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A Health Care Provider Training Guide to Enhance Cultural Competency in Long-Term Care

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A HEALTH CARE PROVIDER TRAINING GUIDE TO ENHANCE CULTURAL COMPETENCY IN LONG-TERM CARE

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This Scholarly Project Paper, submitted by Julia McBrien, OTS and Ashley Prososki, OTS 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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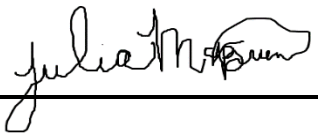

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Abstract

The population of adults over the age of 65 in the United States is steadily increasing and becoming more diverse. Older adults are the greatest consumer of health care services, and they have unique health care needs. One notable health care need pertains to cultural beliefs and wants. When health care providers address the diverse needs of older adults, health outcomes improve for the client and communication across the interprofessional team improves. Therefore, the students of this scholarly project created a series of three, 50-minute long training sessions focused on training health care providers how to be culturally competent in long-term care facilities. The sessions utilize a proven group protocol and are to be led by an occupational therapist, as occupational therapists are trained in occupation-based group process, cultural competency, and principles of teaching and learning.

Chapter I: Introduction

The students of this scholarly project were interested in cultural competency and the geriatric population. Both concepts are important not only to occupational therapy, but also to all health care professionals and society as a whole as the population continues to grow more diverse and older. The average life expectancy in the United States is 78.8 years (Arias, Heron, & Xu, 2017) and the median age of the population continues to increase (United States Census Bureau [USCB], 2017). Adults over the age of 65 comprise 15.2 percent of the total population in the United States (USCB, 2017). Coupled with an aging population, the United States is becoming more diverse, with the Hispanic population being the largest ethnic group (USCB, 2017). Clients from diverse cultural backgrounds are at higher risk of negative health consequences, receiving a low quality of care, or being unsatisfied with their care (Ihara, 2004). As the population grows more diverse and older, it is imperative to address the needs of older adults while providing culturally competent care.

One approach to providing culturally competent care is to train the interprofessional team members. Interprofessional teams support improved health care outcomes and processes (Zwarestein, Goldman, & Reeves, 2009). As health care providers become more culturally competent in delivering services, health outcomes of the client improve (Horvat, Horey, Romios, & Kis-Rigo, 2014). Hall et al. (2015) asserted the need for culturally competent education for health care professionals to reduce health care disparities for people of color.

Occupational therapy plays a unique role in the health care field by providing client-centered, inclusive care; therefore, occupational therapists can provide responsive and culturally competent services for client of diverse cultural backgrounds. Because of the training occupational therapists receive on multicultural competence and group leadership, occupational

therapy can lead the interprofessional team to provide culturally relevant health care. The students of scholarly project created a training program for health care professionals to provide culturally competent care for older adults in long-term care facilities.

Chapter two is an overview of the literature regarding consequences of providing non-culturally competent care and benefits of providing culturally competent care. It defines the role of occupational therapy on the interprofessional team in providing culturally competent care. In addition, chapter two introduces the model, the ecology of human performance (Dunn, Brown, & McGuigan, 1994), which was the framework for the project. The ecology of human performance was chosen for its unique ability to be applied across cultures and for the end goal of increasing performance range.

Next, cultural constructs are defined to provide a basic understanding of the terminology used throughout the project. The literature review goes on to discuss needs of older adults, the current state of cultural competency in health care, and the most effective methods of providing education to adults. Finally, the review discusses diversity training, from current programs in existence to the proposed product for the scholarly project.

Chapter three is a discussion of the methods implemented by the students to create the scholarly project. It systematically analyzes the decisions and strategies that were executed and provides rationale for all aspects of the project. The methodology explains how the students chose the topic, the approaches in which they conducted the research, and how the product evolved from an idea to something tangible.

Chapter four is the epitome of the scholarly project. It contains the product that was developed by the students. The product is a training for interprofessional health care team members working in long-term care. The training educates health care professionals on

strategies to provide culturally competent care to older adults. It consists of three, 50-minute training sessions. The first session introduces culturally competent care through a role-play activity. Using a role-play activity actively engages participants by thinking from multiple perspectives and emphasizes the use of empathy as care providers. The second session actively tests knowledge and memory regarding cultural concepts and terminology. The session continues to build on foundational concepts through discussion and group processing. The final session concludes the training series with a cultural mimicry activity to enhance adaptability and suggests alternative approaches to providing instruction to different populations. The training series is brought together full circle through pre-test, post-test, and continuous self-reflection while considering culture in the long-term care facility.

Finally, chapter five is a summary of the entire scholarly project. It provides an overview of the key information derived throughout the process and states recommendations for how to disseminate the product. It further provides suggestions for future cultural competency trainings that could be developed to expand the product. Lastly, it addresses the limitations of the product.

Chapter II: Literature Review

The average life expectancy in the United States is 78.8 years (Arias et al., 2017), and the median age of the population continues to increase (USCB, 2017). Adults over the age of 65 comprise 15.2 percent of the total population in the United States (USCB, 2017). With that, the older adult population is the greatest consumer of health care services. In 2002, adults over 65 spent 70% more on health care services than adults under 65 (Stanton & Rutherford, 2006).

Coupled with an aging population, the United States is becoming more diverse, with the Hispanic population being the largest ethnic group (USCB, 2017). Clients from diverse cultural backgrounds are at higher risk of negative health consequences, receiving a low quality of care, or being unsatisfied with their care (Ihara, 2004). Therefore, there is a need to enhance health care provider education on cultural competency within long-term care facilities, where the resident population consists of increasing numbers of older adults from diverse cultural backgrounds.

Consequences of Providing Non-Culturally Competent Care

Taylor (2003) asserted that health care has a "culture of no culture" and graduate programs often do not align with real life cultural competency. Health providers must pay special attention to client's narratives and lived experiences because a lack of cultural competency may lead to patient dissatisfaction (Ihara, 2004). It may also lead to poor experiences and outcomes for migrants, racial, and ethnic minority clients (Owiti et al., 2014). As a result of the health care team not collaborating to provide culturally competent services, clients from diverse cultural backgrounds are at higher risk of negative health consequences, receiving a low quality of care, or being unsatisfied with their care (Ihara, 2004).

Specifically, African Americans, Latinos, and Asian Americans were more likely than Whites to report that they believe the quality of care would have been better if they had been of a

different race or ethnicity (Collins et al., 2002). In addition, African Americans were more likely than other minority groups to feel disrespected by a health care provider due to being either talked to rudely, talked to in a condescending manner, or ignored (Collins et al., 2002). Another alarming finding was that Asian Americans were least likely to feel that their doctor understood their background and values in comparison to other minority groups (Collins et al., 2002). Further, racial and ethnic minority clients are more likely to perceive bias and lack of cultural competence than whites when seeking health care (Johnson, Saha, Arbelaez, Beach, & Cooper, 2004).

When clients do not feel a connection with their providers due to being of a different race or culture, it may result in a loss of connection with their provider (Azevedo et al., 2013), which in turn, could decrease the quality of care, lead to misinformation, or culturally insensitive medical practices. In Ireland, Walsh and Shutes (2013) found that health care providers felt that not having a shared cultural perspective with an older resident may hinder the development of rapport. Other factors that influenced the relationship between the health care provider and resident included: use of colloquial language, communication, regional accents, cultural history, customs, and care approaches (Walsh & Schutes, 2013). In a residential facility in Canada, Knopp-Sihota, Niehaus, Squires, Norton, and Estabrooks (2015) found that interactions with residents were the most overlooked component of care. Nichols, Horner, and Fyfe (2015) asserted that being culturally and linguistically competent facilitates relationship building between staff and residents. If the relationship between the team and residents is poor, residents lack a sense of belonging (Walsh & Shutes, 2013).

Not only does race and culture contribute to diversity, but age does as well. Discrimination against older adults due to their age is defined as ageism (Minichiello, Browne, &

Kendig, 2000). Examples of ageism include: assuming older adults are slow in mind and body, discounting experiences, and providing a lower quality of care. Minichiello et al. (2000) found that older adults who experienced ageism from a health care professional had negative experiences in health care. Nonetheless, it is imperative to be mindful of age when considering diversity as well.

In long-term care, a perceived inadequacy of care is a risk factor for depression in residents (Jongenelis et al., 2004). With that, Kramer, Allgaier, Fejtkova, Mergl, and Hegerl (2009) found that 47.4 percent of nursing home residents in Munich, Germany have some form of depression, whether it was major, minor, or acute depression, compared to the depression rate of 48.5 percent of nursing home residents in the United States (Harris-Kojetin, Sengupta, Park-Lee, & Valverde, 2013). Consequently, in Taiwan, Hwang, Hsieh, and Wang (2013) found that managers need to address not only the physical needs of residents, but also the psychosocial needs in long-term care facilities. The authors discovered the residents viewed and valued respectful communication and enriching life as reflections of caring. One strategy to meet the psychosocial needs of residents is for the interprofessional team to collaborate with family members to identify needs and create a unique care plan strategy (Xiao et al., 2017).

Impact of Addressing Cultural Competency

Addressing cultural competency in health care is one method of responding to poor experiences and outcomes of clients of a diverse background (Owiti et al., 2014). It is the responsibility of the interprofessional team to incorporate meaning and understanding into individuals' care. Interprofessional teams support improved outcomes and processes (Zwarestein et al., 2009). As health care providers become more culturally competent in delivering services, health outcomes of the client improve (Horvat et al., 2011). Weech-Maldonado et al. (2012) found that hospitals with greater cultural competency have increased communication among

doctors, better hospital ratings, and more hospital recommendations. Further, minorities felt that interaction with staff, responsiveness, and pain control improved when hospitals had greater cultural competency (Weech-Maldonado et al., 2012).

In addition, family must be considered when working with ethnic minority clients. Across populations, Kramer-Roy (2012) found that mothers felt their beliefs were not being considered, while the fathers felt left out of the treatment process. Siblings were also undervalued in the treatment process. The author concluded that understanding cultural differences, involving the family, and building rapport are essential elements to consider in order to provide the best care.

Role of Occupational Therapy

Occupational therapy plays a unique role in the health care field by providing client-centered, inclusive care; therefore, occupational therapists can provide responsive and culturally competent services for diverse clients. Occupational therapists are trained in planning, implementing, and assessing groups using Cole's Seven Step group leadership model (Cole, 2012). The model aligns with the American Occupational Therapy Association's view on providing holistic, client-centered care (American Occupational Therapy Association [AOTA], 2014). Further, occupational therapists are skilled in recognizing the needs and identities of group members, switching therapeutic modes, assuming an appropriate leadership style, and providing the just right challenge to members (Scaffa, 2014). It is because of the training occupational therapists receive on multicultural competence and group leadership that gives the profession an edge on the interprofessional team. Occupational therapy is a leader in the field and can train team members to provide culturally relevant health care. The students of this scholarly project created a training program for health care professionals to provide culturally competent care for older adults in long-term care facilities.

