Impact of a Cultural Awareness Educational Intervention to Improve Cultural Safety to

Minorities in Hawai'i.

Kimberly U'ilani Chow-Rule

The University of Hawai'i at Hilo

This practice inquiry project has been approved for meeting partial requirements for the Doctor

of Nursing Practice Degree at the University of Hawai'i Hilo School of Nursing

Committee Chair:
Jeanette Ayers-Kawakami

Committee Member:
Katharyn Daub

Table of Contents

Abstract

Globalization has resulted in cultural diversity across the nation. In healthcare, people of minority cultures and ethnicities experience a more significant effect on negative health issues. Health care has evolved into an evidence-based science that does not always take into account the culture of the patient. Culture plays a role in how people interact with others. Cultural safety is a concept that describes the dismissive treatment of native peoples that is not respectful or inclusive of their values and customs. The trust built within these relationships helps to create expectations and cooperation that is mutually beneficial for both parties. Cultural humility is the goal of cultural safety and is a critical factor in building a foundation for a trusting, beneficial relationship. Project participants will receive a three-hour online educational module along with a pre and post-test. The goal for this project is to increase the awareness of the importance that creating a culturally safe atmosphere is an integral part of providing quality health care to Native Hawaiians and other minorities in Hawai'i. It is the assumption that the outcome of this project will result in improved therapeutic relationships between providers and patients, which will translate into improved health outcomes for their patients. The project recruited a small number of participants and as a result, statistical significance was not found. Comments from the participants found the educational module to be timely, important and useful

Keywords: Culture, Cultural Safety, Cultural Humility, Minority, Native Hawaiian, Education

Chapter 1: Statement of the Problem

The relationship between provider and patient often presents an imbalanced power relationship. Often the provider makes decisions on care and treatment with minimum input from the patient, with the expectation that the patient will comply with the plan. When a patient does not follow the care plan, they are labeled non-compliant. Non-compliant is a label commonly attached to many Native Hawaiians and other minorities. Not coincidentally, Native Hawaiians suffer from many health disparities despite efforts to increase access to health care.

The people of Hawai'i are a mix of cultures and backgrounds. Culture plays a role in how people interact with others. The belief, values, and pedagogy taught in medical and nursing schools created and modeled from Western and European education and methods are the best and correct way medical care should be delivered. The lack of inclusion and consideration of native culture and values in health care leads to a lack of cultural safety. The goal of cultural awareness training for nurses and care providers is to increase cultural humility and change attitudes towards the importance of providing cultural safety, which will address the power imbalance and create a mutually trusting relationship between provider and patient. This increase in inclusion and trust may ultimately improve patient outcomes and specifically address the health disparities commonly found in native peoples.

According to a report from the Hawai'i State Center for Nursing (2019) states that only 11% of nurses employed in Hawaii have some Native Hawaiian ancestry. However, the population of Native Hawaiians is 26% (U.S. Census Bureau, 2018.) The imbalance of native caregivers to indigenous patients is another argument of the need for cultural safety and cultural awareness training.

Cultural safety is a concept that describes the treatment of native peoples that is not respectful or inclusive of their values and customs. Cultural Safety is a term coined by the New Zealand Maori (Native people of New Zealand) and Maori nurses to describe discrimination present in medical care and nursing education. Maori nurses argued that their culture was not equally represented in health care and cited the treaty of Waitangi, which recognized native peoples and culture as equals among their European Colonizers (Nursing Council of New Zealand 2011). Their goal was to bring awareness and improvement to both the overt and implicit bias occurring in their health care system.

Native peoples have long suffered from poor social determinants and health disparities, even in the presence of programs aimed to help improve these disparities. Despite advances in health care and evidence-based practice, health care disparities still exist among minorities (Lee, Fitzpatrick, Sung-Yi, 2013). This pattern is continued in Hawai'i. According to a 2013 report published by the University of Hawai'i at Mānoa JABSOM Department of Native Hawaiian Health, Kanaka Maoli (the Hawaiian word for Native Hawaiian) and Pacific Islanders are the poorest among all ethnic groups in Hawai'i, with almost 20% living in poverty and 18% living below the poverty rate (Look, 2013). The life expectancy for Kanaka Maoli has been consistently lower in the state of Hawaii, with an average age of 74.3 years of age. Kanaka Maoli has a disproportionately higher prevalence and mortality rate from chronic conditions such as heart disease, cancer, stroke, and diabetes (Look 2013).

Health promotion programs too often focus on either improving outcomes or on ways of improving healthcare access. What is lacking from these programs is the formation of trusting relationships between client and provider. The trust built within these relationships helps to create expectations and cooperation that is mutually beneficial for both parties. Cultural humility

is the goal of cultural safety and is a critical factor in building a foundation for a trusting,

beneficial relationship. Cultural humility is the ability of the provider to recognize their own

bias and avoid imposing their values or opinions upon another (White, et al., 2017), practicing

cultural humility shifts the power of the relationship from the provider to a shared control

between the provider and client.

Significance

The term cultural safety and cultural awareness is often confused with cultural

competency. Cultural competency is the "attitudes, knowledge, and skills necessary for

providing quality care to diverse populations" (Isaacson, 2014). However, achieving cultural

competency does not necessarily lead to having the knowledge and skill to deal with every

person or situation from a specific culture. Also, cultural competency runs the risk of creating

stereotypes by oversimplifying diversity within a culture or group. It may give that person a

false sense of mastery, which may lead to decreased efforts to expand their knowledge (Isaacson,

2014).

The concept of cultural safety is similar to cultural discrimination but addresses explicitly

the harm that can come from cultural bias. If being safe is to be free from harm, then providing

health care that does not harm someone culturally would be care that is effective and culturally

safe. While cultural competency refers to a person or organization's ability to provide care to

people with diverse beliefs, values, behaviors, and linguistic needs (Health Research and

Educational Trust 2013), cultural safety refers to providing care that protects patients from bias

and stereotype. Because there is an abundance of cultural norms, traditions, beliefs, and

behaviors, providing cultural competency training would be lengthy and complicated to master.

The approach of cultural humility is to have the provider become aware of their own bias so that

they can recognize when their behavior may be affecting the conversation, teaching, or treatment

of their patient (Lee, Fitzpatrick, Sung-Yi, 2013).   This approach provides a safer environment

for patients to participate and feel comfortable working with the health care provider. This

approach aims at improving the relationship between the provider and patient to affect health

outcomes positively.

There are many efforts made to address the health disparities of Kanaka Maoli. Programs

include: Ke Ola Mamo, part of the Native Hawaiian Health system provides access and

educational services to Kanaka Maoli. Community centers such as The Waianae Coast

Comprehensive Health Center and Waimanalo Health Center are community clinics located in

areas with high populations of Kanaka Maoli. These Centers also offer primary health care and

special programs to remove access barriers for Kanaka Maoli. Although these programs are very

beneficial and provided much-needed care and access to Kanaka Maoli, there is still a great need

to improve health outcomes.

According to the Department of Health and Human Services website, Healthy People

(HP) 2020 (2017), determinants of health are factors that contribute to the overall health of a

person. Such factors include economic, personal, social, and environmental. Social determinants

are multi-factorial and interconnected. HP 2020 breaks down social determinants into five

categories: policymaking, social factors, health services, individual behavior and biology, and

genetics. Social factors include barriers such as discrimination and interactions. Health services

include obstacles such as limited language assistance. All the obstacles result in unmet health

needs or delays in receiving care

How Cultural Harm Happens

Kanaka Maoli first experienced the effects of foreign contact by contracting and

succumbing to diseases they had no immunity. Later, European missionaries imposed their

religion and social practices upon Kanaka Maoli with the intent of improving their physical and

spiritual lives. As the European and later American settlers continued to impose their culture and dominance over the Kanaka Maoli, they became more marginalized. Historical trauma is a result of acts and events such as genocide, loss of culture, and other events inflicted on a particular group of people. This trauma results in traumatic stress disorder and deep-rooted anger that perpetuated through generations (Clark 2017). This concept can apply to why some Kanaka Maoli finds it challenging to break familial patterns and stereotypes, resulting in low self-esteem and self-care.

Stoil (2006) found in his study that when the native population speaks the predominant language (English), the assumption is that they (Kanaka Maoli) accept and have assimilated into the dominant culture. Language is more than just the lexicon used to communicate. Communication is also a way of connecting with others and includes words, body language, actions, and customs. This assumption leads to judgments upon the Kanaka Maoli as to why they may not be complying or conforming to the expectations of the predominant culture.

Health care providers may become frustrated with Kanaka Maoli, who does not comply with the prescribed care plan. In the health care setting, increasing the comfort level and communication between the provider and the client would result in higher health literacy, increased engagement with effective health care planning and goal making, which ultimately leads to greater compliance with the agreed-upon plan. Although strategies on client involvement in care planning are not new, cultural humility was not part of that strategy.

Cultural Competency VS Cultural Humility

Cultural competence is a common strategy used to train staff. However, it is overwhelming and impossible to achieve cultural competence in a world of multi-ethnicities as well as variations within the culture. Another downside of cultural competence training is those who believe they are culturally competent may still hold on to negative stereotypes. Cultural

humility and cultural awareness training focus on bringing awareness of the participant's own cultural bias and provides communication skills to elicit understanding by the provider. This skill applies to a variety of situations and social groups such as LGBT, veterans, and disabled groups (Hook, 2013).

