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Cultural Competence Education for Care Coordinators

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This is to certify that the doctoral study by

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Walden University
2015

Abstract

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MSN, Walden University, 2012

MA, McMaster University, 1995

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

Aboriginal people bear a burden of health disparities when compared to non-Aboriginal people in Canada. To date, traditional health-related programs to address these disparities have not been effective. Compounding this problem, the Aboriginal people have also reported dissatisfaction with the healthcare system and the relationships they experience with healthcare providers. However, the literature supports that when providers employ cultural competence in their practice, there is a possibility for improved relationships with patients. Using critical social theory as a framework, the purpose of this project was to conduct a 1-hour class on cultural competence for care coordinators and nurses in a homecare organization in Southern Ontario, and to determine if there was an increase in cultural competence knowledge of Aboriginal people. Fifteen registered nurses attended the educational intervention. Due to the small sample size the non-parametric Wilcoxon signed rank test was used to estimate the difference in scores between pre- and post-test evaluations. Pretest scores were significantly lower than post-test scores ($z = -3.05$, $p < 0.01$). Four of the 7 survey items relating to culture affecting daily work, comfort level with cultural competence knowledge, cultural awareness, and addressing power imbalance in the patient provider relationship were individually statistically significant. The findings were supported by comments written in the surveys. It is hoped that the results of this project will be used to demonstrate the importance of cultural competency in care delivery among the Canadian Aboriginal people.

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Dedication

This project is a result of my time participating in the Practical Nursing with Aboriginal Communities program. To the students, colleagues, staff, and the community, thank you for everything I have learned from you and from the program.

Acknowledgments

There are many people to thank for helping me to get this far. Thank you to Bill, for your unending support and encouragement; to colleagues who answered my many questions; to family and friends who listened and encouraged. This project was made much better through the guidance of my preceptor Dilys Haughton, committee chair Alice Conway, and committee member Marilyn Murphy; many thanks.

Finally, thanks Mom and Dad; I wish you could see this.

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Section 1: Nature of the Project

Southern Ontario is home to the largest reserve of Aboriginal people in Canada (Statistics Canada, 2013). Despite Aboriginal people making up close to 4.5% of the population, they are disadvantaged in many ways. One such area is that of health care delivery. Cultural competence education for healthcare providers is a plausible strategy that could address this gap in inequity (Betancourt & Green, 2010). A 1-hour class in cultural competence was provided for care coordinators and nurses in a home care setting to determine if there is an increase in knowledge about cultural competence with the hope that the increased knowledge will translate into practice.

Background

The term *Aboriginal* refers to First Nations (with and without status, and treaty), Inuit, and Métis peoples. While the emerging term being used among Aboriginal people is *indigenous peoples*, the term Aboriginal people will be used throughout this paper. According to the 2006 Statistics Canada report (Government of Canada, 2013a), approximately 20% of Aboriginal people live on reserves. In 2011, the Government of Canada (2013a) reported that people who self-identify as Aboriginal made up 4.3% of the population, up from 3.8% in 2006. This growth represents a 20.1% increase in the Aboriginal population compared to a 5.2% population increase in the non-Aboriginal population (from 2006-2011).

Haskell and Randall (2009) and Hart-Wasekeesikaw (2009a) described multi or transgenerational trauma among Aboriginal people. This collective historical trauma is the result of colonialism, dispossession of land (Reading & Wein, 2009), and more

specifically, residential schools. Residential schools were designed to assimilate Aboriginal children into the mainstream. Transgenerational trauma occurred as a result of children being forced to attend residential schools, while being detached from an individual's community and family (Hart-Wasekeesikaw, 2009a).

Once detached, there was no home for a person to return to (Reading & Wein, 2009). Due to the social and political realities of the times, Aboriginal people were discriminated against in terms of housing and employment (Haskell & Randall, 2009). All of these circumstances led to an increasing spiral of poverty, unemployment, insecure housing, food insecurity, challenges with health services, substance abuse (Haskell & Randall, 2009) and distrust among Aboriginal people.

Reasons for mistrust among Canadian Aboriginal people are multifaceted. Colonialism and the resultant ways of thinking (Browne & Varcoe, 2006) are primary reasons for the deep mistrust that Aboriginal people experience. Kral (2012) described colonialism as the government changing Aboriginal culture. Over several decades, Aboriginal people were moved onto reserves early in the 20th century and the children moved into day or residential schools. This happened in the first half of the 20th century for First Nations children (Browne & Varcoe, 2006; University of British Columbia, 2009) and in the 1950s and 1960s for Inuit children (Healey, 2014; Kral, 2012). Residential schools were strategies for assimilating Aboriginal people into the dominant society (Hart-Wasekeesikaw, 2009a). In the residential school system, Aboriginal children were removed from their families and communities. They were not allowed to

speak their language, eat traditional food, or in any way participate in their traditional way of life (University of British Columbia, 2009).

The resulting mistrust of Aboriginal peoples continues today. The residential school in a nearby town is referred to as “the mush hole” (The Two Row Times indiegogo campaign, 2013). The name refers to the food that was provided. According to residential school survivors, all of the food looked and tasted like mush. The graduates of these residential schools no longer had any connection with their family, community, or traditions. They were not provided with the tools required for living well, or for raising children. They no longer had access to traditional ways of survival, and were not accepted into mainstream society because of their heritage (Haskell & Randall, 2009). The result of this trauma is often substance use and abuse, and the mistrust includes not only healthcare, but of government in general (Vandenberg, 2010). This trauma can also be evidenced by racialization, which is in part the way that non-Aboriginal people perceive and give meaning to an individual’s Aboriginality (being Aboriginal).

As presented, Aboriginal people could be considered to be a marginalized society in many ways, including housing, family traditions, and the marginalization extends into health care delivery. The Public Health Agency of Canada (PHAC, 2011) reported that Aboriginal people experience more illness and health disparities than the non-Aboriginal population (Joseph et al., 2012; Reading & Wein, 2009). For example, Tang and Browne (2008) posited that the prevalence of diabetes is approximately 19% in Aboriginal people, with some estimates as high as 30% as compared with Caucasians at 7 to 8%.

These are only estimates due to the challenges in enumeration and self-report of Aboriginal status.

