Cultural Safety

Bridging Historical Trauma, Trauma Informed Care and Structural Change for American Indian/Alaskan Native Healthcare

Introduction

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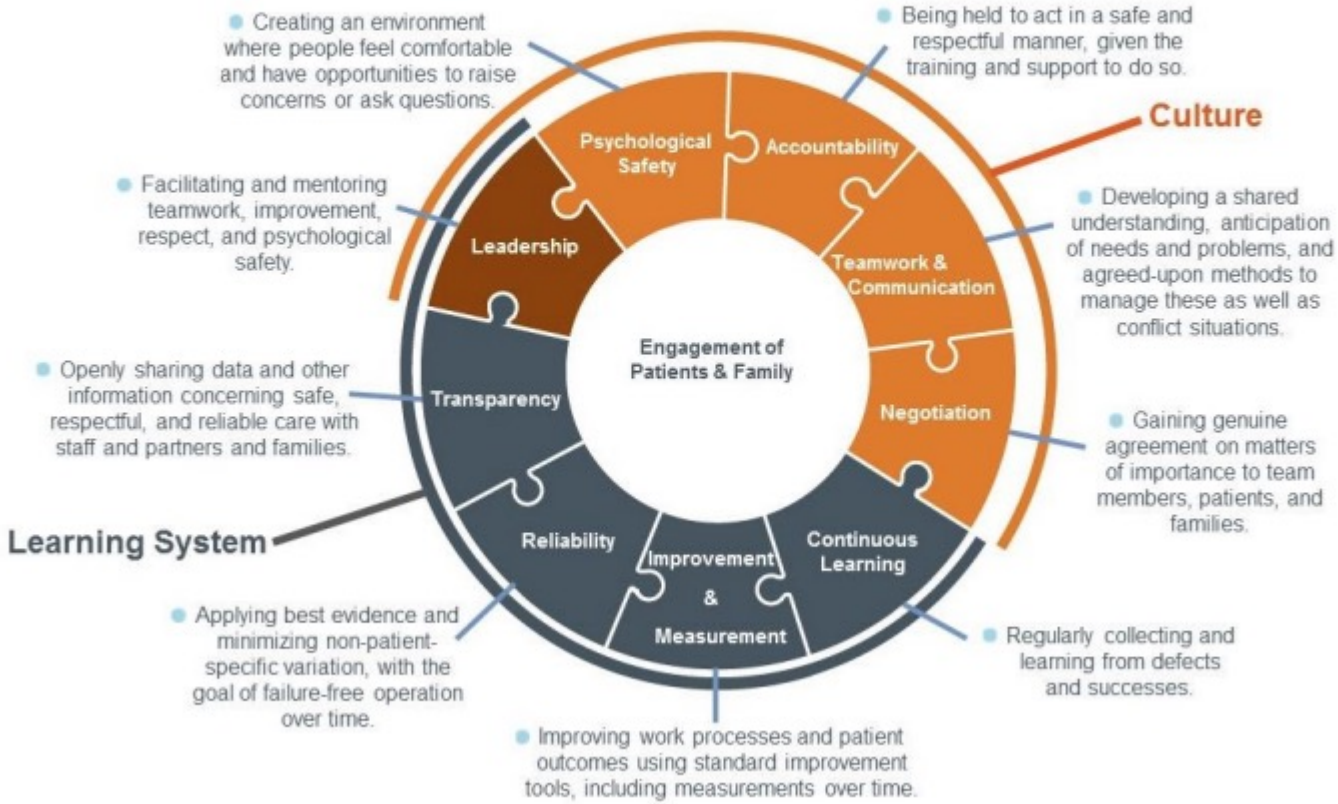
Disclosures

- This presenter has no financial or commercial disclosure for this presentation.

Brief Recap:

Culture of Safety in Healthcare

Figure 2. Framework for Safe, Reliable, and Effective Care — with Descriptive Detail for the Components



- Frankel A, Haraden C,, et. Al (2017) outlined the framework for patient safety to improve quality in healthcare.

Culture of Safety in Healthcare

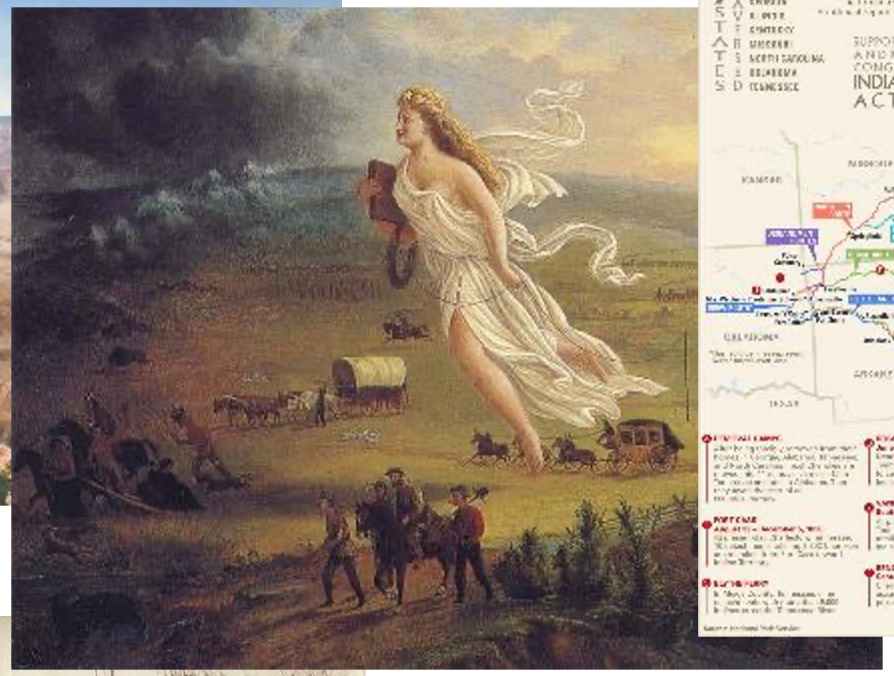
- At the IHI's National Forum in December 2016, Derek Feeley, President and CEO proposed six patient safety "resolutions" outlined in the 2017 white paper:

    1. Focus on what goes right as well as learning from what goes wrong;
    2. Move to greater proactivity;
    3. Create systems for learning from learning;
    4. Be humble — build trust and transparency;
    5. Co-produce safety with patients and families; and
    6. **Recognize that safety is more than the absence of physical harm; it is also the pursuit of dignity and equity.**
        - **This is where we can begin to examine the role of Cultural Safety as the underpinning for the Culture of Safety.**

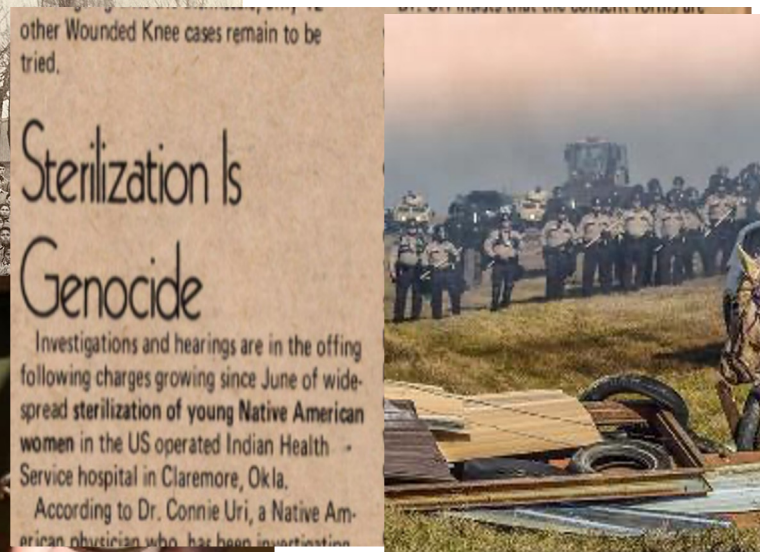
Role of Trauma and Trauma Response during Medical Care

- Trauma is defined as an event, or series of events, or circumstances that can have long lasting adverse effects on an individuals physical, emotional, social, cognitive and spiritual functioning.

