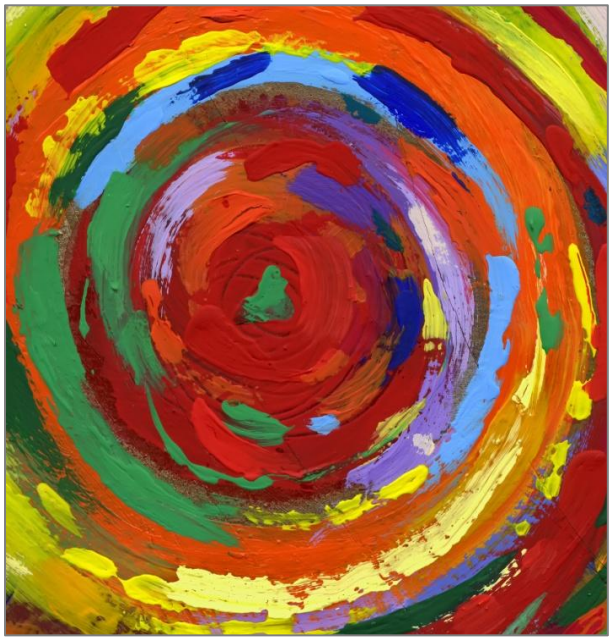

Provincial Diversity and Inclusion Framework

2017-20

Prepared by:
Provincial Diversity and Inclusion Framework Steering Committee
(A joint Nova Scotia Health Authority and IWK Health Centre committee)

Date: August 21, 2017

IWK Health Centre

nova scotia health authority

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Working Together

Nova Scotia Health Authority (NSHA) and the IWK Health Centre are pleased to share our first collaborative Provincial Diversity and Inclusion Framework. NSHA and IWK have partnered on developing this framework to guide the implementation of diversity and inclusion initiatives throughout the health system and across our province.

This framework builds upon the great work that has been happening within our organizations. It was developed in response to feedback from a variety of stakeholders with an interest in building a stronger, more inclusive health system in Nova Scotia.

The framework highlights the following five areas of focus and attention:

- Culturally competent, person-centred and family-centred care and services
- Diverse Workforce
- Engagement and partnership with diverse communities
- Organizational leadership, decision-making and policy
- Equity through data collection and research

Whether it is providing responsive care, services and programs for all individuals and families within our communities; recruiting and engaging a truly diverse workforce; or using a diversity lens in our thinking when it comes to organizational efforts, at its very core the framework is an underlying call to work together in a spirit of respect and inclusion to provide equitable care for everyone.

We all have a role to play, regardless of where we work or what we do each day. By working together to create and maintain respectful environments, where all employees are included and are treated with dignity, we can provide the best for our patients and their families. Excellence in health and wellness happens when we celebrate and nurture our differences.

You are encouraged to consider how you and your teams can be part of our focus on diversity and inclusion. Challenge yourselves and your colleagues to strengthen our workplaces by continuing to build upon diverse community partnerships to strengthen our province and our health system.

We look forward to working with you to champion diversity and inclusion in our workplace, to deliver a place of respect, and to improve health outcomes for patients, families and communities.

Context

Nova Scotia's health system is undergoing significant change. In 2015, the merger of nine district health authorities resulted in two provincial organizations – Nova Scotia Health Authority (NSHA) and the IWK Health Centre. These organizations are committed to providing safe, quality care to the region's population. Each organization released a strategic plan in 2016 outlining directions on how to engage and promote the health and well-being of Nova Scotians and other Atlantic Canadians served by its specialty services. This health system renewal presented an opportunity to reconsider the organizations' efforts toward diversity and inclusion. It also provided circumstances to better ensure sustainability of resources and initiatives, ultimately contributing to achieving the organizations' strategic goals.

