

**The American Occupational Therapy Association  
Report to the Board of Directors**

DATE: October 12, 2005

FROM: AOTA Board Task Force on Health Disparities  
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TO: AOTA Board

SUBJECT: Request for Board Action

TOPIC: Health Disparities

***Executive Summary:***

The Health Disparities Workgroup (hereafter referred to as the “Workgroup”) is one of approximately 10 such groups convened by President Carolyn Baum to investigate and explore issues of relevance to occupational therapy and their impact on the Association’s strategic plan, particularly as it relates to the 2017 vision. The Workgroup examined three related focus areas: health disparities, cultural competency, and occupational therapy workforce development. Each of these areas requires attention and should become priorities for the AOTA strategic plan for the following reasons. Healthy People 2010 has as one of its two primary goals to “eliminate health disparities among different segments of the population” (<http://www.healthypeople.gov>). As a result, many federal, state, and local governments have devoted significant resources toward achievement of this goal and recognize that cultural competency of health practitioners and workforce development in the health professions are critical components of any plan to eliminate health disparities. In addition, many professional associations have specifically included health disparities goals in their key initiatives.

Hurricane Katrina reminded us that the United States still has a long way to go to eliminate health and other disparities that exist due to gender, race or ethnicity, education, income, disability, geographic location, or sexual orientation. Katrina unveiled segments of our society who have fewer opportunities to realize the American dream and are hurt the most when tragedy strikes. Occupational therapy practitioners expressed concern and dismay at the personal and environmental circumstances that limited participation for this population. Many individuals and organizations expressed a strong desire to ‘do something’ and a commitment to work long term to improve the health and quality of life for all of our citizens.

Occupational therapy has the capacity to make significant contributions to our country’s efforts to improve the lives of Americans, but it will require AOTA and its leadership to commit to specific

goals and include specific action strategies related to health disparities, cultural competency, and workforce development. AOTA has had a recent history of specifically attending to multicultural and cultural diversity issues. This targeted effort became a lower priority, however, when there were competing needs and a limited budget. In the mean time, the problems have grown and the needs are greater.

Our federal and state governments are moving swiftly to address health disparities, cultural competency of health professionals, and workforce development. These initiatives present an opportunity for the Association to jump on board and be an important part of improving the health and participation of all our citizens. We have the philosophical and knowledge base to provide leadership in this important area, but it will require that we take the time, resources, and relationship and trust-building necessary to make meaningful gains. A long term commitment to improving the health and quality of life of all citizens will provide occupational therapy an unprecedented opportunity to provide leadership in health care and obtain recognition for significant contributions to the health agenda of the country. If we fail to participate, we risk becoming obsolete as others step in to address the personal, environmental, and occupational needs of our citizens. Our belief is that addressing this topic is no longer an option for AOTA. It is imperative that we do so, as our country has changed and our future jobs will change as well.

***Action Items:***

1. Develop commitment to addressing health disparities, cultural competency, and workforce development at the highest levels of leadership in AOTA and encourage this same commitment in AOTA staff, related organizations, state associations, and occupational therapy education, research, and practice.
2. Identify specific action-oriented objectives related to health disparities, cultural competency, and workforce development for each goal of the strategic plan using past and current recommendations from AOTA stakeholders and national recommendations from the U.S. Department of Health and Human Services agencies. Examples of specific objectives are provided in the section, *Relation to the Strategic Plan*.
3. Assign specific AOTA financial and people resources to conduct an audit of past and current activities, coordinate implementation of specific objectives in the strategic plan, and measure progress toward outcomes of initiatives.

***Relation to Strategic Plan:***

The three goals in the current draft of the strategic plan are an appropriate framework for the needs of AOTA and its stakeholders. However, the current objectives do not identify specific strategies that relate to health disparities, cultural competency, or workforce development. Examples of specific objectives and strategies are provided in this report and are identified in bold. Other objectives and specific strategies are identified in the Implications section or may emerge to assist AOTA in becoming a leader for health professions on this important topic.

