Alberta Health Services

REGIONAL DIVERSITY

DIRECTIONAL DOCUMENT

2008-2012

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Calgary Catholic Immigration Society

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Calgary Drop-In and Rehab Centre

Calgary Immigrant Women's Association

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Calgary Police Service

Canadian Mental Health Association

Capital Health Region, Alberta

Cerebral Palsy Association in Alberta

City of Calgary

Deaf and Hard of Hearing Society

Developmental Disability Resource Centre

Fraser Health, British Columbia

Immigrant Services Calgary

Premier's Council on the Status of Persons with Disabilities

YWCA, Calgary

Executive Summary

As a multicultural country, Canada welcomes immigrants and refugees from a wide variety of cultural backgrounds. In addition to its ever increasing cultural diversity, our country is also home to increasing numbers of Aboriginal Peoples, Persons with Disabilities, Persons living in poverty and experiencing homelessness, Persons with low literacy skills, Seniors, Children, Youth, and Gender and Sexually Diverse Persons.

Calgary is a microcosm of the Canadian mosaic, and the population served by the Calgary Health Region is fast becoming diversely representative.

Although federal and provincial legislation recognize diversity as a fundamental characteristic of Canadian society, health disparities (the population-specific differences in the presence of disease, health outcomes, or access to health care) still exist. Health disparities are well documented as impacting diverse populations, and are often caused by systemic barriers which reduce accessibility of health services for these same groups.

Increasing the diversity competency of health organizations, which includes the recognition and addressing of health disparities and service barriers, results in improved health outcomes for diverse populations. Diversity competency also furthers the realization of social., community, financial., and service improvement benefits.

The Regional Diversity Directional Document articulates the way in which the Calgary Health Region will work to become a proficient diversity competent organization, and a model for other health organizations. In detailing the integrated planning necessary to building diversity competence within the Region, the document highlights the way in which this planning will increase access, reduce barriers and improve health system experiences for diverse populations.

Incorporated in the document are best and promising practices for diversity competency, as well as strategies that make clear the Region's continued commitment to contributing to this growing evidence base.

While written for the years 2008 to 2012, this is a living document that will be reviewed regularly and updated as required.

Diverse Populations

The Calgary Health Region's definition of diversity is broad and, therefore, could theoretically include all people and all populations. For the purposes of this directional document, diverse populations refer to populations who experience health disparities and negative health impacts related to the determinants of health. Specifically, these populations are:

- Immigrants and refugees
- Persons with disabilities
- Gender and sexually diverse persons
- Persons living in poverty
- Persons experiencing homelessness
- Persons with low literacy skills

The Region's Aboriginal Health Program provides a focus for equitable access, culturally appropriate and safe health care to meet the needs of Aboriginal populations.

Accountability

The Regional Diversity Advisory Committee was responsible for providing direction and support for the development of this integrated Regional Diversity Directional Document, while the accountability for implementing this document lies with senior management. Achieving diversity competency is a shared responsibility of all areas throughout the Region. Several formal diversity roles have been established to support, guide and lead the implementation of the work outlined in this document. Specifically these roles are: Healthy Diverse Populations' Manager, Refugee Health and Wellbeing Project Coordinator, Mental Health Diversity Strategist, Diversity Educator, Diversity/Community Liaisons, and Research/Evaluation Diversity Strategist; the Child and Women's Health Diversity Coordinator; the Chronic Disease Management for Diverse Populations Program Manager; the Community Development Diversity Strategist; the Interpretation and Translation Services Manager and Certified Health Care Interpreters.

Evidence, Benchmarks and Indicators

The Region has been helping to build the evidence base for diversity competency for a number of years through the process of implementing and evaluating a wide range of programs. In addition, a number of documents developed by the Region have helped to establish and expand the evidence base.

The Regional Diversity Advisory Committee has developed and ratified six Gold Standard Benchmarks, drawn from research conducted in 2008 identifying best, and promising practices in diversity and cultural competency at the organizational level and the health care service delivery level. The benchmarks are:

1. Regional policies and standards relevant to diversity are aligned with the principles of diversity.
2. Diversity is embedded in all environments, programs, processes, and communications.
3. A workforce, within all levels of the organization, that is reflective of the population served.
4. Diversity competency is a process of continuous quality improvement.
5. Reciprocal relationships with diverse populations enable shared responsibility in addressing the determinants of health.
6. Diversity competency and practice is built on a foundation of existing evidence and/or through the creation of evidence that engages diverse populations.

The process of becoming a diversity competent organization is evolutionary and requires continuous organizational self-assessment, planning, action and evaluation. The Region will measure itself against a series of indicators linked with the gold standard benchmarks. A five-level Continuum of Organizational Diversity Competency is under development by the Region. When complete, this continuum will include descriptions and indicators for each level ranging from "novice" to "proficient" diversity competent organizations.

Diversity Action Plan and Logic Models

The Regional Diversity Action Plan, which describes the overall goal of the Region in relation to diversity, identifies seven priority action areas for planning:

- Building organizational capacity
- Strengthening community action
- Consultations
- Interpretation and translation services
- Accessible and equitable services
- Diversity competent workforce
- Representative workforce

Individual Logic Models have been developed for the seven priority focus areas, each identifying the required inputs, activities, outputs and outcomes. The logic models will be responsive to ongoing assessment. As a result, activities may change over time, although priorities shall remain relatively consistent.

The Regional Diversity Action Plan and Logic Models provide the framework for the Region's diversity initiatives and related work expected to occur over the next 10 years. The indicators of success, which were derived from literature, allow for analysis of the Region's overall performance as it relates to diversity competency.

1 Introduction

The demographic structure of the Calgary Health Region is rapidly changing and this trend is projected to continue in the future. Aside from the increase in culturally diverse populations, demographic changes are also evident in terms of age, religion, ability, socio-economic status, and sexual orientation. The population served by the Health Region is becoming increasingly diverse. Health disparities in diverse populations are well established. These disparities are often a result of systemic barriers (including communication barriers, prejudice and discrimination, insensitivity to diverse beliefs, and mistrust of the health care professionals). These barriers affect the accessibility of health care services by vulnerable groups. In addition, though federal and provincial legislation recognize diversity as a fundamental characteristic of Canada, many diverse persons experience discrimination, inequitable treatment, and exclusion in various aspects in life, including challenges in accessing health care services and employment opportunities. Recognizing and addressing these disparities and service barriers would thus produce organizational benefits, including social., community and service improvements. Financial benefits have also been documented: when diversity competent services are provided, costs to the health care system are lower than those incurred when diversity issues are not recognized and addressed in a competent manner (*U.S. Department of Health and Human Services, 2001*).

Regional Diversity Vision and Mission

Vision: Healthy diverse communities

Mission: To become a proficient diversity-competent organization that is a model for other health organziations.

The Calgary Health Region recognizes that diverse populations experience health disparities which are influenced by a number of factors, including barriers to accessing health services. The Region also recognizes that increased diversity competence within the organization will result in a reduction of health disparities experienced by diverse populations. The Regional Diversity Directional Document is intended to guide the Calgary Health Region as it works to become a proficient diversity competent health organization demonstrative of best or promising practices across the continuum of care. This directional document explains the integrated planning necessary to achieve diversity competence within the Region and the way in which this planning will increase access, reduce barriers and improve health system experiences for diverse populations. While written for the years 2008 to 2012, this is a living document that will be reviewed regularly and updated as required.

Definition of Diversity

The Calgary Health Region defines diversity as ***all the ways we are unique and different from others.*** Dimensions of diversity include, but are not limited to, aspects such as race, religion and spiritual beliefs, cultural orientation, colour, physical appearance, gender, sexual orientation, ability, education, age, ancestry, place of origin, marital status, family status, socio-economic circumstance, profession, language, health status, geographic location, group history, upbringing and life experiences.

The vision for Regional Diversity is ***healthy diverse communities*** and the mission is ***to become a proficient diversity competent organization that is a model for other health organizations***. To successfully address the health disparities experienced by diverse populations (including the impact of the determinants of health), systemic changes are required. The ultimate goal of this directional document is to improve the health of diverse populations through the integration of diversity principles into the Calgary Health Region's daily business. Although several Region staff members have formal diversity-related roles, diversity competence is a shared responsibility of all areas within the Region. Diversity competency is a mind set that must be adopted by every individual and every part of the health system.

As "leaders in health - a partner in care," the Region assumes a role in informing and advocating for diversity competency among other health organizations and sectors.

Diversity Competency

Diversity competency is vital to ensuring effective and responsive services for diverse clients, families and communities. A diversity competent health organization responds respectfully and effectively to people of all diverse backgrounds in a manner that recognizes, affirms and values the differences, similarities and worth of individuals, families and communities while protecting and preserving the dignity of each. More specifically, a diversity competent health care organization:

- Holds diversity and equitable services in high regard
- Continually assesses competence of structures, policies and practices
- Expands diversity knowledge and resources
- Adapts service models to accommodate unique needs
- Creates and seeks meaningful engagement of diverse people in decisions that affect their health and the health of members of their family, community and other citizens

Definition of Diversity Competency

The Calgary Health Region defines diversity competency as the ability of individuals and systems to respond respectfully and effectively to individuals, families and communities of all diverse backgrounds in a manner that protects and preserves their dignity and recognizes, affirms, and values differences, similarities and worth.

Regional Diversity Advisory Committee, Calgary Health Region

Diversity competency is an ongoing process. As the Calgary Health Region strives to become a diversity competent health organization, a range of indicators will provide the rubric through which progress can be assessed. When areas for improvement are discovered, services and systems will be modified to better performance and outcomes. Our commitment to improving the health of diverse populations is shared across all Regional departments and services; however the accountability for implementing or ensuring implementation of this document lies with senior management.

Guiding Principles

The principles that will guide the Region as it strives for diversity competency are outlined below. These principles are manifested in every level of service delivery and are reflected in attitudes, knowledge, practices, structures, policies and services. The principles are:

- Diversity is valued
- Organizational culture is one of inclusiveness and respect
- Organizational capacity for diversity competency is achieved through self-assessment
- Diversity competent health care organizations are made up of diversity competent individuals
- Access to health and employment services is equitable for all diverse populations
- Service delivery is adaptable, is reflective of diversity and is flexible to accommodate various aspects of diversity and the evolution of the community
- Program and policy development, delivery and evaluation is achieved via participatory processes, wherever possible, through the involvement of staff, volunteers, partners and relevant external communities and organizations representing diverse populations
- Diversity knowledge is integrated into practice
- Diversity competency is a shift in awareness, understanding, and skill that is relevant to all staff
- Practice is evidence-based
- Diversity is viewed as a strength

Diverse Populations

The Calgary Health Region's definition of diversity is broad and, therefore, could theoretically include all people and all populations. For the purposes of this directional document, diverse populations refer to populations who experience health disparities and negative health impacts related to the determinants of health.

Specifically, these populations are:

Immigrants and refugees: Immigrants are people who are involved in the process of immigration or who have settled temporarily or permanently in another country. Refugees are people who are forced to leave their country of origin and are unable to return due to environmental factors or a well-founded fear of persecution for reasons of ethnicity, religion, nationality, and membership in a particular social group or political opinion (adapted from *Citizenship and Immigration Canada, 2008a*).

Persons with disabilities: Persons who have a long-term or recurring physical., developmental., sensory, psychiatric or learning impairment and who consider themselves to be disadvantaged by reason of that impairment (adapted from *Canadian Human Rights Commission, 2007*).

Gender and sexually diverse persons: All people who identify themselves as being gender and sexually diverse. This includes but is not limited to people who are lesbian, gay, bisexual., queer, inter-sexed, transgender, and two-spirited *(Calgary Health Region, 2007a*).

Persons living in poverty: A condition of the human being where one does not have sufficient economic and other resources to live with the dignity, choices and power which support full participation in society (from Vibrant Communities Calgary, 2007a).

Persons experiencing homelessness: People who do not have a permanent residence to which they can return whenever they choose (from *Calgary Committee to End Homelessness, 2008*).

Persons with low literacy skills: People who do not have the ability to understand and use reading, writing, speaking and other forms of communication as ways to participate in society and achieve goals and potential (from *Canadian Public Health Association* (n.d.), as cited in *Rootman & Gordon-El-Bihbety, 2008*).

In addition to these specified populations, there are other groups who may experience compounded disparities resulting from other factors, or a combination of factors, such as age (being at the younger or older end of the age spectrum), addictions, mental illness and chronic disease. Although these areas have not been prioritized as part of formal diversity programs and services, we recognize that diversity issues are encountered on a daily basis by frontline staff. This document provides broad strategic intent while other areas within the Region are addressing the needs of these populations more specifically. For example:

People experiencing mental illness and addictions: Work is being done across the Region to address barriers for people experiencing mental illness and addictions. Mental Health and Addictions Services is a comprehensive continuum of approximately 88 dedicated services within the Calgary Health Region with approximately 50 additional contracts for services in the community, funded in whole or part by the Calgary Health Region. These services support an integrated approach to care and works closely with all other areas of health to ensure accessibility, coordination and a quality care experience for clients and families.

Seniors: Work is being done across the Region to address barriers for seniors, e.g., web-based learning modules to increase the knowledge and skills of staff working with older adults so they are able to adapt their care of older adults.

Families in disadvantaged circumstances: Work is being done across the Region to address barriers for families in disadvantaged circumstances, e.g., Best Beginning, a prenatal program offered to pregnant women with a low income and to pregnant teens, aims to reduce the incidence of low birth weight babies and to give babies a better beginning in life. It also helps families access services and provides childbirth preparation information in first languages with special cultural emphasis. The program involves group education and discussion and support through individual contact with a nurse, nutritionist, and social worker. Best Beginning also uses alternative education strategies to deliver prenatal information and childbirth preparation (in first languages) in alternative locations (homes, temples, mosque, community agencies, and resources centers), and in culturally sensitive ways.

Aboriginal Peoples: The Calgary Health Region has a dedicated Aboriginal Health Program designed to meet the unique needs of those communities through focus on equitable access and culturally appropriate and safe health care. The need

to consider the Aboriginal community as separate from other diverse populations is recognized at the federal., provincial and municipal levels. For further information, see www.calgaryhealthregion.ca/programs/aboriginal/index.htm.

Regional Diversity Directional Document

The Regional Diversity Directional Document evolved from the Regional Diversity Strategic Plan. The Regional Diversity Strategic Plan, developed in 2004, sought to outline a strategy that addressed diversity for the period from 2004 to 2008. This plan expanded on the Blueprint for Enhancing Cultural Competency in the Calgary Health Region (April 2002) - a founding document, which broadly identified the direction to take in addressing the needs of the Region's growing diverse populations, including long and short term goals / targets.

This Directional Document incorporates best and promising practices for achieving diversity competency and identifies how the Region will itself contribute to this growing evidence base. It reflects current thinking about a broadened comprehensive view of diversity, about the continually changing demographics of the populations served, about Regional approaches to diversity and the emerging trends in diversity competency. While the document outlines the strategic intent for the period from 2008-2012, the logic models will be reviewed and updated on a continual basis. Logic models articulate how the Region will strive for diversity competence over the next several years (see Section 7). These models are dynamic and will be reviewed according to changing strategic priorities and in reflection of performance against goals. As strengths and weaknesses are identified, and new needs emerge, amendments will be made.

Alignment with the Calgary Health Region

A number of Regional documents support the need for an integrated diversity strategy and were considered in the development of this Regional Diversity Directional Document:

Regional Health Plan 2006-2009

Includes the Region's comprehensive workforce strategy, which takes into account respectful workplaces and a diverse employee population.

Strategic Service Plan 2006-2010

Acknowledges the Region's increasingly diverse community and the need for diversity consideration in all realms. Customized service to meet specific community needs in certain geographic areas is clearly identified.

