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Understanding Culturally Competent Care in Occupational Therapy School to Providing Clinical Practice

by

Tracy Lord, MOTS

Breann Lamborn M.P.A.

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

Grand Forks, North Dakota

May, 2013

Approval Page

This Scholarly Project Paper, submitted by Tracy Lord 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.

_____

Faculty Advisor

_____

Date

PERMISSION

Title: Understanding Culturally Competent Care in Occupational Therapy School to Providing Clinical Practice

Department: Occupational Therapy

Degree: Master's of Occupational Therapy

In presenting this Independent Study in partial fulfillment of the requirements for a graduate degree from the University of North Dakota, I agree that the Department of Occupational Therapy shall make it freely available for inspection. I further agree that permission for extensive copying for scholarly purposes may be granted by the professor who supervised my work or, in her absence, by the Chairperson of the Department. It is understood that any copying or publication or other use of this Independent Study or part thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and the University of North Dakota in any scholarly use which may be made of any material in my Independent Study Report.

Signature_____ Date_____

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

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ABSTRACT

Purpose: This purpose of this study is to determine if the knowledge that is gained in occupational therapy school about working with diverse cultures is continually developed and applied while practicing in the field of occupational therapy. **Methodology:** Data was collected from 18 participants in a quantitative survey and 6 participants in a qualitative interview from four Southwestern states. **Results**: Results of this study suggest that the therapists who have graduated within the last 20 years have a greater understanding of including a client's culture to provide true client-centered care in the delivery of occupational therapy services. 50% of the respondents to the survey indicated that they are routinely providing client-centered care and culturally competent care. Out of those 9, 7 had have been working in the profession under 20 years. **Conclusion:** Those occupational therapists within the Southwest region of the United States who have graduated from educational programs in the last 20 years are more likely to be aware of the importance of culture in relation to providing care to their clients. 50% of the participants surveyed demonstrated that they understood that providing client-centered care must take into consideration a client's culture. Results of this survey suggest that cultural competence training is predominantly provided by educational programs, and it is essential that these programs address the skills necessary to provide culturally competent care in light of the demands of clinical environments. Results of the interview indicated that participants recognized that

cultural competency allows for stronger rapport with clients. Techniques including interviewing, active listening, and respectful curiosity regarding cultural diversity were critical to successful outcomes. Additionally, facilities must support practicing clinicians in attainment of continued cultural competency to provide a client centered and culturally appropriate therapeutic environment by recognizing diversity needs, providing resources and removing barriers.

Chapter 1

Introduction

Rationale

When the author of this research study first moved to Wyoming she experienced a level of culture shock. The move from the more culturally diverse area of Las Cruces, New Mexico to the strong Western culture of Wyoming required a significant adjustment. From this personal experience, to conversations with classmates, faculty and clinicians, the importance of occupational therapists appreciating and integrating a client's culture into treatment become an area of interest. Because the profession of occupational therapy is dominated by Caucasian, non-Hispanic females, it is essential for this profession to appreciate the cultural diversity presented by clients, coworkers, and communities. According to Ennis, Rios-Vargas and Albert, from a report in the 2010 Census Briefs, "More than half of the growth in the total population of the United States between 2000 and 2010 was due to the increase in the Hispanic population" (p. 2). The Southwestern United States is the region that was chosen as the focus of the study, due to a high percentage of existing diversity and a rapidly increasing percentage of Hispanic population.

The Accreditation Council for Occupational Therapy Education (ACOTE) standards for master's level occupational therapy education include an emphasis on diversity and social factors; Standard B.1.7 specifically addresses multicultural

concepts, and states that graduates from master's level educational programs will "demonstrate knowledge and appreciation of the role of sociocultural, socioeconomic, and diversity factors and lifestyle choices in contemporary society" ("Accreditation Standards", 2006, p. 6). The researcher was interested in the degree of carry-over from multicultural education in school to providing clinical practice. The demographics of the United States are ever changing and expanding; occupational therapists must be skilled in providing culturally competent care.

Theoretical Model

The study focus on cultural-competence required a theoretical framework that placed the same emphasis on understanding the importance of culture. Black and Wells' (2007) Cultural Competency Model provides a solid understanding of the importance of culture within occupation:

> The Cultural Competency Model outlines a process for becoming a culturally competent health care provider. It explores a framework that providers, students, and systems can use to develop and acquire the knowledge, skills, and awareness needed to increase their ability to function effectively and provide quality care in a multicultural environment (p. 54-55).

This model provides the basis to address the aspect of multicultural education within occupational therapy from the school environment through the full cycle of becoming a health care provider. The key factors of the model include self-exploration, knowledge, and skill. Black and Wells (2007) identify self-exploration as the process of a

student or health professional looking inward, and emphasize that looking inward is not always a pleasant or risk free process, but that it is necessary for growth. The next factor, knowledge, can again be addressed during any aspect of the process to becoming an occupational therapist. Knowledge, according to Black and Wells (2007), promotes understanding, and a knowledge base of cultures which allows occupational therapist to appropriately modify treatment plans for clients. The final key factor that Black and Wells (2007) address is skill, developing techniques and mastering strategies that make it possible to enhance the delivery of care for the client.

Statement of Problem

Due to the increasing diversity found within the United States, and the lack of diversity found within the occupational therapy profession, are occupational therapists providing culturally competent care and expanding on implementation skills within clinical practice beyond what is taught in occupational therapy school?

Assumption

The assumption underlying this study is that occupational therapy practitioners will feel that they are providing client centered care, but will not always be consistently taking into consideration the client's cultural background. This assumption is based on the tendency of occupational therapy schools to provide theoretical multicultural experience with limited direct population application. The second assumption is that the longer a therapist has been working with a diverse clientele, the greater the possibility that the therapist will consistently take the client's culture into consideration, based on the experience that the therapist gains while working.

Scope and Delimitation

The main variables within the study are the region addressed in the study, the amount of experience of the participants, the emphasis on cultural competency during educational training, and the level of culturally competent care in the clinical setting from the participants' perspective. To increase the likelihood of exposure and awareness of cultural diversity by participants, the study took place within four states in the Southwestern United States. The study was conducted within one year, to follow requirements set by the Institutional Review Board at the University of North Dakota. Justification for this research study is the increasing diversity within the United States, and the increasing impact diversity needs will have on the health care profession.

Importance of the Study

This study will add to the knowledge base for practicing occupational therapy clinicians to develop an environment of cultural competence and client-centered care in an increasingly diverse society. An increased understanding of the skills and knowledge that the participating clinicians felt were most beneficial to their working career will provide valuable information to students and faculty at the Occupational Therapy Department at the University of North Dakota with regard to optimal instructional formats for multicultural diversity education.

Chapter II

Literature review

Introduction

Due to significant diversity in the Southwest region of the United States, occupational therapists in this region must practice from an understanding of the varied cultures that they frequently work with. The American Occupational Therapy Association (AOTA) states in the 2nd edition of the Occupational Therapy Practice Framework: Domain and Process, "The expectations, beliefs, and customs of various cultures can affect a client's identity and activity choices and need to be considered when determining how and when services may be delivered" (p. 651). Culture is included in the core concept of the identity of an individual as defined by the occupational therapy profession. Through culturally competent care, occupational therapists provide true client-centered services with the greatest likelihood for successful outcomes. If a client's culture is not taken into consideration during planning and implementation of services, the occupational therapist is not providing thorough client-centered care.

AOTA's history has included an understanding of the need for respect of the individual, but it was not until the development of the Multicultural Affairs Program in 1991 that specific goals for increased diversity through recruitment of minorities in the profession were adopted by the organization (Black, 2002, p. 144). During this time,

according to Black (2002), the first standards with relation to multicultural knowledgewere included within the content requirements outlined by Essentials and Guidelines for an Accredited Educational Program for the Occupational Therapists of 1991. The standard specifically stated that programs would include “knowledge and appreciation of multicultural factors”, and “analysis of the theories of human adaptation and life satisfaction across the life span, including a multicultural perspective” (“Essentials and Guidelines”, 1991, p. 1081). From that point forward, specific curriculum addressing cultural diversity in both clients and in the profession has been a national standard.

Key Definitions

Culture is an ever changing and dynamic concept that the average person will describe in a variety of ways. The Merriam-Webster Dictionary (2013) defines “culture” as “the integrated pattern of human behavior that includes thought, speech, action, and artifacts and depends upon the human capacity for learning and transmitting knowledge to succeeding generations” (1a, para. 1). Within the realm of occupational therapy, integrating the different dimensions of culture is essential to respecting the human capacity of the client that serves as the core of client-centered care. Epner and Baile (2012) describe culture as “a very elusive and nebulous concept; like art” (p. iii33). This description again fits well with spirit of occupational therapy; the “art” of practice describes how occupational therapists should view the client’s culture as part of the holistic approach to treatment that distinguishes occupational therapy from other professions. People as a whole see, experience, feel, and understand in different and

dynamic ways, reflective of the cultures they identify with. The art of integrated and client centered practice recognizes the need for the therapist to acknowledge the variety of cultures a single client may represent, and design treatment that respects and incorporates these various cultures.