Theory: Ecology of Human Performance

The ecology of human performance (EHP) is a model that fosters cultural competency because context is at the core (Dunn et al., 1994). Context encompasses all aspects of the environment, including cultural, temporal, and social factors (Dunn et al., 1994). No individual has the same context as another. Therefore, EHP provides a framework to evaluate each person specific to his or her own culture within a particular context.

The ecology of human performance has four core constructs: person, task, context, and performance (Dunn, 2017). The *person* has unique abilities, experiences, sensorimotor, cognitive, and psychosocial skills. Each individual has a distinctive skill set and background. She defined *task* as the behaviors necessary to accomplish a goal. These behaviors are objective and can be quantified. *Contexts* are the conditions that surround a person. She listed examples of contexts, which include cultural, temporal, and social factors. Finally, *performance* is classified as the interaction of the person and context that results in task engagement. Performance is the end result. It is essential to understand the dynamical synergy between the person, task, environment, and performance to best understand one's originality (Dunn, 2017).

Dunn et al. (1994) described four assumptions of EHP. First, it assumes that "relationships between people, environments, and occupations are dynamic and unique" (Brown, 2014, p. 499). Heath care practitioners must consider each person individually for their specific needs within the long-term care facility. Further, Dunn (2017) asserted the person cannot be separated from the context. Therefore, to provide culturally competent care, one must consider how the person adjusts to a contrived environment that may or may not support their cultural beliefs.

Secondly, the model assumes the interaction between person and context is transactive, and the person cannot be understood without looking at the context. Sometimes the context may

not provide the person with the supports needed to enhance performance (Dunn et al., 1994). In long-term care, the context is often the same for each person. It is essential to provide individualized variations; otherwise, without these things to support performance, a decline in some aspect of occupational performance will result.

Third, Brown (2014) states that using EHP, changing the environment is more effective than changing the person to increase performance range. "A person's performance range is determined by the transaction between the person and the context" (Dunn, 2017, p. 218). Therefore, if the health care team manipulates the environment, clients can maintain their values, beliefs, and roles, thus enhancing the performance range. Finally, EHP assumes that occupational performance is dynamic and constantly changing because the transaction between person, environment, and occupation is never static (Brown, 2014; Dunn, 2017). Regarding long-term care, it is imperative to never assume that the client is stagnant due to a constricted environment.

Additionally, EHP has five intervention approaches: establish/restore, adapt/modify, alter, prevent, and create (Dunn, 2017). The health care provider uses the prevent approach when there is a desire to avoid adverse experiences or events. Additionally, health care providers use the create approach for all populations and assumes that a disability is not present. The focus is to enhance performance for all. The following scholarly project utilized the prevent and create approach by preventing performance problems related to diversity issues, and a training program for the interprofessional team to provide culturally competent care to older adults in long-term care was created.

Cultural Constructs

Aging Population

The population of the United States is aging. Ortman, Velkoff, and Hogan (2014) defined the construct of aging as an increase in the proportion of older folks in the population. It is well known that the proportion of adults over the age of 65 is increasing. Projections indicate the population of adults 65 and older will be 83.7 million in 2050, which is almost double the estimated population of 43.1 million older adults in 2012 (Ortman et al., 2014). These older adults are frequently referred to as baby boomers. Baby boomers are adults born between 1946 and 1964. They began turning 65 in 2011 (Bonder, 2009). Per Mather, Jacobsen, and Pollard (2015), the baby boom generation could fuel a 75 percent increase in the number of Americans ages 65 and older. Such a large increase would impact nursing home care, increasing from 1.3 million in 2010 to a projected 2.3 million in 2030.

Diverse Population

Along with an increase in the aging population is a growing diverse population. The construct of a diverse population group is defined by members of any ethnic, religious, or social group that share similar values, traditions, and beliefs. Such factors are influenced by economic, cultural, and social contexts along with environmental conditions and availability of opportunities (Stewart & Nápoles-Springer, 2000). Similarly, diversity is "any trait that distinguishes any person(s) from one another, including abilities, talents, interests, ancestry, religion, race, values, or any other specification of a group or individual" (Bucher, 2015, p. 22). Diversity encompasses the whole person, from perspectives, viewpoints, and beliefs to sex, age, or sexual orientation.

Ethnicity

Ethnicity is a construct not to be confused with diversity. Bucher (2015) defines ethnicity as "the conscious of a cultural heritage shared with other people" (p. 20). Examples of ethnic groups include: white, black or African American, American Indian or Alaska Native, Asian, Hispanic, and Native Hawaiian or other Pacific Islander. As of 2010, the largest ethnic group in the United States was Hispanic, comprising 16 percent of the population (Humes, Jones, & Ramirez, 2011). Further, the Hispanic population was the fastest growing ethnic group from 2000-2010, with a 43 percent increase (Humes et al., 2011).

Ethnogeriatrics

Ethnogeriatrics is a specialized construct that describes the various needs of older adults while considering ethnicity. In regard to health care, varying needs include alternative beliefs about illness, disease, and dysfunction as compared to Anglo-Americans. Further, within ethnic minority groups, differences exist regarding culture, language, and socioeconomic groups (Llorens, Umphred, Burton, & Glogoski-Williams, 1993). The older population is becoming more racially and ethnically diverse. By 2060, the older population that is non-Hispanic white is projected to drop from 78 percent to 54 percent (Mather et al., 2015).

Culture

Culture encompasses both diversity and ethnicity. Barney (1991) defined culture as values, beliefs, norms, rationalizations, symbols, and ideologies. It is the way of life for a person or group of persons, which includes their interpersonal relations as well as attitudes (Barney, 1991). Culture varies between ethnic groups and regions. Because culture varies between individuals, it is vital to remain culturally competent when interacting with clients. Cultural competency is defined as actively acknowledging and incorporating culture, assessing cross-cultural relations, analysis of cultural differences, and enhancing cultural knowledge to interact

with a person (Betancourt, Green, Carrillo, & Owusu Ananeh-Firempong, 2016). Being culturally competent also includes being aware of health beliefs and values, views on wellness and disease, and treatment outcomes (Betancourt et al., 2016).

Interprofessional Health Care

To provide the best care for an aging, diverse population, it is recommended to be a member of an interprofessional team. Interprofessional care is the continuous interaction of two or more disciplines that have a common goal to provide the best outcome for the patient (Herbert, 2005). Such disciplines include, but are not limited to: occupational therapy, physical therapy, nursing, physician, social worker, case manager, recreational therapist, dentist, psychologist, psychiatrist, pharmacist, chaplain, and speech language pathologist (Bonder, 2009). Interprofessional teams are client and family centered. Decision-making is considered across disciplines, thus it, promotes continuous communication, respect, and contributions across professions (Herbert, 2005). Lie, Lee-Rey, Gomez, Bereknyei, and Braddock (2011) conducted a systematic review of seven studies that examined the effects of cultural competency training on patient-centered outcomes. The authors found that three studies confirmed beneficial effects of training; no studies reported negative effects. Further, Musolino et al. (2010) found that interdisciplinary health care students who enrolled in the cultural competency and a mutual respect program significantly progressed in becoming culturally competent.

Cultural Needs of Older Adults

Older adults have different health care needs than younger adults and children, as disease, chronic conditions, and treatments affect them differently. Older adults should receive care by specialized health care professionals to meet their needs (Eldercare Workforce Alliance, 2013). Kane and Kane (2001) state that older adults have the right to live a normal and unconstrained life in a context that supports their independence and functioning. In long-term care facilities, older adults obtain assistance in completing activities of daily living and instrumental activities of daily living (IADLs), along with skilled care to manage and treat chronic conditions (Feder, Komisar, & Niefeld, 2000).

Performance

Older adults have entered the developmental stage of generativity, which encompasses productivity and creativity. Two avenues exist at this stage: stagnation and despair versus ego integrity (Erikson, 1963). As health care professionals, it is imperative to foster ego integrity. One method of fostering ego integrity is to find meaning in the absence of clearly-defined roles through occupation (Bonder, 2009). Therefore, occupational therapists can assist older adults finding value in occupation. Rowles (1991) emphasized the need for support networks, including support networks for older adults living in rural communities. Participating in IADLs such as going to the grocery store, bank, and/or post office has positive effects in supporting older adults' health and health care (Rowles, 1991). Occupations such as meal preparation and eating remain vital to older adults (Nichols et al., 2015). Other occupations that are important to older adults include transportation and community mobility, as this may become difficult as adults age (Logan & Spitze, 1988). Additionally, Bonder (2009) identified the need

to help older adults access resources for community transportation services to support their participation in their communities.

Among residential care facilities in Australia, Nichols et al. (2015) found that 60% of people from a culturally and linguistically diverse background knew of a situation wherein a resident had reacted negatively because of visible cultural difference, particularly skin color. Further, the authors discovered that there is a need to understand local customs and how it influences residential care. One particular example was related to food and eating. Some residents observed Ramadan, which influenced energy levels during fasting. Some residents were not familiar with traditional American foods, such as the use of jam on toast and preferred Vegemite. As a result, the authors asserted the need for explicitly addressing factors that influence cross-cultural communication to enhance a multicultural atmosphere in the workplace.

Considering Cultural Needs for the Person

In regard to culture, socioeconomic, racial, and cultural differences widely affect older adults' health statuses (Kahn & Frazio, 2005). Bonder (2009) described that culture affects how a person perceives aging, affecting their overall attitudes and beliefs about entering old age. Further, Arsenault (2004) asserted that each generation has their own culture and traditions that were developed over time by their attitudes, preferences, and dispositions. Baby boomers prefer health care professionals who are caring, competent, and honest (Arsenault, 2004). As a health care professional, it is imperative to be client centered and develop a clear picture of what the resident values about their life and how they perceive what is occurring (McCormack, 2003). Health care professionals can obtain the sense of person through narrative and story, biographical account, and finding meaning in care (McCormack, 2003). Family may also be incorporated into care, as they often are involved in the client's decision making, especially

when a client's health may be poor and the client cannot decide for themselves (Kane & Kane, 2001).

Cultural Competency in Health Care

The goal of cultural competency in health care is to deliver the best care to each patient regardless of race, ethnicity, culture, or language proficiency (Betancourt et al., 2005). Addressing cultural competency in health care is trending because the patient population is becoming more diverse, which translates into different beliefs regarding health care, alternative presentation of symptoms, language barriers, and different expectations regarding health care. In addition, when sociocultural differences are not addressed between the patient and health care provider, health outcomes are worse (Williams & Rucker, 2000). Further, it has been proven that providing client centered care and being culturally competent helps to eliminate health care disparities (Baker, 2001).

