ASSESSING THE RESPONSIVENESS OF HEALTH CARE ORGANIZATIONS TO CULTURALLY DIVERSE GROUPS

BY

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A Thesis
Submitted to the Faculty of Graduate Studies
In Partial Fulfilment of the Requirements
for the Degree of

DOCTOR OF PHILOSOPHY

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THE UNIVERSITY OF MANITOBA

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ABSTRACT

This dissertation describes the development and pilot-test of a document review instrument designed to assess the responsiveness of health care organizations to culturally diverse groups. A draft document review instrument, based on "best practices" identified in the international literature and the results of an initial scan of seven health centers, was piloted at a Canadian paediatric care facility. Best practices were grouped into eight domains: each domain listed documents where one would expect to find evidence of best practice. The instrument also assessed seven "dimensions" of organizational approach to addressing issues of cultural diversity. Preliminary conclusions reached through the document review were compared with data collected through other methods (key informant interviews, a parent focus group, an organizational feedback session and observational methods), and with results of previous self-assessment activities.

The results suggest that both the extent to which the organization had adopted best practice, and the underlying approaches to addressing issues of cultural diversity, can be identified through a document review approach. Results from the document review were not, however, consistent with results from organizational self-assessment activities at the same site. Further research is needed to determine whether the results from the pilot can be generalized to other organizations. While the pilot indicated that minimal resource demands are required to conduct a document review, there is insufficient evidence from this pilot to determine whether the review results would be sufficiently compelling to promote organizational change. Any assessment process used in Canada must reflect the Canadian cultural, historical and health care context.

ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

This dissertation describes the development and pilot-test of a document review instrument designed to assess the responsiveness of Canadian health care organizations to culturally diverse groups. A draft document review instrument was developed, based on an extensive literature review to identify best practice in the area of cultural responsiveness, and the findings from application of a brief guide that was used for an initial scan of publicly available documents from seven Canadian paediatric health centres. The expanded instrument was piloted at one site, a Canadian paediatric care facility.

In order to develop a tool appropriate for assessing the cultural responsiveness of health care organizations, this dissertation first explores key concepts on which assumptions of "cultural responsiveness" are based. There are at least two traditions of discourse and analysis around provision of appropriate and effective care for culturally diverse populations – "access" and "cultural competence." In this dissertation, the term "cultural responsiveness" is used to describe the ability of individuals and organizations to respond in appropriate and effective ways to the health and health care issues of diverse cultural communities.

A review of the literature reveals important underlying differences in approach to addressing issues of cultural diversity in provision of health care. In spite of these differing perspectives however, the literature suggests an emerging consensus on proposed "best practice" related to cultural responsiveness. This includes a shift in focus

of cultural responsiveness interventions (a) from "caring" to health outcomes; (b) from individual providers to systems of care; and (c) from definitions of culture focused on ethnicity to recognition of complex cultural identities.

Several initiatives have explored strategies for assessment of cultural responsiveness at the organizational level. However, many are designed for only one health area, or for use in one jurisdiction. Few have been developed for use in Canada. Much of the literature related to cultural responsiveness comes out of the United States. Differences between the United States and Canada (e.g., in health system organization; legislation, monitoring and enforcement of standards related to cultural responsiveness; data collection; priority populations; and consensus building activities) must be considered in design of an assessment instrument to ensure that measures are appropriate to the Canadian political, cultural, and health care context.

Many instruments rely on self-assessment approaches even though there are concerns about the limitations of self-assessment strategies in this area. An extensive literature review failed to identify any assessment instruments that focused only on a document review strategy, or that attempted to identify underlying organizational approaches to addressing issues of cultural diversity.

Research Design and Implementation

Based on preliminary activities conducted with the National Network for Cultural Competence in Paediatric Health Care (including an initial scan of publicly available

documents from seven participating health centres, and an assessment of the potential of Canadian Council on Health Services Accreditation standards for promoting cultural responsiveness in health care), the investigator developed an instrument designed to assess organizational cultural responsiveness through the process of document review. The instrument included eight domains: (a) General profile of cultural responsiveness; (b) Human resources; (c) Cultural training; (d) Language access services; (e) Organizational framework and integration; (f) Information for clients and communities; (g) Data collection, evaluation, and research; and (h) Partnership with the community. It also addressed seven "dimensions" of approach to addressing issues of cultural diversity: (a) definition of "culture" and "cultural group"; (b) multicultural or anti-racist orientation; (c) voluntary or required action; (d) individual or organizational focus; (e) provider competence or client/community access focus; (f) approach to human resource management; and (g) approach to cultural training. The draft instrument was reviewed, before field-testing, by the Steering Committee of the National Network for Cultural Competency in Paediatric Health Care (a network of health care professionals who focus on the promotion of culturally competent services).

The assessment instrument was piloted at one site, a paediatric care facility in a mid-sized Canadian city. A communication plan to inform staff about the research was developed and implemented in conjunction with an Advisory Committee established at the test site. This committee assisted in locating organizational documents identified in the instrument; provided guidance on organizational structure and reporting; made suggestions of individuals who could be included in the key informant interviews; and acted as liaison between the investigator and organizational management.

Following collection and analysis of organizational documents, preliminary conclusions were developed regarding the extent to which the organization had adopted culturally responsive best practice and the approaches to addressing issues of diversity in health care indicated through the identified documents. The results from the document review were then compared with results obtained from key informant interviews, a parent focus group, observational methods, and an organizational feedback session.

Twenty key informant interviews were conducted. Interview participants were selected on their knowledge of, or responsibility for, domain areas outlined in the instrument. While the majority of key informants were organizational staff, a small number were representatives of community organizations. Interviews consisted of open-ended questions in a semi-structured format. Core questions focused on conceptualizations of cultural diversity, respondent assessment of organizational responsiveness, and perceived areas of strength and needed improvement. In addition, informants were asked specific questions related to their area of expertise and/or responsibility. One parent focus group was held, the primary purpose of which was to explore the similarities and differences in parent and staff perspectives.

When the results had been analyzed, a feedback session on site-specific results of the document review (combined with data obtained from other methods) was conducted with organizational decision-makers. This session provided another opportunity to explore organizational perspectives. A detailed description of findings at the test site is not part of this dissertation, but was made available to the organization at that session.

Key Findings

A sufficient number of documents identified in the assessment instrument were located in each of the eight domains to allow development of preliminary conclusions related to organizational progress in adopting culturally responsive best practice. These documents also provided insights as to the underlying organizational approaches to addressing cultural diversity.

Comparison of results of content analysis of the documents with data obtained through other methods confirmed, and in some cases strengthened, preliminary conclusions about both the extent to which the organization had adopted best practice in each of the domain areas, and the underlying organizational approach to addressing cultural diversity along a number of the identified dimensions. The results also indicated that the document assessment made minimal resource demands on the sponsoring organization. Results from the document review were not, however, consistent with self-assessment results at the same site, reinforcing concerns identified in the literature regarding the limitations of self-assessment approaches in the area of cultural responsiveness.

The intensive exploration at one site, combined with the initial scan of seven health centres, identified a number of issues and themes related to cultural responsiveness of Canadian healthcare organizations. Awareness of current best practice and of the scope and limitations of assessment approaches appears limited in many centres. Organizational initiatives often appear to be driven by commitment of key individuals, rather than organizational policy or research evidence, and appear rarely to be incorporated into

overall strategic planning processes. Narrow definitions of "culture," based on fixed "racial"/ethnic categories appear to be prevalent. Initiatives for immigrant, Aboriginal, Francophone, and other cultural groups are often addressed in isolation from each other. The emphasis on cultural training rather than workforce initiatives observed in many centres reflects a "multicultural" approach to diversity. This approach reflects a belief that lack of understanding of cultural differences is the cause of any problems, and that the most appropriate intervention is to provide cultural awareness training. Review of organizational documents also suggests reliance on voluntary, individual responses rather than required action at the organizational level; and a focus on improving provider competence in working with diverse clients, rather than addressing barriers to client access and community participation.

There is preliminary evidence that the stress of health system restructuring may be contributing to additional barriers to culturally responsive care. In addition, the regionalization of health services – now underway in most provinces – may present challenges to both organizational assessment and to the integration of culturally responsive best practices into organizational structure and process.

Conclusions

The findings from this research indicate that a document review strategy shows promise in assessment of cultural responsiveness at the organizational level. It appears to provide results that are more consistent with organizational practice than self-assessment approaches, the dominant approach used to date. The results suggest that both adoption of organizational best practice within identified domains of cultural responsiveness and the

underlying approaches to addressing issues of cultural diversity can be identified through such a review. As the literature suggests that the underlying philosophy on which interventions are based may affect both the strategies adopted and the effectiveness of these strategies, further development of these assessment approaches is warranted.

However, valuable information was also gathered through observational methods, key informant interviews, and focus groups. These methods provide perspectives on larger community issues, the level of consensus/dissonance between various stakeholders, and the historical and political context in which interventions have been developed to date. This information is essential for planning and should be incorporated into any assessment process.

Revisions have been made to the instrument as a result of the pilot, and changes made in the definitions of and the elements included in some domain areas. Questions designed to guide exploration of organizational approach on each of the seven dimensions have been refined and expanded. However, the results of the pilot suggest that it is the *process* of undertaking the review that should be emphasized, rather than the specific elements contained in the instrument. The instrument requires a good knowledge of the diversity literature and research related to cultural responsiveness best practice. It is not intended for self-assessment.

A document review process can be conducted with little impact on the resources of sponsoring organizations. However, unless time is built into the assessment process for organizational orientation, involvement, and feedback, organizations may not find the

results sufficiently credible or compelling to promote action. This research was unable to assess the potential of a document review to promote awareness and organizational change, as commitment to organizational follow-up was not part of the agreement with the sponsoring site.

Additional research is needed in two key areas. First it is necessary to explore the extent to which findings from this preliminary research can be generalized to other settings. A larger pilot – including organizations at various stages of development of cultural responsiveness initiatives – is required. This expanded pilot should ensure organizational commitment to the assessment at senior levels of the organization (including a commitment to develop an action plan based on assessment results), strategies for organizational involvement, and adequate time for education, feedback, and interpretation of results.

Additional research is also needed in the area of knowledge translation, in order to determine the most effective strategies for addressing the specific challenges related to cultural responsiveness research. It is necessary to identify strategies to facilitate and promote organizational interest and engagement in cultural responsiveness research, as well as to test the effectiveness of various strategies to promote adoption of best practice.

PREFACE

Overview of Research

This dissertation describes the development and pilot-test of a document review
instrument designed to assess the responsiveness of health care organizations to culturally
diverse groups. A draft document review instrument was developed based on an
extensive literature review that identified best practice in this area, and the findings from
application of a brief guide used for an initial scan of seven Canadian hospitals. This
instrument was piloted at one site, a Canadian paediatric care facility. Preliminary
conclusions reached through the document review were then compared with data
collected through other methods – key informant interviews, focus group, feedback
session, and observational methods – and with results of previous self-assessment
activities previously undertaken at the same site.

Organization of Dissertation

The first section summarizes the context and background of the research. **Chapter 1
(Introduction and Description of the Context of Research***)* introduces the context in
which this study of one strategy for assessing the cultural responsiveness of health
organizations takes place. **Chapter 2 (Conceptual Framework)** provides a critical
discussion of the literature related to cultural competence and access to health care in
order to propose a theory of cultural responsiveness on which this research is based.
Chapter 3 (Best Practices of Culturally Responsive Organizations) focuses on how

research has guided development of best practices within health care and identifies

priorities for future research in the field. It includes a review of findings of preliminary

activities undertaken with the National Network for Cultural Competency in Paediatric

Health Care, describes the rationale for development of a document review process, and

outlines strategies used in developing the instrument.

The second section, **Chapter 4 (Research Design and Implementation)** summarizes the

project design, objectives and methods, and discusses ethical considerations in

conducting the research.

The third section discusses findings from the application of the instrument at the test site.

Chapter 5 (Results: Pilot of Assessment Instrument) discusses application of the pilot

instrument, how findings from the document review compared with results using

qualitative methods (key informant interviews, parent focus group, and observational

methods), as well as implications for future assessment. It also compares the results from

the document assessment instrument with self-assessment approaches at the same site.

Chapter 6 (Cultural Responsiveness of Canadian Health Organizations) explores

some of the themes and issues emerging from the pilot, the initial scan of hospitals, and

current Canadian planning activities. The final chapter, **(Summary and Conclusion)**,

explores the contributions and limitations of this research, as well as suggested directions

for future research.

Terminology

Terminology related to cultural diversity is often contentious. A glossary of terms, as used in this dissertation, can be found on pages xxiv-xxv. Table 2, on page 55, provides an outline of some of commonly used definitions as they relate to "categories" of diverse and underserved populations. Many of the terms related to culture are explored in detail in the text itself, particularly in Chapter 2. Terms that are commonly used in the literature, but where there may be concerns about accuracy, where the meaning may be contested, or where there are many variations in how terms are interpreted – e.g. "race", "minority" or "cultural competence" – have been placed in quotation marks.

Format

The body of the text is in regular font. Direct quotes from transcripts of interviews and focus groups, as well as from the cited references, are in italics. Excerpts from interviews and focus group use only thematic quotes, and to do not refer to the specific question asked, although they are placed within the context of the topic discussed.

The agreement made with the test site and key informants was that the focus of the research would be on evaluation of the instrument, not the test site. The commitment to masking the test site and identity of individual informants has also resulted in removal of identifying information from quotes and case examples.

GLOSSARY

Aboriginal: All indigenous person of Canada of North American Indian, Inuit or Métis ancestry.

Culture is defined for the purposes of this research as aspects of individual and group identities that include language, religion, ethnicity, gender, experience of migration/immigration, social class, political affiliation, family influences, age, sexual orientation, geographic origin, and other life experiences. Chapter 2 of this dissertation explores the various interpretations of culture, as well as responses to cultural diversity.

Dimensions: In this dissertation, the term "dimensions" is used to describe a number of identified approaches to responding to issues of cultural diversity. These are described in section 2.5, pages 52-81.

Discrimination: An act of differential treatment toward a group, or an individual as member of group. Discrimination may be deliberate or unintentional. *Systemic discrimination* results from seemingly neutral policies, practices, and procedures that have different – and often unintended – effects on different groups of people.

Diversity: This term is used to describe variation between people in terms of a range of factors such as ethnicity, national origin, gender, ability, age, physical characteristics, religion, values, sexual orientation, socio-economic class, or life experiences.

Domains: Thematic areas related to cultural responsiveness. This dissertation defines eight domains that provide the organizing framework for the document assessment instrument. The domains used are listed on page 132.

Ethnic group: An ethnic group shares a common language, "race", religion or national group.

Equality: A situation where all are treated the same.

Equity: Equality of opportunity, access, and outcome. *Equitable access* in this document refers to the provision of health services in a way that provides an equal opportunity for all citizens to achieve optimal health.

Knowledge Translation: "The exchange, synthesis and ethically-sound application of knowledge – within a complex system of interactions among researchers and users" (Canadian Institutes of Health Research, 2003a). *Knowledge transfer* is often used interchangeably with the term knowledge translation: however, it is also used to refer simply to the process of passing knowledge or skills along to specified audiences.

Minority: A misleading term to describe non-dominant ethnic identities. Minorities are not always minorities in numbers.

Multiculturalism: An official policy of the Canadian government recognizing the diversity of Canadians in ethnicity, national or ethnic origin, colour and religion, as a fundamental characteristic of Canadian society. In this dissertation however, *the multicultural approach* refers to a specific approach to addressing cultural diversity within health care. This approach is described on pages 58-63.

National Network Steering Committee. Steering Committee of the National Network for Cultural Competency in Paediatric Health Care, which acted as an expert review committee in preparation of the draft instrument.

Organizational culture: The values, customs, and traditions shared by members of an organization.

Race. A term used in the past to define a biological category used to classify humans based on physical characteristics such as skin colour, hair texture, stature, and facial features. Race as a biological category has been discredited, and "race" is now recognized as a social category. Therefore many object to use of the term and state that there is only one human "race". Some prefer the use of the term *"racialized"* which indicates that the characteristics of race are socially determined.

Site Advisory Committee: Committee established at the test site to guide the pilot of the assessment instrument.

Stereotype: Belief held about the presumed physical, psychological, and social characteristics of individuals based on their membership in a specific group of people.

Underserved areas: Geographic regions, usually rural and remote, that experience difficulty in recruiting and retaining a sufficient number of health personnel to meet the needs of the population, and/or are undersupplied with certain health services.

Underservice: The increased likelihood that individuals will, because of their membership in a certain population, experience difficulties in obtaining needed care, receive less or a lower standard of care, experience differences in treatment by health personnel, receive treatment that does not adequately meet their needs, and/or be less satisfied with health care services (Bowen, 2000).

Visible minorities: The Employment Equity Act of Canada defines visible minorities as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour".

CHAPTER 1: INTRODUCTION AND DESCRIPTION OF THE CONTEXT OF RESEARCH

This chapter summarizes the context in which the research project was conducted. The first section briefly outlines the development of interest in "culture" within healthcare, including the current forces now affecting research on cultural diversity and health disparities. The second section focuses on the Canadian policy and cultural context for research in this area. The particular importance of cultural responsiveness in provision of paediatric services is also reviewed.

Context of Research

The Development of Interest in "Culture" Within Health Care

Over the past few decades, there has been increasing recognition of the critical role of culture in the experience of health and illness. Although exploration of the concept of "culture" has a long history in the field of anthropology, incorporation of the concept with health services has been relatively recent. Among academics and researchers, the work of Kleinman (1980) in the 1970's focused attention on the importance of culture to the experience and expression of health and illness. In the field of nursing, Leininger (1978) developed and promoted the concept of "transcultural nursing", which has continued to influence the nursing profession. Since that time many thousands of books, articles, and monographs have been written on the topic of health and culture. However, much of this work uses simple definitions of culture, often disconnected from the disciplines of anthropology or other social sciences.

It is now generally accepted by health care providers that an individual's "culture" is important to his or her understanding of the causes of disease, as well as to beliefs and attitudes related to health maintenance, accidents, disability and death. It is also commonly understood that this "culture" may affect how symptoms are expressed, how issues are communicated to providers, and what is expected of those providers. While it is generally recognized that providers have an obligation to respond to this diversity in sensitive and appropriate ways, it has been only recently that the impact of health providers' attitudes towards cultural groups (and the effect of provider attitudes and behaviors on health disparities) has been explored (van Ryn, 2002). Far less attention has been given to the "culture" of health care and of individual providers (Hahn, 1995) than to the "culture" of clients.

Recognition of the demographic changes that have resulted in increased diversity of both the patient population and the health workforce in North America have given greater urgency not only to the need for providers to be sensitive to individual needs, but for health systems to develop the knowledge and skills necessary to meet the needs of diverse communities. By the late 1980's, the growing consensus that cultural awareness and sensitivity were "not enough" to provide quality care led to a shift from a focus on cultural awareness and sensitivity to a demand for competence (Chin, 1999). In 1989, the monograph *Towards a Culturally Competent System of Care* (Cross, Bazron, Dennis & Isaacs, 1989), considered by many to be a seminal work in the field, was published. The concept of "cultural competence" has since made its way into the language and

practice of the health system. At the same time, the role of "access" – and barriers to it – in the health and health care of underserved groups has also received increasing attention.

Many different reasons are given for undertaking initiatives to address the "cultural" needs of health system users. It may be viewed as the moral and ethical thing to do (Emanuel, 1996; Richardson, 1999); a means of complying with required legislation and standards (Office of Minority Health, 2001a); a way to express caring across cultures (Leininger, 1995); a means for increasing participation and compliance (Kinsman, Sally & Fox, 1996); a way of increasing cost effectiveness (Goode, Sockalingham, Brown, & Jones, 2001; Hampers, Cha, Gutglass, Binns, & Krug, 1999; Hampers & McNulty, 2002; Health Human Resources and Services Administration, 2001; Hornberger, 1998); a strategy to improve health outcomes (Brach & Fraser, 2000; Office of Minority Health, 2001a; Shaw-Taylor & Benesch, 1998); or a way to protect organizations from liability due to medical errors and rights violations (Paez, 2003a). In the United States an interest in providing accessible and effective care to cultural communities is also fed by economic imperatives as a private system recognizes that ethnic "minorities" make up an increasing "market share" of the North American population (Cohen & Goode, 1999; Health Resources and Services Administration, 2002; Herreria, 1998; Rutledge, 2001). There is increasing emphasis on the "business case" for culturally responsive care (AMSSA, 2000; Gandz, 2001; Paez, 2003a).

Most recently, however, the drive for more "culturally effective care" has been fuelled by increasing research generating evidence of disparities in health between ethnic/"racial"

groups; the impact of these disparities on the health of society (Kawachi & Kennedy, 2002; Wilkinson, 1996); and the failure of the service delivery system to be responsive to all segments of the population (Carrillo, Green & Betancourt, 1999; Chin, 1999; Cohen & Goode, 1999; Geiger, 2001; Office of Minority Health, 2001a). In the United States an important focus of research in recent years has been on differences in health status, utilization, and quality of care between various ethnic /"racial" groups. It has become apparent that even when economic factors (socio-economic status or health insurance status) are accounted for, there remain disturbing differences not only in health status but also in access to care and quality of care received by various ethnic/"racial" groups (Collins et al., 2002; Smedley, Stith & Nelson, 2002).

In Canada, there is striking evidence of the poorer health status of Aboriginal peoples (Health Canada, 1999; Martens et al., 2002; Tjepkema, 2002). In contrast, immigrant (though not refugee) populations are found to have higher health status on arrival than the Canadian-born, although this advantage moderates over time and approaches the Canadian norm (Hyman, 2001). Potential differences in quality of care for culturally diverse groups have, however, received little research attention in this country. While there is increasing discussion of the need for increased "cultural competence" (Canadian Nurses Association, 2003; Kueber, Maloff, & Penman, 2002; National Network for Cultural Competency in Paediatric Health Care, 2002), the tradition of discourse around care for culturally diverse groups in this country has tended to focus on the language of "access" for populations underserved by the health care systems (Bowen, 2000; Federal, Provincial and Territorial Advisory Committee on Population Health, 1999).

Defining "Cultural Responsiveness"

Because there are at least two distinct traditions ("access" and "cultural competence") in the discussion of issues related to the health and health care of culturally diverse populations (as well as important conceptual and philosophical differences in the use of the commonly used term "cultural competence"), in this dissertation I will refer to effectiveness in addressing health care needs and concerns as "responsiveness" to diverse communities and populations. This action is taken with the hope of facilitating a broad discussion of the domains involved in providing equitable and effective care to a diverse society, and encouraging critical analysis of various approaches to providing such care. Such "responsiveness" is defined simply as the ability of individuals and organizations to respond in appropriate and effective ways to the health and health care issues of diverse cultural communities. How that "responsiveness" is defined at an organizational level will be discussed in more detail in Chapters 2 - 3.

The Canadian Policy and Cultural Context

"Any health system is an outgrowth of the political culture, the social and moral values and the economic imperatives of the society it services. One cannot make neat distinctions between the legal, ethical, clinical, political and economic factors which all play a role in shaping the country's health care system." (Canadian Bar Association Task Force on Health Care, 1994:1)

The historical emphasis in Canada on "access" rather than on "cultural competence" in health care can be partly explained by a review of the history and cultural environment for provision of health care in this country.

Canada's system of universal health insurance grew out of a commitment to removing financial barriers to health care for all Canadians. The country provides universal medical coverage to all its citizens under the terms of the Canada Health Act (1984). The Canada Health Act (CHA) is based on five principles: universality, portability, accessibility, comprehensiveness and public administration. It states that the primary objective of Canadian health policy is to protect, promote, and restore the physical and mental well-being of residents of Canada, and to facilitate "reasonable" access to health services. As a nation, Canada is therefore committed both to health promotion and protection (keeping people healthy) and to restoring well-being (treating them when they are not healthy). Although health care is a provincial responsibility, the Canada Health Act states that the insurance plan of a province

> *must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by user charges made to insured persons or otherwise, reasonable access to those services by insured persons.*

The Canadian system of universal health insurance is part of a larger commitment to social welfare programs, which grew out of a philosophy of mutual aid and a willingness to protect the less fortunate. The health system is intended not only to remove financial barriers to health services, but also to be part of an environment of social support. However, the emphasis on financial barriers as the primary factor affecting "reasonable access" has resulted in less attention to other factors. For example, penalty provisions in the Act focus on user fees and extra billing.

Today, Canada is considered to have one of the best health systems in the world and ranks well above most other countries on most measures of population health. With the

exception of services for refugee claimants (Citizenship and Immigration Canada, 1998)

and jurisdictional issues surrounding health services for First Nations peoples (O'Neil,

Lemchuk-Fauel, Allard, & Postl, 1999; Royal Commission on Aboriginal Peoples, 1993),

there are few differences in explicit financial barriers to *insured* services faced by

underserved groups and the general population. Nevertheless, there are persistent and

troubling inequities in health status, and increasing awareness that a number of

populations are under-served by the health system in Canada (Federal, Provincial and

Territorial Advisory Committee on Population Health, 1999).

Because "access" is not defined, it is not clear what would constitute "reasonable" access

to healthcare. Historically, access has most often been defined simply as the absence of

explicit financial barriers, such as user fees (Birch, Eyles & Newbold, 1993). It has been

proposed that the emphasis on equality in access in Canada has been on equality of

treatment once a disease or condition has been identified, rather than to access to

assessment – which would identify conditions requiring treatment (Culyer, 1991). While

the passage of the Canadian Multiculturalism Act (1988) gave some support to the

development of initiatives in the area referred to as "multicultural health"[1] (Bowen &

Kaufert, 2000), health care issues have been peripheral to the debate around

multiculturalism in Canada.

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[1] In Canada, the term "multicultural health" generally describes a field of study limited to those of non-English, non-French immigrant backgrounds, and excludes both Aboriginal peoples and "cultural groups" not defined by ethnicity. However, in other countries, and within the counselling profession, the term "multicultural competence" is often synonymous with "cultural competence", discussed in Chapter 2.

To date, the focus of health policy and research in Canada has been on the removal of financial barriers to access, while other barriers (such as language or cultural barriers) have not been well explored. Increasing recognition of the importance of socio-economic status to health has reinforced this emphasis. As research priorities reflect the values and beliefs of a society (Krieger & Fee, 1994), it is not surprising that health services research in Canada has emphasized economic barriers rather than "racial"/ethnic differences. Not only was the Canadian health system designed to address financial barriers to care, but Canada's definition of itself as a "multicultural" country may also, according to critics, contribute to a tendency to minimize or ignore factors that may be associated with "race" or ethnicity, and to deny the existence of institutional racism (Bissoondath, 2002; Fleras & Elliot, 2002). Little Canadian-based research has explored the question of whether all cultural, religious, language or ethnic groups have "access" to the same quality of care as other residents, although issues of regional and geographic disparity have received significant attention. Therefore, with the exception of qualitative studies with underserved groups themselves, and some research related to registered First Nations, little is known about non-financial barriers to health care for "ethnic" or racialized groups in Canada.[2]

Comparison of Canada and the United States in Addressing Issues of "Culture"

As much of the "cultural responsiveness" literature originates in the United States, it is important to reflect on important differences between the two countries in history, legislation, and health system organization. Although the instrument developed for this

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[2] A proposed framework of terminology used to describe membership in various underserved and culturally diverse groups is described in Table 2, page 55.

research was designed for use in Canada, much of the research on "cultural competence" has been undertaken in the United States. This section provides a brief overview highlighting some examples of these differences (organization of the health care system, legislative framework, data collection, priority populations, and recent consensus building activities). These issues, which have had an important impact on the development of the concepts of culturally responsive "best practice", are revisited in Chapter 3, where the questions of how "best practice" is determined, and what "best practices" are appropriate for application in Canada are addressed.

Organization of the Health Care System

Perhaps the most obvious difference between the two countries is the absence in the United States of a national system of health insurance, with the result that tens of millions of Americans are without health insurance, and there are important differences in service availability based on health insurance status. As a result, one of the major factors considered in health research in the United States is insurance status – which is recognized to be both a marker for socio-economic status and a determinant of access and care received.

Another major difference is the growth of managed care organizations in the United States. The focus on cost containment within these organizations, and "the business case" orientation that results from this focus, has had an important impact on cultural competence initiatives in the United States, and has contributed to much of the recent research in this area.

It is important also to note that the context of "access" in a country such as Canada cannot be assumed to be the same as in countries without universal health coverage, even when comparing groups with equivalent insurance status. This is because the "social insurance" form of Canadian health coverage operates from very different principles than that of private health insurance, which is based on the principles of actuarial fairness (Stone, 1993).

Legislation, Monitoring, and Enforcement

Another important difference between the United States and Canada is the presence in the United States of specific legislation (Title VI of the 1964 Civil Rights Act and the Americans with Disabilities Act of 1990) requiring health organizations to provide language and cultural access for "minority" groups (Perkins & Vera, 1998). For example, Title VI of the United States Civil Rights Act states

> *No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.*

This provision has significant influence as the two national insurance plans – Medicare (which covers older Americans) and Medicaid (which covers individuals on welfare) – require providers to comply with the provisions of the Civil Rights Act. Recently, there have been specific policy guidelines requiring recipients of federal funds to provide equal access to all members regardless of the language they speak (U.S. Office of Civil Rights, 2001). There is a bureaucratic structure for monitoring and actively enforcing civil rights violations, with regional offices of the Department of Health and Human Services and of Civil Rights assuming an active role in monitoring compliance, identifying violations,

and enforcing the responsibilities of federally funded programs (including hospitals,

managed care providers, clinics and other health and social services programs). In spite

of such provisions, however, concerns have been raised regarding the effectiveness of

this enforcement (Stork, Scholle, Greene, Copeland, & Kelleher, 2001).

Unlike the United States, where issues of access and cultural competence have been

framed as "minority rights" issues, in Canada rights to linguistically and culturally

appropriate service are addressed by the Official Languages Act, interpretation of the

Canadian Charter of Rights and Freedoms, and federal and provincial human rights

legislation. Passage of the Official Languages Act in 1969, entrenched in law the rights of

both English and French speakers to a range of services in their own language.

Aboriginal languages have special recognition as protected languages in some regions

(Bastarache, Braen, Didier & Foucher, 1987), and with the creation of Nunavut, Inuktituk

has become an official language of the territorial government. There are also unique

jurisdictional issues related to health services for First Nations peoples, which remain the

responsibility of the federal government. Language and other access issues faced by

immigrants have not been directly addressed in legislation, and have generally been

understood as "newcomer" issues (rather than "minority rights" issues) that will naturally

resolve over time. There are no requirements to ensure language access to health services

for these populations.

Global provisions in the Canadian Charter of Rights and Freedoms are similar to U.S.

statutes prohibiting discrimination on the basis of factors such as "race", colour, and

national or ethnic origin; however, Canada lacks the monitoring and enforcement framework present in the United States. Rights to health care "access" are not made explicit (Bowen & Kaufert, 2000), leading to a situation where claims of "rights" must be brought forward by stakeholder groups (as legal challenges under the Canadian Charter of Rights and Freedoms, for example). Federal support for enforcement has been limited, and much responsibility is at the provincial level, resulting in significant interprovincial variation.

One example of a challenge under the provisions of the Canadian Charter of Rights and Freedoms is the "Eldridge" case (Eldridge v. British Columbia [Attorney General], 1997). This case was a challenge to limited language access made by three individuals who were born deaf and preferred to use American Sign Language. Their claim was that British Columbia's Health Care Services Act violated the provision of the Canadian Charter of Rights and Freedoms. They asserted that lack of provision of sign language interpreters – the service had been discontinued in 1990 because of budget cutbacks – caused them to receive a lesser quality of care. While the "Eldridge" decision confirmed the rights of Deaf patients to medical interpretation, this challenge was pursued under the disability provisions of the Charter, and it was specifically noted that the decision was not setting a precedent for other language groups (Stradiotto, 1998; MacDougall, 2000). The Canadian Human Rights Act also addresses "accessibility" directly only as this relates to persons with a disability.

Data Collection

In the United States, unlike Canada, health data is routinely categorized based on "race" and ethnicity. Early U.S. censuses recorded data on white free persons and slaves; the concepts of "free" and "slave" evolved to those of "white" and "black." Until recently, "race" was defined in white/black terms, with other "races" being marginalized (Nobles, 2000). However, the growing number of immigrants from other countries has forced the concept of "race" to undergo enormous change. Additional "racial" categories have been added, based on "origin" in various world regions. The Office of Management and Budget requires five minimum "racial" categories, and who is to be included in these categories is well defined. Funded health research generally requires collection of health data according to these determined categories. Categorization by "ethnicity" defines all individuals as either Hispanic/Latino or non-Hispanic/Latino. It has only been recently, however, that research in the United States has begun to focus on financial barriers to care and to improved health status.

In Canada, historically more attention has been paid to factors such as ethnic origin, Aboriginal status and language, than to "race." Canada, which grew out of a resolution of conflict between two European powers, has historically paid close attention to the numbers and characteristics of the French and English "stocks" in its population, and also tracked how other "multicultural" populations were blending with, and affecting numbers of, these two dominant groups (Kralt, 1980). Tracking the numbers and status of Aboriginal peoples has also been an important objective, with detailed data collected on Aboriginal status (Inuit, Status, non-status, Metis). Since 1996, the Canadian census has

also collected data on visible minority status, however, unlike the United States, these categorizations are not included in health data collection systems. Aboriginal peoples are not defined as a "race," but as an ethnic group, and are not included in the visible minority categorization. Canada can, therefore, be described as categorizing the population into three broad "racial" groups: whites, Aboriginals, and other non-white, non-Aboriginal peoples.

While health information is collected on Status Indians, this is the result of federal jurisdiction for health of First Nations peoples; the same requirements do not apply to non-status and Metis individuals. Data on First Nations peoples has been collected because of the historical relationship of the federal government with Aboriginal people; "status" is a legal category which historically has been used to limit and define different rights for Aboriginal people, and to differentiate between individuals for whom there were differing jurisdictional responsibilities. Data on French and English language use, a key question in the Canadian census, is inconsistently collected in health data. Significantly more research attention has been directed to examining the impact of income on health status and service utilization.

The tradition of collection of "race" statistics in the United States –supported by specific legislation – provides insight into a number of issues affecting utilization, quality of care, and health status that have not been addressed in Canada. When "race" as a biological construct was discredited (Goodman, 2000; Kreiger & Fee, 1994), it was often assumed that any observed "racial" differences were related to socio-economic status and financial

barriers, and that provision of coverage to uninsured persons would address access barriers. However, it has since been demonstrated that although much of the disparity between ethnic/"racial" groups can be explained by socio-economic factors and differences in insurance coverage (Krieger & Fee, 1994; Shi, 1999; Weech-Maldonado, Morales, Spritzer, Elliott, & Hays, 2001), disturbing differences remain.

While it is proposed that racism within the larger society may affect health status and health need (Krieger & Sidney, 1996), there is good evidence that in many cases the care provided also differs by "race" even when income, insurance status, and health status are controlled for (Mayberry et al., 1999; Smedley et al., 2002; Watson, 1994). This has led to an increased attention to non-financial barriers to access, and discussion of "minority health" within the context of civil rights (Watson, 1994). Relevant factors include those emerging from the clinical encounter (such as bias, clinical uncertainty, stereotypes, and patient's reaction to these factors) and those related to the operation of the health care system itself (issues related to the health care organization, or the larger health system) (Smedley et al., 2002). The availability of data categorized by "race" has facilitated research on social discrimination and racism, with the result that it is now underserved, racialized populations who are often the strongest supporters of collection of "racial" and ethnic data.

In Canada, however, collection of such data remains controversial. There is not a national consensus on ethnic coding of health data, and "race" is often seen as a proxy for socio-economic status (Robinson, 1998). "Race", however, becomes invisible if not recorded.

The availability of data on First Nations communities (because of coding by Treaty status) for example, has highlighted significant gaps, on almost every health indicator, between First Nations peoples and the general Canadian population. It has been an important factor in directing attention and resources to First Nations health issues. The absence of such data on other cultural communities makes it possible for Canadians to avoid the question of whether, like the United States, patients of different ethnic/"racial" backgrounds receive different treatment from the health care system.

Priority Populations

As suggested in the previous section, priority populations (defined either in terms of total populations, or based on health status and access barriers) differ between the two countries in important ways. In the United States, the historical division between "black" and "white" has directed attention to health differences between the two populations. It has long been recognized that the "black" population experiences lower health status, although the explanations for this have evolved over time. Recent research has also highlighted the differences in care received by black patients, resulting in open discussions of racism and discrimination within the health care system (Smedley et al., 2002). The growing numbers of Hispanic/Latino citizens has resulted in Spanish being the second language in the country (although it does not have official status), with much language access research focusing on this population. This research is facilitated by the requirement to collect data based on Hispanic/non-Hispanic ethnic categories.

In Canada, Aboriginal peoples are recognized as having lower health status than other populations. This is attributed to widespread and historical inequities in socio-economic status, racism, and social injustice. The recognized health and social inequalities, the unique historical and jurisdictional issues related to federal responsibility for First Nations health, interest by many Aboriginal peoples in self-determination of health services, and the initiation in 1986 of a program to transfer control of First Nations health services to First Nations people themselves, have all served to focus increased attention on Aboriginal health issues. Health access for Francophones outside of Quebec (and to a lesser extent, Anglophones within Quebec) is a priority, as official language rights have been defined in legislation. Health care accessibility for Canadians living in rural, northern and remote communities also remains a concern. While increasing attention is directed to the issues facing new immigrants, this is often limited to the large Canadian cities that currently receive the largest numbers of new arrivals.

Consensus Building Activities

In addition to legislation providing a framework for development and monitoring of services for underserved populations, there have been – particularly over the last five years – a number of activities that have focused attention on "cultural responsiveness" in the United States. A high profile multi-year national initiative intended to develop national consensus on standards for culturally and linguistically appropriate care, sponsored by the Office of Minority Health, resulted in the report "National Standards for Culturally and Linguistically Appropriate Services in Health Care" (Office of Minority Health, 2001). This report has helped frame discussion of cultural responsiveness issues,

promoted development of standards and guidelines, and provided a base for further research. The 2002 Institute of Medicine report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" (Smedley et al., 2002) focused attention on the extent of – and explanations for – identified health disparities between various ethnic / "racial" groups that cannot be explained by income or insurance coverage. "Cultural competence" has been identified as a key issue in standards for managed care and quality management at the national level (Paez, 2003a, b).

In Canada, in contrast, there have been very few national initiatives focusing on cultural responsiveness. A national consultation on language access in health care (Rochefort, 2001) resulted in little follow-up. Although some provinces have undertaken specific initiatives, they are not nationally coordinated. Issues of cultural responsiveness have not received high profile attention in recent health service review initiatives such as the Romanow Commission.

The Impact of Health Reform and Devolution to Regional Health Authorities

The demand for "increased responsiveness" to diverse cultural groups is taking place within the context of major changes within the health care system, and at a time when health services are facing a number of intense and competing demands. In many parts of the country, hospitals and other health services are coming under regional governance, and programs and services are being amalgamated. One of the stated objectives of regionalization is to make health services more responsive to the needs of local communities. Regionalization may provide the potential for larger, coordinated systems

to better respond to the needs of many smaller diverse groups. For example, provision of health interpretation for a small language community may be more feasible if the service unit is an entire region rather than one specific health service. There is, however, concern that needs of these diverse groups may fail to compete with other more pressing health service issues, and that smaller, less established communities may be at a disadvantage compared to more established and better represented stakeholder groups. Health restructuring may even risk compounding existing health disparities (Chin, 2000; Siegel et al., 2000). Bowen (2000) notes a number of challenges related to regionalization development of cultural responsiveness:

- Underserved populations have not traditionally been represented in decision-making structures;

- Data collection systems do not collect data in a way that assists in identifying or measuring needs of underserved groups;

- There is inadequate research on the non-financial barriers to access, or the needs of underserved groups resulting in neglect of these groups in planning;

- Traditional funding patterns have resulted in "access" services being excluded from core funding;

- A cost-containment emphasis results in reluctance to identify need for additional programs; and

- Effects of health care restructuring have focused public concern and planning responses on what are perceived to be more pressing issues (e.g., wait lists).

Additional difficulties may be experienced in implementing change in the large inter-institutional systems resulting from regionalization, as diverse "organizational cultures" must be brought together in the planning process (Jones, Bond & Cason 1998). Restructuring itself requires additional skills in navigating the system, which may place some groups at special disadvantage (Anderson, Scrimshaw, Fullilove, Fielding & Normand, 2003).

In addition, adoption by many planners of a population health approach to health, and an expanded focus on broad health determinants, has tended to de-emphasize the importance of health services in influencing the state of health of the population. In spite of the advantages of this approach, one result in Canada has been a lack of attention to the potential of inequities in health care delivery to function as a social determinant of health. Therefore, in spite of stated recognition of the need for cultural sensitivity, "cultural" issues may not be identified as a priority by health care planners.

Importance of Cultural Responsiveness to Paediatric Services

As will be discussed in section 3.6, this research grew out of developmental work with the National Network for Cultural Competency in Paediatric Health Care, a network of health care professionals in Canadian paediatric health care centres who are focusing on the promotion of culturally competent services. As it was necessary to pilot the draft instrument in a specific setting, there are a number of reasons that suggest it is

particularly appropriate to pilot an instrument to assess cultural responsiveness within paediatric health services.

In 2001, 18.4% of residents were not born in the country, and 6.2% of the population had arrived in Canada within the past 10 years (Statistics Canada, 2003b). Over the past few decades there has been a dramatic shift in source countries of immigration from Europe and the U.S.A., to the countries of Asia, Africa and Latin America. Immigrants from these countries are more likely to face both language barriers to care, and cultural differences with their health care providers. A higher percentage of the immigrant population, compared to the general Canadian population, is made up of children and youth. One in five school-aged children in Vancouver and Toronto arrived in Canada over the last 10 years (Statistics Canada, 2003b). In addition, a higher proportion of recent immigrants are in their childbearing years. For example, approximately 50% of immigrants arriving in 2000, compared to approximately 31% of the general population, were in the 25-44 year age group (Citizenship and Immigration, 2001; Statistics Canada, 2002). As a result, an increasing number of Canadian children are born into first generation immigrant families (Kobayashi, Moore & Rosenburg, 1998). Many new arrivals speak neither English nor French on arrival (61% of those arriving in the 1990s). Half of school-age children in Toronto speak a non-official language at home; this rises to 61% in Vancouver (Statistics Canada, 2003b).

Similar demographic trends are found among Canada's Aboriginal population, and in the north and the prairies, the Aboriginal population comprises a large proportion of the total

population. Over 1.3 million Canadians report Aboriginal heritage, a total of 4.4% of the total population (Statistics Canada, 2003a). Over one-third of the Aboriginal population, compared to one-fifth of the general population, is under the age of 15 (Statistics Canada, 1998), and higher fertility rates among Canadian Aboriginal women are contributing to trends of dramatic growth in the Aboriginal population in many regions (Canadian Institute of Child Health, 2000; Statistics Canada, 1998). This growth in population, combined with lower health status of Aboriginal children on most health indicators (Health Canada, 1999), creates an imperative for development of culturally responsive and effective systems of care within Canada's Aboriginal communities.

The health of a nation is in large part determined by the health of its children and their families (Campinha-Bacote, 1997). The period around childbirth and early parenting is often a family's first significant contact with health care services (Health Canada, 2000), and these experiences with the health care system can have a long term impact on future attitudes to care and patterns of utilization. Health care providers working with young families have an opportunity to strengthen bonds between family members, and therefore the well being of the developing family unit (ACOG Committee on Health Care for Underserved Women, 1998). Paediatric services offer unique opportunities for preventive care and education, interventions that have higher requirements for linguistic and cultural appropriateness. The literature dramatically illustrates the potentially devastating effects of failure to provide culturally responsive paediatric care, not only on the health of young patients, but also on the functioning of the entire family unit (see for example Fadiman, 1997; Flores et al., 2003; Free, Green, Bhavnani, & Newman, 2003;

Haffner, 1992; Holden & Serrano, 1989; Jacobs, Kroll, Green, & David, 1995; Ratliff, 1999).

Conclusion

The purpose of this chapter is to outline the context within which this research – development of an instrument for assessment of the cultural responsiveness of Canadian health organizations – takes place.

In the absence of Canadian research and planning, there may be a tendency to generalize results related to health status, utilization and outcomes from the United States (and other international settings) to the Canadian context. One cannot, however, assume that these findings are applicable, as there are significant differences between countries in health system organization, in the historical/legal/cultural context in which care to "minorities" is delivered, and in population density/diversity.

Many of the issues identified in this chapter will be revisited in subsequent sections, as one of the challenges of developing the assessment instrument was to determine how "best practices" should be identified, and to address specific issues related to their application in Canada.

CHAPTER 2: CONCEPTUAL FRAMEWORK

In order to develop a tool appropriate for assessing the cultural responsiveness of health care organizations – the focus of this research project – it is first necessary to explore key concepts on which assumptions of "cultural responsiveness" are based. As indicated in the previous chapter, there are at least two traditions of discourse around provision of appropriate and effective care for culturally diverse populations – "access" and "cultural competence." A review of the literature reveals important differences in underlying philosophy regarding the role of culture in health, and the best ways to respond to the needs of a culturally diverse population. These differences will also be explored.

Exploring the Concept of "Cultural Competence"

Over the past decade "cultural competence" has been receiving increasing attention within health care, and the concept has been addressed within different health disciplines and specialties (Hains, Lynch & Winton, 2000; Smith, 1998; S. Sue, 1998). Many professional organizations have developed position papers and standards (American Academy of Paediatrics, 1999, 2000, 2001; ACOG, 1998; American Nurses Association, 1991; National Network for Cultural Competency in Paediatric Health Care, 2002). How the term is interpreted, however, and to what extent the concept has been adopted, has varied across specialties. For example "technology-based specialties" are less likely to view cultural competence as relevant, whereas counselling and community-based or primary care programs have generally been more responsive. Nursing has tended to

focus on issues of patient care, with a common emphasis on expressing caring across cultures; whereas medicine has tended to place greater emphasis on skills related to diagnosis and issues related to increased prevalence of certain conditions by ethnicity (Lavizzo-Mourey & Mackenzie, 1996).

Interest in "cultural competence" is of course not limited to the health field. It has emerged as major issue in the fields of justice, education, social services, business, and intercultural/cross-cultural relations. Within the business world, responses to the increasing diversity of society focus both on reaching a diverse market and on workforce management, and are framed as issues of "organizational diversification" or "managing diversity". This is more apparent in the United States, and many authors view the U.S. as the leader in the "diversity movement" (Gandz, 2001; Glastra, Meerman, Schedler, & Vries, 2000). Within health care, organizational "diversity" or organizational "cultural competence" has only recently received the same attention (Weech-Maldonado, Dreachslin, Dansky, De Souza, & Gatto, 2002).

Defining Culture, Competence and Cultural Competence

Because the term "cultural competence" is so dominant in the literature, a critical evaluation of the concept requires that both "culture" and "competence" be defined (Smith, 1998)."Cultural competence" is an evolving concept, and while it is emerging as a new behavioural expectation, it is one that has not been well defined or developed, and there is not consensus on a theoretical framework that would guide action (Campinha-

Bacote, 1999; Chrisman & Schultz, 1997; Henry J. Kaiser Foundation, 2003; St Clair &

McHenry, 1999).

Defining Culture

The concept of culture, has its roots in anthropology (Helman, 1990), but is found in

many different disciplines (e.g. sociology, education, nursing, psychiatry, social work,

organizational theory). A variety of definitions of culture are assumed in the discussion

around cultural competence. The lack of consensus on definitions, and differing

assumptions about the nature of "culture," appear to underlie much of the current

controversy about the concept of cultural competence.

Many definitions of culture are closely aligned with those of ethnicity. For example

Spector (2000: 284) defines culture as: *"Nonphysical traits, such as values, beliefs,*

attitudes, and customs that are shared by a group of people and passed from one

generation to the next." Similarly, Leininger (1995:60) defines culture as *"learned shared*

and transmitted values, beliefs, norms and life practices of a particular group that guides

thinking, decisions, and actions in patterned ways."

Broader definitions include *"a shared system of values, beliefs and learned patterns of*

behaviours," which are *"not simply defined by ethnicity"* (Carrillo et al., 1999:829).

Some definitions expand the conceptualization of "cultural group" to include underserved

and under-represented socio-economic groups, people with physical or mental illnesses

or disabilities, children and adolescents, women, older adults and people at the end of

life, people of alternate sexual orientation, and people affected by such issues as domestic violence, homelessness, or organ donation (Betancourt, Green, & Carrillo, 2002; Donini –Lenhoff & Hedrick, 2000). Culture may be defined to include these broader aspects of diversity, or may be seen to be influenced by them (Canadian Nurses Association, 2000). Broader definitions are often, but not always, accompanied by the terminology of "diversity." At the extreme end of the continuum is the concept of diversity as *"anyone who is not me,"* and the use of the term "culture" to incorporate all aspects of the self (Coleman & Pope-Davis 2001).

It has been observed that religion or spirituality is often minimized in many definitions of culture, in spite of the importance of religious belief to the daily lives of many people (Barnes, Plotnikoff, Fox, & Pendleton, 2000; O'Hagan, 2001).

Concepts of "culture" are also used in organizational theory, where organizations are viewed as mini-worlds with their own values, beliefs, and practices. Definitions employed in this setting are often similar to definitions used within health professions. For example, Cox (1994:5) defines a cultural group as an *"affiliation of people who collectively share certain norms, values, or traditions that are different from those of other groups."* Organizations also have a "culture"; organizational culture can be defined simply as the *"way we do things around here"* (Burford, 2001: 190). "The role of organizational culture is to guide behaviour so that it is appropriate to the presumed needs of the organization" (Weiner, 1997:24).

Defining Competence

Competence can be defined as *"the capacity to function effectively"* Cross et al. (1989:iv)
or *"an ability or capacity equal to the requirement," "responding effectively to the*
purpose or goal" (McPhatter, 1997:255). There is less confusion about what is meant by
"competence," although there are different models for describing levels or stages of
cultural competence, and vastly different responses to the question of "competence in
what?" Underpinning the concept of cultural competence is the assumption that
competence somehow transforms knowledge and understanding into effective health care
responses or interventions.

Defining Cultural Competence

Every author defines competency somewhat differently – definitions may focus on the
process necessary to achieve cultural competence, the criteria to decide if it exists, or
necessary overarching principles (Chin, 1999). Conceptualizations differ markedly both
between and within health disciplines, even though there appear to be several areas of
overlap. Some current definitions include:

> *a complex combination of knowledge, attitudes and skills* (Spector, 2000: 284).
>
> *care that is sensitive to the differences individuals may have in their experiences*
> *and responses due to their heritage, sexual orientation, socioeconomic situation,*
> *ethnicity and cultural background* (Meleis, 1999:12).
>
> *an ongoing and interactive process, based on respect for others beliefs and*
> *traditions* (ACOG, 1998: 99).
>
> *showing respect for the rights, preferences, cultural values and mores of each*
> *individual co-worker and client, within the context of his or her reference group*
> (Dienemann; 1997:vii).

the process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client (individual, family or community) (Campinha-Bacote, 2002: 181).

an ability to provide services that are perceived as legitimate for problems experienced by culturally diverse persons (Dana & Behn, 1992:221).

the demonstrated awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy, ...which must be addressed in an integrated fashion (Lavizzo-Mourey & MacKenzie, 1996:919).

simply the level of knowledge-based skills required to provide effective clinical care to patients from a particular ethnic or racial group (US Department of Health and Human Services, 2002).