The development of a provincial diversity and inclusion framework for NSHA and the IWK is intended to support the effort to enable sustainable diversity resources and initiatives throughout the province. The framework serves to align ongoing planning in various areas, notably:

- culturally relevant and appropriate care for patients and clients
- training and education for employees, physicians, learners and volunteers
- diverse workforce
- engaging populations, including those considered priority or vulnerable populations

A provincial diversity and inclusion steering committee was formed in 2015 to provide strategic advice and support in developing the framework. The group was comprised of diversity leads from the IWK and from NSHA's four zones, and included representatives from Population Health, People Services and Communications. See Appendix A for a list of members.

Building the Framework

Diversity and inclusion has emerged as a worldwide practice critical to an organization's success. In the past two decades in Canada and around the world, there has been a surge in research and organizational practices to address issues around social exclusion, equity, conflicts, and workplace diversity. Although proposed interventions on policies, measures and best practices are not a one-size-fits-all model, new initiatives around integrated approaches, training, and improved management systems are gaining traction (Northwood Group of Companies, Div. Strategy, 2015). As with other disciplines, such as quality and safety, standards are needed to establish criteria by which to measure and monitor progress (O'Mara & Richter, 2016). It is fundamental for a system to have a defined strategic framework to provide direction on how to address its diversity and equity initiatives to effect change and achieve better health outcomes. See Appendix B for Core Concepts and Terminologies.

The Provincial Diversity and Inclusion Steering Committee conducted a provincial environmental scan to understand what work was already underway in the area. It consulted IWK and NSHA zone diversity and inclusion committees to gather data. The committee also scanned current literature to identify best practices and success factors.

Environmental scan

The environmental scan was conducted in the summer of 2015 and provided insight into the structures, guidelines and support mechanisms that existed at the IWK and the province's former district health authorities. It identified existing strengths and highlighted opportunities for improvement. The scan identified various supporting structures for diversity work, including committees, working groups, councils and dedicated positions leading diversity work. Several communities were targeted for services, including Acadian and Francophones, First Nations, immigrants, African Nova Scotians, LGBTIQ and people with disabilities.

Despite considerable success, however, it should be noted that gaps exist. This was identified as largely due to the lack of comprehensive strategies, and limited focus, support and sometimes resources for diversity work.

The committee discovered that work in the area of diversity and inclusion is not always tied to specific measurable results related to the health of the populations. Among other things, the driving energy behind the work has been the realization that some communities do not have full access and benefit from the health system. To address this disparity, each NSHA zone and the IWK had done work that they deemed could yield their desired results. Yet, this work has often been in isolation and dependent on project funding from the Nova Scotia Department of Health and Wellness (DHW).

Committee engagement

Engagement with NSHA and IWK committees highlighted several themes; they are:

Language clarity

There is a need to have shared definitions for commonly used terminology, including clarifying the link between diversity and health equity.

Sustainable leadership and an accountability structure

Organizational commitment of adequate human, material and financial resources was top of mind in many discussions. Committee members would like to see senior leadership supporting coordinators and champions, as well as advocating at all levels of the organizations for strong and obvious leadership for the health of diverse populations. They also identified a need to streamline capacity-building efforts – e.g., consistent curricula and cultural competence education – and to mobilize and bring together the province's diversity efforts.

Guidance

There is a need for clear guidelines and organizational commitment for diversity and inclusion throughout the health system, as well as a need for strong support to develop local strategies.

Preservation of what works best in the different contexts

Although committee members were ready for change, they did not want to lose what they knew. "What we know should be the foundation for what is to come," one member offered.

Trust

The fear of losing community trust, and the desire to keep or start building trust in some instances, was strongly expressed at committee meetings. This means support for local efforts, as well as for champions to do their work efficiently. Messages communicated across the provincial and local committees should be consistent to sustain and build on established relationships.

Understanding communities

Using community profile data to help understand communities is seen as a means to provide appropriate services that are focused on the health of specific communities and groups.