- GOAL I: TO BUILD AND MAINTAIN SYSTEMS AND PROGRAMS THAT ENSURE A MEMBER-CENTERED FOCUS AND A FINANCIALLY SOUND ORGANIZATION
  - A. Expand and diversify revenue streams.
  - B. Develop broad-based **and specific** membership recruitment and retention strategies **that depict AOTA as the association we want to become.**
  - C. Recruit individuals to the field, **using recommended national workforce development strategies that will help occupational therapy become a health profession that is truly representative of American society.**



G. Foster the use of occupation-based practice.

PRINCIPLES EMPLOYED IN STRATEGIC EFFORTS:

1. Assess and manage risks.
2. Respect and routinely monitor internal and external environments.
3. Practice ethically responsible resource management.
4. Align resources, structures and actions with strategic goals.
5. Use the governance documents to guide decision-making.
6. Demonstrate respectful and responsible leadership to and for members.
7. **Adopt national recommendations to strengthen occupational therapy's involvement in efforts to eliminate health disparities, improve capacity for the provision of culturally competent services, and develop a workforce that is more representative of society.**

*Fiscal Implications (Indicate who prepared the projections):*

The Workgroup proposes that AOTA allocate specific budget funds and seek funds to promote the development efforts to address health disparities, cultural competence, and workforce issues in practice, education and research. In part, a designated budget would assist AOTA to prepare evidence based practice initiatives, pursue a broad policy agenda with Congress and federal agencies, develop continuing education programs, and increase awareness of potential opportunities in practice, education and research.

## ***Full Report:***

### **I. Statement of the Problem**

To understand the problems related to with health disparities, cultural competency, and workforce development within our profession and the Association, we must look at national health reports, AOTA historical data, and other available information.

#### ***Health Disparities***

*Definitions of Health Disparities.* Health disparities have been defined as “differences in incidence, prevalence, mortality, and burden of diseases and mortality, and burden of diseases and other adverse health conditions that exist among specific populations” (National Institutes of Health), “that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation” (U.S. Department of Health and Human Services, Healthy People 2010, 2000) or as “differences in diseases, adverse health conditions and outcomes, and access to health care” (National Institutes of Health, Health Resources and Services Administration). Health disparity has been defined in narrow terms as how different or unequally a specific population is from the overall population on the basis of race, ethnicity, gender, education, wealth, health, health care access and many other variables (Pearcy & Keppel, 2002). Defined more broadly disparity may be considered as the magnitude of variations across all subcultures (Pearcy & Keppel, 2002).

*Incidence of Health Disparities.* The United States is an increasingly diverse country with anticipated majority shifts to non-white racial and ethnic groups in the near future. The ever-increasing multiculturalism creates challenges for the health professions on many levels (Wittman & Velde, 2002). One of these challenges is recognizing the degree and types of health disparities that exist. In fact, a 1999 Kaiser Family Foundation study found that most Americans do not know that health disparities even exist (Kaiser Family Foundation, 1999).

Health disparities are evident for the 15 leading diseases in the United States, with increased incidence, earlier onset, and poorer survival rates for some groups. This is especially concerning because even though overall health of the U.S. population has improved in the last 50 years, health disparities are either unchanged or have widened (Williams, 2004). For example, the prevalence of diabetes among African Americans is 70% greater than what exists among white Americans. Infant mortality remains a health concern for African Americans as well, with rates twice as high when compared to white Americans (Black Health Care, 2005).

*Causes of Health Disparities.* Disparities in health are believed to be due to several factors: root factors (e.g., poverty, oppression, discrimination), behavioral and environmental factors (e.g., built environment, social capital, structural factors, services and institutions), and medical services (e.g., access, screening, treatment) (Prevention Institute, 2004). The Institute of Medicine has concluded that “the reasons for these health status disparities are complex and poorly understood, but may largely reflect socioeconomic differences, differences in health-related risk factors, environmental degradation, and direct and indirect consequences of discrimination. Differences in access to healthcare are also likely to play a role in these health disparities” (Unequal Treatment, Institute of Medicine). Also, cultural barriers such as language trust and values impact relationships with health care providers (Coridan & O’Connell, 2001) as well as health illiteracy and poor education.

*Cultural competency and workforce development.* Cultural competency of health care professionals and workforce development are two important strategies for addressing health disparities. The Institute of Medicine report, *Unequal Treatment* (2003), has identified alarming issues in the health care system related to unequal treatment by health care providers to people of diverse backgrounds. The

report, *Missing Persons: Minorities in the Health Professions* (The Sullivan Commission, 2004) identified specific needs related to workforce development in the health professions.

