Online Cultural Competency Education for Millennial Dental Students

Lorraine Evans, Ph.D.; Philip J. Hanes, D.D.S., M.S.

Abstract: Teaching cultural competence is now an educational requirement for U.S. dental curricula to meet 2013 accreditation standards. The question now is, given time restrictions, limited resources, and budget constraints faced by the majority of dental schools, how can they provide effective cultural competency education to prepare future dental professionals? An additional concern regarding instruction is the recent focus on techniques to engage Millennial learners since this generation is characterized as technologically savvy with a preference for multimedia and general dislike of traditional lectures. With these issues in mind, Georgia Regents University developed Healthy Perspectives, an online, interactive course in cultural competence designed to engage Millennial students. Both before and after the course, the students were asked to complete a modified version of the Clinical Cultural Competency Questionnaire. Of the eighty-eight students in the course (eighty-one first-year dental students and seven entering radiology students), seventy-one completed the questionnaire both before and after the course, for an 81 percent response rate. Seventy-five students also completed the course evaluation. The pre and post questionnaires showed statistically significant gains for students across the four primary areas of self-awareness, knowledge, attitudes, and skills. Student evaluations of the course were generally positive, particularly regarding content, but somewhat surprisingly their assessment of the interactive components (which were designed to meet generational expectations) was ambivalent.

Dr. Evans is Assistant Professor, Office of Diversity and Inclusion, Georgia Regents University; and Dr. Hanes is Professor and Associate Dean for Academic Affairs and Advanced Education, College of Dental Medicine, Georgia Regents University. Direct correspondence and requests for reprints to Dr. Lorraine Evans, Office of Diversity and Inclusion, Georgia Regents University, 1120 15th St., AA 2028, Augusta, GA 30912; 706-721-7566; loevans@gru.edu.

Keywords: dental education, cultural competence, diversity, Millennials, online teaching

Submitted for publication 8/14/13; accepted 11/26/13

The impetus for education in cultural competence is often associated with the 2002 Institute of Medicine report that noted sources of health disparities include failures in the overall health care system, cultural and linguistic barriers, and a subtle mix of bias and prejudice during patient-practitioner interactions. Health disparities and poor health outcomes are most evident among racial and ethnic minority groups, broadly defined by the U.S. Census Bureau to include people who are African American, Asian, Hispanic, American Indian, and Pacific Islander. Fueling the current focus on addressing health disparities, moreover, is the awareness that these minority groups are poised to become the majority of the U.S. population by the middle of the current century. Consequently, accrediting agencies, licensing organizations, and policymakers promote cultural competency education as a mechanism to help address health inequities and improve patient outcomes. These goals are also included in the American Dental Education Association (ADEA) Competencies for the New General Dentist, the ADEA Foundation Knowledge and Skills for the New General Dentist, and the 2013 program standards of the Commission on Dental Accreditation (CODA).

The term “cultural competence” has been questioned because it can imply a technical skill in which one can gain expertise rather than an interactive approach that includes the patient perspective in treatment decisions. We use the term “cultural competence” in this study to refer to a set of behaviors, skills, and attitudes that enable an organization or individual to communicate effectively with individuals and communities in cross-cultural situations.

When educators develop methods to teach cultural competence, there may be a tendency to focus the content on non-dominant groups under the guise of informing future health care practitioners of population differences. As noted by Kleinman and Benson, such an approach can “become a series of dos and don’ts that define how to treat a person of a given background” with differences “synonymous with ethnicity, nationality, and language,” and this can lead to stereotyping. Studies have highlighted the potential for material to reinforce the idea that culture is something possessed by the Other, rather than the Self, leading to curriculum structured around an “us” and “them” mentality rather than one focused on building an empathetic relationship with the patient. The dominant groups are often excluded...
An intersectional framework and strong cultural self-awareness components can offset these tendencies of a checklist approach and “othering.” Intersectionality theory addresses the multiple social statuses held by an individual at any given time and recognizes how a combination of key constructs has a stronger influence on life choices than any single identity. For instance, wealth can stratify a group of males and affect life chances; when racial identity is included in the analysis, however, a more complex stratification system emerges as the interaction of the constructs creates, in effect, new categories. Being male or being affluent or being white—each commonly used as discrete constructs when examining groups—does not, when examined separately, reflect the cumulative advantage or disadvantage of holding all or none of the three statuses.

