

FRAMEWORK FOR ACTION

Cultural Proficiency & Diversity



THE MISSION, VISION AND VALUES OF THE WINNIPEG REGIONAL HEALTH AUTHORITY ORGANIZATION ARE:

MISSION

To co-ordinate and deliver safe and caring services that promote health and well-being.

VISION

Healthy People. Vibrant Communities. Care for All.

VALUES

- Dignity - as a reflection of the self-worth of every person
- Care - as an unwavering expectation of every person
- Respect - as a measure of the importance of every person

OUR COMMITMENTS

- Innovation - that fosters improved care, health and well-being
- Excellence - as a standard of our care and service
- Stewardship - of our resources, knowledge and care

Regional strategies are currently underway to ensure that our Values and Commitments are realized in delivering safe and caring services.

One of these strategies involves 'Dignity in Care'—incorporating core human values into our care practices such that dignity and respect are inherent in the administration and provision of all health and wellness services. This initiative is prominently expressed "as a reflection of the self-worth of every person" in the Commitments component of our strategic direction.

Another strategy is the ' Collaborative Care' strategy which acknowledges respect for the unique perspectives that come from the broad spectrum of practices which deliver patient-centred care - from nursing to physician care to allied health and housekeeping, and others—such that each health-care professional has a valued and important contribution towards improving health and health outcomes.

This document introduces Diversity and Cultural Proficiency a strategy that also supports our regional strategic values and commitments, and is interconnected with our Dignity in Care and Collaborative Care strategies. Within this document you will learn the importance of this interconnectivity, and how these fundamental principles of care work together with focus on our patients, residents and clients, and in turn help realize our vision of Healthy People, Vibrant Communities and Care for All.



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KEY POINTS

“Ongoing training is needed to give both clinical and non-clinical staff the knowledge, tools, and skills to successfully engage in the process of cultural proficiency.”

GOAL

To change a “one-size fits all” health care system to one that is responsive to the needs of a diverse population.

- The WRHA will develop a **Cultural Proficiency & Diversity Strategic Plan** that outlines organizational, structural, and clinical implementation of the interventions. **[p. 53]**
- The WRHA will implement interventions that **promote a leadership and workforce that are racially/ethnically and culturally diverse** (*representative of the patient/client population*).
- All cultural proficiency initiatives undertaken by the WRHA will be **manageable, measurable and sustainable**. Quality improvement and evaluation activities will be incorporated in the interventions with full consideration on their impact on the population being served.

RESPONSE

The WRHA will respond appropriately to the diverse population of the region and as such will **go beyond the routine application** of culturally appropriate interventions and practices.

- The WRHA will work with First Nations and healthcare teams to address recommendations of the Framework for Health Adaptation and Collaborative Strategic Action Plan resulting from the Aboriginal Health Transition Fund Project.
- The increasing number of newcomers to the province of Manitoba calls for the development of a strategic vision that incorporates **immigrant/refugee health** into health system planning and delivery of health care services.
- The Cultural Proficiency & Diversity Framework will be used as a platform to reintroduce the regional implementation of **language & ethnicity data collection**.
- The WRHA will continue to engage in and strengthen processes of **community development, intersectoral partnerships, and collaboration** to address the broader determinants of health and other factors that create barriers for racially/ethnically and culturally diverse groups from accessing health care.

PRIORITY

Priority will be given to the evolution of a region wide “**primary care system**” that is the foundation of the health care system and supports key principles, such as continuous comprehensive care and a health care system that promotes equity and access to quality care.

INTERVENTIONS

WRHA “cultural proficiency” and “workforce diversity” **training interventions** will be addressed. Ongoing training is needed to give both clinical and non-clinical staff the knowledge, tools, and skills to successfully engage in the process of cultural proficiency.

Figure 1: *Key Points*

GOAL ▶	RESPONSE ▶	PRIORITY ▶	INTERVENTIONS
<p>To change a “one-size fits all” health care system to one that is responsive to the needs of a diverse population</p> <ul style="list-style-type: none"> • Development of a Cultural Proficiency and Diversity Strategic Plan • Implementation of interventions that promote a leadership and workforce that are racially, ethnically and culturally diverse • Initiatives that are manageable, measurable and sustainable 	<p>Response will be appropriate to the diverse population of the region and will go beyond routine application of culturally appropriate interventions</p> <ul style="list-style-type: none"> • ‘Framework for Health Adaptation’ • Immigrant/refugee health • Language & ethnicity data collection • Community development, intersectoral partnerships and collaboration 	<p>Priority will be given to the evolution of a region wide “primary care system” that is the foundation of the health care system and supports key principles</p>	<p>WRHA “cultural proficiency” and “workforce diversity” training interventions will be addressed</p>

EXECUTIVE SUMMARY

“Ongoing training is needed to give both clinical and non-clinical staff the knowledge, tools, and skills to successfully engage in the process of cultural proficiency.”

BACKGROUND

The demographic changes in Manitoba and Winnipeg in particular are making the region increasingly diverse. A large body of evidence confirms health disparities among racial/ethnic groups. The literature also points to socio-cultural factors that deny patients/clients from racially/ethnically and culturally diverse backgrounds equal access to health care services. Moreover, there are concerns about the quality of care that diverse patient/client populations receive because of socio-cultural and language barriers.

The WRHA embraced **Cultural Proficiency** as a strategy to respond in an appropriate way to the diversity in the region.

The goal of cultural proficiency is to create a health care system that can deliver the highest quality of care to every person regardless of their race/ethnicity/culture or language proficiency.

While the WRHA has implemented several initiatives to respond to the increasing diversity in the region, there was a need for the development of a Cultural Proficiency & Diversity Framework to capture existing and future initiatives in a more comprehensive plan.

In 2010, a Cultural Proficiency and Diversity Services Advisory Committee was established to oversee and

guide development of the framework and the process of promotion of cultural proficiency and diversity within the WRHA.

ENVIRONMENTAL SCAN

The environmental scan includes a review of the literature to identify: cultural proficiency frameworks and core components, best practice recommendations, and cultural proficiency assessment tools.

The frameworks/models reviewed define cultural proficiency as a dynamic process that involves acquiring certain knowledge and skills; it requires both **individual and institutional change**. This process also involves continual progression and involvement of all levels of the health care system.

An assessment of the strengths and areas for further development in the process of cultural proficiency within the WRHA is important. The literature identifies various models of cultural proficiency assessment tools, but the WRHA needs to assess if administration of such a tool at this time is effective for the organization.

The core components of cultural proficiency are:

- 1] Values & Attitudes
- 2] Structures & Policies
- 3] Practices
- 4] Training/Staff Development
- 5] Evaluation & Research

The core components include the essential domains that need to be analyzed and addressed when dealing with issues of diversity in health care. Together with the frameworks, the core components describe the fundamental concepts of cultural proficiency. While these fundamental concepts are important, it is even more important to have an understanding of how to move the concepts of cultural proficiency from theory to action. Best practice recommendations is to bring forward strategies for systemic changes that support the successful implementation of culturally proficient initiatives.

Best practice recommendations include:

- 1] Commitment from leadership.
- 2] Integration of Cultural Proficiency into all existing systems and services of a health care organization, particularly quality improvement efforts.
- 3] Changes are manageable, measurable, and sustainable.
- 4] Commitment to making the business case to support cultural proficiency and ensure long-term sustainability.
- 5] Community representation and feedback at all stages of implementation.
- 6] Ongoing staff training is crucial.

An analysis of the six best practice recommendations shows that WRHA’s leadership is committed to cultural proficiency since the senior managers, managers, and the Board

all support the values/principles of cultural proficiency. This is critical to bring about organizational change as leadership sets the tone for the rest of the staff.

Other best practice recommendations that have been successfully implemented by the WRHA include: the community development process, community consultations such as the CHACs, and feedback forms.

Staff training is on-going but needs some adaptations to address certain knowledge and skills gaps.

The best practice standards that the WRHA needs to develop further include: integration of cultural proficiency into all existing systems and services of the organization; ensure that changes are manageable, measurable, and sustainable; and making the business case to support cultural proficiency efforts.

ORGANIZATIONAL SCAN

The WRHA has undertaken several initiatives to respond to the needs of the increasingly diverse community of Winnipeg and Manitoba in general. Some initiatives have grown and become very successful in time, others need further development, and some are brand new initiatives.

Examples of some initiatives include:

- Aboriginal Voluntary Self-declaration Form for WRHA staff
- Aboriginal voluntary self-declaration for employment applications (*WRHA website*)

- Preferred Aboriginal Hiring philosophy
- Respectful workplace policy & campaign
- Workforce diversity training
- Aboriginal Health Programs: recruitment, outreach, and retention initiatives for Aboriginal staff
- Cultural Proficiency/ Diversity Workshops
- Language Access Interpreter Services
- Regional French Language Services policies
- Bilingual public WRHA communications (English/French) format
- Winnipeg Integrated Services and the development of ACCESS centres
- Chronic Disease Collaborative
- BridgeCare Clinic
- Immunization for disadvantaged populations
- Community development
- Public engagement:
 - a] Part of WRHA’s strategic directions 2011-2016
 - b] Community Health Advisory Councils
 - c] Feedback Form on WRHA website

CULTURAL PROFICIENCY & DIVERSITY FRAMEWORK: *Interventions*

“ The ultimate goal of these interventions should be to decrease health disparities experienced by racially/ ethnically and culturally diverse populations.”

The Cultural Proficiency & Diversity Framework is built on three levels of interventions:

1] Organizational Interventions

Efforts to promote representative leadership and workforce that are racially/ethnically and culturally from diverse backgrounds.

Organizational interventions include “diversity” and “minority recruitment” initiatives.

2] Structural Interventions

Efforts to make the processes within the health care system more client-friendly and culturally appropriate to ensure that patients/clients have full access to quality health care.

Structural interventions encompass a variety of measures that can be categorized as follows:

- Interventions to support communication competency
- Interventions to improve design and functioning of the health care system
- Socio-cultural assessment of population
- Community development and participation
- Collaborative partnerships

3] Clinical Interventions

Efforts to equip health care providers with the knowledge of how socio-cultural factors affect health and provide health care professionals with the tools and skills to manage socio-cultural factors in the clinical encounter.

Clinical interventions involve cross-cultural (*cultural proficiency*) training programs that include: cross-cutting cultural/social knowledge, communication skills, know-how concerning cultural health assessment. These skills and tools are needed to ensure that health care providers do not make diagnostic and treatment decisions based on inaccurate information and/or biases. In addition, clinical interventions include having the know-how for dealing with specialized health care needs of immigrant and refugee populations.

CONCLUSION & RECOMMENDATIONS

The WRHA embraced cultural proficiency as a strategy to respond to the diversity in the region and through the years has implemented several organizational, structural, and clinical interventions. These interventions are

designed to increase equal access to health care services and ensure quality health care to every person regardless of their race/ethnicity, culture or language proficiency. The ultimate goal of these interventions should be to decrease health disparities experienced by racially/ethnically and culturally diverse populations.

Leadership and responsibility should be assigned to a team of the Advisory Committee to ensure the implementation of the recommendations proposed in this framework and monitor on an ongoing basis the health issues facing diverse communities and needs for service provision/adaptation.

The recommendations are summarized below:

Integration Of Cultural Proficiency

- Develop a Cultural Proficiency & Diversity Plan: implementation of the organizational, structural, and clinical interventions still needed and those that need to be enhanced (*see p.53*). This should be incorporated into the Strategic Plan and must be communicated to the whole organization.
- Incorporate cultural proficiency into all aspects of WRHA: all existing systems, relevant policies, procedures/guidelines, services, WRHA mission statement and core values.

Quality Monitoring & Improvement

- Incorporate quality monitoring, improvement activities and evaluation processes in all cultural proficiency initiatives undertaken by the WRHA.
- Develop standard instruments to measure culture proficiency efforts and their impact on the population being served.

Organizational Interventions

- Maintain & strengthen existing “diversity” and “minority recruitment” initiatives. Evaluate their impact and make adjustments based on the evaluation findings.

- Maximize diversity among WRHA staff and leadership:
 - Enhance policies and initiatives to promote representation of other racial/ethnic and cultural groups besides Aboriginal ethnicity.

Structural Interventions

Maintain & strengthen initiatives that guarantee full access to quality health care to all patients/clients:

- Interventions to support communication competency
- Interventions to improve design and functioning of the health care system
- Socio-cultural assessment of population
- Community development; community participation; health care consumers’ feedback
- Collaborative partnerships

Clinical Interventions

- Adapt existing cultural proficiency training to include identified gaps in knowledge and skills.
- Evaluate existing cultural proficiency training to assess impact on WRHA staff’s knowledge, attitude and skills related to cultural proficiency.
- Evaluate impact of cultural proficiency training on health outcomes of population served.



1. INTRODUCTION

“ The purpose of this report is to give a description of a proposed framework for the promotion of cultural proficiency and diversity within the Winnipeg Regional Health Authority. ”

The Winnipeg Regional Health Authority (WRHA) Human Resources together with Aboriginal Health Programs, WRHA's Research & Applied Learning Program, and Primary Health Care Program have prioritized cultural proficiency as a component in enhancing health care services. A cultural proficiency framework will guide the organization's work in striving for excellence in addressing existing diversity in the region.

The purpose of this report is to give a description of a proposed framework for the promotion of cultural proficiency and diversity within the Winnipeg Regional Health Authority. The report starts by examining the background and context for the proposed framework which also includes the definition of terms used and the rationale for cultural proficiency.

The results of an environmental scan are presented in the next section.

This includes frameworks and models of cultural proficiency, the core components of cultural proficiency, assessment tools, and best practices of cultural proficiency as identified in the literature. Section 4 of this report includes an organizational scan which gives an overview of the cultural proficiency and diversity initiatives that have already been undertaken by the WRHA. Furthermore, suggestions for development of a cultural proficiency assessment tool for the WRHA are presented and existing initiatives are assessed according to best practice recommendations. Section 5 presents the Cultural Proficiency & Diversity Framework by capturing the current and suggested interventions in a comprehensive three level approach. In addition, points for the development of a cultural proficiency and diversity strategic plan are outlined.

Finally, the report concludes with proposed recommendations to support the process of cultural proficiency within the WRHA.

2. BACKGROUND

“The WRHA has undertaken various initiatives to respond to the increasingly diverse community of Winnipeg and Manitoba in general.”

Cultural proficiency is a concept of increasing importance to the WRHA. In the past couple of years, the WRHA has undertaken various initiatives to respond to the increasingly diverse community of Winnipeg and Manitoba in general. During development of the WRHA Language Access Interpreter Services (LAIS), staff as well as community members identified the need for a broader response to diversity. At that time it was decided to proceed with development of LAIS with the understanding that a more comprehensive plan would follow in which these services would be integrated.¹ Later in this report, more information will be provided about language access and the important role it plays in delivering culturally proficient care.

In 2007, a Cultural Proficiency Framework Project Charter was drafted that proposed the development of a cultural proficiency framework for the WRHA. To oversee and guide the process of promotion of cultural proficiency and diversity within the WRHA a Cultural Proficiency and Diversity Services Advisory Committee (*hereinafter referred to as the Advisory Committee*) was established in 2010.

The role of the Advisory Committee is as follows:

- Promote culturally and linguistically appropriate health care services within the Winnipeg region that reflect diversity and equity.
- Promote meaningful community participation/input into strategies for collaboration with diverse communities and regional stakeholders.
- Identify, on an ongoing basis, health issues facing diverse communities and needs for service provision/adaptation.
- Provide guidance to the WRHA in the development of best practices for addressing diversity in health.

Before proceeding any further, it is important to define the terms “**culture**” and “**cultural proficiency**” and the concepts associated with these terms.

There are many definitions for the word culture. The definition that frequently comes to mind is one that is associated to the ethnic/racial background of a group of people and the belief system and values of that group. However, culture is not simply defined by ethnicity. A broader definition of culture recognizes that each individual has many “cultural identities” and that cultural groups can include individuals who are poor, with physical or mental illnesses or disabilities, women, people of alternate sexual orientations, and people affected by domestic violence or homelessness.^{2,3}

Culture, therefore, can be defined as an integrated pattern of human behavior that includes the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious, or social groups.⁴

Cultural Proficiency refers to the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.⁵

The Advisory Committee decided to limit the present Cultural Proficiency & Diversity Framework to the ethnic/racial aspects of the definition of culture, given the time frame for this project (*see Appendix 3 for a glossary of terms*). Other social groups will be included in subsequent cultural proficiency & diversity projects of the WRHA.

2.1 TERMS AND DEFINITIONS

“Cultural proficiency requires both individual and institutional change and is dependent on long-term commitment being achieved over time.”

The literature emphasizes the importance of providing services that incorporate culture and meet unique cultural needs of populations. Various terms have been used to describe the use of knowledge, skills and values in health care practice to benefit the individual and the community being served. Since this is an emerging field, the concepts and principles are still evolving. The literature identifies the following terms: cultural safety, cultural humility, cultural competence, and cultural proficiency.

Cultural safety refers to the process of respectful engagement in the process of interaction between individuals. Cultural safety is an outcome. It is about power relationships in the health care setting where the recipient of a service feels as though they have been respected or at least not challenged or harmed.⁶

Cultural humility, a concept developed by Tervalon & Murray-Garcia [1998], is described as a lifelong process of self-reflection and self-critique. Health care providers are encouraged to develop a respectful partnership with each patient through patient-focused assessments that explore the similarities and differences between the health care provider's assumptions and beliefs and each patient's priorities, goals, and capacities.⁷

Cultural competence is a process in which health care providers continually strive to work effectively within the cultural context of a patient.⁸ It is therefore, the routine application of culturally appropriate health care interventions and practices.⁹

Cultural proficiency is a dynamic developmental process that evolves in stages over time. The stage of proficiency is reached when cultural competence goes beyond the routine application of culturally appropriate health care interventions and practices.

