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School of Occupational Therapy

Creating a Cultural Competence Toolkit for Indiana First Steps Providers

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Abstract

The purpose of this capstone was to evaluate the effects of a cultural competence toolkit on early intervention (EI) providers' self-reported levels of comfort in providing culturally competent services to minority families on their caseload. This quantitative, quasi-experimental design study used a pretest posttest method to assess change in comfort level scores relating to cultural awareness, knowledge, skills, and practice using an adapted version of the Cultural Competence Assessment Inventory (CCAI). Adaptation of the CCAI was completed to tailor the questions to the needs of the site and of the project. This capstone was conducted at a pediatric autism center with its' affiliated EI service providers. Participants included 10 occupational, physical, speech, and developmental EI therapists (N= 10). Participants completed a pre-outcome measure and were then presented with the cultural competence toolkit that they completed and integrated for five weeks. Following the completion of the toolkit, EI therapists participated in an open-dialogue, virtual reflection session. Immediately following, participants completed the post-outcome measure. Pre and post data were collected in Likert scale form and were later assessed using SPSS and the Wilcoxon's signed-rank test. EI providers demonstrated a statistically significant improvement in comfort levels when addressing minority families after the intervention. Aggregate scores improved 3.9 points from 27.8 on the pretest to 31.7. Cultural competence education in an EI setting where providers must interact and step in-home with culturally diverse families significantly enhances attitudes, knowledge, communication, and advocacy in therapeutic services.

Keywords: early intervention; cultural competence; multicultural diversity; ethnic minorities; pediatrics

Creating a Cultural Competence Toolkit for Indiana First Steps Providers

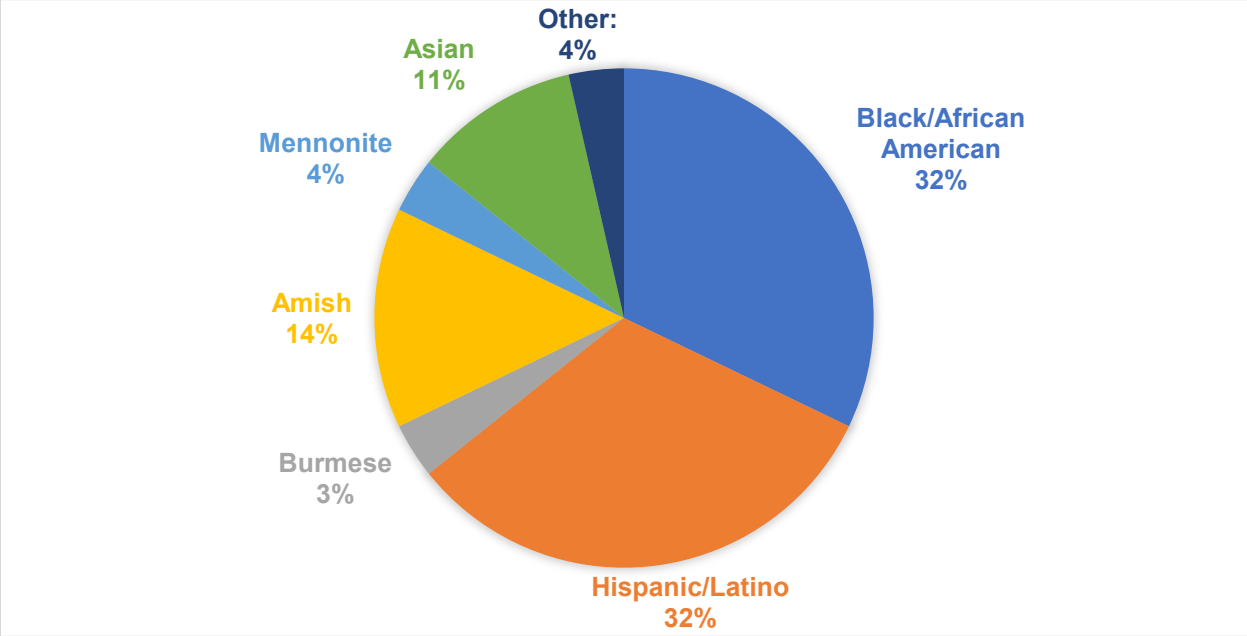
"All children have the right to equitable learning opportunities that help them achieve their full potential as engaged learners and valuable members of society" (NAEYC, 2019). Within early intervention (EI) services and throughout the United States, minority populations continue to grow (Durand, 2010). This growth urges EI professionals to develop skills that support proficient, multicultural services. To develop skills that meet the needs of society, therapists need organizational support and readily available resources within the workplace. Unfortunately, therapists often report feeling unsupported by their organizations (Grandpierre et al., 2018; Martinez & Leland, 2015).

Possibilities Northeast (PNE) is a pediatric therapy clinic in Fort Wayne, Indiana whose vision is to develop programs that meet the needs and unique differences of all children and families served (Possibilities Northeast, n.d.). The clinic offers EI services that address the needs of children aged zero to three from Burmese, Hispanic/Latino, African American/Black, Amish, and Mennonite backgrounds (C. Elder, personal communication, February 22, 2021). Population data is presented in Figure 1.

First Steps, Indiana's EI program, provides occupational, physical, speech, and developmental therapies to children from birth to three years of age who face developmental delays or disabilities. First Steps' goal is to ensure that children receive help early to support them in their future. Reporting more than 20,000 families and children served, EI therapists see a multitude of cultures and ethnicities daily (Family and Social Services Administration, 2020). First Steps is guided on providing client-centered, culturally competent, and individualized services (Family and Social Services Administration, 2020). Without cultural competence development, EI professionals are unable to carry out the foundations that drive the program.

Figure 1

Populations Served by Indiana First Steps Providers at Possibilities Northeast



Note. Data collected was from 10 First Steps therapists (*N*=10). Response in "Other" category was "Indian."

Approximately 92% of EI staff at PNE is White (C. Elder, personal communication, February 22, 2021). With many diverse families seeking EI care, a predominantly White staff struggles to provide culturally competent services (C. Elder, personal communication, February 22, 2021). PNE fails to provide therapists with trainings that address diverse population care, resulting in decreased levels of comfort when caring for minority families (C. Elder, personal communication, February 22, 2021). A lack of confidence in multicultural care puts minority families at risk of not obtaining high quality services. The purpose of this capstone was to develop a cultural competence toolkit that enabled EI therapists to develop the necessary skills to address multicultural needs when providing in-home services. The toolkit included four modules (see Appendix A). This capstone aimed to increase organizational support and EI therapist comfort levels when providing services to minority families.

