



calgary health region

**Blueprint for Enhancing  
Cultural Competency  
in the  
Calgary Health Region**

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**Prepared for the Regional Diversity Steering Committee**

**By:  
Russell Kueber  
Bretta Maloff  
Yvette Penman**

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## EXECUTIVE SUMMARY

More and more health care organizations are responding to the call of ethnocultural communities to reduce disparity in health services. Language, culture and information barriers are identified as key challenges in accessing health and social services. The growth in the immigrant and refugee populations in Calgary, approximately one fifth of the population, points to the need for reducing barriers to the health services offered by the Calgary Health Region (CHR).

The purpose of the *Blueprint for a Culturally Competent Organization* (Blueprint) is to guide the design and provision of culturally competent health services within the CHR. Some of the benefits of implementing this Blueprint are:

- alignment of organizational philosophy and values with client services
- provision of a focus for enhancing organizational cultural competency

The Population Health Promotion Model (Hamilton and Bhatti, 1996) increases our understanding of the factors within and beyond the health system that influence the health of a population. Research on immigrant and refugee populations related to health status reveal a number of determinants of health that influence overall health and well being. Some of these influences are income, education, employment, gender and culture.

To provide a context for the Blueprint, a definition of diversity, links to organizational values and guiding principles are outlined. In addition, nine elements that are essential to achieving a culturally competent organization are described. These include governance, administration, policy and decision making, human resource practices, training, organizational culture, service delivery, partnerships and collaboration, and communication. To enhance performance and support accountability, indicators for measurement are outlined for each of the nine elements. These measures and indicators serve as benchmarks for monitoring progress towards becoming a culturally competent organization

To successfully facilitate the implementation of the Blueprint three organizational change factors are identified. These factors include appropriate alignment of organizational structures and relationships, development of champions and fostering innovation and best practices.

# 1. BACKGROUND

The Canadian Health Care system is lauded as one of the best in the world. While that is true for many Canadians, there continue to be marginalized and vulnerable groups who are under-served by health services. Some of the groups that experience health inequities are lower income groups, homeless, racial and culture communities, gays and lesbians and street youth (Masi, 1998, 2000).

More and more health care organizations are responding to the call of ethnocultural communities to reduce disparity in health services. Language, culture and information are identified as key barriers in accessing health and social services (Stevens, 1993; Wong, 1999). These particular barriers can result in lack of understanding of the health system and/or services, lack of knowledge of resources and difficulty explaining medical problems (Wong, 1999).

Recent developments in health services include bridging programs and services such as the adoption of medical interpretation (Jackson-Carroll, Graham, and Jackson, 1998). Other strategies include:

- interpretation and translation services (City of Calgary, 2001; Calgary Health Region, 2002; Roppe, 1997)
- cultural sensitivity training for health and medical personnel (Hart, 2000; City of Calgary, 2001)
- modifications to service delivery models to reduce barriers (Hart, 2000; City of Calgary, 2001)
- recruitment of bilingual staff (US Department of Health & Human Services, 1998; Calgary Health Region, 2002)
- delivery of health services in multiple languages (US Department of Health & Human Services, 1998)
- enhanced mechanisms for ethnocultural community participation in service planning, delivery and evaluation (Calgary Immigrant Aid Society, 2001; City of Calgary, 2001; Calgary Health Region, 2002)
- promoting awareness of health services for ethnocultural communities (Calgary Immigrant Aid Society, 2001; Calgary Health Region, 2002)

For more than a decade, the Calgary Health Region (CHR) has committed a number of resources to address the increasing needs of the ethnocultural communities (Appendix A). The Region's vision, mission and strategic directions provide the foundation and demonstrate the commitment for the directions outlined in the Blueprint. These are highlighted below.

## **CALGARY HEALTH REGION STRATEGIC DOCUMENTS**

The CHR has two core businesses in common with all Regional Health Authorities in Alberta. These are to ensure delivery of quality health services and to encourage and promote healthy living.

“Our community working together for excellence in health” is the CHR vision. The business of the Region is further guided by its mission - “..... is committed to excellence in providing an accessible, accountable and integrated community based health system which promotes shared responsibility for improved health”. The Healthy Communities portfolio supports these directions. The portfolio’s mission is to” .... positively influence and collaboratively address the factors that determine the health of the people and communities served by providing a range of programs and services including prevention, promotion, protection and medical intervention”. These statements point to the interest of the CHR in responding to health needs in partnership with members of the community.

The CHR has also adopted the Balanced Scorecard model in detailing its business plan goals, performance measures and performance reporting. The Region’s Balanced Scorecard encompasses four key result areas: financial accountability; people and partners; innovative service delivery; and patients and clients. The CHR Board and Executive Team are committed to these four key result areas and have defined goals and measures/targets for each.

## **REGIONAL DIVERSITY SERVICES: THE LOCAL CONTEXT**

Regional Diversity Services for the CHR are coordinated within the Healthy Communities portfolio. Collaborating with the community and all regional portfolios, Diversity Services aims to support equitable access to health services for all populations including ethnocultural background, gender, physical and mental capacity, education level, age, ancestry, sexual orientation, marital status, socio-economic status and religious belief.

Regional Diversity Services mandate is to:

- identify, develop and recommend integrated strategies, protocols and policies that enable the Region to be flexible and responsive to diversity issues;
- support appropriate, responsive and accessible health care services for diverse populations and to promote fair and equitable employment practices;
- facilitate implementation and evaluation of the Region’s diversity strategies, initiatives, protocols and policies; and
- promote diversity initiatives that encourage collaboration as well as innovation across the spectrum of all divisions of the Region, as well as linking and partnering with the broader community to address the determinants of health.

The Regional Diversity Steering Committee (see Appendix B for Terms of Reference and Membership) aims to enhance the capabilities of the CHR to address issues related to diversity for the populations served and within the workforce of the CHR (Appendix C). This means that residents from diverse backgrounds can access the health system in a timely manner; are satisfied with the services received; and receive equitable, quality, cost effective care.

## 2. DEVELOPMENT OF THE BLUEPRINT

The development of the *Blueprint* involved numerous stages. In 2001 the CHR initiated the development of a Regional Diversity Steering Committee. It should be noted that the aboriginal population in the region remains the responsibility of the CHR Regional Aboriginal Health Program.

The Regional Diversity Steering Committee adopted the Framework for a Culturally Competent Organization (Appendix D) developed by the Cultural Diversity Institute (Ngo, 2000). To further develop the Culturally Competent Organization framework and identify measures/indicators, a Healthy Communities team was assembled between January and March 2002. The resulting Blueprint was based on a review of the literature, service delivery materials and former needs assessments conducted within, and beyond, the CHR.

### PURPOSE AND RATIONALE

The purpose of the Blueprint is to guide the design and provision of culturally competent health services within the CHR. This Blueprint outlines the direction and a common set of organizational prerequisites needed to become a culturally competent organization. The Blueprint offers a common language and context for staff regarding diversity.

Some of the benefits of implementing this Blueprint are:

- alignment of organizational philosophy and values with client services
- provision of a focus for enhancing organizational cultural competency e.g.:
  - understanding among ethnocultural communities regarding the CHR strategies and services designed to increase access to health services;
  - reduced language and cultural barriers in accessing health services;
  - involvement of diverse communities, agencies and organizations in decisions affecting health services;
  - incorporation of the values and assumptions of ethnocultural communities in regional services planning; and
  - increased understanding of health care system capacity for delivery of services.

The impact of immigration on Canada's population is changing how health and social service needs are addressed (Stevens, 1993) and is mirrored in Calgary with the growth and change in ethnocultural communities. Several factors are influencing health care delivery including: consistent and growing ethnocultural populations; the identification of cultural barriers; the influence of health determinants, and the expectations of the public to shape public policy. Each of these factors is detailed below.

## **Ethnocultural Communities in the Calgary Area**

The growth in the immigrant and refugee population in Calgary points to the need for continuing to reduce barriers to health services offered by CHR. For example, the 1996 Census of Canada (City of Calgary, 2000) indicates that over 21% of Calgary residents had immigrated to Canada while a further 0.6% were non-permanent residents. Over four percent of these Calgary residents are considered 'newcomers' meaning that they immigrated to Canada in the past five years (City of Calgary, 2002).