The stage of cultural proficiency involves integrating cultural competence at various levels:

- Culture of the organization
- Professional practice
- Teaching/training
- Research.¹⁰

In concrete terms, cultural proficiency is “the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes”.¹¹

Thus, cultural proficiency requires both individual and institutional change and is dependent on long-term commitment being achieved over time. The literature identifies key elements that must be present in the health care system to support cultural proficiency. These elements will be discussed in depth in subsequent sections of this document.

The Advisory Committee has chosen the term cultural proficiency and, therefore, it is the term that will be used in this report.

2.2 IMPORTANCE OF CULTURAL PROFICIENCY

“The goal of Cultural Proficiency is to change a one size fits all health care system to one that is more responsive to the needs of an increasingly diverse patient population.”

*—Adapted from:
Betancourt et al. [2005]*

Health is determined by complex interactions between social and economic factors, environmental, physical, individual and genetic factors. These factors are known as the **determinants of health**. Culture is an important determinant of health in many ways. First, culture is related to health behaviors. Second, culture is related to people’s perception of illness. Finally, culture determines the extent to which people use health care services.

It is important to keep the link between culture and health in mind to understand the rationale and context for cultural proficiency.

In the document Social Determinants of Health: The Canadian Facts, Mikkonen and Raphael [2010] point to 14 social determinants of health. Social determinants of health are the economic and social conditions, or living conditions, that shape our health.¹²

Two of the social determinants are Aboriginal status and race.

The Canadian facts show lower average income and education levels for the Aboriginal community. Aboriginal people are also four times more likely to live in crowded environments and have higher rates of infectious and chronic diseases than their non-Aboriginal counterparts.¹³

Research confirms race-associated differences in health status. The National Population Health Survey shows that non-European immigrants (*especially people of color*) experience a decrease in health status over time compared to Canadian-born residents and European immigrants.¹⁴

Race-associated differences in health outcomes may be due to racism. Racism may affect health and

personally mediated racism, and internalized racism (see Appendix 1 for a description of these terms). This framework is useful when examining race-associated differences in health outcomes and when designing effective interventions to address those differences.¹⁵

The literature provides increasing evidence that confirms health disparities among many ethnic and racial groups.¹⁶ Furthermore, research suggests a range of sources for these health disparities. They include factors at the systemic level (e.g. *health system administration, geographic location*), patient-level (e.g. *patients' attitudes and preferences*) and care-process level (e.g. *healthcare providers' biases/stereotypes; uncertainty when interacting with minority patients*).¹⁷

Similarly, research reveals a link between health disparities experienced by racial/ethnic groups and access to health care services. In fact, socio-cultural and language barriers faced by racial/ethnic groups deny them equal access to health care services. These barriers influence the patient's presentation of health care needs, the dynamics in the health

encounter, utilization of health care services including preventive and screening services, and navigation of the health care system.¹⁸

Evidence of the association between language barriers and lower participation in cancer screening programs, negative effects on health service utilization in general, increase utilization of higher intensity services, and hospital admission and length of stay have been documented in the Language Barriers WRHA report.¹⁹

Language and cultural barriers have also been identified as one of the three most significant issues impacting the health of newcomers (immigrants & refugees) in the 2008 report of the WRHA Community Health Advisory Councils.²⁰

A diverse population not only challenges health care professionals/policy makers regarding how to deal with health disparities experienced by racial/ethnic groups, but also how to ensure quality of care.

Quality of health care is compromised when racial/ethnic and cultural aspects of a patient are not taken into consideration. Two important

requirements for the delivery of quality health care are: patient safety and patient centeredness. Patient safety guarantees that medical treatments are not harmful to the patient. And the goal of patient centeredness is to ensure that patient preferences and beliefs are taken into account. Further, to ensure that patients have the information they need to be active participants in their own care.²¹

The discussion thus far sustains the importance of cultural proficiency based on evidence from research. Demographic data also corroborate the importance of cultural proficiency. There is increasing diversity in the Canadian and Manitoban population. In many regions of the country the proportion of Aboriginal population is growing faster than that of the population as a whole. Between 1996 and 2006 Manitoba's Aboriginal population grew by 36%. In 2006, Aboriginal people accounted for 15.5% of the Manitoban population. This is the highest proportion of Aboriginal people among Canada's provinces, with Saskatchewan ranking second at 14.9%.²²

“Several initiatives have already been undertaken to provide culturally and linguistically appropriate health services to the Aboriginal as well as the diverse immigrant/ refugee population.”

Besides the increase in Aboriginal population, the number of immigrants to Canada and the province of Manitoba in particular has increased in the past few years. In 2009 Manitoba received a total of 13,520 immigrants. This was a 20.5% increase from the previous year.²³

The change in demographics and increasingly multicultural diversity combined with the evidence of racial/ethnic health disparities have made the WRHA increasingly aware of the need to respond in an appropriate way to the diverse population of the Winnipeg health region. Several initiatives have already been undertaken to provide culturally and linguistically appropriate health services to the Aboriginal as well as the diverse immigrant/ refugee population. These initiatives will be discussed in detail in the following sections of this report.

Cultural proficiency emerged as a strategy to address the challenges of cultural diversity, racial/ethnic health

disparities, access to health care and the provision of quality health care to a diverse population. The goal of cultural proficiency is to create a health care system that can deliver the highest quality of care to every person regardless of their ethnicity/ race, culture or language proficiency. The long term benefits of cultural proficiency include improved health outcomes and a more efficient and effective health care system that will ultimately support the need to control health care costs.

The conclusion is that an increased awareness and consensus exists among health care professionals of the importance of cultural proficiency. However, there is little consensus on the best approach to address a diverse population with multiple cultures and racial/ethnic backgrounds.

The following section reviews various approaches/models that have been identified in the literature.



3. ENVIRONMENTAL SCAN: *Reviewing the Evidence*

“We do not see things as they are, but as we are.”

—Immanuel Kant

3.1 CULTURAL PROFICIENCY FRAMEWORKS AND MODELS

A large body of literature exists about the approaches to address diversity of cultures and racial/ethnic backgrounds. The following discussion presents some models/frameworks frequently cited in the literature. The frameworks found in the literature can be categorized in two groups: theoretical and methodological. The theoretical approach sees cultural proficiency as a developmental process or continuum that an individual or organization goes through. It involves going from a state of being unaware or destructive to the stage of being culturally proficient. The methodological approach focuses on the methods a health care professional might use to become culturally proficient and provide culturally proficient care.²⁴

THEORETICAL APPROACH

A frequently cited work in this field is that of Cross, Bazron, Dennis and Isaacs. In their document “Toward a Culturally Competent System of Care, Volume 1” [1989], the foundation for different models was laid. The framework developed by Cross et al. made a new contribution to the field by extending the scope of cultural competence beyond the health care provider. This cultural competence framework includes the organization and system’s capacity to integrate principles and values of cultural

competence into its policy, structures, attitudes, behaviors and practices. The core concepts and principles found in the work of Cross et al. are still relevant today. In addition, many definitions that have emerged in this field find their roots in this work, but have been adapted for specific disciplines and/or fields.

The **Cultural Competence Continuum** developed by Cross et al. includes six stages.²⁵

- 1] Cultural destructiveness:** individuals and organizations at this stage view cultural differences as a problem and engage in activities to purposely destroy a culture.
- 2] Cultural incapacity:** individuals and organizations at this stage lack the ability to help cultures from diverse communities. The goal is not to intentionally harm other “cultures”, but these individuals or organizations believe in the superiority of their own racial/ethnic group and assume a paternalistic posture toward “lesser” cultures or groups.
- 3] Cultural blindness:** this is the midpoint of the continuum. At this stage individuals or organizations do not perceive and can not benefit from the valuable differences among diverse groups. They see themselves as unbiased and believe that they are addressing cultural needs when in fact they are not.

4] Cultural pre-competence: individuals and organizations start to move toward the positive end of the continuum. They recognize the weaknesses in their attempts to serve diverse cultures and make some efforts to improve the services offered to diverse populations.

5] Cultural competence: individuals and organizations at this level accept and respect differences, and they participate in continuing self-assessment regarding culture. These organizations continuously expand their cultural knowledge and resources and adopt service models that better meet the needs of minority populations.

6] Cultural proficiency: individuals and organizations that are culturally proficient hold diversity of culture in high esteem. They add to the knowledge base of culturally competent practice by conducting evaluation and research, developing new therapeutic approaches that incorporate culture, publish and disseminate the results of demonstration projects. Culturally proficient organizations hire staff members who are skilled in providing culturally competent care.

Furthermore, Cross et al. describe the conditions that must be present in order for the health care professional to move along the cultural competence continuum. Health care professionals must:

- Value diversity
- Understand their cultural biases
- Be conscious of the dynamics that occur in cross cultural encounters
- Internalize cultural knowledge
- Adapt service delivery to reflect cultural diversity

Each of these conditions must function at every level of the health care system in order for that system to provide culturally proficient care.²⁶ Cultural proficiency is part of a developmental process that evolves over an extended period of time. Health care professionals as well as health care organizations are at various levels along the cultural competence continuum.

Another frequently cited model that also looks at cultural competence as a developmental process was developed by Campinha-Bacote in 1998. This model called **The Process of Cultural Competence in the Delivery of Healthcare Services** requires health care professionals to see themselves as “becoming” rather than already “being” culturally competent. It consists of five constructs.²⁷

1] Cultural awareness is the self-examination and in-depth exploration of one’s own cultural and professional background. This process involves the recognition of one’s own biases and prejudices toward individuals who are different/ from other cultures.

2] Cultural knowledge is the process of seeking and obtaining the right information about diverse cultural and ethnic groups. In obtaining this knowledge base, the health care provider needs to focus on three issues:

a] Health-related beliefs and cultural values: this involves understanding the client’s/ patient’s worldview. It is this worldview that guides how he/ she interprets his/her illness and shapes his/her thinking, doing, and being.

b] Disease incidence and prevalence: disease incidence and prevalence varies among racial/ethnic groups. This requires accurate epidemiological data to guide decisions about treatment, health education, screening, and health programs that will have a positive impact on health outcomes.

c] Treatment efficacy: drug metabolism varies among racial/ethnic groups (*Ethnic pharmacology*). This is an important aspect of provision of quality health care.

“It is more important to know what kind of patient has a disease than what kind of disease a patient has.”

—William Osler

- 3] Cultural skill is the ability to collect relevant data regarding a patient’s/ client’s presenting problem. It involves learning how to conduct a cultural assessment. A cultural assessment is a “systematic examination of individuals, groups, and communities as to their cultural beliefs, values, and practices to determine explicit needs and intervention practices within the context of the people being served”.
- 4] Cultural encounter is the process that encourages the health care provider to directly engage with client/patients from culturally diverse backgrounds. This process also involves assessment of the client/patient’s linguistic needs.
- 5] Cultural desire is the motivation of the health care provider to “want to” rather than to “have to” engage in the process of becoming culturally aware, knowledgeable, skilled and familiar with cultural encounters. Cultural desire involves the concept of caring. This process includes a genuine compassion and commitment to be open and flexible with others, to accept differences and build on similarities, and be willing to learn from others as cultural informants. This is referred to as a lifelong learning process called “cultural humility.”

Similar to Campinha-Bacote’s model, the **Cultural Developmental Model [CDM]** is another model based on a developmental process. This model proposed by Wells [2000] is a synthesis of several concepts from different models. It consists of six stages and suggests that individuals and institutions progress along a continuum from cognitive through affective phases.²⁸

The cognitive phase consists of three stages: cultural incompetence, cultural knowledge, and cultural awareness. This phase is characterized by learning and acquiring knowledge about culture and its manifestations.

- Cultural incompetence: lack of knowledge of culture’s influence on health and health behaviors.
- Cultural knowledge: learning of the elements of the culture and their role in shaping and defining health behavior.
- Cultural awareness: recognizing and understanding the cultural implications of behavior.

Likewise, the affective phase consists of three stages: cultural sensitivity, cultural competence, and cultural proficiency. The goal of the affective phase is to accomplish attitudinal and behavioral change through the application of the knowledge acquired in the cognitive phase of the continuum. Development through the stages of the affective phase requires actual experience working with people of diverse groups. Moreover, progression through these stages requires more of a commitment and investment to cultural diversity by health care professionals and health care organizations.

- Cultural sensitivity: the integration of cultural knowledge and awareness into individual and institutional behavior.
- Cultural competence: the routine application of culturally appropriate health care interventions and practices.
- Cultural proficiency: the integration of cultural competence at various levels.
 - a) Culture of the organization
 - b) Professional practice
 - c) Teaching/Training
 - d) Research

The stage of cultural proficiency is a mastery of the cognitive and the affective phases of cultural development.

METHODOLOGICAL APPROACH

Other approaches as those developed by Caraballeira, Leininger, and Davidhizar and Giger are methodological in nature and focus on the methods that health care professionals can use to become culturally proficient and provide culturally proficient care. In these frameworks, cultural proficiency is a goal to be reached when the skills are learned with proper training.

Caraballeira describes the interaction between a provider and a client/patient as a cross-cultural exchange of attitudes. In the health care setting, the client/patient reacts to the health care provider's "cultural attitude". The provider's attitude falls within a range: superiority, incapacity, universality, and sensitivity, to competence. The "LIVE & LEARN" model was developed as an approach to cross cultural service delivery. In this model, the acronym "LIVE" stands for Like, Inquire, Visit, and Experience. And "LEARN" stands for Listen, Evaluate, Acknowledge, Recommend, and Negotiate. The model presents

the provider with a practical, phased approach to important skills needed in cross-cultural encounters and service delivery. The skills are: respect client's beliefs and values, avoid stereotyping, and strive to develop mutually acceptable objectives and measures for changed behavior in a treatment plan.²⁹

Leininger's "Sunrise Model" provides a method for assessing patients in order to provide comprehensive and culturally sensitive care. The Western medical model fails to explore cultural patterns of illness. This model proposes that the world view and social structure of the client/patient are important areas to investigate and can be explored using seven dimensions:

- 1] Cultural values and lifeways
- 2] Religious, philosophical, and spiritual beliefs
- 3] Economic factors
- 4] Educational factors
- 5] Technological factors
- 6] Kinship and social ties
- 7] Political and legal factors

“Using this assessment model will assist health care professionals in providing care that is sensitive and tailored to the needs of culturally diverse individuals.”

Health care professionals must develop the skills, knowledge, and patience to explore and validate what the patient says and does. Once information is obtained for each of the dimensions, health care professionals can guide patient treatment and interventions. According to the Sunrise Model, providers should base their selection of a treatment approach or combination of approaches on information gathered from the assessment.³⁰

Similarly, Davidhizar and Giger present a “**Transcultural Assessment Model**” to help health care professionals assess patients from diverse cultures that focuses on six factors:

- 1] *Communication*
- 2] *Space*
- 3] *Time*
- 4] *Social organization*
- 5] *Environmental control*
- 6] *Biological variations*

According to Davidhizar and Giger, health care professionals should receive training in how to use these factors to assess the health beliefs and practices that may have a significant impact on an individual’s response to treatment and patient education. Using this assessment model will assist health care professionals in providing care that is sensitive and tailored to the needs of culturally diverse individuals.³¹

The frameworks/models reviewed in the foregoing discussion define cultural proficiency as a dynamic process that involves acquiring certain knowledge and skills. This process also involves continual progression and involvement of all levels of the health care system. There are certain elements or core components that need to be present at the individual and organizational level to support cultural proficiency. The next section examines the core components of cultural proficiency.

3.2 CORE COMPONENTS OF CULTURAL PROFICIENCY

The following five domains emerge from the literature as core components of cultural proficiency:

- 1] Values and Attitudes
- 2] Structures and Policies
- 3] Practices
- 4] Training/Staff Development
- 5] Evaluation and Research

1. VALUES AND ATTITUDES

One of the essential elements in the developmental journey towards cultural proficiency involves an examination of one's cultural biases and assumptions and/or prejudices against those of a different racial/ethnic/cultural background than oneself. These biases and assumptions have their root in the values and attitudes associated with our cultural background, which usually are "invisible" or "hidden" from our consciousness. However, they define our behavior. Weaver and Paige describe this as an iceberg where nine-tenths of it is below the water.³²

In a cross-cultural health encounter, there is a cross-cultural exchange of values and attitudes between the health care provider and the health care consumer. This process, involving exchange of values and attitudes, is critical to understanding the

socio-cultural barriers that people of diverse racial/ethnic and cultural backgrounds experience in accessing the health care system. Failure by health care providers to see this important link between their own socio-cultural factors and those of the health care consumer leads to a communication breakdown and lack of trust. This in turn may lead to patient dissatisfaction, poor adherence to medications and health promotion strategies, and poorer health outcomes.³³

To address the issues related to values and attitudes, health care providers and health care organizations need to be involved in cross-cultural training and assessment. These principles are discussed further in point 4: training/staff development.

2. STRUCTURES AND POLICIES

Cultural proficiency is a strategy to ensure the provision of equitable and quality health care to a population of diverse racial/ethnic and cultural backgrounds. When looking at health care delivery, it is important to note that it does not take place in a vacuum; it is part of a health care system. Thus, one needs to examine how the health care system works in the context of its structures and policies and whether they support culturally proficient care to a diverse population.

Structures refer to the design and functioning of the health care system. Therefore, the questions that health care providers and planners need to ask include, but are not limited to, the following:

- How complex is the health care system? Is the design bureaucratic?
- Are race/ethnicity and language data collected for service planning & delivery purposes?
- How long are the waiting times for appointments?
- Are the referral mechanisms complex?
- Are language barriers addressed?
- Are health education materials culturally appropriate?
- Are intake processes client-friendly?
- Is patient participation encouraged as part of organizational learning?