Background

In 2015, the United States Census Bureau projected that by the year 2020, more than half of the nation's children would belong to a minority race or ethnic group (U.S. Census Bureau, 2015). As U.S. minority populations grow, a cultural competency toolkit is necessary to prepare EI professionals to work with cultures different than their own (Agner, 2020). Govender et al. (2017) defines cultural competence as:

> A process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, and ethnic backgrounds in a way that recognizes, affirms, and values the worth of the individual and protects and preserves the dignity of each. (pp. 2)

The continued advancement of the occupational therapy profession relies on the preparation of therapists to practice across multicultural settings (Sonn & Vermeulan, 2018). With a "majority-minority" nation ahead (U.S Census Bureau, 2015), culturally competent healthcare is vital to increasing patient satisfaction (Govere & Govere, 2016).

Cultural competence programs have been created in variety of forms, but with similar aims to improve attitudes, knowledge, and skills of healthcare professionals (Jernigan et al., 2016). One study suggests that approximately 40% of programs have based their trainings on the foundations of Betancourt et al. (2003) that identifies attitudes, knowledge, and skills as necessary to build cultural competence. Attitudes and self-awareness measure healthcare professionals' recognition of biases, curiosity, and empathy (Association of American Medical Colleges, 2022). As cultural competence cannot begin until one understands how personal cultural values affect their health care beliefs (Govender et al., 2017), understanding how one's own views affect work cross-culturally is imperative. Programs addressing attitudinal barriers

increased confidence among professionals (Kaul & Guiton, 2010; Lie et al., 2010; Campbell et al., 2011; Parisi et al., 2012).

Improving culturally diverse knowledge is targeted among cultural competence programs. Some existing programs view culturally diverse knowledge as properly addressing families and identifying cultural customs (Dabney et al., 2016), while others view it as understanding how to enable understanding of cultural competence, racial awareness, and appropriate clinical behaviors (Webb & Sergison, 2002; Crandall et al., 2003). Many cultural competence programs lack providing healthcare professionals with the norms, values, and beliefs of the very minority populations they serve. Easy access to this information may allow therapists to be more open to learning about their client's cultures, leading to greater knowledge of their background, and increasing cultural competence.

One factor consistent in determining patient satisfaction in minority populations is communication (Govender, 2017; Martinez & Leland, 2015; Mirza & Harrison, 2018). Occupational therapy relies on communication to deliver effective intervention (Govender, 2017). Without communication, exchanging vital information pertaining to intervention, recommendations, and parent/caregiver education will lack. As a result, language discordance can have a detrimental impact on cultural competence and therapeutic services (Govender et al., 2017). Several cultural competency training programs address cross-cultural communication through effective education on communication strategies and interpreter usage (Aeder et al., 2007; Crandall, 2003; Webb & Sergison, 2002; Cha-Chi et al., 2010). By incorporating cross-cultural communication education, therapists may feel more comfortable and equipped to provide higher levels of care to minority populations (Brown et al., 2016).

An online cultural competency toolkit will not be effective on its own. Mirza and Harrison (2018) highlight the importance of combining online trainings with reflective assessments to produce long-term effects. To sustain long-term cultural competence, maintaining higher-level moral thinking through cultural awareness is necessary (Henderson et al., 2018). Involving healthcare professionals in open dialogue supports the advancement of culturally competent care (Manis, 2012). Different than other training programs, this toolkit included open dialogues with EI professionals to promote development of culturally competent skills. Sonn and Vermeulen (2018) found that therapists need to be supported in participating in culturally diverse situations. This toolkit pushed therapists beyond education and supported them in taking advantage of their position as EI professionals to apply their knowledge within in-home services. The repetition of self-reflection provides reinforcement of behaviors that lead to more culturally competent services (Mirza & Harrison, 2018).

A needs assessment with therapists, directors, and First Steps coordinators of PNE determined that therapists require increased support and resources when addressing families with diverse cultures. Creating a cultural competency toolkit that addressed attitudes, knowledge and skills enabled PNE and their EI therapists to meet the unique needs and differences of all children and families served, as their vision statement delineates (Possibilities Northeast, n.d.). This unique toolkit enabled therapists to not only feel better prepared to conduct face-to-face interventions with multicultural families, but took a distinctive approach to cultural competence, more aligned with cultural humility. An encyclopedic knowledge of cultures was not expected from therapists; instead, the toolkit challenged therapists to undertake a lifelong commitment of self-evaluation, self-analyzation, and self-progression to create permanent changes in their cross-cultural service delivery (Stubbe, 2020; Rajaram & Backrath, 2015).

Theory to Guide Practice

Occupational Adaptation

The Occupational Adaptation (OA) model focuses on the interactive processes between a person, their environment, and the internal adaptive process that occurs when the individual is engaged in occupations (Cole & Tufano, 2008). When an environment demands more than what the individual can competently meet, decreased occupational performance results (Cole & Tufano, 2008). PNE creates a high demand for culturally competent therapists but does not provide resources that prepare therapists to provide culturally competent services. The OA model delineates the importance of guiding change through intrinsic motivation (Cole & Tufano, 2008). Incorporating a cultural competence toolkit allowed therapists to self-reflect and recognize the need to change, modify, or adapt their services. This behavioral change allowed therapists to go through an adaptation response mechanism, or a plan for action (Cole & Tufano, 2008). Integrating a cultural competence toolkit enabled PNE to provide resources for therapists to meet their environmental expectations.

Ecology of Human Performance

The Ecology of Human Performance (EHP) guided satisfactory occupational, physical, speech, and developmental therapy services received by multicultural populations. The EHP focuses on the impact that context has on task performance (Cole & Tufano, 2008). The EHP looks at four constructs: the person, context, tasks, and how well the person can perform tasks in their environment (Cole & Tufano, 2008). For this DCE, a child's personal variables disrupt the way they can independently engage in occupations and roles. The toolkit addressed the contextual factors that minority families were in, having trickling effects that supported their child's personal variables. The cultural competence toolkit addressed how therapists can better

understand the families' environment, culture, and expectations to equip them on how to modify, adapt, or establish tasks and roles (Cole & Tufano, 2008). The EHP guided the DCE project as it helped navigate how cultural competency trainings allow therapists to better adapt to the contextual needs of minority families.

