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Culturally Responsive Care for American Indians and Alaskan Natives: An Online Training Module for Occupational Therapists

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Culturally Responsive Care for American Indians and Alaskan Natives: An Online Training Module for Occupational Therapists

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PERMISSION

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Abstract

The unique profession of occupational therapy (OT) values cultural aspects when working with clients, therefore it is crucial for practitioners to be aware of various cultural backgrounds to provide greater culturally sensitive and client-centered services. The objective of this scholarly project was to create an educational opportunity for occupational therapists (OTs) who work in communities with a notable population of American Indian/Alaska Natives (AI/AN) through the use of an e-learning module designed to increase culturally competent care. Currently, there is limited literature suggesting the existence of such educational materials regarding this population, including online learning modules. This project was the result of an in-depth literature review of existing evidence-based publications which indicated a gap in training of this nature. The product created for this project, an e-learning educational module, was designed to be implemented during orientation training or to augment annual continuing education competencies for OTs working with AI/AN populations. This product aims to optimize healthcare through improvement of cultural relations in healthcare settings in order to change organizational attitudes, institutional culture, and OT practitioner interactions with AI/AN clients. Though the proposed education module is evidence-based, additional research is needed to more fully support AI/AN clients through culturally sensitive healthcare practices. Furthermore, education modules should be tailored to reflect the tribal cultures of the regions they are implemented in. It is likely that by incorporating this education module into health systems, rapport and trust among OT practitioners and AI/AN clients will improve in a time-efficient and cost-effective manner.

Chapter I: Introduction

Providing education and training of health care professionals in cultural competence is recognized as an important approach to providing culturally sensitive and responsive care to diverse populations (Perry, Woodland, & Brunero, 2014). Overall, definitions of cultural competence address themes related to the cross-cultural barriers present in social, cultural, and economic populations of diverse upbringings and backgrounds (Perry et al., 2014). While there are multiple definitions of the term *cultural competence*, for the purpose of this scholarly project, *cultural competence* is defined as "the ability to effectively interact with those who differ from oneself and is often described… as encompassing cultural awareness and attitudes, cultural knowledge of self and others, and cultural skill" (Schell, Gillen, & Scaffa, 2014, p. 185).

According to Campinha-Bacote and Munoz (2001), the most influential variable in health beliefs and practices is culture. Bassett et al. (2012) stated that "culture is medicine" which identified the importance of integrating cultural aspects into the promotion of recovery in health (p. 25). Recognizing that diverse populations possess individualized beliefs, values, and culture which are essential in developing cultural competency, and understanding the effects of cultural education in health care (Abrishami, 2018).

Currently, there is evidence suggesting cultural competency among healthcare providers, specifically to American Indian (AI) or Alaskan Natives (AN) cultures, is insufficient (Noe et al., 2014). Additionally, limited literature exists with a focus on cultural competency for health professionals working with AI/AN individuals in the United States (U.S.), particularly occupational therapy (OT) professionals, thus a gap in research exists. This problem is significant to our country; an estimated 6 million individuals identify as AI/AN in the U.S. population (United Census Bureau, 2018), and though AI/AN individuals make up a small

portion of the population, their unique needs should not go unnoticed in regard to health care. Additionally, apart from moral duty, failure of healthcare professionals to provide culturally competent and sensitive services can result in legal fines and penalties, civil lawsuits, patient dissatisfaction, and organizational accreditation conflicts (Govere & Govere, 2016). Therefore, the purpose of this scholarly project is to address the identified problem by increasing awareness of professional obligations to culturally responsive care through the education and training of occupational therapists.

Health care organizations have a multitude of strategies available to address cultural competence, including the use of interpreters, new hire orientations, and department in-services (Perry et al., 2014), however, there continues to be little evidence supporting the application of cultural competency trainings among healthcare providers working with diverse populations such as AI/ANs. Perry et al. (2014) identified that education and training of health care providers is essential to "developing culturally sensitive, congruent and responsive clinical practice," and that cultural competency training itself can "improve attitudes, knowledge, skills, and behaviours" of health care professionals, as well as the overall improvement of patient satisfaction (p. 219). Thus, a tool designed to target AI/AN cultural competence of healthcare professionals, specifically OTs, may significantly benefit healthcare practice today.

An approach to training and education shown to be effective among healthcare practitioners is the use of e-learning (Ruiz, Mintzer, & Leipzig, 2006). E-learning is a form of education delivery that uses web and advanced technology to enhance knowledge and performance through interactive online content to promote and enhance user engagement (Delf, 2013; Ruiz, Mintzer, & Leipzig, 2006). E-learning can improve learner knowledge and performance through individualized learning opportunities and interactions by incorporating

"multimedia such as text, graphics, animations, audio, or video to produce engaging content that learners access via a computer" which enables active participation (Ruiz et al., 2006, p. 208). Additionally, Delf (2013) discovered that e-learning offers interactive features including visual aids, self-tests, hyperlinks, and audio tracks, which may increase the efficiency and usability for the learner. Incorporating active and engaging learning environments may increase the learner's interests and reinforce application of materials, which leads to improved user motivation and overall performance (Ruiz et al., 2006).

Little to no literature currently exists focusing on the development and implementation of a cultural competency e-learning training module for OTs working with AI/AN populations. The proposed product is an online cultural competency training module for occupational therapists with the purpose of increasing culturally sensitive and responsive care to AI/AN populations. The module is specifically designed for OTs as an annual competency to be provided by a healthcare facility. The design of the module and information included were meticulously researched to ensure learner readability, understandability, and ease of use. The module content incorporates information regarding AI/AN health trends, individual and family cultural considerations, communication, spirituality and healing practices, and barriers to care. Use of reflective case studies and a post-test provide an active and engaging learning environment which can increase learner interest and reinforce applications of gained knowledge, leading to improved user motivation and overall performance (Ruiz et al., 2006).

The proposed scholarly project enables OTs to reflect on personal biases and stereotypes associated with AI/AN individuals, as well as provides pertinent information regarding AI/AN healthcare needs. This project also enables OTs to increase their overall culturally sensitive and responsive care leading to more efficient and client-centered services.

Though cultural competency is essential to every healthcare professional, OT has a unique role in providing holistic and culturally responsive services that includes the cultural aspects of clients. More specifically, "values, beliefs, and spirituality" are included within the "client factors" component of the *Occupational Therapy Practice Framework* (AOTA, 2014, p. S7). Throughout the OT service delivery process, and especially in the initial stage of the occupational profile development, the OT uses information and background gathered from the client in order to make effective, client-centered treatment decisions. Thus, an online training module designed for OTs with a focus on AI/AN populations is strongly indicated.

This scholarly project includes the incorporation of two separate theoretical frameworks. Regarding the intended implementation of the product, and the achievement of anticipated learner outcomes, the Canadian Model of Occupational Performance and Engagement (CMOP-E) was implemented. The CMOP-E is comprised of three specific focuses including the person, occupation and environment (Turpin & Iwama, 2011). The person consists of physical, cognitive, affective and spiritual aspects (Turpin & Iwama, 2011). Occupations include self-care, productivity and leisure (Turpin & Iwama, 2011). The final component includes physical, institutional, cultural, and social environments (Turpin & Iwama, 2011). The CMOP-E also emphasizes that occupation is the "bridge that connects person and environment" (Townsend & Polatajko, 2007, p. 23). The intended population and target for this scholarly project is occupational therapy practitioners and is represented as the person in this model. Additionally, the module was intended to target the person's essence of self, which is described as a spirituality component in the CMOP-E (Krupa, 2016). The occupation includes the act of participating in and completing the developed module, specifically in the subcomponent of productivity. Finally, the environment includes a culturally-sensitive environment in which

services are being provided to AI/AN populations. The intent of the developed project and module includes bridging the practitioner to a culturally-sensitive practice environment through the successful completion of the developed module.

Additionally, social identity theory was used in the development of the internal content of the product itself. According to Hogg (2006), social identity theory addresses areas including "prejudice," "discrimination," "ethnocentrism," "group polarization," "organizational behavior," and "group cohesiveness" (p. 111). More specifically, social identity theory proposes that people identify with certain social groups through unconscious cognitive processes (Rowling, 2019). In turn, positive aspects including self-esteem, comfort and security may result from affiliation with their identified social "ingroups" (Rowling, 2019, para. 2). However, adversely, other outside social groups may be depreciated by the individual ingroup to protect and favor one's own social identity (Rowling, 2019). The ingroup and outgroup nature of social identity theory was used during the development of the internal content presented in the module. Specifically, content was presented in an effort to decrease a clinician's own personal biases that encompass their social identity, and to increase acceptance of other social groups. The module includes several self-reflection components where the occupational therapy practitioner is encouraged to not only recognize that they may hold their own biases and stereotypes of a culture other than their own, but also to consider another culture's unique aspects during the provision of care.

Following the introduction, chapter two explores current evidence-based literature regarding AI/AN culture, their interactions with and needs of the healthcare system, and the use of online learning techniques. Additionally, chapter three is comprised of the methodology related to the development of the scholarly project. Chapter four includes snapshot images of the

developed module. Finally, chapter five includes a discussion of the implications for implementation of the module, and descriptions of future implications for the scholarly project.

Key terms and definitions operationally defined and utilized throughout the project are presented below:

American Indian and Alaskan Native: While AI/AN individual's often refer to themselves according to their tribal affiliation, *American Indian* or *Alaskan Native* is more often preferred over names such as *Indians* or *Native Americans* (Palacios, Butterfly & Strickland, 2005).

Client-Centered Care: "An approach to service that incorporates respect for and partnership with clients as active participants in the therapy process… emphasizes client's knowledge and experience, strengths, capacity for care, and overall autonomy" (Boyt Schell, Gillen, & Scaffa, 2014, p. 1230).

Culture: "Refers to our way of life including everything that is learned, shared and transmitted from one generation to the next… language, values, and beliefs and even the material things we create are all part of one's culture" (Bucher, 2015, p. 2).

Cultural Competence: "the ability to effectively interact with those who differ from oneself and is often described… as encompassing cultural awareness and attitudes, cultural knowledge of self and others, and cultural skill" (Boyt Schell, Gillen, & Scaffa, 2014, p. 185).

Culturally Responsive Care: " An approach that communicates a state of being open to the process of building mutuality with a client and to accepting that cultural-specific knowledge one has about a group may or may not apply to the client they were currently treating" (Boyt Schell, et al., 2014, p. 1232).

Diversity: “Refers to all of the ways in which people are different… this includes individual, group, and cultural differences.” (Bucher, 2015, p. 2).

E-learning: “refers to the use of Internet technologies to deliver a broad array of solutions that enhance knowledge and performance… and is also called Web-based learning, online learning, distributed learning, computer-assisted instruction, or Internet-based learning” (Ruiz, et al., 2006, p. 207).

Prejudice: “...an irrational and inflexible opinion formed on the basis of limited and insufficient knowledge” (Bucher, 2015, p. 72).

Stereotype: “Often what we hear and accept as true, an unverified and oversimplified generalization about an entire group of people” (Bucher, 2015, p. 68).