“In order to provide culturally proficient care, health care providers and health care organizations need to have principles, philosophies, and policies that support culturally proficient practices.”

Policies, procedures and guidelines refer to the programmatic tools through which organizations can facilitate the delivery of culturally proficient care. These include, but are not limited to, the following:

- Conflict resolution processes
- Hiring procedures including degree to which cultural proficiency indicators are written in job descriptions and incorporated into hiring decisions
- Breadth of health care provider networks
- Degree to which health care provider networks match health care consumers
- Incentive systems such as degree to which cultural proficiency indicators are integrated into promotion, salary recommendations.

As individuals and organizations move along the continuum of cultural proficiency they begin to understand the interplay between policy and practice and commit themselves to policies, procedures and guidelines which support services to a diverse population. One essential component for the development of policies and procedures that support an organization’s journey towards cultural proficiency, involves partnering with health care consumers who reflect the diversity of the population being served.

3. PRACTICES

Practices include the dynamics that take place in the clinical encounter and the services that are provided by health care organizations. Cultural Proficiency in the clinical encounter means delivering effective and respectful care to the patient/client. It is a process that is **patient-focused and does not simply mean the memorization of lists of racial/ethnic and cultural facts**, but involves flexibility from the health care provider to properly assess and treat the patient/client. Patient-focused care incorporates a less controlling and authoritative style of interaction between the health care provider and patient/client which demonstrates that the practitioner values the patient’s/client’s beliefs and perspectives. In fact, **when the patient/client is encouraged to be an active participant in the clinical encounter and share about how his/her culture influences his/her health beliefs, then there is no need for the health practitioner to have a mastery of every racial/ethnic and cultural group’s health beliefs.** Hence, it requires humility from the health care provider to maintain mutually respectful and dynamic partnerships with individual patients/clients and the community at large.

In order to provide culturally proficient care, health care providers and health care organizations need to have principles, philosophies, and policies that support culturally proficient practices.

Culturally proficient practices include three important elements:

- Communication
- Intervention/treatment models
- Family and community participation

The Communication element encompasses the variety of ways in which information is exchanged among those involved in the health care delivery process. It involves verbal and written communications including interpersonal communication and exchanges between individuals and organizations. According to Coffman [2004], communication (*language and other methods of sharing information*) is the primary barrier to providing culturally sensitive care. Other research also points to the influence of cultural factors, power dynamics, verbal and non-verbal behaviors in the communication process.³⁴ Socio-cultural factors influence the communication that takes place between health care providers and health care consumers.

Cultural proficiency attempts to bridge gaps that arise due to the influence of these socio-cultural factors by creating concordance in communication styles. In addition, cultural proficiency supports the provision of language access services (*e.g. language interpretation & translation*) to improve communication. To address the communication needs of a diverse population, health care organizations need to present information in a way that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities (*Deaf and Deaf-Blind persons*). See Appendix 2 for more information on communication (*including linguistic*) competency requirements and Appendix 3 for information on language access services and definitions of Deaf/Deaf-Blind persons.

Intervention/treatment models involve aspects of evaluation, diagnosis, treatment, and referral services. These can include issues like ethnic pharmacology, how traditional healing beliefs interrelate with the Western medical model, decision-making

processes, and care coordination. Making cultural proficiency a key aspect of intervention/treatment models involves making a diagnosis based on a **cultural assessment** that is sensitive to the needs and beliefs of the patient. Furthermore, it involves sharing the diagnosis and treatment with the patient in a way that he/she can understand. This can clearly improve the patient's compliance with the treatment regimen and address the health concerns of the patient.

Family and community participation refers to family-centered care that acknowledges the important role of the family and the larger community in the provision of health care. Participation of the community in assessments and community outreach activities provides valuable information to health care providers about the socio-cultural issues of the community being served. In addition, community participation allows health care providers to include community perspectives in health care policy planning and other activities.

“A good starting point for cultural proficiency training/staff development is an assessment of the health care provider’s individual knowledge and skill level related to cultural proficiency.”

4. TRAINING/STAFF DEVELOPMENT

Another core component of cultural proficiency is training/staff development. The focus here is on equipping health care professionals with the knowledge and skills required for culturally proficient care. To achieve this, training must be provided to health care professionals who are already practicing as well as health care professionals in training at academic institutions.

A good starting point for cultural proficiency training/staff development is an assessment of the health care provider’s individual knowledge and skill level related to cultural proficiency. Several of the authors mentioned in section 3.1 (*Campinha-Bacote, Caraballeira, Leininger, Davidhizar and Giger*) argue that health care professionals need to be trained in the collection of relevant cultural data when conducting health histories and assessments.³⁵

Furthermore, there is an increased consensus among health professionals that more clinical training for physicians needs to take place in community settings, away from university-based, largely tertiary medical centres. The rationale for this argument is that training needs to happen where most physicians will be practicing: in community settings.

Part of this training should include population health principles that encompass disease prevention and health promotion strategies.³⁶

Various training programs have been developed to equip health care providers with the knowledge and skills to manage socio-cultural issues in cross-cultural encounters.

The literature argues for differentiation between two types of training: “**workforce diversity**” training and “**cultural proficiency**” training. Workforce diversity training focuses on improving relationships and interactions among members of a diverse workforce. The goal of cultural proficiency training, on the other hand, is on improving the quality of health care for and enhancing service provision to diverse patient populations.

It is important to recognize the difference between the two types of training for they have different goals and objectives. Thus, facilitators of these training programs should be individuals who are aware of, and competent in the different skill sets required for each type of training.³⁷

A systematic review of 34 studies that evaluated culturally proficient educational interventions showed

that these educational interventions have a positive impact on the knowledge, attitudes and skills of health professionals. There is also good evidence that demonstrates a positive impact on patient satisfaction. However, there is insufficient evidence to demonstrate whether these educational interventions improve patient adherence to therapy, health outcomes and equity of services for racial/ethnic groups.³⁸

5. EVALUATION AND RESEARCH

It is important to set goals for monitoring and evaluating culturally proficient initiatives undertaken by health care organizations and the impact of these initiatives on health outcomes of the population being served. Evaluation and research activities include the following:

- Data collection on demographics of the population being served including race/ethnicity and language data.
- Assessment of the degree to which health care providers hired at an organization match the demographics of the population being served.

- Identification of the health challenges that disproportionately affect racially/ethnically and culturally diverse populations. In addition, evaluation and research needs to be conducted on successful interventions that address the health challenges experienced by these diverse populations.
- Ensuring that racially/ethnically/culturally diverse populations are represented in clinical studies.
- Ensuring patient/client, family and community participation when conducting evaluation and research.

Evaluation/research should also be conducted to determine which cultural proficiency educational methods and content are most effective.³⁹

Finally, evidence should be gathered about standard instruments to measure patient/client outcomes related to culture proficiency. A review of the literature to determine the health outcomes of cultural proficiency is promising, but is still in the preliminary stages of development. The majority of the literature explores and defines the concepts and identifies

important research questions related to cultural proficiency. The current evidence provides information about intermediate outcomes of short-term interventions, but it does not directly address the ultimate outcome of decreased incidence of disease for a population, or a decrease in morbidity or mortality as a result of the intervention used.^{40,41}

Having looked at the core components of cultural proficiency one needs to answer the following question: how do these components work together to take cultural proficiency from theory to action? The answer is presented in the next discussion.

3.3 BEST PRACTICES OF CULTURAL PROFICIENCY

The literature was scanned for “best practice” recommendations of cultural proficiency and diversity. Best practice recommendations are the result of an analysis of existing standards to bring systemic

changes that support the successful implementation of culturally proficient initiatives. The recommendations, described below, ultimately ensure the delivery of quality health care to a diverse population.^{42,43,44}

Figure 2: *Best Practice Recommendations*

CULTURAL PROFICIENCY



COMMITMENT FROM LEADERSHIP



INTEGRATION INTO ALL EXISTING SYSTEMS AND SERVICES



CHANGES ARE MANAGEABLE, MEASURABLE, AND SUSTAINABLE



SUSTAINABILITY



COMMUNITY REPRESENTATION AND FEEDBACK



ONGOING STAFF TRAINING

1] Commitment from leadership is a key factor to success.



Commitment from an organization's leadership is the most significant factor to successfully implement culturally proficient initiatives. If leadership is not convinced of the importance and is not committed to cultural proficiency, it will be difficult to get the rest of the staff to embrace the values/principles of cultural proficiency. An organization's leadership must value diversity and culturally proficient practices.

2] Cultural proficiency must be integrated into all existing systems and services of a health care organization, particularly quality improvement efforts.



Cultural proficiency must be incorporated into all aspects of an organization and its structures. Cultural proficiency must not be treated as a separate issue or a distinct function.

3] Changes made should be manageable, measurable, and sustainable.



Organizations are most successful when changes are incremental and manageable relative to the organization's capacity. Changes should be implemented in a methodical fashion, with

identification of successes and challenges of each initiative, and impact must be measured to create an objective base for continuing efforts despite change of leadership or funding.

4] Making the business case to support cultural proficiency efforts is key to long-term sustainability.



Making a strong business case is a powerful motivator for implementation of culturally proficient initiatives. Establishment of a business case must take into account the long-term benefits of cultural proficiency to a diverse patient/client population as well as the community. An organization and health system will pay more in the future if culturally proficient care is not provided. A business case can be made by using different sources of data, such as literature about health disparities and ability of language access services to improve access and utilization of services.

5] Community representation and feedback is essential at all stages of implementation.



Community involvement is essential to cultural proficiency. Meaningful community participation provides a health care organization with an understanding of its patients' needs, and helps to allocate resources effectively. Community participation

also promotes a system that holds the health care organization accountable for provision of quality services.

Health care organizations, therefore, must have meaningful and flexible processes for community representation and feedback, such as focus groups, advisory committees, and board representation. For a detailed discussion on Community Development and Community Engagement, refer to WRHA's Community Development Framework [2010].

6] Ongoing staff training is crucial.



Continuous staff training is a very important component of successful culturally proficient interventions.

Training provides an important forum to discuss diversity issues and helps cultivate an understanding among staff of cultural proficiency efforts. Ongoing training is needed to give both clinical and non-clinical staff the knowledge, tools, and skills to successfully engage in a process of change.

3.4 CULTURAL PROFICIENCY ASSESSMENT TOOLS

“The results of an assessment tool identify the strengths and areas for growth in the process of becoming culturally proficient.”

Various cultural proficiency assessment tools have been identified in the literature. They range from very simple to very complex and target the health care organization as a whole as well as the individual health care professional. After all, organizations are made up of individual staff members. The objective of a cultural proficiency assessment tool is to reflect the existing level of cultural proficiency of an individual or organization. The intent should not be to score or rate an individual or organization, rather, to provide a “snapshot” as to where the individual or organization is at a particular point in time.⁴⁵

The results of an assessment tool identify the strengths and areas for growth in the process of becoming culturally proficient. In other words, the results should be used to strategically plan long- and short-term objectives to enhance the organization’s capacity to deliver culturally proficient services. At the organizational level, administration of cultural proficiency assessment tools should follow certain steps for planning and implementation. Self-assessment is most productive when it is conducted in an environment based on the following principles:

- Participants are given the opportunity to give honest responses about their level of awareness, knowledge and skills related to cultural proficiency.
- Participants are provided with the opportunity to share their individual perspectives in a candid manner.
- The information provided will be used to effect meaningful change towards cultural proficiency within an organization.⁴⁶

The discussion below merely highlights some examples of cultural proficiency assessment tools developed by national as well as international organizations.

The Cultural Diversity Institute based in Calgary, Alberta developed a “Cultural Competency Self-Assessment Guide for Human Service Organizations”. This assessment instrument consists of 9 tools each with its own objectives with respect to cultural proficiency, the people who are responsible for completing the questionnaire, and particular guidelines. Tool 1 to 8 provide “snapshots” of specific organizational functions, including governance, administration, management, policy

development, program development, service delivery and client feedback. Tool 9, “Interpreting Your Results”, is a compilation of all the tools for reporting and planning purposes.

Above mentioned Self-Assessment Guide enables organizations to:

- Recognize the impact and relevance of cultural proficiency in their administrative and direct service functions;
- Evaluate whether their existing policies, programs and practices are designed to achieve and promote cultural proficiency;
- Identify the areas in decision making, policy implementation and service delivery where cultural proficiency is essential;
- Assess progress in culturally proficient service delivery;
- Identify what changes are needed and who should assume responsibility for those changes;
- Develop specific strategies to address cultural proficiency issues.⁴⁷

The IWK Health Centre and the Nova Scotia Department of Health developed a self-assessment tool to assess an organization’s cultural proficiency level and a self-assessment tool designed specifically for primary health care providers. Both serve as a starting point for discussion and development of a plan for action. The organizational tool includes the following areas for assessment: **1]** Organizational Policies and Practices, **2]** Informed Leadership in Policy Implementation, **3]** Communication and Decision-Making, **4]** Progress in Reduction of Barriers, **5]** Service Planning, and **6]** Staff Recruitment and Retention.

The tool for primary health care providers assesses the level of cultural proficiency by looking at the following issues in the clinical encounter: **1]** Communication Styles, **2]** Social Interaction, **3]** Health, Illness and End of Life Issues, **4]** Assumptions, Attitudes and Values, and **5]** Physical Environment, Materials and Resources.⁴⁸

The Lewin Group [2002] designed the “Organizational Cultural Competence Assessment Profile”. Its development resulted from the growing realization of the importance of cultural proficiency as a critical component for “accessible, responsive, and high-quality care”. The Profile identifies 7 “domains” and related “focus areas” in which cultural

proficiency should be evident. The seven domains are: **1]** organizational values, **2]** governance, **3]** planning and monitoring/evaluation, **4]** communication, **5]** staff development, **6]** organizational infrastructure and **7]** services/interventions. The “focus areas” are the observable and measurable characteristics of a culturally proficient organization.⁴⁹

Campinha-Bacote, whose model of cultural proficiency was presented earlier, developed the Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals [IAPCC-R]. This is a personal assessment instrument composed of 25-items designed to measure the five constructs of Campinha-Bacote’s model: cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire. The scores for this assessment tool range from 25 to 100 and indicate whether a healthcare professional is operating at the level of cultural proficiency, cultural competence, cultural awareness or cultural incompetence.⁵⁰

The National Center for Cultural Competence [NCCC] at Georgetown University in the United States created several assessment tools to identify and promote growth among individuals and within organizations that strive to deliver culturally proficient services.

The NCCC also developed a guide to assist organizations in the process of planning and implementing self-assessment tools. This guide offers a rationale for organizational self-assessment, essential elements for the process, benefits, and useful steps in planning and implementation of an organizational self-assessment.

In addition, the NCCC developed the Cultural and Linguistic Competence Policy Assessment [CLCPA] as a tool to assess the strengths and areas of growth for policy development and administration within organizations. The CLCPA identifies 7 areas;

- 1] Knowledge of Diverse Communities
- 2] Organizational Philosophy
- 3] Personal Involvement in Diverse Communities
- 4] Resources & Linkages
- 5] Human Resources
- 6] Clinical Practice
- 7] Engagement of Diverse Communities.

For individual self-assessments, the NCCC created four checklists and the Cultural Competence Health Practitioner Assessment [CCHPA]. The goal of the checklists is to increase awareness and sensitivity to the importance of cultural proficiency in health care professionals who specifically work in the areas of early childhood, early intervention, primary health care, mental health, children and youth with special health care needs, and sudden infant death

syndrome, and other infant death. The CCHPA is designed as an on-line self-assessment tool and educational tool.

It is not available in printed form and has not been validated as an instrument that can be used for research studies and evaluation purposes.⁵¹

Consider two of the above mentioned assessment tools:

1] *The Cultural Competency Self Assessment Tool from the Cultural Diversity Institute.*

This assessment tool is quite thorough in its application of the core components of cultural proficiency at an organizational level as it assesses specific organizational functions, including governance, administration, management, policy development, program development, service delivery and client feedback. In addition, this tool has been developed for the Canadian context.

2] *The Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals [IAPCC-R].*

This instrument assesses cultural proficiency at the individual level. It is a simple instrument composed of 25 items designed to measure the five constructs of Campinha-Bacote's model: cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire. This assessment

tool takes approximately 10-15 minutes to complete, making it consumer-friendly.

The IAPCC-R is a revision on the previous model IAPCC (*The Inventory for Assessing the Process of Cultural Competence among Healthcare Professionals*). The reliability of the IAPCC is quite high (*Reliability Coefficient Cronbach's alpha of .81*). The reliability of the IAPCC-R has been tested in various countries, including Canada. Further research on the IAPCC-R was conducted and led to the development of the IAPCC-SV designed to measure cultural competence among undergraduate students in health professions. Researchers using the IAPCC-R noted that its reliability was slightly lower when used with students.⁵²

An excellent review of the psychometric properties of IAPCC-R and research literature using the IAPCC-R from 2003 to 2010 is presented in: Riley, D. [2010]. *Cultural Competence of RN to BSN Students*, at <http://digitalcommons.library.unlv.edu/thesedissertations/343>



4. ORGANIZATIONAL SCAN

“Culturally appropriate health education materials that reflect the diversity of the region have been developed to a limited extent and some of these materials have been translated and printed in languages other than English and French.”

4.1 CULTURAL PROFICIENCY AND DIVERSITY INITIATIVES WRHA

To develop a Cultural Proficiency & Diversity Framework for the WRHA, an organizational scan was conducted that included several activities.