Community Service Development Strategy

Shows a commitment to shifting the emphasis of the health care system towards systematic decision-making, streamlining services and targeting services to meet community needs, incorporative of strategies that address the determinants of health and diversity.

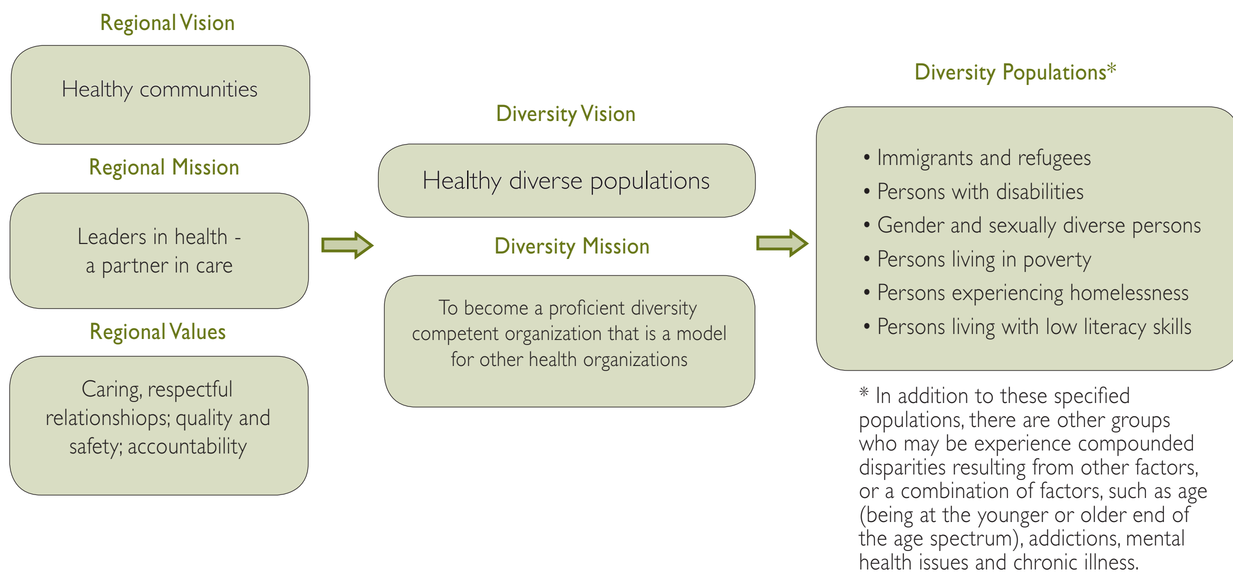
East Calgary Health Services Planning Project Report

Responds to the disparities of vulnerable communities identified in the 2005 Health of the Region Report.

Health of the Region Reports and Population Health Strategic Plan

Identify several diverse populations most at risk of suffering a greater burden of illness and/or of becoming ill and not receiving appropriate care, and review the barriers obstructing access (by these disadvantaged populations) to health care services.

Incorporating concepts from these guiding documents and aligning with the Regional direction in general (illustrated as follows) will enable continued growth in diversity competency, ensuring it becomes a strongly integrated and highly important aspect of the Calgary Health Region.



2 Diversity in the Region

As the composition of the Canadian population continues to diversify, so too do the populations served by health organizations. As a multicultural nation, one in five Canadians is foreign-born (19.8%), the highest proportion in 75 years (*Statistics Canada, 2007a*). However, diversity is a broad term and is not limited to cultural diversity alone. As indicated earlier in the document, diversity (according to Calgary Health Region) encompasses all the dimensions which would make an individual unique and different from others. Currently, the Calgary region serves over 1.2 million people (*Calgary Health Region, 2008*), a significantly diverse population in terms of ethnic origin, cultural orientation, language, socioeconomic situation, and age distribution. As well, the population is diverse in terms of age, religious affiliation, disability, and sexual orientation.

According to Statistics Canada (2007b) smaller proportions (20%) of Canadians were living in rural areas compared to urban areas (80%) in 2006. Statistics Canada defines rural areas as those areas outside urban centers with a population of 10,000. Small town and rural areas grew by 1% between 2001 and 2006, after declining by 0.4% between 1996 and 2001. The rural population in Alberta grew 3.8% between 2001 and 2006, the fastest growth in any Canadian province. In rural areas close to urban centers, population growth was close to the national average between 2001 and 2006; however, there had been a decline in population growth in remote rural areas. In the same period, the urban growth rate in Alberta (in the north-south corridor from Edmonton to Medicine Hat, including Red Deer and Calgary) was higher than the national average of 5.4%. Between 2001 and 2006, Calgary's population increased by 13.4%, the second highest among Census Metropolitan areas. Edmonton's population grew by 10.4%, (fourth highest in Canada).

Demographics of Diverse Populations

Immigrants and Refugees

Immigrants

Canada's foreign-born population is growing at a rapid pace, increasing by 13.6% between 2001 and 2006 (as compared to a 3.3% increase in the Canadian-born population during the same period) (*Statistics Canada, 2007a*). The composition of immigrants is shifting; in 1971, 61.6% of immigrants to Canada were of European descent, but in 2006, this figure dropped to 16.1%, with individuals of Asian descent comprising 58.3% of the immigrant population (*Statistics Canada*).

According to the 2006 Census, Alberta is the fastest growing province in Canada. Its population increased by 10.6% between 2001 and 2006, double the national growth rate (+5.4%), accounting for over 3 million Albertans (*Statistics Canada, 2008a*). In the first three months of 2008, Alberta's population increased 0.41%, even though inter-provincial migration declined in this period (*Statistics Canada, 2008b*). The main source of population increase in the province was new immigrants and non-permanent residents. In the first quarter of 2008, 5,300 immigrants and 4,000 non-permanent residents came to Canada (*Statistics Canada, 2008b*). Out of the total immigrants in Alberta,19.7% were recent immigrants, (i.e. have been in the country for 5 years or less).

Calgary's population grew 13.4% between 2001 and 2006 *(Statistics Canada, 2008c*), with 5.4% attributed to recent immigrants. Of 23.6% that is Calgary's total immigrant population, 22.9% were recent immigrants (*Statistics Canada*). According to Citizenship and Immigration Canada (CIC) (*2008b*) Calgary continues to be the fourth choice of destination for new immigrants. Recent statistics released for permanent residents in the country show that 8.8% of the total immigrants in Canada in the year 2007 selected Alberta as their new home with 4.7% choosing to settle in Calgary (*CIC*). The data also indicated an increase in new immigrant settlers in Red Deer and other Alberta regions. According to *Health Atlas* (*Calgary Health Region, 2007b*), 3.5% of recent immigrants settled, in two East Calgary social districts; 9 (8.0%) and 3 (6.8%). In 2001, 3.6% of recent immigrants settled in Calgary, and 2.8% had selected the Capital Health Region as their new home.

Newcomers to Canada are more likely to report a first language other than English; nearly three-quarters (70.2%) of the foreign-born population reported a mother tongue other than English or French in 2006, with 18.6% reporting Chinese languages; 6.6% Italian; 5.9% Punjabi; 5.8% Spanish; 5.4% German; 4.8% Tagalog; and 4.7% Arabic (*Statistics Canada, 2007a*).

The Health Atlas (*Calgary Health Region, 2007b*), based on 2001 Census, indicates that Calgary's North-East quadrant (social districts 3 and 6 reports over one-third of its population spoke neither English nor French as a first language. 18% of the population in the Calgary Health Region reported neither of Canada's official languages as their first language. Calgary's percentage was higher than Canada's, but slightly lower than the Capital Health Region.

In addition, 13.9% of Alberta's population was a visible minority in 2006, compared to 16.2% in Canada (*Statistics Canada, 2008a*), and 22.2% in Calgary (*Statistics Canada, 2008c*). The four largest visible minority groups in Alberta were: Chinese (3.7%), South Asian (3.1%), Filipino (1.6%), and Black (1.4%), while in Calgary, the four largest visible minority groups were: Chinese (6.2%), South Asian (5.4%), Filipino (2.4%), and Black (2.0%) (*Statistics Canada*).

In 2001, the majority (89%) of Canada's total immigrant population lived in urban areas (*Beshiri, 2004*). During the same period, most new immigrants reported residing in urban areas, with only around 12,000 of the new immigrants living in rural regions. Immigrants who settled in rural areas tended to prefer higher-income provinces (British Columbia, Ontario, and Alberta) and the Yukon. The study found that 16% of all rural immigrants were a visible minority. According to the 2006 Census, 96% of all visible minorities in Canada live in urban census metropolitan areas (as compared to 68.15% of Canada's total population) (*Fenlon, 2008*).

According to Bernard (2008), vulnerable immigrant groups (such as immigrants and refugees with a lower level of education) integrate rapidly in small, less urbanized areas. He found that immigrants with a high school or lower level education earned 46% less in very large urban areas, whereas in small towns or rural areas this income gap was 23%. The income gap shrinks very slowly in large cities: even after 13 years, the gap was still 20%. On the other hand, the income gap shrunk to less than 10% by the fifth year in small towns and rural areas.

Refugees

In 2008, there were approximately 11.4 million refugees around the world (*CIC, 2008c*). Operating under resettlement programs, refugees from 70 different nationalities were resettled in Canada in 2007 (*CIC*). According to the Government of Canada, 4,025,546 people migrated to Canada between 1979 and 2001, out of which 15.4% were refugees (as cited in *CBC, 2008a*). Of these refugees, 56.7% were government sponsored and 43.3% were sponsored privately.

100,000 refugees are annually resettled in 19 countries around the world and 10% of these refugees were resettled in Canada as permanent residents (*CIC, 2008b*). In 2007, 11.8% of refugees became permanent residents in Canada.

Refugees in our small towns and rural areas represent only 5% of immigrants to Canada. Findings show that refugees living in small urban areas, smaller cities, and rural areas tend to integrate well and more rapidly from an economic standpoint, regardless of their country of origin or official language competency (*Bernard, 2006*).

Persons with Disabilities

A significant share of the Canadian population self-identifies as having a disability. According to the 2006 Participation and Activity Limitation Survey (PALS) (*Statistics Canada, 2008e*), more than 4.2 million individuals aged 15 and over had some form of disability. Approximately 511,670 individuals were severely disabled and in need of assistance. Of these individuals, 41.3% used assistive technology for their needs, as compared to 75.9% of those who had a mild disability. The survey also found that over half of those with more severe disabilities have some unmet needs, as compared to 75.9% of those with mild disabilities. According to Literacy Alberta (2005) approximately 10% of Canadians have a learning disability and a vast majority of these individuals have difficulty learning to read.

According to the Office for Disability Issues (2006) approximately 15% of Albertans are living with a disability, the third lowest disability rate among 15-year-olds and older in Canada. The three most common disabilities identified were related to pain, mobility, and agility. Seniors appear to be most affected by disabilities among the 15 and older age group. 56% of adults aged 75 and over reported having some form of disability as compared to 35.3% of those aged 65 to 74 years (*Office for Disability Issues, 2006*).

Albertans with disabilities have the second highest employment rate in Canada. 55.6% of those between the age of 15 and 64 were either employed or were actively seeking employment. The report (*Office for Disability Issues, 2006)* does indicate a clear disadvantage for the disabled in attaining university level education. For example, 12.7% of females with a disability had a university degree, compared to 19.9% of females without disabilities.

The percentage of persons with a disability living in Calgary is likely higher than the provincial percentage as more services are available in an urban setting (*Personal Communication, Premier's Council on the Status of Persons with Disabilities, 2008*).

According to a background paper released in September 2004, approximately 31,500 Albertans were receiving Assured Income for the Severely Handicapped (AISH) payment (*Keenbon, 2005*). Most of the disabilities of AISH receivers were 'invisible' but permanent and debilitating in nature: 45% of AISH receivers had a physical disability, while 23% had a developmental disability, and 32% had a chronic mental illness. Among AISH payment receivers, 52% were between 40 and 59 years of age, 37% were between 18 and 39 years old, and approximately one in every 10 (11%) AISH recipient was between 60 and 65 years of age (*Keenbon*).

Gender and Sexually Diverse Persons

Estimates of the proportion of the Canadian population self-identifying as bisexual or homosexual range from 1.7% (*Statistics Canada, 2004*) to 8.1% (*Personal Communication, Wilde Marketing, 2005*). Literature indicates that often it is difficult to get accurate information on a sensitive topic from research participants (*Snowden, Wichter, & Gray, 2008*). There is a possibility the marginalized and vulnerable groups may feel threatened or apprehensive in revealing personal information. According to Statistics Canada (*2004a*), 1.0% of Canadians between 18 to 59 years of age were homosexual and 0.7% were bisexual. 1.3% of men perceived themselves as homosexual compared to 0.79% of women. More women (0.9%) than men (0.6%) considered themselves to be bisexual (*Statistics Canada*). Approximately 362,000 Canadians aged 18 years and older (1.5%) reported as being gay, lesbian or bisexual (*Beauchamp, 2008*).

1.2% of Albertans considered themselves to be homosexual or bisexual (*Statistics Canada, 2004a*). It is estimated that at between 5 and 10% of Calgarians identify as sexual minorities (*Calgary Outlink: Centre for Gender and Sexual Diversity, n.d.*).

A comparison between the health related needs of heterosexuals, homosexuals and bisexuals indicates that homosexuals and bisexuals had more unmet health related needs (21.8%) than their heterosexual counterparts (12.7%), (among 18 to 59 years age group). In general., homosexuals and bisexuals reported finding life stressful more often than heterosexuals (*Statistics Canada, 2004a*).

Persons Living in Poverty

According to Statistics Canada (2008e), in 2006 approximately 3.4 million Canadians (10.5%) were living in low income households (after taxes). 11.3% of Canadian children (under the age of 18) were residents of a low income household. Among these children, 40% were living in a single parent family and close to 33% were living with a single mother. In 2006, low income families on average needed $7,000 to move above the low income cut-off (LICO).

Despite Alberta's booming economy, 9.1% of Albertans live in poverty or in low income households (*Statistics Canada, 2008a*). 10.3% of Alberta's children are living in low-income households, and in the Calgary Health Region over a quarter of individuals living in social district 9 (28.1%) and social district 10 (25.2%) were living below the LICO in 2001 (*Calgary Health Region, 2007b*). The total proportion of population living below LICO in the Calgary Health Region in 2001 was 13.3%. 16.2% of Canadian residents were living below LICO.

On average, incomes in rural Canada were lower than in urban areas (Laurent, 2002). This income gap decreased by 16% between 1980 and 1995; however, in 2000, rural regions had higher unemployment rates (7.2%) compared to urban areas (5.4%) (*Laurent*). Between 2000 and 2006, the employment rate in Canada rose 12.6%, but the employment rate in smaller urban and rural regions was only 9.6% (*Statistics Canada, 2007c*).

Fortin (2008) found that in 2003, the proportion of the working poor in both rural (8.6%) and urban (7.8%) areas was similar. For both these groups, family income was approximately 30% below the LICO, however, low income workers had different profiles, depending on where they lived. The study showed that poor rural workers were more likely to be older in age, to be living in dual-income families with children and had a lower probability of holding a university degree (*Fortin*). The same author reported differences in the labour marker characteristics of the poor rural and urban workers. The rural working poor on average worked 300 hours more per year, had more work experience, and were also more likely to be self-employed that their urban counterparts. The rural poor workers were also less likely to receive Social Assistance benefits (7%) than urban poor workers (13%), and more salaried rural workers (30%) reported receiving Employment Insurance (EI) benefits than their urban counterparts (20%). Rural to urban migration seems to improve economic outcomes for the working poor. The reverse was not true.