While ethnocultural communities have grown slightly, the birth place of Calgarians has changed little from 1986 to 1996 with the majority (78%) being born in Canada, 9% in Europe and a further 9% in Asia and the Middle East. Of the newcomers (those who have immigrated in the past five years), almost 12% were born in China and over 11% in India. Other newcomers have come from the Philippines (8.1%) and Pakistan (6.3%).

## **Identification of Cultural Barriers in the Health System**

The US Department of Health & Human Services (1998) suggests that cultural competence in primary care helps to reduce barriers to care and improve quality and health outcomes.

Participants in Calgary's Building Bridges Forum identified a number of cultural barriers in accessing health services. These included language, lack of sensitivity or respect towards alternative health practices and rituals and differences in beliefs regarding health care and approaches to treatment (Gallop, 2000).

Follow up with several ethnocultural communities and organizations regarding CHR services (Calgary Health Region, 2002) revealed a number of ongoing service limitations that require attention. Some themes that emerged were: lack of awareness of interpretation and translation services, lack of awareness of health services, lack of outreach services, lack of trained health professionals from diverse communities, and the need for more cross-cultural training of health professionals. For some ethnocultural communities, the inadequate number of female physicians is a significant barrier to accessing health services.

## **DETERMINANTS OF HEALTH**

The overall goal of the Population Health Promotion (PHP) Model (Hamilton and Bhatti, 1996) is to improve the health of the population through a comprehensive approach (Appendix E). The PHP model addresses questions related to: "on what should we take action?", "how we should take action?" and "with whom should we act?". With respect to "how", the model emphasizes several strategies including collaboration with sectors outside of the health system to leverage actions that impact people's health. The "who" identifies several groups for involvement ranging from individuals to society as a whole.

With respect to the question of "what", the model focuses on the determinants of health. Much has been learned over the past several decades about what determines health and where efforts should be concentrated. The research evidence suggests that we

need to examine the factors both inside and outside the health system that affect health. At every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behavior. These factors do not exist in isolation from each other and it is the combined influence of the determinants of health that impact health status.

Factors related to the health determinants that affect ethnocultural communities are highlighted below.

**a. Social Support Networks**

Primary factors include isolation and adjustment which in turn, affect other determinants of health including food, employment, safety, housing, language ability and knowledge of the health system (University of British Columbia, 1998). Separation from family is a major stressor for immigrants and depression is much higher for those who arrive alone (Health Canada, 1999).

**b. Education**

Federal data indicates differing levels of education among immigrants (Health Canada, 1999). Twenty nine percent of immigrants over the age of 15 were university graduates while 41% had less than 12 years of schooling. While most new arrivals intend to work (67% among immigrants, 80% among refugees), those with lower skill levels have more difficulty becoming employed.

**c. Income and Social Status**

It has been well established that health improves with each additional level of income. There is recognition that visible minorities continue to be over represented in the population with low-income status. In 1995, for example, about 36% of the visible minority population in Canada lived in low-income situations (Health Canada, 1999). Data on immigration trends showed that 35% of immigrant and refugee families and 51% of those who arrived between 1991-1996 are living in poverty compared to 11% of non-immigrant families (Health Canada 1999). Toward a Healthy Future: Second Report on the Health of Canadians (1999) also indicates that “poverty compounds the stresses that all families face and can have a negative effect on children’s development . . . the greatest number of children who experience difficulties are found in the bottom 20% of the socioeconomic scale” (Health Canada, 1999, p. 73-74). Poverty is linked with ineffective parenting, parental psychopathology, intrafamilial hostility and single parent families (Beiser, Hou, Hyman and Tousignant, 2002).

**d. Personal Health Practices and Coping Skills**

Research indicates that immigrants and refugees are at greater risk of communicable diseases (e.g. tuberculosis and hepatitis A) and have higher mortality rates from suicide and lower cancer survival rates (Health Canada, 1999).

The literature also emphasizes the fact that immigrants, and particularly recent immigrants, have fewer chronic conditions or disabilities compared to the Canadian-born population (Health Canada, 1999). However, there are some differences

among immigrants. Data from various provinces suggest that immigrants report health problems less and perceive their health less positively than Canadian born individuals. Other information points to problems related to poor oral health, stress, lack of preventive behavior, and low health care utilization rates. The health status of refugees is poorer than that of other immigrants because of their experience prior to arrival in Canada and a differing selection process (Health Canada, 1999).

**e. Healthy Child Development**

Studies show that refugee children are more likely to have serious problems associated with disease, physical injuries, malnutrition, brain damage and sexual and physical abuse and that these conditions may affect cognitive, emotional and social development (Health Canada, 1999). A recent analysis of data from a Canadian study on children between 4 – 11 years of age suggests that protective factors associated with immigrant family life may counteract some of the negative effects of poverty such as mental health risk (Beiser et al, 2002).

**f. Health Services**

A 1994 Calgary based study indicated that approximately 25% of Calgarians whose first language was not English indicated difficulties in setting appointments with health care providers. Of all the immigrants coming to Calgary in 1998 close to half (46.4%) indicated that they could not communicate in English or French (City of Calgary, 2000).

A similar Calgary based survey found that, of the 45 interviewed, one third of health care providers did not feel competent in delivering culturally sensitive health care services (Chugh, Agger-Gupta, Dillmann, Risher, Gronnerud, Kulig, Kurtz and Stenhouse, 1994).

**g. Working Conditions, Physical & Social Environments and Biology & Genetics**

While more information is available on the other determinants of health, little research has been conducted in the area of working conditions, physical and social environments and genetics. It has been suggested that this type of information may be useful in understanding the decline of health over time among immigrants (Health Canada, 1999). It is thought that immigrants that are employed in shift and weekend rotations experience stressors similar to non-minority populations. Others have noted industrial accidents are higher among immigrant workers and this may be due to language difficulties and reduced knowledge of workplace hazards. Exploratory studies suggest that minority group status and discrimination also affects housing adequacy (Health Canada, 1999).

**h. Culture**

Researchers have identified that perception of quality of life, and the ways in which health is understood and discussed varies from culture to culture. It is suggested that cultural belief patterns related to health and health seeking behaviour influence individuals approach to health care and subsequently the appropriateness of the services received (Spector, 1991). For example, the duration of breast-feeding has been shown to be related to the mother's country of birth (Health Canada, 1999).

**i. Gender**

A number of studies have investigated gender bias. Some of the data point to a male bias in settlement services so that women's needs are not met in the receiving country (Health Canada, 1999). Other factors such as the proscription of women's roles, dependency on the partner for financial security and lack of understanding and access to services (justice, health) result in various health problems e.g. depression.

## **KEY CONSIDERATIONS**

Creation of the Blueprint required explicit recognition of a number of considerations. While the intent is to apply the Blueprint in a consistent manner there are some factors that may influence its application. These include, but are not limited to regulatory requirements, current diversity activities, scope, accreditation and expectations by the public. Each of these considerations is described below:

**a. Regulatory Requirements**

The Blueprint is intended to augment and enhance services to address the needs of ethnocultural communities who reside within the CHR. In some cases, application of the Blueprint and response to identified concerns may be influenced by provincial legislation. These include the Regional Health Authorities Act and other provincial legislation, notably the Hospitals Act, Provincial General Hospitals Act, Nursing Homes Act and the Public Health Act, Coordinated Home Care Regulation and the Health Care Professionals Act. It should be noted that the CHR does not fall under the Employment Equity Act, is not considered a Federal Contractor or a Legislated Employment Equity Program organization. As well the organization must also comply with union contractual obligations related to hiring practices.

**b. Current Diversity Activities**

The development of the Blueprint does not imply this is the first work undertaken by the CHR. In fact, this Blueprint builds upon past efforts and provides a context for future activities (Appendix A).

**c. Scope**

It is recognized that the definition of diversity (Section 3) encompasses a number of groups within our region. As noted earlier, while the intent of the Blueprint is to serve as a foundation for diversity, initial attention will be directed at the needs of ethnocultural communities. However, there may be limitations in the allocation of resources specifically to diversity services depending on the array of priorities presenting at any given time within the CHR.