In one Canadian province, the per capita cost for Aboriginal people with diabetes is estimated at 34% higher than for Aboriginal people without diabetes, and 69% higher than it is for non-Aboriginal people with diabetes (PHAC, 2011). This increase in cost is due to the higher incidence of comorbidities such as congestive heart failure, for Aboriginal people with diabetes (PHAC, 2011). Sandy Lake First Nation reserve in northwestern Ontario has the third highest rate of diabetes in the world (Health Canada, 2013). According to this report, at least 26% of the population of Sandy Lake Reserve has diabetes.

Similarly, PHAC (2011) reported that between 34 and 44% of Aboriginal people smoke compared to 16% of the non-Aboriginal population. The government of Canada reports smoking as a risk factor for some types of cancer, respiratory problems, and other health problems (2012). Pearce, Schwartz, and Greaves (2008) discussed the different uses of tobacco in Aboriginal culture. Traditionally, tobacco (Nicotiana rustica) was used for ceremonies and rituals. Nicotiana tobacum, introduced by the Europeans, was used as a commodity, for recreation, and trade. It is this second type of tobacco that has resulted in the increase in certain cancers and other co morbidities for Aboriginal people.

Despite the disparities that exist among the Aboriginal people, many are reluctant to engage in the current health care delivery system. Skye (2013) reported that overall, Aboriginal people are dissatisfied with their healthcare experiences. Bourque Bearskin (2011) posited that Aboriginal people have a different interpretation of reality. This

worldview includes healing practices and ways of developing and maintaining relationships not always consistent with Western medicine (Bourque Bearskin, 2011).

Aboriginal people are in need of health care services. Yet, they are reluctant to engage in health care services given the dissatisfaction and lack of confidence that they have in their current providers. Chipps, Simpson, and Brysiewicz (2008) concluded that providing cultural competence education for front line health providers could reduce the power imbalance and positively affect attitudes towards health care engagement by Aboriginal people. Similarly, DeSouza (2008) demonstrated that cultural competency is a plausible strategy to help with collaborative relationships for capacity building with individuals and communities. Horvat, Horey, Domios, and Kis-Rigo (2011) posited that when cultural competence is part of the fabric of healthcare, appropriate care can be provided for patients with diverse social and cultural needs.

Providing a culturally competent environment for healthcare and wellness may be enough to decelerate the rising health disparities (Horvat et al., 2011), and in this situation, the disparities experienced by Aboriginal people and communities. By educating care coordinators and nurses on cultural competence, it is hoped that the outcome will be more culturally competent care for patients (particularly Aboriginal patients) of home care. Thus the purpose of this scholarly project was to provide a 1-hour class on cultural competence for care coordinators and nurses practicing in a homecare setting.

The Education

The cultural competence education was presented in a 1-hour class. The class began with a discussion of what culture is and why it is important to recognize that culture can influence decisions, especially health decisions. This learning was supported by a brief activity intended to help participants begin to identify how they think of culture (Betancourt & Green, 2010). The second section of the class included a presentation of highlights from history that have reinforced colonialism (Ontario Federation of Indian Friendship Centres, 2013). This review of history identified for non-Aboriginal people how transgenerational trauma has occurred (Hart-Wasekeesikaw, 2009; Haskell & Randall, 2009). The second activity demonstrated the effects of residential schools. This activity is a modified version of one completed during a workshop presented by the Ontario Federation of Indian Friendship Centres (2013) and is a powerful demonstration of the negative effects of residential schools.

The third section of the class dealt with power, both perceptions of power, and how power is used. The activity involved participants discussing where they and their patients would be placed on the flower of power (University of Victoria, n. d.). The final part of the class was a description of the Two Row Wampum as a way to describe the concept of relationship. The Two Row Wampum is an appropriate framework for thinking about relationship as it describes how to work together, thus addressing the power imbalance that Aboriginal people feel. Maintaining respectful relationships with Aboriginal patients has the potential to allow for an improved patient experience.

As care coordinators and registered nurses learn about cultural competence they can start to incorporate the principles into practice. Aboriginal people report that when healthcare providers are aware of the effects of colonialism and the power imbalance, there is a sense of being valued (Skye, 2013). When Aboriginal people feel valued, then improved healthcare is possible (Betancourt & Green, 2010). Managing cultural competence knowledge through awareness of the Two Row Wampum helps to guide discussions and situate Aboriginal patient and healthcare provider in a strong, mutually respectful relationship (Akwesasne, 2013).

Purpose and Problem Statement

The purpose of this project was to measure the knowledge gained from a class on cultural competence for care coordinators and nurses in homecare. The intervention was a 1-hour class on cultural competence similar to that reported by Delgado et al. (2013). The sample involved in this current project is the care coordinators and registered nurses at a homecare agency in Ontario Canada.

Project Question

Does a cultural competence educational intervention increase knowledge in cultural competence among care coordinators and nurses in a homecare agency?

Project Objectives

By the end of the presentation, each participant was expected to describe examples of health disparities faced by Aboriginal people in Canada, compare three key aspects of cultural competence, evaluate two examples of using power, and create three ways to demonstrate cultural competence in practice.

Reduction in Gaps and Implications for Social Change

The identified gap of increasing health disparities experienced by Aboriginal people places a burden on Aboriginal people both as individuals and as a community (Hart-Wasekeesikaw, 2009a). One strategy for reducing this gap is by providing cultural competence education to healthcare providers (Khanna, Cheney, & Engle, 2009). Cultural competence education provides the groundwork for care coordinators and nurses to examine their own biases and prejudices, which can then lead to thinking about system inequities (Browne, 2000). When providers engage in the ongoing process of cultural competence, there is more potential for improved relationships with patients, leading to improved health outcomes in general (Ihara, 2007; Reading & Wein, 2009). Social change will be evidenced as culturally competent care leads to improved health (Betancourt & Green, 2010).

Definitions of Terms

Care coordinator: Care coordinators are nurses and other registered healthcare providers including physiotherapists, occupational therapists, and social workers whose role includes case management and system navigation (Government of Ontario, 2007).

Cultural awareness: The awareness of one's biases and culture, and how these affect care delivery (Starr & Wallace, 2011).

Cultural sensitivity: Includes one's own and others' cultural practices as reflective of their cultural background, respect, and acceptance of diversity (Starr & Wallace, 2011).