*National Initiatives to Address Health Disparities.* There are multiple national and state initiatives underway to address health disparities. Healthy People 2010 (HP 2010) has identified elimination of health disparities as one of its two goals. HP 2010 targets the determinants of health (biology, behavior, social and physical environments, policies and interventions, access to quality health care) as the focus areas for prevention and intervention programs. The U.S. Department of Health and Human Services (HHS) has both the Office of Minority Health (OMH) and The National Center on Minority Health and Health Disparities (NCMHD). NCMHD was established in 2000 to “promote minority health and to lead, coordinate, support, and assess the NIH effort to reduce and ultimately eliminate health disparities.” It has a wide variety of initiatives including the Centers of Excellence in Partnerships for Community Outreach, Research on Health Disparities and Training (Project EXPORT). Over 50 projects have been funded to date and each project has millions of dollars in funding. The Centers for Disease Control and Prevention (CDC) created its own Office of Minority Health to address health disparities. These governmental agencies have specific goals, programs, and funds to address the critical needs in this area.

State governments and an array of non-governmental organizations (e.g., Kaiser Family Foundation, Robert Wood Johnson Foundation, Prevention Institute) have also devoted significant resources to this national problem. A review of the web sites of professional associations in related fields finds that many have begun initiatives in this area as well.

*AOTA Initiatives to Address Health Disparities.* Health disparities and their implications for our profession have never really been addressed by AOTA in a deliberate, coordinated fashion. The issues of multiculturalism and health disparities have often been put together as one topic and not really understood contextually as different issues. Occupational therapy practitioners need a basic understanding of the differences and the tools to become leaders in addressing the causes of health disparities. Cultural diversity implies creating an environment in which everyone is equally valued and productive. The distinctions, similarities and relationships of health disparities and cultural diversity are not clear and continue to evolve. These terms require clarification and clear implications for practitioners to move forward with a specific agenda.

The occupational therapy literature does show some emerging themes of social justice, occupational deprivation, occupational justice, and client advocacy (Whiteford, 2000). However, many of these references are from international journals. A preliminary search in the Occupational Therapy Bibliographic System, using a combination of key words as search terms, for terms related to health disparity identified a limited number of references relative to occupational therapy: cultural diversity (120 references); occupational therapy and prejudice (23 references); health care justice (6 references); occupational therapy and minority (5 references); and occupational therapy access (72 references). Using the term health disparity and including a focus on all subheadings provided resulted in: OT BYBS (1 reference); Ovid Medline (71636 references); and CINAHL (16463); CDRS, ACP Journal Club, DARE, CCTR (716 references). This search shows that the occupational therapy literature has not evolved to reflect the growing emphasis on health disparities.

It has been stated that occupational therapy’s most effective explorations on the topic of diversity were conducted during the early – mid 1990’s (Black, 2002). Although race and ethnicity have been studied in occupational therapy, it represents only one level of cultural diversity (Blakeney, 1987; 1989; 1993). Each person participates in multiple cultures such as families, workplaces, institutions, professions, classes, and neighborhoods (Mattingly & Beer, 1995). Occupational therapy practitioners need to address all these multi-cultural dimensions including healthcare disparities and distributive justice (Cassidy, 1988) in a more systematic and comprehensive manner.

*Key Problems:*

- Health disparities are a critical problem that affect the health and quality of life of many U.S. citizens.
- Health disparities are caused by complex factors which relate to areas of concern in occupational therapy, including root factors, behavioral and environmental factors, and health care services.
- Many governmental agencies and non-governmental organizations have identified elimination of health disparities as a primary goal and have designated substantial resources to reaching the goal. At this time, AOTA does not have a major initiative in this area.

***Cultural Competency***

*Definitions of Culture and Cultural Competency.* The *CLAS Standards* issued by the HHS Office of Minority Health provided definitions of concepts related to culture and cultural and linguistic competence.

Culture: “The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given. In sum, because health care is a cultural construct, arising from beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services treatment and preventive interventions. By understanding, valuing, and incorporating the cultural differences of America’s diverse population and examining one’s own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture” (Katz, Michael. personal communication, November 1998).

Cultural and linguistic competence: “Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities” (Based on Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care*, Volume I. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center).