The income gap between rural and urban populations decreased between 1980 and 2000 (*Statistics Canada, 2004b*). Average incomes in rural Canada increased in the past two decades, often at a faster rate than average incomes in urban regions. Therefore, the rural population living in low income conditions decreased more than the urban population living in low income conditions. In predominantly rural areas, the average income increased 25.7% from 1980 to 2000. In predominantly urban areas the average income grew 21.6% in the same period.

Persons Experiencing Homelessness

There is a lack of accurate homelessness statistics in Canada because Census data is representative of only those living in a shelter when Census surveys are conducted (*Turnbull, Muckle, & Masters, 2007*). The Census data excludes those living in motels, transiently with friends, at a YMCA or a YWCA, or on the street (*Turnbull et al.*). Despite the lack of data, it is evident that there has been a substantial increase of homelessness in the nation. For example, in Calgary, the homeless population increased 32% between 2004 and 2006 (*City of Calgary, 2006*).

Documented evidence reveals a changing and increasingly diverse face of homelessness. In the past, overwhelming proportions of the homeless were alcoholic single men. In recent years the proportion of children, adolescents, single mothers, families with children, underemployed, seniors, and recent immigrants experiencing homelessness has increased (*City of Toronto, 2001; City of Calgary, 2006; Turnbull et al. 2007*).

Homelessness in Calgary was a relatively rare phenomenon in the early 1990s; however, a number of changes in Calgary caused a dramatic rise. Increased migration to Calgary, a decline in real earnings for those with low incomes, and a growing scarcity of affordable housing put the vulnerable at risk of, or into, homelessness. Government and social service barriers have also impacted the most vulnerable of the homeless (*Calgary Committee to End Homelessness, 2008*).

Homelessness in Calgary has risen a staggering 650% in the last decade. Along with this rate jump came increasing severity: between 1997 and 2002 the percentage of people who reported being homeless for over a year more than

doubled. Equally disturbing is the fact that about half of the homeless people in our city have jobs, but still cannot afford to house themselves (*Calgary's 10 Year Plan to End Homelessness*).

The bi-annual count of homeless people in the City of Calgary (*City of Calgary, 2008*) found more than 4,000 Calgarians were homeless, an 18.2% increase since 2006. The number of people living on the street also increased 14% in the same period. The survey found that close to 200 of these Calgarians were families and 96% of those homeless families included children. Significant demographic characteristics of the homeless include 78% male; 62% Caucasian, 15% Aboriginal and 11% visible minorities; 43% working age (aged 25-44) and 29% middle-aged (45-64). 11% of the enumerated homeless were 17 years old or under and 2% were aged 65 years or older.

There is a lack of demographic information related to homelessness in rural communities in Canada. According to HRSDC (2007), these communities often do not have the capacity to deal with homelessness issues. As a result, homeless individuals or those who are at risk of homelessness frequently move to urban communities.

Persons with Low Literacy Skills

Past research has established a link between literacy, level of education and health status (*Canadian Council on Learning, 2007; Center for Health Care Strategies, 2005; Karmakar & Breslin, 2008*). Literacy skills play an important role in social., economic, and political issues (*Corbeil, 2006*), impacting functioning capacity in the economy as well as society (*Sen, 1999*).

Although literacy rates specific to Calgary are not available, Canadian literacy information reveals that a substantial number of adults in Canada have low levels of literacy: Canadians over the age of 16 scored 48% below the minimum level of knowledge and skills needed to understand and use information from text, and to locate and use information contained in materials. 55% scored below the minimum level of knowledge and skills required to apply arithmetic operations embedded in printed materials (*TD Bank Financial Group, 2007*).

Young working people and those with advanced levels of education have higher literacy levels while seniors tend to have lower levels of literacy. Lower levels of literacy are also found among people whose mother tongue is neither English nor French, as well as people who are not in the labour force (*Rootman & Gordon-El-Bihbety, 2005*).

Poor youth literacy is known to contribute to high school drop out rates, long-term unemployment and higher crime rates. Weak adult literacy contributes to poverty and to Canada's dismal productivity performance. Poor literacy in English and French amongst immigrants severely hampers the ability of many new residents to integrate into the Canadian economy and society at a time when their skills are needed more than ever. (*TD Financial Group, 2007*).

Those with low literacy skills are also disadvantaged when it comes to health literacy. Health literacy requires an availability of simultaneous multiple skills (*Canadian Council in Learning*, as cited in *Rootman & Gordon-El-Bihbety, 2008*). Therefore, those with impaired literacy skills must rely on others for assistance (CCL, as cited in *Rootman & Gordon-El-Bihbety*). According to the same study, there is variation in literacy scores across Canadian jurisdictions. The Yukon, Saskatchewan, and Alberta had the highest literacy average in the country, however, each province and territory still had a large number of adults with low health literacy.

According to Health Atlas (*Calgary Health Region, 2007b*), in 2001, 4% of residents aged 20 years and older had less than a grade 9 level of education and 16% had less than a grade13 level of education. At the same time, 22% had a Bachelor degree or higher; 32% had a trade/college/university certificate or diploma, and 26% had high school education. Further, the Region's social districts 6, 10 and 17 had the highest proportion of residents with less than a high school level of education. In social district 17, 10% of the residents had an education level of less that grade 9 and 27% had grade 9 to less than13 level of education. While, in social district 10, 9% had less than grade 9 and 28% had grade 9 to less than 13 level of schooling.

A comparison between the Capital Health Region and the Calgary Health Region shows that the percentage of those who had high school or higher levels of education was greater in the Calgary Health Region (79%) than the Capital Health Region (75%). A further breakdown indicates that in the Calgary Health Region, 5% had less than a grade 9 level of education, versus 6% in the Capital Health Region (*Calgary Health Region, 2007b*).

15% of Canadian–born individuals, aged 25 to 59 years, have not attained a high school diploma. Similar percentages of immigrants have not graduated from high school. On the other hand, a larger proportion of immigrants reported being university graduates (*Beshiri, 2004*). On average, in 2001, immigrants in rural areas reported a higher level of education than their Canadian-born counterparts (*Beshiri*). Interestingly, rural and urban residency seems to have an effect on the education level of both Canadian-born and immigrant residents. In urban areas, 11% of native-born Canadians have not graduated from high school. In comparison to students from urban schools, students from rural schools attained lower reading scores (*Statistics Canada, 2002*). Urban students in Newfoundland and Labrador, Prince Edward Island, New Brunswick and Alberta obtained significantly higher scores than their rural counterparts. However, rural students in Alberta scored higher than the national rural average and exceeded the scores of urban students in some other provinces.

Quick Facts about Calgary's Diversity

Immigrants:

- 23.6% of Calgarians were born outside of Canada.
- Approximately 12,000 new immigrants arrive in Calgary per year.
- 22% of Calgarians were visible minorities in 2006.
- 43.6% of new immigrants to Calgary in 2006 were born in Asia.
- 18% of Calgarians in 2001 spoke neither English nor French as their first language.

Refugees:

- Approximately 1,300 refugees arrive in Calgary each year.
- 1/3 are government-assisted refugees destined to Calgary and are received through the Calgary Catholic Immigration Society; 2/3 are migrants to Calgary (from original destinations in Canada).

Persons with disabilities:

- Nearly 10% of Albertans aged 15 and over report having one or more disabilities.
- Many persons with disabilities live in poverty, or are at risk for living in poverty.
- More than half of Albertans with disabilities aged 15 to 64 are employed.

Gender and sexually diverse persons:

- 5 – 10% of Calgarians self-identify as lesbian, gay, bisexual, queer, inter-sexed, transgender or two-spirited.

Persons living in poverty in Calgary:

- 1/3 of all persons with disabilities, 1/2 of all Aboriginal persons, almost 1/2 of all recent immigrants, close to 1/3 of all visible minority persons, over 1/2 of all single parent families, over 1/4 of seniors, and 1/5 of Calgary's children live in poverty.

Persons experiencing homelessness:

- 4,060 Calgarians were absolutely homeless (living on the street with no physical shelter, including those who spend their nights in emergency shelters).
- The true number of homelessness in Calgary would be probably much higher if the numbers of "hidden homeless" are considered (particularly women, families and youth).

Persons with low literacy skills:

- 40% of Canadian youth and 48% of Canadian adults have inadequate literacy skills.
- Youth from disadvantaged backgrounds, including those from lower socio-economic status, are vulnerable to low literacy.

3 Background Issues

Health disparities in diverse populations are well documented, and are attributable in part to communication barriers, deficits in provider knowledge, insensitivity to cultural beliefs, values and practices, prejudice and discrimination, and client dissatisfaction or mistrust of the health care profession (*Benkert, Peters, Clark & Keves-Foster, 2006; Facione & Facione, 2007; Garroutte, Kunovich, Jacobsen & Goldberg, 2004; Giger et al., 2007; 2007; Pratt & Apple, 2007;*). The goal of diversity/cultural competence in health care is to reduce such barriers and ultimately reduce health disparities, as the following bullets illustrate:

- A review of research conducted by the U.S. Institute of Medicine (2002, as cited in *Callister, 2005*) identified ineffective and inappropriate communication as a leading contributor to disparities in health care among culturally diverse populations.
- Increasing cultural awareness, knowledge and skills of health care providers is associated with the reduction of health disparities.
- Sensitivity to individual diversity in symptom recognition, interpretation and attribution, and in thresholds for seeking care, as well as greater understanding of diversity in health care practices (e.g. use of traditional healers) enhances the provision of health care to diverse populations (*Anderson et al., 2003; Betancourt, Green, Carrillo & Ananeh-Firempong, 2003*).
- Real or perceived discrimination as well as perceptions of intimidation have been shown to result in the delay or refusal of medical treatment (*Anderson et al., 2003; Potocky, Dodge & Greene, 2007; Pratt & Apple, 2007*), while clinical barriers more generally may arise when socio-cultural differences are not accepted or understood (*Betancourt, Green, Carrillo & Ananeh-Firempong, 2003*).

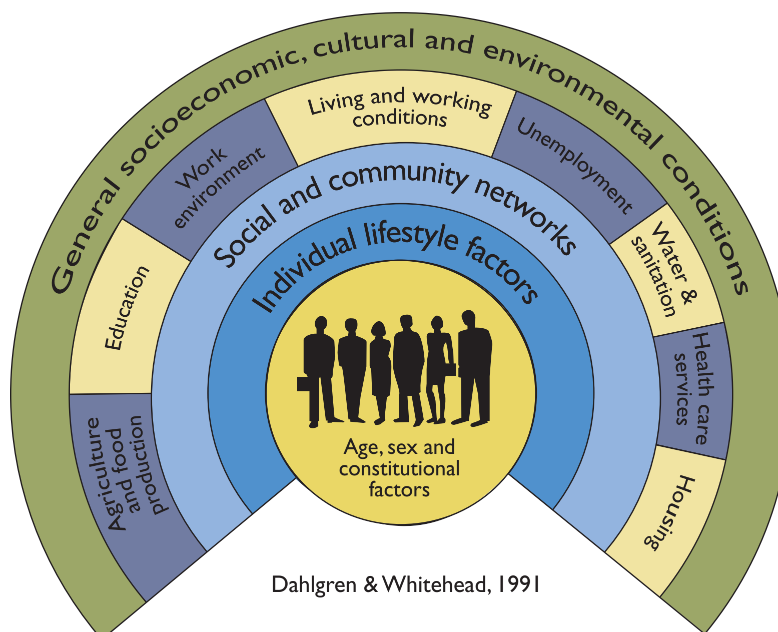
In addition to shifting population demographics and growing awareness of barriers to health care, health care organizations are further motivated to provide diversity/culturally competent care in response to municipal., provincial and federal legislation addressing diversity as fundamental to Canadian society (such as *Canadian Charter of Rights and Freedoms; Canadian Multicultural Act; Alberta Human Rights, Citizenship and Multiculturalism Act; Employment Equity law; City of Calgary Cultural Diversity Strategy*).

Determinants of Health

As illustrated by the following diagram, the health of a community (and the individuals within it) is influenced by many factors including age, hereditary riskrs, individual lifestyle, social and community networks and living and working conditions. These factors, or determinants of health, are unequally distributed throughout the population. Consequently, there are tremendous variations in the health of a population—some people are thriving while others are at greater risk of experiencing poor health, reduced access and poorer experience in the health care system because of the negative impact of the determinants of health on their lives. In addition, the effects of adverse conditions are cumulative, especially during the early years of life.

The Calgary Health Region strives to positively impact the health of the population as a whole and to mitigate the impact of inequities in the determinants of health. Extra effort is made to reduce the barriers faced by vulnerable groups who are at increased risk of experiencing poor health by virtue of their membership in certain sub-groups, including diverse populations.

Determinants of Health



Health and Diverse Populations

Several literature reviews of Canadian publications were completed to provide evidence and information on the health status of diverse populations, and to identify perceived health issues experienced by diverse populations. A summary of these findings is provided as follows.

Immigrants and Refugees

Immigrants

Research into the health of Canadian immigrants is of increasing importance considering Canada's rapid immigration rates and increasing ethno-cultural diversity. Each year, Canada welcomes between 200,000 and 300,000 immigrants and refugees *(CIC, 2008).*

Canadian immigrants are an extremely diverse group in regards to their country of origin, length of stay, socioeconomic status and reasons for migration. These factors are important to consider when investigating the health of this population as they can have a significant impact on the health and lifestyle of an individual. Regardless, immigrants tend to have an overall health status that is better than the Canadian-born population. In general., research shows that immigrants have a lower prevalence of chronic illness, depression and alcohol dependency compared to the Canadian-born population (*Ali, 2002; Perez, 2002*). This said, certain chronic diseases, such as diabetes, cancer, hypertension and heart disease, have been reported at higher prevalence among the immigrant population compared to the Canadian-born population (*Perez*).

Research shows an interesting phenomenon involving the health of immigrants over time. This common trend is termed "healthy immigrant effect" and involves a deterioration of immigrant health status over time. Upon arrival in Canada, immigrants are relatively healthy. However, as the time since immigration passes, the prevalence of certain chronic and mental health conditions increases. Ultimately, the prevalence of certain health conditions tends to mirror or be worse than that of the Canadian-born population. Contributing factors (such as poverty, unemployment, discrimination, difficulties accessing services and language barriers) have the potential to accelerate the deterioration of immigrant health status to a point worse than the general population. This outcome is called "immigrant overshoot."

Newcomers to Canada have basic settlement needs. These include orientation on arrival., accessing employment, enrolling children in school, opening a bank account, and learning language. In addition, refugees may have special health needs as many may have escaped torture and abuse and may have physical., psychological and emotional health issues relating to their experiences.

Immigration and health information specific to the following populations can be found on the Healthy Diverse Populations website at: www.calgaryhealthregion.ca/programs/diversity/index.htm

- Chinese Canadians
- Philippine Canadians
- SouthEast Asian Canadians
- Vietnamese Canadians
- African Canadians

Refugees

Refugees are a special type of immigrant forced to leave their country of origin as a result of political and/or economic unrest. Much of the research to date has incorporated refugees into research on immigrants, therefore, findings indicate that refugees experience healthy immigrant effect and immigrant overshoot much like immigrants who voluntarily resettle in Canada, however, the initial health status of refugees upon arrival to Canada may be significantly worse. It has been stated that the health status of refugees is poorer than that of immigrants in general because of their experiences prior to arrival and the less stringent selection process (*Health Canada, 1999*).

Research shows that refugees are at high risk of arriving to Canada with a number of physical and mental health conditions (*Dillman, Pablo, & Wilson, 1993; Redwood-Campbell et al., 2003; Tribe, 2002*). The possible stress and pre-migration trauma, coupled with separation from family, cultural conflict and communication barriers may contribute to the poor mental and physical health status reported among refugees entering Canada.

