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Access to Care Barriers for Native American Veterans

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Access to Care Barriers for Native American Veterans

by

Joanne Kristen. Rhoads

A DNP Project

California State University Northern Consortium

Doctor of Nursing Practice

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Abstract

There are very few studies that examine Native American Veterans and access to care issues. Therefore, the researchers implemented an exploratory, descriptive, qualitative project to explore and identify the potential barriers that Native American Veterans have experienced with access to healthcare and participation in veteran benefit programs. A purposeful sample consisted of 14 Native veterans from the American Indian Veteran Association who were eligible for veteran services, and were willing to participate in the project. Fieldwork was performed in the natural environment of the Sierra Nevada foothills on the ancestral homeland of a California Tribe. The facilitator utilized a demographic survey and observation to assess the dynamics of the group, to view the interactions between the participants and the environment, and to recognize nonverbal clues through body language and behavior. Through semi-structured focus group sessions or “talking circles”, the American Indian Veteran participants provided data that produced 14 themes of rich and meaningful descriptions, and identified 28 access to care barriers. The participants offered up creative and viable solutions to reduce these barriers that may be of significant value to the Native American communities across the United States by satisfying a crucial need in bridging the access to care gap.

Keywords: Access barriers, Native American veterans, culture congruent care, health disparities

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Table of Contents

Abstract.....	2
Acknowledgments.....	3
Chapter 1: Introduction.....	5
Statement of the Problem ...	5
The Research Question.....	8
Significance for DNP Practitioner and Profession of Nursing.....	9
Theoretical Framework.....	10
Chapter 2: Literature Review.....	13
Chapter 3: Methodology.....	16
Sample and Subjects	16
Setting	16
Project Implementation.....	17
Potential Risks and Benefits.....	17
Data Collection.....	19
Data Analysis Plan.....	22
Chapter 4: Reporting the Results.....	23
Demographic Survey Data.....	23
Observational Findings	24
Focus Group Findings.	26
Chapter 5: Discussion.....	46
Significance to the Nursing Profession.....	47
Limitations.....	47
Recommendations for Future Research.....	48
Conclusions	48
References.....	49
Appendices	52

Chapter 1

Introduction

As designated in Healthy People 2020 (2010), one of the 10 Leading Health Indicators for improving the health care in the United States., is the priority to promote access to quality health care. However, among Native American Indians and Alaskan Natives a significant disparity remains in the area of access to health care when compared to other groups (Steele, Cardinez, Richardson, Tom-Orme, & Shaw, 2008). Despite the above mentioned facts, there are relatively few studies focusing on Native American Indians and their access to health care. When reviewing the literature, there were even fewer studies examining Native American veterans and access issues. Therefore, this author proposed an exploratory, descriptive, qualitative project that explored the cultural beliefs and the potential barriers that Native American Indians face that effect participation in veteran benefit programs and access to healthcare. This project also identified leadership challenges and a need for change in the delivery of culturally congruent healthcare.

Statement of the Problem

During the last several decades, the art of nursing has developed into a discipline and a profession that has continued to evolve at a rapid pace in order to effectively respond to the diverse needs of society. A viable expanse of nursing knowledge and technology now exists with a major emphasis based on evidence based practice (Melnik & Fineout-Overholt, 2011). However, as discovered during the literature review for this study, there are relatively few studies focusing on Native American Indians and their access to care, and even fewer studies that examine Native American veterans and access issues.

There are three organizational structures that are relevant to this DNP project. The Indian Health Service (IHS), an agency of the U.S. Department of Health and Human Services, provides health care services to Native Americans associated with Federally Recognized Tribes. The Indian Health Service has a fiduciary responsibility to provide healthcare services due to historical treaties and trust obligations. But not all healthcare services are covered by IHS, because when compared to other federally funded healthcare programs, the funding per capita for this agency falls drastically short, well below Medicaid, the Federal Prison System, and the Veterans Administration (Kehle, Greer, Rutks, & Wilt (2011).

According to the Office of Minority Health (2012), there are an estimated 6.2 million American Indian and Alaskan Natives that represent about 2% of the population in the United States. Approximately 2.1 million Native patients receive healthcare from the IHS. Using these statistics, 28% live at the poverty level. In addition, educational attainment falls well below that of the non-Hispanic whites, with only 4.5% of American Indians and Alaskan Natives attaining advance graduate degrees. As of 2011, there are 566 federally recognized tribes in the United States.

The United States Department of Veterans Affairs provides healthcare services to eligible veterans through Medical Centers, Community Based Outpatient Clinics, and long-term health care facilities across the U.S. A study by Kramer, et al (2009), examined healthcare utilization of Native American Veterans to determine patterns and preferences of healthcare delivery systems (see figure 1 following on next page).

Figure 1. Veterans Health Administration and Indian Health Service: healthcare utilization by Indian Health Service enrollees, by Kramer BJ, Wang M,

Jouldjian S, Lee MI, Finke B, & Saliba D, 2009. Photo by Vincent Schilling.

Additional statistical analysis performed by the US Department of Veterans Affairs (2010), examined the number of Native American Veteran patients living in highly rural, rural, or urban locations when compared to non-Native Veterans. The differences were statistically significant ($p < .001$) and revealed that higher numbers of Native veterans lived in rural and highly rural areas. This data was analyzed utilizing statistical computer programs such as SASTM and SPSSTM. These statistics were useful in planning strategies for gathering the data for my DNP project. However, according to Kaufman, et al (2013), the Veteran Health Administration data do not include information in regards to distance to health, tribal affiliation, cultural practices, or barriers to care.

The third organizational structure consists of individual Native American Tribes that are federally recognized and function with established governments as sovereign nations. The Indian Self-Determination Act (Public Law 93-638) gives the authority to Tribal governments to contract programs and services that are carried out by the Federal government provided by the BIA or IHS. Each Tribe has their own constitution and ordinances in which to guide governance and Tribal programs.

Therefore, a major component of this author's DNP project was to interact with Native American Indian Veterans in order to develop and initiate a qualitative project with focus groups and a demographic survey that resonated the true voice of the Native American Veterans' story. One that exemplified the cultural dynamics, barriers to care, preference of health care delivery systems, and overall quality of life as told by Native American Veterans.

The Research Question

The research question was formulated by utilizing the PICOT format as discussed by Melnyk and Fineout-Overholt (2002a). The population was Native American Veterans and the intervention was to identify potential access to care barriers. The comparison was studied to determine if differences existed between various groups. The desired outcome is to improve access to care and to promote cultural awareness, sensitivity, and culturally congruent care in order to ultimately improve health outcomes. The question studied in this DNP project was as follows: Among Native American Veterans what are the barriers that effect their access to healthcare and veteran benefit programs?

