Oklahoma City Area Inter-Tribal Health Board, Tribal Epidemiology Center Cultural Orientation Technical Assistance Manual:

How to Develop a Cultural Awareness Orientation for your Tribe/Health Care Program

Ver 01.2013

Preface

For the past decade, efforts have been made to address and eliminate health disparities in our nation. Research has shown that communication and cultural competency are important components of quality of care for underserved populations. As early as 1976, cultural orientation was recognized as a key component for doctor-patient relationship within the American Indian community (the Indian Health Care Improvement Act, IHCIA). Unfortunately, while the need was recognized, it remained unfunded, and thus, cultural awareness program implementation was few and far between.

In December 2000, the Office of Minority Health (OMH) at the U.S. Department of Health and Human Services (DHHS) released the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) to address inequities that existed in the provision of health services and to provide a framework for guidance about and a common understanding of cultural competence in healthcare. These standards were developed by professionals dedicated to cultural competency. Based on an analytical review of key laws, regulations, contracts, and standards in use by Federal and State agencies, as well as other national organizations, these standards were developed and refined with significant input from a nationwide public comment process, as constitutionally required, and the guidance of two national project advisory committees. These standards can be found on the Office of Minority Health website https://www.thinkculturalhealth.hhs.gov/.

By 2002-2003, cultural competency for health care workers received additional support as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) added adding cultural competency components to its accreditation standards. This inclusion increased the recognition of cultural competency's significance in quality health care. In fall of 2010, the OMH launched the CLAS Standards Enhancement Initiative to revise the Standards to reflect the past decade's advancements, expand their scope, and improve their clarity to ensure understanding and implementation.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

Principal Standard:
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Forward

*The **goal** of this manual is to provide tribal health care facilities with the materials to create successful cultural orientation trainings for health care professionals who are working cross-culturally.*

This Cultural Orientation Technical Assistance manual will provide strategies and a framework for a tribal entity to develop its own personalized cultural orientation for health care providers. It will also provide strategies to assist the tribe finding opportunities to assess how the long term employees can help shape the content of the cultural interactions and activities. This is an opportunity for the Tribal Advisory Board to have input and influence on the quality of care that is delivered. And finally, a cultural competency training program is an opportunity for the tribe to share its histories and explore its commonalities and differences with the health care employees.

Section IV of this manual provides a robust literature review that highlights why a health care provider working with American Indians should be oriented about the tribal history, cultural beliefs, mores, symbolism, and language. Funding for the creation of this technical assistance manual and the accompanying cultural orientation curriculum is provided by the Office of Minority Health. These materials were developed by the OCAITHB as a part of the AI/AN Health Disparities Program, grant number AIAMP070006.

Table of Contents

I. Introduction

The Oklahoma City Area Inter-Tribal Health Board (OCAITHB) Tribal Epidemiology Center (TEC) received a five-year grant to help identify and reduce American Indian/Alaska Native (AI/AN) Health Disparities. This grant receives funding from the Office on Minority Health, Department of Health and Human Services. Objective Three (3) of the grant was "***To provide training to leadership at all levels in the areas of cultural competency and issues specific to AI/AN health disparities.***"

The National Indian Women's Health Resource Center (NIWHRC) is a partner on this grant to assist in the development of cultural competency products. One of these products is this technical assistance manual that serves as a guide for tribal leaders, tribal health directors, and Indian Health Service CEOs to develop their own location- and tribe-specific cultural orientation program.

Pamela Iron representing the NIWHRC, in partnership with the OCAITHB, wrote this cultural orientation manual to assist tribal health advisory boards guide tribal healthcare facilities' efforts to implement cultural competency training programs for health care providers. These trainings are aimed at providers who are non-native, who have not worked with Native Americans in the IHS Oklahoma City Area, and who care for Indian patients within hospitals or clinics. Some tribes operate their own health care delivery systems, and this technical assistance manual will help them develop a cultural orientation program or hone the one already implemented.

II. Methods

This section describes the methods used in creating a cultural orientation program.

To create this training manual and the sample orientation program, the research team followed a general pattern of gathering information, synthesizing it, and creating orientation materials using that information.

