

The Best of Both Worlds

Culturally Safe Integrated Care Research

Phase 2 Report

Evaluation of the Best of Both Worlds Cultural Safety  
Education Workshop

Prepared for Naandwechige-Gamig  
Wikwemikong Health Centre  
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Northern Ontario  
School of Medicine  
École de médecine  
du Nord de l'Ontario  
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Bonnie Akiwenzie	Aboriginal Diabetes Initiative Outreach Worker
Dr. Ken Barss	Physician, Northeastern Manitoulin Family Health Team
Rita Corbiere	Elder Advisor
Diane Jacko	Nadmadwin Mental Health Program Manager
Margaret Jackson	Noojmowin Teg Health Services Board Member
Urban Mejaki	Elder Advisor
Karen Pitawanakwat	Long Term Care Supervisor / Doctors Liaison
Melissa Roy	WHC Executive Assistant
Kendra Still	Diabetes Nurse
Mary Jo Wabano	Health Services Director
Gladys Wakegijig-King	Social-Health Services Portfolio

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Authors: Sara Lacarte, Dr. Kristen Jacklin, Dr. Cindy Peltier, Louise Jones, Dr. Wayne Warry

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Please direct all inquiries to  
Dr. Kristen Jacklin, Principal Investigator  
Northern Ontario School of Medicine at Laurentian University  
Phone: 705-662-7277  
Email: [kjacklin@nosm.ca](mailto:kjacklin@nosm.ca)

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## **Executive Summary**

Cultural safety education has been recommended as a method to help health care providers and organizations better develop relationships between patients and health care providers by addressing communication issues, social challenges, biases, and discrimination. The Best of Both Worlds Cultural Safety Training Workshop was held on March 3<sup>rd</sup>, and May 14<sup>th</sup>, 2015. Workshop participants included 34 interprofessional health care providers from the Wikwemikong Health Centre, Noojmowin Teg Health Centre, Northeastern Manitoulin Family Health Team, and Manitoulin Physiotherapy. The workshop featured content on the history of Indigenous people of Canada with a specific focus on the Anishinaabek of Wikwemikong; colonialism and intergenerational trauma; historical policies and their effect on health conditions; provincial and federal jurisdictional challenges; cross-cultural communication; and patient-provider relationship development. Cultural safety education has been endorsed by many organizations including the National Aboriginal Health Organization, the Association of Faculties of Medicine of Canada, the Indigenous Physicians Association of Canada, and the Aboriginal Nurses Association of Canada. Despite this, there has yet to be any systematic evaluation of a cultural safety workshop, such as Best of Both Worlds, as a method of health quality improvement.

The purpose of this research study was to develop a cultural safety training course for Naandwechige-Gamig Health Centre and assess the effectiveness in improving care. A research advisory group, comprising patients, Elders, health care professionals, and managers guided the research process. The results of the evaluation and recommendations for improving the workshop are presented here. Evidence of the effectiveness of the workshop was collected through a mixed-methods research design consisting of a pre/post workshop survey ( $n=26$ ;  $n=8$ ); a workshop evaluation survey ( $n=34$ ); interviews with patients ( $n=18$ ); interviews with health care providers ( $n=22$ ); and a medical chart review ( $n=297$ ). The research process was developed according to the principles of community-based research.

## **Key Findings**

### **1. Workshop Evaluation**

- A majority of workshop participants (80%) agreed that the training met the objectives, that the material was relevant (96%), and that they would apply the content in their practice (92%).
- Many participants felt that the workshop content required more time than what was available in a one-day workshop format and several thought it should be repeated at least every year.

- Although some participants had received other cultural safety/competence training concerning colonialism in the past, there was agreement that the focus on the local historical experiences as described by community members and elders along with the use of historical archive documents and video was a valuable addition to their knowledge and was impactful.
- Participants reported that the ‘Dorothy Monologue’ case was a highlight and helped them see the complexities from the patient’s perspective. They also found the facilitated discussion of the case was effective in improving their understanding of the roles of the different health care providers in their small groups.
- Participants felt better informed about local cultural practices following the training and reported improved confidence in discussing Anishinaabe medicine with patients. Some reported that they were grateful for the opportunity to participate in a smudging ceremony.
- Participant’s identified concrete was to improve relationships and provide more culturally safe and effective care on their post workshop surveys. The majority of participants committed to empowering patients, working collaboratively, taking more time, and listening more and/or better.
- Providers reported that the structure of the workshop was beneficial to relationship development between different types of providers (e.g., physicians and mental health workers).
- The training was effective in addressing some of the identified structural barriers that limit providers and patient’s abilities to provide integrated and culturally safe care (for example, improved understandings of services and roles). However, the workshop alone could not change larger issues that continued to be identified by participants such as inter-organizational communication, hierarchy of services, different EMRs, HCP turnover, and larger issues around health policy.

## 2. Post-Workshop Evaluations with Patients and Providers

- Similar to earlier interviews with people with diabetes in Wikwemikong, during the post workshop patient interviews many continued to report using Anishinaabe medicines but also report having not discussed this with their physician or provider. Comments from some patient participants suggest that patients would benefit from greater awareness of Anishinaabe medicine and cultural services available through the health centres.
- Post workshop interviews with patients found that patients were highly satisfied with their relationship with their provider. Patients shared stories of working together with their physician through disability processes and difficult health matters.

- Patients emphasized the importance of good patient-provider rapport to ensure effective communication. The post training interviews resulted in fewer reports of communication difficulties with providers, although some continue to struggle with the use of medical terminology during visits.
- Post workshop interviews with health care providers suggest that in the longer term, communication between or among health care providers improved in some cases but not in others.

### 3. Chart Audit Results

- The primary function of the Chart Audit component of the evaluation was to establish a process and structure for conducting chart audits collaboratively with the Northeastern Family Health Team over time. The Chart Audit component of the evaluation does not provide any conclusive evidence of changes in outcomes or practices following the training. This finding was the expected outcome.
- While the chart audit results do not allow for us to make pre-post workshop conclusions they are useful in highlighting key areas in diabetes health monitoring that continue to raise concern, most notably, a high proportion of patients with A1C and ACR levels higher than target. Also, counseling sessions between health care providers and patients in regards to adjusting health care treatment plans, weight, and setting of self-management goals are either under-reported or are not occurring frequently.
- The chart audit shows that most patients with diabetes see their physicians for care more often than any other provider suggesting that despite models promoting team care, physicians remain central to diabetes care.

### 4. Strengths and Limitations

- The collaborative and participatory approach to the research resulted in a training strategy that had value and relevance at the local level. The establishment and continued engagement with the Wikwemikong Diabetes Advisory Group provided an inter-professional environment to talk through strategies from multiple perspectives and develop relationships between organizations.
- Two key issues affected our ability to fully measure changes in practice following the training (1) turnover in health centre staff, and (2) a low response rate to the post workshop survey.

The 3-year funding cycle for the project allowed for a concentrated effort to develop locally relevant cultural safety training but was insufficient to meet some of our other goals aimed at addressing interjurisdictional issues in care.

## **Recommendations**

The following recommendations concern the future delivery of the Best of Both Worlds cultural safety workshop and on-going challenges affecting the delivery of culturally safe health care services. These recommendations have been formulated on the basis of on-going discussions with the Wikwemikong Diabetes Research Advisory Group.

### **Recommendations for Improvements to the Best of Both Worlds Cultural Safety Workshop**

- The sustainability of the Best of Both Worlds cultural safety training workshop should be prioritized. Ideally, the workshop should be offered at least annually with repeated participation encouraged to help solidify the important messages.
- The length of the workshop and strategies for delivery should be revisited. The time available for learning the content should be increased and/or better supported with online readings and activities.
- Future workshops need to be updated to incorporate the Truth and Reconciliation materials and findings.
- The workshop should include further discussion on the concept of cultural safety as well as additional education on contemporary models of Indigenous health care.
- Due to project time constraints, the “Dorothy monologue’ was a borrowed case. We recommend it is advisable to work toward the development of a local video case based on the Wikwemikong diabetes research conducted to date. Future workshop facilitators should also explore preparing an alternative case study to the Dorothy monologue video that includes a discussion focusing on interprofessional health care providers that a patient would encounter at the Wikwemikong Health Centre. The video or descriptive case study could be based on local history and common circumstances affecting patients with diabetes in Wikwemikong.
- A future workshop should include a group exercise on patient-provider communication, with examples of how to simplify complicated medical jargon or dialogue. Participants should be encouraged to share strategies they have found to be effective in communicating with patients.
- The workshop could serve as an opportunity for Western biomedical health care providers and Anishinaabe knowledge keepers/healers to meet and interact.