'Cultural competence' in health care entails: understanding the importance of social and cultural influences on patient's health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g. at the level of structural processes of care or clinical decision making); and finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003: 297).

Perhaps the most commonly accepted is the definition of Cross et al. (1989: iv) and will be adopted as the working definition assumed in this paper:

a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.

There has been a tendency for the concept of "cultural competence," now in common usage, to subsume other terms related to cultural knowledge and skill. While most writers differentiate "cultural competence" from concepts such as "cultural sensitivity," "cultural appropriateness," or "cultural congruence" (often seeing them as components of the larger construct), others make few distinctions. Similarly, some writers differentiate between terms such as cross-cultural, transcultural, intercultural or multicultural health

(Brink, 1999) where others do not (Purnell & Paulanka, 1998). These terms define a field

of study, whereas cultural competence focuses on a knowledge/skill set. "Culturally

sensitive" often refers to constructive attitudes towards diverse cultural groups and

addresses the affective aspect of cultural competence; "culturally appropriate" tends to

imply a knowledge of specific culture and services that are congruent with that culture. It

is often assumed that culturally appropriate care is best delivered by a provider from

one's own background. Leininger (1999:9) defines "culturally congruent" care as

providing *"care that is meaningful and fits with cultural beliefs and lifeways."* Culturally

appropriate or congruent care tends to emphasize the importance of mastering cultural

knowledge about other groups. The term "culturally effective health care" is preferred by

the American Academy of Pediatrics (1999), which states that this term refers to the

interaction between provider and patient, rather than focusing on the attributes of the

provider.

Most definitions of cultural competence include some combination of attitude (or

awareness), knowledge and skill. There is consensus that cultural awareness and

sensitivity is "not enough" to be competent – one must be able to perform effectively in a

cross-cultural setting (Cross et al., 1989). Most commonly accepted definitions

emphasize that cultural competence is a process rather than an end point (Camphina-

Bacote, 1999; Paez, 2003a; Sue & Arredondo, 1992). An important evolution is the

emphasis on "effectiveness" as a key criterion, however this is not included in all

definitions. As will be discussed in following sections, there are important differences in:

how "cultural groups" are defined; underlying theoretical perspectives; the focus of

cultural competence interventions; and the dimensions or components of cultural competence.

There are a number of different models of "cultural competence." However, these models may explain the constructs that are believed to make up cultural competence or the components of culturally competent care (Camphina-Bacote, 1999); the domains of "culture" (e.g. Purnell & Paulanka, 1998); the process of developing cultural competence (e.g. Cross et al., 1989; Lister, 1999; Papadopoulos, Tilki & Taylor 1998; Wells, 2000); or models for patient assessment (e.g. Davidhizar, Bechtel, & Giger, 1998). Many focus on individual rather than organizational development (Tator, 1998).

Is "Cultural Competence" Anything More Than Patient-Centred Care?

It has been argued that a "patient-centred" approach could address many of the concerns raised by proponents of cultural competence (Lister, 1999), and that cultural competence (or "cultural humility") must be based in the patient-focused interviewing process. The patient-centred approach recognizes that "*only the patient is uniquely qualified to help the physician understand the intersection of race, ethnicity, religion, class*" and other factors (Tervalon & Murray-Garcia, 1998: 121), and to clarify the relevance and impact of this intersection on the present illness or wellness experience. This approach asserts that all patients, not only those from designated racial and ethnic groups, have a "culture" that should be respected and affirmed.

In theory, patient-centred care should address the cultural background of all patients and include the full range of cultural factors (including, for example religious beliefs, education, or life experiences such as discrimination). It is not yet, however, evident that in practice, a patient-centred approach adequately addresses cultural issues. Communication skills research (Kaplan, Greenfield & Ware, 1989; Stewart, 1995; Stewart et al., 1999, 2000) generally does not include cross-cultural issues. Most research has been undertaken in a western setting, and has excluded linguistic minorities. It is not known whether concepts such as "patient-centredness" are transferable across cultures (Skelton, Kai, & Loudon, 2001). One study found significant differences in patient-centredness of interviewing when an interpreter was present (Rivadeneyra, Elderkin-Thompson, Silver & Waitzkin, 2000). In spite of these limitations, however, there is significant overlap between the two concepts that requires greater exploration.

Defining Access

The term "access," as it relates to health care, has also been variously and inconsistently defined by policy makers, researchers and the general public (Birch & Abelson, 1993). The Oxford dictionary defines accessibility as "capable of being used, entered or reached" and as "open to the influence of." This implies that access is more than availability: it assumes the provision of services in a way that is both responsive to the needs of users, and open to the participation of underserved groups in the planning of services.

In the health service literature "access" has been defined as "availability of service", "use of health care by individuals with a need for care", "ability of clients to acquire or receive services", "equal quality of care received", "affordability," or "wait times" (Birch et al., 1993; Bowen, 2000; Mokuau & Fong, 1994; Mooney, Hall, Donaldson, & Gerard, 1991). It is often used to describe distance or other physical barriers to use (Barer & Stoddart, 1999; Jones & Tamari, 1997). "Access" is also commonly used as a construct measured by the discrepancy between use and need, (Penchansky & Thomas, 1981), and so has become closely related to the concept of "barriers" – generally understood as those things that prevent or hinder access, however access is defined.

There is confusion about the range of factors included within the concept of access, the "location" of access barriers, or whether access is a characteristic of health services, or of clients. Access and availability are closely related terms – often used interchangeably – although availability usually focuses on presence of health services and personnel. In Canada, "reasonable access" is generally understood to mean equal access for equal need, however it is less clear whether access refers to the use of needed services or to the opportunity to use them.

Access or Utilization?

The concept of "access" is closely tied to – and often confused with – the concept of utilization; many writers view it as either synonymous with utilization, or as one or more factor influencing utilization (Penchansky & Thomas, 1981). While there are important distinctions between the two concepts, in Canada most research on access actually reports

on utilization. Mooney et al. observe that *"we have here what Bob Evans might describe as an example of 'moving the target to hit the bullet'. It is a case of measuring what is measurable – in terms of current technologies – i.e. utilization, rather than measuring the policy relevant variable i.e. access"* (1991:478).

There are a number of limitations to focusing on utilization. Utilization data are generally limited to insured services, usually delivered by physicians or hospitals. However, some of the greatest barriers to access are those to preventive services, for which utilization data are not maintained. Some access barriers (such as language) also prevent exposure to "ambient" health information such as social marketing campaigns or news items. If the purpose of health policy is not to provide health services but to achieve the best possible health of the population, measuring utilization is inadequate (Bowen, 2000, 2001).

Because in an equitable system, use of services should be associated with health status, differences in utilization do not necessarily tell us if barriers to access exist. Lower utilization may indicate barriers to access, lower need, or even different patterns of utilization for the same condition. For example, a recent review of the immigrant health literature (Hyman, 2001) found that utilization of health services by immigrants was less than that of the overall Canadian population. This is generally assumed to result from immigrants' higher health status; however, it may also be that under-utilization occurs because of barriers to access, or because of reliance on alternative providers.

Different barriers to "access" may also have different types of effects on utilization. Some barriers (e.g. barriers to initial access) may result in decreased utilization, particularly of preventive programs; while others (e.g. those that result in miscommunication, misdiagnosis, or lower patient understanding) may result in increased utilization (Blais & Maiga, 1999; Bowen, 2001; Siegal et al., 2000). The Metropolis project recognized that availability and utilization of services are inadequate to describe access and, in defining research domains related to access for immigrant groups, included questions related to racism, provision of culturally accessible services, and rights to access (Health Canada, 1998).

In the health literature, under or over-utilization has generally been conceptualized as resulting from personal choice. Attributing differences in service use to individual choice locates problems related to individuals or communities rather than on the structures and processes that prevent certain groups from having the same opportunities to use services, and thus can be perceived as a form of victim-blaming (Williams, 2001).

Comparing utilization data tends to be most useful where data are collected on well-defined interventions and where there is an expectation of use by all populations with similar characteristics (e.g. screening programs). Canadian studies have identified important differences in screening between some underserved groups and the general Canadian population (Grunfeld, 1997; Hislop et al., 1996; Woloshin, Schwartz, Katz, & Welch, 1997). Utilization data also have the potential to assist in identifying whether there are differences in prescribed treatments based on membership in a population group

– but only if there is some form of "coding" in health data to identify membership in an underserved group (a situation that is only rarely achieved in Canada).

Access and Equity

"Access" can only be understood within the context of equity. In Canada, equity is generally described as "equal service for equal need;" however, there is confusion about whether equity is defined as receipt of care or by opportunity to utilize care (Mhatre & Deber, 1992; Mooney et al., 1991). Culyer and Wagstaff (1993) provide an overview of four definitions of equity (utilization, distribution according to need, access, and equity in health).

The focus of equity in Canada has been on socio-economic status and explicit financial barriers to care – the barriers that the Canada Health Act was intended to address (Bowen & Kaufert, 2000). It has been observed that

> *lack of attention to other non-price factors that might be expected to influence the demand for and/or supply of care appears to imply that service free at the point of delivery is sufficient condition for 'reasonable access' to services* (Birch & Abelson, 1993: 632).

It is recognized that those who are sicker or face greater risks to health should receive a greater intensity of services. Some researchers have suggested that while more services are provided to those at the lowest income level, the difference does not necessarily correspond with differences in heath status (Roos et al., 1999).

Frameworks and Models of Client Access

A number of frameworks and models have been developed to describe access to health services.

Penchansky and Thomas (1981) define access as the degree of 'fit' between clients and the system. Specific dimensions of access in their framework include: (a) availability (the relationship of the volume and type of existing services and resources to the clients' volume and types of needs), in other words to supply issues; (b) accessibility (the relationship between location of supply and location of clients); (c) accommodation (the relationship between the manner in which the supply resources are organized and the clients ability to accommodate to these factors, as well as the client's perceptions of their appropriateness); (d) affordability (price factors, ability and willingness to pay); and e) acceptability (the relationship of clients' attitudes about personal and practice characteristics of providers to providers attitudes about clients). Often acceptability is used to refer to issues such as age, gender, ethnicity, or neighbourhood.

The authors suggest that problems with access have three potential effects: utilization of services, client satisfaction, and provider practice patterns. They find significant relationships between satisfaction with these aspects of access and utilization (Thomas & Penchansky, 1984). They also acknowledge that the dimensions of access are not easily separated and represent closely related phenomena. For example, absence of bicultural / bilingual personnel could be perceived as either an issue of availability (Mokuau & Fong, 1994), or accommodation or acceptability.

Not all authors use these dimensions. For example Chin (2000), in her description of access for culturally diverse groups, differentiates between access (the degree to which services are convenient, quickly and readily obtainable, and in which category she places linguistic/cultural barriers to care), utilization (which services are used, how often, and how appropriately) and quality (how good the care is once it is received).

Perhaps the most widely used model related to health access is the "Behavioural Model," first developed by Andersen in the late 1960's, and which has since been expanded and revised several times (Andersen, 1995). The focus of this model is on understanding why families and individuals use health services and thus is a utilization model.

The initial model included predisposing variables, enabling variables, and need as the independent variables that predict or "explain" utilization. Predisposing variables included characteristics such as ethnicity or race and health beliefs, whereas enabling variables included characteristics of the family, and community. Andersen differentiated between discretionary and non-discretionary utilization, and hypothesized that where there was little discretion, need would be the principal predictor of use. Enabling and predisposing factors become more important as the opportunity for discretion increases. This is consistent with the observation made by those working with underserved groups that language/ cultural barriers appear to have different impacts on different types of care. Andersen proposed that in an equitable system the need for care and key demographic characteristics (e.g. age) would be the principal determinants of utilization.

The original model has been revised several times and has evolved from a three-factor unidirectional model to one that accommodates a number of different interacting factors. A second version incorporated predisposing, enabling and need predictors into individual determinants, and broke out societal determinants and health services system features as other important determinants. More recent versions of the model reflect the recognition that there is an expected link between health services and the health of a population, acknowledging that increased access is not necessarily the goal.

The main limitation of the Behavioral Model in addressing "access" for underserved populations is that as a utilization model – even in its expanded version – it does not include aspects of "quality" or the appropriateness of services delivered. The original model was designed to explain the use of personal health services rather than focus on the important interactions that take place as people receive care, or on health outcomes (Andersen, 1995). In addition, the focus of behavioral models is on why clients behave as they do, rather than why the system operates the way it does (and as a result prevents access). Williams (2001), in contrast, differentiates between reasons for under-utilization (client-focused factors) and barriers that prevent access (service-focused factors).

Other frameworks focus on "barriers" to access. For example Williams (2001) identifies some of the barriers to access as culturally insensitive or offensive services, language barriers, user fees or other financial barriers, service locations and times, and lack of information about services.

Bowen (2000), based on a review of the literature related to access for a variety of underserved groups in Canada, developed a framework that categorized factors that may preclude "equitable access" in Canada for various populations. This framework includes a) availability of services, b) financial barriers, c) barriers to first contact with the health care system, and d) barriers to equitable quality of care.

Factors related to availability of services include services that are not insured under Medicare, long waiting lists that mean insured services are not available when needed, and geographic factors that prevent equitable use (this may include provincial/territorial differences or issues of rural/remote supply). Availability is not limited to physician hospital services, but may also apply to health promotion/prevention initiatives.

Financial barriers include explicit barriers to insured health services, explicit barriers to uninsured services (such as dental care), and other financial costs associated with access (e.g. transportation, child care, time lost from work).

Most discussions of access for underserved populations focus on barriers to initial contact with the health system. These barriers include such factors as: lack of information on service availability and eligibility; physical barriers; linguistic barriers; perceptions of services as discriminatory or culturally unresponsive; client beliefs about the importance and appropriateness of services; and practice patterns (service location, hours of operation, etc.) that discourage utilization by certain groups (Bowen Stevens, 1993; Jones & Tamari, 1997; Khoshnood et al., 2000; Weinick & Krauss, 2000; Wlodarczyk, 1998).

Barriers to equitable quality of care include factors in a number of different categories. The first are those barriers to physician-initiated service that may occur after the client has presented for care, such as referral to different types of service or follow-up based on group membership (Bowen Stevens, 1993; Canada's Drug Strategy, 1996; Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; Tyas & Rush, 1993). A second category relates to the quality of technical care delivered by providers (Mayberry et al., 1999; Smedley et al., 2002). A third category relates to the quality of psychosocial care, including client's trust in the provider (Saha, Komaromy, Koepsell, & Bindman, 1999) or discrimination on the part of provider (Feinberg, 2001; Rutledge, 2001). Also included in barriers to quality of care are communication barriers (Bowen, 2001), systemic discrimination on the part of the health system (Stevens, 1993; Williams, 2001), lack of provider information on prevalence of specific conditions or concerns of underserved groups (Giuliano et al., 2000; Sell & Becker, 2001), failure to ensure informed consent or confidentiality (Kaufert & Putsch, 1997; Champion, 2000), and environmental factors (Jones & Tamari, 1997).

Levels of Cultural Competence and Access Interventions

The focus of interventions intended to improve responsiveness to culturally diverse groups can be directed at several levels: that of the individual provider; the program or service delivery level; the organizational level; or the level of educational, accreditation, or government systems (the systems level). Table 1 on the following page outlines examples of each of these levels.

Table 1: Levels of Cultural Responsiveness Interventions

Individual Provider Level	Program Level	Organizational level	Systems level

What characteristics of individual providers contribute to improved access and quality of care?
 	
• Awareness
▪ Attitudes
▪ Knowledge
▪ Skills
▪ Practice
	What characteristics of specific programs contribute to improved access and quality of care?
	
	▪ Availability of service
	▪ Costs to consumer of program participation
	▪ Service standards
	▪ Language access
	▪ Culturally appropriate programs
	▪ Physical access
	▪ Provider characteristics & skills
		What structures and processes within organizations affect access and quality of care?
		
		▪ Representative governance
		▪ Organizational policy
		▪ Planning process
		▪ HR management
		  o Workforce representation/ diversity
		  o Practitioner eligibility
		  o Training
		  o Performance & standards
		  o Hiring practice
		▪ Quality – standards of care
		▪ Research and evaluation policy, capacity & focus
		▪ Resource allocation
		▪ Risk management and evaluation
			What issues need to be addressed by legislation, provincial governments, training institutions, & licensing bodies?
			
			▪ Pre-service education
			  o Access to programs
			  o Curriculum content
			▪ Professional standards
			▪ Licensing / accreditation standards
			▪ Services publicly funded
			▪ Rights legislation
			▪ Provincial/federal health policy
			▪ Research funding body guidelines
			▪ Affirmative action, employment equity legislation / requirements

Individual interventions focus on provider training (often in the form of cultural awareness or cultural competence training). Program level responses include flexible hours of operation, outreach programs, linking functions (such as cultural/linguistic interpreting), population specific programs, and distance technology (Bowen, 2000).

Organizational interventions focus on changes in organizational structure, governance, policy and programs, and have been described as the infrastructure that supports the provision of cultural competence at the front lines (Paez, 2003a). Systems-level interventions include such initiatives as training for health professionals (Cappon & Watson, 1999; Flores et al., 2000; Redwood-Campbell, MacDonald, & Moore, 1999), access to health professions for members of marginalized communities (Barer & Stoddart, 1992; Bowen & Simbandumwe, 1998; Mata, 1999), rights and national standards for language access (Rochefort, 2001; Stradiotto, 1998), and provider payment and funding models for underserved communities (Closson & Cott, 1996; Hurley et al., 1999; Pottie, Masi, Watson, Heyding, & Roberts, 2000).

It is common for organizations to focus on one or two strategies for improving cultural responsiveness. For example, one institution may adapt programming to be more acceptable to the specific clients served. Another may institute a language interpretation service. Still another may undertake a program of cultural competence training for staff. Many program responses are provided as an add-on supplement to core programs and so are vulnerable to changes in personnel and funding (Bowen Stevens, 1993). Many of these interventions are intended to address issues of "client access" (the degree to which

individuals can obtain a specific service), rather than those of "organizational access" (the extent to which consumers are represented and/or participate in the planning, development and delivery of services) (Doyle & Visano, 1987).

The ongoing difficulties and dissatisfaction reported by clients from underserved groups suggest that interventions at the client-provider level alone are inadequate. It is argued that making minor modifications to facilitate access to existing programs, while leaving intact traditional service structures – developed without the input of marginalized groups themselves – will not result in equitable service (James, 1998b).

Access and Cultural Competence at the Organizational Level

While cultural responsiveness can be promoted at a number of levels, this research focuses on competence and access at the organizational level – the infrastructure and mechanisms necessary to support culturally responsive health care. There is emerging consensus that in order to ensure access, or provide "culturally competent" care, changes are needed at the level of organizations and health systems (Office of Minority Health, 2001a). In the United States, organizational competence is being defined as an integral component of systematic patient-centred care that has the potential to improve both access to care and quality of care (Lewin Group, 2002). Organizations affect the care received in the individual clinical encounter by providing supportive policies and systems that promote, monitor, and reward individual behaviour. Without this infrastructure (by

making available trained interpreters for example), even a sensitive and competent provider may be unable to provide quality care (Quander, 2003).

There is also an additional level that affects the ability of both individuals and organizations to be culturally responsive – this is the "systems level" outlined on page 43. Although system-level factors (such as professional education curricula, licensing and accreditation standards, rights legislation, government health policy, and research funding guidelines) play an important role in promoting or hindering development of culturally responsive organizations, this level is not the focus of this research.

Initial discussions of "cultural competence" focused only on the provider-patient interaction and emphasized quality of care issues. However, strategies for implementing culturally competent systems of care (in contrast to those focusing on cultural competence of providers) address barriers to both initial access and to equitable care (Cross et. al, 1989; Siegal et al, 2000). The growing recognition that cultural competence must evolve from aspirational principles (Chin, 1999) to implementation of professional and regulatory standards that can be translated into quality indicators and outcomes (Office of Minority Health, 2001a), has provided further impetus to the focus on systems of care rather than individual competence. At the organizational and systems level, cultural competence refers to the on-going commitment to, and institutionalization of, appropriate policy and practice for diverse populations (Dreachslin, 1999; Office of Minority Health, 2001a; Tator, 1998).

The concept of "access" initially focused on availability of health services and the ability of clients to make contact with them. "Access" has since evolved to a conceptualization of equitable access as provision of health services in a way that provides an equal opportunity for all citizens to achieve optimal health (Bowen, 2000). Critiques of the traditional interpretation of the role of "access" in addressing health disparities recognize that cultural competence is also required in order to address disparities (Zust & Moline, 2003), and stress the importance of quality care as a mediating factor in access (Cooper, Hill & Powe, 2002). Organizational access, like culturally competent systems of care, requires adoption of appropriate policy and practice.

As a result, some interpretations of the two concepts ("culturally competent systems of care" and "organizational access") now substantially overlap – and initiatives for both include many of the same domains for action. Increasingly the two concepts are combined. See, for example, the web site for Community and Preventive Medicine, at http://www.thecommunityguide.org/social/soc-int-competent-system.pdf, which lists as a topic area "Improving access to culturally competent healthcare systems" (Anderson, 2003). Factors contributing to the convergence of the two concepts include the increasing emphasis on outcomes in health research, and the shift in the approach to cultural competence from a way of providing "sensitive caring" to a means of addressing health inequalities (Baxter, 2001). Both "access" and "cultural competence" interventions now address the goals of addressing health inequities and improving health outcomes.

Culturally competent systems of care, like strategies for organizational access, require: mechanisms for ensuring participation of marginalized groups at the level of planning and decision-making; policies that establish and enforce quality standards; concrete strategic plans to ensure administrative and program responses; and data collection and information systems that include human resource monitoring and facilitate research and evaluation on the health of marginalized communities.

Developing "Culturally Responsive" Organizations

In Canada, evidence suggests that there is greater awareness of the need for individual practitioners to be culturally responsive than there is of the need for an organizational level response (Children's Hospital of Eastern Ontario, 2000; Wityk, 2003). Lack of attention to barriers to change at the organizational level within health services appears to be one reason why access issues for marginalized groups have not been addressed effectively. While it is common for organizations to articulate a commitment to diversity and addressing access barriers, few focus on the next step, that of operationalizing principles into concrete action (Chin, 2000; Tator, 1998).

Several models for increasing organizational cultural diversity have been proposed. Cox (1994) presents a framework for managing and valuing cultural diversity that includes leadership, research/measurement, education, changes in culture and management systems, and follow up. Dreachslin (1999) presents a five-part process for diversity leadership: discovery, assessment, exploration, transformation, and revitalization. She

relates this model to Lewin's generic model of organizational change ("unfreezing", "implementation", "refreezing") and Cox's diversity-specific model of change. Through a review of the literature, she identified performance indicators for each of the five stages.

Some frameworks are based on a continuum of development ranging from negative or destructive responses, through various stages of understanding and action (Cox, 1994; Cross et al., 1989; Dreachslin, 1999; Minors, 1998). Minors (1998) outlines an anti-racist continuum of change that includes three phases: discrimination, non-discrimination, and anti-discrimination. Each of these has two stages. He proposes that change begins at the individual level, followed by interpersonal and intergroup behaviours, and that gradually organizational policies, structures and practices also change.

The model proposed by Cross et al. (1989) outlines a five-stage continuum that can be applied to organizations as well as to individuals. This model includes the stages of cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence and advanced cultural competence. Both the Cross' and Minors' models recognize that barriers are not simply the absence of an appropriate response, but may result from negative actions (e.g. prejudicial attitudes, or specific discriminatory behaviours).

Tator (1998) describes four models for addressing issues arising from "racial" and cultural diversity, focusing on barriers at an institutional/systemic level. What he calls the "monocultural/assimilationist" model views racial and ethnic diversity as irrelevant in

determining policy and practice. The values of the dominant society are reflected in all aspects of organizational life, including policies, programs, employment practices, language, service delivery and communications. Racism and discrimination, when recognized, are believed to be limited to certain individuals, and biases within the organization are not recognized (Cox, 1994; Salimbene, 1999). Consequently, any cultural responsiveness interventions also tend to be directed at the level of the individual. Organizations reflecting the monocultural model emphasize that services are available to everyone, and everyone will be treated the same (Bowen Stevens, 1993). They are often unaware that "facially neutral policies and practices" can have a disproportionate effect on "racial"/ethnic groups (Watson, 1994).

Some organizations do, however, identify access barriers to equitable service. The "add-on multicultural" approach undertakes specific activities to improve access, usually at the level of client access. Cultural responsiveness is not, however, integrated into the organization's strategic plan: issues of cultural diversity are seen as separate from the day-to-day operations of the organization. The task of addressing barriers is often left to specific front line workers who have little status or power in the overall organization (Bowen Stevens, 1993; Tator, 1998). Many community-based health programs and some hospitals adopt this model, which is often characterized by creative initiatives undertaken by a specific program or department. This approach allows some response to the most obvious needs, without requiring fundamental organizational change.

The "integrated" model develops an organizational framework to support cultural responsiveness initiatives, which are integrated into all aspects of the organization (Office of Minority Health, 2001a). Accountability is established at the highest levels of the organization (Office of Minority Health, 2001a, b). This model recognizes that systemic discrimination, not the behaviour of few individuals, contributes to disparities (Williams & Rutter, 2000). As this model addresses governance, strategies for community participation, recruitment, retention and promotion of diverse staff, professional education, strategic planning, research and evaluation (Brach & Fraser, 2000; Chin, 1999; Dreachslin, 1999; Lonner, 2000), organizational change is required.

Within the private sector, "organizational cultural diversification" has been identified as an important characteristic of successful organizations, and linked to creativity, productivity and profitability (Cox, 1994; Fine, 1995; Gandz, 2001; Poole, 1997). Organizations that employ diverse staff, and provide services appropriate for a diverse clientele are believed to have advantages in achieving their business objectives and in competing in the marketplace (AMSSA, 2000; Cox, 1994; Gandz, 2001; Taylor, 1995). The "business case" for diversity has become part of the rhetoric of health care provision in the United States; it is less apparent, and – given the nature of publicly funded health care – less persuasive in Canada.

The goal of the "ethnospecific" model is not to serve a diverse group of patients. Rather, the intent is to fill an unmet need for one or more specific underserved populations, and to act as an advocate for these populations within the larger system (Tator, 1998). An

ethnospecific organization focuses on providing culturally competent care in large part through matching of patients and providers from similar language and cultural backgrounds. This model is one alternative to providing culturally appropriate care, and is often advocated for by Aboriginal communities. However, development of ethno-specific services will not eliminate the need for cultural responsiveness in general health services, as they are often only able to provide primary care services, and must refer patients to larger institutions for secondary and tertiary care. Development of ethnospecific responses may also result in generic health services off-loading "culturally different" patients to these ethno-specific services. This may have the effect of fewer options for clients, and a lack of skill development and change within the larger system.

Health organizations and systems are often perceived to be slower to respond to issues of cultural responsiveness at the organizational level than the business, social service and educational sectors (Williams, 2001). The essence of intercultural understanding is the recognition that there is more than one good way to do things. This is a perspective that is not easily accepted within the health system, which prides itself on being evidence-based, and on providing the best possible care. The belief in the superiority of the western medical system, the hierarchical power structure, and the many diverse "cultures" found within the various health professions, all create significant challenges to organizational change. It is also difficult for professionals in identified "caring professions" to recognize personal or organizational barriers that may result in lower standards of care (Culley, 1996). Lack of diversity in the health care leadership and workforce, systems of care poorly designed for diverse patient populations, and poor communication between

providers and patients have been identified as major barriers to culturally responsive care (Betancourt et al., 2002).

It has been noted that there is little guidance for health care organizations on how they can become culturally competent (Brach & Fraser, 2000; Kalloo & Migliardi, 2002; Ponterotto & Alexander, 1995; Weech-Maldonado et al., 2002). While there are a number of general frameworks and planning guides for organizational diversification that have been used both within the social service and private sector (Arrendondo, 1996; Canadian Heritage, 1995; Carr-Ruffino, 1999; Poole, 1997; Taylor, 1995; Weiner, 1997), there is a general lack of empirical research on organizational diversity. Most of the literature relies on theoretical and anecdotal reports (Gandz, 2001).

Differences in Approach to "Cultural Responsiveness"

In previous sections the concept of "cultural responsiveness" (which incorporates dimensions of both "access" and "cultural competence" at the organizational level) was developed and explored. While the two concepts have evolved to share many of the same dimensions at the organizational level, both remain inconsistently defined, and fundamental differences in philosophy and approach to addressing health care needs of diverse groups are found within each of these traditions.

These differences in philosophy and approach – driven by varied political, cultural and historical forces – tend to be associated with specific stakeholder groups and interests. Different approaches have important implications for organizational policy and practice,

and have the potential to result in vastly different responses to perceived inequalities among culturally diverse groups (Buchanan & O'Neill, 2001). However, they are rarely made explicit in planning for organizational diversity, and assessment of these philosophical differences has not been incorporated into organizational assessment tools so far developed.

The following sections outline a number of these approaches, which form the basis for the "dimensions" that were incorporated into the development of the document review instrument described in this dissertation. Where appropriate, each section includes discussion of the implications of positions along these dimensions (including challenges for adoption of specific approaches and specific issues related to the Canadian context).

Identifying "Cultural Groups" for Consideration

Proponents of both "cultural competence" and "improved access" face the challenge of defining which "cultural" groups are of interest to their initiatives. There are important differences on the emphasis placed on "cultural differences" other than "race" and ethnicity. Table 2 on page 55 summarizes the many different terms used to define those who are considered "minorities", "culturally different", "at risk", or "hard to reach."[1] Note that the concept of "underservice" is unique in that it does not define the "problem" as related to the characteristics of the client group, but rather the ability of the system to provide care. This makes it a useful concept for determining what "cultural" groups

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[1] This summary is based on my review of the literature, not on a formal content analysis, and is not meant to indicate that there is consensus on these definitions.

should be of most concern to culturally responsive organizations. Groups are included not because they are "different" but because there is evidence that their health status and/or healthcare access is in some ways impaired. Bowen (2000:80) defines underservice as the

> *increased likelihood that individuals will, because of their membership in a certain population: experience difficulties in obtaining needed care; receive less or a lower standard of care; experience differences in treatment by health personnel; receive treatment that does not adequately recognize their needs; or be less satisfied with health care services.*

"Underserved populations" should be differentiated from "underserviced areas" – geographic regions, usually rural and remote, which experience difficulty in recruiting and retaining sufficient numbers of health personnel to meet the needs of the population, or are undersupplied with certain health services (Barer & Stoddart, 1999). Underserved populations, in contrast, may not have the same access or receive the same quality of care as others in their community, even though there may be "sufficient" resources in the community where they live. Many underserved populations share the characteristics of lower income and social disadvantage. However, they cannot be defined by low socio-economic status alone. "Underservice" is closely linked to health disparities: many underserved groups also have lower health status, although this is not invariably the case. A number of diverse groups may be considered underserved: Aboriginal populations, language minorities, those of alternate sexual orientations, immigrants, refugees, ethnically and/or racially diverse populations, persons with disabilities, the homeless, sex trade workers, and certain low income segments of the population (Bowen, 2000).

Table 2: Terminology Related to Underserved Groups

Term	Implications	WHO IS INCLUDED?									
		Aboriginal	Immigrant	Visible Minority	Disability	Language	Poor	Women	ASO	STREET	AGE
Aboriginal	Includes First Nations, Inuit, Métis, and non-registered Aboriginal People	X				X					
Multi-cultural	In Canada, this term, along with expressions such as "ethno-cultural" generally refer to "minority" groups who are neither English, French, or Aboriginal		X	X		X					
Ethnic and "racial" minorities	While commonly used to describe non-white, non-European racial and ethnic groups this term is losing favour	X	X	X		X					
Ethnically and culturally diverse groups	Used generally to include both immigrant minorities and Aboriginals, although Aboriginals are not always included.	X	X	X		X					
Culturally diverse groups	Expands the definition of culture to include a variety of other "cultures," including women. Commonly used in workforce analysis	X	X	X	X	X	X	X	X	X	X
Marginal-ized groups	Inconsistently used, often implies those pushed to the margins of society, and sometimes used to identify those who lifestyle choices have led to marginalization	X	X	?	X	X	X		?	X	
Vulnerable groups	Used to describe those who are at risk of exploitation and abuse, and are unable to protect themselves	?	?	?	X		?			X	X
Under-served Populations	Focuses on the system rather than the characteristics of the group.	X	X	?	X	X	X		X	X	

DISABILITY – Persons with a disability   LANGUAGE – Persons who lack proficiency in an official language
POOR – low SES   AGE – children and elderly
ASO – Alternate sexual orientation, includes gay, lesbian, bisexual, transgendered, Two-spirit.
STREET – includes marginalized groups such as injection drug users, sex trade workers, and homeless people.

The literature on cultural competence at first emphasized definitions focused on "racial" and ethnic "minorities," and many authors still limit their discussion of competence to these groups (Henry J. Kaiser Family Foundation, 2003). Over the last decade, however, many have broadened the definition of "cultural groups" from one limited to ethnicity or "race" to include those who – for whatever reason – are underserved by the health system.

<u>Analysis of the Expansion of the Definition of "Cultural" Groups</u>

Some authors, while recognizing that the "culture" of all patients should be considered, point to the greater importance of culturally appropriate care for "minority groups" that receive care from systems organized and staffed by those of the dominant culture (Brach & Fraser, 2000). They propose that "cultural groups" should be defined as those whose members receive different and usually inadequate health care compared with that received by the dominant culture (Nunez, 2000). These groups are not limited to "racial" or ethnic "minorities." Gay, lesbian and transgendered persons, for example, may experience less sensitivity and appropriate care than "racial" or ethnic "minorities" (Eliason & Raheim, 2000; Feinberg, 2001; Ryan, Brotman, & Rowe, 2000), as may persons with disabilities (Jones & Tamari, 1997), those living with HIV/AIDS (de Bruyn, 1998) or homeless people (Hwang, 2001).

Advocates of a broader definition of culture stress that all individuals have multiple cultural identities, and that ethnicity may or may not be particularly relevant to the patient's experience or expression of illness. They highlight the risks of stereotyping that

often result from focusing only on colour or ethnicity (Fuller, 2002). This perspective also reflects awareness of the broad literature on the impact of socio-economic factors on health status and – in many countries – on health care access (Green, Betancourt, & Carrillo, 2002).

Authors also differ in the extent to which they recognize issues of cultural identity and the possibility of multiple or ambiguous cultural identities. In general, those using a broader definition of "culture" are more likely to recognize both the diversity within particular ethnocultural groups, and the multiple cultural identities that an individual may assume.

The trend towards a broader and more complex conceptualizations of culture has a number of advantages: it recognizes that each of us have a culture which should be recognized and valued, and avoids the negative impacts of stereotyping that often result from narrow definitions based on "race," ethnicity, language or national origin. Incorporating these broader definitions into the training of health professionals can be expected to increase the quality of care provided to individual patients, and support the goals of patient-centred care. There are, however, clear limitations of such broad definitions for policy and planning purposes. It is often necessary to identify specific communities for both program development and for data collection. It is clearly not feasible (or even desirable) to collect data on all possible "cultural" attributes, leaving open the question of what characteristics should be prioritized, and considered acceptable for categorization.

Underlying Philosophy

"Multicultural" vs. "Antiracist" Orientation

Approaches to cultural responsiveness reflect important underlying differences in philosophy about the best ways to address issues of ethnicity and culture within health care (Culley, 1996; James, 1998a; Kelleher, 1996; Lister, 1999; Papadopoulos, 2001; Williams, 2001). Two broad perspectives have been identified, often described as the "multicultural" and the "anti-racist" approaches.

While some authors differentiate between terms such as cross-cultural, transcultural, intercultural or multicultural health as fields of study, these approaches usually share many assumptions. The "multicultural" approach views culture as the key to understanding and competence. Problems are believed to result from "differences" between the cultures of providers and patients. Incompetence, and any resulting inequalities, are believed to result from lack of information on the part of the caregiver about the "culturally different" patient (Lister, 1999). Education, therefore, is recommended as the most effective intervention. Through understanding of different cultural traditions, it is argued, appropriate and sensitive care will be provided, contributing to improved health outcomes (Papadopoulos, 2001).

The multicultural approach remains dominant in health care, although it has been actively challenged in the fields of education and social work. This approach has been criticized for downplaying the importance of racism and its social and economic effects, at both the individual and institutional level (Culley, 1996). A review of the literature on cultural

competence reveals that many resources, in spite of cautions to avoid stereotyping, rely

"on a reductionist discussion" of stereotypes that fails to address underlying structural

problems of inequality (Culley, 1996: 567).

The multicultural approach has even been critiqued as evidence of a new form of racism.

The way people think and act is primarily explained and understood in terms of their

ethnic or national origin (Glastra et al., 2000); people who are "different" are categorized

in terms of "culture" (Ahmad, 1996). Ethnicity, it is claimed, is often viewed as a "form

of cultural determinism" where vaguely defined ethnic differences are used to explain a

range of behaviours and differences in health status without consideration of other

factors, such as socio-economic status or systemic barriers (Krieger & Fee, 1994).

Culture itself – often viewed as static and unchanging – becomes the problem. An

emphasis on the "culture" or characteristics of marginalized groups, critics argue, has

contributed to a tendency to focus on problems or deficits of communities or individuals,

while often ignoring both the characteristics of "health culture" that create structural

barriers to equitable care, and the significant diversity found within a particular

ethnic/cultural group (Ahmad, 1996; Kaufert, 1990; Meleis, 1996).

The anti-racist approach sees the focus on culture as a diversion from racism (Hillier &

Kelleher, 1996). There is emerging evidence from research in other countries that racism

itself has an important impact on health, both in determining health status (Krieger,

Rowley, Herman, Avery, & Phillips, 1993) and in access and quality of care (Mayberry et

al., 1999; Smedley et al., 2002). Proponents of an anti-racist approach argue that health

inequalities can only be addressed if emphasis is placed on the forces that structure social relationships and access to power and resources (Papadopoulos, 2001; Williams, 2001). This includes not only recognizing and addressing the social determinants of health, but also implementing specific interventions within the healthcare system. Proponents of this approach place less importance on education, and more on structural interventions (e.g., workforce representation strategies) to promote equity.

While there has been limited research in this area, when the hypothesis of "culture" has been examined empirically, systemic issues such as organization of services, failure to address language barriers, or absence of a regular provider (rather than traditional cultural beliefs and practices) have tended to explain most of the differences in health behaviour (Bowen, 2001; Jenkins, Le, McPhee, Stewart, & Ha, 1996; Marks et al., 1987; Naish, Brown & Denton, 1994; Solis, Marks, Garcia, & Shelton, 1990). Qualitative studies with various "cultural communities" in Canada confirm that patients often identify structural issues (including discrimination) as more important than cultural beliefs in presenting barriers to care (Bowen, 1999; Browne, Fiske, & Thomas, 2000; Cave, Maharaj, Gibson, & Jackson, 1995; Chugh, Dillmann, Kurtz, Lockyer, & Parboosingh, 1993; Gravel & Legault, 1996).

The anti-racist approach also has a number of limitations. It is often based on a black/white or Aboriginal/European dichotomy that can marginalize other visible minorities (Papadopoulos, 2001). It often fails to recognize that there may be many contradictory, and often competing oppressions, such as those against the poor, persons

with disabilities, or of alternate sexual orientations (Abrums & Leppa, 2001; Bishop, 1994). Some authors believe that preoccupation with race and racism can hinder professionals becoming more culturally aware, culturally sensitive or culturally competent as this preoccupation may preclude serious consideration of other forms of discrimination (O'Hagan, 2001).

Although there are clearly ideological differences between these two perspectives, the differences are not clear-cut (Papadopoulos, 2001, Williams, 2001). Both multicultural and anti-racist approaches have limitations, and either may blind us to the shared cultures that may exist between individuals of different "races" or ethnicities, as well as the great diversity found within a particular ethnic or "racial" group (Abrums & Leppa, 2001).

Papadopoulos (2001) suggests that there is actually a "third way," an emerging approach that has the potential to avoid the limitations of either the "multicultural" or "anti-racist" perspectives. This approach is outcome-oriented and integrates the health needs of "minority" ethnic groups within a broader agenda focused on the eradication of inequalities. It proposes that health services should be based on an analysis of community needs, rather than on any assumptions that primary differences between populations are based on culture (Maggi & Cattacin, 2003). It appears in many ways to be a maturing of the anti-racist approach, as it is based on a recognition that the health system has failed to provide effective care to certain underserved groups, and that structural change is needed. A review of the recent literature addressing health

inequalities suggests that this "equity" approach is now increasingly reflected in the discussion around health services to culturally diverse groups.

Table 3: Philosophical Approaches: Multicultural, Anti-racist, Equity

Approach	Definition of priority groups	Assumptions	Interventions emphasized	Key Limitations
Multi-cultural	Ethnic/racial groups recognizably different from dominant society. Often a focus on new immigrants.	Problems arise from a. lack of information about the culturally different; b. "differences" between cultures	Intercultural training for providers and clients "Bridging" programs	Often fails to recognize institutional racism, structural issues Focuses on "differences" May fail to recognize *diversity within* groups In some centres Aboriginal issues not included.
Anti-racist	Racial minorities. Often a focus on African Americans (U.S.), Aboriginal peoples (Canada).	Problems are rooted in historical & structural inequality The health system/services are inherently biased	Workforce initiatives Community control of health services	May present Black/White or Aboriginal/European dichotomy that marginalizes other minorities Does not recognize other cultural identities May increase tension within or between communities.
Equity	Groups with lower health status or with demonstrated problems with access.	The health system must respond to groups where there is evidence of health inequalities	Planning based on identified disparities in health status, differences in access and quality of care.	Theoretical approach, little evidence to date.

Approaches to Cultural Training

Training and development of staff to work effectively with a diversity of patients is the most common response to identified needs for culturally responsive care. Proponents of the "multicultural" approach are not only more likely to promote education and training as key responses, but also within that training to focus on knowledge about specific ethnic groups and folk traditions. Advocates of an anti-racist approach, in contrast, tend to place less importance on training, emphasizing instead strategies to increase the representation of under-represented groups in the workforce. While these advocates also support cultural training, they propose curricula that focus on racism awareness, attitude change, and structural barriers within the health system.

Education and training may occur at all levels: an individual provider may take the initiative in developing his or her own skills; programs or organizations may implement inservice training programs; or larger systems (such as universities or professional associations) may develop curricula to promote cultural competence among all their members. However, training in cultural issues, at both the preservice and inservice level, is sparse and uneven (Carrillo et al., 1999; Nunez, 2000). Recent reviews of the curricula of medical and nursing schools in both Canada and the United States indicate that not only is there inadequate coverage of any approach to cultural diversity training, but that current education often relies on descriptive approaches, and fails to reflect the current multicultural population (Azad, Power, Dollin & Chery, 2002; Duffy, 2001). Content is often sporadic and uncoordinated, and attendance is often optional (Flores, Gee & Kastner, 2000; Loudon, Anderson, Gill, & Greenfield, 1999; Redwood-Campbell et al.,

1999). Students themselves may be exposed to racism and homophobia (Risdon, Cook, & Willms, 2000; Robb, 1998; vanIneveld, Cook, Kane, & King, 1996).

In addition, there are concerns that educational faculties themselves may not represent "minority" cultural groups (Gonzalez, Gooden, & Porter, 2000). Educators often lack experience or formal preparation in cultural competence or diversity issues, and there is no consensus on the philosophy for training (Kai, Spencer & Woodward, 2001). Difference is often problematized, and the focus is on the need for students to understand and accommodate cultural groups, rather than a larger social analysis (Paterson, Osborne, & Gregory, 2003). There are different assumptions about who is best qualified to provide cultural competence training. Some feel that the most qualified are those from the culture itself. They find it offensive or disempowering to have "cultural outsiders" speak about their experience (Poleschek, 1998). Others believe that without special training, those from a particular background are not the best trainers because "cultures" are often unconscious to group members (Salimbene, 1999).

While a number of different programs have been developed, implemented and evaluated, these vary significantly in length, content and approach. The emphasis of training is often only at the level of awareness and sensitivity (Carrillo et al., 1999; McPhatter, 1997). "Awareness" may refer only to awareness that there are "cultural differences" between people, or may emphasize self-awareness (including attitudes about those who are different from us), ethnocentrism, discriminatory behaviour, and structural barriers to equity. The importance given to attitude also varies. Although much awareness training

emphasizes facts rather than attitudes (Bonder, Martin, & Miracle, 2001), some authors stress that emotion is as important as, or more important than, knowledge in the area of cultural competence (Abrums & Leppa, 2001; Dreachslin, 1999; Dyche & Zayas, 1995; Tervalon & Murray-Garcia, 1998).

What knowledge is considered important also varies considerably – it may range from knowledge of the beliefs and traditions of various ethnic groups, to knowledge of communication styles, to racism and oppression within societal systems, to specific physical, biological and physiological variation among ethnic groups (Camphina Bacote, 1999; Lavizzo-Mourey & Mackenzie, 1996). The curricula of many programs tend to emphasize ethnicity rather than issues of "race," gender, class or sexual orientation (Abrums & Leppa, 2001). Much culture-specific teaching focuses on traditional and folk practices even though clients themselves often minimize the importance of these factors and stress the importance of communication barriers (Bowen, 1999; Bowen Stevens, 1993; Cave et al., 1995; Chugh et al, 1993; Gravel & Legault, 1996).

Knowledge may be "culture-general" or "culture-specific". A culture-specific approach presupposes a cognitive basis for practice for each group (Dana & Behn, 1992; Davidhuzar et al., 1998), whereas culture-general knowledge focuses more on both the similarity among – and diversity within – cultural groups, as well as on the skills for working in a diverse environment.

The recent literature emphasizes the need for caution in focusing on ethno-specific knowledge. Although a culture-specific approach may illustrate important differences among cultures and help promote openness to alternative viewpoints, there are a number of limitations. This approach tends to promote stereotyping; it may fail to recognize within-group diversity; and may give a false sense of confidence to providers (Health Resources and Services Administration, 2002). Tervalon and Murray-Garcia note

> *an isolated increase in knowledge without a consequent change in attitude and behaviour is of questionable value. In fact, existing literature documenting a lack of cultural competence in clinical practice most reflects not a lack of knowledge but rather the need for a change in practitioners' self awareness and attitudes towards diverse patients* (1998: 119).

Skill development tends not to be emphasized in most cultural training programs (Carrillo et al., 1999; McPhatter, 1997). Skill may refer to the ability to communicate effectively (Nunez, 2000; Carrillo et al., 1999), to collect relevant cultural data and perform a culturally specific physical assessment (Camphina-Bacote, 1999), to challenge and address discrimination, or to negotiate compliance with a plan of care (ACOG, 1998; Nunez, 2000; Carrillo et al., 1999; Papadopoulos et al., 1998).

As there are no standardized curricula or accreditation systems, and no validated assessment tools, it is difficult to determine the effectiveness of training programs (Donini-Lenhoff & Hedrick, 2000; Loudon et al., 1999; Office of Minority Health, 2001a). Not all training is equally effective and training can have negative effects depending on the approach taken (Brach & Fraser, 2000; Williams & Rucker, 2001). Culture-specific approaches (which tend to focus on facts about different "cultural groups," and may rely on a "recipe book" approach) appear to be associated with many of

the limitations of cultural training identified in the literature. These limitations include relying on academic knowledge, stereotyping, focusing on differences, and overlooking the importance of social, political and structural factors (Carrillo et al., 1999; Kai, Bridgewater & Spencer, 2001; Meleis, 1996; Sue & Arredondo, 1992).

In summary, the content (and underlying assumptions) of a specific cultural training program will promote a certain view of culture and its role in health and health service provision. Impacts of training may therefore vary greatly. Even if effective, training alone has limited potential to address broader access issues. There is increasing recognition within the business sector that awareness training has little impact unless it is incorporated into broader initiatives. Training must be linked to the organization's strategic goals and have the commitment of senior management (Hemphill & Haines, 1997; Shaw-Taylor & Benesch, 1998; Taylor, 1995).

Approaches to Diversity in Human Resource Management

If provider training is the most commonly identified strategy emerging from a "multicultural" approach to cultural competence, then recruitment, hiring and promotion strategies are perhaps the most common solutions advocated by those proposing an anti-racist approach. There are four approaches within this category, each of which presents different policy implications. These approaches are summarized in Table 4 on the following page.

Table 4: Workforce Approaches

Approach	Assumptions	Policy Responses	Definition of Cultural Group	Implications
Mono-cultural	The organization does not discriminate, special initiatives are not needed.	- Non-discrimination policy -No specific policy addressing workforce diversity	Variable	-Workforce inequities not recognized. Belief that commitment to non-discrimination is sufficient
"Ethnic matching"	The best care is provided by caregivers of the same "race"/ethnicity/language.	-Specific direction to prioritize hiring of *providers* of same background as community served. This may be limited to specific programs or locations.	"Racial"/ethnic and language minorities	-Provider-client focus -May "ghettoize" providers and clients -Does not address planning/decision-making -May not recognize broader definitions of culture
"Workforce representation"	The overall workforce, including senior management should reflect the ethnic/racial makeup of the community served. This will result in improved responsiveness.	-Policy commitment to reflect the community in overall workforce makeup -Workforce audit by level -Encouragement for employees/applicants to self-disclose ethnicity	"Racial"/ethnic groups	-Focus on community makeup, structural inequalities -May target only specific groups -Focus on race/ethnicity
"Workforce diversification"	Organizations of excellence encourage diversity in all forms in order to better achieve their goals.	-Commitment to diversity as source of organizational strength.	"Racial"/ethic groups, gender, sexual orientation, disability etc.	-Broader definition of culture -Diversity seen as an organizational strength, not simply a way to address client needs or societal inequity.

The **monocultural approach** remains the most prevalent within health care today. This approach focuses on protecting staff from discrimination, and is committed to ensuring that all staff are "treated the same."

Ethnic matching attempts to match clients with providers of the same background. This approach is often advocated not only by proponents of an "anti-racist" approach or those supporting separate ethno-specific services, but also by some health administrators. They argue that those from the dominant culture cannot be expected to understand, or be sensitive to, the life experiences of clients from "minority" cultural groups.

There is some evidence that matching clients and providers of the same ethnic background will not only improve communication (by in many cases allowing the patient to communicate directly with the provider in a non-official language), but may also promote the confidence and trust of patients in their care, appropriate utilization, and satisfaction (Cooper-Patrick et al., 1999; Saha, et al., 1999; Saha, Taggart, Komaromy & Bindman, 2000; Snowden, Hu, & Jerrell, 1995).

However, there is also conflicting evidence. Ethnic matching appears to be effective for some outcomes but not others, and the processes that account for the results are not known. Some authors point out that ethnic or language matches do not ensure cultural or cognitive matches (Sue, 1998). Ethnic matching may fail to recognize the number of cultural identities that are of concern to patients (Meleis, 1996). For example a woman may prefer a female provider over a male of her own ethnic background; a gay

Aboriginal man may prefer a gay-positive white provider over an Aboriginal provider who is uncomfortable with alternate sexual orientations. Providers of a different social class, religion, region, or generation may have little in common with many patients from their own countries of origin. There is also significant diversity in spoken language between generations and regions, even within groups identified as speaking the same language (Li, McCardle, Clark, Kinsella, & Berch, 2001). Ethnic matching may even contribute to distrust if the patient and provider are of different political, socio-economic, religious or regional backgrounds, particularly in small or politically divided communities (Bowen, 1999; Bowen Stevens, 1993). It may also contribute to "cultural blind spot syndrome," where differences are not recognized because the client appears similar to the interviewer (Lin, 1983).