Group differences should be considered collectively when examining health disparities in order to better recognize the potential impact of culture and identify key patterns and trends in the data; however, a single individual does not embody the group norms, and group membership does not automatically mean everyone has the same perspective. Utilizing an intersectionality frame and building recognition for the multiple identities held by a single individual help to minimize the potential for stereotyping and can avoid the dos and don’ts model of cultural competence.

A review of education in cultural competence across thirty-four U.S. dental schools found the majority included the topic to help prepare students to meet the needs of a diverse and changing society. Six of the schools in that study had a stand-alone course, and although the other twenty-eight reported integrating the topic into a core requirement or mandatory course, only half of those provided academic credit. Most schools incorporated the topic in the first year (83 percent) and employed such traditional teaching techniques as lectures (88 percent), small-group discussion (67 percent), case studies (55 percent), and videotapes/vignettes (36 percent). Recent pedagogical studies in the area, however, recommend an instructional approach that focuses less on memorization and encourages more student engagement.

Some student engagement strategies believed to involve Millennial students in the educational process can bridge the gap between a technology-infused world and the traditional lecture-based classroom. Millennials, the generation born after 1982, reached adulthood in the new century and, according to generational theory, share some significant cultural and historical events that differentiate them from previous generations. For Millennials, the distinguishing factor is technology because, unlike Baby Boomers or even Gen X, they have grown up with computers, cell phones, text messaging, video games, and the Internet always around. Indeed, this group is also referred to as “digital natives” because they are so familiar with technology and it extends beyond gadget use to permeate their lives and influence social relationships. About 95 percent of 2010 dental school enrollees nationwide would be classified as Millennials, and 75 percent of them were under the age of twenty-five.

Professional education programs, in contrast to the media-filled landscape of Millennials, are usually organized into conventional classroom contexts that rely on lectures and books. Consequently, recent scholarship in the field of higher education suggests that a multimedia approach to content is more likely to engage Millennial learners than these traditional methods. The primary principles of learning theories such as self-direction and relevance are not ignored; however, Millennial-focused strategies build on these learning principles to include more media and technology to better reflect the world of this generation.

Research on educational trends regarding Millennials indicates that an ideal learning environment would be interactive yet regulated and structured; they want to know the rules for success and struggle with ambiguity. Twenge describes Millennials as demanding educational consumers, and reports that content should be perceived as real and relevant because education overall is considered a means to an end. These authors do not exclude conventional pedagogies but build on engagement strategies to utilize a multimedia approach (including videos) and include peer interaction with personally relevant content. Blue surveyed sixty-nine dental hygiene students to determine their learning styles and concluded that the majority followed the Millennial learner profile articulated in the literature. Those students valued sharing ideas and appreciated group interactions and were most satisfied with a structured and secure learning environment. An investigation into the satisfaction of Millennial dental residents...
Healthy Perspectives
Course Design

Healthy Perspectives (HP), developed with Millennial learners in mind, is an interactive, online course in cultural competence at Georgia Regents University designed to meet the health care needs of a diverse population. Its overall purpose is to build self-efficacy and communication skills that facilitate empathetic patient encounters in which practitioners recognize what really matters to the patient and, as a result, consider the patient’s perspective in treatment options. The educational context of the course includes professional accreditation standards as well as Joint Commission guidelines. HP has two primary learning goals and six student learning objectives (SLOs) developed by committees of patients, faculty members, students, and staff from across the health sciences colleges of Georgia Regents University over a two-year period from 2009 to 2011 (see Table 1). Overall, the course is designed to develop students’ cultural self-awareness, address the three main areas of cultural competence (knowledge, attitudes, and skills), and help them build cross-cultural communication skills. These goals, which correspond with the current Accreditation Standards for Dental Education Programs, shaped the overall HP curriculum, and the SLOs were used to develop and organize content across five modules.