### **Recommendations for the Delivery of Culturally Safe Health Care Services**



- The Wikwemikong Health Centre could facilitate a sharing circle with traditional knowledge keepers/healers and primary health care providers. This would offer both traditions the opportunity to discuss collaborative relationships with a focus on culturally safe health care practices.
- The Health Systems Navigator, or a similar position, could act as a point of reference liaising community members to external Anishinaabe knowledge keepers.
- The diabetic flow sheet should be amended to include traditional medicine as an option for patients. The diabetes nurse could then inquire if a patient is interested in traditional medicine, and if so, the nurse could refer the patient to the Health Systems Navigator for further information.
- Educational programming should be offered to dispel rumours and misinformation about traditional knowledge and healing methods in relation to western medical care.
- The Nadmadwin Mental Health Team should be playing a larger role in diabetes care, especially after a patient receives a diagnosis. The mental health team can provide mental health support to any lifestyle changes and social circumstances the patient may be experiencing.
- Health promotion efforts should encourage patients to prepare a list of questions and concerns to bring to health care appointments. Discussing a list of concerns will offer an opportunity for education and counselling that is required for the patient to make informed decisions regarding their health.
- Health care providers should take into consideration issues with cross-cultural communication and adjust their language and pace during clinical visits to allow for comfort and time for patients to understand the conversation.
- For patients with complex health issues, the creation of a shared care plan could help to overcome limitations of inter-organizational communication. This shared care plan would be discussed at case-based conferences where the patient and their family could attend.
- The Wikwemikong Health Centre should continue to measure quality improvement and examine trends within the organization. Working with patients and their families to obtain service satisfaction feedback is beneficial in building rapport, addressing health care inequities, and increasing service utilization.

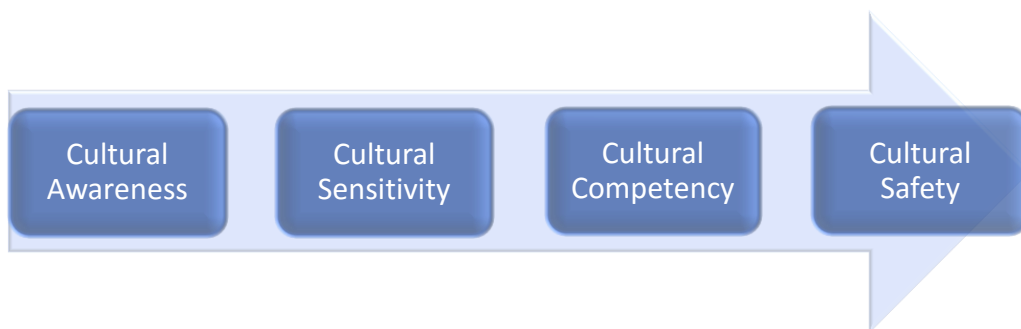
## Introduction

In 2015, almost 3.4 million Canadians (9.3% of the population) were living with type 2 diabetes (CDA, 2015). Higher rates of type 2 diabetes were seen in lower socio-economic status groups, residents of rural communities, and members of certain ethnic backgrounds, in particular Indigenous peoples (CD, 2015; PHAC, 2011). For adults who are 18 years of age and older living on First Nations reserves, the rate of diabetes is an estimated 15.3% (FNIGC, 2011). The estimate for the prevalence of diabetes in Wikwemikong Unceded Indian Reserve (WUIR) is 16% for the adult population (Jacklin & Farmer, 2008). Among those aged 50 years and over, 50% reported having diabetes (Jacklin & Farmer, 2008). Findings from a 2008 medical chart review of patients in Wikwemikong showed a range of co-morbid conditions and diabetes related complications, including dementia, depression, hypertension, coronary artery disease, nephropathy, and neuropathy (Jacklin & Farmer, 2008). These estimates indicate that diabetes is becoming endemic in Wikwemikong.

As a means to improve the health of First Nations, Inuit, and Métis patients, Indigenous health care associations have been advocating for cultural safety in the health care system (IPAC-AFMC, 2009; NAHO, 2009; ANAC, 2009). Cultural safety is grounded in an understanding of the history of colonial relations and Indigenous peoples' culture and beliefs, leading to a process of self-reflection regarding patient-provider relationships in health care treatment (Brascoupé, 2009; IPAC-AFMC, 2009).

Cultural safety is often viewed as operating along a continuum moving from cultural awareness to cultural safety, inclusive of cultural sensitivity and cultural competency (Figure 1).

Figure 1. The Cultural Safety Continuum



Although these terms may appear synonymous, they are distinct concepts involved in achieving culturally safe health outcomes. *Cultural awareness* concerns the health care provider's acknowledgment and respect of differences; *cultural sensitivity* involves learning about the history, customs and practices of a particular patient; and *cultural competence* occurs when a health care provider develops the skills, knowledge, and attitudes required

to appropriately integrate a patient's culture and values into a health care plan. The shift to *cultural safety* entails recognition that every patient-provider encounter involves two interacting cultures. Since patients experience health care encounters through their own cultural lens, what occurs in culturally safe health care encounters is a power shift from provider to patient; the patient determines whether the encounter was safe or not (Papps & Ramsden, 1996). Cultural safety education and training for health care providers and organizations can help bridge barriers such as language, social challenges, and institutional racism. Participants develop necessary advocacy skills to work collaboratively with Indigenous patients to achieve better health outcomes (Browne et al., 2009; Gray & McPherson, 2005; IPAC-AFMC, 2009).

Despite the promise of cultural safety training, there has yet to be any systematic evaluation of its potential impact (Brascoupé, 2009). The purpose of the Best of Both Worlds project was to develop, implement, and evaluate a cultural safety education workshop for interprofessional health care providers (HCPs) who serve adult patients at the Naandwechige-Gamig Wikwemikong Health Centre with type 2 diabetes. The evaluation focused on two primary components:

1. **Training:** The training is the main tool used to transmit the elements of a culturally safe care model and as such, the evaluation examined the effectiveness of the training itself.
2. **Implementation:** The evaluation sought to identify changes in culturally safe practices as a result of the training.

Recommendations include improvements for future delivery of the cultural safety workshop, as well as considerations for improving culturally safe health care practices at the Wikwemikong Health Centre.

## Methods

The Best of Both Worlds study was led by Dr. Kristen Jacklin, Associate Professor at the Northern Ontario School of Medicine (NOSM), along with staff members from the Centre for Rural and Northern Health Research (CRaNHR), in partnership with the Wikwemikong Health Centre (WHC) and Diabetes Research Advisory Group. This study used mixed methods to evaluate the cultural safety workshop.

The development process of the workshop has been detailed in a previous report titled, *The Best of Both Worlds: Developing a Culturally Safe Integrated Care Plan for the Wikwemikong Health Centre Naandwechige-Gamig* (Jacklin et al., 2015). For additional details about the content of the workshop, please refer to Appendix A: The Best of Both Worlds Workshop Descriptive Agenda.

Throughout the entire research process, the Diabetes Research Advisory Group, consisting of representatives of the community, the Wikwemikong Health Centre (WHC), and health care organization partners Noojmowin Teg and the Northeast Manitoulin Family Health Team, provided guidance to the research team.

The evaluation involved five components:

### **1. Workshop evaluation and feedback survey**

The workshop evaluation and feedback survey sought to determine workshop participants' level of satisfaction with the training. The survey collected feedback about strengths and weaknesses of the workshop design and delivery and allowed participants the opportunity to make suggestions for improvement. Participants were also asked changes they could make to practice. The evaluation survey was administered at the end of the workshop.

### **2. Pre/post-workshop surveys**

Requests to participate in the workshop surveys were delivered by email. A web link to an online survey was included. Participants were assigned a numerical identifier to link their pre and post-survey responses. The pre-workshop survey was administered one month prior to the start of the first workshop. The pre-survey assessed level of knowledge and comfort with culturally safe care prior to the workshop. Six months after the second workshop, the post-workshop survey was administered. Responses were compared to measure change in participant understanding and application of cultural safety as a result of the training.

### **3. Interviews with health care providers**

Interviews were conducted six months post-training to determine if participants had made changes to their practices related to cultural safety. Workshop participants were asked for insights on the strengths and weaknesses of the workshop content and delivery. Interviews were audio-recorded and transcribed verbatim.