It is generally not feasible to match patients with providers of their own background, even if there were good evidence that this is effective (Bowen, 2001). There are logistical challenges to ethnic matching, particularly in regions where there are smaller numbers of many ethno-cultural groups dispersed over a broad geographic area (Li et al., 2001), the situation in much of Canada. Even when the primary provider is of the same background, the client will need to deal with other health professionals within the system (Downing & Roat, 2002). Ethnic matching – particularly when "minority" staff are limited to working with clients of their own background – may not only fail to contribute to cultural competence within an organization, but may also decrease alternatives for both client and provider (Williams, 2001).

Workforce representation (recruiting and retaining staff that reflect the demographics of the patient population) is primarily a response to demands for employment equity (Human Resources Development Canada, 2003). It is assumed, however, that employment of higher numbers of staff from non-dominant cultural groups will contribute to cultural responsiveness through improved communication, confidence and user-friendliness experienced by minority populations; a greater likelihood that services will be organized in a way that meets needs; and less likelihood that "minority" staff will show discrimination (Betancourt & King, 2000; Brach & Fraser, 2000; Saha et al., 1999). Unlike ethnic matching, which focuses on the provider-client interaction, this strategy is not primarily directed towards improved client service, but rather is intended to address broader issues of societal inequity. It is concerned with workforce representation at all levels of the organization – particularly at the decision making level (Office of Minority Health, 2001a; Weiner, 1997).

Workforce diversification (creating an environment that allows access to the talents of diverse persons (Cox, 1994; Thomas & Woodruff, 1999), does not focus on ethnic matching, or even on "proportional" hiring. Instead, the emphasis is on removing barriers to organizational participation of a variety of diverse cultural groups in order to increase organizational creativity and flexibility. Proponents of this approach often focus on diversification as a means for achieving organizational goals rather than a means of ensuring equity (although equity is seen as essential for achieving them). Employment equity and anti-discrimination approaches are often seen as precursors to this "diversity" approach (Gandz, 2001). While the historical contribution of these earlier approaches is

recognized, critics argue that a continued focus on redressing historical inequities in isolation from organizational theory poses significant limitations (Glastra et al., 2002). However, while the workforce diversification approach is the trend most commonly reflected in the current business literature, it has had far less impact in the field of healthcare.

Each of these workforce approaches rests on different assumptions and has different implications for policy at both the organizational level and at the level of larger systems (e.g. training institutions or provincial and national licensing/accrediting bodies). In spite of these differences, they present some similar challenges – the development of human resource policy that removes barriers to participation of diverse cultural groups. A major challenge to any attempt at "matching" or "representation" relates to how communities are defined, and who "represents" a particular community. This issue is discussed in more detail in section 3.2.4

Strategies for creating a diverse or representative workforce include recruitment, retention and promotion at the organizational level, and facilitation of entry into health professions of diverse cultural groups at the systems level (Bowen, 2000). This may include, for example, expanded efforts to address barriers to employment faced by internationally trained medical graduates – who face what are often perceived as discriminatory licensing and accreditation barriers to practice (Mata, 1999; Williams, 2001); and also to professional school eligibility faced by Aboriginal applicants (who

because of conditions of larger societal inequity and barriers to advanced education,

remain significantly under-represented in the health professions).

In general, less attention has been paid to workforce than to patient care issues related to

cultural responsiveness (Weech-Maldonado et al., 2002). The Canadian health care

system has been identified as presenting specific barriers to workforce participation. For

example, while lack of recognition of international credentials is an issue highlighted in

the diversity literature, governance bodies and provincial policy have been especially

slow to address barriers to licensing and accreditation faced by new immigrants, in spite

of ongoing critical health human resource shortages (Bowen & Simbandumwe, 1998;

Williams, 2001).

The "organizational diversity" movement has received more attention in the United

States than most other countries, and has been influenced by the historical and policy

context of that country. "Affirmative Action" responses, for example, frame many of the

U.S. responses to increasing representation of under-represented groups, whereas Canada

is guided by Employment Equity legislation. However, a number of Canadian authors

have done significant work in framing these issues in the Canadian context (see for

example, Buchanan, 1998; Buchanan & O'Neill, 2001; Gandz, 2001; Harvey & Blakely,

1996). Minors, 1998; Tator, 1998; Taylor, 1995; Weiner, 1997). Their work has informed

this summary of the literature, and the four models of response described in pages 68-72

are applicable to describing approaches to workforce diversity in Canada.

However, while there is evidence that a diverse workforce can bring benefits to organizations and to clients, it cannot be assumed that either workforce diversification or representation, by themselves, will result in improved culturally competent care for all clients (Shaw-Taylor & Benesch, 1998).

Voluntary or Required Action

While there is increasing awareness of the importance of providing culturally responsive care to clients, organizational commitment may be limited to broad philosophical statements and aspirational principles, rather than framed as established standards of care with formal guidelines. The focus remains on information rather than practice. However, as Dr. Thomas Dolan, the president and CEO of American College of Healthcare Executives observed: *"The time has come to ask ourselves some tough questions – about our actions and about those of our organizations. It is not enough to have policies promoting equal opportunity; we must ensure that current practices support those policies"* (Dolan, 1998, as referenced in Weech-Maldonado et al., 2002). The extent to which best practices have been incorporated into required action is, therefore, an important dimension to be measured.

The most recent development in the literature is the move towards adoption of guidelines and standards by organizations and professional bodies; however, this is most evident in the United States. In that country, a legislative framework, incorporation of "cultural competence" measures into assessment of managed care organizations, and a number of consensus-development processes, have all contributed to a shift from viewing cultural

competence as an aspiration to a requirement, from an optional "extra" to a standard of care. While there have been some initiatives to develop cultural responsiveness standards and competencies in Canada, there has been greater reliance on voluntary measures, and confidence in the power of education about cultural differences to affect behaviour change.

Individual or Organizational Focus

Another dimension of difference in approach to cultural diversity is the level at which interventions to improve cultural responsiveness are focused. As discussed earlier, the tradition of "cultural competence," has tended to emphasize interventions geared towards individuals, often through training initiatives; and many organizations continue to limit cultural responsiveness initiatives to those focused on the individual provider. It is increasingly believed, however, that focusing on competence at the provider-client level is inadequate for developing culturally appropriate systems of care, and that without institutional change, even competent individuals will be limited in their ability to practice in a competent manner (Chin, 1999; Jones et al., 1998; Quandar, 2003).

Provider "Competence" or Client/Community "Access"?

While a growing convergence can be observed between the two concepts of "cultural competence" and "access" regarding what actions must be taken by organizations to increase their cultural responsiveness, there remain two major approaches to how "cultural differences" can best be addressed. One (the "provider competence" approach) focuses on increasing the skills of the provider. "Cultural competence" remains in large

part the language of professionals and health care systems, describing what they think they should do to address "the problem" of cultural difference. The "client/community access" approach, in contrast, emphasizes strategies to enable clients and diverse communities to participate in all levels of the organization – from the clinical visit to organizational governance.

Health care providers from a number of disciplines were among the first to articulate the need for "cultural competence." Providers deal directly with the frustrations and risks of providing quality care to patients who do not share the same culture or language. Understandably, their focus is on cultural competence at the level of the provider-patient interaction, not societal inequalities, or institutional barriers to participation. In this context, cultural competence has emerged as a behavioural expectation of providers, an additional set of competencies required to practice effectively and ethically in an increasingly diverse environment. It should come as no surprise that the most common solution identified by providers is the development of knowledge and skills to effectively manage the health care encounter. Generally the focus is on differences between providers and clients due to "ethnicity." Negotiating client compliance in the face of different beliefs, practices and communication difficulties is often a concern.

Because providers are working within a "monocultural" system that continues to be dominated by individuals from white, middle class backgrounds (Tator, 1998), the cultural biases within the organization that may lead to inequity in care are often not recognized (Cox, 1994). It is also difficult for professionals in identified "caring

professions" to recognize personal or organizational barriers that may result in lower standards of care (Culley, 1996).

The focus on "competence" in the provider-patient interaction, which continues to dominate much of the discussion on culture in health care, remains rooted in the traditional – and inherently unequal – relationships between provider and patient. The emphasis is on building resources within existing organizations and individual providers, rather than undertaking systemic change that would allow greater participation in planning and decision-making by underserved clients and communities.[2] Responses are built around the provider's perceptions of needs, which are often framed in terms of mastery of a finite body of knowledge, and demonstration of specific skills (Tervalon & Murray-Garcia, 1998), and assume continuation of the traditional provider-client relationship. The tendency to view "cultural differences" as a problem (rather than an opportunity) for which the health system itself must find the solution does not promote structural change, and there is little evidence that providers as a group feel the need for change at this level.

This approach, however, has faced increasing criticism over recent years, and there is significant variation in perspectives among individuals within specific provider groups. Dreher and McNaughton (2002) emphasize the "ecological fallacy" inherent in many approaches to cultural competence, as well as the tendency to nest accountability for competence with health care providers, where they believe application of cultural

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[2] Some of the challenges in determining "who represents the community" are explored in Section 3.2.4.

information is likely to be least useful. Some writers not only express concern regarding the underlying theoretical perspectives guiding many approaches to cultural competency, but reject, altogether, the concept of "competency" – often interpreted as *"demonstrable mastery of a finite body of knowledge"* (Tervalon & Murray-Garcia (1996: 118). Alternate approaches to cultural competence, such as "cultural safety" (Coup, 1996; Polaschek, 1998; Ramsden, 1993), and "cultural humility" (Tervalon & Murray-Garcia, 1998) have emerged as critiques of the focus on mastery of knowledge about culturally diverse groups.

The concept of cultural safety, which has emerged from Maori nursing in New Zealand, reflects an antiracist approach. Cultural safety involves recognizing the position of certain groups within a society, and focuses on how these groups are perceived and treated, rather than the different things their members think or do (Polaschek, 1998). "Unsafe" nursing practice includes *"actions that diminish, demean or disempower,"* whereas culturally safe practices *"recognize, respect and nurture"* (Polaschek, 1998: 453). Culturally safe care is defined by those who receive the service (Wepa, 2003), whereas in many cases cultural competence is defined by those who provide it.

Although cultural safety is often contrasted with a particular approach to cultural competence, that of transcultural nursing, many of the critiques also apply to the concept of cultural competence as it is commonly applied. Focusing on individual interactions is seen to be inadequate, and "cultural safety" proponents critique the idea that publicly funded health care is a simple service provided equally to all individuals. This approach

not only downplays the importance of specific cultural knowledge, it highlights the risks of disempowerment which may result from creating "experts" on oppressed peoples, and the added health risks that may result from stereotyping (Coup, 1996). It focuses not on ethno-specific information but on power relations (Reimer Kirkham et al., 2002). *"Rather than focusing on exotic belief systems of people from different ethnocultural backgrounds, and treating each group as a distinct entity, we are challenged, instead, to examine the unequal relations of power that are the legacy of our colonial past and neo-colonial present"*(J. Anderson et al., 2003: 196).

Cultural safety, which focuses on nursing education, has been controversial in New Zealand and used by few researchers in other countries, although some Canadian research has been informed by this approach (J. Anderson et al., 2003, Browne et al., 2000; Reimer Kirkham et al., 2002). It is unclear to what extent the focus on the impact of colonialism, so important for the health of indigenous communities, may be equally useful in examining other power relationships (such as gender, education, or socio-economic class).

Tervalon and Murray-Garcia (1996) suggest that "cultural humility" is a more appropriate goal than cultural competence. They propose that – as this approach represents a commitment to self-examination and critique, redressing power imbalances in the patient-physician dynamic, and developing partnerships with communities – it is more consistent with the emerging goals in health care, and facilitates greater communication and understanding between providers and patients.

Providers who are themselves members of racialized minorities may not support commonly held perspectives on cultural competence, which often reflect the assumptions of multiculturalism. Some providers, such as internationally trained physicians or Aboriginal health providers, identify structural barriers, including racism and discrimination, as key issues and are more likely to advocate for workforce representation or workforce diversity responses. Professional associations and unions may, however, function as a barrier to such approaches as their focus is on protecting the positions of current members. While these bodies have an important role in ensuring fairness in the treatment of their members, loyalty to those already in the system (and for whom the existing system may function well), along with a potential lack of appropriate representation from those excluded from organizational participation, may result in lack of support for some proposed cultural responsiveness initiatives, particularly those related to workforce diversification.

While providers have often proposed "cultural competence" as a response to the needs of "culturally different" clients, clients themselves have tended to use the language of "access." There is concern that "cultural competence" has in large part been defined and analyzed from a white, middle-class perspective, and may not best represent the approach preferred by underserved communities themselves. The voice of the consumer is generally not included in cultural competence research (Canales & Bowers, 2001; Hains et al., 2000; Pope-Davis, Liu, Toporek, & Brittan-Powell, 2001). In addressing barriers to "access" the focus is not on the competence of providers already within the system, but more pragmatically, on the barriers that prevent community members from participating

in health care organizations and services. While many patients highlight barriers to client access (such as failure to provide language access services), community advocates may also focus on barriers to organizational participation, particularly within the workforce and governing body.

However, there may be important differences in perspectives among users of health care services. Members of recent immigrant communities are most likely to identify issues of client access (e.g., language barriers and lack of orientation to services) as barriers to care. They are often struggling with the immediate issue of understanding the health system and communicating with providers. There is often a willingness to participate in services as they now exist. In contrast, strategies proposed by Aboriginal peoples often reflect awareness of the larger societal context of historical inequity and a desire to take responsibility for managing their own health services.

The Example of Language Access

Analysis of these underlying philosophical assumptions related to cultural competence and access provides some insights as to why certain approaches have received more support within the Canadian health care system than others. The issue of language access provides an interesting example.

Research has highlighted the effects of language barriers on ability to obtain care, participation in preventive and screening activities, perceived health status, patient satisfaction with care, diagnosis, patient understanding, and protection of patient rights

(Bowen, 2001; Bowen & Kaufert, 2000). Language barriers also often result in clients receiving different treatment (Bischoff et al., 2003) than those who speak an official language. They increase the incidence of "miscommunication, misdiagnosis, inappropriate treatment, reduced patient comprehension and compliance, clinical inefficiency, decreased provider and patient satisfaction, malpractice injury and death" (Office of Minority Health, 1999). Four of 14 national standards for culturally and linguistically appropriate care, recently developed in the United States to address cultural and linguistic competence, address the issue of language access (Office of Minority Health, 2001a). However, in Canada – with the exception of medical interpretation services for Deaf patients (Stradiotto, 1998) – the rights of patients to trained health interpretation have not been established, nor have the responsibilities of health services to ensure provider-patient communication, national training, accreditation and service standards (Rochefort, 2001). As a result, there is wide variation found between regions in availability of language access services, models of service provision, and program standards. Although there is compelling evidence of the dangers of using family, friends, or untrained volunteers to interpret for families, this approach is the most common in many areas of the country.

Given that of all the strategies identified for increasing cultural competence, addressing language barriers is the only one for which clear evidence of effectiveness is available (Brach & Fraser, 2000), it is useful to explore why there has been, in many jurisdictions, limited action taken to address the need for language access programs, and why, even

when interpreters are available, they are often not called upon (Burbano O'Leary

Federico, & Hampers, 2003).

A lack of response to language needs is consistent with the "provider competence"

approach. As many educational interventions focus on learning "facts" about specific

ethnic groups (rather than, for example, skills in intercultural communication, including

working with an interpreter), the result has often been that lower priority is given to

issues such as development of professional interpretation programs. Some approaches to

cultural training may, at worst, result in shifting attention and resources away from the

importance of language access services (which allow the client to participate in the health

care encounter as an active partner). Case study research has documented instances where

providers have relied on their supposed "knowledge" of specific cultural practices as a

substitute for individualized assessment based on accurate communication (Bowen

Stevens, 1993; Tervalon & Murray Garcia, 1998).

"Culturally competent" care cannot be achieved simply by ensuring linguistic

communication between provider and patient. Those who do not speak an official

language are likely to face additional barriers to equitable care. However, language

access is a pre-requisite for culturally competent care to occur. Unless there is effective

communication, it is not only impossible to be sure that the "facts" about the client's

condition have been established, but exploration by the provider and patient of the

relationship and importance of the client's various cultural identities (gender, education,

income, sexual orientation, and life experiences) to the client's health and illness is often prevented (Bowen, 2001).

Effectiveness of responses to addressing language barriers will differ based on the level at which the intervention is made. Although individual providers may make a commitment to call for interpreters when needed by their clients, this personal initiative may be of limited effectiveness unless there is commitment at the organizational level: policy development, appropriate financial support, and integration of language access services into the strategic plan (Carrillo et al., 1999). Failure to ensure organizational level interventions (relying instead on promoting individual competence) tends to contribute to a de-emphasis on interventions such as professional interpreter programs.

Summary: An Emerging Theory of Organizational Cultural Responsiveness

In spite of diverse definitions and differing perspectives on how best to meet the needs of culturally diverse clients, my review of the literature suggests an emerging consensus on characteristics and approaches of effective responses. These trends I have described as a transition from "caring" to "outcomes," from a focus on culturally competent providers to culturally competent systems of care, and from a focus on ethnicity to recognition of complex cultural identities.

From Caring to Outcomes

It is generally agreed that cultural competence is not an end in itself (Campinha-Bacote, 1999; Lonner, 2000; Paez, 2003a), but a necessary condition for ensuring equitable care,

and ultimately improved health outcomes. There has been an important shift in the rationale for cultural competence from a way to show "sensitive caring" to patients, to a means of addressing health inequalities. As Baxter (2001) observed, it is now considered good practice to emphasize competencies and outcomes in relation to achieving organizational goals; best use of human and financial resources; and the strategic action required to bring about a paradigm shift from goodwill to competence.

From Culturally Competent Providers to Culturally Competent Systems of Care

There is also increasing recognition that while culturally competent providers are an essential component of culturally competent care, improving the competence of individual staff is not enough. The focus must be on achieving competent systems of care: this requires organizational change. Related trends include shifts in emphasis: (a) from staff training to organizational development; (b) from provider-patient interactions to "how we do business"; (c) from voluntary guidelines to mandated standards, and (d) from separate "add-on" programs to cultural responsiveness as an integral component of the organizational strategic plan.

From a Focus on Ethnicity to Recognition of Complex Cultural Identities

There is growing awareness of the importance to cultural identity of a variety of shared attributes (such as gender or sexual orientation) or shared life experiences (e.g., parenting a disabled child or experience of sexual abuse). It is increasingly accepted that cultural competence must be defined to include factors other than "race", language and ethnicity. Related trends include the evolution from deterministic to complex and interactive

conceptualizations of culture, and from a focus on differences between cultural groups to recognition of differences within groups. This is mirrored in the business "diversity" literature, where a broad definition – one that goes beyond the visible differences of race, ethnicity, age and gender – is the trend, and where factors such as education, socio-economic status, and work experience are seen as often more potentially important than ethnicity (Kohnen, 2003; Society for Human Resource Management, 2003).

Conclusion

In the traditions of both improved "access" and "cultural competence", there has been an important shift in the literature from a concern about "sensitive caring" to an emphasis on health outcomes and equity of treatment. This outcome-oriented approach, if adopted, may help resolve many of the differences found between proponents of improved cultural responsiveness. It will define groups based on evidence of differences in health outcomes (including intermediate outcomes such as access to needed services, treatment prescribed, and satisfaction with care); it will avoid many of the limitations of both the multicultural and anti-racist approaches; and allow interventions to be evaluated on evidence of change in health outcomes (or indicators of health outcomes). It also provides an impetus to align cultural responsiveness with other quality initiatives. This approach converges with the approach to cultural diversification used within the business community, where cultural competence is aligned with an organization's "business plan."

The next chapter focuses on defining and identifying "best practices" as they relate to cultural responsiveness of health organizations.

CHAPTER 3: BEST PRACTICES OF CULTURALLY RESPONSIVE ORGANIZATIONS

At the same time that these trends in organizational cultural responsiveness have been emerging there has been increasing interest in identifying "best practices" of culturally responsive organizations. The first section in this chapter outlines the current state of research related to culture and health; the second discusses the concept of "best practice" as it is used in this dissertation. The third section summarizes "best practices" as identified through a review of the literature. These "best practices" have been organized into seven domains: institutionalization of responses; ensuring language access; cultural training for staff; human resource policy; community participation; information for clients and community; and data collection, evaluation and research. Included in the discussion of each domain area is an overview of the challenges in implementing these identified "best practices", and of their appropriateness for adoption in Canada.

Subsequent sections discuss issues related to assessment of cultural responsiveness at the organizational level, and report on preliminary activities undertaken with the National Network for Cultural Competency in Paediatric Health Care. The chapter concludes with a description of the process used to develop a document review instrument designed to assess the cultural responsiveness of health care organizations.

Limitations of Current Research on Culture and Health

Limitations of research related to cultural responsiveness are experienced in several areas. First, there is a paucity of research on cultural competence and health care access, particularly on the impact and effectiveness of various approaches (L. Anderson et al., 2003; Brewster, Buckley, Cox & Greip, 2002; Henry J. Kaiser Family Foundation, 2003). Much of the literature on "cultural competence" is based not on research evidence but on theory (Betancourt et al., 2002; Sue, 1998), and much of the research on "access" is limited to analysis of utilization. While it is theorized that improved responsiveness has the potential to improve health outcomes and increase efficiency (Brach & Fraser, 2002), with the possible exception of language access programs (Bowen, 2001; Brach & Fraser, 2000), there is insufficient evidence to determine the effectiveness of specific interventions (L. Anderson et al., 2003). One major perspective missing from the research is that of "minority" groups themselves (Canales & Bowers, 2001; Hains et al., 2000; Pope-Davis et al., 2001). Most health research and policy is based on the "minority health disparity" assumption, and does not consider the strengths of "minority" cultures and what the health system can learn from these strengths (Bowen Stevens, 1993; Hayes-Bautista, 2003).

One of the difficulties is that, until now, there has been no consensus on definitions of cultural competence or access, and little attempt to link specific activities with proposed outcomes. Conceptual models, which outline these links, are required to provide a base for future assessment (Brach & Fraser, 2000). Nor is there an agreed-upon categorization

of "domains" of culturally responsive interventions, which are categorized differently by different authors.[1]

Second, there is good evidence that both health services and clinical research routinely exclude cultural minorities, especially those lacking official language proficiency (Frayne et al., 1996; Giuliano et al., 2000; Jacobs, Hardt & Alvarado-Little, 2001; Li et al., 2001; Lovato, Hill, Hertert, Humminghale & Probstfield, 1997). Few health services, for example, take steps to ensure that program evaluation includes the experiences of linguistically and culturally diverse clients. This exclusion limits the generalizability of research, affecting not only the health of "minority" groups, but also the population as a whole (Li et al., 2001).

Third, with the exception of coding related to treaty status, Canadian data on health status and service utilization generally does not designate ethnicity (Robinson, 1998; Sheth et al., 1997), although it may record which of the official languages is spoken. There is, at present, no consensus about whether collection of data on ethnicity, "race" or language is desirable; nor about what aspects of ethnicity are of importance. The absence of ethnic identifiers places significant limitations on the ability to research differences in health processes and outcomes among populations (Bierman, Lurie, Collins & Eisenberg, 2002).

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[1] For example Brach & Fraser (2000) in their review of the literature identify nine domains for cultural competence: 1) interpreter services, 2) recruitment and retention of culturally diverse staff, 3) training, 4) coordinating with traditional healers, 5) use of community health workers, 6) culturally competent health promotion, 7) inclusion of family and community members, 8) immersion in another culture, and 9) administrative and organizational accommodations. Siegal et al. (2000) suggest the domains of needs assessment, information exchange, services, human resources, policies and procedures, and culturally competent outcomes. The 14 standards for Culturally and Linguistically Appropriate Care (Office of Minority Health, 2001) also describe domains for attention.

The availability of data on First Nations communities – made possible because of this ethnic coding – has highlighted the significant gap in health status between First Nations peoples and the general Canadian population (Health Canada, 1999; Martens et al., 2002). The same information is generally not available on language minorities or other ethnocultural groups. While some institutions do collect data on ethnicity or language, there are no standards or requirements for consistency. This results in data of variable quality that cannot be compared or combined with that of other institutions. There is also variability in ethnic data available on the health workforce. Employment equity legislation identifies visible minority, Aboriginal, and disability status (Harvey & Blakely, 1996), but this may not be collected in all organizations. This historical and policy context presents additional challenges for Canadian researchers intending to undertake research on differences in health status, health access, and quality of care.

Fourth, many methodologies used in general health research are themselves either culturally biased, or fail to make accommodation for the realities of working in a diverse environment. The result is that much research overlooks those likely to be most vulnerable. For example, sampling strategies may fail to capture the experience of specific "minority" groups (Li et al., 2001). Assessment instruments may not be valid when translated or used in other cultural contexts. There are serious limitations in use of patient satisfaction instruments in cross-cultural contexts (Crow et al., 2002). Many studies use patients' assessment of their own symptoms, functioning, satisfaction, and preference. However most of these measures have been developed in English, and for clients from the mainstream culture. There is evidence that they may not be relevant or

appropriate for use with other linguistic or ethnic groups, as important differences, particularly in use of rating scales, have been found by measures of ethnicity (Berkanovic, 1980; Flaskerud, 1988; Hayes & Baker, 1998; Murray-Garcia, Selby, Schmittdiel, Grumbach & Quesenberry, 2000; Ren & Amick, 1998; Taira et al., 1997; Villarruel, 1998). These differences make it difficult to determine whether differences in subjective measures are related to actual quality of care, or to variation in patient perception, expectation, or response style.

Research designed to determine the interaction effects of membership in more than one underserved group is still in its infancy, and little research has simultaneously studied the effects of factors such as gender, and cultural, "racial" or economic factors (Krieger et al., 1993) even though the effect of one factor (e.g. income), may have different effects by gender, "race" or ethnicity.

Although research focusing on "culturally competence" is a developing area, guidelines for how it is to be conducted have been developed (see for example, Meleis, 1996; Villarruel, 1999). Organizations must first recognize that minorities have been excluded from much research, and consider the effect that this exclusion has on the knowledge of health care providers.

Defining Organizational "Best Practice"

The paucity of research in the area of cultural responsiveness creates particular challenges for determining related "best practice." Definitions of best practice are

generally based either on firm evidence linked to specific outcomes, or developed to ensure compliance with regulatory or legislative standards. In the United States, some "best practices" are based on specific legislation and standards; this is generally not the case, however, in Canada.

As outlined in the previous section, very little evidence related to the impact of specific cultural responsiveness interventions on health outcomes is available, and there is a continuing need for development and assessment of conceptual models linking specific cultural competence interventions with health outcomes. (Brach and Fraser (2000) provide such a model, focusing on the example of interventions to ensure language access). What is evident from the research from a number of countries, however, is that some population groups have lower health status. There is also strong evidence from U.S. research that members of specific ethnic/"racial" groups are treated differently by the health system. Some evidence, in particular differences between populations groups with regard to participation in preventive and screening programs, is also available for Canada. Given that there is strong evidence of a "problem," and a theoretical base for specific interventions, it can be argued that there is direction for action, and that practitioners and organizations should proceed based on the best evidence available. The paucity of funding for cultural responsiveness research in Canada also suggests that waiting for incontrovertible evidence may result in non-action even in the face of evident disparities.

Many health care experts make clear connections between cultural competence, quality improvement, and elimination of disparities. In the absence of definitive research, best

practice is often identified through expert consensus combined with available research and emerging evidence (Betancourt et al, 2002). As a result "cultural competence" in health care is now promoted as an important strategy to address health inequities, and there is emerging consensus on best practices related to cultural responsiveness at the organizational level. While this trend is most evident in the United States, the language of "best practice" is now common in many other countries, including Canada – where organizations, nursing associations and health regions are developing standards and "competencies" related to cultural responsiveness. As this "best practice" terminology is now in common usage in Canada, I have adopted this term to describe the emerging expert opinion identified through my review of the literature.

The following summary of identified "best practice" at the organizational level is based on: a) emerging trends in the theoretical literature; b) academic research; c) the literature on organizational diversification; d) criteria, standards and guidelines developed through the national consultation process sponsored by the U.S. Department of Health and Human Services Office of Minority Health; e) guidelines and standards developed by other organizations and systems; and f) descriptions of exemplary programs. Several recent reports (Betancourt et. al., 2002; Health Human Resources and Services Administration, 2001; Henry K. Kaiser Family Foundation, 2003) have highlighted concrete examples of how these best practices have been implemented in specific organizations.

I have grouped identified best practices into seven areas: institutionalization of response; ensuring language access; cultural training for staff; human resource policy; community

participation; information for clients and communities; and data collection, evaluation and research. These "best practices" have been selected based on their appropriateness for use in the Canadian context. Each section discusses some of the challenges related to assessing best practice in this area, and the relevance for their application in Canada.

Domains of Culturally Responsive "Best Practice"

Institutionalization of Responses

Effective organizations institutionalize cultural competence (Health Human Resources and Services Administration, 2001): they develop an organizational framework to support cultural competence initiatives (Office of Minority Health, 2001a: Standard 8); and integrate cultural competence activities into all aspects of the organization. It is not enough to have culturally responsive programs. *"The service's strategic goals, plans, policies, and staff designations should not be framed in a way that a department initiative or activities are set apart from the rest of the life of the organization"* (Office of Minority Health, 2001a: 85). It is impossible to implement and manage cultural responsiveness activities without a structured and strategic approach (Office of Minority Health, 2001a).

A number of criteria have been suggested in this domain: (a) accountability for cultural responsiveness at the highest levels of the organization; (b) representation of community diversity at the levels of governance and senior management; (c) clear commitment to cultural responsiveness in the organization's mission, values, and operating principles; and (d) a written strategic plan that outlines clear goals, policies, and operational plans. Development of this cultural and linguistic services plan should incorporate the

participation of clients and community. The plan should include activities, time lines and milestones, and establish accountability and responsibility for initiatives.

Specific policies related to diversity, access and cultural competence (including policies related to language access; staff recruitment, retention and promotion; data collection; and complaint and grievance procedures) must be developed. In addition, mechanisms for performance monitoring must be established, and appropriate allocation of resources for cultural responsiveness initiatives (e.g. interpretation, translation and research) ensured.

Some authors identify the first step in assessment and planning as assignment of responsibility for the initiative (Paez, 2003a). The options for doing this include: integrating cultural responsiveness assessment and strategic planning processes; integrating such assessment and planning into the work of existing teams whose efforts are closely aligned with the purpose of improving culturally and linguistically appropriate service (e.g., quality improvement); creating a new position or department to lead the process, or assigning responsibility to specific individuals. There is consensus that a critical requirement for effective organizational integration is a clear and unequivocal statement by organizational leaders on the importance of diversity; it is also recognized, however, that more than statements are required to bridge the gap between espoused and enacted values (Gantz, 2001).

<u>Challenges and Implications for Canadian Practice</u>

These "best practices" are consistent with the management and organizational development literature, and have been demonstrated to be important in a range of organizational settings, and related to many different "best practice" areas. They are not, therefore, either "new," or applicable only to cultural responsiveness initiatives. However, it has not been the tradition in Canada to integrate or institutionalize culturally responsive practice at the organizational level, and reliance on voluntary initiatives focused on individual service providers remains the norm. The challenge, therefore, lies in gaining acceptance of "cultural responsiveness" as an issue of sufficient importance to be addressed at the organizational level, and one to which organizational development principles apply.

<u>Ensuring Language Access</u>

Culturally responsive organizations recognize that language access is a fundamental prerequisite of culturally competent care. Several criteria have been identified. Policy and programs should be in compliance with relevant equity legislation. Written policy should be in place that addresses: (a) a client's rights to free health interpretation; (b) requirements for providers to use interpreters; (c) specific actions to ensure interpreter coverage at all points of access; (d) specific policy addressing use of family members as interpreters; (e) standards for training providers to work with interpreters; (f) the training and/or accreditation required by interpreters; and (g) appropriate mechanisms for evaluating interpreter competence and client satisfaction. Interpretation programs should receive adequate resources to support the services required.

Successful programs recognize the complexity of language interpretation, and reflect the awareness that communication is more than simply shared language. They recognize: (a) linguistic variation within a cultural group; (b) cultural variation within a linguistic group; and (c) variation in literacy within a language group (Health Human Resources and Services Administration, 2001).

While many different models of interpretation service have been developed, the strengths and limitations of these models is poorly understood and little comparative research is available (Bowen, 2001; Downing & Roat, 2002). However, there is expert consensus on a number of key issues and on minimum standards of service provision (Appendix A). While specific models developed should reflect local community demographics and needs, any model adopted should ensure that these minimum standards are achieved. Reliance on family members and other untrained volunteers in not acceptable. It is likely that for many centers a combination of models will be necessary depending on the populations served, presenting problems, skills needed, and availability of resources (Carr, 1995; Durbach, 1994).

Challenges and Implications for Canadian Practice

Bowen (2001), in a comprehensive review of the literature related to language access, analyzed research evidence from a Canadian perspective, and assessed implications for the provision of health care in Canada. She concluded that there was strong evidence from Canadian programs that patients who do not speak an official language often do not receive the same standard of ethical health care as other Canadians, and that much

(though not all) of the international research evidence on the negative impact of language

barriers can be appropriately generalized to the Canadian context.

Significant research has been undertaken in many countries on the effects of language

barriers, and there is strong evidence of negative impacts on treatment received, patient

satisfaction, understanding and compliance, and health outcomes. There is also mounting

evidence that language barriers have a larger negative effect on quality of care than does

"race" or ethnicity (Bowen, 2001; Weech-Maldonado et al., 2001). While Canada lacks

the legislative framework mandating provision of language access services to all

language communities, evidence related to the risks and benefits of various responses to

addressing language barriers is relevant in this country. There is also strong international

consensus on risks of untrained interpretation and minimum standards of service

provision.

Standards development appears to be most developed in the area of language access. A

number of U.S. jurisdictions have developed comprehensive policy and standards in this

area (see for example, Paez, 2003b; Torres, 2001). In Canada, there is significant

variation in service availability and development of standards both between provinces

and between individual health service institutions/organizations.

Canada faces some particular challenges in this area as language access for separate

language constituencies (official languages, First Nations and Inuit languages, visual

languages and "immigrant" languages) is governed by different legislation, and often the

responsibility of different government departments. In many centres, provision of interpretation services has not been taken on as a responsibility of the health system, and reliance on family/volunteers or community groups, with no accountability to health services, is common. Awareness of existing research on the impacts of language barriers remains low: a particular challenge relates to framing the issue of language access as an essential component of quality of care.

Cultural Training for Staff

Culturally responsive organizations ensure appropriate education and training for staff (Office of Minority Health, 2001a: Standard 1). Training should be comprehensive and avoid simplistic stereotypes. "Recipe-book" approaches should be avoided. The following list of "best practices" in cultural training is adapted from criteria identified through the consensus process undertaken by the Office of Minority Health (Office of Minority Health, 2001a), and also reflects the emerging consensus on key elements of cultural training identified by a number of authors (Abrums & Leppa, 2001; Brewster et al., 2002; Carrillo et al., 1999; Canadian Paediatric Society, 1999; Casse, 1981; Coup, 1996; Dreher & Macnaughton, 2002; Duffy, 2001; Fuller, 2002; Green et al., 2002; Kai, Bridgewater & Spencer, 2001; Lavizzo-Mourey & Mackenzie, 1996; Nunez, 2000; Tervalon & Murray-Garcia, 1998):

- awareness of the impact of one's own individual culture on knowledge and attitudes, and the effects of this culture on interactions with patients and colleagues
- effects of the cultures of the organization, one's own profession, and the health care system, including potential barriers to care presented by organizational cultures

- effects of culture on health outcomes, satisfaction and management of disease

- effects of cultural differences on health promotion, diagnosis and treatment, and supportive, rehabilitative and end-of-life care

- specific information related to priority patient populations

- differences in clinical management of diseases indicated by the "race", ethnicity or country of origin of patients

- diversity found within "ethnic" groups; and the impact of other cultural characteristics (e.g. poverty and socioeconomic status, "race" and racism and other socio-cultural factors affecting access to care, utilization, quality of care and health outcomes)

- effective communication, including how to work with interpreters

- strategies for the resolution of racial/ethnic and cultural conflicts, including organizational policy and complaints/grievance procedures

- rights to culturally competent care, including federal and provincial/territorial legislation.

Challenges and Implications for Canadian Practice

Best practice guidelines in this area specifically address the need to provide training within the political, legislative, and historical context in which care is provided, while at the same time incorporating relevant research and expert international consensus on effective cultural training. These guidelines are therefore appropriate for application in a range of settings and countries.

A particular challenge for many Canadian settings is acceptance of the need for expansion of training from a culture-specific approach to one that also incorporates skill development (for example, skills in intercultural communication and working with an interpreter), elements of anti-racism training, and a focus on organizational responsibility.

Human Resource Policy

Management of human resources is a critical aspect of culturally responsive organizations. In these organizations, the goal of staff diversity is incorporated into the organization's mission statement, strategic plan and goals (Office of Minority Health, 2001a: Standard 2). Proactive strategies must be developed both to build a diverse workforce, and to establish mechanisms for assessment and monitoring of the cultural competence of providers. Human resource policy and practices (including those related to recruitment, candidate selection criteria, performance evaluation guidelines, and reward systems) must reflect a commitment to diversity. There is a need for human resource information management systems that can monitor changes in workforce diversity over time, and by level. Strategies to identify training needs and standards must also be developed and implemented.

Challenges and Implications for Canadian Practice

While there is an increasing emphasis on workforce representation and affirmative action strategies in the United States, in Canada cultural awareness or sensitivity training appears the most common response to demands for improved "cultural responsiveness." Although there is widespread acceptance of the need to ensure that applicants and

employees from all ethnic/"racial" backgrounds are treated the same (often reflected in anti-discrimination policy), strategies to increase the representation of specific ethnic/"racial" groups remain contentious, in spite of the evidence of barriers to employment and promotion faced by visible minority and Aboriginal applicants (Kunta, Milan & Schetagne, 2000). These strategies, often perceived as providing "special" opportunities for specific groups, are often viewed as "unfair" by employees and the public, and may not be supported by unions and professional organizations. Much of the discomfort with such initiatives results from lack of awareness of the impacts of systemic – rather than individual – racism and discrimination. An additional barrier may be the traditional separation of immigrant from Aboriginal equity issues, which may result in competition for acknowledgement and resources.

In addition, there are important differences in approach to addressing workforce diversification (described in Chapter 2 as the "ethnic matching", "workforce representation" and "workforce diversity" approaches). A review of the recent business literature related to organizational diversity indicates that a number of limitations have been identified in some of the approaches to date, particularly those based only on "correcting" past injustices (Gandz, 2001; Glastra et al., 2002). Considerable work is needed to develop consensus on the most equitable, effective and acceptable strategies in this area. At the same time, there is growing acceptance of the need for representation and participation of all sectors of the community in governance, decision-making, and staffing. A challenge for organizations, however, is that many of the barriers to workforce participation must be addressed at the systems, rather than the organizational level (e.g.,

strategies to increase enrolment of Aboriginal peoples in health-related faculties, or to address barriers to accreditation/licensure faced by immigrant professionals).

Community Participation

Culturally responsive organizations involve the diversity of the community in all aspects of planning, program implementation and evaluation. This includes community involvement in the development of policy, the implementation and evaluation of services, and – where appropriate – identification of research priorities and appropriate methods. In a culturally responsive organization, organizational governance reflects the diversity of the community served. Mechanisms for ongoing input and feedback from clients and the community are established and maintained. Strategies are developed for community representatives to participate in needs assessment and developing community profiles, service planning and evaluation, and development of organizational policies, evaluation strategies and communication strategies. Linkages with other agencies, associations and educational bodies are formalized, and the organization participates in community activities and is involved in community issues. Concrete strategies are developed to address barriers to participation in program evaluation and research activities.

Culturally responsive organizations identify innovative strategies for participation. A variety of different methods may be used, including liaison workers, focus groups, key informant interviews, or community advisory committees. Strategies must recognize the inherent power imbalances between health care organizations and community members (Office of Minority Health, 2001a). Culturally responsive organizations take steps to

avoid "token" representation, accept the challenge of recognizing the diversity within

identified "communities," and ensure that input is received from all sectors (Bowen

Stevens, 1993).

Challenges and Implications for Canadian Practice

While it is now commonly accepted in Canada that some form of partnership with the

community is important for good practice (see for example Canadian Council on Health

Services Accreditation (CCHSA), 2001), there are a number of complex issues to be

considered in bringing community representation into the decision-making process.

Organizations with little diversity experience often make serious errors by selecting

spokespersons who may not be perceived by the community as representing their

interests. Health care institutions are particularly vulnerable as they are often less

connected to various communities in their catchement area than are primary care or

community-based services. Bowen Stevens (1993) suggests that careful preliminary

community-based assessment be undertaken before community representation is selected.

This requires developing informal networks and communication channels to determine

how "communities" are to be defined, sectors of the community that are priorities for

representation, and who has credibility within specific defined "communities." She

provides a step-by-step guide that can help organizations avoid common pitfalls: e.g.

failing to recognize ethnic, language, class, or religious diversity within a defined

"community"; selecting representatives with whom staff feel comfortable but who may

not have credibility within their community; or becoming aligned with one particular

political orientation. To achieve appropriate and effective representation, it is necessary for healthcare organizations to prioritize the skills necessary to undertake this type of community networking and consultation in hiring for key positions, and to dedicate the time required for research and consultation before selecting representation for governance and advisory bodies.

Information for Clients and Community

In culturally responsive organizations, information on services, rights to service, and complaint/grievance procedures are readily available to all patients. This information should be available in the most widely-used first languages of the community. Orientation to health services, and the beliefs and practices of the culture of the health care system should be made available as appropriate. A culturally responsive organization establishes guidelines and minimum standards for translation and development of health materials, and involves the community in resource development. Consent forms, applications, and medical or treatment instructions are made available in the common languages of the community. Appropriate signage (universal signage, and/or signage in the most commonly used languages of the community) is available throughout the facilities.

In addition, culturally competent organizations provide opportunities for information sharing between the organization and the community served. This includes provision of information on organizational services, and the results of needs assessment and program evaluation activities.

Challenges and Implications for Canadian Practice

A key challenge for any organization lies in determining which languages, and which information, is a priority for translation. As it is not feasible to provide all information in all languages, a good knowledge of the community (and partnership with specific ethnocultural communities) is required to set these priorities. Cost is a major factor in materials development and translation, requiring careful evaluation of the benefits of materials provision in other languages. While organizational policy (and provincial or federal legislation) may require information in the two official languages, there may be awareness or attitudinal barriers to addressing needs of other communities, and to exploring less costly (and perhaps more effective) alternatives (for example signage, or training community-based educators) for providing information to other language or ethnic communities.

Data Collection, Evaluation and Research

Collection of Data on Individual Clients/Consumers

Culturally responsive organizations ensure that relevant data on "race," ethnicity and language are collected into health records and integrated into an organization's management information system. Specific organizational policy related to ethnic/language coding is established, and codes used to identify ethnicity/culture are integrated into the organization's information management systems. This categorization should ideally be consistent with national practice in order to allow comparisons between facilities and provinces. The categorization must also recognize the diversity within large "racial" and ethnic categories, and the range of possible ethnicity-related factors

that may affect health (such as Aboriginal or visible minority status, immigration status, length of residence in Canada, or language proficiency). Analysis of service data should include this coding, in order to compare processes and outcomes across populations.

Collection of Data on Communities

Culturally responsive health care organizations maintain current demographic, cultural and epidemiological profiles of the community, and undertake community assessments to plan and implement services that respond to the cultural and linguistic characteristics of the service area (Office of Minority Health, 2001a: Standard 11). Kinds of data collected include: a) descriptions of geographic, demographic and socioeconomic status; b) languages spoken in the community; c) factors related to need for interpretation services; d) population densities; e) analysis of cultural needs, practices, and behaviors; f) community resources and assets; and g) community perceptions of current health services. This data is used to guide planning, evaluation and research activities.

Research and Evaluation

Culturally responsive organizations recognize the importance of research, ensure that research they undertake includes issues related to culture, and removes barriers to the research participation of culturally diverse groups. "Culture" is incorporated into the overall research plan of the organization. There are strategies in place to include the participation of the community, where appropriate, in identification of research priorities and appropriate research methods, and in research implementation and analysis. Specific strategies are developed to address language and cultural barriers to participation in

relevant evaluation and research activities. At a minimum, consumer assessments are compared by measures of ethnicity, as any variation between groups is a measure of organizational performance (Weech-Maldonado et al., 2001). There is recognition of the challenges of using measures (e.g., related to satisfaction or self-rated health) in cross-cultural environments. In addition, the organization is prepared to play an advocacy and education role with educational, research and funding bodies, in order to promote awareness and knowledge of cultural issues.

Challenges and Implications for Canadian Practice

In the United States, data collection must adhere to racial and ethnic categories specified in the OMB (Office of Management and Budget) policy directives. In Canada, collection of such data is not required, and there continues to be debate about whether it is useful, or even allowed. Routinely collected data, such as administrative data, at present only includes information on Registered (Treaty) Indian status. Use of identifiers for First Nations and other Aboriginal communities requires consultation with, and permission of, these communities themselves.

Much of the research on income factors related to health status and utilization relies on data linkage. For example, anonymized patient data may be linked to the average income data related to the postal code in which they reside. Such methods are not well suited to analysis of differences based on ethnicity. However, some relevant data is available through census information and to a limited extent through national health surveys.

As a result, Canadian health services face real limitations in adopting some of the best practices described in this section. The absence of "ethnic coding" in health data places limitations on the ability of health systems and specific organizations to identify and respond to any disparities between populations. Many key issues must be addressed at the systems rather than the organizational level; there must be consensus at the provincial and national levels on the benefits of ethnic coding, and agreement on the "categories" in which data will be collected. Legislation must be established to permit and monitor this use. While some Canadian health organizations have instituted systems of ethnic or language coding for their own institutions, this coding varies between organizations, and even among programs under the same health authority.

Many other best practices in this area, however, can be implemented at the organizational level. Organizations can initiate discussion of issues related to ethic coding, and incorporate some markers within their information management systems. They can develop and enforce guidelines for research design and participation that promote culturally competent research, and support research on disparities in health and treatment received between specified populations. They can provide education opportunities for researchers and program evaluators related to the limitations of many research methods in a culturally diverse population, and advocate with funding agencies for support of appropriate cultural responsiveness research.

Development of Standards for Cultural Responsiveness

Based on the growing consensus around best practices, a number of number of bodies have developed position papers on cultural competence: e.g., ACOG, 1998; American Academy of Pediatrics, 1999, 2000; American Nurses Association, 1991; Canadian Association of Speech and Language Pathologists and Audiologists, 2002; Canadian Mental Health Association, 2001. However, in many cases it is not clear how the principles expressed in these documents are to be operationalized, monitored, or enforced.

In the United States, several organizations have developed extensive standards for cultural competence. Most standards are limited in scope to only one issue, or sub-field of health (Office of Minority Health, 2001a). The field of mental health appears to be one of the most advanced in this area. For example, an extensive set of competence standards for managed mental health care (including implementation guidelines, and recommended performance indictors, outcomes and benchmarks) has been developed for mental health (Western Interstate Commission for Higher Education (WICHE), 1998), and the American Psychological Association (2002) has developed guidelines for providers of psychological services to ethnic, linguistic and culturally diverse populations.

The report "National Standards for Culturally and Linguistically Appropriate Services in Health Care", published by the U.S. Office of Minority Health (2001a), is intended to develop a national approach across disciplines and organizations. A national advisory committee developed draft standards based on a review of existing cultural and linguistic

competence standards and measures. This draft was then circulated nationally to a variety of stakeholders for the purpose of input and consultation. Of the 14 standards, three relate to culturally competent care, four to linguistic access and seven to organizational supports for cultural competence. These standards are based on an analytical review of key laws, regulations, contracts and standards currently in use by federal and state authorities and other national organizations in the United States. The national standards are meant to correct inequities that currently exist in provision of health services, and make these services more responsive to the individual needs of all patients and consumers. They are also intended to provide a means for health professionals, policy makers and others to create accountability within their organization. A practical guide for their implementation has also been developed (Office of Minority Health, 2001b). The standards are expected to have an impact on structural requirements, process requirements and outcome expectations of health organizations (Shaw-Taylor, 2002), although there are differences in legislation between states, and related to regulation within professions.

A similar process of coordinated national consultation has not yet been initiated in Canada, although some preliminary consultations have been held regarding development of national standards for language access (Rochefort, 2001), and draft standards for paediatric care were developed by the National Network for Cultural Competence in Paediatric Health Care (National Network for Cultural Competence in Paediatric Health Care, 2002).

Strategies for Assessing Best Practice at the Organizational Level

<u>Development of Indicators and Outcomes of Culturally Responsive Service Delivery</u>

An indicator can be defined as a performance measurement tool, screen or flag, that is used as a guide to monitor, evaluate, and improve the quality of client care, clinical support services, and organizational functions that affect client outcomes (CCHSA, 2001). An indicator can measure outcomes (changes that are the result of the service provided), processes (content and quality of activities, services, programs), or structure (resources used) (Donebedian, 1988). While there is "a national movement toward a focus on outcome, better quality measurement, and comparative reporting" (CCHSA, 2001; Indicators: 8), indicator development remains a challenge in all areas, and only a few health service indicators currently in use meet all the criteria for validity. The CCHSA suggests that indicators be considered "tools" that are used to ask questions and generate improvement, and recommends that national indicators be selected.

"Cultural responsiveness" may be viewed as a strategy for achieving a desired outcome (process), or, if the concept of outcomes is expanded to include results of interventions at multiple levels, we can speak about cultural responsiveness as an outcome, i.e., a change in a level of the system other than the consumer (Woocher, 1999). As cultural responsiveness is not an end in itself, but a means to the ultimate goal of improved health outcomes (Campinha-Bacote, 1999; Lonner, 2000; Sue & Arredondo, 1992), these health outcomes can be viewed as essentially "culture free" (Jones et al., 1998). In other words, differences in outcomes across or between groups result from the processes and structures of care. In measuring outcomes of culturally responsive care at the individual level,

already validated indicators (related to wait times, medication incidents, breastfeeding initiation rates or unplanned readmissions, for example) could be employed. Differences between cultural groups on these indicators would indicate different needs, or different processes of care. What is required, however, to measure any differences in client health outcomes is some form of coding which allows analysis of outcomes by group membership. In order to allow comparisons between regions and provinces, it would be necessary to have national consensus on these coding categories, as well as a system for training in their use.

If, on the other hand, outcomes are measured at the organizational level, specific indicators of "cultural responsiveness" can be developed. These indicators of processes that are proposed to affect health outcomes can be based on the "best practices" identified in the literature. Examples of such indicators include: the number of staff by cultural group and by workforce level; presence of a cultural competence plan; percentage of staff receiving cultural competence training; availability of translated materials; or number of client satisfaction surveys conducted in a specific language. Proposed indicators have been developed for diversity measurement within organizations in general (Brewster et al., 2002), and specifically for health services (Lewin Group, 2002). However, no "benchmarks" have been established for these indicators.