Significance for DNP Practitioners and the Profession of Nursing

The relevance of diversity to the DNP practice is very significant and helps to promote a more contemporary approach in order to provide culturally competent care, and for formulating transcultural research with the inclusion of technology to improve access and outcomes to underserved patient populations. According to the American Association of Colleges of Nursing (2006), as stated in *The Essentials of Doctoral Education for Advanced Nursing Practice* (Essential VII), the DNP graduate must be prepared to utilize concepts focusing on cultural diversity and psychosocial issues.

In order to achieve optimal outcomes for our patients, the practitioner's assessment must be accurate, and the interventions appropriate to the individual, family, or community of patients. The recognition and understanding of Native American beliefs, values, customs and social structures are essential in gaining a knowledge of cultural practices in this population. Nursing professionals who value insight into the traditional lifestyles and culture of diverse patient populations are better able to develop the trust and acceptance of those they serve.

Creative strategies and innovative technologies open up new areas of interest for nurse practitioners in both primary care and a variety of specialty services. New opportunities abound in the rural and urban areas to improve access to care, and to promote quality of care in reducing the disparity in health care delivery to the Native American veteran population as well.

A foundation of wisdom that is gained from observation is the ability to see the big picture, according to Porter-O'Grady and Malloch (2011). As leaders, we look to the future with a unique vision to identify unmet needs, we are the mavericks of creative ideas of innovation.

Theoretical Framework

The Native American Indian view of health is quite similar in philosophy to that of holistic health, and is widely known in society today. The shared belief is that health and illness are functions of the entire person, and that health is a person's state of wellbeing, harmony, or balance with nature. For that reason, a theoretical framework chosen for this project is based on Madeleine Leininger's (1988) Cultural Care: Diversity and Universality Theory. This transcultural care theory is grounded on concepts researched in philosophy, ethnography, and anthropology, with a strong emphasis on holistic health and culturally congruent care. Leininger (1988) utilized the Sunrise Model to depict the theory's interrelated components as they influence care and health patterns of individuals, families, and cultural groups (see figure 2).

Figure 2. Source: Leininger, M (1988). Leininger's theory of nursing: Cultural care diversity and universality. *Nursing Science Quarterly*, (1), 157.

To complement Leininger's transcultural care theory, I incorporated Giger and Davidhizar's (2002) transcultural model of cultural competence with a focus on listening and learning strategies when developing the survey and facilitating focus groups with the Native American veterans participating in the project. The blend of the transcultural care theories fit well into the foundation of this project to promote cultural congruent care and effective communication, and were compatible and applicable in the outreach setting of the Native American Veteran Community. The major concepts of Leininger's theory are care, caring, and cultural competency as viewed on the following graphic (see figure 3).

Figure 3. Source: Leininger (2002). Culture care theory: A major contribution to advance transcultural nursing knowledge and practices. *Journal of Transcultural Nursing* 13 (3), 189-192. Graphic created by Joanne Rhoads.

In today's challenging healthcare environment, it is important for every person to be able to gain access into a health care system, to be treated in a timely manner, to receive care from a health care provider with open communication and respect, and to foster a meaningful and trusting relationship that may lead to an improved quality of care and overall healthy life in accordance with Healthy People 2020 (2010). However, the Indigenous People of this country face many barriers in accessing healthcare. These problems result in severe disparities when compared to any other population nationally. The emphasis of this DNP project was to identify the barriers and gaps in regards to healthcare access through the concerns, life experiences, symptoms, and self-perceptions of health and quality of life as reflected by this diverse and vulnerable population.

Chapter 2

Literature Review

The conversion of research evidence into action requires careful consideration of the identified problem, the patients' needs and preferences, the demographics of the patient population, the context and setting environment, the desired outcomes, the effect size, and the cost of producing and implementing the practice action. Literature reviews are essential in determining the need for further research, new tools, progressive intervention strategies, improved treatment protocols and the formulation of best practices guidelines.

As previously mentioned, there is a very small number of studies that examine Native American Veterans and access to care or participation in veteran benefit programs. The initial search through CINAHL produced 39 articles, but only 2 of those produced some useable information. An additional search through PubMed produced 125 articles initially, but only 6 of those met the inclusion criteria.

The review of these 8 studies provided some useful information regarding Native American Veterans and disparities in healthcare access. Kaufman, et al (2013), and Kramer, et al (2009), both qualitative studies, also utilized data abstraction from VA and IHS data sources to evaluate service utilization and preferences for care. In a previous study, Kramer, et al (2006), performed a bi-variate analysis of Native American Veterans and their identification in administrative data of the VA and IHS. The authors recognized that the Native American Veterans were significantly underrepresented in the IHS data. In this study, the implications for practice included the need for accurate identification of veterans among IHS users, the development of a data variable to identify dual eligible IHS and VA users, and

the improvement of coordination between IHS and VA for increased resources and information sharing.

Johnson, et al (2010), Fortney, et al (2012), and Brooks, et al (2013), were 2 descriptive correlational studies and one qualitative study that revealed significant findings which substantiate the premise that geographical barriers produce access disparities for Native American veterans living in remote areas. Implications for practice included the need for remote monitoring, utilization of telemedicine, and the improvement in the quality of biomedical services.

Authors, Johnson, Blewell, Call, and Davern (2012), performed 3 surveys in order to determine how the choice of a data source impacts study conclusions. The study revealed that different data sources produced substantially different results in regards to disparity, even when utilizing the same population. The authors assert that the data source may influence conclusions regarding health care disparity among Native American veterans.

Kehle, Greer, Rutks, & Wilt (2011), conducted a systematic review to determine what interventions have enhanced access to healthcare for Veterans in general, and if processes and clinical outcomes have improved as a result. The authors' literature review initially produced 673 articles, with only 16 of these that met the inclusion criteria. However, these studies were largely of poor to fair methodological quality, and yielded a limited amount of data. The conclusions formulated were that interventions can improve access to healthcare for veterans, that improved access was linked to increased primary care utilization, and that there was decreased data in relation to a link between access to care and clinical outcomes. Once again, this systematic review was not specific to Native American Veterans. However, the findings were relevant to health policy and clinical practice, and exhibit generalizability to Native American Veterans and their access to care issues.