To begin, the research team selected tribes, tribal facilities, and tribal leaders to participate in focus groups and interviews. Tribal participation was chosen based on geographic location, population size, and compact and direct service status. These groups were chosen to assure a diverse set of experiences (including urban and rural, traditional and modern, etc...) on which to base our cultural orientation material. Focus groups were held with health care providers from all health disciplines to determine what they would like to know regarding the culture of their patients. Interviews with tribal leaders were used to determine what information is important for non-Indian health care providers to know when they are treating Indian patients.

The researchers conducted numerous focus groups across the state. One tribal focus group was held with the Pawnee Tribal Health Advisory Board, which consisted of tribal representatives from the local area tribes including the Pawnee, Otoe-Missouria, Osage, Tonkawa, Ponca, Kaw, and Iowa. Health care provider focus groups were held at the Ponca White Eagle Clinic, the Lawton Indian Health Service Hospital, and the Kickapoo Tribal Health Center.

Key informant interviews were conducted with the Lawton Tribal Leaders, the Kansas Tribal Directors, and the Chickasaw Tribal Council members due to scheduling conflicts when setting up focus groups. Health provider key informant interviews were held with the Chickasaw providers.

III. Steps to Creating a Cultural Orientation Program

This section succinctly describes the steps to creating a cultural orientation program. As a tribe or a tribal healthcare facility identifies a need to increase cultural competency among the healthcare providers, the following are steps that can be taken to create a cultural orientation program to address those needs.

1. **Get <u>buy-in</u> from leadership and decision makers.**
    a. Attain support from tribal and clinic leaders along with other decision-makers. This will be extremely important because the competency training may call for organizational policy and procedure changes
    b. You may need to survey or complete a needs assessment to determine the organization's willingness to implement a cultural orientation program.
    c. The stage must be set for the leadership of the tribe, the tribal health administration, or the CEO of the tribal facility to understand the importance of cultural orientation and to have an interest in developing a cultural orientation program.
    d. The literature review section in this manual can be used to help leadership understanding how provider cultural competency improves the quality of health care and is a starting place for elimination of health disparities.

2. **Find a <u>champion</u> for the program.**
    a. The program's "champion" actively promotes, supports, and advocates for the benefits of the program. This person will also need to help the organizations understand the importance of investing in cultural competency training.
    b. The champion will also need to remove barriers to facilitate the program.

3. **Formalize a <u>cultural orientation planning workgroup</u>.**
    a. The planning workgroup will decide on the topics for the training, review the tribal resources to identify individuals who have presenting skills and currently work in a capacity related to culture (such as language immersion, craftsman, natural resources, museums, and historians), make

recommendations about the specific content of each topic, set the session length, and order the sequencing of the topics.

b. This workgroup will also estimate a budget needed for the development and for delivery of the cultural orientation.

c. Membership for the workgroup will vary greatly depending on the size of the organization and scope of the orientation program to be implemented. Membership may include patient care advocates, traditional elders, tribal historians/linguists, health care providers, tribal council members, and community leaders.

4. **Hire or assign a <u>presenter</u> and/or <u>coordinator</u>.**

a. The workgroup formed in step 3 should be able to recommend a presenter for the material as well as a coordinator to set up the trainings. The presenter and coordinator may be the same person; however the duties will differ slightly. The presenter will be in charge of orally presenting the course material to the participants and providing guidance during the course. The coordinator will be in charge of printing any necessary materials, advertising, making travel and lodging arrangements for the presenter(s) and participants, and reserving a place to conduct the course. A cultural center, if available, can be a good location to house the course.

b. The presenter and/or coordinator should be incorporated into the developmental process as soon as possible to understand how the course developed. This will serve as an orientation course for the presenter and/or coordinator and may save time when the course is ready for implementation.