Persons with Disabilities

The term "disability" is complex and refers to limitations placed on daily activities and functioning. Disabilities exist in many different forms and severities and therefore can result in a wide range of health complications. In general., individuals with a disability tend to have reduced life expectancy, a higher prevalence of serious health conditions, and increased morbidity and mortality compared the general population (*Bittles at al., 2002; Kerr, 2004*). Co-disability is common, meaning that disability typically coexists with another disease or condition. For example, individuals with Down Syndrome have a greater prevalence of heart defects, skin disorders, thyroid disease and intellectual impairment (*Canadian Down Syndrome Society, 2006*).

According to Statistics Canada (2002), an estimated one in eight Canadians are living with some type of disability. Although disability can affect anyone at anytime in their lives, the general trend indicates that the prevalence of disability increases as one ages. This may be of concern as the large baby boomer population ages. Clinically treating an individual with a disability may be difficult for the health care provider, and can lead to poor communication between the health care provider and the patient. In turn, this can lead to the development of chronic conditions that may have been prevented if detected earlier. For example, a greater number of individuals with disabilities have undetected hearing and vision problems in part due to their inability to communicate health needs.

Mental health problems are common among individuals with any type of disability (*National Advisory Council on Aging, 2004*). An impaired ability to describe psychological symptoms, combined with a lack of clinical expertise in dual diagnosis of disability and mental illness both contribute to the high prevalence of mental health problems among this population.

Little is known about the prevalence and incidence of disability among different ethno-cultural groups. Although Canadian data is somewhat outdated, the Health and Activity Limitations Survey of 1991 indicated that the overall prevalence of disability in the general population was 15.5%, and 31% in the Canadian Aboriginal population (*Health and Activity Limitations Survey, 1991*).

Gender and Sexually Diverse Persons

According to the 2003 Canadian Community Health Survey, 21.8% of self-identified homosexual or bisexual Canadians, compared to 12.7% of heterosexuals, have an unmet health need (*Statistics Canada, 2004a*). While the exact percentage of the population served by the Calgary Health Region self-identifying as lesbian, gay, bisexual., queer, intersexed, transgender or two-spirited (*LGBQITT*) is not known, a rough estimate can be calculated. According to Statistics Canada (2004b), 1.2% of Alberta's population self-identifies as 'homosexual' or 'bisexual.,' however, the number is very likely higher (given that the provincial estimate of 1.2% excludes youth and seniors, and excludes individuals not identifying as homosexual or bisexual but who may otherwise identify as a sexual minority; moreover, the use of the provincial estimate does not account for the higher concentration of LGBQITT individuals in the province's urban areas). If the same proportion is served by the Calgary Health Region (*Statistics Canada, 2001*), almost 13,000 individuals would self-identify as gay or bisexual and of those, almost 3,000 could be said to have an unmet health need.

Studies have shown that experiences of bias, insensitivity, discrimination and inappropriate or inadequate health-related services can result in a distrust of the health care system, potentially leading to avoidance of regular and preventive health care (*Jackson, 2006; Ontario Public Health Association, 2000*). According to the Coalition for Lesbian and Gay Rights in Ontario, an estimated 15% of lesbian women forgo regular health checkups for fear that their sexual orientation will negatively impact the quality of their care (1997, as cited in *Davis, 2000*). A national study conducted in the US recently found that 75% of lesbians (compared to 54% of heterosexual women) had previously delayed obtaining health care and of those, nearly one-third (27%) cited negative past experiences as their main reason for doing so (*Mautner Project, 2005*; see also *Bowen et al., 2004*). Clearly, an understanding of the barriers to health care experienced by LGBQITT individuals will contribute to the development of inclusive and appropriate, or 'diversity competent', health care environments.

Recent studies have found lesbian women three times and bisexual women two times more likely than heterosexual women to report nulliparity *(Case et al., 2004)*, which has been associated with breast cancer (*Cochran et al., 2001*) and ovarian and endometrial cancer (*Davis, 2000*). Tobacco use, associated with cardiovascular disease and cancer, is also more prevalent in these groups, with 19% to 37% of lesbian and up to 50% of bisexual women reporting current smoking behaviour, compared to about 10% of heterosexual women (*Aaron et al., 2001; Case et al., 2004; Cochran et al., 2001; Diamant et al., 2000a; Gruskin, Hart, Gordon, & Ackerson, 2001; Roberts 2001; Tang et al., 2004*).

Lesbian and bisexual women are also more likely than their heterosexual counterparts to be overweight or obese *(Aaron et al., 2001; Cochran et al., 2001; Mravcak, 2006; Valanis et al., 2000)*. A national American study recently found a 50% greater prevalence of obesity among lesbian women and a 40% greater prevalence among bisexual women (Case et al., 2004). Greater participation in vigorous physical activity, however, has also been observed *(Aaron et al., 2001; Case et al., 2004; Mravcak, 2006)*.

There is concern that lesbian and bisexual women are less likely than heterosexual women to undergo routine preventive screening, in part because of a reduced need for birth control that might result in fewer opportunities for routine gynecological care.

HIV/AIDS remains a significant health issue for gay and bisexual men. An estimated 56,000 Canadians were living with HIV/AIDS by 2002 and of those, 58% of cases were among men who had sex with men (*Myers & Allman, 2004*).

Other health issues for which gay and bisexual men are believed to be at greater risk (due to lower rates of preventive screening) include urethritis, proctitis, pharyngitis, hepatitis A and B, syphilis, gonorrhea, chlamydia and herpes (*Peterkin & Risdon, 2003*). This group is also at greater risk for stroke, coronary artery disease and myocardial infarction due to a greater prevalence of smoking (*Tang et al., 2004*). There is also an indication of higher rates of illicit drug use among gay and bisexual men; just 34.5% of gay and bisexual men participating in the Ontario Men's Survey had not used recreational drugs within the previous year (*Myers & Allman, 2004*). Gay and bisexual men may also be at greater risk for eating disorders (*Lee, 2000a*).

LGBQITT individuals tend to be at higher risk for depression and suicide, resulting from lived experiences and internalization of heterosexism and homophobia, as well as experiences with discrimination, stigmatization, social isolation, HIV-related grief and anti-gay violence (*Bockting, Robinson, Benner & Scheltema, 2004; Case et al., 2004; Cochran, Sullivan &*

Mays, 2003; *Gilman et al., 2001; Meyer, 2003; Mravcak, 2006*).

Intimate partner abuse and anti-gay violence constitute significant health risks for LGBQITT persons. According to the 2004 General Social Survey (GSS), 15% of Canadians self-identifying as homosexual have experienced partner violence (as compared to 7% of heterosexuals; *Statistics Canada, 2006a*).

Persons Living in Poverty

The relationship between health and poverty is well established. Researchers have consistently found a strong correlation between life expectancy and socio-economic status (*Marmor, 1986; Marmot, 2004; Evans, Barer, & Marmor, 1994; Health Canada, 1999*). Documented evidence shows that countries with a higher level of income inequality tend to have lower average life expectancy (*Collins & Hayes, 2007*).

Although Canada has a universal health care system, disparities in health and access to care exist (*Stewart, Makwarimba, Barnfather, Letourneau, & Neufeld, 2008*). Low-income persons are one of the most vulnerable groups. Previous studies show that low-income people are less healthy and have more medical conditions when compared to higher income groups (*Mustard et al., 1995; Reutter, 2000*). Despite greater health needs, low-income Canadians are more likely to report unmet health needs or not receiving health care (*Kasman & Badley, 2004; Wilson & Rosenberg, 2004*).

As cited by Raphael (2003), federal as well as provincial governments in Canada have acknowledged poverty as a key determinant of health (*Government of British Columbia, 2000; Government of Ontario, 1994; Hamilton and Bhatti, 1996; Health Canada, 1998*). According to Orpana, Lemyre, and Kelly (2007), low-income households with incomes of less than $20,000 were three times more likely to perceive a decline in their health than individuals with the highest incomes.

A recent Canadian study (*Statistics Canada, 2008f*) found that childhood obesity was more prevalent in Canada's poorest neighbourhoods. Children living in the poorest neighbourhoods gained more weight than children living in middle-class neighbourhoods. Similarly, despite Canada's egalitarian health care policy, Pilote and Associates (2003) found that socio-economic status was a significant factor in patients' access to cardiac procedures after acute myocardial infarction (AMI) in Quebec. The researchers found that patients living in neighbourhoods with lower socio-economic status were less likely to receive coronary angiography when compared to their more affluent counterparts. The likelihood of receiving the procedure varied from 10% to 30%, depending on factors such as gender and time interval since AMI. No significant difference was reported between socio-economic groups and the use of revascularization procedures (done after AMI).

According to Sachs (2001) poverty is often an outcome of poor health, while good health could help in reducing poverty. A relationship between good health and poverty reduction has repeatedly been established in literature. Past findings have shown that healthy individuals are in a better position to gain education, training, and employment and thus have an improved chance of availing economic opportunities to overcome poverty (The Socialist Republic of Vietnam, as cited in *Gien et al., 2007*).

Lower socio-economic status has been related to poor health outcomes and fewer healthy behaviours (*Michie, Jochelson, Markham, & Bridle, 2008*). For instance, in Great Britain, only a quarter (25%) of low socio-economic groups were participating in sports and exercise versus 50% of those who were in higher socio-economic groups (NHS Health and Social care Information Centre, 2004, as cited in *Michie et al., 2008*).

Persons Experiencing Homelessness

Homelessness is a serious health and social issue. Homeless individuals are at increased risk of premature death, injury, medical problems, infectious disease, mental illness, substance abuse and chronic health conditions, and may encounter significant barriers in accessing health care services. In general., homelessness involves more than just an absence of adequate housing. Homelessness arises as a result of a complex set of issues.

Homelessness affects individuals of all genders, ages, sexual orientations and racial and ethnic backgrounds (*Gaetz, 2004*). There is no single cause for homelessness. For most homeless individuals, the state of homelessness is a one time, short-term and temporary condition. Moreover, the health implications from the short duration of homelessness are typically minimal. However for others, homelessness is a chronic and common condition with enormous health implications.

Factors associated with increased risk of homelessness include traumatic childhood, mental illness, substance abuse, low educational attainment, lack of job-related skills, family violence and breakdown, poverty, high living and housing costs, language barriers, racism, unemployment and poor employment conditions (*Frankish, Hwang, & Quartz, 2005; Gaetz, 2004*).

Access to a safe and secure shelter is a major determinant of health and one of the most basic of human needs. The physical environment in which an individual lives has a significant impact on health status and overall wellbeing. Individuals living in poverty are at increased risk of homelessness, especially those living on a low and limited income. An illness, layoff or missed pay check can lead to eviction and penalties leaving individuals and families without a home. Individuals living in poverty who are mentally ill, victims of abuse/violence, addiction or those who lack social support are also at increased risk for homelessness.

In addition to the impacts of poverty and comorbidity, homeless individuals also face a number of internal and external barriers to accessing medical care services. Homeless individuals may ignore their health problems and concentrate on their basic needs (such as food, clothing, shelter, and safety). Further, health care providers may be more likely to become prejudiced and frustrated when it comes to caring for homeless individuals, leading to a low quality of care. The homeless may be unable to pay for medications prescribed to them and therefore have poor prescription and treatment compliance (*Plumb, 2000*).

Persons with Low Literacy Skills

Canada is a multicultural nation with an ethnic and linguistic composition that is diverse and rapidly changing. With the evolution of computers and new technologies, in addition to the abundance of text based materials and increased organizational development and globalization, the basic literacy requirements for functioning in Canada's knowledge-based economy are immense. Literacy affects many aspects of human life including health, social status, income, employment and education.

Health and literacy are crucial resources for everyday living and functioning. Literacy skills play a critical role in allowing a person to act on health information and take control over total health. Low literacy skills can be a barrier to accessing medical services and supports, understanding health promotion and prevention education, making knowledgeable decisions regarding self-care practices, as well as treatment of illness.

Examples of literacy challenges that can result in daily health risks include the following:

- Administration of correct medication dosages
- Communicating need for medical services (such as referral to a health specialist)
- Safe operation of electric household appliances
- Following specific instructions for a diabetic or low-cholesterol diet
- Completing and understanding medical forms and informed consent

Research evidence exists to support the complex relationship between literacy and overall health status (*Health Canada, 2003; Literacy BC, 2005; Perrin, 1998; The Canadian Public Health Association, 2005*). Negative effects of low literacy levels on health are evident in many health related areas such as life expectancy, utilization of preventative services, accidents, parenting skills and lifestyle practices. Literacy barriers affect an individual's access to education, decent jobs and sufficient income. Limits can be placed on overall opportunities, control, and access to resources as well as the ability to make well informed lifestyle decisions. Low parental literacy levels may create difficulties in providing early childhood education, which in turn may impact overall child development. Individuals with low literacy skills are more likely to live and work in unsafe conditions and suffer the associated health consequences; in addition, they are more likely to experience a high degree of stress. Access to health services and health information may be limited for those individuals with low literacy skills due to their difficulties reading and understanding health information. They may be unaware of the services available to them and the process involved in gaining access to these services.

Seniors, immigrants, and Aboriginal people are three distinct groups that have been identified as having generally low literacy skills in Canada (*Statistics Canada, 2003*). In addition, individuals with learning disabilities, mental illness and those whose first language is not English are suggested to have poor literacy skills (*Bowen, 2001*). Awareness of such diverse

groups is essential in supporting the needs of clients.

Culture and language also play a role in the relationship between literacy and health (*Rootman, 2004*). Differing cultural groups view health and literacy differently. Different experiences with literacy and health mean that unique opportunities may arise for improving literacy levels and overall health. Furthermore, language barriers may exist and provide a significant barrier in accessing medical services and health information (*Bowen, 2001*). Culture and language can have a significant impact on health and literacy and should not be ignored. Results of the 2003 International Adult Literacy Skills Survey reported that 45% of adults who scored a level one (lowest level) on the literacy skills component were immigrants (*IALSS, 2003*). The literacy performance by Aboriginal populations was significantly lower than the general population. This is of concern, indicating that literacy may be considerably impacting the health of immigrants and Aboriginal Peoples. The impact of culture and language on health and literacy must be taken seriously.

Other Diversity Related Factors Affecting Health

In addition to the six recognized areas of diversity, other factors play a significant role in health and accessibility of health care services. Although it is not possible to list each and every factor that may affect health, literature indicates that geographical locations (such as rural and urban regions), racism, prejudice and discrimination play key roles. Descriptions of these factors are provided below.

Rural and Urban Areas Comparison

Health disparities have been closely associated with a difference in social., cultural., economic, and political circumstances (*Bloom, 2001; Chen & Fou, 2002; Rogers, 1997*). In addition to these, geographical location has also been recognized as a determinant of health (*Forbers & Janzen, 2004*). Romanow's (2002) report found that residents in rural and remote regions of Canada had a poorer health status and encountered more barriers in accessing health care services than their urban counterparts. Furthermore, literature also indicates that seniors in rural areas have lower life expectancy, lower income, lower level of education, and higher impairment in some activities of daily living than seniors in urban settings (*Forbers & Janzen*). The literature also indicates a lack of access to health care services (such as hospitals, home care, physicians, and other health care professionals) and greater distance to travel to health services (*Forbers & Janzen*).

Rural and urban differences can also be observed in the health status of Canadians. Romanow's (2002) commission report on Canada's health care system found that the rate of disability in rural or smaller communities was higher, and that residents of remote northern communities were the least healthy with the lowest disability-free life expectancy. Laurent (2002) reported similar finding in relation to life expectancy in rural areas in Canada. This difference was evident only for men, whose life expectancy at birth in remote, rural regions was 74 years, as opposed to 76.8 years in urban areas (Canadian Institute for Health Information, 2006). Research shows that compared to their urban counterparts, small town, rural area, and northern region residents have a greater chance of rating their general health as fair or poor (*Laurent, 2002; Mitura & Bollman, 2003*): 28.6% of urban area residents in Canada perceived their health as excellent whereas, only 20.2% of those in rural regions and 20.8% of northern dwellers rated health as excellent (*Mitura & Bollman*).