Chapter II: Literature Review

In 2018, the United States (U.S.) population consisted of approximately 329 million individuals (World Population Review, 2018). Of the entire U.S. population, an estimated six million individuals identified as being American Indian (AI) or Alaskan Native (AN), including those who considered themselves as more than one race (United States Census Bureau, 2018). Further, it is estimated that two percent of the U.S. population includes those of AI/AN descent (Office of Minority Health, 2018). While the AI/AN population is rather small in comparison to other major racial groups identified within the U.S., the unique needs of AI/AN individuals should not go unnoticed in regard to healthcare. Of the many healthcare disciplines that may serve AI/AN individuals, occupational therapy (OT) is a unique profession that recognizes cultural factors as an important aspect of client-centered care. Currently, limited literature exists with a focus on cultural competency for professionals working with AI/AN individuals, particularly OT professionals. Thus, relevant AI/AN population information, understanding of cultural identity, and knowledge regarding barriers to healthcare will be discussed. Additionally, cultural competency and current online module platforms used in healthcare training are also explored further. The purpose of this literature review is to support the development and implementation of an online cultural competency training module designed for OT professionals working with AI/AN populations or individuals.

American Indian/Alaskan Native Population

In order to increase cultural awareness and cultural competency, one must understand information relevant to AI/AN populations. The following information particularly focuses on AI/AN demographic data, including tribes, income, education, and health conditions.

Demographic Information

As previously noted, 5.6 million self-identified AI/AN individual's encompass approximately two percent of the total U.S. population (Office of Minority Health, 2018). According to the World Population Review (2019), the prevalence of AI/AN individuals is relatively high amongst several midwestern states, including South Dakota, Montana, North Dakota, and Wyoming. Due to the authors' geographical location of Wyoming at the time of writing, the upper midwestern states identified were the primary focus of this literature review. Specifically, 8.66% of the population in South Dakota, or approximately 74,000 individuals, identifies as being AI/AN (World Population Review, 2019). In Montana, 6.49% of the total population, approximately 66,000 individuals, are classified as AI/AN (World Population Review, 2019). Approximately 5.30% of the North Dakota state population, 39,000 individuals, identify as AI/AN (World Population Review, 2019). Finally, in Wyoming, 2.32% of the population, approximately 13,000 persons, identify as AI/AN (World Population Review, 2019).

Tribes. According to the Bureau of Indian Affairs (2019), there are currently 573 federally recognized tribes within the forty-eight continental states and Alaska. The term "federally recognized tribe" is defined as an identified tribe that has a "government-to-government relationship with the United States" (Bureau of Indian Affairs, 2019, p. 1200). Further, these tribes possess inherent rights to their own government and to certain benefits, including healthcare (Bureau of Indian Affairs, 2019).

Federally recognized tribes are provided certain healthcare services and educational opportunities through the Indian Health Service [IHS] (Payne, Steele, Bingham & Sloan, 2018). A common misconception includes the belief that IHS is a health insurance entity for AI/AN individuals. On the contrary, the IHS is not health insurance, but is an agency that provides

health care and funds to health care programs for AI/AN tribes and individuals (Centers for Medicare & Medicaid Services, 2016). Specific healthcare services offered through IHS facilities include but are not limited to: behavioral health, dentistry, diabetes management, immunizations, inpatient care, optometry, outpatient care, physical rehabilitation, pharmacy, and prenatal care (Indian Health Service, n.d.). The services and programs available to AI/AN individuals are dependent on each IHS facility (Indian Health Service, n.d.). According to Zuckerman, Jaley, Roubideaux and Lillie-Blanton (2004), "IHS facilities provide primary care services free of charge, and limited free specialty services are available through contracts with private providers" (p.53), but these services may be limited due to service areas that include smaller communities in which they must contract with private providers for services such as x-rays, mammograms, and specialty procedures. It is important to recognize that IHS does not provide service to every AI/AN individual, but only to those who are descendants and members of federally recognized tribes (Zuckerman et al., 2004). As of April of 2019, IHS served approximately 2.56 million AI/AN individuals across the country (Indian Health Service, 2019).

Additionally, because the federal government recognizes the right of tribes to govern themselves, the Americans with Disability Act of 1990, which ensures individuals with disabilities the rights and opportunities of any other individual, does not provide federal rights protection depending on whether the tribes that have adapted their own disability and healthcare policies (Lomay & Hinkebein, 2006). Previous studies on AI/AN health coverage and healthcare needs identify the following as barrier factors: income, education, and availability and utilization of IHS services (Zuckerman et al., 2004). Barriers such as access and utilization of IHS facilities will be discussed further in the chapter.

Income. In 2017, the median household income for AI/AN individuals was approximately $41,882 in comparison to the total U.S. population's median income of $60,336 (United States Census Bureau, 2018). Further, the poverty rate amongst all AI/AN people was revealed to be 25.3% in 2017, compared to 13.4% of the total U.S. population (United States Census Bureau, 2017). In 2016, the poverty rate amongst single race AI/AN individuals was higher than any other racial group in the U.S. (United States Census Bureau, 2018).

Education. In 2012, 82% of AI/AN individuals aged twenty-five years and older had a high school diploma, 17% had at least a bachelor's degree, and 6% had at least an advanced graduate degree in comparison to other major racial groups within the U.S. (Office of Minority Health, 2012).

Health conditions. The AI/AN population is known to be at-risk for a variety of chronic health conditions due to risk-taking behaviors, existing comorbidities, access to medical care, and lack of seeking out medical services (Burhansstipanov et al., 2018; Rogers & Petereit, 2005). It is imperative for healthcare providers who serve AI/AN populations to understand common health disparities among this population.

AI/AN individuals between the ages of 16 and 64 have one of the highest rates of disability than any other racial group, which often results from diabetes complications, heart disease, traumatic brain injury, and alcoholism and drug dependence (Lomay & Hinkebein, 2006; Nesoff, Brownstein, Veazie, O'Leary, & Brody, 2017). Additionally, the average life expectancy for Northern Plains Indian populations from 1996 to 1998 was 65.4 years compared to 76.5 for the overall U.S. population (Rogers and Petereit, 2005). The most common causes of death in the AI/AN population consist of heart diseases, malignant neoplasms, unintentional

injuries, diabetes mellitus, and liver disease (Rogers & Petereit, 2005). Of the several medical conditions listed above, a few will be discussed further.

The Centers for Disease Control and Prevention (2017) identified cardiovascular diseases and related heart conditions as being the leading cause of death among AI/AN populations in 2017. Nesoff et al. (2017) explained that due to risk-taking behaviors and common comorbidities seen with AI/AN people, severe heart conditions are often eminent. Specifically, a history of type II diabetes, tobacco use, obesity, and hypertension have been directly linked to the development of cardiovascular disease over time (Nesoff et al., 2017).

According to Burhansstipanov et al. (2018), cancer is the second leading cause of death among AI/AN individuals who are over the age of 45. Rogers and Petereit (2005) noted that the cancer mortality rate for AI/ANs located in the Aberdeen, SD, Bemidji, ND, and Billings, MT IHS areas were 40% higher than the overall population of the U.S. Similarly, it was found that AI/ANs in the Northern Plains region, including North Dakota, South Dakota, Iowa, and Nebraska, had higher rates of colorectal cancer at 58%, lung cancer at 62%, cervical cancer at 79%, and prostate cancer at 49% (Rogers & Petereit, 2005, p. 2129).

Non-insulin-dependent diabetes mellitus (NIDDM), also known as type II diabetes, is a growing health concern in the U.S., especially among the AI/AN populations (Burhansstipanov et al., 2018). According to Berinstein, Leonardson, Stahn, Herlihy, and Welty (1997), NIDDM diagnoses have increased drastically within the Northern Plains Indians populations. Particularly, the diabetes age-adjusted rate of diagnosis is 92.4 per 1,000, which is 3.7 times higher in Northern Plains Indians than all other populations within the U.S. (Berinstein et al., 1997). In addition, it is estimated that in the U.S., approximately four to six million people have diabetic retinopathy (Berinstein et al., 1997). Within the U.S. alone, new cases of color blindness in those

between the ages of 20-74 are associated with diabetes, resulting in the diagnosis of diabetic retinopathy. Berinstein et al. (1997) conducted a study to investigate the diabetic retinopathy prevalence among Sioux Indians in South Dakota. It was found that of the 417 participants in the Strong Heat Study whose eyes were examined, 45.3% had diabetic retinopathy, concluding that NIDDM and diabetic retinopathy pose a significant health threat to this particular population (Berinstein et al., 1997).

A common misconception regarding AI/AN populations includes the assumption of a natural predisposition to alcoholism (Berens, 2016). In reality, several factors influence addiction, particularly the participation in the consumption of alcohol. While alcoholism is highly prevalent within the AI/AN population, according to Garcia, Castro, and Sánchez (2019), chronic liver disease is a common result amongst AI/AN individuals. Similarly, substance abuse, specifically smoking, is another health deficit among AI/AN populations. According to Hodge and Struthers (2009), smoking rates for adult AI/ANs ranged from 34% to 79% in the U.S. and were particularly higher in rural areas and in northern states (Centers for Disease Control and Prevention, 2019). AI/AN's are especially at risk due to increased smoking rates and decreased cessation rates, partially because of a lack of education about the harmful effects of tobacco use (Hodge & Struthers, 2006). Thus, it is essential to provide smoking cessation education in order to prevent future complications caused by tobacco use.

Finally, mental health is another major area for concern, as there is a high prevalence of mental health issues amongst the AI/AN population. Noe, Kaufman, Kaufmann, Brooks, and Shore (2014) conducted a study in which cultural competency was explored in services being provided to AI/AN veterans. Noe et al. (2014) revealed that there was a higher incidence of AI/AN experiencing mental health problems compared to Caucasian veterans. Payne et al.

(2017) also reported that AI/AN individuals experienced the "poorest mental health outcomes in the United States" (p. 5).

Additionally, suicide is another mental health area of concern for AI/AN populations. According to O'Keefe, Tucker, Cole, Hollingsworth and Wingate (2018), AI/AN's are "dying by suicide more than any other group in the U.S." (p. 776). The rate of suicide among AI/AN's aged 15 to 24 are two times higher than any other ethnicity and three to six times higher in same-aged persons in the U.S., thus the need to combat high suicide rates among AI/AN populations is paramount (O'Keefe et al., 2018).

AI/AN Cultural Identity

While demographic information is pertinent in understanding AI/AN populations, specific aspects of AI/AN culture should also be investigated. Information gathered regarding AI/AN family aspects, communication, self-care considerations, and traditional medicine practices will be further discussed.

The AI/AN population embodies a set of highly diverse culture factors, including rich histories, the use of languages, locations, and spiritual beliefs (Bassett, Tsosiem & Nannauck, 2012). It is commonly misperceived that all AI/AN people are culturally congruent in terms of background, traditions, beliefs, health practices, values, and other tribal characteristics (Urban Indian Health, n.d.). In reality, more than 500 AI/AN federally recognized tribes currently reside in the U.S., and each encompasses their own unique set of traditions, practices, rituals, and values which must be accounted for when considering specific healthcare needs (Rybak & Decker-Fitts, 2009). Thus, it is impossible to classify all AI/AN members as being culturally identical. For the purpose of this literature review, it will not be possible to address each registered tribe, but rather AI/AN people as an entire cultural group. Furthermore, discretion is to

be used in the interpretation of the information provided, as individual tribes may practice unique traditions, spiritual beliefs, and health practices.