*Cultural Competency of Health Care Practitioners.* A 1999 Kaiser Family Foundation survey found that the majority of Americans are not aware that disparities in health, health access, health services, and health care even exist (Source: <http://www.kff.org/minorityhealth/upload/Race-Ethnicity-Medical-Care-Chartpack-1999.pdf>). Although a survey of perceptions by health care professionals was not conducted, there is growing concern that the limited cultural competency of health practitioners is a contributing factor in many health disparities. The Institute of Medicine’s, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, highlights the problems that are associated with health care by race and ethnicity. This report “found that a consistent body of research demonstrates significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable. This research indicates that U.S. racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health

services.” Improving cultural competency of health care professionals is viewed as one of the important mechanisms to address unequal treatment.

*National Plans to Address Cultural Competency of Health Care Professionals.* In 1994, the Office of Minority Health (OMH) was mandated by Congress (P.L. 101-527) to “develop the capacity of health care professionals to address the cultural and linguistic barriers to health care delivery and increase access to health care for limited English-proficient people” (<http://www.omhrc.gov/cultural/background.htm>). The mandate also required OMH to “support research, demonstrations, and evaluations to test new and innovative models aimed at increasing knowledge and providing a clearer understanding of health risk factors and successful prevention intervention strategies for minority populations.”

In the 1990s, it became clear that there were no comprehensive standards on culturally and linguistically appropriate services (CLAS) in health care. Thus, there were few guidelines on how to help health care professionals and organizations improve their cultural competency. In 1997, the OMH began the development of national standards to provide guidelines and a consistent, comprehensive approach to cultural and linguistic competence. The current draft of the CLAS standards is intended to be used by organizations to audit and improve the cultural competence of health professionals. To obtain funding for research in federally supported grants, agencies are now required to demonstrate how they are addressing four of the 14 National Standards for Assuring Cultural Competence.

*AOTA Initiatives to Address Cultural Competency.* Multiculturalism and diversity issues had received a lot of attention by AOTA during the 1990s and early 2000s. AOTA had a multicultural staff person who had primary responsibility for this area during most of the 1990s. Publications were developed to improve cultural awareness and competency of occupational therapy practitioners. AOTA was viewed by many practitioners as quite advanced in its work on multiculturalism during this time. But when the multicultural program manager position was eliminated in 1998, initiatives in this area became a lower priority (four different staff persons have, in addition to their other duties, served as liaison to the multicultural networks since 1998). Because there are no longer designated resources, effective relationships with the networks/caucuses have diminished in the last decade and the work of different committees and consistency of activities under different leaders was lost or underused.

The occupational therapy literature has focused more on cultural diversity than on health disparity issues. Cultural diversity issues regarding membership, inclusion, and cultural awareness and sensitivity issues were promoted extensively at the national level in the 1990s (American Occupational Therapy Association, et al. 1999; Dunn, Foto, Hinojosa, Schell, Thomson, & Hertfelder, 1996; Hinojosa, 1992; Hinojosa & Kramer, 1994; Jackson, 1996; Scott, 2002). Cultural diversity in direct care has also been described in the literature (Matuska, Giles-Heinz, Flinn, Neighbor & Bass-Haugen, 2003; Opacich, 1997; 2000; 2004). Cultural diversity implies creating an environment in which everyone is equally valued and productive. The distinctions, similarities and relationships of health disparities and cultural diversity are not clear and continue to evolve. These terms require clarification and clear implications for practitioners to move forward with this social agenda.

In order to provide effective guidelines for practice occupational therapists need more education about evaluation, intervention, disease prevention and wellness of cultural sub-groups confronting a variety of disparities including but not limited to: ageism (Savino, 1998), mental health issues (Kamil, 1998), gender bias (Tapper, 1996), stigma (Segal, Mandich, Polatajko, & Cook, 2002), chronic conditions (Crabtree, 1993), children in context (Opacich & Savage, 2000), women with HIV (Opacich, 2004), homecare (Opacich, 1997), wellness for older adults ( Matuska, Giles-Heinz, Flinn, Neighbor, & Bass-Haugen, 2003).