Approximately 15.3% of Canadians have arthritis/rheumatism. Rural areas have significantly higher proportion of arthritis/rheumatism: 18.4% compared to 13.4% in urban areas. This difference is also seen in depression: it is expected that 7.7% of Canadians have a 90% chance of suffering a major depression episode, but in Northern regions and small metro communities the chance is 10.1% (*Mitura & Bollman, 2003*).

Canadians with mental and physical disabilities encounter more challenges and barriers in accessing health care services, (*Romanow, 2002*), and the majority of efforts to bridge this service gap has been focused in urban regions.

Racism, Hate Crime and Systemic Discrimination

Hate crime

A hate crime, according to the Criminal Code of Canada "is committed to intimidate, harm or terrify not only a person,

but an entire group of people to which the victim belongs. The victims are targeted for who they are, not because of anything they have done." (*CBC, 2004*). These crimes may target race, nationality or ethnicity, language, colour, sex, age, mental or physical disability, sexual orientation, professional or political beliefs or any other similar factors (*Dauvergne, Scrim, & Brennan, 2008*).

In 2006, 0.04% of all criminal incidents reported to the police were hate crimes, accounting for 3.1 incidents per 100,000. 60% of all these incidents were motivated by race/ethnicity, 25% by religion, and 10% by sexual orientation (*Dauvergne et al., 2008*). Previous research shows that the effect of hate crime on victims is more profound that those associated with non-hate crimes (*McDevitt, Balboni, Garcia, & Gu, 2001*). For instance, Schaffer (*1996; as cited in Dauvergne et al., 2008*) found that hate crimes had more severe psychological effect on the victims than non-hate crime victims. The recovery period for hate crime victims could also be longer (*Herek, 1999* as cited in *Dauvergne et al.,. 2008; McDevitt et al., 2001*).

Of the approximately 60% of hate crimes committed with racial or ethnic roots (*Dauvergne et al., 2008*), Blacks (48%) were the most targeted group in 2006, followed by South Asians (13%), East and Southeast Asians (5%), Caucasians (5%) and Aboriginal Peoples (3%). Of religion-based incidents, close to two-thirds targeted the Jewish faith (63%). Followers of Islam faith (21%) and Catholic faith (6%) were the second and third most targeted groups in the country. Although over half of all race and religion motivated hate crimes were property-related, those motivated by sexual orientation, such as homosexuality, were violent in nature (*Dauvergne et al., 2008*).

According to Statistics Canada report (*Dauvergne et al., 2008*), Calgary has the highest rate of hate crime in the country: 9.1 incidents per 100,000. This is three times the national average (3.1). Close to three-quarters (72.8%) of all hate crime in Calgary is race or ethnicity related. The Calgary Police Service refuted Statistics Canada's findings (*Calgary Herald, 2008*) suggesting the higher rate is related to a higher reporting rate by city residents because of the trust in city police. Another possible reason according to the Calgary Police Service could be different reporting methods used by the police forces across our country (*Calgary Herald*).

Racism and Systemic Discrimination

Racism is an ideology that suggests human inferiority or superiority based on race. This ideology is formulated on the assumption that certain biological characteristics such as skin colour or facial features determines human intelligence (*Macionis & Gerber, 2005; Mullaly, 2002*). Racism assigns hierarchical status to racial groups, and accordingly, allocation of society goods and resources (*Bonilla-Silva as cited in Ahmed, Mohammed, & Williams, 2007*).

Systemic discrimination refers to an organizational system (which has become a part of the workplace culture, administrative structure and decision-making process) that grants privilege for some groups and disadvantage for others (*Agocs, 2002*).

Past research has shown that both racism and discrimination have negative effects on health (*Ahmed et al., 2007; Kelaher et al., 2008*). Kelhaher et al (2008) found that education and ethnicity often determine the extent of discrimination an individual might encounter. Documented research reveals a link between racism and discrimination and poor physical and mental health, including blood pressure (*Moghaddam, Taylor, Ditto, Jacobs, & Bianhi, 2002; Ryan, Gee, & Laflamme, 2006*), breast cancer (*Taylor et al., 2007*), self-perceived health (*Rex, Amick, & Williams, 1999; Schulz et al., 2006; Larson, Gilles, Howard, & Coffin, 2007*), and depression (*Schulz et al., 2006*).

Additionally, the effects of racism and systemic discrimination have also been documented in relation to education, employment and other health indicators. According to Codjoe (2001), systemic racism has a significant effect on academic achievements of Blacks in Canadian society. Research has shown that negative racial stereotypes of teachers towards their Black students affect school outcomes negatively (*Taylor* as cited in *Codjoe, 2001*). According to the Canadian Race Relations Foundation (CRRF) report (2000), under-representation or lack of representation of racialized groups in education institution hierarchy, higher drop-out rate of racialized students, and curricula that is non-reflective of the positive contributions of all ethnic groups are ways in which the education system perpetuates and contributes to the experiences of racism and discrimination.

Empirical evidence indicates that lesbian and bisexual women often have worse health status than heterosexual women

(*Diamant, Schuster, McGuigan, & Lever, 1999; Solarz, 1999*). Factors such as higher rate of smoking and alcohol, increased number of overweight cases, and greater use of mental health services among lesbians and bisexuals (*Diamant, Wold, Spritzer, & Gelberg, 2000; Gilman et al., 2001*) could play a role in determining their health status; however, discrimination faced by gays, lesbians, and bisexuals has been reported as a deterrent in accessing health services (*Barbara, Quandt, & Anderson, 2001; Denenberg, 1995, Eliason & Schope, 2001;*). These negative experiences result in avoidance or delay in seeking health care (*Bergeron & Senn, 2003; Stein & Bonuck 2001*). Researchers also show that lesbian and bisexual women have higher unmet health care needs (*Diamant & Wold, 2001; Diamant et al., 2000; Tjepkema, 2008*).

Cultural., racial., and linguistic discrimination (*Metropolis Project, 2001*) are major systemic barriers also faced by the immigrant and refugee population in Canada.

The effect of racism and systemic discrimination in the workplace is documented in Canadian literature. Agocs (2002) has identified four groups in Canada as the most vulnerable and disadvantaged in employment. These groups are: "women of any race or ethnicity; visible or racial minority; aboriginal peoples; and persons with disabilities" (*Agocs, 2002*). CRRF's (2000) findings suggest visible minorities as the most disadvantaged group as they continue to lag behind non-racialized groups in relation to employment and income. Other scholars have pointed out non-recognition of immigrant credentials as discrimination, especially when qualifications are equivalent to Canadian-born counterparts (*Reitz & Banerjee, 2007*).

4 Building the Evidence Base for Diversity Competency

For a number of years, the Calgary Health Region has been helping to build the evidence base for diversity competency through the process of implementing and evaluating a wide range of programs. In addition, a number of documents developed by the Region have helped to establish and expand the evidence base for diversity.

Progress towards Diversity Competency

Key activities that illustrate progress made by the Calgary Health Region in becoming a ***Diversity-Competent Health Organization*** are highlighted in the following time line.

1989	The **Child and Women's Health Multicultural Committee**, with internal and community representation, is established. Today, the committee continues to champion the goals of respect for diversity, cultural competency, and partnership with the ethno-cultural community in pediatric and women's health.
1998	An **interpreter of Asian languages** is hired to provide interpretation services to community health centres. Pursuant to the Supreme Court of Canada's mandatory sign language decision for health organizations, the Region provides **sign language interpretation** for clients/patients who communicate in American Sign Language, through contractual agreements with professional sign language community providers. **24/7 over the phone interpretation** is available to community health centres and emergency departments through a contractual agreement with AT&T Language Line. The **Multicultural Awareness Program** is piloted at the Peter Lougheed Centre to improve access to mental health services for culturally diverse populations and to improve the cultural competency of mental health professionals in the Region.
1999	The Calgary Health Region produces one diversity report.
2000	The **Regional Diversity Advisory Committee** is established and sponsors the development of Diversity Services, which is formally acknowledged as the Regional diversity program.
2001	The Calgary Immigrant Aid Society and the Region host the **Multicultural Health Care Symposium** and produce the Applying Best Practices Final Report.
2002	**Diversity Services Manager** position is established to coordinate and support Diversity Services, the Regional diversity program. **Interpretation and Translation Services** is formally established as a Regional service to reduce language barriers between limited and non-English speaking clients/patients and Regional staff by providing Certified Health Care interpreters, 24/7 access to over the phone medical interpreters through Language Line Services, American Sign Language interpreters, and translation of patient education materials. Based on the success of the Multicultural Awareness Program model at the Peter Lougheed Centre, the **Mental Health Diversity Coordinator** position becomes permanent. This position is responsible for working to improve access to mental health services for diverse populations and to improve the diversity competency of mental health professionals in the Region. The **Diversity Coordinator position at the Alberta Children's Hospital** is established to support the development of culturally competent service delivery throughout the Child and Women's Health Portfolio. The **Ethno-cultural community** is consulted to assess their response to existing diversity services and those that were planned for the future. This consultation identified that language was the key barrier to accessing health services for members of the Ethno-cultural communities.

	The ***Blueprint for Enhancing Cultural Competency in the Calgary Health Region*** is completed and intended to guide the development of the Diversity Services Strategic Plan and the provision of culturally competent health services within the Region. The Calgary Immigrant Aid Society and the Region host the ***Multicultural Health Care Dialogue: Continuing the Journey*** to address the first recommendation from the 2001 Multicultural Health Care Symposium. The **Indo-Asian Diabetes Initiative**, a culturally sensitive and community-based diabetes intervention project, is piloted to identify best strategies for addressing the unique needs of ethno-cultural populations in Calgary. The project lasted until 2004 and was extremely successful in terms of building strong partnerships between the region and diverse communities, improving access and health outcomes. The Calgary Health Region produces three diversity reports.
2003	The **first Certified Health Care Interpreter program in Alberta**, a joint venture between the Region and Bow Valley College is offered. All Regional interpreters are now required to demonstrate English and target language proficiency and complete the Certified Health Care Interpreter program. A **diversity education day for staff**, *Diversity: Building the Business Case*, is hosted in collaboration with the Calgary Diversity Institute, University of Calgary. The Child and Women's Health Diversity Program sponsors a **pre-conference session in conjunction with the Canadian Association of Pediatric Health Centres (CAPHC)**, entitled Moving the Agenda of Cultural Competency Forward in Pediatric Health Care: An Organizational Change Perspective. **Two multilingual Calgary Health Link phone lines** are launched - one in Cantonese and one in Mandarin. In addition, interpreters from Language Line Services are brought on the phone line for all multilingual callers to Calgary Health Link to help them and the nurse speak to each other. Health Link is a 24-hour-a-day, 7-day-a-week nurse telephone advice and health information service.
2004	The ***Regional Diversity Strategic Plan 2004 – 2008***, vetted through the Regional Diversity Advisory Committee, is released. The document assisted the Region to begin to articulate the elements of a diversity competent health care organization, measure its level of diversity competence, and implement strategies to ensure progress is made towards becoming a model diversity competent health care organization. ***Diversity is included as a regular GROW*** (General Regional Orientation & Welcome) topic. GROW is a Regional orientation program to welcome all new staff to the Calgary Health Region, and includes an overview of information relevant to new employees. **Multicultural Chronic Disease Management** is formally established to reduce chronic disease-related health disparities across the full continuum of care and to enhance the access, health and well-being of diverse populations. The first annual ***Diversity and Wellbeing Conference: Connecting Research, Policy and Practice*** is held in partnership with the Alberta Cancer Board and University of Calgary. This conference is designed to bring health practitioners, policy/decision-makers and researchers together with community organizations to discuss health issues that affect diverse populations. A full time, permanent ***Interpretation and Translation Services Assistant Manager*** position is established to assume the lead role lead role in maintaining a high quality of service and appropriate resource utilization, and to manage the day to day operations of the service. The **Early Childhood Diversity Strategist** position is established to provide leadership to develop, support and enhance diversity competent and responsive health promotion services to children aged 0-6 years and their families. The **Child and Women's Health Diversity Program** becomes situated under the umbrella of the Southern Alberta Child and Youth Health Network (SACYHN). ***Enhancing Cultural Competency: A Resource Kit for Health Care Professionals*** is launched by the Child and Women's Health Diversity Program and the Mental Health Diversity Program. The Calgary Health Region produces one diversity report.

2005	The Calgary Health Region is the Recipient of the *Immigrant Services Calgary's 2005* ***Immigrants of Distinction - Organizational Diversity Award***. This award recognizes an organization for its implementation of equity and diversity initiatives in the workplace. Online ***Diversity Competency Self Assessments*** are developed and available to all staff as a way of measuring diversity competency of Regional employees and to: help staff evaluate their attitudes and behaviours toward individuals from diverse groups, evaluate the extent to which their programs or units are equipped to meet the needs of diverse clients/patients; and to increase their awareness of the importance of diversity competence in the workplace, especially in the delivery of health care services. The 2nd annual ***Diversity and Wellbeing Conference: Promising Directions in Research, Policy and Practice*** is held in partnership with the Alberta Cancer Board and University of Calgary faculties of Education, Medicine, Nursing, and Social Work to explore diversity research, health disparities and development of effective policies; and to identify future opportunities to create sustainable linkages that support evidence-based practice related to diversity. The Diversity Services **website** is launched. The site contains a wealth of information to assist health professionals and health systems increase their diversity competency. The ***Inclusive Language*** booklet is launched and distributed to Regional staff, volunteers and Board members to encourage active use of language that is inclusive and non-discriminatory when interacting with patients/clients, families and staff at work. The Calgary Health Region produces one diversity report.
2006	Staff in diversity leadership and formal diversity roles are awarded the Calgary Health Region's 2006 ***PeopleFirst Award - Caring for Community*** Category. The Caring for Community award honours people and teams who actively engage the community to significantly impact health care. The **Diversity Educator** position is established to support the development of diversity competency of Regional staff as outlined in the Regional Diversity Learning Plan. Three **Diversity Liaison** positions are established to build linkages between diverse clients, families and communities and the health system. The 3rd annual ***Diversity and Wellbeing Conference: Taking Action on Homelessness and Health*** is held in partnership with a number of community partners to create awareness of the impact of homelessness on health; to improve understanding of homelessness and health issues among human service professionals; to create a forum for dialogue among community stakeholders; and to share effective strategies and develop action plans for addressing health disparities experienced by homeless populations. The Child Welfare system in Australia request permission to adapt and use the ***Multicultural Competencies Practice Tool***, an assessment tool to raise health professional's awareness their practice with culturally diverse families, developed by the Child and Women's Health Diversity Program and the Child and Women's Health Multicultural Committee. The ***Immigrant and Refugee Women's Health Practices: A Guide for Health Care Professionals*** booklet is launched and distributed. The Calgary Health Region produces one diversity report.
2007	Title of *Diversity Services* is changed to ***Healthy Diverse Populations*** to better reflect the work of this business unit, which is responsible for establishing the Regional strategic direction related to diversity and increasing organizational capacity to carry it out. The *Multicultural Chronic Disease Management Program*'s name is changed to ***Chronic Disease Management for Diverse Populations*** to reflect the expansion of the program to socially and culturally diverse populations such as the First Nations and the Homeless population. The Mental Health Diversity Coordinator position becomes the **Mental Health Diversity Strategist** and is transferred to Healthy Diverse Populations to strengthen the alignment of this work with the Regional diversity strategy.