Challenges to Cultural Competency in Health Care

Betancourt et al. (2005) asserted that cultural competency in health care could lower costs by improving the efficiency and effectiveness of care. However, there is no direct evidence to support this statement. Another challenge is the cost to the health care facility to invest in personnel, training, multilingual services, quality measurement, and resistance to change. Further, stereotypes and biases must be broken (Betancourt et al., 2005). For example, to be culturally competent in health care, it is imperative to not group one ethnic group under the same umbrella, as variations in beliefs, values, routines, and roles exist.

Cultural Competency in Long-Term Care Facilities

In a study by Kwak, Lee, and Kim (2017), residents in nursing homes in Korea were less satisfied than their counterparts receiving home health services due to the availability of occupations available to them, the amount of autonomy regarding their health care concerns, and explanations about care from their caregivers. The authors suggested that there should be a

continuing focus on improving the quality of care in residential facilities and ongoing training for caregivers that focus on enhancing knowledge and attitudes. If attention is devoted to enhancing cultural competence among caregivers, the interprofessional team will be more responsive and sensitive to resident's needs. Therefore, client centered care and satisfaction will improve.

Culturally Competent Education for Adults

Andragogy

Andragogy is the art and science of teaching adults (Knowles, 1990). The educator serves as a facilitator, and the relationship between the educator and adult learner is linear (Bastable & Dart, 2011). In the training developed in this scholarly project, the educators provide the framework for cultural competency education. The educators are there to implement the session, rather than directly instruct throughout.

Andragogy has four basic assumptions. The first is that self-concept evolves from dependent to an independent, self-directed role (Bastable & Dart, 2011). The training provided emphasizes independent learning through interactive activities. Interaction increases participation and increases the responsibility of the participant to learn independently.

Secondly, previous experience is a valuable resource for learning (Bastable & Dart, 2011). The training draws from the participant's past experiences. Participants are encouraged to share both positive and negative encounters with the group. Utilization of participants as a resource not only enhances the value of the training, but it also enhances the feeling of value of the participants.

Thirdly, readiness to learn aligns with social roles (Bastable & Dart, 2011). In long-term care facilities, health care professionals assume the roles of caretaker, friend, advocate, and resource professional. Skilled communication is required across all of these roles. Being culturally competent requires professionals to be language and linguistically proficient to enhance rapport with the resident and family. Therefore, participants will be motivated to learn because it will augment their social roles as a health care professional.

Finally, there is a shift from postponed, subject centered learning to immediate, problem centered learning (Bastable & Dart, 2011). The training focuses on a developing problem and trend in health care: an increase in the aging population and an increase in diversity. Health care professionals will leave the training with the skills needed to provide greater culturally competent care. The following scholarly project utilized the assumptions of andragogy to provide a framework for the cultural competency training.

Education and Training

Javadi and Zandieh (2011) added that adults learn through motivation, reinforcement, retention, and transference. With that in mind, certain delivery methods are better for teaching adults. Educators must assess needs, wants, concerns, and current abilities (Javadi & Zandieh, 2011). With regard to training adults in multiculturalism, Kai, Spencer, and Woodward (2001) found as they were training health care professionals in multiculturalism, there were a few challenges to discussion: where to start the conversation in the professional setting, how the discussion relates to health service, and challenges in offering ethnic diversity training. Bucher (2015) described "diversity education by referring to all approaches that promote diversity consciousness, developing understanding, awareness, and various diversity skills" (p. 27). Diversity skills include: being a flexible thinker, communicator, team member, leader, networker, and problem solver.

How to Implement Diversity Training

To be effective in diversity training on an organizational level, the organization must define diversity and the value diversity has within the organization. Bucher (2015) recommends to focus diversity training on substantive changes, not cosmetic changes; incorporate multiple teaching approaches into training, specific to the setting; matching the goal of the training to the goals of the organization; and, follow up to hold learners accountable for understanding material from the training program. Training is considered a long-term investment and should be integrated into organizational functions and leadership. It is important to include support from leadership and have strong focus (Bucher, 2015). If diversity training is successful, education, training, and development will improve. Stone and Harahan (2010) indicate that a high-quality workforce depends on the investments from the organization in education and ongoing training of new and experienced team members.

Current Diversity Training Strategies

Currently, several employers across the United States are encouraging and requiring diversity training in business, government, health care, education, and other settings (Bucher, 2015). Deriving input from health care professionals to shape training is integral as well. Herschell, Reed, Person, Mecca, and Kolko (2014) found four themes from surveying health care professionals of different disciplines with regard to training in the workplace. The first theme is that clinicians have time restraints; thus training periods should be flexible and of proper length. Secondly, training should include support from trainers, agencies, supervisors, and peers within and across departments. Thirdly, facilitators should provide interactive trainings, rather than lecture-based formats. Finally, trainings should be offered in areas of interest that empower practitioners.

In addition, Springer, Stanne, and Donovan (1999) asserted that various forms of small group learning promote greater academic achievement and more favorable attitudes towards learning. Marsland and Bowman (2010) used a 50-minute training session, web resources, and follow up to significantly increase desired skill set from health care professionals.

Benefits of Diversity Training

The facility benefits from cultural training programs. Some benefits include: minimizing costly communication errors, decreased risk of costly lawsuits, and promotion of client-centered care (Bucher, 2015). Further, interprofessional collaboration interventions can improve health care processes and outcomes (Zwarenstein et al., 2009). Cost, embracing as part of the vision, and public recognition of the distinct value of care are some barriers to implementation. However, to be an effective practitioner, all strides must be paired with diversity and inclusion (Taff & Blash, 2017). Common barriers for providing culturally competent care include language barriers, poverty, health disparity, and health literacy (Howard, Beitman, Walker, & Moore, 2016).

Strategies to Enhance Cultural Competency

There is no one method for delivering client centered, culturally competent care. One strategy is international service learning in developing countries. Trainings are short-term format, using measures of self-report student learning as opposed to focusing on client satisfaction (Howard et al., 2016). Horvat et al.'s (2011) training approach included: education content with knowledge, assessment, application, and skills; pedagogical approach; and structure with delivery, frequency, assessment, evaluation, organizational support, and participants.

Another method for addressing issues includes using a cultural filter, defined as a lens through which someone views a person who has a different culture. Every person has

experiences and views unique to them; therefore, should be treated within that context. Interventions are to be tailored to a person's culture. Strategies to incorporate culturally sensitive interventions include: training, use of protocols, culturally sensitive assessment methods, and family involvement (Barney, 1991). Other methods to increase cultural competency include the use of diversity booklets, cultural presentations, international fieldworks, and empathy narratives (Bueno, Ghafoor, Greenberg, Mukerji, & Yeboah, 2013).

In addition, another strategy is to maintain active curiosity through cultural specific expertise, scientific-mindedness, and dynamic sizing skills (Bonder & Gurley, 2005). The researchers recommend using current knowledge, clarify/confirm with the client, and then evaluate the outcomes to refine and improve the intervention for the next client. Meghani-Wise (1996) suggests that professionals reach out to various ethnic groups in the community (church, volunteering, socializing) and inform populations on services. A competent occupational therapist should consider continuing education in the workplace and whether or not to provide integrated treatment in the clinic with similar clients. Spreading occupational therapy knowledge to various countries in need and securing funding for such community-based programs is essential to program success (Simo-Algado, Mehta, Kronenberg, Cockburn, & Kirsh, 2002).

Current Cultural Competency Programs

There are programs that exist for cultural competency training. Current cultural training programs revolve around reading, volunteerism, workshops, CDs, Internet, and online discussions (Bucher, 2015). One example of an existing continuing education program is Think Cultural Health. Think Cultural Health is a program aimed at "advancing health and equity at every point of contact" (U.S. Department of Health & Human Services [USDHHS], 2017a). Think Cultural Health created a *Guide* that is designed for health care professionals to learn

about culturally and linguistically appropriate services (CLAS). The *Guide* is an online resource and reference tool intended to help build and use communication skills and language assistant services with individuals for a diverse population. It focuses on four areas: cross-cultural communication skills, verbal communication, written communication, and providing notice of language assistance services (USDHHS, 2017b). It is based on the national CLAS standards, which are to provide "effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" (USDHHS, 2017c).

Pecukonis, Doyle, and Bliss (2008) created an interprofessional training program based on interaction, data, expertise, and attention (IDEA). Interaction is the process during which the professional works and learns directly with individuals from other health disciplines. Data involves obtaining accurate information about other health professions. Such data includes understanding other's roles, the person, and how that role fits within the team. Expertise is the ability to communicate clearly and effectively with other disciplines concerning the values and processes of patient care associated with one's own profession. Pecukonis et al. (2008) suggest that expertise is "the first and most important step in developing interprofessional cultural competence is a willingness to enter into a dialogue with another professional" (p. 424). Attention involves exploration of one's personal and professional cultural background while simultaneously recognizing one's biases, prejudices, and assumptions about individuals who are trained in different health care professions (Pecukonis et al., 2008).

Although there are programs that focus on cultural competency training, current programs do no provide interactive, live training. Online programs do not ensure that all material is covered, as the trainee may skip modules or refrain from reading entire sections. Live

trainings ensure interaction and participation. In addition, live training provides the opportunity to ask questions, have discussion, and provide clarity.

Outcome Measures

To measure the effect of interprofessional training programs, Owiti et al. (2014) used a satisfaction questionnaire for patients and health care professionals prior to interprofessional cultural training and as a follow up. With feedback from the questionnaire, Owiti and colleagues (2014) emphasized the importance of having a diverse staff providing treatment, developing a broad sense of culture, providing narrative-based assessment methods, challenging assumptions, expectations, and biases, and understanding patient-centered care.

Another measure was developed by Horvat et al. (2011). They summarized outcomes using primary and secondary outcome categories. Primary (patient-related) outcomes included: treatment (e.g. clinical assessments), health behaviors (e.g. attitudes), involvement in care, and evaluation of care (e.g. patient satisfaction). Secondary outcomes included: knowledge and understanding, consultation processes, evaluation of processes (e.g. job satisfaction), adverse events (e.g. complaints), quality and safety measures, use of services, costs of care/intervention.

Interaction Between Aging and Diversity

Baltes and Smith (1999) stated individuals' need for culture inflates with age and efficacy of culture deflates with age, causing individuals to feel at a loss with their cultural identity. Therefore, it is more important than ever to address the interaction between the aging population and diversity. Therapists must consider changes across the lifespan and lifestyle changes in order to make therapy most beneficial to the client (Dyck, 1993). Therefore, due to the increasing aging population of people from culturally diverse backgrounds, there is a need to train health care professionals to provide client-centered, culturally competent care for older adults in long-term care facilities.

Discussion

From the literature, it was determined that the population of the United States is aging and becoming more culturally diverse (USCB, 2017). A lack of cultural competency in health care leads to poorer health care outcomes across all populations and leads to patient dissatisfaction (Ihara, 2004). Further, a lack of cultural competency may lead to poor experiences and outcomes for migrants, racial, and ethnic minority clients (Owiti et al., 2014). In contrast, an awareness and delivery of cultural competency in health care leads to better outcomes across all populations (Horvat et al., 2014; Weech-Maldonado et al., 2012).

