthcare practitioners and educators:** According to Andrulis and Brach (2007), the ability for a clinician to be culturally competent is

| B.6.1. | Evaluate and address the various contexts of health care, education, community, political, and social systems as they relate to the practice of occupational therapy (pg. 28). |
| B.6.2. | Analyze the current policy issues and the social, economic, political, geographic, and demographic factors that influence the various contexts for practice of occupational therapy (pg. 28). |
| B.6.3. | Integrate current social, economic, political, geographic, and demographic factors to promote policy development and the provision of occupational therapy services (pg. 28). |
| B.6.5. | Analyze the trends in models of service delivery, including, but not limited to, medical, educational, community, and social models, and their potential effect on the practice of occupational therapy (pg. 28). |
| B.6.6. | Utilize national and international resources in making assessment or intervention choices and appreciate the influence of international occupational therapy contributions to education, research, and practice (pg. 28). |
affected by the level of support available from others on the health care team. In order for individuals to receive culturally competent care all members of a rehab team must be trained and be culturally competent in their intervention with the individual to provide consistent treatment.

Time was found to be barrier to limited cultural competence training of health care professionals. The assumption remains that cultural competence can be obtained and maintained with little time and effort. To the contrary, literature has shown that much dedication must be made to the continual development of an individuals’ cultural competence. Dickie (2004) stated that, “cultural understanding is never complete - there is too much to learn, and nothing stays the same” (Dickie, 2004, p. 172). The demands of the health care professionals leave a limited amount of time for cultural competence training (Andrulis & Brach, 2007.)

Limited fiscal support was also identified as a major contributing factor to lack of cultural training (Lindsay et al. 2014). This limited fiscal support has a significant effect on the training, and type of cultural competence education. Related to these barriers, Dogra, Reitmanova and Carter-Pokras (2009) found faculty support and development of academic curricula for cultural competence education is typically left to only one individual, usually the advocate faculty. To be successful it is necessary that all faculty members must be consistent and trained in the process of educating students on cultural competence in the healthcare field in order to provide that consistent knowledge and background to the students. The need for fiscal and training support directly applies to the clinical world as well.
**Discrimination:** Ethnocentrism is a way an individual thinks and assumes that their way of thinking and acting is naturally superior to another individual’s beliefs (Bucher & Butcher, 2010). This thought process has led to practitioners becoming culturally incompetent within practice. According to Capell, Dean, & Veenstra (2008), ethnocentrism has led to impairments in health care providers’ abilities to provide safe and adequate care to all their patients.

Yaffa (2013) and Tripp-Reimer, Choi, Kelley, & Enslein (2001) also found that rigid institutional culture has led to practitioners inability to look at the client in a holistic way. Instead a mindset of “this is how we do things” overpowers the key factor of cultural competence when working with individuals from different cultural backgrounds.

Culturally inappropriate communication can be another barrier for practitioners not practicing culturally competently. Practitioners have limited amount of time with patients and with limited resources may choose not to get an interpreter (Yaffa, 2013). This leads to miscommunication, frustration, a poor evaluation and intervention and a poorer health outcome for the client.

**Unsystematic format/structure of cultural competence education material:**
Dogra, Reitmanova and Carter-Pokras (2009) reviewed and compared main concepts from key documents that have shaped cultural diversity education in North America and the United Kingdom for undergraduate medical students. The authors found common issues in implementing cultural education in the United Kingdom, United States of America, and Canada. These issues include: conceptual issues; methods, and the structure and format for cultural diversity education was unclear and not systematic between different universities. Educators of the topic demonstrated a weak understanding of
cultural diversity education and limited support from other faculty members. There is identified a lack of congruency among definitions which is a barrier to providing the optimal client-centered care within the medical profession Garneau & Pepin (2014). This challenge is readily apparent in the OT profession as well.

In the literature, many students appeared to resist multicultural courses because students felt that since they are part of the ethnic group or live in a multicultural context that they do not need further education, which led to low morale in support of multicultural coursework. Another barrier affecting the ability to create a format for cultural competence education is the lack of evidence supporting the most effective teaching methods of cultural competence. The following section identifies teaching techniques/methods that have resulted in health care providers having increased confidence in the use of cultural competence practice.

**Teaching Methods**

“Current key issues in cultural competence education in curriculum design focus on faculty development and evaluation of teaching effectiveness” (Watts, Cuellar & O’Sullivan, 2008, pp. 137). With the ever-increasing diversity in the United States, it has become evident that health care professionals must be provided with proper training and education so that they may provide their patients with culturally competent care. Capell, Dean, & Veenstra (2008) found that increasing an individuals’ cultural awareness may lead to a decrease in the negative effects of ethnocentrism.

Clinical cultural competence is gained through cross-cultural training and education. Cultural competence includes building communication skills, building personal awareness of racial and ethnic disparities in health, and identifying the impact of
race, ethnicity, culture, and class on clinical decision-making (Carpenter-Song, Nordquest, Schwallie, & Longhofer, 2007). According to the National Center for Cultural Competence (p.4, n.d) “Systems and organizations that exemplify cultural competence demonstrate an acceptance and respect for cultural differences and they:

1. Create a mission statement for the organization that articulates principles, rationale, and values for cultural and linguistic competence in all aspects of the organization.
2. Implement specific policies and procedures that integrate cultural and linguistic competence into each core function of the organization.
3. Identify, use, and/or adapt evidence-based and promising practices that are culturally and linguistically competent.
4. Develop structures and strategies to ensure consumer and community participation in the planning, delivery, and evaluation of the organization’s core function.
5. Implement policies and procedures to recruit, hire, and maintain a diverse and culturally and linguistically competent workforce.
6. Provide fiscal support, professional development, and incentives for the improvement of cultural and linguistic competence at the board, program, and faculty and/or staff levels.
7. Dedicate resources for both individual and organizational self-assessment of cultural and linguistic competence.
8. Develop the capacity to collect and analyze data using variables that have meaningful impact on culturally and linguistically diverse groups.
9. Practice principles of community engagement that result in the reciprocal transfer of knowledge and skills between all collaborators, partners, and key stakeholders.

In 2008, Brown and Mokuau found that students who received training and felt prepared to practice culturally competent care generated positive results. Results showed that students went into the workforce with knowledge and skills that are compatible with culturally diverse individuals. Students developed attitudes and values that honor diversity and a dual focus on the responsibilities of the practitioner and institution to improve policy, practice and research related to cultural competent practice. Similar findings were found by Suarez-Balcazar, Rodawoski, Balcazar, Taylor-Ritzler, Portillo,
Barwacz & Willis (2009) in which therapist with more training, both formal and informal, perceived themselves as having high levels of cultural competence. For current and future healthcare practitioners to be culturally competent in their practice they must have proper training and education. Five strategies were identified in the literature as being effective in preparing students and current healthcare practitioners to practice culturally competently. The five strategies include the following:

- Workshops/Lecture
- Cultural Humility
- Reflection
- Case studies/Guest speakers
- Cultural Competence through Community Integration/engagement Programs

**Workshops/Lecture**

When searching the literature on the effectiveness of workshops on gaining cultural competency the results mixed. Porter and Krinsky (2013) conducted a quasi-experimental study with 76 healthcare providers participating in a five-hour workshop. The curriculum focused on: 1) addressing myths and realities of LGBT aging and; 2) exploring prejudice and identifying barriers to providing quality services for LGBT older adults. The group then developed strategies for improving access and enhancing knowledge about public policies of importance to LGBT older adults. Results found that individuals that participated in the workshop had increased awareness of resources for individuals in the LGBT community, increased knowledge of the community/culture, increased knowledge of public policies, and increased confidence in their own abilities to challenge homophobic/transphobic remarks. Assemi, Mutha & Suchanek (2007)
developed, implemented and then evaluated the impact of a cultural competence train-the-trainer workshop for pharmacy educators. Their evaluation results indicated that after completing the workshops the participants self-rated confidence has significantly increased. Carter et al. (2006) also developed and evaluated the effectiveness of an interactive workshops designed to improve third year students attitudes, beliefs and cross cultural communication skills. The results indicated that the students did have an increase in cultural awareness and they considered the workshop appropriate and valuable. A systematic review by Beach et. al (2005) stated that “there is excellent evidence that cultural competence training improves the knowledge of health professions and good evidence that cultural competence training improves the attitudes and skills of health professionals” (p. 356).