The "cultural context", according to AOTA (2002), in the 2nd edition of the Occupational Therapy Practice Framework: Domain and Process, "includes customs, beliefs, activity patterns, behavior standards, and expectations accepted by the society of which the client is a member" (p. 642). It is important for occupational therapists to take into consideration not only the client's personal context, but also the societal and historical contexts surrounding the client. Additionally, the therapist may be not only an invited participant to the culture, but a member of the culture personally, and therefore influenced by the context at a personal level separate from objective practice.

With emphasis on culture and the every changing demographics of client populations across the United States, the term "culturally competent" has become prominent in the literature. Suarez-Balcazar et al. (2009) developed a definition of cultural competence, adapted from work by Campinha-Bacote (1999), stating that:

> Cultural competence is demonstrated when the practitioner understands and appreciates differences in health beliefs and behaviors, recognizes and respects variations that occur within cultural groups, and is able to adjust his or her practice to provide effective interventions for people from various cultures (p. 499).

Two of the key words in this definition are “appreciates” and “respects”. It is necessary when providing culturally competent care to have respect and appreciation for the differences that the client brings to the therapeutic relationship. If there is no true respect, and only an educational understanding of the client’s culture, the therapeutic relationship, while still potentially effective, may not be as fully developed.

An additional definition of cultural competency from Black and Wells (2007), discusses the concept of cultural competency as a journey;

> Cultural competency is a journey rather than an end. It is a lifelong process designed to foster understanding, acceptance, knowledge, and constructive relations between people of various cultures and differences. It is an evolving and developing process that depends on self-exploration, knowledge and skills. (p. 31)

The importance of this definition is the understanding that cultural competency is an exchange between two culturally influenced individuals. Culture is not a stagnant concept; it is ever changing. For occupational therapists to truly be culturally competent, they need to evolve within, and be cognizant of, the cultural influences around them.

The concept of “client-centered care” is found throughout the Occupational Therapy Practice Framework: Domain and Process 2nd Edition. While there is no set definition within the practice framework, the concept of client-centered care is the main model and service approach in occupational therapy (AOTA, 2002). “Using a client-

centered approach, the occupational therapy practitioner gathers information to understand what is currently important and meaningful to the client." (AOTA, 2008, p. 649). The terminology of "client-centered" care comes from the humanistic psychologist and psychotherapist Carl Rogers. McMurtry and Bultz, (2005) state that "Carl Rogers is credited with developing the structure of client-centered therapy, a concept grounded in the necessity of 'empathy, warmth and genuineness'" (p. 701).

Culture within Occupational Therapy and the Medical Field

In the United States (U.S.), cultural demographics are dramatically changing. 16 percent of the total U.S. population is Hispanic or Latino. This is a change from 12.5 percent of the total population in 2000. ("The Hispanic Population: 2010", 2010). According to Ennis, Rios-Vargas and Albert, from a report in the 2010 Census Briefs, "More than half of the growth in the total population of the United States between 2000 and 2010 was due to the increase in the Hispanic population"(p. 2). When comparing the United States ethnic demographics to demographics of student populations in occupational therapy programs, there is a stark contrast between the ethnic and racial diversity found in each. The white, non-Hispanic or Latino female population dominates the profession of occupational therapy, and comprises the largest ethnic student group. According to the AOTA in the 2010-2011 Academic Programs Annual Data Report, students in master's level occupational therapy programs are 94.6 percent White Non-Hispanic or Latino. With those receiving an occupational therapy assistant degree, the percentage of students who are White Non-Hispanic or Latino is 91.4 percent.

According to the 2010 United States Census form, race includes White, Black, African American, Negro, American Indian, Alaska Native (allowing a space to distinguish which tribe), and Asian Indian with ten specific options to select from. There is also a blank space for the respondent to write in an additional race not specifically identified. The 2010 Census form also distinguishes Hispanic, Latino, or Spanish as additional ethnic options. The options include no identification as Hispanic, Latino, or Spanish; and positive identification as Mexican, Mexican American, Chicano, Puerto Rican, Cuban, another Hispanic, Latino, or Spanish ethnicity, and also provides a blank space for respondents to write in an additional ethnicity not specifically identified.

According to the AOTA Academic Programs Annual Data Report (2010-2011), white is the largest race representation in graduate level occupational therapy programs at 86 percent of enrolled students. African American students account for six percent of the population of master's level occupational therapy students and Asian American students represent five percent. African Americans account for 13 percent of the population of occupational therapy assistant programs, which makes African American the largest minority population within the field of occupational therapy (p. 15).

Additionally, according to the 2010-2011 AOTA Academic Programs Annual Data Report, at the master's level, 89 percent of the students are female, data that is similar to the occupational therapy assistant program statistics, at 85 percent female (p.16). This is a staggering statistic and shows how Caucasian females dominate the entire field of occupational therapy. These statistics are relevant in relation to the importance of cultural-competence within the occupational therapy profession. As identified through

the literature, cultural competency skills must be continually developed to meet the demands and standards of service delivery for the diverse populations of the United States. Education of the Caucasian female dominant culture about other cultures is of primary importance to assure that the most optimum care possible is being provided to clients.

Suarez-Balcazar et al. (2009) examined how occupational therapists perceived their own level of cultural competence. According to their survey results, one of the greatest influencing factors on cultural competence was the therapist's attitude towards cultural competence. To be able to provide cultural competent care, the therapist first needs to be open to the idea of being influenced by and accepting of other cultures. Steed (2010) examined the beliefs and attitudes of occupational therapists within the culturally diverse state of Louisiana. The author found that after completing a six-hour cultural competency workshop, where disparities of the African American population was addressed, only three of the 13 white female occupational therapists indicated that they would actively advocate for the African American population located within their state. This coincides with the Suarez-Balcazar et al. (2009) study, which highlighted the reality that if occupational therapists do not feel that cultural competence is an important factor for providing service, their attitude will not reflect this skill as being essential.

Abreu and Peloquin (2004) published a reflective article that discussed the positive idea of occupational therapists being able to embrace diversity within and as a part of the occupational therapy profession, where the "central aim is to propose an

appreciation of difference" (p.353). The authors highlight how important it is to appreciate and respect the cultural differences, but also to look past the differences and see the similarities that connect the occupational therapist to their client, (Abreu & Peloquin, 2004, p. 356). Those occupational therapists that develop respect and find a connection between themselves and their clients will be able to provide the highest standard of client-centered care.

Current Multicultural Trends and Requirements within Schools

One of the first steps for an occupational therapist to develop cultural competence is by becoming aware of this essential concept during their higher education experience. Black and Wells (2007) describe multicultural education as a broad and comprehensive notion, meaning that providing multicultural education is not a simple task. To provide multicultural education, Black and Wells (2007), state "It [multicultural education] means learning about, preparing for, and celebrating cultural diversity" (p. 59). One of the most interesting factors that Black and Wells (2007) discuss is that multicultural education needs to encourage all learners to learn about different cultures and enrich their lives with the new knowledge. For a student to truly embrace, celebrate, and feel enriched by multicultural education, they will have to be shown the way by a professor who is open to multicultural education and feels the importance of providing this guidance.

Brown, Munoz, and Powell (2011) surveyed occupational therapy schools within the United States and described the multicultural training that takes place within occupational therapy programs. The factors of diverse teaching methods, most often

taught skills, and the challenges that the schools face were discussed to give a better understanding of what takes place within this educational aspect. The main challenges Brown, Munoz, and Powell (2011) identify within the school setting are providing actual exposure to different races and ethnic groups, and finding the time to try to develop and provide exposure to multicultural situations. D. Pope-Davis, Prieto, Whitaker, and S. Pope-Davis (1993), examined the different educational levels that influence practicing occupational therapists, including the level of their degree and if they had taken any multicultural course work or seminars. The findings of both of these studies support that working with those of different racial or ethnic backgrounds and taking multicultural coursework increases the cultural competency of occupational therapists.

The idea of experiential learning is a concept that supports the development of cultural competence, but is challenging to achieve. According to Brown, Munoz, and Powell (2011), the amount of time that it takes to organize and follow through with a community or self-directed outing limits the ability to plan and implement experimental learning opportunities. D. Pope-Davis, Prieto, Whitaker, and S. Pope-Davis (1993), state "enabling students to gain experience in working with persons who are racially or ethnically different during their clinical training may also enhance their multicultural awareness before they engage in professional practice" (p. 842). The ability of occupational therapy schools to provide this experience is limited; this means that developing cultural competence needs to be an ongoing, self-driven process. According to Black and Wells (2007), "It [cultural competence] is dynamic and develops overtime"

(p. 33). It is essential for the occupational therapy practitioner to take responsibility to achieve cultural competence within, to better serve the population that they work with.