Cultural competence: Having skills, knowledge, judgment, and attitude regarding culture (CNO, 2014; Kratzke & Bertolo, 2013), and cultural competence is evidenced when care is provided in the context of the patient's culture (Starr & Wallace, 2011). Also included in cultural competence, is assessing for and addressing perceptions and imbalances of power (Matteliano & Street, 2012).

Aboriginal: The term that will be used to include First Nations, Métis, and Inuit. The term "Indigenous" can be used interchangeably with "Aboriginal" (National Aboriginal Health Organization (NAHO), 2015).

Aboriginality: Identification that someone is Aboriginal including the meanings and perceptions that non-Aboriginal people attribute to being Aboriginal (Tang & Browne, 2008).

Racialization: Refers to the historical, political, and social discourses that allow non-Aboriginal people to see Aboriginal people as Aboriginal (Tang & Browne, 2008). The racialization process allows the embeddedness of "otherizing" (this includes the historical and political context of the thinking of Aboriginal) and normalizing discrimination as part of everyday discourse. An example of the use of racialization is taken from Lipsitz (1995) describing a reporter asking about the "Negro problem" in the United States, the reply from Richard Wright was "there was only a White problem" (p. 369).

Assumptions and Limitations

The primary assumption of this project is that care coordinators and nurses will integrate the principles of and value the need for cultural competence. One limitation of

cultural competence is the possibility or fear that, in highlighting marginalized people, we are doing just that, continuing to marginalize or "otherize" people (Browne et al., 2009). The challenge with this is that nurses (providers) might be defensive because of the thinking that treating everyone equally is the same as equal access to care (Browne et al., 2009; Tang & Browne, 2008). This class does not provide specific information about examining patient's health or wellness beliefs, nor is it all that is needed. Cultural competence is a process that requires at the very least, regular reflection on the part of the care coordinator and nurse (Ihara, 2004; Khanna, Cheyney, & Engle, 2009).

Summary

Aboriginal people experience a growing degree of health disparities. Cultural competence is a way to redress these issues. For care coordinators and nurses, this can include self-examination or reflection, and redressing power imbalances. If each nurse (healthcare provider) valued cultural competence then the environment for providing care and promoting wellness could be conducive to improved outcomes. An improved patient experience is a benefit for each patient and is an organizational goal.

Section 2: Literature Review and Theoretical Perspective

There is evidence that at least part of the health disparities faced by Aboriginal people may be caused by institutionalized racism, prejudice and bias (Browne, 2000; Tang & Browne, 2008; Vandenberg, 2010). The focus of this literature review is on health disparities and social determinants of health, cultural competence, and cultural competence education in a homecare setting. The theoretical perspective is social critical theory. Given the historical and social contexts of health for Aboriginal people in Canada, and perceptions of discrimination, a different approach is required to improve health outcomes. Cultural competence is a way for health care providers to examine their practice and professional values with the intent of improving relationships with and care for Aboriginal people.

The literature search was conducted using the CINHAL and MEDLINE simultaneous search, CINHAL plus with full text, and ProQuest nursing and allied health source databases. Keywords and phrases included “cultural competence”, “cultural competence education”, "Aboriginal * healthcare”, “culture * Aboriginal”, and “critical social theory * Aboriginal”. Articles were selected based on applicability in terms of cultural competence education, cultural competence as it applies to Aboriginal people, particularly in Canada, and critical social theory as it applies to Aboriginal people in Canada. Some articles were selected because the information resonated with this project, for instance a class on cultural competence that used similar strategies to this project.

Health Disparities

The World Health Organization (WHO, 2013) described the social determinants of health as avoidable differences in health status. Mikkenon and Raphael (2010) authored a report outlining 14 social determinants of health in Canada. Included are poverty, race, social exclusion, health services, and being Aboriginal. While Aboriginal status itself cannot be changed, the factors leading to this being a social determinant of health can change. The transgenerational trauma experienced by many Aboriginal people, typically resulting in poverty and inequity in accessing healthcare, can be addressed by policy (Mikkenon & Raphael, 2009). Other social determinants that directly affect many Aboriginal people are employment status, education status, income, social exclusion, early childhood development, health services, and housing (Mikkenon & Raphael, 2010).

In addition to social determinants affecting health outcomes, the way that health care is provided can affect outcomes. Reading and Wein (2009) reported 13.5 % of First Nations people living on a reserve report health care as being culturally inappropriate. Tang and Browne (2008) conducted a study using in-depth interviewing and participant observation in the Emergency Department (ED) of a large hospital in the core of a major Canadian city. While nurses talked about providing “the same care to everyone” (Tang & Browne, 2008, p. 116), Aboriginal patients expressed feelings of not being listened to, being pre-judged, and being dismissed (Tang & Browne, 2008). Oda and Rameka (2012) differentiated between the interpersonal racism that might be demonstrated by unfair treatment (even in healthcare), and institutional racism, which is embedded in everyday language and policies.

Health disparities exist for Aboriginal people (Frohlick, Ross, & Richmond, 2006) and there is a sense from Aboriginal people that there is a feeling of being discriminated against (Tang & Browne, 2008). Larson et al. (2011) reported that 40 % of the family medicine residents in their study felt underprepared to provide healthcare for Aboriginal patients. Some of the comments from residents who had some experience in providing care for Aboriginal people included identifying the barrier of negative interactions in ED that involved Aboriginal people and alcohol overuse. This finding was consistent with the discussion by Reading and Wein (2009) on the embedded ideals that we have of Aboriginal people and alcohol overuse.

The social determinants of health have to be addressed in order to close the gap experienced by Aboriginal people in terms of healthcare; however, there is another way to begin to address the problems that Aboriginal people experience in healthcare. Oda and Rameka (2012) iterated the direct correlation between Aboriginal health in New Zealand and health professional behavior. Professional behavior in this situation involves the way that providers think about their own values, their position of privilege, and how they think about Aboriginal people; it allows for culturally competent care to be provided. Cultural competence encompasses knowledge of one's own biases and prejudices, and being aware of the contexts of health, and addressing power imbalances (Matteliano & Street, 2012: Starr & Wallace, 2010).

