

5-1-2015

The voices of the people: Lower Sioux Indian Community members speak out on what they need and want in a primary health care clinic on the reservation

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THE VOICES OF THE PEOPLE: LOWER SIOUX INDIAN COMMUNITY
MEMBERS SPEAK OUT ON WHAT THEY NEED AND WANT IN A
PRIMARY HEALTH CARE CLINIC ON THE RESERVATION

By

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May 2015



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entitled

Voices of the People: Lower Sioux Indian Community Members Speak Out on What They Want and Need in a Primary Care Clinic Located on the Reservation

is approved in partial fulfillment of the requirements for the degree of

Doctor of Nursing Practice

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EXECUTIVE SUMMARY

American Indian/Alaska Native (AI/AN) people who live on reservations or in urban areas typically receive their health care in clinics that are operated by their tribe or are affiliated with Indian Health Service (IHS), a federal agency that provides care to AI/AN people. The Lower Sioux Indian Community (LSIC) is a federally recognized tribe located in southwest Minnesota near Morton, MN. LSIC members currently receive health care from outside providers at various locations near the reservation. The outsourced services include primary care, emergency care, hospitalization, surgery, dentistry, and podiatry. Because the providers are independent groups and do not work for the LSIC, continuity among health care providers is highly variable, as is the cultural awareness and competence necessary to provide high quality health care for AI/AN people. This often results in fragmented, episodic care as well as variation in levels of patient satisfaction with services. Transportation also poses an obstacle to care for LSIC members. The nearest health care provider is five miles from the middle of the LSIC.

Compounding these issues for the LSIC and other tribes are the tremendous health disparities between AI/AN people and U.S. population averages. Diseases such as diabetes and cancer are rampant among the AI/AN population and require ongoing, coordinated primary care. Deterring such diseases or minimizing their devastating effects requires a major paradigm shift to wellness and prevention. The use of primary care services that feature a more local, patient-centered medical home (PCMH) may help improve health outcomes. A PCMH emphasizes care that is coordinated, connected, and communicated in ways that ensure it is being provided as the patient wants.

The LSIC has secured funding through its gaming operations and a commercial bank loan to build a new health care clinic within the community. Tribal elders have been hearing from tribal members who want to be involved with operations and care delivery. The building will be located close to the tribal government center and children's play area. Because it is on tribal land, there is no cost to purchase the land or taxes to be paid. IHS resources will include environmental, biomedical, and recruitment services. The approximately \$5 million facility was scheduled to break ground in spring 2015, with a projected opening in fall 2015.

This building project presented a golden opportunity to include the voices of the people in planning for the new primary health care clinic, in hopes of improving patient satisfaction and outcomes. This DNP project involved a qualitative case study using focus groups to discuss what LSIC members want in their clinic and how they would like to be cared for. The project involved several small focus groups that were asked open-ended questions while dialogue was recorded. The results helped determine the most appropriate, culturally competent health care delivery model for providers and staff to use in the new clinic. The value of this project is significant to the LSIC as well as to other tribes in the Midwest that are considering building or expanding health care services within Indian country.

ACKNOWLEDGEMENTS

Thank you to my project committee members: Dr. Lori Candela, committee chair, for your leadership, expertise, and commitment to a story that needed to be told; Dr. Carolee Dodge-Francis for your insight on qualitative research and navigation of focus groups within the American Indian community; Dr. Tish Smyer for embarking on the journey of this project as a committee member; and Dr. Patricia Gatlin for your joining the journey as a committee member through to the end.

Thank you also to the Lower Sioux Indian Community Tribal Council for your support of this project and resources to gain insight from the community members in an effort to improve their health and wellness.

I would like to acknowledge the funding that was provided from the Lower Sioux Indian Community for project expenses.

For my family, those here today and those here in spirit, thanks for all of your support and understanding. I may be the first doctoral student in our family, but I know I won't be the last. Thanks to my mother, Cheryl Prescott, for her continued support and believing in me; and to my brother, Gabe, sister-in-law, Kara, nephews Makale and Kohen, and niece Reese Prescott for their continued love and support. To my Dad, Michael W. Prescott, and my grandparents who are with us in spirit.

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CHAPTER 1

Introduction

American Indians and Alaska Natives (AI/AN) are identified as enrolled members of 565 federally recognized tribes of AI/AN people in the United States. The 2010 U.S. Census identified 5.3 million people as AI/AN, either alone or in combination with one or more other races. Out of this total, 2.9 million people identified as American Indian and Alaska Native alone; the remaining 2.3 million identified themselves as AI/AN in combination with one or more other races. Of interest, the AI/AN combination population experienced rapid growth, increasing by 39% between 1991 and 2000 (Norris, Vines, & Hoeffel, 2012). One could surmise from this trend that the increasing acceptance that facilitated blended relationships between races will grow. As the number of AI/AN people grows, so do the demands on the health care system that serves their unique needs. The need for cultural competence in health care continues to be prevalent within the AI/AN community, with growing recognition of this population's historical trauma, exposure to violent crimes, and health disparities. Thus, increasing numbers of people require culturally competent health care. Cultural competence has been defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable effective work in cross-cultural situations" (Paez, Allen, Carson, & Cooper, 2008, p. 1205). The need for cultural competency and the effects it may have on patient satisfaction and outcomes have been recognized by the Institute of Medicine.

Culturally competent care can be ideally provided within a patient-centered medical home (PCMH). The care provided in a PCMH promotes a culturally sensitive

approach by health care providers in order to meet the needs of patients and to improve patient and staff experiences, outcomes, and safety as well as system efficiencies.

Blending cultural competency with creating a PCMH would conceivably enhance the patient-provider relationship and promote positive outcomes (Jackson et al., 2013).

Cultural competence represents an integral step to success in an AI community's health care delivery. Ensuring that providers understand the history and current challenges of AI people is necessary to set the stage for positive relationships, which can lead to improved outcomes. An understanding of cultural beliefs, values, attitudes, traditions, language preferences, and health practices of AI/AN people can help produce positive health outcomes (Indian Health Service, n.d.b).

One AI tribe has an opportunity to implement these concepts from scratch. The Lower Sioux Indian Community (LSIC) is a federally recognized tribe located in southwest Minnesota in Redwood County, approximately two miles from the town of Morton, MN (Appendix A). Its 874 members have been receiving health care through a disparate array of outsourced providers near the tribe's reservation. The LSIC has secured funding through its gaming operations and a federal loan to build a new health care center within the community. Support for the health care center is high among members of the tribe. Tribal leaders have heard from tribal members who want to be involved with operations and care delivery. The approximately \$5 million facility was scheduled to break ground in spring 2015 and open in fall 2015.

Socioeconomic Health Disparities

The health status of AI/AN people is significantly lower than that of other populations in the United States. Combined life expectancy was 73 years for AI/AN

people versus 77.7 years for all other populations in the U.S.; in the Indian Health Service (IHS) region where the LSIC is located, it was 70.2 years (Indian Health Service, 2014). IHS is a federal agency created through treaty rights to meet the health care needs of AI/AN people. It is divided into 12 regions, among which the LSIC's region had the third lowest life expectancy (Indian Health Service, 2014). In the AI/AN population, preterm births, defined as a gestational age of <37 weeks, occurred at a rate of 13.6%, compared to 12% of all U.S. pregnancies (Hwang, Shrestha, Yazzie, & Jackson, 2013). AI/AN people were twice as likely to develop diabetes and possessed double the infant mortality rates of Caucasians (Broome & Broome, 2007). Cancer was the leading cause of death among AI/AN people from 1999 to 2009, and their use of tobacco, a known carcinogen, was higher than any other group in the United States (Centers for Disease Control and Prevention, 2014). These disparities highlight not only the need for culturally competent primary care providers to treat current health conditions but also the need to promote a shift in paradigm to wellness and prevention.

Sadly, even child maltreatment, in the forms of neglect and psychological, physical, or sexual abuse, was more common in AI/AN populations than in others. Among AI/AN children, 21.7 of 1,000 experienced maltreatment compared to 20.2 of 1,000 African American children (Sarche & Spicer, 2008). The effects carried into adulthood were predictable and contributed to health disparities. Childhood exposure to sexual and physical abuse, violence, poverty, and racism often translated into symptoms of posttraumatic stress disorder (PTSD) in AI/AN people (Brockie, Heinzelmann, & Gill, 2013). By providing information on these experiences in an orientation or introduction to the community for health care providers and staff, the problems have a better chance to

be recognized and addressed. Recognition of these symptoms and awareness of this history can facilitate providers addressing patients in a way that can lead to better compliance and outcomes.

Health care provided in a community setting offers the opportunity to provide more in-depth training and community input with providers and staff. Better understanding of history can enhance the relationships with patients and impact outcomes through effective provider-patient relationships.

Historical trauma also falls under the umbrella of PTSD. PTSD is more common in American Indian populations than among other populations. Historical trauma involves the cumulative trauma of families and communities beyond those who originally suffered the trauma (Gray, Shafer, Limb, & Busby, 2013, p. 590). Trauma experiences for AI/AN people may include institutionalization in boarding schools, relocation to cities and reservations away from what was known as home, and assimilation into Caucasian culture through discipline and native culture loss. This historical trauma impacts the family unit as well as the trust in resource personnel such as health care providers. Once the trauma was inflicted, family dysfunction ensued and was carried on by future generations (IHS Division of Diabetes Treatment and Prevention, 2012).

Violence and crime rates were substantially higher among AI/AN people. Victimization was widespread among AI/AN communities. AI/AN people were 2.5 times as likely to experience violent crimes including simple and aggravated assault, almost twice as likely to be a victim of robbery, and at least two times as likely to experience rape or sexual assault crimes compared to all other races in the United States (Perry, 2004). In Minnesota from 2004 to 2007, 345 AI/AN women and children from

the Minneapolis and Duluth Harbors area were sexually trafficked (Pierce, 2012). Arrest data in Hennepin County, which encompasses the Minneapolis area, showed that AI/AN women represented 24% of prostitution arrest data (Pierce, 2012, p. 38). In Minnesota there was much travel by AI people between metropolitan areas and reservations, which are located in rural areas of the state. Approximately 1 out of 4 suspects investigated by the U.S. Attorney's Office for violent crimes was from Indian Country (Perry, 2004, p. vii). Forty-six percent of AI people released from prison in 1994 were convicted of a new crime within three years (Perry, 2004). The number of AI/AN people sentenced to death was proportionately higher by 2% versus all races (Perry, 2004). The picture of AI/AN people as victims and perpetrators was significant and affected overall health and socioeconomic status.

In addition to disparities in health and crime, AI/AN people experienced disparities within the socioeconomic arena including poverty, education, and unemployment. The socioeconomic status of AI/ANs represented a significant inequality compared to the overall general population. The poverty rate of AI/AN people was 2.5 times greater than the general population (National Survey of Drug Use and Health, 2010). "More than one-quarter of the AI/AN population lives in poverty" (Sarche & Spicer, 2008, p. 126). This rate was more than double that of the general U.S. population and in certain tribal groups as many as 40% lived in poverty (Sarche & Spicer, 2008). Of the 10 poorest counties in the U.S., five were home to a reservation (Brockie, Heinzelmann, & Gill, 2013). The Sioux Tribe in Pine Ridge, SD, was one of them. Income data in the state of Oklahoma revealed that 76% of AI/ANs earned below \$25,000 per year compared to 35.3% of whites and 55.1% of other minority groups (Min

& Savage, 2012). Unemployment rates among AI/ANs were three times higher than the national unemployment rate (Sequist, Cullen, & Acton, 2011). Unemployment ranged from 14.4% to 35% in reservation communities, whereas the general population had an unemployment rate of 6.3% (Sarche & Spicer, 2008; Bureau of Labor Statistics, 2014). Only 71% of AI/AN people possessed a high school diploma or GED versus 80% of the general population. The college graduation numbers were even bleaker: Only 11.5% of AI/AN people held a bachelor's degree versus 24.4% for the general U.S. population. Enrollment of AI/ANs in post-secondary undergraduate degree programs was consistently 1% in U.S. Census data from 1980, 1990, 2000, and 2010 (Aud et al., 2012).

Of all races, AI/AN people had the highest rate of violent victimization and were exposed to repeated loss with high rates of early, unexpected, and traumatic deaths due to injuries, illness, accidents, suicide, homicide, and firearms all exceeding the rate for the general U.S. population by at least two times. Alcoholism rates were seven times that of the general population (Sarche & Spicer, 2008).

Defining a Tribe

A Federally Recognized Tribe is one that has been identified as having a “government-to-government relationship” with the United States (Bureau of Indian Affairs, n.d.). This was supported through treaties that were established with tribes in the 1800s. Tribal sovereignty supports the tribes’ government-to-government interaction, dialogue, and resolution. “Tribal sovereignty ensures that any decisions about the tribes with regard to their property and citizens are made with their participation and consent” (Bureau of Indian Affairs, “What does tribal sovereignty mean,” n.d.).

AI/AN people reside on reservations, as well as in proximities and towns close to reservations, in urban areas, and in cities throughout the United States. A reservation is defined as “an area of land reserved for a tribe or tribes under treaty or other agreement with the United States, where the federal government holds title to the land in trust on behalf of the tribe” (Bureau of Indian Affairs, “What is a federal Indian reservation?” n.d.). Approximately 56.2 million acres are held in trust by the United States for various Indian tribes. There are approximately 326 Indian land areas in the United States administered as federal Indian reservations and communities. The largest is the 16-million-acre Navajo Nation Reservation located in Arizona, New Mexico, and Utah. The smallest is a 1.32-acre parcel in California where the Pit River Tribe’s cemetery is located. Many of the smaller reservations are fewer than 1,000 acres (Bureau of Indian Affairs, n.d.).

Tribal reservations may be considered either closed or open with regard to the extent of sovereignty exerted. A closed reservation is one that exercises full sovereignty where state courts, law enforcement, and jurisdiction are not recognized by the reservation. The Lower Sioux Indian Community is an open reservation and has working relationships with county services such as the sheriff’s office and human services.

Indian Health Service

The Indian Health Service (IHS) has worked in partnership with tribes and urban AI/AN groups to enhance the health and wellness of AI/AN people since 1955. The agency, which operates under the U.S. Department of Health and Human Services, provides three areas of service: federally operated facilities and services, independently operated tribal facilities and services, and urban health care service centers. Federal

facilities provide primary care, some specialty services, and pharmacy services. Additionally, IHS allocates Contract Health Service (CHS) funds to pay for health care services that are not available at the federal facilities. Tribal facilities also receive CHS dollars to support services in cases where a federally operated IHS facility is not within a reasonable distance from the tribal member. Tribal facilities vary in the level of community health services, primary care, specialty care, and hospitals they provide. Urban IHS programs serve AI/AN patients who reside near urban clusters, many of whom were relocated through the Indian Relocation Act. Some reside in these areas by choice (Sequist, Cullen, & Acton, 2011). IHS is a provider reimbursed by Medicare, Medicaid, and private insurances.

Innovation within IHS was evident thanks to the dedication of the agency's leadership and staff. Telemedicine was one example. It created a way to connect patients in isolated areas with specialty providers to receive consultative care. It also allowed provider-to-provider contact through both a synchronous and asynchronous mode. Retinopathy was one example of success. Through telemedicine, digital retina images were taken in an IHS facility and reviewed by an ophthalmologist in another facility, with treatment prescribed. Results increased from 50% to 75% of AI/ANs receiving treatment for diabetic retinopathy as a result of the teleophthalmology program (Sequist, Cullen, & Ayanian, 2005, p. 2177). Use of health information technology was evident in the development of the Resource Patient Management System (RPMS), which functions as a medical record as well as a data repository. RPMS also triggers delivery of patient education materials based on patient data entered. Educational materials are written at a fourth-grade level to better ensure health literacy. Culturally relevant patient

education linked to diagnostic codes assists in tracking data, billing, and ensuring positive patient outcomes (Sequist, Cullen, & Acton, 2011).

Lower Sioux Indian Community

The LSIC is one of four Sioux Communities in Minnesota. The LSIC and its three sister communities are located in the southern half of the state and include the Shakopee Mdewakanton Sioux Community, the Upper Sioux Community, and the Prairie Island Sioux Community. Minnesota also has five Ojibwa Reservations in the northern half of the state. The four Sioux Communities are Dakota people who, with the War of 1862, were banished from Minnesota. Hence, Sioux Communities are not reservations, but communities.

The LSIC is governed by a Tribal Council consisting of five elected officials including a president, vice president, treasurer, secretary, and assistant secretary/treasurer. The LSIC has a community center that serves as the government center. Other tribal-operated buildings house services that include community health, social services, behavioral health, a recreation center, a tribal court, tribal police, an office of environment, and a gaming commission. The current resident population, defined as living within a 10-mile radius of the reservation, includes 874 members.

Lower Sioux Health Care Center

LSIC tribal leaders discussed the concept for a tribal health care clinic several times over the past decade. In 2014, the LSIC Tribal Council approved building a health care facility to include medical, dental, optical, pharmacy, dietician, and podiatry services. Currently, members of the LSIC receive health care from outside sources in the private sector or at the Veterans Administration Medical Centers in Minneapolis, St.