Dreachslin (1999), based on her review of the literature, suggests that indicators can be related to different stages of organizational transformation towards cultural competence. For example, in the initial phase of organizational development, the emphasis of

indicators may be on: (a) gathering information on the demographics of the community, its workforce, and on the relationship between "race"/ethnicity and health behaviours; (b) acknowledgement by providers and administrators of the need for training and development; and (c) incorporation into the strategic plan of the goal of a representative workforce, and equitable health outcomes for all "racial"/ethnic groups. Indicators developed for later stages of organizational development include detailed measures of workforce diversity, health care delivery, leadership, and daily operations.

There is no consensus on "state of the art measures of quality, satisfaction, and outcomes related to culturally and linguistically appropriate care" (Office of Minority Health, 2001: 90). One of the challenges in developing indicators is linking a concept to an observation that can be collected in an information system (Casebeer, Deis & Doze, 1999). The literature has not linked cultural competency or access activities with the outcomes that could be expected to flow from them (Brach & Fraser, 2000), and these concepts have not been translated into quality indicators or outcomes that are monitored, evaluated or mandated as professional and regulatory standards (Chin, 1999). While a number of indicators have been suggested, there is often confusion between process and outcome indicators, and between indicators, criteria,[2] and activities. However, as the summary of best practices (Section 3.2) indicates, there appears to be emerging consensus in many areas on indicators relevant to assessment of culturally competent organizations.

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[2] "Standards" refer to goals to be reached; "criteria" to activities that lead to meeting the standards (CCHSA, 2001).

Assessment Tools and Strategies

It is often recommended that, as a first step in identifying organizational factors that

facilitate or hinder cultural responsiveness, organizations should undertake an internal

assessment based on established criteria (Freeman, 2002; Goode, 2001; 2002; Office of

Minority Health, 2001a, b). This enables an organization to identify assets, limitations

and opportunities before a strategic plan is developed (Office of Minority Health, 2001a).

A number of tools for organizational assessment have been developed for use in the

private sector (Harvey & Blakely, 1996; Poole, 1997) – these tend to emphasize human

resource management issues.

Beginning in the 1990's, several assessment instruments were also developed for use

with human service organizations – many focused on mental or child health (Canadian

Mental Health Association, 2001; Child Welfare League of America, 1993; Mason,

1994). With the recent focus on culturally and linguistically appropriate care as an aspect

of quality, specific assessments and guidelines have also been developed for "cultural

competence" in health organizations (Andrulis, Delbanco, Avakian & Shaw-Taylor,

2002; Goode, Jones & Mason, 2002; National Center for Cultural Competence, 2003;

Paez, 2003a, Paez, 2003b; Quander, 2003), some of which include indicators of

performance measurement (Dreachslin, 1999; Siegal et al., 2000; WICHE, 1998). Many

include guidelines and checklists for auditing organizational policy and practices. Most of

these assessment tools have been designed for use in a particular service area (Office of

Minority Health, 2001a) and may not be applicable in other health systems or

jurisdictions.

A more comprehensive approach appropriate for health service organizations can be found in the resource manuals "Providing Oral Linguistic Services: A Guide for Managed Care Plans" (Paez, 2003b) and "Planning Culturally and Linguistically Appropriate Services" (Paez, 2003a), and particularly "Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile" (Lewin Group, 2002). Canadian resources include "Cultural Competency: A Self-assessment Guide for Human Service Organizations" (Ngo, 2000) and the "Cultural Assessment Tool" (Vancouver Ethnocultural Advisory Committee of the Ministry for Children and Families, 2002), although no health specific resources were located.

These instruments use various domains for assessment. For example, The Lewin Group (2002) identifies the domains of organizational values, governance, planning and monitoring/evaluation, communication, staff development, organizational infrastructure and services/interventions. The Calgary Health Region Blueprint identifies nine "elements" grouped into four result areas: Financial Accountability (governance, administration, policy and decision making); People and Partners (human resource practices; training); Innovative Service Delivery (organizational culture); and Patients and Clients (service delivery, partnership and collaboration, communication) (Calgary Health Region, 2002). The resource "Planning Culturally and Linguistically Appropriate Services" (Paez, 2003a) lists "topic areas" for assessment of organizational infrastructure as: organizational mission statement; policies and procedures; assignment of accountability; budget allocation; database and information systems; continuous quality improvement systems; provider network relationship; and planning. Research on

diversity management within Pennsylvania hospitals used six diversity performance scales: planning, stakeholder satisfaction, diversity training, human resources, healthcare delivery and organizational change (Weech-Maldonado et al., 2002).

The Cultural Competency Assessment Tool developed by the Vancouver Ethnocultural Advisory Committee of the Ministry for Children and Families (2002) identifies the "areas of impact" of: organizational foundation statements and documents; program policies and procedures; program practices; personnel policies and practices; skills and training; organizational composition and climate; community consultation; and communication. The brief assessment instrument proposed by the Louisiana Department of Health and Hospitals uses a process that focuses on the Agency, Administrative and Service Delivery levels (Quander, 2003). Another example is the CMHA "Diversity Lens" which provides an organizational checklist including four major categories: communications; policy; recruitment/evaluation; and programs and services (Canadian Mental Health Association, 1999).

Limitations of Existing Assessment Strategies: Priorities for Additional Research

While there is emerging consensus on organizational best practice for meeting the needs of a diverse community, there has been less progress in determining ways in which this responsiveness (or "competence" or "improved access") can be measured. Most instruments are survey tools, and rely heavily on individual and organizational self-assessment. There are a number of benefits proposed for self-assessment strategies. Self-assessment is usually seen to be non-threatening as it is an internal process, and the

process of completing the assessment can build the support and awareness necessary to proceed to next steps (Goode, et al., 2002) It is recommended that self-assessment be viewed a continual process rather than a one time event, and experts stress that the benefits of self- assessment come from comparing change within the same institution over time. An internal process may therefore promote more openness and self-exploration.

However, such tools are also subject to the limitations of self-assessment strategies. One finding at the individual level is that self-rating is affected by the respondent's level of cultural awareness; e.g. those who have more cultural awareness may be less likely to evaluate themselves as competent or responsive (Alpers & Zoucha, 1996; Austin, Gallop, McCay, Peternelj-Taylor & Bayer, 1999). A review of studies of guideline adherence found that self-report studies are subject to bias and may not give an accurate assessment (Adams, Soumerai, Lomas & Ross-Degnan, 1999). It is not known whether the same factors would affect rating at the organizational level. Some self-assessment strategies are susceptible to social desirability response bias (e.g.. self-assessment in preparation for accreditation may encourage organizations to put the "best face" on current practice).

Many instruments are presented in the form of checklists – inexperienced organizations may think they have "passed the test" if they can check off a list of specific criteria rather than responding to what is needed by each community (Health Human Resources and Service Administration, 2001). Objective review of current practices against established benchmarks (e.g., the presence of specific policies, policy elements, or programs) is

necessary to assess the gap between organizational self-perception and best practice (Gandz, 2001).

An important limitation of all tools is that indicators used in these assessments have not been validated, and it is unclear to what extent the results of assessments are predictive of actual practice. If, for example, "best practice" policy is in place, but is not reflected in practice; or, alternately, "best practice" is observed in the absence of organizational factors considered "indicators" of such practice, then assessments are of little value. These limitations led the Office of Minority Health in the United States to recommend against publicizing the results of assessment checklists (Office of Minority Health, 2001). Other authors also stress the importance of using results to identify ways of improving services, not to give a "rating" (James Mason, as quoted in Goode, 2001). There is general agreement that these assessments are more appropriately used as internal tools for exploration and planning. However, few of them provide guidance about "what to do" when the assessment is completed (Kalloo & Migliardi, 2002).

Most of the tools for assessment of cultural responsiveness (often focused on "cultural competence") have been developed in the United States, and many of these were designed for a specific health care context (e.g., managed care organizations). Little assessment has been undertaken in Canada. It is essential that assessment and planning tools recognize and reflect the legal, political, cultural and economic factors that shape the environment in which health services are delivered. They must also recognize the country's population density and makeup. Many Canadian provinces are sparsely

populated and serve many diverse populations. The history and status of Aboriginal peoples, jurisdictional issues related to delivery of services for First Nations, combined with the desire of First Nations peoples to take responsibility for their own health services, creates a significantly different context for the design and management of health programs in regions with a large Aboriginal population, than in centres where there are large recent immigrant or visible minority populations. As services for Aboriginal persons have generally developed separately from "multicultural" health initiatives (and French language issues are commonly unconnected to either), there may be challenges in developing an assessment instrument that would be acceptable to all communities.

No instruments were identified that utilized a document review process. While some self-assessment instruments (see for example Ngo, 2000), do include the presence of some documents, these are limited to a few key points in a limited number of documents.[3] My review of the literature also failed to identify any instruments that attempted to identify, and make explicit, important differences in underlying philosophy and approach to providing effective care to culturally diverse populations, even though these differences may result in adoption of very different approaches, priorities and activities. At the same time, it is recognized in the literature that certain interpretations of cultural "responsiveness" (particularly those that emphasize culture-specific learning or individual competence rather than organizational change) may fail to adequately address issues of underservice and access, and may even exacerbate barriers to equitable care,

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[3] For example, the "document checklist in Ngo (2000) includes only 6 points which state simply that *"the mission statement* (or policy statements, policy and procedure manual, personnel manual, program manuals, or promotional materials) *specifically refer to the services to culturally diverse people"*. (Responses are to be rated yes, no or in progress).

either by inadvertently promoting stereotypical views, or by disempowering individual patients and communities (Coup, 1996). Stereotypical responses (such as treating a patient based on a "sociocultural profile") may, for example, result not only in offence, but also an increased risk of misdiagnosis, with the result that clients face additional barriers to quality care than would have been present without such "cultural competence" interventions (Meleis, 1996; Tervalon & Murray-Garcia, 1998).

Failure to differentiate between what are often radically different approaches may be one of the reasons why the literature on effectiveness of cultural responsiveness is inconclusive (L. Anderson et al., 2003; Brach & Fraser, 2002). It is therefore essential that assessment of organizational responsiveness also include assessment of underlying philosophy and approach in order not only to assist organizations to better explore and respond to the implications of approaches taken, but also to facilitate the research needed to determine the impact of cultural interventions.

Competing demands for limited health care resources require that interventions used are feasible and effective, and that results are shared with other organizations across the country. Assessment tools and processes, if they are to be recommended, should be appropriate for the setting in which they are utilized, make minimal resource demands on the sponsoring organization, and demonstrate the potential to increase interest and awareness of the importance of cultural responsiveness.

There are concerns that a patchwork of isolated initiatives to develop standards and best practices may result in inefficiency, inconsistency and failure to benefit from shared activities (Children's Hospital of Eastern Ontario, 2000; Office of Minority Health, 2001a). One objective of associating the project with a national organization already promoting improved practice and standards in this area is to facilitate dissemination of research results.

Preliminary Activities with The National Network for Cultural Competency

This project grew out of extensive preparatory work undertaken on behalf of the National Network for Cultural Competency in Paediatric Health Care. The network is comprised of health care professionals in Canadian paediatric health care centres who are focusing on the promotion of culturally competent services. The goals of the network are to:

- establish and support linkages among cross-cultural/multicultural programs at Canadian health centres through the creation of a Canada-wide information-sharing network

- raise awareness about the importance of evidence-based practice in the provision of culturally competent health care

- develop a Canadian Best Practice Model in Culturally Competent Pediatric Health Care

- establish accreditation standards specific to cultural competence in consultation with the Canadian Council on Health Services Accreditation (CCHSA)

- urge other health centres and organizations across Canada to endorse and promote the principles of cultural competency in pediatric services.

In the winter of 2001-2002, I was invited by this network to develop a background paper on cultural competency of paediatric health services in preparation for the Second National Forum on Cultural Competency in Paediatric Health Care held in Vancouver, British Columbia in March 2002. This background paper provided a synthesis of issues related to "cultural competence" in paediatric health care delivery, and was intended to serve as a discussion paper for participants who attended the forum. A key objective of the report was to identify key characteristics and best practices of culturally competent health organizations (Bowen, 2002).

As part of this contract I was also asked to review established accreditation standards, with the objective of determining the extent to which they may already address issues central to the provision of culturally competent services, and show potential to form the base for further development. Because the accreditation process is an important focus of quality development for a range of health care services, integrating cultural competence initiatives with these standards would have a number of benefits. For this purpose, an initial review of the 2001 Canadian Council of Health Services Accreditation Standards was undertaken, focusing on standards for Acute Care.

In addition, I was requested to undertake an initial scan of participating organizations that would provide an assessment of the extent to which paediatric centres in Canada appeared to be adopting the best practices identified through the literature review. I developed a simple assessment tool that required review of a number of publicly

available documents provided by seven Canadian paediatric health centres (the list of materials reviewed at this stage is found in Appendix B).

Participants at the March 2002 Forum represented cultural diversity experts from major paediatric health centres, professional organizations and the Canadian Council for Health Services Accreditation (CCHSA). The focus of the forum was on competence at the organizational level. At this forum participants developed a position paper and draft standards for the organization related to cultural competence of paediatric healthcare organizations (National Network for Cultural Competency in Paediatric Health Care, 2002). Representatives from the CCHSA participated in the forum, and a working group was established to continue to explore the potential of developing guidelines to advance the agenda of standards development for cultural competence.

<u>Initial Review of Organizational Documents</u>

The initial assessment of organizational materials, which reviewed materials from seven health centres in five different provinces for evidence of best practice related to organizational responsiveness to culturally diverse groups, was undertaken in the winter of 2001-2002. I generated a list of non-confidential materials (Appendix B), based on my review of the literature, which I postulated could provide evidence of organizational practice related to cultural responsiveness (Bowen, 2002). Steering committee members of the National Network then provided the documents related to their own organizations. All seven organizations in this defined sample provided documents for the review, which were then assessed for:

a) the extent to which a commitment to cultural competence or diversity was reflected in organizational materials

b) evidence of cultural competence best practices at the organizational level

c) evidence of underlying approaches to cultural competence

d) degree of consistency between programs.

The intent of the overview was to provide an initial objective assessment of the development of organizational cultural responsiveness across Canada, in order to assist in strategic planning towards nationally coordinated standards. The focus was on indicators at the organizational level, not individual competency or specific diversity or multicultural programs. No attempt was made to evaluate or compare organizations or programs. As this was an initial overview based on a limited number of documents, it was recognized that the materials selected might not accurately or appropriately reflect the activities or approach of the organizations.

Key Findings From Initial Review

- **All of the participating hospitals showed some initiatives at the organizational level.** There did, however, appear to be important differences in the approaches taken by various centres and the degree to which initiatives appear to have been developed. On a number of key issues several respondents stated that policies or materials were still in development. Some of the materials provided were in draft form. Most organizations had not undertaken any form of cultural assessment or audit.

- **The extent to which cultural competence was integrated throughout organizations appeared limited.** In general, the diversity of the paediatric population in the largest Canadian cities was not well reflected in key organizational documents. Most centres did not include any mention of "cultural competence" or "diversity" in their mission statement, although some included this in their organizational values. Wording commonly focused on *"sensitivity to"* and *"respect for"* diversity. Most of the organizations surveyed did not explicitly include diversity or cultural competence in their strategic plans, either as specific objectives/goals, or integrated into other goals and objectives.

Diversity and/or cultural competence/responsiveness were often not visible in annual reports, although there were often general comments about the diversity of the community served, and the visuals of some organizational materials included patients and staff of diverse ethnic/racial backgrounds. Occasionally "diversity" appeared as a separate section in an annual report. Cultural competence/responsiveness was not integrated into the discussion of key topics such as "excellence" or "workforce challenges."

Most organizations provided a generic non-discrimination/harassment policy, although the policy detail specific to "racial" harassment differed. There were few policies specifically related to cultural competence, staff training, employment equity or a representative workforce, although there were a few notable exceptions. The

general impression from the review was that issues of staff diversity were not currently being addressed.

Some organizations reported collecting patient data on language and religion. A number of respondents, however, indicated that there were inconsistencies between programs of the same institution or health authority, suggesting limitations to the ability of such data to identify differences between various groups. Data collection appeared to be one of the areas of least development, although two organizations indicated that they were currently in process of assessing the benefits of "ethnic coding" of patient data (e.g., discussion papers).

Most organizations provided indication of availability of some patient materials in other languages. One organization had developed detailed guidelines for translation of materials. No copies of patient satisfaction instruments were identified as being available in other languages. It appeared that none of the organizations provided information on the client complaint process in languages other than English or French.

Most organizations were able to identify local demographic information that included ethnic/visible minority status of the community, however the level of detail varied. One organization included detailed information that included analysis by determinants of health (e.g., employment and poverty) and ethnicity. Information on

library resources ranged from no mention of diversity or culture, to an indication that

the library served as a major resource for cultural competence activities.

As a general rule, information on diversity or culture was not integrated into

staff/patient materials, but if included it was inserted as a separate heading in reports,

orientation handbooks or other materials. There were, however, important

differences between organizations. In some organizations, cultural responsiveness

was not included in staff orientation training or resources. There were only a few

examples where issues related to cultural competence had been integrated into

general polices or information (e.g. confidentiality statements). From the limited

material provided on the topic of cultural education, it appeared that cultural training

was not mandatory for staff in any of the institutions, and in some cases topics of

culture did not appear to be incorporated into staff orientation. The available training

materials suggested an emphasis on individual awareness training, sometimes with an

ethno-specific focus. Materials from one program, however, indicated a

developmental approach and dealt with issues of power.

- **Much of the documentation reviewed reflected a "multicultural approach".**
  Where diversity or cultural competence were included in the mission and values, the
  language used tended to focus on "cultural sensitivity" and "respect" for diversity.

While policies related to human rights and equal treatment were common, human

resource policy of these seven centers did not appear to address strategies of

workforce representation, even though most organizations did identify staffing as a major challenge.

Documents tended to use one of two "languages" related to cultural competence: the language of "diversity"(which was often associated with discussion of access), and the language of "multicultural health." More recently developed programs appeared more likely to use "diversity" language – some of these had incorporated the work and language of recent U.S. standards development initiatives. Generally, there was little discussion of "barriers" to equitable access. Some organizations, however, used both "languages" in their materials.

The position of Aboriginal patients within the organizations' diversity strategies was at times unclear. While some organizations identified Aboriginal peoples in their strategic plans and diversity materials, others had separate Aboriginal activities that were not necessarily reflected in the materials provided. The documents, therefore, reflected the historical separation of "multicultural" and Aboriginal initiatives in Canada.

- **There were many differences between organizations in staffing and resources dedicated to "cultural diversity initiatives."** While some organizations had no designated staff responsible for such initiatives, others appeared to have well-established positions. There was also variation in the reporting relationships of such positions. In most cases the position of these roles within organizational structure

suggested limited influence and authority. Similar variation was found between "diversity" committees in reporting structure and roles, and many appeared to be in process of development. Some committees appeared to have a limited role in assisting or facilitating design and adaptation of programming, in others there was a commitment to addressing structural issues.

- **Most organizations had some policy related to language access.** However, a review of these policies indicates important differences in the commitment to providing interpreters and the acceptability of various approaches. For example, policy language ranged from general statements that staff should *"encourage"* or *"facilitate"* to clear directives that they *"must"* arrange for interpreters. There were differences in whether using staff as interpreters was considered acceptable. Some institutions had specific procedures but little policy. No organization provided documentation of requirements for staff training on working with interpreters.

At the second national forum, I made a presentation on preliminary results obtained from the assessment of the seven participating organizations. Response from participants indicated that these findings accurately reflected the state of development of cultural competence initiatives across Canada at that time. Difficulties in obtaining funding and in having activities integrated within the larger organization were identified at that time. There was significant interest expressed by members of the National Network in developing an assessment instrument that could be used in centres across Canada. Consequently – as these initiatives were already underway when I had made a decision to

undertake the development of a document review instrument to assess the cultural

responsiveness of health care institutions – it seemed appropriate to test the instrument in

a paediatric setting. The National Network agreed to act as an Expert Committee in

review of the draft document.

Development of a Document Review Instrument

As the initial scan indicated that the document review process might give a good picture

of the extent to which best practices related to cultural responsiveness have been adopted

within an organization, a more comprehensive instrument was developed.[4] This expanded

instrument was based on an extensive review and analysis of the research literature

related to health services access, cultural competence, organizational diversification, and

health services issues as identified by culturally diverse groups. Several other assessment

instruments were also reviewed (for example, Andrulis, 2002; Child Welfare League,

1993; Dana and Behn, 1992; Dreachslin, 1999; Lewin Group, 2002; Ngo, 2000; Paez,

2003a, 2003b; Quandar, 2003; Vancouver Ethnocultural Advisory Committee; 2002).

The instrument was designed to undertake two types of organizational assessment: the

extent to which the organization had adopted identified best practice, and the approach to

cultural diversity taken by the organization.

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[4] Although the original intent of this research was the development of an "instrument" for assessment, the role of the tool changed as the project progressed. Section 5.7.3 outlines how the conceptualization moved to an evaluation of a *process* rather than of a specific instrument.

It was recognized that presence of "best practice" in organizational policy might not accurately reflect the practice of that organization. There may be informal practice that reflects good practice in the absence of any policy requirement to do so, for example. Similarly, even well-developed policy may not be implemented in everyday practice. For this reason, a range of materials – not limited to organizational policy – were included in the assessment instrument in order to attempt to determine the impact of policy on day-to-day organizational operation. It was also proposed that as the focus of the assessment was on cultural responsiveness at the organizational level (rather than an attempt to measure quality of care at the level of the individual encounter), one could reasonably assume that if the infrastructure to support responsiveness was in place, there would be evidence of it in organizational documents.

Domains of Organizational Cultural Responsiveness

Based on my review of the literature, and the results of the initial organizational scan, I identified eight domains appropriate for a document review process of organizational cultural responsiveness:

1. General profile of cultural responsiveness and its importance within the organization
2. Human resources
3. Education and training
4. Language assistance services
5. Information for clients and community

6. Organizational framework to support diversity and integration of diversity initiatives

7. Data collection, evaluation and research

8. Participation of community.

These domains are based on the areas of "best practice" identified through the literature review in section 3.2, with the addition of the first category (the general profile of cultural responsiveness and its importance within the organization). These domains are spheres in which it was proposed that cultural responsiveness should be evident within an organization through a document review process. Some of the differences between the domains used in this instrument and other tools can be explained by the fact that this instrument was designed specifically to address issues that could reasonably be assessed through a document review (not a broader review of practice or outcomes). In addition, some "domains" identified by other authors (e.g., "culturally competent care") were defined as the objectives of the domain areas studied, and as such not addressed directly. These domains were seen as a practical way to organize materials, although it was recognized that there is some overlap between domains.

The next step was to identify documents where one would reasonably expect to find evidence of indicators of progress in the domain area. This approach can perhaps be best described as looking for evidence "in all the right places" (Lavis et al., 2002). In other words, after best practices were identified, the question was asked: In which documents would one reasonably expect to find evidence of such practice?

For example, in the domain "language access services" two types of documents were identified:

1.   Specific documents (e.g. Interpreter policies and procedures and documentation of services provided), and

2.   General documents that could indicate activities in this area (for example, the instrument included training curricula to determine whether educational opportunities were made available to providers on working effectively with interpreters, and patient orientation materials were included to determine what information on availability and rights to an interpreter were provided to clients).

The rationale for including each document was that if there was some kind of organizationally supported program to provide qualified language access to patients and families, one might reasonably expect to find evidence of it in one or more of these documents. Terms of documents were kept as generic as possible in order to facilitate identification of relevant materials. A copy of the initial draft of the expanded instrument can be found in Appendix C.

At this point the draft instrument was circulated for review to members of the Steering Committee of the National Network. It was presented in the format of (a) documents to be requested and (b) key elements from best practice guidelines to be assessed within each document. For example, related to the domain of Data Collection, Evaluation and

Research, key elements related to patient satisfaction forms would include those outlined in Table 5 below:

Table 5: Example of Key Elements for Patient Satisfaction Instruments

Document	Key Elements
Patient satisfaction forms	Patient satisfaction forms 1. are in plain English 2. are available in other languages 3. address or encourage feedback on aspects of culture/diversity

Questions asked of the Steering Committee at this time were:

1. Does the list of documents include all policies and other materials that should be included? Are there any others you would suggest?

2. Are there some documents/materials that you would recommend deleting?

3. Would you know from the list of materials what specific documents were being asked for? If not, which ones are unclear? Could you suggest alternate wording for the ones that are not clear?

4. From a quick review of the materials list, do you foresee any difficulties in locating and obtaining access to the documents identified?

5. Is the list of key elements complete for the document item(s) they refer to?

6. Are the key elements listed appropriate for the document item(s) they refer to?

Eleven individuals from eight health centres provided feedback. Minor changes and additions were made to the instrument based on this feedback. In general, Steering Committee members confirmed the selection of documents and key elements. A few respondents expressed concern about the extensive nature of the documents requested. While they indicated that they could logically be included, they anticipated that few organizations would have well-developed responses. Some wondered whether a simpler, shorter instrument would be advisable. The decision at this time was to proceed at the test site with the full instrument and, through implementation and analysis, decide whether some of the documents could be omitted, and which were of greatest importance.

The next step was to develop guidelines for review of the documents identified. Table 6 gives an example of guidelines developed for review of language access policy.

Table 6: Example of Guidelines and Key Elements for Language Access Policy

Document	Key Elements	Guidelines
Language access policy	1. Language access policy in place. 2. Policy includes Best Practice elements (Appendix A).	1. Determine presence of policy. 2. Assess policy for elements identified in Appendix A. 3. Determine language constituencies to whom policy applies.

The Seven Dimensions

The second area of assessment focuses on the organization's philosophical approach to issues of cultural diversity. Because one of the research objectives was to determine whether philosophical differences in approach to culture and cultural responsiveness could be assessed through a document review, the final step in the development of the instrument was to review the list of documents to determine where evidence of various philosophical approaches might be found. These approaches (defined as "dimensions" in this dissertation), were described in Chapter 2 (definition of cultural groups; multicultural or antiracist orientation; approach to human resource management; approach to cultural training; voluntary or required action; individual or organizational focus; and provider competence or client/community access). Guidelines for analysis of these key dimensions were developed and incorporated into the instrument. Table 7, on the following page, outlines the seven dimensions with examples of key data sources for review. A matrix guiding review of both domains and dimensions can be found in Appendix D.

Table 7: The Seven Dimensions

Dimension	Research Question	Key data sources (e.g.)	Key words /concepts (e.g.)
1.Definition of culture and cultural group	What groups are perceived as culturally different? At risk of inequities?	Mission/vision, strategic plan, anti-discrimination and related policies	Multicultural, ethnicity, Aboriginal, diversity, underserved, marginalized, at risk
2. Provider competence or client/community access & participation	Are responsiveness interventions focused on increasing provider competence, or on addressing barriers to organizational participation?	Mission/vision, strategic plan Cultural training curricula Human resource policy	Cultural competence, skill, access, barriers, sensitivity, cultural appropriateness, participation, representation
3.Multicultural/antiracist	What are the underlying assumptions regarding the cause of lack of responsiveness? What motivates responses?	As above. Specific program descriptions.	Rights, racism, inequity cultural differences, education,
4. Individual/ organizational focus	At what level are identified interventions directed?	Strategic plan, program descriptions, all policy	Institutional barriers, racism, discrimination, skill, sensitivity
5. Voluntary/required	To what extent are actions required of organizational members? What are the consequences for non-compliance?	All policy	Must, require, ensure encourage, facilitate, support
6. Approach to cultural training	What are the underlying assumptions demonstrated by cultural training provided by the organization?	Policy related to cultural training, list of all organizational training offered, cultural curricula and objectives	Awareness, knowledge, sensitivity Rights, racism, systemic discrimination, power
7.Approach to human resource management	Is the underlying approach to HR management monocultural, ethnic matching, workforce representation or workforce diversity?	Human resource policy and procedures	Representative, equality, anti-discrimination, employment equity, affirmative action, similar background, diversity

To give a concrete example, the following guidelines were added to the review of the domain of Language assistance services, related to three of the seven dimensions:

1.   ***Definition of culture and cultural group.*** Review policy and program descriptions to determine which "languages" or language constituencies the policy/program applies to (e.g. all languages, official languages, immigrant languages, Aboriginal languages, American Sign Language (ASL).

2.   ***Voluntary or required.*** Review policy and procedures for wording: whether use of interpreter was required (e.g. providers *"must"*), voluntary (providers are *"encouraged to"*), or whether no direction was given.

3.   ***Individual or organizational focus:*** Assess all related documents for the level of comprehensiveness of policies and procedures, systems and resources to support and monitor interpreter use – compared to policy and procedure that focus on provider discretion.

Summary and Conclusion

Best practices in any area are ideally determined through a review of empirical research. Research on "cultural competence" and "access" in health care, however, is still in early stages of development. While the theoretical literature suggests improved responsiveness should have beneficial results for patients, there is limited research evidence about what techniques are effective (L.Anderson et al., 2003), and even less on when and how to

implement them (Brach & Fraser, 2000). In spite of these limitations, however, there is emerging expert consensus on "best practice" in the area.

An initial scan of public organizational documents suggested that a document review process could provide a useful strategy for assessment of the progress made by health organizations in implementing these identified best practices. Consequently, a more comprehensive instrument was developed to assess the usefulness of this approach. This instrument organized best practices into eight domain areas – General profile of cultural responsiveness and its importance within the organization; Human resources; Education and training; Language access services; Information for clients and community; Organizational framework and integration; Data collection, evaluation and research; and Participation of the community. It also incorporated guidelines for assessment of differences in approach to addressing issues of cultural diversity. These seven "dimensions" included: definition of "culture" and "cultural groups"; multicultural or antiracist orientation; approach to human resource management; approach to cultural training; voluntary or required action; individual or organizational focus; and provider competence or client /community access emphasis. Design and implementation of the research project to pilot this instrument is described in the next chapter.

CHAPTER 4: RESEARCH DESIGN AND IMPLEMENTATION

Purpose of Research

Although in recent years significant work has been undertaken to identify best practices (and in some settings actually establish standards) for access and cultural competence at the organizational level, most of this activity has been based in the United States. Little work has been done in Canada, and initial work with the National Network for Cultural Competency in Paediatric Health Care suggested that awareness of best practices remains limited. It is unclear what strategies for assessment of cultural responsiveness would be most appropriate and effective in this setting, or what effect the lack of a national consensus development process in Canada may have on acceptance of best practices identified in other jurisdictions.

The purpose of this dissertation research was to explore the usefulness of a document review process for assessing the responsiveness of Canadian health care organizations to culturally diverse groups. The document review is based on the assumption that if best practices are in place within an organization, there should be evidence of them within the policies, planning documents, program descriptions and other materials produced by the organization. The document assessment tool, described in the previous section, was used to guide this review of documents.

Although the preliminary review undertaken in conjunction with the National Network indicated that, in many institutions and organizations across Canada, there would be a

limited number of documents available, it was anticipated that this research would provide insight as to:

a.   whether a document review process provides useful information related to the actions and approach taken by specific organizations to address barriers and provide culturally responsive care

b.   how extensive the scope of a document review should be

c.   whether results from a document review would be accepted by organizational decision-makers.

Research Objectives

Following development of a draft document review instrument (described in section 3.7, and resulting in the instrument found in Appendix C), this project explored, at one site, whether the document review process appropriately reflected (a) organizational practice, and (b) decision-maker/provider knowledge and attitudes related to organizational responsiveness to culturally diverse groups.

Secondary objectives of the study were to explore the impact on the organization of the document assessment process and supplementary qualitative activities, and the potential of the assessment process to promote development of cultural diversity initiatives.

The project addressed the following specific research questions:

1. *What are the indicators of "best practice" of health services that are responsive to the needs and priorities of culturally diverse and marginalized groups, and how can these be integrated into an assessment instrument?*

   a. What indicators, appropriate for use in Canada, can be used for policy/document review?

   b. What indicators are associated with specific approaches?

These questions were addressed in Chapters 2 and 3 of this dissertation.

2. *Are the results of a document review consistent with findings obtained through other methods?*

   a. To what extent do organizational documents reflect organizational practice?

   b. How do results of document assessment compare with attitudes, knowledge and practice of specific stakeholder groups?

   c. How do results from a document review compare with self-assessment activities?

3. *What effects does undertaking such an assessment have within an organization?*

   a. What are the challenges in undertaking an assessment?

   b. What time and other resources are required?

   c. What is the potential of such assessments to promote awareness of the implications of various approaches and action to improve organizational responsiveness?

4. *What recommendations can be made regarding use of a document review instrument?*

    a. Can a document review provide useful insights related to organizational cultural responsiveness?

    b. At what level within a regional health authority should assessment of policies and practices be focused?

    c. To what extent are assessment results accepted by various stakeholder groups?

    d. What additional or alternate strategies could be recommended to aid organizations evaluate their ability to assess cultural responsiveness and develop strategies for addressing areas of weakness?

As the project evolved, specific objectives related to knowledge transfer/translation were identified and refined (more information on events leading to this are described in section 4.8.4.1). As a result an additional research question (which incorporated some aspects of questions 3. and 4. above) was developed.

5. *What issues emerged, related to transferring research findings to the sponsoring site?*

    a. What barriers general to research utilization are of particular concern in this context?

    b. Are there specific issues related to topics of culture and health that pose barriers to knowledge transfer/translation?

c. What preliminary recommendations can be made to maximize the likelihood

that findings from an assessment process are incorporated into organizational

planning?

Summary of Methodology

This project employed several research methods:

- Synthesis and critical analysis of the research literature (identification of "best

  practice"; and selection of indicators as outlined in Chapters 2 and 3)

- Development of draft document assessment tool (as described in Chapter 3)

- Policy/procedure review at the test site

- Content analysis (e.g. public communication [newsletters, annual reports, etc.];

  strategic planning documents; client information materials; program evaluation/client

  assessment activities; organizational reports and commissioned studies; Board and

  senior management meeting minutes; organizational structure; research/evaluation

  guidelines)

- Key informant interviews

- A parent focus group

- Participant and unobtrusive observation

- Feedback session with organizational stakeholders

- Follow up survey.

Each of these methods is described in more detail later in this chapter (Section 4.8).

Research Participants

Organizational Participants: The Test Site

In-depth assessment of the draft instrument was undertaken within one organization: a

paediatric care facility in a mid-sized Canadian city. The facility treats over 100,000

children each year and provides service to a large geographical area, including remote

and northern areas. It is part of a larger health complex, which itself is part of a larger

health region, and as such does not have a separate Board of Governors. The facility is a

designated bilingual English/French language service facility.

Like most facilities in large and medium sized cities, it serves a culturally and ethnically

diverse community. There is a long-established Francophone community. Aboriginal

peoples make up 11%, of the provincial population and visible minorities approximately

11% of the city population. A significant proportion of general hospital patients are

Aboriginal. While the region does not receive the same large numbers of immigrants as

Canada's three largest cities, the number and pattern of immigrant and refugee arrivals is

similar to that of other mid and small size cities. Of the 1996 provincial population,

74.7% reported English as their mother tongue; the remainder reported either French or a

non-official language (Statistics Canada, 1998; Fédération des communautes

francophones et acadienne du Canada, 2001).

Although the initial intent of this research was to focus on the entire child health program

of the region, on the advice of the site advisory committee it was decided – given the

resources available – to limit this exploratory study to one specific facility. The Program

Management Team of the sponsoring organization gave strong and public support to the project, and facilitated implementation of the project.

Individual Participants

In addition to a review of organizational documents, the investigator conducted key informant interviews and a focus group with representatives of a number of stakeholder groups (e.g. management, staff, parents) at the test site, as well as with some community representatives. The selection and characteristics of these participants is described in more detail in sections 4.8.3. and 4.8.4.

Time Line of Activities

The research was undertaken in five phases, as outlined in Table 8 on the following page. The *Pre-implementation Phase* included analysis of preliminary activities and consultation with the National Network for Cultural Competency in Paediatric Health Care. At the site level it focused on initial consultation with organizational representatives, establishment of a steering committee within the organization, development of the draft instrument, development of the research proposal, and obtaining formal ethical approval.

Phase 1 consisted of three activities: finalization of the assessment instrument; development of a communication strategy and communication of the project within the test site; and collection of relevant materials.

Table 8: Project Phases and Activities

	Preliminary Instrument development	Pre-Implementation Phase	Phase 1	Phase 2	Phase 3	Phase 4
Time line	Oct. 2001-March 2002	July – November 2002	October – January 2003	November – March 2003	February –June 2003	June – December 2003
Activities	-Initial literature review -Development of indicators -Consultation with National Network Steering Committee	-Consultation with test site -Establishment of site advisory committee -Development of draft instrument	-Finalization of trial instrument -Communication plan -Collation of documents	-Analysis of documents -Finalization of interview questions -Sample selection (interviews)	-Key informant interviews -Analysis of interviews/docum ent review findings -Focus group	-Analysis of data from all sources. -Development of recommendations -Revision of instrument -Feedback session
Role of National Network Steering Committee	-Consultation, feedback on initial tool	-Review of draft instrument			-Update on project progress at National meeting, June 2003	
Test site role		-Establishment of steering committee -Assignment of contact people -Consultation in project design & implementation strategy	-Assistance with communication strategy -Assistance with document collation	-Consultation re sample selection	-Interviews with staff	-Planning of, participation in organizational information session

Phase 2 focused on analysis of the identified documents. In addition, sample selection and interview questions for key informant interviews were finalized based on findings from the document review.

Phase 3 included scheduling and conducting key informant interviews, and analysis of these interviews (including comparing results with those of the document assessment process). It also included a reassessment of the plan for conducting focus groups, development of questions for the focus group activities, and conducting a parent focus group.

Phase 4 focused on writing the preliminary report, including a summary of findings from the test site. A preliminary feedback plan was developed and a feedback session conducted at the test site. The results were incorporated into recommendations for utilization of a document review process. It is recognized, however, that additional follow-up may occur; information from any such activities are not included in this dissertation.

Advisory Process

Two advisory groups were associated with the project: a Site Advisory Committee and the Steering Committee of the National Network for Cultural Competency in Paediatric Health Care. The relationship between these committees, the sponsoring organization, and the researcher is outlined in Figure 1.

Figure 1: Relationship between Committees and Researcher
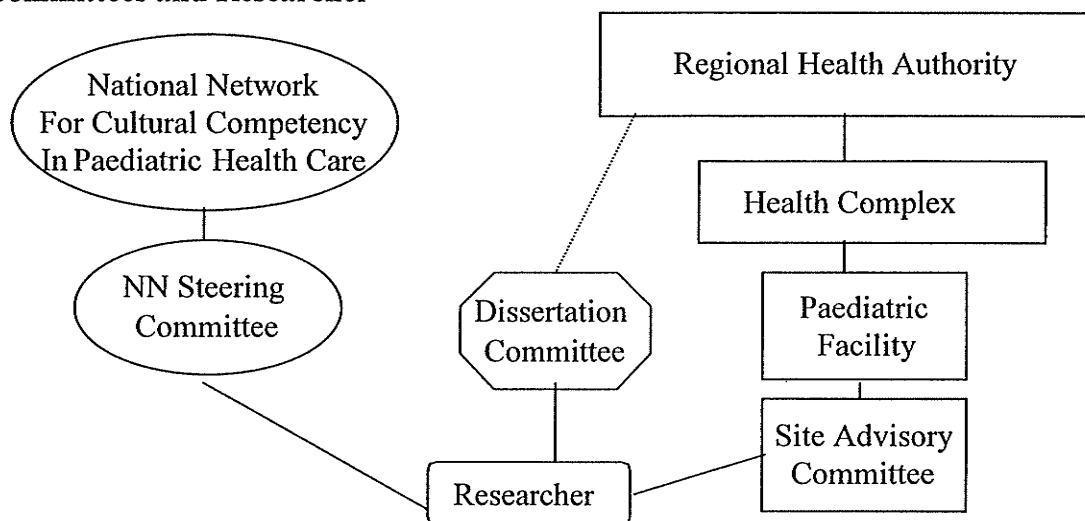
Site Advisory Committee

The facility that agreed to be the test site established an advisory committee that reported

directly to the Senior Management Team. Committee meetings were held approximately

once a month from October 2002 to May 2003, with additional meetings held from

November 2003 – February 2004. A Terms of Reference was drafted over the first few

meetings (Appendix E). The role of this committee was to assist the researcher in

understanding organizational structure and functions; suggest key informants in identified

areas; assist in developing the communication plan; and be available for questions or

problems as they arose.

Although the focus of the research was on the document review instrument, it was

expected that extensive site-specific information would be provided through piloting of

the assessment instrument. There was, therefore, also an expectation on the part of the

organization that this committee would take the lead in follow-up on these findings. The Site Advisory Committee played an important role in encouraging adequate time be made available for feedback sessions. At the time of writing it is unclear whether members of the committee will be involved in follow-up activities.

One member of the Site Advisory Committee was a member of the facility program management team, who provided updates to management on an as-needed basis and acted as liaison between the advisory committee and management. In addition, I made short written or in-person reports to the program management team, on an occasional basis.

Role of the Steering Committee of the National Network for Cultural Competency in Paediatric Health Care

The Steering Committee of the National Network for Cultural Competency in Paediatric Health Care (hereafter referred to as the National Network Steering Committee) agreed to act as the "Expert Committee" for the project. As described in section 3.6, I had previously undertaken development of a background paper and initial scan of organizational documents on behalf of this network. The National Network Steering Committee wrote a letter of support for the project, and members provided initial review of the draft instrument.

Some Steering Committee and other National Network members provided in-person feedback on the draft instrument in Montreal and Toronto, January 2003. I was also asked

to make a presentation at the Third National Forum on Cultural Competency in Paediatric Health Care, which was held in Calgary in June, 2003, on the topic of "Assessing the cultural responsiveness of health care organizations: Indicators of best practice." An update on project activities was given to a meeting of the National Network Steering Committee at that time.

Profile of Researcher

As a result of previous employment and research positions, I have undertaken community-based consultation with several marginalized and culturally diverse communities (immigrant/refugee; Aboriginal; persons with disabilities; gay, lesbian, bisexual persons; families involved in the mental health system; HIV affected individuals, etc.), and maintain connections with some community groups and service agencies. These contacts gave me not only a good understanding of how encounters with health services are experienced by members of these communities, but also opportunities for consultation, planning and interviews.

During the time the project was underway, I was involved in a project which trained medical students to assist refugee clients with health access issues; I was also invited by a provincial organization to make a presentation on previous research related to language access in health care. In other professional roles I have designed and managed programs to facilitate access to health services for marginalized groups, and provided consultation to some national initiatives and to the regional health authority. I have also published in the area of cultural competence and access to health care for underserved populations.

Continuing contact with local and national service providers in the area of cultural diversity (including the preliminary organizational scan undertaken on behalf of the National Network) provided preliminary evidence that cultural responsiveness of health organizations across Canada often did not meet the standards of practice identified in the research literature. These findings, along with my direct experience with community-based organizations and prior research with members of underserved communities, led me to anticipate that there would be limited evidence of cultural responsiveness at the test site.

Strengths and Limitations of Research Design

This project was intended to develop and pilot, in one setting, an assessment instrument utilizing document review methods. There are important advantages to a document review process: it was anticipated to make minimal resource demands on the organization, and, as document review is relatively non-intrusive, to cause minimal disruption in service delivery. These characteristics are of importance in an environment where there are increasing demands on the financial and human resources of health care systems. In addition, this instrument was designed to include objective measures that could be used in a range of Canadian health care settings.

There are, however, a number of limitations to this approach. The focus of such an instrument is on organizational structure and process, not directly on services provided. Because, however, the focus of assessment is at the level of the organization, it is

appropriate to focus on the infrastructure necessary to support appropriate care. In addition, as there is minimal capacity within Canadian health services to measure health outcomes by any measure of "culture" (i.e. to differentiate the health care experiences of patients by official language capability, or Aboriginal or immigrant status, for example), this approach is a necessary and important step. Another limitation is that this research provides for only limited inclusion of client perspectives. While it is recognized that the ultimate "assessment" of the effectiveness of an organization in responding to a culturally diverse population is the experience and health outcomes of clients from those communities (and of providers who serve them), the focus of the instrument is on the infrastructure necessary to support culturally responsive care.

It is also recognized that a document review process provides a "snapshot" of policies and other documents at one point in time – it may not capture emerging shifts in approach or the early stages of important initiatives that have not yet made their way into organizational documents. Nor is there evidence on whether, or to what extent, "best practice" evidence observed in organizational documents is predictive of its implementation in day-to-day practice.

The regionalization of health services (now underway in most provinces) presents additional challenges to a document review process. Relevant policies and other documents may be found at a number of different levels: the specific facility or program under review; a larger health complex to which the facility or program may belong; or the regional health authority. The most appropriate level at which to direct organizational

assessment has not been determined. In this project, given the resources available, the focus was at the level of one facility – it did not include policies and procedures that applied to specific programs or units, i.e., a program level review. However, as would be the case in many centres, two additional organizational levels (at which policy and planning are undertaken) also had to be considered: the larger health complex of which the paediatric care facility was a part, and the regional health authority.

Another limitation of the research is that this project involved in-depth testing of the instrument in only one location. However, as indicated in section 3.6, a simpler review was undertaken with seven participating hospitals (in five provinces) only a year earlier. That assessment provided limited information on a number of centres and – as it included a feedback component – also allowed for evaluation of whether the findings from the initial "instrument" provided an accurate reflection of organizational activities in Canada.

Description of Methods

Communication Plan

Once the draft instrument was completed, a communication plan was developed for the sponsoring site, in conjunction with the Site Advisory Committee and with the support of Program Management Team. This communication plan was put in place before any contact was made with specific individuals. An important message of the communication plan was that the purpose of the research was to evaluate the assessment instrument, not the cultural responsiveness of the site itself. The communication plan had three components, described below.

Presentations to Key Committees and Organizational Meetings

A member of the program management team facilitated these sessions by officially welcoming the initiative and stating organizational commitment to it. I then made a brief presentation summarizing the project, following which questions were solicited. A total of nine presentations were made – I personally made seven to Senior Management, management advisory committee, allied health, quality committee, clinical council, nursing council, and section heads. Selection of these groups was made in conjunction with the Site Advisory Committee and Program Management Team. In addition, the chair of the Site Advisory Committee gave a presentation to Staff Forums, and a committee member gave a presentation to the facility parent group early in the project.

The intent of these presentations was to ensure that management from all areas of the facility was aware of the project and its objectives; to respond to any questions and concerns; and to gather additional suggestions regarding the overall communication plan. Several suggestions were made – resulting in the additional communication steps described below.

Information on the Facility Web Site

Again in consultation with the Site Advisory Committee, a brief description of the project was posted on the facility web site linked to the main page (Appendix F). Contact information for both the researcher and the chair of the Site Advisory Committee were included for those who required more information. A link was also made to the CAPHC (Canadian Association of Paediatric Health Centres) web site, which included a page on

the standards initiative of the National Network for Cultural Competency in Paediatric Health Care.

Attachments to Employee Pay Stubs

Although it was anticipated that the first two methods would make the project visible to most in managerial/professional positions, there was concern that all facility staff should be informed of the project. It was recognized that some of the greatest ethnic/cultural diversity among staff were in departments such as housekeeping and maintenance, many of whom would not have work internet access. Consequently, it was suggested that a simple description of the project attached to pay-stubs would be the most effective way to ensure that all staff were notified. The handout, which included contact information for questions and input, was designed with the assistance of the Site Advisory Committee, and Program Management Team facilitated arrangements to have it distributed (Appendix G).

Collection of Materials

When the draft instrument had been completed, I reviewed the list of materials identified in the instrument with the Site Advisory Committee, and subsequently with a representative of Program Management Team, to determine the best process for locating the materials. The administrative secretary for the Program Management Team was assigned to assist with this task.

Some documents were readily accessible – they were available through the organizational

website, located in policy and procedure manuals or were available in public areas of the

facility. The Table of Contents of each Policy and Procedures manual was reviewed in

order to identify policies listed in the assessment tool, and any other policies that – while

not identified in the assessment tool – may also be relevant to cultural responsiveness.

This second step was taken to ensure that elements of identified policies were not

"hidden" in other policies not specifically identified as relating to cultural/diversity

issues. The general objectives of the manuals were written quite broadly, so it could

reasonably be expected that if policies did exist they should be evident in the manuals

(e.g., the Introduction to the corporate Policy and Procedure manuals gave as the purpose

of the manuals: 1) to ensure consistency of action; 2) to serve as a record of specific

board and administrative decisions; 3) to assist in the orientation of new employees; and

4) to help meet accreditation standards).

A list of documents for which the location was not apparent (and where it was unclear if

any relevant policies or documents did exist) was then reviewed with the Site Advisory

Committee to determine which staff might be the most knowledgeable in the particular

area. A member of the Program Management Team gave additional advice regarding

materials that were not readily located, and identified key contact people in specific

areas. The administrative secretary then sent, on behalf of the Program Management

Team, an email request for specific materials to these identified individuals.

As "regionalization" of services is still ongoing at the test site, the areas or domains investigated through the document review fell under three different levels of governance: that of the facility itself (e.g., the patient education resource committee); the larger health complex of which the facility was a part (e.g., Human Resources); and the local health authority (e.g., Aboriginal services). The search for documents began at the institutional level (i.e. the paediatric care facility). If the documents were not available at this level, availability at the next level (the health complex) was determined. Finally, if requested documents were not available at either of these levels (or if the relevant program was operated at a regional level), a search was undertaken at the health authority level. In some cases, relevant documents were included from all three levels (e.g., mission, values, strategic plans).

Additional documents were added to the assessment instrument as they were identified through review of the Table of Contents of policy and procedural manuals, analysis of individual policy/documents, and – in later stages of the project – key informant interviews. The list of materials reviewed can be found in Appendix H.

Through the process of collecting and analyzing documents, changes were made to one of the domain areas. Domain 6 (Organizational framework and integration) was further broken down into two sub-domains. The first (organizational framework) addressed the structure and resources provided to support diversity initiatives. The second (integration) focused on the degree to which the concept of cultural responsiveness appeared to be integrated throughout organizational activities. It became apparent, through the document

review process that, these were two different areas for assessment, and that an organization could make progress in one area and not the other.

Document Analysis

Analysis of organizational materials was undertaken based on indicators developed within the eight categories of best practice (the "domains"), and along the seven dimensions of philosophical approach described in the previous chapter.

Analysis was undertaken according to the guidelines outlined in the draft instrument. As each document was analysed, it was compared with documents that had been analyzed earlier in order to identify similarities and differences between documents within the same domain, between different domains and at different organizational levels.

Further analysis was undertaken when all documents had been collected. In addition to the analysis of specific documents, an overall analysis addressed the following questions:

1. What policies, procedures, planning and decision-making processes and practice are in place at various levels within the organization to promote and support cultural responsiveness?

2. How is official policy reflected in materials, communication, organizational structure, etc.?

3. How do policy and stated practice compare with best practices identified through the literature?

4. What philosophical approaches to cultural diversity are indicated through organizational policy, priorities, structure, and process?