**d. Accreditation**

Accreditation is described as a comparison of an organization's services and method of operation against a set of national standards (The Canadian Council on Health Services Accreditation, 2002). Routine accreditation processes and requirements may identify particular areas for immediate attention or priority. For example the

CHR Accreditation 2002 team, Maternal Infant and Newborn Services Access in Northeast, identified multicultural issues focusing on access issues and service delivery gaps. In addition, various other accreditation teams addressed diversity as it relates to ethnocultural populations in Calgary.

**e. Expectations Regarding Public Participation**

Community members are expressing more and more interest in providing input regarding the organization and delivery of health services. The Provincial Health Council reported that Albertans have expressed an interest in influencing how health services are structured and delivered (Calgary Health Region, 2001). Clearly, there is increased attention towards involving members of the public in decisions that affect their health and well being. As outlined in the Public Participation Framework (Calgary Health Region, 2001) there are a number of benefits identified regarding the involvement of the public in decision-making processes. These include “ . . . improved quality of decisions; better relationships with the public; enhanced credibility; fewer potential problems; assistance in identifying issues, concerns and public priorities; and mediating between competing interests” (Calgary Health Region, 2001, p.1). In addition, the CHR’s Public Participation Framework (2001) indicates that public participation processes offer the opportunity to develop skills of the public and of health professionals and enhance the capacity of both parties.

As attention is increasingly focused on enhancing services to diverse populations, the necessity for needs assessment, consultation and partnerships has increased. Numerous reports and task forces over the past several years indicate an increasing interest and willingness among service providers and ethnocultural communities to work together to address the needs of their respective communities.

**WORKING ASSUMPTIONS**

A number of assumptions have been made with respect to current conditions within the CHR. The organization:

- recognizes and is responding to the need for culturally competent and accessible health services for culturally diverse communities;
- involves ethnocultural communities as active participants and/or partners in supporting sound health practices and initiatives to improve access to health services;
- responds through consultation, planning and collaboration to the identified issues expressed by ethnocultural communities and their respective advocates; and
- supports an infrastructure to promote diversity and incorporate culturally competent service strategies.

### 3. BLUEPRINT FOR A CULTURALLY COMPETENT ORGANIZATION

The *Blueprint* is an organizing tool to guide a comprehensive approach to diversity health services and identifies the expected outcomes of the region's efforts. Some of the key definitions follow and others are outlined in the glossary (Section 7).

#### DEFINITIONS

The Regional Diversity Steering Committee adopted the following definition of diversity:

**Diversity:** All the ways we are unique and different from others. Dimensions of diversity include, but are not limited to, such aspects as race, religion and spiritual beliefs, cultural orientation, colour, physical appearance, gender, sexual orientation, physical and mental ability, education, age, ancestry, place of origin, marital status, family status, socio-economic class, profession, language, health status, geographic location, group history, upbringing and life experiences (Agger-Gupta, 1997).

While this definition is all encompassing, the initial focus of the Blueprint is ethnocultural in nature. In time, the Blueprint will extend beyond an ethnocultural context.

For the purposes of this document **cultural competency** is defined as “the ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds and religions in a manner that recognizes, affirms, and values the cultural differences and similarities and the worth of individuals, families, and communities and protects and preserves the dignity of each.” (Cross Cultural Health Care Program, 2002, p. 1).

A **culturally competent organization** “... holds cultural diversity and equitable services in high regard. It continually self-assesses its structures, policies and procedures, adapts to a variety of service models and engages culturally diverse people in all aspects of the organization” (Ngo, 2000, p. 10).

#### VALUES TO GUIDE THE BLUEPRINT

The values that guide the Blueprint are consistent with the organizational values of the CHR outlined in the 2000/2001 annual report and Healthy Communities Directions Document (2001). These values include: people and communities, competence and knowledge, accountability, relationships, innovation and a healthy work environment.

## **GUIDING PRINCIPLES FOR DIVERSITY SERVICES**

Guiding principles represent the actions to operationalize and reflect an organization's values. Guiding principles for cultural competence provide the foundation for decision-making processes aimed at reducing barriers and increasing access for ethnocultural communities (Hart, 2000; US Department of Health & Human Services, 1998). These include:

- institutionalizing cultural knowledge;
- building capacity for cultural self-assessment;
- creating awareness of the dynamics when cultures interact; and
- adapting service delivery reflective of cultural diversity.

The National Centre for Cultural Competence (US Department of Health & Human Services, 1998) recommends that these principles be manifested at every level of the organization and are reflected in the organizations' philosophy, structures, policies and services.

These guiding principles are recommended as the underpinnings for the Blueprint.

## **OVERVIEW OF THE BLUEPRINT**

Figure 1 (page 15) details the Blueprint. This Blueprint has been adapted from the work of the Cultural Diversity Institute (Ngo, 2000; see Appendix D). Outlined in the Blueprint are nine critical organizational elements linked with key measures for achieving organizational cultural competency. The Blueprint integrates the region's balanced scorecard approach by mapping the nine comprehensive elements to the four key result areas detailed in the CHR's Balanced Scorecard (see Figure 1). Two of the four key result areas, and five of the nine elements focus on internal activities e.g. governance, policies, human resources. One of the balanced scorecard key result areas and three accompanying elements are externally focused and include service delivery, partnerships and collaboration and communication efforts. The foundation of the Blueprint rests on the remaining balanced scorecard key result area and one element, organizational culture.

These nine elements are interdependent and changes in one have the potential to influence and support changes in the other. In this sense, the elements are synergistic and interactive. The arrangement of the elements and direction of the arrows in the Blueprint is intentional. Organization change theory suggests that internal forces such as system alignment and infrastructure impact culture (attitudes and behavior) which collectively influence and shape external services and relationships (Jick, 2000). A brief description of the nine elements with the rationale for the importance of each in supporting cultural competency in the CHR follows.

## **Financial Accountability**

### **1. Governance**

Governance serves as the critical element with which to organize the thoughts, activities, structure and relationships of governing boards to provide the needed leadership for organizations (Carver 1990). Carver also suggests that successful board governance encourages a greater emphasis on external needs versus the internal issues of the organization, and serves to role model diversity and unity for the rest of the organization. By providing clear direction and policies, the board makes transparent its values that guide planning by management and staff.

As a result, governance measures highlighted in the Blueprint reflect the need to optimize the richness of diversity in board composition, ensure board participation in demonstrating cultural competencies, and aligning the mission and vision to the external needs of diverse communities.

### **2. Administration**

Like the Board, administration provides key leadership by translating the board direction and policies into actionable plans for staff to advance cultural competency within the organization. In addition, administration is accountable for reporting on progress towards achieving a culturally competent organization (Ngo, 2000).

Wilson (1997) has suggested that achievement of cultural competence may be limited by barriers within administration such as a lack of awareness, education, commitment and skills. Strategies to address the unique needs required by administration to successfully implement cultural competency plans and goals are essential.

### **3. Policy and Decision Making**

The essence of an organization is manifested in its policies. Policies according to Carver (1990) embody values (beliefs) and perspectives (approach or conceptual point of view). Organizational policies, practices and procedures (including business plan goals and objectives) are the prime focal point for incorporating cultural and linguistic principles (US Department of Health & Human Services, 1998). Examples of this are human resource practices that promote a diverse workforce and cross-cultural training.

## **People and Partners**

### **4. Human Resource Practices**

Another strategy in attaining cultural competence is to consciously recruit health care professionals reflective of the populations being served. The aim is to have a workforce that reflects the multicultural and multilingual components of the community (US Department of Health & Human Services, 1998; Riddick, 2000).

Participants in Calgary's Building Bridges Forum communicated that an ideal health care system would include the integration of health care providers who had been

trained in other countries (Gallop, 2000). More specifically, participants suggested that professional certification requirements be revisited to include recognition of foreign trained professionals. With respect to foreign credentials, it should be noted that professional and licensing bodies for health care professionals are responsible for assessing the certification requirements.

The CHR does not fall under the Employment Equity Act, is not considered a Federal Contractor or a Legislated Employment Equity Program organization. Although not legislated to implement employment equity programs or to comply with specific equity related requirements, the CHR is committed to supporting cultural competency.

## **5. Training**

Respect, client centered approaches and understanding of the influence of cultural beliefs are recognized as contributing to cultural competency (US Department of Health & Human Services, 1998). Educational opportunities and professional development aimed at building the cultural competence of health care providers are essential to enhancing organizational cultural competency.