- Brown, Ashford et al. (2022) write regarding trauma response during medical care that trauma response can interfere in treatment, or retrigger trauma:
  - "For some survivors of trauma, the experience of the ED may be re-traumatizing or trigger past experiences.
  - Survivors of trauma may experience **emotional dysregulation** (ie, trouble controlling strong emotions) or hypervigilance (ie, increased threat perception and **reactivity**).
  - The close interplay between executive functioning and emotional regulation **may impact both the patient and the care team's navigation** of the encounter.
  - Similarly, hypervigilance could make the often-hectic environment of the ED, as well as **interventional procedures, harder to tolerate**."



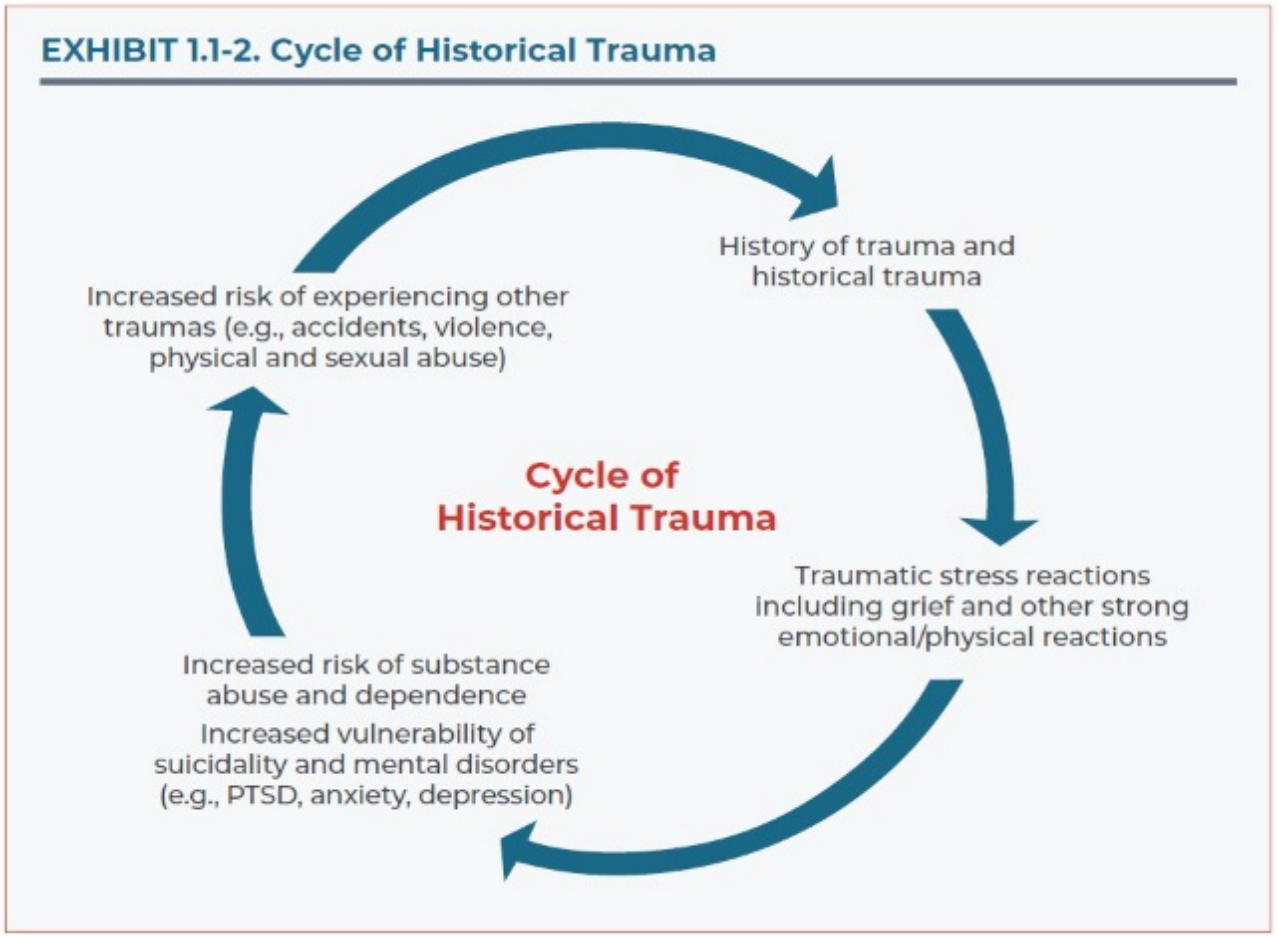

TRAIL OF TEARS
5045
SUPPORTED BY PRESIDENT ANDREW JACKSON CONGRESS PASSED THE INDIAN REMOVAL ACT OF 1830
MAJOR 5 TRIBAL NATIONS

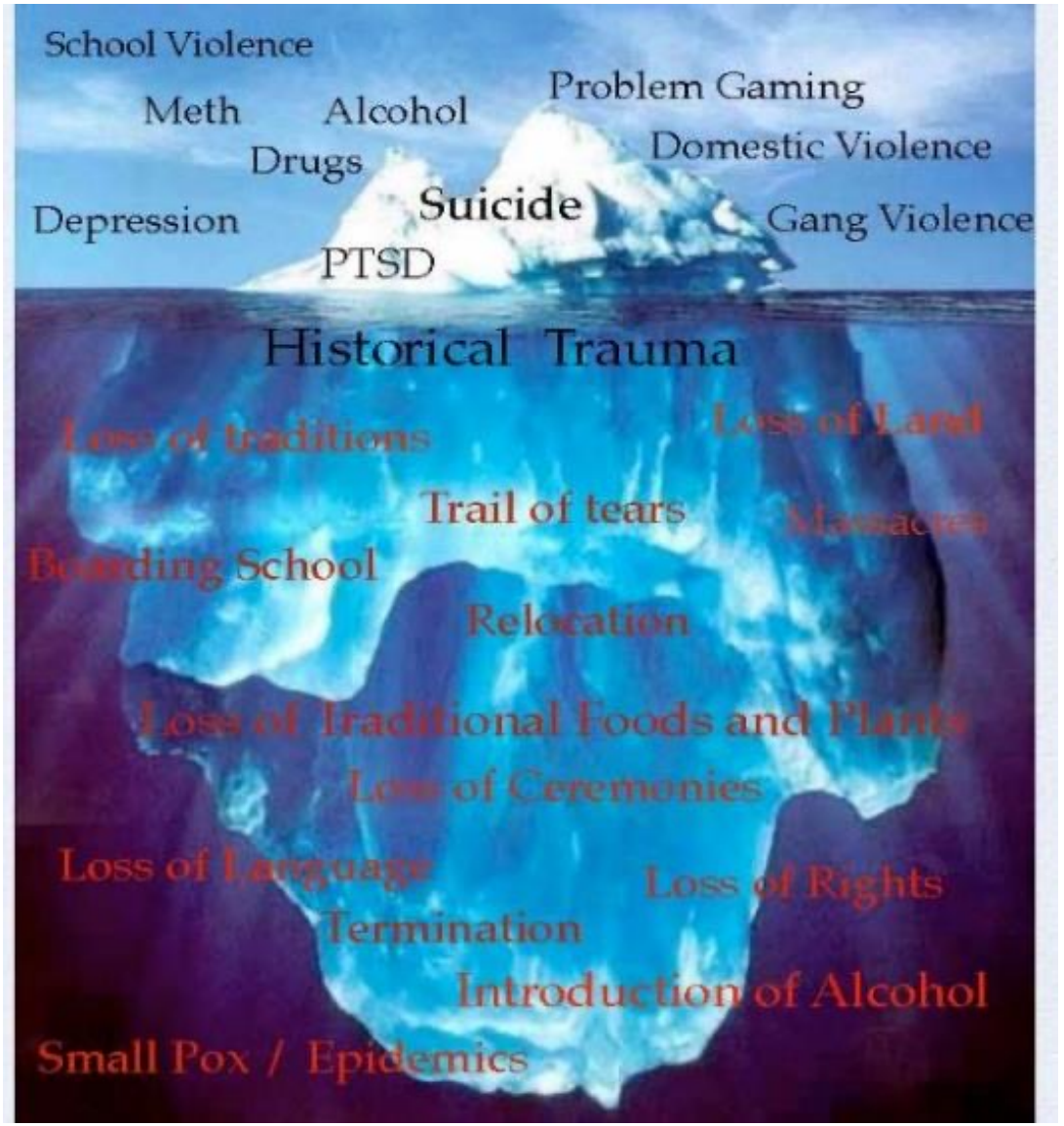

other Wounded Knee cases remain to be tried.
Sterilization Is Genocide
Investigations and hearings are in the offing following charges growing since June of widespread sterilization of young Native American women in the US operated Indian Health Service hospital in Claremore, Okla.
According to Dr. Connie Uri, a Native Am-