Cloud, MN, or Sioux Falls, SD. LSIC members have Blue Cross Blue Shield commercial insurance for which 30% of the premium is paid by individual contributions and the other 70% comes from tribal gaming operations. Contract Health Service funds through IHS are used to cover balances not paid for by insurance. A priority list exists within IHS based on acuity of illness. The highest acuity illnesses are covered first and lesser-priority care may not be covered. An acuity system that is translated into priorities is necessary due to limited funding. This priority list is followed, beginning with the most emergent cases, such as loss of life or limb, and descending to lesser emergent needs (Appendix B).

The tribe's current health care system also presents a physical barrier for those who lack transportation. The nearest health care provider is five miles from the middle of the LSIC. A visit to any health care provider requires a car and driver or emergency medical service personnel. For those who are unable to drive, the tribe provides resources including two vehicles, two staff members, insurance, and additional safety devices (e.g., child car seats) to transport members to medical and dental appointments.

Because of the variations in where members choose to receive their care, quality varies and there is no common link to track quality outcomes or a venue to address whether care is being delivered in culturally acceptable ways. The value of cultural competence in an AI community project such as this is that the cultural competency components can be embedded in the development, orientation, and workflow of the new health care center. Without a new health care center, LSIC members would continue to receive care at various locations that lack connection or cohesion. As medical costs grow

and resources shrink, it may become difficult to guarantee the same level of insurance provision.

The need for the LSIC health care center is based on tribal members' general request for care that is culturally competent, readily available, and provided within the LSIC. The health care center would also give tribal members who have graduated from various colleges and training programs in medical fields an opportunity to work within and care for their own community. Elders groups voiced support for the fact that the tribe's members will be involved in the center's operation and in the provision of care.

Funding for the health care center comes from the tribe's gaming operation revenues as well as from a federal lending program. The site will be near the tribal government center, near the dedicated powwow grounds and children's park. The building plan included nine exam rooms, four dental bays, and space for clinical consultation in mental health, chemical dependency, and nutrition.

The health care center will be open to community members, employees, and nontribal members. The tribe was recruiting an established provider-partner to assist in the development of the facility with physicians and nurse practitioners. Two major medical providers had expressed interest as of June 1, 2014. Opening was planned for fall 2015.

Problem Statement

Currently, members of the LSIC receive primary care through various medical and advanced-practice nursing providers in an array of outside facilities. There is no consistency in or tribal control over quality, patient satisfaction, or cultural competence. Costs are significant to the community, as pricing for services vary among providers.

Additionally, commercial insurance premiums are rising annually with little to no input or control by the tribe's CHS administrators. In July 2014, LSIC members' per capita income from gaming operations was reduced in an effort by the tribal and casino leadership to invest more revenue in the infrastructure and marketing needed to build the gaming business in a challenging rural economy. This income cut will create difficulty for members who already work with limited incomes and health care coverage. The creation of the Lower Sioux Health Care Center is intended to alleviate much of the problem of quality and cost.

Project Purpose

The creation of the LSIC health care facility presented an opportune time to gather input from a variety of tribal members. The importance of empowerment is evident to set the stage for success in the launching of Lower Sioux Health Care Center. Banerjee and Duflo (2008) identified that poor and underserved populations are often handed the responsibility for making things better for themselves, largely without being asked whether this is what they want. This project will help to ensure that the perspectives of tribal members with regard to what they want and expect in their tribal health care facility will be taken into consideration as the health care center is designed and business operations are developed. Caring for individuals and families in a way that is culturally competent; allowing them input into the development of the facility and their individual care, is expected to increase satisfaction, compliance, and healthy outcomes. This DNP project used a focus-group methodology to gather this data for the development of the Lower Sioux Health Care Center.

CHAPTER 2

Review of the Literature

Literature searches were completed using the following databases accessed through the University of Nevada Las Vegas Lied Library and Mayo Clinic Library: PubMed, Proquest, and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). Search phrases included AI/AN, medical home, primary care, patient satisfaction, conducting research on, co-morbidities, access to health care, health disparities, focus groups, hegemony, and Ecological Process Model of Change. Comparative articles were found with applicability and implications to AI/AN populations. Supplemental resources were also identified by the doctoral committee member with expertise in qualitative research.

Health Disparities

Disparities among AI/AN populations were concerning when compared with Caucasian populations and other minority groups in the United States. Sources of health care were one disparity. Shi, Chen, Nie, Ahu, and Hu (2008) found racial disparities in not having a consistent source where health care is received among minorities compared with their white counterparts having increased access to health care. The need to improve minority groups' access to primary care providers represents an opportunity to help the poor and underserved with chronic conditions (Shi et al., 2008). A general theme of underserved populations with higher disparities in health care and outcomes was apparent. Services for these populations have almost always been comparatively suboptimal with many opportunities to improve (Buchwald, Furman, Ashton, & Manson, 2001). Disparities in treatment among AIs were found whether the prevailing diseases

were acute infections (e.g., smallpox and measles), chronic infections (e.g., tuberculosis), or other conditions such as heart disease, diabetes, alcoholism, and depression (Jones, 2006). Further, a meta-analysis by Hutchinson and Shin (2014) revealed rates of obesity, diabetes, cardiovascular disease, and metabolic syndrome to be clearly higher for AI/AN populations.

Disproportionately higher health disparities have been identified in AI/AN people compared to all non-Indian populations. Cobb, Espey, and King (2014) reported that AI/AN people had a higher prevalence of tobacco use, obesity, and physical inactivity, and lower prevalence estimates of fruit and vegetable consumption, cancer screening, and seatbelt use. A survey of AI/AN people in California revealed that almost half of the participants rated their perception of their own health and wellness as fair to poor (Hodge & Karabi, 2011).

Additionally, there exists mistrust among minority people of nonminority health care providers. A literature review by Dovidio et al. (2008) identified disparities and distrust among black people in health care settings as largely caused by the impact of stereotypes harbored by white providers.

AI/AN people have had myriad experiences that increased their mistrust of health care providers. IHS providers were not historically known to be enthusiastic about their work with AI/AN people. Some of the unethical research practices and nonconsenting procedures performed on AI/AN people increased mistrust of government and health care providers. Historical trauma and experiences being institutionalized in boarding schools contributed to mistrust in service providers among AI/AN people.

Life expectancy among AI/AN people was 4.7 years less than that of white people (Indian Health Service, 2014). AI/AN people had a significantly higher death rate than other Americans from an array of conditions. Examples included: tuberculosis, 600% higher; alcoholism, 510% higher; vehicle crashes, 229% higher; diabetes, 189% higher; injuries, 152% higher; and suicide, 62% higher (National Congress of American Indians, n.d.). At 16.1%, AI/AN people had the highest prevalence of diabetes among all U.S. racial and ethnic groups (American Diabetes Association, n.d.). Further, a 68% increase in youth diagnosed with type 2 diabetes in ages 11-15 was seen from 1994 to 2004 (Dodge-Francis & Chino, 2012). This may be attributed to changes in eating patterns, diet, and physical activity compared to previous generations.

The Great Lakes Inter-Tribal Council, Inc. (2013) conducted a secondary data analysis regarding the epidemiology of suicidal behaviors among AI/AN populations using the IHS electronic medical record database. Of the data reviewed, including 5,922 records, suicide by overdose of prescription medications was the most prevalent method of suicide attempt found. The implications of this review indicate a need for increased mental health screening and intervention, as well as collaboration between pharmacists and health care providers to educate patients about safe medication storage and handling.

Cancer represented the second leading cause of death among AI/AN people over age 45 (American Cancer Society, 2014). “AI/AN people have one of the highest cancer rates among all U.S. ethnic groups, second only to Hispanic people” (Espey et al., 2007, p. 2121). Over the past 20 years, cancer mortality rates have decreased for white populations, but remained stagnant in AI/AN populations (White et al., 2014, p. 377). Espey et al. (2007) pointed out that these numbers may be even higher, because reported

data rely on patients' and providers' reporting of patients' ethnic origins. Patient registration includes ethnicity, and in some cases includes options to identify as multi-racial or leaning toward one choice. In some cases, AI/AN people may not have been registered correctly or may not have disclosed their ethnicity. A retroactive chart review of the classification of AI/AN patients in a state cancer registry compared to the participating tribal clinics found that, due to racial/ethnic misclassification, the number of AI cases of cancer increased by 21.3% after corrections to the registry were made (Creswell et al., 2013). AI/AN patients may not have been identified accurately by staff or been asked specifically the question regarding their race.

The AI/AN population had the highest rates of both smoking and using smokeless tobacco (Ubina, Van Sell, Arnold, & Woods, 2011). Commercial tobacco consists of cigarettes, chewing tobacco, and pipe tobacco. Tobacco in its natural form does not possess the added addictive components of commercial cigarettes. Traditional tobacco, in a natural form, has ceremonial uses in tribes and this is sometimes confused by tribal members with commercial cigarettes and chewing tobacco. This adds to the challenge of promoting smoking cessation and prevention while differentiating between commercial tobacco products and the natural tobacco that is often used amongst tribal members as part of ceremonies.

Stroke mortality was higher for AI/AN men in all age groups except for those 85 and older (Schieb, Ayala, Valderrama, & Veazie, 2014, p. 368). Heart health is a concern among AI/AN people and requires a collaborative approach to address controllable and uncontrollable risk factors. The northern plains held the highest rates for heart disease deaths among AI/AN people over whites (Veazie et al., 2014, p. 3).

As the population ages, elder care is a growing concern in AI/AN communities. The older population of AI/AN people will proportionately double by 2055 because of increased longevity (Smyer & Stenvig, 2007). However, “Despite medical advances increasing life expectancy, morbidity, and mortality statistics suggest that the health of older American Indians lags behind the majority population” (Goins & Pilkerton, 2010, p. 343).

Primary Care and the Patient-Centered Medical Home

The goal of primary care is to address health needs and problems, provide person-focused (not disease-oriented) care over time, and provide care for all but very uncommon or unusual conditions. Primary care moves beyond episodic care to develop relationships. Further, it coordinates or integrates care, regardless of where the care is delivered and who provides it. Optimization and equity are addressed to enhance patient health status and ensure that cultural components are taken into consideration by providers (Johns Hopkins Primary Care Policy Center, 2014). Providing a person-focused approach represents a significant benefit for a community such as a tribe where individuals may have similar histories and nuances.

Physician shortages compound the challenge of delivering continuous primary care. The opportunity to increase access to consistent primary care by building a tribal health care center offers a significant boost for AI/AN people because of these physician shortages, especially in rural and underserved areas. By 2025, the United States will experience a shortage of 130,000 physicians, with primary care accounting for 37% of the shortage (Brown, 2013). This shortage will increase opportunities for nurse practitioners, physician assistants, and other professionals to work within the full scope of

their practice. While physician care is often associated with primary care, licensed independent nurse practitioners are increasingly working as primary care providers. In light of the shortage of primary care providers, care delivery must adapt to meet the needs of AI/AN patients. Relief from the physician shortage can come from using a team approach of multidisciplinary providers, maximizing enhanced information technology, and letting providers such as nurse practitioners, physician assistants, and registered nurses work within the full scope of their respective practices (Green, Savin, & Lu, 2013).

The importance of developing a primary care provider relationship is somewhat new to AI/AN patients who have been accessing care in Indian Health Service facilities, where care has typically been given on a first-come, first-served basis. Similarly, AI/AN patients at private-sector facilities may or may not see a consistent provider where a relationship can be developed. Use of emergency rooms or urgent care settings for episodic treatment results in fragmented care through lack of consistency in care providers.

The concept of a medical home is defined as “a model of primary care transformation that seeks to meet the health care needs of patients and to improve patient and staff experiences, outcomes, safety, and system efficiency” (Jackson et al., 2012, p. 169). A health care team provides care for the patient across the health care system to improve outcomes. Relationships between health care providers and patients that feature high-quality interaction and are thoughtful are associated with improved outcomes including better recall, adherence, satisfaction, and health, and reduced hospitalization (Garrouette, Sarkisian, Goldberg, Buchwald, & Beals, 2008). The patient-centered

medical home (PCMH) is a model that has been shown to improve primary care, quality, access, and health outcomes (Driscoll et al., 2013). The PCMH is positioned to reduce health disparities among populations facing needs for prevention and chronic disease management. A study analyzing emergency care use among 45 AN patients' medical record data found that after a PCMH was implemented in the population, emergency care use and duplication of diagnostic testing were reduced (Driscoll et al., 2013, p. 41). Its deployment with AN children showed improved continuity of care.

Having a medical home with consistent primary care providers may help provide continuity of care and increase opportunity for positive outcomes. The need for such a model is apparent when considering how living conditions affect health on a community level. For instance, a study conducted among 234 AI women in an outpatient IHS facility in Albuquerque, NM, revealed that 76.5% of respondents reported some type of childhood abuse or neglect and more than 40% reported maltreatment (Duran et al., 2004). Results also indicated that a number of respondents were diagnosed with mental health disorders as adults. In 2012, a study of AI/AN patients ages 1–17 showed that the prevalence of having a medical home with a specific provider or care team was 27% less than for non-Hispanic white children (Barradas, Kroelinger, & Kogan, 2012).

Relationships are key to creating a successful primary care medical home. “We must not only ask our patients what is the matter with them, we must also ask what matters to them most” (Bartol, 2014, p. 8). This statement may represent a transition for both the provider and the patient. As I developed the project plan, this statement reinforced the need to get candid input to set the stage for a patient-centered medical home in the new LSIC health care center. The natural connectivity within an AI/AN community, plus

patients knowing providers and staff, can help foster relationships that will enhance patient outcomes.

Community-Based Care

The literature revealed positive support and opportunities for community-based health care among AI/AN people. Community-based health care allows for the opportunity to deploy culturally competent interventions to support sustainable positive change. Small-scale community-based clinics offer opportunities to naturally establish primary care medical homes through the relationships developed by the circumstance of being a smaller clinic. Both small and large practices can achieve the PCMH model of primary care. However, the smaller practice can often informally navigate patients, their care plan, interventions, and strategies (Berry et al., 2013). Size alone does not indicate positive outcomes. The LSIC health care center will have space for two providers at one time, increasing access and opportunities to build relationships on a personal level.

Patient navigation represents both a level of coordination and a provision of advocacy for a patient. Both coordination and advocacy are germane to nursing. A study of 52 patients experiencing personalized patient navigation at Rapid City Regional Hospital's Cancer Care unit revealed that AI patients who received patient navigation during their treatment had a higher level of satisfaction with their care, although no difference was noted in medical trust levels (Guadagnolo, Cina, Koop, Brunette, & Petereit, 2011). The use of patient navigation is a positive movement in AI patient care, with additional effort needed on development of a trusting relationship to facilitate further satisfaction and support patient outcomes. With the LSIC's new health care

center, the opportunity to engage staff and patients with patient navigation as part of the customary care will presumably increase patient satisfaction, compliance, and outcomes.

Assessments of AI/AN communities have recommended the need for improved access to culturally drive health care and screenings. A survey was administered to a group of 404 adult North Dakota AIs using the Behavioral Risk Factor Surveillance System to assess health, medical functioning, and medical concerns. The results revealed a higher rate of heart disease, myocardial infarction, smoking, obesity, and heavy alcohol use. Identified opportunities for improvement included improved health care access, better preventive screenings, culturally appropriate community-based health promotion programs, and policy changes to reduce health disparities (Holm, Vogeltanz-Holm, Poltavski, & McDonald, 2010). As medical homes strive to meet the many needs of AI/AN people, it is important to keep focused on specific strategies that will be sustainable.

The Lower Sioux Health Care Center has an opportunity to define what services and programs will support sustainable changes to the community's health status. Programming that targets the health of AI/AN people should be narrowly focused and community driven to gain trust, sustainability, and engagement (Geana, Greiner, Cully, Talawyma, & Daley, 2012). It is clear that community disparities can be better addressed through engagement and consistency.

Access to Care

Access to health care among AI/ANs is a significant concern, as shown by the dramatic health disparities in the population compared to others. Access to care is imperative to ensure success, especially in a new health care clinic. Access to care

involves ensuring that the facility and providers meet the needs of the population and make efforts to ensure that access is attainable by the population. One advantage for the LSIC health care center project is the community size. A study regarding patient access among 1,999,523 patients revealed that among the ethnic minorities, access was better in small practices with fewer than 2,000 patients (Kontopantelis, Roland, & Reeves, 2010). In addition, hours of operation were noted as a barrier for the working class by several study participants when facilities kept standard hours of 9 a.m. to 5 p.m.

While the physical ability to visit a provider is an important component of access, there are other considerations. Because of high cost or scant health care coverage, advanced technology and treatment modalities are typically not available to AI/AN people. For instance, Warne (2006) found that IHS formularies were on such a restricted budget that more expensive versions of some medications, such as once-a-day or long-acting diabetic medication, might not be available. Medications to be taken on a once/day basis typically cost more than multiple doses administered several times daily (Warne, 2006). A study by Baldwin et al. (2008) identified financial constraints as the primary reason why specialty care access was limited for AIs in the rural states of Montana and New Mexico. An advantage with the Lower Sioux Indian Community is that funds have been secured and partnerships with existing medical providers are being pursued to ensure that access is available to a consistent group of physicians and advanced practice registered nurses within the tribe.