	The **Community Development Diversity Coordinator** position is established to coordinate and oversee the collaborative model of the East Calgary Health Services Initiative and the Calgary Learning Village Collaborative (a collaboration of education, health, social., recreation and cultural services) to address identified needs for children, youth and families of immigrant, refugee and other diverse populations. The ***Refugee Health and Wellbeing Project*** is initiated to positively impact the health of refugees through the facilitation and strengthening of collaborative partnerships that collectively enhance community capacity. A Refugee Health and Wellbeing Project Coordinator position is created to lead this project. The 4th annual ***Diversity and Wellbeing Conference: Applied Research and Programs for Diverse Populations*** is held to provide a forum to discuss new and innovative evidence-based approaches for addressing the impact of the social determinants of health on the health of diverse populations. **Interpretation and Translations Services** reduces language barriers between limited and non-English speaking clients/ patients and families and their health care providers by completing: • 10,000 in-person interpretations in more than 20 languages and 865 translations with a staff of 50 Certified Health Care Interpreters • 113,000 minutes and 7451 over-the-phone interpretations in 61 languages, 10 of which were new to the Region, through Language Line Services • 170 American Sign Language interpretations A revolving ***multilingual "welcome" banner*** and multilingual materials on various health topics are added to the Calgary Health Region website to provide health and health services information to limited and non-English speakers in their first language. An ***American Sign Language video stream*** is produced and published on the home page of the Calgary Health Region website to provide accessible health system information for persons who are deaf or hard of hearing and who communicate in this language. The Calgary Health Region produces five diversity reports.
2008	Recognizing the ever growing demand for language interpretation and translation, Interpretation and Translation Services is established as an **independent Regional business unit** in the Community Health Services Portfolio. The **Diversity Research/Evaluation Strategist** position is established to advance the evidence base for diversity-related initiatives the Region. A **Community Liaison** position is established to support the work of the Refugee Health and Wellbeing Project. Planning is in progress for the 5th annual ***Diversity and Wellbeing Conference: The Diverse Faces of Mental Health*** and it intended to share successful approaches to addressing the mental health needs of diverse individuals, families and communities; facilitate opportunities for networking and connections among stakeholders; and create momentum for collective approaches that improve the mental health of diverse populations. Planning is in progress for the second ***National Transcultural Conference*** to be held May 2010 in Calgary The 2008 – 2012 ***Regional Diversity Directional Document*** is released. This document incorporates the best and promising diversity competency achievement practices gathered through literature reviews, environmental scans and focus groups conducted by the Calgary Health Region. The Calgary Health Region produces four diversity reports.

5 Projects, Services and Roles

Prior to the creation of Alberta Health Services and the subsequent reorganization of Region bodies, Diversity projects and services were integrated throughout the Calgary Health Region under the guidance of the Regional Diversity Advisory Committee. In several areas of the organization, staff members in formal diversity roles still seek to increase access, reduce barriers and improve experiences in the health system for diverse populations.

As we work toward becoming a diversity competent health organization, past successes and learnings are foundational. Many individuals and committees are instrumental in raising awareness of diversity issues, contributing to forward movement along the diversity competency continuum.

Notable diversity-related accomplishments by the **Calgary Health Region** include:

- Receiving Immigrant Services Calgary's 2005 Immigrants of Distinction - Organizational Diversity Award. This award recognizes an organization for its implementation of equity and diversity initiatives in the workplace.
- Staff in diversity leadership and formal diversity roles receiving the Calgary Health Region's 2006 PeopleFirst Award - Caring for Community Category. The Caring for Community award honours people and teams who actively engage the community to significantly impact health care.

Regional Diversity Advisory Committee

The Regional Diversity Advisory Committee was formed within the Calgary Health Region in 2000. The committee included representation from operational portfolios, meeting quarterly to provide direction and support to the development and implementation of an integrated Regional Diversity Directional Document.

Formal Diversity Roles

Several formal diversity roles play a significant role in carrying out the work outlined in this document. These formal roles, situated under three former Regional portfolios, are as follows:

Child, Women's Health and Specialized Services

- Child and Women's Health Diversity Coordinator

Community Health Services Portfolio:

- Manager, Interpretation and Translation Services
    - Certified Health Care Interpreters
- Program Manager, Chronic Disease Management for Diverse Populations
    - Program Coordinator
- Community Development Diversity Coordinator

Public Health Portfolio:

- Manager, Healthy Diverse Populations
    - Refugee Health and Wellbeing Project Coordinator
        - o Community Liaison

- Mental Health Diversity Strategist
- Diversity Educator
- Diversity Liaisons
- Diversity Research/Evaluation Strategist

Projects, Services, and Roles

Child and Women's Health and Specialized Services Portfolio

The Child and Women's Health Multicultural Committee includes internal and community representation and has championed the goals of respect for diversity, cultural competency and partnership with the ethno-cultural community in pediatric health care since 1989.

Child and Women's Health Diversity Coordinator

The coordinator provides culturally competent clinical consultation, training and workshops to staff, supporting the development of culturally competent service delivery throughout the Child and Women's Health Portfolio. The Diversity Coordinator (located in the Family and Community Resource Centre at the Alberta Children's Hospital) conducts research and quality improvement projects aimed at reducing the barriers that exist for immigrant families in accessing health services. The coordinator also partners with ethno cultural community organizations to continue the dialogue of inclusiveness in health care.

Notable accomplishments by **Child and Women's Health Diversity Program** include:

- Two staff rounds; a video entitled God Sleeps in Rwanda and a presentation focusing on Poverty, Culture and Mental Health initiated by the Multicultural Committee.
- Roll-out of four cultural competency staff development modules within the Portfolio.

Community Services Portfolio

Interpretation and Translation Services

Since 1990, the Calgary Health Region has made language interpretation available to reduce barriers between Region staff and limited/non-English speaking clients/patients and families. Over time, the program has expanded significantlty and now offers formalized Interpretation and Translation Services, access to Certified Health Care Interpreters in many languages, modes, and American Sign Language, and translated patient education materials in numerous languages. Interpretation and Translation Services is administered through the Community Health Services Portfolio and managed by a Manager.

Notable accomplishments by **Interpretation and Translation Services** include:

- 48 interpreters provide in-person and over-the-phone interpretation throughout the Region, 12 hours a day in 21 languages. In addition, an external organization (Language Line Services) is contracted to provide over-the-phone medical interpreters 24/7 in 170 languages.
- In-house interpretations increased from 1,033 in 2001/02 to more than 10,000 in 2007/08. During the same time period, interpretations contracted to Language Line Services increased from 973 to more than 8,000. An overall average increase of 27% of total interpretations per year has been noted since 2004/05.
- A standardized Regional translation process ensures accuracy and readability of all translated documents including health information, medical history, and immunization records.
- Language proficiency testing of bi/multilingual staff ensures high quality health services in first language.

Chronic Disease Management for Diverse Populations

Chronic Disease Management (CDM) for Diverse Populations was formally established in 2004 with a mandate to reduce chronic disease-related health disparities across the full continuum of care. From promotion and prevention, to screening and detection, to treatment and care, the Program seeks to enhance the access, health and well-being of diverse populations. In fostering strong and sustained partnerships with diverse communities and providing diversity-competent, accessible, integrated and effective chronic disease prevention and management services to people from diverse backgrounds, CDM for Diverse Populations continues to meet its mandate.

Program Manager, Chronic Disease Management for Diverse Populations

The Program Manager is responsible for establishing solid and sustainable partnerships with diverse community organizations, leaders and other relevant allies with whom we share the responsibility of care. Seeking or creating opportunities to incorporate community values and/or provide input into service planning and provision, the manager is also responsible for development and implementation of socio-culturally competent services that meet the needs of clients from certain ethnic, cultural and social backgrounds who may have access barriers to CDM programs. A full-time Program Coordinator contributes to the achievement of program goals.

Multilingual and multidisciplinary teams lead diversity-competent CDM programs such as nurse case management, education (targeting diabetes prevention, diabetes, HTN, dyslipidemia, COPD and GDM), exercise and self-management. These programs are offered in Cantonese, Mandarin, Hindi, Punjabi, Urdu, Gujarati, Vietnamese and Tagalog languages, and are delivered in accessible community-based sites such as temples, mosques, and cultural and community centres.

Notable accomplishments by **Chronic Disease Management for Diverse Populations** include:

- Solid and sustained partnerships with multiple community partners
- Enhanced quality of life, improved clinical outcomes/access and decreased service utilization among patients
- Funding opportunities from Health Canada, Public Health Agency of Canada and the Lawson Foundation for exploring best strategies for effective services to diverse populations
- Diversity-competent Chronic Disease Prevention and Management Program in Cantonese, Mandarin, Hindi, Punjabi, Urdu, Gujarati, Vietnamese and Tagalog languages
- Creation of innovative teaching tools and resources to enhance access to information.

East Calgary Health Services Initiative

The East Calgary Health Services Initiative was championed by numerous internal and external stakeholders. Now within the Community Health Services portfolio, the East Calgary Health Services Initiative is involved in the assessment, planning, implementation and evaluation of diversity-related activities within East Calgary and includes the Calgary Learning Village Collaborative, a collaboration of education, health, social., recreation and cultural services.

Established in 2007, the Community Development Diversity Coordinator position coordinates and oversees the collaborative model, and addresses identified needs for children, youth and families from immigrant, refugee and other diverse populations.

Public Health Portfolio

Healthy Diverse Populations

Diversity Services was formally acknowledged as a Calgary Health Region program in 2000 and has since undergone a name change to its current title: Healthy Diverse Populations. This business unit, administered through the Public Health Portfolio, is responsible for establishing the Regional strategic direction related to diversity. The work of Healthy Diverse Populations contributes to and is reflected in each key priority area identified in this Regional Diversity Directional Document.

Manager, Healthy Diverse Populations

The manager is responsible for overseeing the development and implementation of the Region's Diversity Directional Document, for monitoring the Region's progress towards diversity competency and for managing the Healthy Diverse Populations business unit. The manager is also the principal consultant on diversity-related issues and diversity initiatives within the Calgary Health Region.

The Refugee Health and Wellbeing Project

The Refugee Health and Wellbeing Project, initiated in 2007, aims to positively impact the health of refugees through the facilitation and strengthening of collaborative partnerships to collectively enhance community capacity. Through literature reviews and an environmental scan, the project has identified promising practices to enable refugees to improve their health outcomes. This project is made possible through a generous donation to the Calgary Health Trust's *Reach!* program.

The ***Refugee Health and Wellbeing Project Coordinator*** leads the project, working in partnership with the Calgary Refugee Health Program and the Calgary Catholic Immigration Society.

The ***Refugee Health and Wellbeing Community Liaisons*** provide coordination and support services to refugees seeking health services in the Calgary Health Region. The liaisons work to facilitate connections between refugee clients/

patients, families, communities and Calgary Health Region staff, as well as with those community organizations that provide services to the refugee population in Calgary.

Mental Health Diversity Strategist

Based on the successes of the Peter Lougheed Centre's Multicultural Awareness Program model, the Mental Health Diversity Program was initiated in December 2001. Established to improve access to mental health services by diverse populations and improve the diversity competency of mental health professionals in the Region, the Mental Health Diversity Services Program amalgamated with Healthy Diverse Populations in January 2006. The Strategist provides leadership to the development and enhancement of diversity competent and responsive mental health services. The Strategist also conducts extensive consultations, liaising with mental health professionals, diverse communities and organizations to provide education and training, resource information, referrals, and case consultation.

Diversity Educator

The Diversity Educator position was established in July 2006 and named responsible for planning, developing, implementing and evaluating diversity-related resources and education for all staff as outlined in the Regional Diversity Learning Plan. Diversity workshops are offered regularly through the Regional Learning Guide and customized education sessions for staff are available on request. Healthy Diverse Populations has developed and gathered an abundance of resources in different modalities to assist staff in their development of diversity competency. The Educator maintains this extensive diversity resource library.

Diversity Liaisons

The initial two Diversity Liaison positions were established in September 2006, followed by an additional two positions in 2007. Functioning primarily to build linkages between diverse clients, families and communities, Regional staff, and the health system, the liaisons provide a broad range of support services to individuals, families and communities accessing appropriate community and Regional resources/services. The Liaisons also assist in identifying and addressing barriers to accessing health services.

Diversity Research/Evaluation Strategist

The Strategist position was established in March 2008, with responsibility to advance the evidence base for diversity related initiatives. In providing knowledge, skills, advice and support in the area of diversity research and evaluation, the Strategist plays a key role in program planning and assessment. The Strategist also supports rigorous and accountable practices by working with team members in the design, implementation and evaluation of evidence based projects and activities, and develops learning opportunities and other creative methods for disseminating research and evaluation results.

Notable **Healthy Diverse Populations** accomplishments include:

- Establishing relationships and partnerships with multiple community organizations that represent diverse populations and other sectors
- Completing over 100 annual diversity consultations with internal and external stakeholders for the purpose of positively impacting the health of diverse populations
- Offering ongoing customized and standard diversity learning opportunities for staff
- Building a comprehensive website that receives an average of 4500 hits/month. The website features a variety of resources to support the development of diversity competency
- Hosting an annual Diversity & Wellbeing Conference to bring together stakeholders, share successes in addressing the health needs of diverse communities, facilitate networking and create momentum for change
- Broadcasting and publishing multi-media, multilingual articles on a variety of health topics in ethno-cultural media and website(s).

6 Measurement of Success

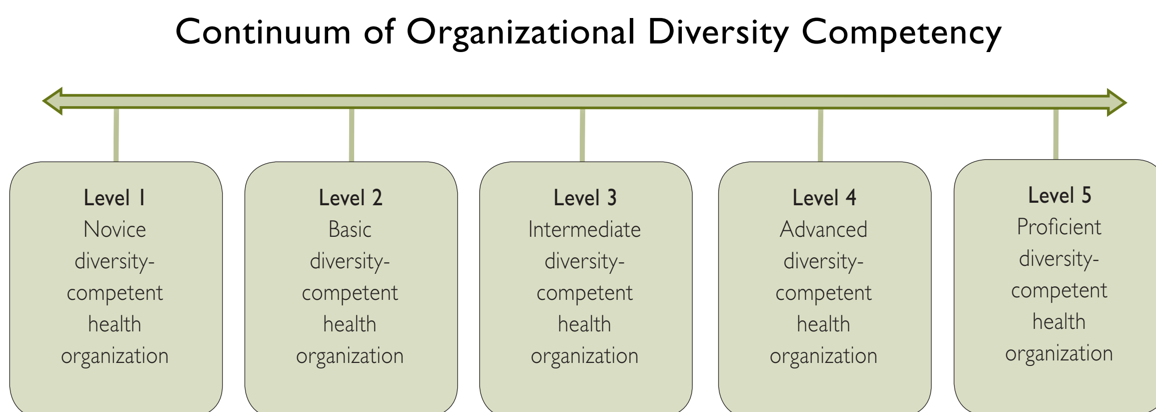
The process of becoming a diversity-competent organization is evolutionary. Over time, competency is integrated into core business practices; however achievement of diversity competency requires continuous organizational self-assessment, planning, action and evaluation. The Calgary Health Region will measure itself against a series of indicators linked with Gold Standard Benchmarks. These have been developed from a strong base of evidence.

Continuum of Organizational Diversity Competency

Diversity competency requires ongoing progression, growth, evolution and change. As such, the development of a diversity-competent organization occurs along a continuum representative of novice diversity competency through model diversity competency.

In determining its place on the Continuum of Organizational Diversity Competency, an organization can accurately assess its state of readiness and preparedness, as well as its current level of functioning (see below). This assessment enables the organization to take definitive and intentional action when creating strategies for forward movement.

Continuum of Organizational Diversity Competency



The five levels on the Continuum of Organizational Diversity Competency represent the progressive ability of an organization to respond respectfully and effectively to individuals, families and communities of all diverse backgrounds in a manner that protects and preserves their dignity and recognizes, affirms, and values differences, similarities and worth. Placement along this continuum is determined by the number of and degree to which indicators are achieved (within the six Gold Standard Benchmarks).