Murden et al. (2008) investigated occupational therapy students' perceptions using a self-rated score. Within the results "nearly 90 percent strongly agreed that cultural influences are important in occupational therapy" (Murden et al., 2008, p. 195). Within the same study, entry-level therapists supported the idea that working with diverse clients would be the most beneficial way to increase their confidence in their ability to provide cultural competent care. Hawala-Druy and Hill (2012) examined the educational aspects of millennial students within the development of their cultural competence. One aspect that this group of students found important was having an understanding of their own culture. This may be the first step in developing cultural competency, not starting with the important aspect of working with diverse clients like Murden et al. (2008) found, but starting with the culture of the student for an understanding of the personal importance of culture. This understanding may then make it possible for the student to understand the importance of culture to others.

Cultures Involvement in Treatment Planning Decisions

According to Abreu and Peloquin (2004), human occupation is diverse and this aspect of diversity needs to be taken into consideration for occupational therapists, especially due to the fact that occupation is the foundation of occupational therapy. The profession of occupational therapy focuses on the occupations that the clients need and want to complete. Understanding that the client's diverse occupations are often developed around their culture is essential to providing true client-centered care.

Bonder, Martin, and Miracle (2004) also address the importance of considering culture when looking at occupation. To have an occupational therapist ignore the aspect of culture when implementing occupation based interventions will lead to low rapport and a lack of open communication between therapist and client. Daily activities that people employ are learned or developed by the culture(s) that influenced their development.

Bonder, Martin, and Miracle (2004) state, “a client’s choice of activity level, engagement in particular occupations, and perceptions about the value of particular occupational outcomes are all influenced by his or her cultural beliefs” (p, 165). Research solidly supports that a client’s culture influences their occupations, but it is not well documented how occupational therapist take into consideration a client’s culture when developing treatment plans. Munoz (2007) discussed how the practitioners that he surveyed and interviewed discussed why it was important to have interventions that were recognized by the client’s culture. To incorporate the client’s culture within the therapy interventions, a greater rapport will be built between client and therapist.

The purpose of this study is to determine if the knowledge that is gained in occupational therapy school regarding culturally competent clinical care is actively developed and applied while practicing in the field of occupational therapy. AOTA (1995) refers to cultural competency as a process that is actively developing while working with cultures that are different than the therapist's own. This study seeks to determine if culture is indeed a part of the occupational therapy process in therapists' continued competency and treatment plan development. The researcher of this study anticipates that occupational therapists will be aware of the cultures that they work

within, but will not be aware of the degree to which culture influences their clients, or consistently involve cultural influence in treatment planning decisions.

Chapter III

Methodology

Overall Research Design

The purpose of this research study is to determine two aspects of cultural awareness in occupational therapy, that of the educational training received by students in occupational therapy programs, and how that training then translates into culturally competent treatment. To address these two aspects, the researcher determined that a mixed methods design was necessary to collect data for each aspect of the research question. A quantitative survey gained baseline information regarding education and knowledge related to client-centered care, and culturally competent care. The interview phase of the research design provided expressive qualitative data related to application of skills and knowledge in creating a multicultural treatment environment.

The quantitative data that was collected in the survey provides baseline statistical data on the educational content taught in each participant's training. The survey also collects information on the practicing therapist's understanding of what client-centered care entails and if the therapist considers the client's culture as a part of their understanding of client-centered care. The survey was designed utilizing a Likert scale with responses on a range from "not at all", "slightly", "usually", "most of the time", to "always". Short answer questions were also included within the survey to gain an understanding of why the respondents choose the specific range on the Likert scale.

This additional narrative detail with the survey provided an opportunity for greater detail of information.

The second phase of the project was designed as a semi-structured phone interview, with one therapist at each of the seven hospitals represented. Those who volunteered to participate in the interview returned their contact postcard along with informed consent in a separate envelope from the survey data to assure confidentiality and minimize interviewer bias. The interviews determined ways that the occupational therapist addressed diversity with their clientele, skills that they had developed in practice, and the greatest challenges regarding diversity that they face on a daily basis. This data was coded thematically in relation to the implementation of culturally competent care.

Sources of Data

The inclusion criteria for this study were registered occupational therapists and certified occupational therapy assistants at seven specifically selected hospitals located in the Southwestern United States. The hospitals include Watsonville Community Hospital, Watsonville, CA; Fallbrook Community Hospital, Fallbrook, CA; Mimbres Memorial Hospital, Deming, NM; Mountain View Regional Hospital, Las Cruces, NM; Oro Valley Hospital, Oro Valley, AZ; Northwest Hospital, Tucson, AZ; and Deaconess – OKC, Oklahoma City, OK. The gatekeeper at each facility, generally the Chief Executive Officer (CEO), was contacted to gain approval to utilize facility employees. An approval letter was obtained from the CEO of each facility as requested by the Institutional Review Board at UND. After approval was obtained from each CEO, the Rehabilitation Director

at each facility was contacted for confirmation that approval had been given to the researcher of this study to contact the OTR's and COTA's at each approved facility. The Rehabilitation Directors then provided the number of OTR's and COTA's at that facility and agreed to present the research packets containing informed consent, the survey and the request information for participation in the interview, to each staff therapist.

Institutional Review Board Certification

The Research Study Approval Certification from the Institutional Review Board (IRB) at the University of North Dakota was received on August 8th, 2012, after completing the requirements set by the IRB Board. This research study was approved as "exempt" due to the fact that no vulnerable populations were utilized in the research, and risk to participants was determined to be minimal. Six of the seven hospitals did not require IRB for this research project. One hospital required completion of a facility IRB, which was granted approval on May 15th, 2012.

Locale of the Study Prevalence and Demographics of Diversity within the Regions

The location of this study was the Southwest region of the United State, specifically Arizona, New Mexico, Oklahoma, and the southern part of California. The specific hospitals that were selected for this research study were available to the researcher through the initial gatekeeper of this study, who provided access to the CEO of Community Health Systems, the parent company of the participating seven hospitals. All participants were employees at the seven hospitals identified above. The hospital locations were taken into consideration due to the cultural diversity identified through U.S. Census data within that facility's geographical location. The participants were

chosen in these locations due to the high probability that they experience frequent clinical work with diverse cultures. The demographics of each town and state where the seven hospitals were located were identified with regard to their population, the ethnic demographics, and the race demographics.

In the state of California, the facilities selected were located in Fallbrook, and Watsonville. According to the 2010 United States Interactive population map, the population of Fallbrook, California is 30,534 people with the largest race being white at 20,054 residents. When ethnicity is looked at for this city, the Hispanic or Latino population is 13,800 and the "not Hispanic or Latino" population at 16,734. The map identifies that there are 6,254 Caucasian European White residents within the community and that the percentage of Hispanic population is 45 percent. In comparison, the overall population of Watsonville, California is 51,199 residents. The largest race in Watsonville is "some other race" at 23,844. The largest ethnicity is Hispanic or Latino at 41,656 residents, with the not Hispanic or Latino population at 9,543. When comparing the two cities, Fallbrook has a lower population density, with a higher percentage of European White residents, while Watsonville has 20,000 more residents, with a much larger Hispanic or Latino population, at 81 percent of the total population of the Watsonville community. Watsonville shares the large Hispanic or Latino population with the two New Mexico cities (U.S. Census Bureau, 2010).

Las Cruces, New Mexico and Deming, New Mexico were selected as locations for this state's representation in the study. Las Cruces, New Mexico is the second largest city within the state of New Mexico. According to the 2010 United States Interactive

population map, the population of Las Cruces is 97,618 residents, while the total population of Deming, NM is 14,855. The most represented race in both communities is White. Las Cruces' population of Caucasian residents is 73, 513 from the total population (U.S. Census Bureau, 2010).

When the ethnicity of Hispanic or Latino is taken into consideration there are 18,070 Caucasian residents within the community of Las Cruces. When examining the demographics for Hispanic or Latino residents, Las Cruces has 55,443 Hispanic or Latino residents, which accounts for 56.7 percent of the total population. The Caucasian population within Deming is 11,383. When compared to the Hispanic or Latino population, only 1,193 of the population identifies as Caucasian. Overall, the Hispanic population accounts for 68.5 percent of the population in Deming (U.S. Census Bureau, 2010).

Tucson, Arizona is located within 20 miles of Oro Valley, Arizona, and although the cities are geographically close, they have very different racial and ethnic demographics. Tucson is the second largest city within the state of Arizona, with a total population of 520,116 residents. Oro Valleys' total population is 41,011, and the largest race sector being White with 36,825 persons self-identifying. Those identifying as Hispanic or Latino is 4,731; this means that the Caucasian ethnicity is the largest population within Oro Valley, AZ at 88 percent (U.S. Census Bureau, 2010).

Within Tucson, however, the largest race sector is also White, at 363, 649 residents. When looking at the self-identified ethnicity of Hispanic or Latino, this group comprises 216,308 of the total population. These numbers indicate that the Hispanic or

Latino population accounts for 41.5 percent of the total population (U.S. Census Bureau, 2010). Oro Valley is considered a suburb of Tucson, which explains the close proximity of the two towns. It is interesting to see the difference in ethnicity within such a close proximity.