Cultural Humility

According to Bonder & Martin (2013) cultural humility is the willingness to admit what they do not know and be flexible and humble in interactions with others, recognizing the importance of self-reflection and lifelong learning. Tervalon & Murray-Garcia (1998, p.117) defined cultural humility as an ongoing process of self-reflection & self-critique as a lifelong learner & reflective practitioner

1. Aware of personal beliefs; not letting them get in the way
2. Mutual respect and partnerships with patients
3. Recognition of inherent power imbalances in communication by using patient focused care

Griswold, Zayas, Kernan and Wagner (2007) identified, through their study, that when medical students would listen to the refugee stories of war and death, it led them to
reflect on their own values, beliefs and lifestyles. Students were impressed by the refugee’s resilience. Students were able to view the refugee patient as ‘teachers’ of their culture and gain awareness of the patient’s perception of the provider. The medical students reported feeling better prepared to interact with new refugees once in practice.

The ability to demonstrate cultural humility and reflection is essential for both the clinician as well as the academician. In fact this is an aspect of the ACOTE Standard B.5.6 which states: provide therapeutic use of self, including one’s personality, insights, perceptions, and judgments as part of the therapeutic process in both individual and group interaction. In order for cultural humility and reflection to occur, the OT must reflect and evaluate his or her own personality, insights, perceptions and judgments.

Reflection

According to Bucher & Bucher (2010) continuous self-monitoring and self-assessment enable practitioners to discover their strengths and weakness and develop their interpersonal skills. In congruence, Taylor (2008) contends that for a therapist to effectively collaborate with a client and use a client-centered approach it is essential for a therapist to have self-awareness. In doing this therapist are able to recognize, control, and correct potential nontherapeutic reactions. Griswold, Zayas, Kernan and Wagner (2007) found that reflection increases the healthcare providers’ ability to meet the patients’ emotional needs and concern for refugee integration into the community. This integration is key for individuals maintaining a healthy physical and mental life. Taylor (2008) discussed that when a therapist has self-reflection it allows them to understand and recognize what the illness means to the patient. It also allows the therapist to individualize the intervention session and provide the best approach necessary to meet the
needs of the patient. Reflection and critical thinking/reasoning can facilitated through the use of case studies and guest speakers.

**Case Studies & Guest speakers**

Xakellis et al. (2004) found that interactive case studies and case studies with diverse ethnic background issues, self-assessment tools and having guest speakers are key strategies used in culturally competent academic preparation. The following section identifies teaching techniques/methods that have resulted in health care providers having increased confidence in the use of cultural competence practice. Haack (2008), found similar results that pharmacy students who participated in an advanced pharmacy practice experience (APPE) to improve students’ cultural competence had increased knowledge about resources available for their patients from non-white ethnic backgrounds and culturally specific nutrition plans that individuals in the community follow. Andrulis and Brach (2007) identified successful clinical outcomes with patients and providers when the clinicians learned about their patient’s health literacy, language and culture to improve rapport and self-management support.

Muzumdar, Holiday-Goodman, Black and Powers (2010) found that pharmacy students that covered cultural competence material through laboratories, lectures, and experiential/out-of-class assignments reported higher confidence levels and more prepared to talk to patients from different cultures. Students suggested an educational course on history of different cultures and bringing in guest speakers from different ethnic backgrounds as a beneficial way to increase their cultural competence. Long (2012) identified seven teaching methods as key components in teaching cultural competence to undergraduate nursing students. The seven teaching methods included
group discussions, clinical experiences, self-reflection, guest lecturers, mentoring and consultation, educational partnerships and lived immersion/study abroad. Each method brought a new perspective to the students, but no one teaching method produced greater cultural competence than the other.

**Cultural Competence through Community Integration/engagement Programs**

Research has supported the use of community engagement/integration to the benefit of the clients served, the students providing the service and the community members as a whole (Orth, 2007; Valen, 2007; Schnepper, 2007. Griswold, Zayas, Kernan and Wagner (2007) found that students had increased cultural awareness of the cultural backgrounds of refugees when they had clinical encounters with new refugees who had been in the country for less than three months. Medical students reported increased cultural awareness in terms of cultural beliefs and values, and increased confidence in use of interpretation services. Schnepper (2007) found that nursing students initially expressed frustrations with the diverse populations they were serving, feeling as though they were not trying to access health care appropriately and didn’t follow through with the recommendations. After their engagement experience the nursing students identified feelings of respect and appreciation for the efforts and challenges these individuals experienced. Orth’s (2007) study had similar results. Her analysis identified significant improvements in students’ knowledge and skills. The results also showed positive changes in the nursing students attitudes and perceptions with a decline in self-reported biases.

The National Institutes of Health of the US Department of Health and Human Services state that cultural competence has a positive effect on enabling providers to
deliver services that are respectful of and responsive to the health beliefs and practices of diverse patients. The literature supports the value of culturally competent practitioners and identifies effective training strategies to build student and practitioner’s cultural competence.

**Research Purpose**

The purpose of this study was to assess the effectiveness of the University of North Dakota (UND) Occupational Therapy Multicultural course (OT 451) in preparing graduates toward cultural competence. The second adjoining question: how effective do graduates feel the University of North Dakota’s Occupational Therapy Multicultural course (OT 451) was preparing graduates toward cultural competence?

This was accomplished through the implementation of a survey in which graduates from the program, over a five-year span, participated in the study. Survey questions were structured around 6 constructs: (1) participant demographics, work information and client demographics, (2) if the course met the course objectives for the participants; (3) the value of the course activities and teaching strategies; (4) the participants assessment of their confidence in regard to cultural competency; (5) the participants perspective on the national and global issues regarding the importance of cultural factors; and (6) the participants understanding of the cultural competency preparation of their colleagues in comparison to their preparation. The sample, instrumentation and data collection procedures are provided in Chapter III.
CHAPTER III

Methodology

The Institutional Review Board at the University of North Dakota approved the study proposal and survey on July 30, 2014 (Project number: 201407-037). The methodology section describes the research design, sampling procedures, course descriptions, instrumentation and research procedures used in this study.

Design and Sample

A retrospective, causal non-experimental survey design was used to gather data to answer the research question. The purpose of survey research is to obtain accurate objective descriptions about a specific universe of people or entities (Stein, Rice, & Cutler, 2013). An online survey allowed the researcher to reach a wide range of potential participants that met the inclusion criteria. A survey would allow the researcher to identity key strengths and weaknesses within the OT 451 course and learn about the general attitudes of the participants who took the course.

Participants were invited to participate in the survey via mail. Refer to Appendix (B) for participation invitation letter. The participation invitation letter included the purpose of the study, risks and benefits, and included the URL link to access the survey. The survey was accessed through the University of North Dakota Qualtrics server. The survey began with the purpose of the study, consent form that again identified risk and benefits of participation and the choice to enter a drawing for a $50 gift card. Participation in the survey was entirely voluntary. Participation letters were sent out twice: August 1, 2014 and September 9, 2014. The survey remained open till October 1, 2014.
Subject Characteristics: That target population had the following inclusion criteria: (1) at least one year's worth of OT clinical experience, (2) graduates from the UND OT program from 2009-2013, and (3) it was mandatory to take OT 451. OT alumni who did not graduate during this time frame were excluded. There were 161 participants contacted; overall, 51 completed the informed consent and online survey.