Topics covered in HP include demographics, data, and theories that illuminate and explain the how

---

Table 1. Healthy Perspectives course goals and student learning outcomes

Course goals:
1. Improve self-efficacy to perform in cross-cultural situations.
2. Demonstrate improved communication skills when interacting with culturally diverse patients, families, and health professionals.

Student learning outcomes:
1. Recognize the importance of understanding self and personal biases, assumptions, and one’s own cultural background/s and practices.
2. Appreciate the differences that exist within and across cultural groups and the need to avoid overgeneralization and negative stereotyping.
3. Demonstrate knowledge about varying cultural beliefs about health, disease, and treatment that influence health care.
4. Explain changing demographics in the United States, the presence of health disparities in health care, and strategies to reduce disparities and improve the quality of health care.
5. Demonstrate verbal and nonverbal communication in culturally competent practice that includes sensitivity to dimensions of diversity such as age, disability, gender, sexual orientation, socioeconomic status, race, ethnicity/nationality, and religion.
6. Demonstrate the ability to work with interpreter services and take a cultural profile.

---

found similar preferences, including a preference for frequent feedback and relevance. Indeed, the results from a comprehensive SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis completed by 2,421 dental students regarding their education support the general trends preferred by Millennials. The students’ concerns included pedagogical techniques (primarily a lecture-only format) that were considered tedious and focused on rote memorization, a lack of constructive feedback from supportive faculty, and wasting time through an inefficient course structure. The latter comment was considered the most common by the study authors, a factor they assigned to the preference of Millennials for organization, clarity, and efficiency.

The need to include cultural competence in dental education has been well documented, and the literature on Millennial learners is also quite robust. However, there is little research that directly addresses the interaction of the two nor are there studies that examine the impact of interactive teaching strategies and a media-infused course structure on Millennial dental students’ learning outcomes and evaluation of pedagogy. Thus, this article has three main purposes. The first is to outline the process and describe the pedagogical strategies involved for designing a cultural competence course to engage Millennial students. The second purpose has two parts: to present findings regarding the success of the course, and to present the students’ perspectives on the pedagogical strategies purported to engage Millennial learners. The final purpose is to discuss the results and share the lessons learned.

---

June 2014 • Journal of Dental Education

869
and why of health inequities that lead to outcome disparities, including but not limited to race/ethnicity, social class/wealth, and gender. Four of the modules in the asynchronous course were constructed using an interactive software tool to ensure the course was not merely a PowerPoint to read or a taped lecture to watch. One module might have only ten slides, but each slide contains layers of embedded information, links, and graphics to keep students engaged with the materials. The purpose is not to “entertain” students—a familiar criticism of media-infused pedagogy—but to connect with Millennial learners and facilitate their active engagement in the education process through technology and media.

The multimedia segments and web links illustrate or contextualize the theories and concepts related to culture and cultural competence. For instance, in the module on building self-awareness, students are linked to Project Implicit (https://implicit.harvard.edu/implicit/), a self-test on bias housed at Harvard; and in the segment on cultural beliefs and language, an audio link to The Providers Guide to Quality & Culture (http://erc.msh.org/provider/transcripts/custodio1.html) is provided to illustrate the importance of clear communication when talking with patients. Also included are YouTube videos (e.g., www.youtube.com/watch?v=pJwnRmeG9n0&feature=related), commercials on YouTube (e.g., www.youtube.com/watch?v=6_WAm7cMdK), newspapers (e.g., www.nytimes.com/packages/html/national/20050515_CLASS_GRAPHIC/index_01.html), television shows (e.g., www.pbs.org/wgbh/pages/frontline/video/flv/generic.html?sf=flol02s42d&continuous=1), and data sites and government web pages (e.g., http://nccam.nih.gov/health/herbsataglance.html). Content specific to dental health is also included, such as a clip from the Frontline documentary “Dollars and Dentists” (http://video.pbs.org/video/2249915413), but the overall focus is culture and health care more broadly. The intent is to develop a cultural awareness that extends beyond the dos and don’ts model to one that reflects self-awareness and patient-focused care. The script was completed with the cooperation of Interpreter Services at the university to ensure the accuracy of content as well as the proper translation into Spanish. The interactive program was developed by an external vendor and was housed in the university learning management system. The thirty-minute simulation provides video responses to a series of questions selected by students as they navigate a patient encounter. The competencies include knowing how to work with an interpreter, such as talking directly to the patient and using concise language, and communication techniques such as how to ask questions regarding health beliefs.