Cultural Competence

Starr and Wallace (2011) and the Ontario Federation of Indian Friendship Centres (2013) described cultural competence as part of a continuum including cultural awareness

and sensitivity. Being aware that one's biases and culture can affect care delivery is at the beginning stage of the continuum followed by sensitivity. Cultural sensitivity addresses diversity in cultural practice and the beginning of developing respect for these differences (Starr & Wallace, 2011). Cultural competence is the next step along this continuum. The College of Nurses of Ontario (CNO, 2014), and Kratzke and Bertolo (2011) described cultural competence as having the knowledge, skills, and attitude to deliver culturally appropriate care.

Awareness of cultural competence means that the care coordinator or nurse is aware of her or his own biases and prejudices. Understanding that learning cultural competence is an iterative process and cannot be learned in one class is an emerging part of the concept (Betancourt & Green, 2010). Matteliano and Street (2012) added that redressing the power imbalance in the healthcare provider-patient relationship is essential to cultural competence. Redressing the power imbalances in the healthcare provider patient relationship is central to cultural competence as it applies to Aboriginal people in Canada (Ontario Federation of Indian Friendship Centres, 2013).

Cultural Competence Education

Cultural competence education then, has to address the key aspects of cultural competence. Didactic and interactive learning opportunities dealing with an historical perspective of colonialism and power were included in the class for this project. The Two Row Wampum was presented as a way to frame relationship building. Framing

relationships in this manner has the potential for supporting other initiatives in this area dealing with cultural competence thereby providing consistency in the healthcare system.

Delgado et al. (2013) reported the effects of a 1-hour class on cultural competence. In this pilot project, Delgado et al. found that self-reported cultural competence increased after participation in the class "What's Culture Got to do With It?" Campina-Bacote and Narayan (2000) described cultural competence as a life-long learning process, while Horvat et al. (2011) iterate the importance of cultural competence learning both in terms of individual practitioners and at the organizational level. The protocol that Horvat et al. proposed includes four components; the educational content, the way the course is taught, the structure of the class, and the characteristics of the participants. Betancourt and Green (2010) iterated the importance of cultural competence education for specific populations and developing strategies for encouraging provider buy-in for this education.

Health disparities exist for Aboriginal people in Canada. Aboriginal people report not being heard or valued in the healthcare provider to patient relationship. Simply adding more programs has not been effective in reducing disparities. Cultural competence is an iterative process in which the healthcare provider continually develops the knowledge, skills, and attitude required to provide care for culturally diverse patients. Education on cultural competence at the workplace is one strategy for ensuring that providers start the process of becoming culturally competent.

Theoretical Framework

Social determinants of health and cultural competence are situated within a broader context, that of society in general. Critical social theory is a way to examine the inequities that influence nursing, and in particular, nursing with Aboriginal people (Browne et al., 2009). The ideal in Canada is that healthcare is universal with equal access (Health Canada, 2012). This idea is effective for the dominant culture, but has been demonstrated to be less than ideal for nondominant cultures (Tang & Browne, 2008; Vandenberg, 2010). While people might have equal access, the actual care might not be considered equal (Tang & Browne, 2008). Tang and Browne and Vandenberg located this acceptance of popular ideas of cultural categories as fact in the essentialist versus nonessentialist view of culture. Looking at others as belonging to a static group precludes the critical examination of the contexts of health (Browne & Varcoe, 2006). For the Canadian Aboriginal population, these contexts include the social, political, and historical (Hart-Wasekeesikaw, 2009a).

Critical Social Theory

Critical social theory (CST) provides structure in order to examine the disparities experienced by Aboriginal people in Canada and to explore the strategy of cultural competence education for care coordinators as a way to address the disparities. As an action oriented approach (Green, 2010), CST sets the stage for cultural competence as an interpretive lens through which the nurse will develop emancipatory knowledge in order to engage in a respectful relationship with Aboriginal patients (Browne & Varcoe, 2006).

An interpretive lens is both a way to look at culture, and the relationships with the interpretive part being the awareness of discrimination, power imbalance, and perceptions of culture. Chinn and Kramer (2008) reported the primary goal of CST as promoting social change. This kind of emancipatory knowledge is required by nurses in order for this particular change to happen (Chinn & Kramer, 2008). The effects of colonialism continue to be evidenced in the health disparities seen in the Aboriginal population (Hart-Wasekeesikaw, 2009a). Providing a way for nurses to learn about the effects of colonialism is just one step, further steps are required. Critical reflection about one's values, ideas of discrimination and racism, and the use of power are also required for cultural competence (Matteliano & Street, 2012; Tang & Browne, 2008). The opportunity for this kind of reflection can occur in an interactive learning activity as part of the cultural competence class.

Browne and Varcoe (2006) concluded that it is important for nursing to go beyond cultural sensitivity and limited views of culture. The way that we look at culture affects the way that we build and maintain our relationships with Aboriginal people. An example of good relationship can be found in the Aboriginal description of treaties and Wampum belts. The Haudenosaunee people made treaties with the Europeans who came to their land. The Two Row Wampum is a white beaded background symbolizing either the river of life, or a background of purity. One row of purple beads represents the Aboriginal canoe (the Haudenosaunee people), and the other row of purple beads represents the European ship (the non-Haudenosaunee people).

There are three rows of white beads alternating with the purple rows, binding the two groups together and keeping them apart. The three rows or white beads stand for friendship, peace, and respect (Akwesasne, 2013). The Two Row Wampum provides an excellent way to look at the idea of relationship in healthcare (see Appendix B).

The need for cultural competency in healthcare will be driven by the fact that more Aboriginal people are migrating to urban areas (Snyder & Wilson, 2012). Snyder and Wilson (2012) examined healthcare utilization in two major cities in Canada, but did not look at the correlation between non-use of healthcare services and mistrust of the system, or even why healthcare was not accessed. Larson, Herx, Williamson, and Crowshoe (2011) found that 40% of family medicine residents felt under-prepared to deal with Aboriginal people. Wilson, Rosenberg, Abonyi, and Lovelace (2010) used the results of two federal surveys to look retrospectively at health and aging in Aboriginal and non-Aboriginal populations. Variables such as smoking, household crowding, income, and education were considered along with urban versus rural living. Wilson et al. looked at whether Aboriginal people accessed healthcare, but did not pursue the subsequent question of why healthcare was not accessed. Mortensen (2010) highlighted the need for culturally competent care to be provided with the intended outcome of improved health for Aboriginal people. In an integrated review of the literature, Hart-Wasekeesikaw (2009b) iterated the importance of encouraging cultural competence in nursing education for Aboriginal students so that access to care will be improved in this population.