Sampling Procedures: A purposive sample was used to gather participants, due to the specific characteristics of the population and inclusion criteria. Mailing addresses of participants were accessed through the University of North Dakota Alumni Center. A total of 161 UND occupational therapy alumni were sent a participation invitation letter via direct mail. This letter included the purpose of the study, risks and benefits, and included the link to the URL to access the survey.

Local of the study: The surveys were completed by participants in an online format at a location of the participant’s choice. Participants had from August 1, 2014 till October 1, 2014 to complete the survey. The participants were able to use any device that allowed them to access the Internet and respond to the survey. Participants did not have to complete the survey all at once. The ability to access the survey anywhere and anytime allowed flexibility for the participants.

Course Description

The OT 451 Multicultural Competency in O.T. is designed to be an introduction to the major concepts of culture, race and ethnicity within the context of providing occupational therapy services. The course syllabus states (p1):

Through self-disclosure, individual experiences and project presentations, students gain knowledge of themselves and others in relation to multicultural competency. By
studying the multicultural/diverse aspects of our society, students will identify, develop and demonstrate the skills that are essential for cultural competency and to become instrumental in identifying barriers in health care. Gaining an understanding of where the ‘self’ fits in relation to the larger sociocultural, socioeconomic, diversity factors and lifestyle factors is essential as well as understanding the influence of social conditions and the ethical context in which humans choose and engage in occupations.

The course is offered in the spring semester in the second year of the curriculum. Students have been engaged in a series of courses that prepare them to assess and analyze their behavior as it relates to occupational therapy roles, theory and practice that require self-evaluation and reflection. There are three courses prior that focus; therapeutic use of self, effective communication, individual responsibility for professional development, dynamics of constructive feedback, and observation. OT 451 would be the fourth and final course of this series.

There are three units in the course. Unit I focus is on establishing a personal and interpersonal foundation and understanding.

**Table 2**  
*Unit I Course Objectives*

<p>| | |</p>
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<tbody>
<tr>
<td>1.</td>
<td>Demonstrate an awareness as to the importance and value of the student’s own culture and its impact on his/her own behavior</td>
</tr>
<tr>
<td>2.</td>
<td>Demonstrate the exploration of feelings, biases, anxieties, misperceptions and counterproductive attitudes that may influence our interactions with others</td>
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<tr>
<td>3.</td>
<td>Explore and discuss the challenge of personal reflection and change within our value and belief systems</td>
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<tr>
<td>4.</td>
<td>Demonstrate an understanding as to how self-awareness relates to the therapeutic relationship and therapeutic use of self.</td>
</tr>
<tr>
<td>5.</td>
<td>Identify and give examples as to how to modify the barriers to therapeutic use of self in the therapeutic relationship through personal change</td>
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<tr>
<td>6.</td>
<td>Demonstrate an understanding of the OT Code of Ethics</td>
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</table>

Unit II focus is on understanding the complexity of culture and cultural interactions.
Table 3

_Unit II Course Objectives_

<p>| | |</p>
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<tbody>
<tr>
<td>1.</td>
<td>Explain the meaning and dynamics of occupation and activity, including the interaction of areas of occupation</td>
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<tr>
<td>2.</td>
<td>Express support for the quality of life, well-being, and occupation of the individual, group, or population to promote physical and mental health and prevention of injury and disease considering the context (e.g., cultural, physical, social, personal, spiritual, temporal and virtual).</td>
</tr>
<tr>
<td>3.</td>
<td>Consider factors that might bias assessment results, such as culture, disability status and situational variables related to the individual and context.</td>
</tr>
<tr>
<td>4.</td>
<td>Describe the current social, economic, political, geographic, and demographic factors to promote policy development and the provision of occupational therapy services.</td>
</tr>
<tr>
<td>5.</td>
<td>Differentiate among the contexts of healthcare, education, community, and social systems as they relate to the practice of occupational therapy.</td>
</tr>
<tr>
<td>6.</td>
<td>Articulate the role and responsibility of the practitioner to address changes in service delivery policies to effect changes in the system, and to identify opportunities in emerging practice areas.</td>
</tr>
<tr>
<td>7.</td>
<td>Articulate the trends in models of service delivery and the potential effect on the practice of occupational therapy, including, but not limited to, medical, educational, community, and social models.</td>
</tr>
<tr>
<td>8.</td>
<td>Demonstrate understanding of the current social, economic, political, geographic, educational and demographic factors that influence the delivery of healthcare, policy development and ultimately the provisions of OT services.</td>
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Unit III is the final Unit and it focuses on application and summary of the information learned and discussed throughout the semester.

Table 4

_Unit III Course Objectives_

<p>| | |</p>
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<tbody>
<tr>
<td>1.</td>
<td>Demonstrate an awareness of the role of culture and multicultural factors within the profession of occupational therapy</td>
</tr>
<tr>
<td>2.</td>
<td>Differentiate among the contexts of health care, education, community, and social systems as they relate to the practice of occupational therapy</td>
</tr>
<tr>
<td>3.</td>
<td>Discuss the current social, economic, political, geographic, and demographic factors to promote policy development and the provision of occupational therapy</td>
</tr>
<tr>
<td>4.</td>
<td>Examine the role of O.T. Practice Framework and Code of Ethics regarding culture, cultural factors, multiculturalism and diversity.</td>
</tr>
<tr>
<td>5.</td>
<td>Identify the characteristics of a culturally competent therapist and methods to become and maintain culturally competence as a therapists</td>
</tr>
<tr>
<td>6.</td>
<td>Acknowledge personal responsibility for planning ongoing professional development</td>
</tr>
<tr>
<td>7.</td>
<td>Identify the responsibilities of culturally competent therapist in regard to advocacy, conflict resolution, and the identification and removal of barriers in health</td>
</tr>
<tr>
<td>8.</td>
<td>To take under consideration factors that might bias assessment results, such as culture, disability status, and situational variables</td>
</tr>
</tbody>
</table>

The learning activities for the course include:
1. DVD’s coupled with small group discussion and reflection papers;
2. reading of two books with online blackboard discussion;
3. a monthly community learning experience with a population they have minimal to no knowledge of or volunteering with a New Americans Refugee population for the entire semester;
4. guest speakers
5. journal reflection
6. presentation on a cultural group that will be in the community where they are doing one of their Level II fieldwork experiences and;
7. self-assessments with reflection

Instrumentation and Data Collection

An online survey was developed using the Qualtrics server through the University of North Dakota. The survey took approximately 15-20 minutes of the participant’s time. The survey consisted of 60 questions containing both close-ended and open-ended questions to collect both quantitative and qualitative data. There were 52 close-ended questions and 8 open-ended questions. The survey questions were structured around 6 constructs: (1) participant demographics, work information and client demographics, (2) if the course met the course objectives for the participants; (3) the value of the course activities and teaching strategies; (4) the participant’s assessment of their confidence in regard to cultural competency; (5) the participants perspective on the national and global issues regarding the importance of cultural factors; and (6) the participants understanding of the cultural competency preparation of their colleagues in comparison to their preparation. A Likert-scale was used to rate participants responses for constructs two through five. A nominal scale was used for constructs one and six.
Knowles Theory of Andragogy basic principles were used to guide the research by helping design the research question, interpret the data and propose explanations of causes or influences allows for a guide that is evidence based and grounded in previous research (Cole & Tufano, 2008). The principles consider the following: adults are self-directed learners, reflecting on past experiences and to what the learner already knows, learning is related to developmental tasks of social roles, and learning is person centered or problem centered (Smith, 1999). The survey enabled participants to reflect on their experience in the course and identify how it helped develop their role toward being a culturally competent occupational therapist in their current settings.