### **4. Patient satisfaction interviews**

Interviews were conducted with patients (18+ years) who visited the health centre immediately following a diabetes health care appointment with one of five physicians or nurse practitioners who had completed cultural safety training. Participants must have had an appointment pertaining to their diabetes care with the presiding doctor or nurse prior to the workshop training as well. Questions centred on the level of satisfaction with care, the provision of culturally safe care, and access and barriers to programs and services.

### **5. Chart review of the Northeastern Manitoulin Family Health Team medical records**

A medical chart review of Wikwemikong patients with type 2 diabetes who are patients of the four participating primary care physicians at the Northeastern Manitoulin Family Health Team was undertaken to determine changes in diabetes outcomes following the training. Results were compared to recommendations by the Canadian Diabetes Association Clinical Practice Guidelines. The chart audit was conducted between May, 2014 and February, 2016.

### **Research ethics**

All research procedures and evaluation measures were approved by the Laurentian University Research Ethics Board (certificate #2015-01-11) and the Manitoulin Anishinaabek Research Review Committee. The Project is supported by the Wikwemikong Health Centre Health Services Committee through a motion of support and by a Wikwemikong Band Council Resolution (BCR#3874, October 28th, 2013).

### **Data analysis**

A total of 20 health care providers, and six medical students and residents responded to the pre-survey. By the time the post-workshop survey was administered, six workshop participants had stopped working at the WHC. From the remaining 14 participants, only 8 responded. None of the medical students or residents responded. A comparative statistical analysis of pre and post-surveys was undertaken for exploratory purposes to determine if any improvements were made in health care providers' knowledge and application of cultural safety since participating in the workshop. The Wilcoxon-signed rank test was employed to compare the scores on the pre/post workshop surveys.

Workshop evaluation and feedback surveys were collected from 34 participants, however, only 33 participants signed the attendance sheet. Since no identifiers were collected, there is no certainty who the additional health care provider may be. The data from the extra survey was included in the analysis regardless. Quantitative data from the survey were analyzed using descriptive statistics. Since all participants completed the survey anonymously, responses to open-ended questions quoted within this reported are cited as "workshop participant". The chart audit analysis is informed by the Educating for Equity project<sup>1</sup>. Analyses were performed with Excel and SPSS v. 20. A total of 297 patient files were audited.

Pre-workshop interviews were conducted with 22 health care providers, 16 of which completed the training. Twelve participants had individual interviews, two small group interviews were held with two participants in each and one physician focus group with six

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<sup>1</sup> For more information about the Educating for Equity project, please visit: <http://www.educating4equity.net/indigenous-health-and-educating-equity>

participants was conducted. The 16 health care providers who complete the cultural safety training also participated in post-workshop interviews. .

Structured interviews were conducted with patients with type 2 diabetes pre-workshop. A total of 18 community members participated (8 men, 10 women). Respondents ranged in age from 22-79 years. The average age of the 10 female participants was 50 years, and the average age of the male participants was 65 years. Interviewers took detailed notes throughout the course of the interview.

Interviewer notes from patient interviews and transcripts from health care provider interviews were analysed thematically using key domains of cultural safety identified in the development of the workshop (Jacklin et al., 2015): (1) Indigenous determinants of health; (2) culture, health, and spirituality; (3) relationship development; (4) cross-cultural communication; (5) self-reflection; and (6) structural barriers.

## Findings

### Cultural Safety Workshop Results

A total of 34 interprofessional health care providers and managers participated in the workshop sessions.

Objectives of the cultural safety workshop were well received (Table 1). Significantly, the evaluation found that a total of 80% of participants strongly agreed or agreed that the workshop was successful in meeting all five of the objectives.

**Table 1. The Program Met the Stated Objectives of Improving Health Care Providers' Capacity to:**

n=34 (%)	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
1. Describe how Aboriginal health disparities stem from historical, cultural, and socio-political contexts.	14 (41.2)	19 (55.9)	1 (2.9)	0	0
2. Explain the implications of First Nations health care policies for Aboriginal patients with diabetes.	8 (23.5)	17 (50.0)	9 (26.5)	0	0
3. Describe effective approaches to promote communication and relationship building with Aboriginal patients.	9 (26.5)	17 (50)	5 (14.7)	3 (8.8)	0
4. Describe how to support Aboriginal diabetic patients who wish to utilize cultural health care practices.	12 (35.3)	14 (41.2)	7 (20.6)	1 (2.9)	0
5. Describe the importance of reflexivity and demonstrate methods of self-reflection.	16 (47.1)	10 (29.4)	6 (17.6)	2 (5.9)	0

Table 2 shows level of satisfaction with content and delivery of the workshop. Participants gave high ratings of strongly agree or agree to every statement. The majority of providers (96%) found the workshop content to be relevant to their occupation and 92% stated that the content learned will be used in their practice.

**Table 2. Level of Satisfaction with Program Content and Delivery**

n=34(%)	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
1. The program content was relevant to my role as a health care provider.	19 (55.9)	13 (38.2)	2 (5.9)	0	0
2. The program met my expectations.	14 (41.2)	12 (35.3)	7 (20.6)	1 (2.9)	0
3. The program was well organized.	16 (47.1)	15 (44.1)	3 (8.8)	0	0
4. Disclosure of potential conflicts of interest was clearly communicated.	26 (76.5)	6 (17.6)	2 (5.9)	0	0
5. Presenters were effective in delivering/facilitating the program.	19 (55.9)	13 (38.2)	2 (5.9)	0	0
6. At least 25% of the session was interactive.	20 (58.8)	10 (29.4)	4 (11.8)	0	0
7. There were adequate opportunities to interact with the presenters.	19 (55.9)	12 (35.3)	3 (8.8)	0	0
8. The information I learned will be used in my future practice.	19 (55.9)	12 (35.3)	3 (8.8)	0	0

Overall, feedback on the delivery was positive. During post-workshop interviews with health care providers, some agreed that similar cultural safety training should occur more frequently to solidify the important messages.

*I think, just like we should have ongoing training, like, if it happened more than once a year, then people would start to get it. (HCP 203)*

*I think you just need to keep having it frequently because I think the more people that understand about cultural awareness, the historical trauma things that happened in this community and other communities, I think the more educated people are about that, the better. Because then you have such a broader understanding of the community itself. (HCP 206)*

However, several participants felt that the amount of information being shared in a one day time frame was too great or that the expectations for the workshop were too high. One participant felt the workshop was too long and that it was hard to keep focused. A few participants thought the expectation of reading the online material in addition to a full day workshop was too demanding of their time. Other participants in the evaluation survey commented that the workshop should span two days:

*There is much to provide and not enough time. There needs to be more of this available to providers. Maybe the training should span 2 days. (Workshop Participant)*

For some participants, the notion of cultural safety was contentious because they perceived an implication that participants lacked understanding or were not delivering quality care. One participant suggested that naming the workshop “cultural safety training” could be construed as offensive because it was felt that by taking the training it assumes the care currently provided is unsafe.

*I did access the website. And I accessed it because I was offended by the title of the workshop and I thought ‘Cultural Safety? What on earth is that all about?’ and I took it almost as an offence, thinking that somehow I was – ‘Am I threatening the safety of this culture? What is this?’ (HCP 223)*

There was also a sense of discomfort felt by non-Indigenous participants who were reminded that they are in a position of privilege and power. There was a sense of awkwardness in a classroom environment where one’s privilege is being pointed out:

*Reverse racism was present - speakers referring to western medicine as “white medicine” – though this is not sensitive or accurate. Interprofessional collaboration was not promoted with content – videos discuss male doctor. Overall very good! But potentially to help break down the barriers, promoting other cultures including white man as being positive should be important! (Workshop Participant)*

There were non-Indigenous participants who voiced concerns that participants may not feel safe participating in a workshop where difficult conversations are inevitable.

*... There is sometimes guilt. There’s shame, there’s fear, there’s all of those sorts of emotions ... So as we’ve been engaging in cultural safety and people learn the history and as someone said, ‘It’s not, it’s not our history, it’s not your history, it’s our history’ that that’s been very difficult for people to comprehend. It’s been difficult sometimes for people to read about and sometimes there’s the feeling that ‘Oh what, you’re expecting me to feel guilty about this? This wasn’t me.’ So but those are the, those are the things that we need to have those discussions on ... for those that who are feeling that and that who are not Indigenous, that’s not a safe environment for them ... It’s important for them to feel safe that they can have that discussion without, without feeling that it’s not safe to say so. (HCP 222)*

Recent and ongoing media attention in Northern Ontario draws attention the extreme sensitivity that some participants have when being asked to participate in similar training. The comments from participants in the Best of Both Worlds training should be taken in this light. Overall, the evaluation suggests that the workshops created a positive and respectful environment for cross cultural learning, collaboration and dialogue.