Literature review

Through a scan of the literature and discussions with leaders in the field of diversity, inclusion and cultural competence, several approaches to addressing disparities were identified.

Diverse populations approach

This approach targets and addresses unique needs of diverse and vulnerable populations. Special attention is paid to diverse populations and local needs that are expressed by the community or researched and confirmed by the provider organization before programs are developed or dispatched. This requires strong knowledge of the populations identified, as well as partnerships and engagement with communities.

System approach

This approach expands its focus to include staff, policies, leadership, accountability and all decision-making tools in an organization. It sees the organization as a system breaking down barriers and changing attitudes of its professionals. It requires several conditions:

- Building capacity for diversity within all departments
- Ensuring that policies and standards are inclusive
- Clear articulation of importance by senior leadership (top-down approach)
- Strongly shared accountability, measures and reports
- Collective and other employee agreements are culturally sensitive
- Advocacy and active search for diversity in talent

Cultural competence approach

This approach has been defined as "a program's ability to honour and respect those beliefs, interpersonal styles, attitudes and behaviors both of families who are clients and the multicultural staff who are providing services" (Alberta Health Services, Diverse Populations, 2016). Recommended practice in the cultural competence approach includes addressing cultural difference, cultural humility, high level of sensitivity, sharing knowledge back and forth and the service provider learning as much as possible about the service receiver, training on skills such as communication, and learning about each other's cultures.

Diverse workforce

Embodied in this approach is the ideal of a workforce being representative of the population at all levels. Other elements include promoting an inclusive, culturally competent workforce that values diversity; identifying and removing systemic barriers to employment; and advancing members of designated groups on the promotion ladder to achieve a workforce where the designated groups are equitably represented.

Cultural Safety model

Developed in Aotearoa/New Zealand in the 1980s, Cultural Safety model is an Indigenous term that is primarily about examining one's own cultural identities and attitudes, and being open minded and flexible in their attitudes towards people from cultures other than their own (Downing R., Kowal E. and Paradies Y, 2011). According to National Aboriginal Health Organization (NAHO) Fact Sheet on Cultural Safety (2006), "Cultural safety moves beyond the concept of cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization and relationships with colonizers, as they apply to health care". Therefore establishing trust with patients and families is a key element in achieving culturally safe practice. The approach considers how social and historical contexts, as well as structural and interpersonal power imbalances, shape health and health care experiences (Anishnawbe Health Toronto, 2011). Cultural Safety "is an outcome that is based on respectful engagement which recognizes and strives to address power imbalances inherent in the health and social services system." (First Nations Health Authority of BC) The only person who can determine if services are culturally safe is the person receiving them. "The provider and the system cannot claim to be culturally safe.

Therefore Cultural Safety can be defined as an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together (Williams, R., 1999, pg 213)" abstract from Janet Pothier, 2017.

Structural Competency framework

Structural competency has emerged as a new framework designed to understand and respond to the inequalities that make individuals and populations sick. It analyzes institutional and structural hierarchies, systemic power, and discrimination in order to confront the ways these lead to sickness and disease (Structural Competency, 2017). The framework aims to further bridge research on social determinants of health to clinical interventions, and prepare clinical trainees and health professionals to act on systemic causes of health inequalities (Metzl, J. M., Petty J. and Olowojoba O. V., 2017). It recognizes efforts by many health professionals to address structural determinants of health and builds on "cultural competency, which focuses mainly on identifying clinician bias and improving physician–patient communication. It further emphasizes diagnostic recognition of the economic and political conditions that produce and racialize inequalities in health in the first place" (Metzl, J. M. and Petty, J. 2017).

According to Dr. Ingrid Waldron (November 1st, 2016) structural competency consists of training in five core intersecting competencies namely; recognizing the structures that shape clinical interactions, developing an extra-clinical language of structure, rearticulating "cultural" formulations in structural terms, observing and imagining structural interventions, and developing structural humility.