Because of the very limited number of studies relating to Native American Veterans and access to care barriers, this author believes that new evidence is necessary in order to break new ground that may improve access to care and ultimately improve the overall health status for many Native American Veterans.

Chapter 3

Methodology

The design was an exploratory, descriptive, qualitative project. The focus was to determine the potential barriers that Native American Indian Veterans experience with access to healthcare and participation in veteran benefit programs. A qualitative design was useful in the unfolding of meaningful information of depth and detail to gain an understanding of underlying reasons in the disparity of access to care in this population.

Sample

The first contact between the researcher and the participants was established face to face at a Native American social gathering prior to the project's data collection stage. The participants were made aware that the researcher was conducting this research as part of a DNP project exploring the access to care barriers that Native American Veterans face when seeking healthcare or veteran benefits.

A purposeful sample was used to select the informants. The sampling criteria consisted of Native American Veterans between the age of 21 to 95 years of age who are members of the American Indian Veterans Association, who are eligible for veteran services, and who were willing to participate in this project. Fourteen veterans volunteered to participate. Two non-randomized focus group discussions were conducted with seven participants in each group.

Setting

Fieldwork was performed within the local community environment of the Native American participants in October 2014. The setting was agreed upon by the American Indian

Veterans Association leader who has granted approval for the study to be conducted (see Appendix A). The location was this author's ranch located in the Sierra Nevada foothills on the ancestral homeland of a Native California Tribe. A healthy breakfast was served, and each group alternately had the opportunity to view the archaeological sites, and watch the hawks fly. The natural environment was safe, comfortable, private, and was conducive to participant engagement and transparency.

Project Implementation

The requirements of the IRB for California State University Fresno was strictly adhered to, and approval for this project was determined to meet the criteria for Minimal Risk IRB review by the California State University, Fresno School of Nursing IRB approval Committee. See (Appendix D) to view the IRB approval letter.

The informed consent for participation in research (see Appendix B) was provided both verbally and in written form during the introduction of each focus group session. The project introduction covered pertinent information, such as: a statement that participation was voluntary, the purpose, the potential risks and benefits of the project, what would be involved as a participant, how private information and confidentiality would be safeguarded, what information would be needed and how it would be collected, and notification that the focus group discussions (also known as "talking circles" in the Native American community) would be audio recorded. All written and verbal information was at an eighth grade level in order to be easily understood by all participants, and 10 minutes was allotted for questions.

According to Warne (2006), historically, trust has been a significant barrier when conducting research in Native American communities. Many Tribal People may refuse to sign

documents or consent forms due to negative experiences in the past. Therefore, in this project, implied consent was obtained through the following statement, "By the completion of this survey and participation in the talking circle, you will be implying your consent to participate in this project". This statement was prominently placed as the first line of the demographic survey and on the project information presented during the introduction as well.

The following potential risks of this DNP project were controlled for with the utmost consideration to protect confidentiality and privacy by stressing the ground rules of the importance of not discussing personal information or names of other participants outside of the focus group sessions, being respectful to each other, and with only one person speaking at a time. During the discussions we used a first name basis, but in the project reports, no names were disclosed. All of the project data remained unidentifiable (without names, dates of birth, etc.), and were securely stored in a locked cabinet and accessed only by the project team. Additional safeguards included the assignment of numbers to each participant to ensure accurate coding of their information. All audio recordings were destroyed once transcribed and accuracy confirmed. There were no psychological symptoms that presented during the project, however, a list of available mental health services (IHS, VA, and Vet Center) was available to the participants. No symptoms required urgent or emergent intervention, but a crisis management plan was in place to call 911 for immediate transport to the nearest medical or mental health facility for treatment if needed. The following possible risks and benefits of participation were disclosed as follows:

Potential Risks

- Psychological Harm: May result as an undesired changes in emotions and thoughts (but not greater than attending a regular meeting of the AIVA).

- **Privacy Risks:** May occur during the observation of participants' behaviors and reactions to questions during participation of "talking circle" interactions (but not greater than attending a regular meeting of the AIVA).
- **Breach of Confidentiality Risks:** May occur due to an information breach from one participant to another (but not greater than attending a regular meeting of the AIVA).

Potential Benefits

- Identification of access to care barriers.
- An opportunity for the Native American Veterans to voice their ideas and perspectives.
- To improve communication and collaboration between shareholders.
- To optimize cultural competency and quality of care by healthcare providers serving the Native American communities through a future educational video -not during this project.

Data Collection

Multiple data collection strategies were used in this project. First, a demographic survey (see Appendix C) was completed by the American Indian Veterans to provide a better picture of the sample population (age, gender, Tribal affiliation, military service information, IHS and VA eligibility status, and where they get their healthcare). Second, observations by the researcher was used to reveal the dynamics of the group, to provide insight into the bigger picture, demonstrate interactions between the participants and the environment, and provide nonverbal clues through body language and behavior. Third, focus group sessions or "talking circles" as previously mentioned were conducted as a gathering of seven veterans per group, and were facilitated by this DNP student investigator. The facilitator has previously worked on national

research teams studying cardiovascular disease in Native Americans, and she has conducted studies on acculturation and health status among Native American Tribes. The facilitator is skilled in semi-structured group discussions and has maintained consistency with the data gathering process. As a Native American, this Family Nurse Practitioner possesses an understanding and an appreciation of the cultural beliefs, historical perspectives, traditional care practices, and socioeconomic factors of the indigenous Native People.

Each focus group session lasted 1 ½ to 2 hours. Audio recording and field notations were used to maintain accurate documentation of the participants' conversations and of the researcher's observations. A modified Guide for Dialogue was developed with open-ended questions which allowed for expression and discovery of unknown topics for exploration as they produced deep, rich, and unexpected answers. The main questions asked during each of the focus groups, and the probing prompts when necessary were as follows:

1) Please describe your definition of health and quality of life.

*What is health?

*What is quality of life?

*How does your health and quality of life fit with your definition?

*How can you become healthier?

*Please tell me more.

2) What barriers or difficulties effect your access to VA healthcare or benefit programs?

*Does the VA need to be reformed?

*What do you believe caused the barrier?

*Can you give me more examples?

*Are your health care providers knowledgeable about Native American culture?

*If not, do your health care providers show an interest in learning?

*Can these barriers be overcome?

3) How has the lack of or delay in access to healthcare effected you personally?

*Think back to that experience and explain what happened.

*How did that make you feel?

*What did you do?

*Were you successful in relieving the problem?

*How could the delay in access to healthcare be prevented?