Summary

CST provides a lens through which to see inequities and a framework to then address these inequities. Examining one's own biases and prejudices and engaging in reflective practice will augment the education on cultural competence. Changing perceptions and shifting the way that we as care coordinators and nurses understand relationship and power can impact the way that Aboriginal patients perceive the healthcare system and may help to improve health outcomes.

Section 3: Design and Methodology

The project included planning and implementing a one-hour class on cultural competence for registered nurses and care coordinators practicing in a homecare setting. Participants were recruited from a homecare organization. Participation was voluntary and participants could decide to leave at any time during the class. An increase in education was assessed using pre and post class surveys. Survey results were analyzed using SPSS v.21 software.

Population, Sample, and Setting

The sample for this project were the care coordinators and registered nurses at a homecare organization serving five branches of rural, urban, and suburban geographic areas. There are some large cities and expansive farmland (Hamilton Niagara Haldimand Brant (HNHB) Local Health Integrated Network (LHIN, 2013). The HNHB LHIN (2013) report demonstrated that a considerable number of Aboriginal people live below the poverty line. Six Nations and New Credit reserves are located in this geographical area (New Credit is a small part of the reserve), which is the largest First Nations community in Canada (Six Nations Council, 2013). Care coordinators provide case management and system navigation services to this diverse and large population.

The Project

This cultural competence class was presented to care coordinators and registered nurses in the branches of homecare agencies closest to the Six Nations area. The module itself consisted of didactic information and several interactive activities. Cultural competence fits well with the organization's mission to provide a "seamless experience

through the health system for people in our diverse communities, providing equitable access, individualized care coordination and quality health care" (HNHB CCAC, 2014, para 4). Cultural competence also fits well in the 2013–2014 corporate work plan (n.d., All Staff Forum, July 31, 2013), particularly the focus on improving the patient experience.

Procedures

Following IRB approval from Walden University, care coordinators and registered nurses who function out of the branch offices closest to Six Nations, were invited to participate in the education session. These sites were selected because of the proximity to Six Nations and because of the higher proportion of Aboriginal people living in the community. Potential participants were informed about the education session via internal e-mail, and an invitation was extended to attend one of several scheduled sessions. A statement was provided in the invitation, explaining the purpose and length of the education session. Voluntary participation in the education session and completing the anonymous survey indicated informed consent. Direction for withdrawing assent and participation was discussed prior to starting the education session. In order to determine an adequate number of participants, an a priori power analysis was estimated. Using a small to medium effect size, a priori alpha set at 0.05; and 80 % power, it was estimated that 20 to 25 participants would be necessary to detect an effect of the intervention (Hair, Black, Babin, & Anderson, 2007; Pallant, 2013; Polit & Beck, 2014).

Data Collection

Prior to the education session, each participant was provided a survey and asked to complete nine questions printed on the front page. The first two questions were demographic questions that identified the individual's professional designation and current role. The remaining 7 questions were statements that related to the participant's knowledge of cultural competency. Using a Likert scale of 1 to 5, where 1= *strongly disagree*, 2= *disagree*, 3= *neutral*, 4= *agree*, and 5= *strongly agree*, the participants were asked to rank the 7 statements using the Likert Scale. Following the educational session, the participants were then asked to rate the same seven questions using a Likert scale of 1 to 5, where 1= *strongly disagree*, 2= *disagree*, 3= *neutral*, 4= *agree*, and 5= *strongly agree*. The post survey was printed on the back of the pre survey, thus eliminating the need for identifying information or coding. There was additional space where participants could provide additional comments at the end of post-survey. Participants were asked to leave their completed surveys on a table as they departed from the educational session.

The survey consisted of 7 questions that reflected the content of the educational session. Face validity of the survey was established by the student who is an expert among her colleagues given her extensive work with the Canadian Aboriginal people as well as a Masters in Anthropology. Polit and Beck (2014) described face validity as the extent to which a test or survey is subjectively viewed as covering the concepts it purports to measure. Face validity represents a simple form of validity in that the validity of the survey appeared to measure the target variables of the project (Polit & Beck, 2014).

Following completion of the session, the data were entered into an Excel spreadsheet and then downloaded into SPSS v.21 for analysis. (Only the care coordinator and RN data were analyzed.) The data were cleaned and assessed for missing data, normality, and outliers (Pallant, 2013). Based on the normality and linearity of the data, a Wilcoxon signed-rank test was used to estimate the data given the sample size of 15 participants (Pallant, 2013). The Wilcoxon signed-rank test is a nonparametric test used when comparing two related samples to assess where the mean ranks differ. It can be used as an alternative to the paired *t*-test when the population cannot be assumed to be normally distributed. While the data demonstrated normality of distribution, the assumptions of the Wilcoxon signed-rank test provided a stronger goodness of fit (data are paired; pairs are chosen randomly and independently; data are measured at least on an ordinal scale, Pallant, 2013). Both individual and aggregate scores of the individual questions were analyzed. While it was hoped that 20-25 care coordinators and nurses would participate, there were 15 care coordinators who were RNs.

Summary

A 1-hour class in cultural competence was provided for care coordinators and nurses in a home care setting to determine if there is an increase in knowledge about cultural competence with the hope that the increased knowledge will translate into practice. This paper is a description of a project designed to present an education session about cultural competence to the care coordinators and nurses at a homecare organization. This description includes the importance of cultural competence, the

importance of care coordinators and registered nurses valuing cultural competence, and a description of the methodology including data collection for the project.

Section 4: Summary and Evaluation of Findings

The purpose of this quality improvement project was to determine if there was a difference in perception and knowledge following a one-hour class on cultural competence among health care providers. The education took place in two branches of a home care organization in Southern Ontario. The two branches were selected because of their proximity to the largest First Nations reserve in Canada (Six Nations Elected Council, 2013). The goal of the educational intervention was to increase the current educational level among healthcare providers regarding cultural competency with the hope that the principles would be incorporated into their practice and over time, the overall care delivered to the Aboriginal people will improve.