The Continuum of Organizational Diversity Competency is still under development by the Calgary Health Region. Descriptions for the five levels will be available soon.

Measuring the Region on the Continuum of Organizational Diversity Competency

The Continuum of Organizational Diversity Competency and the benchmarks and indicators provide the Calgary Health Region with tools to assess, develop and implement change that improves understanding of needs and ability to meet the needs of diverse populations. Although the Region is not a novice organization, we are also not yet a proficient diversity-competent health organization, and as such, must continue to monitor our progress against the previously identified benchmarks. We are committed to continually determine effective ways of measuring the Region's place on the continuum so as to accurately plot our progress over time.

An evaluation plan will be developed to determine measures to be used against benchmark indicators.

Benchmarks, Evidence and Indicators

A literature review and environmental scan conducted in 2008 identified best and promising practices in diversity and cultural competency at the organizational and health care service delivery levels. Based on this research, the Regional Diversity Advisory Committee developed and ratified six Gold Standard Benchmarks, established as the universally accepted best practice standards for organizations that are concerned with diversity competency. It is important to note that the Calgary Health Region has adopted a broad definition of diversity, although the literature focuses more heavily on language and culture.

The 6 Gold Standard Benchmarks are:

- **Gold Standard Benchmark #1**
  Regional policies and standards relevant to diversity are aligned with the principles of diversity
- **Gold Standard Benchmark #2**
  Diversity is embedded in all environments, programs, processes, and communications.
- **Gold Standard Benchmark #3**
  A workforce, within all levels of the organization, that is reflective of the population served.
- **Gold Standard Benchmark #4**
  Diversity competency is a process of continuous quality improvement.
- **Gold Standard Benchmark #5**
  Reciprocal relationships with diverse populations enable shared responsibility in addressing the determinants of health.
- **Gold Standard Benchmark #6**
  Diversity competency and practice is built on a foundation of existing evidence and/or through the creation of evidence that engages diverse populations.

Indicators of success and achievement were developed and linked to evidence. Indicators are the 'what,' in terms of what will indicate successful achievement of the benchmark. 'How' the indicators will be measured will be described in an evaluation plan, which will be developed at a later date. Measurement will include both qualitative and quantitative methods.

The benchmarks and related evidence and indicators are summarized on the following pages and linked to the evidence base. Through Logic Models, a selection of these indicators will be adapted to the local context of the Calgary Health Region (in order to measure diversity competency).

Gold Standard Benchmark #1

Regional policies and standards relevant to diversity are aligned with the principles of diversity.

EVIDENCE[†] (best and promising practices)	INDICATORS[‡]
Institutionalize diversity/cultural competency as an underlying organizational philosophy rather than a discreet set of initiatives.	Diversity and commitment to diversity competent services recognized in the organization's vision, values, mission and goals.
	Formalized diversity plan developed and disseminated with accountabilities, activities, timelines and milestones identified.
Develop and maintain the infrastructure necessary for the cultivation and practice of diversity/cultural competency.	Adequate resources allocated to implement diversity competency plan.
Systematically involve consumers, key stakeholders, and diverse communities in all stages of diversity / cultural competency development, implementation and evaluation, and cultivate partnerships with diverse communities to enhance all aspects of health care delivery.	Community representatives involved in setting policies, procedures, standards in defining and addressing service and policy needs.
Codify diversity/cultural competence values in formal statements.	Diversity principles incorporated into all policies where appropriate.
Review human resource policies and practices for fairness and bias, ensuring that policies not only prohibit discrimination, but promote respect for difference.	Workplace policies promote respect for differences and prohibit discrimination.

[†] Evidence was drawn from: Best/Leading Practices in Diversity Competency Literature Review and Environmental Scan, prepared for Healthy Diverse Populations, Calgary Health Region, 2008.

See this document for references.

[‡] Indicators were developed from the evidence base and ratified by The Regional Diversity Advisory Committee in 2008.

Gold Standard Benchmark #2 Diversity is embedded in all environments, programs, processes, and communications.	
EVIDENCE † (best and promising practices)	INDICATORS ‡
Provide services in inclusive and welcoming climates/environments.	Respect for the right of individuals to their customs, beliefs and practices demonstrated.
	Organizational culture of inclusiveness and respect demonstrated.
	Openness and acceptance of differences demonstrated.
Translate organizational philosophy of diversity/ cultural competence into practice at all levels of the organization.	Dimensions of diversity incorporated into management and service delivery strategies.
	Leadership at all levels held accountable for implementing diversity goals.
	Diversity principles applied as appropriate in all aspects of service delivery, including assessment, planning, intervention and evaluation.
Implement strategies to reduce barriers preventing diverse populations from accessing services.	Diversity-appropriate methods of service delivery employed.
	Facilities where health services are provided are universally accessible.
	Administrative accommodations considered, e.g., hours and locations of operation and multi-language information material.
Implement strategies to reduce barriers resulting from linguistic/language diversity, e.g., qualified health care interpreters/translators, multi-lingual workforce, competency in cross-cultural communication norms and non-verbal communication and communication strategies that accommodate variation in levels of health literacy.	Professional language assistive services offered and available.
	Where feasible, health services provided in first language by multilingual professional staff.
	Low health literacy is being addressed.
Provide linguistically and culturally appropriate print materials.	Signage, health information and health system materials accessible in plain language, multiple languages and linguistic formats.
	Diversity of the community reflected in facility signage, text and visuals where appropriate.
	Culturally appropriate health materials accessible.
	Diverse writer's/artist's work included in publications.
Systematically involve consumers, key stakeholders, and diverse communities in all stages of diversity/cultural competency development, implementation and evaluation, and cultivate partnerships with diverse communities to enhance all aspects of health care delivery.	Clients, families and community members involved as health team members where appropriate.
	Outreach strategies in place to facilitate participation by diverse people.
	Expertise solicited from diverse community leaders, traditional healers and elders and applied to planning and practice.

Gold Standard Benchmark #3 A workforce, within all levels of the organization, that is reflective of the population served.	
EVIDENCE [†] (best and promising practices)	**INDICATORS [‡]**
Recruit and retain a workforce at all levels of the organization that is representative of the composition of the populations served.	Staff demographic data related to diversity collected.
	Diverse staff/volunteers actively recruited.
	Diversity composition of the community reflected in organizational leadership, staff and volunteers.
	Health services provided in first language where possible.
Use diversity-sensitive and appropriate orientation materials.	Diversity-sensitive and appropriate orientation materials employed.
Employ strategies to enhance job satisfaction of employees identifying with diverse populations, such as sensitivity to the assumptions and expectations held by diverse staff members, encouragement of open communication about those assumptions and expectations.	Diverse staff and leadership recruited, retained and represented at all levels within the organization.
	Diversity skills identified as requisite for selection criteria in staff recruitment, in performance review processes, and in staff competencies.
Foster a comfortable and welcoming work environment for all employees.	Respect for the right of individuals to their customs, beliefs and practices demonstrated.
	Organizational culture of inclusiveness and respect demonstrated.
	Openness and acceptance of differences demonstrated.
Develop clear protocols and staff development in cross-cultural communication.	Cross-cultural communication protocols and staff development training in place.
Develop appropriate responses to unfair treatment.	Appropriate human resource policies and practices in place.

Gold Standard Benchmark #4 Diversity competency is a process of continuous quality improvement.	
EVIDENCE [†] (best and promising practices)	INDICATORS [‡]
Routinely assess and evaluate strengths and limitations in diversity/cultural competency using assessment tools that are standardized, employ a broad definition of diversity, operationalize and measure diversity competency in the broadest sense, do not rely solely on self-assessment, measure outcomes at multiple organizational levels and are strength-based.	Broad definitions of diversity and diversity competency adopted.
	Organizational diversity competency assessed by multiple methodologies at multiple levels, first at benchmark and then ongoing intervals.
	Diversity-competent measures integrated into internal audit, improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
	Conflict resolution processes are in place, which are capable of identifying, preventing, and resolving conflicts or complaints by diverse consumers.
Health care practitioners and staff cultivate cultural sensitivity and awareness of the relationships between diversity/culture and health, develop culturally appropriate care practices by developing cultural knowledge and cultural skills.	Diversity competency resource materials and learning opportunities available for staff.
	Diversity management knowledge and skills identified as requisite requirements for leadership positions.
Ensure staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. Deliver through a diverse set of strategies, avoiding low intensity or passive training.	Ongoing diversity competency skill development opportunities available for all staff and volunteers and made available for physicians.
	Ongoing diversity competency skill development opportunities made available for senior decision makers.
	Learning outcomes measured over time and by multiple methods.
	Inclusion of diversity competency education and practice in professional health care curricula.

Gold Standard Benchmark #5 Reciprocal relationships with diverse populations enable shared responsibility in addressing the determinants of health.	
EVIDENCE † (best and promising practices)	INDICATORS ‡
Systematically involve consumers, key stakeholders, and diverse communities in all stages of diversity/cultural competency development, implementation and evaluation, and cultivate partnerships with diverse communities to enhance all aspects of health care delivery.	Recommend that there is diverse representation on senior decision making teams.
	Diverse communities are routinely consulted to identify issues and strengths.
	Clients and communities empowered to navigate health system.
	Diverse communities are consulted to identify needs and develop program goals, objectives and activities.
	Participatory collaborative partnerships with diverse communities are established.
	Formal and informal mechanisms to facilitate community involvement in designing and implementing programs, services, and initiatives are in place.
	Information about the organizational progress and successful innovations in implementing diversity strategies made available.

Gold Standard Benchmark #6

Diversity competency and practice is built on a foundation of existing evidence and/or through the creation of evidence that engages diverse populations.

EVIDENCE † (best and promising practices)	INDICATORS ‡
Understand the diversity of target populations and apply this understanding in the development and delivery of diversity/culturally competent health care practices and services.	Current demographic diversity profile of the community is maintained to plan for and implement responsive services.
Evaluate organizational diversity competency measures over time to garner an indication of their effectiveness and to identify areas needing improvement.	Data related to dimensions of diversity collected in health records and population health surveys and included in service planning and delivery.
Keep abreast of research and identify practices considered "best" or "promising" through rigorous empirical testing or because they show promise.	Evidence base for diversity competency is easily accessible and kept up to date.
Contribute to diversity competency body of knowledge and provide for the dissemination of research and evaluation results, e.g., publish evaluation reports, disseminate findings through training workshops and to committees and other decision-making structures, and publish in peer reviewed scientific and professional literature.	Active participation in diversity-related research.
	Dissemination of diversity research and evaluation results to the wider community occurs.
	Participation in community networks to advocate and advance diversity competency occurs.

7 Regional Diversity Action Plan and Logic Models

Diversity competency is an ongoing process requiring continual appraisal. As such, the Calgary Health Region will use the Diversity Competency Continuum to monitor its progress and identify areas in need of change and improvement. It is not beneficial for any organization to overestimate its capacity to deliver diversity competent services. Likewise, it is inappropriate to underestimate the challenges of preparing the organization and its personnel to become diversity-competent.

The Regional Diversity Action Plan and Logic Models provide the framework for the organization's diversity initiatives and related work expected to occur over the next 10 years. Intermediate and long term outcomes have been established to identify what must be accomplished in the next five years (intermediate term) and 10 years (gold standard benchmarks, long term). The indicators of success, which were derived from literature, allow for an analysis of the Region's performance.

Diversity Action Plan

The Regional Diversity Action Plan identifies seven priority action areas for planning:

- Building organizational capacity
- Strengthening community action
- Consultations
- Interpretation and translation services
- Accessible and equitable services
- Diversity competent workforce
- Representative workforce

These priorities will help with identification of resources and categorization of the work of individuals in formal diversity roles over the next several years. In addition, these priorities will influence the direction of other programs and services as related to diversity.

Regional Diversity Logic Models

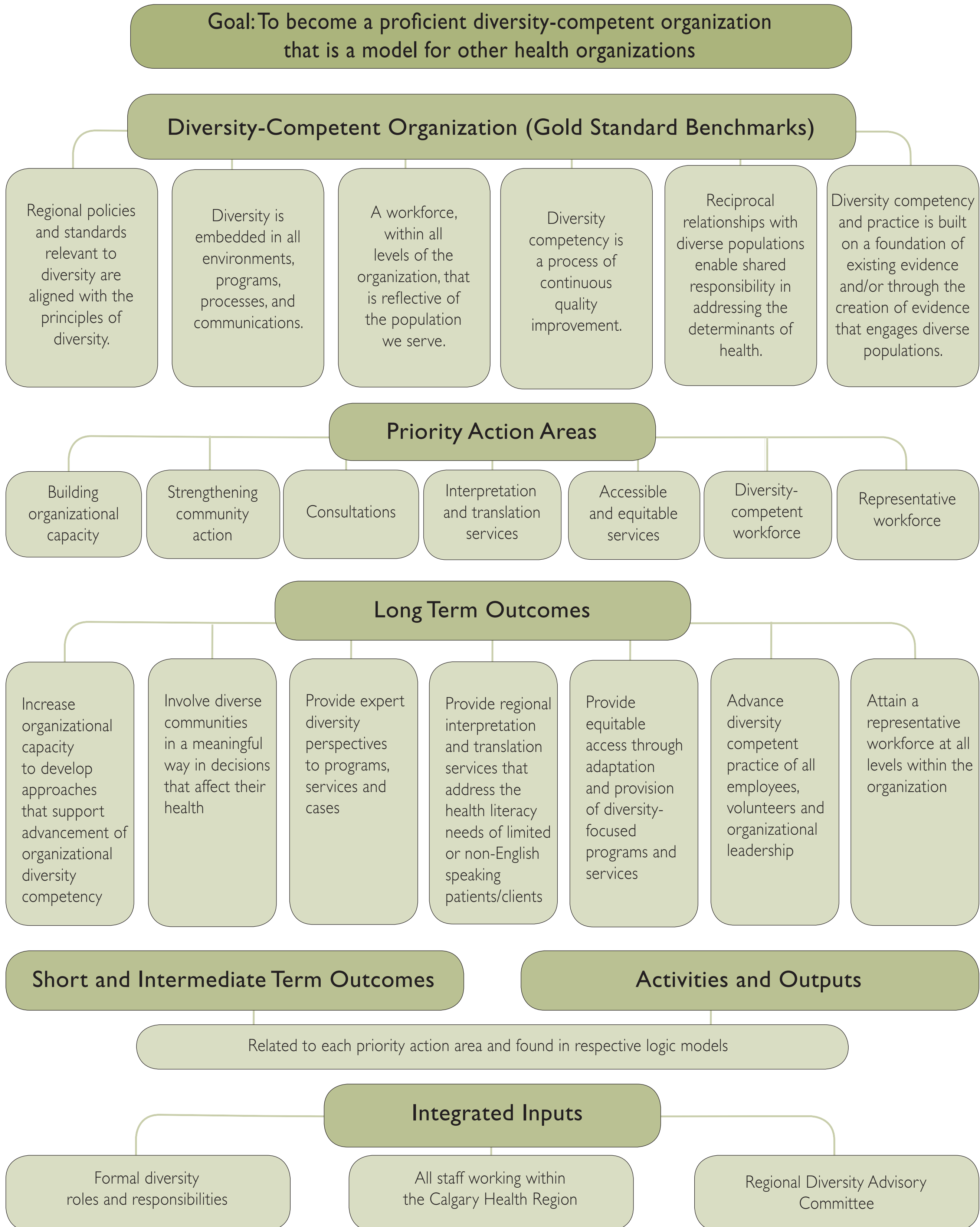
Individual logic models have been developed for each of the seven action focus areas, as specified in the Regional Diversity Action Plan.