Interviews were held with each member of the WRHA Cultural Proficiency and Diversity Services Advisory Committee. Additional information was acquired from an organizational assessment that the members of the committee completed. Likewise, other key informants involved in WRHA’s cultural diverse initiatives were consulted. Finally, various WRHA documents and reports were reviewed to get an overall view of the culturally proficient initiatives that have taken place in the past and/or still going on.

LANGUAGE ACCESS INTERPRETER SERVICES

This initiative is aimed at reducing the impact of language barriers on access to health care. There is solid evidence that language barriers result in lower participation in preventive and health promotion services. Even if the patient/client presents for care, language barriers compromise the quality of care he/she receives.⁵³

Several other negative implications of language barriers have been presented in the 2004 report “Language Barriers within the WRHA”. The overwhelming evidence from this report and other documents created the context for development of the Language Access Interpreter Services.

For the Aboriginal community, health interpreter services have been provided in Winnipeg for Ojibway, Cree, and Oji-Cree/Island Lake dialects since 1972. In addition, the Kivalliq Inuit Health Services provides health interpretation in the Inuktitut language for the Inuit community. The Inuit Health Services functions independently through support from the Government of the Northwest Territories in the Keewatin Region.

Since 2007, trained interpreters (*WRHA casual employees*) provide interpreter services for the languages of the immigrant and refugee communities. Currently, in-person interpreter services (*face-to face, conference call, message relay, reminder call, whispered simultaneous, sight translation*) are available in 28 languages. When a WRHA trained interpreter is not available, the WRHA Language Access Services contracts

over-the-phone interpretation services. These services are available in approximately 170 languages.

It is important to note that even though above mentioned interpreter services are provided and organized by different programs of the WRHA, there is one centralized phone number to access interpreter services for Aboriginal, Inuit, immigrant/refugee languages and American Sign Language. Catering to the various language needs is itself an important structural intervention and providing these services via **one** centralized phone number (*an efficient and client-friendly way of addressing the language issue*) exemplifies a culturally proficient response.

Besides the interpreter services that address the verbal communication needs between the health care provider and the patient/client, the region provides bilingual print materials (*both official languages*) for all patients/clients. There is also evidence that some of the health communication needs in print form for languages other than English and French have been addressed. Culturally appropriate health education materials that reflect the diversity of the region have been developed to a limited extent and some of these materials have been translated and printed in languages other than English and French.

DIRECT SERVICES IN BOTH OFFICIAL LANGUAGES

The language needs of the Francophone community in the Winnipeg Region have been addressed via the WRHA French Language Services [FLS] since 2003. In fact, there are five Regional French Language Services policies in place that calls for services within the WRHA to be offered in French in accordance with the Government of Manitoba French Language Services Policy and pursuant to the laws of Manitoba. Hence, since 2004, all public WRHA communications are presented in a bilingual (*English/French*) format. Currently, there are a total of 24 designated facilities, programs, services and agencies that provide direct services in French to the Francophone community. Furthermore, designated bilingual positions have been created.

COMMUNITY DEVELOPMENT

There is not one particular definition of community development for it encompasses a range of practices within many sectors. The following description of community development emerges from the various definitions, principles, and practices as documented in the literature.

Community development acknowledges that health and well-being can be improved through a broad approach that employs certain processes and relationships between individuals and organizations. Community development involves change in a community and it initiates and supports community action and outcomes. It builds on assets, enhances skills and capacities (*i.e. individual, organizational and community*), builds relationships, creates and connects resources, increases quality of life, empowers communities to address their priorities, and solve their problems through collective action.

Since the establishment of the WRHA in 1999, it has been involved in community development as an approach for improving health and well-being. WRHA's rationale for using community development in the health system lies in the fact that community development empowers individuals to have more control over decisions that influence their own health and health of their communities. An empowered community uses its assets and attributes to improve health by addressing the underlying social determinants of health. The guiding principles of the WRHA community development practices are outlined in Appendix 4.

“Aboriginal Health Programs can arrange Elder or Healer services for matters such as smudging, offering of prayers, teachings, etc for Aboriginal patients who request them.”

One of the key aspects of community development is relationship building, and as such, communication is an essential part of it. The development of health advisory councils and community consultations are concrete examples of this communication process. The role of the Community Health Advisory Councils [CHAC's] is to provide community perspectives and suggestions to issues that are a priority to the WRHA.

The CHAC's have explored and provided feedback to the WRHA on a great number of issues, such as: issues impacting the health of seniors, WRHA communications with communities across the region, compassionate care, effective patient flow, access and barriers regarding chronic disease management, and health issues of immigrants & refugees in the region.⁵⁴

In addition, the CHACs have provided insights and recommendations concerning cultural proficiency of health care providers. See Appendix 5 for excerpts from the CHACs' reports concerning cultural proficiency. In October 2011, the CHACs plan to explore the topic of Cultural Proficiency and how it aligns with the WRHA's strategic direction: Enhance Patient Experience.⁵⁵

ABORIGINAL HEALTH PROGRAMS

WRHA's continued efforts to reach the Aboriginal community; address the inequities in health status for Aboriginal peoples and improve health outcomes for the Aboriginal population brought about the establishment of the Aboriginal Health Strategy in 2001. The Aboriginal Health Strategy included two regional programs: Aboriginal Health Services and Aboriginal Human Resources Initiative. In 2006, these programs amalgamated to form one comprehensive program called the Aboriginal Health Programs.

The goals of the Aboriginal Health Programs are:

- Ensure effective communication and collaboration within health care facilities, programs and multi-disciplinary teams in meeting the needs of Aboriginal patients, clients, and families.
- Provide appropriate support services to all Aboriginal patients and their families.
- Liaise with external agencies and communities and make referrals as required in order to facilitate a comprehensive continuum of care for Aboriginal patients.
- Ensure effective and efficient program operations.

An important principle that guides the services provided by the Aboriginal Health Programs is a commitment to the values, beliefs and culture of the Aboriginal patient/client and the Aboriginal approach to healing. The traditional Aboriginal approach to healing is different from the Western medical model that often focuses on the body and individual risk factors associated with diseases.

The Aboriginal approach to health can be described as a holistic model that recognizes the interconnectedness of body, mind, emotions and spirit. For an Aboriginal person, health encompasses all aspects of a person's being and his/her relationship with the external world.

Spiritual care as part of a holistic approach to healing is an important aspect of care. Aboriginal Health Programs can arrange Elder or Healer services for matters such as smudging, offering of prayers, teachings etc for Aboriginal patients who request them. Furthermore, a Traditional Wellness Clinic located at the Health Sciences Centre gives Aboriginal and non-Aboriginal individuals the opportunity to seek healing using traditional methods. This clinic is open two days per month.

The Aboriginal Health Programs provides direct services to patients in medical care through its discharge coordination & planning services. Aboriginal patients, who have to travel from rural or remote areas to Winnipeg to receive health care services, require a coordinated approach to discharge planning. Discharge planning coordinators work with interpreter/resource workers to plan complex discharges for Aboriginal patients, and ensure that the patients are fully aware of services available. These services may include housing arrangements, transportation and/or information about prescribed medication.

Lastly, the Aboriginal Health Programs addresses the determinants that affect the health status of the Aboriginal community through the provision of culturally appropriate services, community involvement, improved accessibility, advocacy and human resource activities. The human resource component has been a key strategy in the creation of a WRHA workforce that is representative of the Aboriginal population of Winnipeg and Manitoba. The Aboriginal Health Programs plays an active role in recruitment, outreach, and retention initiatives of Aboriginal people. Aboriginal Health Programs also functions as a resource to facilitate the provision of culturally responsive care through the development of cultural awareness programs.

WORKFORCE DIVERSITY & RESPECTFUL WORKPLACE POLICY

Since 2002, WRHA has had a Voluntary Self-declaration Form for Aboriginal staff members who choose to declare their Aboriginal ethnicity.

In March of 2010, the WRHA made changes to employment applications on its website by incorporating the option for job applicants to voluntarily self-declare as Aboriginal. On the website there is also a statement that encourages Aboriginal individuals to apply for positions at the WRHA. Since the Aboriginal self-declaration is voluntary it does not allow the Human Resources department of the WRHA to fully capture the racial/ethnic background and diversity among its staff and job applicants.

While the WRHA does not have an employment equity module similar to the Federal government, it has adopted the "preferred hiring" philosophy for Aboriginal individuals.

The existing workforce diversity data collection is limited to individuals from the Aboriginal community. Data is not currently collected of the WRHA staff and job applicants from other racial/ethnic backgrounds and diversity.

“The absence of language and ethnicity data impedes service planning and delivery of health care ”

A WRHA human resources policy related to diversity matters is the Respectful Workplace policy. The main goal of this policy is to ensure that the WRHA staff can work in a respectful environment free of disrespectful behavior including discrimination, harassment, sexual harassment, personal harassment and workplace violence. The protected characteristics in this policy, as defined in the Manitoba Rights Code, include:

- Ancestry, including colour and perceived race
- Ethnic background and national origin
- Sex, including pregnancy, the possibility of pregnancy or circumstances relating to pregnancy
- Sexual orientation and gender-determined characteristics
- Age
- Religion or creed, or religious belief
- Marital or family status
- Source of income
- Political belief, activities or associations
- Physical or mental disability or related characteristics or circumstances

While the Respectful Workplace policy has been in place for some years already, in the Fall of 2010, a Respectful Workplace campaign was launched to make the WRHA staff aware of the existence of this policy and reinforce its content.

LANGUAGE & ETHNICITY DATA COLLECTION

Canada, unlike many other countries, has not (*with the exception of some coding for Registered First Nations peoples*) included “ethnic indicators” in the health data in any systematic way. The WRHA is aware of the importance of these indicators as increasing evidence points to an association between language and ethnicity indicators and disparities in health status, access, care provision, and health outcomes.

There is also evidence that the absence of language and ethnicity data impedes service planning and delivery of health care (*e.g. interpreter services, translation services, specialized services*). Furthermore, absence of such data affects the ability to determine additional needs for designated bilingual staff at appropriate service delivery points. Lack of “ethnic indicators” also makes

it difficult to monitor differences across populations (*e.g. health status, incidence/ prevalence of conditions, service utilization, process of care, prescribed treatment*) and hinder evaluation efforts that look at differential impact of health services and initiatives, and the development of effective strategies to address health disparities.

In light of above mentioned findings, the WRHA established a Regional Language & Ethnicity Data Collection initiative. In April 2007, language and ethnicity questions were introduced into the patient registration process at St. Boniface General Hospital [SBGH]. The collection of language and ethnicity took place in conjunction with the launch of a new regional Hospital Information System [HIS].

This initiative prepared the groundwork for the collection of language and ethnicity data in other regional applications. Unfortunately, although much collaborative and developmental work preceded the implementation of the language and ethnicity data collection initiative, it had to be withdrawn due to some significant challenges.

The language indicators were well accepted by registration staff and clients, but with room for improvement in certain areas. However, the collection of ethnicity indicators

presented several challenges, and was temporarily discontinued until an evaluation could be completed and key issues addressed. In 2007-2008, the WRHA's Research & Applied Learning Division conducted evaluation and research activities concerning the language and ethnicity data collection.

The evaluation and research findings were published in an internal WRHA report titled: Supporting the Implementation of Regional Language & Ethnicity Indicators: Summary Report of Key Research & Evaluation Findings.

One of the recommendations presented in this report was that the ethnicity questions should not be re-introduced until the following actions were undertaken:

- Issues around quality of language data collection are resolved.
- There is a commitment to comprehensive staff training.
- Needs for patient and community education are addressed.
- There are adequate resources to monitor and evaluate implementation.

For a display of the other recommendations, refer to above mentioned report.⁵⁶

In the meantime, various developments and WRHA projects which are in progress are showing the need for the collection of language and ethnicity indicators. Such data collection has become increasingly necessary given the changing demographics of Manitoba, and Winnipeg in particular, the evolution of Language Access Services, French Language Services, and the renewed commitment to addressing diversity in the region.

After a briefing note was presented to the WRHA Senior Management in 2010, it was decided to continue with the Regional Language and Ethnicity Indicators Committee [RLEIC] under an assigned leadership, namely, the Executive Director of the Research & Applied Learning Division. Two units within this division that will play a key role in the language and ethnicity data collection initiative are: Research and Evaluation because of its past involvement in the project and the need for further evaluation; Health Information Services since language and ethnicity data collection is part of the core function of health information gathering.

“The WRHA, being committed to quality health care, has given a prominent spot to comments and concerns of its patient/client population on the homepage of the WRHA website.”

The Language and Ethnicity data collection initiative is a work in progress. At the writing of this report no details have been presented regarding how collection of the ethnicity indicators will be reintroduced, and if the previously mentioned challenges related to this initiative have been addressed.

CULTURAL PROFICIENCY/ DIVERSITY WORKSHOPS

WRHA Aboriginal Health Programs and the Organization & Staff Development [OSD] team of WRHA Human Resources offer cultural proficiency and workforce diversity workshops.

The OSD provides educational and developmental services for staff working across the Winnipeg Health Region, in hospitals, community-based health services, personal care homes and clinics.

Since 2008, OSD has offered a workforce diversity workshop for managers titled “Culture and Conflict”. The focus of this workshop is not on developing culturally proficient knowledge and skills, but more on conflict resolution. Thus far, a total of 157 of the WRHA staff have participated in this workshop.

The Aboriginal Health Programs offers the following workshops:

- *The Aboriginal Cultures Awareness Workshop [ACAW]* was developed in 1996 and first offered at the Health Sciences Centre. The ACAW provides information about the contemporary, historical and cultural issues that influence stereotypical impressions of Aboriginal people. It assists in altering perceptions that may result in failure to provide culturally appropriate care or resistance to hiring Aboriginal employees. Ultimately, this workshop promotes the development of an equitable work environment for all staff within the WRHA.
- *“Aboriginal Retention for Managers” (Formerly called Honouring all Cultures: Aboriginal Cultures and Diversity Workshop)* focuses participants to deepen understanding on various aspects of service delivery, policy, and practice. The workshop explores the themes and issues emerging from participant experiences and knowledge to identify concrete and productive ways which lead to a) improved retention for Aboriginal employees and b) creating an environment that values diversity.

The workshop has been offered through the Manitoba Blue Cross Employee Assistance Programs since 2007. To date, 9 workshops have been provided to the WRHA and affiliates with a total of 115 participants.

- **“Palliative Care: Aboriginal Perspectives on End of Life”**

This workshop explores Aboriginal perspectives on death and dying. Traditional beliefs and values that may impact how Western medicine provides care are explored. The holistic approach presented in the workshop aligns with all cultural beliefs/values yet at the same time it respects individual perspective and needs.

This workshop was piloted in November 2010.

- **“Traditional Aboriginal Teachings and Sweat Lodge Teachings**
“Building on the existing Aboriginal Cultures Awareness Workshop participants in this workshop receive teachings on the sweat lodge ceremony and have opportunity to participate in a teaching sweat. This workshop provides participants with teachings about other Aboriginal holistic healing practices as

presented by the Elder in residence at the Circle of Life – Thunderbird House. This workshop is presented by and in partnership with the WRHA and Circle of Life – Thunderbird House.

The workshop has been offered to the WRHA staff since 2009.

In addition to above mentioned workshops, Lunch and Learns sessions have been offered. These sessions offer a variety of topics related to Aboriginal health, historic and current events. The following Lunch and Learns sessions have been offered:

- **Residential Schools [2009]:**
Interconnectedness of language, culture and identity.
- **Land Claims and Treaties [2010]:**
Lasting impacts of treaties signed with First Nations.
- **Aboriginal Patient Advocacy [2011]:**
Understanding the role and need of advocates.
- **Treaties [2011]:**
A historical reflection.
- **Advanced Nursing Practice & the Seven Sacred Teachings [2012]**

WRHA WEBSITE: FEEDBACK FORM

The WRHA, being committed to quality health care, has given a prominent spot to comments and concerns of its patient/client population on the homepage of the WRHA website.

On March 30, 2010 an on-line “Feedback Form” was launched on the WRHA website. The Feedback form can be accessed via the “Contact Us” tab and clicking on “Comments & Concerns”. This new feature provides the WRHA with another tool to receive feedback from the public concerning the health services provided; to know when things go well and when improvements are needed.

All the feedback forms land in the WRHA Client Relations inbox, with an automated acknowledgement of receipt generated instantly. The Client Relations Coordinator contacts the person who submitted the feedback within 3 business days.

“Opportunities for intersectoral collaboration and partnerships should be pursued to address the non-health needs that are resulting in over-utilization of health care services by some patients.”

Besides this on-line feedback form, the WRHA also encourages the public to talk with someone at the place where they received care regarding any questions or concerns they may have about the care received. For this purpose, a link is provided on WRHA’s website with information of contact persons at community offices, hospitals, and personal care homes.

CHRONIC DISEASE COLLABORATIVE

With chronic disease being a serious and growing problem in the Winnipeg Health Region and across Canada, a directional document was produced for the WRHA entitled “Lifting the Burden of Chronic Disease: What’s Worked, What Hasn’t, What’s Next” [May 2008]. This document contains a detailed synthesis of research evidence that can inform the design and implementation of interventions.

The document looks at the evidence in support for **a)** chronic disease prevention and **b)** chronic disease management. For chronic disease prevention, **environmental interventions** focusing on changes to unhealthy lifestyles, policies that make healthier choices more convenient and affordable, restrictions on unhealthy products, and addressing the social

determinants of health have the strongest basis of support from the literature. In addition, community development—where trained facilitators follow the community’s lead in identifying problems and coming up with solutions—is supported by research evidence.