Assessment for HP in the first year took place in three arenas: a personal e-log, a discussion board, and short quizzes. The quizzes were content-based multiple-choice questions housed on the university’s learning management system. The e-log was designed to provide a site for critical thinking, self-reflection, and personal growth as students consider some potentially difficult topics. This is also the site where faculty members engaged with students one-on-one, providing the rapport outlined by Price and allowing students to make the content personally relevant. Each of the four discussion groups had twenty to twenty-four randomly assigned students who were asked to discuss topical issues as a mechanism to build community and higher order thinking. The interactions were peer-based, rather than faculty-student based, and allowed students to engage with others informally. Overall, these assessment tools are considered particularly engaging for Millennial learners.

**Methods**

The protocol for the study was approved by the Institutional Review Board of Georgia Regents University. In fall 2012, eighty-eight students were enrolled in Healthy Perspectives: eighty-one first-year dental students and seven entering radiology students. Quantitative and qualitative methods were used to assess the students’ learning and perspectives on the course design. With permission, the Clinical Cultural Competency Questionnaire (CCCCQ) was adapted for use as a pre- and posttest survey. This adaptation entailed omitting questions beyond the scope of the students’ knowledge and experience, such as those addressing end-of-life issues, but retaining others with no change to the wording. The self-awareness section, for example, had the same three questions...
as the original survey, while the knowledge matrix was reduced from ten to five questions by omitting questions on such topics as ethnopharmacology and reproductive health. This instrument has been validated across many health professions with previous versions adapted to assess the cultural competence of pharmacy students, osteopathic medicine students, and cardiovascular physicians.30,31

For data analysis, a paired t-test was conducted in SPSS on four main areas of interest in cultural competence: self-awareness, knowledge, attitudes, and skills. All the scales had good internal consistency as measured by Cronbach’s alpha. The self-awareness scale (α=0.87) consisted of three questions such as “How aware are you of your own racial, ethnic, or cultural identity?” The five-question scale for knowledge asked “How knowledgeable are you about?” and listed demographic and sociocultural issues (α=0.83). The five-question scale for skills (α=0.89) asked “How skilled are you in dealing with sociocultural issues in the following?” and focused on communication techniques. The attitude scale (α=0.79) consisted of four questions framed with “How comfortable do you feel in dealing with the following cross-cultural encounters or situations?” and centered on interpersonal interactions. The response option for all questions was a five-point scale in which 1=not at all, 2=a little, 3=some, 4=quite a bit, and 5=very.

The second tool used was the course evaluation, which was specific to the course and included common closed-end questions on the structure, organization, clarity, and content of the course. Two open-ended questions allowed students to comment on course strengths and weaknesses. Students were asked to comment on their experience in two additional open-ended questions: “What are the strengths of Healthy Perspectives learning modules? What works?” and “How can we improve the Healthy Perspectives learning modules? What do we need to fix, leave out, or add in?” The purpose of these questions was to gather overall feedback and uncover students’ perceptions of the pedagogical techniques employed in HP. The comments were sorted into categories resulting in five topic areas: content, web-links and videos, simulation, e-log and discussion board, and other. All the surveys were distributed through SurveyMonkey, and the results were downloaded into an SPSS program for statistical analysis.