Native American Deaths from COVID-19 Highest Among Racial Groups

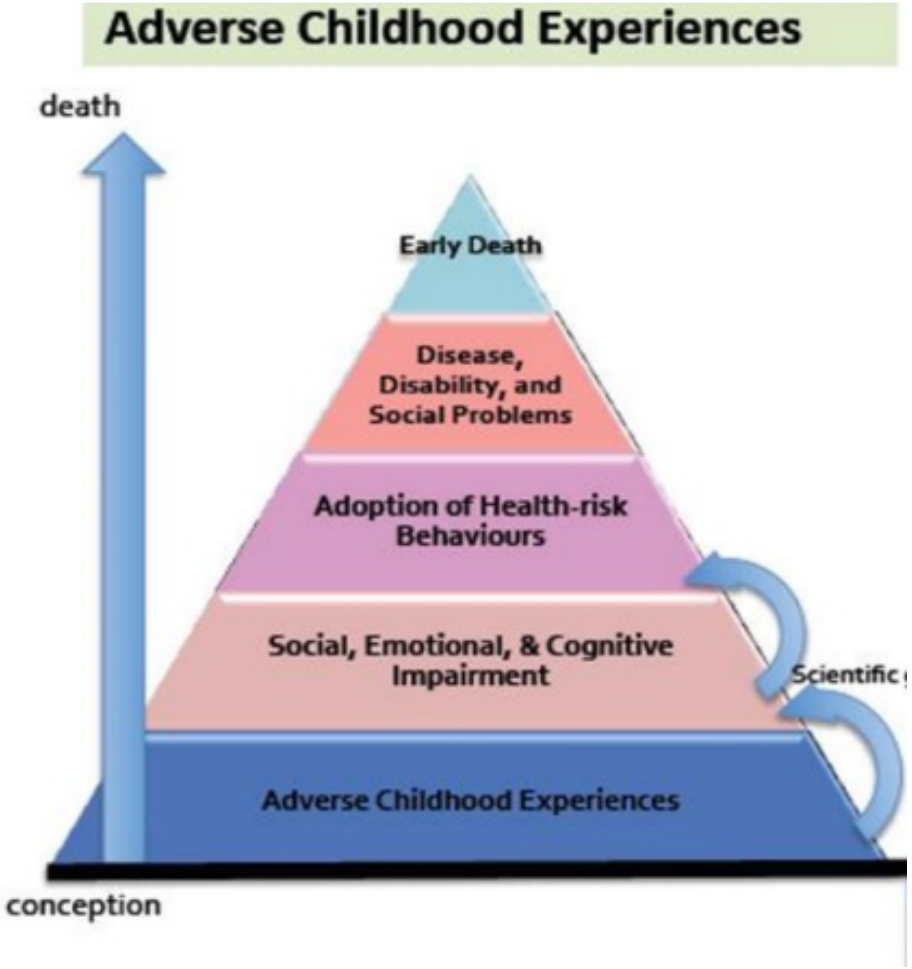
Role of Trauma and Historical Trauma

- Historical Trauma is defined as: The cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma
- Historical trauma response: can include suicidal thoughts and acts, IPV, depression, alcoholism, self-destructive behavior, low self-esteem, anxiety, anger, and lowered emotional expression and recognition



