



BEST PRACTICES IN DIVERSITY COMPETENCY

Literature Review and Environmental Scan

HEALTHY DIVERSE POPULATIONS
Alberta Health Services
2008

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ACKNOWLEDGMENTS

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GLOSSARY OF TERMS

Best Practice: A process or methodology that has been proven to work well and produce good results, and is therefore recommended as a model.

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, cited in Bowen, 2004).

Diversity: All the ways people are unique and different from each other. 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, 2008, p 3).

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 differences, similarities and worth (Calgary Health Region, 2008, p. 4).

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 (Rootman & Gordon-El-Bihbety, 2008, p. 11).

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, 2006).

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, 2006).

EXECUTIVE SUMMARY

The population served by the Calgary Health Region is increasingly diverse. To reduce barriers to health services and ultimately, health disparities among diverse populations, the Region is striving to develop health services that are accessible and appropriate for diverse individuals, families and communities. To this end, the Region commissioned a review of the literature and an environmental scan to identify best/leading practices in diversity competency and to identify ways in which the Region can grow in this area.

This report presents best practices in diversity competency garnered from a review of scholarly and of non-refereed or 'grey' literature and from interviews with nine key informants from four Canadian health regions, representing management and service provision levels. Best practices at the systemic or organizational level are presented first, followed by best practices in the provision of diversity competent care. Best practices in diversity competency education, in human resources, and in assessment and evaluation are presented next. The report concludes with a review of challenges facing health services as they strive for diversity competency and with a summary of the successes of and challenges facing the Calgary Health Region.

Systemic/Organizational Diversity Competency Best Practices

Characteristics of health service organizations exemplifying diversity competency include:

- The institutionalization of diversity competency as an underlying organizational philosophy, rather than a discreet set of initiatives. The philosophy reflects a deep commitment to valuing diversity and to developing an organizational culture reflective of this value and supportive of diversity competent practices;
- The codification of diversity competency values in formal statements (for example mission statements, strategic plans or directional documents), and regular reviews of policies and other organizational documents for biases and exclusionary practices;
- The development and maintenance of the infrastructure necessary for the cultivation, promotion and practice of diversity competency. Infrastructure includes adequate financial resources and the capacity to develop, implement and evaluate mechanisms that ensure organizational leadership is representative of the diverse populations served;
- An understanding of the diversity within target populations and use of this understanding in the development and delivery of health services. This understanding includes awareness of the demographic, cultural and epidemiological characteristics of the population as well as available community resources, such as traditional health and social institutions;
- Translation of the philosophy of diversity competency into practice through the development of formal initiatives at all levels of the organization. Examples include the development of diversity plans, policies and practices that reflect and support diversity competency;
- The systematic involvement of consumers, key stakeholders, and diverse communities in diversity competency development, implementation and evaluation (for example through involvement on advisory committees), and the cultivation of partnerships with diverse communities to enhance service delivery; and

- Routine assessment and evaluation of the organization's strengths and limitations in order to identify diversity competencies and areas for improvement.

Diversity Competency Best Practices in the Delivery of Health Services

Best practices facilitating diversity competency in the delivery of health services include:

- The provision of inclusive and welcoming climates or environments. Diversity competency is enhanced when consumers are made to feel welcome, valued and respected, when physical environments are reflective of the diverse populations served, and when services are offered at times, in locations and in formats that are appropriate and easily accessible for diverse populations;
- The implementation of strategies to reduce barriers to health services resulting from linguistic/language diversity. Communication is enhanced through the provision of qualified health interpreters, a multi-lingual workforce, and linguistically-appropriate print materials; through competency in cross-cultural communication norms and non-verbal communication; and through communication strategies that accommodate variation in levels of health literacy;
- The encouragement of health practitioners and staff to develop cultural sensitivity and awareness. Personnel are encouraged to explore their own beliefs, values, and biases and to understand the influence of those beliefs (and those of their client) on the service encounter. Personnel are also encouraged to develop strategies for resolving conflict arising from differences in viewpoint, are encouraged to seek guidance from diversity competent role models, and are encouraged to recognize and address inequitable behaviours when they occur. Practitioners and staff are further encouraged to develop an understanding of the relevance of diversity to health, including ways in which health disparities are related to access-to-care issues and to sociocultural circumstance;
- The cultivation of diversity knowledge and skills among health practitioners and staff, leading to the provision of diversity-sensitive health assessments, interventions and treatments. With diversity knowledge and skills, practitioners are aware of disease patterns among diverse populations, and have a point of reference for understanding clients' beliefs about health, including how clients define illness and treatment. Diversity knowledge and skills further enable practitioners to identify and incorporate, where appropriate, traditional or alternative health practices, and to engage family members or religious leaders for example as resources or participants in the delivery of care;
- The empowerment of all consumers of health services. Empowerment may be facilitated by encouraging clients to become active participants in their care, by educating consumers on how to navigate the health services system, and by providing linguistically-appropriate complaint-process information.

Best Practices in Diversity Education

There is consensus in the literature that post-secondary health and medical education is lacking in diversity competency training, and a concurrent call for health services organizations to take the lead in developing and delivering continuing education opportunities in this area. Continuing education may be delivered through speaker sessions, workshops and poster sessions.

However, research has found that high-intensity approaches (those involving a brief but intense interaction between the educator and practitioner or those requiring immersion among diverse populations) are more effective than low-intensity or passive training formats.

Recommended topics for continuing education include the demographic composition of the service area; local diversity-related health disparities; organizational, legal and regulatory requirements pertaining to diversity competency; diversity-sensitive interpersonal and communication skills; and methods of assessing language needs and of accessing interpretation services. Recommended topics further include diversity-appropriate assessment and treatment; diversity in health-related beliefs and values; differences in disease incidence and prevalence; and treatment efficacy for diverse populations. More generally, continuing education should stress that practitioners need not become experts in all diverse populations, but should strive to increase their awareness of differences that might arise (in such areas as worldview and health-related norms and practices for example) and their influence on the service encounter.

While there is a lack of research on the outcomes of continuing education in diversity competency, a few studies have indicated that continuing education produces measurable changes in efficacy, attitudes and behaviour among health service practitioners. It is recommended that standardized assessment tools be used to evaluate the outcomes of education interventions and that educators keep abreast of research and modify their interventions in light of new findings.

Diversity Competent Best Practices in Human Resources

Diversity competency is cultivated through workforce diversification, by managing diversity in the workplace, and by ensuring that human resource policies and practices are diversity competent.

A diversified workforce can improve patient-practitioner communication and create a more welcoming environment. To develop workforce diversity, it is recommended that human resource departments have access to community and existing workforce demographic and socio-cultural data in order to identify areas of under-representation. It is also recommended that measures, such as employment outreach programs, be implemented to recruit personnel from under-represented communities/populations. In addition, it is recommended that recruitment practices be reviewed for diversity competency, and that systemic biases in the selection process be eliminated.

With respect to managing diversity in the workforce, it is recommended that steps be taken to enhance the job satisfaction of employees of diverse backgrounds. Managers should examine their assumptions about, and expectations of, diverse staff members, should be sensitive to the assumptions and expectations held by diverse staff members themselves, and should encourage open communication about those assumptions and expectations.

Diversity competency is also enhanced when practitioners and staff members feel confident in their ability to provide diversity competent care. Confidence in diversity competency does not require personnel to have acquired a great deal of information about the health beliefs or practices of a certain diverse group, but requires that personnel be mindful and accepting of 'difference' in individual interactions and know where to find relevant information and advice.

Finally, human resource policies and practices should be reviewed to ensure that they not only prohibit discrimination but promote respect for difference. In addition, orientation sessions for new staff should be utilized as an opportunity for articulating the organization's diversity competency values, practices and expectations. Finally, diversity competency should be incorporated into employee job descriptions, and diversity competency-related measures should be integrated into performance reviews.

Best Practices in Diversity Competency Assessment/Evaluation

The assessment or evaluation process enables organizations providing health services to gauge their effectiveness in identifying and responding to the needs and preferences of diverse populations. When conducted on a regular basis, evaluations also enable organizations to identify changes over time. Evaluations further provide insight for strategic planning and resource allocation, and when conducted in consultation with consumers and key stakeholders, provide opportunities for cultivating and strengthening community partnerships. Specifically, evaluations can provide an indication of the effectiveness of an organization's diversity competency policies, procedures and practices; can generate feedback from diverse communities and individual clients with respect to their experiences of the organizational climate; can be used as a tool for measuring the diversity competency of health service providers and staff; and can provide an indication of additional continuing education or professional development requirements. Examples of evaluation tools identified in the literature include document review, cultural audit, and individual cultural competency self-assessment for practitioners. Evaluation tools are considered strongest when they are standardized; when they use a broad definition of diversity and a broad measurement of diversity competency; when they employ multiple methods and measure outcomes on multiple levels; when they are strength-based (identifying and promoting growth); and when they include provisions for the dissemination of the results and for the development of action plans.

Challenges in Achieving Organizational Diversity Competency

Several factors pose challenges for health organizations striving for diversity competency. 'Traditional' models or ways of thinking about diversity may need to be overcome. One example is the idea that 'culture' is a fixed or static variable or is the 'property' of individuals. Others include the belief that 'diversity' may be reduced to or be synonymous with race or ethnicity and the belief that diverse populations are homogenous. In addition, organizations may encounter difficulties conducting evaluations because there is a scarcity of published research providing baselines and proven evaluation methods. There is also the danger of over-emphasizing staff and practitioner education at the expense of developing practical workplace and service initiatives. Lack of senior management support, reflected for example in the inadequate allocation of resources for diversity competency measures, can further pose barriers, as can lack of practitioner and staff 'buy-in' or support for diversity competency initiatives.

Strengths of the Calgary Health Region

The Calgary Health Region exemplifies many diversity competency best practices, which may be summarized as follows:

- The Region adopts a broad definition of diversity¹, and keeps abreast of research identifying practices that have shown promise for enhancing diversity competency in health services². In addition, the Region adheres to diversity competency as an underlying organizational philosophy, having codified this value in key organizational documents³, and having committed the necessary infrastructure to cultivate and deliver diversity competent care⁴.
- The Region strives to develop and implement health services that are most responsive to the needs of diverse populations. This is accomplished in part by garnering a solid understanding of the diverse populations served by consulting community demographic profiles and census data; by consulting with community organizations representing diverse populations; and by conducting focus groups with members of diverse community. The Region draws on this information to tailor services toward specific diverse populations considered at risk for health disparities.
- The Region reduces language barriers by employing certified health interpreters to provide interpretation throughout the Region, 12 hours/day in 21 languages, and contracts an external service to provide telephone interpretation 24/7 in 170 languages. In addition, bilingual and multicultural staff members are approved to perform their duties in the first language of their clients only upon successful completion of language proficiency testing. The Region also provides 24-7 on-site access to professional American Sign Language Interpreters through contractual agreement with Deaf and Hard of Hearing Services.
- The Region is aware of the need for staff members to develop diversity self awareness; the Regional Diversity Directional Document 2008-2012 recommends staff examine their identity, values, attitudes and assumptions for ways in which they may affect their relationships with diverse clients; avoid imposing their own views on others; become aware of how their own behaviours may marginalize diverse groups; and avoid engaging in the belief that their own ways are superior. The Directional Document further recommends staff have a willingness to learn and seek opportunities to immerse in other cultures to enhance their appreciation for and understanding of diversity.
- To help practitioners understand the perspective of clients of diverse backgrounds, the Calgary Health Region has produced a Cultural Competency Check Card: Basic Communication Tools to Ensure Cultural Competency. This Card includes key questions that may be asked of clients to establish a basis of understanding, including why patients think they have their symptoms; what they have done to try to get better; and how their

¹ Including immigrants and refugees, persons with disabilities, gender and sexually diverse persons, persons living in poverty, persons experiencing homelessness and persons with low literacy skills

² The Region has undertaken a number of reviews of the literature and environmental scans to ensure that the initiatives undertaken to foster diversity competency are evidence-based.

³ Including Calgary Health Region. (2005). Population Health Strategic Plan 2005-2015. Unpublished; Calgary Health Region. (2006). Strategic Service Plan 2006-2010. Retrieved February 20, 2009, from http://www.calgaryhealthregion.ca/newslink/publications/reports/strategic_service_plan.html; Calgary Health Region. (2007). Health Plan 2007-2010. Retrieved February 20, 2009, from <http://www.calgaryhealthregion.ca/newslink/publications/>; the Region further articulates its commitment to diversity competency in its vision ("Healthy diverse communities") and its mission ("To become a proficient diversity competent organization that is a model for other health organizations").

⁴ The Region has committed considerable resources and infrastructure support, including the establishment of Health Diverse Populations, a Regional diversity department with the following staff positions: Refugee Health and Wellbeing Project Coordinator; Mental Health Diversity Strategies; Diversity Educator; Diversity/Community Liaisons; and a Diversity Research/Evaluation Specialist; a Chronic Disease Management for Diverse Populations program; and a formalized Interpretation and Translation Services unit with Certified Health Care Interpreters. A number of additional diversity positions have also been established, including a Community Development Diversity Strategist (Community Health Services Portfolio) and a Child and Women's Health Diversity Coordinator (Child and Women's Health and Specialized Services Portfolio).

condition is perceived in their culture. To facilitate the provision of diversity-appropriate services, the Region also encourages, the Regional Diversity Directional Document 2008-2012, the forming of relationships with traditional healers of cultural groups where available and the involvement of family and/or community members as part of the health services team where appropriate.

- The Region has developed a Regional Diversity Learning Plan to facilitate ongoing staff education in diversity competency as well as self-directed learning. The Region also hosts an annual Diversity and Wellbeing conference which provides a forum for health professionals and providers, researchers, decision-makers and the community to share and explore issues, research, best practices and solutions related to diverse populations and their health and wellbeing.
- Diversity competency in human resources is reflected in workplace policies that promote respect for difference and prohibit discrimination.
- The Calgary Health Region demonstrates best practices in diversity competency assessment and evaluation through its development of six Gold Standard Benchmarks of a diversity competent health service organization which will enable the Region to assess its diversity competency. The Benchmarks are considered universally accepted best practice standards that most organizations concerned about diversity competency attempt to reach.
- The Region has developed four online diversity competency self assessments for managers, health professionals/providers, support staff and project/program developers. Collectively, the results provide an overall assessment of the level of diversity competency of staff and assist with program planning for improvement.