**Coding**

In order to easily identify the variables in SPSS constructs two through six received a code. The following table shows the individual codes for each construct.

<table>
<thead>
<tr>
<th>Code</th>
<th>Construct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>participant demographics, work information and client demographics</td>
</tr>
<tr>
<td>MC0</td>
<td><strong>Multicultural Objectives:</strong> Assessed if the course met the course objectives for the participants.</td>
</tr>
<tr>
<td>MCA</td>
<td><strong>Multicultural Activities:</strong> Assessed the value participants placed on course activities and teaching strategies.</td>
</tr>
<tr>
<td>CC</td>
<td><strong>Cultural Confidence:</strong> The following questions related to the participant doing a self-assessment of cultural competency and their confidence level.</td>
</tr>
<tr>
<td>CCI</td>
<td><strong>Cultural Competence International:</strong> Assessed how the participant felt national and global issues related to cultural competency.</td>
</tr>
<tr>
<td>FCC</td>
<td><strong>Facility Cultural Competence:</strong> Assessed the participants understanding of the cultural competency preparation of their colleagues in comparison to their preparation</td>
</tr>
</tbody>
</table>
Statistical Analysis

The results of the survey were analyzed using the Statistical Program for the Social Sciences 22.0 (SPSS) software program. Descriptive statistics were generated to answer the following research question: how effective is the University of North Dakota (UND) occupational therapy multicultural course (OT 451) in preparing graduates toward cultural competence? An analysis was performed to determine the following: (1) participants demographics, work information, and client demographics, (2) if the course met the course objectives for the participants, (3) the value of the course activities and teaching strategies, (4) the participants assessment of their confidence in regard to cultural competency, (5) the participants perspective on the national and global issues regarding the importance of cultural factors, and (6) the participants understanding of the cultural competency preparation of their colleagues in comparison to their preparation. An analysis was run to calculate the total score (sum) for each construct. An independent-samples t test was done to compare the use of cultural competence in practice between graduates from 2009-2011 and graduates from 2012-2013. A one-way ANOVA was run between the sums of construct three and construct six. Lastly, a three-factor analysis was run on construct two to increase validity and reliability of the survey and identify four factors that increased participant’s cultural competence. The results of the analyses are presented in Chapter IV.
CHAPTER IV

Results

The statistical analysis of the results from the online survey: Cultural Competence: The Effectiveness of a Multicultural Course on Preparing Future Occupational Therapists for Culturally Competent Practice is presented in this section. The survey was divided into six constructs: (1) participant demographics and work information; (2) course met the course objectives for the participants; (3) value of the course activities and teaching strategies; (4) participants assessment of their confidence in regard to cultural competency; (5) participants perspective on the national and global issues regarding the importance of cultural factors; and (6) participants understanding of the cultural competency preparation of their colleagues in comparison to their preparation. Chapter IV also includes the results of an independent sample t test. Data was downloaded from the Qualtrics server in SPSS format and uploaded into SPSS 22.0 for data analysis.

Construct (1): Participant Demographics and Work Information

An analysis of the participant’s age, current position and graduation year from the UND OT program was completed. The results are presented in the following.

Gender: Participant gender was assessed in the survey, due to high volume of females compared to males; insignificance came from the data and will not be incorporated into the final analysis.

Age: Results showed that 76.5% (n=39) of the participants’ age ranged from 20-29 years of age. The second 19.6% (n=10) between the ages of 30-34, and finally 3.9% (n=2) were between 35-39 years of age.
**Current Position:** The main position held by the participants was that of staff therapist consisting of 84.3% (n=43) of the participants. Senior therapist consisted of 9.8% (n=5) of the participants. There was one person who identified his or herself as a fieldwork (FW) coordinator, and 3.9% (n=2) held a position in administration.

**Graduation Year:** The greatest number of participants was from the UND OT class of 2013 with 25.5% (n=13). There was 23.5% (n=12) of participants who graduated in 2012, 11.8% (n=6) graduated in 2011, 11.8% (n=6) graduated in 2010, and 21.6% (n=11) graduated in 2009.

Findings show that recent graduates from the program had a higher response rate than the other graduate years and the average age of participants were between 20-29 years of age.

**Construct (2): Course Objectives**

OT 451 has objectives, goals, and expectations to meet during the course, each spring as were presented prior in the methodology chapter. This section assessed how adequately the participants felt the course met those objectives, goals, and expectations. A rating of not met (1), somewhat met (2), completely met (3), and not applicable (0) were used in ordinal-scale form. Possible scores varied from 6.00-72.00, with the high value equivalent to cultural competence.
Participants who said somewhat or completely met for all questions would have a score of 48 or higher. Results showed that over half of the participants had a score of 68 or higher. 23.5% (n=15) of participants chose the value completely met (3) for all questions. 9.8% (n=5) of the participants identified N/A, which is considered missing data. These results support the value of the multicultural course provide by the UND OT program. The course objectives, goals, and expectations are met throughout the semester the course is provided.

**Construct (3): Value of Course Activities and Teaching Strategies**

The following eight activities and/or teaching strategies were assessed in the online survey: (1) BaFa BaFa Cultural Activity; (2) Online Quizzes; (3) Videos (Waging a Living, Crash, Ellis Island, American History X, A Place at the Table, Being Gay); (4) Speakers; (5) Book Blackboard discussion (Nickel & Dimed, The Spirit Catches You, Diversity Consciousness); (6) Cultural Presentation; (7) Food Stamp Challenge; and (8) Cultural Events. Each of activities/strategies will be presented in more detail in the following sections.
A rating of low value (1), moderate value (2), high value (3), and not applicable (0) were used in a likert-scale. At the end of construct five a space was provided for participants to provide additional comments related to any of the course activities or teaching techniques. Included with the quantitative results are the qualitative results.

A challenge with this construct is that not all participants had the same experiences over the five-year period. All course activities were used consistently across this period with the exception of Being Gay, which was initially used in 2013 and the Food Stamp Challenge became required only in 2013. American History X was no longer used after spring semester of 2012.

Table 7
Analysis of BaFa BaFa Cultural Activity

![Bar chart showing the percentage of participants placing low, moderate, and high value on the BaFa BaFa cultural activity.]

Results show that 2.0% (n=1) of the participants place a low value on the BaFa BaFa cultural activity, 29.4% (n=15) place a moderate value, and 41.2% (n=21) place a high value on the BaFa BaFa cultural activity. 27.5% (n=14) participants responded not applicable to the class activity, which was identified as missing data. Participant’s responses in relation to the BaFa BaFa activity include:
“I would not change any of the experiences I gained from this course and these activities especially the BaFa BaFa and cultural presentation.”

“The BaFa BaFa Cultural Activity was a big eye opener for me as well as the Food Stamp Challenge.”

Overall, 36 out of 51 participants found the BaFa BaFa class activity to be of moderate to high value.

Table 8
Online Quizzes

The online quizzes results show that 56.9% (n=29) of the participants identify the online quizzes as having a moderate value. Only 3.9% (n=2) participants placed high value on the activity, and 19.6% (n=10) identified that activity as low value to their learning experience. Lastly, 19.6% (n=10) participants chose N/A to the online quizzes, which were considered missing data. Participants’ response to the online quizzes include:
“I believe that some of the activities could potentially have increased value if they were left as just the event/task themselves; when the additional written work, reflection paragraph, etc. was added to the assignment, they lost value.”

The value was lost when the students' minds/attention goes towards "I have to get this done and checked off my to do list," instead of coming to class and discussing it without the added stress of an extra assignment. The more valuable aspects of the class activities came from real discussion that was genuine/volunteered versus the assignments that were required.”

Both in the quantitative and qualitative results, participants identified online quizzes as having a moderate value to their learning experience within the course.