Cross-cultural training and education for health care providers (Gallop, 2000) also assist staff in their ability to interact sensitively and respectfully with diverse clients. In addition, training promotes the overarching values and attitudes desired within the organization. On a more local level, health care professionals who participated in the Calgary based study by Chugh et al (1994) also indicated an interest in, and need for, cross-cultural training opportunities. Local training requests included those related to all aspects of religious, cultural and health beliefs as well as traditional and ritual approaches regarding health. More and more health professionals are recognizing the need for professional competencies in order to provide quality care (Campinha-Bacote, 1999; Salimbene, 1999).

Other areas of training related to bridging services between ethnocultural communities and service organizations have also been identified. An area of particular interest in the literature relates to interpretation (Jackson-Carroll et al, 1998). It is suggested that interpretive services need to go beyond providing medical terminology to include the appropriate cultural context for example, health belief systems.

## **Innovative Service Delivery**

### **6. Organizational Culture**

Organizational culture is included in the Blueprint and has been referred to in a range of ways. For example, culturally and linguistically friendly physical environments and resource materials have been identified as being an important domain (US Department of Health & Human Services, 1998). Organizational culture is recognized as a pervasive force that either enhances or minimizes cultural competence depending on the prevailing values and norms within an organization. For this reason, organizational culture is positioned as a foundational element within

the Blueprint. The organizational culture is shaped by both the system and the human resource elements while simultaneously reinforcing and advancing these elements.

## **Patients and Clients**

### **7. Service Delivery**

A culturally competent organization reduces or eliminates barriers to care and has been shown to improve the quality of services as well as health outcomes (US Department of Health & Human Services, 1998). Recommendations regarding service delivery typically refer to local service provision and culturally sensitive design and delivery.

Stevens (1993) emphasizes the need for service providing organizations to “multiculturalize” existing services. He further suggests that the community health centre should provide culturally appropriate programs for members of their catchment area and that a culturally competent model extends beyond a generic programming model. Stevens (1993) also emphasizes the role of health and social service sectors to accept the challenge and responsibility of responding to the new reality to support equal access to services for all Canadians, including those from other cultures. It should be noted that equal is not necessarily equitable, the latter being the preferred approach for marginalized populations.

Locally, participants in the Building Bridges conference supported the concept of local service delivery and stated that they would like health services to be provided within the community (e.g. from community health centers) (Gallop, 2000). These views were also expressed in the Health Symposium (Calgary Immigrant Aid Society, 2001). This is consistent with the CHR consultation (2002) which identified the need for further outreach services.

### **8. Partnership and Collaboration**

Involvement of community members in health program development and delivery is identified as one of the contributing factors to successfully attaining cultural competence (Academy of Educational Development, 2000; US Department of Health & Human Services, 1998).

The Center for Community-Based Health Strategies (2000) indicates that community involvement results in more thoughtful design, increased support and programs that more effectively serve the needs of the community. The Center details a number of criteria that increase opportunity for success:

- integrated approaches involving a full spectrum of affected individuals, stakeholder groups and funders;
- equality among stakeholders;
- objectives defined by the community and funders;
- evidence based decision making;

- measurable outcomes that meet the intended objectives; and
- a strong infrastructure.

There is a myriad of definitions related to the concept of working together. The following are two outlined in the World Health Organization (WHO) Health Promotion Glossary (1998).

Partnership is defined as a “. . . *voluntary agreement between two or more partners to work cooperatively towards a set of shared health outcomes*” (World Health Organization, 1998, p. 17). WHO views partnerships as being part of inter-sectoral collaboration or an alliance for health. In addition, WHO recognizes that partnerships of this sort may be limited by the pursuit of a clearly defined goal or may be ongoing, covering a broad range of issues and initiatives.

Inter-sectoral collaboration is defined by the World Health Organization (1998, p. 15) as a “. . . recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector alone.”

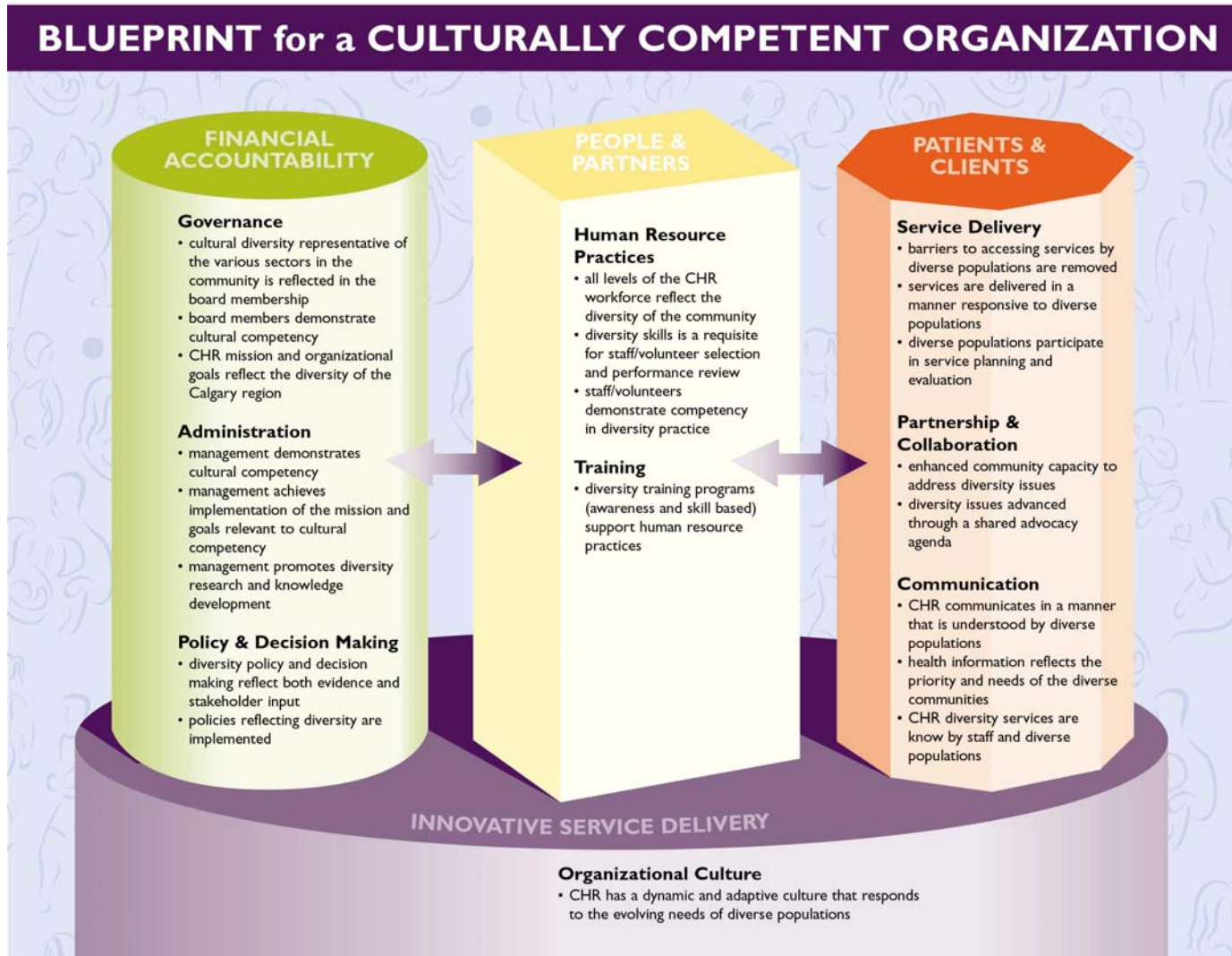
The CHR supports partnerships and collaboration as an important approach to advancing the health in the community. The above definitions are consistent with our understanding of collaboration.

Consultations with the ethnocultural communities in the Calgary region have highlighted the need for government and nongovernmental organizations to work together (Gallop, 2000; Calgary Immigrant Aid Society, 2001). Ethnocultural communities in Calgary identified a willingness to participate in planning, delivery and evaluation of health services (CHR, 2002). They also expressed the need for a range of participation opportunities and the need for education about the CHR and how to participate.