Family

Family is a major aspect of the AI/AN culture that should be considered when working with AI/AN clients. Specifically, the close-knit nature of AI/AN families is notable. Martin and Yurkovich (2014) explored the definition of healthy families amongst adult AI/AN tribal members. It was revealed that the close-knit nature of family comes from "having strong social ties with immediate and extended family members" (Martin & Yurkovich, 2014, p. 58). Family members are also described as having connectedness and closeness among one another (Martin & Yurkovich, 2014). The ability for a family to adjust and adapt to imbalances, have stable and committed members, and increase children's personal growth with parental assistance is included (Martin & Yurkovich, 2014). It was noted that a family that did not "get along," was categorized as "unhealthy" by Martin and Yurkovich's (2014, p. 58) study participants.

Familial relationships amongst the AI/AN population often influence individual health beliefs and values, as well as cultural practices (Martin & Yurkovich, 2014). Notably, families are often involved in aspects of decision-making, especially in regard to healthcare (Palacios, Butterfly & Strickland, 2005). Additionally, in many AI/AN tribes, family support during healthcare procedures through gift and food giving is very common (Palacios et al., 2005). Clients in acute or long-term care settings may want to share food with family, friends or other visitors and in turn receive gifts or food, thus, it is important to recognize that "kinship boundaries" can be extended to patients who are not blood-related (Palacios et al., 2005). It is emphasized that these non-blood related visitors may also feel entitled to the facility's food, parking, or other rights the patient has during their stay (Palacios et al., 2005). Additionally, it is

also common for family members to stay with patients overnight during the recovery from illness or injury (Palacios et al., 2005).

Communication

Communication amongst the AI/AN population is also important to consider when working with clients and families. For AI/AN populations, communication is influenced by several additional cultural aspects, including "learning through story-telling, intuitiveness, preference for a low-key profile, group harmony," and more (Chiang, 1993, p. 6). Chiang (1993) discussed several non-verbal communication components unique to the AI/AN culture, noting that nonverbal communication is often "culture bound" (p. 4), although it was emphasized that these findings were generalizations, and different tribes may have different communication style preferences. These components included the prominence of limited eye contact, differing facial expressions indicating disapproval or approval, and increased physical distance between people (Chiang, 1993). An "avoidance of direct eye contact should not be interpreted as inattentiveness or evasiveness" but rather may reflect respect to the practitioner (Palacios et al., 2005, p. 30). Chiang (1993) also discussed that some tribes may have physical touch expectations including no physical touch between people, while other tribes may value close proximities between people and touching (i.e. hugging). Healthcare practitioners working with AI/AN individuals should always introduce themselves to the client and their family with the addition of a light handshake (Palacios et al., 2005). A firm grip or a pumping handshake is viewed as disrespectful (Palacios et al., 2005). Additionally, it is noted that respect for elders in AI/AN culture is highly valued and practitioners should be mindful of this important aspect when communicating with older AI/AN individuals (Chiang, 1993).

Satter, Veiga-Ermert, Burhansstipanov, Luis Pena, and Restivo (2005) described components of respectful verbal communication relevant when interacting with AI/AN populations. These included understanding the common dialect used amongst tribal members, pauses during verbal speech, and pain considerations (Palacios et al., 2005; Satter et al., 2005). Similarly, understanding the intentional use of long pauses amongst AI/AN populations is also crucial. Often, AI/AN people will take the time to interpret what is being said before responding and may speak noticeably slower (Chiang, 1993; Satter et al., 2005). Interrupting others while speaking is considered disrespectful amongst the AI/AN culture (Satter et al., 2005). Thus, long pauses and withdrawn behaviors may be presented by AI/AN individuals. Finally, considering that there are over 500 federally recognized tribes in the U.S, tribal recognition amongst AI/AN individuals is highly valued and respected. AI/AN individual's often refer to themselves according to their tribal affiliation, for example, Chippewa (Palacios et al., 2005). As a practitioner, asking about an AI/AN person's tribe is recommended (Satter et al., 2005). As previously discussed, *American Indians* or *Alaskan Natives* are more often preferred terms over names such as *Indians* or *Native Americans* (Palacios et al., 2005).

It is important to recognize that symptom management, specifically pain, is often undertreated in this population due to substance abuse stereotypes or because AI/AN individuals are commonly unwilling to show or complain about pain (Palacios et al., 2005). Practitioners must frequently ask about pain with these individuals and use of a number scale may be most understood and therefore practical (Palacios et al., 2005). Additionally, Palacios et al., (2005) emphasized that patients may be willing to express pain to family or friends, therefore collaboration among the healthcare team, the client, and their family must be encouraged.

Story-telling is also common amongst the AI/AN population as a learning method as well as a technique for self-expression and is touched on later in this literature review as a traditional practice.

Activities of Daily Living

Activities of daily living (ADLs) may hold different meanings among AI/AN individuals. Presence of a modesty taboo is flexible depending on the tribe or individual, and should be assessed with caution; healthcare practitioners should offer a gown or drape to clients, and same gender practitioners may be important for specific examinations regarding private body parts (Palacios et al., 2005). If an AI/AN individual wears sacred objects such as feathers, medicine bags, or herb bundles, it is important as a practitioner to not remove them personally; rather, if removal is essential to treatment, asking the client or a family member to remove the object is preferred (Palacios et al., 2005). Hair care is an important consideration when working with AI/AN individuals, as hair may have spiritual meaning to clients and also may be associated with health or mourning practices (Palacios et al., 2005). Practitioners should always ask before touching a client's hair, and ask if the client would prefer a family member to complete grooming (Palacios et al., 2005). Privacy for toileting tasks is often appreciated by AI/AN individuals, and practitioners should always ask regarding a need for bed pans or commodes (Palacios et al., 2005). For self-care tasks, it is appropriate to offer assistance to elders and disabled persons, however, many AI/AN individuals will attempt to complete tasks on their own and refuse assistance offered (Palacios et al., 2005). Most AI/AN tribal diets were traditionally low in fat, however, due to the historical placements on reservations and lack of natural resources, many diets today are consistent with high fat, salty, and sugary foods (Palacios et al.,

2005). If working with individuals who have diabetes, practitioners should be mindful of the client's diet choices.

Historical Trauma

Following European settlement in America, AI/AN populations were subjected to disease, resource and land theft, genocide, oppression of cultural identity, as well as denial of equal opportunity and rights (Rybak & Decker-Fitts, 2009). The effects of this trauma are still prevalent in today's AI/AN society (Rybak & Decker-Fitts, 2009). Before European colonization, AI/ANs had the original rights to all U.S. land, which was later slowly lost due to government policy development (Palacios et al., 2005). Through the development of government policy, federally recognized tribes were granted small areas of land throughout the U.S., referred to as reservations (Palacios et al., 2005). The government policies and acts further sought to "civilize" and assimilate AI/AN tribes by implementing and encouraging "Christian education" (Palacios et al., 2005, p.28). Additionally, the Congressional Termination and Relocation Act of 1954 subsidized and encouraged tribes to relocate from rural to urban areas for better employment opportunities, leaving many families without promise of "financial and social-service support" (Palacios et al., 2005, p. 28).

An emphasis is placed on the slow development of trauma effects following the occurrence of historical events with the AI/AN population. Martinez (2014) discussed several symptoms and indicators of trauma affecting multiple generations in the publication, *Engaging Native Wellness*. Specific symptoms included: "alcohol abuse," "drug abuse," "compulsive behavior," hyper-vigilance or threat response," "rigid negativity or loss of hope," generalized anger and anxiety," "chronic depression," and "diminished self-efficacy" (Martinez, 2014, pp. 23-24). Additionally, Ehlers et al. (2013) conducted a study to describe the extent of historical

experience, relationship of current traumatic events, associations in cultural identification, and frequency of thoughts and feelings associated with historical loss among an AI sample. Of the 306 participants, more than half indicated thinking about historical losses associated with Native American culture as causing distress in cultural identification and substance dependence (Ehlers et al., 2013). Factors such as loss of language and respect for elders, thoughts of broken treaties, trauma from boarding school, land loss, and relocation were consistent among the sample (Ehlers et al., 2013). In addition, it was emphasized that mental health is a common health disparity for AI/AN populations due to historical trauma and lack of trust with U.S. government agencies (Payne et al., 2017). Higher scores were found on the Historical Loss Associated Symptoms Scale in the study by Ehlers et al. (2013), indicating the experience of assaultive trauma post-traumatic stress disorder (PTSD) and the presence of an anxiety/affective disorder has influenced thoughts of historical losses, as well as impacted the participants emotionally (Ehlers et al., 2013).

Martinez (2014) also listed several risk considerations that should also be taken into account with AI/AN populations, including:

> Familial historical trauma experiences, recalled history of boarding school abuses and experiences, knowledge of one's culture or language, lifelong experiences of marginalization and racism, poor or misguided interpretation of cultural identity or definition of self, sense of disconnectedness from health family and community, references to or reports of adverse childhood experiences, and childhood experiences and perceptions of an unhealthy family experience. (p. 24)

As a practitioner, the potential for these risk factors must to be taken into consideration when working with AI/AN individuals.

Traditional Practices

Another important aspect of AI/AN culture includes the use of traditional practices and medicine. According to Bassett et al. (2012), it is estimated that "up to 90% of the AI/AN population... relies on traditional medicine (TM) for primary healthcare needs" (p. 19). According to the World Health Organization (WHO), identified by Bassett et al. (2012), TM is defined as "includ[ing] diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral-based medicines, spiritual therapies, manual techniques, and exercises, applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness" (p. 19). Additionally, Payne et al. (2018) indicated that AI/AN individuals are more likely to seek help from tribal and spiritual leaders and healers, rather than seeking out counseling or therapy. Specific traditional practices including the Medicine Wheel, powwows, smudging and sweat lodges, and pipe-ceremonies and storytelling will be further discussed in the following section.

Medicine wheel. Medicine and healing practices of the AI/AN culture differ greatly from those of the current Western medical model. The Medicine Wheel is a commonly used symbol and is comprised of a circle with four quadrants or "spokes", representing north, south, west, and east (Rybak & Decker-Fitts, 2009, p. 335). The east quadrant is representative of spirituality and the color red, while the west is representative of the "physical aspects of life" and the color black (Rybak & Decker-Fitts, 2009, p. 335). The north quadrant represents "cognitive aspects of life" and the color white, while the south exhibits "nature" and the color yellow (Rybak & Decker-Fitts, 2009, p. 335). While tribes have their own variations of the Medicine Wheel, many have similarly instilled values and belief systems within their tribe, and it is believed that if any of the

spokes of the wheel are compromised, an unhealthy balance will result (Rybak & Decker-Fitts, 2009).