Health disparities include chronic diseases such as diabetes and hypertension and are prevalent in the primary care setting. Therefore, if primary care settings improve their communication with Kanaka Maoli, trusting relationships may result. It is within these relationships that mutually agreed upon care plans are crafted, resulting in compliance with the care plan increases. There may be times that the client may not be ready to address their health issues due to socioeconomic barriers. A trusting relationship between provider and client facilitates safe and open communication to discuss the matter and find potential solutions for the problem. A client will more likely address the more significant concerns of health when fundamental issues such as food security and safety.

Problem Statement

The relationship between provider and patient often presents an imbalanced power relationship where the provider makes decisions and plans and expects the patient to follow that plan. The people of Hawai'i are a mix of cultures and backgrounds. Culture plays a role in how people interact with others. Cultural safety is the term used to describe a relationship and environment between health care workers and patients that impose their values and discounts on the cultural beliefs and values of the patients. The goal of cultural awareness training is to increase cultural humility and cultural safety, which can address the power imbalance between health care workers and patients, resulting in improved patient self-efficacy and job satisfaction.

Among Registered nurses and Nurse Practitioners who work on O'ahu, Hawai'i, how would cultural awareness training affect the attitudes and behaviors?

The expected short-term effect of this project is to educate providers to be aware of their attitudes and behaviors regarding the care they give to Kanaka Maoli and other minorities in providing a culturally safe therapeutic environment. The long term effect of this project intends to decrease health disparities among Kanaka Maoli and other minorities.

Aims and Objectives

Aim 1.   Increase knowledge of cultural awareness among health care workers in a rural health care setting. Objective 1- Identify evidence-based models regarding cultural safety in the healthcare setting. Review these various models for potential use in the educational training session. Objective 2 - Based on the model identified, develop or identify an online educational module that Registered Nurses and Nurse Practitioners can easily access.

Aim 2. Provide education regarding cultural safety concepts to healthcare employees in rural community healthcare settings. Objective 1- Participants will complete the pre and post-test as part of the educational module. The results will be utilized to measure cultural awareness and attitude change among the study participants. Objective 2- Participants will utilize a self-reflection written assignment on how the training will impact the way they practice.

Aim 3. Determine the effectiveness of the educational module regarding cultural safety in the healthcare setting for potential use in staff training. Objective 1- Using a pre and post-survey, evaluate the results and effectiveness of the educational module regarding cultural safety practices and personal bias. Objective 2- Based on the survey results, determine the feasibility of the online educational training for potential adoption in rural healthcare settings as an educational tool for employee training. Objective 3. Present findings to organizations that provide care to minorities, such as Wai'anae Coast Comprehensive Health Center and Queens Medical Center, and recommend the use of the educational module to be adopted as part of their continuing education for frontline providers.

Chapter 2-Background and Project Description

Cultural safety issues among other native populations such as those in New Zealand and Canada have been identified. Kanaka Maoli experiences a parallel history and experiences as these native populations with similar concerns of cultural safety in healthcare. It would be easy to assume that the interventions to promote cultural safety among native populations outside of the United States can be adopted here.

Cultural Safety and Cultural Humility

The terms of cultural safety, cultural humility, and cultural competency are often mistakenly used interchangeably. The term cultural competency refers to training regarding the values and practices of a specific culture to gain understanding. Cultural competency intends to work together with the client by understanding their culture. (Martin, 2016). This concept is described in the Transcultural Nursing Theory (also known as the Culture Care Theory) by Madeline Leininger (1991). According to Leininger, culture influences health, perception, and coping skills. Cultural knowledge is an essential component of nursing care. In developing cultural competency, one develops understanding and respect for the beliefs and values of others. Dudas (2012) echoes this same understanding that cultural competence is a process of understanding and awareness of different attitudes and beliefs. However, there are concerns that this type of training can lead to miscommunication and stereotyping. Someone trained in cultural competency may have a false sense of confidence in their ability to work with a person of a different culture from them. It is this stage that is the most dangerous for misunderstandings and for cultural jeopardy to occur (Isaacson, 2014).

Cultural safety recognizes and respects the cultural identity of the client and the provider. Cultural safety acknowledges that cultures can still have variances within them and allows a person to express their values and beliefs about how they wish to do so. It also recognizes that

the provider has their own beliefs and values. Cultural safety is a practice that also shares power in the client-provider relationship (Polaschek, 1998). Providing culturally safe care recognizes a person's membership in a cultural group and its position in society. Cultural safety respects and nurtures the cultural identity of the client (Polaschek, 1998).

Cultural safety is the result of cultural humility. Cultural humility the lifelong process of self-reflection, self-examination, and the ability to address the power imbalance that exists between the provider and client. (Lee, Fitzpatrick, Sung-Yi, 2013). The QIAN model was created to describe the process of cultural humility. The acronym is as follows: Q- questioning as in the importance of continuous self-questioning. I- immersion, recognizing the importance of cultural immersion. When a provider is working with a particular cultural group, the provider can gain understanding and respect by attending and participating in cultural activities. A- active listening. More than just passively hearing what is said, active listening requires the use of all senses, concentrating, and seeking to understand what is communicated. N- negotiation, as in when working on a plan of care, being flexible to involve the client in the plan and with the outcomes of that plan (Foronda, 2015)

Health Status of Kanaka Maoli

The health of native peoples subjected to colonialism has consistently been poor when compared to the predominant population. According to Hutchinson (2014), the American Indian and Alaska Native population has higher rates of obesity, diabetes, cardiovascular disease, and metabolic syndrome. The same is true for the Kanaka Maoli. Life expectancy for a Kanaka Maoli is 6.2 years lower when compared with the general population of the State of Hawai'i. Kanaka Maoli has the highest rates of mortality from chronic diseases than any other ethnicity and ranks among the worst for chronic disease morbidity (Look 2013).

According to Danaher (2011), people with lower income and education correlate to poorer health, higher rates of chronic diseases, and shorter life expectancy. The same is true for Kanaka Maoli. Before the arrival of Captain Cook to the Hawaiian Islands, an estimated one million people lived and thrived in these islands. With the introduction of western illness, the population declined. As more foreigners arrived, strange ways and customs were introduced and integrated into everyday life. Businesspeople recognized the value of the land and began acquiring it for plantations. As time went by, Hawai'i became more colonialized, and the Kanaka Maoli became marginalized. With the overthrow of the monarchy in 1893, Kanaka Maoli developed a distrust for the newly formed white government. With the expansion of the sugar and pineapple industries came a massive influx of immigrant workers. Kanaka Maoli found themselves displaced further from their land and culture. The Kanaka Maoli struggled to keep their cultural identity while struggling to survive in modern Hawai'i.

According to a 2013 report published by the University of Hawai'i at Mānoa JABSOM Department of Native Hawaiian Health, Kanaka Maoli and Pacific Islanders are the poorest, both in health and wealth, as compared to other ethnic groups residing in Hawai'i. Almost 20% of Hawaiians live in poverty, and among those, 18% live below the poverty line (Look, 2013). The life expectancy for Kanaka Maoli has consistently been the lowest when compared with the general population in Hawai'i. According to Wu et al. (2017), the average lifespan for people in the state of Hawai'i is 82.4. For Hawaiians, the average lifespan is 76.6. Kanaka Maoli has a disproportionately higher prevalence and mortality rate from chronic conditions such as heart disease, cancer, stroke, and diabetes (Look, 2013).

The colonialization of native peoples, including Kanaka Maoli, have resulted in historical trauma. Trauma from being separated from their culture, values, government, and land results in

poverty, domestic violence, family stress, alcoholism, and a cycle of self-destructive symptoms. The trauma inflicted on one generation gets passed down to the next generation and the next (Ross, nd).

Social Determinants

Health care is more than just medical care received in a clinic or hospital. The influence of social-economic factors plays a much more significant role in health (Lee, Fitzpatrick, Sung-Yi, 2013). Cultural differences, lack of minimal health care access, poverty, and care from professionals that are not culturally safe are a significant contribution to health disparities (Lee, 2013; De, 2008).

There are many programs in existence to reduce disparities. These programs intend to educate Kanaka Maoli on the importance of diet and exercise and other self-care behaviors. Programs also exist to help with access to health care. However, efforts to improve disparities need to go beyond these actions. Health is a lifelong adaptive process that addresses the needs of the person (Halfon, 2002). Despite the recognition that health disparities among native people are widespread and significant, the literature on preventative care is sparse (Capell, 2008). Inequities in the health care workforce are also present. According to Isaacson (2014), only 16% of all nurses in the US are from a minority group. Only 11% of nurses in Hawai'i identify as Native Hawaiian (Hawaii State Center for Nursing, 2019). With a workforce that does not represent the changing racial demographics of the United States and Hawai'i, it is essential for health care providers to have better training in working with a culture other than their own (Dudas, 2012).

Health Care Ethnocentrism

With the emphasis on evidence-based practice in providing quality health care, ethnocentrism exists in the studies used to provide the evidence. Many studies either do not

include or do not identify the ethnicities of participants. Research studies also contain a bias of western view on health, the body, and what health behaviors are (Lee, Fitzpatrick, Sung-Yi, 2013). Ethnocentrism is blind. Many people with the best intentions and desires to help others may not realize how their own cultural bias is creating harm. Issacson (2014) described a group of nursing students who participated in a cultural immersion activity with Native Americans. The students were instructed to write their reflections on the experiences before, during, and after the activity. The reflections were analyzed and found that many of the students held unrealized prejudice and stereotypes. Another typical response from the students was how uncomfortable they felt being a minority for the first time in their lives. Had the students not have that cultural interaction, they would not have realized their own bias.