Recommendations for the Calgary Health Region

The best / leading practices identified in this report serve as a basis from which a number of recommendations can be made to help the Calgary Health Region continue to become diversity competent. Recommendations include:

- Further operationalizing the concepts embedded diversity competency to facilitate their practical application;
- Continuing to identify best or leading practices in diversity competent care, and contributing to the knowledge base, particularly with respect to non-ethnocultural diverse populations;
- Continuing to keep abreast of the developments in diversity competency by networking with other health services organizations and engaging in period literature reviews;
- More fully engaging community stakeholders in the development, implementation and evaluation of practices and programs meant to enhance diversity competency;
- Developing mechanisms to ensure that community data is available to and meaningful for program and service planners;
- Systematically reviewing health services physical environments to ensure they are welcoming and diversity inclusive;
- Evaluating the linguistic and visual elements used in print materials, such as signage, brochures and posters displayed in health services environments to ensure they are appropriate for and inclusive of diverse populations;

- Examining health services utilization data to identify patterns of use by diverse populations; the disproportionate use of services on weekends or during evening hours for example may indicate the need to increase the availability of services during these hours.
- Implementing measures to ensure consumers of health services are informed of their right to and means of accessing health interpretation and ASL interpretation services;
- Undertaking additional initiatives to measure and address deficiencies in the health literacy of all populations;
- Enhancing efforts to incorporate preferred health and healing practices of diverse populations to the extent that is reasonable and possible;
- Continuing to develop targeted initiatives that reduce barriers to access to health services;
- Taking steps to foster client/patient empowerment, for example by facilitating their active participation in their care or by helping diverse clients/patients navigate the health care system;
- Ensure health services personnel have access to educational opportunities in the areas of interpersonal communication; diversity in health beliefs, attitudes and practices; and cultural, demographic, and epidemiologic characteristics of the population served;
- Reviewing the composition of the present workforce (including leadership) to identify gaps in representation of diverse populations, and implementing dedicated recruitment practices to increase diversity in the workforce;
- Becoming instrumental in encouraging the recruitment of members of diverse populations to post-secondary health and medical programs and fostering diversity within residency and fellowship programs;
- Enhancing the job satisfaction of employees of diverse backgrounds, enhancing the confidence of all staff members in providing competent care to diverse populations, and reviewing personnel policies to ensure they foster a respectful and welcoming environment for all personnel;
- Continuing to review the fairness of human resource policies and practices;
- Developing a logic model and evaluation plan based on the six Gold Standard Benchmarks;
- Ensuring evaluation measures are standardized to allow for valid and reliable measures over time and across disciplines and departments;
- Using a wide variety of evaluation measures to ensure all aspects of diversity competency and multiple perspectives are captured in service/program evaluations;
- Ensuring evaluation include provisions for the dissemination of findings and for the development of further plans of action, and ensuring that results are disseminated to the broader health services community as a means of advancing the knowledge base pertaining to diversity competency.

1.0 INTRODUCTION

The Calgary Health Region strives to serve as a model organization for diversity competency. To this end, the Region has commissioned a review of the literature and environmental scan to identify best/leading practices in diversity competency and identify ways in which the Region can grow in this area.

1.1 Rationale for Diversity Competent Health Services

Diversity of the Canadian Population

The Canadian population, including that served by the Calgary Health Region, is increasingly diverse. Statistics Canada's 2006 Census data show that one in five Canadians is foreign-born (19.8%), the highest proportion in 75 years (Statistics Canada, 2007a). Canada's foreign-born population is also growing at a more rapid pace, increasing by 13.6% between 2001 and 2006 compared to a 3.3% increase in the Canadian-born population during the same period (Ibid.).

The composition of newcomers to Canada is shifting; in 1971, 61.6% of newcomers 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 newcomer population (Ibid.). Newcomers to Canada are more likely to report a first language other than English; nearly three-quarters (70.2%) of newcomers reported a first language 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 (Ibid.). Newcomers are also more likely to settle in smaller metropolitan areas than in the past, with 16.5% making their home in Calgary, Ottawa-Gatineau, Edmonton, Winnipeg, Hamilton and London, compared to 14.3% in 2001 (Ibid.).

The population served by the Calgary Health Region, currently exceeding 1.2 million, is increasingly culturally and linguistically diverse (Calgary Health Region, 2008). Increased immigration from non-European countries (such as China, India, Philippines, Pakistan and Korea) and the high proportion of immigrants unable to effectively communicate in either official language requires the Region to continue to monitor and further develop health services that are culturally and linguistically appropriate (Ibid.).

Canada's population is increasingly diverse in terms of age, religious affiliation, disability, and sexual orientation. As of July 1, 2007, 13.4% of Canadians were aged 65 years and older, compared to 12.7% of the national population in 2002 (Statistics Canada, 2007b), and a growing number of Canadians report such religions as Islam, Hinduism, Sikhism and Buddhism (Statistics Canada, 2003). According to the Office for Disability Issues (2006), approximately 15% of Albertans are living with a disability. The three most common disabilities identified in this report were related to pain, mobility, and agility. Older seniors appear to be most affected by disabilities; 56% of older adults aged 75 and over reported having some form of disability compared to 35.3% aged 65 to 74 years (Ibid.).

Finally, while the share of the population served by the Calgary Health Region that self-identifies as lesbian, gay, bisexual, queer, intersexed, transgender or two-spirited (LGBQITT) is not known, a rough estimate can be calculated. According to Statistics Canada (2004), 1.2% of the provincial population self-identifies as 'homosexual' or 'bisexual,' although the number is very likely much higher: the provincial estimate excludes youth, seniors as well as 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 LGBTQITT individuals in the province's urban areas. Extensive interviews with individuals and organizations serving this population have led to estimates that 5-10% of population served by the Calgary Health Region identifies as LGBTQITT (Calgary Health Region, 2007a).

Reducing Health Disparities

Health disparities in diverse populations are well documented and are attributable, in part, to communication barriers, deficits in provider knowledge, insensitivity to diverse beliefs, values and practices, prejudice and discrimination, and client dissatisfaction and mistrust of the health services profession (Benkert, Peters, Clark, & Keves-Foster, 2006; Facione & Facione, 2007; Garrouette, Kunovich, Jacobsen, & Goldberg, 2004; Giger et al., 2007; Pratt & Apple, 2007). The goal of diversity competency in health services 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, cited in Callister, 2005) identified ineffective and inappropriate communication as a leading contributor to inequities in health services among diverse populations. Ineffective communication is associated with patient dissatisfaction and lack of trust in the quality of care received (leading to delays in future help-seeking); diagnostic errors; inappropriate treatment; poor comprehension of treatment; and noncompliance with treatment recommendations (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003; Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Brach & Fraser, 2000; Calgary Health Region, 2008).
- Increasing diversity awareness, knowledge and skills of health service providers is associated with the reduction of health disparities. For example, familiarity with the prevalence of certain conditions among diverse populations can ensure appropriate screening and increase the accuracy of diagnoses (Brach & Fraser, 2000). Familiarity with the use of alternative medicines may help avoid undesirable drug interaction effects (Ibid.), and the use of patient navigators has been shown to increase breast cancer screening, follow-up and treatment adherence in some populations (Freeman et al., 1995, and Jandorf et al., 2005, cited in Fisher, Burnet, Huang, Chin, & Cagney, 2007).
- Sensitivity to differences in symptom recognition, interpretation and attribution, and in thresholds for seeking care, as well as greater understanding of diversity in health practices (e.g. use of traditional healers) enhance the provision of health services to diverse populations (Anderson et al., 2003; Betancourt et al., 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, K., & Greene, 2007; Pratt & Apple, 2007). Clinical barriers more generally may arise when socio-cultural differences are not accepted or understood (Betancourt et al., 2003). Examining and challenging discriminatory practices and attitudes, prejudice and social stereotypes, and the awareness and acceptance of difference more generally, are believed to reduce health disparities (Anderson et al., 2003; Brach & Fraser, 2000; Reynolds, 2004), as is the fostering of relationships of trust and rapport between health service providers and patients (Garrouette et al., 2004).

Responding to Legislation

In addition to shifting population demographics and growing awareness of barriers to health services, health service organizations are further motivated to provide diversity competent care in response to municipal, provincial and federal legislation which addresses 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).

1.2 Current Trends in Diversity Competency Literature

Before turning to the literature on best/leading practices, it is useful to identify some recent shifts in the conceptualization of diversity competency. In doing so, the direction of current thinking may be contextualized and current competency practices better understood. Specifically, current thinking reflects:

- A broadening of definitions of culture and diversity and recognition of in-group heterogeneity;
- A broadening of definitions of diversity competency;
- A shift in focus from patient-provider to systemic and organizational diversity competency; and
- Moving from simply *conceptualizing* diversity competency to actually implementing, assessing and evaluating initiatives.

While early diversity competency literature approached diversity largely in terms of discreet categories of race and ethnicity, the present literature is concerned with the many dimensions of diversity; the Calgary Health Region (2008) for example exemplifies a much more inclusive scope, with 'diversity' referring to:

...all the ways people are unique and different from each other. Dimensions of diversity include, but are not limited to, such aspects as ethnicity, 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 (p. 3).

A more inclusive definition of diversity, such as the one above, better captures the complexity of diverse identities (Bowen, 2004; Jackson, 2007), and is a reminder that shared ethnic or racial identity, for example, does not imply homogeneity:

Even when a provider and patient share the same ethnic or racial heritage, other aspects of diversity remain to be addressed (Schim, Doorenbos, & Borse, 2005, p. 355).

A broad definition of diversity is also necessary given the inseparability of social and cultural factors, leading some authors (e.g., Betancourt et al., 2003) to shift the focus from racial/ethnic barriers to the broader socio-cultural barriers to health services.

A broader interpretation of diversity competency also informs current thinking. In earlier work, discussions of competency often centered on ways practitioners could enhance their sensitivity to and respect for difference (Chin, 2000), and reduce linguistic barriers (Reynold, 2004). In contrast, the current literature understands diversity and cultural competency as a process

involving cultural sensitivity, cultural knowledge, cultural skills, cultural desire⁵, and cultural proficiency (Bowen, 2004; Brach & Fraser, 2000; Campinha-Bacote, 2003, 2007; Schim et al., 2005; Wells, 2000). Moreover, the influence of culture on health services is being expanded to include awareness of the culture of Western biomedicine itself (Hunt, 2007b; Potocky et al., 2007).

Third, current thinking reflects a widening of focus from the patient-provider relationship to health service systems, or the development of diversity competency as an organizational practice (Betancourt et al., 2003; Bowen, 2004; Chin, 2000; Kairys et al., 2002; Wells, 2000). For example, Van Ngo (2000) identifies the 'model' diversity competent organization as being diversity competent in the areas of organizational culture, governance, administration, policy and decision making, personnel practices, service delivery, community relations, and communication.

Finally, within the current literature there appears to be a greater effort than in the past to operationalize diversity competency so that it may be implemented in practice and evaluated (Chin, 2000). Notably, Black (2005) and Bowen (2002) (cited in Kumanan, 2004) suggest that this shift is still in its infancy, as there remains a lack of literature on how the values of diversity competent care are applied in practice, or on the 'how-to' of diversity competent health services.

This report will now proceed to

- Describe the methods used to identify leading or best practices;
- Present best practices at both the organizational and service delivery levels of health services;
- Discuss leading practices in educational interventions, human resource practices, and assessment and evaluation; and
- Look at the work being done at the Calgary Health Region.

⁵ Cultural desire is defined as the motivation of practitioners "to 'want to' engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and seeking cultural encounters. It stands in contrast to the feeling of 'having to' participate in this process" (Campinha-Bacote, 2003, p. 4).

2.0 METHODS

2.1 Literature Review

The literature review was prepared with computer-assisted database searches (EMB Reviews – Cochrane; EMBASE Review; CINAHL; Ovid Medline; Health Source; Health STAR; PubMed Restricted; Web of Science; Scopus; Academic Search Premier; IBSS; Social Services Abstracts; Social Works Abstracts Plus; SocINDEX; Sociological Collection) with key words “cultural competence, cultural competencies, cultural diversity, diversity services, diversity competence, diversity competency, diversity measures, diversity organizations, diversity models, cultural models, cross cultural comparison, cultural characteristics, and cultural deprivation.” These terms were combined with “family practice, delivery of health care, health services, evidence based, best practice,” using wild card and MeSH headings, to identify North American and international articles published between 2001 and 2008. Articles were also identified through Internet search engines (Google and Google Scholar).

2.2 Environmental Scan

The environmental scan included a review of non-refereed (‘grey’) literature identified through Internet search engines (Google and Google Scholar) with a particular focus on organizations exemplifying ‘best’ or ‘leading’ practices in diversity competency. Key informant interviews were conducted with four diversity/community liaisons with Healthy Diverse Populations, Calgary Health Region; one community liaison with the Refugee Health and Wellbeing Project, Calgary Health Region; and four managers of interpretation and translation services programs across western Canada (Fraser Health, Winnipeg Regional Health Authority, Calgary Health Region and one unnamed interpretation and translation service).⁶

2.3 Criteria for Determining Best/Leading Practices

Because few practices in diversity competency have been systematically evaluated and empirically tested, evidence of their ability to produce desired outcomes is lacking (Chrisman, 2007; Fisher et al., 2007; Whaley & King, 2007; Whitley, 2007). This is attributed in part to the relative infancy of the field, as well as a lack of standardized assessment tools (Doorenbos, Schim, Benkert, & Borse, 2005; Siegel, Haugland, & Chambers, 2003). Rather than rely exclusively on evidence-based outcomes, the current review included practices considered to exemplify the cultivation of diversity competency because they were:

- Identified as ‘promising’ through systematic reviews of published literature; or
- Recommended by multiple reliable sources; or
- Components of conceptual definitions or models of diversity competency.

⁶ Key informants helped to identify best practice examples. Data from these interviews also has been incorporated into two other Calgary Health Region reports focused on direct service delivery: Arnold, S. and de Peuter, J. 2008. *Best Practices in Diversity Liaison Services* and Arnold, S. and de Peuter, J. 2008. *Best Practices in Interpretation and Translation Services*.

3.0 BEST/LEADING PRACTICES IN DIVERSITY COMPETENCY

In this section we discuss practices that have been identified in the literature and environmental scan as contributing to the diversity competency of health services at the organizational level. Promising practices include, in brief, the institutionalization of diversity competency as a philosophy; codification of that philosophy in organizational statement; provisions for infrastructure; understanding diversity in populations served; translating organizational philosophy into practice at all organizational levels; involving diverse communities in the cultivation of competencies; and routine assessment and evaluation of organizational strengths and limitations. Promising practices for health service delivery are discussed in the subsequent section.

3.1 Systemic/Organizational Best/Leading Practices

Diversity competent organizations institutionalize diversity competency as an underlying organizational philosophy rather than a discreet set of initiatives.