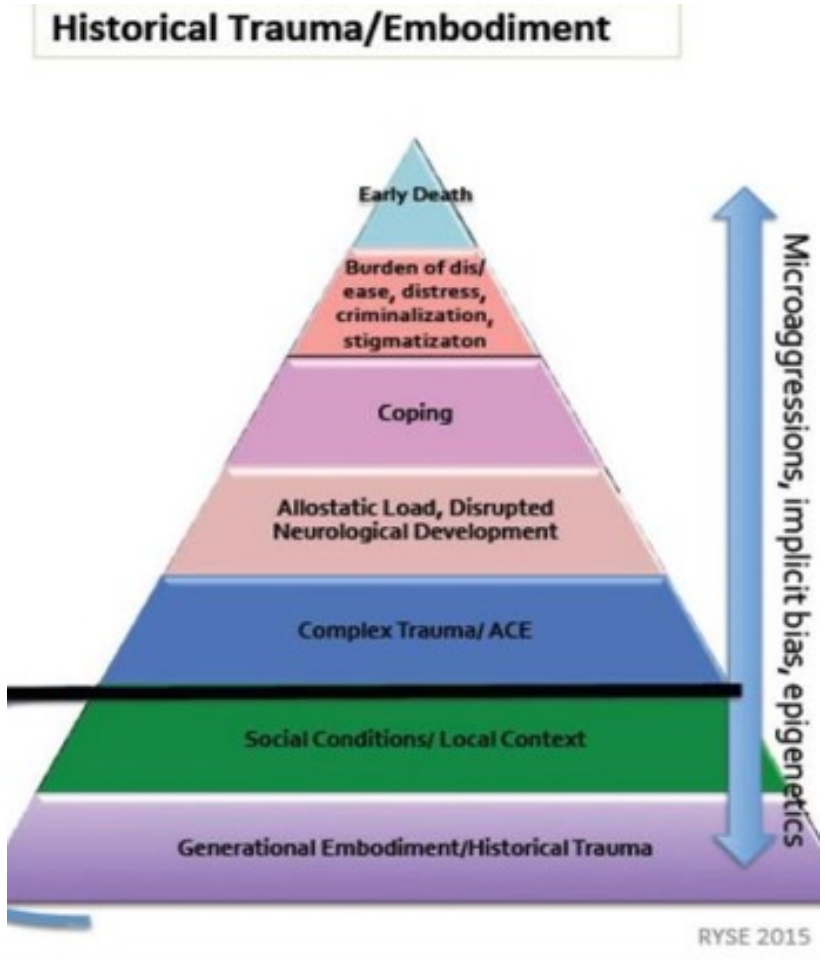


SAMHSA TIP 61, 2019



Ryse Center, 2015

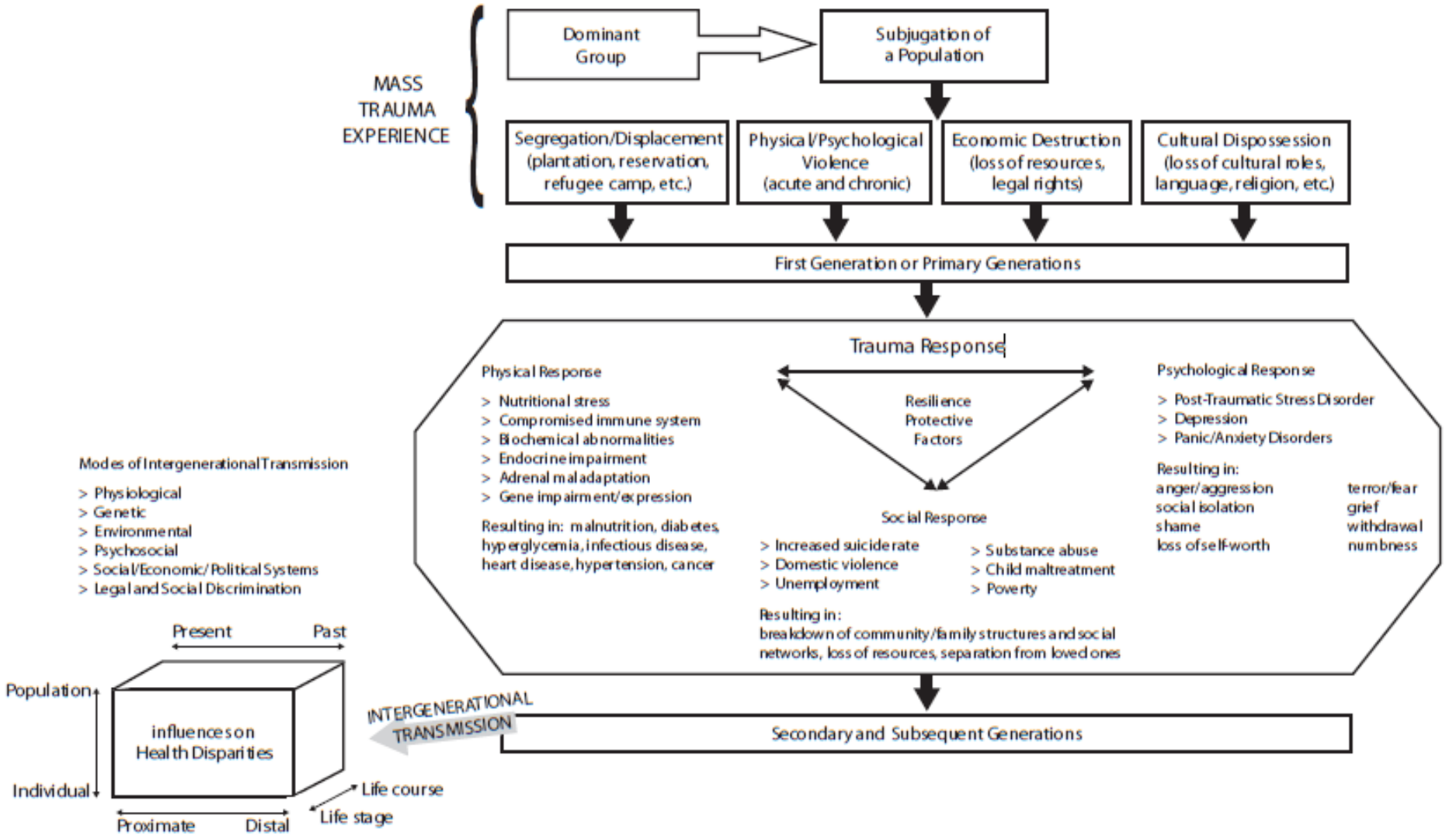
Carlisle Student Body, 1884. John N. Choate. Carlisle Indian School Digital Resource Center. Dickinson.edu



Ryse Center, 2015

Carlisle Student Body, 1884. John N. Choate. Carlisle Indian School Digital Resource Center. Dickinson.edu

Figure 1. Conceptual Model of Historical Trauma



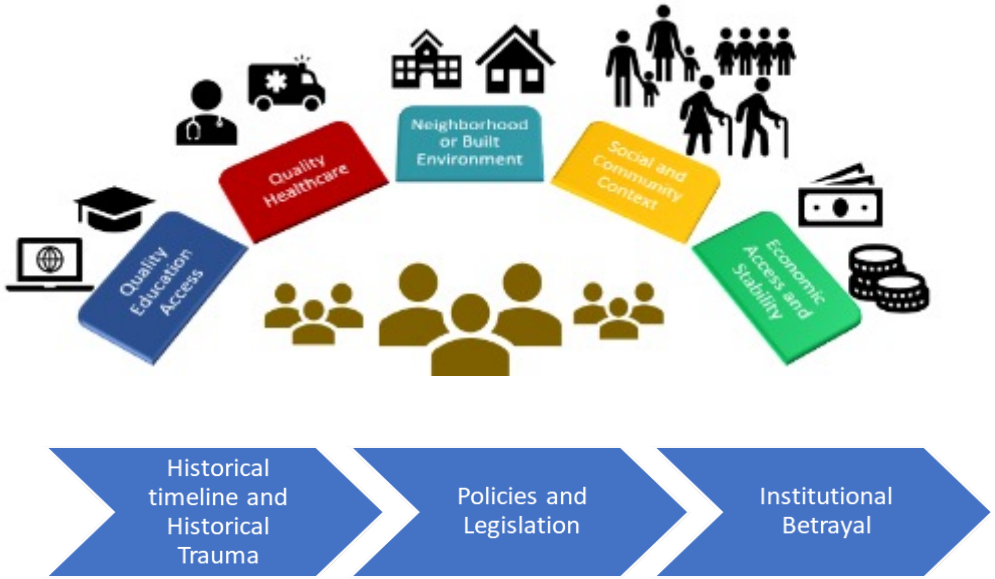
Sotero, M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. Journal of health disparities research and practice, 1(1), 93-108.

Historical Oppression

- McKinley and colleagues (2017) posit that Historical Trauma does not fully explain the pervasive and chronic oppression that Indigenous populations continue to experience,
- The concept of Historical Oppression is described as
  - "the chronic, pervasive, and intergenerational experiences of oppression that, over time, may be normalized, imposed, and internalized into the daily lives of many Indigenous peoples (including individuals, families, and communities)"
- Historical oppression includes both historical and contemporary forms of oppression

Social Determinants of Health and Structural Violence

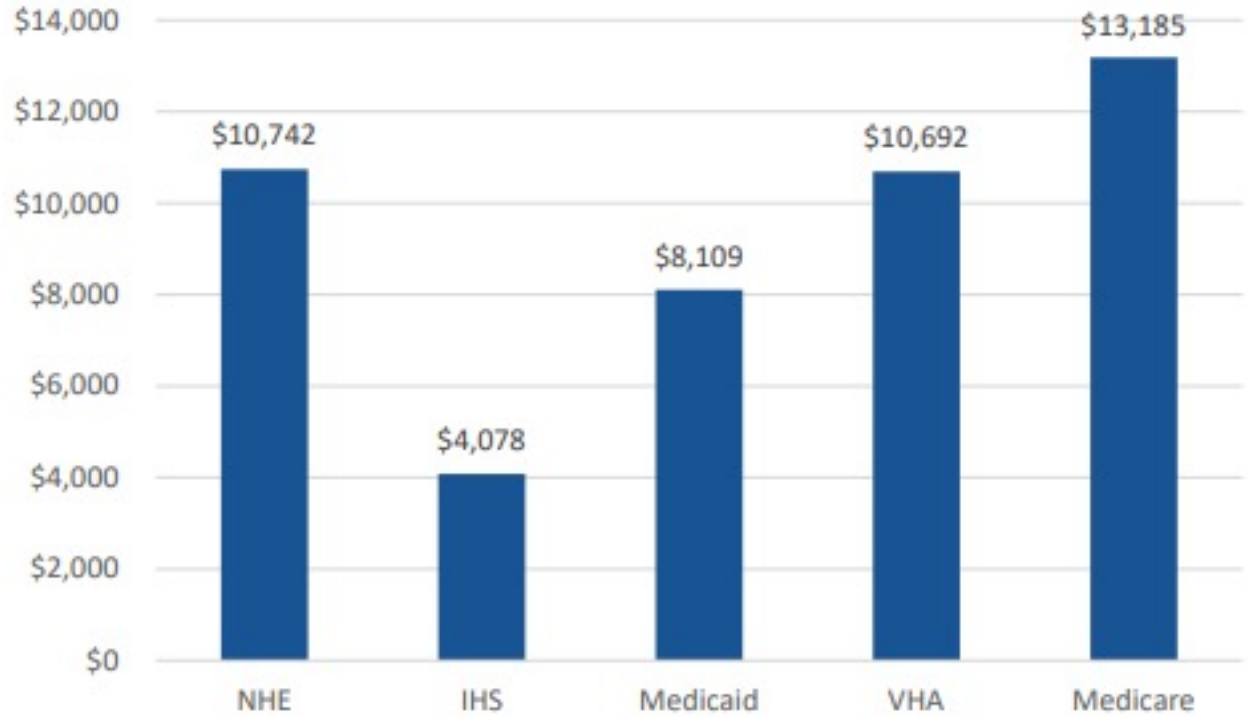
- The term Structural Violence or structural racism is increasingly understood in population & public health as a major determinant of the distribution and outcomes of social and health inequities.
- Structural violence refers to the multiple ways in which **social, economic, political, and systems structures expose particular populatio to risks and vulnerabilities leading to increased morbidity and mortality**.
- Structural violence creates the conditions which sustain the proliferation of health and social inequities.