For chronic disease management, the evidence points to **system redesign within primary care**. This includes interventions that improve scheduling of care, and interventions that reshape health care roles (*multidisciplinary team-based care and an expanded role for non-physician personnel*). Moreover, opportunities for **intersectoral collaboration and partnerships** should be pursued to address the non-health needs that are resulting in over-utilization of health care services by some patients.⁵⁷

The Chronic Disease Collaborative was established as a direct result of the Lifting the Burden of Chronic Disease report and facilitates the whole process of chronic disease prevention and chronic disease management in the region. The goal of the Collaborative is to “connect the dots” between the different initiatives that are ongoing regarding prevention and management of chronic disease and facilitate the process of system redesign within primary care.

PRIMARY CARE SERVICES

The WRHA, recognizing the importance of primary care and the role it plays in a continuous comprehensive care and equity in access to quality care, developed an Action Plan that includes “building blocks” upon which primary care services are constructed in the Winnipeg Health Region. The building blocks are:

- **Building block 1:** *develop primary care home processes.*

The College of Family Physicians of Canada [CFPC] recommends the introduction of the medical home concept for all Canadians. A Primary Care home can be referred to as a medical home or patient-centered medical home when four key features are present:

- 1] Accessibility for first contact care for each new problem or health need.
- 2] Long-term person-focused care (*longitudinally*).
- 3] Comprehensiveness of care, meaning that care is provided for all health needs except those that are too uncommon for the primary care practitioner to maintain competence when dealing with them.
- 4] Coordination of care when patients need to be referred elsewhere.

- **Building block 2:** *develop networks of primary care providers.*

A primary care network is a geographically distributed network of care providers responsible for a continuum of services to patients in a coordinated fashion and across time. The providers in a network include medical health professionals at a single clinic as well as health educators, hospitals, home care agencies, and community-based groups.

- **Building block 3:** *information systems and technology.*

Enable all primary care sites within the Winnipeg Health Region to have access to both the EMR (*patient data collection within the primary care home*) and e-charts (*patient health information across multiple settings*). This is essential in supporting continuous and comprehensive client centered primary care.

- **Building block 4:** *improved system integration across the continuum of care.*

Development of a primary care system requires an integrated process involving partnerships and collaboration to improve working and consultative

relationships across all sectors of the health system and within community services.

- **Building block 5:** *support the development of a skilled workforce and working collaboratively.*

A skilled, competent, well-trained inter-professional workforce is essential to a sustainable primary care system. There are benefits to the patients, health care providers and health care system as a whole when interdisciplinary teams of health care professionals are part of the primary care setting.

- **Building block 6:** *evaluation and quality improvement.*

For a successful implementation of primary care system change, attention needs to be paid to the evaluation of the implementation processes and outcomes in relation to health system performance, quality improvement and patient perspectives.⁵⁸

“In an effort to address the initial health needs and issues of immigrant and refugee populations, the WRHA has opened the BridgeCare Clinic (refugee health clinic).”

BRIDGECARE CLINIC

The increased number of immigrants and refugees in Manitoba has challenged the health care system in how to appropriately respond to newcomers. Health assessment services for newcomers to Manitoba are not centralized or located in one site.

Newcomers to Canada often experience acute and complex health needs. Immediate and short term health concerns of many refugees include physical and psychological effects of trauma, and in some cases torture, malnutrition, reproductive health issues, dental health concerns and infectious disease.

In an effort to address the initial health needs and issues of immigrant and refugee populations, the WRHA has opened the **BridgeCare Clinic (refugee health clinic)**. It opened at the end of November 2010 and serves as a first point of access in health care for government sponsored refugees to Canada who live in Winnipeg.

The services offered at BridgeCare Clinic are:

- Immediate and short term physician services
- Assistance in locating a permanent primary care provider
- Orientation services to refugees with respect to the Canadian health care system
- Screening and assessment services
- Mental health services
- Access to language interpreter services
- Outreach services including health care service navigation
- Collaboration with Labour and Immigration Settlement Services

WRHA PARTNERSHIPS

Besides aforementioned initiatives, the WRHA forged partnerships with other organizations (intra-sectoral and intersectoral) to promote cultural proficiency & diversity. The next discussion highlights these partnership and their contributions.

ACCESS Centres

- ACCESS centres are the result of partnerships between the WRHA, Manitoba Health, and Family Services and Housing. With the

construction of ACCESS centres a wide variety of community-based health and social services and programs such as primary care, community mental health, public health, home care and employment and income assistance are accessible in one-stop, convenient locations for people in their neighborhoods.

Southern Chiefs' Organization

- In 2007, the Southern Chiefs' Organization [SCO] and the WRHA entered a partnership (*through the federal Aboriginal Health Transition Fund*) to identify the gaps and challenges impeding First Nations Peoples access to existing health care systems and services. This collaborative effort resulted in the development of a "Framework for Health Adaptation" and a "Collaborative Strategic Action Plan". As a foundational tool, the framework provides an overarching structure under which the strategic action plan was developed.

The SCO/WRHA Framework for Health Adaptation consists of three levels. The symbol that is used for the framework is that of a Tipi, where the top layer identifies the program goal: improved health status through adaptation of existing health services. The middle layer

identifies the Strategic Objectives. The bottom layer, the strategies level, includes five broad strategies: 1] Access, 2] Quality, 3] Awareness, 4] Structure, and 5] Communication.

These broad strategies are further developed in the SCO/WRHA Collaborative Strategic Action Plan [CSAP].

Thirteen principles (*13 poles in the frame of a Tipi*) support all three levels and serve as the foundation for the Framework for Health Adaptation. In addition, these principles are designed to guide effectiveness at all levels including individual, community, organizations and system overall.

Two principles are worth noting here: "Cultural Appropriateness" and "Communication".

Culture is a significant determinant of health and is referenced and/or cited as a critical consideration for any project involving First Nations peoples. The principle of "Communication" emerged as the most recurrent theme in the process of engagement of stakeholders and focus group participants for the SCO/WRHA project.

The relevance of culture in the Framework for Health Adaptation and CSAP is to emphasize the importance of having a common definition and understanding of what culture is, and its place in improving health care for Aboriginal peoples within the Winnipeg Health Region. An understanding of culture not only as it applies to individuals but to their surrounding environments such as the social, economic, political and historical experiences of the patient/client. In this sense activities might be undertaken to restore the culture within health system adaptation activities and strategic efforts should be inclusive of Aboriginal Peoples way of life, history and experiences.

The Framework for Health Adaptation provides an outline of the parameters of change within the health system, whereas the CSAP spells out more clearly the parts of the system that requires closer examination. From there, it is anticipated that collaboration and partnership will ultimately result in the achievement of the overall goal which is: **"Improved health status through the adaptation of existing health services"**.



The SCO/WRHA Framework for Health Adaptation together with the CSAP are being used to guide the development of a process to improve health and reduce health disparities.^{59,60}

Manitoba Labour and Immigration

The action strategies of Manitoba Labour and Immigration are as follows:

- a] Support the safe and effective recruitment of temporary workers and permanent immigrants to meet Manitoban and Canadian existing and prospective economic needs.
- b] Provide accessible and relevant settlement services before and after arrival to ensure integration, labour market success and retention.
- c] Promote and support communities that welcome newcomers and strengthen and celebrate Manitoba's cultural diversity.
- d] The collaboration between the WRHA and the Manitoba Labour and Immigration has been particularly important for service planning and efforts to address the health needs and issues of immigrant and refugee populations.

Dignity in Care Initiative

The WRHA partners with the Manitoba Palliative Care Research Unit [MPCRU] in the Dignity in Care initiative.

Patients/clients who use health care services are affected in their sense of dignity in many ways. The challenge for health care providers is to comprehend how different factors affect an individual's sense of dignity, and how they can address these factors. The Dignity in Care initiative provides solutions, based on research, to guide them in this task. Dignity in Care is based on four core values: the "ABCDs of Dignity in Care" (see Appendix 6).

The Dignity in Care initiative encompasses ten strategies and action points that started in March 2010 and will continue during the course of 2011. They include among others: the Dignity Toolkit for managers and educators,

the Dignity in Care website, and the Dignity in Care Facebook page. For a summary description of all 10 strategies and more information on Dignity in Care, refer to Appendix 6.

CULTURAL PROFICIENCY & DIVERSITY SERVICES ADVISORY COMMITTEE

In 2010, an Advisory Committee was established to oversee and guide development of a framework and the process of promotion of cultural proficiency and diversity within the WRHA. One important ingredient in this process is forging partnerships with other health care institutions and community organizations to improve health of a population and reduce health disparities among population groups.

The WRHA Advisory Committee includes representation of other organizations that also have experience in the provision of culturally proficient services. They are: Kivalliq Inuit Centre/Kivalliq Inuit Services, Mount Carmel Clinic, and CancerCare Manitoba.

The ideas and experiences shared between these organizations and the Advisory Committee is valuable. Moreover, these partnerships contribute to network building among health care providers that benefit

“The cultural proficiency process that the WRHA is engaged in does not take place in a vacuum.”

the patient/client population. Refer to Appendix 7 for a brief description of above mentioned partners’ mission and culturally proficient services.

Refer to Appendix 8 for a timeline of the culturally proficient initiatives presented in this chapter. Noteworthy is the great number of initiatives that have taken place in 2010.

The cultural proficiency process that the WRHA is engaged in does not take place in a vacuum. It is part of health system developments happening at the provincial level. In fact, these developments helped inform WRHA’s Building Blocks Action Plan and is contributing to changes in design and functioning of primary care services. One of these developments is The Physician Integrated Network [PIN] Initiative.

PHYSICIAN INTEGRATED NETWORK [PIN] INITIATIVE

The Physician Integrated Network [PIN] is a provincial primary care renewal initiative that focuses on fee-for-service [FFS] physician groups. The goal of this Manitoba Health initiative is to facilitate systemic improvements in the delivery of primary care. The vision and objectives of PIN are as follows:

Vision:

Quality primary care is available to all Manitobans through networked primary care physicians in collaboration with other providers.

Objectives:

- To improve access to primary care ~ “Right provider, right place, right time”.
- To improve Primary Care Providers’ access to and use of information ~ “Right information, right time to support effective decision making for the provision of care and for effective management of the group practice”.
- To improve the work life for all primary care providers ~ “Ensuring a supportive, healthy and sustainable work environment”.
- To demonstrate high quality primary care with a specific focus on Chronic Disease Management ~ “Doing the right thing at the right time to achieve the best possible results”.

To date, the PIN initiative has been implemented at thirteen sites with both rural and urban settings represented. PIN strives to improve access to patients through practice change. These changes may include the use of inter-professional and collaborative care teams; and employing non-physician medical professionals such as registered dietitians and nurses to assist family physicians with different aspects of testing, screening, education, and follow-up of patients. This approach provides physicians with more time to focus on patients with more complex medical needs.⁶¹

4.2 CULTURAL PROFICIENCY ASSESSMENT TOOL WRHA

“ An assessment is most productive in an environment where people feel safe to give honest responses about their level of awareness, knowledge, and skills of cultural proficiency.”

It is important for an organization to assess attitudes, practices, policies, structures, and health care services in the systematic process of planning for and incorporating cultural proficiency. An assessment is most productive in an environment where people feel safe to give honest responses about their level of awareness, knowledge, and skills of cultural proficiency.

While the literature abounds with various models of cultural proficiency assessment tools, the WRHA needs to assess if administration of such a tool at this time is effective, for the organization. It may be more appropriate to assess how the WRHA is meeting best practice standards of cultural proficiency. The strengths and areas for further development in the process of cultural proficiency could be evaluated according to best practice standards.

According to the six best practice recommendations, outlined in section 3.3, WRHA's leadership is committed to cultural proficiency since the senior managers, managers, and Board all support the values/principles of cultural proficiency. This is critical to bring about organizational change; for leadership sets the tone for the rest of the staff.

Other best practice recommendations implemented by the WRHA include community representation and feedback. The community development process, community consultations such as the CHACs, and feedback forms have been successfully implemented in WRHA's journey of cultural proficiency. Staff training as a best practice recommendation is also on-going but needs some adaptations to address certain knowledge and skills gaps as identified in section 5.1.3.

“Three tools were ultimately selected and analyzed for their fit with the WRHA organization overall.”

The best practice standards that the WRHA needs to develop further include: integration of cultural proficiency into all existing systems and services of the organization; and ensure that changes are manageable, measurable, and sustainable. These recommendations are presented in the next section (*framework and considerations for a strategic plan*).

Making the business case to support cultural proficiency is also a best practice recommendation. Unfortunately, research to support the business case for cultural proficiency is still a work in progress. A costs and benefits analysis of cultural proficiency is complex and not yet well documented. At this time, insufficient evidence exists to draw any definitive conclusions on the cost-benefits of cultural proficiency in health care.⁶² The business case to support cultural proficiency efforts in the WRHA has not been fully addressed yet.

A review of the literature produced an extensive list of assessment tools designed to reflect the existing level of cultural proficiency of a health care organization and its individual staff members. Three tools were ultimately selected and analyzed for their fit with the WRHA organization overall. In order to encapsulate the magnitude of the organization, the range of service delivery, and the populations being served the Cultural Diversity Institute model originating from Calgary, Alberta has been deemed the best fit for the WRHA. The Framework described in the following section will act as a guide to determine the best use of the tool as the Cultural Proficiency & Diversity Strategy starts its development.

5. CULTURAL PROFICIENCY & DIVERSITY FRAMEWORK WRHA

5.1 Three Level Approach

As outlined in the previous section, the WRHA has undertaken several culturally proficient initiatives. Positioning these initiatives under one overarching comprehensive plan is precisely the intention of the Cultural Proficiency & Diversity Framework presented in this report. This framework is an important step to support the continued commitment of the WRHA to culturally proficient health care services. At the same time, the framework is in accordance with the mission, vision, and values of the WRHA and the strategic directions as described in the WRHA 2011-2016 Strategic Plan "Planning with Care". For a description of the mission, vision, values, and strategic directions of the WRHA, see Appendix 9.

Cultural proficiency emerged as a strategy to address the challenges of cultural diversity, racial/ethnic health disparities, access to health care, and the provision of quality health care to

a diverse population. Needless to say that in order to tackle such a huge task, a comprehensive approach is needed that looks at the health care system from multiple levels.

The proposed Cultural Proficiency & Diversity Framework encompasses three levels with the core components, described in section 3.2, integrated in the framework. The three levels of the framework are essentially the interventions that the WRHA needs to address to promote cultural proficiency and diversity. Capturing these interventions in three broad categories is a practical and simple way to build a framework to address the complex and multiple issues of cultural proficiency. This approach provides the Advisory Committee with an overall view of the areas that are already being addressed and which may need further development. In addition, the framework provides an overview of the areas that are not yet developed in the continuum of care and where capacity building is required.

The three levels of the framework are described below.

- 1] *Organizational Interventions:*** efforts to promote representative leadership and workforce that are racially/ethnically and culturally from diverse backgrounds.
- 2] *Structural Interventions:*** efforts to make the processes within the health care system more client-friendly and culturally appropriate to ensure that patients/clients have full access to quality health care.
- 3] *Clinical Interventions:*** efforts to equip health care providers with the knowledge of how socio-cultural factors affect health. Furthermore, these efforts include providing health care professionals with the tools and skills to manage socio-cultural factors in the clinical encounter.

5.1.1 ORGANIZATIONAL INTERVENTIONS

“A diverse workforce creates an environment that promotes creativity that comes from cooperation among diverse staff members.”

These interventions include initiatives that promote a leadership and workforce that is diverse and representative of its patient/client population.

Workforce diversity benefits both the health care professionals and the patient/client population as recipients of care. Workforce diversity can facilitate adoption of culturally proficient practices among health care professionals. It creates opportunities for exposure to diversity and promotes interaction among staff members that may result in greater understanding of cultural proficiency values and principles. In addition, a diverse workforce creates an environment that promotes creativity that comes from cooperation among diverse staff members.

Workforce diversity also plays an important role in development of health care policies, procedures and guidelines. Health care systems and the processes that take place in these systems are influenced by the

leadership and workforce that develop health care policies, procedures and guidelines. Racial/ethnic minority under-representation in health care results in policies, procedures, guidelines and practices that are not appropriately designed to serve diverse populations.

In addition, evidence shows that racial concordance between patient and physician is associated with greater patient participation in care processes, greater patient satisfaction, and greater adherence to treatment.⁶³ Research also demonstrates that a racial/ethnic match between patient and physician correlates with a higher self-rated quality of care.⁶⁴

Organizational culturally proficient interventions include “**diversity**” and “**minority recruitment**” initiatives. The WRHA has implemented the following organizational interventions.

ORGANIZATIONAL INTERVENTIONS	TARGET GROUP
Diversity	
• Respectful Workplace Policy	All staff
• Respectful Workplace Campaign	WRHA managers
• Diversity workshops [OSD]	All staff
• ACAW: some components of the workshop	All staff
• Lunch & Learns [AHP]	All staff
Minority Recruitment	
• Preferred Hiring Philosophy	Aboriginal job applicants
• Voluntary Self-declaration Form	Aboriginal staff
• Employment application (<i>WRHA website</i>): voluntary self-declaration & statement encouraging Aboriginal job applicants	Aboriginal job applicants
• Recruitment, outreach, retention [AHP]	Aboriginal job applicants/staff
• Recruitment French/English speaking staff for designated bilingual positions	Bilingual job applicants/staff

“Racial/ethnic diversity in health care leadership and workforce is an important strategy in delivery of care to a diverse population.”

The minority recruitment and retention efforts so far have focused on the representation of Aboriginal peoples in the workforce. However, existing data do not reveal to what degree WRHA Aboriginal staff matches the Aboriginal population of the region. Since data for Aboriginal job applicants and staff are provided on a voluntary basis, they do not provide an accurate portrait of the representation of this ethnic group among the WRHA workforce. Data on representation of other racial/ethnic groups in the WRHA workforce is nonexistent.