This framework draws from a wide scope of the approaches and models listed above, as well as current realities identified through the environmental scan, engagement of diversity and inclusion committees and the literature scan. It also focuses on addressing NSHA's and the IWK's strategic directions and aspirations. Focusing on addressing the health inequities and aiming for positive and specific health outcomes for our priority populations is part of the mission of both organizations.

The joint Provincial Diversity and Inclusion Framework Steering Committee has adopted five pillars for its framework:

- Culturally competent person- and family-centred care and services
- Diverse workforce
- Engagement and partnership with diverse communities
- Organizational leadership, decision-making and policy
- Equity through data collection and research

The IWK and NSHA will use the framework to develop strategic provincial and local action plans to improve health outcomes of diverse populations.

The Five Framework Pillars

1. Culturally competent person and family-centred care and services

To achieve this, the organizations will aim to

1.1 Provide care and services that are responsive to the experiences of individuals and families and to the characteristics of specific communities and their health priorities.

1.2 Create and maintain environments that are safe, inclusive and accessible.

1.3 Meet the communication needs of those receiving care and services.

2. Diverse Workforce

To achieve this, the organizations will aim to

2.1 Recruit, hire and retain a diverse workforce representative of the communities we serve.

2.2 Provide welcoming, safe, inclusive and productive workplaces that are respectful and free of discrimination.

3. Engagement and partnership with diverse communities

To achieve this, the organizations will aim to

3.1 Work with priority populations in the planning, implementing and evaluating of programs and services through collaboration.

4. Organizational leadership, decision-making and policy

To achieve this, the organizations will aim to

4.1 Embed diversity and inclusion in policies, processes, plans and practices.

4.2 Provide resources and establish structures to support the implementation of diversity and inclusion efforts necessary to meet strategic and business objectives.

5. Equity through data collection and research

To achieve this, the organizations will aim to

5.1 Collect data to reflect health disparities and inequities to inform service planning and delivery.

5.2 Increase province-wide outcomes-based research that uses a diversity lens to improve delivery of quality health service to priority populations.

1. Culturally competent person-and family-centred care and services

Client and family-centred care is an approach that guides all aspects of planning, delivering and evaluating services. The focus is always on creating and nurturing mutually beneficial partnerships among the organization's staff and the clients and families they serve. Providing client and family-centred care means working collaboratively with clients and their families to provide care that is respectful, compassionate, culturally safe, and competent, while being responsive to their needs, values, cultural backgrounds and beliefs and preferences. (Accreditation Canada, adapted from the Institute for Patient- and Family-Centered Care (IPFCC) 2008 and Saskatchewan Ministry of Health 2011).

1.1 Provide care and services that are responsive to the experiences of individuals and families and to the characteristics of specific communities and their health priorities.

Suggested Measures of Success

- Reported increase in patient satisfaction from patient satisfaction and employee surveys.
- Clinical leadership and practices reflect increasing cultural competence.

1.2 Create and maintain environments that are safe, inclusive and accessible.

Suggested Measures of Success

- Number of buildings leased and owned that meet accessibility legislation, i.e., physical environment accessible to all users.

1.3 Meet the communication needs of those receiving care and services.

Suggested Measures of Success

- Increase awareness of process to access and use interpretation services and production of written materials and signage that consider linguistic and literacy factors.

Options for consideration

- Actively offer language interpretation, including American Sign Language (ASL); build and support staff competency in using interpreters and other communication support systems.
- Develop and revise translation and interpretation policies that clearly set out how patients and families can communicate with care providers when language is a barrier.
- Make communication options available and accessible for patients and families with hearing, visual and speech impairment.
- Use written materials, navigation signage and volunteer supports within facilities that respect health literacy and language of patients and families.
- Ensure our facilities are accessible, welcoming, safe and inclusive.
- Develop a comprehensive communications strategy, including community feedback and response and recognition of care provision innovations.

