Recommendations for Promoting Culturally and Resource Appropriate Care for Native American (NA) Patients at Flagstaff Medical Center (FMC)

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Submitted in Partial Fulfillment of the Requirements
for the Northern Arizona University School of Nursing
Doctor of Nursing Practice Program

May 4, 2014

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Flagstaff Medical Center (FMC) is a primary referral center for its surrounding Native American (NA) communities. As such, FMC has a unique patient population with distinctive needs related to culture and available resources. This executive summary explores the provision of quality care to NA populations by discussing the execution of a clinician focused education needs assessment, implementation of an education program based upon this data, and synthesis of the experience to provide institutional recommendations for ongoing efforts to optimize the care of NA patients from a cultural and resource perspective.

Significance and Background

FMC is a 267-bed community hospital in Northern Arizona and serves as the primary referral center for Indian hospitals and clinics in Northern Arizona and portions of New Mexico and Utah (Flagstaff Medical Center, n.d.). One-third of FMC's inpatient population is Native American, primarily from Navajo and Hopi tribes (Flagstaff Medical Center, 2012). The mission of FMC to provide "exceptional care while transforming the health of the communities we serve" is supported by the population health department, which directs efforts to improve the care of NA populations in Flagstaff and the surrounding area (Flagstaff Medical Center, 2014b, para. 1).

Health and resource inequities are prevalent within NA populations (Baldwin et al., 2009; Indian Health Service, 2011; G. Kim, Bryant, Goins, Worley, & Chiriboga, 2012; Sarche & Spicer, 2008; Vernon, 2007). These disparities are reflected in the Navajo community served by FMC (Gone & Trimble, 2012; Hochman, Watt, Reid, & O'Brien, 2007; Holman et al., 2011; Navajo Division of Health, 2004). The Indian health system is complex, chronically underfunded and difficult to navigate (National Indian Health Board, 2013; Sequist, Cullen, &

Acton, 2011; Sequist et al., 2011). Health and cultural beliefs further influence the provision of quality care to this population (Carrese & Rhodes, 1995; Devi, 2011; C. Kim & Kwok, 1998; Mays et al., 2009; Weaver, 2004).

NA health disparities and the provision of culturally appropriate healthcare are part of regional and national health policy agendas. NA health is specifically addressed in the Patient Protection and Affordable Care Act (PPACA) and is a focus of other federally funded programs such as Racial and Ethnic Approaches to Community Health (REACH; Centers for Disease Control and Prevention, 2013; US Senate Committee on Indian Affairs, n.d.). The US Office of Minority Health, state statute, and regulatory agencies mandate the provision of culturally and linguistically appropriate care (Hoffman, 2011; Shaw & Armin, 2011; US Office of Minority Health, 2000). These priorities are mirrored on an institutional level as evidenced by a Flinn Foundation grant secured by FMC for the purpose of improving the care of Anglo, Hispanic, and NA cardiac patients as they transition from the hospital (Flagstaff Medical Center, 2014a).

Though NA populations demonstrate significant disparities and unique needs related to culturally and resource appropriate care, there is a paucity of literature addressing the provision of culturally competent (CC) care to these populations (Edmondson, 2013). Additionally, there is a lack of published material related to CC education and practicing clinicians, and limited evaluation of specific education interventions (Edmondson).

Purpose and Framework

The purpose of this project is to explore clinician CC specific to the NA populations served by FMC, with the following objectives.

1. Measure clinician's perceived need for/interest in education related to NA populations through a formal needs assessment survey.

2. Develop an institution specific education program based upon needs assessment data and measure the value of the educational program though self report.
3. Provide institution specific recommendations for future efforts to enhance the provision of CC care and quantify outcomes.

Camphina-Bacote's model of CC in the delivery of healthcare is the framework for this project (2002). This model views the constructs of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire as dynamic and interwoven elements integral to the provision CC care. This framework was used both in the development of the needs assessment and evaluation of the of the education program. Viewing CC from this perspective allows one to identify ongoing CC needs within the institution and to target interventions appropriately.

Results

The author developed a population specific needs assessment based upon available literature and content expert contribution. The needs assessment was distributed to all clinicians with privileges at FMC (N = 508). A 14.2% response rate was achieved. Only 26.4% of clinicians felt "greatly" equipped to care for NA patients. Ninety-seven percent of respondents reported that they would either "somewhat" or "greatly" benefit from additional education in this area. More than 60% of clinicians supported education in all four pre-identified topic areas, which included the Indian Health system, Indian reservations of Northern Arizona, traditional health beliefs, and end of life issues. End of life issues stood out as the subject of most interest. Additionally, working effectively with interpreters was brought forth as a desired subject.

Data from this needs assessment was used as a framework for the creation of an institution specific education program. A four part lecture series was developed and integrated

into FMC's existing Grand Rounds format, which allows for lecture attendance both in person and remotely. All of the above topic areas were included in the curriculum. At the time of this writing two of the four programs (Interpreters and Indian Health System) are complete with evaluation data being available for analysis. Attendance was 31 and 33 respectively (this does not include remote attendees), which compares favorably with other FMC Grand Rounds programs. Post-program evaluations demonstrate that the programs met stated objectives, provided useful insights to practice, were clinically relevant, and featured skilled speakers. Specific learning points and information likely to be applied to practice were identified.

Recommendations

The education needs assessment clearly demonstrates a clinician knowledge deficit related to NA issues, and a desire to participate in education efforts. This assertion is confirmed by high attendance rates and positive program evaluations. The success of this initial effort supports expansion of the Grand Rounds series with additional topics related to NA populations and the provision of CC care. Translating the content to more enduring formats is appropriate. It is recommended that FMC invest in the technology to allow future lectures to be recorded and accessed remotely for an extended period. Development of a computer-based self-learning module would be valuable in ensuring that this content is available to a wider audience and new clinicians.

The education programs have proven effective in identifying specific care issues that are of importance to the provision of quality care to NA populations. For example, 31 of 33 attendees at the Indian Health System lecture identified the importance of collaborative relationships between institutions as being the most important learning point. This suggests that FMC would benefit from investing in the development and maintenance of collaborative

relationships, and educating clinicians as to how to effectively maneuver within these structures. Furthermore this supports FMC's Flinn Foundation grant, which is dedicated to improving care processes as patients transition between systems. Similarly, 12 out of 31 attendees at the Interpreter lecture felt that they gained information that would allow them to more effectively interact with NA patients. This suggests that additional education in this area is necessary for all patient care staff, and personnel support in the form of additional language interpreters and cultural liaisons would be of benefit to the organization.

The primary measure of the efficacy of this project is clinician self-report. While useful, this measure is limited in that it is not an objective measure of quality care. To support FMC's population health focus it is necessary gauge culturally competent care using objective criteria. Quality parameters such as patient satisfaction, provider satisfaction, length of stay, and readmission rates are examples. It is important that these measures be examined from a population perspective to identify disparities that may be related to culture and resources. If inequities are identified, population specific interventions can be initiated. Trending these objective measures over time provides a mechanism by which FMC can judge the impact of CC interventions on patient outcomes. Additionally, parameters such as readmission rates directly impact reimbursement. Culturally based interventions that improve both quality outcomes and reimbursement will positively impact the institution from a financial standpoint.

Conclusion

This executive summary supports an institutional focus on culturally and resource appropriate care. The needs assessment survey and resultant education program demonstrate clinicians' desire to improve both skill and knowledge as related to cultural encounters. The insights gained from this experience should be used by FMC to expand CC education

opportunities, develop population specific interventions directed towards improving care, and to quantify the impact of these efforts.

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