It is important to keep in mind the differences between “workforce diversity” and “cultural proficiency” training (*described in section 3.2*).

The diversity workshops offered by OSD are classified as workforce diversity training. The Aboriginal Cultures Awareness workshop, for example, falls mainly in the category of cultural proficiency training, but it also has components of workforce diversity training. The differences between the two types of training need to be made clear to WRHA staff and managers to avoid confusion in application of these concepts.

Almost all of the organizational interventions implemented so far are targeted towards the Aboriginal community. The diversity workshops [OSD], Respectful Workplace policy, and Respectful Workplace campaign are organizational interventions that are broader in scope and target a diverse group.

Racial/ethnic diversity in health care leadership and workforce is an important strategy in delivery of care to a diverse population. Consequently, WRHA’s “diversity” and “minority recruitment/retention” efforts are essential and should continue. At the same time, policies and initiatives should be enhanced to include representation of other racial/ethnic groups to maximize diversity among WRHA staff and leadership.

5.1.2 STRUCTURAL INTERVENTIONS

Structural culturally proficient interventions encompass a variety of initiatives to ensure that the processes within the health care system guarantee full access to quality health care to all patients/clients. The WRHA has implemented an impressive amount of structural interventions. Each, with varying levels of success, has contributed towards the goal of making the processes of care more client-friendly and culturally appropriate which ultimately improves access to care for the health care consumer.

The structural interventions implemented by the WRHA can be categorized in the following broad categories:

- Interventions to support communication competency
- Interventions to improve design and functioning of the health care system
- Socio-cultural assessment of the population
- Community development and participation
- Collaborative partnerships

STRUCTURAL INTERVENTIONS	REMARKS
<p>Communication Competency</p> <ul style="list-style-type: none"> • Regional Interpreter Services Policy • Language Access Interpreter Services: <ol style="list-style-type: none"> 1] Aboriginal community 2] Francophone 3] Immigrants & refugees 4] Deaf and Deaf-Blind individuals • Health education materials: culturally and linguistically appropriate • Health education materials: literacy level • Regional French Language Services Policies • Bilingual public WRHA communications (<i>English/French format</i>) 	<p>WRHA: one of the leaders in Canada for language access services.</p> <p>With the exception of bilingual French/English materials: limited in nature; need further development. Assessed to some extent; not standard practice. Area for further consideration. Active offer of French at the Regions designated bilingual facilities, programs, and services.</p>
<p>Design & Functioning of System</p> <ul style="list-style-type: none"> • Building Blocks Action Plan • Chronic Disease Collaborative • BridgeCare Clinic (<i>refugee health clinic</i>) 	<p>Specialized refugee orientation, screening & assessment: starting point integration immigrant/refugee primary care.</p>
<p>Socio-cultural Assessment</p> <ul style="list-style-type: none"> • Language & Ethnicity data collection 	<p>Ethnicity component temporarily put on hold.</p>
<p>Community Development & Participation</p> <ul style="list-style-type: none"> • Community development; community facilitators in 12 community areas • CHACs and community consultations • Public engagement: part of WRHA's strategic directions 2011-2016 • Feedback form on WRHA website • FLS feedback mechanism 	<p>Separate from general feedback form on WRHA website (flsfeedback@sbgh.mb.ca).</p>
<p>Collaborative Partnerships</p> <ul style="list-style-type: none"> • ACCESS centres • SCO/ WRHA Framework & CSAP • Manitoba Labour & Immigration • Dignity in Care 	<p>Successful: Downtown, River East and Transcona ACCESS centres won award for accessible design.</p>

The WRHA has successfully implemented structural interventions that support communication competency. Improvements are still needed in certain areas as indicated in the Table above. Communication Competency (*which includes linguistic competency*) refers to the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences. A diverse audience includes persons of limited English language proficiency, individuals who have low literacy skills or are not literate, individuals with disabilities, and those who are hard of hearing, deaf or deaf-blind.⁶⁵

Structural interventions that fall in the category of **design and functioning of the health care system** involves reviewing the intake processes, waiting times for appointments, referral mechanisms, and procedures of care and continuity of care. When these aspects of health system design are not functioning properly, access and quality of health care diminishes. Thus, interventions at this level encompass measures that involve changes in design and functioning of the health care delivery system to ultimately improve access to care for the health care consumer.

The WRHA recognizes the importance of primary care and the role it plays in a continuous comprehensive care and equity in access to quality care. In light of this, an Action Plan was developed

that contains the “**building blocks**” to develop a primary care system within the Winnipeg Health Region. This Action Plan proposes primary care networks and the concept of a primary care home. **Primary care networks** are designed to improve patient access and coordination to various health services within the community, by supporting extended hours of service and after hours call. These networks are built on the premise of population health principles which are essential to improve health of an entire population and reduce health disparities among population groups. Moreover, the Building Blocks Action Plan conforms to best practice recommendations of cultural proficiency since evaluation and quality improvement processes are incorporated in this initiative.

The provincial **Physician Integrated Network [PIN]** initiative is worth mentioning here since it supports the Building Blocks Action Plan. PIN facilitates systemic improvements in the delivery of primary care to accomplish the vision of making quality primary care available to all Manitobans through networked primary care physicians in collaboration with other providers. This is a promising development in the efforts to change processes within the health care system to guarantee full access to quality health care to all patients/clients.

Not only is the WRHA addressing primary care system redesign, but

has specifically targeted chronic disease prevention and management in the region. The Chronic Disease Collaborative is a new initiative that involves system redesign within primary care with the goal of improving access to care for patients/clients with chronic disease. In fact, the Family Medicine/Primary Care Program of the WRHA intends to work with the Chronic Disease Collaborative on system redesign issues, beginning with diabetes. The Chronic Disease Collaborative provides a platform to bring about changes in the design and functioning of the Region’s health care delivery system. Ultimately, system redesign efforts within primary care will also benefit WRHA’s cultural proficiency process. Stakeholders of both initiatives should come together to strengthen a systemic approach to health care delivery redesign.

The WRHA approved the opening of BridgeCare Clinic as a strategy to deal with the health needs and issues of immigrant and refugee populations. In a draft report titled “Understanding the Health and Health Issues of Immigrant and Refugee Populations” [2010], WRHA’s Research & Evaluation Unit advises against the development of a segregated primary care clinic for immigrant/refugee populations since it does not reflect the principles of an integrated service response. The recommendation is for provision of specialized newcomer orientation, screening and assessment of services with the goal of assisting clients to

“The WRHA is engaged in successful partnerships that are essential in planning for and promoting culturally proficient services in the Winnipeg Health Region.”

access the health services available to all residents. Of note is the role of the BridgeCare clinic in ensuring that patients/clients and their families are successfully referred to a “primary care home”.

Another important structural intervention is a socio-cultural assessment of the population being served. A key component of such an assessment includes **language & ethnicity data collection** as it is essential for service planning and delivery of health care (*e.g. interpreter services, translation services, specialized services*). This data collection is needed to monitor differences across populations (*e.g. health status, incidence/prevalence of conditions, service utilization, process of care, prescribed treatment*). Lack of such data impedes evaluation efforts that look at the differential impact of health services and initiatives, affects the ability to determine additional needs for designated bilingual staff at appropriate service delivery points, and development of effective strategies to address health disparities.

An attempt has been made by the WRHA to collect language and ethnicity data. However, due to certain challenges, collection of the ethnicity indicators has temporarily been put on hold.

The language & ethnicity challenges, as outlined in the Regional Language & Ethnicity Indicators: Summary Report [2009], should be addressed in order to reintroduce language & ethnicity data collection. If it is not possible to introduce the “whole package” now, implementation of language data collection independent of the ethnicity indicators should be explored. Language collection could potentially be framed as a first step in a broader, long-term strategy towards more comprehensive data collection.⁶⁶

Community development has been used by the WRHA as an important process to improve health and well-being in communities. The guiding principles of the WRHA community development strategy reflect the values and core components of cultural proficiency. The community development principle of “meaningful participation” has been successfully implemented through the work of the community facilitators and Community Health Advisory Councils [CHAC’s]. The CHAC’s provide valuable community feedback and suggestions to the Board of the WRHA. In fact, evidence supports community development initiatives in which community members set their own priorities.⁶⁷

The recently developed “Feedback Form” on the WRHA website is another feedback tool for the public to submit comments regarding quality of health care services. In addition to the on-line feedback tool, the WRHA encourages the public to directly approach someone at the place where care was received with their questions or concerns. Similarly, the FLS also has a feedback mechanism for the francophone patients/clients and public to express themselves about the services they received. These are great examples of best practices of cultural proficiency, where a health care organization is held accountable for provision of quality services.

The WRHA is engaged in successful partnerships that are essential in planning for and promoting culturally proficient services in the Winnipeg Health Region. The importance of collaborative partnerships (*sectoral and intersectoral*) has been established in the literature. **Intersectoral partnerships**, in particular, recognize that health and health disparities are determined by many factors. The health sector alone can not address all the

health determinants and causes of health disparities. Hence, collaboration is needed between the health sector and other sectors to positively influence health outcomes.

Partnerships enable services/ organizations to share ideas and experiences, learn from each other, build and strengthen competencies, and develop more effective community action. At the same time, these partnerships shape policy and structural interventions that address the social determinants of health and improve access to health care and social services (*e.g. ACCESS centres*).

Other noteworthy examples of intersectoral partnerships that reflect cultural proficient principles are the SCO/WRHA collaborative project and the Dignity in Care initiative. The SCO/WRHA collaborative project plays a key role in improving the health status of First Nations peoples through the adaptation of existing health services. The Dignity in Care partnership helps to build and strengthen cultural proficiency values/principles, knowledge and skills among WRHA staff.

5.1.3 CLINICAL INTERVENTIONS

“It is impossible to give health care providers an encyclopedic knowledge of specific cultures and their beliefs and practices that affect health.”

The literature and experts in the field agree that health care providers need to understand and know how to manage socio-cultural issues in the clinical encounter. To serve this purpose, cross-cultural (*also called cultural competence/cultural proficiency*) training programs for health care providers have been developed. The educational methods developed for cross-cultural training programs vary in approach.

The “categorical” approach teaches health care providers specific facts about racial/ethnic groups. It focuses on description of relevant attitudes, values, beliefs and behaviors of certain cultural groups. This approach, traditionally used in the field, that gives a list of do’s and don’ts to health care providers has not proven valuable. First of all, it is impossible to give health care providers an encyclopedic knowledge of specific cultures and their beliefs and practices that affect health. Secondly, such a limited approach does not account for the existence of intra-group variability due to multiple factors such as socio-economic status and

acculturation. The categorical approach may also contribute to stereotyping. Furthermore, it is not good practice for health care providers to base treatment on general assumptions of cultural beliefs and practices of a patient/client. This approach might prevent individualized assessment that is so essential to quality and safety of care.

It may be more helpful to make health care providers acquainted with some cultural specific information such as disease incidence and prevalence among certain populations; ethno-pharmacology; the effect of war and torture on refugee populations and how this affects the interaction between the health care provider and patient in the clinical encounter; and how cultural and spiritual beliefs and practices might interfere with prescribed treatment.

A newer approach in **cross-cultural education** focuses on the process of communication and teaches health care providers to be aware of cross-cutting cultural and social issues and health beliefs that are present in all cultures.

Here the emphasis is on identifying and negotiating different styles of communication, decision-making preferences, roles of family, sexual and gender issues, and issues of mistrust, prejudice, and racism, among others. Ultimately, a balance of cross-cultural knowledge in combination with communication skills is proposed as the best method for cultural proficiency education/training. This approach allows the health care provider to be flexible and modify care plans to incorporate patient and family perspectives.^{68,69}

Clinical culturally proficient interventions also involve addressing specialized health care needs of immigrants and refugees. Newcomers from areas of the world where certain infectious/tropical diseases are endemic to their country of origin have created challenges for health care providers. Often providers do not have experience with diagnosis and treatment of these infectious/tropical diseases.

Other health care needs of immigrants and refugees that particularly require a culturally proficient approach are mental health and sexuality/reproductive health services.

Assessment and treatment of mental health issues is often language-based and culturally determined. There are cultural differences in how distress is expressed, acceptability of mental illness, and in patient/provider communication that presents challenges to diagnosis and treatment; patients may fear breakdown of confidentiality; and patients affected by torture and war trauma often require cross-cultural mental health/counseling services.⁷⁰

Similarly, health care providers need to show particular sensitivity in the area of sexuality and reproductive health since these issues are greatly affected by values, cultural beliefs and practices. Female Genital Mutilation [FGM] is one example of a sexuality related cultural practice with important health implications. There are many forms of FGM, with varying implications for reproductive health and sexuality. The WRHA draft report "Understanding the Health and Health Issues of Immigrant and Refugee Populations" [2010] referred to gaps in the provision of sensitive reproductive health and obstetrical care of women who have undergone FGM.⁷¹ With the newly opened BridgeCare Clinic this should be an issue of the past.

Thus, clinical culturally proficient interventions involve equipping health care providers with skills to effectively manage socio-cultural issues in the clinical encounter. A balance of cross-cultural knowledge in combination with communication skills is proposed. This involves teaching health care providers about cultural health assessment and good communication skills so that diagnostic and treatment decisions are not based on inaccurate information and/or biases.

In addition, clinical interventions include having the know-how for dealing with specialized health care needs of immigrant and refugee populations.

Systematic reviews of 34 studies conducted by Beach et al. [2005] examined the effectiveness of cultural proficiency educational interventions for health care providers. The findings reveal that cultural proficiency training improves the knowledge, attitudes, and skills of health professionals.⁷²

“An examination of cultural proficiency training programs offered by Canadian academic institutions lies beyond the scope of this report”

While above mentioned findings are promising, it should be noted that insufficient information is provided about the “skills” component in these studies. It is not clear if these studies looked at the skills needed to do a cultural health assessment of the patient/client and the expertise needed to address specialized health care needs of immigrants/refugees.

The cultural proficiency training provided by the WRHA so far has addressed Aboriginal culture and issues (*historical facts, Aboriginal approach to healing, cultural beliefs and practices*). While existing workshops equip health care professionals to manage cross-cultural clinical encounters, some gaps remain. Cross-cutting cultural and social issues are not addressed, nor are certain knowledge and skills. These include communication skills necessary to manage socio-cultural issues, know-how concerning cultural health assessment of the patient/client, and expertise needed to address specialized health care needs of

immigrants and refugees. Whereas, some of aforementioned gaps are more relevant to clinical staff, care should be taken to train non-clinical staff as well to improve their knowledge, attitudes, and skills regarding cultural proficiency. Staff training is a crucial element to successfully implement culturally proficient initiatives.

Priority should be given to development of education programs that address above mentioned gaps. The WRHA could also consider partnerships with other organizations that already have educational programs in place that address these issues.

An examination of cultural proficiency training programs offered by Canadian academic institutions lies beyond the scope of this report. However, it is an important area of investigation for these institutions prepare future health care professionals and provide continuing education programs.

The clinical culturally proficient interventions that have been implemented by the WRHA are outlined below.

CLINICAL INTERVENTIONS	REMARKS
Cultural Proficiency Training	
<ul style="list-style-type: none"> Aboriginal Cultures Awareness Workshop 	
<ul style="list-style-type: none"> “Palliative Care: Aboriginal Perspectives on End of Life” 	Going through accreditation process. Offered approximately 4 times per year.
<ul style="list-style-type: none"> Traditional Aboriginal Teachings & Sweat Lodge Teachings 	Offered approximately 4 times per year.
<ul style="list-style-type: none"> Dignity in Care Initiative: <ol style="list-style-type: none"> 1] Dignity in Care Grand Rounds 2] Dignity in Care Website 3] Toolkit <i>(for managers and educators)</i> 4] Multimedia Learning Tool 	



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CAUTION: NEVER TOUCH THE
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PATIENT OR YOURSELF WITH THE
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CUFF STRAP.
EYE PROTECTION IS REQUIRED FOR
PATIENTS WITH EYE INJURY OR
SURGERY.
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EYE PROTECTION IS ALSO
REQUIRED FOR PATIENTS WITH
EYE SURGERY OR INJURY.

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5.2 WRHA CULTURAL PROFICIENCY & DIVERSITY FRAMEWORK

“Ultimately, the impact of cultural proficiency initiatives on health outcomes needs to be investigated.”

The following table presents the Cultural Proficiency & Diversity Framework for the WRHA.

The framework outlines the three levels of organizational, structural and clinical aspects of the organization and the two categories of interventions: the interventions that have already been implemented and those that require further consideration. Additionally, the table is also cross-referenced with the core components of cultural proficiency outlined on p. 53 to establish a structure for drafting the Cultural Proficiency & Diversity Strategy that is highly recommended for the organization.

Next steps must be considerate of the core components to ensure the interventions are meaningful

for diverse staff and patients, and that they are imbedded within the organization and focus on issues of sustainability for long-term success. As such, Evaluation & Research is an essential ingredient throughout the entire process of cultural proficiency. Data needs to be collected to ensure that culturally proficient initiatives are evidence-based. At the same time, all cultural proficiency initiatives have to be evaluated and monitored for service planning purposes and development of effective strategies to address health disparities, improve access to health care, and provide quality health care. Ultimately, the impact of cultural proficiency initiatives on health outcomes needs to be investigated.

Finally, the key considerations for a Strategic Plan of Cultural Proficiency & Diversity are outlined on p. 16.