4) In your opinion, what can be done to improve your health and quality of life?

*Have you thought about what it would take to make a difference?

*Please help me understand.

*What are the biggest difficulties you face when trying to improve your health?

5) When considering all of the things discussed today, what is the most important to you?

*What is the first thing that comes to mind?

*You mentioned_____, what about_____?

The focus group facilitator began the discussion by asking a broad opening question that set the stage for open and thoughtful communication between the American Indian Veteran participants. The facilitator listened and observed the discussions with as little intervention as possible, allowing the veterans to verbalize their knowledge and express their opinions about the topic. Developing the focus group discussion in this fashion allowed the participants to become the leaders of the discussion with the production of large amounts of information in a short

while, and the researcher became the observer of the group interactions. By directly observing the interactions in a social context, this DNP student researcher was then able to develop a holistic and cultural congruent perspective with more in-depth detail in the descriptions of what was actually heard through the voice of the veterans, thereby providing protection from potential investigator bias. Data collection ended and saturation was achieved, when there were no further questions or comments from participants or researcher.

Data Analysis Plan

Clarity and consistency of field notes and transcriptions were essential for the information to be organized and easily identified, and included notable quotes, key points and themes, possible follow-up questions, big ideas, passionate comments, facial expressions, and changes in voice tones that indicated interest or excitement in a topic.

The discovery of emerging themes derived by the data, the identification of patterns and connections between and within categories, and similarities and differences between the groups were hand coded and continually refined until consensus was achieved. A matrix was used to visually display how the key themes were coded and the relationship between groups. NVivo™, a qualitative software package was utilized for data management

The specific concept of access to care barriers was explored and described by the Native American Indian Veterans based on their personal experiences and expressed in their own voices. The descriptive narrative as included in the next chapter of this DNP project report, and a copy of the study will be provided to the American Indian Veterans Association of Central California when completed.

Chapter 4

Reporting the Results

The findings and interpretations of this project have been provided during a face to face debriefing with the American Indian Veterans Association of Central California. By obtaining feedback from the participants, the descriptive understanding of the data will represent the accurate perspectives of the Native American Veterans who participated in the study. By including this step in the qualitative research process, investigator bias is reduced, and the validity of the researcher's interpretation is substantiated.

Demographic Survey Data

The 66 to 80 year age bracket held the largest number of participants totaling nine veterans (64%). While four veterans (29%) responded that they were between the ages of 51 and 65 years. One veteran was in the age bracket of 36 to 50 years of age. All seven participants in group 1 were between 66 to 80 years of age.

One female and thirteen male Native American Veterans participated in this project. Seven tribal affiliations were reported, representing regions from Alta California to the Eastern Coast.

The branches of the U.S. Armed Forces that were represented by the participants in this project included the Army, Marine Corp, Navy, and Air Force. The majority of the participants (79%) served during the Vietnam War. One participant served during the Korean War (7%), and two participants served during the Gulf War (14%).

All participants were eligible for veteran benefit programs. However, only four of the participants knew for sure that they were eligible to receive care at Indian Health Services (IHS). Five participants were not eligible for Indian Health Services due to tribal recognition issues, and five had never determined their eligibility status with Indian Health Services.

At the time of the survey, thirteen participants (93%) received healthcare from the Veterans Administration (VA). Four participants received healthcare services from private practice providers (three in conjunction with VA, and one exclusively with private providers). For those participants receiving care at more than one place, the response (100%) revealed a preference for the private practice providers.

Observational Findings

The Native American Veterans who graciously participated in this project were very willing to share their experiences, cultural values, beliefs, and ideas for improvement. During the time spent with the participants, many interactions and observations occurred that promoted an enlightened meaning to the project.

On the day of data gathering, as the veterans arrived to the ranch, they greeted each other and visited over coffee. The final breakfast preparations were completed, and we all gathered together as one of the veterans led us in a prayer of thanksgiving. As is our Native custom, the elders are always served first as a sign of respect. Plates were emptied and cups were filled as the aroma of coffee filled the air. Cheerful conversation and laughter joined one another together in unity. When the last bite was taken, several of the veterans helped clear the table and arrange the chairs in a circular pattern on the patio overlooking the oak filled horse pasture and beyond to

the High Sierra mountains. The sun was warm and the sky was blue as focus group 1 sat down to begin, and focus group 2 went to explore the archaeological sites on the ranch.

The participants in focus group 1 were attentive and vigilant at the beginning of the session, and exhibited intense and serious affects during the demographic survey completion segment. However, as the verbal discussion began, they became more relaxed, had improved eye contact, with all participants becoming actively engaged by nodding in agreement, showing concern and compassion for one another when regret or disappointment was obvious, and smiling or laughing in response to a humorous comment. The participants exuded passion and calmness as they exhibited transparency and honesty in their willingness to reflect back on their experiences. Satisfaction and contentment were observed as focus group 1 concluded.

The participants in focus group 2 were relaxed, but alert, as the session began. As a whole, they exhibited composure and confidence during the entire focus group interaction. Participants showed comradery through supportive concern and care when another's tone of voice exposed anger, sadness, or disappointment. Sometimes, the participants would sit quietly in consideration and meditate upon the question. At other times, the discussion became passionate and full of energy, and the ideas flowed like a rushing river, freely and rapidly. During these times, critical thinking was showcased as problem solving ideas provided responsive, valid, and logical solutions for the access to care barriers that were identified by this focus group.

As the day of data gathering closed, we exchanged beautiful gifts that expressed our appreciation for the day. As we said our good-byes, a magnificent red-tailed hawk soared across the sky.

Focus Group Findings

The focus group discussions as previously described, provided a significant amount of information, and generated very viable solutions to the access to care barriers that were identified during the course of this project. The focus group facilitator motivated the participants to discuss relevant topics, and listened and observed with as little intervention as possible. The goal was for the participants to interact with one another by using their own words and developing their own themes to blossom into full bloom, thereby producing rich data of depth and detail. The fourteen main themes that were mirrored between the two focus groups are shown in figure 4.

Figure 4. Access to Care Barriers for Native American Veterans Focus Group Themes

Health. Both focus groups had very similar definitions of what health meant to them. They described health as “a sense of well-being”, “not being in pain”, “being strong and feeling good”, and as “a mental, physical, spiritual, and emotional well-being”.