One method of enhancing cultural competency is involving the interprofessional team. Interprofessional teams support improved outcomes and processes (Zwarestein et al., 2009). Therefore, training the interprofessional team on delivery of culturally competent care can enhance health outcomes for clients. As such, it is imperative to implement cultural competency training among the interprofessional team in long-term care facilities. The following chapter will provide a detailed description of the strategies and methods the students of this scholarly project utilized to create the project.

Chapter III: Activities/Methodologies

The methodology for developing this scholarly project was strategically implemented by utilizing skills gained in both quantitative and qualitative research courses. The research obtained guided the development of the scholarly project. The following is a systematic analysis of the ideas, decisions, reasoning, and research methods used to create the scholarly project.

Conducting the Literature Review

The literature review began by the students finding articles to review, termed "reading summaries." The students used three databases, CINAHL, Google Scholar, and OT Search, to find scholarly articles for the literature review. Terms pertaining to the scholarly project topic were searched. The following terms were cross-searched among the databases: culture, training, cultural competency, skilled nursing facilities, education, cultural awareness, patient satisfaction, depression, long-term care, health care, health care disparities, aging population, diversity, diversity training, older adults, elderly, cultural identity, occupational therapy, interprofessional team, ecology of human performance, and performance range. After searching terms and saving articles based on their title and abstract, further analysis of the articles was conducted with key points and results addressed.

Using the *reading summaries*, the students began the outline of the literature review based on the key concepts of the scholarly project and highlighted concepts found in the articles reviewed. To further develop the outline, the students sought feedback from their scholarly project advisor, who recommended addressing the *bee in the bonnet*, or an attention-grabbing statistic. Next, the students added more evidence to the concepts included in the outline. After revising the literature review, the students received ongoing feedback, as literature review was developed to ensure the concepts were compelling and fully supported by the literature.

Results of Literature Review

From the literature, it was determined that the population of the United States is aging and becoming more culturally diverse (USCB, 2017). Older adults are the greatest consumer of health care. Adults over 65 spent 70% more on health care services than adults under 65 in 2002 (Stanton & Rutherford, 2006). Therefore, it was imperative to address the aging, diverse population in health care, which was the objective of the scholarly project.

Cultural competency needed to be addressed because a lack of cultural competency in health care leads to poorer health care outcomes across all populations and leads to patient dissatisfaction (Ihara, 2004). Further, a lack of cultural competency may lead to poor experiences and outcomes for migrants, racial, and ethnic minority clients (Owiti et al., 2014). Specifically, African Americans, Latinos, and Asian Americans were more likely than Whites to report that they believe the quality of care would have been better if they had been of a different race or ethnicity (Collins et al., 2002).

In contrast, an awareness and delivery of cultural competency in health care leads to better outcomes across all populations (Horvat et al., 2014; Weech-Maldonado et al., 2012). Weech-Maldonado et al. (2012) found that hospitals with greater cultural competency have increased communication among doctors, better hospital ratings, and more hospital recommendations. One method of enhancing cultural competency is involving the interprofessional team. Interprofessional teams support improved outcomes and processes (Zwarestein et al., 2009). Therefore, training the interprofessional team on delivery of culturally competent care can enhance health outcomes for clients.

Gaps in Literature

Live training programs for cultural competency were not found. Rather, online trainings and modules, use of CD's, books, online discussion, volunteerism, and education obtained in college were the primary modes of delivering cultural competency training for health care professionals.

Although there are the existing programs that focus on cultural competency training, current programs do not provide interactive, live training. Online programs do not ensure that all material is covered, as the trainee may skip modules or refrain from reading entire sections. Live trainings ensure interaction and participation. In addition, live training provides the opportunity to ask questions, have discussion, and provide clarity.

Another gap was the lack of evidence for the cost to create and implement a cultural competency training program. Betancourt et al. (2005) asserted that cultural competency in health care could lower costs by improving the efficiency and effectiveness of care. However, there is no direct evidence to support this statement. Another challenge is the cost to the health care facility to invest in personnel, training, multilingual services, quality measurement, and resistance to change (Betancourt et al., 2005). Further, stereotypes and biases must be broken (Betancourt et al., 2005). For example, to be culturally competent in health care, it is imperative to not group one ethnic group under the same umbrella, as variations in beliefs, values, routines, and roles exist.

Lastly, a gap observed in the literature is the lack of addressing cultural competency specifically with the aging population. Mather et al. (2015) projected the non-Hispanic white older adult population will drop from 78 to 54 percent. Paired with the "culture of no culture" discussed by Taylor (2003), there is a depression rate 48.5 percent of nursing home residents in the United States largely due to lack of culturally-relevant activities (Harris-Kojetin et al.,

2013). With the baby boom generation aging, Mather et al. (2015) projected a 75 percent increase in the number of Americans ages 65 and older, which would increase demand for long-term care. As a result, it is important to address cultural needs in the long-term care facility.

Rationale for Topic Selection

Initially, the students planned to develop a training program specifically for the Hmong to address the growing Hmong population in the Twin Cities of Minnesota. After reviewing some literature, the students realized the literature on the Hmong population was saturated. Further, the students felt that because they were not of a Hmong background that they would be unable to speak on the needs of the Hmong population. After discussion, the students decided to address the cultural competency with the aging population as determined by the gaps in the literature.

From the literature review, it was evident that there was a need to develop a cultural competency training for an aging, more diverse population. It was determined that the training be delivered to the interprofessional health care team, as communication across all team members improves the quality of client care. In addition, it was clear that an occupational therapist must facilitate the training, as occupational therapists are trained in group process and delivery. Finally, the topic was chosen due to the students' interest in elder care and multicultural competence.

Rationale for the Ecology of Human Performance

The students chose the occupational model, the ecology of human performance (EHP), because of its ability to be applied across cultural contexts and due to the research supporting EHP in educational settings (Dunn et al., 1994). Context encompasses all aspects of the environment, including cultural, temporal, physical, and social factors (Dunn et al., 1994). No individual has the same context as another. The model can be applied to both the

interprofessional team members and clients. Therefore, EHP provides a framework to evaluate each person involved in the health care interaction specific to his or her own culture within a particular context.

In addition, EHP uses terminology that is understandable to the layperson and to interdisciplinary team members. EHP uses an outcome goal of increasing performance range (Dunn et al., 1994), which is the ability to perform more tasks within the person's context. In a long-term care facility, it is imperative to work toward providing culturally competent care to all residents; therefore, increasing the performance range, which is the objective of the cultural competency training and EHP.

Rationale for Cole's Seven Steps

Cole's Seven Steps (Cole, 2012) was chosen because of its effectiveness in group process and group delivery. The model aligns with the American Occupational Therapy Association's view on providing holistic, client-centered care (AOTA, 2014). The model provides a concrete framework for group leadership that can be adapted across populations, members, and contexts. In addition, the group process model was developed by an occupational therapist, making it an obvious choice for the scholarly project.

Cole's Seven Step format can be adapted according to the dynamics of the group. The facilitator can assume a different leadership style depending on the member characteristics and activity characteristics. In addition, the model promotes team building and provides strategies for conflict resolution (Cole, 2012). Occupational therapists are flexible and adaptable, making them an ideal match to lead and implement the group.

Rationale for Occupational Therapy Specific Facilitators

The training was initially designed for any health care interprofessional team member to deliver it. However, the students of this scholarly project implemented one of the sessions at a local long-term care facility and discovered that health care professionals who have not been trained in group leadership and group facilitation lack the skills to successfully lead a group training session. It was evident that the health care professionals lacked the ability to extract feelings from group members and involve all members. Therefore, it further provided evidence that the training program be delivered by occupational therapists, as they are trained in planning, implementing, and assessing groups using Cole's Seven Step group leadership model (Cole, 2012), which aligns with the American Occupational Therapy Association's view on providing holistic, client-centered care (AOTA, 2014). Further, occupational therapists are skilled at recognizing the needs and identities of group members, switching therapeutic modes, assuming an appropriate leadership style, and providing the just right challenge to members (Scaffa, 2014).

Methodology for Developing the Product

Session Framework

Per the literature review, Marsland and Bowman (2010) discovered that outcomes of health care provider education were increasingly beneficial when presented in an in-person, interactive session at a time of day convenient for the attendees, which led the students to design the sessions to be delivered over the lunch hour. After discussing with the scholarly project advisor, the students finalized the decision to use Cole's Seven Steps as a framework for the training sessions. Cole's Seven Steps provided a general framework for the education sessions by including an introduction, an activity portion, and discussion. Cole's Seven Steps were adapted using table formatting suggested by the advisor and with use of the model, EHP.

The training sessions were structured using EHP by breaking sessions down into the task, context, and person as illustrated in the product. The sessions focused on the health care provider, while offering cultural information pertaining to long-term care through use of discussion components as well as the activity portions. While developing the training sessions, the students referenced their education course textbook, geriatric textbook, and multicultural textbook to provide guidance for the education sessions. The education textbook, *Health professional as educator: Principles of teaching and learning,* by Bastable, Gramer, Jacobs, and Sopczyk (2011) was utilized to align the education sessions with principles of adult learning and Fitzgerald's (2011) descriptors of engaging aspects of learning to generate activity ideas.

Activity Rationale

The first activity idea was planned because role playing is an effective, active learning intervention for adults to feel emotionally invested (Fitzgerald, 2011). Using role playing as an

activity uses read/write, auditory, kinesthetic, and visual components to address health care providers with various learning styles or preferences.

The second activity was built to engage participants emotionally, cognitively, and enthusiastically through use of gaming (Fitzgerald, 2011). The activity involves a competitive component, which can be offer as an alternative motivation tool for the education session. Additionally, the cultural terminology is included in a written format to provide as a read/write and visual learning tool as well as an aural and kinesthetic resource through the activity and discussion.

The third activity was developed with inspiration from the BaFa' BaFa' (Simulation Training Systems, 2017) activity from a multicultural course during the second year of the Master's of Occupational Therapy Program at the University of North Dakota. The BaFa' BaFa' (Simulation Training Systems, 2017) activity provides two different groups with two different set of instructions. The concept of different cultural instructions was generalized to a smaller-scale activity, which involved one-to-one instruction. One-to-one instruction positions the learner in an active role while engaging them cognitively, affectively, and through psychomotor processes.

Session Implementation

The students conducted a trial run of the third session during a nursing staff meeting in Grand Forks, North Dakota. The students gathered feedback from participants to alter questions in discussion. After presenting, students modified their pre-test, post-test, and addressed any additional questions by the nursing staff at the long-term care facility. Feedback received included to have someone specifically trained in providing group sessions lead the education

session, to eliminate extraneous questions, and to not use headers to the discussion questions, as they were misleading.