**Results**

The eighty-eight students were asked to complete the CCCQ prior to beginning the six-week course and again at the end. Eighty-five students completed the pretest, and seventy-one completed the posttest. Seventy-one students completed both questionnaires for an 81 percent response rate, although the final number for each element varied because of missing questions in that category. About 65 percent (forty-six) of the respondents were white, and 35 percent (twenty-five) were African American, Asian, or Hispanic; 60 percent (forty-two) were male, and 40 percent (twenty-nine) were female. Seventy-five students also completed a course evaluation. Both data sets were used to examine the two main questions regarding the course: was it effective in teaching cultural competence, and what did the students think about the infusion of media and strategies to engage them in the learning process?

Table 2. Pretest and posttest results for characteristics of cultural competence

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>Pretest Mean (SD)</th>
<th>Posttest Mean (SD)</th>
<th>Range</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>69</td>
<td>13.04 (3.51)</td>
<td>17.46 (3.34)</td>
<td>5-25</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Skill</td>
<td>70</td>
<td>13.70 (4.59)</td>
<td>17.94 (3.98)</td>
<td>5-25</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Attitudes (comfort)</td>
<td>68</td>
<td>13.85 (3.04)</td>
<td>14.96 (2.59)</td>
<td>4-20</td>
<td>0.031</td>
</tr>
<tr>
<td>Self-awareness</td>
<td>68</td>
<td>12.07 (2.29)</td>
<td>12.88 (1.99)</td>
<td>3-15</td>
<td>0.045</td>
</tr>
<tr>
<td>Overall cultural competence</td>
<td>64</td>
<td>53.20 (10.1)</td>
<td>63.54 (9.3)</td>
<td>17-85</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Note: The p-values were determined by a two-tailed paired means test. Lower scores indicate a lower level of cultural competence, and higher scores indicate a higher level.
The pretest average of 53.20 indicated that the group was not particularly confident in their overall cultural competence when they began the course. The posttest average increased more than ten points, however, to 63.54, indicating a significant increase in cultural competence. It is interesting to note that the range of the scores shifted, shortening from 53 in the pretest to 38 in the posttest, with most of the gains lifting the lower margins by 20 points (from 27 to 47) rather than bumping the upper margin, which moved only five points from 80 to 85. In other words, many students initially described moderate levels of cultural awareness but reported an improved sense of self-efficacy by the conclusion of the course.

Each of the four characteristics of cultural competence was assessed separately to ascertain if gains were made primarily in certain areas or were equally distributed across the constructs. There was a slight difference between the variables, indicating the most substantial gains were in two areas. Gains in the mean knowledge score—up about 4.5 from 13.04 to 17.46 (out of 25)—and the mean skill score—up 4.24 from 13.70 to 17.94 (out of 25)—were highly significant (p<0.001) and quite notable. Gains in the means for attitudes (comfort) and self-awareness were significant also (p<0.05), but the actual increases reflected by the means were not very substantial at 1.1 and 0.8, respectively.

A primary focus of the course evaluation was an assessment of the pedagogical techniques to engage Millennial learners (Table 3). The evaluation revealed some interesting ambiguities, and it is clear from these results that students did not always appreciate the technological efforts to engage them.

There were three main instructional efforts to engage Millennials: media and web-links, personal e-logs, and group discussion boards. The technique that received the most positive reviews was the inclusion of web links and videos, with 74 percent of the students finding them very useful or useful. It is notable that only one student found them not useful at all, especially when compared to the other two engagement strategies. The simulation, using a skill-building media technology, garnered more support from students too. At least 70 percent reported that it was very helpful or helpful for practicing cross-cultural communication and working with an interpreter, while only a small number said it was not helpful at all.

The e-logs were designed as a space for student self-reflection to generate a personally relevant connection to the material; however, the students did not respond as positively to them as we expected. Fifty-seven percent of the students reported the e-logs were very useful or useful for exploring personal perspectives on cultural issues, while 25 percent found them only slightly useful and 18 percent said they were not useful at all. The discussion boards, the primary site for peer interaction and social connectivity (which is generally important to Millennials), were reported to be even less useful for exploring cross-cultural issues in health care than the e-logs. Forty-six percent of the students said they were very useful or useful, but more than half said they were only slightly or not useful at all. The discussion boards were the least successful element of the course.