Quality of life. The discussion of this theme was also very similar between the two focus groups. Comments on quality of life included the “ability to function”, “having a job you like”, “being able to support the family”, “being able to help other veterans”, and “living a good healthy and normal life”. Also discussed was “the ability to enjoy hiking, bicycling, jogging, and yoga, and to be at a point when you are not suffering from the adverse effects of asthma, hypertension, diabetes, or other things that we, as Native Americans have more prevalence for.” Other responses were “Not having to deal with the pain all the time”, “How we spend our lives”, and the “Quality of life encompasses the physical, financial, and social wellbeing”.

Self-perception of health and quality of life. When the discussion arrived to the topic of how the participants viewed their own health and quality of life, the two focus groups had very different opinions.

Some comments from focus group 1 included:

“I don’t have a very good quality of life. I have increased stress and increased pain. I have a lot of problems being able to cope. I can’t do the things I would have normally done.”

“Not very well. I have chronic back pain, and have been given pain pills. It’s not only the physical pain, but it’s the mental and emotional pain that we suffer from as well.”

“I don’t believe at the VA that there is a whole lot that can be done to improve my quality of life and health.”

“Not so good. I just have to cope and struggle through.”

Whereas, focus group 2 commented as follows:

“Good. Yoga and meditation help with pain and improves my quality of life.”

“As individuals, we must know what is best for ourselves. We must care about ourselves. We must take the time to try and improve our own quality of life.”

“Sometimes you have to think outside the box and change certain things in our lives as we get older. When things start creaking and falling apart, we have to change our diet and learn how to deal with our pain.”

Health promotion. Meaningful comments from the focus groups summed up the discussion as to what they believed health promotion to be.

“By taking care of our physical, emotional, and spiritual needs. To be healthy, and to live well.”

“To become healthier we must maintain a healthy lifestyle through exercise, a good diet, and learning more through education. De-stress. Spend more time doing what you enjoy!”

Dissatisfaction with current system. As the focus of the discussion turned towards the difficulties or barriers that the participants have faced, the theme of dissatisfaction with the current system became a “hot topic”. All participants expressed a need for the reform of the system that provides healthcare services to our Nation’s veterans. The Native Veterans’ concerns with the current system and ideas for change are included in the next several pages under the theme most closely related to the discussion topic.

Access to care barriers. When asked to discuss the barriers that effect their access to healthcare and veteran benefits, the following data was formulated by focus group 1.

- “The VA does not provide options to include traditional Native American treatments.”
- “The VA does not readily accept Native healing practices as effective.”
- “There are long delays in getting an appointment date.”
- “Constant changes in doctors.”
- “Short on staff.”
- “No savvy about Native American culture.”
- “Lack of outreach in the Native communities.”
- “Poor communication.”
- “They hire doctors from countries that we fought against.”
- “Uncaring attitudes.”
- “Insensitivity is a big problem.”
- “Inexperienced and unqualified doctors.”
- “A lack of knowledge about the benefit programs.”
- “Lack of cultural awareness.”
- “No healthcare available when you need it.”
- “It’s a constant cycle of seeing different doctors and having medications changed.”
- Denial. “There are very few veterans that go in for help in their 20’s and 30’s. They have the same mentality as I did, that nothing is wrong with me, it’s the world that’s messed up.”
- Risk of stigmatization. “I didn’t want to be labeled as having PTSD, because I thought I would never get a job if people thought I was looney.”

Access to care barriers. Focus group 2 also provided new insight into the barriers that impede the ability of Native Veterans in accessing healthcare and acquiring veteran benefits.

- “Poor attitudes”
- “Apathy”
- “Stereotyping”
- “Prejudice”
- “Distrust”
- “Poor communication”
- “Sometimes, we have to go to the outside world, the private doctors to try to get something fixed, because the VA system that we have to deal with is so slow.”
- “It’s like they will see you two years from now, or a year from now, and they will see you if your injuries are actually related to your military service.”
- “The hoops they make you jump through makes us have to think outside the box, and find ways of taking care of ourselves, when they drop the ball.”
- “Sensitivity is a big barrier. Nurses and doctors should care about the patient and the care that they provide. If they have entered the healthcare profession, they should be aware of what is required of them.”

Cultural competency. All participants unanimously agreed that their healthcare providers were not knowledgeable about Native American culture, nor did they show a genuine interest in learning about Native culture. The following comments built the foundation of this theme.

- “The spirituality of Native American culture is not addressed.”
- “Currently, there are only two VA hospitals in the United States, San Diego and Los Angeles, which have sweat lodges for the Native American Veterans.”

- “How important it is to take care of our physical, emotional, and spiritual needs.”
- “Cultural competence is needed to have the doctors and nurses understand our cultural beliefs and practices, so that they can provide better care.”
- “The traditional healing practices of our people are useful, but not encouraged by the VA doctors.”
- “There is a lack of sensitivity and knowledge about the co-morbidities of disease among Native American People.”
- “They believe us to be homicidal and suicidal alcoholics, and that is the typical stereotype.....the most information they have about Native Americans.”
- “They aren’t taught a lot about what the culture is, and what medicinal practices are used. Unfortunately, a lot of doctors don’t really understand the value of them.”
- “Mental, physical, spiritual, and emotional parts work together as one. Because one without the other just doesn’t work. They just don’t get that.”
- “We need to take care of our health in the ways we were raised by our ancestors.”
- “We need to rely more on the natural aspect of things and use the medicine people.”

Reflection. Reflecting back on one’s past experiences is an important component for contemplating choices for present or ongoing dilemmas. The positive or negative outcomes of an experience can produce consequences or memories not easily forgotten. The focus group 1 participants were all Native Elders and provided a substantial number of reflective and heartfelt stories that made an obvious impact on all who shared in the experience of hearing them. One Army Veteran stated, “If I would have had help from the beginning when I got back from Vietnam, maybe I would have been a better person.....maybe I would have been able to

keep my family together.” Another Vietnam Marine Veteran concurred, “When I came back from Vietnam, NO help was available to us veterans.”

The lack of help was the major topic reflected upon by the participants in focus group 1. The quotes listed below will provide some insight to the causes that the project participants recognized as playing a major role in the lack of help they received upon returning home.

“Many of our Korean and Vietnam Combat Veterans were given a clean bill of health. There was not a thorough medical checkup that we went through. No one told us where we should go to get our ailments treated... physical, mental, or spiritual. They just would tell us, ‘There’s the door Jack, you’re out of here’. Of course we were all willing to sign the paper that said nothing was wrong with us, we just thought it was the world that was messed up. Many of us just self-medicated with alcohol, and didn’t realize until our 50’s or 60’s, that it was us, and the anger, PTSD, and TBI’s that were the problems.”