Overall, the demographics of Oklahoma are the most variable when compared to the other locations include within the study. Oklahoma City, Oklahoma has the largest overall population within any of the cities utilized, at 578,999 residents. Self-identifying Caucasians account for 363,646 of the total population. The Hispanic or Latino ethnicity of Oklahoma city self-identifies in 100,038 residents, which makes the Hispanic or Latino population 17 percent of the total. This indicates that Hispanic or Latino is the second largest racial or ethnic group within Oklahoma City; the third largest racial group is self-identified as the African American, with 87,354, or 15 percent, of the total population. This information from the 2010 United States Interactive population map shows that the two minority groups of Hispanic or Latino and African American are similar in size within this large city (U.S. Census Bureau, 2010).

The specific demographics of each location found within the study are variable in the population size, and within the racial and ethnic demographics. The one commonality is that each location had a sizeable population of minority representation. Due to the location of the hospitals in the study, this minority representation was most often the Hispanic/ Latino populations.

Population/Sampling of Quantitative Survey

The populations surveyed within these hospitals were all registered occupational therapists or certified occupational therapy assistants, as determined by the inclusion criteria. This population was of interest due to the diversity located within each state in which they practice and the high likelihood that there would be active multicultural awareness within the facility. Cluster sampling was conducted, as all occupational therapists and occupational therapy assistants within the identified facilities were asked to participate.

Population/Sampling of Qualitative Interview

The population of the interview was comprised of volunteers who had completed the survey at one of the identified facilities, and who agreed to be contacted for an interview. The therapists who returned the signed informed interview consent and the contact postcard were randomly selected to participate in the interview from the total pool of volunteers at each individual facility. While randomization was conducted inside of each facility pool, quota sampling served as the overarching sampling method to assure a study representative from each facility in the interview phase.

Instrumentation and Data Collection

The materials provided for the study were comprised of a packet that contained the quantitative survey, the survey informed consent, a contact postcard for interview volunteers, the interview informed consent, mailing envelopes for both the survey and the interview volunteer contact, and an introduction letter to the project. Once the

number of occupational therapists was determined at each facility, packets were sent directly to the Rehabilitation Directors for distribution to staff therapists. The purposive sampling survey contained general demographic questions, Likert scale questions, and open-ended questions, to gain an understanding of why the respondents choose the specific range on the previous Likert scale response. The survey content was designed to establish baselines of education, continued competency, and the therapist's general idea of how often they provided cultural competent client centered care. Within the informed consent, the subjects were informed of the purpose behind collecting the data and how the data would be used.

The data collection for phase 2 started with the contact postcard. On the contact postcard, the participants were asked to provide their name, telephone number, and email address. If they filled out the contact postcard, they were also required to sign and return the interview informed consent. In the interview informed consent, the participants were informed of how the interview data would be utilized. The data from the interviews was used to gain a greater understanding of how practicing occupational therapists and assistants utilize a client's culture in development of treatment plans and in providing client-centered care. The interviews were completed over the phone, with the researcher using a university issued recording device to be able to record the interviews for later transcription and coding.

A validity measure of the research project was the confidentiality measure in handling the survey data, informed consent between the surveys and interviews, and separation of the survey data and volunteer contact information for the interview. By

first completing a pilot study of the survey tool, the researcher could have increased the validity of the project. This would have helped ensure that each question asked would have been creating the desired response. Stratified random sampling was used on the returned contact postcards to increase the validity. The validity of the interview participants was increased through this process, with all randomly selected subjects being registered occupational therapists.

The reliability was stable within the research project due to the design of the survey and the semi-structured interview questions. Each participant was sent the same survey, and each person who was interviewed was asked the same questions. The interview was semi-structured was due to allow the researcher to ask follow-up questions providing the subject an opportunity to elaborate on an idea. However, all interviews were conducted by the study researcher solely, for increased inter-rater reliability in the application of the interview process. The reliability was also consistent due to the requirement that the participants being registered occupational therapists or occupational therapy assistants working for the same hospital structure.

Tools for Data Analysis

The data collected from phase 1 from the surveys, all Likert scale questions, were given a code of 1 through 5. Similar codes were given to all the other questions, except for the final question, which asked the respondents to circle aspects of culture. The data from the final question was collated and distributed into a pie chart to visually display the most prominent aspects of culture that the respondents identified.

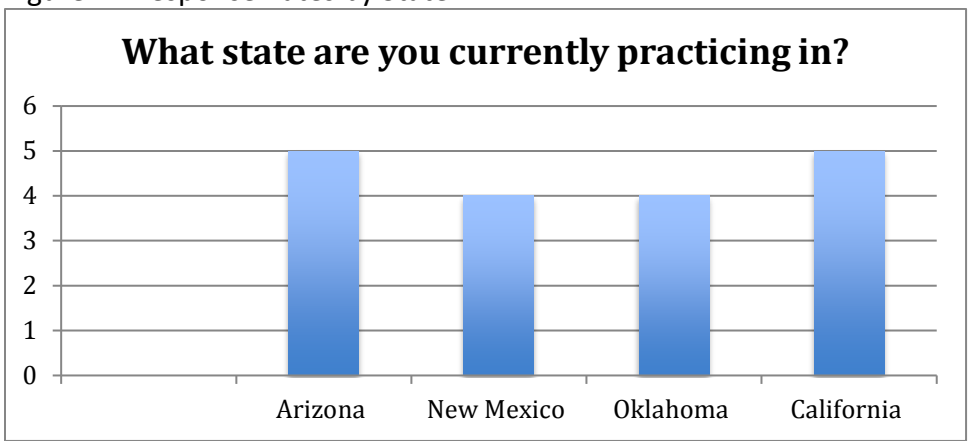
The data collected from the interviews was transcribed and then sorted into thematic codes. These codes were broken up into three main categories. Once the codes and categories were identified, the patterns that influenced the codes were placed into the coding table. Once all data had been placed into the table, the development of the study assertion was possible.

Chapter IV

Results

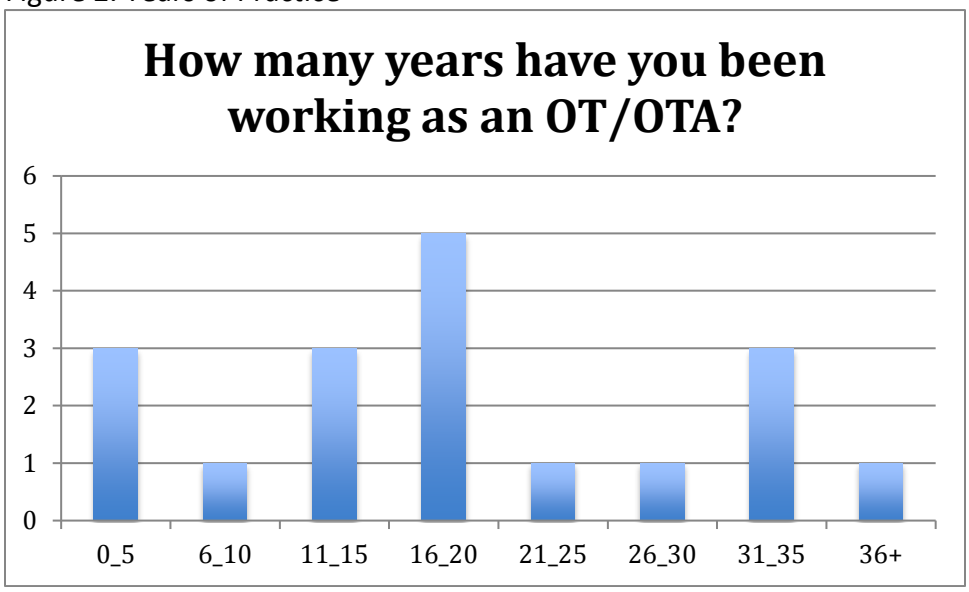
The quantitative survey was sent to 7 hospitals in the CHS Community Health System in August of 2012. 18 respondents returned surveys between September and December, 2012, for a return rate of 45%. One additional survey was returned in March, 2013 and was not included in the data analysis.

Figure 1. Response Rates by State



Arizona, 29% of contacted therapists responded to the survey.
New Mexico, 80% of contacted therapists responded to the survey.
Oklahoma, 40% of contacted therapists responded to the survey.
California, 62.5% of contacted therapists responded to the survey.
Overall, the survey response rate was 45%.