For a majority of AI/AN tribes, health and healing are a balance of spiritual, mental, and physical components that encompass connections between not only people, but animals, plants, rivers, rocks, and the cosmos (Rybak & Decker-Fitts, 2009). The connection is a phenomenon known to many tribes as "The Red Path" and attributes to "wholeness and harmony with nature" as well as the "feelings of belonging, a sense of mastery, respect for independence, and promotion of generosity and unselfishness" (Rybak & Decker-Fitts, 2009, p. 335). Additionally, "The Red Path" is said to be a line running north to south in the Medicine Wheel often referred to the path of "good" (Rybak & Decker-Fitts, 2009, p. 335). In contrast, "The Black Path," runs perpendicular, west to east on the Medicine Wheel, and is referred to as the path of "warfare and destruction" (Rybak & Decker-Fitts, 2009, p. 335).

While there are many tribes that identify with components of the Medicine Wheel, many tribes have their own means of health traditions, ideals, beliefs, and healing practices. However, for the purpose of this literature review, the Medicine Wheel and its spokes serve as an important guide for health care professionals.

Powwows. Another significant aspect of AI/AN culture includes specific ceremonies called powwows. Powwows are popular ceremonies held by many AI/AN tribes where people participate in dancing, drumming, singing, and the wearing of traditional clothing, sacred objects, and headdresses (Palacios et al., 2005; Rybak & Decker-Fitts, 2009). The drumming and singing aspects of AI/AN culture are not only associated with powwows, but they hold a spiritual and symbolic experience for many tribes as well as a connection between the past, present and the future (Rybak & Decker-Fitts, 2009). Drumming can be associated with the "heartbeat of the

world," while singing is interchangeable depending on special events and circumstances (Rybak & Decker-Fitts, 2009, p. 336). Dancing, drumming, and singing are often "routes to spiritual connectedness, health and healing" (Palacios et al., 2005, p. 28). Other common ceremonies consist of the Sundance, Gourd Dances, and Spirit Dances, the use of which have been associated to decreasing alcohol and substance abuse among AI/AN tribes (Rybak & Decker-Fitts, 2009).

Smudging and sweat lodges. Smudging is a common traditional healing practice used to rid of evil spirits and energies by burning sage, sweetgrass, and cedar (Rybak & Decker-Fitts, 2009). Sweat lodges are used as a purification technique and are often associated with wedding ceremonies, sun dances, or vision quests (Rybak & Decker-Fitts, 2009). The lodge is designed in such a way to keep in steam from heated stones with the use of tarps and blankets; during a sweat lodge ceremony participants sing, pray, and herbs are placed on the stones to fill the lodge with scents (Rybak & Decker-Fitts, 2009). A sweat lodge is said to increase the "emotional and spiritual wellbeing" of AI/AN users (Rybak & Decker-Fitts, 2009, p. 337). AI/AN individuals who sweat, may sweat for long periods of time, thus, it is important and appropriate for practitioners to ask about sweating habits, and collaborate on length of sweat time, especially if dehydration or other medical issues conflict with sweating (Palacios et al., 2005).

Pipe ceremonies and story-telling. Additional practices used by many AI/AN tribes include pipe ceremonies and story-telling. Contrary to popular belief, tobacco is not traditionally used in pipe ceremonies, rather red willow and sage are used more commonly (Rybak & Decker-Fitts, 2009). According to Rybak and Decker-Fitts (2009) participants in this ceremony sit in a circle and pass a pipe while praying to the creator. Pipe ceremonies can also be used for grieving or making important decisions with other leaders (Rybak & Decker-Fitts, 2009).

For many AI/AN tribes, story-telling is an essential method of communicating and passing along information (Rybak & Decker-Fitts, 2009). Galanti (2004) explained that AI/AN individuals may use anecdotes and/or metaphors when conversing with others. Rybak and Decker-Fitts (2009) explain that story-telling "kept alive tribal and human origins, histories, and ceremonies" while offering "hope and faith" to those who may be healing from illness or disease (Rybak & Decker-Fitts, 2009, p. 337). Similarly, Heaton et al. (2018) noted that "storytelling is a potential mechanism to communicate health messages" amongst AI/AN individual's (p. 2). Specifically, story-telling about another individual may reflect one's own experiences (Galanti, 2004). For instance, an AI/AN person who shares a story about an ill person, may be attempting to convey that they are experiencing similar symptoms (Galanti, 2004).

The information regarding traditional healing practices and rituals described above is important for health professionals to be aware of when providing client-centered care to AI/AN individuals. In light of building a cultural competency training module for incoming occupational therapy staff working in settings within the Northern Plains region, it is essential to incorporate traditional healing practices and beliefs so practitioners can understand these unique cultural aspects of AI/AN populations to better serve clients' health needs.

Barriers to Accessing and Utilizing Healthcare

Unfortunately, many individuals within the U.S. suffer from limited access and utilization of healthcare services. Below, general culturally specific barriers for AI/AN populations are discussed.

General Culturally Specific Barriers

Additional barriers to disability include a lack of culturally competent healthcare services, awareness and knowledge of AI/AN culture among service providers, funding, and

access to healthcare facilities, all of which contribute to inefficient healthcare to AI/AN populations (Lomay & Hinkebein, 2006). Specific barriers and disparities include rural location, lack of education, low health literacy, poverty and unemployment (Lomay & Hinkebein, 2006). Additional healthcare disparities that result in barriers to AI tribes consist of finances, caregiver and family support, knowledge of disease including treatment and screening, and the burden of working with multiple health care facilities (Rogers & Petereit, 2005). This burden can result in test delays and associated results, lack of referrals, payment, overall distrust of Western medicine, and lack of research (Rogers & Petereit, 2005). As previously mentioned, the AI/AN population has the highest poverty rate compared to other racial groups in the U.S. Consequently, the lack of employment and low incomes impacts one's ability to obtain health care services, especially services of high quality. Similarly, limited services are offered via IHS programs and health insurance plans for AI/AN individuals, thus accessibility is unfortunately limited.

Lack of culturally competent care. Cultural competency amongst healthcare providers, specifically with regard to AI/AN cultures, has been shown to be insufficient (Noe et al., 2014). Noe et al. (2014) conducted a study to explore the organizational factors within Veterans Affairs (VA) healthcare facilities that impact the implementation of culturally competent services amongst AI/AN veterans. Surveys were administered to both VA healthcare staff and AI/AN veterans being served at such facilities to assess perceptions of use and implementation of native-specific services (Noe et al., 2014). The results revealed that only 42% of the participants indicated their healthcare facilities had programs intended to benefit AI/AN veterans (Noe et al., 2014). Similarly, only 30% reported their facilities had culture-related resources available for veterans (Noe et al., 2014). Finally, only 15% of the respondents indicated traditional medicine

and related services were provided at their facilities (Noe et al., 2014). Furthermore, the survey results indicated that there are limited resources and guidance within the organizational realm of healthcare facilities regarding culturally-relevant care for AI/AN veterans (Noe et al., 2014).Thus, we believe that the development of an online training module that focuses on the AI/AN population's culture and health needs would be beneficial to both practitioners as well as AI/AN clients in the future. The positive impact of culturally-competent care outcomes are discussed further in the chapter.

Health literacy. Education amongst the AI/AN population is another barrier for accessibility to healthcare services, specifically in regard to healthcare literacy. After investigating AI/AN's perceptions of needs for cancer assessments, Burhansstipanov et al. (2018) revealed that participants overall had poor knowledge regarding cancer risks. It was also indicated that the study participants wanted more educational opportunities available to them for cancer screenings (Burhansstipanov et al., 2018). Very little literature has been identified with a focus on health literacy within the AI/AN population, thus future research addressing this issue is necessary.

Trust versus mistrust. Trust versus mistrust of modern healthcare systems amongst AI/AN individuals has been investigated; the noted studies demonstrated consistencies that are significant to the culture of these individuals. In a study conducted by Simonds, Goins, Krantz, and Garroutte (2014), patient trust was examined in relation to cultural characteristics with AI elders. It was found that individuals who recognized high cultural identity reported significantly lower institutional trust in regard to the medical healthcare system (Simonds et al., 2014). Similarly, using in-depth interviews, Nesoff et al. (2017) investigated AI/AN insights into health care for myocardial infarction (MI), which revealed that tribal members reported feeling distrust

of the medical system due to previous experiences and rumors. Additionally, requests for use of a spiritual healer due to mistrust and suspicion may be requested by an AI/AN individual, thus, a practitioner may use want to consider this collaboration in conjunction with Western medicine methods to promote harmony (Palacios et al., 2005). It is important for practitioners working with AI/AN individuals to collaborate with the client and the healer to determine appropriate healing approaches such as scheduling time for private ceremonies (Palacios et al., 2005).

Access and utilization of IHS facilities. Access and utilization of IHS and other healthcare facilities are significant barriers to AI/AN people living in rural and isolated areas (Noe et al., 2014). In a study conducted by Zuckerman et al. (2004), AI/AN reported experiencing increased issues when accessing and utilizing health care facilities in comparison to whites, specifically the lack of confidence in their families' ability to access care, dissatisfaction with the quality of care they received, lack of ER services, and poor communication with their providers (Zuckerman et al., 2004). According to Noe et al. (2014), AI/AN veterans are less likely to seek out services due to challenges with timely services and accessing specialty care. Nesoff et al. (2017), explained that AI/AN individuals who live on reservations often do not have access to personal transportation, thus impacting their ability to access clinics. This is particularly problematic for emergent healthcare situations. Nesoff et al. (2017) conducted a study exploring the time to treatment amongst rural AI/AN individuals with myocardial infarction (MI) cases. It was revealed that the lack of access to timely care was a significant barrier to obtaining treatment in the event of an MI, compared to AI/AN individual's living in urban areas (Nesoff et al.).

According to emergency medical staff interviewed by Nesoff et al. (2017), IHS has limited ambulance services with minimal equipment assigned to large geographical regions. Not

only does this impact the quality and amount of services that can be provided in emergent situations for AI/AN patients, but it also impacts time-to-treatment significantly (Nesoff et al., 2017). For example, Rapid City Regional Hospital in Rapid City, South Dakota serves nearly 60,000 AI's in a 200-mile radius, often consisting of mostly Sioux tribes from the Aberdeen IHS area, including the Rosebud, Oglala, and Cheyenne River Sioux Tribes (Rogers & Petereit, 2005). Rogers and Petereit (2005) found that one of the most significant barriers to cancer diagnosis, treatment, and care was the distance traveled to Rapid City Regional Hospital, with 37% of AI/AN patients requiring 150+ miles of travel. Culture-specific barriers to healthcare among AI/AN populations exist and should be taken into consideration when working with AI/AN clients.

Cultural Competency

In light of the unique cultural characteristics of AI/AN populations, careful consideration of cultural competence among healthcare providers is essential in efforts to appropriately serve AI/AN individuals. Thus, definitions of cultural competence, current use of cultural competency education and trainings, benefits of trainings, evidence of lack thereof, as well as the occupational therapy perspective, are further discussed below.

Definitions

Emerging populations bring with them individualized beliefs and values, which are crucial to understand for increasing cultural competency, as well as the effects of cultural education in health care (Abrishami, 2018). There remain multiple definitions to describe cultural competence due to inconsistencies between researchers and health care practitioners. However, a generalized purpose of the definition is needed to address issues related to the cross-cultural barriers with regard to social, cultural, and economic populations of diverse upbringings

and backgrounds (Perry, Woodland, & Brunero, 2014). The following definitions are examples extracted from various sources of literature.