Table 9
Analysis of in class Videos

<table>
<thead>
<tr>
<th></th>
<th>Low value</th>
<th>Moderate value</th>
<th>High value</th>
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<tbody>
<tr>
<td></td>
<td>0</td>
<td>20</td>
<td>80</td>
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</table>

Assess the value you place on the following course activity or teaching strategy since your part...Videos (Waging a Living, Crash, Ellis Island, American History X, A Place at the Table, Being Gay)

Movies and documentaries were a considerable part of the course. There are three movies that were consistently used from 2009-2013: Ellis Island, Crash and Waging a Living. American History X was used from 2009-2012. Being Gay was used in 2012-2013. The use of movies and documentaries was identified by 66.7% (n=34) of the participants as being of high
value. Followed by 19.6% (n=10) of the participants identifying it as a moderate value to their learning experience and 3.9% (n=2) placed a low value on videos. Of the participants 9.8% (n=5) identified N/A to the videos, which were identified as missing data. The use of two of the movies/documentaries only in 2012-2013 could possibly be a factor in the 9.8% that responded not applicable.

Table 10
Guest Speakers

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
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<tbody>
<tr>
<td>Moderate Value</td>
<td></td>
</tr>
<tr>
<td>High Value</td>
<td>100</td>
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</tbody>
</table>

Assess the value you place on the following course activity or teaching strategy since your participation:

Guest Speakers

No participants placed a low value on guest speakers. Results showed that 76.5% (n=39) of the participants placed high value on guest speakers as increasing their knowledge and learning experience in a positive way. Followed by 13.7% (n=7) placed moderate value on guest speakers. Of this teaching strategy 9.8% (n=5) of participants responded N/A, which were identified as missing data.

The following is a participant’s response to guest speakers:

“…the cultural events and guest speakers along with discussions after movies were of great value to me and my learning.”

Bringing in individuals of different ethnic backgrounds and sharing their personal experience with students is identified as having high value to the students.
Each semester three books are read in OT 451 that include *Nickel & Dimed*, *The Spirit Catches You*, and *Diversity Consciousness*. Blackboard discussions are done online between classmates to reflect and discuss key points from the readings. Results showed that 47.1% (n=24) of the participants identified blackboard discussions having moderate value to their learning experience. Followed by 33.3% (n=17) of participants placing high value on the learning activity and 11.8% (n=11) of the participants placed a low value on blackboard discussions. Lastly, 7.8% (n=4) of participants rated the learning activity as N/A to their learning experience, which were identified as missing data.

The following are multiple comments to the books read in class:

“The book Nickel and Dimed was great- I still talk about it!”
“I enjoyed reading the various books in this class but often found blackboard discussions difficult. It made sense we were required to write so much but I personally prefer face to face interactive discussions.”

“The books read in that class are some of my favorite books ever to this day.”

“More time should be given to Spirit Catches You & less weight given to Nickel & Dimed. Our class had difficulty with the accountability of the author.”

One individual indicated the following:

“Blackboard was the worst, very little value and I took nothing away from it…”

Not only were the class books a learning opportunity within the program, but have also been a tool that the participants have used to translate knowledge to co-workers till this day.

Table 12
Cultural Presentations

During the semester students would pair up and chose a culture to present to the class. Results showed 62.7% (n=32) of the participants identified cultural presentations as being of
high value to their learning. Followed by 27.5% (n=14) of the participants identified the learning activity of moderate value and 3.9% (n=2) as low value. Lastly, 5.9% (n=3) of the participants identified the cultural presentations as being N/A to their learning, which were identified as missing data.

Table 13
Food Stamp Challenge

For one week students had to live off the allotted amount of money provided by SNAP (Supplemental Nutrition Assistance Program) for the state of their choice. Each state has a differing amount allotted per person per day. The students could not spend more than the allotted amount of money for that week. Results showed 35.3% (n=18) of the participants placing high value on the class activity and only 2.0% (n=1) identified the food stamp challenge as having low value in their learning experience. Lastly, 49.0% (n=25) of the participants identified the food stamp challenge as not applicable to their learning experience, which was
identified as missing data. This was due to the food stamp challenge not being a required assignment till 2012.

The following are multiple comments about the food stamp challenge activity:

“Many of us already came from backgrounds in which we learned how to be thrifty due to financial struggle. If individuals take the cultural presentation & food stamp challenge seriously, these are very helpful learning activities.”

“The food stamp challenge made the experience more personal than just reading about it!”

Both quantitative and qualitative results show the importance/value the food stamp challenge had on the students learning experience. The interactive activity allowed the students to reflect the experience of living on food stamps.

Table 14
Cultural Events

<table>
<thead>
<tr>
<th></th>
<th>Percent</th>
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<tbody>
<tr>
<td>Low value</td>
<td></td>
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<tr>
<td>Moderate value</td>
<td></td>
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<tr>
<td>High value</td>
<td></td>
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</tbody>
</table>

Assess the value you place on the following course activity or teaching strategy since your participation—Cultural Events
Students in OT 451 are required to individually attend 4 cultural events during the semester and then write on their experience. Results showed 64.7% (n=33) of the participants identified cultural events as having high value and 27.5% (n=14) of the participants identified it has being of moderate value to their learning experience. Only 2.0% (n=1) of the participants identified cultural events as having low value and 5.9% (n=3) identified it as being N/A to their learning experience, which were identified as missing data.

The following are comments from participants about the overall experience of OT 451:

“I am glad that we were required to take this course. Going into the class, I didn't know what to expect but the class far exceed. The things that we learned can seem like common knowledge to me now and it surprises me when people don't know these basic cultural competency things. I'm happy that we had the real-life experiences during the class such as BaFa BaFa or food stamp challenge. These activities truly opened my eyes to others' experiences”,

“Excellent variety of teaching options”,

“I thought the activities that were engaging and interactive (presentations, BaFa BaFa activity) were most beneficial and educational”, and

“Growing up in a small town in North Dakota, I was not exposed to much diversity as a child and teenager. Completing activities like these in the OT program opened my eyes to some of the other ethnicities and cultures other than my own, and helped me understand some of my own biases and how they would eventually affect me as a practitioner. I found many of
these activities very beneficial and I do believe that they have helped me develop good relationships with my patients.”

This shows the value of interactive activities and having students participate in community events that involve multicultural learning.

The results from Construct (3): Value of Course Activities and Teaching Strategies show that the course activities and teaching strategies are beneficial to the students learning, and led to a higher outcome of learning. Some activities (cultural presentations, BaFa BaFa, etc.) are valued higher than other activities (blackboard discussions). Incorporating a variety of activities and teaching strategies resulted in a higher value of learning for the students. Participants identified a high value of learning in this course, but did it increase their confidence when entering the field? Construct four will assess the confidence of participants in regard to cultural competency.

**Construct (4): Confidence regarding cultural competency**

The participant did a self-assessment of their confidence level in being culturally competent within practice. They had to rate their confidence level with each statement in relation to how the course prepared them. A rating of very confident (1), somewhat confident (2), not very confident (3), and not confident at all (4) was used in Likert-scale form. A score range of 6.00-24.00 was possible. A low score value was equivalent to greater cultural competence confidence. When discussing cultural confidence, the research was trying to determine if OT 451 increased participant’s confidence when going into a situation of clients from different ethnic backgrounds and having language barriers.
Results showed that two-thirds of the participants had confidence as being culturally competent in practice. 11.8% (n=6) of the participants identified a score of 6.00 and 11.8% (n=6) identified a score of 7.00, which represents the participants as being very confident and somewhat confident. Of the participants 5.9% (n=3) put N/A, which were identified as missing data. These results mean that participants felt confident when having to work with clients from different ethnic, cultural, or spiritual background. These findings show that OT 451 multicultural course does give UND OT students confidence when practicing culturally competently within the profession.
**Construct (5): National and global issues**

This section assessed the participants’ perspective on the national and global issues regarding the importance of cultural factors. They had to identify the extent to which they agreed with the statement. A Likert-scale rating form of strongly agrees (1), agree (2), don’t know (3), and disagree or strongly disagree (4) was used.