5. **<u>Developing/Customizing</u> the cultural orientation content.**

a. The workgroup will need to develop the cultural orientation content for the training. The information presented should be customized to the particular tribes served by the healthcare providers.

b. To help them with this process, the workgroup may need to hire or assign someone with curriculum/training development skills, like teachers, professors, or others with an education background.

c. This step is a continually-evolving process. After the course is implemented, this step serves to assure that accurate and up-to-date material is presented. The ideas to keep in mind when developing content are:

    i. What content and topics will be covered?

    ii. How in depth will the content be?

    iii. Will different content be given to different groups?

    iv. What will be the sequencing of content?

    v. What is the recommended session length? Will your training take less than a day, a full day, or be a multi-day training? Keep in mind that policies will need to be developed in the organization to allow staff the time to attend the training.

    vi. Pilot testing of developed material will be necessary.

d. The OCAITHB has developed course content material that may be used to facilitate this step. You may contact the OCAITHB for this material.

6. **Implementing the cultural orientation program.**

a. The program coordinator will oversee the implementation of the cultural orientation course. The planning process will be unique for each site: it could be completed in 2 weeks or 3-6 months with another 6 months to develop material and implement the course.

b. As a part of the implementation a pre- and post-test can be given to determine 1) knowledge, skills, and attitudes of the participants, and 2) the impact of the program. Adding this will provide valuable feedback to ensure that trainees are comfortable with the culture. If you would like assistance in developing a pre- and post-test, please contact the OCAITHB.

IV. Literature Review

Before and during the development of this manual, the OCAITHB conducted in-depth literature reviews about developing curriculum content and training materials for Native Americans. The OCAITHB also reviewed topics related to areas of interest revealed by the focus group and key informant interviews. The goal of this section is to use cultural orientation literature to explain why we should implement cultural orientation programs.

1. <u>Communication and cultural competency are important components of quality of care for underserved populations.</u>

Communication is regarded as an important factor of quality of care. In its 2002-2003 *Comprehensive Accreditation Manual for Ambulatory Care,* the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) established standards for addressing cultural and language differences. (*See* chapters on Patient Rights and Organizational Ethics; Assessment of Patients; Education of Patients and Family; and Leadership.)

Cross-cultural communication involves not only words that are spoken and how they may be translated, but it also includes differences in interpretation of non-verbal gestures and behaviors, variations in learning styles, and the entire context in which the interaction occurs. Context is not just the immediate environment but also the broader historic, social, cultural and economic experiences that affect meaning. In a cross-cultural setting, the patient and the provider may have such different life experiences that verbal and nonverbal expressions hold very different meanings. For example, an American Indian patient may avoid eye-contact as a sign of respect, but the non-Indian physician may interpret it as a sign of embarrassment, shame, shyness, deceit, or lack of proper training in social skills.

The following definition of cultural competence incorporates the key elements that many organizations have used:

> *A set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations. It reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices, and*

communication patterns of clients and their families to improve services, strengthen programs, increase community participation, and close the gaps in health status among diverse population groups. Cultural competence also focuses its attention on population-specific issues including health-related beliefs and cultural values (the socioeconomic perspective), disease prevalence (the epidemiologic perspective), and treatment efficacy (the outcome perspective). (Williams 2001)

The pioneering work in identifying cultural issues of health care and developing definitions of cultural competence started with mental health services (Bazron et al 1989, National Latino Behavioral Health Workgroup 1996), where the cultural context of behavior made greatly impacted diagnoses of mental illness. There has been a growing realization that cultural beliefs and practices can also affect the diagnosis and treatment of other illnesses. The potentials for misunderstanding, mistrust and poor health outcomes as a result of a lack of cultural understanding were documented in the popular book, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures,* by Anne Fadiman (1997). This book has been used in the curriculum of medical schools to help sensitize doctors to cultural issues.

Do health care providers behave in ways that contribute to the disparities in care and outcome, and if so, how? This topic has been raised by van Ryn and Fu (2003). Some of the contributing mechanisms they identify for this include communications, such that health care providers may "intentionally or unintentionally reflect and reinforce societal messages regarding help seekers' fundamental value, self-reliance, competence, and deservingness". They also state that health care providers' lower expectations for disadvantage patients can cause those patients to also lower their own expectations for the health care they receive or seek. For example, physicians are less likely to tell patients of color on dialysis about kidney transplant options. Flores et al (2002) concluded:

Failure to appreciate the importance of culture and language in pediatric emergencies can result in multiple adverse consequences, including

difficulties with informed consent, miscommunication, inadequate
understanding of diagnoses and treatment by families, dissatisfaction with
care, preventable morbidity and mortality, unnecessary child abuse
evaluations, lower quality care, clinician bias, and ethnic disparities in
prescriptions, analgesia, test ordering, and diagnostic evaluations. (p.271)