Project Design

To measure EI therapist comfort levels when providing services to multicultural families, a quasi-experimental design with a pretest posttest method was used. Through convenience sampling, 10 EI therapists participated in completing the cultural competence toolkit. Prior to the completion of the toolkit, therapist comfort levels were assessed using the Cultural Competence Assessment Instrument (CCAI). The CCAI, a 36-item tool created by Suarez-Balcazar et al. (2011), measures cultural competence among rehabilitation practitioners who serve individuals with disabilities from diverse backgrounds. Demonstrating strong psychometric properties, the CCAI looks at four cultural factors: awareness, knowledge, skills, and practice. Due to our focus on comfort levels in these four areas, the CCAI was modified to consist of 13 items that are rated on a three-point Likert scale with a rating of "3" indicating "very comfortable," a rating of "2" indicating "somewhat comfortable," and a rating of "1" indicating "not comfortable," to fit the needs of the site and of the therapists of being quick to use (Preston & Coleman, 2000). The pre and post outcome measures were developed on Qualtrics, an online survey software, and sent to EI therapists. The adapted version of the CCAI was administered during the second and 10th week of the DCE to obtain changes in comfort levels when serving minority families.

Due to limitations in technology and usage by PNE EI providers, modules were created using Microsoft PowerPoint, a familiar system to all therapists, to increase effectiveness (Hode et al., 2018). An overview module was sent out, along with the pre-outcome measure, to provide

therapists with a background of the project. The other modules, created using evidence-based findings, included: Attitudinal Barriers, Learning About Cultures, Communication, and Resources.

The capstone was divided into three phases: initial implementation, reflection, and dissemination. EI therapists who completed the pre-outcome measure, were sent an email containing a timeline of the project and attachments to all modules. Successful implementation of the capstone required delegating roles to different site stakeholders. The primary role of the executive director of PNE included sending out email communications, pre and post outcomes measures, and project files. Due to staff shortages, the director faced difficulties in sending out email communications on time, setting back the project timeline. This timeline setback forced an adjustment of dates for phase two which included open dialogue reflections.

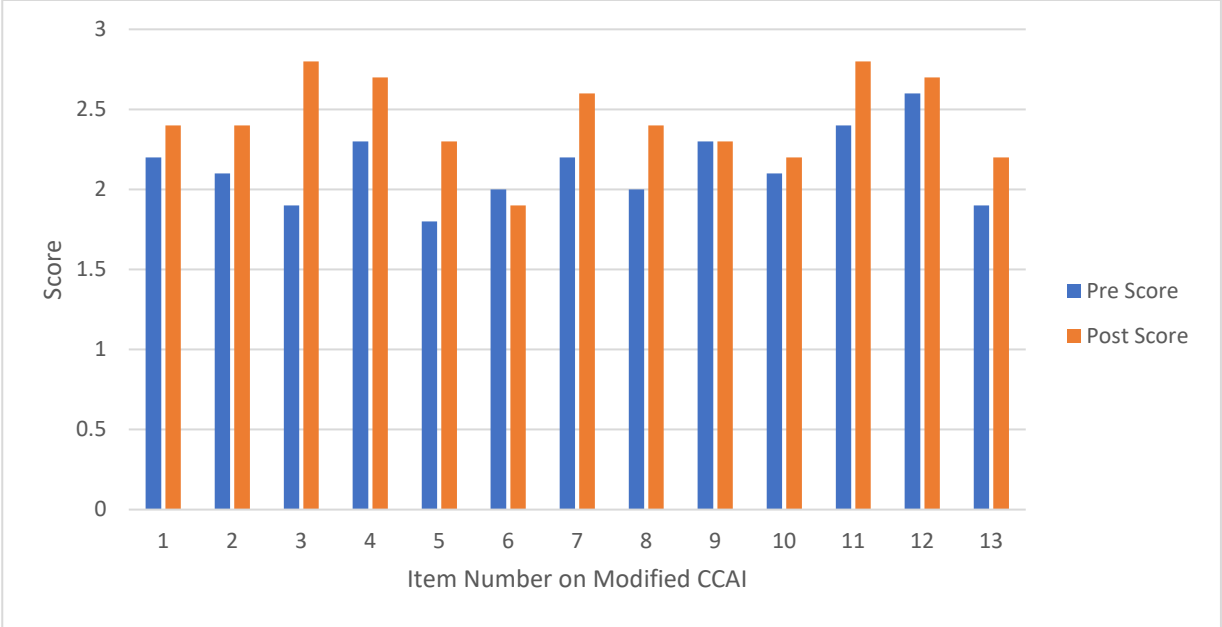
10 EI therapists participated in a five-week implementation period where they completed the toolkit and actively implemented suggested strategies into their First Steps sessions. Due to COVID-19 concerns, communication with therapists occurred through email and Zoom, a video conferencing platform. After the implementation period, a reflection session was conducted via Zoom. By eliciting thought and innovation through open-ended questions, participants actively considered their and others' thoughts and actions and used "reflective thinking as a tool for continuous improvement" (Helyer, 2015). Open-ended questions were guided by Gibbs reflective cycle to allow for reflection about their learned experiences (Markkanen et al., 2020; see Appendix B). To evaluate the efficacy of the toolkit, therapists were sent a post-outcome measure immediately following the reflection session. At the final dissemination, all participating therapists, and the director of PNE were presented with the project outcomes and discussed future directions and implications of the project.