Table 16
Cultural Competence International

A score range of 6.00-24.00 was possible. A low score value was equivalent to greater cultural competence confidence. Results showed that two-thirds of the participants scored between a 6.0 and 7.0. This confirms participants acknowledge that cultural factors influence a client’s occupational performance, the occupational therapy process, and outcome of the occupational therapy intervention. Results show that an understanding of individuals’ culture is
crucial in the outcome of therapy. The final construct will assess the department of the participants and their implementation of cultural competency within that department.

**Construct (6): Department Cultural Competency**

The final construct assessed the participants understanding of the cultural competency preparation of their colleagues in comparison to their preparation within the UND OT program and how their current facility is promoting cultural competent therapists. A nominal scale identifying either yes or no was used for participants to answer four questions. If the participant responded yes to the questions, space was available following the question for further explanation.

Table 17
Colleagues Cultural Competency

The results showed that 80.4% (n=41) of the participants were not aware of their colleagues receiving cultural competency training/education in their professional program and 11.8% (n=6) of the participants were aware of their colleagues receiving cultural competency
training/education. Lastly, 7.8% (n=4) of the participant did not respond to the question, so it was documented as missing data.

Table 18
Clinical Department Cultural Competency

![Bar Chart]

Results showed that 54.9% (n=28) of the participants replied no about their department having a cultural competence focus. Only 39.2% (n=20) of the participants identified a cultural competency focus in their department and 5.9% (n=4) of the participants did not respond to the question.
Results showed that 80.4% (n=40) of the participants marked yes for their current work department as meeting the Joint Commission Standards on cultural competency and 11.8% (n=6) of the participants replied no, that their department does not meet the Joint Commission Standards on cultural competency.
Table 20
CLAS Standards

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) was developed in 1997 by the Office of Minority Health (OMH) to improve the quality of care, access to care, and overall, health outcomes of minorities. It would do so by educating health care organizations and staff on responding with sensitivity to the needs and preferences to diverse populations (Office of Minority Health, 2001). This question asked, is your department aware of the CLAS Standards (National Standards for Culturally and Linguistically Appropriate Services in Health Care)? Results were that only 23.5% (n=12) of the participants responded yes to their department being aware of CLAS, 70.6% (n=36) of the participants responded no, and 5.9% (n=3) did not respond to the question.

**Independent-Samples t Test**

It was of interest to see the difference in view/opinion between classes on the course activities and teaching strategies. An independent-samples t test comparing the cultural competence between UND OT graduates from 2009-2011 and UND OT graduates from 2012-
2013 found significant differences between the means of the two groups (t-4.496 p<.001). UND OT graduates from 2009-2011 group was significantly lower (m=15.87, sd = 3.31) than the mean of the UND OT graduates of 2012-2013 group (m=19.83, sd=2.62).

Table 21 Independent-Samples t Test

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<thead>
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<tr>
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<tr>
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<tr>
<td>Total MCA 9-11</td>
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<tr>
<td>Total MCA 12-13</td>
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<table>
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<tr>
<th>Independent Samples Test</th>
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<td></td>
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<tr>
<td>Levene's Test for Equality of Variances</td>
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<td>---</td>
</tr>
<tr>
<td>Total MCA Equal variances assumed</td>
</tr>
<tr>
<td>Total MCA Equal variances not assumed</td>
</tr>
</tbody>
</table>

The results show that UND OT graduates from 2012-2013 place higher value on the course activities and teaching strategies in preparing them to practice culturally competently. UND OT graduates from 2009-2011 places a lower value on the course activities and teaching strategies. As stated prior not all participants had the same experiences over the five year period which had an impact on the variation in the data regarding some of the course activities.
The one-way ANOVA was run to compare construct two (MCA) with construct six (FCC) question one. The results identified no significance. The average MCA totals are not different between people with low, medium, or high department cultural competency.

The final statistical analysis that was run was a three-factor analysis. The analysis identified four factors that increased participant’s cultural competence. The four factors included role of OT guidelines, understanding other cultures, demonstrating knowledge of cultures, and becoming culturally competent. Multiple variables contributed to the factors in which lead to increase cultural competency of the participants.

The results show that OT 451 is beneficial in preparing UND OT student in practicing culturally competently. Using a variety of activities and teaching strategies are crucial throughout the process. In the following section there will be a summary of the findings, conclusion and future recommendations.
CHAPTER V

Conclusions and Recommendations

Chapter V includes the following: review of the purpose and research design, the relationship between the results and the previous research, implications for practice, limitations of study, and recommendations for future research.

According to the U.S. Census Bureau the nation’s population will be more ethnically and racially diverse by 2050 (U.S. Department of Health and Human Services Centers for Disease Control and Prevention, 2013). Occupational therapists work with individuals from different ethnic and cultural backgrounds everyday to enhance or enable their participation in everyday life activities (occupations). According to Murden, Norman, Ross, Sturdivant, Dedia, & Shah (2008), cultural competences is now an essential element in the standard of care and is emphasized among educational objectives in the occupational therapy practice framework.

AOTA identifies a diverse workforce in the Centennial Vision. The AOTA’s Centennial Vision states:

“We envision that occupational therapy is a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society’s occupational needs” (AOTA)

Though, according to Academic Programs Annual Data Report (2014), 82% of students are Caucasian. Based upon this, the profession has two focus areas; 1. Ensure preparation of an OT workforce toward cultural competency due to its high homogeneity and 2. Recruit and retain
more minority students so it more effectively represents the demographic changes in our society. Section B of the ACOTE standards acknowledges cultural factors as part of various academic standards. Though, cultural competency is not a term used within the ACOTE standards or Centennial Vision. This disconnect makes it difficult in preparing OT students to practice culturally competently in the workforce.

The purpose of the study was to investigate the effectiveness of OT 451: Multicultural Competency in Occupational Therapy. An online survey of 60 questions was developed to answer the following question: how effective is UND OT Multicultural course (OT 451) in preparing graduates toward cultural competence? The andragogy theory was used to guide the development of the survey. Participants would reflect on their past experience with the class activities and teaching strategies used and relate them to how those benefited them in the workforce in being a culturally competent occupational therapist.

Through data analysis it was found that the course objectives, goals, and expectations are met throughout the semester. The course demonstrates an appreciation for the individual’s perception of quality of life-well being, and occupation in regards to diversity and multicultural issues. This was shown by 45% of the class chose a score between 68.00-72.00, which means participants placed moderate to high value of the course meeting the goals, objectives and expectations.

The factor analysis results identified four factors within the course objectives that help students become culturally competent. The four factors include: 1. Role of OT guidelines, 2. Understanding other cultures, 3. Demonstrating knowledge of cultures, 4. Becoming culturally competent.
Role of OT Guidelines

Participants identified examining the O.T. Practice Framework regarding culture and cultural factors as beneficial to their learning. It was also important for the participants to assess the role of the Occupational Therapy Code of Ethics regarding culture, multiculturalism, and diversity. By doing this in class participants were able to reflect on how they can not only be culturally competent in practice, but also ethically correct. In order to practice culturally competently the participants had to have a foundational understanding of other cultures.

Understanding Other Cultures

ACOTE Standard B.5.6 which states: provide therapeutic use of self, including one’s personality, insights, perceptions, and judgments as part of the therapeutic process in both individual and group interaction. Participant’s felt the course allowed individuals to recognize their own diversity in relationship to the larger society, and understand and respect the social-cultural diversity of others. Participant’s also experienced exploration of their feelings, biases, anxieties, misperceptions and counterproductive attitudes that may influence our interactions with others. This reflection allowed therapists to demonstrate an appreciation for the other individual’s perception of quality of life well-being and occupation in regard to diversity and multicultural issues.