The unknown bias that exists in health care providers results in a lack of awareness, skill, and support in providing appropriate care for native peoples. As a result, patients-treatment nonadherence, reduced patient satisfaction, diagnostic errors, recovery complications, and poor outcomes continue to occur (Delgado, 2013). The best way to address personal bias is with an awareness of one's thoughts and values. Having the desire to understand personal bias and values is necessary to understand the needs of others.

It is also essential to recognize that people can identify with more than one group. A person may belong to a cultural group, a social, and an occupational group. Each of these factors influences one's overall values and behaviors (Dollarhide, 2016). The lack of this acknowledgment can result in discord between the provider's belief that they are providing the best and most unbiased care and the patient's understanding of health and priorities resulting in health inequality and disparities (White, et al., 2017).

Benefits of Cultural Safety Training

The culturally diverse population that exists today calls for better communication and relationship building between provider and client. There is overwhelming evidence of disparities among native peoples despite the many programs and services created to address it. As a result, there are many missed opportunities to positively affect health and decrease disparities (Delagdo, 2013). With increased cultural safety comes earlier interventions resulting in earlier diagnosis and treatment plans, which are culturally congruent with the values of the patient, family, and community. Supporting the patient's health practices, along with western medicine, improves opportunities for health promotion and disease prevention and promotes the quality of care initiatives (Dudas, 2012). Cultural humility among the health care provider increases communication and fosters mutual trust—a trusting relationship results in improved overall health for individuals and community resiliency (Danaher, 2011). A provider who places value in understanding and seeking to provide cultural safety will foster a shared understanding of a client's needs. Increasing indigenous staff also aids in a supportive environment and fosters better communication and understanding (Gomersall, 2017).

Think cultural health. The U.S. Department of Health & Human Services created a website called Think Cultural Health. It was launched in 2004 to improve health equity by providing continuing education opportunities and educational resources for health care professionals. The website includes information on the National CLAS standards, educational modules specific to various health care disciplines, educational resources. The site offers educational modules designed specifically for behavioral health professionals, disaster personnel, nurses, oral health providers, and physicians. There is also a module provided in the Spanish language. The modules are cost-free and provide accredited continuing education credit for completion of the modules. The module fits well with the aims of this project. The nurse

specific courses specifically cover how to deliver culturally and linguistically competent nursing care, self-awareness tool, strategies for providing patient-centered care, communication techniques, language assistance tools, and reviews the CLAS standards. The Physician (Nurse Practitioner) modules cover the CLAS standards and strategies for delivering patient-centered care, communication, and language assistance, and reviews CLAS related activities, including strategic planning and community assessment.

Malama kou piko. In her book Nānā I Ke Kumu, Pukui, Haertig, and Lee (1972) describe the Hawaiian concept of the piko. By definition, the piko (Image 1) is the umbilical cord, the genital organs, the posterior fontanel, or the crown of the head. These points represent an attachment or a relationship with one's ancestors, health, and descendants; it is now known as the Triple Piko.

The Piko Po'o (head) is the connection to ancestors and gods. Specifically, it is the area where the hair whorl or cowlick is located. This area is where the spirit enters or leaves the body during dreams or excursions and is the symbolic umbilical cord between mortal man and his ancestors.

The umbilical cord is the link between the infant and its mother. The Piko Kino (belly button) is the symbolic link to all blood-kin. Close relatives may poetically refer to a child as "my piko." This piko is the connection to the earth, to family here on earth. It is also the symbolic connection to health, food, and the 'āina (land). There are many customs and ceremonies around the cutting of the umbilical cord. The technique depended on the rank or gender of the child, where, and who severed the umbilical piko. Even the storing of the piko and the placenta held many instructions necessary for the health of the child.

The Genital Piko is said to be the source of creation, the progenitor. Kanaka Maoli both

revered and enjoyed the Genital Piko. Songs and hula were written and danced in honor of the

Genital Piko.   The Hawaiian mindset never considered this to be vulgar. They felt that without

this piko, there would be no children, no descendants. This piko represents the future and all it

holds.

PIKO: Head
Aumakua, Ke Akua (God)
'Uhane (spirit) Ancesters,
Culture

PIKO: Genitals
Future Decendents,
Responsibility

PIKO: Navel
Physical Health,
Family, Earth,
Education, Legacy
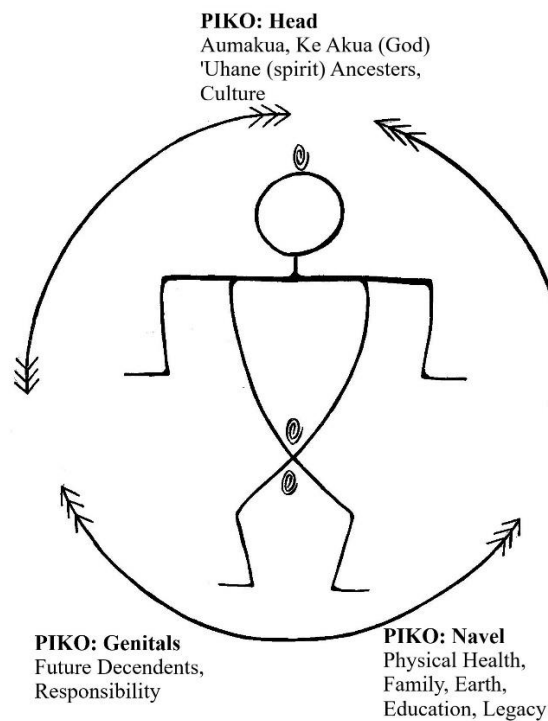
Image 1 The Triple Piko

Even in modern times, this concept of mālama kou piko (take care of your piko) exists.

David Sing (2008) wrote about how his mother would often implore to her children and

grandchildren to "mālama kou piko." Sing writes about how his mother would ask her family to

take care of each other, to maintain and nurture the relationship with those in the present, past,

and future. Sing describes that his mother would emulate mālama kou piko by the respect she

showed her siblings and her family, respecting her womanhood, through the stories she told and

through her actions towards others. This concept of mālama kou piko has been passed down through generations. However, for some families, this concept may have been passed down incompletely, with some of the concepts are present with other parts missing. This passing of an incomplete health concept may contribute to the ill health of the Kanaka Maoli, without them even knowing it. Many young Kanaka Maoli today are re-learning and reviving these concepts.

Models and Theories

The theoretical model used in this project is the Tucker Patient-Centered culturally sensitive health care model. The model depicts how provider cultural sensitivity not only leads to a change in health-promoting lifestyles and adherence but also shows how it leads to trust in the provider and willingness of the patient to try a new regimen or medication.
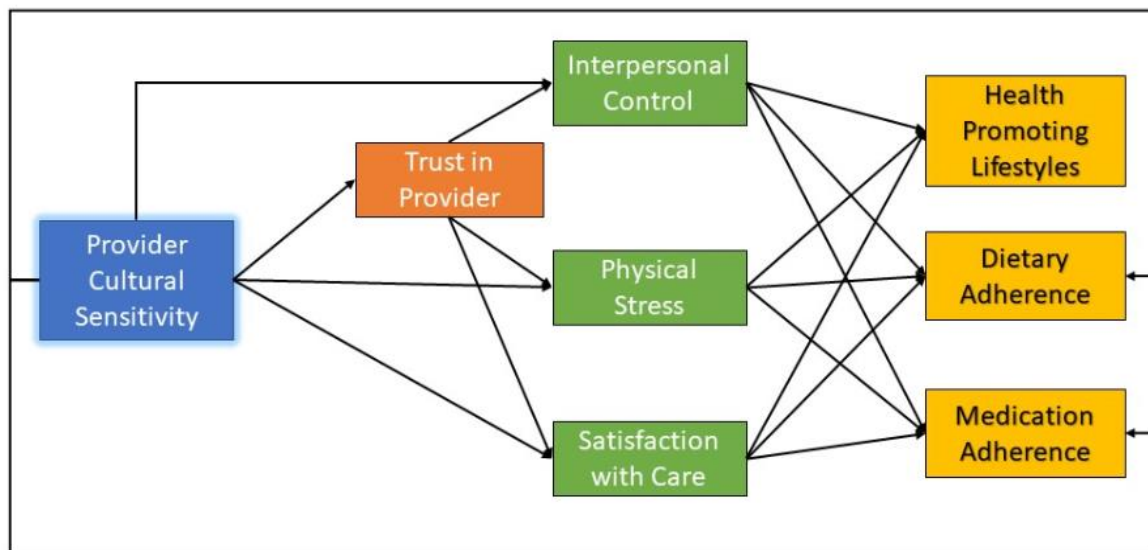

Figure 1. The Tucker Patient-centered, culturally sensitive health care model.

The Health Empowerment Theory, as described by Shearer (2009), is based in part on Rogers' Science of Unitary Human Beings. The theory states that health empowerment comes from a synthesis of personal resources and social-contextual resources. It recognizes that a

person's environment, awareness of patterns, and the ability to participate in health and health care decisions affect their overall health and well-being. The four principles of the theory are: 1) empowerment is the power that is inherent in the individual and is ongoing 2) empowerment is a relational process, expressive of the mutuality between person and environment; 3) empowerment is a continuing process of change that is continuously innovative and 4) empowerment is expressive of a human health pattern of well-being.