Cultural Competence

Culture impacts communication and response to health information. The need for cultural competence in health care continues to build based on patient expectations and

performance indicators. Cultural competence is defined as the ability of health organizations and practitioners to recognize the cultural beliefs, values, attitudes, traditions, language preferences, and health practices of a population and to apply that knowledge to promote positive outcomes (Indian Health Service, n.d.b). Provider knowledge of a patient's history is a strong indicator of how a patient will respond to recommendations or interventions. Understanding a population's history is helpful in determining interventions that will support positive outcomes (Indian Health Service, n.d.a).

Because the LSIC has not had a community clinic before, tribal members have experiences from an array of medical providers. This project helped to determine how cultural competence weighed on their experiences with health care organizations and providers. Specifically, how did their experiences impact how tribal members felt, and were their outcomes impacted by experiencing an organization and provider who were seen as culturally competent?

Patient Satisfaction

Cultural competence has an effect on patient satisfaction among minorities. There is limited research on patient satisfaction specific to AI/AN people. Comparative patient satisfaction among other minority populations does exist. The need for a respectful and engaging experience is of significant importance among AI/AN patients. A study was conducted among the Cherokee Nation involving 115 people ages 50 and older to examine the relationship between ethnic identity and patient satisfaction. The results demonstrated that those AI people who rated their ethnicity of higher importance also rated their patient satisfaction lower in the areas of social skill and attentiveness of the

provider (Garrouette, Kunovich, Jacobsen, & Goldberg, 2004). The need to educate providers on the history and customs of AI people will be imperative prior to the Lower Sioux Health Care Center opening in order to respect ethnicity while promoting patient satisfaction.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is used to measure patient satisfaction. Weidmer-Ocampo et al. (2009) adapted the CAHPS survey for 696 AI/AN patients. A 58% response rate indicated that the adapted tool was useful for assessing the satisfaction of AI/AN people with the health care they received in clinics (Weidmer-Ocampo et al., 2009). When a new clinic opens, it is important to deploy patient-satisfaction surveys that are designed to address ethnicity as part of the patient experience, in order to receive accurate data from the start. By analyzing responses on expectations before the clinic opens, specific areas of satisfaction can be addressed prior to survey data received after the opening.

Another factor in patient satisfaction rates is trust of health care providers. Benkert et al. (2009) conducted a study in which 100 African-American adults completed several cultural inventories based on trust levels of health care providers. Results indicated significant mistrust of European American providers and of the health care system. However, high levels of trust and satisfaction were found specifically with nurse practitioners (Benkert et al., 2009). The trust level with nurse practitioners is remarkable and points to an opportunity for further development in minority communities. Improving provider relationships is indicative of decreasing racial and ethnic disparities. A study by Rodriguez, von Glahn, Grembowski, Rogers, and Safran (2007) revealed that out of 49,861 AI/AN patients visiting 1,588 primary care physicians, patients perceived

the provider focus to be on their disparity versus on patient satisfaction. Further opportunity exists in focusing on racial and ethnic minorities to reduce disparities (Rodriguez et al., 2007).

Ecological Process Model of Systems Change

To facilitate the change process to a new health care system, this project used the Ecological Process Model of Systems Change. “The ecological process model of systems change focuses on the end state of transformation, telling us what changed and if the objective was achieved; it does not reveal how the change was made” (Peirson, Boydell, Ferguson, & Ferris, 2011, p. 310). The advantage of this model is that it can be used in real time or retrospectively. The model was useful for this case study project because evaluation of the end state could be accomplished through the dialogue of the study participants. The results of that dialogue provided insight and opportunity in the development of the Lower Sioux Health Care Center in such areas as staff training, services, environment of care, hours of operation, and provider competencies.

Barriers to change seen by the author have been navigated using the Ecological Process Model of Systems Change and included intra- and interrelation items. Intrarelational items included different levels of education among tribal health care providers and elected leaders of the Tribal Council, community member sense of entitlement, and transition to a tribal health care center from area provider clinics. Inter-relational items included transitioning members from area clinics to the tribal health care center, bringing in providers to the community from a respective clinic, and licensure and accreditation. While these barriers existed, the development of the Lower Sioux Health Care Center has the opportunity to make a positive impact on the health of the

community in a culturally competent manner affecting co-morbidities, outcomes, and patient satisfaction.

Needs Assessment and Project Description

Population Identification

The population includes AI adults of the Lower Sioux Indian Community located in southwest Minnesota. Approximately 471 adults and 403 children are within the community's 10-mile radius, including the towns of Morton (3 miles) and Redwood Falls, MN (6 miles). The LSIC is located in Redwood and Renville counties of Minnesota. Two, two-lane county roads intersect in the middle of the reservation, facilitating traffic to area businesses (Appendix A). Minnesota's harsh winters create challenges navigating and traveling to area towns and larger cities for health care. The area is primarily agricultural and the LSIC is surrounded by a combination of farmland and woods as well as the Redwood River Valley adjacent to the Minnesota River. Principle sources of employment for the LSIC include Jackpot Junction Casino Hotel, Dakotah Ridge Golf Course, LSIC government and services, and private employers in Redwood Falls and Morton.

Project Sponsor and Key Stakeholders

The LSIC owns and operates several businesses including Jackpot Junction Casino Hotel, Dakotah Ridge Golf Course, and Oyate' ("the people's") convenience store—all located on the LSIC. Revenues from tribe-owned businesses, particularly gaming, are being used toward the \$5 million clinic project. This DNP project was pursued with approval from the Lower Sioux Tribal Council, an elected body of the enrolled members of the LSIC (Appendix C). The motivation for the Lower Sioux

Health Care Center was to offer culturally competent care within the LSIC. This has not been done before. Further economic opportunities included the support to bring revenues to the community by medical billing and through insurance processing and payments filtering back to the community. Currently, the tribe strictly pays out medical expenses that insurance does not pay. Stakeholders included the Tribal Council, community members, and primary care clinic development staff involved in the care delivery model. Community members were engaged in and supportive of the Lower Sioux Health Care Center.

Supportive internal groups of the Lower Sioux Health Care Center in the LSIC included the elders group (a weekly meeting), Unity (a school youth group), Quilters (a weekly activity group), and community members who expressed support at various community meetings. In February 2015, a health and human service advisory group was established to obtain community input on issues pertaining to health and social services within the community. Supportive external groups connected to the LSIC included interested potential partners Affiliated Community Medical Centers, Allina Health Care, Mayo Clinic Health System, and Sanford Medical. Partnership with an existing organization for provider coverage will be of great value in getting the clinic staffed with a blend of partner-provided providers and staff members from the LSIC. The key to success will be the development of a cultural training program specific to the LSIC for all staff and providers to learn at the same time and build rapport that will facilitate positive communication and enhance patient interaction in the future.

Organizational Assessment

The Lower Sioux Indian Community is located in southwest Minnesota and is one of four Sioux tribes in Minnesota. There are 874 members residing in the tribe's service area, which includes a 10-mile radius of the reservation. A Tribal Council of five is elected by the LSIC members and serves as the governing body for the tribe. The tribal members' primary care needs are met by local medical clinics and critical-access hospitals located off of the reservation. The most used medical clinic was Affiliated Community Medical Centers in Redwood Falls, MN, with approximately 1,972 visits annually. The second most used was Allina Medical Center in New Ulm, MN, (35 miles from the LSIC) with just over 200 visits annually (Contract Health specialist T. Schemmel, personal communication, June 6, 2014). A data gap existed because there is no access to tribal patient data among the area providers; each clinic is an independent entity that may or may not collect or share the same data elements.

Enrolled members of the tribe have Blue Cross Blue Shield health insurance. These members are also eligible for Contract Health Service funds, which cover co-pays for treatment received where insurance does not cover. Contract Health Service is regulated through Indian Health Service, a federal program developed based on treaties between tribes and the U.S. government.

Available Resources

Resources for this DNP project included the support of the Lower Sioux Tribal Council with regard to conducting the project. This followed after obtaining approval from the University of Nevada Las Vegas Institutional Review Board in October 2014. Assistance came from a Lower Sioux Indian Community health nurse, a Contract Health

Service specialist, a community health representative, transportation assistant, a grants manager, the finance director, and the tribal historic preservation officer. Assistance from these individuals consisted of promoting the opportunity to participate in the focus groups. The grants manager and finance director were involved in processing payments that were submitted by the researcher and approved by the LSIC Tribal Council.

Team Selection

The team consisted primarily of the student investigator with assistance from community health staff, the Tribal Council, a consultant, and eventually the selected partner that will provide the licensed independent practitioners for the new clinic. Other team members included the tribe's finance director, and staff in the office of the environment. An outside transcription service was also used to transcribe focus group recordings.

Mission Statement

The mission of the Lower Sioux Health Care Center is to enhance and/or restore the health of LSIC members and patients by engaging in the delivery of culturally competent health care.

Goal

The goal of this DNP project was to seek LSIC members' health care expectations and apply the results to all aspects of primary care development in the Lower Sioux Health Care Center.

Objectives

1. Engage members of the LSIC through solicitation of needs, wants, expectations, ideas, and desires regarding the Lower Sioux Health Care Center.
2. Identify opportunities to implement cultural competence through dialogue among LSIC members in a focus group regarding the Lower Sioux Health Care Center.

CHAPTER 3

Theoretical Underpinnings of the Project

The theoretical underpinnings of the research project are crucial to its success, particularly with the AI/AN population, which has been in some cases harmed as a result of past research activities (Hodge, 2012, p. 432). Insight into the need to proceed carefully when working with AI/AN people was drawn from a historical review of unethical research and medical care before and after the famed Tuskegee experiments. In those experiments, which began in 1932, the U.S. intentionally did not provide treatment to poor, rural African-American men who had syphilis so that researchers could study the disease's progression (Hodge, 2012, p. 431). The program operated under the guise of providing free medical care to the men.

Mistrust and skepticism of non-AI people in general are commonplace in tribes due to historical and recent events. Hodge (2012) wrote about the history of mistrust between AI/AN people and researchers. In the 1700s, smallpox-infected blankets were distributed to tribes during the French and Indian War, devastating the populations of several tribes by purposely infecting them. In the 17th and 18th centuries, body parts of AI people were removed from battle sites and hospitals, and skulls were studied for shape and potential intelligence. This practice, Hodge noted, went against the belief of many AI/AN people that one cannot enter the spirit world without being physically intact. From 1900 to 1930, tarsiectomies (removal of eyelids) were commonly performed on AI patients with trachoma and later became prophylactic on nonsymptomatic AI people. There was no study to suggest this was successful. This disfiguring operation continued until the 1930s, when sulfa drugs were invented. Hodge also found that in the 1950s, AN

elders recruited tribal members into a study that involved administering radioactive isotopes to non-English speaking men, women, and children—with unknown effects on the subjects’ overall health and reproductive function. The elders recruited others in the belief that they were trading their participation for medical treatment in rural villages.

According to Hodge, in the 1970s, an estimated 3,400 AI females between the ages of 15 and 44 underwent sterilization procedures such as hysterectomy and tubal ligation. Investigation by the Comptroller General of the United States later found that consent for these procedures was gained through coercion through support of misinformation about losing Bureau of Indian Affairs benefits. Also in the 1970s, a study of ANs age 15 and older was conducted to determine the role of alcohol use in traumatic deaths to determine appropriate interventions. Hodge noted that the study was quickly ended after tribal members filed charges regarding lack of proper consent of youth and adults.

Harding et al. (2012) described an extreme and recent example that occurred in the 1990s, when a study was completed with the Havasupai Indian Tribe through Arizona State University in which more than 200 blood samples were drawn for type 2 diabetes research. The samples were taken to the university with the agreement that any unused blood would be returned to the tribe to be kept as part of the wholeness of one’s self that tribe members believe is needed in order to pass into the next world. Instead, the blood samples were used for additional unauthorized studies on inbreeding and schizophrenia, and the remaining samples were sold to foreign countries for further research of unknown intent. As Syed (2010) noted, this research ignored the original premise wherein the principal investigators, the Tribal Council, IHS physicians and personnel, and data

collectors believed, according to the scope of the project, that consent for participation was limited to diabetes research. However, the specimens were actually used for genetic testing. After significant legal action and pursuit of the university, the tribe reached a settlement, receiving the remaining blood samples and a formal apology from the university with promises to work with the tribe on health, education, and economic development. Those promises had not been acted on as of 2012, according to Hodge. This tragic example of an agreement not upheld has generated further mistrust of research being conducted within the AI/AN community. On a positive note, it has promoted the accessing and development of tribal internal review boards as well as community-based participatory research policies and procedures. These examples highlight the importance of transparency and the use of culturally appropriate theoretical underpinnings.

Focus Groups

The theoretical underpinnings of this project were guided by the use of qualitative focus groups to obtain information that is most relevant to the development of the Lower Sioux Health Care Center. Focus groups are a form of group interviews that capitalize on communication between research participants in order to generate data (Kitzinger, 1995). Focus groups differ from other types of research in that the individual interviews and laboratory experiences occur in and are facilitated in a group setting (Stewart, Shamdasani, & Rook, 2007, p. 19). Focus groups allow for stories of the individual to be related in a small setting. Because research was a new experience for the LSIC, the need for careful implementation while giving voice to the people was prevalent. As Medicine (1998) stated, the need is to engage AI/AN people in the research to drive improvement, not to use them as consultants.

In facilitated small groups, data are collected and funneled into common groups of feelings regarding experiences or expectations. The recommended size for focus groups is generally 6–12 people (Stewart, Shamdasani, & Rook, 2007, p. 58). While this number is recommended, the researcher found that smaller groups with the AI population were more comfortable and facilitated more detailed dialogue. Questions play an important role and open-ended questions offer the best opportunity for clarifying and asking follow-up questions.

In parallel, talking circles have been found to be effective within the northern plains AI/AN community with a 12-session group focusing on education of type 2 diabetes. The talking circles were held with eight participants on two reservations in the Midwest. The results indicated that participants openly discussed challenges with their type 2 diabetes as the groups met weekly for the 12 weeks (Struthers, Hodge, Geishirt-Cantrell, & De Cora, 2014). Being able to build familiarity and comfort with repeated sessions may be an advantage of a recurring group versus one-time focus groups. Nevertheless, the significance for this project was seeing that focus groups can be facilitated and effective within the AI/AN community.

Data analysis follows systematic coding procedures that move from the individuals' detailed statements to summarizing broader statements to trending into themes. What is described as the end product is the essence—what the group members experience or would like to experience and how they felt or would like to feel (Creswell et al., 2013). Data analysis then consists of determining overarching themes and subthemes supported by the group dialogue.

Because the author is a member of the LSIC, specific boundaries had to be deployed to ensure that the focus groups were led to hear the voices of the participants in a nonbiased manner. In cases where a researcher is closely involved with the subject matter being investigated, the researcher may “bracket himself or herself out of the study by discussing personal experiences with the phenomenon” (Creswell et al., 2013, p. 78). This practice is useful when writing about the data collected because it serves to disclose the student researcher’s familiarity with the subject matter to the reader so as not to sway the participant by implying that existing assumptions are new information within the research findings. As Health & Human Services director for the LSIC, the researcher was very familiar with the Lower Sioux Indian Community and the planning for the Lower Sioux Health Care Center. Therefore, it was imperative to maintain a neutral stance to engage dialogue among participants.

Using focus groups in the proposed qualitative project facilitated the author’s attempt to understand the essence of experiences and expectations that LSIC members want for a primary care clinic located within their community. This was determined through the sharing of positive and negative experiences as well as positive expectations of the members engaged in the discussions. Data were collected through focus groups and categorized to determine themes that could be applied to the development of the Lower Sioux Health Care Center in order to better serve the community.

Social Ecological Model

The Social Ecological Model (SEM) of behavior was developed in the early 1980s by Urie Bronfenbrenner in response to an increasing societal interest in behaviors that prevent disease and death. Behaviors affect and are affected by multiple levels of

influence. The original SEM by Bronfenbrenner divided environmental systems into micro-, meso-, exo-, and macrosystem levels of influence (Figure 1). The microsystem is the immediate environment including those closest to the person. The mesosystem involves interactions with groups the individual facilitates with, such as in the workplace or social groups. The exosystem refers to the larger social system with which the individual is affiliated. Finally, the macrosystem refers to the cultural beliefs and values embedded throughout the micro- and macrosystems. The subsystems affect behavior and adapt to changes in membership. A framework was later developed to account for the individual, family, social, and cultural influences that were specific to child abuse (McLeroy, Bibeau, Steckler, & Glanz, 1988). The model, shown in Figure 1, is adapted to identify the relationships from closest to farthest and can range from simple to complex. The model is adaptable to various societal issues. Figure 2 shows an adaptation for cancer.

This project addressed how individuals would like to see their health care delivered at the Lower Sioux Health Care Center, beginning with the perception of the relationship between health care providers and one's self, then moving to family, society, culture, and, finally, to referral to outside providers for services beyond the scope of the tribal clinic.

