

Exploring the impact of an Aboriginal Health Worker on hospitalised Aboriginal experiences: lessons from cardiology

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Abstract

To enhance Aboriginal inpatient care and improve outpatient cardiac rehabilitation utilisation, a tertiary hospital in Western Australia recruited an Aboriginal Health Worker (AHW). Interviews were undertaken with the cardiology AHW, other hospital staff including another AHW, and recent Aboriginal cardiac patients to assess the impact of this position. The impact of the AHW included facilitating culturally appropriate care, bridging communication divides, reducing discharges against medical advice, providing cultural education, increasing inpatient contact time, improving follow-up practices and enhancing patient referral linkages. Challenges included poor job role definition, clinical restrictions and limitations in AHW training for hospital settings. This study demonstrates that AHWs can have significant impacts on Aboriginal cardiac inpatient experiences and outpatient care. Although this study was undertaken in cardiology, the lessons are transferable across the hospital setting.

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What is known about the topic?

Cardiovascular disease is the leading cause of death in Aboriginal Australia and is responsible for significant rates of hospitalisation. Although there is considerable evidence for the effectiveness of cardiac rehabilitation, the participation of Aboriginal people is extremely poor.

What does this paper add?

While there is considerable research regarding the issues facing Aboriginal admissions to acute settings, little research has been conducted on the effect of an Aboriginal health professional in this setting. This paper presents data identifying the impacts an Aboriginal Health Worker had in a hospital setting, from improving the cultural security of care for Aboriginal patients and facilitating more effective communication mechanisms, to increasing patient contact time and follow-up, and enhancing cultural safety skills of other staff.

What are the implications for practitioners?

Aboriginal Health Workers can have substantial positive impact in acute care settings.

CARDIOVASCULAR DISEASE (CVD) is the leading cause of mortality in Aboriginal Australians,* and is responsible for contributing to high rates of Aboriginal hospitalisation.^{1,2} Compared with other Australians, Aboriginal people have three times the rate of coronary events and more than twice the in-hospital coronary heart disease death rate.²

Cardiac rehabilitation (CR) is an organised approach to secondary prevention and cardiac care involving exercise, risk reduction, behavioural modification and education.³ With convincing evidence attesting to the effectiveness of CR in reducing coronary death by as much as

* Throughout this article, "Aboriginal" is used to refer to Aboriginal and Torres Strait Islander people of Australia.

25%,^{4,5} increasing the participation of Aboriginal people in CR has become an issue of critical importance.³ However, despite being twice as likely to die from CVD,⁶ Aboriginal people are less likely to participate in CR than non-Aboriginal Australians.^{7,8}

In the hospital setting, a significant opportunity exists to inform Aboriginal patients about cardiac health and post discharge CR programs. However for many Aboriginal patients, communication barriers and a cultural mismatch with the hospital setting can leave them anxious, and unable to understand hospital procedures or fully engage with health information.⁹⁻¹¹ Although the impact of this on follow-up care and attendance at outpatient services is not well documented, arguably, poor inpatient experiences will reduce the chances of patients utilising outpatient programs.

Supported by evidence of the successful use of Aboriginal Health Workers (AHWs) in hospitals,^{12,13} there has been increasing interest within hospitals in recruiting AHWs to improve Aboriginal inpatient experiences. The 2008 National Health and Hospitals Reform Commission interim report states a commitment to increasing the Aboriginal health workforce.¹⁴ In terms of cardiac care, involving an AHW in the care of Aboriginal patients has been suggested as critical in improving their utilisation of CR programs.¹⁵ In a tertiary hospital in Western Australia, despite Aboriginal patients representing about 7% of all ischaemic heart disease admissions (and likely to be higher, as not all patients are correctly identified as Aboriginal on admission), Aboriginal patients did not have access to a dedicated Aboriginal health professional.¹⁶ In response to this — and the suboptimal attendance of Aboriginal patients in CR programs — a 6-month position for an AHW in cardiology was created. The role was designed to work closely with cardiac nursing and medical staff as well as CR staff to provide support and culturally appropriate health information (including education about CR) to Aboriginal patients, assist with linking them to post-discharge CR services and provide outpatient follow-up.

An AHW raised in a remote area of Western Australia with primary health care experience was

appointed in December 2006. Despite interest from the hospital in continuing the position, in June 2007 the AHW left for “personal reasons”. Research was conducted between November and December 2007, to explore the impact of the position and the lessons learned. This paper presents these results and illustrates how hospital programs that are inclusive of AHWs can positively impact Aboriginal patient outcomes and thus contribute to chronic disease care.