The institutionalization of diversity competency is premised on a deep commitment of the organization to value diversity, to hold this value as an underlying philosophy, and to develop an organizational culture reflective of this value and supportive of diversity competent practice (Black, 2005; Bowen, 2004; Callister, 2005; Campinha-Bacote, 2002; Chrisman, 2007; Doorenbos et al., 2005; Matus, 2004; Kairys et al., 2002; Kim-Godwin, Clarke, & Barton, 2001; Reynold, 2004;). Embedded in a culture of diversity competency is the assumption that the health service organization will seek to understand and support the needs and preferences of diverse clientele (Callister, 2005), promote diversity self-awareness among its members (Black, 2005; Campinha-Bacote, 2002) and motivate members at all levels to develop diversity sensitivity and the desire to practice diversity competent care (Callister, 2005; Campinha-Bacote, 2002, 2003; Doorenbos et al., 2005; Kairys et al., 2002).

Approaching diversity as an organizational value, rather than a set of initiatives, has been identified as a best practice in six of the 'flagship' non-profit organizations thought to exemplify diversity competency in Washington, D.C. (Bartlett, 2003). The U.S. Department of Health and Human Services (2001a) also identifies the institutionalization of diversity competency as one of the characteristics of health service organizations considered successful in delivering diversity competent care. This practice is further cited as one of the Cultural and Linguistic Competency Standards by the County of Los Angeles Department of Health Services (2003).

Diversity competent organizations codify diversity competency values in formal statements.

Diversity competent health organizations codify their philosophy of diversity competency in formal statements (e.g., mission, vision and value statements; guiding principles; strategic plans or directional documents; policy statements; codes of conduct; and accountability/oversight mechanisms) and regularly review such statements for biases and exclusionary practices (Bowen, 2004; Brach & Fraser, 2000; Chrisman, 2007; French, 2003; Kairys et al., 2002; Matus, 2004; Reynold, 2004). Expressing the organization's commitment to diversity competency in formal statements is confirmed as a 'best practice' by the U.S. Department of Health and Human Services, Office of Minority Health (2001b), the Registered Nurses' Association of Ontario (2007), the Ethnic Communities' Council of Victoria Inc. (2006), the Canadian Nurses

Association Position Statement (n.d.), and the Immigrant Women's Association of Manitoba, Inc. (2006).

Diversity competent organizations develop and maintain the infrastructure necessary for the cultivation and practice of diversity competency.

Best Practice Example

Corporate support for diversity competency practices and programs can lead to greater allocation of resources for such practices/programs. An interview with a key informant from one Canadian Health Authority revealed that interpretation services had operated informally for a number of years, but following an official Corporate Directive for the provision of interpreter services the program was able to garner greater resources for staffing and gained a budget for telephone interpretation services (Anonymous Language Services Program Manager).

In addition to the codification of diversity competency values, another best or leading practice is the development and maintenance of the infrastructure capacity to enable the development, promotion, and practice of diversity competent care (Bhui, Warfalk, Edonyal, McKenzie, & Bhugra, 2007; Ethnic Communities' Council of Victoria Inc., 2006; Gilbert, 2003a; Government of Australia, National Health and Medical Research Council, 2005; NICHQ, 2005).

Best Practice Example

The Calgary Health Region codifies its philosophy of diversity competency in a number of key organizational documents, including the Strategic Service Plan 2006-2010 (stating that the organization will provide care that is tailored to the needs of specific diverse communities); the Population Health Strategic Plan (identifying the reduction of health disparities as one of three priority areas); and the 2006-2009 Health Plan (articulating the development of a workforce strategy that will "attract the required health care workforce, create a culture that emphasizes a healthy and respectful workplace, develop the health care workforce and utilize the skills and talents of the health care workforce"). In addition, the Regional Diversity Directional Document 2008 - 2012 articulates the organization's respect for diversity within the workforce and within the populations served. The Region's vision ("Healthy diverse communities") and mission ("To become a proficient diversity competent organization that is a model for other health organizations") further embody the organization's commitment to the principles of diversity competency.

Infrastructure includes the allocation of adequate financial resources⁷, as well as the capacity to develop, implement and evaluate mechanisms that ensure organizational leadership is representative of the diverse populations served by the health system (Betancourt, Green, & Carrillo, 2002; Betancourt et al., 2003; Bowen, 2004). Ensuing diversity within leadership structures is discussed in more detail in Best/Leading Practices in Human Resources (below).

⁷ For example, the Registered Nurses' Association of Ontario (2007) recommends having dedicated funding for staff positions for planning, implementing and evaluating competency strategies.

Best Practice Example

Corporate support in the Calgary Health Region is exemplified by the resources allocated to diversity competency initiatives. Infrastructure dedicated to diversity competency includes a Regional diversity department (Healthy Diverse Populations) which is led by a Manager and includes the following staff positions: Refugee Health and Wellbeing Project Coordinator; Mental Health Diversity Strategist; Diversity Educator; Diversity/Community Liaisons; and a Diversity Research/Evaluation Specialist. The Region has several additional diversity staff positions, including Child and Women's Health Diversity Coordinator (Child and Women's Health and Specialized Services Portfolio); Manager, Interpreter and Translation Services; Certified Health Care Interpreters; Program Manager, Chronic Disease Management for Diverse Populations; and Community Development Diversity Coordinator (Community Health Services Portfolio). The work of staff in formal diversity roles is guided by the Regional Diversity Advisory Committee and a number of foundation documents including the Calgary Health Region, Regional Diversity Directional Document 2008-2012.

Diversity competent organizations understand the diversity of their target populations and apply this understanding in the development and delivery of diversity competent health services.

In order to provide services that are diversity competent, health services organizations need to develop and maintain data sources pertaining to the composition of the population served (including demographic, cultural and epidemiological characteristics). The California Pan-Ethnic Health Network (2001) recommends routinely assessing such demographic trends as age, gender, education, income and occupations as well as immigration and refugee status and available community resources, including alternative and/or traditional health and social institutions.

Best Practice Example

Fraser Health reports that BC Immigration announces when large refugee/immigration groups are expected to arrive in the province. When announcements are made in a timely fashion, the Language Services Program Manager is able to recruit interpreters to meet the anticipated demand (Language Services Program, Fraser Health).

Data may be garnered from a local or national census or may be supplied by community service agencies (NICHQ, 2005; U.S. Department of Health and Human Services, 2001b).

Best Practice Example

The Calgary Health Region uses community demographic profiles to tailor services toward specific diverse populations considered at risk for health disparities / barrier to care, including immigrants and refugees, persons with disabilities, gender and sexually diverse persons, persons living in poverty, persons experiencing homelessness and persons with low literacy skills. Data is garnered from Statistics Canada and the City of Calgary, as well as from community organizations that represent diverse populations such as the Calgary Refugee Health Program (Calgary Health Region, Regional Diversity Directional Document 2008-2012). In addition, focus groups conducted with members of diverse communities were integral to the collection of data for the completion of two recent reports, *Gender and Sexual Diversity* and *Persons with Disabilities* (2008) to understand the perceived health issues and barriers to accessing health services faced by these communities.

Diversity competent organizations 'translate' their organizational philosophy of diversity competency into practice at all levels of the organization.

Best Practice Example

In their review of eight American hospitals exemplifying diversity competence, Wynia and Matiassek (2006) found that hospitals routinely involve representatives of diverse communities on community advisory boards and actively partner with them on specific programs.

Organizations exemplifying diversity competency codify the value of diversity in formal statements, but further put the philosophy 'into practice' by developing formal initiatives at all levels of the organization. At the highest levels this may include the development of diversity plans stating activities, time-lines and milestones, as well as organizational charts identifying the responsibilities of personnel in the implementation of diversity competent practices (Bowen, 2004). At the departmental level this may include the re-working of policies and practices and personnel handbooks, for example, to ensure they reflect and support diversity competency (NICHQ, 2005; Simmons, 2004).

Diversity competent organizations systematically involve consumers, key stakeholders, and diverse communities in all stages of diversity competency development, implementation and evaluation, and cultivate partnerships with diverse communities to enhance all aspects of health services delivery.

The scholarly literature clearly identifies the organization's involvement of consumers, key stakeholders, and diverse communities in all stages of diversity competency development, implementation and evaluation as a best or leading practice (Betancourt et al., 2002; Bowen, 2004; Callister, 2005; Horner et al., 2004; Mullins, Blatt, Gbarayor, Keri Yang, & Baquet, 2005; Reynold, 2004). The environmental scan also identified the inclusion of diverse communities in the development of competency measures as a component of the mandates or standards of government, professional associations, and interest groups (California pan-Ethnic Health Network, 2001; Canadian Nurses Association, n.d.; Ethnic Communities' Council of Victoria Inc., 2006; Immigrant Women's Association of Manitoba, Inc., 2006; U.S. Department of Health and Human Services, 2001b).

Inclusion strategies such as encouraging representatives of diverse communities to serve on advisory committees and/or inviting community leaders to act as liaisons serve to cultivate relationships and promote partnerships, whereby specific community needs may be better identified and more appropriately addressed (The National Initiative for Children’s Healthcare Quality, 2005).

Community relationships are most effective when they are reciprocal; for example, when community leaders serve as educators in diversity competency (speakers at brown-bag lunches in health services organizations for example) or assist health services organizations in reducing access barriers within their community (e.g. by promoting preventative care among community members; Anderson, Calvillo, & Fongwa, 2007).

Diversity competent organizations routinely assess and evaluate strengths and limitations in diversity competency.

The literature recommends as an organizational best or leading practice the routine assessment and evaluation of strengths and limitations in diversity competency (California Pan-Ethnic Health Network, 2001; Callister, 2005; Chin, 2000; Horner et al., 2004; Matus, 2004; O’Connell, Komer, Rickles, & Sias, 2007). Evaluations enable organizations to determine their current competencies, as well as gaps or existing needs that require further attention. Assessment and evaluation of best/leading practices are discussed in greater detail in a later section (“Best/Leading Practices in Assessment and Evaluation”).

3.2 Best/Leading Practices in Health Service Delivery

Best/leading practices facilitating diversity competency in service delivery include: developing environments that are inclusive and welcoming; reducing linguistic or language barriers; cultivating diversity sensitivity, awareness, knowledge and skill among practitioners; and actively empowering all consumers of health services. Each is discussed in this section.

Diversity competent organizations provide inclusive and welcoming service delivery climates / environments.

Best Practice Example

The unprecedented population growth experienced by the City of Calgary and surrounding areas and an increase in the prevalence of chronic diseases and ongoing health disparities required the Calgary Health Region to re-evaluate the sustainability of current health services delivery and to strategize and develop an innovative approach to health services (Calgary Health Region, 2006). The Community Service Development Strategy (CSD) was developed as a response to this call for innovation, and is intended to help the Region become a community-focused organization with an increased focus on health promotion, wellness and disease prevention (Calgary Health Region, 2007b). The East Calgary Health Services Initiative (ECHSI), the first opportunity for the Calgary Health Region to operationalize and evaluate the CSD strategy, drew on information garnered through focus groups with members of the community (representing Aboriginal, Métis, Spanish and Chinese populations) to identify health-related issues

Diversity competency is enhanced when consumers of health services are made to feel welcome, valued and respected, and made to feel as though they belong. With respect to the physical environment, clients can be made to feel welcome by ensuring the surroundings acknowledge and celebrate diversity. Inclusiveness may be enhanced by displaying artwork and using color schemes that are significant to diverse populations, by using graphics depicting diverse populations in posters and brochures, and by using multi-lingual signage (Bartlett, 2003; Government of Nova Scotia Department of Health, 2005; NICHQ, 2005; Simmons, 2004; Wynia & Matiasek, 2006).

Diversity inclusive environments are further enhanced by ensuring services are offered at times, in locations, and in formats that are appropriate and easily accessible for diverse populations. This may include extended clinical hours, community clinics, or outreach, as the following examples illustrate:

A solo practitioner organized group patient visits for Vietnamese patients all of whom were dealing with depression that was manifesting as physical symptoms such as back pain, headaches, and lethargy. She conducted group visits for back pain for these patients and used this as an opportunity to address not only the pain, but also underlying depression, in a way that was compatible with their cultural beliefs, practice, and in their preferred language. Another clinic took a similar approach using its on-site dental clinic as a vehicle for Saturday morning group visits to meet with Spanish-speaking parents of toddlers. The children are given a basic dental exam and the parents are provided with information about dental care (NICHQ, 2005, p. 26).

Best Practice Example

Using focus group and interview methods, Bowl (2007) investigated the experiences of South Asian in-patients of a mental health facility, and found that the environment created barriers to prayer practices of importance to participants. For example, participants were invited to use the hospital chapel for prayer, but praying in a chapel is inappropriate for Muslims. Moreover, praying numerous times a day, customary in the Muslim tradition, was interpreted by uninformed staff as obsessional behaviour, and praying between midnight and 1am was considered odd, but only because the staff were not aware that this is the holy hour in some cultures. Participants also reported that the physical environment of the hospital did not accommodate their cultural practice of washing privately, as wash basins were located within public view.

Inclusive service delivery environments may also require increased knowledge of and sensitivity to diversity in spiritual or religious practices, as the textbox below illustrates.

Diversity competency in the delivery of health services requires strategies to reduce barriers to health services resulting from linguistic/language diversity

Barriers to health services resulting from linguistic/language barriers are well documented in the literature. Best or leading practices meant to enhance communication include: the provision of qualified health interpreters and translators and qualified American Sign Language (ASL) interpreters; the cultivation of a multi-lingual workforce; and the provision of linguistically-appropriate print materials. Best practices also include developing competency in cross-cultural communication norms and non-verbal communication, and employing communication strategies that accommodate variation in levels of health literacy. Each is discussed in this section.

Qualified Health Interpreters / Translators / ASL Interpreters

The provision of qualified health interpreters and translators, and of qualified ASL interpreters is a necessary step in becoming diversity competent⁸ (Betancourt et al., 2003; Black, 2005; Hunt, 2007b; Jackson, 2007; Reynold, 2004).

Best Practice Example

The Calgary Health Region employs 45-48 certified health care interpreters to provide in-person and over-the-phone interpretation throughout the Region, 12 hours a day in 21 languages. In addition, the Region contracts an external service to provide over-the-phone medical interpretation 24/7 in 170 languages (Interpretation and Translation Services, Calgary Health Region). The contracted over-the-phone service is considered to be a supplemental service for use when an interpreter is needed instantly or after hours of the regular service or when services are needed in an infrequently encountered language. The Region also provides 24-7 on-site access to professional American Sign Language Interpreters through contractual agreement with Deaf and Hard of Hearing Services.