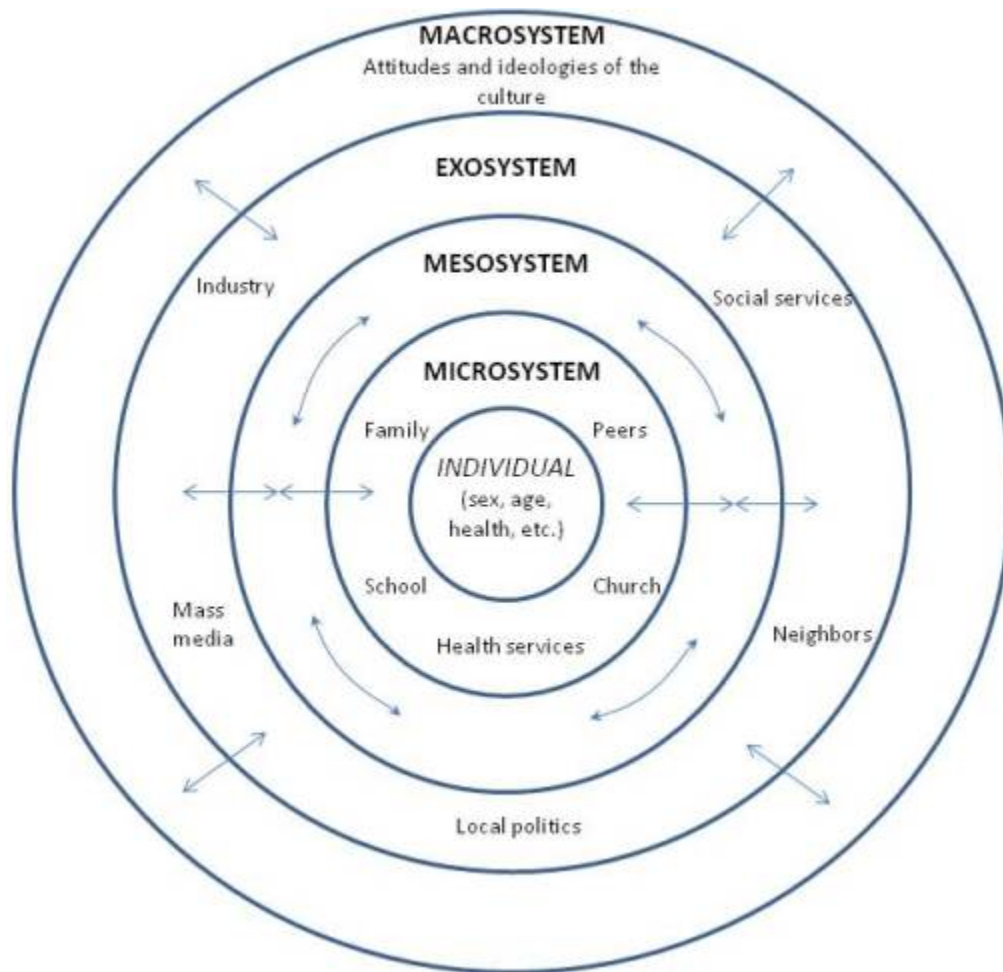


Figure 1. Urie Bronfenbrenner's Social Ecological Model. Downloaded from http://en.wikipedia.org/wiki/File:Bronfenbrenner%27s_Ecological_Theory_of_Development.jpg



Figure 2. Sample SEM framework. A recent version of Urie Bronfenbrenner’s Social Ecological Model uses a similar framework adapted for cancer treatment. Downloaded from <http://www.cdc.gov/cancer/nbccedp/sem.htm>

The SEM has been applied in an AI population. A study by Saftner, Martyn, Momper, Loveland-Cherry, and Low (2014) used the SEM in identifying urban AI adolescent girls’ framing of sexual risk behavior. The study took place in talking circles and individual interviews held in the Minneapolis, MN, area with 15- to 19-year-old AI females. The results found similarities to other adolescent behaviors from other racial and ethnic groups, but noted differences in family structure, cultural heritage, and cultural history. The results within the various systems revealed that the microsystem consisted of identifying the girl’s self-influence as perceiving herself as normal, her cultural identity, and having goals for the future. The mesosystem identified six components of influence on sexual behavior comprising family, friends, neighborhood, school, mass

media, and health care. The macrosystem did not identify a specific link between policy and the girls' daily lives (Saftner et al., 2014).

The SEM served as a model to describe overarching and subthemes surrounding health care as an individual, a family, and a community among study participants. A strong tie existed between focus groups and the SEM in determining common threads and perceptions from the participants' experiences as individuals, in a family, in a community, and in a population. The perceptions and desires that were shared in voices of focus group participants were aligned within the SEM and will be helpful in determining care delivery for the Lower Sioux Health Care Center.

CHAPTER 4

Project Plan

The LSIC received financing and was actively pursuing construction of a brand-new health care clinic within the community during this research project. The Lower Sioux Health Care Center will be the resource for primary care and health and wellness activities for all members of the LSIC. Providers of care will include physicians, advanced-practice registered nurses, a registered dietician, a registered nurse, and ancillary personnel. The target date for opening the Lower Sioux Health Care Center was the fourth quarter of 2015. The LSIC Tribal Council was supportive of this research project with regard to supporting expenses associated with conducting the focus groups and the use of the researcher's time. The Tribal Council felt strongly that this research was an opportunity to gain input that would support the implementation of a health care center within the community.

The DNP project plan consisted of conducting five focus groups with LSIC members in order to determine their expectations and desires for care in the new facility. Initially, the plan was to interview a minimum of 30 community members, with participant group sizes of approximately 5–7 people. However, after I conducted the first focus group, I reduced the size to 2–4 participants. This allowed for increased sharing among participants. I observed that the larger group had a difficult time and experienced some awkwardness in sharing. Participants often waited for someone else to share first, thus hindering the dialogue I had hoped to engage in. Further, the smaller focus groups were easier to facilitate.

Analysis of each group's transcript was completed following each session. Saturation with two overarching themes of frustration and empowerment had emerged by the conclusion of the fourth focus group. Despite this, the fifth focus group was still held because it was already scheduled, with two participants planning to attend. Full details of the project plan are described below.

Setting

The focus groups were conducted in the private dining room of the Dakota Restaurant, located inside a hotel casino located within the LSIC, on the southwest border of tribal land. The site had ample parking, including designated spaces for people with disabilities and for tribal elders. The restaurant was near the hotel entrance, so individuals did not have to access the gaming areas to reach the restaurant. This location was familiar to the community members. Additionally, posted signage and casino staff helped provide directions to the dining room. A luncheon menu was provided, and each participant was allowed to choose an entrée item up to \$15 and a nonalcoholic beverage. The room was configured with a circular table to facilitate open dialogue and group interaction. Lighting was sufficient for reading and the acoustics supported a meeting space outside of the restaurant's larger open space.

Population

The population and sample of interest consisted of the enrolled members of the LSIC, ages 18 and older. The enrolled adult members residing in the tribe's service area represented the patients, parents, and caregivers of patients who will use the Lower Sioux Health Care Center. Because this will be the tribe's first health care facility located

within the community, LSIC members were key stakeholders in providing input on how they want to be cared for in the Lower Sioux Health Care Center.

According to the tribe's financial director, as of July 1, 2014, there were 471 adults and 403 children residing within the LSIC's service area, consisting of the community boundaries and a surrounding 10-mile radius (M. Farmer, personal communication, July 11, 2014). Of the adults, 123 were age 55 or older, which meets the LSIC's definition of an elder (M. Farmer, personal communication, July 11, 2014).

To participate in a focus group for this project, participants needed to meet the following criteria:

- Be 18 years of age or older;
- Be an enrolled member of the Lower Sioux Indian Community; and
- Agree to participate in a 60- to 90-minute focus group of up to seven participants.

Measures, Instruments, and Activities

After approval was received from the University of Nevada Institutional Review Board (IRB), recruitment for the project began. This included advertisement in a flier located within the Lower Sioux Community Center. The information flier for the focus groups was placed on a bulletin board near the public entrance of the community center building. Interested participants were asked to call the LSIC health department and speak with the researcher or a community health assistant to determine eligibility and sign up for a focus group date. Because of the small community, the student researcher and health staff were knowledgeable of whether community members met the requirements to participate. No interested participants were deferred from participating in a focus group.

On the day of the focus groups, I contacted participants by telephone to remind them of the time and location of the focus group and offered to answer any questions. I then arrived approximately 30 minutes before the session began to set up the audio recorder and an easel to display each question as it was asked. The focus group sessions began with a brief explanation of the new clinic, the research project, and the purpose of the focus group in giving input about how individuals and families would like to be cared for in this new health care facility within the LSIC. Further explanations included:

- That an audio recorder would be used to accurately capture the input from the participants;
- That the recording would be transcribed by a professional transcriptionist;
- That common themes would be coded based on conversations from the present group and other focus groups that were part of this project;
- That the focus group would conclude within 60 minutes following lunch;
- That participants had the freedom to abstain from answering any questions;
- That participants could leave the focus group at any time without repercussion;
- That audio data would be saved electronically for three years on a password-protected computer drive, then be erased; and
- That consent forms and transcribed materials would be kept in locked file cabinet of the LSIC for three years, then be destroyed by shredding.

IRB-approved consent forms, printed in English, were handed out for participants to review (Appendix D). For those who chose to participate, the forms were signed, collected, and saved as part of the focus group participant data. If any attendees chose not to participate, they were still able to order the free lunch in the public part of the

restaurant. All participants chose to participate and were briefed on the sequence of lunch and questions.

Participants chose pseudonyms in lieu of using their real names for the recording. This also served as an ice-breaker, lightening the atmosphere for the group as most knew each other's real names. The focus group discussion consisted of five open-ended questions (Appendix E). The guiding questions opened with asking participants what they would like to see in health care delivery within the LSIC. Further discussions covered questions such as, "What do you expect for services of the Lower Sioux Health Care Center?"

Strategies to facilitate the group included following a sequential order for discussion and calling on individuals to elicit their input if they were reluctant to speak. In the event of silence, the author used tactics such as rephrasing the question, or acknowledging that it was acceptable to take time to formulate thoughts of a response. If any participants manipulated or monopolized the conversation, the author was prepared to intervene by asking them to listen to another participant. However, this did not noticeably occur during the groups conducted.

During each focus group, I attempted to bracket myself from influencing the conversation through my experience as Health & Human Services director for the LSIC. Creswell et al. (2013) discussed a tactic that mentally suspends our understandings to facilitate the group moving the dialogue forward. As discussions around providers and services proceeded, I made a point not to intervene in conversation that was not germane to the objectives of the study. An example of where I did redirect the conversation was when a participant in the first focus group asked whether nonmember employees of the

LSIC would use the clinic. Because this population was not specific to the study, I answered the question—yes, they could—but pointed out that this study was specific to the members of the LSIC.

After the focus groups were complete, the researcher's committee chair and qualitative analysis committee member reviewed transcripts from the sessions and recommended follow-up with specific individuals to gain more detailed information to explore the themes around frustration and empowerment. Because the focus groups were small and the participants were all known to the researcher, this was completed using either in-person or telephone conversations.

Project Timeline

Recruitment of focus group participants began in November 2014, after project approval was received from the University of Nevada Las Vegas Institutional Review Board, a requisite of the LSIC Tribal Council (Appendix F). The focus groups were conducted in November and December. Data transcription and analysis were conducted after each focus group session. The plan was to finalize the project by April 2015, in time to use the results in planning and developing health care services for the new health care center (Table 1).

Table 1

Project Timeline

Deliverable	Date
Chapters 1–4 to committee members	August 10, 2014
Proposal defense	August 19, 2014
University of Nevada Las Vegas IRB approval	September 2014
Participant solicitation and selection	November 2014
Project focus groups conducted	November–December 2014
Transcription of recorded sessions	November–December 2014
Data analysis	January 2015
Writing of project results	February 2015
Defense of project results	March 20, 2015

Project Tasks and Personnel

The student researcher completed all project tasks with recruitment assistance from LSIC health staff and outside professional transcription. The student researcher advertised recruitment for the focus groups in the LSIC through a flier located at the front desk of the Lower Sioux Community Center building, where many community members passed through on a daily basis. Recruitment ads requested that interested participants call the LSIC health department and speak with the researcher or one of the community health assistants, who offered dates available and recorded the caller’s name and telephone number. The Community Health Representative responsible for driving community members to appointments used the drive time to discuss the opportunity to participate in a focus group. I called and reminded the participants of the session on the morning of each focus group. The student researcher submitted requests for all planned expenses, ensuring they were attributed to the appropriate cost center that was supported by the LSIC.

Resources and Supports

Resources included the LSIC Tribal Council support of the project work being conducted by the researcher. Authorized financial support was obtained for expenses including copies, computer use, software use, electricity, postage, paper, transcription, and the cost of meals for participants in the focus groups. As an employee of the LSIC, the researcher was approved to conduct activities regarding the project during working hours and thus was paid for the time involved with arranging and conducting the focus groups. There was no additional cost associated with using the private dining room in the restaurant beyond the cost of the lunches. The student researcher informed the tribe's finance department of expenses, provided receipts for documentation, and took responsibility for submitting expenses for payment processing.

Risks and Threats

Lack of interest or reluctance from community members was a potential threat to the project. To alleviate this, the researcher monitored the signup schedule to determine whether there was sufficient interest or whether additional recruitment efforts were needed. When appropriate during informal interactions, the student researcher and community health staff promoted the opportunity to participate in the focus groups as a way to impact care given in the LSIC and for future generations. It was through active recruitment that interest was received from community members. There were no direct responses to the posted flier; rather participation was gained through word of mouth.

Severe weather was a possibility in Minnesota. Local public school closure was the determining factor in deciding whether to cancel a session. However, the weather

allowed for all selected dates to be used. Participants were given the opportunity to decide at the last minute not to participate based on objections to audio recording or any other reason. No one declined to participate. On two occasions, participants indicated that they needed to leave precisely at the session's scheduled end time. However, each session concluded on time and all participants completed the sessions as scheduled.

Evaluation Plan

Recruitment Plan

Once Institutional Review Board approval was received from the University of Nevada Las Vegas, recruitment began. The flier advertising the focus group opportunity was posted from early November 2014 to early December 2014 on a bulletin board near the front desk at the Lower Sioux Community Center. The success in recruitment came from the word-of-mouth efforts by the health department staff, after monitoring of signup activity showed no response to the flier. The plan was successful in that each focus group had attendees.

Financial Plan

The Lower Sioux Tribal Council was supportive of the project and approved expenses of the researcher as an employee of the tribe, as well as specific costs associated with the project. These costs included:

- 25 lunches at the Dakotah Restaurant totaling \$351.00;
- Transcription services totaling \$357.30;
- Photocopies, advertising, and postage; and
- Author's time during working hours conducting and preparing focus group sessions.

Institutional Review Board Approval

Institutional Review Board (IRB) approval was received in October 2014 from the University of Nevada Las Vegas. Support of the Lower Sioux Tribal Council was contingent on approval of the university's IRB. The LSIC does not have its own IRB; therefore the Lower Sioux Tribal Council decided to accept the approval of the University of Nevada Las Vegas as the approving IRB before recruitment for the project could commence. A letter of support for the project from the tribe was obtained (Appendix C).

CHAPTER 5

Summary of Implementation and Results

The purpose of this qualitative research project was to determine what members of the LSIC want and need in the new Lower Sioux Health Care Center. This involved determining overarching themes from the group dialogue in order to direct efforts to support successful implementation. The objectives of the project were to engage members of the LSIC about their hopes and expectations for the new health care center through the focus groups and to identify opportunities to implement cultural competence through dialogue.

This chapter describes the project's participants and their thoughts and stories, and examines the themes and subthemes that evolved from data analysis. Themes and subthemes that emerged were related to the community members' past experiences, stories from the past, and hope for the future to receive health care in a culturally sensitive manner. The experiences discussed included those that have both enhanced health care and hindered health care relationships.

Overall, two primary themes emerged from the focus groups with individual, organizational, and community implications. Results were supported by the literature search. I adapted the SEM to describe the two overarching themes of frustration and the opportunity for health empowerment. These themes were placed on the adapted model as individual, organizational, community, or policy levels of influence. This was based on the conversations from the transcripts.

Initiation of the Project

Following university IRB and LSIC Tribal Council approval, focus groups were initiated in November 2014 and concluded in December 2014, with a total of 20 participants. All focus groups were held as planned in the Dakota Restaurant's private dining room. A total of 20 people participated in one of five focus groups ranging in size from 2–7 participants. Each participant was an enrolled member of the LSIC. Membership was verified through personal knowledge of the participants by the researcher. All people who attended the information luncheon agreed to be a part of the study, completed informed consent forms, and participated in the focus group offered at that time.

Collectively, the groups were 65% female and 35% male. Being a member of this tribe, I knew that 80% of the participants were employed and 20% were retired or not employed. Their ages ranged from 20s to 60s. Thirty percent of the participants met the tribe's definition of an elder—being age 55 or older.

Threats and Barriers to the Project

A barrier to the research project included the researcher's close relationship to the community and the health care center project. In each group I clarified my role as a student researcher. At the same time, I attempted to make focus group participants feel as comfortable as possible, whether or not they knew me or were acquainted with my background.

As an enrolled member of the LSIC, I found myself at times wanting to participate in the discussions. To bracket myself, I used a script to keep on task with each session. The same questions were asked in each of the five focus group sessions. I

also reviewed the transcripts after each session specifically to review any questions and my answers to make sure that I was not influencing the participants into specific discussion points or topics beyond the prepared questions.