2. Diverse Workforce

The diverse workforce ideal is a workforce that represents the population it serves. Specifically, diverse workforce seeks to achieve equitable representation of under-represented groups.

2.1 Recruit, hire and retain a diverse workforce representative of the communities we serve.

Suggested Measures of Success

- Increased and more diverse recruitment outreach for priority populations.
- Number of staff from diverse populations hired and advanced within the organizations.
- Lower turnover rate for priority populations.

2.2 Provide welcoming, safe, inclusive and productive workplaces that are respectful and free of discrimination.

Suggested Measures of Success

- Increased engagement and responsiveness to employees from priority populations.

Options for consideration

- Develop a province-wide employment diverse workforce policy that will guide recruitment and retention practices; provide resources and tools to HR staff and hiring managers to support them through recruitment and retention.
- Work strategically to remove barriers to provide equitable employment opportunities.
- Develop partnerships with organizations and educational institutions to promote careers in health for diverse communities.
- Develop strategies to ensure career development opportunities are available to a wide variety of diverse potential leaders at all levels of the organization.
- Encourage diverse workforce and cultural competence training for leaders.
- Work collaboratively with communities to encourage community members to consider employment or volunteer positions with NSHA and/or IWK and work to remove barriers.
- Work to create a healthy, inclusive, respectful workplace where diverse ideas and viewpoints are respected, valued and encouraged; address issues of discrimination and harassment in a consistent manner.
- Review employee benefit package with a diversity and social inclusion lens to support retention and success of under-represented communities.
- As operations allow, meet the cultural, religious and spiritual needs of employees, physicians, volunteers and learners (e.g., observing religious holidays, flexible work hours).
- Engage in dialogue with unions (at HR and leadership levels) to support employees from under-represented communities to advance their careers within NSHA and IWK.

3. Engagement and partnership with diverse communities

The engagement of diverse communities is essential to having a culturally competent health system. Meaningful community participation provides a health care organization with an understanding of patient needs strengthens relationships with diverse communities and helps to allocate resources effectively. Community engagement promotes a system that holds the health organization accountable for the provision of quality services and mutually agreed upon health outcomes.

3.1 Work with priority populations in the planning, implementing and evaluating of programs and services through collaboration.

Suggested Measures of Success

- Number of programs and services developed in partnership with priority populations that address health needs.
- Diverse priority populations are represented on community health boards and patient/family advisory councils.
- Number of recommendations from community health boards and patient/family advisory councils that reflect the needs of diverse priority populations.

Options for consideration

- Identify or create opportunities for awareness and learning about diverse communities and populations.
- Support quality teams, IWK and NSHA patient councils, and community health boards to have inclusive and diverse client/family/community voices.
- Provide opportunities for participatory and empowered decision-making to improve health.
- Work with partners in other sectors to create conditions for shared learning and action.

4. Organizational leadership, decision-making and policy

Informed, committed leadership, as well as shared responsibility and individual accountability, is essential to succeeding in diversity and inclusion efforts. Leadership commitment can be demonstrated through the use of policies that impact the structure of the organization, as well as explicitly demonstrating commitment to reducing health disparities in its strategic and business plans.

4.1 Embed diversity and inclusion in policies, processes, plans and practices.

Suggested Measures of Success

- Consistent use of diversity and inclusion lens in the development and revision of policies, practices, standards and templates (e.g., business plan).

4.2 Provide resources and establish structures to support the implementation of diversity and inclusion efforts necessary to meet strategic and business objectives.

Suggested Measures of Success

- Structures are in place, with dedicated funding, at the provincial, organizational and zone levels to support implementation of the framework.