Student comments provided in the evaluation illuminate the quantitative data. The open-ended questions designed to solicit feedback were “What are the strengths of Healthy Perspectives? What works?” and “How can we improve Healthy Perspectives? What do we need to fix, leave out, or add in?” There were forty-eight responses to the strengths question and fifty-four to the needs improvement section. The number of comments is shown by category in Table 4.

The students reported that the course content was both the main strength and area for improvement in the evaluation. More than half of all the strength comments were positive notes about the content,

<table>
<thead>
<tr>
<th>Table 3. Students’ evaluation of the usefulness or helpfulness of engagement techniques, by percentage and number of respondents to each question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>How useful were the videos and web links in illustrating the concepts?</strong></td>
</tr>
<tr>
<td><strong>How useful were the e-logs for exploring and considering personal perspectives on cultural issues?</strong></td>
</tr>
<tr>
<td><strong>How useful were the discussion boards for exploring and considering peer perspectives on cultural issues in health care?</strong></td>
</tr>
<tr>
<td><strong>How helpful was the simulation for practicing cross-cultural communication?</strong></td>
</tr>
<tr>
<td><strong>How helpful was the simulation for practicing working with an interpreter?</strong></td>
</tr>
</tbody>
</table>
such as a growing awareness of health disparities as reflected in the following example: “I liked how the data were . . . straight to the point. Health disparities are out there and the modules definitely expressed that.” The second most frequent strength comment centered on building self-awareness, as expressed in the following: “A definite strength of this program was it forced me to evaluate myself and my own beliefs. To me, that stood out even more than the things I learned about other cultures. The program forced me to learn about myself and I needed that.” Indeed, as one student noted, “I have a better understanding of how important the doctor-patient relationship is in maintaining the integrity of our profession.” Interestingly, about one-third of the students said the content needed improvement, but the focus was not on the content but the amount of material or the time it took to read it. For example, one student noted, “The modules were very resourceful, applicable, and useful, but I did tend to feel like too much information was being covered.” The comments on the content, both positive and negative, corroborated the statistical data on self-perceived gains in knowledge and self-awareness.

The students’ reviews of the engagement strategies provided some interesting insight into the techniques. The comments regarding the web links were generally positive, with comments such as the following: “I really think the addition of e-learning through YouTube was a strength because our generation can easily relate to learning from YouTube because we learn almost everything there is to know on YouTube these days. Continue adding interesting YouTube and web links.” The main issue reported was the time it took to visit the sites rather than the inclusion of the links, as one student noted, “At times it was a bit too much with all the links and videos and clips. It was very easy to spend over an hour on one module. In dental school an extra hour is hard to come by.” The simulation, which again earned quite good ratings in the data analysis, also earned more positive than negative comments, with the common theme being how it was, as one student put it, more “effective than reading about how to work with an interpreter.”

The low number of student comments regarding the e-log and discussion board reflects the general lack of support for these engagement techniques. More students cited problems rather than strengths, and comments were a variation on one theme, as expressed by one student: “The discussion section did not facilitate a lot of actual interaction. The class is just getting to know each other so no one wants to offend another. It would be more representative if it was anonymous I believe.” The limited positive comments about this venue were of the minimal “I liked it” type so did not really add to our understanding.

### Discussion

The results of this study indicate the online course was effective in elevating the students’ levels of cultural competence and self-awareness. Recognizing the disparities that cultural competence is supposed to address and seeing how disparities are directly related to practice are critical to the effectiveness of the training. Student evaluations on the content and focus of the course were positive in this regard, with the comments illuminating the student perceptions. However, the elements of the course designed to appeal specifically to Millennial learners were met with mixed reviews: there was some appreciation for multimedia in the course, but less support for the personal e-logs and group-based discussion boards.