2. American Indian and Alaska Native Health Care

There are 565 federally-recognized tribes in the United States with a wide range of languages, cultures, and health care services. More than 2.5 million Americans are members of these tribes, and 1.5 million of those tribal members use health care facilities and services funded through the Indian Health Service. The Indian Health Service (IHS) is the federal agency responsible for American Indian/Alaska Native (AI/AN) health care that is delivered either directly by the IHS, through tribes, or by urban Indian clinics (collectively called the "I/T/U"). As tribes exercise their rights to self-determination, many tribes are operating their own health care services. Self-determination is the means by which tribes implements their sovereign powers and exercise self-governance and decision making on issues that affect their own people. Often these clinics and hospitals operate side-by-side with traditional healers.

Many of the physicians, midlevel practitioners, dentists, and pharmacists who work in the Indian health facilities are not tribal members. Typically, when they start employment at an Indian health clinic or hospital, there had been a period with staff vacancies, a backlog of patients, and the need to begin work immediately with minimal orientation. Any cultural information they receive is often passed along from other health professionals who are not tribal members, and it may be erroneous or incomplete.

Most AI/AN patients speak English as a first or second language, however there are patients who need translators. While many employees at Indian health facilities are tribal members who can serve as translators, this often not sufficient to assure adequate communications of complex medical ideas. Some problems often associated with medical translation by untrained employees and others include errors of omission, addition, substitution, editorialization and false fluency that have been associated with

translators who are not specifically trained for medical interpretation (Health Care Risk Management 2003). Even if the patient is fluent or capable of communicating in English, the patient often has low educational and literacy levels, and basic terms relating to body parts, body functions, disease processes and health care may not be understood. Research suggests that low health literacy is related to poor health outcomes (Shillinger et al 2002).

Finally, in many places, AI/AN people, as with other minority population, will not ask questions of authority figures, including health providers.

Health status is a major concern for AI/AN people and disparities only make the problem worse. Many of the health disparities have lifestyle and behavioral risk factors that can only be addressed with a full understanding of the cultural, historic, social, political and economic context in which the AI/AN people live. To communicate effectively, providers must understand the tribe's social structure, cultural patterns of communication, and beliefs about causation of illness, traditional healing practices, taboos, and motivations.

3. Improving the Problem

While some tribes offer language programs, it is not practical to expect health care providers to become proficient in AI/AN languages. A more realistic approach is to provide training that develops skills and knowledge to communicate more effectively in a cross-cultural setting using the English language.

Fundamental to cross-cultural communications is the ability to understand the worldview of a different culture. Some people have tried to identify values that are common to many American Indian tribes (Harris and Wasilewski 1992, Heavy Runner and Morris 1997). This is a good way to begin the exploration of differences between indigenous people and the dominant American culture. However, there is a huge range of variation between the cultural groups of American Indian and Alaska Natives. Furthermore, there is a range of acculturation among members of any tribe. As Weaver (1999) states, "Each client is an individual who may or may not have a strong cultural connection or may experience that cultural connection differently than another native person" (p. 221).

It is only natural that people process information in a way that relies on social categorization or stereotypes (van Ryn and Fu 2003). However, this can be ameliorated through training that raises awareness of the process, motivates providers to detect and inhibit stereotypes, and "allows providers to have sufficient cognitive resources to overcome and replace automatic cognitive processes" (van Ryn and Fu 2003, p. 252).

Research has identified some key subjects to be covered in cultural competence training. For example, Weaver (1999) identifies the following topics for cultural competence among social workers serving AI/AN:

- knowledge of diversity, history, culture, and contemporary realities;
- skills of communication and problem-solving; and
- Values related to helper wellness and self-awareness, humility and willingness to learn, respect, open-mindedness, a nonjudgmental attitude, and social justice.

In order to function effectively providers need to know specific information about the history, culture and contemporary realities of the tribe they are serving.