American Indian and Alaskan Native Emergency Medicine and Emergency Departments

- In 2014, researchers undertook a profile of the Indian Health Service system Emergency Departments.
  - 40 Eds (both I.H.S and 638) serving 574 Tribes.
  - 24 reporting as part of the survey
- Bernard et all (2017) find that only 85% of EDs within the I.H.S System had 24 hour coverage and only 13% were board certified or board prepared in emergency medicine
- Small and midsized EDs were more likely to be staffed with nonboard-certified or nonboard-prepared emergency physicians compared with larger-volume centers.
- Bernard et al note that it is incumbent on the "Indian Health Service, local hospital leadership, and emergency medicine governing bodies to ensure that these providers are capable of delivering high-quality evidence-based ED care."
- Most interventions to improve ED staffing and quality will depend at least in part on improved revenue for Indian Health Service hospitals.

Figure 7. Estimated Per Capita Spending for Select Federal Health Care Programs, 2017



Note: IHS collects payments from various payers such as Medicare, Medicaid, and private insurance, which are captured in the per capita spending estimate for IHS listed above. For 2017, per capita funding for Medicaid ($411/user), Medicare ($126/user), Private Insurance ($78/user), and VA reimbursement ($4/user) are included in the $4,078 IHS per capita calculation.

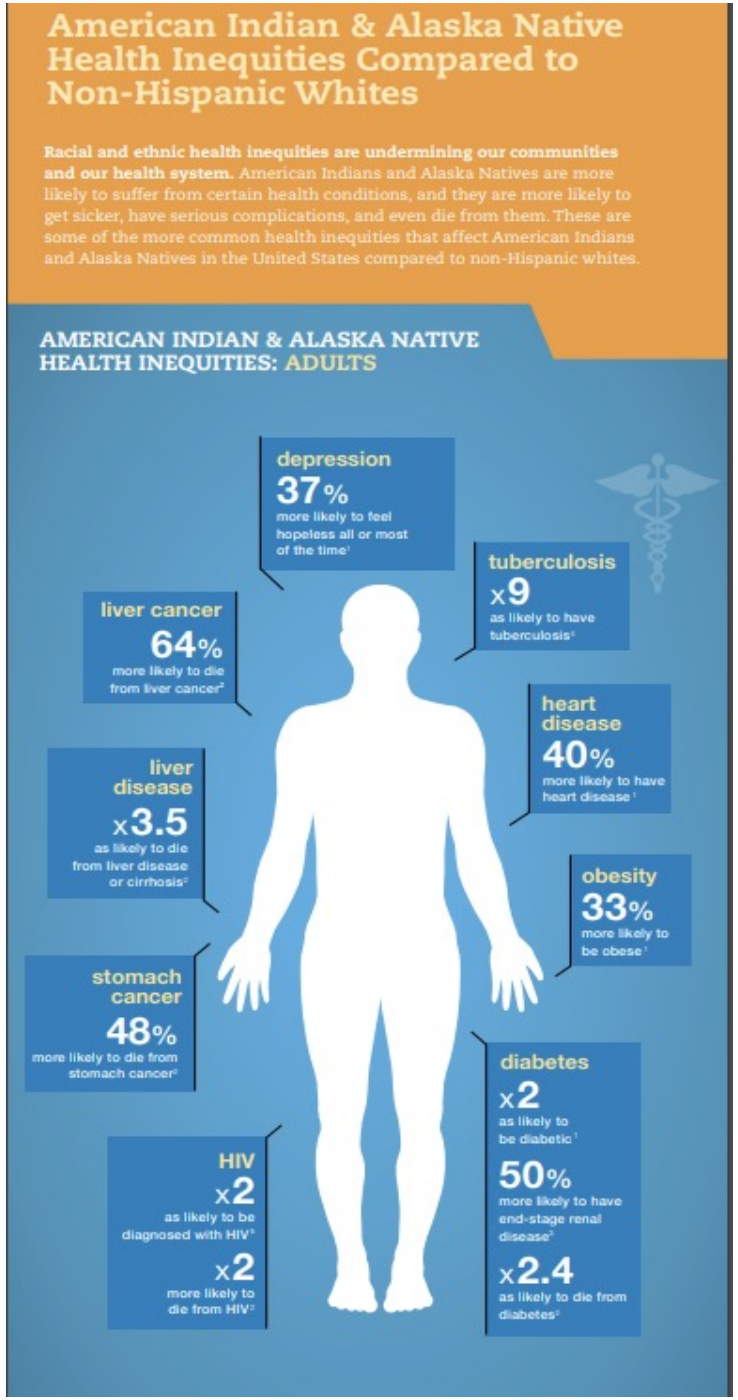
Sources: U.S. Government Accountability Office. Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs. December 2018 (GAO-19-74R); Keehan SP, Cuckler GA, Poisal JA, et al. National Health Expenditure Projections, 2019-28: Expected Rebound in Prices Drives Rising Spending Growth. Health Affairs, 39(4), March 2020.

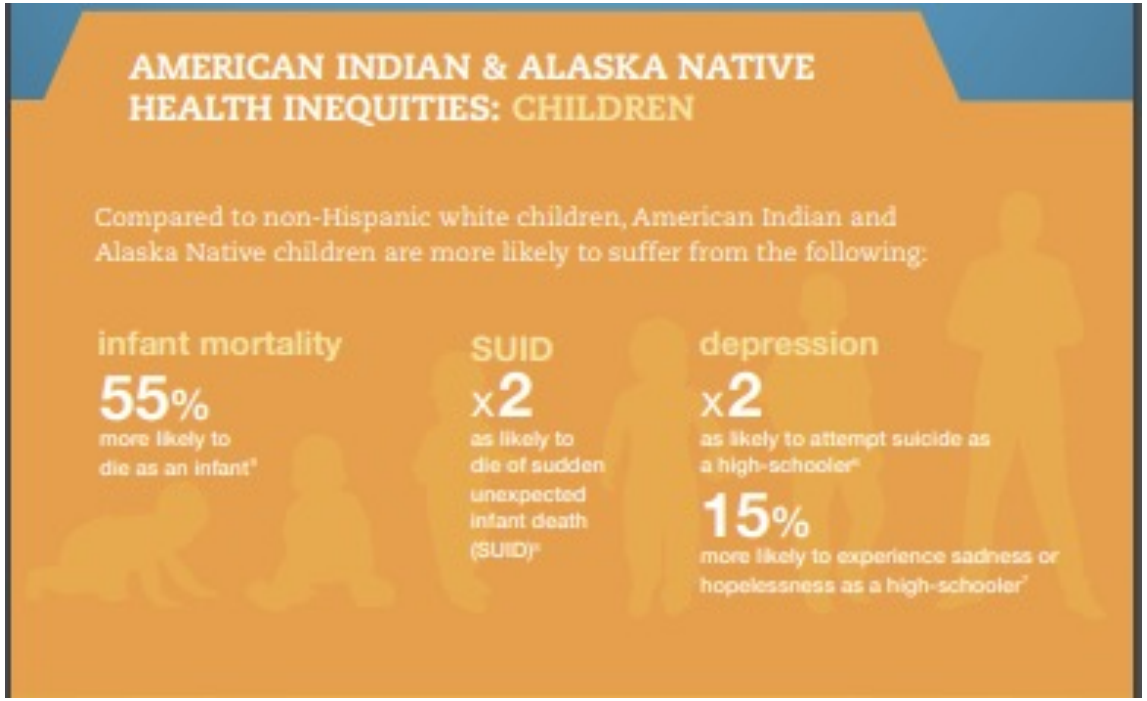
The Body Politic

- "Sickness is not just an isolated event, nor the unfortunate brush with nature. It is a form of communication-the language of the organs-through which nature, society and culture speak simultaneously. *The individual body should be seen as the most immediate…where social truths and social contradictions are played out."*

- "Our body,…is, in fact, a talkative, social and political construction but in it – and in every socio-cultural order – the three dimensions of experience (social, political and individual) are not divided."