Key Informant Interviews

Objectives of Key Informant Interviews

The key informant interviews were intended to "check" the validity of conclusions reached through review of organizational materials. Specific objectives were to:

- confirm that all relevant organizational documents had been identified

- explore the knowledge, attitudes, and approaches to cultural responsiveness of key stakeholder groups

- explore perspectives on the level of responsiveness achieved by the organization

- assist in planning for the final phase of the project (focus groups).

Selection of Informants

Following collection and analysis of materials, I sought to identify individuals with responsibility and/or knowledge in each of the eight domain areas (Profile of cultural responsiveness within the organization; Human resource management; Education and training; Language assistance services; Information for clients and communities; Organizational framework; Data collection, evaluation and research; and Partnership with the community). A number of different strategies were used to generate potential names for the interviews:

- preliminary discussions with the Site Advisory Committee, focusing on the organization of facility programs and functions, and identification of key individuals within each of the eight domain areas

- suggestions from members of the Program Management Team of individuals or positions relevant to this research

- investigator review of organizational structure

- suggestions made by other informants during interviews.

Several dozen prospective participants were identified through this process; many more than could be interviewed for the project. A purposive sample was then selected through creation of a matrix that included the eight domain areas. Key selection criteria related to the role of the individual within the organization, and his/her expected knowledge related to the domain areas. The sample was selected to ensure representation from a variety of stakeholder groups (including a variety of "cultural groups"), and functional disciplines within the facility. As individuals were selected, their contribution to each of the domain areas was noted. Position and area of work within the facility were also noted, as there was an attempt to ensure responses from individuals with a variety of disciplinary backgrounds and from various units and positions within the facility.

When, in the opinion of the researcher, interviews were not revealing new information related to a particular domain area – i.e., the point of redundancy had been reached (Lincoln & Guba, 1985) – selection focused on individuals in other domain areas. The

interviews were therefore conducted in "waves" to allow this type of selection to take place. The list of those selected for interviews was confidential.

Most informants were facility, health complex, or regional staff. However, as services for some cultural groups were only provided by services outside the facility/health authority itself (e.g., provision of interpreter services for some populations), representatives of specific community organizations were also included in the interviews.

It is important to note that selection of informants was focused on addressing the goal of the research project (assessment of the document review instrument). This resulted in different individuals being selected than may have been expected had the project other research objectives or methodology (e.g., organizational ethnography or organizational assessment).

Contacting Selected Informants

A personalized form letter was sent to each potential informant at his or her work address (a copy of the letter can be found in Appendix I). Both the Site Advisory Committee and Program Management Team reviewed the letter before it was finalized. I located informant addresses through the site employee directory. Letters were placed in envelopes with the university return address, marked confidential, and mailed from the university. The letters, which outlined the purpose of the project and the objectives of the interview, included my phone number and email address, and a copy of the Information

and Consent form (Appendix J). Potential informants were asked to respond before a certain date, after which time I indicated that I would follow up by telephone.

The facility gave authorization for interviews to take place on work time. However, because of a concern identified by the site ethics committee regarding shift coverage for some staff (e.g., those involved in direct patient care), I provided two alternatives in scheduling interviews for these particular staff. They could either arrange to meet outside of work time, or alternatively, they could notify their supervisor (or have the researcher notify the supervisor on their behalf) to request release during work time. Related ethical considerations are discussed in section 4.9.1.

A total of 24 individuals were sent letters: the vast majority took the initiative to contact me directly. In the few cases where contact was not made within the specified time frame, I made a follow-up phone call. If there was no response to the follow-up phone call, no further contact was made. I then reviewed the matrix of suggested informants and chose a replacement individual if I felt there was still a need for information in this area. In one specific activity area, two separate key individuals failed to respond; no further attempts were made.

At the time phone contact was made I offered to answer any questions about the project and invited respondents to schedule an interview at a time and in a place that was the most convenient for them.

<u>Development of the Interview Guide</u>

Interviews consisted of open-ended questions, in a semi-structured format. An interview guide format was used – while topics and issues were set in advance, the actual wording and sequence of questions was determined during the interview (Patton, 2002). Two types of questions were included. Core questions asked of most informants focused on conceptualizations of culture diversity and personal ratings of organizational responsiveness (e.g., *When people use the expression* "culture", *or* "cultural group" *they often have particular practical definitions in mind. In your position as ___ how would you define these terms? In your opinion, how are these terms understood by staff of the organization? Given the number of challenges facing health care providers today, how important do you feel "cultural responsiveness" is?).* Other questions explored participants' understanding of strengths and weaknesses of the organization and why programs had evolved the way they had.

In addition, specific questions related to the informants' area of expertise/responsibility, which were designed based on review of the relevant materials. (For example, *What implications do you feel that improved responsiveness to culturally diverse groups would have for (name of department or service area)? In other words, what do you see as needing to be done in (name of department or service area)*? Informants were also asked whether specific documents in their area of expertise/responsibility were in existence, and encouraged to suggest other documents that may be appropriate, to ensure that all relevant documents were included in the review.

New questions were added to and some deleted from the interview guide in subsequent interviews, as a result of issues raised during previous interviews. For example, some of the later respondents were not asked the question: *"To your knowledge, has this organization undertaken any activities to assess the cultural responsiveness of the facility?"* after several informants indicated that no previous activities had been undertaken. A sample interview format can be found in Appendix K.

Conducting the Interviews

There was good response to the request for interviews, with most participants indicating an interest in the project, although a few expressed doubts that they had much to contribute. Many stated that they thought this was an important area for research. Several suggested other individuals who they thought should be interviewed. Of the 24 individuals who were contacted, 20 completed interviews. One person contacted declined via secretary because of lack of time. Two others did respond after a follow-up phone call was made but then failed to get back in touch as promised, even after a second follow-up call was made. Some months later, I was contacted by one of these individuals who had been away on extended leave. One person did not respond to either the letter or the follow-up call.

Those interviewed represented all three organizational levels (paediatric care facility, health complex, and regional health authority), from many different patient and administrative areas, with a variety of job responsibilities and backgrounds. A small

number represented community or other organizations. Most facility, health complex, and regional staff interviewed were in management or supervisory/coordinator positions.

All organizational staff chose to meet in their office or elsewhere in the facility. Interviews with community informants took place in their offices. Interviews were anticipated to take from 45 minutes to one hour, the time indicated in the letter of invitation. However, several of the initial interviews were closer to one and a half hours. Interviews were not audio-taped; notes of the conversation were taken during the interview and later transcribed. As a result, the transcripts did not include long verbatim narratives, although some quotes were captured directly.

Analysis of Interviews

Notes of interviews were transcribed immediately after the interview was conducted, and field notes were recorded. Analysis was undertaken continually with data collection. Changes to subsequent interviews were made based on the initial analysis – the focus of the interview and the specific questions asked changed as the interviews progressed. Questions that began as core questions, for which adequate confirmatory data were obtained, were dropped from future interviews in order to allow for new questions resulting from earlier interviews.

When all interviews had been completed, the interviews were re-analyzed in two different ways. As the major purpose of the interviews was to determine whether the findings from the document review reflected organizational experience (including

whether all documents had been located), analysis first focused on direct responses to specific questions that been asked in order to determine the range of perspectives and to what extent there was consensus in key areas. Cross-case analysis (organized around specific questions) was used at this level of analysis. Data from this source were then compared with data in the relevant domain(s), obtained from the document review.

Transcripts were then re-analyzed in order to identify themes emerging from the data – many of these cut across the topic areas that were the initial focus of analysis. Some themes were defined by responses to a particular interview question (e.g. awareness of national standards); others emerged through analysis of transcripts. Using an open coding approach, the interview data were reviewed for previously unidentified or unexpected themes (Strauss & Corbin, 1990). Key words or phrases identified through the interview analysis were used as codes (e.g., "*above and beyond*"). Some codes were combined to make larger categories (e.g., codes such as "*not on the radar screen*", "*oblivious*", "*unaware*" and "*invisible*" were combined into the theme of "invisibility"). Particular attention was given to similarities and differences in response based on roles within the institution, scope of responsibility, and community or family vs. staff perspectives. These themes were then compared with the dimensions identified through the document review.

Focus Group

Initial Plan for Focus Groups

In the original research proposal, a number of different focus groups were proposed. The objectives of these groups were to:

- obtain feedback on initial findings from a variety of levels/units within the facility

- assess the extent to which results of a document review would be accepted within the organization

- assess similarities and differences in perspective between stakeholder groups

- assess the impact of the assessment/feedback on the organization.

It was anticipated that several groups would be scheduled to ensure input from a variety of disciplines and patient care areas, and to enable staff with advocacy or access roles and community representatives to participate.

From Focus Groups to Feedback Sessions

Following the completion of the key informant interviews, findings from the interviews were analyzed for planning the focus groups. At that time I concluded that focus groups as originally designed would likely duplicate much of the material already identified through the key informant process, albeit with a broader group of individuals. Based on a concern that limited new information would be obtained (and aware of the cost in time/resources to the facility of conducting these), this plan was reconsidered after consultation with the Site Advisory Committee.

Instead, a series of feedback sessions were proposed. These feedback sessions had the objectives of providing further opportunities for clarification, and determining whether (a) a document review approach would be accepted by institutions, and (b) whether the specific findings/ conclusions would be accepted by this organization. The focus of these

sessions was to be on findings of the document review related to the particular site. It was anticipated that the sessions would address particular interests of the sponsoring site, and would enable more people to participate. The Site Advisory Committee was supportive of this approach.

Parent Focus Group

Only one focus group was conducted. Consisting of parents belonging to the facility's parent group, the main purpose of this focus group was to ensure that there was input from a consumer perspective. A focus group has the advantages over individual interviews in being time and cost effective. Other advantages are enhanced data quality provided though participants providing checks and balances on each other, and facilitated assessment of the extent to which views of participants are similar or divergent. Focus groups are suited to situations where the research emphasis is on identifying major themes, and where analysis of subtle differences is not required (Krueger, 1988; Patton, 2002), as was the intent in this setting.

A list of members of all members of the parent group was obtained. A decision was made to combine the focus group with a regular meeting so as to maximize attendance, and invite only parents to that component of the meeting. In addition, I phoned the parent co-chair of the group to invite questions, and solicit ideas on how best to proceed. I then either mailed or emailed a letter of invitation and a copy of the Information and Consent form (Appendix L).

A total of six individuals attended the focus group, which took just over an hour. Participants were parents of birth, adoptive, and foster children, most of whom had longstanding, major medical problems, and were therefore not representative of all families served by the facility. However, as regular users of services it was anticipated that they would have greater opportunities for interaction and observation, making them valuable informants. One parent was a member of a visible minority group; some other parents stated that they were parenting Aboriginal children.

After a review of the objectives of the project and provision of an opportunity for participants to ask questions about the project and the focus group, the consent form was reviewed, signed and collected. The consent included permission to audio-tape the session. Although the group was known to each other, the types of questions asked were not anticipated to inhibit frank response, as no staff were present and the researcher was independent from the facility. Questions focused on quality of care at the facility, whether participants felt that care differed by ethnic/"racial" group, and the kinds of problems they had observed or experienced in this area (Appendix M).

The focus group discussion was transcribed and analysed in a fashion similar to the interviews. While the transcripts identified the voices of particular speakers (e.g., female voice 1), analysis of focus group transcripts was not by individual participant, but rather around identified themes. As this was the only parent input gathered through the project, particular emphasis was placed on identifying similarities and differences between parent and staff respondents.

Observational Methods

The project required the researcher to be on site at the test location over a period of several months, attend meetings, travel to different parts of the complex, and have phone contact with various individuals, during the process of gathering materials and conducting interviews. This provided the opportunity for both participant observation (e.g., attending meetings) and unobtrusive observation (e.g. sitting in a waiting area or walking through facility corridors) (Patton, 2002). In the latter case, the status of the researcher was unknown and, therefore, would not be expected have an effect on those observed.

In addition, knowledge of the project and my presence at the site led to some direct requests for informal consultation on cultural issues. In the course of collecting materials, some informal conversations also took place where opinions and perspectives were volunteered. Consent was not obtained for these informal interactions, and no comments made during these discussions were used in feedback sessions or this report. However, these requests and informal conversations provided additional insight on awareness of organizational documents as well as on individual perspectives and organizational challenges.

Process Documentation

All meetings and informal contacts were documented, and copies of correspondence related to the project were filed. In addition, I kept a log of activities and interactions that included: the process of initial consultation; meetings with the steering committees;

development and implementation of the assessment instrument; and the process of coordinating and facilitating interviews and focus groups. This log also made note of related activities that occurred during the time of the project and that provided perspective on the issue of cultural responsiveness within the test area, even though they were unrelated to the project (e.g., experiences of medical students and settlement staff with whom I was working).

The intent of this documentation was to assist in evaluating the implementation process and developing guidelines and recommendations for similar activities in other settings (e.g., by identifying potential obstacles to project implementation, providing estimates of time required, and the numbers of individuals necessary for consultation, interviews, and focus groups). This process documentation also noted unanticipated issues and impacts that arose, and described the response of stakeholders to various components of the assessment process.

Developing Report on Site-Specific Findings

Following completion of the interviews and focus groups, the findings from the document review were compared with those from the interviews, the focus group and observational data. Additional materials gathered through the interviews were reviewed to determine whether items should be added to the assessment instrument. The results from all methods were compared, and themes specific to the site identified. This was summarized in a confidential 50-page analysis (intended for my use only and not part of this dissertation) of site-specific findings resulting from the document review,

observational and interview/focus group data. Strengths and weaknesses related to each of the domain areas were identified. Evidence of specific philosophical approaches (e.g. definition of culture and cultural group, voluntary or required, individual or organizational focus) was also determined, along with a general assessment of organizational issues related to cultural responsiveness as indicated through the assessment process. The report also included analysis of anecdotes and specific "trouble" cases (Kaufert, Koolage, Kaufert & O'Neil, 1984) – cases that elicited problematic areas or structural factors that were used as part of the internal organizational discourse – identified during the interview process.

Feedback Session

From the time the project was first initiated it was planned that feedback would be provided to the sponsoring site. When I had completed the initial analysis of documents, interviews, and focus group, I proposed a feedback session to facility management. Initially, it was suggested by a member of Program Management Team that the joint executive of the facility/health complex/regional health authority be the first group for presentation of the study findings. The Site Advisory Committee agreed with this suggestion. However, due to time constraints this was not approved.

The subsequent plan was to invite these senior management representatives to two presentations planned as part of existing committee meetings. One hour was requested for these sessions; however, again due to time constraints, the time made available was limited to one half hour. Due to concerns regarding how feedback on such a complex and

potentially sensitive topic could be conveyed, I then suggested that I field-test the planned presentation with the Steering Committee.

The interview process had provided a good overview of the level of awareness of best practices within the organization. For example one of the questions asked of key informants in individual interviews was whether they were familiar with any national or international standards related to cultural responsiveness. With few exceptions, none of the informants were aware of such initiatives – and of those who were aware of issues related to cultural responsiveness in general, some were aware only through exposure in other positions in the non-health sector. As many of the key informants were senior or mid-level managers, who were selected because they were in a position with anticipated expertise or responsibility, the indication was that it may be necessary to provide significant background (e.g., what best practices had been identified, standards in other jurisdictions) before specific results were shared.

One hour was set aside for this "trial run" with the Site Advisory Committee. Following this presentation and the resulting discussion, the committee made a recommendation to Program Management Team that the scheduled sessions be postponed until adequate time could be made available. It was agreed that, in order for the feedback to achieve its objectives adequate, time would be needed in order to: a) outline best practices; b) describe how assessment of these practices was undertaken through analysis of documents; c) review findings specific to the test site; and d) allow time for questions and discussion around these findings.

The steering committee also recognized that there was the potential for sensitive findings, and that it would not be wise to proceed with a presentation of complex findings if adequate time was not made available to provide necessary background and allow for debriefing.

Another feedback issue related to the fact that responsibility for policy, programs and services was located at three different levels. Feedback at only one level could result in either disinterest or resentment, if that level did not have the authority to address the specific issues raised.

There was concern that unless the feedback was provided appropriately, findings related to best practice may not be perceived as supportive by the "champions" of cultural responsiveness within the organization who had provided leadership for initiatives developed to date. It was also believed that it would be inappropriate to provide general feedback sessions before management had the opportunity to respond to the feedback it had received and could be involved in planning for additional sessions. Therefore, the sessions were postponed, with the anticipation that appropriate time could be scheduled in early autumn 2003.

Clarifying Objectives of Feedback Sessions

Feedback from the pilot session with the Site Advisory Committee helped focus objectives for this final stage of the project. While there is growing consensus in the literature on best practices related to cultural responsiveness and access for underserved

and culturally diverse communities (Office of Minority Health, 2001a), there has been limited progress in having these conclusions brought into practice, or in disseminating the results of related research through the health care system. Within health care, even awareness of cultural responsiveness as an organizational issue is in its infancy.

As a result, the feedback phase was "separated out" from the rest of the project. Where before it was seen as one of the phases in development of the instrument, it was now defined and developed as a component with research questions specific to knowledge translation (or knowledge transfer) within health institutions. This was considered of significant importance, as any other centres that might consider using the revised instrument would also benefit from an assessment of barriers and effective strategies. The focus of the feedback sessions therefore evolved to encompass two major objectives:

1. *To provide an initial assessment of the extent to which findings of the document review would be received by decision makers and stakeholder groups*
   a. To assess the acceptability/credibility of a document review process for assessment of cultural responsiveness
   b. To assess the openness of the facility to findings related to its own institution.

2. *To provide the facility with the opportunity to clarify and respond to assessment findings*
   a. To provide an overview of site findings compared to identified best practice

b. To facilitate future action on project findings

c. To provide the opportunity for the site to clarify or correct conclusions reached through the assessment process (feedback stage of research).

This phase was anticipated to assist in development of recommendations for further use of the document review process and to facilitate transfer of review findings.

Conducting the Feedback Session

There were a number of delays in setting up the feedback session, which was not scheduled until December 2003. The session was organized by the facility Quality Council, and in addition to Council members, special invitations were sent to the facility management team, representatives of the executives of both the health complex and the health region, and the Site Advisory Committee. A total of 22 people attended this session, which included seven special guests who otherwise would not have attended. Three others of those specially invited were Council members. Two of those attending were parent representatives. Several Quality Council members did not attend.

One hour was allocated to this session. A PowerPoint presentation covered three areas: best practices related to cultural responsiveness of health care organizations; research objectives and methods; and findings related to the test site. Time was also allocated for discussion, in order to assess the response of participants to the findings. This session focused on site-specific findings that were anticipated to be of interest to the sponsoring organizations, and was based on the confidential report described in the previous section.

The details of the review at the sponsoring site are not included in this dissertation, which is focused more broadly on the assessment of a document review process and general issues emerging from review of documents from all eight locations.

Follow-up Survey

Following the feedback session, the chair of the Site Advisory Committee distributed a simple informal survey of seven questions to Advisory Committee members, Program Management Team, and the administrative support staff assigned to the project. The questions focused on estimates of time required to support the project, evidence the project's impact, and assessment of how useful the process had been. Four of a possible seven individuals responded to this survey, an additional respondent gave verbal estimates in regard to questions about time spent on the project (Appendix N).

Assessment of Document Review Strategy

Application of Instrument

The process of the document review itself was also assessed. The first step was to assess the application of the instrument. Evaluation of the instrument included the following categories:

1. **Selection of domains of inquiry:** Through content analysis of organizational materials, the following questions were explored: Were relevant documents available for all of the best practice domains selected through the literature review? Did all domains give useful information on the organization? Was there overlap or repetition?

2.   **Ease of implementation:** Process documentation, and key informant interviews were used to explore the questions: How easy or difficult was it for the organization to identify and locate requested materials? How much time was required to gather the documents? What kind of information was required by contact people within the organization in order to facilitate the task? Who needed to be involved? What obstacles to implementation were experienced?

3.   **Selection of documents:** Using the methods of content analysis, key informant interviews and focus groups, the research addressed the questions: Did the documents requested provide the information sought? Were there particular documents whose presence, absence, or approach are particularly useful for assessment?

4.   **Philosophical approaches:** Content analysis was employed to determine whether the indicators selected for assessment of various philosophical approaches (as described in section 2.5 and 3.7.1) were found in the documents selected for review.

5.   **Indicator selection:** Content analysis, key informant interviews, and focus groups were the methods employed to evaluate the indicators selected for inclusion in the instrument. This was to address the questions: Were the indicators identified in the assessment instrument found in the documents requested? Did a review of the documents suggest other factors?

Congruence Between Instrument Findings and Other Data Sources

The extent to which the conclusions reached through the document review reflected the perspectives and achievements of the facility related to cultural responsiveness was evaluated by comparing the findings obtained through the document review with data from other methods (such as key informant interviews, the focus group, and observational methods). Analysis focused on similarities and differences in data obtained through these different methods (methods triangulation) and through different data sources (triangulation of sources) (Patton, 2002). The feedback session to senior organizational representatives provided an additional opportunity to "check" conclusions, by providing a direct opportunity for organizational response.

The findings of this project (document review combined with interviews, focus group and observational methods) were also compared with results from two self-assessment activities undertaken at the same site. These activities are described in section 5.4.

Impact of the Assessment on the Sponsoring Organization

A secondary focus of exploration was that of the impact of the document review activity. This had two aspects: the time and resources required from the organization; and the impact of the document review and interview/focus group activities on the organization. Several data sources were used in this analysis:

- observations made in the course of undertaking the project (e.g. feedback from the Site Advisory Committee, difficulties experienced in locating material, time for document retrieval)

- interview analysis, particularly direct comments or other indication that the project (or the specific question) was having an effect

- review of verbal and written communication regarding the project, including unsolicited comments and observations, and events and activities that may have resulted from the research

- contacts with the researcher initiated by staff as a result of the project

- a brief survey of the Site Advisory Committee, Program Management Team members and other key individuals most closely associated with the project.

These activities, along with the feedback session, were also reviewed for evidence that the document review process would have any effect on future organizational planning and activities. Chapter 5 outlines the conclusions reached regarding the usefulness of the document review process.

Ethical Considerations

This project focused on policy review and development, and did not involve access to patient information or access to any confidential employee or organizational material. Nor, with the exception of the parent focus group, did it involve contact with facility clients. However, the design of the project did address several other critical ethical issues.

Access to the Site

Before the proposal was developed, approval in principle was obtained from the

management of the sponsoring paediatric care facility. Ethics approval was received from

both the University of Manitoba (Faculty of Medicine Health Research Ethics Board) and

from the relevant review committee of the test site. This committee focused on the

potential impact of the project on the resources of the facility (specifically what staff time

would be required to assist with the project and participate in interviews, and whether

there would be any other financial costs to the institution).

Consent and Confidentiality

The design of the project required that the issues of consent and confidentiality be

addressed at two levels: that of the individual participants and of the organization that

agreed to be the test site.

Consent

At the organizational level, the health complex, the regional health authority, and

specifically the paediatric care facility which served as the test site, gave approval to the

project and gave the investigator permission to contact board, management, and staff.

They also gave permission for staff to participate in project activities (e.g., interviews) on

work time. Because "cultural diversity" was defined in this project in broad, general

terms, and the focus was not on the community context or validation from a community

perspective, consent was not sought from particular ethnocultural community

representatives.

Individual consent was obtained from all participants in individual interviews and the focus group. Participants were contacted directly by letter as described in 4.8.3.2. Included with the letter was a copy of the information and consent form (Appendices J and L), which also provided a link to the facility web site that provided additional information (Appendix F). Participants were informed that participation in these activities was entirely voluntary; that they could choose not to answer any questions; and could terminate their participation at any time.

The consent form for the focus group also included permission for audio-taping. Interviews were not audio-taped, as it was felt that the formal atmosphere created by taping the conversation might create a less relaxed atmosphere and inhibit frank sharing of informant perceptions.

Confidentiality

Confidentiality at the level of the individual

There was little difficulty in protecting the confidentiality of individual respondents. Participants were given information on how the sample had been selected and informed that the list of those chosen for interviews was confidential, as would be their decision about whether or not they chose to participate.

It was recognized, however, that it might be necessary for some interview participants (e.g., those scheduled to specific shifts of direct patient care) to notify their supervisor of their participation if they wished to participate on work time. In the letter of invitation to

individuals in these roles, potential participants were provided with two options should they agree to participate in individual interviews. One option was to meet outside of work time (in which case confidentiality of participation could be provided). However, if they wished to be released during a scheduled shift, they were required to notify their supervisor. In such case, information on participant participation would not be confidential. Although I offered to contact the supervisor on the respondent's behalf, no interview participants requested this.

Only parent members of the facility parent group were invited to participate in the focus group, in order to facilitate frank sharing of information that may have been inhibited if staff were present. Focus group participants were informed, however, that while the investigator would maintain confidentiality of comments made in the session, confidentiality could not be guaranteed because of the nature of group discussion.

Notes on interviews were identified with a code only, and stored in a locked cabinet in my private office (which is independent from both the university and the test facility). Audiotapes were similarly safeguarded and erased following the completion of the project. Interviews and focus groups were held in a private location, at a site chose by participants, and where there was no risk of other staff over-hearing the conversations.

Information that might potentially identify an informant (e.g., position or unit of the facility or health complex) was removed from any quotes or examples used in this dissertation or in the feedback session. Only summary/composite information was used

in reports. However, participants were informed that, because of the nature of purposive sampling and the small number of participants, absolute confidentiality could not be assured in spite of these precautions.

One issue that arose was the sharing of anecdotes related to patient care, some of which were reported by more than one informant. In no case were names of patients shared with the researcher. However, if they were to be described in a public report, the individuals affected (patients, and in some case staff) could potentially be identifiable. None of these cases have been included in this report, or in public feedback sessions, although they have been shared with the Site Advisory Committee.

Confidentiality at the level of the organization

This project also includes safeguards regarding the confidentiality of participating organizations. Greater challenges were experienced in addressing confidentiality at the organizational level. Although the test site is not named, there are identifying characteristics that could make it identifiable.

While the focus of the assessment was on the instrument, and not on evaluation of the cultural responsiveness of the institution, it became clear that concrete examples would be needed to illustrate key findings related to use of the assessment instrument. In order to provide confidentiality to the sponsoring site, findings from other activities have been included in the examples given in the discussion sections. Assessment activities related to the preliminary instrument, undertaken in early 2002, utilized information from seven

paediatric health care centres. In addition, current members of the National Network for Cultural Competency were asked to providing anonymous case studies that could be used in the report. This allowed the report to be written with anecdotes from additional sites, facilitating anonymized discussion of the issues identified.

Need for Sensitivity in Sharing of Findings

As the assessment focused on issues around which there are often intense and conflicting perspectives and responses (e.g., rights of cultural minorities, employment equity initiatives, racism and discrimination within health care systems), it was anticipated that the project could potentially identify trends, issues or incidents of concern. The literature review identified fundamental differences in assumptions and approaches to "cultural diversity": this suggested that exploring these dimensions within an organization could potentially uncover important differences in philosophy, priorities, and values. It was also recognized that the process of asking questions about organizational responsiveness and diversity had the potential of bringing to the surface underlying conflict or dissatisfaction.

The project was designed to recognize this potential. Materials for the communication plan were reviewed with the Site Advisory Committee, to ensure that wording was neutral and did not appear to suggest that this project was a forum for specific complaints. Interview questions were designed to use neutral, non-leading language wherever possible. In all cases, the privacy and confidentiality of the source of any information was protected. Where contentious issues are identified, the report does not

identify parties with particular positions. It was made clear that the primary source of data was analysis of the documents; the interview data was used to confirm/challenge those findings.

While the interview process did identify some discomfort and lack of consensus regarding how cultural issues and needs were currently being handled within the organization, there was no indication that the process of asking questions on this topic was itself creating dissention or difficulty. However, at the time that the draft presentation on site-specific conclusions of the assessment was prepared, a number of concerns related to sharing of findings were identified. The key ethical issue identified was the need to ensure that all steps were taken to share findings with the organization, while at the same time avoiding – to the greatest extent possible – any damaging effects of sharing this information. The decision to delay feedback sessions until adequate time could be found for senior management to participate was one response to these concerns.

Organizational Participation and Feedback

A commitment was made to ensure that diverse stakeholder groups from within the organization had the opportunity for input. All staff of the participating facility were provided with information on the project (see section 4.8.0), and questions and concerns about the process were welcomed before the project was launched. The Site Advisory Committee worked closely with the investigator over the life of the project, and regular reports were made to the Program Management Team regarding project progress. As investigator, I offered to provide feedback sessions within the organization that would

focus on the site-specific findings, and at the time of writing, one feedback session has been presented.

Availability of Assessment Findings to the Sponsoring Organization

While the intent of the project was to evaluate an assessment tool and process, not the sponsoring organization, the assessment did provide specific information of direct interest to the sponsoring organization. The intent of the feedback session was both to provide the opportunity for participants to ask clarifying questions and provide additional information that may have been overlooked in the review; and to provide the organization with the opportunity to benefit from the assessment and use the results in future planning.

A brief summary announcing the completion of the project is to be posted on the facility web site, with information on where a copy of this dissertation can be found. A copy of this dissertation will be provided to the sponsoring facility and the executive summary will be sent to all interview and focus group participants.

Benefits and Risks to the Organization

The major potential benefit to the test site of participation in this pilot was the opportunity to obtain a baseline of information related to organizational policy and practice compared to identified "best practice," and attitudes and knowledge of organizational stakeholders regarding current policy and direction related to cultural responsiveness. It also provided the opportunity to clarify the approach(es) demonstrated through policy and programming to date, and to further explore the implications of these

approaches. Greater awareness of these issues positions the organization to better develop strategies for improved responsiveness to culturally diverse groups, and to compete for funding for special projects in this area. In addition, by participating in a project supported by the National Network for Cultural Competency, there are increased opportunities for national networking and information sharing.

Potential risks or disadvantages to the organization included the time required of staff to participate in the project, and the unknown impact of the process of raising questions about cultural responsiveness issues (at the individual level), and of sharing of research findings (at the organizational level). Given the design of the project, and the "document review" approach, resource commitment was expected to be minimal. It was limited to staff time (a) for consultation with the researcher in defining stakeholder groups and assisting with the sampling framework, (b) in assisting with gathering materials for the document assessment, and (c) participating in interviews. A time commitment was also required from the organization in order to receive feedback on research findings. However, any decision on the feedback sessions was at the discretion of the organization.

Evidence of resource demands and other impacts of the project on the organization is discussed in Section 5.5.

Summary and Conclusion

This chapter summarizes the research design and methodology employed to evaluate the pilot of a document review instrument at one specific site – a Canadian paediatric care facility. Methods included policy review and content analysis of identified organizational documents, and a variety of methods (key informant interviews, unobtrusive and participant observation, focus group and feedback session) that provided data with which the conclusions of the document review were compared. Process documentation, a brief survey and a feedback session to organizational decision makers, were used to assess the organizational resource implications of undertaking a document review, and to gather initial data regarding the impact of the project on the organization.

Strategies to address the ethical issues associated with the research included a formal information and consent process for interview and focus group participants, masking strategies used in writing the dissertation and making public presentations, and strategies for ensuring appropriate organizational feedback.

CHAPTER 5: RESULTS: PILOT OF ASSESSMENT INSTRUMENT

Overview

This chapter addresses the question of whether the results from the test site indicate that document review is a useful strategy for assessing the cultural responsiveness of health organizations. An extensive literature review failed to identify cultural responsiveness assessment tools that utilized a document review approach. Nor have assessment strategies identified to date attempted to assess organizational approaches to addressing cultural diversity, although many attempt to address the extent to which best practice has been adopted. Results of this pilot, therefore, may give direction as to whether further development of this approach is warranted.

The first area of evaluation relates to the instrument itself. Were relevant documents found within each of the domains? Did they address the identified elements within each domain? Were all domains equally valuable in providing relevant data? As the instrument also included indicators of the underlying approach to cultural responsiveness (the "dimensions"), it is also important to determine whether the document review process was able to provide insights regarding organizational approach on these dimensions.

If relevant documents were located and appeared to address (either by their content or by its absence)[1] key elements included in the assessment instrument, the next question – and one of critical importance to this research – is whether the conclusions reached through

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[1] Absence of document evidence in a domain area was interpreted to mean that best practices had not been formally incorporated into the structure and process of the organization.

content analysis of identified documents were reflective of the actual progress and perspectives of the organization.

A third question relates to the impact of the review and feedback process on the test site, in terms of a) resource demands, b) acceptance of findings by organizational decision makers, and c) interest and activity generated through the review and feedback process.

This section also discusses the results of a comparison between the findings of the document review and self-assessment activities conducted at the same site. It concludes with discussion of the potential for future use of a document review instrument and recommendations for further utilization of this strategy.

Appropriateness of Selected "Domains" of Cultural Responsiveness

Analysis was focused at two levels. The first step was to determine whether or not specified documents were in existence at any level at the test site. If documents were located, they were then assessed for a) evidence of best practice, and b) indication of philosophical approach along the identified dimensions. This section summarizes findings related to the specific "domains" of best practice at the test site, with reference to the simpler document review undertaken with the seven participating hospitals in 2002 (described in section 3.6).

Relevant documents were found in all domains at the test site. **Domain 1: Profile** (which attempts to capture evidence of organizational commitment to cultural responsiveness at

the most public and "visible" level) includes materials, displays and other information that would be apparent to patients, visitors or new staff. Statements of organizational mission, vision and values, as well as the organizational web site were located and evaluated, as were annual reports, and a variety of publicly accessible miscellaneous documents (e.g. official organizational brochures, program descriptions, patient handbooks, or reports to the community). "First impressions" of the physical environment (signage, visuals) determined through a walk-through of the public areas of the facility, combined with unobtrusive observation, were also included in this category. These activities focused on questions such as: What messages were conveyed in the public areas of the facilities through signage, décor, etc? What languages were visible? Was information on services and rights readily located, and in which languages? For this domain, materials were reviewed from all three levels of the organization, with a focus on the paediatric care facility.

All materials included in the review instrument were found at the level of the individual facility. Materials were reviewed for evidence of a clear commitment to providing culturally responsive care.

The literature suggests caution in interpreting data within this domain. Concerns have been raised that many organizations provide "lip service" in their mission and other broad value statements, but fail to "walk the talk" in practice (Gandz, 2001). This review found, however, that the messages conveyed at this level were consistent with findings in other domains. This may be because the analysis also included evidence related to underlying

philosophy of cultural diversity, not simply the presence or absence of particular statements. One document that did not appear to reflect practice was the organizational code of conduct, although it was easily identified and visibly displayed in some locations. Some key informants spontaneously referred to this code as not being consistent with organizational practice. This reinforces the need, in any organizational review, to compare broad statements of principle with specific indicators in other domains.

Examples of the resources requested for review in **Domain 2: Human Resources** included human resource policy and procedures, along with additional materials (e.g., workforce audit/employment review, job postings, staff/volunteer orientation materials). This was supplemented by time I spent waiting in the general employment office, and unobtrusive observation of signage, postings, and job applicants in the office. As the paediatric facility did not have a separate HR department, human resource materials were reviewed at the health complex level (with a brief overview of regional documents).

Fewer of the materials identified in the assessment instrument were located in this domain at the test site (e.g., no workforce audit or employment equity policy, monitoring systems, guidelines for performance evaluation related to cultural responsiveness; nor policy requiring attendance at Cultural Awareness training were located). The preliminary review indicates that some, but perhaps not all of these documents are available in other institutions. Additional relevant documents (in this case, specific initiatives for one cultural group, not specifically identified in the instrument) were easily located.

The review indicated that relevant documents did give a good indication of the approach taken. However, at the test site there were differences noted between the health complex and the region. In addition, different requirements and initiatives were in place related to HR policy directed at specific identified "cultural groups," compared to overall employment equity policy. For example, a "preference clause" for those with knowledge and experience in working with one cultural group was included in postings for most positions; and information on only this employment equity category was collected by the HR department. These specific groups were those highlighted in materials identified in Domain 1.

Documents reviewed for **Domain 3: Education and Training**, included website and print materials that outlined in-house training for management and staff, the list of all training courses and workshops offered through the health complex and the region, along with a detailed outline of the cultural training offered. These materials were analyzed for evidence that training included identified key elements (as described in Section 3.2.2). Information on training attendance figures was requested and the process for monitoring attendance clarified.

Materials indicated that the site relied largely on an ethno-specific approach to training; that many of the key elements of recommended training (see section 3.2.2) were not included; and that attendance at cultural awareness training, although encouraged, was voluntary. There was not evidence that issues of culture had been integrated into other training or orientation programs.

Documents reviewed for **Domain 4: Language Access Services** focused on specific policy and program materials related to provision of interpreter and other language access services (e.g., designated bilingual positions would fall in this category). Materials from all three organizational levels were reviewed and compared to performance guidelines defining best practice (Appendix A). Materials included policy related to provision of language services, program descriptions, information provided to patients, interpreter job descriptions, and available program statistics. In addition, a broad array of general documents was reviewed to assess the extent to which language needs had been considered within general facility activities (e.g., consent forms, consent policy, complaint process, patient satisfaction instruments, or volunteer services policy and programs).

At the test site, many of the documents identified in the assessment instrument were not in existence. The preliminary scan indicated significant variability among other facilities in this regard, with many settings having some of the documents listed. In addition, it was discovered that there were some language services (used regularly by facility staff or patients), about which no written information was located. These programs (specifically, community-based interpreter programs) did not "belong" to the facility, indicating that it was necessary to add a specific item related to community language services to the assessment instrument. Assessment of this area required development of a matrix for analysis, as different language constituencies (Aboriginal, Inuit, French, other) fell under different responsibility areas (and some had no designated responsibility centre). There were significant differences in services and information available for each group.

Domain 5: Information for Clients and Communities included an overview of the range of patient education materials available, and information for patients and the community on rights and services. It also included a request for any policy or guidelines related to translation and development of resources, signage, or consultation with the community. Lists of materials available for patient education and through the resource centre were reviewed, as were patient information directories. Existence of basic minimum information identified through the best practice review (consent, right to interpreters, complaints) was determined and the languages in which materials were available (including a general assessment of the language level of English language materials) were assessed. Few of the identified materials in this domain were located.

Application of the instrument at the test site resulted in review of **Domain 6: Organizational Framework and Integration** from two different perspectives:

a) One is *the extent to which the organization provided the structure and resources to support cultural responsiveness initiatives*. This included determination of whether there was a diversity plan in place, the support structure and resources allocated for identified diversity initiatives, and a review of accountability mechanisms for designated programs and positions (including the reporting structure).

b) The other is *the extent to which cultural responsiveness issues had been integrated into organizational structure and processes.* This aspect looked at questions such as whether, and to what extent, cultural responsiveness had been incorporated into the strategic and business planning process, or integrated into the work of relevant committees and relevant policy, program or service delivery

areas. It required review of a wide range of documents (e.g., committee terms of reference, board, executive and committee agendas, strategic and operational plans, research activities). In addition to all materials collected for the other seven domains, it included a review of recent initiatives to determine whether issues of cultural responsiveness were incorporated where it was appropriate to do so.

Consultation with the Site Advisory Committee and Program Management Team was required to identify relevant documents in this area – e.g., it was initially unclear what should be provided as a "strategic plan," what committees were of greatest relevance, and what initiatives were of current interest. This process resulted in clarification of some items included in the review instrument and addition of others (e.g., some quality council materials were not originally listed).

The review found that it was necessary to analyze materials on organizational structure and resources by specific "cultural group," as at this site there was no overall diversity umbrella or initiative that applied to all groups. It was also necessary to assess the extent of integration separately for each cultural group. This pilot use of the instrument confirmed the appropriateness of the decision to divide this domain into the two categories described above, as they appear to be two different processes: progress on establishing a diversity plan and accountability for a specific diversity initiative did not appear to be reflected in the extent to which cultural issues were integrated into strategic planning, the overall committee framework, policy or service delivery areas, or initiatives such as quality scorecards.

For **Domain 7: Data Collection, Evaluation and Research,** patient data templates were reviewed to determine current "ethnic" codes used in data collection, and any policies or other documents related to participation of diverse groups in research and evaluation were requested. The materials accessed incorporated few ethnic identifiers, and there was evidence of variation in data collected between programs, a situation also observed at other sites. Recent internal and external research reports, patient satisfaction instruments, lists of internally supported/funded research projects, and descriptions and reports of research programs were also reviewed. These were relatively easy to locate, but often did not contain evidence of "best practice".

The final domain, **Partnership with the Community**, focused on evidence of partnership with the community, in particular, representation throughout the organization of diverse ethnic and cultural groups. Formal policy related to community partnership, committee terms of reference, and requirements for consulting with the community were requested. These materials, along with facility publications and other documents, were reviewed for evidence of a) established relationships with community groups, and b) participation by a diversity of communities in committee membership, development of publications and other activities. Little evidence of such participation was found in the documents, although there were some differences between the facility and the region in this regard. For example, the region was in the process of instituting community advisory committees for each health district; no similar initiatives were found at the facility or health complex level.

Issues Related to Assessment of Domain Areas

While in some domains (Domains 2, 4, and 7, for example) several of the documents listed in the instrument were not located; this does not necessarily indicate that the instrument is inappropriate, as absence of certain policies or other materials may give a useful indication of organizational level development in this area (one informant described this situation as "*absence speaks loudly*"). In fact, relevant documents were found in all domains, and those located were sufficient to draw preliminary conclusions related to the extent to which the facility appeared to be adopting best practice.

It was necessary in many cases to search beyond the parameters of the individual facility to locate relevant documents. Relevant policy and other documents were found at all three levels – the paediatric care facility, the health complex and the regional health authority. Observations made at one organizational level were not necessarily applicable to other levels. In Domain 1, for example, significant differences between the facility and region in wording used to describe commitment to specific cultural groups suggested underlying differences in approach. Documents unavailable at the facility level were most often found at the health complex level, but many important documents were found only at the regional level and some materials appeared to be unavailable at any level. This issue is revisited in Section 5.7.1.

Care was taken to collect all relevant documents. The Site Advisory Committee and Program Management Team were consulted to identify any existing organizational documents included in the assessment instrument. In addition, key informants (who were

selected on their presumed knowledge and responsibility for certain domain areas) were asked directly whether any other materials – not identified in the instrument – should be included. In spite of these precautions, it is possible that there may have been documents or initiatives that were not identified, particularly at the regional level. However, it would be unlikely that any existing unidentified materials would substantively affect the conclusions as, if (a) materials were not readily apparent, and (b) key individuals were not aware of their existence (or did not think to mention them), one might reasonably assume that for all practical purposes these documents were not "living documents" in the daily life of the organization.

Some "detective work," with the assistance of the Site Advisory Committee, was occasionally necessary to identify the most appropriate materials (e.g., what documents best fit the criteria of "strategic plan") and to locate them. Some of the additional materials identified through meetings with key informants were relevant to the analysis. It is unclear to what extent revisions to the document review instrument could prevent "overlooking" key documents when they fall under very different management levels, especially in settings where there is no overall coordination of services for different cultural groups.

Not all domains proved to be equally "rich" in terms of data collected. Little information was found in Domains 5 (Information for Clients and Community) and 8 (Partnership with the Community), suggesting that these two could be combined. On the other hand, Domain 6 was separated into "Organizational Framework to Support Diversity" and

"Integration of Diversity Initiatives", as it appeared that these may be two different, though often overlapping processes. The revised instrument (Appendix O) incorporates these changes.

Identification of Underlying Organizational Approach to Addressing Cultural Diversity

Content analysis was used to identify the underlying organizational approach(es) to responding to cultural diversity. These dimensions (definition of culture and cultural groups, multicultural or anti-racist orientation, approaches to cultural training and workforce management, individual or organizational focus, voluntary or required action, provider competence or organizational access) are described in section 2.5. For example, did the materials use the language of cultural "awareness", "sensitivity" or "competence"? Were issues identified as "multicultural" or "diversity"? Did documents refer to "respect for" or "a commitment to addressing needs of," or "ensuring participation of," diverse communities? What cultural groups were acknowledged in the documents? Was there specific acknowledgement of the presence of racism and discrimination?

As suggested by the graphic on page 204, materials from specific domains provided varied amounts and richness of data in assessing specific approaches, but indication of philosophy on at least one dimension was found in each domain. Note that the two dimensions "approach to workforce management" and "approach to cultural training" are not included in the table. The most useful information on these dimensions was provided,

as might be predicted, through review of Domains 2 (Human Resources) and 3 (Cultural Training). Content analysis identified the approach taken to workforce management (monocultural, ethnic matching, workforce representation, diversity), although important differences in approach were found between organizational levels. Similarly, in Domain 3, review of curriculum materials indicated that a culture-specific approach was dominant (and gave useful information on the operational definition of culture within the facility).

Table 9: Sources of Data for Analysis of Organizational Approaches, by Domain

	Definition of cultural group	Multicultural or anti-racist	Culture general or culture specific	Approach to workforce management	Voluntary or required	Individual or organization	Competence or access
General Profile	▓	▓	▓				
H.R.		▓		▓	▓	▓	▓
Training	▓		▓		▓	▓	
Language access	▓			▓	▓	▓	▓
Information for clients	▓						▓
Organizational support, integration	▓	▓	▓	▓	▓	▓	▓
Data, evaluation, research	▓				▓	▓	
Partnership						▓	

Observations across domains were useful in determining the strength of conclusions related to specific approaches – if consistent evidence was found in all domains, greater confidence could be expressed in the conclusions. I found that the domains most useful in analysis of the dimensions were consistent with, but not identical to, those initially proposed in Appendix D (Matrix of Domains and Dimensions). I also found that a more "global" overview of all documents was useful in assessing the dimensions, rather than

the guidelines relating to particular documents. General questions to guide assessment of organizational approach along the identified dimensions have been summarized in Appendix P.

During the pilot I found evidence of different strategies and standards for different "cultural groups." It is therefore recommended that any assessment include analysis of the definition of "cultural group," and determine which populations are included in each policy or initiative. Key factors for assessment are designation of responsibility and authority, and evidence of funding allocation – program initiatives or population groups perceived as more important by the organization can be expected to have more direct reporting lines to the CEO, and are more likely to have dedicated funding.

Document analysis also found preliminary evidence that a different approach may be emerging at the regional level than had existed in the past at the facility or health complex level. The mission, vision and related documents at the three levels used different terminology to describe their commitment to cultural diversity (e.g., "*we declare our commitment to the x community in implementing actions that address health care needs through employment initiatives, active participation in the health system and improved service delivery options,*" compared to "*It will be culturally sensitive*" or that patients will be "*respected for their beliefs, religious practices and customs*"). As the process of regionalization is recent, and program and policy development is ongoing, regional level documents may give a better indication of future direction than documents at the facility level.

Preliminary Conclusions: Congruence Between Document Review and Qualitative Methods

Sufficient data on both the "domains" and the "dimensions" identified in the instrument were obtained to enable development of preliminary conclusions related to the test site. This section explores the question of whether these conclusions were supported by evidence gathered through other methods and from additional sources. It is important to note that I found as much evidence related to the "dimensions" (or approaches to cultural diversity taken by the organization) as for the specific "domain" areas.

Even though application of the instrument indicated that relevant materials were in existence and contained information appropriate to this analysis, the crucial question is whether the findings of the document review reflect actual organizational perspectives and practice. There was no attempt through this project to measure the "cultural responsiveness" of patient care provided, but rather the focus was on the infrastructure to support such care. Key informant interviews were designed to gather data regarding the perspectives of stakeholders on progress towards best practice and approach to cultural diversity. While the interview sample was of limited size, and the comparison was made at only one site, these activities are an important step in determining whether further development of a document review strategy would be advised. Feedback from the parent focus group, observational methods, and the feedback session on preliminary conclusions were also used to assess the extent to which the document review reflected "what was actually happening" at the facility.

It should also be noted that in some of the sub-domain areas there was sufficient data available on organizational practice from the document review and observational process alone. If, for example, organizational policy directed staff to call overhead paging for an interpreter, and this paging was overheard, one might reasonably assume that this was current practice. What the document review could not determine, however, were the perspectives on this practice within various sectors of the facility (or whether difficulties were experienced).

A high degree of consistency was found between data obtained through the document review and other methods (interviews, focus group, observational methods).[2] Key informant interviews confirmed – and in many cases strengthened – the conclusions of the document review. While there were individual differences in perspective among informants at the test site, there did not appear to be important differences by sector (e.g., the perspectives of parents and community members were not substantively different – although comments may have differed in tone – from those of staff informants). However, given the small number of individuals interviewed, and the fact that previous evaluations within the same health authority had found differences between internal and external informants, these observations should be interpreted with caution.

The feedback session to decision makers and Quality Council representatives (and the report on which it was based), explored the site-specific findings from both the

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[2] In order to maintain the commitment of confidentiality to the test site, detailed discussion and examples of comparison between the document review and other methods is not included in this dissertation, but was part of a confidential report on which these conclusions were based.

"domains" (evidence of adoption of identified best practice) and the "dimensions" (approaches to addressing issues of cultural diversity). Comments from the Site Advisory Committee and the feedback session suggested that conclusions reached regarding the "dimensions" was perhaps as convincing as those related to organizational progress in the eight domain areas.

The feedback session did not result in additional evidence that would have led to revision of the conclusions – there was not sufficient time allocated for in-depth discussion. Response from this session indicated, in the words of one participant, that the *"the findings could not be challenged."* However, as discussed later in this chapter, it is unclear whether findings were persuasive enough to promote change.

Comparison of Document Review and Self-Assessment Approaches

Most cultural responsiveness assessment tools rely on self-assessment activities – many of which are fairly open-ended and subjective in nature. As discussed in section 3.5, the literature suggests caution in use of self-assessment and self-report instruments. Self-assessment ratings may reflect awareness of expectations and standards more than compliance (Adams et al., 1999). There is also some evidence that cultural responsiveness (or "competence" or "access") may present additional problems for accurate assessment. If general awareness of best practices in cultural responsiveness throughout healthcare institutions is low, those who have less cultural awareness may be

more likely to evaluate themselves as competent (Austin et al., 1999; Alpers & Zoucha, 1996).

The application of the instrument at the test site provided the opportunity to compare results of two different processes, the "best practice" measures used in this instrument, and two self-assessment activities recently undertaken by the organization: a) the self-assessment component of the most recent CCHSA Accreditation; and b) a family-centred care assessment tool developed in another location that had been implemented at the site several months before the project began.

Potential of CCHSA Standards for Assessing "Cultural Responsiveness"

The comparison of findings obtained through the test instrument with the CCHSA self-assessment component at the test site was of particular interest. One of the preliminary activities undertaken before the project began was a review of the CCHSA standards for acute care at the request of the National Network for Cultural Competency in Paediatric Health Care. One of the initiatives of the National Network was to explore the potential of using structures and processes already in place to advance the agenda of standards development for cultural competence. During the year the project was conducted, the National Network Steering Committee was engaged in developing guidelines to support established accreditation standards. Because the accreditation process is an important focus of quality development for a range of health care services, integrating cultural competence initiatives with such standards would have a number of benefits (Kagawa-Singer & Kassim-Lakha, 2003).

My review of CCHSA Acute Care Standards, undertaken in 2002, found that in many instances, the standards directly acknowledge issues related to cultural competence, either by addressing a specific issue related to language or culture, or by articulating general standards that are essential to culturally responsive care. Many examples of the former are found in sections related to client care. For example:

- Standards state that the intake, admission, screening process is to be adjusted for clients and families with special needs, including language and culture (Acute Care Standard 6.4). Assessment should include *"consideration of the clients level of education, language and culture."* Assessment is to be completed in the preferred language of the client where possible (Standard 7.1), and is to include "cultural preferences" (Standard 7.2).