V. Appendix

<u>General Information</u>

The Research Investigator and the Oklahoma City Area Inter-Tribal Health Board (OCAITHB) staff began the cultural orientation project by submitting Institutional Review Board (IRB) applications to the Indian Health Service - Oklahoma City Area Office and the Oklahoma State Department of Health. The project received exempt status from both of the organizations IRB's.

What is Cultural Competency?

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Bazron, 1989).

And why is it important?

Cultural competency is one the main ingredients in closing the disparities gap in health care. It's the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

Culture – the thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Culture and language may influence health, healing, and wellness belief systems; how illness, disease, and their causes are perceived; the behaviors of patients/consumers

who are seeking health care and their attitudes toward health care providers; as well as the delivery of services by the provider who looks at the world through his or her own limited set of values, which can compromise access for patients from other cultures.

Culture defines how:

- health care information is received
- how rights and protections are exercised
- what is considered to be a health problem
- how symptoms and concerns about the problem are expressed
- who should provide treatment for the problem
- what type of treatment should be given

Tribal Leaders Focus Group Questions:

1. Have any of you set up or have been a part of sharing your culture with other individuals or groups outside of your community? What were the difficulties in explaining or how did you feel?

2. When you hear the word cultural competency what immediate word, (words) or thought pop into your head?

3. What is the one single area of your culture that you would like providers to understand?

4. What is the one area of your culture that you feel gets miss-represented the most by non-Indians or the general public?

5. How do you share information about yourself and being Indian with your doctor or other non-Indians that you might work with?
   Does it seem necessary sometimes?

6. Describe differences in the dominate society and the Indian culture from your point of view?

7. I am going to show you are chart; I want you to rank these as far as what are the three most important ones to you. (Show the chart of the Difference between the dominant society and the American Indian Society)

8. What ceremonies/traditions of your tribe if any that you think a provider should experience?

9. How do you think a health facility (physical building) should express the American Indian culture, specifically your culture?

10. How do feel about mentoring a new health care provider regarding to your culture when he/she is new?

Health Care Provider's Focus Group Questions:

1. Did you receive any formal cultural orientation when you started work here or at any other tribal or Indian Health Service facility? If so please describe the orientation that you received.

2. If you did not receive orientation were their barriers that you faced in your first six months on the job? If so what were they?

3. Looking back, what are some of the key pieces of information on American Indian culture would have been helpful? (Specifically, the tribe you are working for)

4. If you could design a culture orientation at your facility what would be the components or subjects that you would include?

5. How would you use the local tribal leaders and elders in this course?

6. What length do you think the course should be? (Spread out over a month or a 40 hour course?)

7. What do you think about ongoing classes and refresher courses regarding other culturally related issues regarding communication

8. How do you feel about the culture being integrated into the clinics health practices? (Example learning the language, clinic design reflecting the culture.)

9. Is an understanding of cultural mores and values having an effect on how a health care provider approaches health literacy with their patient?

10. What is your definition of cultural competency?

11. Is there any other information that would be helpful to know when designing a cultural orientation program for health care providers?

VI. References

Joint Commission on Accreditation of Healthcare Organizations (JCAHO). 2002-2003 *Comprehensive Accreditation Manual for Ambulatory Care.*

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VII. Evaluation

Evaluation is a critical part not only determining the effectiveness of the program but of informing the presenters' ways to improve their own skills and their own programs.

> *"Program evaluation is an essential organizational practice in public health. Program evaluation supports our agency priorities. When programs conduct strong, practical evaluations on a routine basis, the findings are better positioned to inform their management and improve program effectiveness."*
> *(http://www.cdc.gov/eval/index.htm).*

Instructions

Provide each trainee with a copy (either paper or electronic) of the evaluation. (pages 24 and 25). Collect all of the evaluation forms.

Scan and send the evaluation forms to Cuyler Snider MPH [Cuyler.Snider@ihs.gov] or mail the evaluation forms to

OCAITHB

Attn: Cuyler Snider

P.O. Box 5826

Edmond, OK 73083

Or

Download the evaluation forms from here http://ophtc.ouhsc.edu/CCC.html

Some evaluation questions that you can measure yourself.

- What percent of learners returned the evaluation? (Response Rate)

- What was the mean value of each question?