It is important that health organizations implement effective processes for assessing patients' language skills, needs and preferences (County of Los Angeles Department of Health Services, 2003; Gilbert, 2003b), such as standardized questionnaires (NICHQ, 2005), and that practitioners realistically assess their own proficiency before providing services in second languages (Gilbert, 2003b).

Practitioners should also know how to access and work with interpreters and translated written materials (U.S. Department of Health and Human Services, 2001b; County of Los Angeles

Best Practice Example

Bilingual and multilingual staff members at the Calgary Health Region undergo language proficiency testing (oral and reading) before they are approved by the Region to perform their duties in the language for which they have been tested. Ensuring the staff members are skilled in their first language helps to ensure quality control for interpretation (Interpretation and Translation Services, Calgary Health Region).

Department of Health, 2003). In Bowl's (2007) research on the experiences of South Asian persons receiving mental health services in the UK, respondents reported that many sessions continued on without an interpreter, even after practitioners realized that an interpreter was necessary. Bowl's research reinforces the importance of professional education in the proper and timely use of interpretation services.

⁸ The use of informal interpreters (such as family or friends) is discouraged as their use is associated with "misunderstanding, dissatisfaction, omission of vital information, misdiagnoses, inappropriate treatment, and lack of compliance" (U.S. Department of Health and Human Services, Office of Minority Health, 2001a, p. 10).

Best Practice Example

As interpretation services are implemented in various sites in the Winnipeg Regional Health Authority, the sites are provided with a package that includes signage and other materials providing information on the services, including protocols for requesting an interpreter (Language Access, Winnipeg Regional Health Authority).

The literature further recommends organizations provide visible and accessible information about patients' rights to language assistance services (NICHQ, 2005; U.S. Department of Health and Human Services, 2001b). It is also recommended that interpretation needs are anticipated in advance and longer appointment times and interpreter availability be arranged in advance (NICHQ, 2005; Phokeo & Hyman, 2007).

Multi-lingual Workforce

According to the literature, adequate and appropriate interpretation services are necessary in health services delivery, but the provision of bilingual staff is ideal (Anderson et al., 2003; Callister, 2005; Chin, 2000; Wynia & Matiasek, 2006). According to the U.S. Department of Health and Human Services (2001a) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care:

Language services include, as a first preference, the availability of bilingual staff who can communicate directly with patients/consumers in their preferred language. When such staff members are not available, face-to-face interpretation provided by trained staff, or contract or volunteer interpreters, is the next preference. Telephone interpretation services should be used as a supplemental system when an interpreter is needed instantly, or when services are needed in an unusual or infrequently encountered language (p. 8).

The development of a diverse workforce, including the recruitment of bilingual personnel, is revisited in a later section.

Provision of Linguistically-appropriate Print Materials

The provision of linguistically-congruent print materials is a well-documented best practice in diversity competency⁹ (Betancourt et al., 2003; Brach & Fraser, 2000; Callister, 2005; Chin, 2000; Reynold, 2004). In addition, Andrulis and Brach (2007) suggest that symbol signs be culturally appropriate and refer the reader to the "Hablamos Juntos' Signs that Work" project which addresses the intersection of literacy, culture and language by testing symbol signs to determine if they are meaningful across language and cultural groups¹⁰.

Competency in Cross-cultural Communication Norms and Non-verbal Communication

Cultural norms in communication, including variations in styles and patterns of communication and concepts of space and physical contact, if understood, can enhance the delivery of health services (Betancourt et al., 2002; Gilbert, 2003b; Government of Nova Scotia, 2005). In some cultures, for example, it is considered disrespectful to question persons in positions of authority. Patients may indicate that they understand how to take medication, for example, rather than express misunderstanding or question the treatment (NICHQ, 2005). Similarly, the Nova Scotia Department of Health (2005) Guidelines state that practitioners should be familiar with cultural

⁹ Print materials include but are not limited to signage, patient intake forms, patient education materials, consent forms, medication information, advance directives, patient complaint forms, patient rights and responsibilities, and appointment reminder notices.

¹⁰ See www.hablamosjuntos.org/signage/default.index.asp

variations in expressions of distress, noting that cultural norms may prohibit patients from showing or acknowledging pain, or more generally, may require patients to maintain emotional control when asked about upsetting subject matter. Betancourt et al. (2002) and Anderson et al. (2003) further recommend that health information materials be aligned with the cultural norms of diverse populations.

In addition to understanding the cultural communication norms of diverse populations, the Registered Nurses' Association of Ontario (2007) recommends practitioners be aware of their own communication style, and how it affects both colleagues and patients, and that practitioners learn to use a range of effective communication skills (e.g., empathetic listening, reflecting, non-judgmental open-ended questions).

Finally, practitioners should strive to understand and respect normative non-verbal communication (Betancourt et al., 2002; Gilbert, 2003a; Kairys et al., 2002) including the normative use of eye contact, facial expressions, touch, body language, spatial distancing practices, and acceptable greetings (Purnell, 2002).

Communication strategies that accommodate variation in levels of health literacy

While the term 'health literacy' originally focused on an individual's ability to read and understand health information, the focus has recently expanded to include the ability of health systems and care providers to communicate in relevant and easy to understand ways. Nutbeam (2000, as cited in Rootman, 2002) identified three levels of health literacy: 1) functional literacy (the ability to read and write well enough for basic understanding); 2) interactive literacy (the ability to communicate effectively with others about health needs; and 3) critical literacy (the ability to critically appraise health information). Outcomes of low health literacy include lower health knowledge, misinterpretation of prescriptions and lower receipt of preventive services (Andrulis & Brach, 2007).

Andrulis and Brach (2007) recommend clinicians and health services organizations recognize the interrelatedness of culture, language and health literacy, and ensure that health service communication is competent in all three areas. This approach is necessary because even when easy-to-understand language is used in print materials, the materials may not be understood because they employ / assume Western health constructs. This is also a danger in translated materials; health information may be translated into a patient's first language, but the patient may lack literacy skills in their first language. Interpretation should also be sensitive to the interconnectedness of culture, language and health literacy:

For example, interpreters will repeat complicated, jargon-filled communications unless health literacy is addressed along with language barriers. Furthermore, clinicians cannot assume that interpreters and patients share the same culture because they speak the same language (Andrulis & Brach, 2007, p. S126).

This point is further illustrated with respect to standardized health literacy assessment tests (e.g., Rapid Estimate of Adult Literacy in Medicine (REALM) or Short Test of Functional Health Literacy in Adults (S-TOFHLA)), as low scores could be due to low literacy, limited English language proficiency, or lack of familiarity with Western health terms and concepts (Ibid.).

Best Practice Example

A study conducted by the Association of Clinicians for the Underserved (Barrett, Puryear, & Westpheling, 2008) identified five health care facilities in the U.S. exemplifying best practices in addressing low health literacy of patients. One of the best practices exemplified by the facilities is ensuring that staff members take a proactive role in identifying and accommodating patients' health literacy barriers (e.g., assisting clients with paperwork or meeting with clients after the physician visit to ensure the information provided by the physician was clearly understood). A second best practice is the use of standardized communication tools (Teach Back, Ask Me 3, and Motivational Interviewing) to ensure patients with low health literacy understand their treatment plans and to encourage dialogue and determine what patients want to focus on during physician visits. In addition to formal techniques, clinicians use health-education materials designed for patients with low reading levels, individualized health-education sessions for patients with low health literacy, and give patients the opportunity to bring a friend or family member to the appointment. Other practices include scheduling 30-minute appointments with patients known to have low health literacy to allow ample time for discussion of treatment plans, using a fourth-grade literacy level when designing print education material, and providing ongoing staff and physician training.

Andrulis and Brach (2007) recommend clinicians limit the number of messages delivered at one time. They also recommend using simplified, jargon-free language, probe for whether culture and/or language could be a factor in any miscommunication, and have patients explain what they have been told and repeat the information until it is clear that they understand. Clinicians should further record patient preferences and requirements regarding health literacy, culture and language in medical records and tailor health services to the patient's needs.

Education materials should be easy to read and relevant to diverse populations, and translated into appropriate languages. Interpreters should be trained in diversity competency and health literacy as well as medical interpretation, and family members and friends should be encouraged to accompany patients to help with question-asking and decision-making.

Diversity competency in the delivery of health services requires practitioners and staff to cultivate diversity sensitivity and awareness of the relationships between diversity and health

Diversity sensitivity and awareness refers to the understanding that the health services encounter is influenced by the unique perspective of multiple participants, including the patient and their family, staff members, and health practitioners. Diversity competency requires health practitioners and staff members to examine their own worldview and assumptions and to state and explore their personal biases, values and beliefs and how they affect others (Campinha-Bacote, 2003; Ethnic Communities' Council of Victoria Inc., 2006; Gilbert, 2003b; Kim-Godwin et al., 2001; Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003; McGee, 2001; Pratt & Apple, 2007; Rust et al., 2006; Warren, 2007). In addition, the Registered Nurses' Association of Ontario (2007) suggests health practitioners acknowledge their own feelings toward diversity and difference, seek guidance from diversity competent role models, and recognize and address inequitable behaviours when they occur.

Diversity sensitivity further requires health practitioners and staff members to develop an understanding of the relevance of diversity to health, including an understanding of health disparities related to access-to-care issues and sociocultural circumstance¹¹ and become familiar with the socio-cultural demographics and language trends of the populations they serve (Betancourt et al., 2002; Gilbert, 2003b; Immigrant Women's Association of Manitoba Inc., 2006; NICHQ, 2005; Registered Nurses' Association of Ontario, 2007; Rust et al., 2006; U.S. Department of Health and Human Services, 2001b). Practitioners and staff should also be familiar with legal / regulatory requirements, standards and guidelines of professional associations, and the organization's internal diversity policies (County of Los Angeles Department of Health, 2003; Gilbert, 2003b).

Diversity competency in the delivery of health services requires practitioners and staff to develop diversity appropriate care practices by developing diversity knowledge and diversity skills

Best Practice Example

The Calgary Health Region (2008), Regional Diversity Directional Document 2008-2012 states that one priority is to form relationships with traditional healers of cultural groups where available and to involve family and/or community members as part of the health care team where appropriate.

The development and implementation of diversity competent health assessments, interventions and treatments requires health practitioners and staff to acquire diversity knowledge¹² and diversity skills¹³ (Campinha-Bacote, 2003). Diversity knowledge provides practitioners with a point of reference for understanding patients' beliefs about health and sickness, and enables practitioners to better understand how patients define, name, and understand disease and treatment and attribute symptoms (Campinha-Bacote, 2002; Gilbert, 2003b; Hunt, 2007b; Poon et al., 2003; Purnell, 2002):

For example, illness may be seen as a punishment from God, witchcraft, imbalance between yin and yang, or a sign from the universe. Patients may be fatalistic, resigned, or not involved in their own medical care based on these cultural factors (Genao, Bussey-Jones, Brady, Branch, & Corbie-Smith, 2003, p. 137; emphasis original).

¹¹ For example, Richardson, Babcock Irvin, and Tamayo-Sarver (2003) recommend clinicians be provided with sociocultural information about client groups most likely to experience disparities in emergency care.

¹² Diversity knowledge is defined as "the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups" (Campinha-Bacote, 2003, p. 6).

¹³ Diversity skill is defined as "the ability to collect relevant cultural data regarding the patient's presenting problem as well as accurately performing a culturally-based physical assessment" (Campinha-Bacote, 2003, p. 7) and is defined by Kim-Godwin et al. (2001) as the synthesis of sensitivity and knowledge in existing roles, functions and skills.

Best Practice Example

The Calgary Health Region, Regional Diversity Directional Document 2008-2012 recommends staff develop diversity self-awareness through examination of one's own identity and values; being aware of one's own attitudes and behaviour; understanding how one's attitudes and behaviors may affect the relationship with the client; avoiding imposing one's own views; being aware of one's own behaviors that may marginalize diverse groups; and avoiding engaging in the belief that one's own ways are superior. It also recommends having a willingness to learn, having an open mind, and seeking opportunities to immerse in another culture for example for deeper understanding.

Diversity knowledge also enables practitioners to identify and incorporate, where appropriate, traditional / diverse health practices (e.g., pregnancy and death rituals) and to recognize and engage traditional healers or spiritual or religious leaders as resources and participants in the delivery of care (Bhui et al., 2007; Brach & Fraser, 2000; Callister, 2005; Fisher et al., 2007; Hackett et al., 2006; Kairys et al., 2002; Pratt & Apple, 2007). Diversity knowledge further facilitates the development of appropriate outreach initiatives, including targeted health promotion campaigns and engagement of community health workers (Anderson et al., 2003; Callister, 2005; Chin, 2000; Fisher et al., 2007; Reynold, 2004).

Best Practice Example

The Calgary Health Region developed a "Cultural Competency Check Card: Basic communication tools to ensure cultural competency" which includes "Key questions to establish a basis of understanding" (asking patients why they think they may have their symptoms, what they've done to try to get better, how is that condition perceived in their culture, etc); and "Cross-cultural dialogue enhancement" (including respect for differences in health beliefs).

The literature also recommends practitioners become familiar with the disease patterns of diverse populations, including disease incidence and prevalence, and with biocultural ecology (e.g. genetic, hereditary, endemic and topographical diseases; differences in drug metabolism; and awareness of alternative drug therapies; Campinha-Bacote, 2007; County of Los Angeles Department of Health Services, 2003; Gilbert, 2003b; Horner et al., 2004; Kudzma, 2001; Government of Nova Scotia Department of Health, 2005; Purnell, 2002).

Notably, diversity competency does not require health practitioners to become 'experts' in all cultures/diverse populations. Rather, it is critical that practitioners become knowledgeable about the influence of diversity, and view the patient as the 'expert' (Callister, 2001; Chenowethm, Jeon, Goff, & Burke, 2006; Kemp, 2005; Leuning, Swiggum, Wieger, & McCullough-Zander, 2002; Reese, Melton, & Ciaravino, 2004; Stone, 2004). Cone and associates (2003) for example suggest practitioners develop relationships of trust and rapport with patients that will facilitate the sharing of knowledge. Sharing their perspectives can serve to empower patients, and also reduces the likelihood that the practitioner will rely on (and reify) stereotypes (Niemeier, Burnett, D. M., & Whitaker, 2003).