- Standard 13.6 states that the team respects the client's cultural and religious beliefs, and enables them to carry out their cultural or religious practices as appropriate.

- Education for clients is to consider the *"client's and family's beliefs, values, literacy, language and functional abilities"* and the team is to *"ensure that clients and families understand the information"*(Standard 15). In some cases, the standard appears equivalent to best practices identified through the literature review (Bowen, 2002). See for example Standard 9.0 on information available to clients and families, which states that information is available in the languages of

the population served, and that providers are to verify that the information is understood.

Several other standards, while they do not directly address cultural responsiveness, appear to provide the framework for elaboration of criteria related to cultural competence. Examples of CCHSA general standards consistent with specific standards of cultural competence assessment include those related to Leadership and Partnerships (e.g., the *"organization anticipates and responds to community changing needs and health status"*; and *"the composition of the governing body reflects the diversity of the community it serves"*). General standards related to human resource planning, and the use of research to guide practice, are other examples of standards that indirectly support culturally responsive approaches.

In addition, the standards make several clear statements about equality and non-discrimination. The guideline for Acute Care Standard 6.1, for example, states that all clients are to have an equal opportunity to use services, free from any type of discrimination. Standard 9.1 (Human Resources) also states that the environment is to be *"free from discrimination and harassment."*

In spite of these strengths, the standards appear to present a number of limitations as the only response for development in the area of cultural responsiveness, compared to standards identified through the literature review. A closer analysis of the standards reveals an underlying perspective that is "monocultural" in nature.

- For example, guidelines (6.2, 6.4) related to intake, admissions and screening state that the process needs to be "adjusted" for clients and families with special needs (which include language and culture). This implies that the service as designed is appropriate for all, and that structural change is not needed.

- Even the emphasis on non-discrimination reflects a commitment to equality (everyone is treated the same), rather than equity (where everyone has the same opportunity) – the focus is on protection against discrimination rather than on ensuring culturally responsive care. In Standard 6.1 cited above, for example, the focus is on equal use of services as they are currently structured, rather than promoting culturally responsive services.

Many criteria for cultural competence identified through the literature review, and included in the U.S. standards (Office of Minority Health, 2001a) are not specifically addressed. As *"many organizations remain largely unaware of structural and behavioural factors that create barriers to providing service for diverse populations"* (Office of Minority Health, 2001a: 88), it is not surprising that these factors are not included.

In addition, many standards related to access and diversity are directed at the level of individual provider-client interaction – not the level of policy. Language in some places is weak in terms of requirements (e.g., often providers are to "consider" certain aspects, or undertake actions "if possible," rather than ensure that certain practices are followed).

There is also some indication in the language used that "diversity" appears to be viewed as a problem, rather than a potential strength (e.g., patients who don't speak an official language have "special needs").

In other areas, the standards do not appear to support approaches and actions that have been identified through the literature as indicators of best practice. For example, the standards do not promote a representative workforce. While they make a strong statement against discrimination in hiring, they do not take the next step – encouraging review of criteria for selection to ensure that qualifications and hiring practices themselves, do not systemically lead to bias against cultural minorities. There is a standard that states that policies must be free from discrimination and applied to all in the same way, but it does not address policies that are not intended to discriminate, but may have a disproportionate effect on "racial" and ethnic groups (Watson, 1994).

Another example can be found in the standards related to information management – an area highlighted as essential for cultural competence (Office of Minority Health, 2001a). The standards state that the organization's information management processes should *"meet current and future information needs and enhance its performance"*; consider *"changes within and outside the system";* and support the *"collection, analysis and reporting of data and information about clients and communities, including the results of service."* However, they do not address the very real barriers to assessing possible differences in "the results of services" across population groups, that may result from

failure to include ethnic identifiers in health data, or provide guidance on how this issue should be addressed.

It may be, however, that the most important limitations are not due to the wording of the standards themselves. Even where standards provide an adequate base for further development, use of the standards alone – without interpretation – are insufficient. This is because, without additional interpretation and guidelines, it is unlikely that key issues of cultural responsiveness will be identified as falling under the existing standards. Both review of organizational documents from the eight sites, and feedback from participants at the Second National Forum of the National Network, suggested that many health care organizations do not at this point have sufficient knowledge, experience or skill in the area of cultural "responsiveness." Nor do they necessarily recognize its importance (as they would recognize the importance of monitoring medication, or of building safety). If, for example, an organization has a clear process for "*informing clients about research activities that relate to their service needs*" (Acute Care Standard 2.5), can it be assumed that this process addresses communication with clients who do not speak an official language? Will a team involved in research activities necessarily be familiar with issues related to research with underserved populations? (Standard 2.4).

I concluded from this review that the standards appear to make a stronger statement on protection from discrimination and unequal treatment than on ensuring cultural responsiveness (Bowen, 2002). Although the standards do in many ways provide a structure for support of cultural responsiveness standards, they require more detailed

interpretation. It is useful to note that in the United States, a separate process was used to establish standards for culturally and linguistically appropriate care (Office of Minority Health, 2001a). There appeared, however, to be good potential for using the existing CCHSA standards as a framework to which additional criteria, guidelines, and interpretation could be added. Such guidelines could assist in education of health services, and serve as an important strategy for increasing awareness among providers.

<div align="center">Comparison of Self-Assessment with Document Review Findings</div>

At the test site, I reviewed the CCHSA self-assessment ratings for the child health program. These results were broader than the facility itself, but many references were to facility programs. As may have been predicted, the document review strategy provided very different results than the self-assessment. In general, self-assessment results were more positive than the ratings found through the document review process. The clearest examples related to language access services.

Overall, the facility rated itself well on provision of cultural/language services to clients (in general the rating was good or above). While specific areas were identified for improvement, a typical response would assert as an organizational strength that *"interpreters are used when needed."* (The interview process also found that some informants identified as a positive example of organizational responsiveness ad hoc arrangements of maintenance and cleaning staff being used as interpreters). The document review, in contrast, revealed weaknesses such as absence of policy and standards, and lack of availability of trained interpreters for most languages. Key

informant interviews also identified concerns regarding the impact of language barriers on informed consent and patient safety, and noted several instances where it was later discovered that interpreters were not used when needed.

Another self-assessment, a survey of patient-centred care undertaken in May 2002, was also reviewed. This review found, for example, that 41% of respondents selected "very well" in response to the question *"Are translators and interpreters available for patients and families who do not speak English or who use sign language?"* Similarly, 73% felt that families were involved in advisory roles through written surveys, "very well." This is contrast with the lower rating the document review would attribute to this use of family in advisory roles.

There were, however, some areas where self-assessment and document review approaches showed greater similarity. Adequacy of signage, for example, was one area where there was much greater similarity in results between document review and self-assessment methods. This congruence may indicate that self-assessment is more useful in assessing concrete, verifiable indicators, or for use in situations where all respondents have the personal or professional experience to appropriately evaluate organizational performance.

Reliance on self-assessment may also contribute to an acceptance of subjective "gut feelings" as appropriate measures of progress towards cultural responsiveness. Conversations with some diversity advocates over the course of the project identified that

reliance on, and confidence in, self-assessment findings may be a potential barrier to acceptance of document review findings – if these findings were not consistent with self-assessment results. Some referred to the response *"Well, I feel we're doing a pretty good job,"* as a common reaction to messages that the organization may not be currently achieving best practice standards.

In general, findings of these two self-assessments, compared with the document review process, reinforce previously identified cautions related to self-assessment strategies in the area of cultural responsiveness. An important difference between self-assessment and this document review is that the document review process focused on objective indicators – an interpreter policy was either in place or not, and it either contained identified best practice elements, or it did not. In contrast, self-assessment of the same domain relies very much on whether respondents "feel" they are doing well in this area. If there is limited knowledge of the risks of using untrained interpreters, any action taken to find a helper who speaks the client's language may be viewed as an organizational strength. This may lead to acceptance of methods such as using unknown individuals identified through overhead paging, or use of children and other family members, in spite of the evidence of the risks of doing so. Acceptance of subjective measures may also lead to assessment of individual or organizational intent ("we try to be culturally sensitive"), rather than actual performance.

This comparison suggests that there may be two distinct factors limiting the usefulness of self-assessment strategies. One relates to the social desirability response bias

(respondents are aware of standards or acceptable responses, and frame their responses accordingly). This bias can be expected if, for example, accreditation rests on meeting certain identified standards. The second factor relates to lack of knowledge of best practice in a specific area, or of the risks associated with certain practices. In this situation, respondents are unaware of "best practice", and may believe that their practice is appropriate. They may even (as in the example given above) provide an example of questionable practice as evidence that they are providing quality care.

Effects of Project on the Test Site

One of the secondary research objectives of this project was to assess the impact of the assessment on the test site. This can be addressed from two perspectives:

- the resources required from the organization in order to undertake the assessment; and

- the impact of the process of conducting the assessment on the organization. This would include any evidence of increased awareness or commitment to action, as well as any negative effects.

Time and Resource Demands – Sponsoring Site

One of the objectives of the project was to track the time and resource demands of the assessment activities on the sponsoring site. This preliminary information, however, must be considered within the context of the project. As the organization did not request the assessment, but rather responded to the request to provide a site for testing the draft instrument, it cannot be assumed that resource demands would be equivalent in another

setting. The information collected does, however, provide a useful baseline for calculating time required for the document assessment component.

Survey results (supplemented by estimates of time spent by those who did not respond to the survey) indicate that approximately 100-110 hours were dedicated by facility staff to liaising with, advising, and assisting the project over the period of 14 months. This included the time of the three-person advisory committee, Program Management Team, and administrative support. It does not include any time that may have been spent by senior management at the regional level during the time I was exploring regional support for the project. Approximately 10% of the total time was spent in assisting with collection of materials, with the remainder dedicated to guiding the project, or receiving updates on it. I was unable to determine how much time was spent in collecting materials by individuals in specific domain areas. Given the number of documents provided by these informants it is unlikely to total more than a few additional hours.

Some centres have a "diversity" coordinator responsible for a range of services to various cultural groups; however the test site did not have a centralized accountability centre. This had two important implications:

a)   Gathering materials was more time-consuming as there was no central point of contact/expertise. As there was no designated "responsibility centre" the task was delegated to an administrative support person who did not have specific knowledge of the topic area (although most of this "tracking" of the

materials fell to me as the researcher). Time needed to gather materials would, therefore, be expected to be quite different in another organization.

b) The responsibility for project contact and guidance was delegated to a staff person responsible for patient liaison at the coordinator level, not to a member of senior management. This had additional time implications, as it was necessary to take requests up another level for action to be taken. This sometimes resulted in delays.

Another important commitment of time allocated to the project was staff time for key informant interviews. Twenty interviews were conducted, with an average time of just over an hour. Allowing 1.5 hours per interview, approximately 30 hours were dedicated to this activity. An additional two to three hours was spent in phone conversations with specific individuals. Time involved in staff-initiated consultation was not included in this total.

Approximately one and one quarter hours were spent at the feedback session. Allowing additional travel time for the seven special guests who would not otherwise have attended, the total staff hours dedicated to project feedback was estimated at 32 hours. Total time commitment of the organization therefore was approximately 175 hours, over a period of 15 months, including time spent receiving feedback. Even if the collection of materials had been undertaken completely by facility staff, it is reasonable to conclude that the total time required for these activities would not have exceeded 200 hours in total (including the time for one organizational feedback session).

Impact of Research on the Organization

At the time of writing, there is only limited information available on the impacts of the project on the organization, as the first organizational feedback session was completed in December 2003, and information on diffusion of results and any resultant action is as yet unavailable.

Effects on Individual Staff of the Organization

A number of participants in the key informant interviews commented that the interview questions had made them think about things in a different way. One realized, through the interview process, that "culture" had been deleted from the most recent revisions of documents related to her/his area. Others expressed concern about the wording of the generic organizational pamphlet once it had been brought to their attention. Several made comments to the effect that they had not thought about some of the questions posed by the researcher before the interview took place. Feedback from some of the Site Advisory Committee members suggests that they found the process extremely beneficial. However, given the limited number of people with this direct involvement, the total impact of these activities on the organization may be relatively minor.

Requests for Consultation

On three occasions I was asked to consult on relevant issues related to culturally appropriate assessment of patient satisfaction, review of an assessment instrument being considered for adoption, and plans for interpretation services. All of these requests were the result of direct communication with a member of the Site Advisory Committee. This

placed me in a somewhat awkward situation, as I was asked for professional input on specific issues before assessment activities at the site had been completed. Following discussion with my dissertation advisor, it was decided that I should make myself available, with the understanding that these activities could provide additional insight into current organizational practice and staff perspectives.

It is unclear whether external consultation would have been sought in all these cases if I had not been available; and as no updates on these activities have been received, it is also unclear whether the consultation had any impact on organizational decision-making.

Other Impacts

With the exception of the activities described above, it appears that the project has had little impact on the organization to date. In spite of a comprehensive communication plan (section 4.8.0), there were no unsolicited requests, to either the chair of the committee or the researcher, for additional information. With the exception of the three requests for consultation described above, the Site Advisory Committee reports no awareness of planning or other activities as a result of the project, and have had no questions directed to them about the project and its implications. The best indication of whether the assessment findings are accepted by the organization may be the action taken following the feedback session – information that is not currently available.

Potential and Limitations of a Document Review Strategy for Assessment of "Cultural Responsiveness"

These preliminary findings indicate that a document review strategy shows promise in providing an assessment of cultural responsiveness at the organizational level. In this pilot, the document review process provided information that was more "accurate" (based on comparison with data obtained through other methods) than self-assessment approaches, the dominant approach used to date. The results suggest that both a) progress in identified "domains" of cultural responsiveness, and b) the underlying approaches to addressing issues of diversity, can be identified through such a review. The pilot also indicated that it is possible to undertake such a review with minimal disruption and resource demands on the organization.

The value of this "accuracy" may be of limited benefit, however, if either: a) the results of the document review are not accepted by the organization; or b) the process of the review does not generate sufficient interest to motivate further attention to cultural responsiveness issues. However, the conditions under which the instrument was piloted do not allow appropriate evaluation of these questions. Commitment to providing time for feedback was not negotiated at the time the project was approved, with the result that the feedback session was delayed several months (and adequate time was not made available to provide decision-makers with the background necessary to evaluate the implication of findings). At the time of writing it is unknown whether the site will incorporate findings into future planning activities.

At the feedback session, questions related to the methodology – there was not sufficient time to undertake full coverage of this – and to "validity" of findings were raised, even though the findings were not disputed. Concerns about validity may be another indication of limited awareness of appropriate assessment strategies and development of indicators related to cultural responsiveness (as noted earlier, there are no "validated" instruments in this area). Some participants appeared to be looking for a "scale" or rating of facility performance, which this strategy was not designed to provide. A key issue for further research, therefore, is to apply the instrument in a situation where there is a clear commitment from senior management to analyze and act on the results of the organizational assessment, and where adequate time is allocated to provide the necessary background and context before the project begins.

Another limitation of this particular instrument is that it was designed to be used by a person with knowledge of "best practices" in cultural responsiveness and related issues of access and diversity. It was not designed for organizational self-assessment and the comparison between the results of self-assessment activities (and application of this instrument at the test site suggest caution in the use of self-assessment approaches on a topic where there is relatively low awareness of accepted best practices). An instrument designed for use by facility participants themselves would require significant adaptation, along with development of accompanying materials.

Because of inclusion of a number of objective indicators in the assessment instrument, it may be possible for organizational staff to effectively apply the "domains" criteria of the

instrument. It may, however, be unrealistic to conclude that those without extensive exposure to the cultural competence and access literature could effectively identify evidence of philosophical approach (the "dimensions"). The instrument is not designed to give a numerical "score," but to guide the organization through an assessment of organizational strengths and weaknesses related to identified best practice. This requires allocation of time, not only to undertake the review, but also to become familiar with the literature on which the instrument is based.

Issues Affecting Further Development of Document Review Approach

Importance of Multi-method Approach to Assessment

Valuable information, not obtained through the document review process, was gathered through observational methods, key informant interviews and focus groups. These methods provide perspectives on larger community issues, the level of consensus/dissonance between various stakeholders, and the historical and political context in which organizational interventions have been developed to date. They also give insight into difficulties experienced by staff in providing culturally responsive care, their interpretation of these difficulties, and perspectives on organizational progress made to date.

For example, informants at the test site shared concrete examples of quality of care and patient safety issues arising from failure to address language barriers; as well as examples of individual racism directed towards patients. "Invisibility" of some populations in planning and programs was also a concern to several informants. At the same time, there

appeared to be less awareness of the importance of the impact of systemic racism/discrimination. It has been observed that narratives of key informants related to organizational ethnography are often general, rather than policy oriented; this was also my finding. The information obtained through these additional methods – not accessible through a document review process alone – is essential for planning. A document review should, therefore, ideally be combined with other methods.

Appropriate Organizational Level for Assessment

The experience at the test site suggests that there are limitations in focusing cultural responsiveness assessment at the level of an individual facility in provinces where services have been regionalized. In a regionalized system, authority and responsibility for policy and governance rests with the region, as may program responsibility for some of the domain areas in the assessment instrument. Results from the pilot suggested that the region may have a different approach to responding to issues of cultural diversity than some individual facilities. It may, therefore, be more effective to focus interventions at the highest (i.e., the regional) level, followed by specific training and planning activities at the organizational level.

Optimal Length of Instrument

Some members of the Steering Committee of the National Network for Cultural Competency in Paediatric Health Care had originally suggested that the instrument could be shorter in length, as they anticipated that many Canadian organizations would not have many of the materials suggested, and that a shorter instrument might be more "user-

friendly." It has also been suggested that assessments should focus on the stage of awareness and development related to cultural responsiveness (Dreachlin, 1999; Minors, 1998).

One of the risks of a shorter instrument, however, would be the temptation for organizations to adopt the minimum requirements, and then "lose steam" before addressing the long-term issues, such as integrating initiatives throughout the organization. A simpler instrument may also risk oversimplifying important issues, with the result that continued development could be hindered. One of the major advantages of a longer instrument is that it can serve the purpose of educating organizational decision-makers about the broad issues and varied approaches to addressing diversity in health care, as well as current "best practice," providing a solid base for future activities. While initially be more time-consuming, engaging organizational stakeholders in these higher level discussions may save time in the long run by promoting an integrated and strategic, rather than ad hoc response.

Instrument or Process?

The experience of using the instrument led to consideration of whether the emphasis should be on the instrument itself, or whether the actual instrument is a heuristic device that guides the assessment process. The experience of applying the instrument led me to conclude that it was the process of the document review that should be emphasized (and the elements which are to investigated), as much as the specifics of the instrument itself. This is particularly true for assessment of the philosophical "dimensions," as a more

global (rather than document-specific) analysis proved most useful. This is not, however, to say that the actual instrument is unimportant; the draft instrument guided review of specific domains and dimensions, and the results of a review using the instrument appear to be consistent with data from other sources (much more consistent than were self-assessment approaches). However, in this project, the researcher was also the "instrument," and both my knowledge of the literature and my experience working with a diversity of communities informed my interpretation of assessment findings.

Acceptance of Document Review Approach by Health Organizations

For many reasons (including accessibility, cost and privacy), health organizations may be most interested in an instrument that they can apply themselves (self-assessment), and there are a number of these available. Feedback at the site also suggested that interest may primarily be in use of a tool that has been "validated," and preferably to which some score can be assigned. The literature indicates the risks of this approach, and stresses that to date, no instruments have been validated (Office of Minority Health, 2001a). My finding that the observational methods, key informant interviews, and a parent focus group confirm the initial conclusions reached through application of the instrument does not "validate" the instrument, and further piloting is required. The indication of low awareness of standards related to cultural responsiveness among health care planners and decision-makers in Canada, suggests that significant attention must be directed to educating them about the potential and limitations of various assessment approaches.

Results from the test-site suggest that there is a real question whether – in the current

climate of competing demands and high workload – many health organizations would

prioritize cultural responsiveness activities in the absence of a major "incident" (such a

malpractice suit or human rights complaint) that focused attention on cultural issues. The

difficulty experienced in finding time for the feedback session, and the decision to

designate responsibility for the project to a staff member who was not a member of senior

management are two indications that the activity was not seen as a priority by the

organization. Although this can be assumed to result in large part from the fact that the

facility viewed its involvement as supporting a student project rather than initiating one

of its own priorities, feedback from diversity advocates across the country suggest that

cultural responsiveness is generally not viewed as a priority; that it rarely makes it onto

the list of things that "must be done."

Recommendations for Use of Document Review Instrument

While revisions to the instrument have been made (Appendices O and P) based on the

findings of the pilot, a number of cautions should be highlighted.

One of the major advantages of a self-assessment approach is that it has the potential to

engage many people in the organization in assessment activities. This advantage was not

present during the pilot of the document review instrument. While this strategy had the

advantage of placing few resource demands on the organization, these advantages may be

of little practical benefit unless there are also strategies for ensuring: a) senior level

involvement in and responsibility for the activity; b) allocation of adequate time for staff education at the beginning of the project; c) opportunities for staff involvement and feedback throughout the project; d) commitment of adequate time for analysis of findings; and e) incorporation of findings into ongoing strategic planning activities.

The draft instrument was piloted at the test site under somewhat artificial conditions. The interest in testing the instrument came from the researcher, and the site graciously made their facility and staff available to assist in meeting these objectives. In a situation where an organization was itself requesting an assessment, there are a number of recommendations that can be made to facilitate organizational involvement and transfer of assessment findings into organizational planning and decision-making:

1. Responsibility for the initiative should be assigned to a member of senior management, and should be identified as an organizational priority with Board involvement and support. Ideally it should be the responsibility of a high profile leader, who has credibility and support within the organization.

2. A commitment should be made by senior management to any necessary internal orientation/education regarding current best practices, implications of various approaches to addressing diversity, strengths and limitations of assessment strategies, and initiatives undertaken in other jurisdictions.

3. Strategies for organizational involvement should be designed and implemented to encourage interest and engagement in the assessment from all areas of the facility. The decision made in this project to have communication

come from the office the Program Management team was essential in gaining assistance from various departments within the facility.

4.   A plan should be put in place for regular feedback, and for addressing any identified issues once the review has been completed.

5.   Materials should be gathered by staff of the organization. It would be expected that if the responsibility for collection rested with the organization, useful learning regarding what information was available – and what important components might be missing – would lead to greater involvement in the process. It may also identify needs for coordination and global oversight of diversity initiatives.

6.   The document assessment should be combined with other methods (e.g., observational methods, focus groups, or key informant interviews). Feedback sessions based on the initial findings could be used to increase awareness within the organization of best practice standards, refine conclusions, and facilitate future planning.

7.   Serious consideration should be given to involving outside expertise, even if cultural diversity knowledge and skills are well developed within the organization. This will help facilitate objective assessment and avoid many of the limitations of the self-assessment approach.

Summary

A document review process shows promise as an effective strategy, not only for assessing organizational progress in adopting current best practice, but also for determining

organizational approaches to addressing issues of cultural diversity. This is an important finding as the theoretical literature indicates that the underlying philosophy regarding the meaning of "culture," and best ways to address culture in health care, may have significant impact both on the interventions selected, and the effectiveness of overall interventions.

It would be necessary, however, to also incorporate other research methods into the assessment process if there was an intent to actually "do something" with the results of the assessment, as the meanings of the findings can only be understood within the historical and cultural context of the organization. Staff, client and community perceptions of current service and problems experienced are also essential in developing strategies for improvement.

A crucial concern is whether a document review process would be perceived as credible and important to organizational planning – not simply whether the instrument provides an "accurate" picture of organizational response. The assessment process at the test site has had limited impact on the organization to date; however, a commitment to finding time for evaluation and utilization of results was not negotiated prior to undertaking the assessment. Further research is necessary to determine the impact and acceptance of a document review strategy under conditions where organizational commitment to a comprehensive assessment has been secured. Recommendations for future application of the instrument focus on ensuring ownership by and commitment of senior management; developing strategies for staff involvement; and ensuring that adequate time is allocated

for orientation/training, review and analysis of assessment results, and incorporation of findings into ongoing strategic planning activities.

These preliminary results also reinforce concerns regarding the limitations of self-assessment strategies in the area of cultural responsiveness, and suggest caution in use of the document review instrument as a self-assessment tool.

CHAPTER 6: CULTURAL RESPONSIVENESS OF CANADIAN HEALTH ORGANIZATIONS

The preliminary activities (initial scan of seven hospitals and meetings with the National Network for Cultural Competency), combined with the experience of this in-depth application of the document review instrument at one site, highlighted a number of issues relevant to promoting culturally responsive health services in Canada. Unlike the previous chapter, which focused on the findings from application of the expanded instrument at one site, this chapter includes the results of the initial scan of seven participating health centres (Section 3.6) along with those from the test site. Only issues that appeared from these activities to be relatively common are highlighted here. Most of the topics discussed in this section relate to positions on the "dimensions" of approach to cultural diversity discussed in previous chapters. While many of the issues have been identified in the research literature, others may be specific to the Canadian health care context. Some case studies and quotes are from the test site; others were collected through other activities and in other locations.

Awareness of Best Practice

Benchmarking against best practices is considered an important requirement in any organization that intends to improve cultural responsiveness (Gandz, 2001). However this research suggests that in many centres in Canada there is limited awareness of standards development activities related to cultural responsiveness, and of the best practice literature on which these standards are based. The absence of legislation or clearly

articulated national standards may well be a contributing factor. Unlike the United States, Canada has not undertaken broadly-based national initiatives to develop consensus in this area, although informal networks like the National Network for Cultural Competency in Paediatric Health Care have initiated action in specific areas.

Major research funding bodies, such as the Canadian Institutes for Health Research and the Canadian Health Services Research Foundation (Canadian Health Services Research Foundation, 2001) have in recent years directed some strategic funding towards supporting research related to marginalized groups. There was, however, concern expressed by some researchers at the November 2003 consultation "Strengthening the Foundations" (Canadian Institutes of Health Research (CIHR), 2003b) that this funding was not sufficient. Another issue that appears to contribute to lower awareness of "racial"/ethnic health disparities is the absence of ethnic identifiers in health data (an additional concern raised at the same meeting). At the highest policy and research levels, it appears that health disparities are not "on the agenda" to the extent that they may be in the United States. The traditional focus on the effect of economic disparities on health, and a belief that Canada (which identifies itself as a "multicultural country," and takes pride in its universal system of medical insurance) does not have the same problems related to discrimination and disparity of service provision as do some other countries, may also contribute to neglect of this area.

As there is little awareness of related research and proposed "best practices," it should not be surprising if many centres have not made significant progress towards adopting

them. Absence of national standards may also lead to a situation where interventions are not directed by "evidence," but by individual commitment, resulting in variability not only between regions and between centres, but also in interventions taken within specific institutions. Assessment results from the test site, for example, indicate that the organization has made exceptional progress in some key areas, with little or no progress in others.

This lack of awareness has important considerations for planning future assessments. While the document review instrument itself was designed to include indicators of "best practice" that are as equally relevant for Canada as for the United States, additional strategies are required to orient Canadian health care institutions to the research evidence and standards development activities undertaken in other jurisdictions. Without such initiatives, it is unlikely that assessment findings will be persuasive in promoting action.

Forces Driving Cultural Responsiveness in Canada

"Politics and Personalities"

The key informant interviews attempted to explore the "approach" taken to cultural responsiveness at the test site, and in some cases this led to discussion of how current responses had evolved the way that they had. Overwhelmingly, the explanations given related to what some informants described as "politics" and "personalities," rather than reflecting a belief that the approach was the result of a formal planning process or based on research evidence. Consultation with diversity managers in many areas suggests that

this reliance on individual leaders, rather than a formalized strategic planning process, is common.

- *It's individuals and personalities.*

- *I think it's political direction as well as who the players are in the decision making process.*

- *Reasons for the emphasis on (name of one specific cultural group) – purely political...I hate politics, but I understand where it is coming from. There is a high concentration of (name of group) people, it is 'de facto' part of everyday life. But it is myopic in terms of its focus.*

Three major sub-themes were associated with this perception. The first related to the *Canadian political/legal/cultural context.* Where specific cultural programs were in place, program initiatives were generally attributed to events in the larger political/social arena. For example:

> *When we received a bilingual mandate, - it was clear what we had to do, and didn't meet resistance. ... The major catalyst for starting events here (19___, closure of the (name of facility) paediatric ward, so (our program)) was given bilingual status.).....* *It was a political response – exactly.*

> *(Name of program) was triggered by the (name of specific) Inquiry.*

> *I don't think it was a conscious choice, the program was inherited, it didn't originally belong to the hospitals. From (government department) to (name of organization), then it came to (name of another organization). When it was no longer funded, hospitals picked it up.*

In addition to legislative and structural factors, informants also referred to a more generalized climate of what was politically valued, or politically correct (e.g., *"The attitude is that you do anything you have to do to 'pacify' (name of group)". "There is also fear of political correctness".* Or: *" It's all political, government looks good if you do a push for (name of group)."*

The second sub-theme stressed the ***impact of institutional champions.*** Culture-specific responses (rather than a broader diversity strategy) were common in some centres. This was perceived by some to be the result of not simply numbers and need, but of the agendas of particular well-placed champions, who may have a particular commitment to addressing the needs of a specific population group.

> *"The HR initiative is a high profile initiative, one or two individuals decided that organization had to do something with (name of group) and the focus was only on these."*

> *"(Name of senior staff person) has personally worked with kids from that community. There is a real sense of an important thrust at the highest levels of the organization. Broader, I don't know if it is clearly defined."*

At the test site, a number of different non-facility services, delivered by community agencies, were identified as providing interpretation services for clients. However, only one of these appeared to have well-established linkages with the organization. These linkages appeared to enable the program to work effectively in spite of being "invisible" in facility documents. This was attributed by informants to the history of the facility with the original sponsoring group (based on personal relationships and cross appointments), and the priority given to services to this population – even though the total numbers were not larger than those of some other population groups. These ongoing personal relationships appeared to provide continuity of service even after the program was relocated.

The third theme was the ***lack of an overall cultural diversity strategic plan.*** This failure to address issues in a systematic fashion appears to contribute both to separate, isolated responses for different cultural groups, and initiatives that are driven by the interests of

various champions. One of the risks of cultural diversity initiatives being attributed to a "political" agenda, or the individual interests of well-placed champions (rather than on evidence of need or as the result of strategic planning process in which all sectors have participated), is that any resulting intervention may fail to generate the necessary support from staff. It may also lead to a situation of "competing oppressions" (Bishop, 1994), and divisions and tensions with the organization.

Believing is Seeing?

There is also some suggestion from this project that some of the solutions chosen by organizations were the result of a particular "world view" rather than based on "evidence." The document review revealed a number of instances where responses did not seem to be supported by the evidence gathered. For example, the needs assessment that led to the cultural awareness program at one site identified different priorities for training than those actually adopted, even though the identified priorities were more closely aligned with current "best practice." In one setting, the only "audit" of Human Resources located indicated that 38% of applicants were visible minorities. However the responses selected focused only on the record of recruitment and hiring in another employment equity category, rather than that of visible minorities.

Another area of concern identified at the test site was the "invisibility" of some cultural groups in organizational documents – even though they were "visible" to a casual observer walking through the facility. This suggests that the absence of an overall

framework for understanding "culture," and an evidence-based plan to address inequities may result in ad hoc solutions driven by personalities or current political events.

Definition of "Culture" and "Cultural Groups"

The more recent literature related to culture and health, as well as the generic diversity literature, identifies a number of limitations (and risks) associated with a narrow definition of culture. However, it appears that many organizations continue to define culture in terms of "race" or ethnicity (even though a few appear to be adopting the more inclusive language of diversity). Project activities suggest that many of the limitations of narrow definitions of culture identified in the literature may, in fact, be evident within health care settings.

Role of Narrow Definitions of "Culture" in Promoting Stereotyping

One of the major disadvantages of a narrow definition of culture based on "race"/ethnicity is that the diversity within ethnic or national groups is often not recognized, and stereotypes may be reinforced (Fuller, 2002). One example found through this research was the difficulty, demonstrated by some informants who had taken culture-specific training, in differentiating between issues related to poverty and low education and those related to "Aboriginal culture," confirming the observations of Ramsden, commenting on the need for cultural safety, that *"many were confusing the cultures of the indigenous people with the culture of poverty into which the indigenous people have been driven"* (1993:8). Informants also voiced concern that there was often not recognition of the diversity within broad ethnic categories, with the result that all

members of a specific ethnic group (e.g. Aboriginal, or West Indian) would often be viewed as similar.

Failure to Recognize Other Cultural Identities

Another limitation of a narrow definition of culture is that the importance of other (non-ethnic) cultural identities may be ignored, and the expectation of cultural "sensitivity" on the part of staff in responding to these other "groups" de-emphasized. It may result in a situation where there is a high level of sensitivity regarding possible discrimination against "racial" minorities, while at the same time tolerating prejudice against other groups (Deaf parents or those of alternate sexual orientation for example). In one setting, there was recognition that less well-educated or non-assertive parents were often not provided with the same information, or given the same explanations, as better educated parents. A narrow definition of culture could result in low education or poverty not being viewed as a "cultural" issue. In the same vein, another informant commented: *"They don't see Deaf as a culture but as a handicap – this is really apparent in their attitudes to Deaf patients"*.

The shift in the diversity literature towards emphasizing more inclusive and complex definitions of culture reflects the recognition of the potentially negative effects on organizations of adopting of narrower approaches. Other characteristics (such as socio-economic status, education, or gender) may be ignored (Ahmad, 1996; Maggi & Cattacin, 2003). It has also been observed that focussing too narrowly on redressing imbalances and bridging cultural differences, runs the risk both of institutionalizing stereotypes

(Glastra et al, 2002), and of creating resentment and resistance from both dominant and other marginalized groups. Such definitions of culture may therefore be detrimental to group functioning and organizational goals. Diversity experts have concluded that it is necessary for all members and clients of the organization to feel valued and supported, and for all "cultures" to have a place within the definition of culture used (Kohnen, 2003).

While activities related to the initial scan and the in-depth assessment at one site revealed a clearly articulated awareness of discrimination and racism directed towards specific ethnic/"racial" groups, there is often an assumption that only patients have a "culture" that is of concern. However, patients from the dominant culture may also demonstrate discriminatory attitudes towards "minority" staff – an area of concern in an increasing multiracial society. In addition, negative stereotypes and discriminatory action may be expressed not only by providers from dominant groups to specific "minority" groups, but may also affect relationships between marginalized groups themselves. The latter issues are less often recognized in organizational documents. This apparent organizational "oversight" is consistent with a narrow focus on inequities: the relationship of providers, often assumed to be from the dominant society, with clients from "minority" backgrounds. Similarly, a definition of culture that is limited to disadvantaged "ethnic" groups may fail to provide a framework for addressing other cultural issues. For example, several informants described the dynamics of disrespect (and contrasted this with the stated "code of conduct") among members of specific health care professions.

Silos or Umbrellas?

Rather than services specifically designed for particular groups, but falling under a larger "umbrella" of commitment to equitable standards for diverse populations, it appears that in many organizations needs of "cultural groups" are responded to in isolation from each other.

It was observed that initiatives to address cultural diversity within Canadian health organizations often mirrored the divisions and responsibility areas of the larger society. This approach (referred to as "*silos*" of response by one informant), responds to issues of particular "cultural groups" in isolation, even where there may be common concerns (e.g. a need for health interpretation services). Aboriginal health issues are often dealt with in a different way than immigrant issues, which in turn are often not coordinated with minority French or English language issues. Different staff may often be involved, with different accountability centres within the facility – in the same way that services for these groups are structured in the larger society. Diversity initiatives may be defined in a way that limits them to certain groups. In one centre for example, Aboriginal issues were not addressed under the overall diversity planning, but dealt with as a separate initiative. In contrast, another centre focused its cultural awareness activities only on Aboriginal patients, with little attention or recognition given to other groups. Creation of "silos" may result in the almost complete "invisibility" of some cultural groups, while others benefit from high profile initiatives to address what may be similar needs.

One story shared with the researcher described one person's experience in participating in cultural awareness training some years earlier. This story illustrates some of the risks of initiatives that deal with the issues of one or more cultural group in isolation:

> *It was called cross-cultural training – it wasn't. In one session I was absolutely appalled. Sitting next to a man, who had the tattoo on his wrist – you know, from the concentration camp, and someone from (refugee producing country in Africa). And the facilitator said that his was the only culture that had any value or meaning. The others sitting behind me, the man with the tattoo, the African man, got up and left."*

The suggestion that it may be preferable to coordinate diversity initiatives under one "umbrella" is not to argue that some groups do not, or should not, have special status and rights within Canadian society. Nor is it to suggest that specific groups should not have the opportunity to develop unique responses based on community needs and the broader historical, social context (or that, for example, self determination by Aboriginal peoples of their own health services should not be supported). A coordinated approach would not prevent allocation of resources based on the health needs of particular population groups. In fact, a paradigm shift that freed planning from existing "silos" could be expected to promote planning based on evidence of disparities. The challenge is to determine how to recognize and respond to "cultural" differences, evidence of health disparities, and/or discrimination by the health care system without implying different standards of care for different groups of patients.

Failure to ensure a coordinated approach to the needs of various underserved populations may cause the organization to miss opportunities to promote cultural responsiveness as an aspect of organizational vision and culture that merits the full support of stakeholder

groups. Maintenance of separate "silos" may also pose a number of risks for the organization.

One risk is that this approach may indicate acceptance of different standards of care. While it is appropriate to direct resources to groups with the greatest health needs (whether defined by numbers or by health status), there should be concerns if the response to such need reinforces different standards of care. Similarly, while legislation provides special rights and protections to certain groups, professional standards of care do not allow for different standards of treatment depending on whether a client has special rights (e.g. to language access) in legislation. As malpractice cases indicate, the expectation of institutions and professionals are that equivalent standards of care are shown to all (Champion, 2000; Needham & Wolff, 1990).

"Silos" may also contribute to a situation of "competing oppressions" (Bishop, 1994), where there is competition among various underserved groups regarding whose needs are most important; or to simplistic and stereotypical views of minority groups. For example, a "silos" approach may inadvertently reinforce the tendency to attribute factors related to poverty, discrimination or low education to "Aboriginal culture."

Lack of a coordinated approach may fail to allow the institution to benefit from joint solutions to shared problems. If language barriers are an important issue for many different groups, it may be more efficient to plan and coordinate activities such as standards development, data collection, and training among all language constituencies.

Approaches focusing on only certain groups or certain aspects of cultural responsiveness may also mask other issues of racial and cultural equity. One of these issues – expression of racism against providers (Selby, 1999) – was identified by some informants during the project.

While the best practice literature supports responses that are specific to the needs and preferences of each community (Office of Minority Health, 2001a), it must be remembered that the intent of cultural responsiveness initiatives is to address inequities, not to contribute to them. Therefore, any responses that may or may be perceived to contribute to or maintain inequitable access or treatment should be viewed with concern. If policy and practice suggest that it is essential for the health of Francophones to get information on their health condition in their own language, but not important for immigrant language speakers; or that it is a high priority that the culture of Aboriginal families is shown respect, but a matter of indifference if discriminatory attitudes are shown towards Deaf persons, then quality and equity is not being supported. Culture-specific training that focuses on specific cultural groups within the catchment area may also inadvertently convey the message that behaviour towards some groups is of more concern than others.

Some groups may even be completely excluded from the planning process and remain "invisible" in organizational documents. At one site, one ethnic grouping had been singled out for special initiatives based on the large numbers who made up the hospital population, with the result that some informants stated that the organization tended to

define "culture" as limited to that one population (*"operationally think (specific group) because of the numbers"*). At the same site there was also evidence that this may be contributing to a sense of injustice. One informant stated

> *I think everyone should be treated equally. We do see a lot of (specific population) people, but the majority of care providers come from all different backgrounds, we need to give the others a bit of value too.*

Anecdotes volunteered by informants at the test site regarding problematic situations involving Deaf, Aboriginal, Francophone, Inuit and immigrant clients were remarkably similar. Separate responses may, therefore, be masking real and shared needs that would benefit from a coordinated, comprehensive response.

And finally, a response that is based on simplistic and unambiguous "cultural groupings" may obscure a number of similarities between groups. For example, it may be that poor and poorly educated families from all backgrounds may face similar discrimination in the information that is provided to them. As another example, many current Francophone patients are from Africa; these patients may face cultural barriers and potential racism, as well as language barriers.

There is some indication that there may be very different assumptions about what "cultural aspects" are important for different groups. At one site, the most strongly worded policy related to French Language Services. The policy language was directive, clear, and referential to client rights. In general, concerns related to responsiveness to the Francophone community, appear to be framed solely as "language" issues (either through access to French-speaking providers or translated materials) without reference to

"culture." In contrast, the rhetoric around Aboriginal issues tends to focus on "culture", with language often receiving less emphasis. This may well reflect the historical/legal status of the two groups in Canada. French is an official language. Canadian legislation emphasizes language rights and the Francophone population does not see itself in the same category as immigrant or Aboriginal peoples.

Services to Aboriginal peoples, in contrast, appear to be in response to the pressure of current demographics, awareness of lower health status in many Aboriginal communities, and recognition of historical inequity and overt discrimination faced by Aboriginal peoples. This suggests that the emphasis on "culture" may be an organizationally acceptable way to acknowledge the racism and discrimination experienced by Aboriginal people. In spite of the high profile nature of Aboriginal issues, however, policy regarding Aboriginal services remains relatively underdeveloped in many areas of the country. Services for recent immigrants, a priority in many larger centres, are often based on an assumption that the key issues relate to language barriers and "cultural differences"; issues that will resolve in time as these new arrivals adapt to Canadian society.

Multicultural or Antiracist Approaches?

One of the "dimensions" explored through the document review process was the examination of questions such as "What are the underlying assumptions regarding the role of 'culture' and the cause of inequities?" and "What motivates responses?"

It appears from this preliminary review that the "multicultural" approach may be dominant in Canada, with the expectation that once individual staff have gained knowledge of different cultures, care will improve. As one informant at the test site observed

> *The basic assumption was that lack of cultural responsiveness is a" knowledge concern"; the approach is to do educational events (this includes attitudes and emotion). This speaks to the organizational culture – give people information and they will change their behaviour.*

Limitations of the "Cultural Sensitivity" Approach

"Cultural sensitivity" is aligned with the "multicultural approach" to diversity, which identifies lack of awareness and knowledge as key barriers and focuses on attitudinal change. It is also associated with an emphasis on client beliefs and customs, rather than on organizational behaviour (Glastra et al., 2002; Kaufert, 1990).

Many organizations refer in their documents to "respect" for cultural beliefs, religious practices and customs, and often conceptualize the need for improved care as one of "cultural sensitivity." The cultural sensitivity approach tends to focus on promoting attitudes that are respectful and accepting towards individual patients rather than addressing the larger structural and process issues that would enable greater participation of these clients, or perhaps require provider behaviour change. At the test site, exploration of the interpretation of the meaning of the term indicates that "cultural sensitivity" is largely understood to indicate "awareness" of cultural issues and openness to, and respect of differences, rather than an obligation to respond to them – consistent with how the term is defined in the literature. As one informant observed: *"You can be*

sensitive and not competent – (you) can be sensitive, it doesn't require you to do

anything." Cultural sensitivity was described, for example, as:

> *Aware of different needs and ways of looking at things.*

> *That everyone in the institution should be mindful of the role of culture, aware of cultural differences, that one culture is not right or wrong, that all should have equal levels of respect.*

> *For me, I am aware that we care for many families from diverse cultural backgrounds and I may need to be very aware and respectful of cultural diversity and that culture may have some impact on views of health care.*

> *Respecting individual and particular outlooks, beliefs and values and accommodating them to the extent possible.*

> *Recognition of the ways in which cultural values can impact on peoples expectations when receiving health care.*

The emphasis given to cultural awareness training as the key intervention in many centers

is another sign of reliance on a "multicultural approach". Employment initiatives, such as

those promoting a workforce representation approach, are often the priority intervention

by those promoting an "anti-racist" approach or Papadopoulos' (2001) "third way," but

do not appear from this preliminary review to be common.

Reliance on Voluntary, Individual Responses

Cultural Training or Organizational Change?

The research literature has, over the past several years, shifted significantly from an

emphasis on individual competence to organizational level responses. It appears in many

institutions, however, that there has been a failure to "institutionalize" culturally

responsive practice into the structure and processes of care, or to make the organizational

level changes necessary to support responsiveness. This limits the effectiveness of even the most "culturally competent" providers (Quandar, 2003). For example, even providers who showed a high level of awareness of the risks of inadequate interpretation would – unless adequate policy and resources were in place to support trained health interpreters – be unable to provide care that met best practice standards.

Both consultation with the National Network Steering Committee and the implementation of the pilot at the test site suggest that, with a few notable exceptions, there are limited structural or policy initiatives to address issues of cultural responsiveness. This leads to the conclusion that the major emphasis is on cultural responsiveness at the provider level. When asked how they would describe the approach of the facility to cultural responsiveness, informants at the test site identified a strong reliance on individual responses. Some simply stated that there was no approach (e.g., *"Don't think we have an approach – at the service level no organized approach"; "Do they have an approach? It's individuals and personalities"; "We don't have an approach. Leaders try to instil respect"; "Haphazardly in spite of itself, there is no clear strategic plan"*).

Others pointed to a reliance on individual initiative:

> *It's largely dependent on sensitivity and awareness of the care provider – we don't have any systems in place that need to be in place.*

> *Very inconsistent, based on individual personalities of care providers.*

> *It depends so much on the individual, some are wonderful, some have a real attitude.*

> *If things work out well its just the luck of the draw, a nurse who is sensitive, or finding the right advocate.*

The approach is very individual. One nurse may go above and beyond, but that would be an outstanding nurse or resident.

Other informants identified the absence of supportive infrastructure as a barrier. This included "political" decision-making processes; absence of highly-placed champions; and failure to assign responsibility of diversity issues (*It's nobody's responsibility, it cuts across all programs ...No one at a high enough level is responsible"*). Similarly, concerns about racism were often focused on incidents involving individuals, not on organizational or systemic issues. While much distress was expressed over the insensitivity shown in some of the case studies shared, incidents were rarely framed as patient safety or quality of care issues, which result from a failure to institute necessary organizational change.

Voluntary or Required Action

A related issue is the failure to make "cultural responsiveness" a mandatory standard of care rather than a vague expectation. In many centers, for example, "Cultural Awareness" training is not mandatory and there rarely appear to be monitoring or compliance provisions in terms of provision of culturally appropriate care. In some of the centers reviewed, providers are not required to use interpreters when language barriers are present.

However, if an organization was to move towards making behaviours and standards of care mandatory, the onus would be on the organization to provide the necessary resources to meet these standards, whether this be funding for release time for staff taking Cultural

Awareness training, or provision of trained interpretation – a sensitive issue in an era of fiscal restraint. At the same time, failure to require appropriate action communicates more strongly than any vision or value statement, the importance placed on cultural responsiveness by the organization.

Provider Competence or Client/Community Access and Participation

Another dimension explored through the review of organizational documents relates to the focus of cultural responsiveness interventions: are interventions focused on increasing provider competence, or on addressing barriers to organizational participation? Indications of reliance on the "provider competence" approach include the absence of cultural responsiveness issues in key strategic planning processes; failure to integrate responses into the fabric of the organization; and the absence of mechanisms to facilitate/ensure community participation in planning, evaluation and research (e.g. the failure to require, in the terms of reference of key committees, representation of the diversity of the community). As these characteristics were commonly observed in the documents reviewed from all sites (along with a reliance on provider training as the primary response to societal and patient diversity), the provider competence approach appears dominant.

Reliance on Outside Agencies

It appears from this review that some Canadian organizations may be largely unaware of the number of services provided by community, settlement, and advocacy agencies and

may in fact have no formal relationships with many of them. This is of concern as staff

may not be provided with information on the services available or how to access them,

and problems experienced by these external providers may often not brought to the

attention of the organization.

One incident, shared at a meeting of the steering committee of the National Network of

Cultural Competency in Paediatric Health Care during the course of the project,

highlights how service provided by community agencies, often "invisible" to

organizational staff, may prevent the organization from identifying and responding to

general problems:

> *An immigrant, who was being treated in the emergency department, was*
> *accompanied by an untrained community interpreter. As this volunteer had other*
> *commitments, s/he was forced to leave. A program coordinator from the hospital*
> *(who did not have responsibility to provide interpretation services but was*
> *fluently bilingual), volunteered to interpret. At this time, in addition to the*
> *complaint for which the client was being treated, two additional issues were*
> *brought to the attention of the interpreter. Hospital records indicated that the*
> *patient had an appointment for a pregnancy termination; however, she claimed to*
> *have no knowledge of what procedure she had been scheduled for. Secondly, the*
> *patient complained several times to the attending staff that she believed she had*
> *malaria, and wanted to be tested for it. After assertive attempts to bring this to*
> *staff attention, the attending physician finally responded that the test could not be*
> *done at the hospital. The staff person who was providing the interpretation*
> *followed up with a phone call to infectious diseases, and was informed that not*
> *only could the test be done there, but that it should be. The physician was*
> *subsequently contacted to clarify hospital services and policy.*

If, as would normally be the case, a volunteer community member (rather than an

organizational staff member) had been interpreting at that time, it is likely that neither of

these matters (failure to communicate the purpose of the scheduled procedure, or the

miscommunication regarding the hospital role in malaria testing) would have been

clarified for hospital staff. This not only presents risks to the individual patient, but

failure to identify "system errors" may also result in risks to other patients (and

potentially pose an issue of hospital liability).

The Impact of Health System Restructuring

Workload and Stress

Feedback at the test site also highlighted the potential impact of fiscal restraint and

restructuring on provision of culturally responsive care. The need to compete with other

service areas for funding support was perceived by many as an important barrier to

improved cultural responsiveness, as was the current climate and workload within the

health care system. Some of the comments as they relate to cultural responsiveness are

noted below.

> *There has been no improvement; it is a continual battle. It was better 5 years ago*
> *– the workload, people are too busy even to smile.*

> *We have a siege mentality, staff feeling that patients are an annoyance; their jobs*
> *would be fine if only they didn't have to deal with them.*

> *They are so busy and overworked, meeting someone who can't speak English, any*
> *marginalized group; the system is so heavily overburdened it makes lives more*
> *complicated.*

> *The cutbacks lead to a situation where people don't go above and beyond – well it*
> *shouldn't be above and beyond but that is how people see it.*

> *Intensity and stress in the organization. Cultural sensitivity requires time for*
> *thought and reflection. People may recognize it but not have time to deal with it.*

> *People under stress behave badly, and organizations under stress behave badly.*

> *The organization is so stressed that sometimes it brings out the worst side of*
> *people, it can come out as prejudice.*

While caution is advised in interpreting these comments (which may, sometimes, be used as an "excuse" for inappropriate care), many of these observations are supported by learning theory, which suggests that under stress, providers are more likely to resort to time-saving techniques such as reliance on stereotypes (van Ryn & Burke, 2000). This also suggests that "cultural responsiveness" should be promoted and assessed within the larger context of quality of care; and that cultural responsiveness initiatives should be linked with existing practice (Kingsley, 2001), rather than treated as a separate add-on requirement.