According to Noe et al., (2014), "cultural competence encompasses understanding and consideration of culture, economic and educational status, health literacy level, family patterns and situations, and traditions … as well as communication at a level that the patient understands" (p. S548). Additionally, the Australian National Health and Medical Research Council (NHMRC) defined cultural competence as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations" (Perry et al., 2014, p. 218). Finally, Schell et al. (2014) defined cultural competence as "the ability to effectively interact with those who differ from oneself and is often described… as encompassing cultural awareness and attitudes, cultural knowledge of self and others, and cultural skill" (p. 185).

Of the several existing definitions, the definition described by Schell et al. (2014) is most compatible with the purpose of this literature review and would be most beneficial in the development of a cultural competency online training module for occupational therapists.

Current Implementation of Cultural Competency Education and Training

Bassett et al. (2012) revealed that "culture is medicine" (p. 25) which identified the importance of integrating cultural aspects into the promotion of recovery in health and traumatic events. Further, providing culturally competent care is critical to serving populations who utilize traditional medicine into healthcare practices. The WHO defined traditional medicine as the "sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as prevention, diagnosis, improvement or treatment of physical and mental illness" (p.

S263). It is essential that healthcare providers are aware of the traditions, beliefs, and practices used in conjunction with Western medical practices to provide culturally sensitive and competent care (Bassett et al., 2012). The following information includes the current usage of cultural competency trainings and education amongst healthcare providers.

Kesler, Hopkins, Torres, and Prasad (2015) explored and described the traditional healing curriculum used at the University of New Mexico Public Health and General Preventative Medicine Residency Program (UNM PMR), which sought to provide education and training to physicians by learning from traditional healers and participating in culturally specific healing practices from Hispanic and Native American cultures. The goal of this specific traditional healing program was to provide resident physicians with an introduction to cultural healing practices in order to decrease health deficits and adverse outcomes, as well as improve communities and indigenous relations (Kesler et al., 2015). New Mexico has the second highest percentage of AI/AN populations living in U.S., specifically the Navajo Nation (Kesler et al., 2015). The unique cultural practices of the Navajo Nation were incorporated into the UNM PMR program because the only education provided to residents in cultural competency was general cultural diversity training (Kesler et al., 2015). The overall goal of the UNM PMR was for "residents to demonstrate knowledge in traditional healing practices that could be applied in addressing both population and individual patient health and wellness needs" (Kesler et al., 2015, p. S264). The program's curriculum objectives were comprised of: demonstration of foundational knowledge, effective communication skills, professionalism and respect, ability to compare and contrast healing approaches, and to formulate appropriate patient assessment, explaining components of preventions, and applying cultural competency to patient encounters (Kesler et al., 2015). After completing residency, most resident students agreed that the traditional healing

practices and education learned through the curriculum were beneficial in their ability to "demonstrate communication skills, promote cultural sensitivity, and demonstrate knowledge of culturally based healing practices" (Kesler et al., 2015, p. S267). It was apparent through resident feedback that the opportunities presented through the UNM PMR program allowed them to enhance culturally appropriate care to AI/AN cultures within their community and increased the traditional healing knowledge. Opportunities such as the UNM PMR program allow medical professionals to enhance their knowledge and skills of culturally competent care and traditional healing practices, which have positive effects on AI health, wellness, and leading to improved community relations.

In general, there are a multitude of strategies available to address cultural competence in health care settings. Such strategies may involve the use of interpreters, new hire orientations, and department in-services (Perry et al., 2014). While little evidence exists regarding implementation of cultural competency trainings, the research that does exist supports the effectiveness and use of such trainings among healthcare practitioners. Thus, a tool specifically targeting the cultural competence of healthcare professionals may significantly benefit healthcare practice today, especially in the realm of occupational therapy.

Benefits

Several benefits may result from the appropriate implementation of cultural competency training amongst healthcare providers and the carryover of education into practice with culturally diverse populations. Perry et al., (2014) identified that education and training of health care individuals is essential to "developing culturally sensitive, congruent and responsive clinical practice," and that cultural competency training itself can improve "attitudes, knowledge, skills,

and behaviours" of health care professionals, as well as the overall improvement of patient satisfaction (p. 219).

Govere and Govere (2016) evaluated the effectiveness of cultural competency among healthcare providers and its effect on patient satisfaction. Govere and Govere (2016) revealed that the quality of care can be measured and correlated to patient compliance to treatment, including the level of patient satisfaction with care. Not only is patient satisfaction an important aspect of quality care, but it also has a significant impact on a health organization's legal aspects. Increased patient satisfaction is highly associated with pay-for-service factors included in Medicare and Medicaid (Govere & Govere, 2016). Additionally, satisfaction is associated with the minimization of liability and penalty, accreditation issues, and even legal action toward a facility if a patient believes culture has not been appropriately addressed throughout care (Govere & Govere, 2016).

Occupational Therapy Perspective

While cultural competency is a vital skill set necessary for all healthcare professionals, occupational therapy has a unique role in the deliverance of quality culturally aware services. Occupational therapy upholds a holistic perspective to care, including the awareness and attention to cultural aspects of the clients being served. Specifically, "values, beliefs and spirituality" are included in the primary category of "client factors" listed in the widely used and referenced *Occupational Therapy Practice Framework* (AOTA, 2014, p. S7). In the occupational therapy service delivery process, the initial stage of developing an occupational profile includes gathering and interpreting client background information. Not only is the accumulated information used in an attempt to fully understand the client, but ideally, it is used throughout the entirety of the occupational therapy process to provide care that is most-tailored to the client.

Considering that the AI/AN population is at-risk with unique cultural needs, occupational therapists have the unique skills necessary to appropriately and effectively assess and utilize cultural aspects to provide quality care. Thus, an online training module designed for use by occupational therapy professionals with a sole focus on the AI/AN population would be beneficial for the overall care of AI/AN clients.

Current Module Platforms

Modern society consists of the increased use and advancement of technology, especially within healthcare settings. For instance, online training modules are commonly integrated into on-boarding training processes and continuing education opportunities for healthcare providers. Common forms of online modules that have been shown to be effective include eSimulation and e-learning, which will be discussed further. Below, the benefits of online modules, as well as current examples of modules being implemented will be discussed to emphasize the need for the development of an online training module for occupational therapy practitioners working with AI/AN populations.

E-learning & eSimulation

E-learning is a form of educational delivery that uses the web and advancing technology to enhance the knowledge and performance of healthcare professionals (Delf, 2013; Ruiz et al., 2006). Often, the online content is presented through a variety of interactive formats to promote and enhance user engagement (Delf, 2013).

eSimulation is an online learning approach where the trainee is presented with knowledge and information through interactive scenarios with the intent to simulate real-life situations “that encourage experimentation and discovery of principles” (Perry et al., 2014, p. 219). The

implementation of an eSimulation approach has been found to positively affect learners' knowledge, skills, and attitudes (Perry et al., 2014).

Benefits

The use of eSimulation modules is a relatively new strategy and is designed to have a variety of benefits (Perry et al., 2014). The same is reflective of efficient e-learning modules, which should be taken into consideration in the development of a new module. These include accessibility, interactive elements and trackability, which will be further discussed below.

Accessibility. Online training modules, specifically e-learning based materials, "makes economic sense," as educational opportunities are provided to learners regardless of geographical location and time (Delf, 2013, p. 315). Similarly, e-learning is highly versatile, and in turn is cost-efficient, where materials can be accommodated to several different individuals (Delf, 2013). "E-learning technologies offer learners control over content, learning sequence, pace of learning, time, and often media, allowing them to tailor their experience to meet their personal learning objectives" (Ruiz et al., 2006, p. 207). Delf (2013) explained that e-learning can be provided alongside work, provide employers/employees with training opportunities, and support continuing professional development in clinical settings.

Additionally, as productivity standards increase, eSimulation offers a convenient, flexible, time-efficient and cost-effective delivery approach to education and training of health care professionals (Perry et al., 2014).

Interactive elements. According to Ruiz et al. (2006), there is a strong correlation between the effectiveness of e-learning and instructor-led methods, as in traditional use of lectures, and could be used complimentary to one another (Ruiz et al., 2006). E-learning can offer a variety of methods to improve knowledge and performance through individualized

learning opportunities and interactions by incorporating "multimedia such as text, graphics, animations, audio, or video to produce engaging content that learners access via a computer," which enables active participation (Ruiz et al., 2006, p. 208). Similarly, Delf (2013) discovered that the usability and the incorporation of interactive features, including visual aids, self-tests, hyperlinks, and audio tracks, were deemed as key foci in the success of an e-learning module. Incorporating an active and engaging learning environment can increase the learner's interest and reinforce the material provided, leading to improved user motivation and overall performance (Ruiz et al., 2006).

Trackability. E-learning also offers the ability to track user progress through sections of courses and provide outcome assessments through the use of quizzes to determine whether the learner has acquired the appropriate knowledge and achieved the desired objectives (Ruiz et al., 2006). Additionally, Delf (2013) mentioned that e-learning offers the ability to revisit content if needed, which has also shown to be highly effective and valued.

Examples of Implemented Modules

While little to no evidence exists supporting the use of a cultural competency training module with occupational therapy practitioners, current evidence supporting the use of other online modules are described below.

Cultural competency eSimulation. Much like the U.S., Australia is a multicultural country with a diverse population. Within Australia's healthcare system, communication and cross-cultural competence have often been barriers in the delivery of effective and culturally appropriate care (Perry et al., 2014). Perry et al., (2014) discussed the development and implementation of cultural competency training using an eSimulation module for nurses and other healthcare professionals. The purpose of the eSimulation module was to educate and train

healthcare professionals to be culturally sensitive and aware of the beliefs, traditions, and values of the diverse populations in which they serve (Perry et al., 2014).

Results from the study found that the eSimulation module provided the ability of unlimited access to nursing staff working in different locations and various shifts throughout the day (Perry, et al., 2014). The eSimulation module was found to engage staff and resulted in increased "confidence, knowledge, and clinical practice" with regard to culturally competent care (Perry et al., 2014, p. 222). This study stressed the feasibility of implementing an online module used in conjunction with diverse populations, resulting in culturally sensitive and culturally competent care with AI/AN populations.

Value-based healthcare learning modules. Through the Dell Medical School, at the University of Texas, Moriates et al. (2019) developed a set of online interactive learning modules regarding value-based health care (VBHC). The first set, titled *Discovering Value-Based Health Care,* was released in 2017 and sought to educate health professionals at any stage of training on the foundations of VBHC (Moriates et al., 2019).

Each module began with a short patient narrative video with an emphasis on interactions with the healthcare system. The educational content was presented through "multimedia formats, including videos, text, pictures, animations, quiz questions, and activities" (Moriates et al., 2019, p. 7). The final section of each module included an interactive activity that emphasized the module's learning objectives. Following the development of the modules, Moriates et al. (2019) integrated the VBHC modules into the Dell Medical School's curriculum with the intent to examine the implementation of the free modules. In addition, the modules were released online in 2017 through numerous promotional methods to the general public.