Several authors recommend asking the "Kleinman Questions" (Kleinman et al., 1978; cited in Andrusis & Brach, 2007; Stone, 2004) to learn about the patient's explanatory model, or

meaning of the illness, including: “What do you think has caused the illness? What do you think the illness does? How does it work? What kind of treatment do you think you should receive? What are the most important results you hope you receive from this treatment?” Similarly, Conviser and Pounds (2007) recommend practitioners ask the following questions, developed by Aranda-Naranjo et al. (2005) to promote effective communication with clients:

- Do I assume the patient knows why s/he is there?
- Do I assume that I know what s/he wants to get out of the interaction or the visit? Am I clear about what I want to get out of the interaction?
- Do I assume the patient wants to get better? Get better in what regard?
- Am I assuming that s/he will tell me if s/he cannot adhere to the treatment plan?
- Is what I am saying understandable by the patient? Can s/he read?
- Is the patient clear that this is a partnership and that we are engaging in joint care planning?
- Am I presenting the information in a non-judgmental and non-coercive way?
- Is there someone else the patient would like to include in her/his care?
- Has the patient used any other therapies, medications, herbs, elixirs, ointments, teas to help her/him with this problem?
- What can we do to help her/him get better? Address non-medical and medical issues.
- There are things that we may not be able to help with. Are there others we can find to help with these issues?

Best Practice Example

Cooper et al. (2007) describe a ‘bedside’ cultural assessment tool for postpartum and neonatal care developed by and used in the Family Care Unit education committee at Riverside Methodist Hospital. Upon admission, all patients are asked “Do you have any cultural practices that may be affected by this hospitalization?” and if the response is affirmative, the assessment tool is employed. One benefit of the tool is that it prevents staff from relying on stereotypes about care preferences and from assuming that individuals with shared cultural backgrounds will have the same beliefs and practices. The assessment requires an appraisal of linguistic needs and, where appropriate, the provision of qualified interpreters/translators. In terms of outcomes, both patient and staff satisfaction remains high. Staff members seek additional training in cultural diversity in part as a result of witnessing positive patient outcomes resulting from the use of the assessment tool.

Diversity competency in the delivery of health services involves empowering all consumers of health services

Empowerment is an important concept in diversity competency (Black, 2005). Empowerment in the delivery of health services involves: encouraging clients to become active participants in their care (Wynia & Matiasek, 2006), educating consumers on how to navigate the health services system (Betancourt et al., 2002; NICHQ, 2005; Simmons, 2004), and providing linguistically-appropriate information about the process for filing complaints (NICHQ, 2005).

3.2 Best/Leading Practices in Education

In this section we briefly examine the extent to which educational institutions and professional practice bodies build diversity competency within health and medical programs, and then consider various initiatives that health services organizations may support to enhance the diversity competency of the workforce.

Health and Medical Professional Programs

There is consensus in the literature that post-secondary health and medical programs do not provide sufficient education in diversity competency (Bowen, 2004; Genao et al., 2003; McGee, 2001). Flores et al. (2000, cited in Ferguson, Keller, Haley, & Quirk, 2003) for example surveyed all 132 American and Canadian medical schools and found that only 8% provided a course devoted exclusively to cultural competency. Of the remaining schools, 87% taught their cultural competency curriculum in just two-to-three lectures. Since the publication of the study, the Accreditation Council on Graduate Medical Education in the U.S. has begun to require cultural sensitivity as part of professional competency for physicians (Thom, Tirado, Woon, & McBride, 2006); the Liaison Committee on Medical Education in the U.S. has strengthened their accreditation requirements in cultural competency (Lu & Primm, 2006); and in 2005, New Jersey became the first state to require cultural competency training as a condition of physician licensure (Salas-Lopez, Soto-Greene, Bolder, & Like, 2006). In a Canadian context, the Canadian Nurses Association stated in a position paper that educational institutions are responsible for integrating issues of diversity and culture into curricula and for providing educational programs that enable nurses to acquire, maintain and enhance cultural competencies. However, the present literature review did not identify cultural or diversity competency training as an accreditation requirement in Canadian health or medical professional programs and did not identify such training as a condition of physician licensure in Canada.

Continuing Education / Professional Development

While health services organizations might advocate for greater diversity competency training in professional health programs, there is a strong call in the most recent literature for health services to take the lead in developing and delivering continuing education for new and existing personnel (Black, 2005; Callister, 2005; Doorenbos et al., 2005; Jackson, 2007)¹⁴.

Recommended Content of Continuing Education

According to the literature, health practitioners and staff should have access to continuing education in the following areas:

- Local service-area demographics and health disparities (Betancourt et al., 2002; Gilbert, 2003b);
- Organizational, legal and regulatory requirements pertaining to diversity competency (County of Los Angeles Department of Health, 2003; Gilbert, 2003b);

¹⁴ For example, ensuring “that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery” is also one of the U.S. Department of Health and Human Services, Office of Minority Health’s National Standards for CLAS in Health Care (U.S. Department of Health and Human Services, Office of Minority Health, 2001a: 7) and in Canada, organizational provisions for continuing education are recommended by such associations as the Canadian Nurses Association and the Immigrant Women’s Association of Manitoba, Inc. (2006).

- Effective and appropriate interpersonal communication and negotiation skills (Betancourt et al., 2002; Gilbert, 2003b);
- How to elicit and document patients' beliefs and practices (Cone et al., 2003; Gilbert, 2003b; NICHQ, 2005;);
- How to be a keen observer and careful listener (Callister, 2005; Chin, 2000; Cone et al., 2003);
- How to access and interact with diverse local communities for the purpose of understanding their traditional or group-specific health practices and needs (Gilbert, 2003b);
- How to assess language preferences and needs and how to access and use interpretation services (Ibid.);
- Skill development in diversity-appropriate assessment and treatment (Niemeier et al., 2003)¹⁵; and
- Differences in disease incidence and prevalence and treatment efficacy (Cone et al., 2003)

Recommended Delivery Formats for Continuing Education

Formats for continuing education suggested in the literature include having speakers from diverse backgrounds at brown bag lunches, hosting community knowledge and learning sessions, and providing workshops with skilled trainers who help personnel gain skills and confidence by exploring their own prejudices, attitudes and practices (Immigrant Women's Association of Manitoba Inc., 2006). Poster sessions have also been found effective (McGee, 2001), as have in-service training and encouraging health service providers to read the current literature (e.g., academic journals, publications of professional associations addressing diversity competency; Reese et al., 2004; Niemeier et al., 2003).

Best Practice Example

Calgary Health Region has developed a Regional Diversity Learning Plan which includes the delivery of diversity competency education for staff on a continuing basis and the development of self-directed resources that supports the development of staff knowledge and skills to provide quality health services. The Region also hosts an annual Diversity and Wellbeing conference which provides a forum for health professionals/providers, health researchers, health decision makers and the community to share and explore issues, research, best practices and solutions related to diverse populations and their health and wellbeing (Calgary Health Region (2008), Regional Diversity Directional Document 2008-2012)

¹⁵ For example, Niemeier et al. (2003) recommended practitioners learn to conduct and interpret patient assessments "with caution and awareness that existing tests and measurements are frequently based on either normative scores of the majority population or a non-representative sample of minority patient groups" (p. 1242).

Best Practice Example

Cooper et al. (2007) describe “Women’s Health Evening Out Series,” an ongoing cultural competency education program offered to staff at Riverside Methodist Hospital in Columbus, Ohio. The program began in 2001 and has been offered every six months since its inception. The ‘evening out’ is held in a comfortable, relaxed, and culturally-diverse environment (e.g. an ethnic restaurant) and includes presentations on such topics as the cultural aspects of childbirth and cultural perspectives on bereavement. Members of diverse communities are also invited to speak about their experiencing with the health care system. The success of the presentations (with an average attendance of 44) is attributed in part to the ‘fun’ atmosphere (dinner, door prizes, culture trivia games, ethnic decorations, and ethnic movies) and wide-spread advertising. Outcomes of the initiative include increased sensitivity to and knowledge of diversity, with nurses sharing information with one another to enhance patient care, as well as a deeper appreciation for diversity within the workforce itself.

That said, research has found that low-intensity or passive training is only marginally effective, and suggests providing opportunities for immersion among diverse populations, which has been found effective in modifying beliefs and countering stereotypes (Barkin , Balkrishnan, Manuel, & Hall, ., 2003; Campinha-Bacote, 2002; Ekelman, Dal Bello-Haas, Bazyk, & Bazyk, 2003; Foley & Wurmser, 2004; Godkin & Savageau, 2001; Koskinen & Tossavainen, 2004; Simmons, 2004). More generally, continuing education should use a broad and inclusive definition of diversity; should focus on process-oriented tools that would facilitate patient-provider education (rather than focus on factual information about diverse populations); should cultivate the value of ongoing learning; and should utilize a broad range of training strategies (Gilbert, 2003b; Horner et al., 2004).

Outcomes of Education Interventions

Bhui et al. (2007) reviewed articles pertaining to diversity competency education for health and mental health professionals published between 1985 and 2004, and found just three studies (Ferguson et al., 2003; Kirmayer et al., 2003; Siegel et al., 2003) that empirically evaluated the effectiveness of education interventions. While measurable changes in efficacy, attitude and behavior were identified¹⁶, the authors concluded that the outcomes of diversity competency training remain largely unknown.

The present literature review identified a number of studies that would likely not meet the standards of methodological rigour required by Bhui et al. (2007), but nonetheless indicate that various education initiatives have the potential to enhance diversity competency. Brathwaite (2005) for example developed and evaluated a diversity competency course for public health nurses and found a sharp increase in nurses’ perceived level of diversity competency immediately following the course. The evaluation also revealed that participants exhibited increased self-confidence and a number of changes in their behaviours and practices in the workplace following the training intervention. A study by Schim and Associates (2005) on health practitioners in Ontario and Michigan found that those with diversity training scored higher on

¹⁶ For example, Kirmayer et al. found that 48% of health service providers felt they provided better treatment after training and 31% felt their communication, empathy and understanding had improved.

measures of cultural awareness, sensitivity and behaviours following training, though this finding held only for health workers with higher levels of education (e.g. Bachelor's degree).

It may be concluded from the literature that education initiatives meant to enhance diversity competency hold promise, but should be subjected to greater testing to determine their effectiveness in meeting specific education objectives. Several strategies to evaluate the outcomes of diversity competency education are identified in the literature, and may be employed by health services organizations in the assessment of their continuing education initiatives. Specifically, the literature recommends:

- Employing standardized assessment tools to evaluate outcomes of education interventions (Thom et al., 2006);
- Using multiple measures of outcomes, including qualitative measures (e.g., practitioners' self-assessment of sensitivity, knowledge and efficacy) and quantitative measures (e.g. changes in service utilization; *Ibid.*);
- Measuring education outcomes from multiple perspectives (practitioner, staff, management, patient/consumer; *Ibid.*, 2006);
- Employing assessment tools to determine whether training provides a lasting effect, or needs to be repeated periodically (Anderson et al., 2003); and
- Keeping abreast of research that evaluates the outcomes of education interventions and modifying existing educational interventions in light of new findings (*Ibid.*).

3.3 Best/Leading Practices in Human Resources

In this section we present the findings of the literature review and environmental scan as they pertain to best or leading practices in the area of human resources. Specifically, this section focuses on workforce diversification, enhancing job satisfaction of diverse personnel, increasing diversity competency efficacy of all personnel, and ensuring that human resource policies and practices embody the principles of diversity competency.

Workforce Diversity

Workforce diversity refers to the recruitment and retention of a workforce that reflects the demographic composition of the populations served, and is widely cited in the literature as a means of enhancing organizational diversity competency (Betancourt et al., 2002, 2003; Bowen, 2004; Brach & Fraser, 2000; Callister, 2005; Horner et al., 2004; Jackson, 2007; Lu & Primm, 2006; McGee, 2001; Mullins et al., 2005; Purnell, 2002; Reynold, 2004; Simmons, 2004; Wynia & Matiasek, 2006)¹⁷.

Research on the outcomes of workforce diversity on health disparities and patient satisfaction is generally lacking (Anderson et al., 2003), though some studies have found positive outcomes. Smedley et al. (2004, cited in ASHP Ad Hoc Committee on Ethnic Diversity and Cultural Competence, 2005) for example found that patients were more likely to report satisfaction when receiving care from practitioners who mirrored their racial or ethnic background, and Brach and Fraser (2000) concluded from a review of the literature that cultural matching between patients and practitioners creates a more welcoming environment and improves communication.

¹⁷ Workforce diversity is also one of the fourteen National Standards for Culturally and Linguistically Appropriate Care in the U.S. (U.S. Department of Health and Human Services 2001a), and is recommended by the Institute of Medicine (2002, cited in Cone et al., 2003).

To develop workforce diversity, the Registered Nurses' Association of Ontario (2007) recommends human resource departments consult community demographic and socio-cultural data, as well as data on the composition of the present workforce, in order to identify areas of under-representation. The Association also recommends that such measures as employment outreach programs be implemented to recruit personnel from under-represented populations. Finally, the Association recommends reviewing recruitment processes for diversity competency, removing systemic biases in the selection process, and working with national and regional organizations "to collectively establish mechanisms to address barriers to the recruitment and retention of underrepresented groups within the workforce" (2007, p. 37).

The literature also cautions, however, that workforce diversity on its own is not sufficient for the cultivation of diversity competent care (Genao et al., 2003):

The employment of minority nurses is in itself no guarantee to a better service. Minority ethnic health professionals who have undergone traditional training may not practice in less ethnocentric ways or be culturally competent to work with minority ethnic groups (Jackson, 2007, p. 21).

Health services are encouraged, then, to utilize workforce diversification as a complement to other diversity competency strategies.

Enhancing Job Satisfaction of Employees Identifying with Diverse Populations

There is a growing body of literature on managing diversity within the workforce, with particular focus on employee satisfaction and retention. With respect to enhancing job satisfaction and retention of culturally diverse or immigrant staff members, Hunt (2007a) recommends health services managers examine their assumptions about and expectations of 'minority' staff members, be sensitive to the assumptions and expectations held by diverse staff members, and encourage open communication about those assumptions and expectations. The literature also recommends health services employ diversity-sensitive and appropriate orientation materials, assessing the unique learning needs of internationally trained personnel, establishing support and mentoring programs, and offering, in orientation programs, an introduction to Canadian multi-cultural society (Registered Nurses' Association of Ontario, 2007).