Occupational therapy must also look within the profession to identify and eliminate disparities in communication patterns between client-therapist, therapist-therapist, and therapist-work environment

(Abreu & Peloquin, 2004; Duffy, 2000). Examples include foreign-trained therapists (Royeen, 1996); awareness of culturally-sensitive and non-biased assessment (Bennett, 1995; Paul, 1995); awareness of religious diversity and its impact on occupational behavior (Dunbar & Gorlin, 1995); and our teaching strategies for care providers (Blakeney, 1993). Studies have also explored occupational therapy services when working with poor, non-English speaking clients (Blanche, 1996; Warden, 1996) in order to establish better communications as a guide to promote better occupational services to ethnic minorities (McCormack, 1987).

Occupational therapy managers need to monitor the mechanisms used in their organizations to monitor the inclusion practices across all organization arenas, including the hiring process of staff that provide occupational therapy services. Recruiting and hiring a diverse and inclusive staff is promoted and encouraged at all levels of staffing. Embracing diversity in our profession extends beyond the people we serve to ourselves.

Occupational therapy practitioners have healthcare, social, cultural, and clinical pressures to demonstrate ethical care alternatives. Therapists teach different social and cultural groups how to improve their health and quality of life. Our diverse personal and professional interpretations of diversity related to occupation, wellness, and lifestyle for well being needs to be expanded. We can also advocate and improve services by forming partnerships with policy makers such as those who created the Individuals with Disabilities Education Act. Partnerships can help the profession share its expertise and expand the scope of services for clients with and without disabilities (Jackson, 2004).

According to the current ACOTE standards, occupational therapists recognize the importance of cultural diversity factors as a part of the foundation requirements for occupational therapy education.

B 1.7 “To demonstrate knowledge and appreciation of the role of sociocultural, socioeconomic, diversity factors, and lifestyle choices in contemporary society.”

B. 4.6 “ To consider factors that might bias assessment results such as culture, disability status, and situational variables related to the individual and content.”

Adequate preparation of health care professionals, including occupational therapists, is essential for good health care. The need for occupational therapists that are culturally skilled has been well documented in the profession’s literature (Mirkopoulos & Evert, 1994; Bonder, Martin, & Miracle, 2002; Wittman & Velde, 2002). Culturally skilled encompasses an awareness of various cultural backgrounds; an ability to understand gender, socioeconomic and historical perspectives among other factors influencing underserved groups; as well as an adaptability to work with different groups of people. However, there is currently no uniformity in addressing cultural competence in occupational therapy curricula, or strategies to ascertain what is currently being done on an individual program basis. It may be only marginally addressed in programs that have little diversity in students, faculty or the regional population. A lack of attention to diversity between and within cultures, as well as the absence of culturally competent professionals, can create barriers to effective health care (Coridan & O’Connell, 2001).

Generally, occupational therapy students are interested in treating the whole person but do not have the skills to do so if they are unable to consider culture (Fox, personal communication, September 25, 2005). Many students don’t know that disparities exist and often are not aware of their own biases and limited knowledge. Many curricula have limited information on culture. Students need opportunities to explore their own culture before they can begin to understand the culture of others. Both breadth and depth of knowledge and experiences are needed. Understanding culture also requires that students examine SES, education, history of populations in the U.S., gender differences, and health disparities. The accreditation standards for curriculum are general as it relates to culture. These standards allow too much variation in coverage when this is one of the most important areas to address in the professional development of practitioners.

*Key Problems*

- *Major research studies show that health professionals contribute to inequities in health and health care.*
- *Development of cultural competency by health professionals and health organizations is identified as an important strategy to improve the health of people from diverse backgrounds. AOTA made some progress in this area during the 1990s, but currently has not identified cultural competency as a priority for occupational therapy practice, research, or education.*

**Workforce Development**

*Rationale for national health profession workforce development initiatives.* It has been well documented that increasing the number of health professionals of color will lead to a substantial improvement in access to health care and a reduction in health disparities for underserved populations (Noonan & Caswell, 2003). Cultural commonalities and understanding can assist in minimizing barriers to needed care. The report, *Missing Persons, Minorities in the Health Professions* (Sullivan Commission, 2004), identified workforce development as a key strategy for addressing health disparities and improving health care. This report states that increasing diversity of the health professions workforce will improve the overall health of the nation because cultural and language competence will develop throughout the health system and ultimately strengthen health care.