The models follow a typical logic model format: Inputs → Activities →Outputs → Outcomes:

- Inputs are resources (such as money, employees, and equipment).
- Activities are the work activities, programs or processes.
- Outputs are the works that will be delivered.
- Outcomes are the results or consequences of delivering outputs over time. Short term outcomes measure the program in a period of zero to three years, intermediate outcomes measure the program in a period of three to five years and long term outcomes measure the overall program in a period of five to 10 years. Short, intermediate and long term outcomes have been identified for each priority focus area.

The logic models will be responsive to ongoing assessment. As a result, activities may change over time, although priorities shall remain relatively consistent.

Regional Diversity Action Plan



Building Organizational Capacity Logic Model

Building Organizational Capacity Logic Model

Inputs	Activities	Outputs	Short Term Outcome	Intermediate Term Outcomes	Long Term Outcomes
All Regional employees in leadership roles are responsible for developing approaches that support advancement of organizational diversity competency. Formal Diversity Roles: **75% of 1.0 FTE Manager Healthy Diverse Populations** **5% of 1.0 FTE Assistant Manager, Interpretation and Translation Services** **5% of 1.0 FTE Diversity Educator** **5% of 1.0 FTE Mental Health Diversity Strategist** **60% of 1.0 FTE Diversity Research/ Evaluation Strategist** **5% of 0.86 FTE Refugee Health Project Coordinator** **5% of 1.0 FTE Manager Chronic Disease Management for Diverse Populations**	Establish process for measuring organizational diversity competency Review Regional policies and practices with a diversity lens Expand the evidence base for diversity competency Contribute to the literature re: diversity competency, health of diverse populations and best practices Attend and present at conferences Attend diversity-related events Undertake environmental scan to determine accessibility to physical structures to determine priority areas Explore possibilities of ethnicity and language data collection becoming mandatory Explore possibilities of integrating measures of diversity competency into the accreditation process	Report produced comparing the Region's level of diversity competency with that of a model diversity competent health organization. Research reports produced and results disseminated Network and share information about the Region's progress towards diversity competency Report produced outlining an assessment of the accessibility of Regional programs and services Report produced outlining the impact of existing Regional policies and identifying gaps Updated briefing paper on the pros and cons of collecting ethnicity and language data by health care providers. Implementation plans and growth initiatives developed to act on recommendations for additional strategies to reduce system barriers	Tool for measuring organizational diversity competency developed. All Regional policies relevant to diversity reviewed Articles published in health and diversity-related journals and peer-reviewed journals Abstracts accepted for conference presentations Standardized implementation of the City of Calgary's Access Design Guidelines when designing new structures and retrofitting existing structures Clear picture of client ethnicity and language data recording available Staff and clients feel safe to report complaints related to diversity issues	Baseline organizational assessment completed Mandatory ethnicity and language data collection passed through the Regional Policy Advisory Committee Trends associated with client and staff complaints related to diversity issues reduced The Calgary Health Region is seen as a leader in diversity competency	Organizational capacity to develop approaches that support advancement of organizational diversity competency increased

Strengthening Community Action Logic Model

Strengthening Community Action Logic Model

Consultations Logic Model

Consultations Logic Model

Interpretation and Translation Services Logic Model

Interpretation and Translation Services Logic Model

Accessible and Equitable Services Logic Model

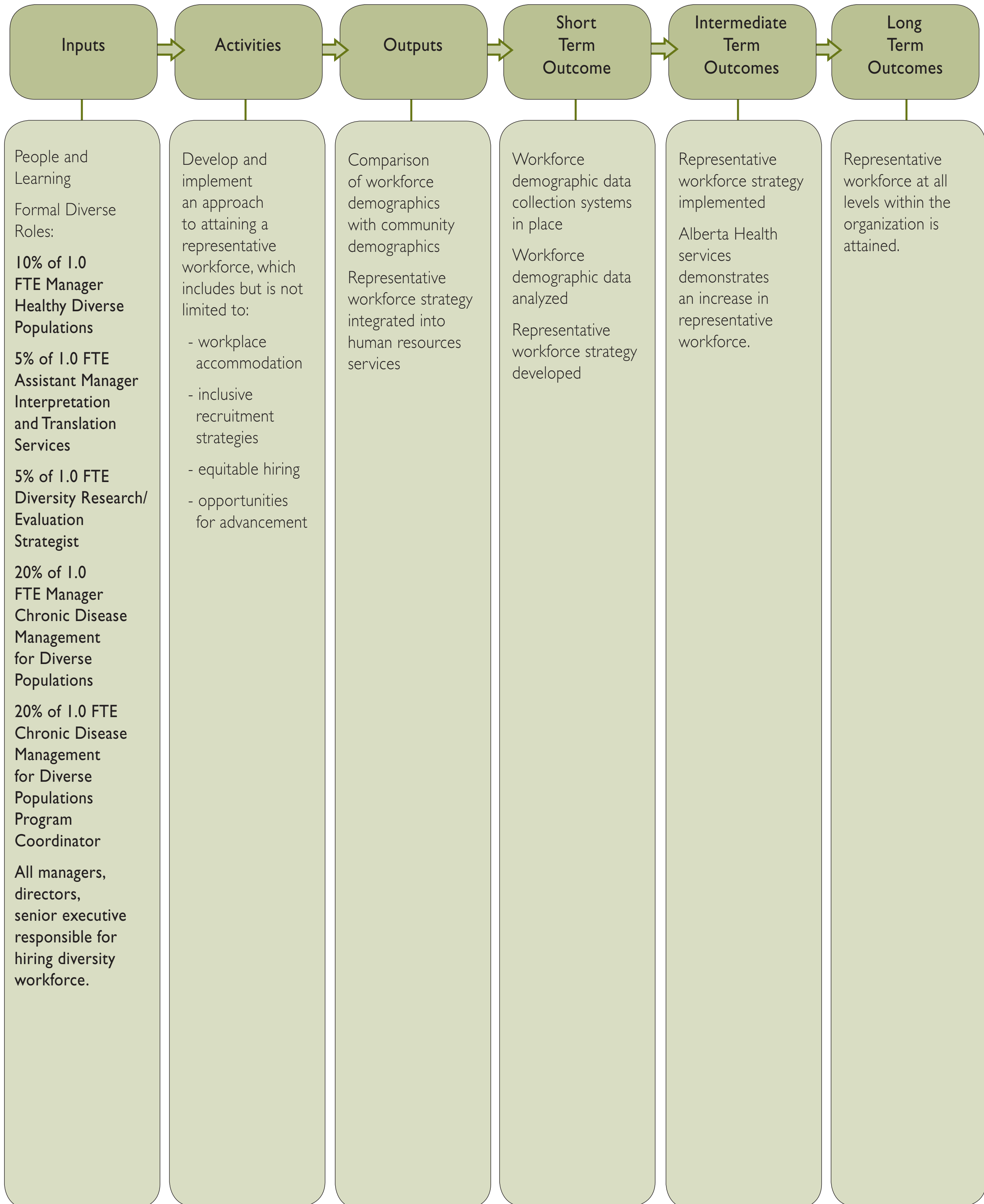
Accessible and Equitable Services Logic Model

Diversity Competent Workforce Logic Model

Diversity Competent Workforce Logic Model

Representative Workforce Logic Model

Representative Workforce Logic Model



Glossary

Accommodation: Refers to making changes to rules, standards, policies and practices in the workplace, culture and physical environment to eliminate negative effects on an individual because of their dimensions of diversity. Accommodation is a requirement by law according to Alberta's human rights legislation (*Human Rights, Citizenship and Multiculturalism Act*).

Best Practices: A range of practices, processes and actions that while not proven, are demonstrating promising results. These practices are consistent with the values of social equity, social justice and democracy.

Cultural Competency: A set of congruent behaviours, attitudes and policies that come together in a system, agency or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations (*Cross et al., 1989, as cited in Bowen, 2004*).

Cultural Responsiveness: Refers to the ability of individuals and systems to respond respectfully and equitably with people of all cultures, ethnic backgrounds, sexual orientations and faiths or religions in a manner that recognizes, affirms and values the worth of individuals, families, tribes and communities and protects the dignity of each (*Bowen, 2004*).

Diversity: All the ways people are unique and different from others. Dimensions of diversity include, but are not limited to, such aspects as race, religion and spiritual beliefs, cultural orientation, colour, physical appearance, gender, sexual orientation, ability, education, age, ancestry, place of origin, marital status, family status, socio-economic circumstance, profession, language, health status, geographic location, group history, upbringing and life experiences (*Calgary Health Region, Regional Diversity Strategic Plan, 2004-2008*).

Diversity Competency: The ability of individuals and systems to respond respectfully and effectively to individuals, families and communities of all diverse backgrounds in a manner that protects and preserves their dignity and recognizes, affirms and values their differences, similarities and worth (*Calgary Health Region, Regional Diversity Strategic Plan 2004-2008*).

Equity: More than treating persons in the same way but also requires special measures and the accommodation of differences, therefore equality is not the same as equity.

Ethno-cultural: Refers to the ethnic or cultural group(s) to which an individual's ancestors belong (*Statistics Canada, 2001*).

Health disparity: Population-specific differences in the presence of disease, health outcomes, or access to health care *(Health Policy Institute of Ohio, 2004*).

Health Literacy: The ability to access, understand, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course. (Access is more than the availability of information and services. It is mediated by education, culture and language, by the communication skills of professionals, by the nature of materials and messages, and by the settings in which health-related supports are provided.) (*Rootman & Gordon-El-Bihbety, 2008*)

Immigrant: Refers to a person involved in the process of immigration or who has settled permanently in another country *(Citizenship and Immigration Canada*).

Inclusive organizations: Refers to organizational norms and practices that promote an environment where diversity is of high value and people are safe, respected and non-discriminated to participate fully in all aspects of the organization (*Immigrant Women's Association of Manitoba*).

Inclusiveness: Refers to an organizational system where decision-making includes perspectives from diverse points of view, internally and externally, where appropriate. Inclusiveness of services refers to the rights of every individual to equitable opportunities, access and participation in all that society has to offer regardless of individual dimensions of diversity.

Inequality: The condition of being unequal; the lack of equality, as of opportunity, treatment, or status; social or economic disparity.

Literacy: The ability to identify, understand, interpret, create, communicate and compute, using printed and written materials associated with varying contexts. Literacy involves a continuum of learning to enable an individual to achieve his or her goals, to develop his or her knowledge and potential., and to participate fully in the wider society (United Nations Educational., Scientific and Cultural Organization (*UNESCO, 2003*).

Persons Living in Poverty: Definitions and measurements of poverty in Canada vary. One of the most widely used is the Low-Income Cutoff (LICO) level developed by Statistics Canada, which has long been used as a measure of poverty in Canada. LICOS are "income thresholds below which families will likely devote a larger share of income to the necessities of food, shelter and clothing than the average family." A second measure is the Market Basket Measure (MBM), a newer measure recently adopted by the federal government to provide another perspective on low income in Canada. The MBM measures how many people live in families which lack the disposable income to purchase the goods and services in the "market basket" within their community; the "market basket" includes food, clothing, shelter, transportation, and other goods and services such as personal care, furniture, basic telephone service, school supplies, recreation, etc. (*Human Resources Development Canada, 2003).*

Poverty: The condition of a human being who does not have sufficient economic and other resources to live with the dignity, choices and power which support full participation in society (*Vibrant Communities Calgary, 2007*).

Promising Practices: Often referred to as "best practices": a range of practices, processes and actions that while not proven, are demonstrating promising results. These practices are consistent with the values of social equity, social justice and democracy (*Immigrant Women's Association of Manitoba*).

Refugee: Any person who is outside his/her country of nationality or habitual residence; has a well-founded fear of persecution because of his/her race, religion, nationality, membership in a particular social group or political opinion; and is unable and/or unwilling to avail himself/herself to the protection of that country, or to return there, for fear of persecution" (*The 1951 Refugee Convention, The Office of the UN High Commissioner for Refugees*).

Representative Workforce: A workforce that reflects the community and the diversity of clients and of the people we serve in all classifications and at all levels (entry, middle and management) of the organization. A representative workforce is about creating a productive workplace where everyone can participate. It is about expanding the pool of qualified candidates, retaining those skilled workers and promoting effective teamwork, which in turn creates greater sensitivity to the diverse clients we serve.

Appendix A

Diversity-Related Reports Developed by the Calgary Health Region

The following reports completed by the Region have helped to establish and expand the evidence base for diversity competency.

2008 *Persons with Disabilities Literature Review and Community Consultation (2008)*
A literature review and consultation undertaken to identify the health issues of persons with disabilities (communication, developmental., intellectual., physical and psychiatric), the barriers they experience in having their health needs met and the ways these barriers can be reduced.

Diversity Competency Models, Benchmarks & Practices Literature Review and Environmental Scan (2008)
An assessment of the current state of knowledge and implementation of diversity/cultural competency.

Interpretation/Translation Services Literature Review and Environmental Scan (2008)
A review of the issues, barriers, models, standards and codes of ethics for interpreter services.

Cultural Liaison/Cultural Broker Literature and Environmental Scan (2008)
A literature review and environmental scan compiling current knowledge on the role and practice of cultural liaisons/brokers.

2007 *Promising Practices, Programs and Approaches for Improving Refugee Health and Wellbeing (2007)*
An overview of promising initiatives and model programs to improve refugees' health over the longer term. Discusses community development as a key component of community-based health initiatives for refugees.

Chronic Disease Management Strategic Plan 2007-2012 (2007)
An evidence-based strategic plan combining historical understandings of the Chronic Care Model with the well established Population Health Model. Used to guide refinement of existing Chronic Disease Management strategies and to develop/implement said new strategies.

Homelessness, Chronic Disease and Access to Care (2007)
An extensive, systematic literature review and needs assessment that compiles current health-related information on homeless people to identify service gaps, short-term and long term service needs and best practices and strategies for provision of sustainable and integrated services.

Gender and Sexual Diversity: Health Services Consultation and Literature Review (2007)
A literature review and consultation undertaken to identify the health issues of people in sexual minority populations (gay, lesbian, bisexual., queer, intersexed, transsexual and two-spirited), the barriers they experience in having their health needs met and the ways these barriers can be reduced.

2006 *Issue and Population Specific Literature Reviews (2006)*
A series of literature reviews looks at a wide range of diverse populations, researching their health issues and ways to reduce barriers to health.

2005 *Environmental Scan and Needs Assessment Study: Expansion of the Chronic Disease Management Program to Diverse Populations in Calgary (2005 - 2006)*
A study conducted to facilitate the program expansion planning process related to diverse populations & Chronic Disease Management.

2004 *Regional Diversity 5 Year Strategic Plan 2004 – 2008 (2004)*
A plan to guide the Calgary Health Region's achievement of Diversity Competence.

2002 *Blueprint for Enhancing Cultural Competency in the Calgary Health Region (2002)*
A document to guide development of the Diversity Services Strategic Plan and the subsequent provision of culturally competent health services within the Region.

Ethno-Cultural Community Consultation (2002)
A consultation with representatives from a number of ethno-cultural communities regarding their responses to existing diversity services and those that were planned for the future.

Evaluation of Language Facilitation Project: For Seniors Who Speak Russian and Yiddish (2002)
An evaluation report that identified the positive reaction of both seniors and health providers to the experience of using a trained interpreter.

2001 *Magnitude of Diabetes Among Indo-Asian Population (2001-2002)*
This review of evidence on the diabetes epidemic among the Indo-Asian population provided the foundation for a culturally-competent, community-based intervention initiative launched in partnership with the target community.

1999 *No Trivial Matter: The Challenge to Create Effective Communication Services for CRHA* Staff working with Limited English Proficient (LEP) (1999)*
A cross-service survey of 2,000 Regional care and service providers that assessed staff perceptions of the need for interpretation services as an enabler of appropriate and effective health care service provision region-wide. (** The Calgary Health Region was previously known as the Calgary Regional Health Authority or CRHA*)

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