Advisement

The students met weekly with their academic advisor to receive feedback and guidance on all aspects of the scholarly project. The students used the feedback to revise, edit, and refine the scholarly project. The advisor guided the students through the sequence of developing the scholarly project, starting with the topic proposal and the *reading summaries*, followed by the literature review, product, methodology, introduction, and summary. The advisor provided suggestions for implementation of the ecological model throughout the scholarly project and gave recommendations to improve readability. Finally, the advisor provided education, examples, and guidance for the oral comprehension presentation and poster creation for Frank Low Research Day in Spring 2018.

Chapter IV: Product, Training Sessions

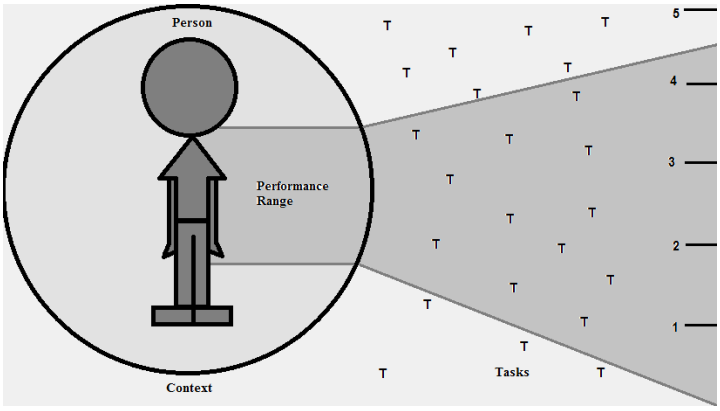
The training sessions are three 50-minute, group-based, interactive sessions created to promote considerations for client-centered care when working with older adults in the long-term care facility, emphasizing cultural competency. Because older adults feel a disconnected from their culture in long-term care facilities, it is vital to provide education to staff to consider how to promote culture (Ihara, 2004). It is the role of the health care provider to address culture and cultural needs in the long-term care facility. The training sessions engage the health care provider into understanding how to promote culture for residents in the long-term care facility.

The following sessions are provided once a month, over the lunch/noon hour, for three months. The structure of the sessions is based on Cole's (2012) Seven Step process for group learning and processing. Each session includes objectives, structure of the environment and session, a warm up, an activity, and a structured discussion to promote processing and learning. Heath care providers are given a self-assessment pre-test, post-test to reflect and evaluate their learning. Developing the product/sessions is explained in chapter two.

The first session introduces culturally competent care by providing a role play activity. Using a role play activity actively engages participants into thinking from multiple perspectives, emphasizing use of empathy as care providers. The second session actively tests knowledge and memory regarding cultural concepts and terminology. The session continues to build on foundational concepts using discussion and group processing. The final session concludes the training series with a cultural mimicry activity to enhance adaptability and approach to providing instruction to different populations. The training series is brought together full circle through pre-test, post-test, and continuous self-reflection while considering culture in the long-term care facility.

The sessions will be led by an occupational therapist to emphasize the importance of *doing* culture-specific activities or occupations in the long-term care facility. Occupational therapists are skilled in providing group intervention, which the training series is modeled through. Occupational therapists are trained in management skills specific to group leadership. As the following training series is developed using Cole's Seven Steps, the occupational therapist (as facilitator) will guide questions to build discussion and processing skills to enhance cultural competency.

The structure focuses around the ecological model (EHP), focusing on environment (long-term care facility), person (the health care professional), and the task of providing culturally competent, client-centered care. The following image depicts the components and interactions of EHP. By addressing the health care professionals in the long-term care facility, the performance range will widen, allowing for further competence in addressing culture as a main component of client-centered care. The format of Cole's Seven Steps naturally suits EHP as it includes: objectives (goal), environmental set up (environment), activity (task), sharing (person and environment), processing (person), generalizing (performance range), application (task), activity description (task, person, and environment), and rationale (task, person, and environment).



Adapted from "The ecology of human performance: A framework for considering the effect of context" by Dunn, Brown, & McGuigan (1994). *American Journal of Occupational Therapy*, *48*(7), p. 599.

Key:
(T) or **Task**=delivering culturally competent, client-centered care
Person=health care professionals
Environment= long-term care facility
Goal=increasing performance range (cultural competency rating); enhancing cultural competency skills of the health care professional in the long-term care facility.

Training Session 1
Role Playing: The Practitioner's Role in Providing Culturally Competent Care

Session 1: Role Playing: The practitioner's role in providing culturally competent care

The following session involves role playing a case study to engage the participants. Fitzgerald (2011) describes role playing as an effective intervention for adult learning as it is active, engages participants emotionally, and develops an understanding of others and their perspectives. Case studies relate the role playing to the health care role in a long-term care setting. Group discussion is used as an emotional and cognitive strategy to actively involve the participants. As group discussion promotes sharing of ideas and emotions, it is important to discuss after the activity to reflect and acknowledge ideas and emotions, while receiving feedback from peers. The activity varies read/write, auditory, kinesthetic, and visual components as to engage participants through various learning styles (Kitchie, 2011).

Session 1	
Training Session Preparation	**Task Title:** Role Playing: The practitioner's role in providing culturally competent care
	Task Objectives As the nation population grows more diverse, there is more demand for cultural competency training in health care facilities. Georgetown Health Policy Institute (2004) asserted involving culture into health care facilities will increase resident satisfaction, especially as the diversity within health care facilities expands. The training series works on enhancing skills addressing culture in the long-term care facility. We are working to incorporate culture into what the resident does in the long-term care facility to promote resident satisfaction. The following objectives are used for self-accountability and will not be used to evaluate work performance. Each of us bring a different background and skillset to the workplace. It is important and appreciated to share your knowledge and feedback regarding culture and providing culturally competent care to older adults in the long-term care facility. 1. By the end of the session (50 minutes), facility staff members will assess their understanding of culturally competent care with residents with the use of a pre-test. 2. By the end of the session (50 minutes), facility staff members will recognize a minimum of three barriers to incorporating culture into interactions with residents. 3. By the end of the session (50 minutes), facility staff members will identify person, task, and environment factors related to culturally competent care in the long-term care setting.
	Supplies and Cost

	The activity requires "Worksheet A" (1 copy per person), "Worksheet B" (1 copy per person), and a writing utensil for each group member at no cost to the member. Each worksheet cost 4 cents per paper (will need 5-6, 1 per member), which will be provided by the facility. The facility will provide a pen or pencil for each group member.
	Environment Physical Environment • Arrange chairs around a table, facing each other to facilitate discussion • Adequate lighting • Close the door, and minimize noise • Bring: Worksheet B and Pre-Test (1 copy per person), extra writing utensils (just in case), copies of cultural competency resources (optional) Social Environment • 4-20 participants, optimally 6-12 participants Temporal • 50 minutes: Introduction and warm up (5 minutes), activity (10 minutes), discussion and wrap up (35 minutes) Cultural Topic addressed
	Introduction • Explain objectives o By the end of the session (50 minutes), facility staff members will assess their understanding of culturally competent care with residents with the use of a pre-test. o By the end of the session (50 minutes), facility staff members will recognize a minimum of three barriers to incorporating culture into interactions with residents. o By the end of the session (50 minutes), facility staff members will identify person, task, and environment factors related to culturally competent care in the long-term care setting. • Expectations for group o What happens in group, stays in group o Respect for others o Participate as you feel comfortable. Some discussion topics may be uncomfortable, but challenge yourself to speak up and step outside your comfort zone. • Outline timeframe for group: Up next, we will do a quick warm-up, proceed to our activity, and have a discussion based on the activity. • Asks for feedback regarding clarity: Is this clear to everyone? Are there any questions? • Warm Up (5 minutes): o [pass out pre-test (see Worksheet A)] We are going to take a couple minutes to complete this survey based on how you currently provide care. These are not evaluated by the facility, but are provided for personal use and tracking individual progress.

	• Request everyone save their sheet of paper for the third session; otherwise, offer to hold it safely for them (ask to write name on sheet). • Introduce culturally competent care. • As a transition from the pre-test to the activity, let's define culturally competency. Cultural competency is defined as actively acknowledging and incorporating culture, assessing cross-cultural relations, analysis of cultural differences, and enhancing cultural knowledge to interact with a person (Betancourt et al., 2016).
Session Structure	**Task Activity** • Pass out copies of Worksheet B (provided below) to each member. Read the instructions aloud. o There are two different case studies. You and a partner are responsible for reading your case study individually. We will have 5 minutes read over the case study. After reading the case study, you will be given time to discuss with a partner. Does anyone need any clarification or have any questions? • After 5 minutes pass, provide verbal cues to begin discussion with their partner. o Now, we can get into pairs and discuss the case study if you have not begun discussion yet. You and your partner will be acting out your case study. • Lead group into role playing by arranging two chairs in an open space of the room. o Next, we will be acting out the case study and some strategies you might use to display culturally competent, client-centered care. Consider the questions asked on the initial pre-test during warm up. Again, I want to emphasize that this is a safe space for learning; we are all learning, so do not be shy to ask the audience for suggestions/guidance as you proceed. We will follow up with discussion and questions at the end of the role plays, so write down any comments, suggestions, questions, or thoughts you have (on your pre-test paper) as we go through the case studies. So, first group, come sit in the chairs and act out your case study, please. Who has case study one? Would you come sit in the two, visible chairs, please? Who is the resident and who is the health care provider? Please share your role as a health care provider (i.e. physician, nurse, physical therapist, occupational therapist, etc.). Begin. • Ask the other group(s) to share their case study, alternating between case study one and two. Shorten/lengthen time to display case study based on number of pairs present for session. o Thank you all for participating thus far. Let us alternate between case studies one and two. Who has case study two? You are up! Tell us who is the resident and who is the health provider, please. What is your role as a health care provider?

	Psychosocial Component of Person (EHP)	**Sharing Experiences**
		• Next, I would like to invite each member to share your experience with the activity:
		  ○ Use a term from Worksheet B to describe what you saw or experienced.
		  ○ What are some resources you currently use to consider incorporating cultural competency into working at a long-term care setting?
		  ▪ Some options include:
		  • National Center for Cultural Competence: https://nccc.georgetown.edu/
		  • University of North Dakota's Occupational Therapy program: Culturally Competency Checklist for the Occupational Therapist: https://med.und.edu/occupational-therapy/_files/docs/competency-checklist-2-25-09.pdf,
		  • California Department of Healthcare services: Cultural and Linguistic Competency Toolkit.: http://www.familypact.org/Providers/cultural-competency/2012-07_CulturalCompetencyToolkitADA.pdf.
		  ○ If anyone has any interest in obtaining these resources, I can write down the web addresses for you and/or print out copies.