Methods

Ethics approval was obtained before data collection from the tertiary hospital’s Human Research Ethics Committee and the Western Australian Aboriginal Health and Ethics Committee. Purposive sampling was used after identifying key hospital staff informants who had worked with the cardiology AHW. Staff were approached via email or telephone and invited to participate in qualitative open-ended interviews. These interviews were guided by a list of issues that had been developed by the research team exploring participants’ views and experiences of the impact of the cardiology AHW position. Staff participants included cardiology ward nurses (4); CR nurses (2); doctors (2); social workers (2); the AHW who had worked in the cardiology position; an AHW appointed to work with renal patients; an exercise physiologist; and a nurse from the Advanced Heart Failure Service. Recent Aboriginal cardiology inpatients (12) were also identified by a CR nurse (who was affiliated with the study) and invited to participate in open-ended interviews to explore their views of AHWs in hospitals.

Staff and patient interviews were recorded on a digital tape recorder, numbered to ensure participant confidentiality, and transcribed verbatim. These qualitative data were then analysed using a framework approach which involved data familiarity, the identification, indexing and charting of key themes and finally, interpretation.¹⁷ Quantitative data regarding the number of Aboriginal cardiac admissions and discharges against medical advice (DAMA) were extracted from the hospital inpatient database (TOPAS), while data relating to the number of Aboriginal patient telephone calls post

discharge were extracted from the CR database. Further information was sourced from the AHW's work diary, where patient contact was recorded. As the AHW had never worked in a hospital setting before, the research team chose not to utilise data from December 2006, based on advice that this month was primarily job orientation. Thus, data were collected for the period January to June 2007, and where relevant, compared with the 5 months before the AHW's commencement (July–November 2006).

Results and discussion

Contemporary Aboriginal perspectives of hospitals continue to be heavily shaped by the effect of colonisation,¹⁸ creating a depth of fear and anxiety that is difficult for the non-Aboriginal community to comprehend.¹⁹ In this study, Aboriginal patients referred to this enduring undercurrent as the key issue influencing their hospitalised experience. One participant said:

Hospitals are colonialism ... that's where the people go and we don't see them again ... it's the place you go to die ... (Aboriginal patient: 9)

Aboriginal patients also indicated that during hospitalisation, the wounds of colonisation are easily aggravated by communication difficulties:

... [the staff] shout at us like we're deaf. And all it is, is that we can't understand the English; the orientation of everything ... And one day I said "I'm not deaf and I do speak English" ... It makes you feel disgusting. Very patronising. (Aboriginal patient: 1)

For staff, limited understanding of Aboriginal culture could easily result in misinterpretations, and affect staff–patient information exchanges:

... the Aboriginal patient is probably a little bit shy, a bit overwhelmed, spends a lot of time looking at the floor ... and not making eye contact, and the staff take that the wrong way ... (that) either they don't understand or they don't care. They don't appreciate that there is a cultural aspect to that as well. So,

then they're probably a bit dismissive of that patient and perhaps don't explain things as well to that patient as they might to someone else who they felt was engaging ... (Nurse: 42)

Hospital system impediments to the delivery of person-centred care coupled with the current emphasis of fast-tracking patients to discharge lounges were also identified by staff as having a serious effect on their capacity to provide cardiac education. One nurse described this:

In the old days patients used to stay here about 6.7 days for an MI. Now ... it's 5.1. So if you've got a small heart attack that's 1.7 days ... the significance of that is ... you have an emergency angioplasty. You're in the lab for 3 hours. You have a sheath for 4 hours. You're resting in bed for 8 hours. That's 24 hours gone. You have something to eat. You have a shower. That's another 4 hours ... So ... if patients are here 1.7 days, you need to start educating them from the time they get off the trolley (but) ... Sometimes patients aren't interested either because they're tired, or in shock, or they've got family, ... Aboriginals tend to have a lot more family. Coronary care only lets you have two visitors at a time. So that means that if there are eight people out there, there's a constant turnover ... The priority is to get people out of ED ... So ... you don't have much time for education. (Nurse: 48)

While these communication difficulties were affecting the delivery of cardiac education, it also raised serious issues around the reliability of informed consent protocols (eg, see also Tanner et al⁹ and Watson et al¹⁰). It is these cultural, communication, resourcing and workforce issues that provided the impetus for an AHW to be placed on the cardiology ward.