This theory fits well into the desired outcome of patient empowerment and mutual trust. It recognizes that the patient's beliefs and values are an integral part of health decisions, which is the premise of cultural safety.

The Health Promotion Model (2011), described by Nola Pender, focuses on three areas: Individual characteristics and experiences, behavior-specific cognitions and affect, and behavioral outcomes. The model also identifies the health care provider as part of the interpersonal environment, which exerts influence on persons throughout their life span. The theory also identifies personal socio-cultural factors such as race, ethnicity, acculturation, education, and socioeconomic status as factors that influence health promotion.

How this theory could fit is by its recognition of how health care providers bring their values, experiences, and concepts into the patient relationship and that the potential of influencing the patient through the imbalance of power may negatively affect the patient's perception of self-efficacy and self-identify.

The C.A.R.E research recruitment model is used to develop relationships with community groups and organizations that could lead to research activities such as community-based participatory research. C.A.R.E. is an acronym that stands for: Communication, Awareness, Relationships, Empowerment. The description for each component of the acronym

is directed towards the community. The C.A.R.E acronym, when applied to cultural safety, fits well together.   However, the model would be better suited for this study if the acronym read A.C.E.R.T with "A" for awareness of the health care provider's values and biases. C: communication techniques that provide a safe and inviting environment for the patient to participate equally in health care planning and decisions, E: empowering the patient to engage in the health planning and to incorporate spiritual and or cultural practices into the plan. R: relationship building may take some time and patience but is rewarded by T: trust, once trust is given mutually, the outcome is beneficial to both the patient by improved health outcomes and by the provider with job satisfaction and perceived success because of the improved health outcomes.

The Logic Model was used to help with conceptualizing the steps and outcomes of the projects. Inputs into the project include the identification of a learning module and activities which include a pre and post-test. The pre-test also included survey questions to gather the participant's demographic data. Output activities included participant reflection on their values to help them recognize where their bias lies if any exists. A review of therapeutic techniques aimed to enhance the communication process with the patient was also included in the educational module. The recruiting goal was 30 participants for the project. The output goal was for all 30 participants to participate in the learning modules and submit the survey and the pre/post-test. The information presented in the modules aimed to engage the participant and motivate them to participate in the module.

The expected short-term outcomes included changes in provider attitudes and awareness of their bias, improved provider relationships with patients, and increased patient trust in the

provider. Medium outcomes involve changes in provider's behavior and increased patient self-efficacy.

Chapter 3: Project Design and Evaluation Plan

The project began with recruitment via a flier delivered via email. Once a participant agreed to participate, instructions on completing the pre-test and access to the educational module was given. The questionnaire helped to determine if the participant meets the project criteria. Qualified participants were given a link to the online educational module. The participant were able to complete the online module at their own pace. Once complete, participants were asked to complete a post-test questionnaire. Data from the pre and post-test surveys were analyzed for changes in the knowledge and attitudes of the participant.

Recruitment. Participants were recruited via email. Participants who work in community health centers with predominantly Kanaka Maoli patients were identified. The flyer included information about the online educational course. The brochure was designed to encourage participation in the activity. Participants who completed the educational module receive 9 CEU credits, which may be used toward keeping their nursing license current. Participants also received a $5 gift card upon submission of the post-test.

The inclusion criteria for participants included Current RN and NPs who work with minorities. RNs who provided education to RN and RN students were also ~~be~~ included. Exclusion criteria included RN or NPs not actively providing direct patient cares.

Once the participant was found to meet project criteria and agreed to participate, they will received the appropriate link to the education module based on their role. The module is available to the public under the Think Cultural Health, Department of Health and Human Services. (HHS.gov, 2019) Refer to appendix C which is the letter of confirmation to use the Think Cultural Health module for this project. If the participant identified as a nurse, they were instructed to click the link to the nurse education program called "Culturally Competent Nursing Care: A Cornerstone of Caring." If the participant identifies as a nurse practitioner, there were

instructed to click the link to "A Physician's Practical Guide to Culturally Competent Care." Both learning programs consist of 3 courses, which delivered the same objectives: CLAS fundamentals, strategies for providing patient-centered care, communication and language assistance, and CLAS related activities and strategic planning.

The time required to complete all three courses is between 4 to 6 hours. Participants were asked to fill out a pre and post-test The survey included questions to gather demographic data of the participant. Educational modules, surveys, and pre/post-tests were all delivered via email. A support email address was given to participants to answer any questions or assist with any issues. The participants were asked to participate in the learning modules and fill out the accompanying surveys within the time frame of the project (total of 4 weeks).

Surveys and pre/post-tests were returned via email and gathered. The results from the post-test were compared to the pre-test, and differences observed and counted. The data were analyzed using the Kruskal-Wallis equality of populations rank test with ties.

External factors that influence the outcomes include the demographic makeup of both providers and patients, the experience and cultures of the patients, and the time available by the provider to participate in the learning modules.
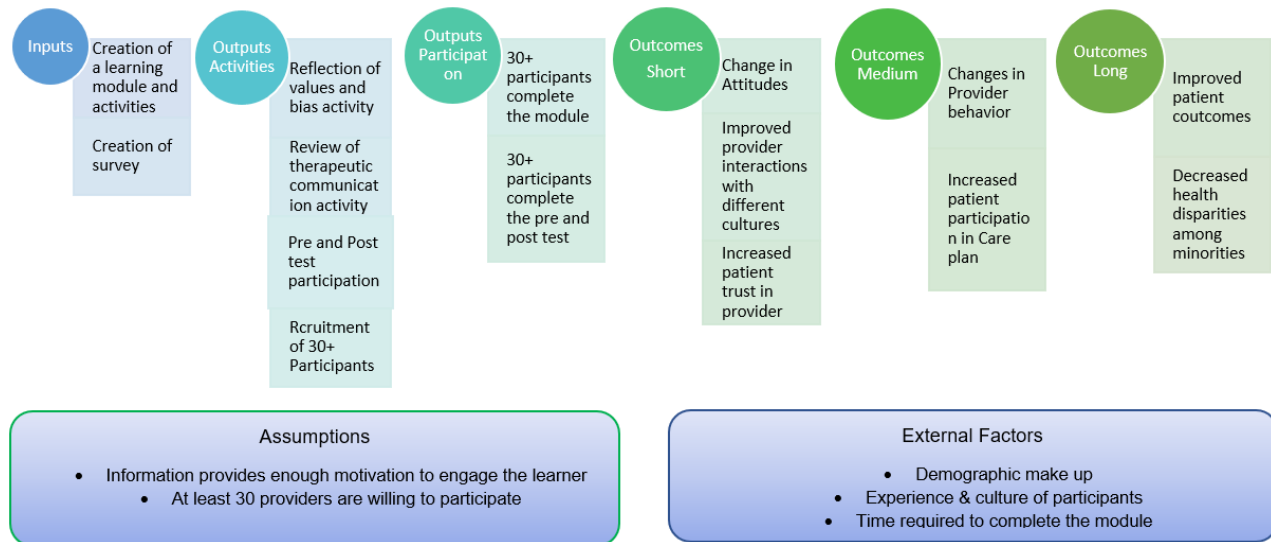
Figure 2.   Project Input and Output

Models and Theories

The transcultural nursing theory by Madeleine Leininger (1991) was the first model to identify the role culture plays in health. A significant concept in the model is cultural competence. As presented earlier, there are drawbacks to this theory used as a stand-alone guide for nursing and health care.

The theory of goal attainment by King (1960) closely follows the nursing process. During the assessment, the nurse utilizes knowledge and skill to assess the client. The client provides information about themselves, along with their perception of their problem. Following the clinician's diagnosis is the planning stage. Goal setting and decisions regarding the plan are agreed upon by both the clinician and the client. The patient's participation in this process is essential. The next two stages of implementation and evaluation also involve participation and input from both the nurse and the client.

What is emphasized in this theory is the attitudes and interactions between nurse and client. The theory emphasizes nursing, including the client in the assessment, planning,

implementation, and evaluation process. This theory is in line with cultural safety. The removal

of the power gradient and inclusion of the patient's values input into the plan of care is parallel to

cultural safety. However, the theory of goal attainment does not address the implicit bias that

may occur when working with a person of a culture different than their own. For this reason,

though cultural safety is not a recognized type of theory, its concepts and emphasis on provider

humility is unique and can stand on its own as a model for improved health care delivery.

ACE Star Model

Cultural safety is a process change on an individual level. Cultural humility, once

understood by the individual, is practiced throughout the lifetime of the practitioner. To gather

the information needed for training and to provide evidence of its benefits, the ACE Star Model

of Knowledge transformation was used to guide the process (Stevens, 2014). The model guides

the gathering and synthesis of knowledge translates it into evidence-based practice. The Star

Model contains five points: Discovery research, which is where the collection of information

occurs. The evidence review is a synthesis of the knowledge gathered and placed into

meaningful summaries. This stage also results in new ideas and conclusions as a result of the

synthesis. The next is the translation to guidelines point, which takes the outcome from the

previous step and provides recommendations for practice. The next point of the star is Practice

integration: The recommendations gleaned from the prior stage can be translated into a clinical

process. The final step is the process, outcome, and evaluation of the new practice. The goal of

this stage is the quality improvement in the health care setting. With the use of the Star model,

this project intends to gather best practices and knowledge from many sources to provide an

educational intervention that will be well received by providers and enhance provider relations

with clients.