		Processing
		• How did you feel as the resident?
		• How did you feel as the health care provider?
		• How did you feel presenting in front of others?
		• Share an example of how that may apply to working with someone of a different background or opinion.
		• What was a positive, culturally competent approach taken by the health care provider?
		• Which case study seemed easier to address? Why?
		• What aspects of the situation seemed especially challenging?
		• What do you feel were effective strategies used by the health care provider?
		• Why do you think we did this activity?
		  ○ We did this activity to "put ourselves in another's shoes", to demonstrate the "do's" and "don'ts" of resident interaction, and to open up conversation regarding feedback/considerations for when you are providing care for your residents at the long-term care facility.
		• Why this activity be important in this setting?
		  ○ The population of the United States is growing more diverse and older.
		  ○ The United States is becoming more diverse, with the Hispanic population being the largest ethnic group (USCB, 2017)

		• Why did you, as the health care provider, ask the questions you did?
		  ○ How might you change the way you phase certain questions to make them more client-centered?
		  • Examples include: Use "Did you live with anyone prior to admission? Who?", rather than saying "Does a husband/wife live at home with you before admission?", which suggests an individual is heterosexual and implies that they should/may be married. Use "us" and "we" versus "them" and "they".
		• How did you feel about sharing your experience of this activity with your peers?
		  ○ How do you feel about hearing peers' experiences with this activity?
		  ○ What might you suggest anyone change regarding their approach to culturally competent care? Why?
		  ○ How can you change your phrasing that it becomes more relevant to the resident and their culture?
		  ○ It is important to show interest in learning about another's culture as they are sharing special, client-specific values. How are you going to involve those values when providing care for the individual?
		• What were some of the questions or comments you had during the pre-test? How might that relate to this activity?
		• What additional comments they would like/be willing to add?

	Cognitive Component of Person (EHP)	**Generalizing**
		• How was the pre-test related to this activity?
		• What is something you learned about yourself from the pre-test?
		• What is the pre-test suggesting you use when providing care at the long-term care facility? Share examples of why you scored yourself well. Write in the comments section some suggestions your colleagues share. Consider adding their suggested practices into your work at the long-term care facility.
		  ○ What were some reoccurring strategies used? Why do you feel they reappeared?
		  ○ What were some common responses from the resident? Why would the resident have responded this way?
		  ○ Did anyone experience a similar scenario to either of these case studies on the job? Share.
		• What were some unique, culturally competent approaches?
		• What differences did you see between groups with the same case study?
		• What differences did you see between heath care provider role(s)?
		• Two principles learned:
		  ○ What did this experience/activity teach you?
		• Did this activity teach you anything new about yourself?

		Application • What are some takeaways from this experience? • How can you use the information you learned in this activity?

		• What will you do to apply this information to your profession as a health care provider? • How do you think this will affect your relationships with residents? • How do you feel this will impact your perception of residents? • What strategies stood out to you that you see yourself implementing into your practice?
	Summary: • Most important points: o This activity was chosen to help bring some awareness to the way we interact with residents of various backgrounds. We reflected on our individual health care practice as well as identifying strategies to better our practice. We reviewed and demonstrated understanding of cultural competency, while acknowledging that it is a constant work in progress and is never perfect. • Acknowledges contribution of members: o I want to thank everyone for participating and abiding our group expectations. Thank you for allowing yourself to be vulnerable during this activity and for your willingness and enthusiasm to engage in discussion. • Reinforces learning: o Revisiting our objectives, do you feel we have met them? [Re-read objectives] • Ends group on time (50 minutes): It looks like we are out of time, but thank you, again, for participating.	

Worksheet A

Session 1: The practitioner's role in providing culturally competent care

Pre-Test		
Instructions: Answer each question based on your past *two weeks* as a health care provider. Rate your ability to provide health care (pertaining to each question) on a scale of 1 through 5 based on *1=strongly disagree, 2=disagree, 3=neutral, 4=agree, 5=strongly agree.* Include any additional comments as a reflective tool or for any thoughts you would like to address in discussion.		
Question	**Rate**	**Additional comments/notes:**
I ask each resident if they have any culture-specific needs or requests.		
I find I am genuinely interested when a resident speaks to me about their interests.		
I consider the resident perspective when sharing a story or an opinion while providing health care.		
I ask questions to learn more about other cultures.		
I consider the resident perspective before feeling upset or frustrated with a "tough client".		
I consider myself an advocate for all my residents.		
I understand that someone may have differing expectations for their health care.		
I am willing and able to answer any questions regarding health care with a patient, respectful tone of voice.		
If a resident has differing values from my own, I provide the same quality of care as I would for someone with my same values.		
I offer resources for residents facing barriers, including: socioeconomic status, language differences, geographic isolation, discrimination, and/or lack of supports.		

Worksheet B

Session 1: The practitioner's role in providing culturally competent care

Instructions: Read the case studies individually. With a partner, discuss your assigned case study. Decide what roles each partner will play (resident or health professional). Act out the case study for the class. Discussion will follow.

Cultural competency: actively acknowledging and incorporating culture, assessing cross-cultural relations, analysis of cultural differences, and enhancing cultural knowledge to interact with a person (Betancourt et al., & Owusu Ananeh-Firempong, 2016).

Case Study 1: Sherif is an Egyptian, Muslim male, age 72, who recently became dependent with regard to bathing, lower body dressing, and standing to wipe after having voided. Sherif has shyly covered himself in the past when nursing has conducted skin checks, but has never expressed his preference for modesty. One day, when a health care professional visited Sherif in his room, his wife asked if she could do all the pieces of assistance that would preserve his modesty. Out of concern for her health and wellbeing, you insist she allows the nurse to help him stand to dress, wipe, or take a shower. His wife shares that she has a background in nursing.

Case Study 2: Mariposa is 75-year-old Latina, Spanish-speaking woman staying at your long-term care facility. Mariposa experienced a right-side hemispheric stroke, heavily affecting her gait, use of her dominant (left) hand, and her ability to transfer from surface to surface (i.e. wheelchair to toilet). Mariposa has 4 sons, all of which are staying on cots in her room. In addition to the stroke, Mariposa is hard of hearing, has arthritis, and has type II diabetes. Her sons bring her homemade food to eat, because they do not like the food provided by your facility. You try to communicate with her family that there are contraindications with eating the homemade meals.

Training Session 2
The Race Race: Cultural Considerations and Terminology

Session 2: The Race Race: Cultural considerations and terminology

This activity involves using a race to engage the participants in the learning method of gaming. Fitzgerald (2011) describes gaming as an effective intervention for adult learning as it is active, engages participants emotionally and cognitively, and promotes learning enthusiasm. Group discussion is used as an emotional and cognitive strategy to actively involve the participants. As group discussion promotes sharing of ideas and emotions, it is important to discuss after the activity to reflect and acknowledge ideas and emotions, while receiving feedback from peers. The activity varies read/write, auditory, kinesthetic, and visual components as to engage participants through various learning styles (Kitchie, 2011).

	Session 2
Training Session Preparation	**Title:** The Race Race: Cultural considerations and terminology.
	Objectives We are all working on cultural competency to better the satisfaction and participating of older adults in the long-term care facility. We all have strengths. It is important to share your strengths as they benefit the group. We will continue to objectives of session 2, working on enhancing our skills in health care in relation to culture and client-centered care. 1. By the end of the session (50 minutes), facility staff members will independently explain 13 terms regarding cultural competency in an aging population. 2. By the end of the session (50 minutes), facility staff members will identify a minimum of three strategies to provide culturally competent care to residents. 3. By the end of the session (50 minutes), facility staff members will identify person, task, and environment factors related to culturally competent care in the long-term care setting.
	Supplies and Cost The activity requires a piece of paper and a writing utensil for each group member at no cost to the member. Each piece of paper cost 4 cents per paper (will need 5-6, 1 per member), which the facility will provide. The facility will provide a pen or pencil for each group member.
	Environment Physical Environment • Arrange chairs around a table, facing each other to facilitate discussion • Adequate lighting • Close the door, and eliminate unnecessary noises • Large, empty wall space front of the room with sticky notes of each term (from Worksheet C).

	Social Environment • 4-20 participants, optimally 6-12 participants Temporal • 50 minutes: Introduction and warm up (5 minutes), activity (10 minutes), discussion and wrap up (35 minutes) Cultural • Topic addressed
	Introduction • Explain objectives. Ask if there are any questions, comments, or concerns. o By the end of the session (50 minutes), facility staff members will independently explain 13 terms regarding cultural competency in an aging population. o By the end of the session (50 minutes), facility staff members will identify a minimum of three strategies to provide culturally competent care to residents. o By the end of the session (50 minutes), facility staff members will identify person, task, and environment factors related to culturally competent care in the long-term care setting. • Expectations for group: o What happens in group, stays in group. This is a safe space for discussion, mistakes, and learning. o Respect for others o Participate as you feel comfortable, though I urge you to try and push yourself outside of your comfort zone. • Outline timeframe for group: Up next, we will do a quick warm-up, proceed to our activity. Following the activity, we will have a discussion based on the activity. • Asks for feedback regarding clarity: Is this clear to everyone? Are there any questions? • Warm Up: Start group with a sense of everyone belonging to a culture. • Share a family tradition or a piece of information regarding your culture.
Session Structure	**Task Activity** • Pass out Worksheet C. Split group into two groups. o Here is our worksheet for today. You will find a few terms and definitions on the worksheet. Read them for the next 5 minutes and discuss with your group. We will be in two groups. • Set up the sticky notes on the large empty wall. Ask groups to line up with their team, resulting in two, single-file lines. o Once you are through discussing the meaning of each term, create two, single-file lines facing the wall. I will read a definition or example of a resident scenario and one member at a time from your team (the person in the front of the line) will race to retrieve the sticky note with the corresponding term. Once a sticky note has been taken, stick the sticky note to your team's side of the wall and return to the back of the line. If you feel the need to use Worksheet C, you are welcome to. Just know, it may take longer to read the definitions on the worksheet then scan for the term. Are you ready? • Read definitions or examples of each of the terms.

- White, black or African American, American Indian or Alaska Native, Asian, Hispanic, and Native Hawaiian or other Pacific Islander
  - Answer: ethnicity
- One's lack of self-awareness, lack of self-discipline, cultural ignorance, and underdeveloped diversity consciousness can act as [blank] when working with a diverse population.
  - Answer: personal barriers
- This group is 53-71 years old in the year 2017.
  - Answer: baby boomers
- This specialty includes addressing needs regarding alternative beliefs about illness, disease, and dysfunction as compared to Anglo-Americans.
  - Answer: ethnogeriatrics
- To describe this concept, I may include details about populations abilities, talents, interests, ancestry, religion, race, values, or any other specification of a group or individual
  - Answer: diversity
- If I were to display behaviors of actively acknowledging and incorporating culture, assessing cross-cultural relations, analysis of cultural differences, and enhancing cultural knowledge, I would be displaying behaviors of what concept?
  - Answer: cultural competency
- If I were to love eating meat, yet understood and respected by another person may not, I would be exhibiting which concept?
  - Answer: double consciousness
- This was the largest growing ethnic group from 2000-2010
  - Answer: Hispanic population
- "Asians are good at math" is an example of what concept?
  - Answer: stereotype
- When one culture perceives themselves as superior to another.
  - Answer: ethnocentrism
- A concept of categorizing individuals by skin color, hair texture, and facial features.
  - Answer: race
- This is a group or groups of people that are denied equal power and opportunity in political, economic, and social regards.
  - Answer: minorities
- Examples of this concept include: groups of thought, tradition, music, language, values, rules, beliefs, and expectations.
  - Answer: culture

Sharing Experiences

- Next, I would like to invite each member to share your experience with the activity:
  - How was this experience for you? How did you have to adjust your thinking during the race versus discussion with your group?