Findings

Sample

The sample for this project included 15 registered nurses. Three staff members voiced interest in the educational sessions as they interact with patients as part of their daily work. While they were included in the sessions, their responses to the survey were not included in the analysis as the inclusion criteria for the project was limited to registered nurses and care coordinators. The final sample included 11 care coordinators, one educator (RN), and 3 client services managers (all RNs), 1 assistant, and 1 participant who did not identify.

Table 1:*Participant Positions*

Identified Position	Frequencies
Care Coordinator (RN, plus managers (RN)	15
Client Services Assistant	1
Other	1
Total Participants	17

Results

Three education sessions were held at each of the branches. The sessions were held at a variety of times in order to maximize attendance. Using a Likert scale of 1 to 5, where 1= *strongly disagree*, 2= *disagree*, 3= *neutral*, 4= *agree*, and 5= *strongly agree*, the participants were asked to rank the seven statements using the Likert Scale. The Wilcoxon signed-ranked test was used to estimate pretest scores to posttest scores. Overall, there was a statistical significant difference between the pretest score rankings and the posttest score rankings (z = -3.05, p = 0.002). Individually, four of the seven statements demonstrated statistical significance between pretest score rankings and posttest score rankings.

Table 2: *Data Analysis*

	Pretest Score Mean, (SD)	**Posttest Score Mean, (SD)**	**z, p**
Total Scores*	26.86 (2.50)	30.0 (2.76)	-3.05, $p = 0.002$
1. Culture greatly affects my day-to-day work life.*	3.86 (1.12)	4.4 (0.63)	-2.06, $p = 0.039$
2. I am comfortable with my knowledge of cultural competence.*	3.0 (0.65)	4.0 (0.75)	-2.65, $p = 0.008$
3. I am committed to learning about cultural competence.	4.40 (0.50)	4.53 (0.51)	-1.41, $p = 0.157$
4. Health disparity exists between Aboriginal and non-Aboriginal people in my community.	4.06 (0.70)	4.0 (0.65)	-1.00, $p = 0.317$
5. The Two Row Wampum is an effective mechanism in framing relationships.*	3.0 (0.65)	4.06 (1.09)	-2.32, $p = 0.020$
6. I understand my perceived power in relation to the patients that I serve.*	3.93 (0.59)	4.46(0.51)	-2.12, $p = 0.033$
7. I value sharing power with others,	4.60 (0.50)	4.60 (0.50)	0.00. $p = 1.0$

*Statistically significant at $p < 0.05$

Discussion of Results

Aboriginal people report (Tang & Browne, 2008) dissatisfaction with how they experience healthcare while experiencing proportionately higher health disparities (Betancourt & Green, 2010; Vandenberg, 2010). The literature supports that simply adding more programs has not helped to reverse either trend. Chipps, Simpson, and Brysiewicz (2008); Betancourt and Green (2010); Delgado et al. (2013); and Lee, Anderson, and Hill (2006) iterated the importance of cultural competence education for healthcare providers in order to address inequities. Like (2011) posited that cultural competence education for healthcare providers is a good strategy to reduce health disparities.

An increase in the awareness of the importance of culture was demonstrated for the first statement "Culture greatly affects my day-to-day work life" as there was a statistically significant difference between the pretest score ranking and the posttest score ranking (z = -2.06, p = 0.039). This demonstrated that the module might be a plausible method to increase cultural awareness for everyday work life. While it is easy to see culture in other people, nurses have to be aware of their own culture as well (Matteliano & Street, 2011) and that culture influences interactions with patients (Polaschek, 1998). Bourque Bearskin (2011) described culture as being everything about people, including our beliefs, actions, and thoughts. The suitcase activity in the learning module helped participants recognize the importance of acknowledging their own culture when interacting with patients.

Similarly, "I am comfortable with my knowledge of cultural competence" demonstrated statistical significance between the pretest score ranking and posttest score ranking (z = -2.65, p = 0.008). One participant shared that following the session she was less comfortable with her knowledge of cultural competence because she had not known what she did not know. Delgado et al. (2013) concluded that nurses may be better able to care for culturally diverse patients when they have cultural competence education. Understanding how patients from diverse backgrounds experience healthcare helps providers to be more effective when providing care (Khanna, Cheyney, & Engle, 2009). Outside of the education sessions, a number of participants asked about the sessions being presented more widely in the organization, and if they could be mandatory for all staff.

"The Two Row Wampum is an effective mechanism in framing relationships" demonstrated the importance of understanding that we are all treaty people. There was a statistically significant between the between the pretest score ranking and the posttest score ranking ($z = -2.32$, $p = 0.02$). Skye (2013) reported that Aboriginal people want non-Aboriginal people to know their history and contexts of health. The actual historical treaty was signed long ago, but we all share in living the values of travelling together along the waters or path of friendship, respect, and peace. An important part of travelling together is that one is not over the other; it is not a big brother little brother relationship, but rather acknowledgement that each has strengths (Two Row Wampum Renewal Campaign, 2013)

The fourth area that demonstrated statistical significance is that "I understand my perceived power in relation to the patients that I serve" with differences between the pretest score ranking and the posttest score ranking ($z = -2.12$, $p = 0.03$). Learning about the Two Row Wampum in terms of framing relationship, and already valuing the sharing of power, it is important to understand how power can be perceived. The tool that was used in the module was a flower of power, adapted from the University of Victoria (n. d.) modules teaching cultural safety. Working through the flower of power and assigning perceived power for an example of a patient-nurse relationship was helpful in really understanding the importance of perceived power. Matteliano and Street (2012) iterated the importance of addressing the power imbalance that occurs in patient provider relationships. As providers, assessing perceived power may not seem important, however,

if the patient perceives the provider as having more perceived power, then health care can be compromised (Matteliano & Street, 2012).

Summary of Written Comments

At each session, the level of participation may be described as highly interactive with the majority of the participants engaging in discussion and 12 of the 15 surveys had written comments. Some of the comments included: “an easy to follow, engaging way to learn”; “the sessions allowed for active participation and encouraged self-reflection”; “the session will be an enhancement to my practice and patient care”. Matthews-Maich, Ploeg, Jack, and Dobbins (2011) discussed the importance of critical reflection and critical discourse for encouraging nurses to use evidence-based practice. Critical discourse is one strategy to assist nurses to recognize that prejudices exist, and that there is a power imbalance in the patient-provider relationship. Learning how to redress these issues is a role for education sessions and may further engage nurses.