Data analysis

The survey included some demographic data (from the pre-test), along with the participants' synthesis of the information gained from the educational module (post-test). The inclusion data consisted of 1) hold an active RN or APRN license. 2) currently providing patient care to patients or working as a teacher of nurses. 3) residing in the State of Hawai'i.

Budget

Much of the study will be conducted online via email. The Think Cultural Health course is free to the public. The US Department of Health and Human Services maintains the site. The continuing education credits are also free for those completing the modules. Participants received nine continuing education credits upon completion of the three modules. When participants submit their post-test, they will receive a $5 gift card delivered via email. The budget of $150, derived from private funds, was set aside to cover 30 participants (the goal of the project).

Goal

The goal for this project was to increase awareness of the importance of creating a culturally safe atmosphere and how it is an integral part of providing quality health care to Kanaka Maoli and other minorities in Hawai'i. The outcomes would ultimately result in improved therapeutic and trusting relationships between providers and patients and will translate to improved health outcomes for their patients.

Aims and Objectives

Aim 1. Increase knowledge of cultural awareness among health care workers to minorities. Frequently, minorities are found to suffer from health disparities. Health care providers are often from a different culture that those they serve. Increasing cultural awareness helps the health care provider to realize that definition of health may differ from those they

provide care. Objective 1- Identify evidence-based models regarding cultural safety in the

healthcare setting. Leininger's Sunrise Culture Care Model is the first to recognize the role

culture plays in health and health decisions. Utilizing the Sunrise culture care model was an

obvious choice in helping to shape the objectives of this project.   Objective 2- Provide an online

educational module that Registered Nurses and Nurse Practitioners can easily access. The U.S.

Department of Health and Human Services (2020) developed a web site and curriculum called

Think Cultural Health. Participants must have access to the internet and a computer. The

website suggests using a computer with an operating system with Windows 2000 or newer or

Mac OSX 10.4 or newer. An internet connection, such as broadband or DSL, was recommended.

Browser recommendations include Internet Explorer, Firefox, Safari, or Google. Most providers

today utilize a computer in their practice and should be familiar with accessing the website.

Assistance or questions regarding the module was given via email.

     Aim 2. Provide education regarding cultural safety concepts to healthcare employees.

The training was accessible to participants via a link provided in the recruitment flyer.

Educational modules were online and can be accessed via the website

thinkculturalhealth.hhs.gov/education. The Department of Minority Health developed the

curriculum. The curriculum was tailored to specific disciplines. The project will utilize two

units; one for Registered Nurses and the other for Nurse Practitioner/Physician/Providers. There

are three modules, each taking one to two hours to complete. The modules contained within the

unit will cover topics such as awareness of one's own cultural bias, cross-cultural communication

skills, verbal communication strategies, written communication strategies, and language

assistance services. Objective 1- Participants will complete the pre and post-test as part of the

educational module. The pre and post-test were created specifically for this specific project.

Questions were derived from reviewing other questionnaires such as the IAPCC-SV by

Campinha-Bacote (2007), and Heritage Assessment Tool by Spector (2013). The pre and post-

test were delivered via Google Forms. The results were analyzed to determine any change in the

cultural awareness and attitude of the participants. Objective 2- Participants were asked to

reflect on how the training would impact the way they practice. The reflection responses were

also analyzed for themes and assimilation of the module. The reflection question was designed

for the participant practice self-reflection, a key component of cultural humility.

      Aim 3. Determine the effectiveness of the educational module for potential use in staff

training. Objective 1- Information gathered from the pre and post-test was collected and

analyzed. A Kruskal-Wallis equality of populations rank test with ties was utilized to determine

statistical significance. Objective 2- Based on the survey results, determine how feasible it

would be to incorporate an online educational module for employee training. The results

provided data that the online cultural safety course designed by the U.S. Department of Minority

Health was effective in changing the attitudes of participants. Objective 3. Present the project

findings to Wai'anae Coast Comprehensive Health Center and Queens Medical Center (two

health care facilities that service Kanaka Maoli and other minorities in Hawai'i). The

recommendation is to use the educational module during their annual continuing education for

frontline providers.

Chapter 4 Results

The Logic Model was used to guide the project activities and to evaluate the results. One of the output activities was to recruit 30+ participants. The recruitment flyer went out to over 200 nurses on the island of O'ahu. Only 22 completed the pre-test. It is assumed that since only 7 completed the post-test, only 7 completed the learning module. It was assumed that the information provided in the recruitment flyer, as well as the educational module would motivate the participant to complete the training. This assumption is difficult to verify because of the small number of participants.

Methods

The data collected from the online survey were summarized using contingency tables that reported the frequency and percentage of responses. Comparisons of variables were made with Fisher's Exact tests to generate p-values that compared categorical variables. After a discussion with a statistician, the Kruskal-Wallis test would produce more accurate comparisons versus the Mann-Whitney test.   For the Likert scale (semi-continuous) variables, comparisons were made using the Kruskal-Wallis equality-of-populations rank test with ties. All p-values were two-sided, and significance was determined if the p-value reached a level of <0.05. All calculations were undertaken using Stata/SE 14.0 for Mac.

Results

The survey yielded 22 responses to pre-test questions. Of these, 7 (32%) individuals also responded to post-test questions. Table 1 shows the descriptive characteristics of the study participants. Most (95%) were RNs or advanced practice nurses, and most (91%) were involved in direct patient care. All lived and worked in Hawai'i. Most were female (95%) with a range of ages from 30 to 70+. About half were born in Hawai'i, with the majority of the remainder born outside Hawai'i in the continental US. The majority (91%) held at least a bachelor's degree.

Question	Value	N	%
Do you currently hold an RN or an Advanced Practice Nurse License?	Yes	21	95.4%
	No	1	4.6%
Role	APRN	5	22.7%
	LPN	1	4.6%
	RN	14	63.6%
	Retired	1	4.6%
	Faculty	1	4.6%
Do you currently provide direct patient care or are you an instructor of nursing?	No	2	9.1%
	Yes	20	90.9%
Do you live and work in the State of Hawai'i?	Yes	22	100%
Do you provide care to minorities? Or, do your students provide care to minorities? (ex: Native Hawaiians, Micronesians)	No	1	4.6%
	Yes	21	95.4%
Gender	Female	20	95.2%
	Male	1	4.8%
Age	30-39	4	18.2%
	40-49	10	45.5%
	50-59	1	4.6%
	60-69	6	27.3%
	70+	1	4.6%
Place of Birth	Continental US	11	50.0%
	Hawai'i	10	45.4%
	Outside US	1	4.6%
Education (Degree)	Associate	2	9.1%
	Bachelors	9	40.9%
	Doctoral	6	27.3%
	Masters	5	22.7%

Table 1: Descriptive Characteristics of Study Participants

For pre-test study variables, the majority (95%) had engaged in cultural competency within the last three years (Table 2). Most (72%) had experienced a clash of values with a patient and were aware of the term cultural sensitivity (69%). Most reported that it was essential to understand their cultural values to provide culturally appropriate care, found it essential to conduct a cultural assessment on their patients, and that a person's cultural beliefs impact their

health practices. Most were willing to include non-evidence-based cultural healing modalities, but the response to this item was less strongly supported than the other questions in this group.

Question	Value	N	%	Mean (SE)
Have you received any type of cultural competency training?	Do not recall/Never >3 years ago Within three years Within last year	1 5 5 11	4.6% 22.7% 22.7% 40.0%	
Have you ever experienced a clash of values and beliefs between you and a patient?	No Yes	6 16	27.3% 72.7%	
Do you know what the term Cultural Safety means?	No Yes	8 13	38.1% 61.9%	
When providing culturally appropriate care, how important is understanding your own culture and values? (Likert scale 1-5)	3 5	2 19	9.5% 90.5%	4.8 (0.1)
A cultural assessment should be conducted on all patients. (Likert scale 1-5)	3 4 5	3 6 13	13.6% 27.3% 59.1%	4.5 (0.2)
In your opinion, how much do a person's cultural values and beliefs impact a person's health practices? (Likert scale 1-5)	3 4 5	1 4 17	4.6% 18.2% 77.3%	4.7 (0.1)
How willing are you to include non-evidence-based cultural healing modalities (appropriate for your patient's culture) into your treatment plan? (Likert scale 1-5)	2 3 4 5	3 6 5 8	13.6% 27.3% 22.7% 36.4%	3.8 (1.1)

Table 2: Descriptive Summary of Pre-Test Study Variables

For post-test study variables (Table 3), the majority (57%) felt that culturally competent nursing care modules were helpful, and all planned to use the suggested techniques from the modules. Most agreed with the statement that they were more aware of cultural bias after the modules. Comparing pre- and post-test questions asking how much a person's cultural values

and beliefs impact a person's health practices, there was no change between pre- and post-test

responses (mean response of 4.8 vs. 4.6, respectively; p>0.05). Responses to the question of

whether the practitioner would be willing to include non-evidence-based cultural healing

modalities (appropriate for their patient's culture) into your treatment plan, the mean pre-test

response was 3.8 vs. 4.4, but this did not reach statistical significance (p-value>0.05).