“When I was discharged, they basically said that you could sign the paper and say that you were OK and get discharged, or you would stay in until this, that, or whatever got done. Like a lot of veterans, I was ready to get out, so I said, yeah, let me sign the paper, even though I knew I had some

problems before being discharged.”

“I didn’t want to be labeled as having PTSD, because I thought I would never get a job if people thought I was looney. I never wanted to go to counseling, or be called crazy. Sometimes, veterans are scared of being labeled. It is really tough when we deny the real problem.”

“I was anxious to go home, so I just hid my problems so I could get released. I didn’t mention them, and they didn’t ask.”

A Native American Air Force Veteran reflected back on his experience.

“When you get out of the service, you have all of this baggage, and you think that you’re going back to your life before the military...but it doesn’t come out that way, you have all these issues and problems. It’s hard to keep a job. You have anger, you get depression, alcoholism, drugs, and you get into all of that stuff.”

Another Vietnam Army Veteran spoke of his return home.

“Back then it was hard for Vietnam Veterans to get any kind of help. I just let it go until it got way bad. I ignored the problem and it got worse. I wish I would have taken care of it when I was a younger man. Eventually, I got treatment.”

Reflections of more recent experiences revolving around access to care issues were shared by the Native American Veterans during focus group 1. The verbatim quotes are the true voices of the participants as they openly shared their firsthand encounters.

“I remember being told that my next appointment would be in one year. I could have been dead by then!”

“I was misdiagnosed. It was very traumatic. I was told that I had stage IV cancer. I went to a private doctor who ran tests and discovered that I didn’t have cancer.”

“At the VA I saw four different providers within two months for pain. None of them ever diagnosed what the problem was. I was finally diagnosed with an appendix ready to burst at an Emergency Room.”

A very honest and straightforward reflective answer was provided by one of the Native Veteran Elders of focus group 1 to explain the difficulties faced when trying to improve their health. The sense of adversity, hardship, and tribulation is easily extracted from the following:

“It’s like I waited too long, and I have lost everything. I spent all my life spinning my wheels. I lost my family. I lost my children. Now, I am an old man. What now? It’s hard to make it up now. I am ready to kick the bucket.”

The focus group 2 participants were less reflective than their elders in focus group 1 in the quantity of the data. However the depth and detail among both groups was valuable in discovering meaning in context of their experiences. Focus group 2 participants centered in on more recent events pertaining to healthcare experiences that were of major concern personally and in the veteran community as a whole. Their expressions are reflected in the following quotes:

“I had a delayed diagnosis of pancreatitis and degenerative disc disease of the cervical and lumbar spine. I was in a lot of pain, but it took several visits before any tests were done, or a diagnosis made.”

“I had a missed diagnosis of a blocked artery even after seven ER visits and being told that it was just reflux, given a white milky drink, and then sent home. I was finally diagnosed correctly and treated at Travis Air

Force Base months later.”

“I had a lot of headaches and ER visits with sinus x-rays for four years, but no one connected it to my service connection of spinal meningitis. Finally, an MRI was done that showed brain damage.”

The participants moved to a solemn subject and one heavy on their hearts. During the course of this project, a widespread scandal involving the Veteran’s Administration and delays in access to care and unsound scheduling practices led to intense investigation at the VA Healthcare System across the country. The concern of participants from focus group 2 is reflected through the following quotes:

“Remember when the 40 VA patients died in Phoenix? One of them was my nephew... How many more are going to die because the VA does not give a damn?!”

“Being able to treat the whole man, to treat the whole individual. It goes back to treating the physical, psychological, and spiritual parts. We are not as simple as we seem to be. There is a whole lot going on..... different aspects of each one of us. There can be a lot what ails us.

Why is it the way we feel? It's the PTSD. We need to be able to treat the whole individual, not just little pieces of us. Until that happens, I don't think we are going to get very far. You're still gonna have people committing suicide, you're still gonna have people hooked on drugs, and you're still gonna have people committing homicides because maybe the VA is not allowed to treat the whole man. But us Indian People, back in the day, we looked to heal the whole person. I'm not sure if that's even possible now."

It was at this time during the focus group that we paused for a moment...as a simple way of honoring those who had passed. The silence was a peaceful reminder of the purpose of this project, to identify access to care barriers that effect Native American Veterans, but may be of value to all veterans in one way or another.

Emotions. During the course of this project, a broad expanse of emotions emerged as would be expected from a project that encompasses human experiences. Both focus groups were willing to be transparent and allow their feelings to be outwardly evident through their facial features, tone of voice, and selection of words.

The facilitator asked about how a lack of or a delay in access to healthcare effected them personally, and how it made them feel? The theme of emotions were coded into three categories, focus group1, focus group 2, or shared in both groups, as shown in figure 5.

Figure 5. Emotions, an emerging theme. Graphic by Joanne K. Rhoads

Relationships. Both focus groups placed strong emphasis on relationships. Personal relationships included their family, their fellow veterans, and other Native People. Professional relationships included interactions with the healthcare professionals providing healthcare services. Both groups discussed concern for their families and for other veterans, and the difficulties that they faced when transitioning back to civilian life. The participants of both groups spoke of the loss of family relationships due to PTSD, ETOH, poor coping, pain, or inability to support their family. They also spoke of the strong bond between “brothers”, as one veteran, or a group of veterans step forward to provide the help that is needed. One Army veteran from group 1 shared their experience, “I thought I was the only one who suffered from

veteran from group 1 shared their experience, “I thought I was the only one who suffered from PTSD, until I met my brothers here. I saw that there are many others who suffer, too. Now, I go out and help other veterans to find the care that they need”. Another participant, a Native U.S. Marine Corp veteran in group 2 provides support to that statement with this quote, “Having a good support system really helps”. An Army veteran added, “We just kept muddling along until other veterans came along side of us to help”.

Both focus groups discussed unsatisfactory relationships with healthcare providers that pointed to lack of communication, insufficient time spent teaching during the patient visit, uncaring attitudes, lack of cultural knowledge, and poor trust, honesty, and openness between staff and patients. The following quotes reflect the major concerns of both groups:

“Poor Attitude is one of the biggest barriers we face. Most anywhere you go in the VA and within any department, it’s the same thing.”

“When I am treated by someone that I can’t understand, someone who can’t speak plain English, I’ve had to fire them and get another one. I just couldn’t understand, and the doctors didn’t really care to explain.”