## **9. Communication**

Communication and communications style are identified by the US Department of Health & Human Services (1998) as being one of the domains for cultural competence. Key components within this domain include awareness, knowledge, sensitivity and alternatives to written communication (US Department of Health & Human Services, 1998). Gallop (2000) describes ideal communication in the health system to be provided via a number of strategies. These include services and resources in multiple languages, support for health care providers (e.g. cross-cultural training), health system orientation for newcomers and the integration of cultural broker and multi-cultural health care workers to bridge the gap between health care services and culture.

Figure 1



## 4. PERFORMANCE AND ACCOUNTABILITY

The CHR has adopted the Canadian Council on Health System Accreditation (CCHSA) “Achieving Improved Measurement” (CHR, 2001) accreditation program as an effective way to demonstrate system performance. In the case of the Blueprint, performance indicators were developed with links to the following dimensions of quality as set out by the CCHSA:

### **Responsiveness**

The organization anticipates and responds to changes in the needs and expectations of the (potential) client and/or community population(s), and to changes in the environment.

### **System Competency**

The organization consistently provides services in the best possible way, given the current and evolving state of knowledge. The organization achieves the desired benefit for clients and/or communities, with the most cost-effective use of resources.

### **Client/Community Focus**

The organization strengthens its relationship with the client and/or community. The organization does this by encouraging community participation and partnership in its activities.

### **Worklife**

The organization provides a work atmosphere conducive to performance excellence, full participation, personal/professional and organizational growth, health, well being and satisfaction.

Indicators are measures, screens, or flags that are used to monitor, evaluate and improve the quality of care, support, and functions of the organization that impact the client’s outcomes. These indicators:

- are useful points of reference for evaluation;
- illustrate trends over time (comparing results over previous years); and
- alert organizational leaders when a program activity has reached an acceptable or unacceptable target.

Table 1 describes the outcome measures and indicators for each of the nine elements in the Blueprint. The outcome measures and indicators developed in the Blueprint also demonstrate linkages to the:

- nine elements in the Blueprint (see Table 1);
- Cultural Diversity Institute Self-Assessment Guide (Ngo, 2000); and
- National Standards for Culturally and Linguistically Appropriate Services in Health Care (US Department of Health and Human Services, 2001) which have been adopted by the Regional Diversity program (Appendix F).

These measures and indicators serve as benchmarks for monitoring progress towards

becoming a culturally competent organization. The measurement of the indicators identified in this document is feasible however it will require the development of an evaluation infrastructure and process.

Apart from the references noted, the literature review did not reveal much data on evaluation of culturally competent organizations.

**TABLE 1: CULTURAL COMPETENCY OUTCOME MEASURES AND INDICATORS**

STRATEGIES	STANDARDS*	MEASURES	INDICATORS
<p>FINANCIAL ACCOUNTABILITY</p> <p>1. <b>Governance</b></p>	2	a. Cultural diversity representative of the various sectors in the community is reflected in the board membership	<p>Number and percent of board members representative of the diversity of the Calgary Region</p> <ul style="list-style-type: none"> <li>▪ ethno cultural communities</li> <li>▪ economically disadvantaged</li> <li>▪ gender</li> <li>▪ persons with disabilities</li> </ul>
	9, 14	b. Board members demonstrate cultural competency	<ul style="list-style-type: none"> <li>• Number and percent of board members oriented to the CHR diversity framework</li> <li>• Number and percent of board members who demonstrate understanding of the CHR diversity policies</li> <li>• Number and percent of policies developed to reflect the values of a culturally competent organization</li> <li>• Number and percent of performance criteria established to reflect a culturally competent board</li> <li>• Number and percent of board members who achieve performance criteria</li> </ul>
	8, 10, 11	c. CHR mission and organizational goals reflect the diversity of the Calgary region	<ul style="list-style-type: none"> <li>• Number and percent of culturally competent services provided in the CHR</li> <li>• Number of management reports outlining progress and emerging issues related to diversity</li> <li>• Number and percent of managers collecting diversity data for planning and reporting purposes</li> </ul>

\* See Appendix F.

STRATEGIES	STANDARDS	MEASURES	INDICATORS
FINANCIAL ACCOUNTABILITY  2. <b>Administration</b>	8	a. Management demonstrates cultural competency	<ul style="list-style-type: none"> <li>• Number and percent of managers oriented to the CHR diversity blueprint and policies</li> <li>• Number and percent of managers who develop and implement a diversity plan that supports the CHR Diversity Blueprint</li> <li>• Number and percent of managers who implement the CHR diversity policies</li> <li>• Number and percent of managers who achieve performance criteria related to a culturally competent organization</li> </ul>
	9, 10, 11 13	b. Management achieves implementation of the mission and goals relevant to cultural competency	<ul style="list-style-type: none"> <li>• Number and percent of managers reporting progress on achieving results of a culturally competent organization</li> <li>• Number and percent of culturally competent services provided in the CHR</li> <li>• Number and percent of emerging needs of the diverse populations reported to the board</li> <li>• Number of outcomes measures and benchmarks for a culturally competent organization established</li> <li>• Number and percent of outcome measures reported on</li> <li>• Number of evaluation strategies developed to report on outcome measures and indicators of a culturally competent organization</li> </ul>
		3. Management promotes diversity research and knowledge development	<ul style="list-style-type: none"> <li>• Number and percent of research initiatives focused on diversity</li> <li>• Number and percent of evidence based practices are diversity applied</li> </ul>

STRATEGIES	STANDARDS	MEASURES	INDICATORS
FINANCIAL ACCOUNTABILITY <b>3. Policy &amp; Decision Making</b>	12	a. Diversity policy and decision making reflect both evidence and stakeholder input	<ul style="list-style-type: none"> <li>Number and percent of stakeholder consultations regarding policy development</li> <li>Number and percent of written policies reflective of stakeholder input</li> </ul>
	1-14	b. Policies reflecting diversity are implemented	<ul style="list-style-type: none"> <li>Number and percent of staff assigned accountability for policy implementation</li> <li>Number and percent of departments reporting action plans to implement policies</li> <li>Number and percent of managers reporting adequate resources to implement the action plans</li> </ul>
PEOPLE & PARTNERS <b>4. Human Resource Practices</b>	2	a. All levels of the CHR workforce reflect the diversity of the community	<ul style="list-style-type: none"> <li>Number and percent of staff representative of the diversity (including language) in the Calgary region</li> <li>Number and percent of employment opportunities advertised through diverse community communications</li> </ul>
	2	b. Diversity skills is a requisite for staff/volunteer selection and performance review	<ul style="list-style-type: none"> <li>Number and percentage of selection and performance criteria established</li> </ul>
		c. Staff/volunteers demonstrate competency in diversity practice	<ul style="list-style-type: none"> <li>Number and percent of staff who achieve performance criteria</li> </ul>
<b>5. Training</b>	3	a. Diversity training programs (awareness /skill based) support human resource practices	<ul style="list-style-type: none"> <li>Number of curricula developed reflecting diverse community /staff needs</li> <li>Number and percent of diversity training programs offered</li> <li>Number and percent of staff that have attended diversity training</li> <li>Number and percentage of staff that express satisfaction with diversity training</li> </ul>

STRATEGIES	STANDARDS	MEASURES	INDICATORS
INNOVATIVE SERVICE DELIVERY  <b>6. Organizational Culture</b>		a. CHR has a dynamic and adaptive culture that responds to the evolving needs of diverse populations	<ul style="list-style-type: none"> <li>• Number and percent of diverse citizens reporting service needs met</li> <li>• Number and percent of external groups identifying CHR as a model for a culturally competent organization</li> <li>• Number and percent of staff reporting satisfaction with the CHR responding to the evolving needs of its diverse staff and communities</li> <li>• Number and percent of health status indicators of diverse populations reflects the health status of the CHR</li> </ul>
PATIENTS & CLIENTS  <b>7. Service Delivery</b>	4, 5, 6, 7	a. Barriers to accessing services by diverse populations are removed	<ul style="list-style-type: none"> <li>• Number and percent of translation services offered</li> <li>• Number and percent of interpretative services offered</li> <li>• Number and percent of communities who demonstrate knowledge on how to access translation and interpretative services</li> <li>• Number and percent of workforce who offer bilingual language services</li> <li>• Number and percent of signage that is offered in the clients language</li> <li>• Number and percent of signage indicating interpretative/translation services offered</li> <li>• Number and percent of outreach services to isolated diverse communities</li> </ul>