Another threat was lack of participants for the focus groups. Initially, there were no calls of interest in response to the recruitment effort, which consisted of posting a printed flier. What worked best for recruitment were one-to-one discussions and interactions with community members, which drew participation through invitation. Since this was the first known research activity with the LSIC, recruitment was also new and the need for careful explanation was apparent to me. When contact was made with interested participants, I took time to explain what the study was and to ensure that people understood that they would be participating in a focus-group setting.

From a facilitation perspective, there was one session where background noise was an issue due to construction in an adjacent area of the casino. The transcription took extra time and the researcher had to fill in portions of the transcription from notes and recollection.

Monitoring of the Project

Monitoring was completed by the researcher through careful reflection after each focus group in an effort to address any problems for the next session. This included discussion with the committee chair and qualitative committee expert on focus groups. One observation was that the size of the group affected the level of participation. The first group comprised seven participants. I found this focus group to be too large. Participants seemed uncomfortable and did not readily respond to questions. In focus groups 2–5, the group size was reduced to 2–4 participants. That was found to be more

manageable and participants engaged in the discussion more openly without waiting for their fellow participants to share. Facilitation of the groups was also easier with the smaller numbers.

Data Collection

Focus group data collection took place through a digital recording of each session and transcription by an outside company. Participants used pseudonyms for the recording. I asked questions of the group and took notes during the focus groups to fill in any unforeseen lapses in the transcription process. As a facilitator, I was also immersed in the conversations of the focus groups.

Data Analysis

Krueger (n.d.) identified four stages to qualitative analysis of focus group transcripts, which I followed. The first stage occurred during data collection, in immersing oneself in the conversation, taking field notes, and transcribing or reviewing the transcription. During the data collection period, I facilitated the discussions, took field notes, and repeatedly reviewed the transcribed interviews.

The second stage involved the identification of concepts or categories. I found recurring concepts such as a desire for opportunities for employment and the need for providers who understand AI/AN culture specific to the LSIC. Initially I found these to be themes, but after discussion with my committee chair and qualitative expert committee member, these were defined as subthemes. At this stage of analysis, I was also able to follow up with five specific focus group members to ask them to expound on thoughts they shared during the session that, upon review, offered opportunity for clarification or further detail. Because I knew the participants, I contacted them in person and noted the

transcribed material from these conversations with capital letters and labeled the additional information as “FOLLOW UP.”

The third stage involved highlighting and sorting quotations to identify overarching themes, through analysis of the transcripts. I started by using the long-table approach to the analysis. This approach is a low-technology method in which the paper transcripts are cut into strips of conversations and placed into groupings of themes or subthemes (Krueger & Casey, 2008). It is useful for a novice qualitative researcher in lieu of learning an extensive qualitative analysis computer application. Initially, this seemed to be an optimal approach to sorting the data points. I printed the transcripts on different colored paper for each of the five groups and then cut them into strips. It became apparent after group one, however, that this was a time-consuming process that required a dedicated, vast expanse of table and wall space with the number of focus group participants and amount of transcript data. While the technique is a valid approach to deciphering data, I felt a smaller number of subjects would better optimize this approach. After consultation with my committee chair and qualitative committee expert regarding the amount of time and resources needed to complete the long-table approach with the number of participants, I decided to try a different approach.

Instead, I used a highlighting approach to identify themes from the transcripts within a Microsoft Word document. Approximately three hours was spent reviewing each transcript. Two overarching themes were found: frustration and health empowerment. Blue highlighting represented health empowerment and yellow represented frustration.

The fourth and final stage of analysis involved identifying and correlating direct quotes to support the identified themes. There were several substantial comments and two stories that supported the overarching themes of frustration and health empowerment. This stage further involved placing themes and subthemes within the Social Ecological Model (SEM) to extrapolate meaning from the transcripts.

Qualitative Data

The focus groups revealed two overarching themes of frustration and health empowerment. Through focus group participant contributions, consultation with committee members, and follow-up interview questioning by the student researcher, several subthemes also emerged. The primary subtheme of frustration was a lack of cultural competence in participants' current health care. Subthemes for the overarching theme of health empowerment included improving access to health care and adding gainful employment within the community.

Theme: Frustration

Data analysis yielded 57 highlighted comments reflecting frustration in the focus group participants. Participants described frustration with their health care by expressing examples of stereotyping, assumptions, health disparities, discrimination, and limited time spent with patients. The situations and experiences they described led to one predominant subtheme of frustration with a lack of cultural competence from their health care providers.

Subtheme: Lack of cultural competence. There were 26 comments with the theme of frustration that were related to participants' perceptions of lack of cultural competence within the health care setting. One participant, Peggy, shared two examples

of frustration about her role as a community health worker and gave examples where a lack of cultural competence was detected:

I've heard comments made related to [patients'] alcohol or drug use when that's not the case at all. They may be acting suspicious, but [providers] need to not assume they're taking pills, drinking, or whatever, but to sit and listen and find out first . . . don't assume. . . .

I would take this person to the clinic every week for a different illness and the doctor said, 'I can't believe you're still here. You should be gone.' That is terrible from them. That should have been reported as far as that one was concerned because this person was there, trying to live, and for them to say that was just devastating.

Lucie shared concern about assumptions being made as part of a diagnosis, saying, "When you go, you feel like you're going to be judged. OK, I hurt my knee; there's something wrong with it, and they're like, 'Well, it's just your weight.'"

Kellie shared concerns regarding misunderstanding of AI family structure:

Grandmas take care of kids and aunties do [too]. It's frowned upon in other communities, but in ours it's how it is. Regardless of how it came about, it's just how we do it. I think other clinics or even the school systems, they don't get that.

Kellie's concerns referred to differences in family structure and caregiver roles within AI/AN populations. The focus with family is on keeping siblings together, which may or may not include the parents if they are unable to meet their children's needs. Grandparents, aunts, and cousins of distant relatives may be raising children if the parents are not present. Consider if the family from the television show "The Brady Bunch" had

been AI/AN and the parents, Mike and Carol, were unable to care for the children. Alice, the housekeeper, may have custody of all of the children in order to keep them together. In contrast, in American society as a whole, the family unit is typically parents and children. Keeping siblings together as a family unit is more of a priority in Indian Country over placing children in foster homes.

Clarice described the need for providers to take additional time to get to know community members, more so than for other clinics:

Overall, it's not going to be the same atmosphere as other facilities where they have five minutes to get everything out of their client when they're sitting in the office with them. They are going to need to understand that they're going to have to spend a little more time to get information. They're going to have to get to know people a little bit better . . . they have to be more personalized and individual than they may be used to.

Nell shared concerns about discrimination that she has experienced:

If you go to [nearby town] and you happen to look like you're Mexican or something like that, they treat you differently there too. They group you into this brown group, or however you want to say it. I say I've got insurance; I'm not here on welfare.

Frustration was clearly an overarching theme that came from the stories and input from the participants. It was both historical, in that stories from elders were passed down in ways community members perceived as being treated badly, and more recent, where perceptions of discrimination were experienced.

Theme: Health Empowerment

Medicine (1998) identified the need to empower people—especially “people of color”—in teaching and researching issues of race, class, gender, and power relations in ways that can be understood as a premise to advancing health equity. “The theory of empowerment is based in part on Rogers’ Science of Unitary Human Beings; specifically the principle of integrality as humans being integral with the environment in his or her daily living and health experience” (Shearer, 2009, p. 4). The environment of an AI/AN community and the historical aspects of family and access to health care have inhibited empowerment. Health empowerment was chosen as a theme in the focus group analysis after discussion with my committee chair regarding the comments that reflected hope for the new clinic to improve access to health care and provide opportunities for gainful employment. Examples of health empowerment came up 13 times during the focus groups. This came through in comments and stories where a sentiment of hope was detected. Participants described health empowerment in the form of hope or opportunities with the new health care center by expressing examples of patient-provider connection and follow-up; stressors; a sense of ownership and pride with a community clinic; and a desire for career opportunities. They described situations and experiences that led to subthemes including employment and access. To think that a medical clinic could potentially impact the health empowerment of the LSIC, one could surmise that the positive effects would also affect health disparities.

Subtheme: Gainful employment. In four of the focus groups, the topic of employment or career opportunities was discussed. Members saw the clinic as an

opportunity to encourage youth as well as employ them at entry levels. Lorraine shared about one of her children wanting to become a doctor:

When I think of opportunities, I can see maybe possibly job opportunities for my kids, because one of them has a goal of becoming a doctor one day. It would be nice if she were able to come back and work for her community when she's that old.

Sally agreed with the benefits of an opportunity for LSIC members who obtain the education to be able to treat their own community members:

Having opportunity to have the community members come back and having our youth then see them as patients—it gives them that perspective of what a future could look like for them. I think having an opportunity to work with, hopefully, Native American physicians and nursing staff will certainly inspire.

Lisa, who works in the casino owned by the LSIC, recognized the need to educate members of the LSIC on the new health care center as an economic opportunity and the need for acceptance by the LSIC of non-Indian patients and providers:

It's going to generate income for us. Just the other day serving [beverage server], every time I served the same gentleman he would say, 'I'm losing my money on the machine and making you rich.' I had to smile and say, 'Good luck sir.' The same thing is going to be there because it's not just for us. It's a business venture, so we have to make sure our own people know that, too.

Blue Star identified the opportunities available with an education in health care as being transferrable to other locations, saying, "If you got in that kind of field [health care] you probably could get a job almost anywhere."

The feedback in the area of gainful employment was positive and inspiring as members talked of job opportunities at the entry level and health care careers where members could attend school and return to the community. The business venture was also seen as requiring strong customer service.

Subtheme: Improved access to health care. Several comments and stories supported the subtheme of improved access to health care as an opportunity to improve the overall compliance and health of LSIC members. While health care is available in the area, it remains fragmented with little collaboration with LSIC resources such as community health and social services.

Clarisse shared the need for a collaborative team with expertise to address health disparities such as high rates of diabetes:

I think along the line of pharmacy, having a pharmacist that is also a CDE, certified diabetes educator, someone that's going to sit down and do a little bit of counseling with each of the patients on their medications, how they interact, and make sure they understand that, so they're taking them properly. Maybe a little follow-up when they're not coming in for the refills—why is that—to make sure they're taking them. Compliance, that's what I'm looking for—checking up on compliance.

Betsy spoke of the need to assess home environment, such as stressors that may be causing physical symptoms that need to be addressed as part of the patient interview. Referrals could then be made to appropriate community resources such as mental health or social services:

[An elderly patient] may be in because their A1C [diabetes test] is high, but it may not just be because they're noncompliant with their medication or their diet needs to be changed. It could be stress at home. What are they doing at home? Are they raising grandchildren? Are they having other issues? There may be underlying issues that [doctors] may have to get from their client to address how they can actually help them.

Peggy, a community elder, shared an inspiring opportunity with regard to care that had in the past required significant travel. Up until the 1970s AI people from the area had to travel to Pipestone, MN, where there was an Indian Health Service hospital. This is approximately 90 miles from the LSIC on [googlemaps.com](https://www.google.com/maps). Peggy recalled her pregnant mother leaving home to go to the hospital well before her due date to receive health care:

I've been going to there [nearby town with a clinic] all my life. Having my mother go to Pipestone, Minnesota, to have her babies and to go and wait there for sometimes a whole month because of transportation. Now [with] our clinic, even though it's not a hospital, but we have health care right here within our community.

Peggy also discussed the opportunity for collaboration as part of a team of community health workers and providers. This collaboration could support the work of reducing health disparities and increasing the optimal health outcomes of LSIC members:

[It would be beneficial] having community health workers go ahead of [patients] and talk to the doctor before and tell them a little bit about this person so they know what they're dealing with, so the person doesn't have to feel intimidated.

For Sarah, the opportunities to develop relationships with a patient and family were seen as a positive influence to use the clinic based on her past experience in one clinic:

I would go [to the doctor] and she would ask me about my family. She would ask about Mom and Dad and sit and ask about them and people in the community who lived there. It was just so nice to talk about me and medical stuff, too. A good relationship with the doctor is really nice.

Jim was looking for more of a partnership with the provider and options that he could decide, but with direction from the provider about what the best option entails:

I'd like to be part of the choice, instead of some[one] saying, 'It's up to you.' If it was up to me, then I would have already made this decision before going in, so I like going to a provider that's going to respect what I have to say, but also give me more input or explain, this is what I think you should do, give me direction.

Lisa was inspired by the idea that the new health care center would bring strength to the community as a collaborative effort to address health care and bring a sense of closeness through using the same health care providers:

I think it would bring families closer together, families and the community as a whole, because some of our other business ventures separated us. I think this one will bring us together. It gives the young ones something to come back for when they've gone off to college, especially if it's eventually going to have some traditional type of offerings and not just Western medicine. I think it will just bring us together as a community.

Kellie further commented on opportunities beyond LSIC members, for the non-Indian employees of the community with regard to their health and wellness:

What [one of my family members] is trying to do, too, with coming into the workplace as a business and making the employees healthier, it's going to cut medical costs down; it's going to cut down people calling in sick. IBM and other big companies have already done it.

While a range of health care is available locally, from private clinics to a critical access hospital, a sense of empowerment came through in discussing the opportunity for a unified approach to health care from within the LSIC. Further, examples identified how fragmented the care currently is among members who need to travel or do not know where to go based on the time of day and what care is available.

Limitations

The researcher being a novice qualitative researcher was a limitation. I attempted to address and minimize this limitation by enlisting the guidance and feedback of my committee members regarding the method, data collection, and analysis. Findings from this project were limited by a lack of gender diversity, with women outnumbering men. The majority of focus group participants were employed and did not meet the tribe's age criteria to be considered an elder. Further opportunity exists to address a larger population of elders.

Social Ecological Model

In analyzing the themes and subthemes from the focus groups, I placed them on the SEM with regard to their application from individual to community (Figure 3). The SEM is described in chapter 2. A subtheme of access to health care was apparent in

discussions with individuals and families. Cultural competence was discussed with regard to family and community, with the need to have providers understand the concept of family in AI/AN cultures. The subtheme of gainful employment fell under community, with general comments being favorable regarding employment and career opportunities. There were no themes that specifically addressed the policy level. Because this was a community-driven project, I was not surprised that the conversations did not evolve to the level of policy. Example topics that could have been discussed in this area included treaty requisites through Indian Health Service or other federal programs that influence AI/AN health care.

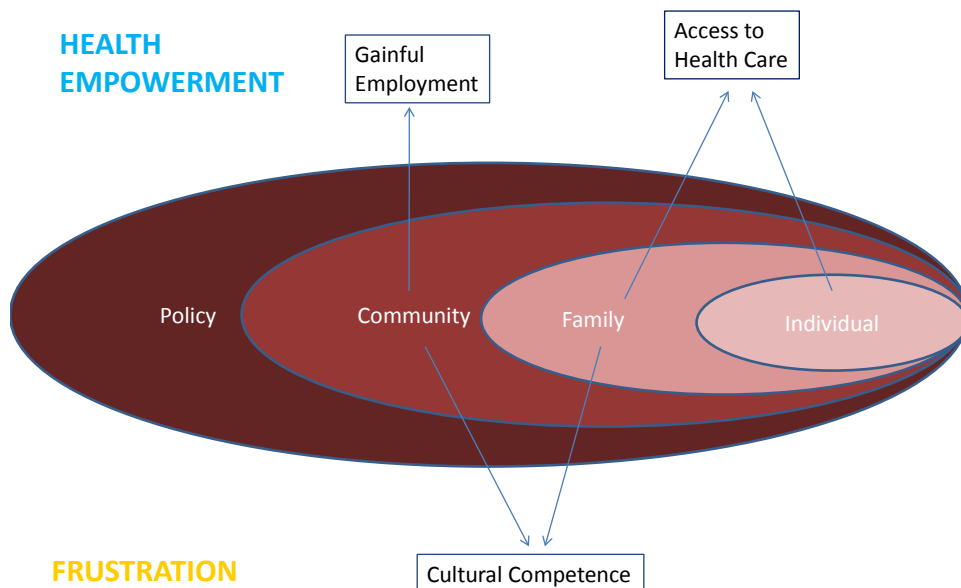


Figure 3. Focus group themes of frustration and health empowerment applied to the SEM.

Dissemination and Utilization of Results

Sharing the information gained from this research project will involve a report to the Lower Sioux community at a future community meeting and dinner. The presentation will describe in general terms who participated, what we learned, and how we will use the data. Further, it will discuss how this data can help the community develop a strong health care delivery system to meet its needs and help other AI/AN tribes that may be developing tribal clinics.

The goal of this DNP project was to seek LSIC members' health care expectations and apply the results to the development of primary care and the patient medical home within the Lower Sioux Health Care Center. In my dissemination of the study results, staff and providers will be educated on the findings and themes. Together we will integrate this information into the care delivery, as well as into the orientation process provided to employees of the Lower Sioux Health Care Center. The employee orientation will consist of a formal classroom discussion, tour of the community and history center, and informal opportunities to meet community members and hear their stories in a facilitated setting. An orientation program was being developed to include specific excerpts from the focus group transcripts with an invitation to select participants to share their stories in a circle setting during orientation. This was to begin in fall 2015. By hearing the themes of frustration and health empowerment, providers and staff can glean opportunities to address community members' needs in a collaborative environment from day one. Ongoing evaluation of the orientation program with opportunities for further exposure to and dialogue with community members will be instituted.