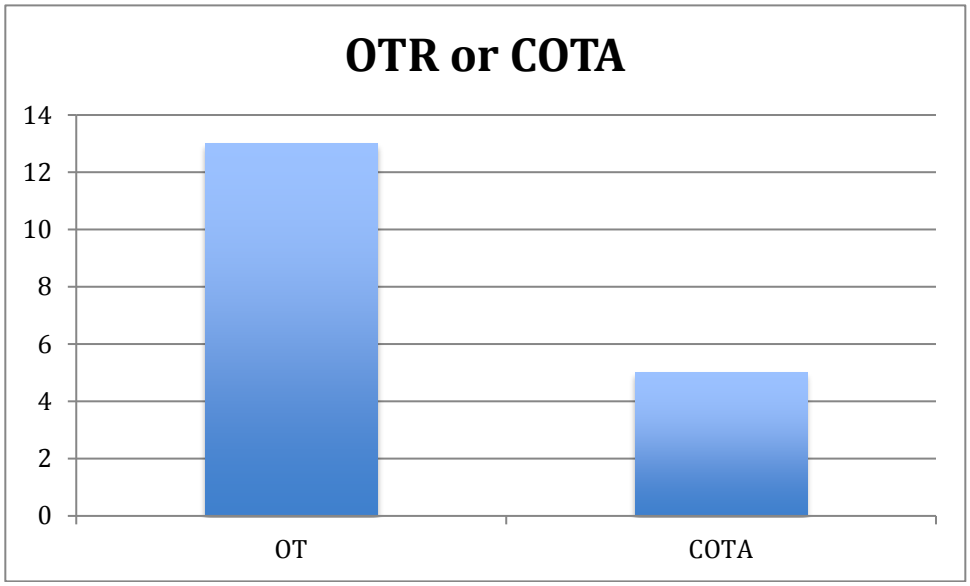
Figure 2. Years of Practice



Out of the 18 respondents, 66% had been working for less than 20 years.

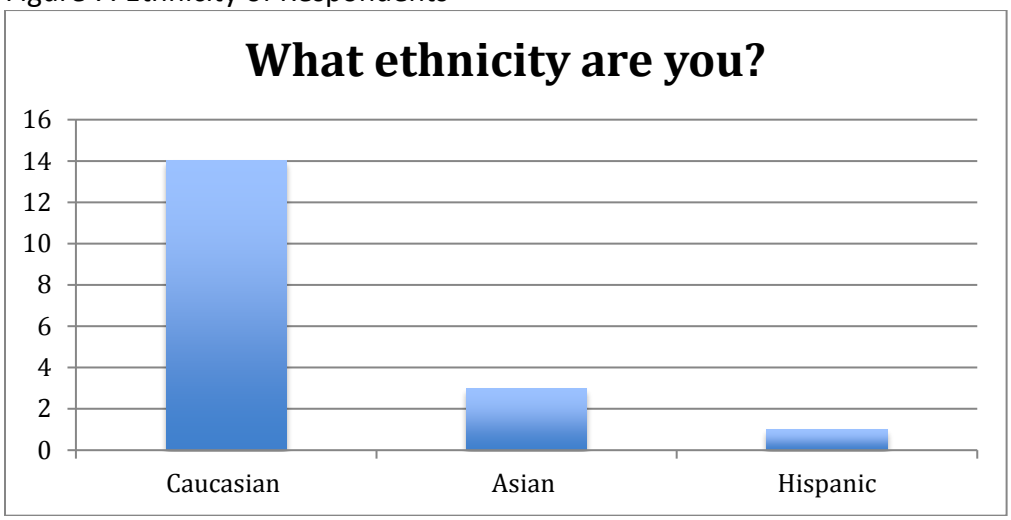
Question 3-Question 6 examined the school the respondents attended for their professional training and if they were specialized within any area of occupation therapy. Their professional credentials were requested.

Figure 3. Percentage of OTR and COTA



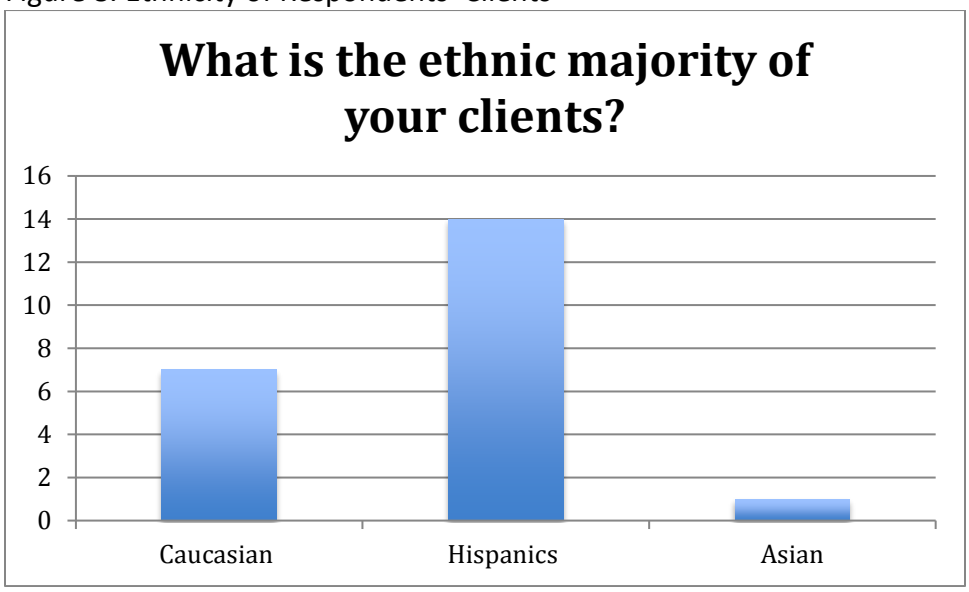
Out of the 18 respondents, 72% (13) were occupational therapists. The remaining 28% (5) were occupational therapy assistants.

Figure 7. Ethnicity of Respondents



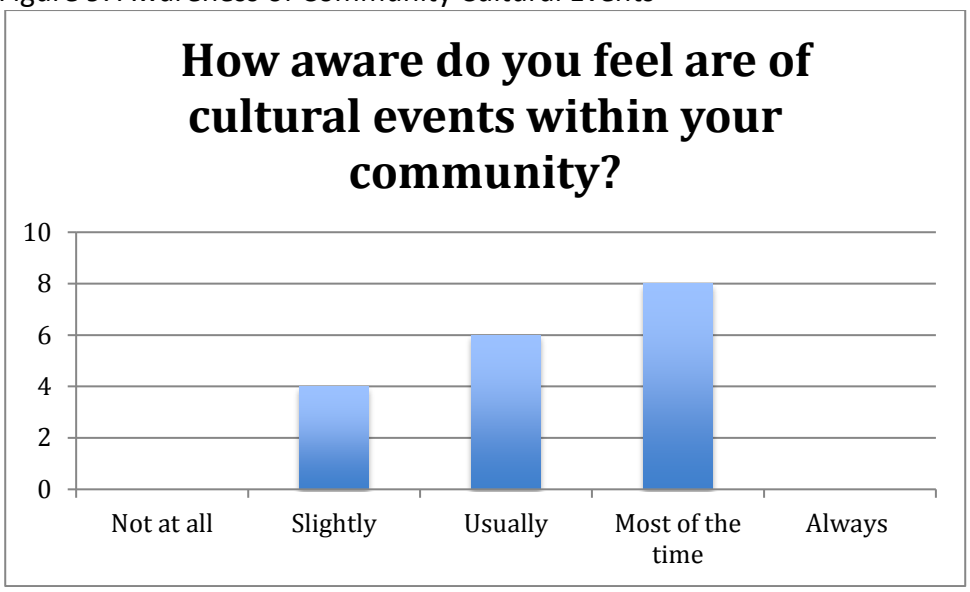
77.7% of the respondents were Caucasian, representative of the ethnic make-up of the profession as a whole.

Figure 8. Ethnicity of Respondents' Clients



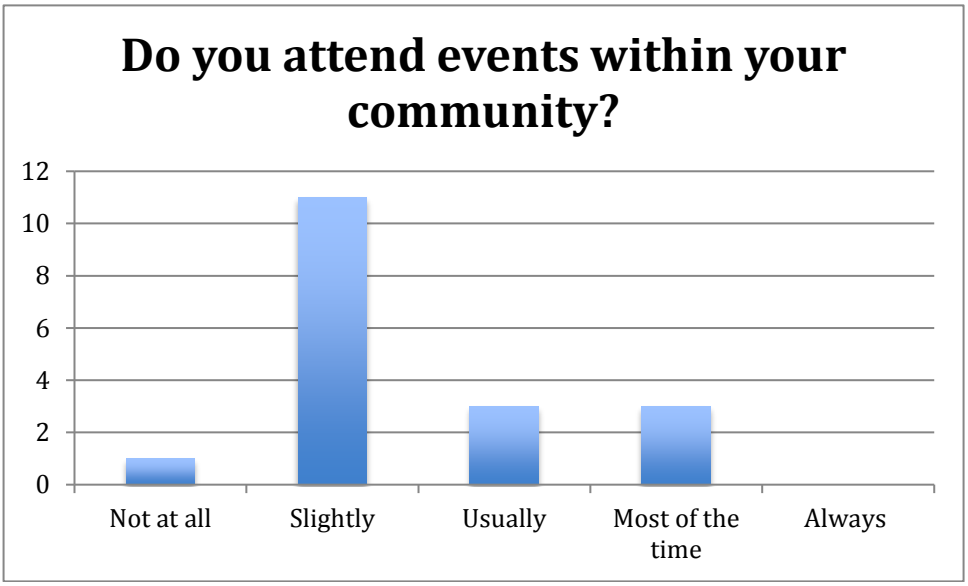
Six respondents identified both Caucasian and Hispanic clients, resulting in 22 reported ethnicities in 18 total respondents.