CULTURAL PROFICIENCY & DIVERSITY FRAMEWORK

	INTERVENTIONS IMPLEMENTED	INTERVENTIONS FOR FURTHER CONSIDERATIONS
<p>1. ORGANIZATIONAL Leadership/workforce: racially/ ethnically & culturally diverse</p>	<ul style="list-style-type: none"> • “Diversity” & “Minority Recruitment” Initiatives 	<ul style="list-style-type: none"> • Enhance diversity initiatives: organizational culture that values diversity • Enhance minority recruitment/ retention initiatives: leadership & workforce • Data collection: racial/ethnic indicators of WRHA staff
<p>2. STRUCTURAL Processes health care system: promote full access to quality health care (<i>client-friendly & culturally appropriate care</i>)</p>	<ul style="list-style-type: none"> • Communication Competency • Design & Functioning of System • Community Development & Participation • Socio-cultural Assessment • Collaborative Partnerships 	<ul style="list-style-type: none"> • Culturally proficient health promotion messages and materials, including assessment of literacy level • Language & Ethnicity data collection • Evaluation design and functioning of health care system • Integration of immigrant/refugee & Aboriginal health into health system planning • Maintain & enhance initiatives that support system redesign efforts, particularly primary care system • Maintain & strengthen community development & participation • Maintain & strengthen collaborative partnerships • Development of more ACCESS centres: primary care network as active participants
<p>3. CLINICAL Health care providers: equip with knowledge, tools & skills to manage socio-cultural issues in clinical encounter</p>	<ul style="list-style-type: none"> • Cultural Proficiency Training 	<ul style="list-style-type: none"> • Cross-cultural training: communication skills, cultural health assessment of patient/client • Capacity building: specialized health care knowledge immigrants/ refugees, Aboriginal groups

Cultural Proficiency Core Components

VALUES & ATTITUDES	STRUCTURES & POLICIES	PRACTICES	TRAINING & STAFF DEVELOPMENT	EVALUATION & RESEARCH
X	X	X	X	
X	X	X	X	
X	X	X	X	X
X	X	X		
	X			X
X	X	X		X
X	X	X	X	X
X	X	X		
X		X		
X		X	X	
	X	X		
X	X	X	X	
X			X	

CULTURAL PROFICIENCY & DIVERSITY FRAMEWORK: *Considerations for Strategic Plan*

1. ORGANIZATIONAL

Leadership/workforce: racially/ethnically & culturally diverse

- Maintain & strengthen existing “diversity” and recruitment initiatives.
- Evaluate impact of existing “diversity recruitment” initiatives; make adjustments based on the evaluation findings.
- Maximize diversity among staff and leadership:
 - Hiring, recruitment and retention practices should be broad building on those targeted to Aboriginal ethnicity.
 - Leadership, senior managers, staff, health care providers must all reflect diversity.
- Explore possibilities for collection of data that reveal to what degree WRHA staff is reflective of its patient/client population.
- Introduce cultural proficiency and diversity concepts in orientation session of new WRHA employees.

2. STRUCTURAL

Processes health care system: promote full access to quality health care (*client-friendly & culturally appropriate care*)

- Maintain & strengthen initiatives that guarantee full access to quality health care to all patients/clients:
 - Strengthen interventions that support communication competency (*language access; health education & health promotion materials/signage that is culturally and linguistically appropriate*).
 - Evaluate design and functioning of the health care system and make improvements.
 - Socio-cultural assessment of population (*language & ethnicity data collection*).
 - Maintain & strengthen community development, community participation and health care consumers’ feedback.
 - Maintain & strengthen collaborative partnerships for service planning purposes and to address the social determinants of health.

3. CLINICAL

Health care providers: equip with knowledge, tools & skills to manage socio-cultural issues in clinical encounter

- Cultural Proficiency Training:
 - Understanding of the value differences between the Western approach to medicine and alternative approaches; respect for health beliefs of racially/ethnically and culturally diverse populations.
 - Knowledge and skills: communication skills; cultural health assessment of health care consumer; ABCDs of Dignity in Care; specialized health care knowledge of immigrants/refugees.
 - Evaluate existing cultural proficiency training to assess the impact on WRHA staff’s knowledge, attitude and skills related to cultural proficiency.
 - Evaluate the impact of cultural proficiency training on health outcomes of population served.

6. CONCLUSION

The WRHA needs to respond appropriately to the demographic changes in Manitoba, and Winnipeg in particular, to ensure quality health care provision to every person regardless of their race/ethnicity, culture or language proficiency.

The WRHA embraced cultural proficiency as a strategic direction to respond to the diversity in the region and through the years has implemented several organizational, structural, and clinical interventions.

While the establishment of a Cultural Proficiency and Diversity Services Advisory Committee and the development of a Cultural Proficiency framework are new processes within the WRHA, the journey towards cultural proficiency started quite some years ago.

Building a framework, which positions the initiatives under one overarching comprehensive plan, is a natural and essential step in the process of change.

This process of change entails internalization of the values/principles and core components of cultural proficiency at the individual as well

as organizational level to inform policy development, service planning and health care practices. The journey towards cultural proficiency starts with self-examination and recognition of one's biases and prejudices toward individuals from other cultures.

Other important elements in the process of change are valuing diversity and understanding the dynamics that occur in cross-cultural encounters. Such encounters involve an exchange of values and attitudes between the individuals involved. Recognition of these dynamics is crucial for it is fundamental to understanding the socio-cultural barriers experienced by people of diverse racial/ethnic and cultural background, which ultimately result in poorer health outcomes. In addition, cross-cultural dynamics play an important role in conflicts that may arise among members of a diverse workforce.

In an effort to improve the quality of health care, enhance service provision to a diverse population and create a culture of diversity within the organization, the WRHA developed several "cultural proficiency"

and "workforce diversity" training interventions. The purpose of these educational interventions is twofold:

- 1] Deepen the knowledge, attitude, and skills of WRHA staff regarding cross-cultural encounters with the patient/client population being served.
- 2] Improve relationships and interactions among members of a diverse workforce and create an environment that values diversity.

Health care systems and the processes that take place in them are influenced by leadership that designs health care policies and procedures. Leadership should, therefore, be diverse, value diversity and be convinced of the importance of cultural proficiency as culture is an important determinant of health.

The commitment to cultural proficiency by leaders and decision makers enables the design of health care policies, procedures and guidelines that support culturally proficient practices. The commitment of WRHA's leadership is critical in the process of organizational change; for leadership sets the tone for the rest of the staff.

7. RECOMMENDATIONS

“Best practice recommendations for cultural proficiency and diversity include integrating cultural proficiency into all existing systems of a health care organization, particularly quality improvement efforts.”

Based on the evidence presented in the literature and the findings from the organizational scan, the following actions are recommended to promote Cultural Proficiency and Diversity within the WRHA.

- Best practice recommendations for cultural proficiency and diversity include integrating cultural proficiency into all existing systems of a health care organization, particularly quality improvement efforts. Translated into practice, this means:
 - Develop a Cultural Proficiency & Diversity Strategic Plan that spells out how the organizational, structural, and clinical interventions will be implemented (*see p. 53*) strategic plan needs to be communicated to the whole organization.
 - Incorporate “a commitment to cultural proficiency” in the mission statement and core values of the WRHA.
 - Review the WRHA policies and procedures to ensure they are according to best practice standards for cultural proficiency and diversity.

- Maintain and strengthen existing “diversity” and “minority recruitment” initiatives of the WRHA. Evaluate the impact of these organizational interventions and make adjustments based on the evaluation findings.

Diversity initiatives:

- Maintain workforce diversity training interventions and evaluate their impact on the workplace environment.
- Incorporate cultural proficiency values and concepts in the orientation session of new WRHA employees.
- Continue creating a workplace environment that values diversity.
- Clarify the difference between “workforce diversity” and “cultural proficiency” training interventions. The goals and objectives of each type of training should be made clear to WRHA staff prior to their participation in the training sessions.
- This will minimize confusions regarding participants’ expectations of these educational interventions.

Recruitment initiatives:

- Incorporate other racial/ethnic groups in recruitment initiatives.
- Modify existing statement on WRHA's website concerning job applicants. Creation of a **diverse workforce** should be highlighted. Aboriginal and other racial/ethnic groups should be encouraged to apply for positions. The website statement can be further supported by making reference to WRHA's commitment to cultural proficiency, a diverse workforce, and the respectful workplace policy.
- Consider possibilities of advertising positions in ethnic newspapers or community-based organizations that represent racially/ethnically diverse groups.
- Explore possibilities for collection of data that reveal to what degree WRHA staff is representative of the patient/client population it serves.
- The Cultural Proficiency & Diversity Framework should be used as a platform to position the regional implementation of the language and ethnicity data collection. The language & ethnicity challenges should be addressed in order to reintroduce the language & ethnicity data collection initiative.

If collection of both indicators remains challenging, possibilities of introducing language data collection independent of the ethnicity indicators should be explored. Language collection could potentially be framed as a first step in a broader, long-term strategy towards more comprehensive data collection.

- Both the "cultural proficiency" and the "workforce diversity" training interventions are essential in the journey towards cultural proficiency. They should be expanded to include additional skills and expertise to manage cross-cultural encounters. These encounters can be of two kinds: **a)** among health care professionals of a diverse WRHA workforce or **b)** between health care professionals and a diverse patient/client population.
- Training interventions should be provided on an ongoing basis.
- Priority should be given to the evolution of a region wide "**primary care system**" (*Building Blocks Action Plan*) since it is the foundation of the health system and it supports key principles (e.g. continuous comprehensive care) and processes within the system that promote equity and full access to quality care.

- Evaluate existing WRHA printed materials and health education materials to determine the literacy level and whether culturally and linguistically appropriate elements are present in these materials.
- Maintain and strengthen meaningful and flexible processes for community representation and feedback. This includes:
 - **Maintain & strengthen the role of CHACs.**
 - **Maintain & strengthen feedback tools such as WRHA on-line feedback forms and FLS feedback mechanism.**
 - **Develop and implement an action plan for the strategic direction "Public Engagement".**
- Develop a strategic plan regarding how to improve access to preventive and health promotion services for a racially/ethnically and culturally diverse population. System redesign initiatives within primary care (such as Building Blocks initiative) should be an essential component of this strategic plan, as well as continued development of ACCESS centres.
- The strategic action points as spelled out in the CSAP must be implemented in order to address unique issues related to health

“The WRHA should continue engaging in and strengthen community development, intersectoral partnerships, and collaboration.”

to jurisdictional factors impacting service as well as the health and social determinants of each population. Further, the CSAP should be used as a tool to guide deeper dialogue on specific areas of the health system that are of mutual interest to stakeholders.

- Develop a strategic vision that incorporates immigrant/refugee health into health system planning and delivery of health care services. Important issues that need to be addressed include decreasing barriers in accessing preventive and health promotion services for newcomers. In addition, specialized health care needs of newcomers have to be addressed.
- The Dignity in Care initiative aims to enhance the overall patient experience, which aligns with WRHA’s strategic directions and WRHA’s cultural proficiency process. The educational tools of this initiative should be used as a resource for continuous learning and quality improvement within WRHA sites and programs.
- All cultural proficiency initiatives undertaken by the WRHA should incorporate quality monitoring and improvement activities in their work as well as evaluation processes.

In addition, standard instruments should be developed to measure cultural proficiency efforts and their impact on the population being served.

- The importance of community development, intersectoral partnerships, and collaboration has been established in the literature. In addition, the importance of these initiatives has been highlighted in various WRHA documents as a strategy to address the broader determinants of health and other factors that create barriers for racially/ethnically and culturally diverse groups from accessing health care.
- The WRHA should continue engaging in and strengthen community development, intersectoral partnerships, and collaboration.
- Leadership and responsibility should be assigned to a team of the Advisory Committee to ensure the implementation of the recommendations proposed in this framework and monitor on an ongoing basis the health issues facing diverse communities and needs for service provision/adaptation.

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APPENDICES

APPENDIX 1

LEVELS OF RACISM

1] Institutionalized Racism

This involves the differential access to the goods, services, and opportunities of society by race. Institutionalized racism is concerned with the structures of society, sometimes legalized and often manifests as inherited disadvantage. It is codified in institutions of custom, practice, and law. So, there need not be an identifiable perpetrator.

Institutionalized racism manifests itself both in material conditions and in access to power.

2] Personally Mediated Racism

This is defined as prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to their race. Discrimination means differential actions towards others according to their race.

3] Internalized Racism

This is defined as acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth. It is characterized by not believing in others who look like them, and not believing in themselves.

Source: Jones, C.P. (2000). Levels of Racism: A Theoretic Framework and a Gardner's Tale. American Journal of Public Health, 90 (8), 1212-1215.

APPENDIX 2

COMMUNICATION (INCLUDING LINGUISTIC) COMPETENCY REQUIREMENTS

Health care organizations and providers need to meet certain requirements to be able to respond to the health literacy needs of the populations they serve. They need to have policies, structures, practices, procedures and dedicated resources to support communication (including linguistic) competency. This may include, but is not limited to, the use of:

- Bilingual/bicultural or multilingual/multicultural staff
- Cross-cultural communication approaches
- Cultural brokers
- Foreign language interpretation services including distance technologies
- Sign language interpretation services
- Multilingual telecommunication systems
- Videoconferencing and tele-health technologies
- TTY and other assistive technology devices
- Computer assisted real time translation or viable real time transcriptions
- Print materials in easy to read, low literacy, picture and symbol formats
- Materials in alternative formats (e.g. audiotape, Braille, enlarged print)
- Varied approaches to share information with individuals who experience cognitive disabilities
- Materials developed and tested for specific cultural, ethnic and linguistic groups
- Translation services including those of:
 - legally binding documents (e.g. consent forms, confidentiality and patient rights statements, release of information, applications signage)
 - health education materials
 - public awareness materials and campaigns
- Ethnic media in languages other than English (e.g. television, radio, internet, newspapers, periodicals)

Source: Adapted from Goode, T.D. & Jones, W. (2009 Revision). Washington, D.C.: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

APPENDIX 3**GLOSSARY OF TERMS****Race**

Race relates to a person's appearance, mainly skin color. It is biologically determined, with genetic traits such as skin color, eye color, hair color, bone structure etc.⁷²

Ethnicity

Ethnicity relates to or is the characteristic of a group of people having certain racial, linguistic, cultural traditions, religious, and certain other traits in common. Thus, ethnicity relates to cultural factors such as nationality, culture, ancestry, language, and beliefs.⁷²

Culture

An integrated pattern of human behavior that includes the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Cultural Proficiency

The integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.

Language access

This is an umbrella term that describes the ability of clients to communicate effectively with those in the health care system, and for providers to communicate effectively with them. Language access can be provided in many different ways: interpretation (in person or remote), availability of health information in a variety of formats and languages, signage, or direct service by bilingual service providers.

Interpretation

For the purposes of this report, interpretation refers to the process by which a spoken or signed message in one language is relayed, with the same meaning, into another language. This definition recognizes the complexity of the task of interpretation. Interpretation may be categorized in the following ways:

- Proximate: the interpreter is present in the encounter
- Remote: the interpreter is not physically present in the encounter but uses e.g. telecommunications technology to do the interpretation.
- Health or medical interpretation: the interpretation for health issues or within the health system.
- Trained health interpreters: interpreters who have appropriate training in the profession of health interpreting, including knowledge of health system organization, medical vocabulary in both languages, and ethical standards and codes of conduct related to health care.
- Ad hoc or volunteer interpreters: these are family members, friends or others who act as interpreters for the client.

Translation

Translation refers to the conversion of a message in one language into an equivalent written message in another language.

Deaf, deaf

The word deaf, with the "d" capitalized, as in Deaf, refers to those who belong to the cultural community of Deaf people. Many of these persons are pre-lingually deaf, and while they may learn to read and write English or French, they learn these as second languages. In contrast, the words deaf or deafened (with a lower case "d") refer to lack of hearing. Not all those who are deaf are members of the Deaf community, or use sign language.

Source: Bowen, S. (2004). Report Language Barriers within the Winnipeg Regional Health Authority: Evidence and Implications.

Source: Cultural Proficiency & Diversity Services Advisory Committee.

APPENDIX 4

WRHA COMMUNITY DEVELOPMENT GUIDING PRINCIPLES

Respect

We value the inherent worth, dignity, diversity, and abilities of all individuals, families, groups and communities. By working together in solidarity with people, we create improved conditions for health and productive relationships.

Equity

We value fairness and justice and believe that we must strive to reduce inequities in the conditions for health, and in health outcomes.

Meaningful Participation

We value inclusive participation meaningful to all people in decisions that affect their lives; we believe that this is fundamental to good health. We will make efforts to include people who are at least heard, to participate in a meaningful way, in decisions that affect their lives.

Meaningful Process

We value hope. We believe that community development and change begins with individual people and that they must have hope that things change through collective action. We believe that community development is an on-going, dynamic process of social change that can lead to sustained improvements in people's lives.

Integrity

We value honesty and transparency of our intent and priorities and believe that we must demonstrate our accountability to all with whom we work. Integrity is our commitment to act in ways that enhance, and to not detract from, community development values.

Inclusion

We value the diversity within communities and their contributions.

Collaboration

We value working together with communities and partners within or across sectors.

Source: Winnipeg Regional Health Authority, Community Development Framework (updated 2010).

APPENDIX 5**EXCERPTS CHAC REPORTS:
CULTURAL PROFICIENCY ISSUES****Primary Care Report (2011) – Address
Cultural and Language Barriers**

Cultural and language barriers need to be addressed and overcome in primary care and Aboriginal approaches to health need to be included and available.

**Addressing barriers for those
living with chronic disease (2009) –
Vulnerable populations may need:**

To be able to talk to someone in their own language, who understands their culture.

**Compassionate Care Report (2007)
- What health care providers and
staff need:**

- To remember that patients are often vulnerable;
- To have clear expectations of behaviour—caring for and interacting with patients and families;
- A compassionate workplace so that they can be compassionate to their patients;
- To have incentives and be rewarded when they provide exceptional care that is compassionate;
- To know that “accepting diversity and understanding cultures is fundamental.” That it is important for all staff to learn more about cultures and to address stereotypes that are sometimes prejudicial.