Question	Value	N	%	Mean (SE)
Have you received any type of cultural competency training?	Do not recall/Never >3 years ago Within three years Within last year	1 5 5 11	4.6% 22.7% 22.7% 40.0%	
Have you ever experienced a clash of values and beliefs between you and a patient?	No Yes	6 16	27.3% 72.7%	
Do you know what the term Cultural Safety means?	No Yes	8 13	38.1% 61.9%	
When providing culturally appropriate care, how important is understanding your own culture and values? (Likert scale 1-5)	3 5	2 19	9.5% 90.5%	4.8 (0.1)
A cultural assessment should be conducted on all patients. (Likert scale 1-5)	3 4 5	3 6 13	13.6% 27.3% 59.1%	4.5 (0.2)
In your opinion, how much do a person's cultural values and beliefs impact a person's health practices? (Likert scale 1-5)	3 4 5	1 4 17	4.6% 18.2% 77.3%	4.7 (0.1)
How willing are you to include non-evidence-based cultural healing modalities (appropriate for your patient's culture) into your treatment plan? (Likert scale 1-5)	2 3 4 5	3 6 5 8	13.6% 27.3% 22.7% 36.4%	3.8 (1.1)

Table 3: Descriptive Summary of Post-Test Study Variables

Finally, responses to the survey questions were compared against prior cultural competency training, age, and place of birth (Table 4). Participants were more likely to consider culturally appropriate care as important if they had more recent cultural competency training (p=0.0181), and older participants were more likely to agree with this statement than younger participants (p=0.0396). No other responses varied by these respondent characteristics.

Question	Groups Being Compared	p-value (degrees of freedom)*	Inference
When providing culturally appropriate care, how important is understanding your own culture and values?	Cultural Competency Training (Do not recall/Never, >3 years ago, Within three years, Within last year)	0.0181 (3)	Participants were more likely to consider culturally appropriate care as important if they had more recent training
A cultural assessment should be conducted on all patients.	Cultural Competency Training (Do not recall/Never, >3 years ago, Within three years, Within last year)	0.2888 (3)	No difference in opinion among groups with different training
In your opinion, how much do a person's cultural values and beliefs impact a person's health practices?	Cultural Competency Training (Do not recall/Never, >3 years ago, Within three years, Within last year)	0.0805 (3)	No difference in opinion among groups with different training
How willing are you to include non-evidence-based cultural healing modalities (appropriate for your patient's culture) into your treatment plan?	Cultural Competency Training (Do not recall/Never, >3 years ago, Within three years, Within last year)	0.4162 (3)	No difference in willingness among groups with different training
When providing culturally appropriate care, how important is understanding your own culture and values?	Age (30-39, 40-49, 50-59, 60-69, 70+)	0.0396 (4)	Older participants were more likely to agree with this statement than younger participants.

Question	Groups Being Compared	p-value (degrees of freedom)*	Inference
A cultural assessment should be conducted on all patients.	Age (30-39, 40-49, 50-59, 60-69, 70+)	0.3506 (4)	No difference in opinion by age
In your opinion, how much do a person's cultural values and beliefs impact a person's health practices?	Age (30-39, 40-49, 50-59, 60-69, 70+)	0.0554 (4)	No difference in opinion by age
How willing are you to include non-evidence-based cultural healing modalities (appropriate for your patient's culture) into your treatment plan?	Age (30-39, 40-49, 50-59, 60-69, 70+)	0.2658 (4)	No difference in willingness by age

Table 4: Descriptive Summary of Post-Test Study Variables

Aims and Objectives

The first aim was to increase cultural awareness among health care workers. Of the

twenty-two participants who completed the pre-test, all but one held an RN or APRN license,

and all but two provided direct patient care. About half of the twenty-two respondents received

some sort of cultural competency training within the last year.   It is assumed that since all the

respondents had an email address that they also had access to the internet and therefore were able

to access the educational module. Of the 22 pre-test responses, 77.3% believed a person's

cultural values and beliefs impact a person's health practices. This result was reassuring that the

participants were aware that culture plays a role in health. Interestingly, when asked if

participants would be willing to include cultural, non-evidenced based healing modalities into a

care plan, the response was mixed. Only 36% were absolutely willing to include cultural

modalities, 14% would not, and about half were somewhat willing to allow cultural practices.

The second aim was to provide education on cultural safety concepts. Sixty-two percent

of the pre-test respondents stated they could define the term "Cultural Safety." The definitions

discussed in Chapter 1 were compared to the responses given in the post-test. Keywords and phrases that were used to compare the responses to were the following: humility, bias, respect the culture of patient and patient, variance within culture, shared power. Of the seven responses, two left the question blank. One participant simply wrote, "nursing care." The remaining four responses contained at least one of the identified keywords or phrases. Based on the post-test, 75% were able to define cultural safety. Unfortunately, the pre-test did not ask this same question, so changes in understanding the concept of cultural safety were not measured.

The third aim was to determine the effectiveness of the educational module in changing the attitudes and behaviors of those who provide care to minorities. Participants were asked to reflect on what they learned from the module and share some thoughts. Themes in responses included being aware of differences, the use of alternative healing modalities, and sensitivity with communication. When the participants were asked if after completing the module did they feel more aware of their own bias, the mean response was 4.6 out of 5 (with 5 meaning much more aware.)

Impact of Results on Practice

Because of the small number of responses, all of the statistical data derived from the pre and post-test was statistically insignificant (p-value < 0.05). However, some values can be gleaned from the results. Among the 22 pre-test respondents, 73% experienced a clash of values and beliefs. This is why cultural safety exists and why cultural safety education is needed. When data was compared to the pre and post-test, older participants were more likely to agree that awareness of your values and culture is an essential part of providing culturally safe care. The awareness among more mature participants may be due to life experience and lessons. According to the Hawaii State Center for Nursing workforce report (2019), 35% of baby boomer nurses are planning on retiring in the next five years. Thirty-six% of the workforce are

millennials (age 23-38). This means that potentially 36+% of the workforce may not consider

cultural bias an issue when providing care to minority patients. When comparing results between

the importance of cultural self-awareness and cultural competency training, participants were

more likely to consider culturally appropriate care as important if they had more recent cultural

competency training.

Chapter 5 Recommendations and Conclusions

The results of the Cultural Safety Project was impacted in many ways. One of the major concerns was the small number of participants, which may be due to the short run of the project. The project ran for only one month. The recruitment flyer was sent to over two hundred nurses at the start of the month, then again, a week later. Only 22 nurses took the pre-test, and 7 took the post-test, which assumes that only 7 completed the educational module.

The length of time for the project to run, one month, was likely another factor in the small turnout. More time would allow busy nurses to complete the training, thereby increasing the number of participants.   The project required participants to use their free time to complete the module. Allowing participants to complete the educational module at work may also have increased participation. Also, this project began during the COVID-19 pandemic. This time was filled with anxiety for many families; nurses may especially have had extra stressors from work that lead to distraction or exhaustion when returning home. Thus, they may not have had time or interest in completing the educational module and post-test. Despite the benefit of receiving free educational credit, the educational module may not have been viewed as necessary enough to dedicate time. Those who do not see the benefit of cultural competency/cultural safety education are likely the ones who are not aware of their own biases (Lee, 2013; White, 2017).

Aims and Objectives

The project's first aim was to increase knowledge of cultural awareness among health care workers in a rural health care setting. The project was successful in identifying a cultural awareness module that is easily accessible via the internet and free of charge, thus increasing access to cultural education. The educational module was offered to any nurse working on O'ahu. However, two facilities that serve rural communities and minorities were identified to present the findings of this project. Wai'anae Coast Comprehensive Health Center serves the

rural community of Wai'anae and Queens Medical Center, which has a facility on the leeward side of the island, and services Wai'anae, Kapolei, Ewa Beach, and Waipahu. Kanaka Maoli and other minorities reside in these communities. The module used was created by the U.S. Department of Health and Human Services and written specifically for health care providers. It is available online and on-demand. Anyone with internet access and a computer may access it.

The second aim was to provide education regarding cultural safety concepts to healthcare employees in rural community healthcare settings. This aim was achieved by leading participants to the online educational module. The pre and post-test were designed to gather descriptive data and to provide statistical information on a participant's attitudes and behaviors regarding cultural safety. The post-test included an opportunity for the participant to reflect on the topic of cultural safety. Reflection is an essential step in both self-awareness and in solidifying new ideas or concepts.

The third aim was to determine the effectiveness of the educational module regarding cultural safety in the healthcare setting for potential use in staff training. With the low participation rate of the project, this aim did not statistically result in proof of effectiveness. The statistical results did not find any significant changes (p-value < 0.05), and the small number of participants (seven) was a factor. This project could be run in organizations such as Queens Medical Center and the Waianae Coast Comprehensive Health Center, which would result in greater participation.

With the educational module available and accessible via the internet, the accessibility portion of the aim was met. Utilizing an educational module that is free to the public and created specifically for health care providers makes this intervention cost-effective.   The alternative would be to create a module specific to the minority or community. However, the concepts

included in the Think Cultural Health modules utilized similar concepts identified as culturally

appropriate for Kanaka Maoli. The benefit of having an educational module created by a team of

experts, tested and available for free, is much more efficient than creating an educational module

from scratch. The issue is that many facilities are not aware of the educational modules and or

may not identify the need for cultural awareness training.