Moriates et al. (2019) revealed that during the first fifteen months of the module release, the curriculum website had 130,098 pageviews with 8,546 users from forty-five states and ten foreign countries. Moriates et al. (2019) noted that a small portion of the users who started and did not complete the modules due to potential lack of engagement was comparable to an in-person session. However, those who completed the modules reported satisfaction with the VBHC curriculum via an assessment survey (Moriates et al., 2019). Thus, interactive online learning, specifically the implementation of online modules, has been shown to be effective.

Necessity For A New Module

As previously emphasized, little to no literature currently exists focusing on the development and implementation of a cultural competency online training module intended for occupational therapy practitioners working with AI/AN populations. Thus, if such a module was developed with e-learning components and a particular emphasis on AI/AN cultural considerations, it is hypothesized that practitioners will increase their overall cultural awareness and effectively provide culturally responsive and client-centered services.

Chapter 3: Methodology

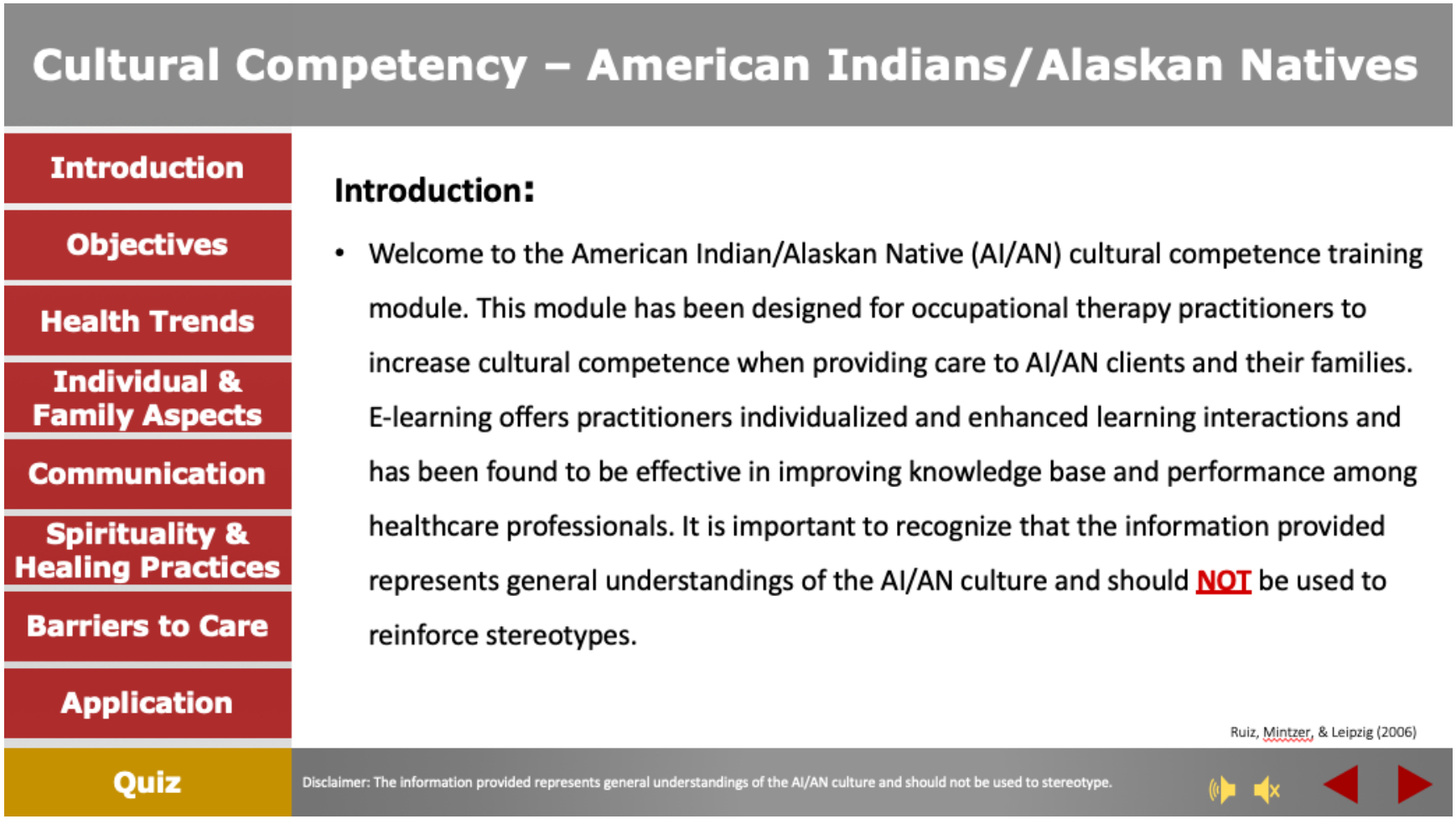
This scholarly project was designed not only with heightened interests of the module developers but also with intent to follow specific scholarly guidelines. The initial step taken in the development of this project included an extensive review of existing literature regarding AI/AN culture, cultural competency, and the profession of occupational therapy in relation to healthcare services provided to AI/AN individuals. Several databases and search engines, including CINAHL Complete, PubMed, Embase, and Google Scholar, were used for the literature review. Terms including "Native American," "American Indian/Alaska Natives," "cultural competency," "culture," "occupational therapy," "online training," and "e-learning" were implemented in the literature searches. These terms were chosen and utilized to directly search for relevant and current evidence related to the desired topic. Another specific source included a chapter in the book titled, *Culture & Clinical Care*, written by Palacios, Butterfly and Strickland (2005), which was highly utilized in the gathering of AI/AN cultural information. While this resource is seemingly outdated, the information provided proved to be accurate and was written by American Indian authors with healthcare experience. Information was gathered from relevant sources to produce a rich and highly detailed literature review.

After gathering information from a breadth of appropriate evidence-based resources, an unmistakable gap in the literature focusing on the implementation of cultural competency trainings among occupational therapy professionals working with AI/AN populations became evident, thus, emphasizing the need for the development of such a product.

Due to the unique complexity regarding human nature and the content provided in the module, two separate theoretical frameworks were implemented throughout the creation of the scholarly project. First, the CMOP-E was referenced and used in the initial development stages

and through the overall intent of the scholarly project. Specifically, components of the model are represented through the desired implementation and expected outcomes of the developed module. Secondly, due to the intention of promoting cultural awareness of one group (occupational therapy practitioners) about another group (AI/AN populations), social identity theory was used in the creation of the internal module content. In particular, components of self-reflection and identification of one's own biases are addressed throughout the module, to not only decrease personal bias, but also to decrease the potential presence of an ingroup and outgroup user mentality. Throughout the entire project development process, weekly meetings with the primary academic advisor were held to gain project guidance and feedback.

Chapter IV: Product



Cultural Competency – American Indians/Alaskan Natives

Cultural Competence Defined:

"the ability to effectively interact with those who differ from oneself and is often described… as encompassing cultural awareness and attitudes, cultural knowledge of self and others, and cultural skill" (Schell, Gillen, & Scaffa, 2014, p. 185)

Disclaimer: The information provided represents general understandings of the AI/AN culture and should not be used to stereotype.

Cultural Competency – American Indians/Alaskan Natives

Importance of providing culturally competent care as an OT practitioner:

- AI/AN populations have identified a desire for culturally competent practitioners
- Little literature exists with focus on cultural competency of OTs working with AI/AN individuals
- Consideration of individual's values, beliefs, traditions, and backgrounds **MUST** be considered when providing best-practice care. Failure can result in:
  - Legal fines and penalties
  - Civil lawsuits
  - Patients dissatisfaction
  - Loss of facility accreditation
- It is your moral duty to provide culturally sensitive services to **all** individuals

Bassett, Tsosiem, & Nannauck (2012); Govere & Govere (2016); Noe, Kaufman, Kaufmann, Brooks, & Shore (2014)

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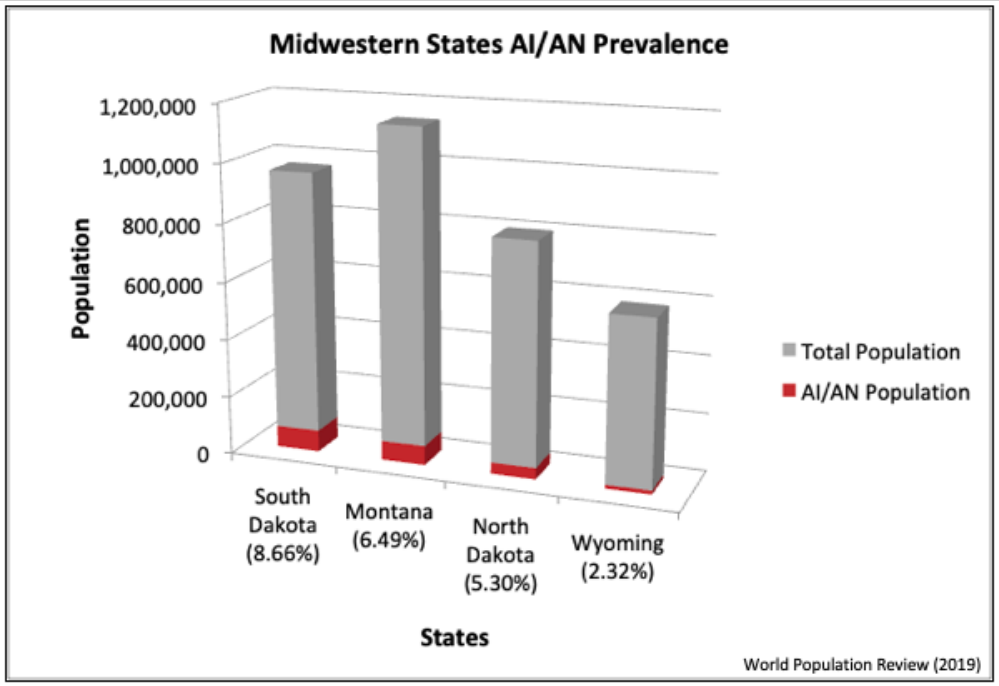
Cultural Competency – American Indians/Alaskan Natives



Continue to Learning Objectives...

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Professional Objectives:

Upon completion of this training module, learners will be able to:

- To change organizational behavior and institutional culture through completion of the module
- To change the way the therapist within the facility is handling their interactions with AI/AN individuals which will benefit the professional, the population, and the facility

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Learning Objectives:

Upon completion of this training module, learners will be able to:

- Gain an understanding of family dynamics often represented in AI/AN cultures.
- Recognize important communication and touch considerations when working with AI/AN individuals.
- Identify spirituality and healing practices common to AI/AN individuals.
- Recognize common healthcare barriers when working with AI/AN populations.

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Expectations and Requirements:

- The module is estimated to take **45 minutes** to complete. You may pause at anytime, and your progress will be automatically saved.
- During the module, participants will be required to interact and apply material by answering questions and inserting comments.
- Recall elements of one AI/AN culturally-focused case study.
- Learners **MUST** be able to complete the quiz at the end of the module with an **80%** to pass this competency.

Continue to Health Trends…

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AI/AN Health Trends:

- In 2017, the most common causes of death amongst AI/AN populations were chronic cardiovascular diseases and related heart conditions.
  - Often associated with comorbidities of type II diabetes and obesity.
- Cancer was the second leading cause of death for AI/AN individuals over the age of 45 in 2018.