The cultural safety workshop evaluation further explored whether there has been improvements in the knowledge and application of cultural safety as a result of the workshop. Workshop evaluation/feedback findings, and pre and post survey results are presented as three broad themes based on the domains of cultural safety: contextual knowledge, relationship development, and addressing structural barriers.

## **Contextual Knowledge**

The theme of contextual knowledge includes two cultural safety teaching domains: (1) the Indigenous determinants of health (including colonialism and local history) and (2) local perspectives on culture, health, and spirituality.

### **Indigenous determinants of health**

In the workshop evaluation and feedback survey, some participants mentioned the historical component of the workshop concerning colonialism as being the least effective part, because as one person explained, they were previous opportunities to learn about the socio-political and historical context of Indigenous peoples' health. Despite this, responses to open-ended questions in the post-workshop survey, participants mentioned that the workshop reinforced previous learning and also that the workshop provided insight into the history of Wikwemikong and the Anishinaabek. HCP interviews stressed that workshop participants saw the benefits of learning the community history of their patients for the provision of health care.

*So were you guys aware of the gate at Wikwemikong? That was the other thing I wasn't aware of ... That doesn't give you a lot of hope for their humanity ... Because like how long ago was that? And then look what's happening in the world now. Nothing has changed. (HCP 215)*

*... it was helpful to know a bit of the history around colonialism and the treaties and the residential school ... you know, greater awareness of those, and that history is obviously, important. (HCP 219)*

Even though a high percentage (73.1%) of participants felt they had an understanding of colonization and its impact on Aboriginal health outcomes prior to the workshop, the post-survey revealed a slight increase participants understanding (Appendix B). As important, the 97.1% of participants felt the first objective, “describe how Aboriginal health disparities stem from historical, cultural, and socio-political context” was met, a higher response than any other learning objective (Table 1).

## **Culture, health and spirituality**

Traditional Anishinaabe medicine and healing practices were used by 13 of 18 interviewed patients. Six patients had initiated discussions of their use of traditional medicine with their health care providers. They believed their providers were respectful of traditional medicine. A few participants mentioned discussing traditional medicine because they were looking for referrals to a traditional healer; at least one participant was not aware of the traditional program or coordinator at Noojmowin Teg, and according to the patient, neither was his doctor. Patients who had discussed traditional healing were under the perception their health care providers would not care whether they used traditional medicine, or stated simply that the topic had never come up in conversation. One participant explained that she would not disclose her use of traditional medicine because it is of “a very personal nature.” She worried how she might be perceived by health care professionals, explained that she makes her own medicines, and suggested her provider may think she’s a “witch doctor.”

Participants who are not using traditional Anishinaabe medicine were interested in learning more, but noted rumors and misconceptions circulating throughout the community caused them to hesitate. One participant said he only uses Western medicine because he heard that the two traditions could not be combined. Patients shared stories about people dying from stopping their Western medicine to use only traditional medicines. Interviewers inquired whether participants would like to attend an information session or meet with a resource person to learn more about traditional Anishinaabe healing practices. Participants were interested in learning the cultural traditions. Taking time to attend a session was cited as a barrier to their learning.

In comparing the pre/post workshop surveys, improvements in ratings were seen in the area of being “culturally informed” for half of the respondents. The remaining half of the participants’ scores did not change. As one HCP described in an interview, the workshop offered an opportunity to learn about cultural practices and build awareness.

*I enjoyed it because a lot of the stuff, the cultural stuff I had never participated in, because I don't even live on Manitoulin Island, right. So I had never smudged. I had never done any of that stuff before I went to that meeting. So it was, you know for me it was very interesting just for an educational perspective. (HCP 217)*

While the post-workshop survey showed some improvements in HCPs confidence in discussing traditional medicine, patients did not detect any difference in discussing traditional medicine or healing practices during post-workshop appointments. It was suggested, however, that the cultural safety training could be strengthened by providing

the opportunities for biomedical health care providers to meet and interact with traditional health care providers.

*I think it would've been helpful if some of the community providers who in fact do provide, you know, traditional care were there. You know if the point is for us to collaborate more with them, then have them at the table, you know. Where is the traditional healer at that meeting? ... to make the workshop as helpful as possible what you want is you want to put the people face to face to each other so that names are known, faces are known, relationships can be developed, and it's like 'Who is this traditional healer?'" (HCP 217)*

## **Relationship Development**

The relationship development theme incorporates the key qualities that providers must have to practice successful therapeutic relationships with Anishinaabe patients. These qualities involve engaging the patient in open and non-judgemental dialogue where providers seek to understand the patient, their health care perspectives, and recommend treatments in line with the patient's values.

The long-term provision of care delivered by most of the physicians helped to build a strong rapport with patients. Twelve of the participants had been a patient of their family physician for 10 years or more. The development of positive long-term relationships with primary care providers was a marker of satisfaction with health care delivery. For some, having the option to change physicians to one that they were more comfortable with permitted a sense of self-control and personal power over care. Patients were positive about doctors and nurse practitioners sharing health information. One participant shared a story about her physician helping her to get on disability after initially being declined. The physician encouraged the patient to appeal and she was successful after the second application. Another patient shared that when she was going through a period of weight gain and depression, her HCP encouraged her to use post-it notes to write positive self-affirmations to herself. While most patients stated that they were comfortable disclosing hardships and social stressors with their HCPs, not all patients felt this way. Two patients noted they preferred to seek counselling from either a mental health therapist or a nurse practitioner. They explained that they do not see their family physician as being able to provide mental health counseling in the same manner that a therapist can.

Participants who spoke Anishinaabemowin were asked if a translator would be beneficial during health care appointments. Only one participant indicated he would be better able to give a description of his ailments in Anishinaabemowin. According to the participants, the difficulty they experience with communication has less to do with translation and more to do with comprehension. Some patients are not able to understand the words and medical

terminology used by their health care provider. In this sense, a family member will “translate” for clarification. Following a four point scale from *understood everything* to *didn't understand at all*, participants were asked about their level of understanding with regards to explanations by providers surrounding medications, procedures and treatments, and follow-up care. Participants were quick to say that they had *understood everything or most of it*. Most participants explained that they will ask their provider for clarification until they feel confident that they understood the information being discussed. Most patients came to their appointments prepared to discuss their health with some preparing a list of written questions.

Patient-provider rapport was also key to effective communication. A lack of rapport with a family physician had left one patient confused about their diagnosis, which led to skipping tests. Once the patient became more acquainted with the physician she felt that she had established a “comfort zone” and felt “safe” with the doctor. Another patient described an incident that occurred a year prior when she perceived a health care provider as behaving rudely toward her, so she stopped all appointments until her complications became too severe to be ignored. The patient said she felt comfortable returning when she heard that the health care provider was no longer employed at the health centre. Other participants described appointments where they were made to feel discounted or rushed out of the office. In these situations, HCPs were perceived to be acting disinterested and talking too fast.

Patients appreciated health care providers who took the time to engage in meaningful conversations about health. For example, patients described HCPs employing visual aids, such as graphs, to help illustrate blood glucose levels. In one instance, a patient was shown a graph of their HbA1C (blood glucose) levels; the patient could easily see that their A1C spiked when they stopped taking their metformin. This was effective in helping the patient to understand the importance of medication in regards to managing A1C levels.