The project findings were presented to the Wai'anae Coast Comprehensive Health Center

Placement Coordinator and Nurse Practitioner and the Queen's Medical Center's clinical

educator. The presentation included current findings on health disparities experienced by

Kanaka Maoli, why cultural safety is essential, and how to access the educational modules. The

project recommended that these facilities utilize the Think Cultural Health educational module as

a competency training program. The Think Cultural Health module should be included as part of

annual educational training for their health care providers, including nurses, physicians, and

allied health providers. The two facilities acknowledged the need and the importance of this type

of training. One of the facilities expressed concern about money. Because the training requires

up to six hours to complete, facilities may be hesitant to fund such training. The facility pointed

out that paying for six hours of training times the hourly pay of each nurse, then multiplied by

the number of nurses in the facility, would be a sizeable financial burden. It was suggested to

appeal to the Hawai'i State Board of Nursing to mandate that this training be required for nurses

to renew their Hawai'i nursing licenses.

The initial goal of this project was to change the attitudes and behaviors of the health care

providers. This change could result in a more culturally safe environment. The true measure of

the effectiveness of a culturally safe environment would be to measure satisfaction among

patients of providers who took the training. The undertaking of this measure would require more

time, support, and IRB approval that was not available with this project. The ultimate test of cultural safety would be to see an improvement in the health disparities experienced by the rural community. Specifically, to see if health disparities among Kanaka Maoli improve.

According to the Hawaii State Center for Nursing, a majority of nurses working in Hawaii are Filipino and White. Native Hawaiian/Pacific islanders had the highest inpatient admissions. This means that the majority of patients will receive care from someone not of their race or culture. The implication of having a caregiver and a patient of different cultures, beliefs, and practices have resulted in poor outcomes and reduced patient satisfaction. One of the questions asked in the pre-test asked if the nurse ever experienced a clash of values and beliefs. 16 out of 22 participants said that they experienced a clash of values. For those who are not aware of their bias, stereotypes and labeling may occur.

Future Implications for Practice

Living in the United States of America provides many advantages and freedoms. The country is made up of many immigrants who arrived over a hundred years ago or one year ago. Thus, the United States of America is a nation of many ethnicities and cultures. This is even more evident in Hawai'i. With the recent death of an African American male individual by a police officer and the civil unrest and protests, the USA is still dealing with racial bias. Thus, the need for cultural awareness/Cultural Safety education is needed now more than ever! The issue is that many do not recognize their own bias. Therefore, these people do not recognize the need for such training. Cultural Awareness/Cultural Safety training will not solve the problem of bias. However, it is a step towards awareness of one's own bias. Awareness is the first step towards improving inequalities and creating a fair and safe environment for all.

References

Campinha-Bacote, J. (2007) *The Journey Continues: The process of cultural competence in the delivery of healthcare services.* Transcultural C.A.R.E Associates.

Capell, J., Dean, E., Veenstra, G. (2008) The relationship between cultural competency and ethnocentrism of health care professionals. *Journal of Transcultural nursing. 16*(2), 121-125. Doi: 10.177/1043659607312970

Ceasar, J., Peters-Lawrence, M., Mitchell, V., Powell-Wiley, T., (2017). The communication , awareness, relationships and empowerment (C.A.R.E. Model) An effective tool for engaging urban communities in community-based participatory research. *International journal of environmental research and Public health, 14*, 1422. Doi: 10.3390/ijerph14111422

Chathura, S., Lim, E., Aggarwal, L., Davis, J., Hixon, A., Chen, J. (2018). Racial/Ethnic and County-Level Disparity in Inpatient Utilization among Hawai'i Medicaid Population. Hawai'*i Journal of Medicine and Public Health. 77*(5), 103-113.

Clark, D. (n.d.). Sharing culture. Retrieved from http://www.sharingculture.info/index.html

Danaher, A. (2011) Reducing disparities and improving population health: The role of a vibrant community sector. *Wellesley Institute*. Retrieved from http://www.wellesleyinstitute.com/wp-content/uploads/2011/08/Reducing-Disparities-and-Improving-Population-Health.pdf

De. D. (2008) Cultural safety: An introduction. *Paediatric Nursing. 20*(2), 39-43.

Delgado, D., Ness, S., Ferguson, K., Enstrom, P. Gannon, T., Gillet, D. (2013). Cultural competence training for clinical staff: Measuring the effect of a one-hour class on

cultural competence. *Journal of Transcultural Nursing*. *24*(2), 204-213. Doi:

   10.1177/10436596122472059

Dudas, K. (2012) Cultural Competence: an evolutionary concept analysis. *Nurse Education*

   Perspective. *33*(5), 317-321

Foronda, C., Baptiste, D., Reinholdt, M., Ousman, K. (2015). Cultural Humility: A concept

   analysis. *Journal of Transcultural Nursing*. *24*(3), 201-217. Doi:

   10.1177/1043659615592677.

Hawaii State Center for Nursing (2019) *Hawai'i State nursing workforce supply 2019*. Retrieved

   from https://www.hawaiicenterfornursing.org/wp-content/uploads/2019/12/2019-

Nursing-Workforce-Supply-Report-vFinal.pdf

Healthy People 2020. (2017). Determinants of health. Retrieved

   from https://www.healthypeople.gov/2020/about/foundation-health-

   measures/Determinants-of-Health

Health Promotion Model. (2011) Nursing Theories. Retrieved from

   http://currentnursing.com/nursing_theory/health_promotion_model.html

Health Research and Educational Trust. (2013, June). Becoming a culturally competent health

   care organization. Retrieved from http://www.hpoe.org/becoming-culturally-competent

Halfon, N., Hochstein, M. (2002). Life-course health development: An integrated framework for

   developing health policy and research. *The Milbank Quarterly*. *80*(3), 433-479. Doi:

   10.1111/1468-0009-00019.

HHS.gov (2019) *Culturally Competent Nursing Care: A Cornerstone of Caring.* Retrieved

   from: https://thinkculturalhealth.hhs.gov/education/nurses

Hook, J., Davis, D., Owen, J. W., E., & Utsey, S. (2013). Cultural humility, measuring openness

        to culturally diverse clients. *Journal of Counseling Psychology, 6*(3), 353-366.

        doi:10.1037/a0032595

Hutchinson, R., Shin, S. (2014). Systematic review of health disparities for cardiovascular

        disease and associated factors among American Indians and Alaska Native populations.

        PLOS ONE 9(1), e80973. Doi: 10.1371/journal.pone.0080973

Isaacson, M. (2014). Clarifying concepts: Cultural humility or competency. *Journal of*

        Professional Nursing, 30(3), 251-258.

Lee, H., Fitzpatrick, J., & Sung-Yi, B. (2013). Why isn't evidence-based practice improving

        health care for minorities in the united states? *Applied Nursing Research, 26*, 263-268.

        doi:10.1016/j.apnr.2013.05.004

Leininger, M. (1991) Transcultural Nursing Theory. Retrieved from http://www.nursing-

        theory.org/theories-and-models/leininger-culture-care-theory.php.

Look, M, Trask-Batti, M., Agress, R., Mau, M., Kaholokula, J. (2013). Assessment and priorities

        for health and well-being in Native Hawaiians & other pacific peoples. *University of*

        Hawai'i, JABSOM, Department of Native Hawaiian Health Report. Retrieved from

        https://health.hawaii.gov/opcrh/files/2014/11/Assessment-Priorities-for-NH-OPP-Mele-

        Look.pdf

Nursing Council of New Zealand. (2011). Guidelines for cultural safety, the treaty of Waitangi,

        and Maori health in nursing education and practice. Retrieved

        from http://www.nursingcouncil.org.nz/Publications/Standards-and-guidelines-for-nurses

Polaschek, N. (1998) Cultural Safety: A new concept in nursing people of different ethnicities.

        Journal of Advanced Nursing. 24,452-457.

Pukui, M.K., Haertig, E.W., Lee, C.A. (1972) *Nānā I ke Kumu*. Honolulu, HI; Hui Hānai.

Ross, K. (n.d.) Impacts of Historical Trauma on African-Americans and its effects on help-
    seeking behaviors. [power point slides]. Retrieved from
    http://www.umsl.edu/services/cps/files/ross-presentation.pdf

Sing. D. (2008) Ike Pono- promoting learning from a Native Hawaiian Perspective. In Wiehaus,
    U. (Ed), *Foundations of First People's Sovereignty.* (pp. 149-158). New York, N.Y:
    Peter Lang Publishing Inc.

Stevens, K. (2012) Star Model of EBP. Knowledge Transformation. Retrieved from
    http://nursing.uthscsa.edu/onrs/starmodel/star-model.asp

Shearer, N. (2009). Health Empowerment theory as a guide for practice. *Geriatric Nursing:*
    30(2 suppl), 4-10. Doi: 10.1016/j.gerinurse.2009.02.003.

Spector, R. (2013). *Cultural Diversity in Health and Illness*. (8th ed.). Upper Saddle River, NJ:
    Pearson.