Education in cultural competence would be similar to Dempsey, Reilley, and Buhlman’s (2014) finding that nurses need training related to the patient experience; this is what will drive an improvement in overall patient satisfaction and may improve patient outcomes. One participant (care coordinator) made the comment that healthcare providers have to remember that “poor health care is not just directed at Aboriginal people, but is Canada wide to all cultures,” a telling statement of general perceptions of healthcare by those we serve. One participant (care coordinator) expressed thanks for the information shared, and also shared her story written by an Aboriginal nurse participating in a palliative care workshop. This nurse told about how she felt the two parts of her

functioning together in order to provide whole care for her patients. The two parts are the "hundred year old woman (healer) and the registered nurse". The most frequent comment was that participants want to learn more about the health care disparities faced by Aboriginal people and more about cultural competence.

The desire to know more about cultural competence is evidenced in Larson, Herx, Williamson, and Crowshoe's (2011) discussion of family medicine residents' reporting discomfort in best caring for their Aboriginal patients. Increasing knowledge in cultural competence is a way to address this kind of discomfort and was seen as important by care coordinators in this project (Question 2, Table A2). Many participants did not know the Two Row Wampum prior to the education session; however, this can be seen, in part, as knowing the history experienced by Aboriginal people. Knowing the history and being aware of the treaty of the Two Row wampum help providers to provide the safe space required for culturally competent care to be provided (Ontario Federation of Indian Friendship Centres, 2013; Skye, 2013).

Findings in the Literature

Cultural Competence

The participants in this 1hour education class on cultural competence now have been provided with the foundation awareness on which to critically reflect on perceptions of power and to further explore ideas of cultural inequities. Matthew-Maich et al. (2010) contended that change is adopted and sustained when nurses engage in critical reflection and discourse. This learning module is an opportunity for nurses to examine their biases and prejudices, and then engage in critical discussion thereby allowing for nurses to

address the systemic racism that aboriginal people experience (Reading & Wein, 2009; Tang & Browne, 2008).

Betancourt and Green (2010) said that cultural competence is a journey, and Matteliano and Street (2012) stressed the importance of redressing the power imbalance in the patient-provider relationship. Having some tools like the Two Row Wampum as a way to frame relationship and the flower of power to think about perceived power can influence how nurses can engage in the continuous learning that is required for cultural competence. Participants in this project identified that the Two Row Wampum is an effective way to frame relationships (Question 5, see Table A2). A program aimed at promoting cultural competence at both the individual and system-wide levels has experienced success. Individuals feel better equipped in terms of cultural competence, and there are indications of system changes (Ambtman, Hudson, Hartry, & Mackay-Chiddenton, 2010).

Critical Social Theory

Participants in this cultural competence education recognized that Aboriginal people face health inequities (Mikkonen & Raphael, 2010; Reading & Wein, 2009). Fourteen out of 18 participants responded that they agreed or strongly agreed that "health disparity exists between Aboriginal and non-Aboriginal people in my community." The Public Health Agency of Canada (2011) and Health Canada (2013) data demonstrate that adding more and more programs has not stemmed the tide of increasing disparities experienced by Aboriginal people. Tang and Browne (2008) and Browne and Varcoe (2006) posit the need for a change in approach in how care is provided. One suggestion is

that if providers learn and practice using the principles of cultural competence, then health outcomes will improve for Aboriginal patients and other patients who experience racial or ethnic disparities (Betancourt, Green, Carrillo, & Park, 2005; Campinha-Bacote & Narayan, 2000; Horvat, Horey, Romios, & Kis-Rigo, 2011). Engaging in a class on cultural competence can be the first step for many nurses to start to address the inequities and health disparities felt by Aboriginal patients. As the participants critically reflect and discuss the issues around racism, prejudice, and power imbalances in the patient provider relationship, emancipatory knowledge is gained (Chinn & Kramer, 2008). As providers develop their cultural competence, relationships will change, and there is real potential for improved health outcomes for Aboriginal patients (Hart-Wasekeesikaw, 2009). The beginning of learning cultural competence is indicated for care coordinators with the statistically significant responses for the survey questions about cultural competence (see Table A2).

Implications for Practice/Action/Social Change

Providing education on cultural competence has the potential to help care coordinators and nurses to shift how they develop and maintain relationships with patients. Redressing the power imbalance with Aboriginal patients can allow for a safe space for the Aboriginal patient to discuss care and perhaps make positive health choices. When more Aboriginal patients make positive health choices, then the possibility exists for improved health outcomes for more of the community. This is the positive social change that can turn the tide and bring balance to the health disparity equation.

Project Assessment

Strengths

An important strength of this project is that health care providers were engaged in a discussion about racism, power, and cultural competence in healthcare. The participants were actively engaged in the topic and it seemed that the topic was important to them. When people from non-dominant cultures perceive racism and power imbalance, then it is essential for healthcare providers to examine and redress these issues.

A subtle strength of this project is that it has started good conversation around cultural competence at the homecare organization. This quality improvement project was included in the presentations for patient safety week and was attended by members of the homecare staff as well as service provider staff. This cultural competence education is now being considered for inclusion in the new staff orientation process.

Limitations

As with all projects, there are limitations that must be addressed. First, a limitation of this project was the number of participants. The a priori power analysis estimated 20 to 25 participants were needed to detect an effect of the intervention; however, recruitment yielded only 15 participants. It is suggested that for future projects, creative and strategic recruitment strategies be used in order to maximize the attendance of the educational session. For this project, having face-to-face sessions may have limited attendance, however, the delivery mode allowed for interaction and engagement among the care coordinators and registered nurses. Identifying convenient times, for example,

scheduling additional sessions while providing lunch may enhance the number of participants.

A second limitation of this project was that face validity of the survey was established by the author of the survey only. For future projects, it is suggested that face validity be established by a group of professionals knowledgeable in culturally competency in order to identify items that are unclear or ambiguous. Establishing more rigorous psychometric properties, including reliability may be explored.