- *"According to this point of view, pathology in the backgrounds of poverty and social discrimination, is …both the overflowing effect of* ***biopolitics*** *and of* ***biopowers*** *on our body…"*





- Disparities in AI/AN health are well documented.
- Indigenous health post colonization has been influenced by histories of trauma, policy and institutional betrayals.

https://familiesusa.org/wp-content/uploads/2018/11/HSI-Health-disparities_american-indian-infographic.pdf

What is Trauma informed care:

- Trauma-Informed Care (TIC) is an approach in the human service field that assumes that an individual is more likely than not to have a history of trauma.
- Trauma-Informed Care recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life.
- On an organizational or systemic level, Trauma-Informed Care ***changes organizational culture*** to emphasize respecting and appropriately responding to the effects of trauma at all levels.
- Four R's of Trauma Informed Care:
  - Realizing the widespread impact of trauma;
  - Recognizes trauma and trauma response,
  - Responds by fully integrating knowledge about trauma into policies, procedures and practices
  - Seeks to actively resist re-traumatization

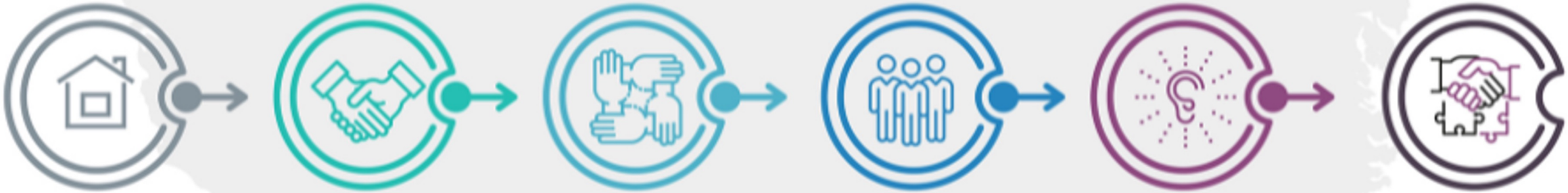
Historical Trauma Informed Care

- Historical Trauma Informed Care includes integration of recognition of tribal culture and history and the impact up to the present. Both must be incorporated in assessment, rapport building and treatment approaches.

SAMHSA TIP 61, 2019

6 GUIDING PRINCIPLES TO A TRAUMA-INFORMED APPROACH

The CDC's Office of Public Health Preparedness and Response (OPHPR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC), developed and led a new training for OPHPR employees about the role of trauma-informed care during public health emergencies. The training aimed to increase responder awareness of the impact that trauma can have in the communities where they work. Participants learned SAMHSA'S six principles that guide a trauma-informed approach, including:



1. SAFETY
2. TRUSTWORTHINESS & TRANSPARENCY
3. PEER SUPPORT
4. COLLABORATION & MUTUALITY
5. EMPOWERMENT VOICE & CHOICE
6. CULTURAL, HISTORICAL, & GENDER ISSUES

Adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. On-going internal organizational assessment and quality improvement, as well as engagement with community stakeholders, will help to imbed this approach which can be augmented with organizational development and practice improvement. The training provided by OPHPR and NCTIC was the first step for CDC to view emergency preparedness and response through a trauma-informed lens.

Trustworthiness and transparency: Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.

Peer support and mutual self-help: These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.

Collaboration and mutuality: There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. One does not have to be a therapist to be therapeutic

Empowerment voice, and choice: Organization aims to strengthen the staff, client, and family member's experience of choice and recognizes that every person's experience is unique and requires an individualized approach. This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.

Cultural, historical, and gender issues: The organization actively moves past cultural stereotypes and biases , offers culturally responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

Safety: Throughout the organization, staff and the people they serve feel physically and psychologically safe.

CULTURAL SAFETY

Structural systemic change and Indigenous lens

Indigenous View of Health

- Relational, Collective
- Anchored in Identity, Culture including historical and traditional knowledge, language, ceremony, tradition, belief, story, art
- Tied to the land and environment.
- Based in core cultural values of what it means to take care of each other and promote cultural perpetuity.

Origins of Cultural Safety

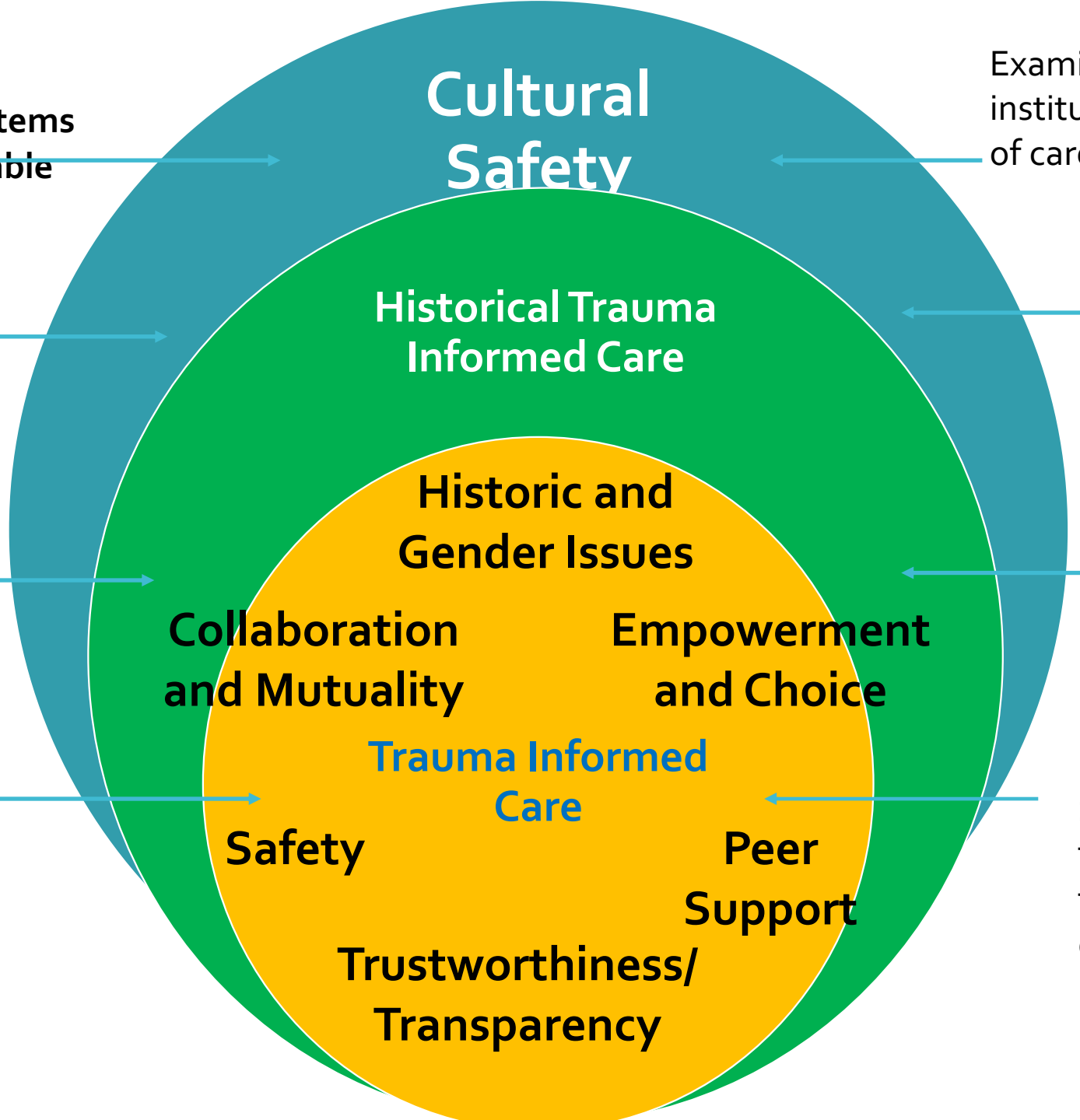
- Developed in 1989 by Irihapiti Ramsden, A Maori nurse researcher.
- Ramsden wrote: "Maori people no longer accept that our world is a perspective on the reality of anyone else. We have our own whole, viable, legitimate reality…We insist *we are not a perspective*"
- "This leads to the question of choices in service delivery. The data on Maori mortality and morbidity and empirical experience has made it quite clear…The health service is not and has not ever been culturally safe for Maori people."
- "The service has not been designed to fit the people, the people have been required to fit the service"