Health care providers were asked about strategies used to enhance therapeutic relationships. Health care providers wrote about listening, creating patient -centered goals, collaborative relationships with patients, and encouraging family to attend appointments. Again, respondents made reference to empowering the patient:

*Supporting clients with greater self-determination over diabetes and focus on self-care, versus dependency on an "expert". (Post-survey Respondent)*

*I endeavor to 'meet people where they're at' and start our work from there. I strive to create client-centered goals in collaboration with the client. (Post-survey Respondent)*

The post-workshop survey asked how HCPs would change their approach to care for patients with diabetes. Taking more time to listen and explore patients' feelings as well as "listen more" or "listen better" were the mostly commonly mentioned changes. Providers wrote that they will work on their communication strategies by listening to patients and validating patients' views of health. One medical student wrote how the awareness of Indigenous peoples' mistrust of the health care system will impact their future therapeutic approach to building partnerships with patients:

*I'm currently a student but I foresee myself much better able to communicate with my patients because I have a better understanding of the struggles they face. I also think that by being more aware of the mistrust that exists for Western medicine, I can tackle that barrier much more effectively and build a more productive relationship.*

(Workshop Participant)

## **Structural Barriers**

The health care of patients in Wikwemikong is impacted by persistent structural barriers. Findings involving structural barriers have been discussed many times in research studies conducted in Wikwemikong (Jacklin & Warry, 2004; Jacklin, 2007; Jacklin & Farmer, 2008) and in the previous research report on developing the Best of Both Worlds workshop (Jacklin et al., 2015). However, these barriers were a recurring theme in interviews with patients and health care providers. As such, we include a discussion of the key structural barriers found during the evaluation process, including: inter-organizational communication, hierarchy of services, electronic medical records/charting systems, and continuity of care. The cultural safety workshop attempted to address the inter-professional communication challenges by incorporating interactive elements to bring inter-professional providers together to discuss their roles in caring for patients with diabetes. The Dorothy monologue, provided by the Educating for Equity project, was regarded as the most effective part of the workshop. Dorothy is a case study of a 55 year old female representative of patients with type 2 diabetes in Wikwemikong. The monologue echoes the 'inside' voice of the Anishinaabe patient that often stays hidden from health care providers. The purpose of exploring this perspective is to provide health care providers with insight into the complex world and issues of Anishinaabe patients with diabetes in order to illustrate opportunities for HCPs to support their patients more effectively. HCPs enjoyed discussing the case study in small, inter-professional groups where they had the opportunity to interact with their colleagues in a novel way. By way of the case-based discussion, HCPs were able to learn about each other's inter-professional roles and skills.

There was some debate as to whether there have been changes in communication between health care colleagues since the training.

*I would say yes, because the one physician in particular...makes contact with the nurses and I can't speak for the rest of the physicians but I know one in particular has that ongoing dialogue with the nurses connected to diabetes. (HCP 225)*

*Not really. No. I haven't seen it. (HCP 203)*

However, despite disagreement in whether there were observable changes in communication, health care providers saw value in the training, especially the opportunity to meet and interact with colleagues to learn about the population they mutually serve, which might not have been possible otherwise.

*So, since that training, have I seen better [communication]? So, I would just say it maybe was evolving before but I think it [the training] helped facilitate it faster because it was a bunch of colleagues getting together and knowing that they were all still serving the same populations ... what you've done with this is cut across all of those barriers or all of those organizations to create something and provide something that resonates with everybody because it's the same ... So, it was specific to this area and it's specific to the populations who live here. I think that that's an amazing thing. (HCP 226)*

*Just by being involved in both sessions I'm hearing and seeing barriers to care is not knowing ... who the key providers [are] within that circle of care. So, understanding one another's role and when we had the first session there were some of those ah ha moments ... (HCP 225)*

One mental health care provider shared how her perception of her colleagues changed during the workshop. The training provided an opportunity for health care professionals from a variety of specializations to work together to foster positive relationship building.

*I like the fact that the doctors were included. Because one of the doctors – or maybe a couple of them – I thought, you know, just personally, man they don't get mental health. And then we sat there together and I went, man, they do get mental health. So that was good. That was learning for me. Because a lot of times we just get pieces of paper from the doctor. Doesn't say a whole lot. (HCP 203)*

The workshop evaluation asked participants to explain how they would change their approach to caring for Anishinaabe patients with diabetes based on what they learned in the workshop. Responses pointed to a common aspiration for regular inter-professional

collaboration with colleagues in an attempt to build towards shared care, as the following two quotes illustrate:

*Explore more opportunities to develop shared care with mainstream practitioners and Aboriginal services within our health system/service. (Workshop Participant)*

*Continued work towards better communication between providers who work with same diabetic individuals and population. (Workshop Participant)*

### **Inter-organizational communication**

After the workshop, HCPs emphasized that inter-organizational communication could still be improved. External partners of the health centre felt that consistent communication was required concerning changes within programs especially concerning roles and responsibilities of staff members.

*I'm not sure that we have a full understanding and a full respect of each other's roles and how they can complement ... So physicians have their own areas and the NPs have their own areas and the nurses have their own areas and this area is over here and so we don't have a working together and I don't know how you do it but we don't have as much of a working together. (HCP 212)*

*So if they're going to do a wholesale flip of personnel they need to, the leadership down there needs to be coordinating that handover and making sure that all the players are aware of what's going on, right. (HCP 223)*

*Yeah, maybe. Or maybe someone's just not understanding that we also do talk therapy, and that we have as much skill as a psychologist. (HCP 203)*

Participants mentioned a venue for improving communication and fostering partnerships might be the Interdisciplinary Diabetes Team/Diabetes partnership meetings, However, there were suggestions for improvements, specifically the frequency of the meetings and inviting relevant partners to participate.

*I wouldn't say that I've ever had a staff meeting with like all health centre staff. But we do like a diabetes partnership meeting ... and those meetings are just like working on our coordination of care... I've never had a meeting with them [mental health] ... our hopes were, to maybe partner with them [mental health] closer. I wouldn't say that's really happened quite yet. So, yeah I mean definitely they should probably be at the table, at those meetings. (HCP 208)*

*Right now we meet twice a year with the interdisciplinary diabetes team. So, we have the administration there, physician, the nurse, dietitian, well and we should have foot care there. But we're not always at that meeting ... We have to*

*just commit to those meetings twice a year ... it could still be your nurse, your dietitian, your CHR and foot care and probably the managers within the respective departments meet at least quarterly to see are we on track with delivering the service.” (HCP 225)*

### **Hierarchy of services**

Health care providers recognized that both communication and referral patterns were affected by the structure of the current health care system and its inherent hierarchy.

*We’re working on communicating better. We still have [silos]. We still have a hierarchical medical system. We still have a medical system that’s driven by dollars. So for example, and this is going to sound anti-physician and it is not meant to be – that I think when I taught I think diabetes care one of the things that we do not, we have not, let me say we have not well incorporated traditional healing. (HCP 212)*

Although the hierarchical structure of the medical system was mentioned by primary health care providers, mental health care providers emphasized this hierarchy and were especially concerned with its impact on referral patterns.

*... We have as much skill as a psychologist. A psychologist can diagnose – and do certain testing. That’s kind of like the one up on us as clinicians and workers. So, and I mean like, he has a long waiting list. We do see anybody who walks in here. And we also have a waiting list but it’s not anywhere near as long as his. So anybody would be, they would get in a lot sooner. (HCP 203)*

*But as for services for when they make referrals to Nadmadwin, it’s usually more likely to the psychologist for whatever reason because the dietitian or the nurse practitioner and the psychologist, they work under Noojmowin Teg. So, you know, then there’s Nadmadwin, which they do make a referral but it’s not like an everyday thing. If there’s an emergency, a walk-in, then they won’t think twice. They’ll come here, say ‘Could you see this individual today?’ That’d be the only time. They wouldn’t ask for...the psychologist. They wouldn’t ask for him. They wouldn’t say, ‘Could you come see this person, could you see this individual?’ So they know the services. It’s just they pick and choose who they want to give access to for their client. (HCP 202)*

Moreover, it was felt that the notion of hierarchy was a barrier reinforced by both health care professionals and community members alike.

*It seems to be all over the place in terms of getting rid of that sense of one service being more important than the other. Our psychologists, people want to see, psychologists more than they want to see a counsellor. And that’s maybe not the appropriate level of care. (HCP 226)*



*... The sense of hierarchy. So, the problem is that our community members have bought into it as well ... if there's an opportunity to see a physician versus a nurse practitioner, they will prefer to see the physician, thinking that they're getting better care ... we need to be able to get the recognition for from the providers themselves, from the community members as well, that all of the services are equally important and that they need to be given the same kind of respect as to why people should be accessing all of those. (HCP 226)*

### **Electronic medical records & charting systems**

As mentioned in the Best of Both Worlds report (Jacklin et al., 2015), the multitude of charting systems utilized by employees of the health centre and external partner organizations continues to fragment care and complicates consistent service provision to community members. Health care providers currently use different charting systems which impede the sharing of important information. These include the Practice Solutions electronic medical record (EMR) system (i.e. NEMFHT physicians) and the Nightingale EMR system used by Noojmowin Teg health care providers (i.e., nurse practitioners, psychologist, dieticians and foot care nurse). To further complicate the issue, the health centre staff were currently transitioning to a different EMR system.

This complex system of communication also affects the referrals process within the health centre programs and between services offered by external partner organizations (i.e., NEMFHT physicians and Noojmowin Teg Health Access Centre).

*I think that's still happening. We have referral forms, and the doctors and dieticians have their own and we still don't get a whole lot of information. They don't really give us a clear idea of why they're being referred. (HCP 203)*

*I tend to refer mostly to [the Noojmowin Teg foot care nurse] when it comes to foot care just because I don't really know how I would communicate that with [the Naandwechige-Gamig Wikwemikong Health Centre foot care nurse]. I guess it would have to be like a paper referral. I don't even have her referral. (HCP 208)*

In general, health care providers agree and recognize the complexity in the multi-charting system as a definite barrier to communication amongst health care professionals and ultimately, to providing quality care to patients.

*I'd definitely say that like there's so many different systems for charting. So, we have Nightingale, the doctors from [Little Current] have Practice Solutions and then the community has their paper charts. So, I would say that that's definitely a barrier. I mean we're getting better at it, at connecting our information but I*

*mean like physicians aren't necessarily looking at our Nightingale notes ... (HCP 208)*

*... if I'm communicating with a physician we do it through messenger on Practice Solutions. With a physician or with [Naandwechige-Gamig Wikwemikong Health Centre diabetes nurse] on Practice Solutions, and then between the nurse practitioners we message on Nightingale to each other ... Oh, it's like god awful ... No, it's like a huge [barrier]. Not just for diabetes, just for nursing in general, health care, it's terrible. [Laughs] (HCP 222)*

HCP participants explained that follow-up and continuity of care is challenged when they could not view the care being provided to mutual patients.

*... one of the nurse practitioners will identify a patient with diabetes, will get all the basic blood work done, all of that stuff happens before the patient ever comes back to my door. And some patients are very, very comfortable and identify the nurse practitioner as their primary care provider ... So even though on paper he's mine, in fact he's really hers because he doesn't see me, he sees her, and so ... my EMR would suggest he's never had blood work ... Or I may get the blood work but then I don't have any of the other stuff because it's all being done by Noojmowin Teg ... He may very well be very well managed, exactly, and I just I don't know. (HCP 217)*

### **Continuity of care**

Continuity of care was handled as a separate sub-theme as a result of most health care providers referring to the staff turnover, difficulty with succession planning, and insufficient communication when role changes occurred.

Problems with continuity of care became evident when the role of Wholistic Coordinator proved difficult to fill.

*Well we do know [Noojmowin Teg's Traditional Coordinator's] there ... We still have [the Community Wellness Worker]. So she's kind of fulfilling the role, but not really at the same time. I mean she wants to, and she has those connections but ... she's busy like the rest of us seeing clients ... (HCP 203)*

Vacancy of certain positions is also dependent on inconsistent government support for programming. Similarly, external services (i.e., the Ministry of Health and Long-Term Care funded Complex Diabetes Care Team) that community members and health care providers had come to rely upon have been discontinued; this has had a negative effect on the continuity of and confidence in the care provided.

*... Starting the [complex diabetes care team] here, then it's ripped out of here. Trying to keep those people – continuity of care as well, you know? I think that's a major thing as well ... they get comfortable. They get that trust, and then – boom – they're gone ... I don't even know if any of their clientele were notified. (HCP 209)*

One of the most significant human resources challenges faced by WHC is staff turnover and the inability to effectively plan for succession or in-service training when new employees are hired.

*... One of the bigger challenges we have is the turnover of staff. So, you just train one person, give them that opportunity for advancing within the position ... you're going through the whole process of educating and training them and whatnot and bringing them up to speed with the physician and then they leave again ... so, the continuity of care from a nurse to the patient becomes a challenge, your community members, then all their confidence in the organization delivering the service becomes compromised ... (HCP 225)*

*... I'm finding that not only do they change, but the people who are being moved back into position haven't yet even completed their training. And the person, for instance when I did my diabetic clinic on Thursday, right, she said "Well I think it's this" and "I think it's that" and "I'm not sure about this" and "I'm not sure about that". So she had no clue herself about like what the process was for the referrals, who they were going to, and what that person could deliver in terms of services. So there's a disconnect at the delivery level. (HCP 223)*

Staff members' confusion about programs and services currently offered by Naandwechige-Gamig Wikwemikong Health Centre could also impact community perception of the health centre and its services.

### **Northeastern Manitoulin Family Health Team Chart Review**

A retrospective chart audit of adult patients with type 2 diabetes from Wikwemikong was undertaken to examine potential effects of the workshop on patient health outcomes. Clinical data was gathered from Practice Solutions Electronic Medical Records system housed by the Northeastern Manitoulin Family Health Team between May 14, 2014 and February 14, 2016. This period is inclusive of 12 months pre-training and eight months post-training. Where applicable, results were compared to a previous chart audit that was conducted in 2008 (Jacklin & Farmer, 2008). Results were also compared to the Canadian Diabetes Society Clinical Practice Guidelines (CPGs) for standards of optimal care.

A total of 297 medical charts of patients with type 2 diabetes were reviewed including 160 females (53.9%) and 137 males (46.1%). The average patient age was 59 years with males being slightly older at 62 years of age. The age of patients ranged from 22 years to 92 years old. On average, patients were diagnosed at 49 years of age; however, there is a wide range in age of diagnosis with females being diagnosed as young as 14 years and males as young as 22 years. The length of time that patients had been living with diabetes ranges between 2 and 29 years for men and 3 and 45 years for women. The average duration of diabetes is 10 years for both men and women.

According to the Canadian Diabetes Society Clinical Practice Guidelines (CPGs), Body Mass Index (BMI) is a reliable measure for most people and is recommended as a screening tool for weight related health conditions. BMIs collected from the medical charts show that most patients are considered obese ( $\geq 30.0$ ). There was no significant change pre- and post-workshop.

Since the 2008 chart audit, there has been an increase in documented foot exams and eye examinations.

**Table 3. Screening for Diabetes-related Complications**

	<b>Pre-Workshop</b>	<b>Post-Workshop</b>	<b>2008 Chart Audit</b>		
	N	%	N	%	%
<b>Foot exam</b>	220	74.1	136	45.8	12.5
<b>Peripheral neuropathy*</b>	171	57.6	126	42.2	n/a
<b>ECG</b>	134	45.1	96	32.3	n/a
<b>Eye exam</b>	145	48.8	117	39.4	31.7

**\*Vibration or 10g monofilament testing**

The Clinical Practice Guidelines recommend that blood pressure be measured at every visit. The target measure is 130/80. There was no significant change in mean blood pressure pre-workshop (132.5/76.7) and post- workshop (129.1/74.7).

HbA1c refers to glycated haemoglobin (A1C) which identifies the average plasma glucose concentration. For a non-diabetic patient, the A1C level is 5%. For a person with diabetes, A1C levels that are greater than 7% indicate uncontrolled blood glucose levels. Findings from the chart review indicate that average A1C level pre- workshop was 7.9% and 8.1% post- workshop.

**Table 4. Glycemic Monitoring and Management**

		Pre-Workshop		Post-Workshop		P-Value	CI (95%)
		Mean		Mean			
Average A1c Level		7.9 ±0.06		8.1 ±0.02		0.57	-0.01- 0.01
		N	%	N	%	P-Value	X²
A1C Levels	A1C ≤ 7.9%	177	59.6	166	55.9	0.93	3.69
	A1C 8.0-8.9%	72	24.2	62	20.9		
	A1C 9.0-9.9%	18	6.1	19	6.4		
	A1C ≥10.0%	30	10.1	50	16.8		

Cholesterol, triglycerides, and high density proteins are all measure of blood components. The Canadian Practice Guidelines recommend triglyceride levels of 1.5 mmol/L, low density lipoproteins values of 2.5 mmol/L, and a value of 4 mmol/L for high density lipoprotein. For the post-workshop assessment, the triglycerides levels are notably higher (2.11 mmol/L), the LDL values are slightly lower (2.06 mmol/L), and the HDL values are also notably lower (1.13). The albumin-creatinine ratio (ACR) is a predictor of cardiovascular and kidney disease. Males should have an ACR value of 2.0 and females should have a value of 2.8. The ACR values for WHC patients on the post-workshop survey are above the recommended levels (3.05 mmol/L) but have lowered slightly since the 2008 chart audit (5.77 mmol/L).