In a study of job satisfaction of long-term care nursing assistants in New England, Allensworth-Davies et al. (2007) found that the strongest predictor of job satisfaction among foreign-born nursing assistants was the perception that the organization was culturally competent. Specifically, job satisfaction was highest among staff who felt the organization had created a comfortable work environment for culturally and ethnically diverse staff and residents, including effective cross-cultural communication and appropriate responses when staff or residents were treated unfairly because of their cultural or ethnic differences. Clear protocols and training in appropriate responses to unfair treatment and training in cross-cultural communication were identified as two techniques to strengthen diversity competency in the workplace. Dreachslin (2007) also identifies the importance of open communication:

In a study of nursing care team performance, Dreachslin, Hunt, and Sprainer (1999; 2000) found that leadership style was the key to reducing the emotional conflict often present in demographically diverse groups. Nurse team leaders who openly encouraged and participated in discussions about race and other group identities as well as listened

to and validated different perspectives were successful in defusing negative emotional conflict and tapping the information value inherent in diverse teams (p. 83).

Overall, health services are encouraged to foster a comfortable and welcoming work environment for all employees:

Organizations should encourage the retention of diverse staff by fostering a culture of responsiveness toward the ideas and challenges that a culturally diverse staff offers (U.S. Department of Health and Human Services, 2001a, p. 6).

Workforce Efficacy

The extent to which all health services personnel feel confident in their ability to provide diversity competent care is an important aspect of the development of diversity competent health services. An important finding in the literature is that attaining general knowledge about specific diverse populations, such as knowledge about beliefs, values, norms and practices of diverse populations, often is not sufficient for health practitioners to feel confident in their ability to provide diversity competent care (Kairys & Like, 2006; Munoz, 2007; Phokeo & Hyman, 2007;). In Gunaratnam's (2007) study, palliative care staff serving diverse ethnic clientele often resorted to 'instinct' or 'gut feeling' rather than knowledge of cultural values, norms and practices when interacting with ethnically diverse clients, and many expressed uncertainty and lack of confidence in their ability to provide culturally competent care. Health professionals participating in a study conducted by Kai et al. (2007) similarly felt incompetent, and experienced heightened anxiety when providing care to diverse patient populations, despite having some degree of 'textbook' knowledge of diversity. Specifically, providers felt "anxious about being culturally inappropriate, causing affront, or appearing discriminatory or racist" (p. 1766).

In response to these findings, Kai et al. (2007) recommend that "uncertainty should be acknowledged and legitimized as inherent to negotiating care responsive to patient needs" (p. 1772), with providers given the opportunity to reflect on and discuss their experiences. They also recommend shifts in emphasis "away from knowledge-based cultural expertise toward a greater focus on the patient as an individual" (Ibid). Because reducing diversity competency to a set of technical knowledge and skills may increase providers' uncertainty and undermine their confidence, it is important to emphasize the human interaction and to foster empathy in that interaction, as well as understanding of another's views, values and practices. This "offers a way forward for health professional practice because it becomes possible to actively embrace, rather than be uncomfortable with, the uncertainty that cultural diversity creates" (Ibid.).

Human Resource Policies and Practices

Human resource policies and practices in general should be reviewed for fairness and bias (Brach & Fraser, 2000), ensuring that policies not only prohibit discrimination, but promote respect for difference (Reynold, 2004).

In addition, orientation sessions for new staff should be utilized as an opportunity for enhancing diversity competency (Reese et al., 2004). The Cultural Competence Guide for Primary Health

Best Practice Example

The Calgary Health Region has developed workplace policies that promote respect for difference and prohibit discrimination (Calgary Health Region (2008), Regional Diversity Directional Document 2008-2012).

Care Professionals in Nova Scotia (Government of Nova Scotia Department of Health, 2005) for example recommends providing all new staff with information on diversity competency values and practices in the organization, defining expectations regarding diversity competency, and providing information on professional development opportunities. Finally, the literature recommends that diversity competency be incorporated into employee job descriptions and that diversity competency-related measures be integrated into performance reviews (Galanti, 2006; NICHQ, 2005).

3.4 Best/Leading Practices in Assessment/Evaluation

Purpose of Assessment/Evaluation Tools

Diversity competency assessments or evaluations enable health services organizations to gauge their effectiveness in identifying and responding to the needs and preferences of the diverse populations they serve. Furthermore, when conducted on a regular basis, evaluations enable the organization to identify changes over time. Evaluation findings provide insight for strategic planning and resource allocation, and when conducted in consultation with consumers and key stakeholders, provide opportunities for cultivating and strengthening community partnerships (NCCC, cited in Goode, Jones, & Mason, 2002).

The literature recommends health services organizations evaluate their diversity competency measures over time to garner an indication of their effectiveness and to identify areas needing improvement. Evaluations may examine:

Best Practice Example

The Calgary Health Region states in its Regional Diversity Direction Document 2008-2012 that evaluations within the region would measure changes in health disparities; percentage of patients receiving care in their preferred language; ability of the organization to identify race, ethnicity and language preference; access to care (the degree to which services are convenient and readily accessible); and utilization (services being used, frequency of use, appropriateness of use). Quality indicators at all points of client contact would incorporate the principles and measures of diversity competence and focus on the policies, procedures and resources needed to provide diversity competent services (Calgary Health Region, Regional Diversity Directional Document 2008-2012).

- The extent to which diversity competent policies and practices have resulted in a reduction of health disparities of diverse client populations (Chin, 2000; Kim-Godwin et al., 2001; Matus, 2004);
- The experiences of clients, including for example how they perceive health practitioners' attitudes and the health services environment more generally, the quality of communication with health practitioners, and the extent to which their treatment preferences were respected (Ibid);
- Health practitioners' perceptions, attitudes, knowledge, self-efficacy, and treatment practices (Ibid.);

- Program policies and procedures¹⁸ (e.g., were they developed through consultation with staff, board, and others who reflect the composition of the target client population; do policies promote a range of diversity appropriate service delivery models);
- Program practices (e.g., is information gathered about the demographics of the targeted client group; are programs developed/reviewed through community consultation);
- Personnel policies and practices (e.g., does the organization have an employment equity plan; do performance evaluations have a section on diversity competency);
- Skills and training (e.g., does the organization provide training to all staff to increase diversity competency);
- Organizational composition and climate (e.g., is the composition of the organization reflective of the targeted client group; does the organization provide a welcoming environment for the relevant target groups; does the organization accommodate diverse religions and cultures);
- Community consultation and communication (e.g., does the organization have a community consultation strategy to assist in service planning and delivery; are promotional and educational materials sensitive and accessible to all client target groups).

Examples of Assessment / Evaluation Tools

While a review of existing evaluation tools is beyond the scope of this report, it is useful to identify some examples. Bowen (2004) proposes the use of a document review process to gain insight into the organization's successes and challenges in implementing best practices and assessing, more generally, the organizational approaches to enhancing diversity competency. Wells (2000) recommends conducting a 'cultural audit' to examine the assumptions underlying organizational culture; for example, a cultural audit would examine the cultural proficiency of mission statements and organizational values, as well as job descriptions, and employee performance criteria.

Best Practice Example

While implementing their interpretation services, Language Access conducted a parallel evaluation. The purpose of the concurrent evaluation was to enable the program to adjust to feedback during the implementation process (Manager, Language Access, Winnipeg Regional Health Authority. personal communication, June 2008).

Similarly, Bopp, Eyford, and Bopp, (2007) developed a *Cultural Capacity Audit* premised on four indicators of organizational cultural competence:

1. **Social Inclusion:** "The degree to which minority cultures are physically represented and the diversity of community-based perceptions adequately taken into account in governance and decision making processes, authority structures, and the program choices and methods of the organization" (p. 5);
2. **Awareness of Self:** "The degree to which assumptions, ways of thinking and implementation choices are understood to be culturally embedded and are open to negotiation" (p. 5);

¹⁸ This and the following five recommendations are adapted from a diversity competency assessment tool developed by the Vancouver Ethnocultural Advisory Committee of the Ministry of Children and Families.

3. Awareness of Others: “The degree to which those leading and driving the organization are able to understand and articulate the nuances of cultural differences, are curious about the implication of these differences for the continuous improvement of programs, and are actively seeking to build understanding among staff and between staff and community” (p. 6); and
4. Adaptive Capacity: “The degree to which the organization is capable of changing and adapting both its ways of working and its services to accommodate the needs and styles of cultural differences within the organization and within the various client communities” (p. 7).

The *Cultural Capacity Audit* is conducted in five overlapping phases:

1. Situation mapping and stakeholder analysis: Meeting with management and document review to garner an indication of cultural diversity within and outside of the organization and the motives for the audit;
2. Adaptation of the tool and process: Develop a strategy for gathering the appropriate information from the organization;
3. Assessment: Conduct focus groups with employees (e.g. on governance, management, personnel policies and practices, social patterns (how employees interact and what they talk about); assessment of the organization’s competence in five domains of organizational life using a Likert scale with responses sorted into categories representing the four indicators of organizational cultural competence (above);
4. Write up and verification: Findings are provided to employees and management for feedback; changes and recommendations are incorporated into the report; and
5. Final report and recommendations.

Best Practice Example

The Calgary Health Region developed four separate online diversity competency self assessments for managers, health care professionals/providers, support staff and project/program developers to assist staff with evaluating their own attitudes and behaviours toward individuals from diverse groups, evaluating the extent to which they and their programs or units are equipped to meet the needs of diverse clients/patients; and increasing their awareness of the importance of diversity competence in the workplace, and especially in the delivery of health care services. Upon completing the self assessments, staff members receive an electronic descriptive score of their results and links to resources to assist with increasing their diversity competence. Collectively, the results of the assessment provide an overall assessment of the level of diversity competency of staff within the Region and assists with program planning for improvement.

The *Cultural Capacity Audit* is participatory and inclusive of individuals working at all levels of the organization, and provides opportunities for individuals to validate the findings through

feedback mechanisms. The authors note that the Audit represents a ‘first step,’ and that the organization will need to invest further time and effort as it progresses toward cultural competency.

Finally, Kairys et al. (2002) propose the use of the Multimethod Assessment Process (MAP), a technique that uses multiple (i.e. qualitative and quantitative) methods to identify unmet health needs and barriers to access, and related deficiencies and strengths in diversity competency.

Best Practice Example

Calgary Health Region, Regional Diversity, has developed benchmarks of a diversity competent health care organization which will enable the Region to assess its diversity competency. The six Gold Standard Benchmarks are understood as universally accepted 'best practice' standards that most organizations who are concerned about diversity competency attempt to reach and include:

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. (Calgary Health Region (2008), p. 40-45).

Assessment and evaluation tools are also available for individuals working in health services environments to gauge their personal diversity competency. Seibert, Stridh-Igo, and

Zimmerman (2002) developed a checklist practitioners can use to ensure patients achieve desired recovery and outcomes; the National Center for Cultural Competence (NCCC) has published a Cultural Competence Health Practitioner Assessment for individual self-assessment; and Doorenbos and Schim (2004) report on the Cultural Competence Assessment (CCA) tool, a 38-item tool for measuring individual cultural awareness, cultural sensitivity, and cultural competency behaviour. Finally, Thom and Tirado (2006) developed and piloted a patient-reported measure of physician cultural competency (the PRPCC scale), and found it to be a valid tool for measuring knowledge of patients (e.g., knowledge of cultural health beliefs), communication skills (e.g., listening; working with interpreters), and cultural brokering (e.g., negotiating a treatment plan with the patient and their family; understanding community resources available to patients).

Considerations in the Development and Use of Assessment / Evaluation Tools

While the literature does not identify 'best practices' in organizational and individual diversity competency assessment, a number of limitations of existing assessment and evaluation methods were identified in the literature, as were several recommendations. Assessment and evaluation tools are considered sub-optimal when they use narrow definitions of diversity (e.g., focusing exclusively on race and ethnicity at the expense of other areas of diversity) and diversity competency (e.g., measuring changes in practitioners' efficacy or attitude but not changes in actual practices or in organizational culture; Doorenbos et al., 2005; Stanhope, Solomon, Pernell-Arnold, Sands, & Bourjolly, 2005); when they rely exclusively on self-assessment (at the expense of other measurable outcomes, such as changes in utilization rates and health disparities; Bowen, 2004; Stanhope et al., 2005); and when they are developed without the input of diverse communities and consumers of health services (Stanhope et al., 2005).

According to the literature, assessment and evaluation tools are strongest when they:

- Are standardized to allow for valid and reliable measures over time and across systems, disciplines, programs and departments (Siegel et al., 2003);
- Employ a broad definition of 'diversity' (Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007);
- Operationalize and measure diversity competency in the broadest sense (including not only providers' knowledge, self-efficacy and attitudinal change, but also, for example, client perception/satisfaction, appropriateness of treatment, and human resource practices and policies; Ibid.);
- Do not rely solely on self-assessment (as respondents tend to over- or under-estimate their diversity competency; Stanhope et al., 2005), but employ multiple methods of assessment, such as staff evaluations, interviews, surveys, document review, complaints review and focus groups (Wynia & Matiasek, 2006);
- Measure outcomes at multiple organizational levels (management, provider, staff; Anderson et al., 2003);
- Are strength-based (identify and promote growth; Goode, et al., 2002; Hackett et al., 2006);
- Include provisions for the dissemination of results (e.g. publication of an evaluation report; dissemination of findings through training workshops and to committees and other decision-making structures, and/or publication of reports in peer reviewed scientific and professional literature; Goode et al., 2002); and
- Include provisions for the development of a plan for further action (e.g., Action Plan; Strategic Plan; Goode et al., 2002).

4.0 CHALLENGES FOR DIVERSITY COMPETENCY

Both the literature review and environmental scan lend insight into some of the challenges health services experience as they strive to become diversity competent. In this section an overview of those challenges and, where available, recommendations for their management are presented.

Limitations of Models / Theoretical Frameworks

There are challenges associated with models or theoretical frameworks of diversity competency. Carpenter-Song, Nordquest Schwallie and Longhofer (2007) reviewed cultural competency models from a mental health perspective, and found common shortcomings to include the treatment of 'culture' as a fixed or static variable or a 'property' of individuals (rather than a dynamic, ongoing process that is emergent in human interaction); the reduction of 'diversity' to racial or ethnic differences; assumptions of homogeneity within groups (leading to inappropriate 'one-size-fits-all' approaches); and an emphasis on cultural differences at the expense of understanding other sources of health disparities (such as structural power imbalances). The authors also identified problems concerning the "naïve applications of culture" in clinical mental health practices, resulting in the unintentional blaming of poor communication or non-adherence to treatment recommendations on patients' culture.

Lack of Outcome Measures

A major limitation in the field of diversity competency is the scarcity of published research studies that would provide quality assessments or evaluations of outcomes of diversity competency approaches / best practices (Anderson et al., 2003):

As noted by Brach and Fraser (2000), substantial research evidence exists that cultural competence is achievable; however, health systems have little evidence about which techniques are effective and efficacious and less evidence on when and how to implement them properly (Giger et al., 2007, p. 99).