	Psychosocial Components of Person (EHP)	○ What term did you not know prior to this activity? ▪ Review terms once more. Read through. ▪ What questions do you have regarding the terminology on Worksheet C? ▪ What term stuck out to you as new? How will you use that term to further your cultural competency in the long-term care facility? ○ Which team has more sticky notes?
		Processing • Share an example of a time you or someone you know did not use cultural competency with a resident? What could they have done differently? • What was one thing you learned? ○ Please share an example of when you have applied one or more of these concepts into working in a long-term care facility. • What concepts are more straight-forward? More abstract? ○ Share an example of when you or a colleague used double consciousness to better an interaction with a resident. ○ An example of using double consciousness could include understanding why a Muslim client may wear a hijab (head scarf) even though you choose not to. • What steps would you need to take to feel comfortable speaking to a resident about their head scarf? What questions might you ask? ▪ Arabs in America (2017) reported that Muslim women choose to wear hijabs to display modesty, though some men and people from other religions also choose to wear hijabs for, often, similar reasons. "Hijab" is Arabic for "covering". • What helped you learn when discussing these terms with your group? ○ How did you distinguish the terms or remember them when working with your group? ○ How did it feel to compete while trying to understand the concepts? • What were some discussion points your group talked about?
		Generalizing • What were some overlapping concepts? • What similarities did you notice between the terms and your role as a health care provider? • What are some similar struggles you and your team members had during this activity? • What is the difference between race and ethnicity? ○ Race is a social construct that groups people together based on specific looks; whereas, ethnicity is a group of people sharing a heritage. ○ What is an example of a race versus an ethnicity?

	Cognitive Component of Person (EHP)	• Do you understand any of the terms differently after having gone through this activity? • What did this experience/activity teach you? • Did this activity teach you anything new about yourself? • Is there a term or concept you heard for the first time today? Which one(s)?
		Application • What are some takeaways from this experience? • What purpose does this activity serve for you? • How might you use what you learned from this activity? • Share something you would like to change about your approach at the long-term care facility. • How can you use the information you learned in this activity? • What will you do to apply this information to your role as a health care provider? • How does this activity and what you have learned specifically apply to a long-term care setting? • How might this affect the way you interact with residents in the future? ○ Refer to your worksheet for some idea. Add strategies for developing a plan to use culturally competent practice with residents. • How does this change your perceptions of others?

	Summary:
	• Most important points:
	  ○ This activity was chosen to help bring awareness to concepts regarding cultural competency. Cultural competency, as learned, is not solely the absence of discrimination but the promotion of individuals' culture.
	• Acknowledges contribution of members:
	  ○ I want to thank everyone for participating and abiding our group expectations.
	• Reinforces learning:
	  ○ Revisiting our objectives, do you feel we have met them? [Re-read objective]
	• Ends group on time (50 min):
	It looks like we are out of time, but thank you, again, for participating.	

Worksheet C

Session 2: The Race Race

Baby boomers: adults born between 1946 and 1964. (Bonder, 2009)

Cultural competency: actively acknowledging and incorporating culture, assessing cross-cultural relations, analysis of cultural differences, and enhancing cultural knowledge to interact with a person (Betancourt et al., & Owusu Ananeh-Firempong, 2016).

Culture: "refers to our way of life, including everything that is learned, shared, and transmitted from one generation to the next" (Bucher, 2015, p. 2)

Diversity: "any trait that distinguishes any person(s) from one another, including abilities, talents, interests, ancestry, religion, race, values, or any other specification of a group or individual" (Bucher, 2015, p. 22).

Double consciousness: "refers to a person's awareness of his or her own perspective and the perspective of others" (Bucher, 2015, p. 109).

Ethnicity: "the conscious of a cultural heritage shared with other people" (Bucher, 2015, p. 20)

Ethnocentrism: considering one's culture is superior to any other culture (Bucher, 2015, p. 66).

Ethnogeriatrics: a specialized construct that describes the various needs of older adults while considering ethnicity. Needs may include alternative beliefs about illness, disease, and dysfunction as compared to Anglo-Americans.

Hispanic population: Hispanic population was the fastest growing ethnic group from 2000-2010, with a 43 percent increase, making Hispanics largest ethnic group in the United States in 2010, comprising 16 percent of the population (Humes, Jones, & Ramirez, 2011).

Minorities: "categories of people whose members are singled out and denied equal power and opportunity in the larger society" (Bucher, 2015, p. 8).

Personal barriers: "refer to those individual factors that get in the way of our success" (Bucher, 2015, p. 62).

Race: a social construct of grouping people based on perceptions of their appearance.

Stereotype: any "unverified or oversimplified generalization about an entire group of people" (Bucher, 2015, p.68).

Strategies to use when working with a resident to promote culturally competent care:

Bastable, (2011, p. 299-301)) lists strategies to working with others of various cultures,

- Identify the resident's first language and establish effective and clear form of communication between health provider and resident, whether using a translator, translation system, and/or body language.
- Observe resident behaviors and interactions (ex. etiquettes, expressions, nonverbal). Ask questions for clarification. Consider family dynamics, the resident's beliefs, and resident's interests.
- Show enthusiasm for the resident and their culture by asking questions, complimenting on new ideas (showing genuine interest), and by offering activities or options to engage client in activities relevant to their stories and cultural descriptions (tailored to the resident's understanding of their culture).
- Understand the practices and rituals for religious beliefs.
- Become oriented to the resident's sense of time and importance of timing.
- Avoid jargon or technical terminology.

Add other strategies (during discussion):

Training Session 3
Clash of Cultures

Session 3: Clash of Cultures

This activity involves a peer activity and engages the participant through the learning method of group discussion, one-to-one instruction, and simulation. Fitzgerald (2011) described group discussion as an effective intervention for adult learning as it is affective and cognitive, creates an active learner role, and stimulates ongoing thoughts regarding ideas and emotions. One-to-one instruction is used as it is cognitive, affective, and psychomotor, creates an active learner role, and is adjusted based on each individual learner. Group discussion is used as an emotional and cognitive strategy to actively involve the participants. As group discussion promotes sharing of ideas and emotions, it is important to discuss after the activity to reflect and acknowledge ideas and emotions, while receiving feedback from peers. The activity varies read/write, auditory, kinesthetic, and visual components as to engage participants through various learning styles (Kitchie, 2011).

Session 3	
Training Session Preparation	**Title:** Clash of Cultures
	Task Objectives The overall goal of the final session (session 3) is to enhance cultural competency in working with older adults in the long-term care facility. Please freely share experiences and strengths as they will benefit the group. 1. By the end of the session (50 minutes), facility staff members will contrast two cultural perspectives with another facility staff member. 2. By the end of the session (50 minutes), facility staff members will distinguish a minimum of three barriers to culturally-sensitive interactions with residents. 3. By the end of the session (50 minutes), facility staff members will identify person, task, and environment factors related to culturally competent care in the long-term care setting.
	Supplies and Cost The activity requires Worksheet E/F, Post-Test, and a writing utensil for each group member at no cost to the member. Each piece of paper cost 4 cents per paper (will need 5-6, 1 per member), which the facility will provide. The facility will provide a pen or pencil for each group member.
	Environment Physical Environment • Arrange chairs around a table, facing each other to facilitate discussion

	• Adequate lighting • Close the door, and eliminate unnecessary noises • Bring: copies of Worksheet E, F, Post-Test, and Pre-Tests if saved. Social Environment • 4-20 participants, optimally 6-12 participants Temporal • 50 minutes: Introduction and warm up (5 minutes), activity (10 minutes), discussion and wrap up (35 minutes) Cultural • Topic addressed
	Introduction • Explain objectives (above). Ask if there are any questions, comments, or concerns. o Does anyone have any questions, comments, or concerns? • Expectations for group: o What happens in group, stays in group o Respect for others o Participate as you feel comfortable, yet challenge yourselves to step out of your comfort zone. • Outline timeframe for group: Up next, we will do a quick warm-up, proceed to our activity, which involves drawing and peer interaction. Following the activity, we will have a discussion based on the activity. • Asks for feedback regarding clarity: What questions do you have? • Warm Up (5 minutes): Have participants go around in a circle and share. • Let's go around in a circle and share about a time you were especially proud of yourself regarding an interaction with a resident in what could have been considered a "clash of cultures".
Session Structure	**Task Activity** • Pair everyone into partners. Pass worksheet E to one of the partners and Worksheet F to the other partner. Ask them to read the instructions quietly, to themselves as to not let their partner know what their instructions say. Ask them to answer the questions on their worksheet after they have completed the task on the top of their worksheet. o In partners, you will complete your activity on the top of your paper. Read your instructions at the top of your worksheet privately; do not let your partner see your paper. Complete the worksheet questions after you have completed the activity under "instructions". Begin. • After 3 minutes, ask everyone to stop. Then ask them to fill out the questions on the worksheet if they have not done so at this point. • Introduce the Post-Test. o Once you have filled out your worksheet, please come get a copy of the Post-Test from me and fill it out quietly. Thank you. o Pass out the Pre-Tests.
	Sharing Experiences • Next, I would like to invite each member to share your experience with the activity: o What was the important word in this activity scenario?

	Psychosocial Components of Person (EHP)	• Let's go around and share your experience with the situation described on the worksheet and briefly describe how both parties may have felt during that situation. • What changes do you see from your Pre-Test to Post-Test? • What comments did you make on your tests? Let us address any unanswered questions.