Burhansstipanov et al. (2018); Center for Disease Control and Prevention (2017); Rogers & Petereit (2005)

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Cultural Competency – American Indians/Alaskan Natives

AI/AN Health Trends:

- Alcohol consumption and substance use is common and is often related to chronic liver disease.
- Unintentional injuries and traumatic brain injuries are common and contribute to high rates of disability within the AI/AN population.
- Mental health issues and suicide amongst AI/AN individuals is high compared to other racial groups.

Berinstein, Leonardson, Stahn, Herlihy, & Welty (1997); Garcia, Castro, & Sanchez (2019); Lomay & Hinkebein (2006); Nesoff, Brownstein, Veazi, O'Leary, & Brody (2017); O'Keefe, Tucker, Cole, Hollingsworth, & Wingate (2018)

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Cultural Competency – American Indians/Alaskan Natives

AI/AN Health Trends:

- **Indian Health Services** (IHS)
  - An agency that provides certain healthcare services and opportunities to federally recognized tribes to **573** federally recognized tribes in **37** states.
  - **NOT** health insurance, rather it provides health care and funds to health care programs.
- As of April of 2019, IHS served approximately **2.56 million** AI/AN individuals.

Indian Health Service (2019); Payne, Steele, Bingham, & Sloan (2018)

Continue to Individual and Family Aspects…

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Individual Aspects:

- **Modesty**
  - Dependent on the individual. Same-gender practitioners are preferred for sensitive therapeutic activities (ex: dressing and showering).
- **Hair care**
  - Hair care and treatment may be associated with health or mourning practices. Practitioners should always ask before touching hair. Cutting hair may be associated with mourning.

Palacios, Butterfly, & Strickland (2005)

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Individual Aspects:

- **Diet**
  - Historically, AI/AN diets were traditionally low in fat. Today, however, many diets are consistent with high fat, salty, and sugary foods.
  - Practitioners working with individuals with diabetes or other medical conditions should consider diet throughout evaluation and intervention process as processed foods may contribute to heart disease or other unhealthy eating conditions.

https://www.maxpixel.net/Apples-Diabetes-Elta-The-Meter-Satellite-Express-3612851

Palacios et al. (2005)

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Individual Aspects:

- **Sacred Objects**
  - Medicine bags or items such as feathers or herb bundles may be worn, and practitioners should take every effort to not remove them.
  - Allow patient or family members to remove to a location within the patient's visibility.
- **Self-care**
  - Individually expected without need for assistance. Help that is offered to elders and disabled persons' may likely not be accepted.

Palacios et al. (2005)

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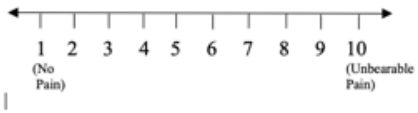
Individual Aspects:

- **Pain**
  - Undertreated due to stereotypes associated with substance abuse.
  - Unwilling to express or under express pain, so the practitioner **must** frequently ask about pain.
  - Individuals may be be willing to express pain to family or friends to relay the message, thus, collaboration with the family is important.
  - Story-telling may be reflective of a patient's current pain.
  - Use a number scale understood by the patient.



Palacios et al. (2005)

Cultural Competency – American Indians/Alaskan Natives

Family Aspects:

- AI/AN families are viewed as "close knit"

Strong social ties, highly connected
Stable and committed familial relations
Able to adjust to imbalances amongst other family members
Resourceful adult members

- Respect for elders has historically been of high importance.

Chiang (1993); Martin & Yurkovich (2014)

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Family Aspects:

- Any illness and related health decisions may involve members of the entire family.
- Extended family is highly valued.
- Hospitality
  - Food and gift giving is common among AI/AN populations.
  - Family members may express the preference to stay overnight or, for extended periods of time with the admitted client.
  - Hospitality boundaries are often extended in AI/AN culture so it is important to recognize that visitors who are not blood related may feel entitled to food, parking rights, etc.

Palacios et al. (2005)

Continue to Communication Aspects...

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Cultural Competency – American Indians/Alaskan Natives

Communication (Verbal):

- The designation for all tribes as "American Indians" or "Alaska Natives" are preferred.
  - Practitioners should always ask clients what they prefer to be called.
  - Asking about tribal heritage is valued.
- Long pauses and slow speaking between verbal responses are common, as time is often taken to listen and think about the question. Thus, give ample time during conversations.
- Talking while others are speaking is viewed as disrespectful.
- Story-telling as a method of self-expression or learning is highly valued and commonly used.

Heaton et al., (2018); Palacios et al. (2005); Satter, Veiga-Ermert, Burhansstipanov, Luis Pena, & Restivo (2018)

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Communication (Verbal):

- **Story-telling:**
  - A method of communicating and sharing information.
  - Anecdotes and/or metaphors may be used.
  - Story-telling about other individuals may be reflective of one's own experiences.
  - Potential mechanism to communicate health messages.
  - Practitioners must engage in active listening to intuitively interview the client.

Galanti (2004); Heaton et al. (2018)

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Cultural Competency – American Indians/Alaskan Natives

Communication (Non-verbal):

- **Eye Contact:** Looking directly into people's eyes is considered not appropriate, especially to AI/AN elders.
  - Avoidant eye contact may be a sign of respect for the practitioner.
  - Clients are not being inattentive or evasive if avoiding direct eye contact.
- **Facial Expression:** Extreme expressions are usually uncommon. Rather, eye movement is common.
  - Disapproval may include: pursed lips
  - Approval may include: smiling and/or head nodding

Chiang (1993); Palacios et al. (2005)

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Communication (Non-verbal):

- **Physical Proximity:** adequate personal space is recommended.
  - Clients may express no touching or close proximities
- **Touch:** Explain why touching may be necessary for certain therapeutic activities.
  - Strong handshakes are **NOT** recommended.

https://www.needpix.com/photo/download/1652886/handshake-hand-icon-symbol-sign-like-flat-icon-flat-design-finger

Chiang (1993)

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Reflection:

At this point during the e-learning module, the learner would pause and interact through reflection.

- As an OT practitioner at a mental health facility, you are conducting a group session with 8 adults with mild-severe mental disorders. During the session, you notice an AI/AN group member who is not highly involved in the discussion, speaks slowly and is not making eye-contact with other group members. Based on your knowledge, should this behavior concern you? What AI/AN communication factors are presented in this scenario?

Comment:

Continue to Spiritual and Healing Practices...

Cultural Competency – American Indians/Alaskan Natives

Spirituality and Healing Practices:

- Health and healing are a balance of spiritual, mental, and physical components that encompass connections between people, animals, plants, water, land, and the cosmos. 
- AI/AN individuals use Traditional Medicine (TM) that includes diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines, spiritual therapies, and manual techniques
- 90% rely on TM for healthcare needs and are more likely to seek help from tribal healers and spiritual leaders.
- Some patients may not choose to disclose traditional practices.

Bassett et al. (2012); Payne et al. (2018); Rybak & Decker-Fitts (2009)

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Spirituality and Healing Practices:

- The Medicine Wheel is a commonly used healing and medicine tool that varies greatly from tribe to tribe but incorporate similar values and beliefs.
- Comprised of 4 Spokes:
  - North: White – "Cognitive Aspects of Life"
  - South: Yellow – "Nature"
  - East: Red – "Spirituality"
  - West: Black – "Physical Aspects"

- It is believed that if any of the spokes of the wheel are compromised or ignored, an unhealthy balance will result.

(Rybak & Decker-Fitts, 2009, p. 335)

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Spirituality and Healing Practices:

- **Smudging:**
  - Is a common traditional healing practice used to cleanse, rid of evil spirits and energies by burning sage, sweetgrass and cedar.
  - Practitioners should be aware of smudging practices as scents may facilitate the healing process.

https://www.flickr.com/photos/dodnewsfeatures/15877977305

- **Sweat Lodges:**
  - Used as a purification technique and often associated with wedding ceremonies, sun dances, or vision quests and said to increase emotional and spiritual well-being
  - If dehydration or medical issues are present that conflict with sweating, negotiate appropriate sweat time with the patient.

Palacios et al. (2005); Rybak & Decker-Fitts (2009)

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Cultural Competency – American Indians/Alaskan Natives

Spirituality and Healing Practices:

- **Powwows:** ceremonies that include dancing, singing, drumming and wearing of traditional headdresses
  - Drumming or the "heartbeat of the world" and singing hold a spiritual and symbolic experience and make the connection of past, present, and future.

https://www.flickr.com/photos/smithsonian/2549228224

- **Pipe ceremonies:** consisting of red willow and sage. The passing of the pipe used for making important decisions and/or grieving.

Rybak & Decker-Fitts (2009)

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Cultural Competency – American Indians/Alaskan Natives

Reflection:

At this point during the e-learning module, the learner would pause and interact through reflection.

- You, an OT practitioner, walk into client's room within an acute care setting on a hospital medical pod. The client has requested to you that he would like to conduct a pipe ceremony. The facility does not allow indoor smoking and his request has been denied. The client then informs you he plans to conduct the ceremony in his vehicle in an adjacent parking lot with his spiritual healer. What are your feelings on this and how you would you respond?

Comment:

Continue to Barriers to Care...

Cultural Competency – American Indians/Alaskan Natives

Barriers to Healthcare:

- **Historical Trauma:**

Historical Event	Consequences
European settlement in America: • Broken treaties • Flawed government policy • Genocide • Subject to disease	Oppression of cultural identity
Loss of land	Denial of equal rights and opportunities
Forced relocation to smaller, less resourceful land ("reservations") through broken treaties	

- The effects of this trauma are still prevalent today through succeeding generations.

Martinez (2014); Palacios et al. (2005); Rybak & Decker-Fitts (2009)

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Barriers to Healthcare:

- **Intergenerational Trauma:** "Risk Considerations" according to Martinez (2014):
  - Familial historical trauma experiences
  - Recalled history of boarding school abuse and/or experiences
  - Lifelong experiences of marginalization and racism
  - Poor or misguided interpretation of cultural identity or definition of self
  - Sense of disconnectedness from healthy family and community
  - Reference to or reports of adverse childhood experiences
  - Childhood experiences and perceptions of an unhealthy family experience

Martinez (2014)

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Health Consequences:

- Practitioners should be aware of and consider intergenerational trauma and response to trauma associated with AI/AN populations.
  - In Martinez (2014) "Symptoms and Indicators" are as follows:
    - Drug and/or alcohol abuse
    - Obsessive thinking or thoughts
    - Compulsive behavior
    - Hyper-vigilance or threat response
    - Rigid negativity or loss of hope that positive change can be affected
    - Generalized anger and anxiety
    - Chronic depression
    - Diminished self-efficacy

Martinez (2014)

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Cultural Competency – American Indians/Alaskan Natives

Barriers to Healthcare:

- **Trust vs Mistrust of the Medical System:**
  - Due to intergenerational trauma, previous experience and stereotypes among AI/AN populations, mistrust of the western medical system has been expressed.
  - It is important to be empathetic and understanding of your client's views and beliefs, as well as potential impacts of trauma. Education regarding the western medical system and the care you will be providing is **crucial** for client buy-in and participation.