Mistrust. Participants in group 1 commented more often in regards to mistrust. They didn’t “see anything down the road getting any better”, they expressed a “lack of confidence with the doctors’ abilities to diagnose correctly”, were “sure that there are a lot of guys misdiagnosed” and believe “that there is a big need for honesty and openness, and that doctors need to let us

know about our conditions". A participant in focus group1 stated, "It bothers me when they put that sign up, 'THE VA CARES', because they are saying one thing and doing another." A participant in focus group 2 also spoke openly about apathy and distrust with the following comment, "The apathy of it when they don't care to explain what they're doing, or what they're talking about. If they don't know, they should just say so. I can deal with that a lot better if they are just honest".

The chance for change. When asked if the current VA system should or could be changed, the focus groups responded definitely and unanimously that change should take place. But when it came down to whether the system could be changed the focus groups responded very differently. Group 1 participants were less optimistic about the chance for positive change or any improvement in care. The Elders comments are as follows:

"I would like to see change, but it will take a lot...it's been that way for a long time."

"I am doubtful."

"I wouldn't count on it."

*I don't believe so."

The group 2 participants revealed more forward-looking approaches in their responses for the possibility of positive change. Their responses are quoted as follows:

"I believe it can with education and more nurses."

"Change could happen through more respect for patients, and less apathy."

"More culturally knowledgeable workers are needed, but it's possible."

"A big change could be made with better attitudes and work ethics throughout the VA."

Pro-Active Behaviors. Both focus groups were genuinely engaged in formulating creative responses on how to improve their health and quality of life. A major theme, pro-active behavior, was produced by inductive coding after the data was collected, and was very evident in both focus groups. Focus group 1 responses reflecting the theme of pro-active behavior in a mentorship or advisor type mode are as follows:

“Now, I go out and help other veterans to find the care that they need.”

“I have come to the conclusion that I have to be the one to improve my own health and quality of life. I got onto the ‘Red Road’ years ago, and I found that way to help me improve way more than anything that I have gotten at the VA.”

“Know what services and benefits are available.”

“It’s up to all of us old guys who have suffered all these years, to tell the young veterans that there is help out there. Don’t wait for 50-60 years until you’re ready to die. That’s why it’s so important for veteran outreach.”

Focus group 2 participants responded in a take action mode as supported by the following quotes:

“Yoga and meditation help with pain and stress.”

“Changing our diet and learning how to deal with our own pain.”

“As individuals, we must know what is best for ourselves. We must care about ourselves. Take the time to try and improve our own quality of life. Be pro-active to promote wellness.”

“Improve your lifestyle. Change your life for the good. Laugh!”

“We must take the initiative to maintain a healthy life-style, and spend more time doing what you enjoy.”

“Care about your health. Care about your wellbeing. Grow in your spirituality, and be strong mentally and physically. Be thankful to be alive every day!”

“Learn to care about yourself...your mind, body, and spirit must come together.”

“Self- reflection is needed to improve your health and quality of life. You have to understand what is most important in life.”

“Improve your motivation.”

“Manage work, time, and responsibilities. Prioritize.”

“Stress is also a big difficulty in trying to improve health. We have to put it all In perspective. This little thing is just a little thing, when we see the big picture.”

“We have to understand our own bodies and adapt to be able to change the way we do things.”

“Don’t hold on to the past hurts, but be proactive. Live your life to the fullest in the present, in a good way.”

These Native American Veterans provided innovative ideas as a means of improving their own, as well as the health and quality of life of other veterans. These pro-active behaviors represent working solutions towards actively making a positive difference. Both focus groups provided additional solutions for reducing the access to care barriers in the final theme, bridging the gap, which are summarized and presented in Figure 6 and Figure 7.

FOCUS GROUP 2

Better triage and more staff

Incorporate Native healing practices

**In-services to teach the health care workers to be culturally sensitive and aware,
and to better understand our healing practices and cultural beliefs**

We need more advocates for Native People

**Seminars to educate the Native Veterans about the healthcare
issues and the programs available...who to see, what to do about
it, and how to take care of the problem**

More efficient scheduling procedures needed

**More disease prevention and wellness programs specific to
common co-morbidities in Native Americans**

More outreach is needed in Native communities

Better prevention services and illness education

Figure 7. Bridging the gap. Themes from Access to Care Barriers for Native American Veterans. DNP project. 2015

Bridging the gap.

FOCUS GROUP 1

Figure 6. Bridging the gap: Themes from *Access to Care Barriers for Native American Veterans*. DNP project. 2015.

Summary of the Results

The aim of this exploratory descriptive qualitative project was to explore and identify access to care barriers that effect Native American Veterans. All of the participants were actively engaged and provided valuable input into this project. The descriptive narratives were filled with vivid and illuminating responses that will most likely enhance understanding, raise awareness of existing disparities in care, and promote change in the delivery of culturally congruent healthcare. Additional discussion, limitations, implications for nursing practice, and conclusions will be presented in Chapter 5.

Chapter 5

Discussion

In the previous chapter, the results were reported through the use of multiple reporting styles. The narrative descriptions were from the participants' point of view, and written in their own words, thus establishing a foundation for descriptive and interpretive validity. The participants were very willing to provide responses. Therefore, the data sets were large and dense. In addition, the depth and the quality of the data illuminated sociocultural perspectives that have the potential to stimulate institutional change. As mentioned earlier in the problem statement, there are very few studies in the literature that examine Native American Veterans and access to care barriers. This project will produce new evidence that will reduce the gap in this literature. Through the voices of the Native Veterans who participated in this study, access to care barriers have been identified, and fourteen major themes were developed through inductive coding directly from the data.

The theoretical framework utilized in this DNP project was a combined use of Madeleine Leininger's (1988) transcultural care theory and Giger and Davidhizar's (1998) transcultural model of cultural competence. These theories were useful in setting up the focus groups and also in performing the analysis. The participants' responses revealed many emotions that were related to the stress and conflict of healthcare they were provided that was lacking in cultural competence. The assumptions about cultural competency in relation to care and caring are essential to understand when providing healthcare services to culturally diverse patient populations.

Significance to the Nursing Profession

The findings of this project may be helpful to illuminate the need for cultural awareness, sensitivity, and competence. Historically, in culturally diverse patient populations, there is evidence of significant disparities in the provision of healthcare. Therefore, the relevance of diversity in the healthcare environment is of great significance. Enhanced education and practice experiences are necessary to promote a more contemporary approach to effectively provide culturally congruent care that in turn may improve access and outcomes for under-served patients. This project may bring awareness and relevance to the practice setting as the practitioners examine their own beliefs, biases, stereotypes, and personal prejudices. It may also help them to understand that cultural congruent care is a dynamic process that develops with experiences, practice, and life in general.