Impacts of the Aboriginal Health Worker position

Delivering more effective health education and care

Arguably, optimal health care occurs when staff share the same linguistic and cultural background as their patients.¹¹ By having the AHW on the

cardiology ward, Aboriginal patients had access to a culturally congruent support mechanism, ensuring health information was being communicated in an effective way. The AHW gave examples of how this was done:

When they don't look or give you eye contact, it could be a sign of respect or something completely different, like they are shamed, so you need to know so you can communicate properly. (AHW: 40)

A key technique the AHW used to deliver health information was to “yarn” with patients, a unique Aboriginal cultural process that involves listening and reciprocating communication.²⁰

The AHW explained:

You sort of yarn and educate all in the one. (AHW: 40)

This utilisation of yarning as a powerful health education and service tool has also been identified in other studies.^{21,22}

The AHW's ability to communicate effectively with Aboriginal patients also helped clarify procedures and demystify the hospital experience:

One patient had said to me he thought he was going for five different operations because he was seeing five different doctors and no one had explained it to him. (AHW: 40)

Several hospital staff commented that having the AHW on the ward visibly affected Aboriginal patients, who appeared calmer and less anxious, and were more likely to engage with other staff. Importantly, the AHWs facilitation of effective communication also meant there was greater certainty that Aboriginal patients gave informed consent, better understood medical procedures and had knowledge of CR programs.

Reducing discharge against medical advice

Staff felt that by having the AHW on the ward, there was a reduction in the number of Aboriginal patients who would discharge themselves against medical advice (DAMA). One nurse recounted a situation that highlighted the significance of the AHW on potential DAMA situations:

We would just lump them, “Oh, they're Aboriginal; they'll want to be in the same room.” We nearly started a war one time. We had two people who were both the same sex, but the family groups were not friends and should not have been together ... and the AHW told us “You need to move these patients straight away otherwise someone will walk.” If she wasn't there we would have had a DAMA situation. (Nurse: 48)

These qualitative responses were substantiated by looking at statistical data. Despite data limitations (although disproportionately represented in cardiac admissions, Aboriginal people remain a small minority of cardiology admissions and the AHW “intervention” was for only 5 effective months), analysis of TOPAS discharge data revealed a significant difference between the number of DAMAs occurring during the AHW's tenure (5) compared with the 5 months before her commencing the position (11). As Aboriginal patients are known to discharge themselves against medical advice more often than non-Aboriginal patients,²³ this reduction of DAMAs highlights an important impact of the AHW not only in improving patient comfort, but also in reducing the risks associated with premature discharge.

Increased time for Aboriginal patient contact

Having an AHW on the ward also increased the time available for patient contact due to the extra resource allocation. Without the AHW, CR nurses were only able to visit the ward in the morning, which meant if an Aboriginal patient was absent or busy during the ward round, or admitted at lunch and moved into discharge early the next day, they could miss being given information about CR. As the AHW visited the ward twice a day she had twice as many opportunities to provide heart health and CR education to Aboriginal patients.

Improving Aboriginal identification

The under-identification of Aboriginal patients is a major issue in health information collection systems.²⁴ While there are various reasons for this (such as Aboriginal people not identifying them-

selves due to fear of racism), identification is critical if hospitals are to ensure all Aboriginal patients have access to culturally appropriate support and care.^{25,26} Qualitative responses suggested that having an AHW on the ward improved Aboriginal identification. Community knowledge meant the cardiology AHW was less reliant on hospital admission data, and able to identify some Aboriginal patients when looking at their surnames on the inpatient board. While the evidence for this is limited, the AHW's alternative capacity to identify patients suggests the potential for improvement in ensuring Aboriginal patients have access to cultural support.

Cultural education to other staff

Part of the AHW's role was to deliver monthly cultural awareness sessions to hospital staff. While these sessions were beneficial, it appears that the practical, hands-on knowledge staff acquired from working alongside the AHW was far more significant. The AHW explained how the sharing of information afforded staff deeper understanding of the real life challenges facing Aboriginal patients:

... there are little things in daily discussion I would tell the nurses. Like, out in the community, their medications get stolen and you need to factor that in to their care plan ... and it was shock, like "Really, does that happen?" (AHW: 40)

For staff, these fluid and informal knowledge exchanges were critical not only in terms of improving patient care, but also in enhancing their appreciation of Aboriginal people. One nurse told:

I got a better appreciation for Aboriginal people. I realised how important family is to them, and I'm a lot more empathetic about their community difficulties. (Nurse: 49)

These responses suggest that workplace partnerships between AHWs and other staff build practical knowledge regarding delivering culturally appropriate care that is more effective than formal cultural awareness training.