Nesoff et al. (2017)

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Barriers to Healthcare:

- **Cost** 
  - AI/AN populations experience the highest rates of poverty compared to other major racial groups.
  - Expenses of primary and specialty medical care may limit one's access to healthcare.
- **Access to care** 
  - Rural living and lack of transportation to healthcare clinics may be difficult.
  - Certain IHS facilities may not offer all services to fit the client's needs.

Rogers & Petereit (2005); United States Census Bureau (2018)

Continue to Application...

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Cultural Competency – American Indians/Alaskan Natives

Barriers to Healthcare:

- **Lack of Culturally-Competent Care:**
  - Evidence supporting efficient AI/AN cultural awareness among healthcare providers is **insufficient**.
    - Impacts individual trust and willingness to seek out care or adhere to therapist's advice
    - Impacts patient satisfaction
    - Impacts quality of care being delivered to clients
    - Disregards client's cultural identity and healthcare preferences

Govere & Govere (2016); Simonds, Goins, Krantz, & Garroutte (2014)

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Cultural Competency – American Indians/Alaskan Natives

Case Study:

Ralph, a 62-year-old American Indian male, was recently admitted to the acute inpatient unit in your hospital. He is obese and underwent a left partial-foot amputation procedure 1-day ago due to complications with uncontrolled Type II Diabetes. You have received physician's orders to evaluate Ralph's ADL's and treat while adhering to a left non-weight bearing restriction. Upon your arrival for the OT evaluation session, several family members are present in Ralph's room. You immediately notice that Ralph is not making direct eye contact with you and appears slightly withdrawn. One of his family members mentions to you that he does not trust the modern medical system but wants to "get better" in order to attend a tribal powwow in his hometown, approximately 100 miles away, in 3 weeks. He plans to discharge home as soon as possible with family. Considering the information provided, please apply the knowledge you have acquired in the following discussion questions.

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Cultural Competency – American Indians/Alaskan Natives

- **What course of action would you take to address the presented barriers?**

Discuss:

- **What potential biases could exist during interactions with the client?**

Discuss:

- **How could the biases and the prejudices of the OT influence the interaction with the patient?**

Discuss:

Continue to Quiz...

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Quiz:

1. Cultural competence among occupational therapy practitioners is crucial for working with AI/AN populations to:
   a) Prevent legal action against you or your organization
   b) Increases patient satisfaction
   c) Address and reduce personal biases and stigmas related to AI/AN individuals/populations
   d) All of the above

2. Indian Health Services (IHS) is a health insurance agency for ALL AI/AN individuals.
   - True or **False**

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Quiz:

3. Barriers to healthcare amongst AI/AN populations may include which of the following?

a) Mistrust in the healthcare system
b) Lack of cultural competence amongst healthcare providers
c) Cost factors
d) Intergenerational trauma
e) Access to care
f) All of the above

4. It is acceptable to remove medicine bags/feathers if needed during therapy sessions without consent.

- True or **False**

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Quiz:

5. Throughout the OT process, a therapist should actively involve a client's family when working with an AI/AN individual.
   - **True** or False

6. Shaking a client/family member's hand strongly is highly-valued amongst AI/AN peoples.
   - True or **False**

7. _____ is a common traditional healing practice used to cleanse, rid of evil spirits, and energies by burning sage, sweetgrass, and cedar.
   a) Pipe ceremonies
   b) Smudging
   c) Sweating
   d) Powwow

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Quiz:

8. Use of client storytelling during therapy may be beneficial to: ****
   a) Storytelling is not effective and should not be used
   b) Increase patient participation
   c) Improve therapeutic relationship
   d) B and C

9. While assessing pain with AI/AN individuals, the use of a number scale may be beneficial.
   - **True** or False

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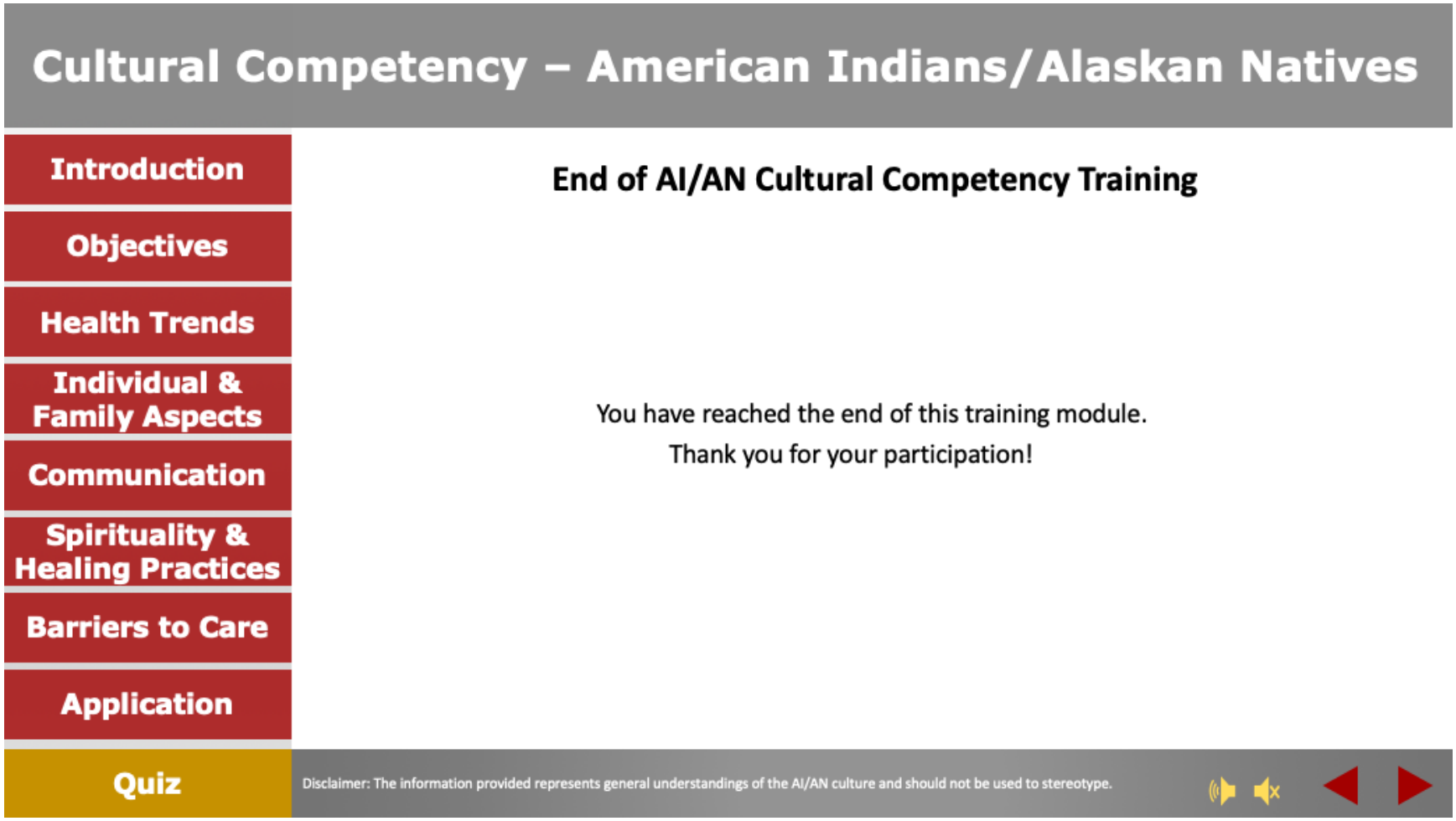
Quiz:

10. According to the Centers for Disease Control and Prevention (2017), what is the most common cause of death amongst AI/AN populations?

a) Unintentional injuries
b) Cancer
c) Cardiovascular Diseases
d) Suicide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End of AI/AN Cultural Competency Training
You have reached the end of this training module.
Thank you for your participation!
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Chapter V: Summary

The developed scholarly project was created with the intent to provide an effective means of continuing education for occupational therapy practitioners to increase their own cultural awareness regarding AI/AN populations to provide overall culturally sensitive and responsive care. The module includes information that may be applicable to occupational therapy practice, including AI/AN health trends, individual and familial cultural considerations, communication, spirituality and healing practices, and barriers to care. The module also includes areas for self-reflection for the practitioner through the demonstration of culturally sensitive case scenarios and various discussion questions. Additionally, a quiz is provided at the end of the module to assess the practitioner's learning regarding the content provided throughout the module.

The scholarly project was created with the intent that it would be directly applicable to occupational therapy clinical practice. Specifically, access for the practitioner was strongly considered throughout the development of the e-learning competency module. In particular, the module was developed with a reasonable time limit for completion. In addition, the intention is for the practitioner to complete the module in a manner that is most applicable and desired by the user. Similarly, depending on the practitioner's needs, the module has audio recording potential to enhance user accessibility.

While the scholarly project was carefully and purposefully created, some limitations exist within the product itself. In particular, the internal content provided within the module approaches the AI/AN population from a generalized viewpoint. Depending on the geographical location of the practitioner, a higher prevalence of individuals who identify with a specific AI/AN tribe may be apparent. Thus, the information presented in the developed module may not be applicable to a particular tribe, as each tribe may have differing cultural beliefs and practices.

Similarly, due to the vast amount of information regarding AI/AN cultures, the information provided in the module consists of primarily broader concepts, thus excluding fine details or other related information. Another limitation includes the lack of advanced visuals to further increase interactivity and engagement from the user. While some visuals including PowerPoint icons and labeled for reuse Google Images were included in the module. The developers only used a small assortment of visuals due to copyright barriers.

The proposed module may be implemented into practice in two ways. The first includes the completion of the module during the on-boarding orientation process of occupational therapy practitioners, working in settings where AI/AN populations are commonly served. It is a possibility that the successful completion of the module is required prior to a practitioner beginning practice. Thus, making the module a requirement of the orientation process would be beneficial. The second method of implementation includes providing the module as a continuing education tool for practicing occupational therapists. If the module became eligible in the provision of continuing education, therapists may be more inclined to complete the module.

While the quiz is the final portion of the developed module to assess the user's knowledge, a participant survey following the completion of the online module would be an effective method to measure the user's perceptions of the product itself. As the module is provided via an online platform, an online survey link either provided at the end of the module or through an email, would be beneficial.

Due to the amount of information regarding AI/AN cultures in current literature, there is room for several future improvements related to the developed scholarly project. One primary improvement includes the creation of modules that encompass specific tribal affiliations as primary foci. This would be beneficial for practitioners working with specific AI/AN tribes,

since the developed product primarily includes generalized information to AI/AN populations as a whole. Another improvement would be to install and use interactive software to add visuals, animations, and other interactive components to further increase participation and attention among users. Finally, the integration and use of an e-simulation within the module would be highly beneficial. Specifically, if a simulated case study was presented to the learner, this could not only increase interactivity, but may emphasize applicability to occupational therapy practice through real life scenarios.

As a suggestion for future implementation, the developed module has been presented to a local healthcare facility where positive feedback was provided regarding the module content. These communications resulted in the expression of potential interest in the implementation of the developed module to the facility's healthcare employees, with the desire to target a variety of healthcare professionals, rather than solely occupational therapy practitioners. Such an opportunity could not only help integrate cultural competency among occupational therapy practitioners but could aid also in the advancement of healthcare practice as a whole.

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