Stoil, M. J., Murphy, S., & Kuramoto, F. H. (2006). Psychocultural influences on health care
    acceptability among elderly U.S. pacific islanders. *Journal of Health & Social*
    Policy, 22(1), 59-75. Retrieved
    from http://cletus.uhh.hawaii.edu:2059/login.aspx?direct=true&db=cmedm&AN=171351
    09&site=ehost-live

Tucker, C., Marsiske, M., Rice, K., Jones, J., Herman, K., (2012) Patient-Centered Culturally
    Sensitive Health Care: Model Testing and Refinement. *Health Psychol. 30*(3), 342-350.
    Doi: 10.1037/z0022967

U.S. Census Bureau. (2018) *Hawaii Population Characteristics 2018.* Retrieved from

    http://files.hawaii.gov/dbedt/census/popestimate/2018_county_char_hi_file/Pop_char_hi_

    2018_final.pdf

U.S. Department of Health and Human Services (2020) Think Cultural Health. Culturally

    Competent Nursing Care: A Cornerstone of Caring. Retrieved from:

    https://thinkculturalhealth.hhs.gov/education/nurses

White, A., Logghen, H., Goodenough, D., Barns, L., Hallward, A., Allen, I., .Llerena-Quinn,

    R. (2017). Self-awareness and cultural identity as an effort to reduce bias in

    medicine. *Journal of Racial and Ethnic Health Disparities.* 1-16.

    doi:https://cletus.uhh.hawaii.edu:4796/10.1007/s40615-017-0340-6

Wu, Y., Braun, K., Onaka, A., Horiuchi, B., Tottori, C., Wilkens, L.(2017) Life expectancies in

    Hawai'i: A multi-ethnic analysis of 2010 life tables. *Hawaii Journal of Medicine and*

    Public Health. 76(1), 9-14.

Appendix A Cultural Safety Education – Participant Pre-Educational Module

Questionnaire (via Google Forms)

1. Do you currently hold an RN or an Advanced Practice Nurse license?

    1. Yes 2. No

2. What is your current role?

    1. RN   2. APRN   3. Other: _____

3. Do you currently provide direct patient care or are you an instructor of nursing?

    1. Yes   2. No

4. Do you live and work in the State of Hawai'i?

    1. Yes   2. No

5. Do you provide care to minorities (Native Hawaiian, Micronesian, etc)

    1. Yes   2. No

6. What is your gender

    1. Female 2. Male   3. Gender fluid   4. Do not wish to answer

7. What is your age?

    1. 18-29   2. 30-39   3. 40-49   4. 50-59   5. 60-70   6. 70+

8. Where were you born and raised?

    1. Hawai'i 2. Continental US   3. Outside the USA

9. What is your level of education

    1. Associates Degree 2. Bachelor's Degree 3. Master's degree 4. Doctorate

    Degree

10. Have you received any type of cultural competency training?

    1. within the last year   2. Within the last three years   3. Greater than three years ago 4. Never

11. Have you ever experienced a clash of values and beliefs between you and a patient?

    1. Yes   2. No

12. Do you know what the term cultural safety means?

    1. Yes   2. No

13. When providing culturally appropriate care, how important is understanding your own culture and values? On a scale of 1-5, with 1 being not important and 5 being very important, select a number on the scale below.

    Not Important   Very important

    1   2   3   4   5

14. A cultural assessment should be conducted on all patients. On a scale of 1-5 with 1 meaning a cultural assessment is not necessary for every patient and a 5 meaning, every patient should receive a cultural assessment, select a number on the scale below.

    Don't agree   Agree

    1   2   3   4   5

15. In your opinion, how much do a person's cultural values and beliefs impact a person's health practices? On a scale of 1-5, with 1 meaning a person's cultural values and beliefs have little impact on their health practices and 5 means that it has a large impact, select a number on the scale below.

    Little impact   Large impact

    1   2   3   4   5

16. How willing are you to include non-evidenced based cultural healing modalities

(appropriate for your patient's culture) into your treatment plan? On a scale of 1-5, with

1 meaning you are not willing to include cultural healing modalities and 5 meaning you

will include it in your treatment plan, choose a number on the scale below.

    Definitely not   Absolutely include

    1   2   3   4   5

Cultural Safety Education – Participant Post-Educational Module Questionnaire (via
Google Forms)

Instructions to participant: Once you have completed the educational module Culturally Competent Nursing Care: A cornerstone of caring, please complete the questionnaire below. Be sure to print out proof of module completion and save for your records. This learning module will provide you with 6 CEU credits that may be used towards the renewal of your nursing license.

1. Did you complete all three learning modules? Yes   No

2.   On a scale of 1-5, with 1 meaning very helpful and 5 meaning not at all helpful, do you feel that the Culturally Competent Nursing Care module was helpful and provided new insight and education.

    Yes   No

    1   2   3   4   5

3. Could you define the term Cultural Safety?

    1. Yes   2. No

4. In your opinion, how much do a person's cultural values and beliefs impact a person's health practices? On a scale of 1-5 with 1 meaning a person's cultural values has little impact and 5 meaning it has a large impact, choose a number from the scale below.

    Little impact   Large impact

    1   2   3   4   5

5. After completing the educational module, do you feel that you are more aware of cultural bias, preconceived notions, feelings and attitudes you may have towards members of a different cultural/ethnic group? On a scale of 1-5 with 1 meaning you have

no change in your awareness and 5 meaning you have greater awareness, choose a

number from the scale below.

    Same awareness   More Awareness

    1   2   3   4   5

6. Do you plan on using any of the techniques suggested in the modules? Choose or

more answers below.

    1. Self-reflection   2. Journaling   3. Seeking out more resources on

    culture

7. How willing are you to include non-evidenced based cultural healing modalities

(appropriate for your patient's culture) into your treatment plan? On a scale of 1-5 with 1

meaning, you will not include non-evidenced based cultural healing modalities and 5

meaning you will include cultural modalities, choose a number on the scale below.

    Definitely not   Absolutely include

    1   2   3   4   5

8. Reflect on how this learning module has changed (or not changed) your idea of self-

awareness and providing culturally safe care. Please share one or two sentences below

from your reflection.

Thank you for taking the time to complete the module and to answer the questionnaire!

Please return this questionnaire to the following email: culturalsafetyPIP@gmail.com

Appendix B Cultural Safety Recruitment Flyer

Cultural Safety Education Project 2020

Diversity is all around us. According to the 2010 census, the major races counted included white, African American, Filipino, Japanese, Native Hawaiian, Chinese, Korean, Samoan, Vietnamese, and the various Marshall Islands. Yet, health care providers are predominantly White or of another race/culture and educated in an American educational institution. This means those who provide care do so through the lens of different cultures, values, beliefs, and practices than their patients. Cultural safety is to create an environment or provide care in a manner that honors one's culture, values, beliefs, and practices.

The Cultural Safety Education Project is part of a doctoral practice inquiry project. The data from your participation in this project will be used to complete the PIP scholarly paper. Send any questions about how the project will run or how your data will be used to culturalsafetypip@gmail.com

Are you providing Culturally Safe care?

The goal of this project is to provide cultural awareness education to nurses, nurse practitioners, and other front-line providers. The aim is to achieve improved communication and connection between health care providers and their patients through cultural humility.

What do I have to do?

1) Click on the link below to take a pretest. The first part of the test will ask questions to see if you qualify to participate in this project. You will also view an brief introductory power point presentation on what cultural safety is any why you should know more about it.

[link]

2) Once you submit your pretest and you meet the project criteria, you will be given the link via the email you provided to the educational module. You will also be given the link to the post test.

Once you're at the Think Cultural Health site, read the description of each option and click the "learn more" link to go that site's overview page. Click "begin module" to start the educational module. Next, you will be asked to register to take the course. Alternatively, if you have registered with the minority health site before, you may bypass the registration and enter your login information. The information you enter into this site will not be seen by me and is required to provide you with your continuing education credits at the end of the module.

The course may take up to six hours to complete. You may start, stop, and resume the course at any time. Print out the certificate of completion form at the end of course three. Upon completing all course modules, you will receive nine continuing education credits that may be used to renew your nursing license.

3) Click the link below to take a posttest. Upon completion, you will receive a $5 gift card in gratitude for your time. It is requested that you complete this education within 2 weeks from receiving the link.

Appendix C Approval Letter to use Think Cultural Health Modules for this project.

M Gmail

Kimberly U'ilani Chow-Rule <chowrule@gmail.com>

Request for permission to utilize a module for a performance improvement project

Nawaz, Brittney <Brittney.Nawaz@gdit.com>
To: "K. U'ilani Chow-Rule" <chowrule@hawaii.edu>

Tue, Sep 17, 2019 at 8:26 AM

Good afternoon,

Thank you for your interest in Think Cultural Health. The Think Cultural Health websites are federally funded; therefore, the content within these programs is in the public domain. If you wish to use this program in any material, OMH does ask that any persons, agencies, or organizations who want to use this material properly cite the source.

Please let us know if you have any other questions or concerns.

Sincerely,

Brittney Puller

Think Cultural Health Technical Team

[Quoted text hidden]

This electronic message transmission contains information from GDIT that may be attorney-client privileged, proprietary or confidential. The information in this message is intended only for use by the individual(s) to whom it is addressed. If you believe you have received this message in error, please contact me immediately and be aware that any use, disclosure, copying or distribution of the contents of this message is strictly prohibited. NOTE: Regardless of content, this email shall not operate to bind GDIT to any order or other contract unless pursuant to explicit written agreement or government initiative expressly permitting the use of email for such purpose.