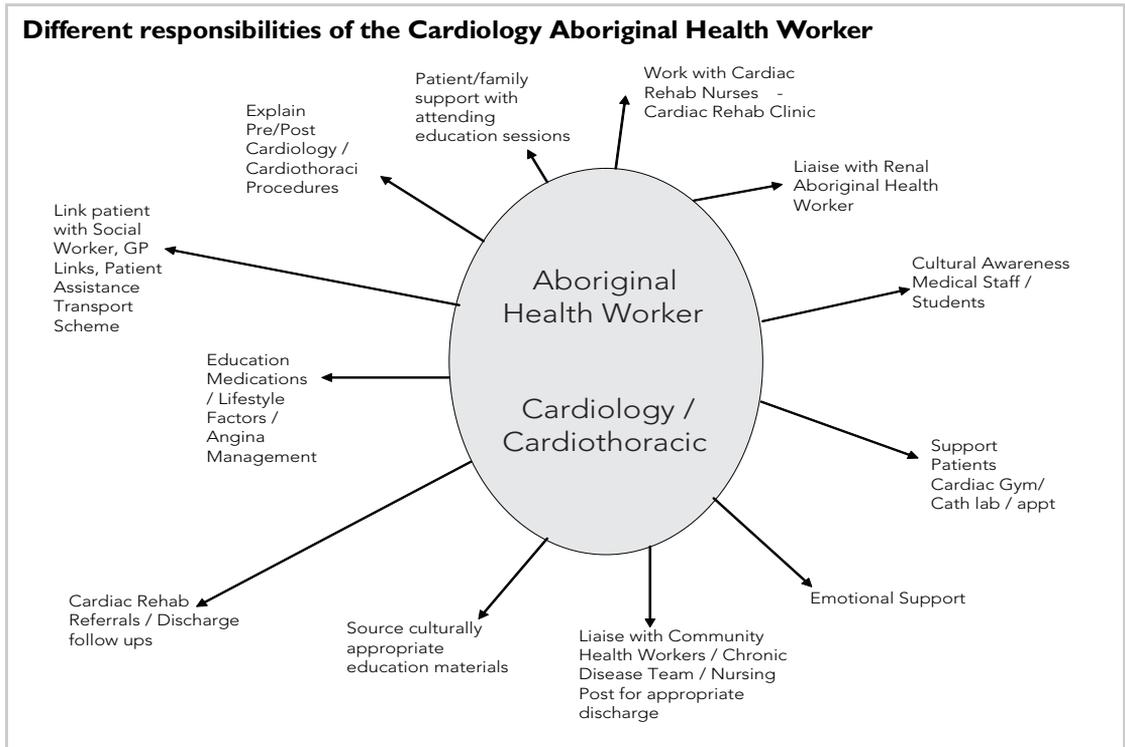
Impact on outpatient follow-up

Studies have shown that telephone follow-up is particularly important in improving coronary risk profile following hospitalisation,²⁷ increasing patient engagement in CR programs²⁸ and enhancing compliance to a wide range of risk-reducing interventions.²⁹ The increase of telephone follow ups to Aboriginal patients by the AHW was reported by staff as one of the critical gaps filled during her tenure. Fifty Aboriginal patients were followed up by phone (with 18 receiving >3 calls) by the AHW, compared with seven (with two receiving >3 calls) during the 6 months before the AHW's placement. For Aboriginal patients coming from outside the metropolitan area, the AHW was also an important link with health services and other AHWs in terms of referrals and patient support. Although assessing the impact of the AHW position on CR uptake is limited due to the short time of the intervention, the increase of telephone follow-up and linkages to primary health care services is arguably fundamental in enhancing the potential of Aboriginal engagement in CR programs.

Lessons learnt

Limitations faced in the cardiology AHW position provide important lessons to hospitals who are considering such placements. Firstly, the AHW training appears to be insufficient in preparing them for a hospital setting. The cardiology AHW reported that unfamiliarity with the hospital environment, coupled with the expectation of explaining complicated medical procedures to patients, created enormous pressure and highlighted a sense of feeling undertrained for hospital work. On the other hand, the clinical capacity of the AHW was restricted in the hospital compared with the AHW training, resulting in a degree of job dissatisfaction:

when I went for the interview they said that it was education and some clinical, but when I got there it was just education. I have not done any clinical ... Even though you've had all this training ... I mean, I can do injections but I'm not allowed to, and I'm thinking, "Bugger this". (AHW: 40)



Until very recently, there was no national uniformity regarding the role and responsibilities of AHWs, and how the role fitted alongside other members of the workforce.³⁰ The ambiguity of the role has been particularly highlighted in hospital settings, where the opportunities for AHWs to use their clinical skills are limited. Confusion of the role of an AHW can prevent effective shared care,⁸ create discomfort both for the AHW and for staff working alongside them, and can undermine the role's importance.