Regionalization

The literature suggests that promoting cultural responsiveness may be more difficult in larger, more complex organizations (Jones et al., 1998). This pilot, at a site where services had been amalgamated under a large health region, found relevant policy and programs located at three different organization levels. In some domains there was evidence of significantly different approaches to cultural diversity between these levels. The process of document collection also demonstrated that it was sometimes unclear exactly where some documents would be located, and that some of the domain areas were in the process of being transferred from the facility or health complex to the regional level. This suggests that the impact of regionalization itself, not only issues related to system stress and fiscal restraint, may have important implications for diversity programs. Further investigation is needed to determine whether the potential advantages of regionalization to culturally responsive care (coordination and continuity of service across location, for example) outweigh some of the immediate challenges (e.g. what was described by some informants as an environment of stress and "crisis management").

These challenges may result in diversity issues, like other non-urgent but important issues, being forced "off the agenda."

Summary and Conclusions

While the "best practices" selected for inclusion in the document review instrument were designed to be appropriate for all health settings, awareness of these practices appears to be low in many Canadian institutions. This presents additional challenges for undertaking culturally responsive organizational assessment in Canada as – without appropriate orientation to the research and standards development activities in other jurisdictions – there may be limited engagement in cultural responsiveness assessment activities.

Rather than development of coordinated, comprehensive and evidence-based diversity plans, it appears that cultural responsiveness initiatives in many centres are driven by "politics" and "personalities," and the needs of specific "cultural groups" are often addressed in isolation from each other. These "silos" often reflect the historical and political divisions of the larger society. Failure to adopt an integrated approach based on evidence of disparities may prevent organizations from gaining the internal support necessary to implement effective change, and may even contribute to ongoing disparities.

There is evidence from this preliminary research that Canadian health care facilities tend to use a narrower definition of culture based on "race" and ethnicity, and that many of the disadvantages of using these narrower definitions, which have been identified in the literature (e.g. encouraging simplistic or stereotypical understanding of specific

population groups), are also found in practice. There appears to be a tendency to rely on "multicultural," voluntary, and individual (rather than mandated and organizational level) interventions. Cultural awareness training is often the primary intervention to address needs for culturally responsive care. Few organizations appear to have adopted significant workforce diversity initiatives.

CHAPTER 7: SUMMARY AND CONCLUSION

Summary

This research piloted, at one Canadian paediatric care facility, a document review instrument designed to assess the cultural responsiveness of health care organizations to culturally diverse groups, The pilot instrument was based on an extensive literature review to identify "best practice" in the area of cultural responsiveness, and on the findings from application of a simpler guide used in an initial scan of seven Canadian health centres.

Comparison of the findings from the document review with data obtained through other methods (key informant interviews, a parent focus group, organizational feedback session, and observational methods) indicated that the document review process provided useful information that accurately reflected organizational progress in adopting identified best practice. Results from the document review were not, however, consistent with the results of self-assessment findings at the same site. These findings reinforce concerns, identified in the literature, regarding the limitations of self-assessment instruments, particularly in relation to issues of cultural responsiveness.

Results from the test site also indicate that a document review process is able to identify the underlying the organizational approach to addressing cultural diversity along a number of "dimensions" defined in the instrument. These include: working definitions of "culture" and "cultural group"; the underlying philosophy ("multicultural" or "antiracist"

approaches); and whether the focus was on voluntary or required, individual or organizational, action. It also revealed philosophical approaches in regard to cultural training and workforce management, and identified differences in these approaches between various "levels" in a regionalized health system.

Contributions to Research on Cultural Responsiveness

A review of the literature indicates that this research is the first attempt to use a comprehensive document review process for assessment of organizational cultural responsiveness. Unlike many assessment instruments, it identifies specific indicators of best practice rather than looking at general statements of principle, and can therefore be expected to facilitate a more objective assessment than many assessment tools currently in use.

It is also, to my knowledge, the only assessment tool that includes the identification of underlying approaches to addressing cultural diversity in health. As the literature suggests that the underlying philosophy on which interventions are based may affect both the strategies adopted, and the effectiveness of these strategies, the finding that these dimensions can be identified through a document review process suggests that additional development of this assessment approach may be not only feasible but beneficial.

While the comprehensive instrument was only tested at one site, results are consistent with an initial scan using a simpler tool, and feedback obtained as a result of that scan. This suggests that further development and testing of a document review process is

indeed worthwhile. The findings are of particular relevance to delivery of Canadian health services. While a number of assessment tools have been developed, most have been developed in other jurisdictions and often for use within only one health area. Most rely on self-assessment approaches. The potential of using this instrument to inform self-assessment activities (such as the CCHSA self-assessment component for accreditation) should be considered.

The resource demands on the organization of undertaking the review were minimal, and feedback from organizational participants suggests that the time and resources allocated would not discourage advising other organizations to engage in this approach. This is of particular interest in a climate of intense and competing demands for health care resources.

Although the pilot was undertaken in a paediatric setting, the instrument was not intended to be limited to use in this area. While some modifications may be required for specific settings (and there may be some variation in the documents selected within domains), the instrument uses generic descriptions of materials that should be available and relevant in other health settings.

Limitations of Research

The assessment instrument was piloted at only one site. Although there was good consistency between results of the document review and qualitative methods employed at the same site, it cannot be assumed that the same results would be found in other settings,

as other factors may affect findings. It is possible, for example, that there would be less consistency found within organizations that were at different points of development in adoption of best practice in "cultural responsiveness." As greater progress is made towards adoption of organizational "best practice," it is possible that there would be less congruence between the results of the document review and data obtained through observational methods and key informant interviews.

The research did not attempt to measure the quality of provider-patient interaction or care provided (the objective of improved cultural responsiveness); nor, with the exception of one focus group, did it include the perspectives and experiences of clients. While the theoretical literature suggests that appropriate organizational supports are necessary in order for front line staff to provide quality care for a diverse society, an essential component of an expanded assessment would be comparison of document review results with patient and community experience and perceptions.

Although the intent of the research was to test a specific assessment instrument (and, as outlined in Appendices O and P, the draft instrument has been revised based on the results of the pilot), the conclusion that the strength of this approach may lie in the process of applying the instrument, not simply the specifics of the instrument itself, suggests other limitations. While the instrument includes a number of specific, objective indicators, this research does not provide information as to whether the same results would have been achieved had the instrument been used internally by staff of the

organization. The usefulness of such an instrument, if applied and interpreted by those with little background in the area, is unknown.

The low demands on staff time required to undertake a document review were associated with other limitations, as the low resource demands appear to be mirrored in a relatively low level of interest in, or ownership of, project findings. This initial pilot did not include a commitment from the sponsoring organization to develop strategies for staff and management participation, or to allocate time and other resources for follow-up on project findings. The next step is to pilot the instrument in an environment where commitment has been made by the most senior levels of the organization to ensure organizational engagement and follow-up.

Another limitation may be the interest of health care organizations in using a document review approach. The instrument is not designed to "evaluate" and give a summary score to an organization by which it can compare itself to others. The literature raises cautions about this kind of evaluation, as there are no validated instruments developed to date (Office of Minority Health, 2001a). Experts in the field agree that cultural responsiveness assessments should be used to develop and monitor internal progress. This instrument is intended to assist organizations in developing greater awareness of the implications – to all areas of the organization – of adopting best practice in specific domain areas, and to identify what steps would need to be taken to address identified gaps. In this way, the strength of the instrument is as much as an educational (and potentially monitoring) device, as an evaluation tool.

However, as many health organizations are primarily interested in an assessment they can undertake themselves (and are often looking for some kind of "rating scale" to accompany it), it is unclear what the interest in this instrument would be. There is a need to develop greater awareness of the limitations of self-assessment strategies and the current lack of "validated" instruments in this area.

Are All Domains of Equal Importance?

A limitation of the pilot instrument is that it does not attempt to weight the domain areas (or elements within domains), even though there is varying research evidence related to the domain areas, and evidence that progress in some domains will result in greater impact on access and quality of care. It does not, therefore, provide guidance as to which interventions may have the greatest impact.

The most compelling evidence of impact on health outcomes of identified best practice is found the area of language access services, and there is international consensus on both the risks of language barriers and the standards that should be in place. It should also be noted that addressing language access is a requirement for making progress in many other domain areas (e.g., unless interpretation or translation is available, many service users will not be able to participate in program evaluation activities). Provision of language access services also has implications for other domains (e.g., if providing trained interpreters is prioritized, there are implications for human resources), and will impact other activities (e.g., focus of cultural training programs). This suggests that directing resources to addressing this domain area should be an organizational priority.

In other domain areas (e.g., cultural training or human resource management), there is less or conflicting evidence of impact. This is because in some domains it may be the approach taken (i.e., factors related to the instrument dimensions) that may be of greatest importance. For example, it has been noted that some approaches to cultural training may result in reinforcing stereotypes. In many cases, the effectiveness of actions in all domains will be affected by the extent to which the organization is able to institutionalize responses and provide the necessary infrastructure to support translating theory into practice.

How Important is Written Policy?

This project was not limited to review of organizational policy and procedures, but included many other relevant materials (e.g. strategic plans, program descriptions, information to patients). While it found that information gathered through review of policy was consistent both with that revealed through other documentation, and with conclusions reached through other methods, one question that emerged in this research relates to the importance of written policy and procedures in promoting and monitoring cultural responsiveness. Do established policies drive best practice, do they reflect actions undertaken that are the result of other factors (e.g. organizational leadership), or is there no relationship between the two? Some authors, for example, suggest that lack of attention to interpersonal mechanisms or mediators of institutionalized discrimination may undermine the strongest policy (van Ryn & Fu, 2003; Buchanan, 1998), or even that leadership is more important than cultural responsiveness policy (Kingsley, 2001). Some informants at the test site also felt that policy was less important. As one said

My own belief is that you cannot legislate behaviours......it must come from within. By and large, the way it works, an organization develops a culture, verbally transmitted from person to person....it's what's going on at the front line that is important, not policies and guidelines.

It can be argued, however, that clear policy to address elements of organizational best practice is a necessary, if not sufficient, component in ensuring culturally responsive practice. First, one role of policy and procedures is to orient new members and direct practice (*"strong policy gives people a guideline"*). This can be expected to have some immediate results. If policy prohibits use of untrained volunteers identified through overhead paging, and if procedures provide staff with contact information for qualified interpreters, one might reasonably expect some behaviour change in this area.

This example, however, also highlights other important issues. How policy is written – how directive the policy is, and how specific the related procedures are – will determine the effectiveness of policy in promoting best practice. A general policy, which simply identifies the importance of using an interpreter and urges staff to call for one when needed, may result in little change in practice. In addition, in many cases appropriate policy reflecting best practice cannot be established until the required programs and resources are in place.

Second, the presence of clear policy provides a framework for development and application of monitoring systems, and a means of recourse should best practices not be followed (*"it gives more ability to promote change, you can refer to policy"*). Evaluation

of whether action is appropriate becomes less a matter of an "opinion," and is more likely to be based on objective indicators.

Third, the presence of policy raises the commitment to cultural responsiveness to the same perceived level of organizational importance as many other quality issues. This can perhaps be best illustrated by comparing how an organizational response to addressing medication errors might be handled – if the same approach was taken in response to this issue as is often the case with issues of cultural responsiveness:[1]

> *No, we don't have any policies in place to ensure that medication is delivered correctly, but our staff are professionals and they cover this in their training. No, we don't know how many errors there are. Set up a system for tracking them? No, we haven't thought of that, and I'm not sure how we would do it. Is anyone else doing this?*
>
> *What do you mean by integrating standards for medication management into organizational quality initiatives? Our mission stresses quality, and making sure that the patient gets the right drug is an aspect of quality. It's included automatically in what we do. Systems? It's the staff at the front line who give the medications, that's where it matters. I don't think you can legislate these things. Ways of monitoring and addressing the performance of staff who make a lot of mistakes? Well, no, though I suppose that the supervisor might raise this in the regular performance evaluation.*
>
> *Oh, and anyway we do offer workshops. No, all staff aren't required to attend – we don't want to provoke resistance, and besides, there are staff replacement costs. No, there are no consequences if staff don't want to go. Well, actually, the workshops aren't about ensuring safety in managing medications in general, we just focus on the specific characteristics of the drugs most commonly used in this hospital. It's analgesics that are used the most so that's what we focus on. General principles that could be applied in all cases? No, that's never been discussed. We don't want to bite off more than we can chew. We can't do everything for everyone – people who need those medications should go to another hospital.*

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[1] This is a constructed narrative based on examples of comments gathered from a number of sources: narratives from the test site, data gathered from the broader review of organizational documents, and cases shared with the author from other settings and other locations.

Evidence that failure to have systems in place to prevent medication error can lead to "clinical inefficiency, decreased provider and patient satisfaction, malpractice injury and death"*? Really? I haven't heard that. Look, as an organization we are committed to being aware of the importance of giving patients the right medication. O.K., we admit that there are a few bad apples who really don't care if you get the right drug or not, but there are also a lot of staff who go above and beyond. We're doing a pretty good job on the whole. Remember, there are a lot of demands on the system right now and a lot more people are aware of the importance of giving the correct medication than there used to be.*

This construction of a theoretical response to preventing, monitoring and addressing medication errors highlights a number of challenges faced by proponents of improved organizational responsiveness. It is unlikely that any issue of recognized relevance to patient safety would be responded to in this fashion. Health care organizations generally recognize that there must be systems in place to train staff, set standards, develop policy and monitor administration of medication. They understand that although different medications are used for different conditions, and have different effects, there are some general principles that can be applied in all cases. They do not rely only on the good intentions of individuals. Resources are directed to accessing and evaluating current research in the area, and to establishing appropriate procedures (including information management systems if appropriate). The fact that statements, such as those included in the narrative above, remain common across the country in discussions related to cultural responsiveness indicates that cultural responsiveness is not accepted as critical to quality of care.

Amalgamation of services into large health regions poses additional challenges. While strong leadership may be effective in ensuring appropriate interventions in a single

institution, it is less likely that consistency of approach and equivalent standards can be maintained in large integrated systems, without clear policy and procedures. As one informant commented, "*I do think we need formal policies and guidelines in place. We have so many staff that we will never be able to achieve a consistent approach without something written.*" Large systems have greater need for written policy to assist in training staff, monitoring performance, and in providing "recourse" if standards are not met.

Directions for Future Research

This preliminary research, undertaken in an area that to date has been under-researched in Canada, suggests two major directions for further exploration.

<u>Generalizability of Research</u>

A larger pilot project, which applied the revised instrument (Appendices O and P) in a number of other settings, would be the next step in determining the overall usefulness of the approach. This larger pilot should not be limited to paediatric health organizations, but include a range of health organizations in order to determine to what extent the same process, using the same guide, is useful in other settings. The pilot should include organizations at different points of development in adopting culturally responsive best practice. It would also be useful to compare the results obtained by different researchers at the same site, in order to determine the impact of the individual assessor. This larger pilot should be structured to incorporate the recommendations for implementation outlined at the end of Chapter 5, in order to assess the impact of application of the

instrument under conditions where the necessary environment to facilitate organizational education, engagement and ownership have been established.

As, in provinces where health services have been regionalized, much responsibility for governance and policy rests with the region rather than the individual program or facility, it will be necessary to pilot the instrument at the corporate level of one or more health regions.

In addition, as the ultimate goal of organizational cultural responsiveness is improved access, quality of care and health outcomes, it is essential that results of the pilots be compared with in-depth assessment of patient/community experience in order to determine to what extent ensuring appropriate structure and processes is reflected in the quality of care provided.

Knowledge Translation (KT)

Another important area for future research relates to the issue of transferring (or "translating") research findings into the health care setting. While there is currently significant interest in "evidence-based practice" and research utilization, the specific challenges associated with knowledge translation (KT) in the area of cultural responsiveness have not been adequately explored. Many organizations remain "blind" to their role in maintaining disparities (Thrall & Freidman, 2003). The literature suggests that there are greater barriers to utilization of some research, and that social science research faces greater barriers than natural science research (Hanney, Gonzalez-Block,

Buxton & Kogan, 2003). Lavis et al. (2002) also suggest that there are differences in KT at different stages – some research is used to get issues "on the agenda," while other is used to direct policy. The relatively low level of organizational awareness indicated by this initial study suggests that an important area of research in Canada is that of getting "cultural responsiveness" on the agenda of health care organizations.

There is also evidence that research that is a part of a larger policy trajectory, and linked with broad organizational agendas (such as "quality"), is more likely to be used (Lavis et al., 2002; Rosenheck, 2001). This highlights the importance of ensuring that cultural responsiveness assessment and related interventions are aligned with current planning priorities and quality initiatives.

There is strong evidence from the knowledge translation (KT) literature that a key element in adoption of research into the practice setting relates to the personal relationships between researchers, knowledge brokers and decision-makers. However, in Canada to date, expertise in cultural responsiveness is often "marginalized" in health care planning, and research on marginalized groups is itself marginalized (CIHR, 2003b). One important strategy to address this gap is to strengthen relationships between organizational planners/decision-makers and communities they serve – particularly populations whose members suffer disparities in health status, access, or quality of care. The "evidence" of their experience with the health system should be incorporated into the assessment process.

One of the characteristics of effective research utilization is that the topic, questions, and framework for research are negotiated before the research takes place (Davis & Howden-Chapman, 1996). Therefore, collaboration in development of objectives for the assessment process, ensuring strategies for staff and community input and participation (including interpretation of assessment results) can be expected to both increase ownership of results by staff and clients, and to facilitate needed action.

In the pilot, personal relationships and the personal interest of key individuals within the organization were associated with specific areas of intervention. Therefore, there is a need to identify effective strategies for gaining support (at the highest levels of the organization) for a comprehensive approach to diversity planning, and to moving cultural responsiveness onto the strategic planning agenda.

In addition to further research to evaluate the document review process, there is also a need for research on the specific knowledge translation challenges in the area of cultural responsiveness. Resources should be directed to exploring generic strategies for incorporating results of existing diversity research (e.g. the growing body of evidence related to health impacts of language barriers) into health planning and decision-making.

Recommendations for Further Testing of a Document Review Strategy

A number of recommendations for further application of the document review instrument were made in Section 5.8. These recommendations focused on: formal commitment by senior management to the initiative; allocation of time for orientation and training before

the project begins; development of strategies to ensure participation from all areas of the organization; provision of adequate time for decision-makers to review and interpret the assessment results; and a commitment to incorporating the results into strategic planning.

Several other recommendations, based on key knowledge translation principles, can be made to help promote interest in the assessment and encourage ownership of assessment results:

- Develop and implement strategies for gaining support for the initiative from credible, high-profile leaders in the organization

- Include the initiative as a standing agenda item on all board, senior management and related committee meetings

- Identify and work with formal and informal knowledge brokers within the organization to develop strategies for research results related to the impact of cultural responsiveness to quality of care, patient safety and organizational liability

- Develop collaborative strategies for including all units and disciplines of the organization in planning for the assessment, clarifying objectives and expectations, participating in collection of materials, and interpreting assessment results

- Identify community resource people who are both knowledgeable on health issues addressed by the organization, and have credibility with service users in their community. Incorporate their knowledge and expertise in planning consultation and feedback strategies to ensure that consumer perspectives are part of the both assessment activities, and the interpretation of results

- Establish mechanisms for regular information sharing between the various stakeholder groups. Provide opportunities for informal networking to build trust and collaboration

- Align the assessment activity with ongoing processes and structures, as well as current high profile initiatives

- Ensure that there is a concrete plan for incorporating assessment findings into ongoing strategic and operational planning

- Ensure that adequate time is allocated for in-depth discussion by organizational decision-makers of the implications of specific approaches to addressing cultural diversity, and to undertake consensus-building around the approaches to be adopted by the organization. Develop a strategy for communicating these approaches and promoting consistency in organizational activities

- Work with supervisors to ensure that processes are in place to reward, rather than penalize, time spent in contributing to planning for improved cultural responsiveness. The multiple demands and stress reported by many working within health care suggest that special effort may be needed to ensure that the initiative does not "get lost" among competing demands.

Conclusion

This preliminary research suggests that a document review strategy shows promise for assessing not only the progress made by organizations in adopting "best practices" related to cultural responsiveness; but perhaps more importantly, providing insight into the underlying organizational approach to addressing cultural diversity on a number of

dimensions. It can be expected that accepted "best practice" will change over time as empirical research provides evidence of the outcomes of specific interventions. For this reason, it is important to view use of the instrument as a support and guide for the process of review. While the specific elements included in a document review instrument can (and should) be adapted or replaced as new evidence becomes available, the overall strategy and specific domains into which the best practices are organized can be maintained.

A limitation of this initial pilot is that it focused only on evaluation of the assessment instrument; it was not able to assess the acceptability of a document review process to health care organizations, or the potential of this strategy to promote awareness or action in improving cultural responsiveness at the organizational level. The next step is to undertake a larger pilot that would test the instrument in a variety of settings, using different researchers. It is also important to undertake the assessment in settings where appropriate organizational commitment and planning has been ensured. Additional research is needed to identify, and develop recommendations for addressing, the specific challenges related to knowledge translation in the field of cultural diversity research.

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APPENDIX A

List of Language Access Best Practices

1. There is a clear policy, and associated standards on language access for the organization
   a. Interpreter services are provided free of charge to the patient
   b. Interpreter services are provided at all key points of contact
   c. Interpreter services are available at all hours of operation
   d. Training is required for interpreters used
2. Providers are required to obtain interpreter in cases where there is evidence of language barriers.
   a. Clear instructions for determining need are provided, along with procedures for contacting approved interpretation services
3. Providers are given training in working with interpreters
4. There are written guidelines for communicating via an interpreter
5. Only trained interpreters are used
   a. Family members or friends are used only at request of patient
   b. Use of overhead paging is forbidden or strongly discouraged.
   c. Bilingual staff members (other than interpreters employed by the institution) are used only
      i. If they have received training in interpretation
      ii. In clearly identified situations, or emergencies
6. Training for interpreters includes
   a. Orientation to facility and programs
   b. Ethics
   c. Medical terminology and concepts
   d. Interpreting skill
7. Training for interpreters is a minimum of 40 hours
8. Patients are provided with information on their rights to interpretation assistance
   a. There is signage in languages of the community
   b. Information on rights and services is available in languages of the community
9. Language access services report directly to senior management
10. There are coordinated records kept on
    a. Language of patients
    b. # of interactions where an interpreter is needed
    c. # of interactions where an interpreter is used
    d. Type of interpreter used (e.g. hospital employed, family member, community worker)
    e. Name of interpreter
    f. Cases where problems occurred due to language barriers
    g. Cases where interpreter not available
11. Position descriptions for interpreters are in place
    a. Position description recognizes complexity of interpreters role
12. Evaluation process for interpreters is in place.

APPENDIX B

MATERIALS REQUESTED FOR INITIAL SCAN OF PAEDIATRIC ORGANIZATIONS

Item	Available (Y/N)	Comments
Organizational mission statement		
Current strategic plan		
Specific policies related to diversity or cultural competence		

Cultural assessment/audit tools used within organization
    ▪ Copy of tools
    ▪ Report on last use		

Organizational orientation package (new staff, volunteers)		
Latest annual report		

HR policies related to:
    ▪ Employment equity and Non-discrimination
    ▪ Other policies related to goal of diverse or representative workforce
    ▪ Employee performance evaluation guidelines/form		

Cultural Competence/Diversity Committee
    ▪ Terms of reference
    ▪ Diversity/cultural competence plan
    ▪ Position, position description of person responsible for plan		

Consumer satisfaction
    ▪ Copy of instrument
    ▪ List of languages in which instrument is available
    ▪ Report on latest survey		

Demographic profile of catchment area		

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Item	Available (Y/N)	Comments
Language Interpretation ■ Policy (right to interpreter, requirement to call interpreter, payment) ■ Procedures ■ Position description/ qualification of interpreters ■ Client information on interpreter services ■ Procedures for monitoring/evaluation of interpreter service ■ Service statistics (latest year)		
Complaint policy ■ Client information on complaint process		
Cultural Competence / Diversity Training ■ Diversity training policy ■ Outlines of required courses ■ # of staff trained last year ■ Total staff trained ■ Training evaluation		
Data Collection ■ Forms identifying language, ethnicity		
Program Development ■ Descriptions of a) ethno-specific programs, b) outreach or other programs to address access of culturally diverse groups ■ Guidelines for community consultation and input		
Translated Resources (List of resources available and in what languages)		

APPENDIX B

MULTICULTURAL AND CULTURAL COMPETENCE RESOURCES

	Name of Resource	Type of resource	Availability
▪ Developed by your organization			
▪ Used by your organization			

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CULTURAL RESPONSIVENESS ASSESSMENT TOOL DOCUMENT POLICY REVIEW GUIDELINES
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Source	Key elements	Guidelines
Mission Statement, Values, Vision	1. Diversity of community is recognized in vision, mission and materials 2. There is a stated commitment to cultural responsiveness (CR) in mission, vision, etc.	Review these documents 1. Determine if culture included in Mission, values, vision 2. Determine prominence in Mission, values, vision (not included, mentioned in general terms, given emphasis) 3. Review for evidence of position on 7 dimensions 4. Review for evidence of workforce response (Table 4)
Most recent strategic plan, agendas of strategic plan planning meetings.	1. Issues of cultural responsiveness are included in strategic plan 2. Issues of cultural responsiveness are integrated into appropriate components of plan 3. Strategic plan developed with input from community groups	Review strategic plan and agendas of planning meetings. 1. Note references to any approach to cultural responsiveness. 2. Compare with mission, values, vision to see if reflected in strategic plan 3. Note if separate component or integrated throughout plan (domain 6) 4. Note # of domains addressed in strategic plan 5. Review for evidence of position on 7 dimensions 6. Determine if plan makes reference to obtaining and using input from relevant cultural groups.
Most recent operational plan	1. Operational plan includes strategies and resources to achieve strategic objectives related to cultural responsiveness.	1. Determine whether operational plan addresses "cultural" components of strategic plan 2. Compare operational plan to strategic plan (appropriate operationalization of cultural responsiveness objectives)

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Staff orientation materials	1. Materials state commitment to diversity 2. Materials includes section on diversity 3. Materials address CR issues in the identified domains	1. Identify areas in orientation materials that include mention of culture in any way. 2. Note if a) separate section or b) integrated throughout 3. Note if statements of value/intent are linked to policy, activity or expectations 4. Note the domains included 5. Review for evidence of organizational approach on 7 dimensions
Volunteer orientation materials	1. Materials state commitment to diversity 2. Materials include section on diversity 3. Materials address CR issues in the identified domains	As above
Board orientation materials	1. Materials state commitment to diversity 2. Materials includes section on diversity 3. Materials address CR issues in the identified domains	As above.
Latest annual report	1. Cultural diversity issues are prominent / highlighted. 2. Coverage of issues reflects community demographics	1. Note whether issues of culture not mentioned, "motherhood statements", separate section, integrated in. 2. Note the domains included 3. Review for evidence of position on 7 dimensions

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Reports to the public and distribution plan, past year. (include notices and ads)	1. Information provided to community reflects community demographics 2. Distribution of information ensures coverage of culturally diverse groups 3. Diversity issues included in content 4. Format and language accessible to those with low literacy 5. Information or links available in other language.	1. Note coverage of cultural issues (# and type) 2. Apply reading level assessment 3. Note availability in other languages. 4. Note cultural groups identified 5. Review for stereotypes 6. Note identification / referral of language/cultural resources
Organizational website	1. Cultural diversity is prominent/highlighted 2. Topics reflect diversity of community 3. Graphics reflect diversity of community 4. Web pages include information of interest to diverse cultural groups 5. There is information in other languages OR 6. There are links to information in other languages 7. Website reflects mission, strategic plan in coverage of CR issues	1. Note role of website – internal, patient/public ed or professional 2. Note inclusion of diversity issues 3. Note approach (7 dimensions), on cultural diversity issues identified 4. Note graphics (including photos), ethnic makeup etc. 5. Note topics, program information of interest to specific cultural groups 6. Note inclusion or links to information in other languages. 7. Review for consistency with statements in mission, strategic plan

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Descriptions of Child health programs	1. Program descriptions acknowledge and address cultural issues 2. There are programs that address health needs of specific groups 3. There is evidence of input from community groups in program development	1. Note acknowledgement of Cultural diversity in program descriptions 2. Review for evidence of consultation with community 3. Review for evidence of position on 7 dimensions 4. Note initiatives for a. specific groups; b. specific problems
Human resource department vision, goals	1. There is stated commitment to cultural diversity of workforce 2. Human resource approach consistent with organizational mission, goals, strategic plan	1. Review for statement of commitment to cultural diversity 2. Review based on Table 2 for definition of cultural groups 3. Review based on Table 4 for human resource approach
Employment equity policy	1. Policy in place 2. Policy includes hiring of new employees and advancement strategies for existing employees	1. Review policy

Job postings (most recent month), including position descriptions	1. Postings include employment equity statement
	2. Postings disseminated to ethnic / Aboriginal media and agencies
	3. Position descriptions include diversity awareness / skills in qualifications
	4. Alternate qualifications are considered
		1. Review postings for
		    a. Employment equity statement
		    b. Acknowledgement of diversity skills needed (relevant positions only)
		    c. Distribution list
		2. Review position descriptions for
		    a. cultural experience/skills listed in qualifications;
		    b. recognition of alternate qualifications

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HR strategic plans	1. CR included, highlighted in strategic plans	1. Review based on Table 4 for human resource approach
Performance Evaluation guidelines	1. Guidelines include section on cultural competence	Review guidelines
Volunteer program policy and procedures	1. Policy includes components that promote diversity 2. Recruitment strategies reflect community demographics 3. Cultural awareness / skill included in position descriptions 4. Volunteer records record language, ethnicity of volunteer	Review relevant policies to identify 1. Stated commitment to diversity objectives 2. Recruitment strategies 3. Cultural skills included in position descriptions 4. Tracking by language, ethnicity 5. Note approach on 5 dimensions
Specific anti-discrimination policy	1. Policy in place on multiculturalism, racism, harassment 2. Policy applies to clients as well as staff	1. Identify relevant policies 2. Review for consistency with provincial legislation
Specific diversity policies	1. There are policies in place that have as goals eliminating barriers to service 2. There is specific diversity policy 3.	1. Review any "diversity" policies for evidence of position on 7 dimensions
HR cultural training policy	CR training required at all levels	Determine from written policy who is required to attend

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Workforce audit	1. Workforce audit in place or is planned 2. Strategic plan addresses issues identified through audit	1. Note presence/ absence of workforce audit a. Note by level 2. Assess appropriateness of strategic plan 3. Review for evidence of position on 7 dimensions
"Ethnicity data" included in HR information systems	HR systems include Aboriginal status, ethnicity, language	Review HR templates
Board Terms of Reference	Board selection policy / process requires consideration of diversity	1. Note if selection process addresses diversity of community 2. Note if addressing inequalities included in T of R. 3. Review for approach on dimension 1, indication of approach re other dimensions

Board committee structure, terms of reference	1. Committee structure and Terms of Reference have clear accountability for CR initiatives
	2. Terms of Reference require
	    a. membership representative of community
	    b. CR skills among membership
		Review committee Terms of Reference for presence of these elements

Select staff committee terms of reference *	1. Committee membership states commitment to inclusion of individuals with CR skills 2. Mandate of committee recognizes issues of CD	Review Terms of Reference for 1. membership criteria which requires cultural diversity 2. CR is specified in committee mandate

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Select community advisory council/committee Terms of Reference *	As above	As above
Organizational training plan	A plan that includes diversity and cultural competence training has been developed	1. Identify if plan in existence 2. Review plan
Training curricula on diversity, culture topics	Cultural training includes components identified through best practice review	1. Review curricula for identified components 2. Review curricula re 7 dimensions
Evaluation of diversity/cultural training	1. There is a process in place to evaluate and adapt Cultural training program 2. Evaluation process includes input from participants	1. Review evaluation policy 2. Review evaluation forms 3. Review collated evaluations for response rates, participant response
Sample of other in-house training programs*	Cultural issues are integrated into inservice / professional development activities	1. Review materials for evidence that CD included as consideration
Guidelines for training / in-service	Guidelines are in place that require consideration of cultural issues on topics as appropriate	Review guidelines to determine if this is required
Cultural training records	1. Records are kept on individuals trained 2. Follow up procedures are in place	1. Determine if records in place 2. Calculate % of those required who attend 3. Calculate % by position/level

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Board cultural training requirements and curricula	1. Board provided with cultural training 2. Training includes identified components of best practice training	1. Determine if policy in place 2. Determine if attendance mandatory 3. Review curricula in light of 8 domains , b. 7 dimensions
Language access policy	1. Language access policy in place 2. Policy includes Best Practice elements (Appendix A)	1. Determine presence of policy 2. Assess policy for elements identified in Appendix A 3. Determine language constituencies to whom policy applies
Language access program descriptions	Language Access Services reflect identified best practice (Appendix A)	Review program description in light of Appendix A
Procedures for interpreter use	1. Procedures in place demonstrate best practice (Appendix A)	1. Determine which elements in place 2. Review procedures on dimensions 1-7 3. Review based on Appendix A
Records on language access services	1. Records for interpreting service in place 2. Records record information identified in Appendix A 3. Records reflect need suggested by demographics	1. Determine what records kept 2. Review based on Appendix A 3. Compare records based on Stats Can data; (local settlement data?)
Job descriptions for interpreters	1. Position description for interpreters are in place 2. Position descriptions recognize complexity of interpreter role. (Appendix A)	1. Determine if position descriptions in place 2. Determine to which language constituencies and types of interpreters these apply 3. Review position descriptions based on items in Appendix A 4. Review for evidence of approach (7 dimensions)

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Training and evaluation requirements for interpreters	1. Training standards for interpreters in place 2. Training meets minimum standards 3. Process in place for interpreter evaluation	1. Review based on identified best practice (Appendix A)
Client information sheets (both official languages, other languages)	1. Information on rights to interpreter, interpreter services available in languages of community+	1. Determine presence of materials, identify languages. 2. If available, review English translation for consistency with policy (above)
Client consent forms (both official, other languages)	1. Consent forms are available in languages of community	1. Determine presence of other language forms and in what languages.
Complaints policy	1. Information on complaints is available in languages of community	2. Review policy for strategies to ensure policy available to diverse groups
Budget for language access services	1. There is a dedicated budget for language assess services	1. Budget reflects need/demographics of community
List of languages in which rights, service information available	1. Client information (services, rights), available in languages of community.	1. Compare list of languages with a. Stats Can or other profiles 2. Compare with needs as identified through interviews/focus groups (to be conducted following review)

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Lists of resources available in other languages	1. Patient information is available in languages of community	1. Obtain list of patient related materials 2. Note availability of materials in other languages 3. Note if this information is obtainable through central listing of patient related materials 4. Compare other language materials a) with list of all patient materials, b) with community demographics
Signage Policy Signage in other languages	1. There is policy around signage in other languages 2. Signage provided in languages of community	1. Determine existence of policy a. Review policy 2. Note signage and languages available in main entrance, emergency, outpatients clinics
List of culture specific materials	1. Educational materials reflect issues/needs and beliefs of key communities.	Identify materials available that were developed (not translated) to respond to needs of specific cultural communities

Policy/guidelines for translation/ development or use of translated materials	1. Guidelines for translation/development in place	1. Determine if guidelines in place (at what level, how many requests to find)
		2. Review guidelines for presence of key elements
		    a. Which languages included
		    b. Voluntary/required language
		    c. Awareness of current translation guidelines (e.g. field testing, back-translation)
		    d. Community involvement in topic selection, development, materials review

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Plan and support structure for cultural responsiveness	1. Diversity plan in place	Review diversity plan for 1. mandate 2. approach (7 dimensions) 3. accountability 4. resources
Diversity Committee, Terms of Reference and. reporting structure	1. Diversity committee in place 2. T of R give decision-making mandate	1. Determine if Diversity committee in place 2. Determine which groups included in mandate 3. Review T of R for role and mandate
Organizational chart	Cultural diversity initiatives report directly to senior manager	Review org chart and identify reporting structure.
Copies of cultural responsiveness evaluation tools used in past, resulting action plans and progress reports.	1. Organization has undertaken CR assessment 2. Action plan to address issues emerging from CR assessment developed 3. Progress report completed in last year	1. Determine whether previous CR assessment undertaken 2. Review results 3. Determine if action plan developed 4. Note date and results of last progress report.
Patient information forms, management system	Patient information forms routinely collect data on ethnicity, Aboriginal or immigration status; language, religion	1. Review patient information forms. 2. Note ethnic codes included and for which programs 3. Note whether optional or required

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Strategic plan for MIS	1. Plans for patient data include measures of ethnicity/ culture /immigration status/ language	1. Identify if this included in strategic plan, and if so what measures proposed
Patient satisfaction forms	Patient satisfaction forms 1. are in plain English/French 2. are available in other languages 3. address, or encourage feedback on, issues of culture/diversity	1. Review latest patient satisfaction forms for literacy level 2. Identify languages in which forms available 3. Determine if forms allow/encourage comments re cultural appropriateness of care
Select program evaluation activities* (back in time for 1 year or five reviews whichever comes first)	1. Diverse cultural groups are included in evaluation activities 2. Evaluation includes assessment of diversity issues 3. Program evaluators acknowledge challenges/limitations of inclusion	1. Review for evidence of that language barriers addressed through translation, provision of interpreters, or low literacy materials 2. Review for specific strategies to include identified groups 3. Review for acknowledgement of limitations
Demographic profiles available in house	1. Provincial and local demographic profiles available in house 2. Organization has more detailed breakdown re ethnicity/language 3. Planning activities refer to these materials	1. Make list of profiles available through research office 2. Identify whether these have been elaborated for local planning a. Review any locally produced materials, for level of detail re ethnicity/language. 3. Review strategic plan for use of material
Local research reports* (past year or past five reports whichever comes first)	Organization has included issues of ethnicity/culture/language in past research activities	1. Review research for comparison by ethnicity/language/ culture 2. Review research for mechanisms to include identified groups 3. Review for acknowledgement of research exclusion

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Research/evaluation guidelines	1. Specific guidelines are in place to facilitate inclusion of minorities in research 2. Guidelines request analysis by ethnicity/ culture/language where appropriate	1. Determine if policy in place 2. Review policy on 7 dimensions
Information on formal community linkages, mechanisms*	1. Organization has formal linkages with appropriate community groups 2. There is policy that directs consultation with community groups in program development and evaluation 3. There is a community consultation; strategy in place a. Strategy recognizes linguistic diversity of the community	1. Identify formal linkages 2. Identify formal policy and review 3. Review community consultation strategy
Planning policies	1. Policies will include requirement to consider cultural diversity of community and clientele 2. Policies will require community consultation which includes diverse cultural groups	1. Review Table of Contents to identify a) topics related to culture, b) topics where cultural / diversity issues would be expected to be relevant 2. Review these policies for inclusion of consideration of cultural issues 3. Where included, review for a) definition of cultural group, b) requirement to consult

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List of inservices over past year, including outlines and objectives	1. List will include specific cultural topics 2. Outlines of other topics will incorporate issues of culture where appropriate	1. Review list 2. Identify definition of "cultural group" used 3. Identify topics areas where culture relevant 4. Review this list for inclusion of objectives, topics related to culture
OTHER Proposed by National Network		
• Code of ethics • Family Advisory Committee Terms of Reference • Agendas of Board, management, committee meetings		

*Specifics to be determined in consultation with sponsoring organization
+ identify source of demographic data (Stats Canada, unless more advanced profiles produced locally).
# base on organizational chart

APPENDIX D: MATRIC OF DOMAINS AND DIMENSIONS

General Category	Global questions (all methods)	Key Data Sources (Documentation only)	Examples of Indicators	Primary Dimensions Explored
1. General profile of CR and its importance within the organization.	- How important is cultural responsiveness to the organization? - How is recognition of diversity described? - What approaches are demonstrated by various stakeholders within the organization?	- Mission statement, strategic plan, annual report, staff /board/ volunteer orientation materials, public communication, program descriptions, etc.	- Recognition of diversity of community in vision, mission and materials - Commitment to responsiveness in mission, vision, etc. - Inclusion in orientation materials	1, 4.
2. Human resources	- What approach(es) to staff cultural diversity are taken (monocultural, matching, representation, diversity)? - What policies are in place to "recruit, retain and promote" a culturally diverse staff/governing body at all levels of the organization? - Are there consequences for lack of cultural "competence", discriminatory attitudes? - Is there an anti-discrimination policy? - How are complaints handled?	- Human resource policies and practices - Workforce audit - Volunteer program and policy - Board, committee Terms of Reference, - Recruitment strategies, hiring guidelines - CHSA accreditation results (leadership) - staff, board, volunteer orientation materials	- Intercultural skills included in job descriptions - Workforce audit in place - Specific policies related to employment equity, affirmative action, etc.	2, 3, 5.

*Dimensions: 1. Definition of culture/cultural group; 2. provider competence vs. client/org access; 3. multicultural vs. antiracist vs. equity; 4. individual or organizational intervention, 5. voluntary or required, 6. approach to cultural training, 7. approach to human resource management.

APPENDIX D: MATRIC OF DOMAINS AND DIMENSIONS

3. Education and Training	- What are the cultural training requirements and to whom do they apply? - What is the philosophy and content of training? - What is the response to training? - What is community involvement in training?	- Human resource training policy. - Curricula for cultural/diversity training - Evaluation process and results - Training records - Volunteer program and board training	- What training is required and by whom. - Key elements of training (checklist) included	1, 3, 4, 5, 6, 7
4. Language Access services	- Does the organization require use of a qualified interpreter? - What strategies are in place to meet language needs of clients? - What resources are provided to support language access? - What protection is given to patient rights to informed consent and confidentiality? - How are responses to language access perceived at various levels within the organization? - What strategies are in place for quality control? - Does policy and practice recognize the complexity of language interpretation?	- Policy and procedures on interpreter use (list of key elements) - Language access program descriptions - Records on services provided - Job descriptions for interpreters - Strategic plan - Languages in which client information available - Training and evaluation requirements for interpreters - Budget	Key elements: - Payment by institution - Providers required to use - Information on rights to interpreter in languages of community - Assessment and evaluation process in place - Policy re family, volunteers, staff	1,2, 3,4, 5,

Dimensions: 1. Definition of culture/cultural group; 2. provider competence vs. client/org access; 3. multicultural vs. antiracist vs. equity; 4. individual or organizational intervention, 5. voluntary or required, 6. approach to cultural training, 7. approach to human resource management.

APPENDIX D: MATRIC OF DOMAINS AND DIMENSIONS

5. Information for clients and community	- To what extent does the organization provide materials in the languages of the community? - Does information address the specific demographic, cultural issues of the community? - What safeguards are in place re: accuracy and appropriateness? - How is the community involved?	- Lists of patient related materials - Lists of resource available in other language - Signage in other languages - List of culture specific materials - Guidelines for translation/ development or use of translated materials - Strategic plan	- List of available patient resources - # of resources in other languages - Community specific materials	1, 2, 4, 5
6. Organizational framework, integration	- To what extent is cultural responsiveness integrated throughout the organization? - Are staff at the program level aware of and supportive of organizational policy? - - How is organizational policy operationalized? - What accountability structures are in place?	- Plan and support structure for cultural responsiveness - Inclusion of responsiveness in strategic plan - Organizational chart - Diversity Committee and reporting structure - CCHSA results - Board, senior management and key committee agendas	-Diversity committee in place -Decision making power of committee -Identifiable person responsible at senior level -CR included in key aspects of strategic plan	1, 2, 4, 5, 6, 7

*Dimensions: 1. Definition of culture/cultural group; 2. provider competence vs. client/org access; 3. multicultural vs. antiracist vs. equity; 4. individual or organizational intervention, 5. voluntary or required, 6. approach to cultural training, 7. approach to human resource management.

APPENDIX D: MATRIC OF DOMAINS AND DIMENSIONS

7. Data Collection, evaluation and research a) Collection of data on individual clients b) Collection of data on communities c.) Research and evaluation	- Has the organization undertaken any assessment in the past? If so what have been the results? - To what extent are cultural minorities included in research and evaluation activities? - What data on ethnic variables are maintained? - What are the attitudes of policy makers and providers to collection of such data? - What information on the community served is available within the organization To what extent is it used in planning? - How are communities involved in needs assessment, research and evaluation?	- Copies of tools used in past, resulting action plans and progress reports. - CCHSA results - Strategic plan - Patient satisfaction forms - Results of other evaluation activities - Patient information forms - Management information systems and planning - Demographic profiles - Strategic plan - Local research reports; program evaluations. - Research/evaluation guidelines	- Client evaluation forms different languages - Research policy that addresses participation of specific cultural/ language groups - Presence of ethnic identifiers - Analysis of data by cultural group	1, 2, 4,5
8. Participation of Community	- What strategies are in place for community participation? - What are perspectives of internal stakeholders on such participation? - What are perspectives of advocates/representatives to such participation?	- Formal linkages, evidence of informal participation at various levels. - Terms of reference, board and key committees	- # and range of groups involved; - - role of community reps (governance, program dev., evaluation, consultation, receipt of information)	1, 5

*Dimensions: 1. Definition of culture/cultural group; 2. provider competence vs. client/org access; 3. multicultural vs. antiracist vs. equity; 4. individual or organizational intervention, 5. voluntary or required, 6. approach to cultural training, 7. approach to human resource management.

APPENDIX E

DRAFT 3: Role of "Cultural Responsiveness" Steering Committee

The "Cultural Responsiveness" Steering Committee is an ad hoc committee appointed by the Program Management Team to liaise with the research study: *"Assessing the Responsiveness of Health Care Organizations to Culturally Diverse Groups"*. The committee will remain in existence until the project is completed (target date for completion: summer 2003).

The functions of the committee are to:
- Act as liaison between "Cultural Responsiveness" study and Program Management Team
- Assist the investigator to obtain access within (NAME OF FACILITY)
  - o Act as liaison between project and staff
  - o Provide practical assistance to project implementation as required.
- Provide consultation to investigator on project communication plan, sampling strategy, identification of resources and implementation of the project
- Provide guidance on issues affecting project implementation as required
- Identify to the investigator potential organizational issues that may affect project implementation and effectiveness
- Develop a plan/recommendations regarding communication of results within the organization
- Evaluate the process of collaboration on student research projects, and make recommendations for future activities.

Frequency of meetings: Every two months or at the call of the chair.

Reporting: The "Cultural Responsiveness" Committee reports to the (NAME OF FACILITY/PROGRAM) Program Management Team.

APPENDIX F: FACILITY WEB SITE POSTING

Assessing the Responsiveness of Health Care Organizations to Culturally Diverse Groups

Many working in the health care system recognize that services must be responsive to the needs of culturally diverse patients and their families. Several tools have been developed to help organizations assess the cultural responsiveness of their programs and services. However, few of these tools have been developed in Canada, and it is not clear whether the results obtained from these assessments are valid or accurate.

To address this need, Sarah Bowen, a PhD candidate with the Department of Community Health Sciences, University of Manitoba, is conducting a research project "Assessing the Responsiveness of Health Care Organizations to Culturally Diverse Groups" that will address the following questions:

- How can indicators of "best practice" in responsiveness to the needs and priorities of culturally diverse and marginalized groups be incorporated into a policy/document assessment tool?

- Are the results of a document review consistent with findings obtained through other methods (such as interviewing staff)?
- What effects does undertaking such an assessment have within organizations?

The Program Management Team of (NAME OF FACILITY) and the (NAME OF HEALTH COMPLEX) Research Impact Committee have approved the project, and agreed that (NAME OF FACILITY) will be the test site for the draft assessment instrument. The proposal has also received ethical approval from the Health Research Ethics Board, University of Manitoba.

The investigator has designed a policy / document assessment tool, based on best practices identified in the literature. This tool is intended to assess the responsiveness of organizations to culturally diverse groups. The Steering Committee of the National Network for Cultural Competency in Paediatric Health Care is providing expert review of the draft instrument. (The executive summary of a background paper prepared by Sarah Bowen, which contributed to the National Initiative for Cultural Competence in Paediatric Health Care, along with background on this initiative, are available at http://www.caphc.org/partnerships_cultural.html).

The instrument is now being applied in one setting –(NAME OF FACILITY)– with additional input being obtained from other paediatric hospitals through the participation of the Steering Committee of the National Network.

Organizational policies and other documents identified in the assessment instrument are currently being collected. After reviewing and analyzing the documents, the investigator will invite some members of the (NAME OF HEALTH REGION) board, management and hospital staff (as well as family and community representatives) to participate in individual interviews or focus groups. This phase of the research (scheduled to take place between March and June 2003) is intended to obtain additional input and feedback on the results of the document review process, and will assist in determining whether the results of this review give an accurate picture of the approaches and activities of the hospital. This information will be used to develop recommendations on whether a document review process is a useful strategy in assessing organizational responsiveness to diverse cultural groups, and should also be used in other hospitals.

Upon completion of the project, the final report of the study will be provided to (NAME OF FACILITY) Program Management Team. The investigator will also schedule a presentation on study findings if there is interest within the hospital. It is hoped that information learned from this study will help the (NAME OF PROGRAM) Program better understand and respond to individuals from diverse backgrounds.

The (NAME OF PROGRAM) Program Team has appointed a steering committee, consisting of (LIST OF NAMES OF COMMITTEE MEMBERS) Regular reports on the project are provided to the (NAME OF PROGRAM) Program Team.

If you have any questions about the project, or would like to make a suggestion, please contact: Sarah Bowen (Project investigator) (email address and phone number) or (NAME), Chair of Site Advisory Committee) (email and phone number).

What makes a (facility) responsive to patients and families from diverse backgrounds?

How can this responsiveness be measured?

To help answer these questions, a research study is now underway. The project researcher is looking at policies and other documents from (Name of Facility) to see what these written materials can say about how well the hospital is meeting the needs of patients, families and staff from diverse cultures. It is hoped that information learned from this study will help the (Name of Program) Program better understand and respond to the needs of individuals from diverse backgrounds.

Between March and June 2003, the researcher will also be interviewing some staff individually, and holding focus groups with staff and community representatives. Staff will be contacted directly if they are chosen to participate in these activities. The purpose of the interviews and discussions is to compare the results of the document review with the experience of staff and families. Do the two approaches (reviewing documents and talking directly to families and staff) paint the same picture?

The (Name of Facility) Program Management Team and the (Name of Health Complex) Research Impact Committee have approved this project.
Additional information is available on the on the (Name of Facility) website at (web site address).

If you have any questions about the project (or would like to make a suggestion) please contact the project researcher, Sarah Bowen at (phone number), or by email at (website address).

Sarah Bowen, the project researcher, is a PhD candidate, Department of Community Health Sciences, University of Manitoba.