		Processing
		• How did your perception change once you caught on to what your partner's instructions read?
		• How did person with Worksheet E feel when you read your instructions?
		• How did person with Worksheet F feel when you read your instructions?
		• Why was "please" so important?
		  o Bucher (2015) explains that in some Eastern cultures, such as in Japan, talking more is perceived as impolite and disrespectful and silence demonstrates more respect. How does that compare similarly to this activity?
		• Generally, who was more stressed, person with Worksheet E or F?
		• What was the purpose of this activity?
		  o We did this activity to change our perception on communication and emphasize the importance of listening to a resident and/or observing what they respond well to.
		• How does this activity relate to health care?
		• Who would be the health care provider in this scenario?
		• Who is the resident in this scenario? Why?
		  o Could you switch the two roles? How would that change the health care delivery?
		• What are some things you learned during this activity?
		  o If you were feeling "worked up", how did you calm yourself down?
		  o How could you use those strategies on the job?
		• Provide an example of what would be strong, client-centered service using your self-assessment.
		• Provide an example of where the components in the self-assessment were not considered in delivering care for a resident? How did it impact the resident, outcomes, and interactions?
		• How did person with Worksheet E view their partner? How did person with Worksheet F view their partner?
		• What were some thoughts you had throughout the activity?
		  o What particularly made you more frustrated or less frustrated?
		  ▪ Time constraints, the instructions, the way your partner spoke to you?
		• What specifically made you change a rating on your Post-Test as compared to your Pre-Test?
		• Are there any questions from your Pre-Test that are unanswered?

	C	**Generalizing**

		• What were some similarities to how person with Worksheet F felt to how you felt in your identified situation with a resident from the first question on the worksheet?
		• What are some similarities between how person with Worksheet E felt to you describe how your resident may have felt in the situation described in the first question?
		  o What were other common themes you noticed?
		• What were some differences you may have noticed?
		• What difference between partners made the activity more challenging?
		• What difference in values between you and your resident made it more challenging?
		  o What could have gone differently to ease the situation?
		• What did this experience/activity teach you?
		  o Did this activity teach you anything new about yourself?

		Application • What are some takeaways from this experience? • How might you use what you learned from this activity? • Thinking about what we have talked about, how might that minimize health care errors? • What will you do to apply this information to your role as a health care professional? • How might you cope during your next cultural mismatch with a resident? • How might you change your perspective during the next cultural mismatch with a resident? • Why is it important to understand how to change your point of view?

	Summary of Effectiveness, Efficacy, and Satisfaction:
	• Most important points:
	  o This activity was chosen to help bring some awareness to the way interact with residents, both positively and negatively. None of us are perfect and we will make mistakes in social situations and as practitioners, but it is important to challenge yourself to stop and reflect rather than allowing yourself to ruminate in frustration. You all did a wonderful job participating, I appreciate that. If you have any further questions or comments, please feel free to share.
	• Acknowledges contribution of members:
	  o I want to thank everyone for participating and abiding our group expectations throughout this training series.
	• Reinforces learning:
	  o Revisiting our objectives, do you feel we have met them? [Re-read objective]
	• Ends group on time (50 min):
	It looks like we are out of time, but thank you, again, for participating.	

Worksheet D

Session 3: Clash of Cultures

Post-Test		
Instructions: Answer each question based on your past *two weeks* as a health care provider. Rate your ability to provide health care (pertaining to each question) on a scale of 1 through 5 based on *1=strongly disagree, 2=disagree, 3=neutral, 4=agree, 5=strongly agree.* Include any additional comments as a reflective tool or for any thoughts you would like to address in discussion.		
Question	**Rate**	**Additional comments/notes:**
I ask each resident if they have any culture-specific needs or requests.		
I find I am genuinely interested when a resident speaks to me about their interests.		
I consider the resident perspective when sharing a story or an opinion while providing health care.		
I ask questions to learn more about other cultures.		
I consider the resident perspective before feeling upset or frustrated with a "tough resident".		
I consider myself an advocate for all my residents.		
I understand that someone may have differing expectations for their health care.		
I am willing and able to answer any questions regarding health care with a patient, respectful tone of voice.		
If a resident has differing values from my own, I provide the same quality of care as I would for someone with my same values.		
I offer resources for residents facing barriers, including: socioeconomic status, language differences, geographic isolation, discrimination, and/or lack of supports.		

Statement of commitment to cultural competency in the long-term care facility:

_____

_____

Specific strategies I will use to achieve cultural competency with residents:

_____

_____

Worksheet E

Session 3: Clash of Cultures

Instructions: READ SILENTLY

You will be asked to draw a figure on the back side of this paper from a partner. Follow their instructions to the best of your ability only if they say "please". If they do not say "please", do not follow the instruction given. They must say "please" for every instruction provided. If they do not say "please", you can choose another behavior instead of drawing; ideas include: draw something they did not ask of you, refuse to draw, say "no", etc.

TO BE DONE AFTER THE ABOVE INSTRUCTIONS ARE COMPLETED

Briefly describe a time you encountered a misunderstanding due to differences in culture?

_____
_____
_____
_____

List emotions: How did you feel after working with this person?

_____
_____
_____
_____

What may they have felt? How may the situation have been perceived from the other end?

_____
_____
_____
_____

List strategies you use when working with someone who has differing perspectives (cultural or value-based).

_____
_____
_____

For discussion: What are some strategies your peers use when they disagree with a resident?

_____
_____
_____

Worksheet F

Session 3: Clash of Cultures

READ SILENTLY

Instructions

Ask your partner to draw a house on the backside of their sheet of paper. Give them specific instructions to draw your ideal house. If the house is not completed by the end of the activity, you fail the activity. After finishing your house, answer the following questions (for discussion and personal use).

TO BE DONE AFTER THE ABOVE INSTRUCTIONS ARE COMPLETED

Briefly describe a time you encountered a misunderstanding due to differences in culture?

_____
_____
_____
_____

List emotions: How did you feel after working with this person?

_____
_____
_____
_____

What may they have felt? How may the situation have been perceived from the other end?

_____
_____
_____
_____

List strategies you use when working with someone who has differing perspectives (cultural or value-based).

_____
_____
_____

For discussion: What are some strategies your peers use when they disagree with a resident?

_____
_____
_____

Product Summary

Overall, the scholarly project was driven by the findings in the literature. The literature indicated that the United States is increasing in age and diversity. Gaps in the literature indicated a lack of live trainings for cultural competency in health care. The ecological model of human performance, Cole's Seven Steps, and principles of adult learning were chosen to provide optimal training for interprofessional team members providing care to clients of diverse cultural backgrounds within the context of long-term care facilities. The resulting product was a culmination of teamwork, joint decisions, and actual implementation.

Chapter V: Summary

Educational sessions address the need of educating long-term care staff on cultural competency regarding residents of an aging, increasingly diverse population. The United States population is growing older and more diverse (USCB, 2017). Health care facilities, especially long-term care facilities, need to adapt for the population it is serving. With a current lack of attention to culture in long-term care facilities, it is vital to train facility staff in providing culturally competent care using interactive and engaging educational sessions (Azevedo et al., 2013). The scholarly project included three education sessions designed to promote cultural understanding of older adults in long-term care facilities. The education sessions involve interactive, evidence-based activities tailored to engage adult learners into discussion and consideration of resident culture.

Using the Literature Review

The literature assisted in developing the product by providing evidence for the need. There was a clear need for cultural competency training, especially with regard to older adults as there is a current "culture of no culture" in long-term care (Taylor, 2003). Due to a lack of addressing cultural needs, clients of diverse cultural backgrounds are experiencing a lower quality of care (Ihara, 2004). The solution to the low quality of care is training for staff to provide best care by involving cultural considerations into treatment.

Use of the Ecology of Human Performance

To develop the training sessions, the occupational therapy students used an occupational therapy theory to guide the development of the training series. Because an occupational therapist will be presenting the training, it is appropriate to use the occupational therapy theory, EHP. EHP focuses on increasing performance range of the person, the staff member. Surrounding the

person is the context, which refers to the staff member working within the long-term care facility. Further, the person, working in the context, is working to improve their ability to complete more tasks (increasing performance range), which translates to the health care provider treating residents with culturally-competent care. Additionally, the ecological model is suitable for education practices and considering culture, which are both focuses of the training series (Dunn et al., 1994).

Developing the Training Sessions

An occupational therapist will implement the program over the noon hour for 50 minutes each session over a span of once a week for 3 weeks. Marsland and Bowman (2010) reported improvement in employees' goal writing skills by offering three 50-minute education sessions over the noon hour for three months. The product was modeled after this study in order to increase health care providers' cultural competency skills in the long-term care setting. The occupational therapist can implement the education sessions in a variety of timeframes due to the flexibility of the education session structure; therefore, if there is a site-specific, convenient timeframe for facilities to engage health care providers in training, the occupational therapist will alter the time of day and offer the education session to reach a wider range of health care providers. The sessions will take place in a long-term care facility in a separate space with tables and chairs set up for health care providers to discuss and participate in activities. A licensed occupational therapist will deliver sessions to the health care team, who will also measure effectiveness of session via pre-tests and post-tests provided at the beginning of the first session and the end of the third. Health care professionals are to use pre-test and post-test scores for personal accountability; if a health care worker cares to share their scores with their facility, they may, though not required.

Limitations

Developing education sessions to enhance the cultural competency of health care providers in the long-term care facility is challenging as staff diversity, discussion practices, and interests vary facility-to-facility. Further, culture is a complex topic to teach, learn, and adapt to through staff and resident preferences. Some limitations for the training sessions include its delivery in English as health care providers may not have English as their first language. Another limitation is only having three sessions; culture is an ongoing process to learn and appreciate and is, therefore, difficult to fit into a finite number of training sessions. The occupational therapists deliver the education sessions aurally with visual and kinesthetic components, but if health care providers have a hearing disability, the occupational therapist will need to adapt the presentation of the information. Such adaptations are not included in the scholarly project and serve as a limitation. Additionally, albeit an occupational therapist delivering the sessions was intentional and well-suited for training health care professionals, it creates a demand for there to be an occupational therapist available to learn the education sessions and have time to deliver them. A limitation perceived by the facility management may include scheduling difficulties and non-billable productivity of health care professionals.

Further Research and Implications

Further research may address more narrow topics, such as: specific ethnic cultures, cultures of aging adults, the Lesbian Gay Bisexual Transgender Queer and Questioning (LGBTQ+) community, specific religious cultures and rituals, and considering culture through documentation. Further development may include follow up education sessions, videos, or activities to engage the health care professionals over a longer span of time. In addition, it is important to consider the methods of delivery and who delivers the trainings. It could be an

option to further explore virtual training sessions and how to best engage the adult learner to enhance competencies, cultural or otherwise.

Summary

Because of the increasingly diverse, aging population coupled with a current "culture of no culture" (Taylor, 2003), it is essential for occupational therapists to provide training sessions to health care providers in long-term care facilities to promote cultural competency; therefore, health outcomes, quality of care, and resident satisfaction of all residents in the long-term care facility will increase. Occupational therapy students developed the three training sessions with a pre-test and post-test to enhance health care provider cultural competency in the long-term care facility and incorporated interactive learning methods to engage the adult learner. The occupational therapy students used a literature review, model, and discussion with an experienced faculty member to develop and refine evidence-based training sessions. Use of the sessions will promote cultural competency among health care workers in the long-term care setting, which will result in higher resident satisfaction and health outcomes.

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