Figure 9. Awareness of Community Cultural Events



44% of the respondents were aware most of the time about a cultural event within their community. 56% identified that they were slightly to usually aware, indicating that less than half of respondents actively noticed the cultural activities available.

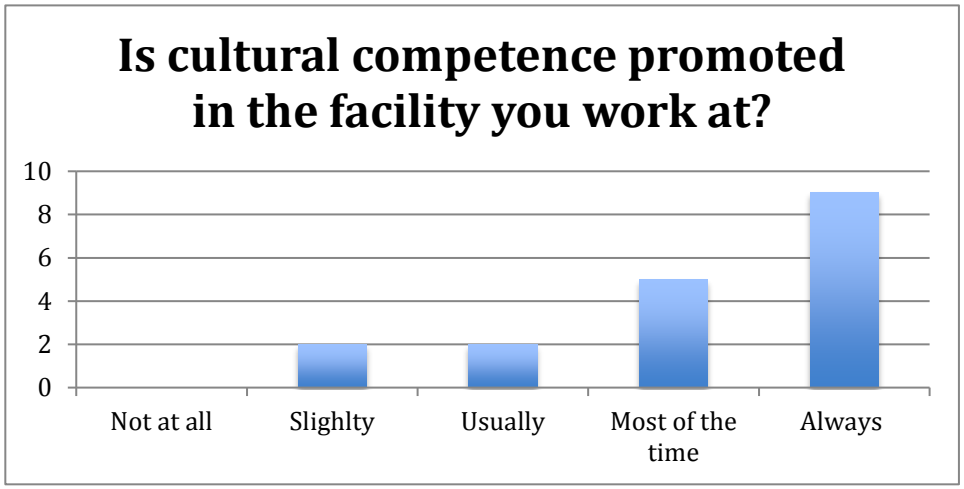
Figure 10. Attendance at Community Cultural Events



Although 44% of participants identified that they were aware of cultural events within their community, only 16% identified that they actually attended the events most of the time.

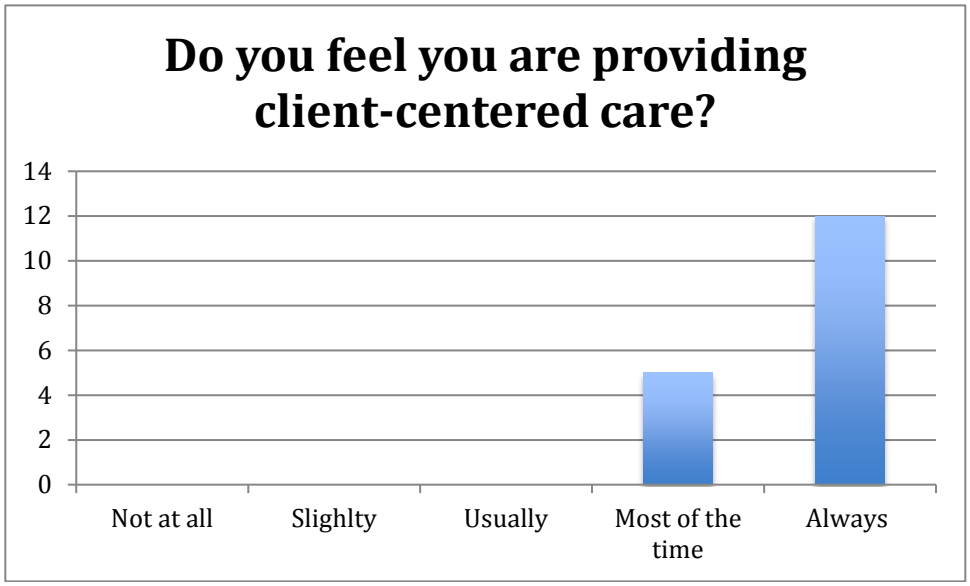
Only 3 respondents said they knew about cultural events (question 10) most of the time and attended most of the time as well.

Figure 11. Facility Promotion of Cultural Competence



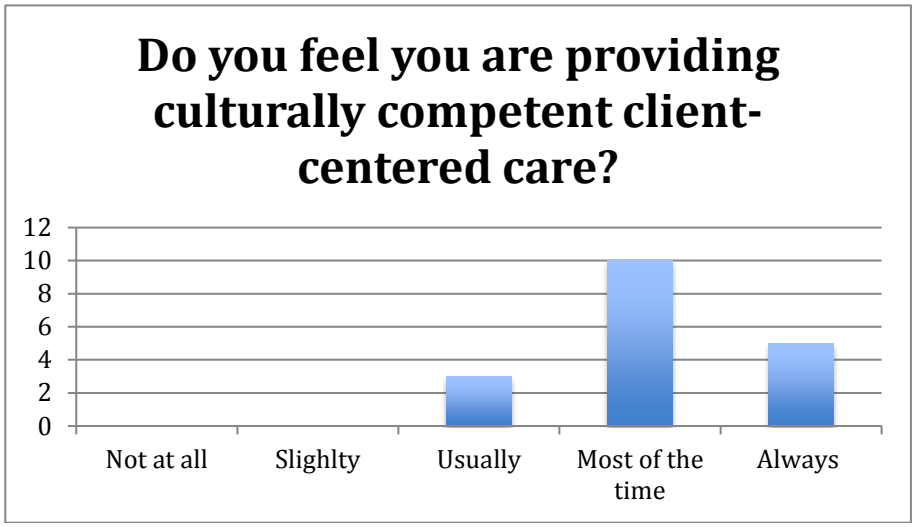
50% of respondents reported that cultural competency was always promoted at the facility they work at, with the most common example being yearly cultural competence quizzes required for facility compliance.

Figure 12. Provision of Client-Centered Care



66% of respondents felt that they are providing client-centered care “always”, and 34 % “most of the time”. No therapists indicated that they failed to provide client centered care.

Figure 13. Provision of Culturally Competent Care



In comparison to the previous question, only 41% of respondents felt that they were always providing culturally competent and client-centered care. This is a decrease of 7 respondents who report “always” when providing client-centered care alone. Because the AOTA Practice Framework definition of client-centered care includes a client’s culture in treatment planning, those who answered “always” for client-centered care in the previous should also have indicated “always” for culturally competent care provision.

Figure 14. Aspects of Culture

Respondents identified that all factors presented in the survey were aspects of culture, but surprisingly, “Food and Diet” were least identified by respondents. As food and diet are significant aspects of both treatment planning and cultural consideration, it is surprising for this aspect to be minimized in participant responses.

Phase I

Quantitative Survey Summary of Data

Out of the 50 percent (9 respondents) who responded supporting culturally competent care, seven out of nine came from urban schools, three out of the nine were a self-identified minority, and seven out of nine had graduated within the last twenty years. Out of those 50 percent who did not link client centered care and culturally competent care, eight of nine were Caucasian, five of nine graduated from urban schools, and five of nine graduated within the last 20 years.

Within the data collected from the quantitative survey, questions nine and ten were designed to gain an understanding of the therapist's comprehension of client-centered care. True client-centered care takes into consideration a client's culture in all aspects of treatment design and implementation. As both questions asked were designed on the same Likert scale, responses between the two questions should have been consistent. 9 of the 18 respondents provided the same response to both questions, indicating both client-centered and culturally competent care was provided routinely. Six of the remaining 9 participants indicated that they always provide client-centered care, but only most of the time did they provide culturally-competent care. The last three participants stated that most of the time they provided client centered care with only usually providing culturally competent care. Statistically, this indicates that only 50% of the time clients are receiving both client-centered and culturally competent care.

7 of the 9 respondents who indicated that they include cultural considerations in treatment have been in the workforce for less than 20 years. This then supports the assumption that those who have more recently entered the work force have benefited from the increased awareness of cultural diversity, which is required through the addition of multicultural ACOTE standards to educational programs beginning in 1991.

Survey data also indicated that attending cultural events within the community did not increase the correlation of the therapist providing the same level of client centered care with cultural understanding. Out of the eighteen respondents, only three stated that they slightly attend events, with the rest stating that they usually or most of the time attend cultural events. There was not an increase in culturally competent care provision with attendance at cultural events.

Phase 2

Qualitative Interviews Summary of Data

The qualitative data gathered through the six semi-structured interviews was coded to identify common themes. The researcher identified four prominent categories: the importance of rapport, interviewing techniques, and the self-fulfillment achieved from learning about and interacting with other cultures. The fourth theme, barriers, was identified by participants as including time to develop rapport, and policies that limit inclusion of cultural considerations.