Millennials are often labeled as self-absorbed, but rarely are they described as self-aware. Developing a course that requires critical self-reflection and linking it to a concrete purpose such as professional development will ideally help build cultural awareness among the students at personal and professional levels. The data and comments indicated the course was successful in both areas. The primary problem with the content was the scope and depth of the material, and the comments indicated the content was fitting but, given this was not a credit-bearing course, it was just a bit too much.

There were some limitations to this study. Because there was no control group, competing explanations cannot be ruled out for the changes observed. However, two data sources were used to
evaluate student gains, and the six-week course occurred at the beginning of year one, when few other professional and clinical experiences were included. Both surveys were anonymous self-reported data, and while identifiable information from the discussion comments or e-log entries was not included, the anonymous comments were included in the course evaluation to provide some corroborating information regarding student outcomes.

While students appreciated the video and web links, they also found the amount of material somewhat overwhelming. Faculty members were perhaps a little overzealous when including content and hyperlinks, and there was little to distinguish between the necessary and important content links from the reference and informational links. Consequently, students thought they had to go to all the webpages when in fact they did not. In the next iteration of the course, the number of links embedded within the modules will be reduced, and the focus of those that remain will be tightened in an effort to support student engagement. The informational and reference links can be included as a bibliography for students to explore as opposed to links in the body of the text. The important content links will remain, but students will know they are required to visit those sites. This adjustment will allow for the inclusion of multimedia while recognizing the importance of structure and relevance, all said to be preferred pedagogies for Millennial students.

The findings regarding the participatory techniques (e-logs and discussion boards) were unexpected. It was anticipated that the students would appreciate an opportunity to reflect and share thoughts on the material as they progressed through the course. The e-logs were not a scored activity, and there was one-on-one interaction with faculty members, but students and faculty members alike reported that this area of the course did not add much to the learning objectives. As a result, this technique will not be employed in subsequent course offerings.

In spite of the low student rating, the discussion boards will be included in future versions of this course. Student comments reveal the tension of participating in discussion boards—a public forum—in a new and unfamiliar context with people who are basically strangers. The perceived benefit of considering cultural issues from a practitioner’s perspective is well received by most students, but the social pressure of learning with a yet unknown but important peer group limits the frank debate that could be useful to them. Efforts will, however, be made to overcome this limitation in future course offerings because the opportunity to discuss relevant issues with colleagues is an important characteristic of professional development. The course faculty agreed that discussion boards could still be a useful if not necessary tool for an online course.

There is an assumption that Millennials, with all their gadgets and connectivity, will take to discussion boards like ducks to water, but this was not the case in this course. Conversing on Facebook or “tweeting” is not the same as required participation on an issue in an academic discussion board, and, frankly, they should not be the same. Personal interactions are different from professional interactions. In future versions of the course, smaller groups will be used in an attempt to facilitate better conversations among students and promote a more collegial and professional atmosphere. The smaller groups will make it easier for the faculty to guide the conversation and model professional engagement as we cultivate a community of learners. This shift will also meet the Millennial learner preference for feedback while sharing ideas too.

The changes to the online course will still be consistent with Millennial learner characteristics but with a slightly different bent. The elements related to course structure, organization, and a preference for clear guidelines will be strengthened, while still including but reducing the multimedia and interactivity components. The content will be more focused, the links specific, and the multimedia requirements clearly presented. The changes to the discussion boards will also reflect a tipping toward structure with a smaller group, while including a stronger feedback component through more faculty engagement.

Our assumption, when creating this online course, was that the interactivity, web links, and video clips were going to be the most important pedagogical elements for Millennial learners. We were pleasantly surprised to learn that the students appreciated and ranked solid content matter, a strong course structure, and clear guidelines above the use of multimedia. This is not to say the technology is irrelevant, but that the students recognized that the media-infused strategies illustrate and highlight, but do not replace, the content. Indeed, these results suggest that faculty and students, of Millennial and other generations, agree that the content is the primary characteristic of a worthwhile course and that the media-infused teaching strategies are tools that
serve to engage learners in the process. Overall, the course content was most appreciated by students, and their gains in cultural competence were notable.

REFERENCES