STRATEGIES	STANDARDS	MEASURES	INDICATORS
PATIENTS & CLIENTS  <b>7. Service Delivery</b>	1, 13	b. Services are delivered in a manner responsive to diverse populations	<ul style="list-style-type: none"> <li>• Number and percent of services evaluated on cultural competency</li> <li>• Number and percent of staff who demonstrate cultural competency in practice</li> <li>• Number and percent of client feedback mechanisms established</li> <li>• Number and percent of diversity clients reporting satisfaction with services</li> </ul>
	12	c. Diverse populations participate in service planning and evaluation	<ul style="list-style-type: none"> <li>• Number and percent of participation processes for involvement in CHR planning and evaluation of diverse communities</li> <li>• Number and percent of diverse communities participating in service planning and evaluation</li> <li>• Number and percent of diverse communities reporting satisfaction with shaping and developing services</li> <li>• Number and percent of diverse communities reporting improved and or increased service delivery for their communities</li> </ul>

STRATEGIES	STANDARDS	MEASURES	INDICATORS
PATIENTS & CLIENTS  <b>8. Partnership &amp; Collaboration</b>	12	a. Enhanced community capacity to address diversity issues	<ul style="list-style-type: none"> <li>• Number and percent of diverse community needs assessments completed</li> <li>• Number and percent of partnerships developed with diverse communities</li> <li>• Number and percent of diverse community members participating in leadership roles</li> <li>• Number and percent of diverse populations addressing health issues</li> <li>• Number and percent of partnership resources created and shared</li> <li>• Number and percent of diverse communities reporting increased awareness of each others roles and responsibilities</li> <li>• Number and percent of diverse communities reporting shared decision making with partnerships with CHR</li> <li>• Number and percent of shared service delivery with diverse groups and organizations</li> </ul>
	12	b. Diversity issues advanced through a shared advocacy agenda	<ul style="list-style-type: none"> <li>• Number and percent of advocacy strategies identified, developed, and implemented with diverse communities</li> <li>• Number and percent of system, policy, and service changes</li> </ul>

STRATEGIES	STANDARDS	MEASURES	INDICATORS
PATIENTS & CLIENTS  <b>9. Communication</b>	4,5,6,7	a. CHR communicates in a manner that is understood by diverse populations	<ul style="list-style-type: none"> <li>• Number and percent of communiqués that demonstrate cultural sensitivity to diverse communities and organizations</li> <li>• Number and percent of CHR materials translated to diverse communities and organizations</li> <li>• Number and percent of CHR communiqués incorporated into diverse community communication methods</li> </ul>
	10, 14	b. Health information reflects the priority and needs of the diverse communities	<ul style="list-style-type: none"> <li>• Number and percent of health information needs, assessed with diverse communities and organizations</li> <li>• Number and percent of priority health needs of diverse communities and organizations incorporated into CHR health information and communication</li> </ul>
		c. CHR diversity services are know by staff and diverse populations.	<ul style="list-style-type: none"> <li>• Number and percent of staff who can identify diversity services by CHR</li> <li>• Number and percent of diverse populations who can identify diversity services by CHR</li> </ul>

## 5. IMPLICATIONS FOR THE ORGANIZATION

A multicultural organizational change process often requires the dismantling of visible and invisible barriers to allow for the full participation of all people in the organization; as well as establishing an inclusive organization reflective of, and responsive to, the entire community (Agger-Gupta, 1997). Evidence from the change management literature suggests that it is vital for organizations to carefully examine those change enablers that influence and drive the longer-term success of well crafted visions, plans and strategies (Jick, 1991). Agger-Gupta (1997) has suggested that multicultural organizational change has significant implications for both the individual and system levels.

The call for successful implementation of organizational change to achieve cultural competence within the CHR requires significant individual and system analysis of prevailing internal and external forces (barriers), a well crafted vision, implementation plans, structural alignments, monitoring processes, and change enablers.

It is recognized that many organizational change enablers exist. However, those change enablers most relevant for successful implementation of the CHR Blueprint - system alignment, development of champions and building on existing innovation are highlighted below.

### ***System alignment:***

System alignment or “task alignment” suggests individual knowledge, attitudes and beliefs are shaped by recurring patterns of behavioral interactions (Beer, Eisenstat and Spector, 1990). This suggests that to reshape behaviors, attitudes and beliefs, individuals need to be placed in new contexts, new roles and new responsibilities. System changes and alignment is achieved through development of a strategic plan that creates a self-reinforcing cycle of commitment, coordination and competence. Beer et al (1990) identify six components for a strategic plan. These are: a shared diagnosis of required organizational outcomes; a shared vision; defined new roles and responsibilities; new team decision making authority; formalizing revitalization through policies, systems and structures; and monitoring and adjusting strategies in response to problems in the revitalization process.

### ***Development of Champions:***

A champion or “change agent” is referred to as an individual who defends another individual or cause, has the ability to identify and influence organizational needs and facilitates change through a variety of strategies (Agger-Gupta, 1997). It is important that champions at all levels of the organization are identified and positioned in ways to leverage and model appropriate attitudes, behaviors and standards for culturally competent care. Champions can generate enormous pressure to meet established performance standards. In addition, champions are key to mobilizing energy for change and shifting the organizational paradigm (Beer et al, 1990).

***Innovation:***

Innovation is critical to building cultural competency. Identifying, recognizing and celebrating staff innovation creates organizational momentum towards achieving desired outcomes (Beer et al, 1990). To foster innovation, certain conditions need to be established. Some of the key conditions include management support, interfunctional networks and teamwork, incentives for risk and experimentation and links to the external learning and research environment (Mohrman and Mohrman, 1993).

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## 7. GLOSSARY OF KEY TERMINOLOGY

### **Access<sup>1</sup>**

The ability, opportunity and means to approach, consult, and utilize an organization's services and organizational structure.

### **Barriers<sup>2</sup>**

Obstacles or limitations that prevent culturally diverse people from having equal access to services.

### **Barriers<sup>1</sup>**

Real and/or perceived obstacles and problems which limit or impede equal access to and participation in any service or programme.

### **Bridging<sup>1</sup>**

The approach, programme, or services which span the physical, cultural and psychological distances between *mainstream organizations* and the individual or group from outside the organization's dominant culture. Bridging is an interactive process along a two-way street between service providers and services recipients of diverse backgrounds.

### **Champion<sup>1</sup>**

"Someone who defends another person or a cause" – Webster's Dictionary (Soukhanov and others 1984, 1988, 1994). Champions, particularly at the top of an organization, are key to the *MOC/Managing Diversity* process because of their ability to influence the agenda and identify the specific needs of the organization. See also *Change agent*.

### **Change Agent<sup>1</sup>**

Person with an interest in, an ability to influence through personal power or position, or a mandate, to facilitate organizational change through a variety of strategies. See *Champion*.

### **Cross-cultural<sup>1</sup>**

Moving from one's own culture to another. This refers to: a) communication – sending, giving, or exchanging information or ideas between two individuals coming from different cultural backgrounds; b) training – this refers to helping people, usually in an organization, learn about another culture by presenting an individual to talk about their own culture and demonstrate cultural artifacts or rituals. This approach is called *culturally-specific* training. *Cross-cultural* is often used as a synonym for *intercultural*, or (inappropriately) for *multicultural* (as in, the "cross-cultural communities"), as though only some communities operated across cultural boundaries.

### **Culturally Appropriate Services<sup>1</sup>**

Services which have been designed to meet the needs of clients from diverse backgrounds.

### **Culture**

Patterns of learned behaviours and values that are shared among members of a group, are transmitted to group members over time, and distinguish the members of one group from another. Culture can include: ethnicity, language, religion and spiritual beliefs, race, gender, socio-economic class, age, sexual orientation, geographic origin, group history, education and upbringing, and life experiences.<sup>1</sup>

Practices, habit patterns, customs, values and structures that are related to a common group experience. Culture can include ethnicity, language, religion or spiritual beliefs, race, geographic origin, group history and life experiences.<sup>2</sup>

### **Cultural Competency<sup>2</sup>**

A set of congruent behaviours, attitudes and policies that come together in a system, agency or profession that enables that system, agency or profession to achieve cultural diversity and to work

effectively in cross-cultural situations.