The multiple responsibilities of the AHW's role and the fluidity of these responsibilities in relation to other hospital positions are evident (see Box). For the AHW, poor role definition coupled with the sociocultural needs of Aboriginal patients meant the role easily became more of a social worker, causing one of the primary responsibilities of providing cardiac health information to be impeded:

... because I was the only Aboriginal person pretty much on that ward the education side

of things were put to the side a little bit because they came to me for all their social stuff. (AHW: 40)

Ambiguity around role function, particularly in relation to a social worker or liaison officer, may also have influenced the underutilisation of the AHW's skills, such as in a clinical cultural advisory role in team patient management procedures. Other issues faced in the role included no personal working space, poor remuneration, and limited career pathways.

Recommendations for improving the AHW role in hospitals

There are a number of recommendations for improving the AHW role in a hospital setting. Firstly, before the commencement of ward duties, hospitals must allow adequate time for AHWs to become comfortable within the environment and to provide basic training in medical terminology and procedures. Secondly, supporting the AHW to build collaborations with other Aboriginal health

staff in the hospital is important in terms of providing workplace support and contributing to retention. Thirdly, having a clearer delineation of job role responsibilities is critical in “mainstreaming” the AHW role in the hospital. Research aimed at identifying the practical sociocultural needs of Aboriginal patients admitted to acute care settings may assist clarifying the AHW role compared with other Aboriginal professional roles.¹⁰

Attracting AHWs to the hospital setting and the demands upon them to fulfil multiple functions requires that the specialised role is recognised with appropriate remuneration, a factor that has been identified in the primary health care setting.³¹ It is critical that the AHW feels supported, respected in their role and informed and competent with respect to relevant health information. Further, with research suggesting patients enrolled in programs using multidisciplinary teams will have significantly fewer hospital readmissions than routine care patients,³² inclusion of the AHW in patient team management is critical. Such suitable acknowledgement within the hospital hierarchy is also likely to improve role effectiveness and has significant implications for staff retention.

Finally, sufficient time must be allocated for the AHW to develop and maintain service linkages with primary health care services including Aboriginal Medical Services (AMS). Critical factors in reducing the risks of patient readmission (and secondary complications) are ensuring patients do not fall through referral gaps following discharge, having tenacious follow-up procedures, and improving utilisation of outpatient programs. This is particularly important for rural/remote patients, as a common experience for Aboriginal post-hospitalised patients is poor aftercare and linkage protocols to AMS.³

Limitations

Limitations included the short time period for the intervention (appointment of the AHW) and the fact that the AHW position was new, so naturally inclusion in the medical management of patients and role definition was a work in progress.

Conclusions

Despite the short length of the AHW's tenure and subsequent data limitations, results from this study demonstrate that an AHW has significant impacts on hospitalised Aboriginal patients by improving the cultural security of health care, reducing DAMAs, and improving follow-up practices and linkages to primary health care services. Having the AHW deliver cardiac information to hospitalised Aboriginal patients is also likely to increase participation in CR, supporting the National Health and Medical Research Council's recommendation for the inclusion of AHWs to strengthen CR services for Aboriginal people.³ Consequently, reductions in repeat hospitalisations and mortality following heart attack could be expected as well as potential health service savings. Importantly, the position simultaneously builds the practical cultural safety skills of other staff.

In the current environment of pressure on hospital beds and working towards prompt discharge, there is a critical need that the specialised needs of Aboriginal patients are not neglected.²⁵ With national health statistics showing disproportionate mortality and hospitalisation of Aboriginal Australians, the responsibility for reducing these health disparities requires commitment from the health care system, through an improved service interface and an adequate Aboriginal workforce.³³ Closing the life expectancy gap between Aboriginal and non-Aboriginal Australians³⁴ is a matter of national priority, and results from this study demonstrate that positioning AHWs in hospital settings are a significant link in improving acute and chronic care service impacts for Aboriginal people.

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Competing interests

The authors declare that they have no competing interests.

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