In developing the National Standards for Culturally and Linguistically Appropriate Services in Health Care, the U.S. Office of Minority Health also acknowledged the need for a "better understanding of the relationship between culturally competent health services and patient satisfaction/clinical outcomes/health status" (2001a: xv). In response to this limitation, the literature recommends health services undertake internal evaluations that are methodologically sound, and disseminate the findings not only within the organizations, but to the broader community as well, through peer reviewed scientific and professional literature (Ethnic Communities' Council of Victoria Inc., 2006; Goode et al., 2002; Canadian Nurses Association, n.d.).

Emphasis on Training at the Expense of Workforce Initiatives

Also presenting a challenge to the advancement of knowledge in the field of diversity competency is the tendency of health services to emphasize education and training, rather than workforce initiatives, as a means of enhancing diversity competency (Bowen, 2004):

This approach reflects a belief that lack of understanding of cultural differences is the cause of any problems, and that the most appropriate intervention is to provide cultural awareness training (p. xv).

While an emphasis on training at the expense of practical initiatives limits the ability of the organization to fully implement processes of change, it also impedes our ability to understand 'what works' and to share those lessons with the wider community¹⁹.

Inadequate Infrastructure

The allocation of sufficient resources for the development, implementation and evaluation of best practices in diversity competency poses a challenge for some health services organizations. Organizations may experience a lack of human and financial resources for the time- and labour-intensive processes of policy review and revision, program planning, professional development, language services and community development (Government of Australia, National Health and Medical Research Council, 2005; NICHQ, 2005; U.S. Department of Health and Human Services, 2001a). Short-term funding for initiatives is also problematic, as the development of organizational and individual diversity competency is a long-term process that requires a sustainable commitment of resources (Government of Australia, National Health and Medical Research Council, 2005). Health services organizations can address this issue by prioritizing diversity competency, and recognizing that the health disparities associated with diversity incompetent health services is more costly, in the long term, than the implementation of diversity competent practices (U.S. Department of Health and Human Services).

Lack of Staff / Practitioner 'Buy-in'

Mobilizing staff 'buy-in' presents a challenge for organizations striving to become diversity competent, and is particularly problematic in cases where the organization does not have dedicated staff for the planning and implementation of diversity competency initiatives (and when these tasks are added to the existing workloads of staff; NICHQ, 2005). Commitments to diversity competency can also be weakened when the organization's leadership fails to incorporate diversity appropriate patient solutions, or implements ad hoc solutions in policies and procedures without considering wider application, and when diversity competency is not expected of health services personnel at all levels (e.g. expected of nursing staff but not physicians, as evidenced by the amount of training each group is required to undertake in diversity competency). Chrisman (2007) in fact concludes that deficits in the system-wide commitment to diversity competency are the greatest barrier to diversity competency in American health services.

Even to the extent that diversity competency initiatives are undertaken, there is the risk of "the unwillingness of individuals and institutions to unearth, examine, and shed light on their underlying assumptions about people whose cultures differ from their own" (Wells, 2000, p. 194). From this, there is the related risk that initiatives meant to enhance provider knowledge of diversity will result in the reinforcement of stereotypes:

Often, this takes the form of providing information about specific populations and communities under the premise that one must know about the beliefs, values, practices,

¹⁹ The literature suggests that health services may have difficulty keeping abreast of the development of leading or best practices (Bowen, 2004). In response, health services organizations might consider strengthening relationships or developing networks to facilitate the sharing of 'what works.'

and lifestyles of a particular culture in order to work with people from that culture. While knowledge of a culture is important, there is a danger of reinforcing stereotypes and discriminatory practices when providers gain only a superficial grasp of cultures or continue to view issues from their own perspectives (Chin, 2000, p. 31).

5.0 RECOMMENDATIONS FOR THE CALGARY HEALTH REGION

As the Calgary Health Region strives to serve as a model organization for diversity competency, it is useful to summarize the areas of diversity competency in which the Region is particularly strong. Strengths are summarized in this section as they pertain to systematic or organizational practices, health service delivery practices, diversity competency education initiatives, diversity competent human resource practices, and evaluation or assessment of diversity competency. This section concludes with a series of recommendations for the Region.

5.1 Strengths of the Calgary Health Region

Conceptualization of Diversity Competency

The Calgary Health Region defines a diversity competent health services organization as one that has the ability “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” (Calgary Health Region, 2008: 2). The Region has adopted a broad definition of diversity, one that includes immigrants and refugees, persons with disabilities, gender and sexually diverse persons, persons living in poverty, persons experiencing homelessness and persons with low literacy skills.

Commitment to Best / Leading Practices

The Region demonstrates a commitment to best / leading practices by keeping abreast of research identifying practices that have shown promise for enhancing diversity competency in health services and those that have proven effective through empirical testing. The Region has undertaken a number of reviews of the literature and environmental scans to ensure that the initiatives undertaken to foster diversity competency are evidence-based.

Institutionalization of Diversity Competency

The Calgary Health Region adheres to diversity competency as an underlying organizational philosophy (rather than a discreet set of initiatives), and has codified this value in key organizational documents, including:

- The Strategic Service Plan 2006-2010, stating that the organization will provide care tailored to address the needs of different communities;
- The Population Health Strategic Plan, stating that the organization will reduce disparities as one of three of its priority areas;
- The 2006-2009 Health Plan, stating that the organization is developing a workforce strategy and plan that will attract the required health care workforce, create a culture that emphasizes a healthy and respectful workplace, develop the health care workforce and utilize the skills and talents of the health care workforce; and
- The Regional Diversity Directional Document 2008-2012, articulating the organization’s commitment to diversity in its values, wherein respect for diversity is fundamental and integral to the workplace and to the populations served.

The Region further articulates its commitment to diversity competency in its vision (“Healthy diverse communities”) and its mission (“To become a proficient diversity competent organization that is a model for other health organizations”).

The Region has committed considerable resources and infrastructure support to cultivate and deliver diversity competent care, including:

- Establishing and staffing a number of programs:
 - Healthy Diverse Populations, a Regional diversity department with the following staff positions: Refugee Health and Wellbeing Project Coordinator; Mental Health Diversity Strategies; Diversity Educator; Diversity/Community Liaisons; and a Diversity Research/Evaluation Specialist;
 - a Chronic Disease Management for Diverse Populations program;
 - a formalized Interpretation and Translation Services unit with Certified Health Care Interpreters
- and establishing a number of additional diversity positions:
 - a Community Development Diversity Strategist (Community Health Services Portfolio);
 - a Child and Women's Health Diversity Coordinator (Child and Women's Health and Specialized Services Portfolio)

The work of staff in formal diversity roles is guided by the Regional Diversity Advisory Committee as well as a number of foundation documents, including the Regional Diversity Directional Document 2008-2012. In addition to the formal diversity staff positions dedicated to support the development of diversity competency in the organization, diversity competency is a shared responsibility within all areas of the Calgary Health Region and it is considered a mindset that must be adopted by every individual and every part of the health system.

The Region maintains an understanding of the diversity of their target populations in three ways:

1. By consulting community demographic profiles and data from Statistics Canada, the City of Calgary, and Regional Statistics Reports;
2. Through intentional consultations with community organizations representing diverse populations, such as the Calgary Refugee Health Program; and
3. Through focus groups with members of diverse communities (such as those conducted in the development of two recent reports, *Gender and Sexual Diversity* and *Persons with Disabilities* (2008) and those conducted with Aboriginal, Métis, Spanish and Chinese consumers of health services in the development of the East Calgary Health Centre Initiative).

The Region draws on this information to tailor services toward specific diverse populations considered at risk for health disparities.

Diversity Competent Service Delivery

The Calgary Health Region strives to reduce linguistic/language barriers through the use of qualified health care interpreters and translators and qualified American Sign Language interpreters. The Region employs certified health interpreters to provide interpretation throughout the Region, 12 hours/day in 21 languages, and contracts an external service to provide telephone interpretation 24/7 in 170 languages. In addition, bilingual and multicultural staff members are approved to perform their duties in the first language of their clients only upon successful completion of language proficiency testing. The Region also provides 24-7 on-

site access to professional American Sign Language Interpreters through contractual agreement with Deaf and Hard of Hearing Services.

The Regional Diversity Directional Document 2008-2012 recommends staff of the Calgary Health Region develop diversity self-awareness through examination of one's own identity and values; being aware of one's own attitudes and behaviour; understanding how one's attitudes and behaviours may affect the relationship with the client; avoiding imposing one's own views; being aware of one's own behaviours that may marginalize diverse groups; and avoiding engaging in the belief that one's own ways are superior. The Document further recommends having a willingness to learn, having an open mind, and seeking opportunities to immerse in another culture for deeper understanding.

The Calgary Health Region has developed a Cultural Competency Check Card: Basic Communication Tools to Ensure Cultural Competency. This Card includes key questions that may be asked of clients to establish a basis of understanding, including why patients think they have their symptoms; what they have done to try to get better; and how their condition is perceived in their culture.

In addition, the Regional Diversity Directional Document 2008-2012 also identifies as a priority the forming of relationships with traditional healers of cultural groups where available and the involvement of family and/or community members as part of the health services team where appropriate. The Directional Document further encourages the use of diversity sensitive assessments and interventions that allow empowerment through patient education; involving clients in needs assessment by including clients' perspectives; and recognizing family, kin and the community as resources.

Diversity Competency Education Interventions

The Calgary Health Region has developed a Regional Diversity Learning Plan. This Plan includes the delivery of diversity competency education for staff on a continuing basis. It also includes the development of self-directed resources that support the development of staff knowledge and skills. In addition, the Region hosts an annual Diversity and Wellbeing conference which provides a forum for health professionals and providers, researchers, decision-makers and the community to share and explore issues, research, best practices and solutions related to diverse populations and their health and wellbeing.

Diversity Competent Human Resources

According to the Calgary Health Region, Regional Diversity Directional Document 2008-2012, the Region has developed workplace policies that promote respect for difference and prohibit discrimination.

Diversity Competency Assessment and Evaluation

The Calgary Health Region demonstrates best practices in diversity competency assessment and evaluation through its development of six Gold Standard Benchmarks of a diversity competent health service organization which will enable the Region to assess its diversity competency. The Benchmarks are considered universally accepted best practice standards that most organizations concerned about diversity competency attempt to reach.

In addition, the Region states in its Regional Diversity Directional Document 2008-2012 that evaluations within the Region would measure changes in health disparities; the percentage of patients receiving care in their preferred language; the ability of the organization to identify race,

ethnicity and language preference; the degree to which services are convenient and readily accessible; and utilization (services being used, frequency of use, appropriateness of use). The Directional Document further states that quality indicators at all points of client contact would incorporate the principles and measures of diversity competency and focus on the policies, procedures and resources needed to provide diversity competent services.

Finally, the Region has developed four online diversity competency self assessments for managers, health professionals/providers, support staff and project/program developers. The assessments help staff evaluate their own attitudes and behaviours toward individuals from diverse groups, evaluate the extent to which they and their programs or units are equipped to meet the needs of diverse clients/patients, and increase their awareness of the importance of diversity competency in the workplace. Staff members receive an electronic descriptive score and links to resources to assist with increasing their diversity competency. Collectively, the results provide an overall assessment of the level of diversity competency of staff and assist with program planning for improvement.

5.2 Recommendations for the Calgary Health Region

This report identifies a number of best / leading practices in diversity competency in health services, and in the preceding section, identified ways in which the Calgary Health Region exemplifies several of these practices. Because diversity competency is an ongoing process, continuously informed by developments and discoveries in research and practice, it is also important to examine ways in which the Region may consider enhancing the diversity competency of its services and practices.

When considering the recommendations made in this section, however, it must be kept in mind that our understanding of the Calgary Health Region has been garnered through in-depth interviews with key informants. While this is a valid method of inquiry, it fails to provide the data necessary for a thorough and systematic evaluation of the diversity competency of the Calgary Health Region and its current practices and programs. It may be the case, then, that the recommendations put forth here have, in whole or in part, already been considered and implemented within the Region.

Commitment to Best / Leading Practices

While the key informant interviews suggest that the Region is taking steps to enhance the diversity competency of staff members and health practitioners, and to develop community-based programs well-suited to meet the needs of diverse populations, it may be suggested that the Region continue to keep abreast of and contribute to developments in diversity competency. Specifically, the Region might consider:

- Further operationalizing the concepts embedded diversity competency to facilitate their practical application; this may involve ongoing assessment of the adequacy of the definition of diversity competency used by the Region as well as consideration of whether the populations considered 'diverse' are inclusive and reflective of the diversity of the populations served by the Region;
- Identifying, evaluating and adopting diversity competency standards and guidelines of scholarly, professional and regulatory bodies to the extent that they are available and appropriate;

- Continuing to identify best or leading practices in diversity competent care for non ethno-cultural diverse populations, such as persons with disabilities, gender and sexually diverse persons, persons living in poverty, persons experiencing homelessness, and persons with low literacy skills, as existing knowledge in these areas is limited;
- Contributing to the body of knowledge around diversity competency, as the current literature focuses on ethno-cultural populations at the expense of additional diverse populations; to this end, the Region might consider making presentations at professional conferences, publishing articles in journals, publishing reports on the Region's website, and sharing information with other health organizations on an informal basis; and
- Continuing to keep abreast of the developments in diversity competency by networking with other health services organizations and engaging in period reviews of peer reviewed and 'grey' literature.

Institutionalization of Diversity Competency

The literature recommends systematically involving consumers, key stakeholders and diverse communities in all stages of the development, implementation and evaluation of programs intended to enhance the diversity competency of health services. While there is evidence that the Calgary Health Region consults with diverse communities to identify service needs and access barriers, the Region might consider moving beyond community consultation in these areas to more fully engage community stakeholders in the development, implementation and evaluation processes. Inviting community leaders to participate in planning activities and partnering with community agencies serving diverse populations in the development of programs are two examples of how the Region could enhance the involvement of diverse populations. Greater participation of diverse populations could help ensure that programs and services are tailored to meet the unique needs and preferences of diverse populations. It could also serve to empower diverse populations by cultivating a sense of ownership and control over their health services and health outcomes.

The institutionalization of diversity competency also involves maintaining a profile of the communities serviced, including demographic, cultural and epidemiologic data which could be used to assist in the planning and implementation of appropriate services. While the Calgary Health Region is improving its ability to collect and manage demographic and linguistic data, it is also necessary that the Region develop mechanisms to ensure that such data is available to and meaningful for program and service planners.