*Current status of the health professions workforce.* During the 1960s to the 1980s, enrollment of minority students increased slightly in health professions’ schools. Since this time, however, enrollments have not kept up with the changing racial and ethnic characteristics of the U.S. population (Sullivan Commission, 2004). For example, about 25% of the U.S. population is African American, Hispanic Americans or American Indians. These same groups make up only 9% of nurses, 6% of physicians, and 5% of dentists. These percentages are similar for currently enrolled students in the health professions’ schools.

*Current status of AOTA members.* The current membership of AOTA has trends that are similar to the other health professions and are not representative of American society. The current student enrollments are slightly better in terms of racial/ethnic diversity but still are not sufficient to meet workforce development needs.

Table 1: 2004 Membership Data for Gender

	OT	OTA	Student	Total
Female	17689	2059	666	20414
Male	1430	160	61	1651
Unknown	4728	995	5891	11614
Total	23847	3214	6618	33679

Category	AOTA Membership	% of AOTA Membership	% 2000 Census
Null	12431	36.39	
African American	563	1.65	12
American Indian	45	0.13	1
Asian American	96	0.28	4
ASIAN	895	2.62	
Hispanic	449	1.31	12

Multiracial	49	0.14	
Other	204	0.60	
White	19429	56.87	71
Total	34161	100.00	100.00

The Spring 2004 AOTA student enrollment statistics indicate that 78.6% (2,391) of OTA students were Caucasian, 9.1% (277) were African American, and 8.4% (256) were Hispanic. Less than 2% were in all other groups, including Asian-American, Native American or Multiracial. For OT students, Caucasian students were 79.7% (6,596) of the total number and African American students were 7.8% (645) of the total number. The current situation in OT student ethnic diversity enrollment rates does not reflect the cultural demographic shifts that the U.S. has experienced. Recruitment and retention efforts geared towards people of color will enhance the profession’s ability to meet health care needs of today, as well as in the future.

*Strategies for national workforce development.* The *Missing Persons* report by the Sullivan Commission cites three principles for any initiative related to workforce development: 1) change the culture of health professions’ schools, 2) explore new and nontraditional paths to the health professions, and 3) secure commitments for change from the highest leadership levels. Key workforce development strategies recommended include 1) broadening the pipeline to the health professions through specific supports for disadvantaged and minority students, 2) review and enhancement of admissions policies and procedures, 3) targeted funding to support diversity programs and eliminate financial barriers, and 4) strong leadership to ensure goals and commitments are met and accountability is part of the process.

*Key Problems*

- *The diversity of the health care workforce and current students are not representative of society.*
- *Lack of diversity in the workforce contributes to limited cultural competency in the health professions and ultimately to health disparities of the U.S. population.*
- *AOTA does not currently have a specific commitment and strategies in place to increase the diversity of our workforce.*

**II. Background Information – Occupational Therapy Contributions**

Reflection on background information by the Board of Directors will need to focus on the changing U.S. demographics and health care statistics, the priorities and initiatives occurring in the broader health care arena, the past preparations and activities of AOTA for the current needs, the long term commitment and investment needed to make progress, the emphasis needed to make this a priority even when there are competing needs, and the vision of our profession for the future. Most of the background information has been summarized in the summary of the problem. Other resources are provided here.

In personal communications with Shirley Wells, Penny Kyler, and LaVonne Fox, it was stated that specific goals and strategies have been frequently proposed to the AOTA Board over the last 15 years. However, the specific needs related to health disparities, cultural competency and workforce development are typically integrated into larger needs of AOTA and thus, are not explicit in the final draft of strategic plans. The history of this issue at AOTA should be in reports, but the Wilma West Library does not routinely receive committee reports that should serve as resources for future groups working on Association initiatives. This topic is not new at AOTA, but has lost its importance due to competing

issues and limited resources. When there have been designated resources, the primary focus has been on development of knowledge rather than action-oriented strategies.