Limitations

Potential limitations may occur when observation as a tool for data collection is conducted by a human who serves as the instrument. Bias may occur from factors such as, age, gender, ethnicity that might influence the observation, analysis, or description.

Another possible limitation may be the project sample size of 14 participants. However, qualitative studies have small sample sizes, and saturation was achieved, when there were no additional responses or questions from the focus group participants or the researcher. Some may consider 14 a small sample size even for a qualitative project.

Purposeful sampling from one centralized Veterans Group may be considered a limitation as far as transferability or generalizability. But, in retrospect, the participants currently lived in the Central Valley of California, but represented seven Tribes from across the country with

widespread environmental and socioeconomic diversity. They also represents four branches of the U.S. Armed Forces.

Recommendations for Future Research

By performing a duplication of this project on a much larger scale with Native American Veteran participants being drawn from American Indian Veterans Association Chapters from across the United States, the criteria of generalizability could be strengthened. By increasing the sample size, valuable data from a broader age and gender sample of veterans could be gathered.

Future research to evaluate the cultural competency of advanced practice nurses who have participated in a curriculum enhanced with cultural education and practice experiences as a core component of their nursing education, compared to advanced practice nurses who attended programs without the enhanced cultural curriculum may be helpful in initiating change to promote culture congruent care.

Conclusions

This project may be of significant value to the Native American Communities across the United States by satisfying a crucial need in bridging the gap between these Native Veterans and the many services that are needed. The Veterans' voices may be heard through this project, but this is just a beginning. The volume and depth of the data gathered goes far beyond the extent of this DNP project. Therefore, it is the hope of this Native American researcher to continue on with this endeavor with the blessing and help of the American Indian Veterans Association and other stakeholders willing to partner in the development of a documentary highlighting Native American Indian Veterans, access to care barriers, health disparities, cultural aspects of care, and their ideas on how to implement change to improve their overall quality of life.

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Appendix A

Permission Granted Letter

**American Indian Veterans
Association of Central California**

(559) 375-2300

Permission Granted

August 4, 2014

Re: Access to Care for Native American Veterans Research Project

To Whom it May Concern:

Permission has been granted to Joanne Rhoads to conduct a Doctor of Nursing Practice research project with individual participant consent, and to publish the research findings acquired from this study. It is also understood that a copy of this research will be provided to the American Indian Veterans Association of Central California when completed. We are hopeful that this initial project will be helpful in identifying the access to care barriers that Native American Veterans face, and that the research findings will be useful in future collaborative efforts between the American Indian Veterans Association and the Indian Health Service and the Department of Veterans Affairs.

Sincerely,

Moises Lozano

President, American Indian Veterans Association, Central CA

Appendix B
Informed Consent

CONSENT TO PARTICIPATE

You are invited to participate in this project for the purpose of helping to identify the barriers that Native American Veterans face when attempting to access healthcare or veteran benefit programs. Those that voluntarily choose to participate will be asked to complete a short survey, and to take part in a talking circle along with the other participants, to further discuss the barriers that you have faced with accessing appropriate care, why you do or do not use veteran benefit programs, and in your opinion what can be done to improve your health and overall quality of life. Your participation will take approximately two hours and will include a breakfast for the participants, as well as a signed and fully illustrated book by this author. You have the right to withdraw your consent or discontinue participation at any time.

The discussions will be tape recorded in order to maintain the accuracy of the conversations, and to include all comments into our analysis. During our discussions we will be on a first name basis, but in the study reports, no names will be disclosed. Your individual privacy and confidentiality of the information you provide will be protected and maintained in all published and written data resulting from the study. All of the study data will remain unidentifiable (without names, dates of birth, etc.) and will be stored in a locked file with access by the project team only. If you have any questions about this study you may contact the student investigator, Joanne Rhoads at (559) 304-5700, or the primary investigator, Sylvia Miller at (559) 278-2041.

Appendix C
Demographic Survey

***By the completion of this survey and participating in the
“talking circle”, you will be implying your consent to
participate in this project. Thank you!***

DEMOGRAPHIC DATA & ACCESS TO HEALTHCARE SURVEY

1) Age

1. 21 to 35 years
2. 36 to 50 years
3. 51 to 65 years
4. 66 to 80 years
5. 81 to 95 years

2) Gender

1. Female
2. Male

3) What Tribe are you affiliated with? _____

4) In which branch of the U.S. Armed Forces did you serve?

1. Army
2. Marine Corp
3. Navy
4. Air Force
5. Coast Guard

5) In what years did you serve in the military? _____

6) Are you eligible for veteran benefit programs?

1. Yes
2. No
3. Don't know

7) Are you eligible for Indian Health services?

1. Yes
2. No
3. Don't know

8) Where do you get your healthcare? _____

9) If you receive healthcare at more than one place, which one do you prefer?

***By the completion of this survey and participating in the
“talking circle”, you will be implying your consent to
participate in this project. Thank you!***

Appendix D

IRB Approval

California State University,
Fresno School of Nursing
IRB Approval

Date: September 8, 2014

RE: DNP-1413 Access to Care Barriers for Native American.

Dear Joanne Rhoads,

As the Chair of the Department of Nursing Research Committee, serving as the Institutional Review Board for the Department of Nursing, I have reviewed and approved your review request for the above-referenced project for a period of 12 months. I have determined your study to meet the criteria for Minimal Risk IRB review.

Under the Policy and Procedures for Research with Human Subjects at California State University, Fresno, your proposal meets minimal risk criteria according to section 3.3.7: Research in which the risks of harm anticipated are not greater, probability and magnitude, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

The Research Committee may periodically wish to assess the adequacy of research process.

If, in the course of the study, you consider making any changes in the protocol or consent form, you must forward this information to the Research Committee prior to implementation unless the change is necessary to eliminate an apparent immediate hazard to the research participant(s).

This study expires: September 8, 2015

The Research Committee is authorized to periodically assess the adequacy of the consent and research process. All problems having to do with subject safety must be reported to the Research Committee. Please maintain proper data control and confidentiality.

If you have any questions, please contact me through the CSU, Fresno School of Nursing Research Committee at tereag@csufresno.edu.

Sincerely,

Terea Giannetta, DNP

School of Nursing, Research Committee, Chair