Definition of Cultural Safety

Cultural Safety is:

- an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system.
- ***Safety is defined by those receiving care***, not by those who provide it.
- Turpel et al. (2020) further defined cultural safety as occurring when:
  - "[an] environment is physically, socially, emotionally and spiritually safe. There is recognition of, and respect for, the cultural identities of others, without challenge or denial of an individual's identity, who they are, or what they need.
  - Culturally unsafe environments diminish, demean or disempower the cultural identity and well-being of an individual. "

- Cultural Safety encompasses cultural humility, but also considers those historical timelines, trauma histories, inequities, and **takes on an active social justice and health justice stance.**
- It is inherently actively Anti-Racist in its basis.
- **It examines the aspects of constructs that impact health outcomes; actively transfers power to the patient and seeks to create systems that support safety and equity.**



Examines and confronts Structural Violence in systems of care and creates equitable access

Examines and confronts institutional betrayal in systems of care.

Examines and confronts implicit bias

Examines and confronts power differentials and creates space free from judgement, racism, stereotyping

Centers cultural connection as supportive and cultural knowledge of a patient as valid and important to healing

Understands historical context of population and historical context of care including hurtful or detrimental issues in care.

Working in collaboration with a patient versus Working on.

Sees care in the context of the impact of trauma and the need for safety and connection

Why does Cultural Safety matter in Emergency Medicine?

- Health disparities in American Indian and Alaskan Native populations are well known and long documented.
- Less is known about specific disparities for AI/AN population treatment in EDs
- Owens, Hons, et al (2020) Conducted a scoping review of the literature on disparities in care in ED's for both the US and Canada from 1990 to 2018
- After review of 453 records screened, 83 studies were included and were clustered for analysis by ED Process
  - Triage
  - Wait times
  - Analgesia
  - Diagnosis
  - Treatment
  - Leaving without being seen (LWBS)/ Leaving against medical advice (AMA)
  - Patient experiences

Why does Cultural Safety matter in Emergency Medicine?

Owens, Hons, et al (2020) found:

- 7 Studies for triage scores found differences between racial and ethnic minority v. majority culture despite similar presenting complaints or pain ratings
- 12 studies examined waiting times, and **11 found minority groups waited longer** on average to be assessed than white patients
- 24 studies in analgesic admin. 15 of 24 found differences in analgesic admin between racial and ethnic groups. 6 studies found **minorities were less likely to receive any analgesics compared to the majority culture**.
- 25 studies found **differences between racial and ethnic minority groups on at least one diagnostic process for testing and treatment** for chest pain, asthma, psychiatric disorders, gastro complaints, trauma and stroke.
- 4 studies **found LWBS/AMA more likely in minority groups than majority group patients**. Minority patients Other than Indigenous patient were Not more likely that their white counterparts to LWBS after controlling for insurance status.
  - AI/AN children have higher rates of leaving ED's without complete evaluation or care.
- 2 studies analyzed patient trust in ED providers. **Both found non-white patients had lower trust scores for providers** than white patients.

- Puumula, Burgess, et al. (2016) write regarding American Indian Children's utilization of ED;s:
- "Many factors affect health care use and access by American Indian children, including low insurance rates, lack of access to quality primary care and higher prevalence of diabetes, asthma, mental health issues, and injuries.
- American Indian children often rely on the ED to access necessary medical care instead of a medical home

- Their study of both implicit and explicit bias of providers in 5 Eds across both rural and urban centers, both servicing large urban American Indian and on reservation American Indian populations, found that 22-32% of providers surveyed believed:
  - "American Indian children were seen as increasingly challenging and parents/caregivers less compliant as the proportion of American Indian children seen during a typical shift increased."

Table. Provisional life expectancy, by age, race and Hispanic origin, and sex: United States, 2021

Age (years)	All races and origins			Hispanic			Non-Hispanic American Indian or Alaska Native			Non-Hispanic Asian			Non-Hispanic Black			Non-Hispanic White		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
0	76.1	73.2	79.1	77.7	74.4	81.0	65.2	61.5	69.2	83.5	81.2	85.6	70.8	66.7	74.8	76.4	73.7	79.2
1	75.6	72.6	78.5	77.1	73.8	80.4	64.7	61.0	68.7	82.7	80.4	84.8	70.6	66.5	74.5	75.7	73.0	78.5
5	71.6	68.7	74.6	73.1	69.8	76.4	60.9	57.1	64.8	78.8	76.5	80.8	66.7	62.6	70.7	71.8	69.1	74.6
10	66.7	63.8	69.7	68.2	64.9	71.5	55.9	52.2	59.9	73.8	71.5	75.9	61.8	57.7	65.7	66.8	64.1	69.6
15	61.7	58.8	64.7	63.2	59.9	66.5	51.0	47.3	55.0	68.8	66.6	70.9	56.9	52.8	60.8	61.9	59.2	64.7
20	56.9	54.1	59.8	58.4	55.1	61.6	46.4	42.7	50.3	63.9	61.7	65.9	52.2	48.3	56.0	57.0	54.4	59.8
25	52.2	49.5	55.0	53.7	50.6	56.8	42.1	38.6	45.8	59.1	56.9	61.0	47.8	44.2	51.3	52.3	49.8	54.9
30	47.6	45.1	50.2	49.1	46.1	52.0	38.0	34.7	41.5	54.3	52.1	56.1	43.5	40.0	46.7	47.7	45.3	50.2
35	43.1	40.7	45.5	44.5	41.7	47.2	34.3	31.2	37.4	49.4	47.3	51.2	39.1	35.9	42.1	43.1	40.9	45.5
40	38.6	36.4	40.9	39.9	37.3	42.5	30.8	28.0	33.8	44.6	42.5	46.3	35.0	32.0	37.7	38.7	36.5	40.8
45	34.2	32.1	36.4	35.5	33.0	37.8	27.4	24.8	30.0	39.9	37.9	41.5	30.9	28.1	33.4	34.3	32.3	36.3
50	30.0	28.0	31.9	31.1	28.8	33.3	24.4	22.1	26.7	35.2	33.3	36.7	26.9	24.4	29.2	30.0	28.1	31.9
55	25.9	24.0	27.6	26.9	24.8	28.8	21.5	19.5	23.5	30.6	28.9	32.0	23.2	20.9	25.2	25.9	24.1	27.6
60	22.0	20.4	23.5	23.0	21.1	24.6	18.9	17.2	20.4	26.1	24.6	27.4	19.7	17.6	21.5	21.9	20.4	23.4
65	18.3	16.9	19.6	19.3	17.6	20.6	16.3	15.1	17.4	21.9	20.5	22.9	16.5	14.8	18.0	18.3	16.9	19.5
70	14.8	13.7	15.8	15.7	14.4	16.7	13.7	12.7	14.5	17.8	16.7	18.6	13.6	12.2	14.7	14.7	13.6	15.7
75	11.5	10.6	12.3	12.4	11.3	13.1	11.2	10.5	11.8	14.0	13.1	14.5	10.9	9.7	11.7	11.4	10.5	12.1
80	8.6	7.9	9.1	9.3	8.5	9.7	9.1	8.6	9.3	10.4	9.8	10.7	8.4	7.5	8.9	8.4	7.8	8.9
85	6.1	5.6	6.4	6.7	6.1	6.9	7.2	6.9	7.2	7.3	6.9	7.4	6.2	5.6	6.5	5.9	5.5	6.2
90	4.1	3.9	4.3	4.6	4.3	4.6	5.6	5.5	5.4	4.8	4.7	4.8	4.5	4.1	4.6	4.0	3.7	4.1
95	2.8	2.7	2.9	3.2	3.0	3.1	4.4	4.4	4.1	3.1	3.1	3.0	3.2	3.0	3.3	2.7	2.6	2.7
100	2.0	2.0	2.0	2.3	2.2	2.1	3.5	3.6	3.3	2.1	2.2	2.0	2.4	2.3	2.3	1.9	1.8	1.9

NOTES: Life tables by race and Hispanic origin have been adjusted for race and ethnicity misclassification on death certificates; see Technical Notes in this report. Estimates are based on provisional data for 2021. Provisional data are subject to change as additional data are received.

SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Cultural Safety creates safe care

- Individuals seeking care are coming sometimes at the most vulnerable moments of their lives.
- Yet perceptions of biases, power differentials, and history of betrayals in care keep our relatives from sharing information about their health struggles
  - And their loss of health can create trauma
- Creating safe, respectful spaces for healthcare can create generations of impact

Operationalizing Cultural Safety: Turning to our Relatives for support.

Operationalizing Cultural Safety: Turning to our Relatives for support.

- The Australasian College for Emergency Medicine developed a report in 2020 titled "Traumatology Talks" noting:
- "When Aboriginal and Torres Strait Islander (ATSI) present to EDs, the full manifestation of their trauma experience presents with them.
- This includes trauma related to historical events with intergenerational and transgenerational impacts; exposure to complex, chronic life stressors; trauma from specific, intense life experiences; and complex and developmental trauma arising from adverse childhood experiences."

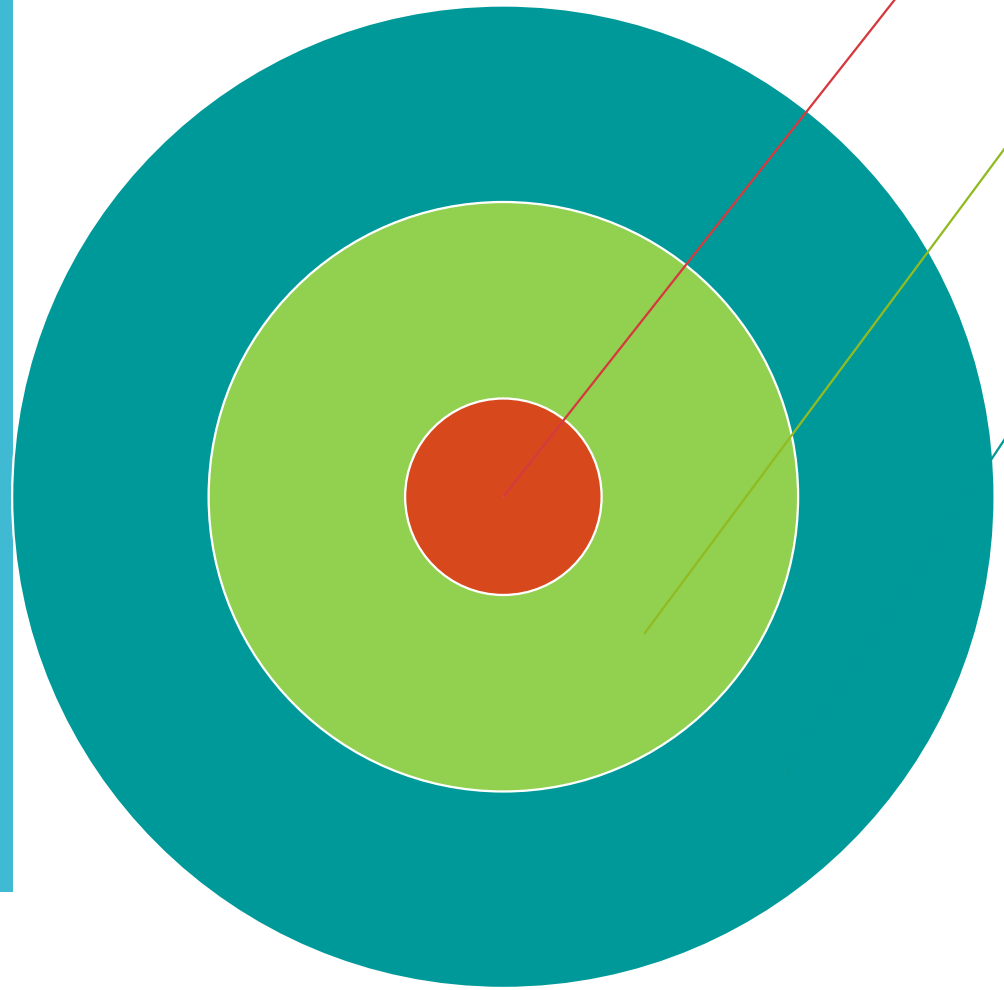
- The report took a deep dive look at Emergency care of Aboriginal and Torres Strait Islanders and the role and need for Cultural Safety.
- Amongst many of the final recommendations made, a few included:
  - Introduce a Social Emergency Care (SEC) discipline by developing curriculum to increase the number of SEC practitioners
    - Who can treat clinical presentations,
    - Who work to understand the experiences of those presenting, and
    - Who ascertain the social and cultural determinants underlying Aboriginal (and other) people's ED presentations
  - Workforce Advocacy including supporting current workforce and increasing ATSI representation across roles.
  - Examining ED environment, policy and procedure

Operationalizing Cultural Safety: Turning to our Relatives for support.

- Dell, Firestone et al (2015) draw on previous work in Canada and Australia to pose four overarching principles and possible resulting actions to address cultural safety in ED care.
  - The patient's way of knowing and being is valid—
    - We need to be able to listen to our patients and their understanding and story of their medical issue/trauma and needs even in this emergency medicine space
  - The patient is a partner in the healthcare decision making process
    - What information can we share and what choices can we provide
    - Understand that the decisions around care are often being considered in the broader context of family, community and even traditional ceremony and constructs and time
  - Recognize the impact of complex intergenerational traumas on health and access to health services
    - Building trust is still key, even in this emergency medicine space—introductions, asking permission, understanding hesitancy and reactivity and mistrust may be related to prior experiences and our work is to bridge to a new positive experience.
  - The patient determines whether the care they have received is culturally safe

- We come with our whole selves, yes our whole traumas and histories and experiences, but we also come with our whole resilience—and when fostered, supported and recognized as valid in our own healthcare, then we see the patient as a whole being.

Intersection of Cultural Safety, Trauma Informed Care and Culture of Safety.



CULTURE OF SAFETY: how we create safety in healthcare service delivery in the day to day processes and procedures (Service Delivery Change)

HISTORICAL TRAUMA INFORMED CARE/TRAUMA INFORMED SYSTEMS OF CARE: How we recognize the intersection of a population and the history and present day interaction with the health care system and other systems of care. (System change)

CULTURAL SAFETY: How we examine and create systems of care that actively create safety, cultural inclusion, collaborative relationship with patients both in service delivery and in service creation, and minimize power differential (Structural Change)

A few more "R's" in Trauma Informed Care and Cultural Safety

- **Replenish:** engaging in your own self care as a provider, and recognizing and addressing burnout and compassion fatigue
  - "Self care is an ethical imperative." (Tujague and Ryan, 2023)
- **Reflect and Re-evaluate (Reflexivity)**: on what we know, and how we put that knowledge into practice.
- **Regenerate and Revive**: Tujague and Ryan (2023) note that our goal as partners and collaborators in our patient populations care, is to encourage and support our {Indigenous} populations engagement in our own local healing frameworks;
- **Resilience** expands on trauma informed care concepts and includes narratives and strategies deeply rooted in community well being.
  - Draws on cultural connection, traditional cultural healing and strengths based approaches.

Our Goal


Meaningful Life Longevity
Wellness & Balance
Cultural Values & Coping Skills
Consistent Corrective Experiences & Cultural Identity Development
Positive Childhood, Family, & Community Experiences
Thriving and Safe Communities
Intergenerational Healing, Tribal Sovereignty, Cultural Revitalization and Traditional Healing

Our Goal

RIdes At The Door 2023

How can you contribute to culturally safe care for American Indian and Alaskan Natives?

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