All statistical tests have their own sensitivities to consider. The Wilcoxon signed-ranked test assumes that one can rank order the magnitude of differences in a matched observances and the median of the difference scores equals zero. While the data met the assumptions of normality of linearity, it is suggested that the results be interpreted with caution (Hair, Black, Babin, & Anderson, 2007; Pallant, 2013; Polit & Beck, 2014).

Recommendations

Given the results of this project, it has been recommended that this 1-hour education class be included in orientation of new care coordinators and registered nurses. Moreover, the education should be made available for all staff that would like to participate. Because of the systemic racism that is felt by Aboriginal patients, more value might be felt by maintaining the voluntary nature of participation in this learning module. As more nurses find value in practicing using the principles of cultural competence, they will critically discuss this with colleagues. This kind of dissemination can help to drive

the change that will lead to culture change about cultural competence and provide for sustainability.

This educational intervention may assist staff, care coordinators and registered nurses to identify and manage their personal biases regarding patients. Balsa and McGuire (2003) described how beliefs about patients may contribute to and perpetuate disparities among specific groups of patients. Given that health disparity is of concern for the Aboriginal people, educating nurses, care coordinators, and staff regarding the importance of cultural competence may allow them to identify with personal biases, reduce disparity towards this specific group, and potentially enhance the care delivery to the Aboriginal people.

Involving the stakeholders, Aboriginal people, whose core beliefs are not fully understood by the care providers, may enhance the content of the educational intervention. Kersey-Matusiak (2012) posited that for providers to understand the needs of the population, the population needs to be involved in their care. Thus, having the cultural program taught, in part, by one of the Aboriginal elders may assist the care coordinators and registered nurses to understand the cultural variations of the Aboriginal people. Then, as a result, the group may come together to create strategies for enhancing patient-centered care for the Aboriginal people.

Analysis of Self as Scholar/Practitioner/Project Developer/or as Professional

One's development or growth as a scholar or practitioner must involve an inner journey similar to Souba's (2006) inner journey of leadership for the growth to be meaningful. This journey of developing and implementing an interactive learning

education module on cultural competence, as a quality improvement project, has been just that. This journey is indeed continuing through the critical reflexive practice that is important in developing cultural competence. Examining my values in terms of respect and empathy (Health Council Canada, 2011) situated in the idea of critical social theory (Lapum et al., 2012) has helped me to identify the parts of systemic racism that I unknowingly perpetuate: And can now redress.

Project development has the potential to inform sustainable quality improvement (Hodges & Videto, 2011). Following the steps of assessing the need, addressing the need, and evaluating the project were all undertaken. Stakeholder engagement was pursued, notwithstanding minor barriers to implementation due to overlooking one essential but previously unthought-of, stakeholder. A major lesson regarding project development and implementation is that the developer's timeline may not mesh with that of the organization. The American Association of Colleges of Nursing (2006) essentials of doctoral education for advanced nursing practice capture the major categories of my learning, particularly the scientific underpinnings for practice and organizational and systems leadership for quality improvement and systems thinking. If health care providers practiced using the principles of cultural competence, there is great potential for attitudes and behaviors to change thereby allowing for improved health for Aboriginal patients.

Summary and Conclusions

The 1-hour class on cultural competence that was presented to care coordinators and registered nurses at a home care organization has the potential to change how care

delivery is practiced. Statistical significance was noted in 4 out of the 7 items on the questionnaire, providing strength in the value of cultural competence education for these providers. The analysis demonstrates that participants increased their knowledge of identifying that culture affects daily work life, achieving a rudimentary understanding of the Two Row Wampum, and learning a way to understand perceived power. The other statistically significant item demonstrated an increase in participant's comfort level with their knowledge of cultural competence.

Section 5: Executive Summary

Health disparities exist for Aboriginal people in Canada. Aboriginal people describe systemic racism and have experienced generalized historical trauma in the form of colonialism and the resultant residential school system. The problem is two pronged; there is evidence that Aboriginal people do not trust mainstream healthcare or healthcare providers and healthcare providers do not provide an environment that makes Aboriginal patients feel culturally comfortable when accessing care.

One solution to this challenging situation is to change the way that providers look at the importance of culture and power in healthcare. Learning about and then learning to value the principles of cultural competence is a way for providers to examine their own biases and prejudices. Engaging in this kind of essential reflection and discourse with colleagues has the potential to encourage examination of society in general in terms of systemic racism. This is the purpose of critical social theory and the goal is social change.

The opportunity exists in homecare in Southern Ontario (and anywhere where social inequity exists) to start to learn about cultural competence. When attitudes change, behaviors change, and the relationship between nurses and Aboriginal patients can shift in terms of power. Recognizing how power is perceived and then learning how to maintain power with instead of power over patients can be an effective way for building confidence and in turn setting the foundation for Aboriginal patients to make healthier choices.

This 1-hour class on cultural competence outlines the social, historical, and political contexts of health for Aboriginal people. There are several activities that help

participants understand how culture affects our daily lives, the effects of colonialism and residential schools, and how power can be perceived. The pre and post class survey demonstrated significance in the learning in relation to four statements: Culture greatly affects my day-to-day work life; I am comfortable with my knowledge of cultural competence; the Two Row Wampum is an effective mechanism in framing relationships; and I understand my perceived power in relation to the patients that I serve.

The recommendation from this author is that cultural competence education be provided for all healthcare providers. The education for this class presented a brief overview of the topics described; more is required for providers to continue to develop their cultural competence. Cultural competence should be evident throughout corporate work plans in healthcare. Continually developing one's cultural competence can allow for real societal change for those with any diversity and most notably for Aboriginal people in Canada.

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Appendix A: Pre-Survey (Post survey has the same questions)

Cultural Competence Education

Your role: CC RN

Cultural Competence: Pre-survey

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Culture greatly affects my day-to-day work life					
I am comfortable with my knowledge of cultural competence					
I am committed to learning about cultural competence					
Health disparity exists between Aboriginal and non-Aboriginal people in my community					
The Two Row Wampum is an effective mechanism in framing relationships					
I understand my perceived power in relation to the patients that I serve					
I value sharing power with others					

Additional comments:

I hope that you find this learning module informative

Appendix B: The Two Row Wampum