- Did the learners report improvement from before to after the training? (Compare the mean value of each question)

- What could you do to improve the training?

Oklahoma City Area Inter-Tribal Epidemiology Center
Cultural Orientation Evaluation

As a result of this training, do you feel that you are more culturally competent? ❏Yes ❏ No

As a result of this training manual and the PowerPoint slides do you think that you can

Knowledge, Skills, Attitudes and Confidence		
Knowledge. Circle below your knowledge level regarding the ***cultural competence*** prior to the workshop and currently. Use the following scale: 1-No knowledge 2-Little knowledge 3-Some knowledge 4-Adequate knowledge 5-Strong knowledge		
	Prior	Current
1 Understanding the importance of the group (tribe, family, etc.) over the individual.	1 2 3 4 5	1 2 3 4 5
2 Some tribal courts may have "restorative justice" systems."	1 2 3 4 5	1 2 3 4 5
3 Components of cultural competence.	1 2 3 4 5	1 2 3 4 5
4 Understanding tribal sovereignty	1 2 3 4 5	1 2 3 4 5
5 Understanding federal trust responsibility	1 2 3 4 5	1 2 3 4 5
Skills. This following consists of statements about your skills in ***cultural competence***. Circle below your agreement regarding these statements. 1-Strongly Disagree 2-Disagree 3-Neutral 4- Agree 5-Strongly Agree		
	Prior	Current
6 I am skilled interacting with American Indians (appropriate eye contact and handshakes).	1 2 3 4 5	1 2 3 4 5
7 I am skilled at dealing with American Indian patients/clients.	1 2 3 4 5	1 2 3 4 5
8 I am skilled at government-to-government relationship	1 2 3 4 5	1 2 3 4 5
9 I can adapt my way of doing my work so that the group effort is valued over one individual's recognition.	1 2 3 4 5	1 2 3 4 5
Attitudes. This following consists of statements about your attitude toward ***cultural competence***. Circle below your agreement regarding these statements. 1-Strongly Disagree 2-Disagree 3-Neutral 4- Agree 5-Strongly Agree		
	Prior	Current
10 The group (tribe, family, etc.) is often more important than the individual.	1 2 3 4 5	1 2 3 4 5
11 Distinctions between my own culture and the other person's culture		
12 Indians have a political relationship with the federal government that distinguishes from other ethnic groups	1 2 3 4 5	1 2 3 4 5
Confidence. Circle below your confidence level regarding ***cultural competence*** prior to this training. Use the following scale: 1-Unsure 2-A little confident 3-Somewhat Confident 4-Confident 5-Very confident		
	Prior	Current
13 My ability to assist tribal communities in learning to heal by grieving for their fore fathers and acknowledging the pain that they suffered	1 2 3 4 5	1 2 3 4 5
14 My ability to deal with historical trauma has impacted American Indians today.	1 2 3 4 5	1 2 3 4 5
15 My ability to respond to or tolerate the ambiguity of new situations, keep options open, and minimize judgmental behavior or attitudes	1 2 3 4 5	1 2 3 4 5

Training. Circle below your confidence level regarding **cultural competence** prior to this training and now. Use the following scale: 1-I don't understand 2-A little confident 3-I understand the basic concepts 4-Confident 5-I can teach other	Prior	Current
1 My ability to assist tribal communities in learning to heal by grieving for their fore fathers and acknowledging the pain that they suffered	1 2 3 4 5	1 2 3 4 5
2 My ability to deal with historical trauma has impacted American Indians today.	1 2 3 4 5	1 2 3 4 5
3 My ability to respond to or tolerate the ambiguity of new situations, keep options open, and minimize judgmental behavior or attitudes	1 2 3 4 5	1 2 3 4 5

What are the main things that you learned?

Circle the number that best reflects your evaluation of EACH Presentation/Speaker

1-Poor   2-Fair   3-Average   4-Good   5-Excellent

	Clarity	**Quality of Materials**	**Relevance to Your Professional**
Power Point Part 1: Gathering the Threads	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Power Point Part 2: Finding the Pattern	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Power Point Part 3: Selecting the Colors	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Power Point Part 4: The Unwoven Flaw	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Technical Assistance Manual	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Additional comment and/or suggestions: