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MACD 598

*Validating the process of using the Human Resource, Training
and Staff Development domain from An Organizational Self-
Assessment Tool for Indigenous Cultural Competency at Interior
Health*

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Table of Contents

	Page
Executive Summary	3
Chapter 1: Introduction and Background	5
1.1 General Problem	8
1.2 Research Question and Project Objectives	9
1.3 Project Client	10
1.4 Report Outline	11
Chapter 2: Literature Review: Cultural Safety, Cultural Competency and Validation Tools	12
Chapter 3: Methodology	22
Chapter 4: Findings, Recommendations and Action Plans:	
Self-Assessment Tool Scoring	26
Chapter 5: Findings and Recommendations from Survey	46
Chapter 6: Conclusion	51
References	55
Appendices	60

Executive Summary

Indigenous cultural competency has been an area of opportunity for a number of years now for British Columbia's regional health authorities. While a number of actions have taken place within Interior Health (IH) to advance this agenda, the organization has identified a need to focus more energy and attention on becoming culturally competent.

The purpose of this report is to assist IH in undertaking preliminary process validation testing of the *IH Assessment Tool for Indigenous Cultural Competency*, an instrument developed in 2015. The focus of this report is on the process of completing the instrument versus testing the actual outcomes of cultural competency achieved by the instrument within IH. Nevertheless, results from the research provide some key ideas on direction in cultural competency achievement and areas for improvement. The project focuses on only one of the seven domains of the instrument, the Human Resources Training and Staff Development domain. This decision was made in the interests of time and resource factors constraining the project and as part of a wider-stepped process for instrument consideration by IH more generally.

The report draws on conceptual definitions that are identified in the literature review and uses data collected from 15 IH employees drawn from the human resources field within the organization. Their completed instrument results along with the results of a separate survey of their completion experience is analysed to provide findings and recommendations for IH consideration. Results suggest areas of success as well as room for improvement. A majority of responses suggest the self-assessment tool would be valuable for use in other portfolios within IH. For improvement, results indicate that more clarity and instructions should be provided prior to users' scoring the tool.

Brad Anderson
MACD 598

The results of this report have already started conversations within the Human Resource and Organizational Development portfolio and the Aboriginal Health Program to develop a working committee to begin to explore action plans identified from this research. While there is much to be done, IH is moving in the right direction on cultural competency improvement and assessment across its workforce.

Chapter 1: Introduction and Background

Historically, relationships between Aboriginal¹ people and government organizations have been strained due to a number of factors, including colonization, residential schools, Indian Hospitals and the 60s Scoop which took place in the 1960's and continued to the late 1980's where Aboriginal children, en masse, were removed from their families and placed in the state child welfare system, primarily without the consent of their families or bands (UBC Indigenous Foundation, 2009). These historical harms are critical to understanding and interpreting this report. "The determinants of health for First Nations people in urban centres, and Aboriginal peoples more widely, cannot be understood in isolation of the backdrop of colonial relations that continue to shape access to health care, health care experiences, and health outcome" (NAHO 2009: p. 25). Aboriginal people on average score lower on many health indicators due to racism, access issues and lack of culturally competent care.

Cultural Competence in health care is defined as: 'understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations.' (Betancourt, Green & Carrillo, 2003, p. 297)

One definition of Cultural Safety has been described as "more or less - an environment, which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they

¹ It is recognised that terminology is important in the topic area covered by this report. Out of respect for different uses and interpretations of terms, the word Aboriginal and Indigenous will be used interchangeably throughout the report.

Brad Anderson
MACD 598

need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening” (Ramsden, 1992, p. 2).

The concepts of cultural competency and cultural safety are integrated and potentially hard to distinguish between each other. The author’s understanding is that cultural competency refers to the service providers taking into consideration cultural values and beliefs and embedding this into their practice so that the client feels culturally safe. Cultural Safety is determined by the clients or users of a service to assess if they feel their cultural needs have been met. A useful way of understanding the relationship between cultural competency and cultural safety is to frame cultural competency as what the *organization* is, does and creates around cultural appreciation whereas cultural safety refers to the experience of *people* interacting with the organization, be they clients, staff or other stakeholders.

Interior Health (IH) is one of five Regional Health Authorities within the province of British Columbia.

The vision of the health authority is to set new standards of excellence in the delivery of health services in the Province of British Columbia. The organization has four goals it continues to strive and work towards with the people it serves in the interior region:

1. Improve health and wellness
2. Deliver high-quality care
3. Ensure sustainable health care by improving innovation, productivity, and efficiency
4. Cultivate an engaged workforce and healthy workplace (Interior Health, 2016)

With an approximate population of 743,000 people in the interior region, the health authority works with 59 municipalities, 7 First Nations, 54 bands, 15 Chartered Metis Communities and a number of urban service providers. IH operates a \$2 billion annual budget with over 19,000 staff. Leadership within the Interior Health Authority is governed by a Board of Directors that oversees the Chief

Brad Anderson
MACD 598

Executive Officer and the Senior Executive Team. The current structure has the Aboriginal Health Program reporting to the Vice President of Population Health (Interior health, 2016).

Indigenous Cultural Competency has been an area of opportunity for a number of years for BC's Regional Health Authorities. In 2009, the Provincial Health Service Authority (PHSA) developed an Indigenous Cultural Competency (ICC) online training program that allows for health care workers to take 8-10 hrs of online training (www.sanyas.ca). The ICC training has been a step in the right direction in bringing awareness about colonization, residential school history and racism; however, it is only a small first step in understanding the needs of Aboriginal populations. The training works through a series of modules to build the competency and understanding of health care workers who interact with Aboriginal patients.

As an organization, Interior Health has taken many strides in becoming more culturally competent. To date Interior Health has:

- (a) established Advancing the Cultural Competency of the Organization as a goal within the Aboriginal Health and Wellness Strategy HWS 2015-2019
- (b) developed an Aboriginal Health Human Resource Plan
- (c) hired an Aboriginal Cultural Safety Educator
- (d) appointed a First Nations community member on the IH Board
- (e) developed and implemented policies and guidelines to support the cultural needs of Aboriginal people across the client and employee categories (Interior Health, 2016)

The organization has taken several additional steps in a positive direction to becoming culturally competent, including the development of the Aboriginal Health Program, Aboriginal Patient Navigators, Peacemaking Circles, Smudging Policies and Sacred Spaces (Interior Health, 2015).

Interior Health has identified the need to focus more energy and attention on becoming culturally competent by making: *Advancing the Organization's Cultural Competency* one of the four pillars within the Aboriginal Health and Wellness Strategy (AHWS) 2015-2019. Failure to work towards this goal will hinder relationships and expectations from IH's First Nations and Aboriginal partners who were instrumental in the creation and partnership of the AHWS 2015-2019. Aboriginal leadership has spoken at length of the need to address the ongoing issue of cultural safety for their community members. IH has identified becoming more culturally competent as a key feature of improving the health outcomes for Aboriginal people. Having patients feel culturally safe depends on whether they have received culturally competent care from providers (Jessica Ball, accessed January 17, 2016).

1.1 General Problem

Currently, Interior Health (IH) has no definitive method of assessing, scoring and monitoring its organizational Indigenous cultural competency. In 2015, UVic Masters Student Brittany Lawrence completed an *IH Assessment Tool for Indigenous Cultural Competency* along with Interior Health staff James Coyle, Judy Sturm, Shawna Nevdoff, Anni Muhlegg and Aboriginal partners Mary McCullough and Cheryl Ward. This tool (attached as Appendix A) outlines six domains within which the cultural competency of an organization can be assessed. The tool, to date, has not yet received any form of validation testing.

The objective of this Masters project is to provide preliminary testing to begin to validate the *IH Assessment Tool for Indigenous Cultural Competency* (Brittany Lawrence et al, 2015) by exploring process issues associated with completing the Human Resources, Training and Staff Development domain of the instrument. Participants will be sent a follow up survey related to validating the tool. (Appendix B) Evaluating and assessing the Human Resources, Training and Staff Development (HR) category will allow for broader validation of the process component of the assessment tool across the

other domains and assist in better understanding the overall effectiveness of the tool as IH advances its overall cultural competency.

It is recognised that the word validation used throughout the report does not refer to the usual strictly scientific method applicable to validation. Instead, the type of exploratory validation used in this research relates more to what might be called an assessment by users within IH of the Cultural Competency instrument. The word validation remains used through the report, however, to encourage the idea of validation being pertinent to ongoing attention by IH for deployment of the instrument across its organization and services. In time, it is expected that IH may pursue more scientific validation research on the content effectiveness of the tool. A staged process commencing with consideration of process issues associated with the tool enables IH to consider different components of tool implementation to enable process and content dimensions to be isolated, thus facilitating detailed inquiry on each of these dimensions. In this way, IH can determine whether and how process vis-à-vis content dimensions drive outcome effectiveness with respect to cultural competency.

1.2 Research Question(s) and Project Objectives

The following research question guides the project:

Using the Human Resources, Training and Staff Development domain, what validity issues are associated with the process of using the instrument known as the IH Assessment Tool for Indigenous Cultural Competency?

Validity, in this research question, is understood primarily to refer to preliminary process-testing issues based on data obtained internally from within IH. The project focuses on the process of completing the instrument versus the actual outcomes of cultural competency. To meet the research question, the following steps were pursued:

Brad Anderson
MACD 598

- The principal investigator performed a literature review to ensure grasp of key concepts and to map the place of validation in instrument assessment.
- 20 participants from IH were selected by the principal investigator to score the IH Assessment Tool specifically with respect to the HR, Training and Staff Development domain.
- 15 participants responded
- A consent form was sent via email to the participants from the Principal Investigator.
- Participants were emailed the tool to score and assess the instrument related to HR, Training and Staff Development.
- A follow-up survey regarding validation of instrument was sent via email to participants.
- The consent form, completed instrument and completed survey were emailed to the principal investigator, who collated the data and performed analysis on results.

Although the Masters project is related to preliminary process testing associated with validating the HR domain of the instrument (one of the 6 possible domains), the potential benefits for IH are also likely to include information concerning focus areas for how clearly to advance the cultural competency of the organization in the future with regards specifically to the HR portfolio. The collective scores from participants will allow leadership to initiate discussion and to begin enacting recommendations that have appeared because of the scoring.

1.3 Project Client

Mal Griffin is the client for this research project. Mr. Griffin is the Vice President of Human Resources and Organizational Development and is based out of Kelowna, BC. Mr. Griffin is interested in process validation of the tool with respect to the Human Resources, Training and Staff Development domain because of his professional position, which enables him to partner with and lead fellow Senior Executive

Brad Anderson
MACD 598

Team (SET) members on moving the organization toward becoming culturally competent with respect to HR.

1.4 Report Outline

Having introduced the general problem that the project is trying to address, identified the objective and research question and introduced the client to the work, the report is structured as follows:

A brief literature review in Chapter 2 considers concepts of cultural safety and competency in health care, in organizations and within human resource departments. Literature on cultural safety and validation definitions, approaches and tools is also explored.

Chapter 3 outlines the methodology informing the report.

The findings and a number of integrated recommendations and action plans emerging from the findings are provided in Chapter 4. Here, the report examines the scoring results from the 15 participants within the Human Resources and Organizational Development portfolio on the self-assessment tool and showcases their comments. The chapter builds on these findings to present recommendations and suggest action plans for each category in the domain to begin to meet the needs of the self-assessment tool for the organization to be culturally safe. The decision was made to integrate findings and recommendations into a single section because of the integrated nature of the process validation exercise.

Finally, a conclusion summarizes the completed report in Chapter 6.

Chapter 2 - Literature Review on Cultural Safety, Cultural Competency and Validation Tools

The following chapter reviews literature related to Indigenous cultural safety in healthcare, organizations and human resources, the relevant definitions, and the historical importance of culturally competent care for the health and wellbeing of a population. This section also presents information related to cultural competency, which has been defined earlier in the report. The second portion of the literature review focuses on validation definitions, tools, and approaches that support the report.

Cultural safety and competency in healthcare

Cultural safety is a relatively new term that originated with Maori nurses in New Zealand and means that there is 'no assault on a person's identity' (Williams, 1999). The purpose and effect of delivering culturally safe service is critical to enhancing personal empowerment and in turn should promote more effective and meaningful pathways to self-determination for Indigenous people (Williams, 1999).

New Zealand sociologist and ethicist Martin Tolich (2002) mentions in his work that there first needs to be an acknowledgement and support for the necessity of work on cultural safety. One must start from a position of wanting to learn more and understand the need to be cultural competent and safe. The Indigenous people of New Zealand, the Maori, are international leaders in cultural safety work. Their motivation to pursue cultural safety was derived from inequalities that they experienced in health care. As a population, they took a leadership stance to dedicate time and resources towards shifting the paradigm in cultural safety for their people in healthcare settings (DeSouza, 2008). This was not always an easy task, given longstanding race inequalities confronting Maori people and suspicion from Pakeha (people of non-Maori descent).

As cultural safety began to gain traction throughout the 1980's and into the 1990's, implementing such a hot and contentious topic was not always a smooth process. There was push back and concerns from

Brad Anderson
MACD 598

New Zealand nursing students, lecturers and the broader community related to cultural safety. The author believes there was early resistance from those professions because individuals don't want to admit to being discriminatory or racist and needing the training. The people in those positions might feel targeted and defensive because they have been identified as working in priority professions on which to focus cultural safety training. Improvements and recommendations had to be considered to move the cultural safety agenda forward. Improvement to materials, research and approaches was done on many different levels with the appropriate stakeholders. Leaders and supporters blazed the trail for cultural safety to be foundational and rooted in the importance of New Zealand as a country (Wepa, 2004).

Cultural safety and competency in organizations and human resources

Cultural safety is the true end goal or objective that organizations or services strive to work towards. However, it requires a phased-in approach to better understand one's culture and the culture of others who participate in, or are served by, the organization. Cultural awareness is the first initial step in understanding that there are differences amongst cultures. The second phase is labeled as cultural sensitivity, which is about self-exploration and trying to understand one's own experience; this is also a self-reflective stage. Cultural safety is then truly defined by the user, or the customers of an organization, when they decide themselves that the care was culturally appropriate and safe (Spence, 2005). Staff of an organization needs to be well versed in these three phases of cultural awareness, sensitivity and safety in order to ensure ongoing cultural safety experiences by organizational users. Moreover, staff themselves needs to experience cultural safety in order to promote culturally safe practices to the external organizational community.

Cultural safety became fairly public and well known in New Zealand when it was commissioned by the leaders of educational institutions that cultural safety education be built into nursing education. The

intent was clearly to improve nursing service. Nursing education was developed to deliver on the following goals:

- To educate registered nurses and midwives to examine their own cultural realities and the attitudes they bring to each new person they encounter with their practice
- To educate registered nurses and midwives to be open minded and flexible in their attitudes towards people from differing cultures to whom they offer and deliver service
- To educate registered nurses and midwives not to blame the victims of historical and social processes for their current plight
- To produce a workforce of well-educated, self-aware nurses and midwives who are culturally safe to practice, as defined by the customer of the service (Ramsden & Spoonley, 1994, p. 164)

What culturally competent care truly feels like is explained in Bowne, Varcoe et al. (2009) work about applying orientation and knowledge exchange. The article focuses on the need to have self-reflection part of the learning process. Having the ability to put oneself into another's perspective and historical experiences allows for better understanding to build relationships and work closely with patients that are in need of appropriate and culturally relevant care (Anderson, Perry et al, 2003).

Beyond defining the terms and concepts involved, making organizations understand the significant value in having culturally competent measures shows a true leadership commitment to doing the right thing by having indicators that make individuals and portfolios accountable. Bringing the right stakeholders together, collecting the appropriate data and developing an assessment tool collaboratively are seen as the best way to move forward (Neiva & Sorra, 2003).

It should be noted as well that many factors can contribute to how cultural safety actually can be considered. Consideration of the patient, the physical environment, the actual space of care and the actual treatment being performed in a health care setting are all indicators of cultural safety. All of the

mentioned factors need to be considered when developing a tool to measure the cultural competency of an organization and its appropriate level of care (Pronovost & Sexton, 2005).

Other examples of how the 'safety of culture' can be strengthened are mentioned in the work of Gherardi and Nicolini (2000) when they make recommendations about security and need for a community practice. Offering a community of practice builds a network of colleagues and professionals with which to interact and begin to debrief, ask for clarity, ask for solutions, ask for support and ask for recommendations. The service providers within or associated with the organization truly feel joined with like-minded colleagues who are working toward the same goals.

Theories have suggested the importance of diversity in the workforce to build a culturally competent organization. Many organizations have diversity policies in place (Milem, Chang & Antonio, 2005). There is much value in ensuring a great deal of diversity in workplace settings. Diversity shows that organizations are willing to show the importance of having many cultures be part of their work and opens the door for cultural competency to evolve. Having individuals use services where they see others with the same color or ancestry allows for better access and more welcoming feelings. All these factors support a culturally competent workforce, leading to a culturally safe environment (Cox, 1993).

Supporting the work of diversity also comes from building a workforce that is representative of its populations. Studies have proven that investing and supporting Indigenous people to work in positions helps them feel empowered and gives them a sense of belonging within the organization. This all leads to stronger recruitment and retention (Rigby, Duffy et al, 2011).

From the perspective of the daily work of a health institution, for many, the perspective of cultural safety strictly relates to the direct benefit of the individual receiving the appropriate level of care; however, there are much larger benefits that affect a community. The ripple effect of having cultural safety involved in one's care allows for healing to occur faster, which in turn lowers costs and moves

positive effects directly from the individual to the family to the community. The positive outcomes affect more than just a single individual (Waters, 2009).

In addition to cultural representation and diversity, evidence has shown that linguistics plays a part in one's health outcomes. If language is a barrier between a health service provider and a patient, the result can be longer lengths of stay, increased rates of readmission, increased amounts of testing in emergency departments and poor compliance with follow-up treatment (Johnstone & Kanitsaki, 2007).

To derive many of the above benefits, the literature speaks to safety culture and suggests ways for organizations to approach this notion. The following were four approaches to consider in Pizzi, Neil, et al (2001, p. 3):

- 1) Acknowledgment of the high-risk, error-prone nature of an organization's activities
- 2) Creation of a blame-free environment where individuals are able to report errors or close calls without punishment
- 3) Expectation of collaboration across ranks to seek solutions to vulnerabilities
- 4) Willingness on the part of the organization to direct resources to address safety concerns

Other suggestions to advance the cultural competency of an organization have been discussed, including the following:

- Build and maintain a culture of patient safety
- Provide leadership for patient safety that establishes a blame-free environment
- Proactively survey and monitor for adverse events
- Continually engineer patient safety into healthcare processes (Ralston & Larson, 2005, p. 61).

Brad Anderson
MACD 598

For any of the benefits and outcomes of cultural safety to be measured by understanding an organization's clients and customers, collecting data on race, ethnicity and language is beneficial. It also helps with planning and the opportunity to provide culturally competent care so service providers can align appropriate cultural care if needed (Zambrana, Molner, et al, 2004).

Despite an institution's desire to implement culturally safe and competent procedures, communication has been described as the single most important factor in the failure of modern health care. Lack of teamwork and communication causes the most harm to a patient (Leonard, Graham, & Bonacum, 2004). It seems so simple and potentially an easy fix, but multi-disciplinary teams with many roles and responsibilities can make coordinated communication challenging. Also, the many different information systems and electronic medical records that don't always connect to one another can cause a great deal of miscommunication.

Holding staff accountable for their actions by management is a strong approach to begin to curb culturally unsafe care, including communication strategies. Having staff on a performance scorecard related to cultural safety shows that it is important and valued by the organizations. Staff can have cultural safety included in their performance reviews and documented through incident reporting if needed (Ulrich, 1997).

As identified in the literature, the Maori of New Zealand are truly international leaders and knew the development of cultural safety curriculum and education would lead to cultural competent care for their members. Huge strides have been made to advance this topic across the world with importance being given to effective communications so that clients feel safe and willing to access services to improve their health outcomes for indigenous populations. The following section will take a closer look at validation definitions, tools and approaches.

Validation definitions, tools and approaches

Validation can be viewed as a very tough and complicated process to work towards. It is extremely difficult for new and innovative models to become verified. Experts believe that it is hard to progress to validation, but rather much easier to suggest something is invalid. Validation has been labelled as the truth, a point that has seen modellers argue conflicting views of using the labels of verified and /or validated (Rykeil, 1995).

The following definitions were sourced on line from the *Bio Med Central Journal section of Health and Quality Health Outcomes*. The article from Enthoine et al (2014) is entitled *Sample size used to validate a scale: a review of publications on newly-developed patient reported outcomes measures*. The definitions assist in determining many different potential validation terms with which to work and were selected as being relevant to this report because of their use and credibility in the health field. Even though a form of process validity is being utilized in this report, the author believes it is important to define and present other methods of validity to display the numerous ways one can approach the rationales and concepts of validity:

Content Validity: The ability of an instrument to reflect the domain of interest and the conceptual definition of a construct. In order to claim content validity, there is no formal statistical testing, but item generation process should include a review of published data and literature, interviews from targeted patients and an expert panel to approach item relevance.

Face Validity: The ability of an instrument to be understandable and relevant for the targeted population. It concerns the critical review of an instrument after it has been constructed and generally includes a pilot testing.

Construct Validity: The ability of an instrument to measure the construct that it was designed to measure. A hypothetical model has to be formed, the constructs to be assessed have to be described and their relationships have to be postulated. If the results confirm prior expectations about the constructs, the instrument may be valid.

Convergent Validity: Involves that items of a subscale correlate higher than a threshold with each other, or with the total sum-score of their own subscale.

Divergent Validity: Involves that items within any one subscale should not correlate too highly with external items or with the total sum-score of another subscale.

Known group validity: The ability of an instrument to be sensitive to differences between groups of patients that may be anticipated to score differently in the predicted direction.

Criterion Validity: The assessment of an instrument against the true value, or a standard accepted as the true value. It can be divided into concurrent validity and predictive validity.

Concurrent validity: The association of an instrument with accepted standards.

Predictive validity: The ability of an instrument to predict future health status or test results. Future health status is considered as a better indicator than the true value or a standard.

Reliability: Determining that a measurement yields reproducible and consistent results.

Internal consistency: The ability of an instrument to have interrelated items.

Repeatability (Test-retest reliability): The ability of the scores of an instrument to be reproducible if it is used on the same patient while the patient's condition has not changed (measurements repeated over time). *Measurement error* is the systematic and random error of a patient's score that is not attributed to true changes in the construct to be measured.

Responsiveness: The ability of an instrument to detect change when a patient's health status improves or deteriorates (Enthoine et al, 2014).

These definitions refer to substantive content aspects of instrument validation. This report is focused on process issues and consequently is most concerned with ideas of face validity.

Since the development of the self-assessment tool for Indigenous Cultural Competency is groundbreaking and little to no work has previously been done to this extent, the author explored the possibility of a few validation definitions. Face validity is targeted at a specific population and can be reviewed by experts by analysis and judging. The self-assessment tool is innovative and developed with Aboriginal partners and experts in the field. The testing of the tool then relies on the implementation of the tool and completion experience of users (Hardesty & Bearden, 2003).

A closer look at content validity shows that it is the formation or combination of tools and measurements that are constructed to form a new framework by an experienced individual, which then needs to be tested. It truly is the expert's knowledge and expertise that formulate a tool to be then implemented for validity (Polit & Beck, 2006). Construct validity focuses attention on the theory and concepts with which an instrument measures the construct it is intended to measure (DeVon, et al, 2007). This is not the focus of this project but may bear interest to IH in terms of future research.

Scholars have argued that to achieve validation, there are important steps that must be considered through the development of a model or process by which to ensure there are accuracies to measurement before one begins to apply these to future opportunities. Validation is achieved by rigour, continuous testing and applying the process to other areas of work many times to get confidence in and accuracy of what is being verified (Maroto et al, 1999).

Brad Anderson
MACD 598

Oral and Kettani's (1991) work speaks to the quartet of the modelling-validation process. All four stages are linked and interactive with one another. A managerial situation moves to a conceptual model to a formal model and then to a decision. Even though the model does have a beginning and end, it is common and suggested to reanalysis, redefine, reconceptualise and revisit different stages within the model to work towards a place of completion and satisfaction of the model one is working towards.

The process of validation can be done in a number of ways to reach validity. The process of self-assessing, testing and surveying a number of participants has demonstrated the approach to reach validation confirmation; however, expert input and collaboration allow for face validation to prove valid.

Chapter 3 Methodology

This project was aimed at preliminary testing and identifying process validation issues for the HR, Training and Staff Development domain of the instrument. Other domains in the tool include; Administration and Governance, Equitable Access and Service Delivery, Policy, Quality Assurance, Risk and Legal, Communication and Community Relations and finally, Planning, Monitoring, Evaluation and Research. No external or community members were part of this research. IH may wish to pursue further research on other aspects of validation of the instrument in the future.

Qualitative methods were undertaken during the project. These methods included data gathering through IH Human Resources and Organizational Development 15 employees conducting tool scoring as well as the participants of this group completing a brief survey of their process experience of completing the tool. Data analysis was conducted by the principal investigator, Brad Anderson.

The principal investigator (PI) sent the cultural competency tool to 20 staff within the HR portfolio in the hope of getting 12-15 respondents. The number of self-assessments and surveys received was 15. To eliminate any perception of power over relationships, no HR Leadership Team members were involved in selecting the participants. Participants were instead selected by the principal investigator based on purposive sampling philosophy using the following criteria:

- Participants had to be sourced throughout the three regions in IH (West, Central & East) to try to secure a measure of geographic representation.
- Participants had to come from many different positions including and not limited to Recruitment, Organizational Development, Talent and Acquisition.

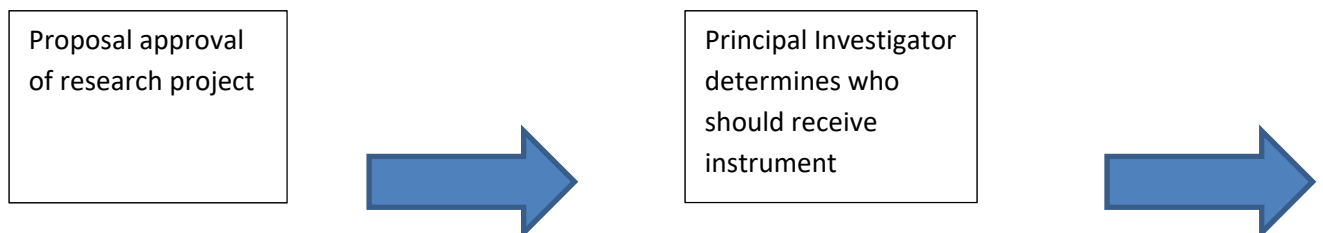
- Gender representation was considered, with the intent of securing a balance of males and females with a variety of work experience in the organization.

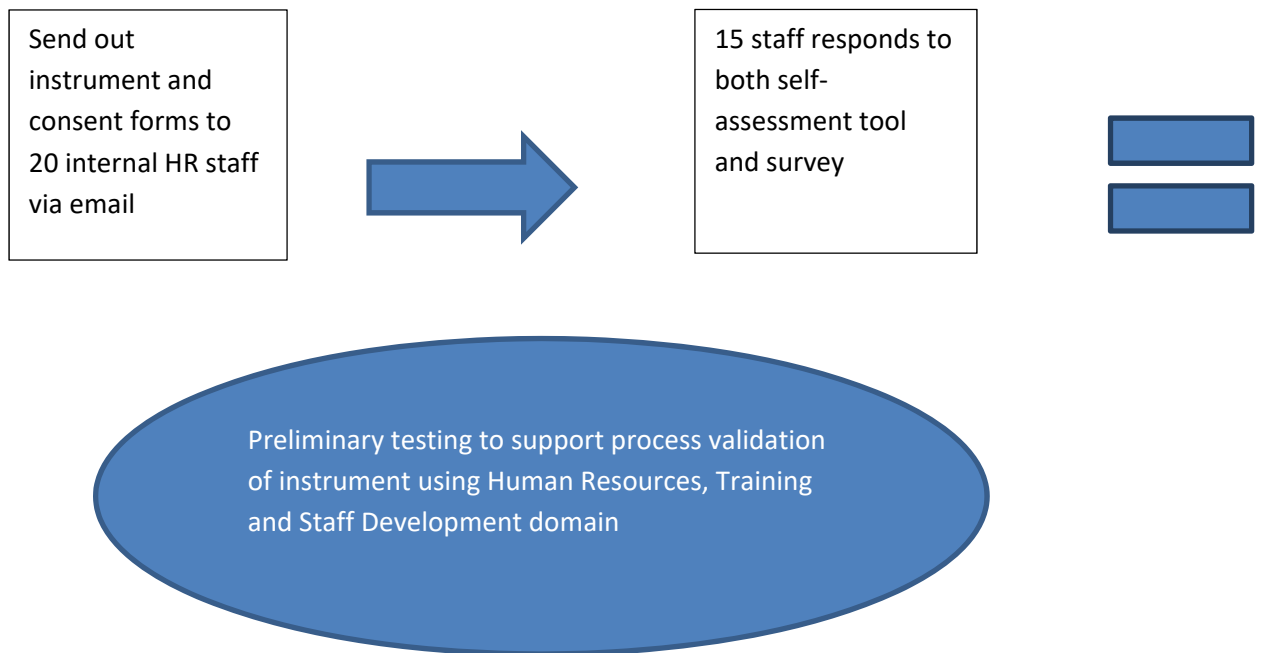
Of the 15 participants that responded, 4 were males and 11 were females. Most of those who responded were from the Central area, totalling 13. Two participants were from the West region, and none were from the East region of the health authority. The larger number of female participants was due to the portfolio having more female employees than male. Most of the employees within the portfolio living in the central area of Interior Health are housed in Kelowna, BC. This represents broader employee relativity emblematic of the organization. The lack of participants from the East is due to very few employees being based out of this region.

After answering the first and second question of the tool (inadequate and immersing), participants were sent a survey to answer a number of process questions concerning their experience completing the tool.

Results were forwarded directly to the researcher, who collated the materials and performed data analysis. Small sample size meant the researcher was aware of participant data and its attribution as part of the data analysis phase. The results of data analysis, however, were anonymized by aggregating results and not identifying participants in the reporting of findings. A visual depiction of the methods process for the project is provided in Figure 1.

Figure 1: Visual process map of project





Strengths of methodology approach

The preferential use of a qualitative methodology involving a survey and scoring of a self-assessment tool allowed for the participants to give personal, written narrative responses. This was in addition to allowing semi-quantitative data to be acquired through survey response results. There was opportunity for the participants to score how they evaluated the self-assessment tool and survey in a very private and confidential way. This allowed for honesty in the actual scoring and feedback from the survey without the participants feeling unsafe or at risk because of the volunteer approach to participate in the project. Doing the project through email was a benefit because of the geographical landscape of Interior Health's region. The approach also allowed for a strong collective response to collect a comprehensive amount of data to build the themes that will be discussed later in the report.

Weakness of methodology approach

Brad Anderson
MACD 598

The report was done online through email, and responses were scanned back to the author, which left very little opportunity for face-to-face interaction. Although the PI made himself available by email or phone for follow up or questions, not many participants took advantage of this or felt the need. There was a very low amount of one-on-one conversation related to the project. As a result, the project did not promote questions to be posed or clarity on the purpose of the project to be fully explained if desired. The voluntary nature of participation potentially took away from the amount of exhaustive input and feedback that was contributed in the sense that responses might have been much stronger if the survey topic comprised the participants' actual work.

Overall, the approach with the methodology was appropriate and provides a defensible means to address the research question given the amount of time for participants to respond and with limited resources attached to the project, including the fact that the PI had to work to a tight timeframe for project completion. While several forces constrain the rigor of the research methodology, the project was purposefully constructed as a preliminary process in a wider validation project, and this context is acknowledged and must be factored in.

Chapter 4 Findings, Recommendations and Action Plans: Self-Assessment Tool scoring

The following chapter presents results collected from the 15 participants who completed the Human Resources, Training and Staff Development domain of the IH cultural competency tool. Analysis of the data received shows a range of opportunities and recommendation areas that can be proposed to senior leaders within IH to progress the agenda of cultural safety in the organization. The seven categories to score were the following: 1) Human Resources Recruitment Strategy 2) Human Resources: Orientation (New Worker & Reorientation) 3) Staff Training and Development: Training Course 4) Staff Training and Development: Volunteers 5) Human Resources: Performance Review 6) Retention 7) Human Resources: Aboriginal Staff Support Systems.

All seven scoring sections within the domain were totalled and then divided by the number of participants, which was 15. The Human Resources, Training and Staff Development domain below describes how the organization is 1) Inadequate 2) Emerging 3) Approaching 4) Meeting Certain Targets. The descriptions and definitions within each section outlined and assisted the participants on how the tool was to be scored. The participants were notified that they were able to score half points (.5) if they felt it was appropriate. A total of seven sections were explored by the 15 participants, allowing for 105 scoring responses. A total of 10 scoring opportunities were either not answered or had NA in the scoring sections. This may have simply been an oversight in some sections, and other participants may not have been aware of the question or didn't feel they had the right knowledge and understanding to answer the question fully. This dimension of non-completion demands attention by IH in further research.

The following sections detail the results identified in each component of the tool.

1) Human Resources Recruitment Strategy: Average score – 2.5

2 Emerging	3 Approaching
<p>There is recognition of the need for a strategy that supports staffing practices towards reflecting the Aboriginal client populations.</p> <p>Indigenous cultural competency is a criterion for the selection of qualified non-Aboriginal staff.</p>	<p>Meets criteria 2 (Emerging score)</p> <p>The strategy in place includes the identification of Aboriginal specific positions, a plan and evidence of action for the active recruitment of Aboriginal staff and staff with skills and experience related to Indigenous cultural competency.</p> <p>Recruitment targets are set and information is collected on the cultural composition of staff for evaluating progress towards a representative workforce.</p>

The following were comments provided by the participants related to Human Resources Recruitment Strategy, which is followed by a short summary, some brief recommendations and an action plan developed by the author’s knowledge and experience and responses from participants:

- We have non-contract job descriptions in place that are specific to the Aboriginal Health portfolio that include in the qualifications section a statement that preference will be given to applicants of Aboriginal Ancestry.
- The recruitment team actively advertises positions to specific Aboriginal audiences, and recruiters are active in promoting available positions. Aboriginal staff is employed through the organization, but the recruitment team do not work to meet targets.
- I am aware of Aboriginal-specific job descriptions within IH that perform liaison/ coordinating roles to address any potential cultural barriers and also act pro-actively to educate and treat the Aboriginal population regarding specific health concerns. There is also a self-identifying Aboriginal tool for existing employees; I am not aware of any such program for potential new hires/ recruitment initiatives to target Aboriginals, but this is not my area of specialty, so these initiatives may very well exist (especially for the specific roles) but I am not sure.
- There are references and tools in IH to support this. There are documents about engagement.
- I am unaware if a strategy exists in the Talent Marketing & Recruitment Portfolio
- There is no strategy by Senior Leadership Tables or SET to specifically recruit Aboriginal clients to the Leadership Talent Management program.
- An Indigenous Cultural competency course has been completed by all staff within our portfolio, Recognition that supports the Five Key Strategies and discussion specific to supporting Rural and Aboriginal Care in our organization.
- There is a clear strategy in place on the InsideNet; we have self-identification options as part of our recruitment strategy, clearly linked to Aboriginal requirements in all the priority file.

Overall, these results indicate that IH has been achieving some success with the Human Resources Strategy, but there remains a way to go to meet the tool objectives in this area.

Brad Anderson
MACD 598

Recommendations:

Aboriginal populations make up 7.7% of the overall population within Interior Health's geographical region. However, the number that have self-identified to date is only 3.74% of IH's entire staff, making up 734 employees within the organization. Interior Health needs to make a concentrated effort to reach out to Aboriginal communities and agencies. Having more targeted job promotions and advertisements that appeal to Aboriginal populations is needed. Interior Health has many vacancies in their rural and remote communities, and many of the 54 First Nation bands are in the rural and remote locations. The Human Resources portfolio needs to attempt to get to the 'Meeting' scoring sector: *Active efforts in recruitment for Aboriginal candidates to fulfill Aboriginal specific-positions. Employment opportunities are advertised through Aboriginal community networks. The selection procedures are reviewed to identify barriers (including systemic issues) that may inadvertently exclude Aboriginal candidates, and ensure accountability and transparency.*

Aboriginal staffs are employed throughout all levels of the organization, and recruitment targets met or exceeded.

Action Plan

- Have an annual calendar of events that is specific to Aboriginal communities
- Try to attend large regional Aboriginal gatherings to recruit
- Work closely with school districts and universities to develop a strategic plan related to recruitment
- Try to obtain a targeted number of Aboriginal employees over a three-year time frame
- Move to a Represented Aboriginal Workforce (Aboriginal population reflected in IH's employees)

2) Human Resources: Orientation (New worker & Reorientation) Average Score -1.63

1 Inadequate	2 Emerging
<p>There is no evidence of a component of Indigenous cultural competency in new worker orientations and reorientations at IH.</p>	<p>IH orientations and training materials include information on the Aboriginal communities served, Aboriginal health, and limited information on culturally competent service delivery.</p>

The following were comments provided by the participants in Human Resources: Orientation (New worker and reorientation), which is followed by a short summary, some brief recommendations and an action plan developed by the author’s knowledge and experience and responses from participants:

- Don't recall anything specific in the new employee orientation because that was many years ago, but I have seen reference to various Aboriginal communities in other general IHA information to keep employees up to date.
- Regional Orientation was revamped and includes Aboriginal specific content. I am not sure about site or department specific.
- I did not enter a score for this portion as I have worked here for over 13 years and to be honest, I don't remember orientation!
- Section is covered in NEO (New Employee Orientation)
- NEO and site specific orientation
- Not aware that this course is a requirement or acknowledged in the Performance Review.

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MACD 598

- Indigenous Cultural competency course has been completed by all staff. To the best of my knowledge, any further strategies do not specifically identify opportunities for cultural competency training or education.
- I have been with IH for 15 years and therefore have not been involved in the orientation packages for many years, so I am not aware of whether there is orientation material available or not
- I have taken the position in this tool that the information is based on my current knowledge of what is available in our system, policies and practices. That the intent of this tool was not to require research on the users part as that would test their research ability and not necessary give an independent view of the information available.
- Aware of training and communication on the Inside Net. Not aware of others

Overall, these results indicate that there is very little knowledge or awareness that IH's Human Resources portfolio has Aboriginal-specific orientation materials.

Recommendations

The score received from the 15 participants puts the section of orientation between Inadequate and emerging. New employees need to see the importance of Aboriginal people within the interior region and need be exposed to this information upon initial hiring. Having information about Aboriginal populations and the Aboriginal Health Program will also allow for further dialogue and discussion on the topic. Showcasing training opportunities, initiatives and projects will allow for more knowledge exchange and the opportunity for new staff to take advantage of learning more. Interior health needs to first strive to the Approaching section: *Content of orientations and training materials for all staff include Indigenous culturally competent approaches to service delivery, services available to Aboriginal clients, Aboriginal Health strategies, historical context of colonization, Aboriginal community networks,*

Brad Anderson
MACD 598

agencies, resources. All staff members are informed of goals, policies and procedures pertaining to Indigenous cultural competency.

IH then needs to begin to move to strategies regarding how it can move into the meeting definition of the section that is described as the following:

Orientations include nation specific protocols-phase training:

- 1 – Foundational (introductory information of Aboriginal population in the region)
- 2 - Nation Specific (information related to all 7 First Nations and Metis Nation of BC)
- 3 - Cultural Protocols (describing nation specific cultural protocols with their input and support)
- 4 - Content Specific (information that is specific to nation data, cultural values or beliefs)

IH supports Nations to create Nation specific training materials with resources and funding.

Action Plan:

- Revise the current orientation package to more be inclusive of the Aboriginal population and existing Aboriginal programs in the Interior region.
- Form a working group from HR and Aboriginal groups to have relevant information and packages to share with employees.
- Work on a plan to have Aboriginal partners put together information that can be shared through orientation.
- Enforce and emphasize training that is available to new staff through orientation

3) Staff Training & Development: Training Course Average Score – 1.96

<p style="text-align: center;">1</p> <p style="text-align: center;">Inadequate</p>	<p style="text-align: center;">2</p> <p style="text-align: center;">Emerging</p>
<p>The staff training strategy does not include a specific component of Indigenous cultural competency.</p> <p>Staff are not provided with any support to seek Indigenous cultural competency training.</p>	<p>Indigenous cultural competency training is available for a limited number of priority staff and areas, and investment in training is limited.</p>

The following were comments provided by the participants related to Staff Training and Development:

Training Course, which is followed by a short summary, some brief recommendations and an action plan developed by the author's knowledge and experience and responses from participants:

- Maybe some i-learning components that include information on the Aboriginal Program and Services, but I have not accessed these
- ICC certification was completed by all my staff. As a manager I was supported financially and allowing staff time to complete the course.
- In my role meeting with Leadership teams to review employee performance, and to set target goals and identify stretch assignments for learning opportunities, there were leaders who

identified the Aboriginal training program as part of the development plan for their future leaders. So for the first portion of Box 3 (The training strategy includes a focus on achieving Indigenous cultural competency for all staff at all levels of the organization through initial and periodic training) I would give this a 3; for the last portion of Box 3 (Commitment to supporting education and specialty training for Aboriginal staff...) I can't enter a score as I'm not sure if these programs are in place or not for Aboriginal staff

- I am not familiar with this
- From the perspective of the Leadership Talent Management program, all LTM clients must have or must complete the Indigenous Cultural Competency online course in Year 1. In Year 2, these folks must start to cascade this course down to their staff.
- Some of 3 is missing, i.e., the commitment to supporting education and speciality training for Aboriginal staff (I'm not aware of programs specifically for aboriginal staff)
- Indigenous cultural competency training is a requirement for all staff. While additional training would be supported, the opportunities for this to happen are not promoted or explored.
- Organization communications has made indigenous cultural competency training mandatory for all staff, occasional discussions I have been a part of have acknowledge the various nations in our HA, it is my understanding that there is monitoring of % of organization that has completed the training and eperformance records allow storage of this information.
- Have taken the ICC training and F2F (face to face) workshop

Overall, the results indicate that majority of the participants were aware of the on-line indigenous cultural competency training and even made sure it went on to staff and managers who work under some of them. However, the score for this category was low.

Recommendations

Brad Anderson
MACD 598

Although the participants scored this section of the domain below Emerging, the author believes there needs to be more communication on the amount of training that is available to staff currently.

Leadership still needs to focus attention and promotional opportunities to the staff in section

Approaching: The training strategy includes a focus on achieving Indigenous cultural competency for all staff at all levels of the organization through initial and periodic training. Staff are supported through time from work and financial compensation to participate in Indigenous cultural competency training.

Commitment to supporting education and specialty training for Aboriginal staff and identifying

Aboriginal students in build capacity building initiatives (i.e. student nurses - professional practice, scholarships or funding support).

IH also needs to strive to meet the needs of Meeting in Some Capacity: *Training in Indigenous cultural competence is mandatory for all staff. Indigenous Cultural Competency training with the Interior region includes Nation specific models and protocol. Monitoring and periodic evaluations of staff uptake of Indigenous cultural competency training is conducted to assess organizational progress and achievements, and are linked to quality improvement efforts. Performance targets are tied to individual managers to ensure accountability. Evaluations are conducted based on client feedback before and after training to assess changes in client quality of experience.*

Action Plan:

- Target a percentage of HR portfolio staff for training to create training champions.
- Have a promotional campaign for IH staff specific to face-to-face Cultural Competency Training alongside the on-line training opportunities.
- Identify areas in the organization that have low numbers and completions and target these areas for training.
- Begin to work with unions on providing backfill opportunities for staff to take training.

- Make training part of performance management for staff.

4) Staff Training & Development: Volunteers Average Score 1.30

1 Inadequate	2 Emerging
There is no volunteer program in place.	There is a volunteer program, but it is not specific to support Aboriginal community members or clients. Volunteers are not offered training in Indigenous culturally competency.

The following were comments provided by the participants related to Staff Training and Development:

Volunteers, which is followed by a short summary, some brief recommendations and an action plan developed by the author’s knowledge and experience and responses from participants:

- I am rating this 3.0 as I am not aware of a "volunteer program that works to build community capacity and partnerships through supporting Aboriginal volunteer training and leadership... However, I did check the Insidenet/ Aboriginal Health page and I found the following link: "Cultural Practices - We provide cultural practices related clinical decision support tools including, policies, procedures, guidelines and protocols. Be sure to take the Interior Health sponsored San'yas Indigenous Cultural Safety Training (ICS)." which is evidence of "Training in Indigenous cultural competency"

Brad Anderson
MACD 598

- I am not familiar with this
- Outside of Aboriginal Navigators, I am not aware that there is any reference to this training.
- To best of my knowledge although I don't have extensive information on volunteer programs
- I am not aware of the volunteer programs or practices currently available at IH.
- I am not aware of what training is offered to volunteers
- No sure where to look

Overall, the results indicate that the participants had little to no knowledge of any training that occurs with volunteers. This was tied with another category as the lowest rated in the instrument.

Recommendation

This, along with another section, was identified as the lowest scoring within the domain. Volunteers are an integral part of any organization and are often the first-contact people in many facilities and hospitals. In order to increase cultural safety and access, having Aboriginal volunteers in sites allows for comfort and a welcoming environment. IH needs to focus its attention in all three aspects of this section. *Emerging: There is a volunteer program but it is not specific to support Aboriginal community members or clients. Volunteers are not offered training in Indigenous cultural competency.*

Approaching: A volunteer program is established to recruit volunteers from Aboriginal communities.

Training in Indigenous cultural competency is offered to all volunteers (mandatory?). Meeting: The volunteer program works to build community capacity and partnerships through supporting Aboriginal volunteer training and leadership, and encourages flexibility in volunteer opportunities including time, locations and styles of conducting meetings. A database of the cultural composition of volunteers is developed for evaluating progress towards a balanced representation.

Action Plan:

- Advertise and work with Aboriginal partners locally to recruit volunteers.
- Continue to have volunteers take the online Cultural Competency course.
- Try to have a targeted Aboriginal percentage of Aboriginal volunteers, relevant to the population in the area.
- Have volunteers be aware of local Aboriginal populations and communities.

5) Human Resources: Performance Reviews score – 1.30

1 Inadequate	2 Emerging
There is no evidence that performance reviews include staff skills, knowledge and abilities in relation to Indigenous cultural competency.	Indigenous cultural competency is recognized as a criterion of competent staff and workforce.

The following were comments provided by the participants related to Human Resources: Performance Reviews, which is followed by a short summary, some brief recommendations and an action plan developed by the author’s knowledge and experience and responses from participants:

- HR is ahead of other Departments
- I can only speak from my own personal performance review experience as I am not a manager with staff. While my general objectives do include specific elements related to competencies in empathy, leveraging diversity, etc., there is nothing specific to indigenous cultural competency.
- The performance management guidelines for managers do not contain information on assessing staff skill on ICC. Only if an issue arose would it be discussed.

- Indigenous cultural competency is recognized as criteria of competent staff and workforce...
"Yes... where and when this is identified as a specific Objective as part of an Excluded employee's Performance Review. If this is an Objective, the rating on the completion of the goal (whether it be additional education, stretch assignment within a specific dept etc.) will be a key part of their overall performance score for that performance year. I have rated this as a 2.5 as it is part of the process, provided that employees/ managers identify this as a key objective; but it is not an Objective for all employees.
- I am not familiar with this.
- Not aware that this course is a requirement or acknowledged in the Performance Review.
- I've not seen any evidence that this is a focused component of Performance Reviews
- The ePerformance system includes cultural competency. I cannot speak to portfolios that have a larger impact of aboriginal staff and whether the review process leads to a score of 3 or 4.
- Own performance review

Overall, the results from the participants indicated that some have embedded cultural competency into their team's performance management or even within their own performance objectives. However, the score was tied with another category as the lowest that was self-assessed due to little standardization.

Recommendation

This section was tied for lowest overall score amongst the seven categories. There is a realistic opportunity within the organizations to make this a true organizational cultural shift. When performance indicators are applied to staff and annually reviewed to receive compensation increases, there is an immediate response and interest in making Indigenous cultural competency a priority.

Interior Health needs to advance in the following categories Emerging: *Indigenous cultural competency is recognized as a criterion of competent staff and workforce* and Approaching: *Assessment of*

Indigenous cultural competency is embedded within performance reviews (i.e. supervisor assessment, self-assessment, client assessment). Meeting expectation is an ultimately goal but much work and education needs to occur in the meantime to allow staff and managers to fully understand what cultural competency is and how to evaluate and performance review it.

Action plan:

- Pilot Performance Management in one facility within IH that has had cultural breaches previously.
- Invest the time and energy to educate and inform staff and management of expectations.
- Evaluate for one year.

6) Retention – Average Score 1.46

1 Inadequate	2 Emerging
Retention rates are not collected for Aboriginal staff members, and there are no policies in place to increase retention.	There is evidence of data collection on Aboriginal staff composition; IH organizational areas and levels are identified with the highest turnover rates of Aboriginal staff in comparison with non-Aboriginal staff; however, no strategy is in place.

The following were comments provided by the participants, which is followed by a short summary, some brief recommendations and an action plan developed by the author’s knowledge and experience and responses from participants:

- New and existing staff have been surveyed based on a voluntary self-identification model. My understanding is that uptake has been low, so it is difficult to know which staff are for certain Aboriginal. Therefore, knowing the retention rates is impossible.
- I am not involved in monitoring retention rates, so have no knowledge about whether or not data is gathered in this regard.
- This is another one that I am scoring based on my awareness of, rather than the potential existence of, specific retention strategies for Aboriginal staff. I do know that there is a tool to self-identify; and there is increased visibility of leaders (i.e. the CEO in the Loop newsletter) visiting Aboriginal communities to foster inclusion and hopefully the outcome of this will be: identification of specific strategies for improved health outcomes; better recruitment and retention of Aboriginal staff; and improved communication/ trust between communities. Over the years, there appears to be more awareness of the importance of working with Aboriginal leaders, and more sensitivity to the specific issues... but I'm not aware of specific programs to support and retain Aboriginal staff.
- I am not familiar with this.
- I am not aware if these metrics exist.
- Data collected but I am not aware of the identification of areas with highest t/o rates.
- I am aware of the identification process for Aboriginal staff; however I am not aware of recorded retention rates.
- IH current uses self-identification as the method to identify volumes of aboriginal staff. The value is reported on the SET dashboard.
- Self-identification clearly has limitations in providing accurate data as there is no way to know if you have 100% of your staff self-identified or 50% or 10%. It does allow reporting of the change in this factor but still leaves uncertainty to the actual level of staff.

Brad Anderson
MACD 598

- Unsure

Overall the results indicate that there is mixed understanding from those that responded whether IH collects retention rates for Aboriginal staff.

Recommendation

Interior Health is able to collect retention comparisons because of the collection of Aboriginal Self Identification on employees. The collection of retention rates allows for further exploration on what is needed as far as resources and understanding. If there is a high turnover, IH can begin to explore why retention rates might be successful in some areas. In order for IH to move to Approaching, they must have a Retention strategy in place and retention targets set for Aboriginal staff. There is evidence of a strategy to support Aboriginal staff in the workplace through training, support system, coping strategies for dealing with colonial violence, and processes for support, in order to support safety in the workplace. To achieve the Emerging section, with Aboriginal staff experiences evaluated and reviewed periodically, IH strives for a High Quality of Experience – Retention Targets Met or Exceeded. Culturally competent Aboriginal staff supports are in place to mitigate high turnover rates and burnout, and there is currently a mandatory safe exit interview.

Action Plan

- Dedicate resources to interview and speak with current Aboriginal employees.
- Discuss challenges and successes related to being an Aboriginal employee within Interior Health.
- Compile a report of recommendations.
- Set up a mentorship program amongst Aboriginal employees.

7) Human Resources: Aboriginal Staff Support System Average Score – 1.86

<p style="text-align: center;">1</p> <p style="text-align: center;">Inadequate</p>	<p style="text-align: center;">2</p> <p style="text-align: center;">Emerging</p>
<p>There is no evidence of a support system for staff.</p>	<p>A universal support system exists for staff across the organization, but it is not culturally specific to Aboriginal staff. There is recognition of the need for an organization-wide, culturally-based support system for Aboriginal staff.</p>

The following were comments provided by the participants related to Human Resources: Aboriginal Staff Support System, which is followed by a short summary, some brief recommendations and an action plan developed by the author’s knowledge and experience and responses from participants:

- I am not aware of any such support system.
- Again, I'm not aware of many the Aboriginal programs in place as I am not Aboriginal myself and my job does not include a lot of interaction with cultural specific communities (I work mainly with management and leadership). A look at the Aboriginal Health page on the InsideNet does provide a lot of information and helpful resource links so I am rating this as 3.5 as it appears there is a robust support system and ample resources for those that wish to access them.
- I am not familiar with this.
- I am unaware if this exists formally or informally within IH.

Brad Anderson
MACD 598

- Evidence is simply based on my awareness.
- I believe there is awareness in our organization of the need for certain programs; however, I don't feel they developed or available.
- Although my only direct knowledge is a score of 2, it is my feeling that with the clear focus on Aboriginal Staff, Client and Patient wellness in IH that is there very likely targeted initiatives specific to the support system for aboriginal staff.
- Hr

Overall the results indicate that there is very little knowledge or awareness amongst the participants related to support systems in place for IH's Aboriginal staff.

Recommendation

Many opportunities exist to explore further what Aboriginal support systems may look like; however, they might be very challenging and difficult to advance. For example, the Meeting section of the scoring system, which involves the support system and resources, includes partnerships with community elders and Aboriginal support groups (e.g., welcoming ceremony with elders). Aboriginal staff can have access to traditional consultants and elders, and the support system is developed through collaboration with Aboriginal staff and partners. Aboriginal staff feedback is collected to ensure there is evidence of awareness, usefulness and appropriateness and achieving success and overall fulfillment. However, this section is very similar to that of Retention, where employee supports need to be considered for sustainability.

Action Plan

- Promote and advertise job opportunities for career advancement.
- Evaluate positions into which to promote Aboriginal employees.

Brad Anderson
MACD 598

- Start building in traditional supports from Aboriginal Health Team (Elders Council).

It would serve IH to investigate this area more substantially including researching best practices from other agencies and jurisdictions.

Chapter 5: Findings and Recommendations from Survey

The following chapter now summarizes results from participants related to answering validation questions. The findings are followed by a recommendation section for each question asked of participants.

1. How long did it take to complete the instrument?

Time to Complete Survey	Number of participants
0 -15 minutes	7
16 – 30 minutes	3
31-45 minutes	1
46 – 1 hr	2
1.01 – 1. 5 hrs	2

Findings: The amount of time from the 15 participants varied between 5 minutes and 1.5 hrs. Depending on the amount of interest by participants, the time frame showed a real variance. The validation process for the tool shows that it can be completed in a timely fashion but that for other more engaged participants, the timeframe for completion is much longer. What emerged from comments is that the timeframe for completion is really dependent on the individual participant level of commitment to the self-assessment tool.

Recommendations: To articulate clearly the expected time of completion when asking participants to respond. To determine whether the directions on how to use the instrument are clear.

2. Are the directions clear on how to use the instrument?

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MACD 598

Overall, the summarized comments suggest that there was no clear indication from participants whether the directions were clear or not. Four individuals simply answered yes as a response, where others provided more detailed information claiming the directions were clear, including comments suggesting it was fairly well explained and easy to follow. However, in contrast, many respondents replied by stating that the directions were not completely clear or that they were uncertain of the purpose of the self-assessment. There were more negative comments than positive, suggesting the directions were unclear. Other comments included that they were asked to score to the best of their knowledge but were given no materials or subsequent information. Finally, there was a comment that a participant found the self-assessment tool hard to navigate.

Recommendation:

The author would suggest that either the tool be updated with clear instructions or a facilitated focus group be hosted for future participants to ensure all questions can be answered and uncertainties addressed before tool completion so all participants know the outcome and what is expected throughout the self- assessment domain.

3) Did you experience any difficulty answering or interpreting the questions? If so, please elaborate.

A majority of the responses were positive about interpreting and answering the questions as many felt there were no issues or problems. Some believed the questions were clear, thus making it easy to follow and answer.

On the negative side, comments from participants included that it was unclear as to what to do with the other fields of the self-assessment tool such as evidence, notes and recommendations. One participant experienced difficulty in answering the questions because of the current positions staff hold that might not necessarily have a cultural competency component attached to it. Others were unaware of the work

Brad Anderson
MACD 598

underway, so they felt they had little knowledge to answer the questions appropriately and suggested an 'unaware' section to check.

Recommendation:

What needs to occur isn't necessarily about how the questions can be better utilized but rather about the participants becoming more aware of what is happening in regards to Aboriginal Health Human Resources. Many responders pointed to the questions not involving their current area of focus. This shows that there needs to be more internal communication within IH, with leaders within portfolios relaying relevant information as well as showing the priority and importance of Aboriginal Health.

4) Elaborate on any problems experienced when using the instrument.

Overall, participant feedback in this area was very similar to that of the previous question asked. However, when asked to elaborate, a comment suggested that the spreadsheet was cumbersome to navigate or that the instructions were vague on how best to approach the self-assessment tool. Other comments said to indicate in the instructions what is expected in each cell of Excel and to ensure a participant can edit properly in each cell as well. One participant appreciated scoring the tool with half points (.5) however did suggest it would be more beneficial to have a tick box in some areas to identify that they are unaware of the answers.

Findings: Once again, many answers pointed to instructions not being fully clear and understandable for participants. There is an opportunity to invest more time with the volunteer participants before they score the self-assessment: hosting teleconferences, creating focus groups and answering all questions relevant to the actual scoring.

5) Do you feel as though any information or questions were missing from the instrument?

Overall, feedback suggested that there was a mixed response to this question. Some participants felt as though there was a sufficient amount of information provided with the self-assessment tool, whereas others simply just did not know enough about cultural competency to assess what else might be needed to be added to the domain. Although the domain had only seven sections, it was extremely comprehensive and covered the main topics within Human Resources and Organizational Development. There are opportunities to have additional information or questions asked, and nearly half of the participants simply believed the tool was sufficient and asked the appropriate number of questions to get a full understanding of the domain. One participant suggested that before using the self-assessment tool, participants take on-line cultural competency training so they are better informed. Finally, one participant suggested that there be more of a focus on clinical questions as well. The self-assessment tool is dependent on the portfolio or domain, so sections within each will vary and thus potentially have different questions to hit targeted audience.

Most respondents suggest no further questions, but comments do highlight the amount of education and knowledge exchange that needs to occur amongst the Human Resources and Organizational Development portfolio related to cultural competency. Some of the suggestions can be further developed amongst users of the tool for IH to consider in the future.

6) Do you believe there is value in using a similar instrument to assess the cultural competency of Interior Health in other areas of the organization?

Overall, the feedback from the majority of the 15 participants believed the self-assessment tool would be valuable in other capacities for the organization. The tool could really assist in the foundation of working toward advancing the cultural competency of the organization. The information and scoring

Brad Anderson
MACD 598

provided help develop action plans that set the stage for future opportunities and initiatives. They also allow for discussion and for senior leaders to better understand the significant changes that need to occur and focus on potential gaps in the system. Many comments supported the importance of moving the organization to be more culturally competent, recognizing that cultural competency can really assist with recruitment and retention efforts. One participant suggested that IH needs to move away from surveys and into action.

Recommendation:

To recommend to the Senior Executive Team that there was strong support from the participants to having this considered a tool to evaluate other areas of the organization.

7) Do you have any further comments related to using or scoring the instrument?

Overall, not all participants replied to this question; however, there were suggestions that the scoring tool should have a 'don't know' section because some of the questions were truly out of their individual scope of work. Other comments were to have a section that was not applicable. The domain can be changed to ensure there are more areas that indicate participants are not aware of what they might be scoring. There was a comment that stated the survey was a great idea because it allowed participants to do more research and information searching on Aboriginal Health.

Recommendation

To add a section in the tool that allows participants to check "I don't know."

Overall, the results from the process validation data from participants show that the Organizational Self-Assessment Tool for Indigenous Cultural Competency at Interior Health is effective and valid. There are

Brad Anderson
MACD 598

areas of opportunities to be clearer with directions and participants' expectations upon scoring.

However, overall results suggest the organization can advance cultural competency in the Human Resources, Training and Staff Development domain.

Chapter 6 Conclusion

This report aimed to address the research question: *Using the Human Resource, Training and Staff Development domain, what validity issues are associated with the process of using the instrument known as the IH Assessment Tool for Indigenous Cultural Competency?*

After contextualising the problem and defining key concepts in the literature review, the report performed this task through research that assessed the findings of 15 IH employees who completed the instrument and completed a qualitative survey answering a range of questions on process validation associated with the tool.

The findings from this research highlight a number of opportunities to advance the cultural competency of the organization within IH. Results also indicate a range of areas where the cultural competency instrument could be improved before it gets applied further across the organization.

With respect to the instrument scoring, it must be noted that the overall results show that the Human Resources and Organizational Development Portfolio has not scored over 2.5 in any of the seven categories across the instrument domain. According to the scoring, IH is not “Approaching” or “Meeting” within any of the Human Resources categories. The report clearly outlines recommendations and action plans in response to these findings to move the work forward in each domain to continue to strive to be culturally competent, although this was not the prime focus of this report. This work will help generate conversations with Human Resources and Organizational Development Leadership to initiate planning for next possible steps. There have been concrete and tangible action plans mentioned in the report that will not cost Interior Health financially to implement such as performance reviews, more strategic analysis of Aboriginal Self-Identified staff and increase the presence of Aboriginal volunteers. The author believes that a significant investment is not necessary to make true organizational and system changes. The ability for senior leadership to support and shift priorities will

allow for noticeable change that will have positive impacts on Aboriginal staff and clients. With the recommendations and actions plans suggested Interior health is positioned to make meaningful changes that can be leading the province within the portfolio of Human Resource and Organizational Development.

It must be acknowledged that these observations have been generated from the perspectives of only 15 participants from one domain area within IH. Furthermore, this is not a content- validation research exercise. Rather, the data and associated recommendations and action plans must be interpreted for what they represent, namely part of a process-validation exercise that involved scoring of an instrument by a select group of IH employees.

The process validation analysis of the tool was complex because such a tool has not been produced or implemented before in IH. Taking into consideration that Aboriginal people and experts, along with extensive research, support the work scoring definition, the self-assessment tool is valid by definition of face validity. The comments and feedback in this report from participants show a range of suggestions, including the greater need for instructions and clarity on the purpose and intent of the self-assessment tool. The length and time it took to complete the self-assessment tool suggests it is dependent on the individual using the tool, however is very manageable. Overall, there were favourable comments from participants who believed the self-assessment tool should be implemented in other portfolios within the organization. According to feedback and recommendations made by the participants it is important to invest the proper time initially with participants on the purpose and intent of the self-assessment tool. Hosting focus groups or teleconferences to gain clarity by users was suggested and proposed in the report. Although the self-assessment tool is largely focused on systems change for organizations there was questions asked if other domains touched on more of a clinical approach to cultural competency. Clinical competency can potentially be an additional consideration in future opportunities.

Brad Anderson
MACD 598

The next steps for IH will be a matter for management to consider on how best to proceed with the other five domains of the self-assessment tool. There has already been support from IH's Strategic Risk Management Committee, which directly supports the SET, to move forward on the domain Administration and Governance as well as Planning, Monitoring, Evaluation and Research. A decision brief has been sent to the Senior Executive Team for December 2016 meetings to gain approval on moving forward with the next two domains next. The scoring results have been presented to the Human Resources and Organizational Development portfolio in October 2016. On the basis of this report, a working committee is being developed between Aboriginal Health and the Human Resources and Organizational Development leaders to begin working on the action plans described in the report. Interior Health is working with the self-assessment tool domains to advance the cultural competency of the organization. While there is much still to be done, IH is moving in the right direction. The results of this report will be helpful in continuing efforts toward cultural competency for the organization.

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Brad Anderson
MACD 598

Appendix A



IH Assessment Tool
for Indigenous Cultur

Appendix B



Survey after completing An Organizational Self-Assessment Tool for Indigenous Cultural Competency for Interior health

Follow up survey after using the instrument for the Human Resource, Training and Staff Development domain:

1. How long did it take to complete the instrument?
2. Are the directions clear on how to use the instrument?
3. Did you experience any difficulty answering or interpreting the questions? If so, please elaborate.
4. Elaborate on any problems experienced when using the instrument?