Project Outcomes

A total of 10 EI therapists participated in the completion of the cultural competence toolkit. Participants included occupational, physical, speech, and developmental therapists. All participating therapists were White females. Pre and post-test scores were compared for each of the 13 items on the modified CCAI. Data from the modified CCAI was imported into a Microsoft Excel spreadsheet and then analyzed in SPSS utilizing the Wilcoxon Signed Ranks Test. The Wilcoxon Signed Ranks Test produces a more sensitive statistical test when using it with paired data that are measured on at least an ordinal scale and is especially effective when the sample size is small (Doane & Seward, 2007; see Table 1). When examining the 13 items, statistically significant improvements, or positive ranks, were notable on 11 of the 13 items (see Figure 2). Additionally, therapists' comfort level total scores (aggregate score for all 13 items) showed significant improvement after completion of the cultural competence toolkit (see Appendix C). Aggregate scores improved 3.9 points from 27.8 on the pretest to 31.7 on the posttest. A Wilcoxon signed rank test revealed that therapist comfort levels significantly increased after completion of the cultural competence toolkit (*Md=2.4, n=13*) compared to before (*Md=2.1, n=13*), z = -2.92, p=.004, with a large effect size, r = .57. These statistical results show that the presentation of a cultural competence toolkit significantly increased therapist levels of comfort when providing services to minority families.

Figure 2

Modified CCAI Pre Outcome Measure Scores vs. Post Outcome Measure Scores



Note. Information displayed demonstrates scores obtained from Modified CCAI (Cultural Competence Assessment Instrument).

Table 1

Wilcoxon Signed Ranks Test

	Ranks	N	Mean Rank	Sum of Ranks
Posttest - Pretest	Negative Ranks	1[a]	2.00	2.00
	Positive Ranks	11[b]	6.91	76.00
	Ties	1[c]		
	Total	13		

Note. Superscript *a* = posttest < prettest, superscript *b* = posttest > pretest, superscript *c* = posttest = prettest.

Therapists demonstrated increased scores in three areas: obtaining resources, having readily available resources, and advocating for the inclusion and healthcare of minority families. During the reflection session, therapists expressed that the cultural competence toolkit was the only resource given to them by their organization that addressed cultural competence needs. Many therapists stated that they found most use in the fourth module as they explored not only the resources made available to them, but the resources available through the state to give to their families. Therapists stated feeling like their role in advocacy needed to increase and felt supported through the toolkit to do so. Item six of the modified CCAI demonstrated a score decrease, meaning that therapists reported decreased comfort in providing quality services to non-English proficient minority families.

Summary

For therapists, it is important to understand their role in advancing equitable care. The demographics reported in this project are indicative of the rapidly growing minority populations needing EI services, increasing the urgency of developing culturally competent therapists. Organizations must rapidly follow suit to increase the support they give therapists to alleviate levels of comfort. Through the exploration of already existing cultural competence trainings, the importance of creating programs that meet the current needs of therapists and society was noted. Integrating innovative practices within the toolkit, such as open-dialogue reflection, further addressed the desired permanency of learned practices, skills, and used resources within therapists' daily services. Examining the effects of implementation of a cultural competence toolkit within EI is important within OT intervention and all other EI services. This toolkit provided EI therapists with cultural competence resources for self-reflection, cultural knowledge, communication, education, and advocacy. The toolkit sought to identify changes in levels of

comfort when providing services to minority families using a pretest posttest measure and addressed gaps within already developed programs to target lifelong learning.

Project outcomes demonstrated a statistical significance in the modified CCAI scores assessed, indicating increased levels of comfort with providing services to multicultural families after completing the cultural competence toolkit. Increased comfort levels in 11 items supported findings in the literature of the predicative relationship between higher organizational support and higher integration of equitable practice (Grandpierre et al., 2018; Martinez & Leland, 2015). The item with a negative rank demonstrated decreased levels of comfort in providing quality services. Based on this project's goal of helping therapists understand their own biases in culturally competent care, the negative rank may be indicative of therapists' renewed understanding that their previous care did not meet the quality standards that they and their organizations once assumed. The decreased score can be reflected to be a positive change in guiding needed modifications within therapeutic practice to meet the needs of the eclectic cultures EI therapists serve. It is important to support therapists' bridge their cultural knowledge gap when caring for families that share differing cultures. Addressing this gap may ultimately help create and maintain rapport with minority families. This capstone may help promote increased therapeutic outcomes in minority homes and help *all* children work towards a more purposeful and meaningful life.

Conclusion

The outcomes of the project were disseminated to therapists and directors of PNE through an in-person presentation that included tables, figures, and easy to understand data followed by a collaborative discussion. Given the significance of the results, the director spoke about the importance of implementing the toolkit within their onboarding programming.

Additionally, a physical therapist at the site is currently developing a project for EI therapists that delineates important contact information for different doctors and specialists in the Fort Wayne area. Due to the nature and topic of this DCE project, many therapists expressed the importance of including contact information of providers who focus on specific minority cultures as a resource for these families.

Obtaining only a small sample size within a suburban city raises several opportunities for future research. This project was designed specifically with PNE at the forefront, but First Steps expands throughout the entire state of Indiana. To further elaborate on this project's findings, future research can venture out to other agencies to acquire data on a wider, more generalizable, scale. Additionally, demographics taken of EI therapists provided us with some knowledge of therapist background. Further investigating how comfort levels may be impacted by income, age, geographical location, socioeconomic status, and graduating year may provide a more accurate baseline depiction of pre outcome measure scores.

Culture is complex and as a result, developing cultural competence will not occur overnight. As occupational therapists, cultural competence is a skill that is necessary to increase the effectiveness of client-centered care. The continued growth of the occupational therapy profession relies on therapists to effectively interact with diverse populations. Therapists are constantly expected to evolve their practices to meet the everchanging needs of the communities they serve but obtaining resources that are pertinent to those needs is not an easy task. Workplaces must be ready to support their staff in developing skills to meet their client's goals. Allowing EI therapists to complete a cultural competence toolkit provided them with the opportunity to seek and implement suggested strategies and learnings within their day-to-day care of minority families. This capstone readily addressed the needs of the site and of the

therapists and provided a foundation for which to improve the quality of care to the minorities they serve.

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Appendix A

Transcripts of Cultural Competence Toolkit Modules

Cultural Competency Tool Kit Module 1: Attitudinal Barriers

”First Steps”
YOU ARE HERE!
Let’s Review…

- What is Cultural Competence?

Understanding Biases

- Who are YOU?
  - Understanding one’s own values “derived from family, background and position in society is critical for developing culturally responsive practice” (Dewees, 2001).
- Let’s Reflect…
  - How do these things position you in society?
- Understanding Your Racial and Ethnic Identity
- Why are Identities Important?
  - One’s racial and ethnic identity is a foundation for self-identity as it is how we identify with a given groups’ culture, values, and beliefs.
  - These identities may influence individuals' perspectives of race/ethnic stressors and how they enable culturally competent practice.

  Information retrieved from: (Woo et al., 2019; Phinney & Ong, 2007; Carter, 2007; Stevenson & Arrington, 2009).
- Critical Self Reflection
- Self-Awareness is Key to Cultural Competence: An Example
  - We are shaped by the world around us, like our geographic location, culture, social groups, etc.
  - Example: Eye contact
    - How we look at people is a basic and clear representation of our cultural values.
    - One individual may be raised in a family on beliefs of “look me in the eyes when I am talking to you!”
    - While the other individual may be raised in a family on beliefs of “don’t you dare look me in the eyes!”
- The White Majority
  - Demographics:
    - OTs: 78.8% White, 8.4% Asian, 6.2% Hispanic/Latino
    - PTs: 73.9% White, 13.7% Asian, 6.0% Hispanic/Latino
    - SLPs: 82.8% White, 8.2% Hispanic/Latino, 4.2% Black/African American
    - Developmental Therapists: 68.1% White, 14.6% Hispanic/Latino, 8.4% Black/African American

  Information retrieved from: (Zippia, 2021).

- Identity Development for White Practitioners
- However, Cultural Competence is **NOT** for White Practitioners Only…
    - Research finds that workplaces often assume practitioners can competently interact with anyone who shares their skin color.
    - The problem? Some racialized individuals carry negative feelings about members of their own race.
    - Negative stereotypes and attitudes toward their own group are often adopted

    Information retrieved from: (Beckford, 2020; Clair and Denis, 2015; Livingston, 2002; Young, 2011).
- Bottom Line
    - All practitioners MUST be cautious not to project their own experiences and biases onto their clients.
- Cultural Bias: Explicit Bias
    - Cultural bias begins when we are no longer neutral, but rather "we have a preference or aversion to a person or a group of people" (Perception Institute, n.d.).
    - Explicit Bias: When "individuals are aware of their prejudices and attitudes towards certain groups" (Community Relations Service, n.d.). The positive or negative preferences are conscious.
        - Examples: racism and racist comments
- Cultural Bias: Implicit Bias
    - How do Biases Impact Therapy
    - Examples of Biases Demonstrated by Therapists

Assessing Your Bias

- Cultural Competence Self-Assessment Checklist
- Use this checklist to identify your strengths and weakness and to develop opportunities for continuous personal and professional development:
- https://www.avma.org/sites/default/files/2020-08/Diversity-CulturalCompetenceChecklist.pd
- We will revisit this checklist at midterm and at the end of the project. The more points you have, the more culturally competent you are becoming.

Up Next:

- Module 2: Learning

Resources

Cultural Competency Tool Kit Module 2: Learning About Cultures

Let's Review…

- Cultural competence is a continuous process with the goal of gaining the skills to work effectively with diverse groups and communities with a "detailed awareness, **specific knowledge,** refined skills, and personal and professional respect for cultural attributes, both similarities and differences" (Suh, 2004).

YOU ARE HERE!

Why is Learning About Cultures Important?

- Knowledge is Key
- Where Early Intervention Falls Short…
    - American Culture is Used as the *"Norm"*
- Understanding Cultures Gives Us Insight
    - "Every interaction we have with a child is a cultural exchange" (Parlakian & Sanchez, 2006).
    - Caregiver routines and traditions are a direct reflection of the values, beliefs, and cultures of families and communities around them (Hyun, 2007).

Cultural Competence Expectations

- Early intervention professionals cannot be expected to develop encyclopedic knowledge of all values, beliefs, and practices in every culture.
- Instead, early intervention professionals should find ways to learn about and understand others' cultures to more accurately deliver services that reflect practices and values of the families they serve.
- By increasing basic knowledge of cultures, early intervention professionals can more effectively integrate family caregiving practices, beliefs, and goals into their therapeutic services.

Information retrieved from: (Jones & Lorenzo-Hubert, 2008; Melendez, 2005).

- In this Module…
    - We will focus on providing quick fact sheets for 6 minority populations:
        - Black/African American
        - Hispanic/Latinos
        - Burmese
        - Amish
        - Mennonite
        - Afghan
- Why these Populations?

Let's Get Started!

- Black/African American Cultural Norms
- Hispanic/Latino Cultural Norms
- Burmese/Myanmar Cultural Norms
    - Burmese and Myanmar Culture
        - 'Burmese' Cultural Norms
        - Traditional Customs of 'Burmese" Families
        - The Karen
        - The Chin
    - Amish and Mennonite Cultural Norms
        - Understanding Amish and Mennonite Communities
            - Many cultural norms are based on the families' "church-community."
            - "Changes in the norms of social interaction between members of a church-community or between the church-community and the

outside world generally indicate changes in the religious beliefs that constitute the community's sense of itself" (Johnson-Weiner, 2007).

- Understanding Amish and Mennonite Communities
  - Amish and Mennonite individuals live in closed, well-defined communities.
  - They follow a lifestyle that separates them from mainstream society.
  - Marriages outside of their community is frowned upon and prohibited.
  - Individuals very rarely convert to their faith. As a result of all these conditions, there is a high degree of genetic relatedness between parents.
  - Increased prevalence of specific genetic disorders present within their communities.

  Information retrieved from: (Sieren et al., 2016).
- Common Genetic Disorders in Amish and Mennonite Communities
  - Amish and Mennonite Cultural Norms
- Afghan Cultural Norms
  - Understanding Ethnic Groups in Afghanistan
    - "One's ethnicity is an instant cultural identifier in Afghanistan and usually defines people's social organization" (IU School of Medicine, 2021).
    - Understand that experiences of persecution differ between ethnic groups. As a result, "members of minority ethnicities may prefer to indentify by their ethnic affiliation" (IU School of Medicine, 2021).
    - Know that most Afghans are Asian, **not** Middle Eastern.
    - "The most common ethnic groups are the Pashtuns, Tajiks and Hazaras" (IU School of Medicine, 2021).
- Afghan Minority Populations
- Research
- Afghan Cultural Norms
- Traditional Customs of 'Afghan' Families

Disclaimer!

- Cultural norms discussed are based on evidence-based research and are **NOT** based on direct in-home observations of individual families.
- Black/African American, Hispanic, Burmese, Amish, Mennonite and Afghan minority groups **DO NOT** all share the same culture. The cultural norms discussed may apply to only some of your families!

Up Next:

- Module 3: Communication

Resources

Cultural Competency Tool Kit Module 3: Communication

What's Next?

- We have discussed attitudinal barriers and the importance of cultural self-awareness.
- We have also dived deep into different minority populations and their cultural norms.
- How do we put these pieces together?

YOU ARE HERE!

Why is Communication Important?

- Culture Plays a Role in Communication
    - Cultural differences can "lead to conflict between patients, families, and clinicians."
    - Culture defines how individuals make sense of the world around them.
    - Culture influences how people view the healthcare experience and how they make decisions.

  Information retrieved from: (Brown et al., 2016).
- Communication Alleviates Unequal Treatment of Minority Families
- Communication Allows EI Professionals to Adhere to Regulations
    - Non-English proficient minority families are aided by federal regulations that protect their rights by requiring that assessments and evaluations be completed in the language that is most dominant to the child, unless it is not feasible to do so (Puig, 2010).
    - EI professionals are expected to identify and assess linguistic resources that may be needed (Puig, 2010).
    - Many states' EI programs acknowledge the need to assess the child in their native language but are often not equipped or required to provide their services in the dominant language of the child (Puig, 2010).
    - "No requirements exist to support EI that builds upon families' cultural and linguistic resources through direct work with children and families in their home languages" (Puig, 2010).
- Communication Allows for Client-Centered Services
- Communication Increases Outcomes

The Foundations for Effective Communication

- Step 1
    - Like previously discussed in "Module 1: Attitudinal Barriers" & "Module 2: Learning About Cultures"
        - Reflect.
        - Understand the inherent beliefs, values, and biases you hold as a healthcare provider.
        - Become aware of the influence your organization/workplace has on your services.
        - Once providers become conscious of these factors, they are more receptive to the beliefs and values of their patients, especially when differences are present.
        - Understand how minority families' beliefs and values impact their views on the healthcare system and your roles as healthcare professionals.
- Step 2
    - Use effective communication strategies that are:

        - Evocative
        - Nonjudgmental
        - Respectful
    - Cross-cultural communication includes:
        - Strategies that address and "acknowledge individual cultural traditions"
        - Consider "one's own beliefs, values, and experiences"
        - "Avoid generalizing patient's beliefs or values" (norms were provided in the previous module, but providers should be careful in addressing all patients on an individual basis

    Information retrieved from: (Brown et al., 2016).

Communication Strategies for Initial Sessions

- Ask-Tell-Ask Strategy
    - Why is this strategy beneficial?
        - Collaborative communication method
        - "Encourages a two-way conversation"
        - Asks open ended questions
        - Assesses patient's knowledge prior to disclosing more information
        - Does not ask EI professionals to tell patients what to do, but rather *ask* patients what they are willing to do and moving forward in a collaborative manner after.

    Information retrieved from: (Brown et al., 2016).
- Examples of Open-Ended Questions When Trying to Better Understand Patients
- How to Properly Convey Information
- Integrating Culturally Competent Communication Strategies
- Linguistic Mismatch
- Ethical Considerations
    - Chabon et al. (2010) point out legal and ethical considerations within their decision-making framework in determining if the SLP should provide services <u>*at all.*</u>
    - However, it is not permissible to refuse services based on a cultural mismatch.
    - If a "language matching" SLP is not available, the only ethical consideration is to locate and work with an interpreter to provide culturally competent services.
    - We know how difficult this can be as an EI provider.

  Information retrieved from: (Chabon et al., 2010).
- SLP Difficulties in Early Intervention

Communication During Treatment Sessions

- "The use of appropriate language services and the right of families and children with limited-English proficiency to access healthcare are inextricably linked" (Basu et al., 2017).
    - For families and children with limited-English proficiency, meaningfully communicating with an EI professional would indicate that EI professional is only using the child and families preferred language of care (Basu et al., 2017).
- Giving Access to Appropriate Language Services

    - As early intervention services, we can begin this process by hiring staff who is bilingual (Basu et al., 2017).
    - *However,* hiring bilingual staff in all patient's preferred language is not always possible (Basu et al., 2017).
    - So, we must have systems in place "for accessing professional language assistance services rather than relying on ad hoc interpreters" (Basu et al., 2017).
- Ad Hoc Interpreters
- Qualified Interpreters
    - "The Department of Health and Human Services establishes competences required to be a qualified interpreter:"
        - "Knowledge of specialized terminology"
        - "Knowledge of interpreter ethics"
        - "Skills to interpret accurately, effectively, and impartially"
    - The use of qualified medical interpreters with LEP patients, "improves comprehension, service utilization, clinical outcomes, and patient satisfaction" with services.

Information retrieved from: (Basu et al., 2017)

- Types of Interpreters
    - Research suggests that patients rate in-person translators higher than remote interpreter services.
    - However, when rating remote methods, patients demonstrated a high preference for video services.

Information retrieved from: (Locatis et al., 2010)

- How to Appropriately Use a Medical Interpreter
- But What If Interpreters Aren't Available?
    - CALD Assist
        - Free application on Apple Store & Google Play.
        - Once downloaded, no internet or is Wi-Fi required.
        - Enables conversation with limited preset phrases led by healthcare professionals in 11 different languages.
        - Specifically designed for healthcare settings.
        - Preset phrases only cover topics or situations "considered within the scope of everyday clinical conversation."
        - Does NOT include topics/situations that "require medical professional interpreters."

Information retrieved from: (Panayiotou et al., 2019)

- How CALD Assist Works
- Why CALD Assist's Limited Phrases is Actually a Good Thing

Communication Methods at the End of a Treatment Sessions

- Teach-Back Method
    - Always check to ensure that communication with your LEP patients has been understood.
    - Asl parents/caregivers/families to explain and/or show you what you have completed with their child during your session that day.

    - Asking them to recall strategies allows for increased carry over into the home.

  Information retrieved: (Talevski et al., 2020)
- Teach-Back + Video Support
    - Videos have a greater influence, when compared to infographics, to communicate healthcare information (Occa & Suggs, 2015)
    - "Didactic messages delivered in video format have the most positive effect on awareness and knowledge" (Occa & Suggs, 2015)
    - Use teach-back strategies first.
    - Example:
        - Have the caregiver show you how to position their child during feeding.
        - Once caregiver shows you, if they appear to struggle with the provided information, provide them with a video that demonstrates how to position a child.
        - Send it to them via email after session to provide a reference for when they are helping child with feeding during the week.
        - If family is willing, have them take video of you positioning their child in their natural environment.
- Teach-Back Strategy + Pictorial Support
    - Using pictorial support is shown to be effective for patients with low health literacy (Negarandeh et al., 2013).
    - Pictorial support is "recommended to be used according to patients' conditions" (Negarandeh et al., 2013).
    - Example:
        - Have caregiver show you how to apply different sensory techniques presented during the session.
        - If they struggle showing you different methods, provide picture reminders of different techniques.
        - BONUS: if the pictorial support is in their native language
- Remember…
- Always Go Back to Teach-Back

Up Next:

- Module 4: Obtaining Resources

Resources

Cultural Competency Tool Kit Module 4: Obtaining Resources

Supporting Our Therapists
YOU ARE HERE!
Roles of Early Intervention Professionals

- Early intervention professionals have a role in helping families resolve difficulties that hinder the child from fully participating in EI services.
    - Because social workers are often scarce on caseloads, our role can extend to link families with resources or other services in their community.

Information retrieved from: (Family and Social Services Administration, 2022)

- Providing Resources for Families
    - TANF – Cash Assistance
    - CHIP - Health Coverage
    - WIC – Food & Nutrition
    - CCDF – Child Care Financial Assistance
    - SNAP – Food Assistance
- Familiarize Yourself First!

In the Last Module…

- We discussed how we could use the teach- back method with videos and pictorial supports to facilitate communication with families who have limited English proficiency (LEP).

In the Next Slides…
Video Support Resources

- Obtaining Video Consent When Necessary
    - In Module 3, we discussed using the teach-back method with video support to further solidify carry over into the home with LEP families.
    - One method discussed was recording yourself and then recording the family completing intervention strategies provided during the session.
    - We understand that if you have not done this before, it may be uncomfortable to initiate this conversation.
    - This video may help in getting the ball rolling:
        - https://www.youtube.com/watch?v=5--GzEeUops
- Intervention Resource: TEIS
    - This YouTube channel has great resources for therapists and parents alike.
    - Examples:
        - Working with Picky Eaters, Symmetrical Movement, Tummy Time Activities, Leg, Arm, and Digestion Massage, Facial Strokes for Babies, Assisted Rolling, Movement/Sensory Play and Techniques, Variety of Play Activities, Crawling, Walking, and Many More!
        - https://www.youtube.com/c/TeisincEarlyIntervention/videos
- Information Sheets: Pathways
    - Allows you and parents to quickly and easily look up milestones by age.
    - Provides quick explanations and videos to supplement what milestones should look like.
    - https://pathways.org/?fbclid=IwAR1UnM3zu8HqZKz6TuII-TRFOFDZoRaxgmcyVv7YeOR5QLaQwDAqWx9bdr4

Pictorial Support Resources

- Information Sheet Resources
    - The Royal Children's Hospital

        - This website provides occupational therapy information sheets with pictures
    - Pathways
        - Downloadable Brochures in English, Spanish, Hindi, Oriya, Turkish, and Greek
        - Depicts developmental milestones by age and skills
        - Provides explanations for parents to understand what is being addressed. In this picture, sensory integration is being explained. A checklist of 'signs' is additionally provided for parents.
    - Resources in Spanish
        - A great resource to use with Spanish speaking families that explains early intervention, what OT does as a profession to help their child and outlines developmental milestones.
    - Intervention Resources
        - Therapy Street for Kids
            - This website breaks activities down by skill areas and then provides a list of activities that will address those areas.
            - Additionally, the website provides homemade play ideas.
        - Mama OT
            - This website provides play ideas using household items.
            - Several of the links provided in the website will redirect you to Pinterest.
    - Multidisciplinary Support Resources
        - Tools to Grow OT
            - Sections out skills by OT, PT, and SLP.
            - However, has a neat section for handouts that can be used multidisciplinary. This may facilitate workload for families and help maintain in-home work to address all 3 therapies with one activity.
            - This is how communication between therapists can be extremely useful!
            - This website does require a subscription for some of their handouts, but many can be accessed free by simply signing up.

Resources to Explain Therapy in Other Languages

- Explaining Therapy in Spanish
    - Occupational Therapy: https://www.youtube.com/watch?v=o2qhpRIMg2Q
    - Physical Therapy (0-1:36) https://www.youtube.com/watch?v=jS9YojHvxvI
    - Speech Therapy: https://www.youtube.com/watch?v=oi3LzsMzqy0
- Explaining Occupational Therapy in Other Languages

Addressing the Gaps

Our Role in Advocacy

- Building Bridges

- Other Potential Physician Roles
- Advocating for First Steps Services
    - Family Voices provides a concise fact sheet with a description of First Steps, eligibility criteria, services provided, cost, and how to get started.
    - Make sure to get updated links for families, as changes may occur with time.
- Clusters
    - First Steps is administered at a local level in regions. These regions are groups of counties known as "clusters."
    - IN.gov provides an interactive map where families can access offices near them.
- First Steps Resource for Spanish Speakers
    - The CDC provides a great Spanish description of First Steps and provides hyperlinks to resources and who to contact by their state.
- Fulfilling Your Role
    - By providing these resources to families, you are fulfilling your role.
    - The purpose of early intervention is to provide families/caregivers and early education practitioners with proper supports and resources to further enable their child's learning and development.

  Information retrieved from: (Disability Rights Pennsylvania, 2017)
- You Have Now Completed:
    - Your role now is to take information from all 4 modules and reflect, learn, and implement different strategies into your sessions with minority families on your caseload.

What's Next?

- Reflection!

Resources

Appendix B

Reflective Session Discussion Questions

Description

Share an experience where cultural competence was necessary.

Feelings

After completing the toolkit, how has your understanding of the term cultural competence changed?

Evaluation

After completing the toolkit, what did you determine as your strengths relating to cultural competency?

Analysis

Discuss your comfort levels then versus now in dealing with clients of varied cultures and language backgrounds?

In what areas did you feel challenged or notice a need for growth?

Conclusion

How does your therapy change the most when working with clients/families who have a different culture and speak a different language than your own?

Action Plan

Did this program provide you with useful materials available in the languages and formats that you can readily use?

What module would you see yourself referring back to the most?

What other materials would you have liked to be included in this toolkit?

Any changes you would like to see within the toolkit for its use in the future?

Appendix C

Modified CCAI Pretest and Posttest Score Comparisons

Modified CCAI Items	Pretest Mean Score	Posttest Mean Score
Question 1: How comfortable are you with integrating a client's culture into the therapy process?	2.20	2.40

Question 2: How comfortable are you in asking your clients questions regarding their cultural beliefs and values ?	2.10	2.40
Question 3: How comfortable are you in obtaining resources to provide to minority families on your caseload?	1.90	2.80
Question 4: How comfortable are you in advocating for the inclusion and healthcare of minority children and families on your caseload?	2.30	2.70
Question 5: How comfortable are you in going into minority homes with readily available resources that reflect the cultures and backgrounds of minority families and children on your caseload?	1.80	2.30
Question 6: How comfortable are you in providing quality therapy services to non-English proficient families and children?	2.0	1.90
Question 7: How comfortable are you working with culturally diverse backgrounds?	2.20	2.60
Question 8: How comfortable are you in identifying cultural beliefs that are not expressed by a caregiver but might interfere with therapy service delivery?	2.00	2.40
Question 9: How comfortable are you adjusting your therapeutic strategies when	2.30	2.30

providing therapy services to minority families and children?		
Question 10: How comfortable are you in using non-verbal communication when providing therapy services to non-English speaking families and children (ex: teach-back strategies, videos)?	2.10	2.20
Question 11: How comfortable are you in examining personal biases related to race and culture that may influence your behavior as a therapy service provider?	2.40	2.80
Question 12: How comfortable are you in considering the cultural values and beliefs of minority families and children when food is involved?	2.60	2.70
Question 13: How comfortable are you going into minority homes with adequate organization/workplace provided resources that help you promote cultural competence within my sessions?	1.90	2.20
TOTAL SCORE	27.8	31.7

Note. CCAI = Cultural Competence Assessment Instrument; scale 1 (not comfortable) to 3 (very comfortable).

Appendix D

Doctoral Capstone Experience and Project Weekly Planning Guide

Week	DCE Stage (orientation, screening/evaluation, implementation, discontinuation, dissemination)	Weekly Goal	Objectives	Tasks	Date complete

1	Orientation	1) Complete orientation by end of the week 2) Complete and get survey out to Nancy 3) Complete Overview Module 4) Complete Module 1	Meet with site mentor Create timeline for project Finalize MOU with any updates and turn in Complete pre/post survey used for outcome measurement	Create survey for evaluation of current need for toolkit Send out pre-survey by end of week Creation of 1st module	
2	Evaluation/Program Development	1) Continue literature to build efficacy of tool kit 2) Complete Module 2	Send out Outcome assessment with one week deadline Meet with Chelsea to determine formatting of toolkit	Send needs evaluation survey to participating therapists Create 2nd module	
3	Evaluation/Program Development	1) Complete Module 3 2) Talk to different staff/therapists to confirm best delivery method of tool kit	Continue to search literature to develop effective tool kit	Create 3rd module Complete draft of Introduction	
4	Evaluation/Program Development	1) Complete Module 4 2) Finalize Tool Kit	Meet with critical stakeholders of the company to determine how this may be implemented after you leave	Create 4th module Complete draft of Background	

			Meet with stakeholders to discuss the importance of the toolkit and present draft		
5	Implementation	1) Tool kit to be received by at least 5 therapists 2) Meet with different therapists in clinic to determine caseload demographics	Open lines of communication to participating therapists and be available to respond to any questions or troubleshooting issues. Find individuals from community of prevalent cultures that can help with increasing health literacy of hand outs	Therapists will begin navigating though tool kit Begin going in-home with therapists serving minority families to observe changes in services Work on increasing health literacy of clinic handouts Project Design Due	
6	Implementation	1) Develop written observations that are articulate and clear for later dissemination	Create a documentation system for in-home observations Develop organization and distribution method to make handouts more readily available to therapists and families	Continue in-home observations of implementation of tool kit. Continue work on clinic handouts.	

7	Implementation	1) Meet with participating therapists and develop good interviewing skills	Set up meetings with therapists via zoom individually or with group to discuss how things are going with navigating the tool kit Ask questions about what they have learned, what they have changed, and how they will continue to grow with their cultural competence	Complete midterm reflections to increase efficacy of tool kit Check in with participating therapists Continue in-home observations of implementation of tool kit	
8	Implementation	1) Develop a continuous understanding of health literacy and how best to show that with clinic handouts	Talk to some of the families (if able and they give permission) to determine some of the things they would like to see change within their care and how we can be better suited to serve them as minority families with minority children	Continue in-home observations of implementation of toolkit Continue work on clinic handouts	

9	Implementation	1) Develop method for collection of data with post survey 2) Compile data of post survey	Develop best way to distribute post survey Compile all data in an organized manner Meet with Chelsea to review the findings together and discuss meanings Determine what findings mean for the company and its future in cultural competency	Send out post-survey with deadline for the end of the week Continue in-home observations of implementation of toolkit Continue work on clinic handouts	
10	Discontinuation	1) Create visual for data	Meet with critical stakeholders such as Nancy and Jake to discuss the importance of the findings	Gather all observations Meet with therapists/email therapists to have them give you final thoughts Compile all data Outcomes draft due	
11	Dissemination	1) Develop most effective dissemination plan	Gather final results Analyze results and their meaning	Finalize results from survey Make visual of pre/post outcomes to	

			Make clear written documentation for presentation in dissemination	show changes (if any)	
12	Dissemination	1) Develop aesthetic and effective dissemination	Discuss with Chelsea best avenue to present project to First Steps therapists Reach out to First Steps therapists and ask what they would prefer in presentation	Complete work on Summary Complete work on handouts Begin work on clinic Dissemination	
13	Dissemination	1) Finalize all work	Continue to work on dissemination Work on presentation Finalize schoolwork and any work for clinic	Continue work on Dissemination	
14	Dissemination	1) Present final project	Prepare to present	Disseminate findings -location TBD	