### **Culturally Competent Organization<sup>2</sup>**

A culturally competent organization holds cultural diversity and equitable services in high regard. It continually self-assesses its structures, policies and procedures, adapts to a variety of service models and engages culturally diverse people in all aspects of the organization.

### **Cultural Diversity<sup>2</sup>**

Differences in race, ethnicity, language, nationality or religion among various groups within a community, organization or nation. A city is said to be culturally diverse if its residents include members of different groups.

### **Ethnocultural Community<sup>1</sup>**

A group of people who share a common distinctive ethnicity, heritage, culture, language, social patterns and a sense of belonging.

### **Immigrant<sup>1</sup>**

A person who has moved themselves (and often their families) to take up permanent residence and often citizenship in the new country.

### **Immigrant-Serving Organization<sup>1</sup>**

Non-profit, non-governmental organization mandated to provide settlement services (see definition below) to immigrants to Canada.

### **Inclusion<sup>2</sup>**

Equitable participation in public or community institutions of all members of the community, as clients, stakeholders or employees as appropriate.

### **Inter-sectoral Collaboration<sup>3</sup>**

“ . . . recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector alone.”

### **Multicultural Organizational Change (M.O.C.)<sup>1</sup>**

This term refers to: a) the process of dismantling visible and invisible barriers to the full social participation of all people in a community, especially people from traditionally non-dominant groups; and b) establishing an inclusive organization reflective of, and responsive and responsible to the entire community.

### **Multicultural Organizations<sup>1</sup>**

An organization that reflects the contributions and interests of diverse communities in their mission, operations, management and services.

### **Partnership<sup>3</sup>**

“ . . . voluntary agreement between two or more partners to work cooperatively towards a set of shared health outcomes”.

### **Visible Minorities<sup>1</sup>**

(sometimes, vis./mins.) people who are not of white/European or Caucasian ancestry. In Canada, the federal Employment Equity Act recognizes as visible minorities people of the following origins: Africans; Chinese and other Asians, including Japanese, Koreans, Vietnamese, Laotians, Thais and other Southeast Asians, including Indo-Pakistani and Sri Lankans; and Latin Americans. While Aboriginal/1<sup>st</sup> Nations people could technically be described as belonging to this grouping, they are usually considered to be in their own category.

1 Agger-Gupta, *Terminologies of Diversity*, 1997.

2 Ngo, *Cultural Competency: A Self-Assessment Guide for Human Service Organizations*, 2000.

3 World Health Organization, *Health Promotion Glossary*, 1998.

## 8. APPENDICES

## **APPENDIX A: SERVICE SUMMARY**

### **Language Line Services**

Language Line Services provides an over-the-phone medical interpretation service. This service uses experienced professionals who interpret from English into more than 140 languages. Language Line Services are available at the following locations 24 hours a day, 7 days a week:

- Alberta Children's Hospital Emergency Department
- Foothills Medical Centre Emergency Department and Maternity Units
- Peter Lougheed Centre Emergency Department and Maternity Units
- Rockyview General Hospital Emergency Department and Maternity Units
- 8th & 8th Health Centre

### **Alberta Children's Hospital Speech Language Pathology Services**

This service is offered in Cantonese and Spanish by qualified speech language therapists to facilitate communication between patients learning English as a second language and CHR health care professionals.

- A Spanish language therapist is available from 8 a. m. to 4 p. m. Monday to Friday
- A Cantonese language therapist is available from 8 a. m. - 4 p. m. Fridays

For more information, or to book a language therapist, please phone (403) 229- 7044.

### **Perinatal Education**

Perinatal Education is provided in six languages:

- Cantonese, Punjabi, Arabic, Spanish, Mandarin and French to all pregnant women
- Perinatal Education Services in Cantonese are available four times a year at the Chinese Senior Centre
- Perinatal Education Services in other languages are available upon request

### **Cross-cultural Mental Health Consultation Project**

This project is looking to provide:

- An outreach program for ethnocultural communities regarding psychosocial issues, mental health and other related services
- Consultation with ethnocultural communities to determine their needs related to mental health
- Education and consultation for staff regarding cultural issues around mental health
- Community referrals and follow-up support for clients

### **Additional Diversity Services and Programs in the Region**

Various services and programs throughout the Region are dedicated to supporting and working with Calgary's diverse communities, as well as increasing staff awareness so they are able to further support our patients and clients. These services include:

- Cultural presentations focusing on the health care beliefs of different cultures.
- Awareness workshops and resource fairs designed to help families new to Canada. Workshops inform families about the health services in the Calgary region, including ways to access services.

### **Volunteers**

The Region benefits from the support of volunteers from within the Calgary and area communities. We value the diversity of our committed volunteers and support of community groups. If you feel you would like to support some of the services listed in this brochure, please contact the Volunteer Resources Department within Healthy Communities at 943-8109.

## APPENDIX B: REGIONAL DIVERSITY STEERING COMMITTEE TERMS OF REFERENCE AND MEMBERSHIP



calgary health region

### REGIONAL DIVERSITY SERVICES STEERING COMMITTEE TERMS OF REFERENCE

(DRAFT)

#### 1.0 AUTHORITY

This committee is a standing committee of the Calgary Health Region (CHR) and shall be responsible to the Executive Director / Medical Officer, Healthy Communities.

#### 2.0 VISION

Respect for diversity<sup>1</sup> will be fundamental and integral to the CRHA workplace and to the populations served. Operating within this vision, the Regional Diversity Steering Committee (hereafter “the Committee”) will seek to enhance the abilities of the CRHA to address issues related to diversity for the populations served and within the workforce of the CRHA.

Excludes the Aboriginal Population, the responsibility for which falls within the CRHA Regional Aboriginal Program.

#### 3.0 PURPOSE

##### 3.1 Planning

To provide direction and support to Healthy Communities Regional Diversity Services in prioritizing regional diversity strategic planning initiatives in the CHR.

To support the standardization of plans and processes related to regional diversity strategic planning.

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<sup>1</sup> “**Diversity**” is here defined as: “All the ways we are unique and different from others.” Dimensions of diversity include, but are not limited to, such aspects as race, religion and spiritual beliefs, cultural orientation, colour, physical appearance, gender, sexual orientation, physical and mental ability, education, age, ancestry, place of origin, marital status, family status, socio-economic class, profession, language, health status, geographic location, group history, upbringing and life experiences (Agger-Gupta, 1997).

- 3.2 Liaison  
To provide a forum for the discussion of planning and logistical issues associated with regional diversity strategic planning.
- 3.3 Promotion  
To develop strategies for promotion of regional strategic planning in the CHR.
- 3.4 Communication  
To facilitate intersite/service communication in the area of regional strategic planning to ensure an integrated regional plan and services.
- 3.5 Recommendations  
To prepare recommendations for Senior Executive relative to issues that require executive consideration and/or direction.
- 3.6 Annual Report  
To prepare an annual report and business plan for Regional Diversity Services.

#### **4.0 REPRESENTATION**

- 4.1 Chairperson  
The Chairperson shall be a member of the CHR and the director responsible for regional diversity services.
- 4.2 Membership  
The committee is composed of the following representatives:
  - Chair, ACH Multicultural Committee
  - Chair, RGH Diversity Services Portfolio Committee
  - Chair, FMC Diversity Services Portfolio Committee
  - Chair, PLC Diversity Services Portfolio Committee
  - Chair, Healthy Communities Diversity Services Portfolio Committee
  - Chair, Care in the Community Diversity Services Portfolio Committee
  - Chair, Mental Health Diversity Services Portfolio Committee
  - Human Resources representative
  - Information Systems representative
  - Clinical Support Services representative
  - Support Services representative
  - Communication Services representative
  - Corporate Business Development representative
  - Physician Representative

Additional guests may be invited to attend to address specific issues. In the event a member is unavailable to attend a scheduled meeting, an alternate should attend.

Corresponding members will include Executive Directors, Medical Directors and Board Chair.

## 5.0 MEETINGS

Meetings shall be held every three months (quarterly) at the call of the Chair.

Written notice of the meetings shall be sent to each member a minimum of two weeks in advance of the meeting.

## 6.0 PROCESS

### 5.1 Agenda Items

Committee members shall provide the chairperson with agenda items, reports, etc. in advance of the meetings.