The literature further recommends developing, implementing and evaluating mechanisms to ensure organizational leadership is representative of the diverse populations served. The key informant interviews did not provide an indication of the extent to which current leadership is representative, nor did they provide insight into the mechanisms currently in place for ensuring that leadership is representative of the diverse populations served by the Region. Nonetheless, it is important that the Region consider this recommendation, and take steps, as necessary, to enhance efforts to recruit and retain members of diverse populations in positions of power and authority.

Diversity Competency in the Delivery of Services

One of the recommendations in the literature for enhancing the diversity competency of health services is the creation of environments that are welcoming and reflective of the diversity of the populations served. Again, key informant interviews did not garner insight into the ways in which

the Region ensures environments are welcoming and inclusive, but it may be suggested that the Region systematically review its physical environments for diversity inclusiveness, and make changes as necessary. Personnel responsible for design elements in physical spaces might be educated in the principles of environmental diversity competency and be encouraged to alter existing environments to ensure they are inclusive of diverse populations. The linguistic and visual elements used in print materials, such as signage, brochures and posters displayed in health services environments should also be systematically evaluated for the extent to which they are appropriate for and inclusive of diverse populations, and should be modified as necessary. Finally, health services utilization data should be examined to identify patterns of use by diverse populations; the disproportionate use of services on weekends or during evening hours for example may indicate the need to increase the availability of services during these hours.

The Calgary Health Region exemplifies many best practices in reducing linguistic or language barriers for diverse populations. However, the Region might consider:

- Taking additional steps to ensure the recruitment and retention of a diverse, multi-lingual workforce;
- Implementing measures to ensure that consumers of health services are informed of their right to health interpretation and ASL interpretation services; this may include for example increasing signage notifying consumers of the availability of interpretation services in all public areas of all health care service environments;
- Ensuring that staff and practitioners have access to information about diversity in non-verbal communication norms and practices, by developing for example online resources or offering in-service education about norms and practices common among specific diverse populations (that may be attended by personnel serving significant numbers of particular diverse populations);
- Undertaking initiatives to address low health literacy among all populations served by the Region; examples include ongoing education for staff and practitioners and examining health education and promotion materials to ensure they are written at an appropriate health literacy level;
- Ensuring print materials are aligned with the norms of diverse populations; materials commonly provided to members of diverse populations could be evaluated by community members for cultural and linguistic sensitivity and appropriateness for example;
- Enhancing efforts to incorporate preferred health/healing practices of diverse populations (such as the use of traditional healers), to the extent that is reasonable and possible;
- Continuing to develop targeted outreach initiatives that might help reduce barriers to access to health services; this may include a review of innovative outreach strategies that have provide effective or promising with diverse or traditionally underserved populations;
- Taking steps to foster client/patient empowerment, for example by facilitating their active participation in their care or by helping diverse clients/patients navigate the health care system.

Diversity Competency Education Initiatives

Key informant interviews revealed a number of ways in which Calgary Health Region personnel are encouraged to become self-aware of their attitudes toward diverse populations as well as

their own values, beliefs, assumptions and biases. The following recommendations for continuing education initiatives can also be made:

- Personnel should have access to opportunities to develop their interpersonal communication (verbal and non-verbal) skills that would enhance their communications with persons of diverse cultural and linguistic backgrounds;
- Personnel should have access to continuing education in diversity of health beliefs, attitudes and practices, including service use behaviours;
- Personnel should have the opportunity to learn about the cultural, demographic, and epidemiologic characteristics of the population served by the Region to the extent that this knowledge would enhance their ability to provide diversity competent care and design programs and services that would be most beneficial and accessible to diverse populations;
- Education materials and delivery should use clear objectives, simplified constructs, avoid the use of jargon, and, where possible, provide opportunities for immersion in diverse populations as a method of modifying existing beliefs and countering stereotypes held by personnel;
- Educational initiatives should routinely and systematically be evaluated and results of evaluation should be used to improve future initiatives;

Diversity Competency Human Resources

A number of general recommendations can be made with respect to enhancing the diversity competency of human resource practices in the Calgary Health Region. Again, a systematic evaluation would provide greater insight into the extent to which current human resources policies and practices are embody the principles of diversity competency. Broadly stated, the Region might:

- Review the composition of the present workforce (including leadership) to identify gaps in representation of diverse populations, and implement dedicated recruitment practices to increase diverse representation;
- Consider ways in which the Region can be instrumental in encouraging the recruitment of diverse populations to post-secondary health and medical programs and foster diversity within residency and fellowship programs;
- Evaluate ways in which the job satisfaction of diverse employees is presently measured, and identifying ways to improve job satisfaction;
- Measuring and increasing the self-efficacy of personnel or their confidence in being able to provide competent care to diverse populations;
- Continue to review personnel policies to ensure they foster a respectful, comfortable and welcoming workplace for all personnel; and
- Continue to review the fairness of human resource practices and compensation of all personnel.

Diversity Competency Assessment and Evaluation

Diversity competency requires health systems to routinely evaluate the extent to which they provide diversity competent health care and to identify gaps or limitations in their ability to do so. The Calgary Health Region presently encourages ongoing data collection in the areas of service

delivery and service utilization, including client feedback, to ensure and enhance the delivery of diversity competent care. In addition, however, the following recommendations emerged from the literature and might be considered by the Region:

- The Region might consider developing a logic model and evaluation plan to allow assessment of diversity competency on an on-going basis; the six Gold Standard Benchmarks offer a starting point to assess diversity competency and, as indicators and methods of measurement are developed, will form a solid foundation for evaluation;
- The Region should ensure that evaluation measures are standardized, to allow for valid and reliable measures over time and across disciplines and departments;
- A wide variety of evaluation measures should be used; evaluations for example should measure health practitioners' diversity awareness, sensitivity, knowledge and skills; practitioners' self-efficacy; the perceptions and levels of satisfaction of consumers of health services; the extent to which assessment and treatment interventions are diversity appropriate and effective; the diversity competency of human resource practices and policies; and the adequacy of continuing education opportunities;
- Self-assessment should not be the sole means of evaluation; rather, multiple methods should be used, including for example staff evaluations, interviews, surveys, document reviews, complaint reviews, and focus groups;
- Evaluations should include provisions for the dissemination of findings and for the development of further plans of action;
- Because there is a lack of empirical evidence of the outcomes of initiative meant to enhance diversity competency in health services environments, the Region might consider disseminating the findings of its systematic evaluations to the broader health services community.

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APPENDIX A: Model Diversity Competent Health Services Organization

The following model of a diversity competent health services organization is based on best practices identified through a review of scholarly and grey literature and interviews with representatives of Canadian health services organizations thought to exemplify best practices in diversity competency.

I. Conceptualization of Diversity Competency

A diversity competent health services organization:

- Adopts a broad definition of diversity (e.g., race/ethnicity, gender, age, sexual orientation)
- Recognizes that diversity competency is necessitated by shifting demographics and the potential for reducing health disparities by reducing communication barriers, improving provider knowledge, enhancing sensitivity to beliefs, values and practices, improving provider attitudes/reducing prejudice, and improving patient trust and satisfaction
- Adopts a broad definition of what it means to be diversity competent, including not only provider competency but addressing barriers to health services and community participation
- Conceptualizes diversity competency not only a set of practices, but as an organizational, system, and workforce value; diversity competency becomes a culture in and of itself
- Recognizes that diversity competency is dynamic and continuously developing

II. Commitment to Best / Leading Practices

A diversity competent health services organization:

- Operationalizes concepts embedded in diversity competency for practical application
- Identifies practices that have been deemed 'best' or 'leading' through rigorous empirical testing or because they show promise; keeps abreast of research in the evaluation of diversity competent practices
- Identifies, evaluates and adopts, where appropriate, published standards and guidelines of scholarly, professional and regulatory bodies (e.g., NCCC recommendations; CLAS)

III. Institutionalization of Diversity Competency: Best / Leading Practices

A diversity competent health services organization:

- Exemplifies diversity competency, including the values of cultural desire, cultural sensitivity, cultural knowledge, and respect for difference, as an underlying philosophy of the organization rather than a discreet set of initiatives
- Codifies diversity competency values in the organization's formal statements (mission, vision and values, strategic planning, and policies and procedures)
- Codifies diversity competency policies and practices in formal initiatives (e.g. has a diversity plan with activities, time-lines and milestones)

- Codifies diversity competency policies and practices at the department level (e.g. in personnel handbooks and policies)
- Develops and maintains the infrastructure to develop, promote and implement diversity competent care
- Has an organizational chart identifying responsibilities of personnel in the implementation of diversity competency practices
- Systematically involves consumers, key stakeholders, and diverse communities in all stages of diversity competency development, implementation and evaluation
- Maintains a profile of the community served, including demographics, culture, and epidemiology, to assist in planning and implementation of appropriate services
- Develops, implements and evaluates mechanisms to ensure organizational leadership is representative of the diverse populations served
- Routinely assesses and evaluates strengths and limitations in diversity competency

IV. Diversity Competent Service Delivery: Best / Leading Practices

A diversity competent health services organization:

- Provides an environment inclusive and welcoming of diverse populations
- Reduces linguistic/language barriers through the recruitment of a multi-lingual workforce
- Reduces linguistic/language barriers through the use of qualified health care interpreters and translators and qualified American Sign Language interpreters
- Provides health services consumers with written notice about their right to access qualified interpretation services
- Reduces communication barriers through awareness and knowledge of diversity in non-verbal communication norms and practices
- Reduces communication barriers by addressing low health literacy (e.g. staff communicate in clear and simple language, avoid use of jargon, watch for signs of misunderstanding)
- Provides diversity and linguistically appropriate print materials (signage, education materials)
- Provides health information that is aligned with norms of diverse populations
- Encourages all members of the health services team to cultivate diversity sensitivity and awareness of the relationships between diversity and health
- Encourages all members of the health services team to cultivate diversity appropriate care practices by developing knowledge and skills
- Involves family and/or community members as part of health services team where appropriate
- Coordinates health services with traditional healers where appropriate and available
- Develops targeted outreach initiatives to reduce barriers to access
- Empowers clients (e.g., by facilitating active participation in care or aiding in the navigation of the health system)

V. Diversity Competency Education Interventions

A diversity competent health services organization provides continuing education in diversity competency for new and existing personnel that facilitates:

- Self-awareness of attitudes toward diverse populations
- Skill enhancement in the area of interpersonal (verbal and nonverbal) communication
- Knowledge of diversity in health beliefs, attitudes and practices, including service use behaviours
- Awareness of local service-area demographics and health disparities; organizational, legal and regulatory requirements pertaining to diversity competency; effective and appropriate interpersonal communication and negotiation; how to elicit and document patients' beliefs and practices; how to access and interact with diverse local communities for the purpose of understanding their traditional or group specific health practices and needs; and how to assess language preferences and needs and how to access and use interpretation services
- Awareness of diversity-appropriate assessment and treatment; in diversity in health-related beliefs and values; and of differences in disease incidence and prevalence and in treatment efficacy
- A view of the patient as having the expertise needed for the encounter

A diversity competent health services organization recognizes the value education initiatives that:

- Employ clear objectives, use simplified constructs, and avoid the use of jargon
- Provide opportunities for immersion in diverse populations as a method of modifying existing beliefs and countering stereotypes

A diversity competent health services organization:

- Employs standardized assessment tools to evaluate outcomes of education interventions
- Measures education outcomes with multiple methods, including qualitative methods (e.g. self-assessment of increased efficacy) and quantitative methods (e.g. changes in service utilization)
- Measures education outcomes from multiple perspectives (trainee, client)
- Employs assessment tools to determine whether training provides a lasting effect, or needs to be repeated periodically
- Keeps abreast of research evaluating the outcomes of various education interventions and modifies existing educational interventions in light of new findings

A diversity competent health services organization:

- Supports the inclusion of diversity competency training in professional health services training curricula
- Supports adherence of professional health services training programs to curriculum guidelines and recommendations offered by professional associations and professional accreditation bodies

VI. Diversity Competent Human Resources

A diversity competent health services organization:

- Ensures the composition of the leadership (e.g., governance, administration and clinical leadership roles), of the health service provider, and of the staff workforce is representative of the populations served
- Supports diverse residency or fellowship programs as a means of increasing diversity in the labour pool
- Strives to enhance job satisfaction of diverse employees
- Cultivates workforce efficacy, or the confidence of all personnel in their ability to provide diversity competent care
- Adopts personnel policies which foster a respectful, comfortable and welcoming workplace for all personnel
- Reviews the fairness of human resource practices and compensation of all personnel
- Encourages human resource professionals to examine their assumptions about diversity, including the myth that there are no qualified candidates from underrepresented groups
- Engages, where appropriate and possible, local human resource consultants with expertise in diversity management and competence

VII. Diversity Competency Assessment and Evaluation

A diversity competent health services organization uses assessment and evaluation tools that:

- Are standardized to allow for valid and reliable measures over time and across disciplines and departments
- Define 'diversity' broadly
- Operationalize and measure diversity competency in the broadest sense (including not only providers' knowledge, self-efficacy and attitudinal change, but also, for example, client perception/satisfaction, appropriateness of treatment, outreach, human resource practices and policies, etc.) and ensure evaluation methodologies are able to provide the information sought
- Do not rely solely on self-assessment (as respondents tend to over- or under-estimate their diversity competency)
- Establish performance measures based on community expectations and goals
- Employ multiple methods of assessment, such as staff evaluations, interviews, surveys, document review, complaint review and focus groups
- Measure outcomes at multiple organizational levels (management, provider, staff)
- Are proven to produce valid and reliable outcome measurements
- Identify desired outcomes / quality indicators on the basis of standards and guidelines developed by the organization, professional associations, scholars etc. and in consultation with representatives of diverse communities
- Are strength-based

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- Include provisions for dissemination of the findings and for the development of a plan for further action (e.g., Action Plan)

A diversity competent health services organization routinely evaluates strengths and weaknesses of diversity competency initiatives by examining:

- Changes in the prevalence of health disparities among diverse populations
- The experiences of clients or patients representative of diverse populations including the extent to which they experience the health services environment as welcoming
- The diversity competency of health education and health promotion materials
- The diversity competency of health practitioners' perceptions, attitudes, knowledge, self-efficacy, and treatment practices
- The diversity competency of program and personnel policies, procedures and practices
- The provision and utilization of diversity competency training
- The extent to which the leadership of the organization is representative of the diverse population served
- Involvement of representatives of diverse populations in planning

A diversity competent health services organization:

- Recognizes the lack of empirical evidence of the outcomes of leading or best practices in diversity competency and supports, and participates in, research studies, and disseminates the findings of its own evaluations or assessments to the wider community

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