The need for data supporting cultural competence as a means to decrease health disparities is substantial. Sharing the data with other professionals through professional publication is probably the most efficient way to make the information available. Professional publication in a peer-reviewed journal such as the *Journal of Transcultural Nursing* or *The Journal of Health Disparities Research and Practice* is my goal. Podium presentations at the Bemidji Area Indian Health Service area leadership meetings, Zeta Chapter of Sigma-Theta Tau Nursing Honor Society annual research conferences, or the University of St. Thomas Qualitative Research Conference are also options. These conferences provide venues where qualitative research results can be shared in an efficient manner, as they often offer sessions with 20- to 30-minute presentations. Poster presentation is also an option, with opportunities including The International Conference on PeriAnesthesia Nursing being held in Copenhagen, Denmark, in September 2015. The themes can assist perianesthesia nursing colleagues with facilitating positive interactions with AI/AN people they encounter undergoing surgery and invasive procedures. The international exposure may also provide me with feedback from other cultural perspectives. I have been selected to attend this conference on behalf of the Minnesota-Dakotas Society of PeriAnesthesia Nurses. Other poster opportunities include the National Alaska Native American Indian Nurses Association annual conference, typically held in October.

The objectives of the project were to engage members of the LSIC through solicitation of needs, wants, expectations, ideas, and desires regarding the Lower Sioux Health Care Center, and to identify opportunities to implement cultural competence

through dialogue among LSIC members in focus groups. The objectives were met through the focus group attendance of those who participated.

This project has opened the door to further research opportunities within the LSIC. The LSIC Tribal Council is engaged in the process of having all requests to conduct research be vetted through a tribal institutional review board. The LSIC health department is currently partnering with the American Indian Cancer Foundation on a qualitative study to address readiness for change with regard to diet and exercise within the LSIC. Plans were to publish the data and apply the findings to other Sioux Communities in Indian Country. The application for funding approval has been submitted to the Great Lakes Inter-Tribal Epidemiology Center.

Summary

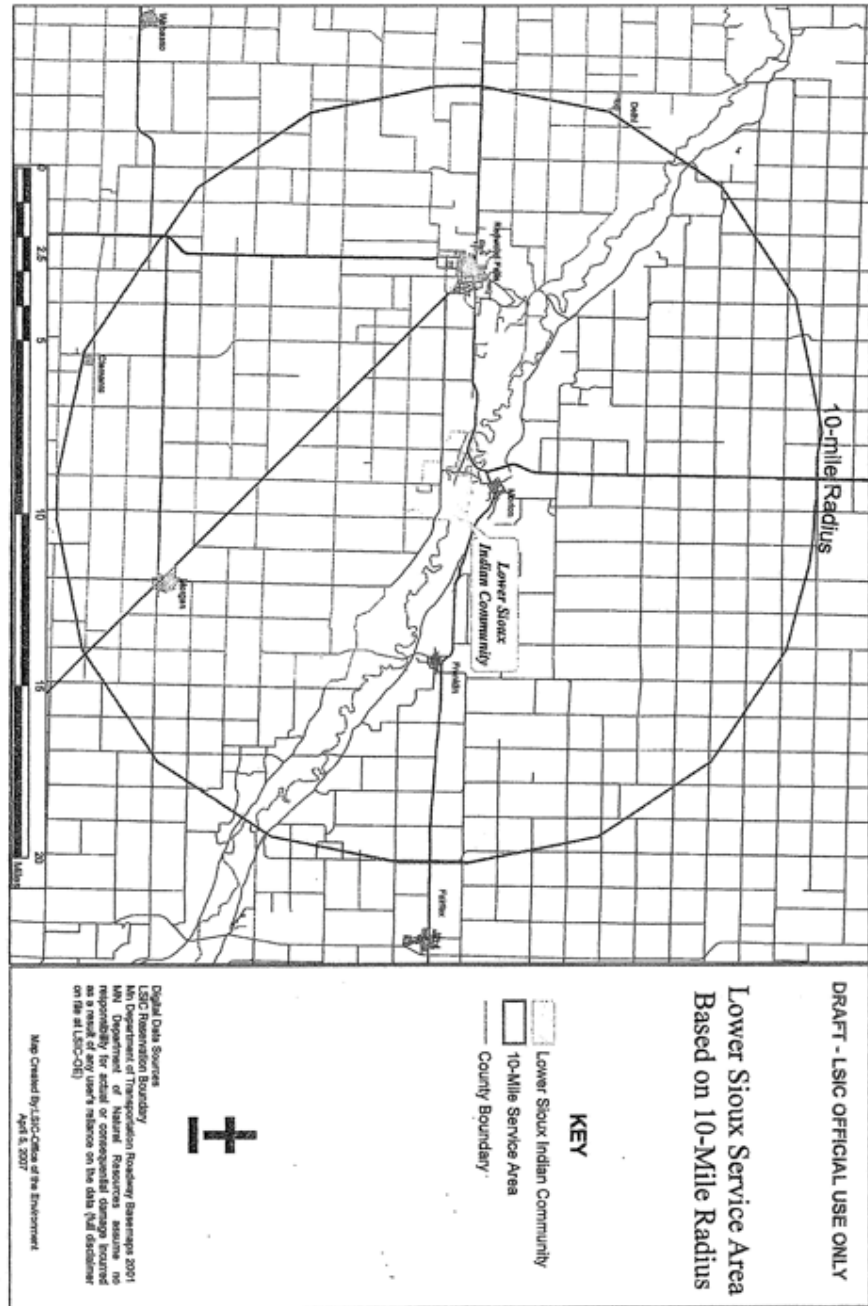
The results of this focus group research indicated significant themes of frustration with health care and health empowerment as an opportunity to reduce health disparities. Health empowerment theory emerges from the synthesis of personal resources and social-contextual resources (Shearer, 2009). AI/AN people have typically been recipients of health care without having input regarding the delivery or what they actually want and need. This project assisted in gaining views of a sample of LSIC members.

In conclusion, future opportunities for formal research are available to gather input from community members and apply the input to decrease health disparities. This project has contributed to first-of-its-kind research within the LSIC that will assist in the development of the first medical clinic located within the LSIC. Because the LSIC has remained relatively untouched with regard to formal research, I used this opportunity as an introduction to qualitative research by using focus groups. More importantly, the

project has brought the opportunity of doctoral-level education to the community members. The impetus was to increase engagement and enthusiasm among community members about the new clinic project. I believe I achieved that, with opportunities to expound on future research.

APPENDIX A

Boundaries of the Lower Sioux Indian Community in Minnesota



APPENDIX B

Indian Health Service Coverage Priority List

BEMIDJI AREA CONTRACT HEALTH SERVICE – MEDICAL PRIORITIES

Definition of Priorities with Examples

<p>PRIORITY IA: Emergency – Threat to Life, Limb, Senses (diagnosis and treatment of injuries or conditions that, if left untreated, results in uncertain/potentially grave outcome).</p> <p>PRIORITY IB: Potential for becoming life threatening; not immediate emergency; is essential to daily function; no acceptable alternatives.</p> <p>PRIORITY II: Primary and Secondary care, Inpatient & Outpatient care services that involve the treatment of prevalent illnesses/conditions that have a significant impact on morbidity and mortality. Treatment may be delayed without progressive loss of function or risk to life, limb, or senses, may require specialty consultation.</p> <p>PRIORITY III: Preventive Care (primary care aimed at the prevention of long term disability).</p> <p>PRIORITY IV: Chronic care services; non-essential inpatient & outpatient services that have less impact on mortality/morbidity; elective services often at a tertiary care facility.</p> <p>PRIORITY V: Excluded (cosmetic, experimental, or investigative). Acceptable alternatives exist. Website – https://cms.hhs.gov/manuals/06_cim/c135aap</p>	<p>PRIORITY IA (Examples) ALL MEDICAL EMERGENCIES Eye (Acute, painful or visually threat conditions) Dental (control bleeding, airway compromise, severe pain, fractures) Mental Health (immediate danger to self or others, regardless of "voluntary or involuntary status" includes physical neglect/abuse, sexual assault, chemical dependency, alcohol/substance abuse)</p> <p>PRIORITY IB (Examples) Acute illness, significant flare chronic condition Pre-natal/Obstetrics Fracture Care (specialty consultation/treatment)</p> <p>Diagnostic Testing/Procedures *Biopsy *EKG, Cardiac/CAD (ECHO, enhanced Stress Testing, Angiogram, Valve Replacement, Stents, Coronary artery Bypass surgery) ** *Endoscopy *Radiologic Testing (MRI, CT, Ultrasound) *Eye – Restorative & Preventative (diabetic retinopathy, glaucoma mgmt.)</p> <p>Health Promotion/Disease Prevention/High Priority Screenings *Immunizations *Mammography (Screening & Diagnostic) *Pap Smears, GYN Colposcopy *Colonoscopy/Sigmoidoscopy (Screening & Diagnostic) ** *Eye – Exams and glasses for youth</p> <p>Area of program specific objectives Non-Emergency surgery for "high-risk categories" *Tubal Ligation (post-partum and high risk) *Vasectomy (high risk)</p> <p>** BEMIDJI AREA: Due to increased incidence of colorectal cancer, heart disease/mortality</p>	<p>PRIORITY II (Examples) Medical/surgical Consultation, Physical Therapy Eye (protective eye wear, mgmt. sub-acute/chronic conditions to preserve vision) Dental (primary prophylaxis, periodontal services) Mental Health (prevent onset or recurrence of severe mental illness/suicide; medical stabilization)</p> <p>Elective Surgery (non-acute): Breast Reconstruction post-mastectomy Cataracts – Extraction w/implants (Adults) Cholecystectomy Family Planning – Tubal Ligation (routine), Vasectomy (routine) Gynecologic (hysterectomy, fertility-related) Hernia Repair Orthopedic Procedures (progressive loss of function) Tympanoplasty</p> <p> deemed medically necessary: Breast Mammoplasty (reduction) Intestinal by-pass (morbid obesity w/complications)</p>
<p>PRIORITY III (Examples) Preventive Services available at most facilities Eye (routine eye exams and eyeglasses for adults) Dental (contain disease process once it has begun) Mental Health Program (home visits, Family Therapy) Radiologic Testing (screening mammography)</p>	<p>PRIORITY IV (Examples) Services not readily available from direct care facility Rehabilitation Care Skilled Nursing Care</p> <p>Organ transplantation (CMS Approved) Eye (contact lenses, visual training) Dental (rehabilitation services/orthodontics) Mental Health (rehabilitation, dual diagnosis treatment) Alternative/Complementary medical care (acupuncture, chiropractic, naturopathy, homeopathy)</p>	<p>PRIORITY V (Examples) Cosmetic procedures Experimental or investigational (per CMS regulations) Extended Care Nursing Home</p>

Dawn Wylie, MD, MPH, CMO/Deputy Director



Jennifer Jenkins, Acting Area Director



Revised 3/11/13

APPENDIX C

Letter of Approval for DNP Project from LSIC Tribal Council



Lower Sioux Indian Community

P.O. Box 308 • 39527 Res. Hwy. 1
Morton, Minnesota 56270
Cansayapi Otunwe

August 1, 2014

Lori Candela, EdD, RN, APRN-BC, FNP
Associate Professor
School of Nursing
University of Nevada Las Vegas
4505 S. Maryland Parkway, Box 453018
Las Vegas, NV 89154-3018

Re: Project Approval for Darin M. Prescott, MSN, MBA, RN

Dear Dr. Candela:

The Lower Sioux Indian Community Tribal Council is writing in support of the proposed project by Darin Michael Prescott, "The voices of the people: Lower Sioux Indian Community members speak out on what they need and want in a primary health care clinic on the reservation." Darin is an employee of the Lower Sioux Indian Community and a doctoral student within the Graduate College of the University of Nevada Las Vegas. We understand the goal of this project will involve developing a framework for health care services to improve health of our community through deployment in Lower Sioux Health Care Center (working title).

Approval of this project is contingent on approval from the University of Nevada Las Vegas' Institutions Review Board. We would ask that Mr. Prescott not proceed with recruitment until approval is received. Project understanding by the Lower Sioux Tribal Council includes:

- IRB approval anticipated in September-October, 2014,
- Project to be completed between fall and spring semesters, 2015,
- Partial work time to complete interviews and other components that must be completed during daytime hours;
- Office supplies such as paper, postage
- Equipment use (computer, software, copier, file cabinet, etc.), and

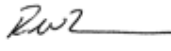
- Departmental, budgeted items including providing lunches for the focus group participants, and transcription costs for the focus group recordings.

Thank you for your support in this valuable project support of American Indian/Alaska Native health. Please feel free to contact us at (507) 697-6185 with any questions.

Sincerely,



Denny Prescott
President



Robert L. Larsen
Vice-President



Earl Pendleton
Treasurer



Gary Prescott
Secretary

APPENDIX D

University of Nevada Las Vegas Informed Consent Form for DNP Project



INFORMED CONSENT

Department of Nursing

TITLE OF STUDY: The Voices Of The People: Lower Sioux Indian Community Members Speak Out On What They Need And Want In A Primary Health Care Clinic On The Reservation

INVESTIGATOR(S): Principal Investigator: Lori Candela, EdD, RN, APRN-BC, FNP, Student Investigator: Darin Prescott, MSN, MBA, RN

CONTACT PHONE NUMBER: Lori Candela: 702-895-2443; Darin Prescott: 507-697-6189

Purpose of the Study

You are invited to participate in a research study. The purpose of this study is to determine what Lower Sioux Indian Community members need and want from a primary health care clinic located on the reservation.

Participants

You are being asked to participate in the study because you fit these criteria:

- Enrolled member of the Lower Sioux Indian Community
- Residing in the community or within the tribe’s ten-mile service area
- 18 years of age or older

Procedures

If you volunteer to participate in this study, you will be asked to do the following: Participate in an audio recorded, small focus group session to answer questions regarding your expectations and needs from a new primary health care clinic located within the Lower Sioux Indian Community.

Benefits of Participation

Lunch will be provided to you as a participant in this study. We also hope to learn from your sharing of experiences, expectations and opportunities to build and deliver care in a way that is beneficial to the Lower Sioux Indian Community.

Risks of Participation

There are risks involved in all research studies. This study may include only minimal risks. Based on information shared in the group, there may be disagreements in what is said or a feeling of being uncomfortable in answering some of the questions. You are welcome to only answer questions that you wish to.

Cost /Compensation

Participant Initials _____

1 of 2

*Deemed exempt by the ORI-HS and/or the UNLV IRB
Protocol 1410-4960M, Exempt Date: 10-23-14*

TITLE OF STUDY: The Voices Of The People: Lower Sioux Indian Community Members Speak Out On What They Need And Want In A Primary Health Care Clinic On The Reservation

There will be no financial cost to you to participate in this study other than transportation to the restaurant. The study will take up to two hours of your time. You will not be directly compensated for your time other than lunch being provided.

Contact Information

If you have any questions or concerns about the study, you may contact Darin Prescott at 507-697-6189 or Lori Candela at 702-895-2443. For questions regarding the rights of research subjects, any complaints or comments regarding the manner in which the study is being conducted you may contact the UNLV Office of Research Integrity – Human Subjects at 702-895-2794 or toll free at 877-895-2794 or via email at IRB@unlv.edu.

Voluntary Participation

Your participation in this study is voluntary. You may refuse to participate in this study or in any part of this study. You may withdraw at any time without prejudice to your relations with the university. You are encouraged to ask questions about this study at the beginning or any time during the research study.

Confidentiality

Written and audio recorded information gathered in this study will be kept confidential. All data collected will be reported without the use of any identifying information. Due to the nature of focus group research, privacy cannot be guaranteed. All participants are asked to respect the privacy of fellow participants and not repeat what was said in the focus group to others. No reference will be made in written or oral materials that could link you to this study. All audio recordings and records will be stored in a locked facility in the office of the principal investigator at the University of Nevada, Las Vegas for three years after completion of the study. Audio recordings will be digitally stored in the Lower Sioux Indian Community data base under a password protected files; accessible exclusively by the student researcher. After the storage time all stored information gathered will have paper documents shredded by a commercial company and/or deletion from password-protected electronic files.

Participant Consent:

I have read the above information and agree to participate in this study. I am at least 18 years of age. A copy of this form has been given to me.

Signature of Participant

Date

Participant Name (Please Print)

Participant Initials _____

2 of 2

*Deemed exempt by the ORI-HS and/or the UNLV IRB
Protocol 1410-4960M, Exempt Date: 10-23-14*

APPENDIX E

Focus Group Script and Questions

Thank you all for coming today. Thank you for sharing your ideas and thoughts on services provided in a clinic located here within the Lower Sioux Indian Community. As community members, you have a great opportunity to share input on how this clinic can serve the members of Lower Sioux in receiving health care. Most of you may know me. My name is Darin Prescott and I am the health and social services director of Lower Sioux. My role today is as a doctoral student researcher in the nursing program of the University of Nevada Las Vegas. Dr. Lori Candela is my faculty and primary researcher at the university. I will be asking questions and taking notes. I will be using a computer to take notes as my handwriting is not good. I will be using a tape recorder to record the comments you are sharing with me to assure I capture your thoughts accurately. In two months I will be compiling the information without identifying you or the comments you share.