#### Federal Resources and References

Healthy People 2010

A systematic approach to health improvement:

[http://www.healthypeople.gov/Document/html/uih/uih\\_bw/uih\\_2.htm](http://www.healthypeople.gov/Document/html/uih/uih_bw/uih_2.htm)

The Cornerstone for Prevention

<http://www.healthypeople.gov/Publications/Cornerstone.pdf>

NCMHD – National Center on Minority Health and Health Disparities

<http://ncmhd.nih.gov>

Center for Linguistic and Cultural Competence in Health Care (CLCCHC)

<http://www.omhrc.gov/cultural/ccwebs.htm>

US Health and Human Services' Office of Minority Health

<http://www.omhrc.gov>

NIH – Centers of Excellence. EXPORT Grants

[http://ncmhd.nih.gov/our\\_programs/excellence/index.asp](http://ncmhd.nih.gov/our_programs/excellence/index.asp)

Unequal Treatment – Institute of Medicine

<http://www.iom.edu/>

<http://www.nap.edu/catalog/10260.html>

Missing Persons: Minorities in the Health Professions. The Sullivan Commission

[http://www.kaisernetwork.org/health\\_cast/hcast\\_index.cfm?display=detail&hc=1141](http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1141)

#### Professional Associations

American Public Health Association

<http://www.apha.org/NPHW/facts/>

National Mental Health Association

Meeting the Challenge: Ending Treatment Disparities for Women of Color

[http://www.nmha.org/substance/women\\_disparities.cfm](http://www.nmha.org/substance/women_disparities.cfm)

#### Foundations

Robert Wood Johnson Foundation

<http://www.rwjf.org/index.jsp>

Kaiser Family Foundation

<http://www.kff.org/>

Prevention Institute

<http://www.preventioninstitute.org/>

#### People Resources

Shirley Wells

LaVonne Fox

Penny Kyler

Input from occupational therapists, Cyndy Goodwin, E. Adel Herge, subsequent to request on AOTA listservs

#### AOTA Resources:

Membership data and ACOTE data

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### **III. Implications**

In addition to the objectives outlined in the Executive Summary, we need to:

#### General

- Define the scope of health disparities that will be addressed in our strategic plan and wisely use existing definitions and resources to move forward.
- Commit to addressing health disparities and workforce development at the highest levels of leadership in our association, related organizations, state associations, schools, and practice.
- Develop partnerships with other professions and disciplines to strengthen our involvement in practice, education, and research.
- Adopt culturally sensitive language in all aspects of our work.
- Identify accountability measures to evaluate our progress
- Re-establish a dedicated staff position at AOTA and a designated Board member that can keep this a priority.
- Have strategies that result in action and be accountable for the outcomes.
- Use previous recommendations to develop strategies. Good work has already been done.
- Require diversity/cultural audits in the Association, practice, publications and educational programs.
- Get involved in diverse communities as community members and work with potential students, parents, and community-based professionals using a variety of strategies (e.g., board members, community classes).

#### Practice

- Educate practitioners on health disparities and their contributing factors, including characteristics of current occupational therapy practice.
- Propose occupational therapy roles to address health disparities.
- Develop and implement an integrated plan to build a diverse practitioner workforce that is more representative of society.
- Emphasize the importance of understanding the cultural context of the people we serve in our practice framework.
- Change our expectations/requirements for continuing education, licensing regulations, NBCOT continuing competency, code of ethics, service learning.
- Build excitement and passion in current practitioners to cultivate change by their involvement in the community.
- Evolve the role of OTA for community settings.
- Examine socialization of practitioners in the profession and address factors that limit our profession's visibility, promotion, and interdisciplinary networks.

#### Education

- Greatly expand our curriculum content and continuing education requirements in the areas of health disparities, cultural awareness/sensitivity/competency and cultural influences on occupational performance.
- Identify youth early who have the interest and potential for OT, especially those representing disparity populations.
- Designate funding for scholarships. Even some smaller amounts of money can help retain students in programs.
- Target our recruitment efforts and materials to underrepresented groups in the profession, including persons with disabilities.
- Improve visibility at the undergraduate level (and not just in the medical division) by offering courses that would appeal to a broad range of students.

- Provide extra supports at different stages of the academic program to students who are first generation college students.
- Increase our public health connections in the curriculum, including epidemiology, change theory, action research, health assessment, environmental design, etc.
- Address barriers that affect recruitment and retention and limit our ability to develop a diverse workforce (i.e., admission policies, retention, laddering, program options, professional school culture, certification examination, licensing, and professional involvement).
- Identify strategies for teaching students and mentoring practitioners from diverse backgrounds.

#### Research

- Greatly expand our involvement in research focused on health disparities, cultural awareness/sensitivity/competency, workforce development, and perspectives of diverse populations and practitioners and publish these outcomes.
- Become more active and visible in current and future NIH – NCMHD work on health disparities.
- Develop practice models that include the influence of gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation on participation.