APPENDIX H

LIST OF MATERIALS REVIEWED AT TEST SITE

POLICY AND PROCEDURES MANUALS

1. **Corporate policies and procedures**
   a. Table of Contents
   b. Introduction
   c. Culture related policies
      i. Inuit people, service to
      ii. Native people, service to
      iii. Admission of uninsured patients

2. **Human Resource Policy and procedures (Health complex)**
   *See also Aboriginal Services
   *See also Employment Systems Review
   *See also Education and Training
   a. Table of Contents
   b. Introduction
   c. Mission statement
   d. Aboriginal Knowledge Preference Clause (found on intranet, not in manuals)
   e. Employee orientation
   f. General Holidays
   g. Recruitment – non-discrimination
   h. Educational Verification
   i. Education/professional development leave (draft Nov. 2002)
   j. Reimbursement for Courses (all non-union employees) (draft)
   k. Guidelines, Management Performance Review Process
   l. Performance Management
   m. Employee Complaint/Grievance Procedures
   n. French language policies
      i. Recruitment to designated French language positions
      ii. French language proficiency testing
      iii. Educational leave, French language training
      iv. Course reimbursement – French language training
   o. Aboriginal Voluntary Self Declaration Form
   p. Aboriginal Human resource Initiative
      i. Materials from regional website

3. **Nursing Policy and procedures**
   a. Table of Contents
   b. Preface

4. **Patient Care policies and procedures**
  a. Table of Contents
  b. Critical elements applied to all patient care policies and procedures
  c. Consent policy (in separate file)
  d. Interpretation policy (in Language Policy file)
  e. Alternative Care: Provision of

OTHER RESOURCES

5. Aboriginal Services (see also Staff training and development – culture)
  a. Fact Sheet: Aboriginal Health Services
  b. Patient Intake Referrals
  c. Aboriginal Health Services Patient/Referral/Consult form
  d. Chart of Aboriginal health services department
  e. Regional job descriptions
      1. Program Manager
      2. Regional Aboriginal Patient Advocate
      3. Aboriginal Liaison worker
      4. Aboriginal regional spiritual/cultural care Coordinator
      5. Patient site coordinator
      6. Regional discharge coordinator
  f. Pamphlets
      i. Aboriginal Health Services
      ii. Aboriginal Health Services – Advocacy
      iii. Aboriginal Health Services – Language and Translation Services
      iv. Aboriginal Health Services – Spiritual and Cultural care
      v. See also Language Services
  g. Continuum of Care Strategy – Aboriginal health services – Binder
      i. See also regional terms of reference
  h. Report of the Aboriginal Services Review committee
  i. Health Complex Aboriginal Affairs Committee Terms of Reference 2001

6. Annual Reports
  a. (Name of Facility) Foundation
  b. Health Complex
  c. Health Region (see health region files)
  d. 2002 Annual Report to the Community, (Name of facility) Foundation

7. Code of conduct
  a. From cultural transformation binder

8. Committee terms of Reference (Staff)
  a. List removed to mask site

9. Committee Terms of Reference (Community)
  a. List removed to mask site

10. Complaints/Conflict Resolution
   a. Description from organization website
   b. Complaint Data Collection Form
   c. Regional Policy and Procedure: Client Complaints Management System
   d. Occurrence Report
   e. Patient Representative Office (Health complex) Record of Patient Contact

11. Consent
   a. Informed Consent Policy (from Patient Care Policy and Procedure manual)
   b. Admission Agreement
   c. Foreign Resident Agreement

12. Employment Systems Review
   a. Selected documents

13. Information for professionals
   a. Names removed to mask site

14. Information for public/clients
   a. General website
       i. Departments and Services
   b. Family Advisory Committee (pamphlet)
   c. Name of Facility (pamphlet)
   d. Learning through play (Child Life Department) (pamphlet)
   e. Music Therapy program (pamphlet)
   f. Family Information Handbook
   g. (Name of Province) Child Injury Prevention News, Winter 2002
   h. (Name of facility) Clinic Newsletter, Fall 2002
   i. Report to the Community, (Region, Spring/Summer, 2002)
   j. Research from bench to bedside
   k. (Health complex) Patient Services and Information Directory
   l. (Health complex) Foundation: The practice of good medicine, March 2003
   m. Additional resources: Names removed to mask site

15. Information Systems
   a. Application for Employment (demographic info collected on staff)
   b. Nursing Data Base
   c. Clinic Registration Form
   d. Emergency Documentation form
   e. Provincial Health Day Care abstract

16. Language Policy and Services
   a. French Language Policy – (Name of Facility) Corporate Policy and Procedures manual)

    b. (Name of Facility) Multidisciplinary Patient Education Committee Policy: French language translation

    c. Information sheet: French language services

    d. Info sheet French language services – Interpreter services (procedures for requesting)

    e. Info sheet – French Language Services – Interpreter's Guide

    f. Announcement: Associate to CEO French Language Services

    g. Interpreter Network September 2002 (list of designated staff available for interpretation)

    h. Job description: Aboriginal Interpreter/Resource Worker

    i. See Also:
          i. Interpretation Service Policy (HSC Patient Care P and P manual)
         ii. French language policies (HR Policy and procedures manual)

    j. Regional Policy and procedures: Communications in Official languages

17.   Mission, Vision, Values

    a. Facility Mission (website), Vision, Family Centred Care position statement

    b. Health complex Mission

    c. Regional Mission, Vision, Values and Principles

    d. Family Centred Care info sheet

    e. See also
          i. (Health Complex) Annual report
         ii. Facility website
        iii. Draft Mission, Vision in Programs and Services

    f. Child Health Mission and Visioning Process Staff Feedback Fall 2002.

18.   Organizational Charts

    a. Region 2001

    b. Slide presentation (Facility)

19.   Patient Education

    a. Facility Patient Education Manual
          i. Introduction
         ii. Index
        iii. Family Information Library – Pamphlet Clearing House Pamphlets by subject, 2002
        iv. Patient Education Standards for Written Materials Used for Teaching Adults and Children

    b. Circle of Smiles Campaign

20.   Program/Service Evaluation

    a. (Name removed to mask site) Child Health Program Final Report May 2001

    b. Child Health Operating room report

    c. Wait times

    d.   Analysis of Orthopedic Reduction data
    e.   Assessment of Family-centred care at (Name of Facility)
    f.   Assessment of Family-centred care at (Name of Facility) PICU
    g.   Analysis of the Family Centred Care In Hospitals Self-Assessment Inventory, Executive Summary
    h.   Review of Aboriginal Services at the (name of two health complexes)

21.   Programs and Service Descriptions/PR
    a.   PowerPoint presentation, November 2002
    b.   (Name of facility) information package
    c.   Child Development Clinic, General Information for Referring Professionals
    d.   Diagnostic Services for Alcohol and Drug Exposed Children

22.   Quality
    a.   See also committee terms of reference
    b.   See also program evaluation
    c.   Facility Quality team: Balanced Scorecard
    d.   AIM quality dimensions

23.   Research Policy/Guidelines
    a.   Terms of Reference, (Health Complex) Nursing Research Committee

24.   Research Studies
    a.   (Health complex) Nursing Research Activities and QI projects (intranet)
    b.   Final Report, Review of Aboriginal Services April 2001
    c.   Second draft of the Evaluation of Cross Cultural Awareness Training, May 13, 1998

25.   Spiritual Care
    a.   (Health Complex) program description, website
    b.   Baptism of Infants and Children 1998

26.   Staff Orientation
    a.   Welcome to(Name of Facility): Staff Orientation Handbook
    b.   (Health Complex)-Wide Nursing Education Program Update: July 17, 2002
    c.   Foundations of Child and Women's Health Nursing Practice Course Content, draft 5
    d.   Foundations of Child Health Nursing Practice Course Content Objectives, draft 6, November 2002.

27.   Staff training and Development - Cultural Training
    a.   Summary list of educational programs and services (website)
    b.   Aboriginal Cultural Awareness Education (website & printed)
    c.   Aboriginal Culture Awareness Training: Participant Manual , 1998

    d. Statistics on HSC Staff participation in Aboriginal Culture Awareness program
    e. Aboriginal Culture Awareness Workshop – HSC Participation 1996-2001
    f. Aboriginal Culture Awareness Workshop – Attendance 2001-2002
    g. Aboriginal cultural Awareness: Training Program Needs Assessment
    h. Aboriginal Cultural Awareness Workshop Content and Agenda
    i. See also Research reports

28.   Staff Training and Development - general
    a. (Health Complex) Education Services Staff Development and Education Courses, Fall-Winter 2002
    b. Education Services – Program Report, Sep 2002-Mar2003
    c. Proposal (Health Complex) – Orientation project

29.   Strategic, Business and Operational Plans
    a. Regional Program 3 year business plan to 2005/2006, Child Health Program
    b. Regional Priorities and Initiatives, 2001/2002 (Website)
    c. Regional Goals, Measures and Strategies
    d. Family Centred Care Implementation plan
    e. Health Complex Goals and Objectives, 2002-2005
    f. Strategic Plan for Child Health 2003-2005: Working document: responding to Health Complex Goals and Objectives

30.   Volunteer program
    a. Volunteer Services Goals and objectives, 2000-2001
    b. Volunteer Policies
    c. Volunteer Handbook

Health Region Documents

31.   Regional Board Agendas and Minutes
    a. Board resource binder Table of Contents
    b. Current fiscal year

32.   Regional Committee Terms of Reference
    a. Ethics Committee
    b. Population Health Committee
    c. Programs/Services Committee
    d. Continuum of Care strategy Planning Working Group; Health status working group, Accessibility Working Group.
    e. See also specific population groups

33.   Regional Policy
    a. See also Language
    b. See also Complaints/Conflict

34.   Regional public materials
      a. Access (name omitted)
      b. Annual report, 2001/2002
      c. Child and Adolescent Mental Health Program

APPENDIX I: LETTER TO POTENTIAL INFORMANTS

Date

Dear

I am writing to invite you participate in an individual interview as part of the research project *"Assessing the Responsiveness of Health Care organizations to Culturally Diverse Groups"*. As you may be aware, the objective of this project, which is based at (Name of facility), is to determine whether a review of organizational policies and other documents is a useful strategy for assessing such responsiveness. More information is available through the (Name of facility) website (website address).

The Program Management Team of (Name of Facility) and the (Name of Health Complex) Research Impact Committee have approved the project, and agreed that (Name of Facility) will be the test site for the draft assessment instrument. The proposal has also received ethical approval from the Health Research Ethics Board, University of Manitoba. The National Network for Cultural Competency in Paediatric Health Care is acting as the expert panel for review of the assessment instrument.

The first two phases of the project (development of a draft assessment instrument, and analysis of materials collected from Name of Facility) have now been completed. The next phase of the project involves interviews with key informants with expertise and responsibility in key areas identified in the assessment instrument. The purpose of the interviews is help determine to what extent the findings of the document review are reflective of actual approach and practice in the area of cultural responsiveness.

Most of the individuals selected for interviews will be from (Name of Facility), but some staff, management and board members of the (the region and health complex) will also be invited to participate. Suggestions for individuals to be interviewed have come from a number of sources: my review of organizational responsibility areas; the Program Management Team and the project steering committee; and other interviewees. The list of those I have chosen to invite to an interview from among this list is, however, confidential.

The objectives of the interview are to:
- confirm that all relevant organizational documents have been identified
- explore knowledge, attitudes, and approaches to cultural responsiveness of key stakeholder groups
- explore perspectives on the level of responsiveness achieved by the organization
- assist in planning for the final phase of the project (focus groups).

Participation in the project is completely voluntary, and your decision to participate will not be shared by me with any other person. You are also authorized to participate in this project on work time. However, it is recognized that it will be necessary for some interview participants (e.g. those scheduled to specific shifts of direct patient care) to notify their supervisor of their participation if they wish to participate on work time. Should these individuals agree to participate, they have two options. One option is to meet outside of work time (in which case confidentiality of participation can be provided). The other is for staff to notify their supervisor, in order to be released during work time. If it is necessary for staff to obtain such permission, I will be happy, at their request, to make arrangements with their supervisor. Interviews are anticipated to take from 45 minutes to one hour.

Please let me know if you would be willing to participate in an interview for this project. I can be reached by phone at (phone number), or by email at (email address). For your information, I have included a copy of the Information and Consent form for the interview. This provides more information on the project, and outlines the safeguards taken to protect confidentiality of participants.

If you have any further questions about the project, please do not hesitate to contact me. If I do not hear from you by (insert date), I will contact you at (recipients phone number) to determine your interest.

Thank you for your support of this project.

Sincerely,

Sarah Bowen, B.A., M.Sc.

APPENDIX J

UNIVERSITY OF MANITOBA | Faculty of Medicine

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

INTERVIEW

Title of Study:
Assessing the Responsiveness of Health Care Organizations to Culturally Diverse Groups.

Principal Investigator: Sarah Bowen, M.Sc.
Department of Community Health Sciences,
University of Manitoba
750 Bannatyne Avenue, Winnipeg, MB R3E 0W9
Phone: (204) 774-6121.

Co-Investigator: Dr. Joseph M. Kaufert
Department of Community Health Sciences
University of Manitoba
750 Bannatyne Avenue, Winnipeg, MB R3E 0W9
Phone: (204) 789-3798.

You are being asked to participate in a research project. Please take your time to review this consent form and discuss any questions you may have with the investigator(s). You may discuss your decision about participating in this study with your colleagues or supervisor before you make your decision. Please ask one of the investigators listed above to explain any information that you do not clearly understand.

Purpose of Study

This research study is being conducted to develop and trial the use of a policy/document analysis tool designed to assess the responsiveness of health care organizations to culturally diverse populations. The impact of such assessment on the organization, and potential for the assessment process to promote development of cultural diversity initiatives will also be explored. The results of the study will be used to develop recommendations for strategies for assessment of organizational responsiveness to diverse cultural groups. This is an independent study conducted by Sarah Bowen, a Ph.D. candidate in the Department of Community Health Sciences, under the supervision of Dr. J. Kaufert.

ASSESSING THE RESPONSIVENESS OF HEALTH CARE ORGANIZATIONS TO CULTURALLY
DIVERSE GROUPS

1 of 4

Participant's initials_____

18/03/2004

The (NAME OF ORGANIZATION) has agreed to provide the site for a trial of this instrument, and has given permission for staff to participate. This trial is focused on one program area, the Child Health Program. The National Network for Cultural Competency in Paediatric Health is also collaborating in this activity, and has provided expert review of the draft instrument.

The study consists of two major components. The first component involved developing the research tool based on best practices identified through a critical review of the research literature. This instrument was used to review (NAME OF REGION, HEALTH COMPLEX AND FACILITY) documents in order to assess organizational responsiveness in eight categories: a) human resource management; b) diversity training; c) language assistance services; d) information for clients and communities; e) an organizational framework to support cultural diversity initiatives; f) data collection, evaluation and research; g) community participation; and h) the general profile of issues of culture and diversity within the organization). This phase of the project has been completed and preliminary analysis of the documents undertaken.

The second phase of the study, in which you are being invited to participate, is exploring the validity of these initial findings through consultation with various stakeholder groups (ORGANZIATION Board, management, and staff, union representatives, and representatives of community organizations and client advocacy groups). The NAME OF ORGANIZATION has given approval to these activities, including permission for staff to participate on work time. Individual semi-structured interviews and focus groups will be conducted in order to explore the perspectives and practice of stakeholder groups regarding organizational responsiveness to culturally diverse groups; knowledge of, and support for, organizational policy; acceptance of assessment findings; and recommendations for future activities.

A total of 30-50 participants will participate in this study, either in individual interviews or focus groups.

Study procedures

You are being invited to participate in an open-ended, semi-structured interview conducted by Sarah Bowen, the principal investigator. Participation in this activity is voluntary, and you may decline to participate. This interview will take 45 minutes to 1 hour. The interview will be scheduled at a time and in a place convenient for you. Interviews will explore the perspectives of various stakeholders on organizational responsiveness to diverse cultural groups; gather information on current practice; and explore other sources that should be included in the assessment.

You may, over the course of project be contacted for follow-up questions. You may decline to participate in these follow-up activities. Following completion of the project, you will not be required to participate in any follow-up activities.

ASSESSING THE RESPONSIVENESS OF HEALTH CARE ORGANIZATIONS TO CULTURALLY DIVERSE GROUPS

Participant's initials_____

If you agree to participate in this study, you may withdraw your participation at any time, or decline to answer any question.

The final report of the study will be provided to the (NAME OF ORGANIZATION). An abstract of the report will be sent to all interview and focus group participants with information on where the full report may be obtained. A presentation on study findings will be scheduled if there is interest from participants.

Risks and Discomforts
No research study is without risks. Because of the small number of individuals participating in interviews, there is always some risk that some of the opinions, discussions or events reported may be recognized or linked to you in some way. If you request to participate in the project on work time, your manager will know that you participated in the project. You may feel some discomfort or anxiety in being asked to respond to questions on this topic. However, you may decline to respond to any question.

Benefits
There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will help the Child Health Program of the (REGION), the (REGION) in general, and other health organizations in Canada by providing a tool for assessing their responsiveness to culturally diverse populations.

Costs
None

Payment for participation
You will receive no payment or reimbursement for taking part in this study. Staff of the WRHA are, however, authorized to participate in the study on work time.

Confidentiality – Individual interviews
No personal information will be gathered in this study. All information gathered will be kept confidential. Participants are authorized to participate in the interviews on work time. Depending on your position, you may be required to request time away from your shift from your supervisor: this would require that your supervisor be aware of your participation. Alternately, if you wish your participation to be completely confidential, you may arrange for the interview to take place outside of work hours. The investigator will not share your decision to participate, or decline to participate with any other person and only the investigator will have access to interview notes. Notes on interviews will be identified by a code only, and stored in a locked cabinet in the investigators private office.

Information gathered in this research study may be published or presented in public forums, however your name and other identifying information will not be used or revealed. Despite

ASSESSING THE RESPONSIVENESS OF HEALTH CARE ORGANIZATIONS TO CULTURALLY DIVERSE GROUPS

1 of 4

Participant's initials_____

efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed. The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

Voluntary Participation/Withdrawal from the Study
Your decision to take part in this study is voluntary. You may refuse to participate, decline to answer any question, or withdraw from the study at any time. Your participation or lack of participation will not influence your employment with the (ORGANIZATION) in any way.

Questions
You are free to ask any questions that you may have about your rights as a research participant. If you have any questions now or after the study, contact the investigator Sarah Bowen at (204) 774-6121, or her supervisor, Dr. Joseph Kaufert, at 789-3798.

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389.

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

Statement of Consent
I have read this consent form. I have had the opportunity to discuss this research study with Sarah Bowen or Dr. Joseph Kaufert. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board, for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I agree to participate in an individual interview for the project *Assessing the Responsiveness of Health Care Organizations to Culturally Diverse Groups*.

Participant signature_____   Date _____

Participant printed name: _____

ASSESSING THE RESPONSIVENESS OF HEALTH CARE ORGANIZATIONS TO CULTURALLY DIVERSE GROUPS

1 of 4

Participant's initials_____

18/03/2004

APPENDIX K

SAMPLE INTERVIEW GUIDE

Review objectives of key informant interviews

- confirm that all relevant organizational documents have been identified
- explore knowledge, attitudes, and approaches to cultural responsiveness of key stakeholder groups
- explore perspectives on the level of responsiveness achieved by the organization
- assist in planning for the final phase of the project (focus groups).

Review consent and information form
- Review objectives of project, address any questions. Stress that the assessment is not of the facility, but of the assessment instrument.
- Review consent, stressing voluntariness and strategies to ensure confidentiality

General Questions:
1. The vision statement of (facility) and many other documents refers to a commitment to *"cultural sensitivity"*. How do you interpret this?

2. Given the number of challenges facing health care providers today, how important do you feel "cultural responsiveness" is? Why do you feel this?

3. To your knowledge, has this organization undertaken any activities to assess the cultural responsiveness of (facility)?

4. When people use the expression *culture*, or *cultural group* they often have particular practical definitions in mind.
    o In your position as _____ how would you define these terms?
    o In your opinion, how are these terms understood by staff of the organization? (Probe, disability, poverty, religion, sexual orientation)
    o In your opinion, which "cultural groups" should be included in CR initiatives?

5. How would you describe the approach and position of (facility/region) in addressing issues of cultural responsiveness?

6. Are you aware of specific national or international standards and best practice related to cultural responsiveness of health organizations?

7. How successful do you feel (the organization) has been meeting best practice standards in cultural responsiveness. Probe
    o Do you think there has been improvement over time?
    o What do you think needs to be done in this area?
    o What are the organizational supports, barriers to such actions?

  ○ What are areas of strength?

8. What implications do you feel that improved responsiveness to culturally diverse groups would have for (specific area) In other words, what do you see as needing to be done in _____ to increase cultural responsiveness?

9. As you know the purpose of this study is to determine whether a document review is a useful strategy to assess cultural responsiveness. I have gathered a number of materials from (facility, health complex, region) identified in the assessment document. For example in your area I have identified *(insert list)*
  ○ Are there any other policies, guidelines, program / service descriptions, research or reports that deal with cultural diversity etc.
  ○ Are there any initiatives in this area, or unofficial policy or practice that you think I should know about?
  ○ Do you think that the policies, documentation *(give specific examples related to area)* I have located accurately reflect the **policy** of the organization? What might be missing? Probe.
  ○ Do you think that the policies, documentation accurately reflect the **practice** of the organization?

Specific Questions based on analysis of documents, and role of informant:

Examples:

10. What formal linkages does the (parent committee) have with community-based groups?

11. Are you satisfied with how the (specific initiatives) have been able to include families from diverse cultural backgrounds?

Closing questions
12. Is there another individual or position within the organization who should be included in these interviews?
13. Is there anything else you think I should know?
14. Any other questions you think I should be asking?

APPENDIX L

Department of
Community Health Sciences
750 Bannatyne Avenue
Winnipeg, Manitoba
Canada R3E 0W3
Fax (204) 789-3905

UNIVERSITY
OF MANITOBA | **Faculty of Medicine**

RESEARCH PARTICIPANT INFORMATION AND CONSENT FORM

FOCUS GROUP

Title of Study:
Assessing the Responsiveness of Health Care Organizations to Culturally Diverse Groups.

Principal Investigator: Sarah Bowen, M.Sc.
                                  Department of Community Health Sciences,
                                  University of Manitoba
                                  750 Bannatyne Avenue, Winnipeg, MB R3E 0W9
                                  Phone: (204) 774-6121.

Co-Investigator: Dr. Joseph M. Kaufert
                                  Department of Community Health Sciences
                                  University of Manitoba
                                  750 Bannatyne Avenue, Winnipeg, MB R3E 0W9
                                  Phone: (204) 789-3798.

You are being asked to participate in a research project. Please take your time to review this consent form and discuss any questions you may have with the investigator. You may discuss your decision about participating in this study with your colleagues or supervisor before you make your decision. Please ask one of the investigators listed above to explain any information that you do not clearly understand.

Purpose of Study

This research study is being conducted to develop and trial the use of a policy/document analysis tool designed to assess the responsiveness of health care organizations to culturally diverse populations. The impact of such assessment on the organization, and potential for the assessment process to promote development of cultural diversity initiatives will also be explored. The results of the study will be used to develop recommendations for strategies for assessment of organizational responsiveness to diverse cultural groups. This is an independent study conducted by Sarah Bowen, a Ph.D. candidate in the Department of Community Health Sciences, under the supervision of Dr. J. Kaufert.

ASSESSING THE RESPONSIVENESS OF HEALTH CARE ORGANIZATIONS TO CULTURALLY
DIVERSE GROUPS

1 of 4

Participant's initials_____

18/03/2004

The (NAME OF ORGANIZATION) has agreed to provide the site for a trial of this instrument and has given permission for staff to participate. This trial is focused on one program area, the Child Health Program. The National Network for Cultural Competency in Paediatric Health is also collaborating in this activity, and has provided expert review of the draft instrument.

The study consists of two major components. The first component involved developing the research tool based on best practices identified through a critical review of the research literature. This instrument was used to review (REGIONAL, HEALTH COMPLEX AND FACILITY) documents in order to assess organizational responsiveness in eight categories: a) human resource management; b) diversity training; c) language assistance services; d) information for clients and communities; e) an organizational framework to support cultural diversity initiatives; f) data collection, evaluation and research; g) community participation; and h) the general profile of issues of culture and diversity within the organization). This phase of the project has been completed and preliminary analysis of the documents undertaken.

The second phase of the study, in which you are being invited to participate, is exploring the validity of these initial findings through consultation with various stakeholder groups (WRHA Board, management, and staff, union representatives, and representatives of community organizations and client advocacy groups). The (NAME OF ORGANIZATION) has given approval to these activities, including permission for staff to participate on work time. Individual semi-structured interviews and focus groups will be conducted in order to explore the perspectives and practice of stakeholder groups regarding organizational responsiveness to culturally diverse groups; knowledge of, and support for, organizational policy; acceptance of assessment findings; and recommendations for future activities.

A total of 30-50 participants will participate in this study, either in individual interviews or focus groups.

Study procedures

You are being invited to participate in a focus group conducted by Sarah Bowen, the principal investigator. Participation in this activity is voluntary, and you may decline to participate. The focus group will take approximately 1 hour. It will consist of approximately 5-10 persons. Questions to be discussed in this meeting will focus on the initial findings from the document review; and perspectives on organizational barriers and facilitating factors which affect responsiveness to diverse groups.

You will not be required to participate in any follow up activities. If you agree to participate in this study, you may withdraw your participation at any time, or decline to answer any question.

ASSESSING THE RESPONSIVENESS OF HEALTH CARE ORGANIZATIONS TO CULTURALLY DIVERSE GROUPS

Participant's initials_____

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The final report of the study will be provided to the (ORGANIZATION). An abstract of the report will be sent to all interview and focus group participants with information on where the full report may be obtained. A presentation on study findings will be scheduled if there is interest from participants.

Risks and Discomforts

No research study is without risk. You may feel some discomfort or anxiety in being asked to divulge information on these topics in front of other participants in the focus group. However, you may decline to respond to any question.

Benefits

There may or may not be direct benefit to you from participating in this study. We hope the information learned from this study will help the Child Health Program of the (REGION) the REGION in general, and other health organizations in Canada by providing a tool for assessing their responsiveness to culturally diverse populations.

Costs

None

Payment for participation

You will receive no payment or reimbursement for taking part in this study. Staff of the (ORGANIZATION) are, however, authorized to participate in the study on work time.

Confidentiality – Focus Groups

No personal information will be gathered in this study. All information gathered will be kept confidential by the investigator. Only the investigator will have access to audiotapes and notes of the session, and audiotapes will be erased following completion of the study. All notes and tapes will be stored in a locked cabinet in the investigator's private office.

However, despite efforts to keep your personal information confidential, confidentiality cannot be guaranteed. Although focus group participants will be reminded of the importance of maintaining confidentiality of comments made within the group, the investigator cannot ensure the confidentiality of comments made in this forum.

Participants are authorized to participate in the interviews on work time. Depending on your position, you may be required to request time away from your shift from your supervisor: this would require that your supervisor be aware of your participation.

Information gathered in this research study may be published or presented in public forums, however comments made will not be linked to individual participants. The University of Manitoba Health Research Ethics Board may review records related to the study for quality assurance purposes.

ASSESSING THE RESPONSIVENESS OF HEALTH CARE ORGANIZATIONS TO CULTURALLY DIVERSE GROUPS

1 of 4

Participant's initials_____

18/03/2004

Voluntary Participation/Withdrawal from the Study
Your decision to take part in this study is voluntary. You may refuse to participate, decline to answer any question, or withdraw from the study at any time.

Questions
You are free to ask any questions that you may have about your rights as a research participant. If you have any questions now or after the study, contact the investigator Sarah Bowen at (204) 774-6121, or her supervisor, Dr. Joseph Kaufert, at (204) 789-3798.

For questions about your rights as a research participant, you may contact The University of Manitoba, Bannatyne Campus Research Ethics Board Office at (204) 789-3389

Do not sign this consent form unless you have had a chance to ask questions and have received satisfactory answers to all of your questions.

Statement of Consent
I have read this consent form. I have had the opportunity to discuss this research study with Sarah Bowen or Dr. Joseph Kaufert. I have had my questions answered by them in language I understand. The risks and benefits have been explained to me. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I authorize the inspection of any of my records that relate to this study by The University of Manitoba Research Ethics Board, for quality assurance purposes.

By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

I agree to participate in the focus group activity for the project *Assessing the Responsiveness of Health Care Organizations to Culturally Diverse Groups,* to take place on May 20, 2003 at 7:00 p.m.

I agree that this focus group may be audio-taped. Audiotapes will be erased once the study is completed.

Participant signature_____   **Date** _____

Participant printed name: _____

ASSESSING THE RESPONSIVENESS OF HEALTH CARE ORGANIZATIONS TO CULTURALLY DIVERSE GROUPS

Participant's initials_____

18/03/2004

APPENDIX M: FOCUS GROUP DISCUSSION GUIDE

Introduction
1. Ask for introductions
2. Review Project, any questions
3. Review Info and consent form, obtain consent
   a. Check consent for taping, turn on machine

Questions

1. The vision of the hospital refers to a commitment to "cultural sensitivity". What does this mean to you?

2. When people use the word "culture" or cultural group they often have very practical ideas in their head. When the staff of the hospital use the words, what do you think this means?

3. From what you have seen in your interaction with the hospital, how would you rate the level of Cultural Responsiveness of (facility) to different cultural groups?
   a. Probe: What is done well? What still needs to be done?

4. In your experience with the hospital, not just your own experience but from what you observe, do you think families from different cultural backgrounds are treated the same?
   a. Probe specific examples.
   b. A number of people have suggested to me that the whether the care received by families at the facility is "culturally sensitive" depends mostly on the individual provider, not on policy or approach of the organization. What is your opinion on this?
   c. How important do you think having policy in this area is?

5. One important area in provision of culturally responsive services is the provision of interpreters for those who cannot communicate in (English). I am wondering what you have observed about how language barriers are handled on a day-to-day basis?

6. It seems from my review so far, that there are there are different approaches, and different services for various groups – (give examples). Does this fit with what you observe or not?

7. Given all of the issues facing health care today, how important do you think cultural responsiveness to diverse groups is?

8. Is there anything else you think it might be useful for me to know?

APPENDIX N: FOLLOW UP SURVEY

ASSESSING THE CULTURAL RESPONSIVENESS OF HEALTH CARE ORGANIZATIONS TO CUTURALLY DIVERSE GROUPS

IMPACT/ASSESSMENT SURVEY
December 4, 2003

This survey is designed to assess the impact of the research project *Assessing the responsiveness of healthcare organizations to culturally diverse groups* on (name of facility). It is being distributed to (name of facility) staff members most involved with this project. Information gathered will be used help the steering committee plan any follow up needed and identify any issues that should be considered in sponsoring similar project. Results will also assist in developing recommendations for use of a document assessment instrument in other settings. Your time spent in completing this brief survey will be much appreciated.

Your responses are confidential. A collation of responses will be provided to the researcher.

Piloting of Instrument

1. Approximately how many hours do you estimate having spent since October 2002 related to this project? (*Do not include time you may have spent participating in an interview with the researcher*).

_____

2. Are there any other staff members to whom you have delegated tasks who should also be assessed?
__ No
__ Yes_____

3. Have you found the time spent a worthwhile investment for the information you have gained from it?
__ Yes
__ No
__ Don't know

4. Was there anything you learned through your involvement?

5.   Given what you know now, would you have supported the decision of
     Children's Hospital to sponsor the project?
     __Yes
     __No
     __Don't know
     Comments:_____

     --

6.   If another health centre were to ask you about the resource implications of
     undertaking a document review, what would you advise?

7.   To your knowledge has sponsoring this project had any effect on the activities
     of hospital (planning, awareness etc).
     __No
     __Don't know
     __Yes. (Please specify).

Response to site-specific findings:

8.   Did the findings reported back at the feedback session fit with the
     understanding you had of the approach and achievements of the hospital/HSC
     regarding Cultural Responsiveness *before* the project began?

     __Yes
     __No
     Comments:

9.   Do the findings, as you understand them, accurately reflect your *current*
     understanding of the approach and achievements of the hospital/HSC
     regarding Cultural Responsiveness?
     __Yes
     __No
     Comments:

10. What follow up do you think is needed?

APPENDIX O: DRAFT INSTRUMENT – REVISED

This revised draft is based on the experience of the initial pilot, which was conducted in only one site. Several adaptations should be noted:

1. Materials are organized by Domain area. There is some duplication of materials requested in each domain,

2. While the number of domains remains at eight, these have been reconfigured. Domains 5 (Information for the Community) and 8 (Partnership with the Community), have been combined, with some of the elements of Domain 5 being reassigned to Domain 4 (Language Access). In addition, the original Domain 6: Organizational integration has been divided into 2 separate domains: Domain 7: Infrastructure to support Cultural Responsiveness, and Domain 8: Organizational Integration.

3. It is not expected that every organization will have all of the materials requested in Column 1. However, absence of evidence should be noted as the assumption on which the instrument is based is that *if* appropriate infrastructure is in place there should be some evidence of identified best practice in organizational documents.

4. This draft does not include guidelines for implementation, which would be necessary for the instrument to be used effectively. It is therefore recommended that both the conceptual framework on which the instrument is based (Chapters 2-3), and the findings and recommendations arising from the pilot (Chapters 4-7) be reviewed carefully before there is any decision to implement in other organizations. It should be noted that this instrument is not designed for self-assessment alone, and it is recommended that the process of assessment be guided by an individual/team with expertise in this area. Contracting with organizational diversity expertise is recommended in order to a) provide objectivity, and b) ensure that expertise related to all domains and dimensions is available.

5. This instrument has not been "validated", and deliberately does not include a scoring key. It is intended to assist organizations in assessing the current organizational infrastructure in place to support cultural responsiveness, and to assist in education of board and staff regarding current "best practice" of culturally responsive organizations. The intent is to promote continual development: the tool is not to be used as a checklist.

6. The instrument is intended for use in a variety of Canadian health care organizations. It is assumed that it will need updating as general awareness of organizational best practice develops, and as more evidence on the effectiveness of various interventions and approaches becomes available. There is built in flexibility to respond to a number of different organizational contexts (see footnotes). Organizations are encouraged to include any other materials that may address these domains. Note however, that oral tradition, or informal but undocumented practice, should not be included. This is because unwritten policy tends to be discretionary, and organizational commitment is reflected in formalization into policy.

7. Guidelines for use of the instrument (Sections 5.8 and 7.2), should be reviewed. Strategies for ensuring ownership of the process at the highest levels (board and senior management), and for ensuring staff participation and feedback should be in place before the assessment is undertaken. The instrument is intended to be used in conjunction with Appendix P.

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Domain 1: General Profile

Documents to be reviewed	Key elements/questions	Comments
-Mission, vision, values statements -Organizational web site -Staff, board and volunteer orientation materials -Latest annual report -Reports to public, notices, advertisements[1] -Organizational program descriptions -Table of contents of Policy and Procedures Manuals	-Level 1. The diversity of the client community is recognized in profile documents Level 2. There is a stated commitment to cultural responsiveness in key documents (mission, vision, values, goals; staff, board, volunteer orientation materials, annual report). -Organizational and program descriptions reflect diversity of community -Content and visuals of materials directed towards public reflect a) diversity of community and b) commitment to cultural responsiveness	Materials in this domain should be reviewed for evidence of approach on all dimensions, with particular attention given to Dimension 1: *Definition of culture and cultural groups*.

-Combine with organizational environmental scan[2]	-Environment in public areas of the hospital
	  a) reflects diversity of community served (e.g. language of signage, décor, reading materials), and
	  b) facilitates awareness and participation of diverse groups (e.g. availability of information on access and interpretation services, complaint procedures, opportunities for community participation).	

[1] To be determined for each organization. Should include all information readily available to the public over the past year.
[2] A walk through of the public areas of the organization, preferably with community representatives and an external diversity expert is recommended to obtain a "picture" of how the environment is perceived by organizational outsiders.

Domain 2: Human Resources

Documents to be reviewed	Key elements	Comments
-Human resource policy and procedures manual -Human resource department vision, goals -Human resource strategic plan -Copies of current and recent job postings, with associated position descriptions[3] -Dissemination strategy for job postings -Performance evaluation guidelines; interview guidelines[4] -Volunteer program policy and guidelines -Workforce audit, related materials[4] -Template of employment equity or other "ethnic coding" data included in HR management system	-There is stated recognition of the value of, and stated commitment to, promotion and support of cultural diversity of workforce -HR policy and planning is consistent with commitment to cultural responsiveness noted in Domain 1. -There is specific anti-discrimination policy in place -There is an employment equity policy in place -Employment equity policy addresses both recruitment/selection of new employees and promotion of employees. -There is recognition of barriers to workforce participation of diverse cultural groups, and concrete strategies in place to address these at the organizational level[5] -There are mechanisms for community consultation and input in development of HR initiatives and in evaluation of organizational progress	These materials also to be reviewed for evidence of approach to Dimension 7: *Approach to HR Management*, Section 2.5.1.2 This Domain should also be reviewed for consistency with Dimension 1 (are cultural groups identified and included in initiatives. consistent with definitions and priorities identified in Domain 1?)

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[3] The postings included should include all those with patient contact, or direct supervisory authority over a designated time period. The time period may depend on the size of the organization. Large organizations would be required to include a shorter time frame due to the number of postings, but postings should be checked to ensure they include representative postings from all levels, disciplines and units.
[4] May not be available in all organizations

[5] e.g. removing non-relevant educational requirements, creation of non-traditional occupations (such as health educators rather than registered nurses to undertake community education and outreach), advocacy with licensing bodies.

-The strategy for staff/volunteer recruitment uses ethnic/alternate media as appropriate, as well as informal channels.
-Job postings and position descriptions require skills for working in diverse environments as relevant for position
-HR management systems collect data on employment equity categories and language capabilities
-The organization monitors employment equity initiatives through workforce audits and regularly revises strategic plans to address progress
-The organization has strategies and procedures in place to monitor and reward culturally responsive performance of employees
  -performance evaluation guidelines require review of cultural competence in applicable positions
-The organization provides guidelines for interviewing and selection of candidates that address barriers faced by candidates from underserved communities
  -alternate qualifications are considered
  - intercultural skills/experience considered an asset
	Cautions: It is not uncommon for organizations to have strong volunteer participation from underserved / culturally diverse groups, but maintain barriers to employment. This is a potentially exploitive situation. For this reason, organizational approach and progress for paid / volunteer staff should be compared.

Domain 3: Cultural Training

Documents to be reviewed	Key elements	Comments

-Policy related to cultural training
-Policy related to language training
-Outlines, objectives and related materials (activities, handouts) for cultural training program
-Records of cultural training attendance
-List of all inservice training offered over past year with outlines and objectives
-Organizational training plan
-Needs assessment and/or evaluations of cultural training programs
	<u>Level 1</u>
	-Cultural training is required of staff at all levels
	-Board members are required to participate in cultural training
	-Records are kept of cultural training,
	    -record of employee participation incorporated into HR records
	    -written strategies to address low participation in place
	-There is organizational policy that promotes and supports language/cultural skill development
	    -e.g. reimbursement of fees for language training in priority areas, credit given to cultural competence training in promotion
	-There is regular evaluation of cultural training program, and program is adapted as required.
	-Training includes elements identified through best practice review (See section 3.2.2)
	<u>Level 2</u>
	-Issues of cultural competence are integrated into relevant inservices.
	-The training plan for staff education a) highlights cultural responsiveness; b) integrates cultural responsiveness into overall training where appropriate.
	-Providers are trained in working with interpreters
		A key element of assessment in this domain is along Dimension 6: *Approach to Cultural training*, Section 2.5.1.1.
		
		Review of training materials is also necessary to determine organizational approach on Dimensions 3 *Multicultural/ antiracist orientation*, and Dimension 1: *Definition of cultural groups*,

Domain 4: Language Access

Documents to be reviewed	Key Elements	Comments

-Needs assessment of community language access needs
-Language access policy (includes interpreter, bilingual positions, use of bilingual staff)
-Language access program descriptions
-Procedures for interpreter use
-Records on language access service
-Interpreter/designated bilingual staff job descriptions
-Training and evaluation requirements for interpreters
-Budget for interpreter services
-Service information available in languages other than French or English
-Client consent forms
-List of patient information available in other languages
-Demographic information on language proficiency of community served
-Organizational web site
-Evaluations of interpreter services provided
	-There is organizational language policy and procedures in place that includes identified best practice elements (Appendix A)
	-There are job descriptions for interpreters in place
	-There are strategies for assessing the language and interpretation capabilities of interpreters
	-Evaluation processes include input from service users
	-Consent forms are available in key languages of community
	-Records are maintained on language access services
	   -comparison of records with estimates of need based on demographic figures
	-Information on rights to interpreter and how to access services is available in languages of community
	-Basic information on organizational services is available in languages of community
	-Information on the complaint process is readily available in the languages of the community
	-Patient education materials are available in key languages of community
	-There are guidelines consistent with current best practice regarding translation of materials
	-There are links from organizational web site in languages of the community to
	   -relevant community resources and language services
		This is a crucial domain for assessment of Dimension 2: *Provider Competence vs. Organizational Access*, Dimension 5 (*Voluntary or Required*), and Dimension 4: *Individual or Organizational Focus*.
		
		Include information obtained through walk-through of facility.

-List of external organizations providing interpretation / translation services - Information on languages provided - Standards, training, evaluation of interpreters - Mechanisms for liaison, complaints, evaluation - Budget allocated for services provided	-links to information in priority languages -Funding for interpreter services is included in organizational budget -There is regular evaluation of the model of interpretation services provided; budget allocation; documentation systems; and provider/client satisfaction with interpreter services -Community providers of interpretation services - utilize only trained interpreters - provide training that includes health specific information and skills (e.g. vocabulary, principles of informed consent and confidentiality, orientation to health services). -There is a clear process for coordinating requests for interpreters - There is a clear process for communicating and documenting difficulties - There is clear process for regular evaluation of services - There are written guidelines for providers in calling, using, and documenting use of community interpreters - There is a dedicated budget for interpreter use

Domain 5: Partnership with the Community

Materials to be reviewed	Key Elements	Comments
-Materials development policy and procedures -Planning policy and procedures -Charts indicating formal linkages with community groups, reporting structure -Board, committee terms of reference[6] -Patient satisfaction surveys and analysis -Records of meetings with community groups -List of community organizations and services to which referrals made.	-The strategic planning process requires consultation with the community, including cultural communities -Board and relevant committee terms of reference require participation of diverse cultural groups -There are formal linkages between community groups and board/senior management -There are strategies, developed in consultation with the community, for regular evaluation of organizational programs -There are regular meetings between senior management and community groups providing language and cultural access services -There are mechanisms, established with input of communities to monitor and address access issues -Strategies recognize the complexity of selecting community representatives (Section 3.2.4)	This domain is important for assessment of Dimension 2: *Provider competence or Organizational Access.* Also review for definition of cultural groups

[6] Key committees to be determined in consultation with organization.

Domain 6: Research and Evaluation

Materials to be reviewed	Key Elements	Comments
-Patient/client information template -MIS Strategic plan -Patient satisfaction instrument(s) -Select program evaluation activities[7] -Demographic profiles available in house -Local research reports[8] -Research / evaluation guidelines	<u>Level 1</u> -Ethnic identifiers are included in patient demographic data (language proficiency, Aboriginal, immigrant status, visible minority status) -OR there is a strategic plan in place to address use of ethnic identifiers -There is policy regarding collection of ethnic identifiers -Patient satisfaction instruments are available in most common languages of community -Planning and research activities incorporate community demographic information <u>Level 2:</u> -Analysis of access, quality and health outcomes incorporates ethnic identifiers -Where appropriate, research and evaluation incorporates questions of cultural responsiveness -There are guidelines and policy in place to ensure participation of underserved communities. -Cultural issues are included in patient satisfaction instruments	This domain is of importance in assessing the degree of integration of cultural responsiveness initiatives.

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[7] To be determined in consultation with the organization. Should include all relevant reports over the past 3 years.
[8] Includes contracted research and evaluation activities.

Domain 7: Infrastructure to Support Diversity Planning

Materials to be reviewed	Key Elements	Comments
-Organizational chart -Diversity strategic plan -Budget for diversity initiatives -Budget for language access services -Terms of Reference for diversity committee -Descriptions of specific diversity initiatives	-There is a diversity plan in place -Accountability for diversity initiatives rests at the highest levels of the organization -positions responsible for CR are given authority and status within the organization -Terms of Reference of diversity committees identify authority and provide direct access to organizational decision makers. -There is a dedicated budget for diversity initiatives -Diversity initiatives are based on evidence of need of underserved communities in catchment area.	It is important to compare findings from this domain with Domain 1. Dimensions 1: *Definition of Culture and Cultural Groups.*

Domain 8: Integration of Diversity initiatives

Materials to be reviewed	Key Elements	Comments
-All materials gathered for other domains AND -Most recent strategic and operational plan -Agendas of strategic planning meetings -Most recent operational plan -Agendas of Board, key committee meetings over past year -List of resources available in other languages -List of culture specific materials -Signage policy -Copies of cultural responsiveness evaluation taken in past, resulting action plans and progress reports -Quality committee strategic plan and meeting agendas (past year); other key quality committee documents (e.g. scorecards, priority lists, etc). -Program descriptions, policy related to spiritual care, counselling services, palliative/grief programs.	-Issues of cultural responsiveness are included in strategic and operational plans -Issues of cultural responsiveness are integrated into appropriate components of strategic plan -The operational plan dedicates resources necessary to support cultural responsiveness initiatives identified in strategic plan -There is evidence of input in plan development from diverse cultural groups -Issues of cultural responsiveness appear regularly on board, senior management and key committee agendas -All key cultural groups of the community are reflected in planning and action -Signage policy reflects commitment to community access -There are regular assessments of CR initiatives, and specific actions are taken to address areas of concern -Other language resources are reflected in lists of patient resources available. -Terms of reference of key committees require participation from the diversity of the community.	Key domain for assessment of Dimension 4: *Organizational or Individual focus.* Incorporate results of facility walk-through.

APPENDIX P

ASSESSMENT OF ORGANIZATIONAL APPROACH TO CULTURAL DIVERSITY (THE DIMENSIONS)

With the exception of the two domains Approach to Cultural Training (which can be assessed through review of materials in Domain 3) and Approach to Human Resource Management (which can be assessed through review of Domain 2), organizational assessment according to the identified dimensions requires review of all materials gathered. Domains of particular importance for review of specific dimensions are noted in column three of the draft instrument (Appendix O).

Dimension 1: Definition of culture and cultural group

Assessment questions:
1. What cultural groups are recognized in any way in organizational materials?
    a. Only racial/ethnic groups (specify)
    b. Only by language groupings/ability
    c. a and b
    d. Definition includes other cultural characteristics (specify)
2. Do documents recognize the complexity of cultural identities?
    a. Diversity within racial, ethnic, national and language groupings?
    b. Shared cultural identities other than ethnicity, race and language that may affect access and quality of care (poverty, disability, immigration status, etc)?
3. Is emphasis on specified cultural groups consistent with demographic data and research into health status, barriers to access and quality of care in catchement area? What groups may be missing? Can this be justified in terms of health status / equality of access?
4. Is there consistency between groups identified in profile documents and other organizational documents?
5. Do cultural and language service standards apply to all cultural groups?

Dimension 2: Provider Competence or Individual/community Access

Assessment questions:
1. Is there a requirement to include community members in planning and evaluation activities?
2. Are there requirements for reflection of the diversity of the community on Board and relevant committees?
3. Is there analysis of organizational performance and user satisfaction by defined cultural group?
4. Are there formal channels established between community groups and board/senior management?
5. Is provider training the only cultural responsiveness intervention?

Dimensions 3: Antiracist or Multicultural

Assessment questions:
1. What strategies for addressing cultural/language differences are identified in organizational documents or indicated through program responses?
   a. Provider awareness of cultural differences
   b. Provider skill in working with those from various cultural backgrounds
   c. Provider awareness, skill, combined with organizational policy and procedures to monitor practice
   d. Workforce interventions to promote a workforce that reflects the community served
   e. Organizational strategies to increase community participation in organizational planning and decision-making.
2. Are cultural differences identified as a "problem"?
3. Do documents reflect awareness of the strengths of "minority" cultures?

Dimension 4: Individual or Organizational Focus

This dimension is best assessed through review of documents gathered in all domains. Organizations that rely on individual approaches will tend to have little organizational policy/procedure in place.

Assessment Questions:
1. Do each of the Domain areas include policy, guidelines or other documents that address best practices?
2. Are interventions other than provider awareness training emphasized?

Dimension 5: Voluntary vs. Required.

While many organizations make a general statement of support regarding the importance of cultural responsiveness, many do not implement the processes and infrastructure necessary to require specific action. Documents in all domains should be reviewed, with particular attention to key documents related to use of interpreters; community consultation, materials development, and cultural training.

Assessment questions:
1. Is provider assessment of client language ability and scheduling of a qualified interpreter:
   a. not addressed in policy
   b. need is recognized, but response left optional
   c. encouraged, or facilitated
   d. required in all cases
   e. required with consequences for non compliance.

2. Is consultation with specified priority communities in program development and evaluation:
   a. not addressed in policy
   b. need is recognized, but response left optional
   c. encouraged, or facilitated
   d. required in all cases
   e. required with consequences for non compliance.
3. Is participation of the community in developing patient education and information materials:
   a. not addressed in policy
   b. need is recognized, but response left optional
   c. encouraged, or facilitated
   d. required in all cases
   e. required with consequences for non compliance.
4. Is attendance at cultural training:
   a. not addressed in policy
   b. need is recognized, but response left optional
   c. encouraged, or facilitated
   d. required in all cases
   e. required with consequences for non compliance.
5. Is representation of the community on key committees:
   a. not addressed in policy
   b. need is recognized, but response left optional
   c. encouraged, or facilitated
   d. required in all cases
   e. required with consequences for non compliance.

Dimension 6: Approach to Cultural Training

Assessment questions:
1. Do materials demonstrate a culture-general or culture-specific approach?
Culture-general:
- general principles for working in culturally diverse environment
- awareness/critique of dominant culture
- awareness/critique of culture of western medicine
- recognition of cultures within the organization
- similarities between cultural groups recognized
- diversity within ethnic/"racial" groups recognized
- incorporates aspects of cultural identity other than language, race, ethnicity.

Culture-specific
- emphasizes facts related to one or more specific cultural/ethnic group.

2. Does training emphasize only awareness and knowledge, or focus on skill development?
3. Are providers required to undertake training in how to work with an interpreter?

Dimension 7: Approach to Human Resource Management

Assessment questions:
1. Is there commitment to addressing employment issues? (recruitment, retention, promotion)
   a. no evidence in documents
   b. commitment in principle (e.g. vision statements)
   c. formal policy (specify)
   d. evidence of action and monitoring
2. What evidence can be found of the following approaches?
   a. Not addressed
   b. Monocultural – organizational commitment to protecting individuals from discrimination and to treating all the same
   c. Ethnic matching – organizational commitment to matching clients with providers of similar ethnic/language background.
      i. hiring initiatives
      ii. internal restructuring
      iii. case-by- case arrangements
   d. Workforce representation – organizational commitment to strategies that result in a workforce that reflects *at all levels* the ethnocultural makeup of the community served:
      i. preferential hiring, particularly at senior levels
      ii. promotion policy
      iii. training initiatives
      iv. recruitment strategies
   e. Workforce diversity – organizational commitment to celebrating advantages (to service quality and to organizational effectiveness) of workforce "diversity" in broadest sense
      i. stated commitment to valuing diversity
      ii. recognition of benefits of diversity to organization, not just to clients
      iii. definition of culture that includes gender, sexual orientation, disability, other factors
      iv. skills in working in intercultural environment given preference in hiring and promotion
      v. non-essential barriers to employment removed
      vi. participation with community in addressing larger licensing, accreditation, training access issues
      vii. creation of non-traditional employment.