It is important for you to understand that even with my job role, I cannot answer questions or advise on specific clinic services at this time. This could alter your thoughts on preferences and perceptions. At the end of the interview, I may be able to address those questions. I will be facilitating discussion and asking the questions.

You all are receiving complimentary lunch today up to a \$15.00 item and a soft drink in appreciation for your time and thoughtful conversation. Please feel free to order anything off the menu within that price range. I think you will find a variety of items to choose from within that price range. To make use of our time, I will ask questions before our food arrives and allow time to eat once our food arrives. Once we have some time to

eat, I will then continue with the questions. We will have a total of 90 minutes with lunch to complete the questions. The importance is the discussion we have with each other. We may not get to all of the questions as we want the discussion and conversation.

1. When you think of a clinic located within the Lower Sioux Indian Community what opportunities do you see for you or your family's health?
2. What should providers and staff know about Lower Sioux Community members when they come to work in our clinic?
3. What services do you currently use in a clinic when you see your doctor or nurse practitioner? What services would you like to see?
4. What does mutual respect look like from a patient and provider in this new clinic?
For children? Parents? Elders?
5. What are the biggest health concerns as you see in our community?
6. How can this clinic help address those concerns?

This concludes the questions today. I want to thank you for taking part in this focus group today. Your thoughts and ideas are going to shape how we deliver care in this new clinic and for other tribes. I will now turn off the tape recorder and discontinue taking notes. Thank you again for being part of the focus group.

APPENDIX F

University of Nevada Las Vegas Institutional Review Board Project Approval Letter



Biomedical IRB – Exempt Review Deemed Exempt

DATE: October 23, 2014

TO: **Dr. Lori Candela**, School of Nursing

FROM: Office of Research Integrity – Human Subjects

RE: Notification of IRB Action
Protocol Title: The Voices of the People: Lower Sioux Indian Community Members
Speak Out on What They Need and Want in a Primary Health Care Clinic on the
Reservaion
Protocol # 1410-4960M

This memorandum is notification that the project referenced above has been reviewed as indicated in Federal regulatory statutes 45CFR46 and deemed exempt under 45 CFR 46.101(b)2.

PLEASE NOTE:

Upon Approval, the research team is responsible for conducting the research as stated in the exempt application reviewed by the ORI – HS and/or the IRB which shall include using the most recently submitted Informed Consent/Assent Forms (Information Sheet) and recruitment materials. The official versions of these forms are indicated by footer which contains the date exempted.

Any changes to the application may cause this project to require a different level of IRB review. Should any changes need to be made, please submit a **Modification Form**. When the above-referenced project has been completed, please submit a **Continuing Review/Progress Completion report** to notify ORI – HS of its closure.

If you have questions or require any assistance, please contact the Office of Research Integrity - Human Subjects at IRB@unlv.edu or call 702-895-2794.

Office of Research Integrity – Human Subjects
4505 Maryland Parkway • Box 451047 • Las Vegas, Nevada 89154-1047
(702) 895-2794 • FAX: (702) 895-0805 • IRB@unlv.edu

REFERENCES

- American Cancer Society. (2008). *Cancer Disparities: Key Statistics*. Retrieved from <http://www.cancer.org/cancer/news/features/cancer-disparities-key-statistics>
- American Diabetes Association. (n.d.). American Indian/Alaska Native programs [Webpage]. Retrieved June 4, 2014, from <http://www.diabetes.org/in-my-community/awareness-programs/american-indian-programs/>
- Aud, S., Hussar, W., Johnson, F., Kena, G., Roth, E., Manning, E., Wang, X., & Zhang, J. (2012). *The Condition of Education 2012* (Publication No. NCES 2012-045). Washington, D.C.: U.S. Department of Education, National Center for Education Statistics. Retrieved from NCES website: <http://nces.ed.gov/pubsearch>
- Baldwin, L. M., Hollow, W. B., Casey, S., Hart, G., Larson, E. H., Moore, K., ... & Grossman, D. C. (2008, Summer). Access to specialty health care for rural American Indians in two states. *National Health Foundation*, 269-278.
- Banerjee, A. V., & Duflo, E. (2008). Mandated empowerment: Handing antipoverty policy back to the poor? *Annals of the New York Academy of Sciences*, 1136, 333-341.
- Barradas, D. T., Kroelinger, C. D., & Kogan, M. D. (2012). Medical home access among American Indian and Alaska Native children in 7 states: National survey of children's health. *Maternal Child Health Journal*, 16:S6-S13.
- Bartol, T. (2014). Patient-centered medical homes or data-centered medical homes? *The Nurse Practitioner*, 39(2), 8-9.
- Beals, J., Manson, S. M., Croy, C., Klein, S. A., Whitesell, N. R., Mitchell, C. M., & the AI-SUPERPPF Team. (2013). Lifetime prevalence of posttraumatic stress

- disorder in two American Indian reservation populations. *Journal of Traumatic Stress*, 26, 512-520.
- Benkert, R., Hollie, B., Nordstrom, C. K., Wickson, B., & Bins-Emerick, L. (2009). Trust, mistrust, racial identity, and patient satisfaction in urban African American primary care patients of nurse practitioners. *Journal of Nursing Scholarship*, 41(2), 211-219.
- Berry, C. A., Mijanovich, T., Albert, S., Winther, C. H., Paul, M. M., Ryan, M. S., ... & Shib, S. C. (2013). Patient-centered medical home among small urban practices serving low-income and disadvantaged patients. *Annals of Family Medicine*, 11(S1), S82-S49.
- Bogdan, R. C., & Biklen, S. K. (2007). *Qualitative research for education: An introduction to theories and methods*. New York, NY: Pearson.
- Brockie, T. N., Heinzemann, M., & Gill, J. (2013). A framework to examine the role of epigenetics in health disparities among Native Americans. *Nursing Research and Practice*, 2013, 9 pages.
- Broome, B., & Broome, R. (2007). Native Americans: traditional healing. *Urologic Nursing*, 27(2), 161-173.
- Brown, J. (2013, January). Primary care physician shortage. *Managed Healthcare Executive*, 30-31.
- Buchwald, D., Furman, R., Ashton, S., & Manson, S. (2001). Preventive care of older urban American Indians and Alaska Natives in primary care. *Journal of General Internal Medicine*, 16, 257-261.

- Bureau of Indian Affairs. (n.d.). Frequently asked questions [Webpage]. Retrieved May 30, 2014, from <http://www.bia.gov/FAQs/>
- Bureau of Labor Statistics. (2014). Employment situation summary [Press release]. Retrieved June 13, 2014, from <http://www.bls.gov/news.release/empsit.nr0.htm>
- Centers for Disease Control and Prevention. (2014). American Indian and Alaska Native death rates nearly 50 percent greater than those of non-Hispanic whites [Press release]. Retrieved February 18, 2015, from <http://www.cdc.gov/media/releases/2014/p0422-natamerican-deathrate.html>
- Cobb, N., Espey, D., & King, J. (2014). Health behaviors and risk factors among American Indians and Alaska Natives, 2000-2010. *American Journal of Public Health, 104*(S3), S481-S489.
- Creswell, P. D., Strickland, R., Stephenson, L., Pierce-Hudson, K., Matloub, J., Waukau, J., & Remington, P. L. (2013). Look local: The value of cancer surveillance and reporting by American Indian clinics. *Preventing Chronic Disease, 10*. Retrieved from the CDC website: http://www.cdc.gov/pcd/issues/2013/pdf/13_0153.pdf
- Dodge-Francis, C. (2009). *The Art of Looping Linear: Perspectives from Tribal College Students and Faculty*. Berlin: VDM Verlag.
- Dodge-Francis, C., & Chino, M. (2012). Type 2 diabetes science and American Indian/Alaska Native culture: Creating a national k-12 curriculum prevention strategy for native youth. *Diabetes Spectrum, 25*(1), 23-24.
- Dovidio, J. F., Penner, L. A., Albrecht, T. A., Norton, W. E., Gaerner, S. L., & Shelton, J. N. (2008). Disparities and distrust: The implications of psychological processes

- for understanding racial disparities in health and health care. *Social Science & Medicine*, 67, 478-486.
- Driscoll, D. L., Hiratsuka, V., Johnston, J. M., Norman, S., Reily, K. M., Shaw, J., & Dillard, D. (2013, May). Process and outcomes of patient-centered medical care with Alaska Native people at south central foundation. *Annals of Family Medicine*, 11(Suppl 1), S41-S49.
- Duran, B., Malcoe, L. H., Sanders, M., Waitzkin, H., Skipper, B., & Yager, J. (2004). Child maltreatment prevalence and mental disorders outcomes among American Indian women in primary care. *Child Abuse & Neglect*, 28, 131-145.
- Espey, D. K., Wu, X.-C., Swan, J., Wiggins, C., Jim, M. A., Ward, E., ... & Edwards, B. K. (2007). Annual report to the nation on the status of cancer, 1975–2004, featuring cancer in American Indians and Alaska Natives. *Cancer*, 110: 2119–2152. doi: 10.1002/cncr.23044
- Fatemeh, R. (2004, November). Focus-group interview and data analysis. *Proceedings of the Nutrition Society*, 63(4), 655-660.
- Garrouette, E. M., Kunovich, R. M., Jacobsen, C., & Goldberg, J. (2004). Patient satisfaction and ethnic identity among American Indian older adults. *Social Science & Medicine*, 59, 2233-2244.
- Garrouette, E. M., Sarkisian, N., Goldberg, J., Buchwald, D., & Beals, J. (2008). Perceptions of medical interactions between health care providers and American Indian older adults. *Social Science & Medicine*, 67, 546-556.
- Geana, M. V., Greiner, K. A., Cully, A., Talawyma, M., & Daley, C. M. (2012, April). Improving health promotion to American Indians in the Midwest United States:

- Preferred sources of health information and its use for the medical encounter. *Journal of Community Health, 37*, 1253-1263.
- Goins, R. T., & Pilkerton, C. S. (2010). Comorbidity among older American Indians: The Native elder care study. *Journal of Cross Cultural Gerontology, 25*, 343-354.
- Gray, A. C., Shafer, K., Limb, G. E., & Busby, D. M. (2013, September-October). Unique influences on American Indian relationship quality: An American Indian and Caucasian comparison. *Journal of Comparative Family Studies, 5*, 589-607.
- Great Lakes Inter-Tribal Council, Inc. (2013). *Suicidal behaviors among American Indian/Alaska Native populations: Indian Health Services resource patient management system suicide reporting form aggregate database analysis, 2003-2012*. Funded by the Indian Health Service, Division of Behavioral Health. Lac du Flambeau, WI: Great Lakes Inter-Tribal Epidemiology Center, Great Lakes, Inter-Tribal Council, Inc.
- Green, L. V., Savin, S., & Lu, Y. (2013, January). Primary care physician shortages could be eliminated through use of teams, nonphysicians and electronic communication. *Health Affairs, 32*(1), 11-19.
- Guadagnolo, B. A., Cina, K., Koop, D., Brunette, D., & Petereit, D. G. (2011, November). A pre-post survey analysis of satisfaction with health care and medical mistrust after patient navigation for American Indian cancer patients. *Journal of Health Care for the Poor and Underserved, 22*(4), 1331-1343.
- Harding, A., Harper, B., Stone, D., O'Neill, C., Berger, P., Harris, S., & Donatulo, J. (2012). Conducting research with tribal communities: Sovereignty, ethics, and data sharing issues. *Environmental Health Perspectives, 120*(1), 6-10.

- Hodge, F. S. (2012). No meaningful apology for American Indian unethical research uses. *Ethics & Behavior*, 22(6), 431-444.
- Hodge, F. S., & Karabi, N. (2011, August). Predictors of wellness and American Indians. *Journal of Health Care for the Poor and Underserved*, 22(3), 791-803.
- Holm, J. E., Vogeltanz-Holm, N., Poltavski, D., & McDonald, L. (2010). Assessing health status, behavioral risks, and health disparities in American Indians living on the northern plains of the U.S. *Public Health Reports*, 125(1), 68-78.
- Hutchinson, R. N., & Shin, S. (2014). Systematic review of health disparities for cardiovascular diseases and associated factors among American Indian and Alaska Native populations. *PLoS ONE* 9(1): e80973.
doi:10.1371/journal.pone.0080973
- Hwang, M., Shrestha, A., Yazzie, S., & Jackson, M. L. (2013, January). Preterm birth among American Indian/Alaskan Natives in Washington and Montana: Comparison with non-Hispanic Whites. *Maternal Child Health Journal*, 17, 1908-1912.
- Indian Affairs Council. (2014). Tribes: Red Lake Nation: Unique in Indian country [Webpage]. State of Minnesota. Retrieved May 30, 2014, from http://mn.gov/indianaffairs/tribes_redlake.html
- Indian Health Service. (2014, May). Life expectancy, American Indians and Alaska Natives, data years: 2005-2007. Washington, D.C.: U.S. Department of Health & Human Services.
- Indian Health Service. (n.d.a). Cultural considerations [Webpage]. Retrieved January 21, 2015, from <http://www.ihs.gov/pharmacy/index.cfm?module=awareness>

- Indian Health Service. (n.d.b). Health care communications [Webpage]. Retrieved June 22, 2014, from <http://www.ihs.gov/healthcommunications/>
- Indian Health Service Division of Diabetes Treatment and Prevention. (2012). A giant step to joy: Understanding historical grief and trauma. *Health for Native Life*, 9, 36-38.
- Jackson, G. L., Powers, B. J., Chatterjee, R., Bettger, J. P., Kemper, A. R., Hasselblad, V., ... & Williams, J. W. (2012, November). The patient-centered medical home. *Annals of Internal Medicine*, 158(3), 169-178.
- Johns Hopkins Primary Care Policy Center. (2014). Definitions [Webpage]. Retrieved June 8, 2014, from Johns Hopkins Bloomberg School of Public Health website: <http://www.jhsph.edu/research/centers-and-institutes/johns-hopkins-primary-care-policy-center/definitions.html>
- Jones, D. S. (2006). The persistence of American Indian health disparities. *American Journal of Public Health*, (96)12, 2122-2134.
- Katz, J. R. (2007). Native American high school students' perceptions of nursing. *Journal of Nursing Education*, 46(6), 282-286.
- Kitzinger, J. (1995). Introducing focus groups. *British Medical Journal*, 311, 299-302.
- Kontopantelis, E., Roland, M., & Reeves, D. (2010). Patient experience of access to primary care: Identification of predictors in a national patient survey. *BMC Family Practice* 2010, 11(61).
- Krueger, R. A. (n.d.). *Focus group interviewing*. Retrieved from <http://www.tc.umn.edu/~rkrueger/focus.html>

- Krueger, R. A., & Casey, M. A. (2008). *Focus groups: A practical guide for applied research*. Thousand Oaks, CA: Sage Publications.
- McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, 15(4), 351-377.
- Medicine, B. (1998). American Indians and anthropologists: Issues of history, empowerment, and application. *Human Organization*, 57(3), 253-257.
- Min, J., & Savage, D. (2012). The influence of socio-economic characteristics on the political attitudes of American Indians. *The Social Sciences Journal*, 49, 494-502.
- National Congress of American Indians. (n.d.). Indian Country Demographics Content [Webpage]. Retrieved June 8, 2014, from <http://www.ncai.org/about-tribes/demographics>
- National Survey on Drug Use and Health. (2010). Substance use among American Indian or Alaska Native adults. *The NSDUH Report*. Retrieved July 17, 2014, from <http://www.samhsa.gov/data/2k10/182/AmericanIndian.htm>
- Norris, T., Vines, P. L., & Hoeffel, E. M. (2012). *The American Indian and Alaska Native population: 2010* (Report No. C2010BR-10). Retrieved May 30, 2014, from the U.S. Census Bureau website: <http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf>
- Paez, K. A., Allen, J. K., Carson, K. A., & Cooper, L. A. (2008). Provider and clinic cultural competence in a primary care setting. *Social Science & Medicine*, 66, 1204-1016.

- Peirson, L. J., Boydell, K. M., Ferguson, H. B., & Ferris, L. E. (2011). An ecological process model of systems change. *American Journal of Community Psychology, 47*, 307-321.
- Perry, S. W. (2004). *American Indians and crime*. Retrieved June 10, 2014, from U.S. Department of Justice website: http://www.justice.gov/otj/pdf/american_indians_and_crime.pdf
- Pierce, A. (2012). American Indian adolescent girls: Vulnerability to sex trafficking, intervention strategies. *American Indian and Alaska Native Mental Health Research, 19*(1), 37-56.
- Rodriguez, H. P., von Glahn, T., Grembowski, D. E., Rogers, W. H., & Safran, D. G. (2007). Physician effects on racial and ethnic disparities in patients' experiences of primary care. *Journal of General Internal Medicine, 23*(10), 1666-1672.
- Saftner, M. A., Martyn, K. K., Momper, S. L., Loveland-Cherry, C. J., & Low, L. K. (2014). Urban American Indian adolescent girls: Framing sexual risk behavior. *Journal of Transcultural Nursing, 1*-11.
- Sarche, M., & Spicer, P. (2008). Poverty and health disparities for American Indian and Alaska Native children: Current knowledge and future prospects. *Annals of the New York Academy of Sciences, 1136*, 126-136.
- Schieb, L. J., Ayala, C., Valderrama, A. L., & Veazie, M. A. (2014). Trends and disparities in stroke mortality by region for American Indians and Alaska Natives. *American Journal of Public Health, 104*(S3), S368-S376.
- Sellers, R. M., & Shelton, J. N. (2003). The role of racial identity in perceived racial discrimination. *Journal of Personality and Social Psychology, 84*(5), 1079-1092.