Demonstrating Knowledge of Cultures

Participants identified demonstrating awareness of their own culture as being important and of value when demonstrating knowledge of cultures. Results also showed that participants felt occupational therapists must take into consideration factors that might bias assessment results, such as culture, disability status, and situational variables. Within the course participants had a primary textbook and three different chapter books to read throughout the semester. These
readings allowed the participants to demonstrate an understanding of terminology related to personal beliefs and to the study of culture, multiculturalism, and diversity.

**Becoming Culturally Competent**

Participants identified acknowledging personal responsibility for planning ongoing professional development was critical in providing culturally competent care. Within the American Occupational Therapy Association (2014) definition of cultural competence they state cultural competency *as a journey, rather than an end*. Being a culturally competent practitioner, you have to continue reflecting and learning throughout life. Within the OT 451 course participants felt activities that focused on methods to become and maintain culturally competent as therapists enabled them to have an entry-level knowledge of being culturally competent. Results support that OT 451 does meet its course objectives, goals, and expectations. In the next section course activities and teaching strategies will be compared with the literature.

Muzumdar, Holiday-Goodman, Black and Powers (2010) found that students that covered cultural competence material through laboratories, lectures, and experiential/out-of-class assignments reported higher confidence levels and felt more prepared to talk to patients from different cultures. Data analysis showed two-thirds of the participants had confidence in being culturally competent in practice. That increased confidence enabled the occupational therapist to provide culturally competent skilled OT when working with individuals.

Similar to increased confidence community integration activities increased cultural awareness. Griswold, Zayas, Kernan and Wagner (2007) found students had increased cultural awareness of the backgrounds of new refugees, when they had clinical encounters during their education program. The analysis found similar results with 64.7% of the participants placing high value on the cultural events. The events allowed the participants to be the minority and see
the interaction between individuals from different ethnic and cultural backgrounds other than their own. This gave a realistic experience to students on how individuals from a background other than European-American may feel in everyday life. It is apparent that OT 451 properly prepares UND OT students to practice culturally competent when entering the workforce. The final construct examined looked at the participants current facilities and how they supported cultural competence within their department.

According to Andrulis and Brach (2007), the ability for a clinician to be culturally competent is affected by the amount of support available from others on the health care team. From the survey, results showed that 80.4% of participants were not aware of their colleagues receiving cultural competency training/education in their professional program. Another alarming result showed that 54.9% of participants replied no to their department having a cultural competence focus. Only 39.2% identified their department having a cultural competency focus.

It appears results establish concrete reasons why the occupational therapy profession is lacking in cultural competency practice. Not all occupational therapy programs throughout the United States include a multicultural course. As well as, current occupational therapists are in the workforce with limited knowledge on cultural competence practice within the field. It is apparent there is a lack of consideration within departments on being culturally competent, even though the United States population is shifting to a more diverse population. Though, departments are meeting the required cultural competency Joint Commission Standards, 80.4% of participants identified their departments meeting the standards, it appears to be the bare minimum. Majority of the departments, 70.6 % were unaware of CLAS and were not incorporating them into the department environment. In order for occupational therapists to
provide culturally sensitive interventions and services to patients, it must start in the core of their education and begin in occupational therapy school.

The knowledge they learn in their program they can bring to the workforce and implement continuing education sessions into their department. In doing this it will expand the knowledge of their co-workers and decrease the health care disparities gap. They will do so by having a greater understanding of their patient population and be able to provide culturally sensitive care to the patient.

**Implications for practice**

The study found that OT 451 does meet the course objective, goals, and expectations. It prepares students to confidently practice cultural competency and bring those techniques and knowledge to the workforce. Using a variety of activities (cultural events and presentations, videos, books, and reflection) and different teaching strategies brings a holistic approach to the students learning experience. It appears that not all students receive a multicultural course in their OT program. The only way to bridge the health disparities gap, is implementing multicultural courses into all accredited programs in the United States. In doing so future occupational therapists will go into the workforce with a foundation of cultural competency. They will be able to incorporate that knowledge into their therapy session and not only bring cultural competency to their department, but will provide culturally sensitive care to their patient.

**Limitations of Study**

This study was limited due to having a purposive sample and it was not randomized. The instrument was an online survey, which has a risk of response set error. This could impact the results. The reliability and validity of the survey was limited due to the research designing the survey. It had not been piloted prior to being distributed to participants. A challenge with this
construct is that not all participants had the same experiences over the five-year period. All course activities were used consistently across this period with the exception to of Being Gay, which was initially used in 2013 and the Food Stamp Challenge became required only in 2013. American History X was no longer used after spring semester of 2012.

**Recommendations**

To further expand this research, it would be beneficial to include occupational therapist from all over the nation to identify what continuing education methods are being used in the clinical setting to increase cultural competence and how to further improve that education. Another step to take would be creating an AOTA committee focused primarily on cultural competency courses within each program and maintaining the standards.
APPENDICES
Appendix A

Survey Questions
The purpose of this proposed study is to assess the effectiveness of the University of North Dakota (UND) Occupational Therapy Multicultural course (OT 451) in preparing graduates toward cultural competence. The results of the survey will be compared to the literature and OT 451 course outcome measures to identify gaps in the course’s preparation of OT graduates.

Demographics
Age
- 20-29
- 30-34
- 35-39
- 40-44

Gender
Male/female

What year did you graduate from the UND OT program? 2009 2010 2011 2012 2013

What state do you work in?

What is your current position?
- a. Staff therapist
- b. Senior therapist
- c. Fieldwork Coordinator
- d. Administration

Please describe your job responsibilities in your current position:

1. Estimated client demographics:
   - a. Gender: _____% Male; _____% Female
   - b. Age: _____% ages children; _____% adolescents; _____% adults;
     ______% older adults
   - c. Ethnicity: ______% white; ______% non-white
<table>
<thead>
<tr>
<th>The following are the multicultural course objectives that the course was striving to meet. In your opinion, how ADEQUATE were the following course objectives/goals/expectations met?</th>
<th>Not met</th>
<th>Somewhat met</th>
<th>Completely met</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand and appreciate concepts like culture, difference, and diversity.</td>
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<tr>
<td>Demonstrate an understanding of the current social, economic, political, geographic factors that influence the delivery of health care, policy development and ultimately the provisions of OT services</td>
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<tr>
<td>Demonstrate an awareness as to the importance and value of the students own culture</td>
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<tr>
<td>Demonstrate an awareness of self, based on our culture and its impact on our behavior</td>
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<tr>
<td>Analyze and apply knowledge about diversity to domestic and global issues.</td>
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<tr>
<td>Explore and discuss the challenge of personal reflection and change within our value and belief systems</td>
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<tr>
<td>Recognize your own diversity in relationship to the larger society, and understand and respect the social-cultural diversity of others.</td>
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<tr>
<td>Demonstrate the exploration of feelings, biases, anxieties, misperceptions and counterproductive attitudes that may influence our interactions with others.</td>
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<tr>
<td>Demonstrate an understanding of the significant of therapeutic use of self in relation to occupational therapy</td>
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<tr>
<td>Identify the characteristics that define a culturally competent therapist</td>
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<tr>
<td>Demonstrate an understanding as to how self-awareness relates to the therapeutic relationship Identify and give examples as to how to modify the barriers to therapeutic use of self in the therapeutic relationship through personal change</td>
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<tr>
<td>Demonstrate understanding of the terminology used when studying culture, multiculturalism, and diversity.</td>
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<tr>
<td>Demonstrate an understanding of the terminology related to personal beliefs: ethnocentrism, prejudice, bias, stereotype, assimilation, race and racism and its potential risk of impact on service delivery.</td>
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<tr>
<td>Demonstrate an appreciate for the individual’s perception of quality of life, wellbeing, and occupation in regard to diversity and multicultural issues</td>
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<tr>
<td>Demonstrate a knowledge and understanding of the American Occupational Therapy Association (AOTA) Occupational Therapy Code of Ethics, Core Values and Attitudes of Occupational Therapy Practice, and AOTA Standards of Practice and use them as a guide for ethical decision making in professional interactions, client interventions, and employment settings.</td>
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<tr>
<td>Discuss strategies for ongoing professional development to ensure that practice is consistent with current and accepted standards.</td>
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<tr>
<td>Examine the role of O.T. Practice Framework regarding culture and cultural factors</td>
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<tr>
<td>Examine the role of the Occupational Therapy Code of Ethics regarding culture, multiculturalism and diversity</td>
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<tr>
<td>Acknowledge personal responsibility for planning ongoing professional development</td>
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<tr>
<td>Identify methods to become and maintain culturally competence as a therapists</td>
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<tr>
<td>Identify the responsibilities of culturally competent therapist in regard to advocacy, conflict resolution, and the identification and removal of barriers in health care.</td>
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</tbody>
</table>
To take under consideration factors that might bias assessment results, such as culture, disability status, and situational variables