Table 8 shows the amount of counselling and education that occurred over the course of the pre-workshop year and the post-workshop evaluation year.

**Table 5. Occurrences of Counselling and Education**

	Pre-Workshop	Post-Workshop
Diet	404	301
Exercise	188	207
Hypoglycemic events	40	21
Adjustment of treatment plan	19	9
Smoking cessation	47	71
Weight	8	6
Setting of self-management goals	8	4
Traditional medicine	1	3

People with diabetes often develop comorbid conditions as a result of diabetes. Table 14 presents a list of conditions that were commonly found in the review of medical charts.

**Table 6. Comorbidities and Complications of Patients with Type 2 Diabetes**

	Pre-Workshop	Post-Workshop
	M(SD)	M(SD)
<b>Number of comorbidities</b>	<b>3 (2.5)</b>	<b>3 (2.6)</b>
<b>Comorbidities</b>	<b>N</b>	<b>N</b>
Hypertension	85	86
Dyslipidemia	40	40
Depression	21	22
Obesity	92	94
Arthritis	132	132
Respiratory disease	71	71
Hypothyroid	17	17
Gastro Intestinal disease	15	15
Stroke	8	5
<b>Diabetes related complications</b>		
Cardiovascular disease	18	18
Kidney disease (including dialysis)	7	7
Nephropathy	25	26
Neuropathy	25	26
Retinopathy	12	12
Other eye disease*	24	26
Diabetic foot disease	7	9
Amputations	2	0
Skin disease	7	9
Erectile dysfunction	31	33

\*Cataracts, glaucoma, macular edema, blindness

Also captured was that physicians are the health care providers that patients visit with the most, followed by a registered nurse. Visits with a diabetes nurse educator appear to be low, but since the diabetes nurse educator is also a registered nurse, this count could have been conflated with the nurse (RN or RPN) count. The chart audit findings do not indicate improvements in patient outcomes post-workshop.

## Limitations

A significant limitation to evaluating the impact of the workshop was the turn-over of the Wikwemikong Health Centre staff. Since the administration of the pre-workshop survey, six health care professionals were no longer employed by the health centre. The small number of staff who completed the post-survey (n=8) made it difficult to measure changes as a result of the workshop. We cannot state with any degree of confidence that these eight post-survey respondents are representative of all 34 workshop participants.

A notable limitation of the Best of Both Worlds study is the three year time period to develop, deliver, and evaluate the cultural safety training. The evaluation component occurred over a short time span of one year. In evaluating cultural safety training, it is important to consider the long-term impacts of the assessment and the effect it has on maintaining and practicing any newly acquired knowledge. The research team recommends that the Wikwemikong Health Centre continue to measure quality improvement and examine trends within the organization. Working with patients and their families to obtain service satisfaction feedback is beneficial in building rapport, addressing health care inequities and increasing service utilization. Insights for quality improvement could be acquired by patient experience surveys and brief patient satisfaction interviews.

## **Conclusion**

Overall, most health care providers reported that they learned new and important information from the workshop and would have liked to have it repeated. A majority of participants felt that the content and delivery were appropriate, though they would have preferred that the training be offered in a less condensed format. Many reported that aside from the content, the workshop provided a space for relationship development between inter-professional health care providers. While some patients shared issues with their health care providers, many patients interviewed described long standing relationships with trusted health professionals who cared for their wellbeing. This trust was particularly true of primary care providers who offered supports for mental health and were accepting of the use of traditional medicine.

The medical chart audit did not indicate significant differences in patient outcomes as a result of the workshop. The Best of Both Worlds promotes fundamental changes to how health care providers interact with Anishinaabe patients. While these changes are key to empowering patients and improving therapeutic relationships, initiatives to improve health services may have limited impact on health inequities as long as they are being continuously reinforced by ongoing systemic barriers rooted in colonization.

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## **Appendix A: Best of Both Worlds Workshop Descriptive Agenda**

Background and course description: Physicians and allied health professionals, who provide care to individuals at the Wikwemikong Health Centre, will be invited to a one day workshop on cultural safety. This workshop differs from other cultural safety workshops in that it is very community specific. The need for this type of training was established through findings from previous studies highlighting the challenges and barriers to offering and receiving culturally appropriate integrated care, particularly for people with complex, co-morbid diseases. Initial consultations with key community partners, along with ongoing support and guidance from a local advisory committee, expressed the need for physicians and allied health professionals to learn more about their community, including their culture, and the impacts colonial policies has had on their identity, their culture, and their health and wellbeing. In learning about the history of the community and how the colonial policies continue to impact the health and wellbeing of the community members, physicians and allied health professionals will have a better understanding of why some of these health disparities exist.

The one day workshop incorporates the Seven Grandfather teachings, inviting participants to take part in cultural teachings; learn about the history of the community, including the current barriers and challenges facing the community, along with the protective measures and strengths the community draws on in these circumstances; and discuss methods one could use to ensure culturally safe care is offered to patients. The methods utilized in the delivery of the content and materials will include facilitated discussion, key speakers, case-based activities using a team analysis, a three part video case study with facilitated discussion after each part, and a reflective learning activity, where participants share what they have learned throughout the day and how they will apply this knowledge in their own practice. The workshop will open and close with a prayer from a traditional knowledge keeper, who will share the teachings behind why meetings within First Nations communities are conducted in this manner. Throughout the day participants will be encouraged to discuss the concepts being presented, as well as ask questions if further clarification is needed.

## Workshop details

Breakfast – 9am - 9:30am

Start time 9:30 am – 4:15 pm

### 1. Workshop Opening

#### a. Workshop start (20 minutes)

- i. Discussion by a traditional knowledge keeper on the gift of tobacco, followed by opening prayer, and smudging ceremony.
- ii. Introductions and disclosure (CME within the BoBW project)
- iii. Overview of learning outcomes, content and process
- iv. Facilitated discussion. Themes identified within the discussion will be documented and displayed on (flip chart paper / power point / whiteboard) for review at the end of the workshop.

#### b. Understanding the need behind the Best of Both Worlds (10 minutes)

This section will outline the background of the project and how the findings from previous research within the community highlight the need for a cultural safety workshop.

- i. Cultural Safety, Health Equity and Indigenous Determinants of Health in Wikwemikong  
By the end of the workshop participants will be able to discuss the different terms used and identify why health disparities are so disproportionate for Aboriginal people.
- ii. Framework for Diabetes Care

### 2. A Historical Perspective of Health in Wikwemikong (50 minutes)

#### a. Traditional understandings of health and wellbeing: now and then. (15 minutes)

A facilitator (Rosella Kinoshmeg) will briefly discuss traditional understandings of health and wellbeing, and explain the importance of Anishinaabe medicines and healers to Aboriginal healthcare.

#### b. Sharing Stories (15 minutes + 20 minutes discussion)

Elder Rita Corbiere will share a story outlining an early experience she had with the health care system and the impacts this has had on her. This is followed by a discussion period where the participants will have time to ask the participating Elders questions.

Possible facilitation question – how would/could early experiences with Western healthcare influence how people interact with the health care system today?

10:50 – 11 am Nutritional Break

### 3. The Colonial Legacy

Colonial practices and policies impacting Aboriginal health and wellbeing will be discussed. By the end of the day participants will be able to explain some of the history behind Aboriginal health disparities and where they stem from.

#### a. Significant Historical Policies Impacting Health in Wikwemikong Today (20 minutes)

At the end of the session participants will be able to describe key pieces of legislation used to limit traditional healing practices, access to healthy foods, and self-determination (Unceded territory and what this means; Indian Act 1876; Indian agents placed on reserves; amendments to ban religious ceremonies – sec 114 [Potlatch in 1884; Sundance 1895]; permit system put in place to limit competition [needed a permit to sell anything that they produced]; compulsory attendance at residential school; sixties scoop [sec 88 - laws of a general application can be applied on reserve lands]; historical and intergenerational trauma).