**Communicating with patients
and families**

Health care providers and staff should communicate well with patients and families, especially those patients who are vulnerable (seniors, people with mental illness, etc.)

**Consider literacy, language,
and culture**

- Health care providers should be aware of and learn about the communication styles of various cultures. This should be an expectation for all staff.
- Create access to first language health care. Ensure that translators or interpreters are available for patients for whom English is not their first language—Aboriginal and immigrant populations.
- Be aware of potential literacy barriers that patients may experience with written forms, etc.—without judgment or discrimination offer assistance
- Develop electronic media (like video, photos on computer, etc.) that provide visual references to help with communication, especially for those experiencing language barriers.

**Community Perspectives of Patient
Safety (2006)**

- Language and cultural barriers experienced by patients creates enormous risk of adverse events and patients who cannot understand what is happening to them, and can therefore not give legal consent.
- WRHA needs to provide cultural awareness training for health care staff so that cross cultural misunderstandings decrease and potential for risks to patient’s safety also decreases.
- WRHA needs to increase availability of translators to assist patients who are unable to communicate in English.

Source: Schneider, C., Manager Community Health Advisory Councils WRHA. (2011). Excerpts from CHAC reports: Cultural Competency of Staff.

APPENDIX 6

DIGNITY IN CARE TEAM

The Manitoba Palliative Care Research Unit (MPCRUC) at CancerCare Manitoba was established to conduct research on psychological, existential and spiritual dimensions of palliative end-of-life care. Its primary goal is to improve quality of life and ease suffering of dying people and their families through research. After studying the importance of dignity in the lives of dying patients, the team began looking at how their compelling findings could be extended to other aspects of health care.

The MPCRUC is directed by Dr. Harvey Max Chochinov, who holds the only Tier 1 Canada Research Chair in Palliative Care of the Canadian Institutes of Health Research (CIHR). For the last 17 years, Dr. Chochinov's program of research has earned him recognition as one of the world's leading palliative care scholars and researchers. He is also a Distinguished Professor of Psychiatry at the University of Manitoba.

Dr. Chochinov has built an interdisciplinary research team with expertise in psychiatry, psychology, qualitative and quantitative analysis, biostatistics, nursing, and palliative care medicine. Collaborating with researchers around the world, they have compiled a large body of work on the Dignity in Care approach.

Dignity in Care Initiative

The Dignity in Care initiative is based on 15 years of study by Dr. Harvey Max Chochinov and the Manitoba Palliative Care Research Unit, in collaboration with researchers from Australia, England, and the United States.

The core values of health care are at risk in the time-pressured world we are living in. The goal of the Dignity in Care initiative is to safeguard these core values of health care and provide

practical ideas and tools to support a culture of compassion and respect throughout the health care system. The principles of this initiative are based on a four core values framework: the "ABCDs of Dignity in Care".

A] Attitude – how do our preconceived ideas affect our actions?

The attitudes and assumptions of the health care provider regarding a patient/client have a profound effect on how people are treated and how the health care services are provided.

B] Behaviour – health care providers should treat patients/clients with kindness and respect.

Once someone is aware of their attitudes then they can more effectively manage their behavior towards others. Health care providers should engage in simple gestures that make the patient/client feel more like a person, worthy of attention and respect and less like a body to be poked and prodded. Simple gestures of kindness and respect can enhance feelings of trust and connection between the provider and the patient/client, which in turn makes them more likely to give valuable information to their providers that is important to the patients'/clients' care.

C] Compassion – the secret to patient care is caring for the patient

Compassion is not something a person knows, but something a person feels. It is a deep awareness of the suffering of another and the desire to relieve it. Compassion is something that needs to be present in patient care.

D] Dialogue – communication is the first step toward understanding.

Good health care relies on an exchange of information between the provider and the patient/client. To provide the best care possible, health providers need to gather information about the whole person and not just the disease/illness. The dialogue must acknowledge the person beyond the affliction, and the emotional impact of a disease/illness.

*Source: Dignity in Care website
(<http://www.dignityincare/en/Cat-1/dignity-explained.html>).*

Ten Strategies of Dignity in Care

Strategy 1: Dignity in Care Humanities of Care Grand Rounds

These rounds provide an interactive learning opportunity aimed at improving the quality of care and the overall patient experience. The patient or family central to the round will be invited to be a partner in the conversation, providing staff with a valuable and unique learning experience, and giving patients and families the opportunity to directly impact and influence patient care.

Five rounds will be hosted from September 2010-June 2011, including a WRHA staff round, hosted by the CEO of the WRHA. A synopsis of the discussion is made and posted on the Dignity in Care website to enable continuous learning.

The outcome of a successful introduction will result in the Dignity in Care Rounds becoming an integral tool for continuous learning and quality improvement within a variety of WRHA sites and programs.

Strategy 2: Bereavement Letter and Feedback

Personal care home facilities within the WRHA and long-term care facilities play a critical role in the delivery of Dignity in Care. When a resident dies, a letter of condolence will be sent from the facility CEO to the primary family contact. About 4-6 weeks later, a survey covering various components of the care experience will be sent to the primary family contact. The family member will be asked to reflect on the care the resident received and offer suggestions for improvement. This project will be piloted at 10 facilities for a period of 6 months and then expanded to include 25 facilities.

Strategy 3: Personal Care Home/Long Term Care Dignity in Care Rounds

Dignity in Care rounds will be hosted at three personal care homes within the WRHA to review resident experiences that highlight the importance of the humanities of care. A panel of discussants, including the residents if possible and/or family will explore the experience and engage with staff in a dialogue about how the care was provided and opportunities to improve care. A written synopsis of the discussion will be developed and posted on the Dignity in Care website.

Strategy 4: Personal Care Home/Long Term Care Community Meetings

Three community meetings will be held at different personal care home or long-term care facilities within the WRHA. Residents and family members will be invited to these meetings where Dignity in Care will be the topic of conversation and participants will talk about opportunities to enhance humanities of care. Following the session, all participants who provided

contact information will receive thank you letter along with a summary of the discussion. This mailing list will be provided to the facility so that they remain in contact with interested participants in the process of supporting Dignity in Care.

Strategy 5: Dignity in Care Communication Tools

A dignity in Care toolkit will be developed to support a clear and actionable message. The toolkit will include a variety of communication aids, including talking points, an elevator speech, Q&As, multimedia PowerPoint presentation that can be tailored to specific audiences, backgrounder, a video of Dr. Harvey Max Chochinov's Dignity in Care presentation and a pocket card.

Strategy 6: The Dignity in Care website

The website launched in June 2010, provides information on the ABCDs of Dignity in Care. The website serves as an accessible knowledge resource tool that provides ready access to consistent, up-to-date, trusted information on Dignity in Care principles, projects and tools. In addition, a library of resources is provided that includes academic articles and other articles, books, video/ audio materials, and links to websites related to dignity in care.

The content of the website is targeted towards three audiences: health care professionals, the public and researchers.

The website is not part of the WRHA website but as one of the partners of the Dignity in Care initiative, there is a link to the WRHA website.

Strategy 7: Dignity in Care Facebook Page

Leveraging the power of social media, a Facebook page will be customized to raise awareness, generate interest/ excitement, celebrate success, document momentum and drive traffic to the dignity in Care site. The look and feel will be consistent with the Dignity in Care website.

Strategy 8: Dignity in Care Multimedia Learning Tool

Using the latest in multimedia technology, four impactful interactive training videos will be developed to encourage people to reflect on the ways they approach and deliver care and interact with patients and families. The videos will be aimed at everyone who has direct contact with patients and families and will be incorporated in orientation programs, will be required viewing for all WRHA staff on an annual or bi-annual basis.

Strategy 9: Keep in Touch

Keep in Touch is a novel research project to measure the impact of improving the "connectedness" of patients in hospital and their families. The pilot is expected to demonstrate that a suite of communication tools can enhance a patient's sense of well-being and satisfaction, while minimizing despair and isolation.

Strategy 10: We're Listening Feedback Tool

Listening to patients is the foundation of Dignity in Care. The "We're Listening Feedback Tool" will empower health care consumers to make their voices heard and to know that their feedback is valued. We're Listening makes it easy to submit feedback regarding care, using either online or paper-based tools. The project will also provide a means of reporting back to community and acknowledging the value of the community's voice.

Source: Neufeld, K., Chief Quality Officer WRHA

APPENDIX 7

Cultural Proficiency & Diversity Advisory Committee: Partnerships

The three organizations that partner with the Advisory Committee are: Kivalliq Inuit Centre, Mount Carmel Clinic, and CancerCare Manitoba. A brief description of the mission and culturally proficient services of each partner is presented next

A] Kivalliq Inuit Centre/Kivalliq Inuit Services

Kivalliq Inuit Centre is a boarding home for Inuit people who come to Winnipeg for medical services. The Centre in association with the Kivalliq Inuit Services provides several services to Inuit people:

- Logistics regarding air travel to and from the Nunavut territory.
- Appointment coordination & transportation to and from medical appointments.
- Health interpretation services in the Inuktitut language (= native language of the Inuit people).
- Posters and health education materials in Inuktitut language.
- Navigation through the medical/health care system (appointments, hospitalization, discharge from the hospital etc).
- Discharge planning
- Nursing care at the Centre after hospitalization.

In addition to above mentioned services, the Kivalliq Inuit Centre/ Kivalliq Inuit Services functions as an advocate for Inuit patients as they navigate the health care system. Kivalliq Inuit Services facilitates the communication process between health care providers and Inuit patients to minimize any barriers that may arise due to socio-cultural issues.

B] Mount Carmel Clinic

Mount Carmel Clinic is a non-profit community health centre located in the Point Douglas community area with a mission to create and promote healthy inner city communities.

Cultural proficiency is one of the core values of this centre's philosophy and policies. Various culturally proficient services are provided to the clients of Mount Carmel Clinic, including early childhood and parent support programs, community development programs, and primary health care services.

The approach of primary health care at Mount Carmel is based on four pillars:

Access: services are offered under one roof and in offsite locations to best suit client needs.

Teams: a health care team provides the best possible care.

Information: providers and clients have access to information to achieve the best health outcomes.

Healthy living: teams focus on health promotion and illness prevention.

Two programs in particular are worth mentioning here. Both focus on health promotion services:

- 1] The health promotion program for the Aboriginal community
- 2] The multicultural wellness program

The multicultural wellness program offers community based, culturally appropriate services that promote mental, emotional, and physical health for immigrants and refugees.

C] CancerCare Manitoba

CancerCare Manitoba is a provincially mandated cancer agency responsible for cancer prevention, detection, treatment, research and education.

CancerCare Manitoba is dedicated to excellence in cancer care, to enhancing the quality of life for those diagnosed and living with cancer and blood disorders and to improving the control of cancer for all Manitobans.

As part of the efforts of CancerCare Manitoba to provide culturally appropriate care to the Aboriginal community of Manitoba, it introduced cultural proficiency training for its entire staff. These training sessions started in 2007 and so far approximately 60% of the staff of CancerCare Manitoba has participated in this cultural proficiency training.

APPENDIX 8

CULTURAL PROFICIENCY & DIVERSITY INITIATIVES

TIMELINE CULTURAL PROFICIENCY & DIVERSITY INITIATIVES WRHA

Year	Initiative
1972	Aboriginal Health Services: health interpreter services in Ojibway, Cree, and Oji-Cree/Island Lake dialect
1996	Aboriginal Cultures Awareness Workshop (ACAW)
1999	Community Development
2001	Aboriginal Health Strategy: A] Aboriginal Health Services B] Aboriginal Human Resources Initiative
2002	Voluntary Self-declaration Form for Aboriginal staff Language Barriers Committee
2005	French Language Services: 5 Regional policies developed and implemented to ensure and support the active offer of service in French at the regions designated bilingual facilities, programs, services and agencies
2006	Aboriginal Health Programs: amalgamation a + b of Aboriginal Health Strategy Language Access Committee

CULTURAL PROFICIENCY & DIVERSITY INITIATIVES

TIMELINE CULTURAL PROFICIENCY & DIVERSITY INITIATIVES WRHA

Year	Initiative
2007	<p>All regional communications in bilingual format (English and French)</p> <p>Language Access Interpreter Services: 4 language constituencies served</p> <p>Regional Language & Ethnicity data collection</p> <p>SCO/WRHA Partnership</p> <p>“Honouring all Cultures” workshop</p> <p>Organization & Staff Development: “Culture and Conflict” workshop for managers</p>
2008	<p>Respectful Workplace policy (revised in 2010)</p> <p>Traditional Aboriginal Teachings & Sweat Lodge Teachings</p>
2009	<p>Lunch & Learns session: Residential Schools ~ Their Legacy and Relevance Today</p> <p>Regional Interpreter Services Policy</p>
2010	<p>Cultural Proficiency & Diversity Services Advisory Committee:</p> <p>A] Development of Cultural Proficiency & Diversity Services framework</p> <p>B] Partnerships: Kivalliq Inuit Centre, Mount Carmel Clinic, CancerCare Manitoba</p>

CULTURAL PROFICIENCY & DIVERSITY INITIATIVES

TIMELINE CULTURAL PROFICIENCY & DIVERSITY INITIATIVES WRHA

Year	Initiative
2010 (cont'd)	Respectful Workplace campaign WRHA website: voluntary Aboriginal self-declaration option for employment applications Feedback Form on WRHA website Building Blocks Action Plan Chronic Disease Collaborative Lunch & Learns session: Land Claims & Treaties BridgeCare Clinic (Refugee Health Clinic) Palliative Care: Aboriginal Perspectives on "End of Life" workshop WRHA partnership: Dignity in Care

APPENDIX 9

CULTURAL PROFICIENCY ASSESSMENT TOOLS: WRHA APPLICABILITY FEASIBILITY

Assessment Tool	Target Population	Focus Area	Purpose	WRHA Applicability
Cultural Diversity Institute: Calgary, AB	Board Administration & Management All staff levels Client Participation	<ul style="list-style-type: none"> Organizational Climate Governance Structure Policy Process, Development & Content Program Development Service Delivery Client Feedback 	<ul style="list-style-type: none"> Recognize the impact and relevance of cultural competency in their administrative and direct service functions Evaluate whether their existing policies, programs and practices are designed to achieve and promote cultural competency Identify the areas in decision making, policy implementation and service delivery where cultural competency is essential Assess progress in culturally competent service delivery/Identify what changes are needed and who should assume responsibility for those changes Develop specific strategies to address cultural competency issues 	<p>PREFERRED TOOL</p> <p>Provides a comprehensive overview</p> <p>Self-managed process</p> <p>Not a means-to-ends</p> <p>Springboard effectiveness (internally drivers to effectiveness)</p> <p>Inclusive Individual & organizational responsibility</p> <p>PDSA circular approach</p>
IWK Health Centre & The Nova Scotia Department of Health	Board Senior Managers Systems Change Leadership Groups (Promoting Health Equity, Dignity & Care, Cultural Proficiency group) Direct Service Providers	<ul style="list-style-type: none"> Structural Organizational Policies & Practices Informed Leadership in Policy Implementation Communication and Decision-Making Progress in reduction of Barriers Service Planning Recruitment & Retentions 	<ul style="list-style-type: none"> Physical Environment Materials and Resources Communication Styles Social Interaction Health Illness and End of Life Issues Assumptions, Attitudes & Values 	<p>Limited Application for a large organization–Not Preferred</p> <p>Primarily Clinical focus</p> <p>Structural and Environmental</p> <p>Engagement underway</p>
Transcultural C.A.R.E. Associates (U.S.)	Patient lens Consumer Use individual Service Delivery	<ul style="list-style-type: none"> Cultural Awareness Cultural knowledge Cultural Skill Cultural Encounter Cultural Desire 	<ul style="list-style-type: none"> Structural assessment for access improvements Identifies healthcare professional status as culturally proficient, competent, aware, or incompetent Tested in various countries with high reliability 	<p>Limited Application for large organization (capacity & timeliness for delivery for individual service providers)</p> <p>Not Preferred</p>

APPENDIX 10**MISSION, VISION, VALUES, AND STRATEGIC PRIORITIES OF THE WRHA****Mission:**

To co-ordinate and deliver safe and caring services that promote health and well being.

Vision:

Healthy People. Vibrant Communities. Care for All.

Values

Dignity—as a reflection of the self-worth of every person

Care—as an unwavering expectation of every person

Respect—as a measure of the importance of every person

Our Commitments

Innovation—that fosters improved care, health and well-being

Excellence—as a standard of our care and service

Stewardship—of our resources, knowledge and care

Strategic Directions

The Winnipeg Health Region's Board of Directors has approved six new strategic directions to guide the Region's operations for the next five years, effective April 2011.

They are:

1. Enhance Patient Experience

Enhance patient experience and outcomes by listening more carefully to patients and considering their needs when designing and delivering services.

2. Improve Quality and Integration

Improve access to quality and safe care through improved integration of services and then use of evidence informed practice.

3. Foster Public Engagement

Work with the community to improve its health and well-being by forging partnerships and collaborating with those we serve.

4. Support a Positive Work Environment

Enhance quality care by fostering a work environment where staff are valued, supported and accountable, and who reflect the diverse nature of our community.

5. Advance Research and Education

Work with stakeholders to enhance academic performance through development of an academic health science network where clinical education and research activities are better aligned and integrated.

6. Build Sustainability

Balance the provision of health care services with the available resources to ensure a sustainable health care system.

The Strategic Directions outlined above are designed to build on the previous Strategic Plan established in 2005.



Healthy People,
Vibrant Communities,
and Care for All.



Winnipeg Regional
Health Authority
Caring for Health

Office régional de la
santé de Winnipeg
À l'écoute de notre santé