With regard to the development of the theme on rapport, the participants were asked if they felt that providing culturally competent care influenced a client's outcomes. All six participants stated that they did believe that successful outcomes

were influenced by culturally appropriate care. Along with rapport, the notion of trust also developed as an aspect of successful treatment. Participants indicated that taking the client's culture into consideration helped the development of trust within the therapeutic relationship. When asked to elaborate, the aspect of rapport was prominent within their responses:

> Participant 1: First, I think it builds rapport with your patients and then when there is rapport there seems to always like be a better response to the treatment or them following the instructions or the home exercise program that you give them. It also builds empathy, like, for you and as well for the client. They seem to be able to feel that you are invested in their care.

Participants, when asked about the most beneficial skill they have developed when providing culturally competent care, discussed the theme of aspects and techniques of interviewing clients during the evaluation process. The skills of listening, asking questions, and developing good communication with clients were all discussed throughout the interviews. The difficulties, as well as the rewards involved in interviewing clients, were addressed:

> Participant 6: I would say over the years you become more comfortable with your interview techniques and trying to get to know people and building a rapport and to get that information that you need to apply. You can interview family, you can interview them, you can ask them

questions so that they can kinda help you through it, because, you know, we are constantly learning about different cultures and so we don't know it all and we don't come out of school knowing everything. So being able to, well, I am just more comfortable talking to the patient and the family and letting them tell me if I am stepping over any lines, that I need to be more conscious about something.

Participant 2: Actually listening. By listening you can learn a lot more then talking. If you take time to listen, you can also pay attention and learn some of the customs, some the different ways, how a certain ethnic group interacts with each other and outsiders. That way you don't upset anybody, you know, you are basically being respectful and that's how I actually learn a whole lot, just by sitting and listening and watching instead of just diving in and creating problems.

When asked to discuss the most rewarding aspects and what the participants liked best about working with a culturally diverse clientele, many participants stated that they felt that working with diverse clients was a self-fulfilling aspect of their job. The chance to work and learn about cultures that are different than their own was identified as intrinsically rewarding. Participant 2 discussed the personal benefits of learning about another culture and being able to learn a new language; this not only increased his ability to provide better care to his Spanish speaking clients, but also provided a way for him to grow personally. Participant 3 identified that learning about

other cultures was something that she enjoyed so much that she viewed it as a selfish aspect:

> Participant 3: I think it is selfish in some ways, you know, I like to learn about other peoples' cultures…for me I think it's about the fact that it allows me to expand my comfort zone and allows me to see a bigger world, whether it be language, or beliefs, or values. I really enjoy it, so I guess maybe it's more selfish than anything else.

The chance for the participants to grow personally from working with diverse cultures was consistently evident throughout the interviews. Another common thread identified was that the diversity was something many of the interview participants enjoyed, but they also acknowledged the fact that the diversity was at times the most challenging part of their job.

> Participant 4: Greatest challenge…again I think if I don't speak the primary language that the patient speaks, that is the biggest challenge in itself because it slows down what it is you are trying to teach them and their understanding of what we are trying to accomplish…not speaking the language is a big issue; you can always try to use an interpreter, but it's just not the same.

The greatest barrier identified by participants in gathering the essential information during the evaluation process is time. Participants discussed how the ability

to find out significant and meaningful cultural information about a client takes more time. The need to structure and to ask appropriate questions and to be to develop the rapport that leaves a client feeling comfortable enough to answer more personal questions requires a significant time investment that the setting may not allow for. Participant 6 discussed the frustrations of having limited time:

> Participant 6: No, I think unfortunately we are put in a position where we don't have a lot of time, sometimes to get the patients as much time as they need, to develop the rapport…unfortunately in the clinics and the hospitals we only have 50 minutes and we have to get in, get what we need, and get out, so you don't get to do it as well as you probably want to.

Also identified as a barrier were those policies inside the organization that limited a therapist's ability to incorporate cultural considerations into treatment, which then lead to a limit on the rapport development, and ultimately the success outcomes of the client. Participant 6 addressed a specific example where organizational policies conflict with a client's cultural concerns:

> Participant 6: You live and learn; you need them to do things but you have to take into consideration what is really important to them and also what the doctor orders, so you have to be able to mesh together what the doctor is asking you to do and what the hospital is asking. I mean everyone has to get bathed, but what if they have not really done

> any of that in a long time. Sometimes you meet people who only bath once a week and they might not smell very good and people are telling them they need to bath, but they are saying “I don’t do it that way”. Well? Do we do what they normally do at their home or do we follow the guidelines where they have to so some type of bathing?

Overall, the occupational therapists who agreed to participate in the interview phase unanimously expressed how much they enjoy and benefit from working with cultures different than their own. These results were not surprising to the researcher, as it was assumed that those who were most interested in cultural-competence would agree to participate in the study and provide the time to be interviewed.

Chapter V

Conclusion

Limitations

The study contained two issues related to sample size. The return rate of 45% was satisfactory, but below the 60% goal set for the study. An additional survey and an additional volunteer for the interview phase were received in March 2013, after the data analysis was complete, and were not included in the data sets. While multiple attempts were made to contact the participating facilities, limited response was seen from Oklahoma, which also constituted the largest representative therapist population of the study. Additionally, the intent of the interview portion was to randomly select a participant from each facility. This goal was achieved with 6 of the 7 hospitals, but no participants volunteered from the last location. To increase the validity of the study, a therapist from each facility would have been preferred for interview. All seven hospitals are also a part of the same health care system, Community Health Systems (CHS). Hospitals inside of this system require staff to complete an online multicultural training, and hospitals within other health care systems could have different requirements for multicultural continued competency; inclusion of additional facilities outside of this system would alter the data gathered from the surveys and interviews to increase the potential for generalization of the findings.

Another limitation identified within the study was the necessary development of the interview questions prior to gathering the quantitative data from the survey. To meet the requirements to gain IRB approval from UND, all documents and questions that were to be addressed with the participants needed to be included in the initial IRB documentation. Breaking the research into different phases for the IRB would have been beneficial, as the researcher would have developed the interview questions more strongly from the data gained from the quantitative survey.

Summary of Findings

Overall, the study supported the fact that occupational therapists are taking into consideration a client's culture within their practice, but are more likely to provide consistent attention to culture if they have graduated since 1991. Clinicians who have graduated prior to the inclusion of the 1991 ACOTE standards indicated on the survey a lower rate of cultural competency and culturally aware service provision. Clinicians at all levels of graduation in relation to the 1991 ACOTE standards indicated that exposure to diverse client populations resulted in strong culturally based outcomes with clients due to prior clinical experience. Techniques the participants indicated that were related to interviewing, active listening and question development regarding diverse cultures resulted in stronger rapport with diverse clients. Lack of time to interview and develop rapport was identified as a significant barrier to incorporating culture into treatment planning. An additional barrier of conflict between organizational policies and a clients' culture also resulted in limited cultural consideration in treatment.

The quantitative data supports the assumption that therapists located in the Southwestern states are aware of cultural competency, but that there is still a disconnect between the awareness of cultural competency and delivery of true client centered care. The CHS system requires that staff complete a yearly computer based program that is required in all facilities inside the system; despite this training, clinicians still struggle to identify that cultural competency is consistently included in treatment decisions.

The qualitative data provided insight into the aspects of working with a diverse clientele. All six participants interviewed discussed how working in a diverse setting was highly personally rewarding to them. Those interviewed also expressed the personal benefits of working in highly diverse contexts while also acknowledging that the aspects they enjoy are also at times the most challenging features in client work. Four main themes were identified from the interviews. The importance of rapport, interviewing techniques, and the self-fulfilling desire to learn about other cultures were the main categories that the participants identified, with the fourth theme, barriers, being identified by participants as time for rapport development and organizational policies that limit cultural inclusion.

Conclusion

The findings of this study imply that there has been an increase in providing multicultural training within occupational therapy schools and within work contexts within the last 20 years. Occupational therapists within the Southwest region of the United States are aware of the importance of culture in relation to providing care to

their clients. However, only half of the participants surveyed demonstrated that they understood that providing client-centered care required taking into consideration a client's culture. With only 50 percent of those surveyed supporting this point, this study suggests that continued cultural competency training is essential within occupational therapy schools and within all work environments. There is a possibility that exposure and experience compensate for these limitations, but more research would need to be completed focusing on this aspect.

Recommendations

In addition to the requirement of meeting the current ACOTE standards, it is important for educational programs to include multicultural education that exposes the student to diverse populations through direct application in the curriculum. Educational programs must provide curriculum related to culturally appropriate interviewing and active listening skills development with regard to time constraints and policy implications in the clinical setting. Employers must emphasize cultural competency and provide an environment that supports continued cultural competency and client-centered care. It is essential for therapists to be provided enough time for development of rapport and inclusion of cultural considerations when working with clients. This time is difficult to come by in fast paced occupational therapy settings, and would need to become a priority for companies to provide the necessary time to gather essential information. Further research recommendations include examination of the role that the therapist's dominant culture plays in relation to their provision of culturally competent care. Additionally, examination of cultural competency as it is observed

from the standpoint of the clients is recommended. Finally, expansion of the study to include other regions and examinations of rural vs. urban settings is desirable.