### 5.2 Decisions

Decisions will be made by seeking consensus of the group.

### 5.3 Terms of Reference

The Terms of Reference will be reviewed and updated annually.

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### Regional Diversity Steering Committee Membership

<b>Name</b>	<b>Position</b>
Amanda Arthur	Healthy Communities
Sybil Braganza	Interpretive Services
Joyce Buzath	Regional Service Planning
Maya Charlebois	Healthy Communities
Sue Conroy	Emergency Services
Jim Merchant	Mental Health
Janet Mezzaroba	Communications
Sandra Parkins	Policy Analysis and Development
Dr. Bob Robinson	Child and Women's Development, Alberta Children's Hospital
Ronnie Wassill	Social Work, Peter Lougheed Hospital
Nicole Zander	Human Resources
<b>Corresponding Members</b>	
Judy Bader	Executive Director, Healthy Communities
Donna Lentjes	Healthy Communities
Dr. Richard Musto	Medical Director, Healthy Communities

## **APPENDIX C: PROFILE OF ASSUMPTIONS REGARDING DIVERSITY INITIATIVES**

(As reviewed by the CHR Regional Diversity Steering Committee)

\*\* See the identified Objectives, Outcomes and Outputs in the Diversity Services Framework for ratified priorities and assumptions.

### Current Working Assumptions

- The CHR recognizes and is responding to the need for culturally competent and accessible health services for culturally diverse communities.
- The CHR involves *ethnocultural* communities as “active participants and/or partners in a) supporting sound health practices, and b) initiatives to improve access to health services”.
- The CHR responds to the identified issues expressed by *ethnocultural* communities and respective advocates through consultation, planning, and collaboration.
- The Regional Diversity Steering Committee supports and liaises with services of the CHR for the purpose of promoting diversity as a priority and incorporating culturally competent service strategies.

### Supporting Evidence

#### **Diversity Planning Strategy (11/01):**

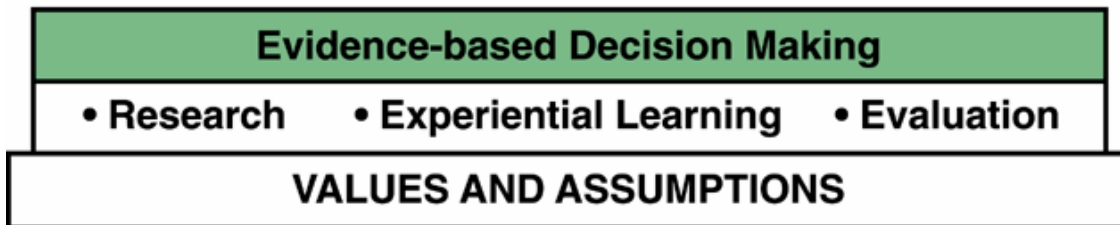
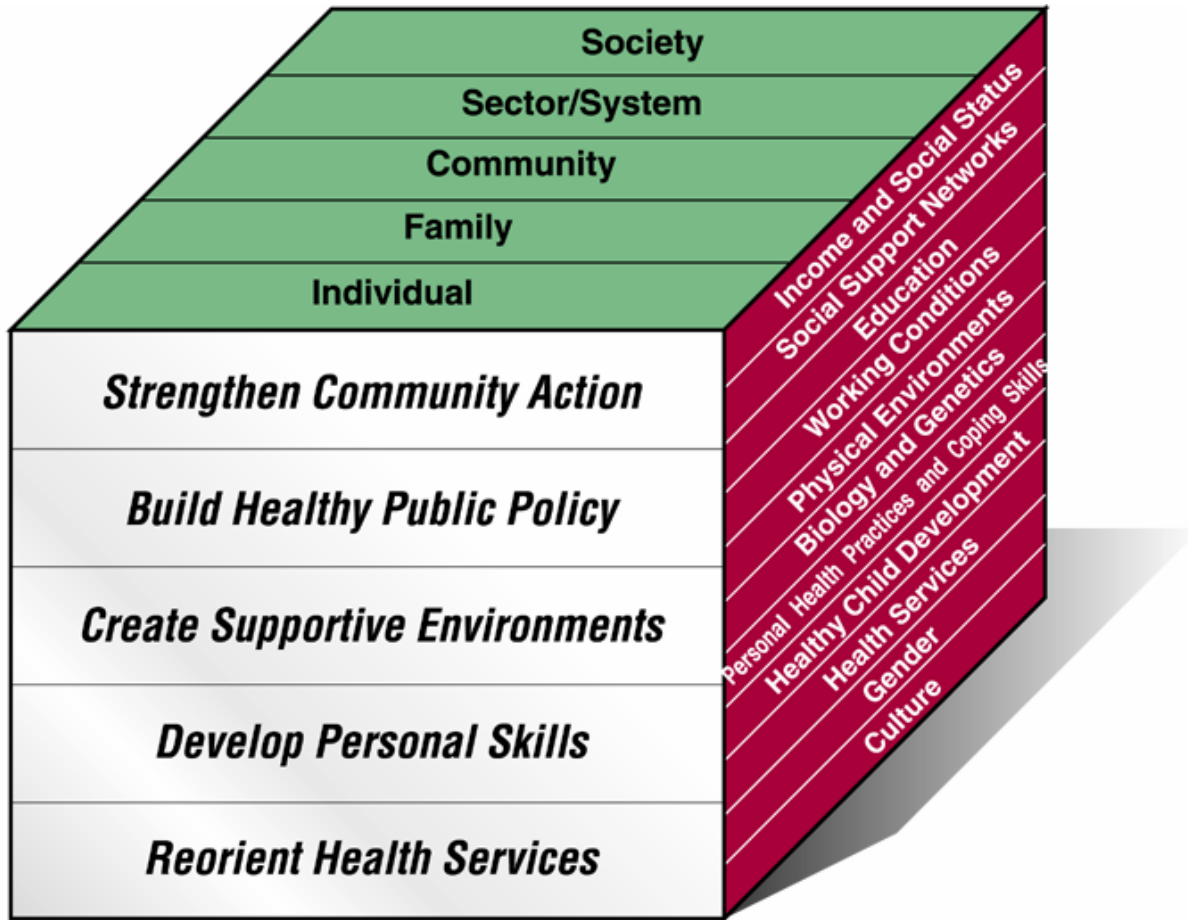
- Refocus energies on strengthening diversity elements at the service delivery level (including priority setting of strategies, e.g. interpreter support more critical than education).
- Realign current working position in the region to support all portfolios to strengthen the diversity elements at the service delivery level.
- Role of positions to include liaison, facilitating interpreter access, training and translations, working with operational portfolios to identify and address diversity issues.
- Clarify and align Language Line services to meet needs in a cost-effective manner.
- Regional Diversity Steering Committee maintain a focus on strategy development with a first priority on service delivery.
- Continue with the external community consultation process

# APPENDIX D: CULTURAL COMPETENCY FRAMEWORK

Adapted from: Cultural Competency: A Self Assessment Guide for Human Service Organizations, Cultural Diversity Institute, 2000



**APPENDIX E: POPULATION HEALTH PROMOTION MODEL**



Source: Hamilton & Bhatti, 1996.

## APPENDIX F: NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE

STANDARD	FOCUS
1 (3, 9) *	Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language
2 (9,11)	Health care organizations should implement strategies to recruit, retain and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area
3 (12)	Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery
4	Health care organizations must offer and provide language assistance services including bilingual staff and interpreter services at no cost to each patient/consumer with limited English efficiency at all points of contact in a timely manner during all hours of operation.
5	Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services
6	Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services except on request by patient/consumer.
7	Health care organizations must make available easily understood patient-related materials and post signage in the languages of the community of the commonly encountered groups and/ or groups represented in the service area
8 (9,10,11,12)	Health care organizations should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9 (8)	Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10	Health care organizations should ensure that data on the individual patients/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems and periodically updated.
11 (12)	Health care organizations should maintain a current demographic cultural and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12 (11)	Health care organizations should develop participatory collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.
13	Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14	Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Source: U.S. Department of Health and Human Services – Office of Minority Health. (2001). National standards for culturally and linguistically appropriate services in health care. Washington, DC: Author.

\* Denotes linkages to related standards.