Assess the value you place on the following course activity or teaching strategy since your participation in the multicultural course (select NA if this was not part of the course when you participated):

<table>
<thead>
<tr>
<th>Activity</th>
<th>Low value</th>
<th>Moderate value</th>
<th>High value</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>BaFa BaFa Cultural Activity</td>
<td></td>
<td></td>
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<tr>
<td>Online Quizzes</td>
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<tr>
<td>Videos (Waging a Living, Crash, Ellis Island, American History X, A Place at the Table, Being Gay)</td>
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<tr>
<td>Book Blackboard Discussion (Nickel &amp; Dimed, The Sprit Catches You, Diversity Consciousness)</td>
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<tr>
<td>Cultural Presentations</td>
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<tr>
<td>Food Stamp Challenge</td>
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<tr>
<td>Cultural Events</td>
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</tbody>
</table>

Comments related to any of these course activities or teaching strategies:

The following are questions related to your self-assessment of cultural competency. Please indicate your confidence level with each statement in relation to how the course prepared you.

<table>
<thead>
<tr>
<th>Statement</th>
<th>very confident</th>
<th>somewhat confident</th>
<th>not very confident</th>
<th>not confident at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am aware of methods to reduce cultural barriers</td>
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<tr>
<td>I am more aware of the influence of a client’s cultural background on his or her behavior, attitude, beliefs and lifestyle?</td>
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</tr>
<tr>
<td>I feel I can ask my clients about their cultural and/or religious beliefs/practices they feel may be pertinent to their treatment</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>I feel confident/comfortable addressing/implementing clients’ cultural and/or religious beliefs/practices into their treatment plan and interventions.</td>
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<tr>
<td>I feel confident/comfortable locating information about particular cultures.</td>
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<td></td>
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<tr>
<td>I feel confident locating and providing various resources to culturally diverse clients that may be available or beneficial to them and may meet their particular cultural, religious, and/or sexual beliefs/practices.</td>
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</tbody>
</table>

Comments related to your confidence level in preparing you as an entry level therapist regarding cultural competence:

The following are national and global issues related to cultural competency. Identify the extent to which you agree with the statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agreed</th>
<th>Agreed</th>
<th>Don’t know</th>
<th>Disagree or strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a need to understand cultural factors when working with clients and colleagues</td>
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<td></td>
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<tr>
<td>Cultural factors do influence a client’s occupational performance</td>
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</tbody>
</table>
Cultural factors should be considered in the occupational therapy process.

Overlooking cultural influences could affect the outcome of the occupational therapy assessment.

Overlooking cultural influences could affect the outcome of the occupational therapy intervention.

The knowledge and skills I learned in my participation in the multicultural course are valuable to me in my current position.

Are there other issues you think should be listed:

<table>
<thead>
<tr>
<th>Cultural competency preparation of your colleagues in comparison to what you received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you aware of any of your colleagues receiving a course that focused on cultural competency in their professional programs?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>If yes, can you expand: No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is cultural competency a part of your departments focus?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>If yes, can you expand: No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How does your department meet the Joint Commission Standards on cultural competency?</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>If yes, can you expand: No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is your department aware of the CLAS Standards (National Standards for Culturally and Linguistically Appropriate Services)?</th>
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<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>If yes, can you expand: No</td>
</tr>
</tbody>
</table>

Qualitative Questions

1. Can you describe examples of how the class did prepare you to work with diverse populations as an entry level graduate?

2. Please list any changes you recommend to improve the multicultural preparation coursework.
3. Can you please provide examples of culturally competent care in your practice:

4. Is there anything that we didn’t ask regarding this topic that you think it would be beneficial for us to know and consider?

Thank you for participating. We will use your information to strengthen the education of future occupational therapists who go through the course and to help them work more effectively with a diverse range of clients and colleagues. We sincerely appreciate your time.
Appendix B

Informed Consent

Online Consent Form
Cultural Competence: The Effectiveness of a Multicultural Course on Preparing Future Occupational Therapists for Culturally competent Practice.

You are invited to participate in a research study to assess the effectiveness of the University of North Dakota (UND) Occupational Therapy Multicultural course (OT451) in preparing graduates toward cultural competence. the results of the survey will be compared to the literature and OT 451 course outcome measures to identify gaps in the course's preparation of OT graduates. This study is conducted by Gemma Saxon, OTS, Taylor Hardina, OTS with their advisor, Dr. LaVonne Fox, PhD, OTR from the University of North Dakota.

This study will take approximately 15-20 minutes of your time. you will be asked to complete and online survey about: 1) if the course met the course objectives for you; 2) the value of the course activities and teaching strategies; 3) your assessment of your confidence in regard to cultural competency; 4) your perspective on the national and global issues regarding the importance of cultural factors; 5) your understanding of the cultural competency preparation of your colleagues in comparison to your preparation and ; 6) suggestions for improvement.

Your decision to participate or decline participation in this study is completely voluntary and you have the right to terminate your participation at any time without penalty form the University of North Dakota and UND OT Department. You May skip any questions you do not wish to answer. If you want do not wish to complete this survey just close your browser.

Your participation in this research will be completely confidential and data will be averaged and reported in aggregate. Possible outlets of dissemination may be the University of North Dakota Essential Studies Committee, journal publication and conference presentations. Although your participation in this research may no benefit you personally, it will help us understand how to improve the course so the upcoming students feel much more confident in working with diverse populations.

There will be no more than minimal risks to the participants in this study. The Study is evaluating if the course prepared you to be able to more effectively meet the needs of your diverse clientele and colleagues in the healthcare setting. If you do not wish to answer an question, you may skip it and go onto the next question, or you may stop immediately. There is always a risk of loss of confidentiality whenever data is shared. The data will be collected with secure, encrypted online data collection system and will only be presented in aggregate form. The only identifying information will be your name and email address if you wish to be entered into the gift card drawing and then that information will be deleted as well. Every effort will be made to keep your
study records confidential but we cannot guarantee it.

If you have any questions about your rights as a participant in this study or any concerns or complaints or have any questions/concerns or wish additional information please feel free to contact us:

  1. Gemma Saxon: 763-218-3154 gemma.saxon@my.und.edu
  2. Lavonne Fox: 701-777-2216 lavonne.fox@med.und.edu

You can also contact the Institutional Review Board (IRB) office at 701-777-4279

Please print a copy of this consent form for your records, if you so desire.

Click here to print a copy for your records.

I have read and understand the above consent form, I certify that I am 18 year old or older and, by clicking the submit button to enter the survey, I indicate my willingness voluntarily take part in this study.

Do you wish to be entered into the drawing for a $50 Gift Card?
REFERENCES