APPENDICES

APPENDIX A

Quantitative Independent Survey
Phase I

1. What state are you currently practicing in:

☐ Arizona ☐ New Mexico ☐ Oklahoma ☐ California

2. How many total years have you been working as an OT/OTA:

☐ 0-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-25 ☐ 26-30 ☐ 31-35 ☐ 36+

3. What occupational therapy/occupational therapy assistant school did you attend and in what state?

_____

_____ _____
Name of School State

4. What year did you graduate from occupational therapy/ occupational therapy assistant school?_____

5. Is there an area within the field of occupational therapy that you are specialized in?

_____

6. What are your professional credentials?

_____

7. What ethnicity are you?

---

8. What ethnicities do you work with?_____

Majority? _____Minority?

_____

9. How aware do you feel you are of cultural events within your community?

Not at all Slightly Usually Most of the time Always

10. Do you attend cultural events within your community?

Not at all Slightly Usually Most of the time Always

11. Is cultural competence promoted in the facility you work at?

Not at all Slightly Usually Most of the time Always

How is cultural competence being promoted at your facility?

12. Do you feel you are providing client-centered care?

Not at all Slightly Usually Most of the time Always

Please describe how you are providing client-centered care?

13. Do feel you are providing culturally competent client-centered care?

Not at all Slightly Usually Most of the time Always

Please describe how you are or why you are not providing culturally competent client-centered care?

14. What steps have you taken to learn what cultural competency entails?

15. Please circle the aspects that you feel are involved in someone's culture.

Ethnicity Religion Spirituality Language

Community Family Friends Physical environment

Gender Sexual orientation Other: _____

What aspects/skills do you think are necessary to work within your diverse population?

_____
_____

APPENDIX B
Qualitative Interview Questions
Phase II

1. Do you feel providing culturally competent care influences client outcomes? Why do you feel this way? For what reason?

2. What is the most beneficial skill that you have developed/are developing in relation to providing culturally competent care?

3. What do you enjoy/dislike about working in a culturally diverse state?

4. What are the greatest challenges in working with a culturally diverse clientele? What are the greatest rewards?

APPENDIX C

Qualitative Phone Interview Informed Consent

My name is Tracy Lord and I am a graduate student at the University of North Dakota in the field of occupational therapy.

I am asking for your participation in a research study examining provision of client-centered care specifically related to culture considerations in the development of treatment plans for occupational therapy. I am contacting your facility, and six other facilities to increase the validity of the research project.

By signing this informed consent, you agree to participate in a qualitative phone interview. Where possible, I will be randomly sampling from therapists who agree to participate in the phone interview. Participation in the interview is limited to registered occupational therapists or certified occupational therapy assistants at this facility. If you agree to participate in the interview phase, and are randomly selected, the phone interview will take approximately 30 minutes.

If you agree to participate in the short phone interview, please sign this consent form and fill out the postcard provided with your contact information. Please place this informed consent and the contact card into the provided envelope. **Please note, a separate envelope has been provided to return the phase one survey. Do not place both the survey and the informed consent/contact card in the same envelope.**

There is no foreseeable risk involved with participating in this research study. The perceived benefit is expanded research in the field of occupational therapy specifically related to culturally competent care. The researcher, UND IRB, people who audit IRB procedures, and the student advisor will have access to the data and informed consents. To increase confidentiality, each component of this research study will be stored separately in a locked storage cabinet in the office of the research advisor for three years. After three years all information will be shredded by the research advisor.

Participating in this phone interview is completely voluntary and you are able to discontinue your participation at any time. If you choose to not participate or you decide to withdraw at any time there will be consequences of any kind to you. If you are selected to participate, a $5 gift card to a coffee shop will be sent as a thank you for your time.

No identifying factors of participants will be included in the data or written analysis of this research study. Participants in the phone interview will be randomly selected where possible, and will be identified by number during data reporting and analysis. If you have questions regarding your rights as a research subject, or if you have any concerns or complaints about the research process, you may contact the University of North Dakota Institutional Review Board at (701) 777-4279. You can also directly contact the researcher, Tracy Lord at (505) 489-4514, or the research advisor, Breann Lamborn, at (307) 268-2223, if you have any questions, concerns, or complaints.

By your signature below, you agree to participate in this phone interview and have your interview responses included in the data analysis for the research study.

_____ _____

Research participant Date

APPENDIX D

Survey Informed Consent

Hello OTR or COTA,

My name is Tracy Lord and I am a graduate student at the University of North Dakota in the field of occupational therapy. You are being asked to participate in a research study titled "Understanding Culturally Competent Care in Occupational Therapy School to Providing Clinical Practice". The purpose of this study is to determine if the knowledge that is gained in occupational therapy school regarding culturally competent clinical care is applied and developed while practicing in the field of occupational therapy. AOTA (1995) refers to cultural competency as a process that is actively developing while working with cultures that are different than the therapist's own. This study seeks to determine if culture is indeed a part of the occupational therapy process in therapists' continued competency and treatment plan development. No vulnerable populations will used to complete this research study. Only occupational therapists and occupational therapy assistants are asked to participate.

If you would like to participate in the short survey please return the survey in the envelope provided. If you only want to participate in the survey, it is not required that you participate in the phone interview. If you would be willing to participate in the phone interview it would be greatly appreciated. For those therapists who are willing to also participate in the phone interview, please complete the contact postcard, and interview informed consent and return them in the separate envelope provided, separate from the survey. This will allow for increased confidentiality of your responses.

The survey is designed to take less than 15 minutes and the phone interview will be kept under 30 minutes. I understand and respect the demanding workload that is required of you and will try to take up as little of your time as possible.

If you are willing to participate in this research survey, it would be greatly appreciated, as it will further the research base related to culturally competent client centered care in the field of occupational therapy.

If you have questions regarding your rights as a research subject, or if you have any concerns or complaints about the research process, you may contact the University of North Dakota Institutional Review Board at (701) 777-4279. You can also directly contact the researcher, Tracy Lord at (505) 489-4514, or the research advisor, Breann Lamborn, at (307) 268-2223, if you have any questions, concerns, or complaints.

Thank you so much for your consideration to participate in this research study and please know that your participation is completely voluntary.

Sincerely,

Tracy Lord
(505) 489-4514
tracy.lord@my.und.edu

APPENDIX E
Introduction Letter

Dear Occupational Therapy Practitioner,

My name is Tracy Lord and I am a graduate student at the University of North Dakota in the field of occupational therapy. I am conducting a mixed method study to determine if the knowledge that is gained in occupational therapy school regarding culturally competent clinical care is applied and developed while practicing in the field of occupational therapy. AOTA (1995) refers to cultural competency as a process that is actively developing while working with cultures that are different than the therapist's own. This study seeks to determine if culture is indeed a part of the occupational therapy process in therapists' continued competency and treatment plan development.

No vulnerable populations will be used to complete this research study. Only occupational therapists and occupational therapy assistants will be asked to participate. I am sending this packet to all registered occupational therapists and certified occupational therapy assistants at your facility for potential participation in a graduate research study.

Contents of this packet include:

- A copy of the phase one survey informed consent (signature not required)
- A copy of the survey
- An envelope to mail the survey
- Two copies (one to keep and one to sign and return) of the phase two qualitative phone interview informed consent
- A postcard to send your contact information if you decide to participate in the phase two qualitative phone interview
- An envelope to mail the interview informed consent and contact postcard

If you would like to participate in the short survey please return the survey in envelope provided. If you only want to participate in the survey, it is not required that you participate in the phone interview. If you would be willing to participate in the phone interview it would be greatly appreciated. For those therapists who are willing to also participate in the phone interview, please complete the contact postcard, sign the informed consent and place them in the second envelope provided.

The survey is designed to take less than 15 minutes and the phone interview will be kept to under 30 minutes. Participants will be randomly selected for the phase two interview and not all volunteers will be contacted for participation. I understand and respect the demanding workload that is required of you and will try to take up as little of your time as possible.

If you are willing to participate in this research survey and interview process it would be greatly appreciated, as it will further the research base related to culturally competent client centered care in the field of occupational therapy.

Thank you so much for your consideration to participate in this research study and please know that your participation is completely voluntary.

Sincerely,

Tracy Lord
(505) 489-4514
tracy.lord@my.und.edu

APPENDIX F
Contact Postcard

Occupational Therapy

PHASE II RESEARCH

INTERVIEW CONTACT CARD

Please fill out the information below and place in the envelope with the Interview Informed Consent

NAME:

_____

PHONE#:

_____

EMAIL:

_____

Tracy Lord Researcher

Occupational Therapy Practitioner

Please Circle:
OTR or COTA

References

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