#### b. First Nations Health Policy and Structural Barriers to Diabetes Care (20 minutes)

Jurisdictional issues - Participants will be able to identify the policies and legislation governing First Nations and Inuit Health Care and discuss the structural barriers that exist when operating within and across provincial and federal health jurisdictions. (Brief overview of the transfer of First Nations health from the department of Indian Affairs to the Department of National Health and Welfare, and later to the First Nations and Inuit Health; Federal Indian Health Policy; NIHB; health transfer and what is not covered)

##### Activity – deconstructing Health Transfer Policy (20 minutes)

1. Participants will review and discuss a case study depicting some of the jurisdictional issues in accessing health care services, medications and medical supplies. In addition to discussing the details of health transfer policy and what services First Nations run health care centres can provide, participants will gain a better understanding of what NIHB covers, what the province covers, and the implications for First Nations diabetes care.

12-12:30 pm Lunch – Informal discussion time with colleagues and community resource people. Participants will also be encouraged to look at reflective questions concerning the morning sessions.

Afternoon

4. Three-part video case study to explore Indigenous peoples experiences with diagnosis and care of Type 2 diabetes (2 hours)
  - a. First Nation Diabetes Case - Dorothy
    - i. Dorothy Part 1 (6:56) minutes  
Possible facilitation questions – What barriers do people in Wikwemikong face in seeking health care services? What resources does WHC have that can support Dorothy’s medical and non-medical challenges?
    - ii. Dorothy Part 2 (5:13)  
Possible facilitation question – What are your experiences working with patients like Dorothy? How do you address patient concerns when they see / hear the diagnosis as a death sentence?
    - iii. Dorothy Part 3 (5:17)  
Possible facilitation question – Are there methods that you have used or will considering using in the future in order to provide culturally safe and wholistic care to Aboriginal patients? Thinking about how care might be delivered here, how could a team approach to diabetes care lead to a better diagnostic experience for Dorothy?

Nutritional break 3– 3:10 pm (possibly move rooms)

5. Participant Sharing Circle – 3:15 – 4 pm
  - i. Reflections on the day and personal commitments to carry forward in one’s own work
6. Closing prayer and teaching (Traditional Healer) 4 – 4:15pm
7. Workshop evaluation (5 minutes)

## Appendix B: Survey Results

Table 1. HCP's Ratings of Culturally Safe Practices Prior to the Education Workshop, n=26 (%)

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Missing
<b>General</b>						
1. I am satisfied with my Aboriginal patients' clinical outcomes.	1 (3.8)	5 (19.2)	9 (34.6)	8 (30.8)	1 (7.7)	1 (3.8)
2. My level of confidence is high with regards to providing care to Aboriginal patients with type 2 diabetes.	0	2 (7.7)	8 (30.8)	13 (50)	2 (7.7)	1 (3.8)
3. I modify my diabetes care approach when working with Aboriginal patients.	0	2 (1)	8 (30.8)	15 (57.7)	1 (3.8)	1 (3.8)
<b>Social Factors</b>						
4. When treating Aboriginal patients with type 2 diabetes, I routinely and specifically enquire about <i>socioeconomic</i> conditions? (e.g. income, employment, education, food security, transportation, housing, access to services)	1 (3.8)	2 (7.7)	7 (26.9)	11 (42.3)	4 (15.4)	1 (3.8)
5. I explore with patients how <i>stress, trauma, and recurrent adverse life experiences</i> have potential impacts on their diabetes outcomes.	1 (3.8)	1 (3.8)	8 (30.8)	11 (42.3)	4 (15.4)	1 (3.8)
6. I advocate for social resources that are key for my Aboriginal patients with diabetes.	1 (3.8)	1 (3.8)	4 (15.4)	16 (61.5)	3 (11.5)	1 (3.8)
<b>Culturally Informed</b>						
7. I am knowledgeable about Aboriginal healing traditions.	0	6 (23.1)	6 (23.1)	13 (50)	1 (3.8)	0
8. *I am skilled at eliciting patients' use of and preferences for culture-based healing methods.	0	8 (30.8)	8 (30.8)	9 (34.6)	1 (3.8)	0
9. *I am skilled at providing culturally sensitive patient education and interventions.	0	6 (23.1)	7 (26.9)	11 (42.3)	1 (3.8)	0
10. I have an understanding of how to facilitate integration of traditional approaches to healing into the care of Aboriginal patients who desire it.	0	7 (26.9)	7 (26.9)	11 (42.3)	1 (3.8)	0
11. I feel confident in my ability to manage my non-verbal behavior and body language in a way that fits with the expectations and norms of Aboriginal patients.	0	5 (19.2)	6 (23.1)	12 (46.2)	5 (11.5)	0
<b>Facilitating Relationships</b>						
12. I have reflected on how my own cultural and professional identity can impact the care I provide.	0	0	3 (11.5)	19 (73.1)	4 (15.4)	0
13. I am an effective communicator with Aboriginal patients.	0	1 (3.8)	6 (23.1)	16 (61.5)	3 (11.5)	0
14. I employ cultural factors in my approach to building a therapeutic relationship with Aboriginal patients.	0	1 (3.8)	7 (26.9)	16 (61.5)	1 (3.8)	1 (3.8)
15. I have an understanding of the Aboriginal community healthcare team, and how to involve them in the care of patients.	0	2 (7.7)	3 (11.5)	19 (73.1)	2 (7.7)	0

16. I am open to learning from Elders and traditional healers.	0	1 (3.8)	2 (7.7)	11 (42.3)	12 (46.2)	0
<b>Addressing Inequity</b>						
17. *I am knowledgeable of the impact of racism and prejudice in healthcare experienced by Aboriginal populations.	0	0	4 (15.4)	16 (61.5)	6 (23.1)	0
18. *I am aware of my own stereotypes of Aboriginal peoples.	0	0	5 (19.2)	18 (69.2)	5 (11.5)	0
19. I have an understanding of colonization and its impact on Aboriginal health outcomes.	0	0	7 (26.9)	13 (50)	6 (23.1)	0
20. I have an understanding of the barriers faced by Aboriginal peoples that contribute to health inequities.	0	0	4 (15.4)	16 (61.5)	6 (23.1)	0

\* modified from CCCQ (Centre for Cultural Competence Questionnaire)

**Table 2. Comparison of Post-workshop Survey to Pre-workshop Survey, n=8**

	Negative	Positive	Tie
<b>General</b>			
1. I am satisfied with my Aboriginal patients' clinical outcomes.	2	0	6
2. My level of confidence is high with regards to providing care to Aboriginal patients with type 2 diabetes.	0	3	5
3. I modify my diabetes care approach when working with Aboriginal patients.	2	1	5
<b>Social Factors</b>			
4. When treating Aboriginal patients with type 2 diabetes, I routinely and specifically enquire about <i>socioeconomic</i> conditions? (e.g. income, employment, education, food security, transportation, housing, access to services)	1	2	5
5. I explore with patients how <i>stress, trauma, and recurrent adverse life experiences</i> have potential impacts on their diabetes outcomes.	2	3	3
6. I advocate for social resources that are key for my Aboriginal patients with diabetes.	0	2	6
<b>Culturally Informed</b>			
7. I am knowledgeable about Aboriginal healing traditions.	1	3	4
8. *I am skilled at eliciting patients' use of and preferences for culture-based healing methods.	0	4	4
9. *I am skilled at providing culturally sensitive patient education and interventions.	2	4	2
10. I have an understanding of how to facilitate integration of traditional approaches to healing into the care of Aboriginal patients who desire it.	0	4	4
11. I feel confident in my ability to manage my non-verbal behavior and body language in a way that fits with the expectations and norms of Aboriginal patients.	0	3	5
<b>Facilitating Relationships</b>			
12. I have reflected on how my own cultural and professional identity can impact the care I provide.	1	2	5

<b>13. I am an effective communicator with Aboriginal patients.</b>	0	3	5
<b>14. I employ cultural factors in my approach to building a therapeutic relationship with Aboriginal patients.</b>	1	3	4
<b>15. I have an understanding of the Aboriginal community healthcare team, and how to involve them in the care of patients.</b>	1	4	3
<b>16. I am open to learning from Elders and traditional healers.</b>	1	3	4
<b>Addressing Inequity</b>			
<b>17. *I am knowledgeable of the impact of racism and prejudice in healthcare experienced by Aboriginal populations.</b>	1	1	6
<b>18. *I am aware of my own stereotypes of Aboriginal peoples.</b>	0	1	7
<b>19. I have an understanding of colonization and its impact on Aboriginal health outcomes.</b>	0	2	6
<b>20. I have an understanding of the barriers faced by Aboriginal peoples that contribute to health inequities.</b>	0	1	7

\* modified from CCCQ (Centre for Cultural Competence Questionnaire)