- Sequist, T. D., Cullen, T., & Acton, K. J. (2011). Indian Health Service innovations have helped reduce health disparities affecting American Indian and Alaska Native people. *Innovations in Care, 30*(10), 1965-1973.
- Sequist, T. D., Cullen, T., & Ayanian, J. Z. (2005). Information technology as a tool to improve the quality of American Indian health care. *American Journal of Public Health, 95*(12), 2173-2179.
- Shearer, N. B. (2009). Health empowerment theory as a guide for practice. *Geriatric Nursing, 30*(2), 4-10.
- Shi, L., Chen, C., Nie, X., Zhu, J., & Hu, R. (2014, March/April). Racial and socioeconomic disparities in access to primary care among people with chronic conditions. *Chronic Conditions and Disparities in Access to Care, 27*(2), 189-198.
- Smyer, T., & Stenvig, T. E. (2007). Health care for American Indian elders: An overview of cultural influences and policy issues. *Home Health Care Management & Practice, 20*(1), 27-33.
- Stewart, D. W., Shamdasani, P. M., & Rook, D. W. (2007). *Focus Groups Theory and Practice*. Thousand Oaks, CA: Sage Publications.
- Struthers, R., Hodge, F. S., Geishirt-Cantrell, B., & De Cora, L. (2014). Participant experiences of talking circles on type 2 diabetes in two northern plains American Indian tribes. *Qualitative Health Research, 13*(8), 1094-1115.
- Syed, K. D. (2010). Lessons from Havasupai Tribe v. Arizona State University Board of Regents: Recognizing group, cultural, and dignitary harms as legitimate risks

- warranting integration into research practice. *Journal of Health & Biomedical Law*, VI (2010), 175-225.
- Ubina, E. C., Van Sell, S. L., Arnold, C., & Woods, S. (2011, July-September). Best practices guidelines for nurse practitioners regarding smoking cessation in American Indian and Alaskan Native youth. *Family and Community Health*, 34(3), 266-274.
- U.S. Census Bureau. (2010). American Indian and Alaska Native Tribes in the United States and Puerto Rico: 2010 [Population table]. Retrieved February 10, 2015, from [http://www.census.gov/population/www/cen2010/cph-t/t-6tables/TABLE%20\(1\).pdf](http://www.census.gov/population/www/cen2010/cph-t/t-6tables/TABLE%20(1).pdf)
- Veazie, M., Ayala, C., Schieb, L., Dai, S., Henderson, J. A., & Cho, P. (2014). Trends and disparities in heart disease mortality among American Indians/Alaska Natives, 1990-2009. *American Journal of Public Health*, 104(S3), S359-S367.
- Warne, D. (2006). Research and education approaches to reducing health disparities among American Indians and Alaska Natives. *Journal of Transcultural Nursing*, 17(3), 266-271.
- Weidmer-Ocampo, B., Johansson, P., Dalpoas, D., Wharton, D., Darby, C., & Hays, R. D. (2009). Adapting CAHPS for an American Indian population. *Journal of Health Care for the Poor and Underserved*, 20, 695-712.
- White, M. C., Espey, D. K., Swan, J., Wiggins, C. L., Ehemann, C., & Kaur, J. S. (2014). Disparities in cancer mortality and incidence among American Indians and Alaska Natives. *American Journal of Public Health*, 104(S3), S377-S387.

CURRICULUM VITAE

DARIN M. PRESCOTT, MSN, MBA, RN, CNOR, CASC

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ACADEMIC PREPARATION

- University of Nevada**, Las Vegas, NV Est. 5/2015
Doctorate of Nursing Practice – Nurse Executive
- University of Phoenix**, Phoenix, AZ 6/2010
Master of Science in Nursing
Master of Business Administration
Master of Health Care Management
- University of Phoenix**, Phoenix, AZ 4/2006
Bachelor of Science in Nursing
- St. Mary's Campus of the College of St. Catherine**, Minneapolis, MN 10/1993
Associate of Applied Science in Nursing

PROFESSIONAL EXPERIENCE

- Lower Sioux Indian Community**, Morton, MN 1/2014-Present
Director & CEO of Health, Social Services & Clinic
- Mayo Clinic Health System**, Mankato, MN 5/2011-Present
Patient Care Manager – Same Day Care & PACU (5/2011-3/2013)
Nurse Administrator – Nursing Clinical Practice, Education & Quality (4/2013-1/2014)
Staff Nurse, Medical & Surgical per-diem (1/2014-Present)
- Centracare/St. Cloud Hospital**, St. Cloud, MN 5/2006-5/2011
Perioperative Educator
- Family Surgery Center**, Willmar, MN 5/2005-5/2006
Director
- Rice Memorial Hospital**, Willmar, MN 4/1999-5/2005
Unit Coordinator, Operative Services
- Olivia Health Care Center**, Olivia, MN 2/2000-4/2002
Staff Development Director
- Meeker County Memorial Hospital**, Litchfield, MN 5/1998-4/1999
Outpatient Nurse Manager

Affiliated Community Medical Center, Willmar, MN <u>Orthopedic Physician Extender</u>	5/1997-5/1998
Willmar Surgery Center, Willmar, MN <u>Staff Nurse</u>	2/1996-5/1998
Redwood Area Hospital, Redwood Falls, MN <u>Staff Nurse on-call (5/1997-1/2014)</u> <u>Staff Nurse, Perioperative (9/1994-5/1997)</u> <u>Staff Nurse, Medical-Surgical (3/1994-9/1994)</u> <u>Student Nurse Intern (12/1990-3/1994)</u>	12/1990-Present
Franklin Health Care Center, Franklin, MN <u>Registered Nurse</u>	4/1994-4/1998
Shakopee Mdewakanton Sioux Community, Prior Lake, MN <u>Assistant Programs Administrator</u> <u>Health Benefits Coordinator</u> <u>Community Health Representative</u>	4/1989-12/1992
Lower Sioux Indian Community, Morton, MN <u>Health Director</u>	5/1988-4/1989
Jackpot Junction Casino, Morton, MN <u>Blackjack Dealer & Cashier</u>	1/1987-5/1991

CERTIFICATIONS

Gerontological Nursing <u>American Nurses Credentialing Center</u>	8/1996-12/2011
Perioperative Nursing (CNOR) <u>Competency & Credentialing Institute</u>	1/1997-Present
Ambulatory Surgery Administration (CASC) <u>Board of Ambulatory Surgery Certification</u>	6/2005-Present
Mayo Quality Fellow – Bronze Level <u>Mayo Quality Fellows Program</u>	6/2011
Mayo Quality Fellow – Silver Level <u>Mayo Quality Fellows Program</u>	1/2013

ACADEMIA, INSTRUCTION, & FACILITATION

Minneapolis Community & Technical College , Minneapolis, MN <u>Perioperative Nursing Instructor</u>	10/2009-4/2013
Rasmussen College , St. Cloud, MN <u>Nursing Instructor</u> <u>Surgical Technology Advisory Committee Member</u>	9/2011-8/2012 4/2008-5/2010
Anthem College , St. Louis Park, MN <u>Surgical Technology Advisory Committee Member</u>	10/2008-Present
St. Cloud Hospital , St. Cloud, MN <u>Surgery Student Clinical Coordinator (Medicine, Nursing, ST, CVT, Paramedicine)</u> <u>AORN Perioperative Nursing 101 Course Facilitator/Instructor</u> <u>Nurse Planner for American Nurses Credentialing Center Contact Hours</u>	5/2006-5/2011
St. Cloud Technical College , St. Cloud, MN <u>Surgical Technology Advisory Committee Member</u>	10/2002-5/2011

COMMUNITY SERVICE

Minnesota March of Dimes <u>Nurse of the Year Planning Committee</u>	2/2012-Present
Mankato Marathon <u>Volunteer RN</u>	10/2012
Office of Safety & Health Administration <u>Editorial Board member for the OSHA safety and health topics webpage</u>	12/2007-Present
Department of Nursing, St. Cloud State University <u>Guest Lecturer: Perioperative Nursing, Board of Nursing</u>	5/2006-5/2011
Department of Nursing, St. Cloud Technical College <u>Guest Lecturer: Perioperative Nursing</u>	5/2006-5/2011
Lower Sioux Indian Community , Morton, MN <u>Education Committee Secretary</u>	3/1997-3/2002
Franklin Fire Department & Ambulance , Franklin, MN <u>Volunteer Firefighter & Emergency Medical Technician</u>	11/1996-05/1998

MEMBERSHIPS, APPOINTMENTS, & OFFICES HELD

American Assembly of Men in Nursing	12/2008-12/2014
American Nurses Association	6/2012-Present
American Society of PeriAnesthesia Nurses	7/2005-Present
<u>Minnesota/Dakota's Component (7/2005-Present)</u>	
<u>Gerontological Subgroup (7/2005-7/2007)</u>	
<u>Leadership Subgroup (7/2005-7-2007)</u>	
Area Health Care Educators of Minnesota	6/2007-6/2011 3/2013-Present
Association of peri-Operative Registered Nurses	4/1995-Present
<u>National Board of Directors (3/2009-3/2013)</u>	
<u>National Nominating Committee (3/2005-3/2007)</u>	
<u>Heartland Chapter Nominating Committee (5/2006-5/2008)</u>	
<u>National Ambulatory Surgery Specialty Assembly Coordinating Council (3/2006-6/2007)</u>	
<u>Executive Director Search Committee (2-3/2007)</u>	
<u>Heartland Chapter Board of Directors (5/2006-5/2008)</u>	
<u>National Next Generation Task Force (4/2004-5/2005)</u>	
<u>National Rural/Small Hospital Specialty Assembly Chair (3/2003-7/2004)</u>	
<u>National Rural/Small Hospital Specialty Assembly Newsletter Editor (3/2001-3/2003)</u>	
<u>Heartland Chapter President (5/2002-5/2003)</u>	
<u>Heartland Chapter President-elect (5/2001-5/2002)</u>	
<u>Heartland Chapter Secretary (5/1999-5/2001)</u>	
Minnesota Board of Nursing	6/2005-12/2009
<u>Secretary (1/2006-12/2008)</u>	
<u>National Council of State Boards of Nursing Delegate (3/2007-12/2007)</u>	
<u>Centennial Planning Committee Chair (1/2007-12/2007)</u>	
<u>Board Member (6/2005-12/2009)</u>	
Minnesota Nurses Association	4/1999-12/2012
<u>Rural Multicultural Task Force (4/2005-Present)</u>	
Minnesota Organization for Leaders in Nursing	3/2006-6/2012
Minnesota Organization of Registered Nurses (ANA Affiliate)	6/2012-Present
Minnesota State Council of the AORN	4/2005-4/2014
National Alaska Native American Indian Nurses Association	12/2005-Present
National Nurses in Staff Development Organization	3/2007-3/2009 3/2013-3/2015
Sigma Theta Tau International Honor Society of Nursing	11/2007-Present

PUBLICATIONS, LECTURES, & PRESENTATIONS

“Taming Toxic Behaviors”

OR Manager Conference, Long Beach, CA (10/2014)

“Start Every Surgical Case on Time” *podium presentation*

Las Vegas Chapter of AORN Conference, Las Vegas, NV (1/2014)

OR Excellence Conference, Las Vegas, NV (10/2013)

“Preadmission Facilitation: Keys to Success” *webinar presentation*

AORN Board Webinar Series (9/2012)

“Strategic Partnerships: OR & Supply Chain Management” *podium presentation*

Florida Council of Operating Room Nurses, Orlando, FL (06/2012)

AORN Congress, New Orleans, LA (03/2012)

“The Heat is on: Evidence-based Practice in Pre-operative Patient Warming” or “Normothermia as a Surgical Site Infection Reduction Tool” *podium presentation*

Denver Chapter of AORN, Denver, CO (11/2013)

Florida Council of Operating Room Nurses, Grand Cayman, CI (10/2013)

Mu Lambda Chapter of Sigma Theta Tau, Mankato, MN (09/2013)

Arkansas Chapter of AORN, Little Rock, AR (08/2013)

Phoenix Area Chapter of AORN, Phoenix, AZ (01/2013)

Mayo Clinic Health System Perioperative Retreat, Mankato, MN (09/2011)

Association for Practitioners in Infection Prevention, Baltimore, MD (06/2011)

Georgia State Council of Perioperative Nurses, Augusta, GA (10/2010)

National AORN Ambulatory Surgery Conference, Denver, CO (9/2010)

Las Vegas Chapter of AORN, Las Vegas, NV (10/2010)

Minneapolis Chapter of AORN, Minneapolis, MN (10/2010)

“Forced-air Warming Gown Use in the Prevention of Unintentional Surgical Hypothermia” *poster presentation*

Texas School of Nursing Evidence-based Practice Conference, San Antonio, TX (7/2010)

American Ambulatory Surgery Center Association Conference, Anaheim, CA (5/2010)

Centracare Perioperative Nursing Conference, St. Cloud, MN (4/2010)

“Achieving Excellence” *podium presentation*

Lower Sioux Graduation Keynote Address, Morton, MN (5/2010)

“CNOR Certification & Re-Certification: Are You Eligible?” *webinar presentation*

AORN Board Webinar Series (9/2010)

“Perioperative Nursing Update” *podium presentation & webcast*

Medi-sota, Redwood Area Hospital, Redwood Falls, MN & webcast (10/2011)

Medi-sota, Redwood Area Hospital, Redwood Falls, MN & webcast (9/2009)

Medi-sota, Redwood Falls Hospital, Redwood Falls, MN (4/2006)

- “Provide Instruments, Equipment & Supplies” chapter in textbook publication**
Competency for Safe Patient Care During Operative and Invasive Procedures,
Competency & Credentialing Institute, Denver, CO, 2009
- “Sterilization: Competency Assessment Module” study guide publication**
Competency & Credentialing Institute, Denver, CO (2/2008)
- “Korean Perioperative Nursing: An American Perspective” podium presentation**
Minnesota Board of Nursing, Minneapolis, MN (12/2007)
AORN Heartland Chapter, St. Cloud, MN (11/2007)
- “Generations in the Workplace” podium presentation**
AORN World Conference on Surgical Patient Care, Seoul, South Korea (10/2008)
- “U.S. Regulatory Requirements: AdvaMed, PhRMA, OIG, ACCME SCS/CEJA Report, ANCC/ACPE” podium presentation**
Aesculap Symposium, Tutligen, Germany (09/2008)
- “CS/OR Education Needs: Past, Present & Future” podium presentation**
Aesculap Symposium, Tutligen, Germany (09/2008)
- “Cleaning, Disinfecting, Packaging & Sterilizing” chapter in study guide publication**
CNOR Exam Study Guide (8/2007)
- “Ladders to Success” podium presentation**
2007 AORN Congress, Washington, DC (3/2007)
- “Decontamination, Sterilization & Disinfection” chapter in publication**
CNOR Study Guide (9/2006)
- “Discover the Leader Within” podium presentation**
2006 AORN Congress, Orlando, FL (3/2006)
- “RN Administration of Anesthetic Drugs” co-author of position statement**
Minnesota Board of Nursing (9/2005)
- “Strategies for Living & Working in a Rural Perioperative Service Area” podium presentation**
2005 AORN Pre-Congress Session, New Orleans, LA (3/2005)
- “Engaging the Next Generation” podium presentation**
2004 AORN Leadership Conference, Denver, CO (7/2004)
- “Implementing the AORN Perioperative Nursing Course 101 in Rural Settings” podium presentation**
2003 AORN Rural/Small Hospital Conference, St. Louis, MO (9/2003)

“What’s in your Toolbox?” *article in publication*
AORN Rural/Small Hospital Specialty Assembly Newsletter (6/2003)

CONSULTATIONS

Aesculap, Inc. – Rose Moss
Facilitator/Presenter (10/2008)

Competency & Credentialing Institute – Mary O’Neale
CNOR Test Item Writer (04-10/2007)
CNOR Cut Score Task Force (04/2006)
CNOR Test Item Reviewer (02/2005)

HONORS & AWARDS

Outstanding Achievement in Perioperative Nursing Management <u>Association of peri-Operative Registered Nurses, Chicago, IL</u>	3/2014
March of Dimes Nurse of the Year – Perioperative <u>Minnesota March of Dimes, Minneapolis, MN</u>	10/2013
Outstanding Achievement in the Application of Evidence-based Practice <u>Nursing Research Committee: St. Cloud Hospital, St. Cloud, MN</u>	5/2010
Sigma Theta Tau International Nursing Honor Society Induction <u>University of Minnesota - Zeta Chapter, Minneapolis, MN</u>	11/2007
Next Generation Achievement Award <u>Association of peri-Operative Registered Nurses, New Orleans, LA</u>	4/2006