Options for consideration

- Disseminate and integrate the framework throughout NSHA and IWK at all levels for the sake of creating an environment that enables increased awareness of staff and communities.
- Leadership develops structures, processes and policies to support the implementation of this framework.
- Use a diversity and inclusion lens in the development of policies, practices and standards (e.g., business planning, communications planning).
- Leaders publicly demonstrate their commitment to diversity and inclusion by either developing or promoting a diversity and inclusion position statement
- Align the LEADS framework to support capacity-building among leaders for cultural and structural competence.
- Use the established diversity and inclusion committees as resources and supports to implement the framework in each NSHA zone and at the IWK.
- Ensure dedicated budget and resources for committees to support the work.
- Improve connections between the zone and IWK committees and other work taking place within the organizations.

5. Equity through data collection and research

To continue addressing health disparities for all populations we serve, health organizations can collect data and promote academic research focused on diverse communities. Such data and research will help to build understanding of health in diverse communities and maximize their accessibility and the quality of care.

5.1 Collect data to reflect health disparities and inequities to inform service planning and delivery.

Suggested Measures of Success

- Health status of priority populations is included in community profiles.
- Increased use of community profiles in health services and program planning.

5.2 Increase province-wide outcomes-based research that uses a diversity lens to improve delivery of quality health service to priority populations.

Suggested Measures of Success

- Percentage of approved research projects that focus on priority populations.
- Number of learning opportunities provided by Research Services of NSHA and the IWK that address diversity within research.

Options for consideration

- Continue to partner with communities to understand and use inclusive approaches to collect and use data.
- Use national, regional and provincial data resources available to eliminate the need to start from scratch and present a learning opportunity, with tools and guidance from other organizations.
- Offer ongoing training to employees to increase understanding of the "why" of data collection.
- Provide confidential and safe space where patient information is collected.
- Review data on an ongoing basis to continuously build knowledge and determine trends in diverse populations.
- Share knowledge collected to inform program and service planning.
- Establish standards and processes and support research department in using the standards and processes and share diversity resources.
- Include diversity and inclusion lens in the proposal criteria for research funding.

Moving Forward

In order to advance the five pillars of the Diversity and Inclusion Framework, and to continue to support the integration of this important work across the organizations, both provincial and location implementation plans will be developed. To operationalize the framework, there is a need to develop actions to support the goals identified under each pillar, a monitoring and evaluation plan to measure our collective progress, and structures at the provincial and local level to engage our partners and advance the work.

A provincial committee comprised of IWK and NSHA staff and leaders will be tasked with developing an implementation plan including a monitoring and evaluation plan, Key Performance Indicators as well as preparing an annual progress report. The provincial committee will be accountable and report to the IWK and NSHA executive leadership teams through the IWK's VP Patient Care and Chief Nursing Executive, and NSHA's VP Primary Health Care and Population Health and VP People and Organizational Development.

The IWK and NSHA zone committees and working groups are champions and support the implementation of the framework at the local level. The committees engage partners and communities in the development of action plans. The IWK and NSHA are committed to continuing to integrate diversity and inclusion in organizational strategies, plans and values. Local leaders, physicians, employees, volunteers and learners will steward and guide the work going forward.

Appendix A

Provincial Diversity and Inclusion Framework Steering Committee – Members 2015 to 2017

Membership

Co-Chair: Mohamed Yaffa, Diversity and Inclusion Coordinator NSHA – Central Zone

Co-Chair: Tyro Setlhong, Diversity and Inclusion Coordinator, IWK

Carol McKinnon, Senior Director – Population and Public Health, NSHA

Sarah MacDonald, Manager – Primary Health, IWK

Anna Jacobs, Community Development Advisor – Diverse Communities, NSHA – Central Zone

Louise Hopper, Diversity and Inclusion Coordinator, NSHA – Western Zone

Dawn Ripley, Health Equity Consultant – Public Health, NSHA – Northern Zone

Kolten MacDonell, Team Lead, Chebucto Community Health Team, NSHA

Arlene MacAskill, Strategic Recruitment Consultant – Human Resources, IWK

Nicole Holland, Interpretation and Language Services Coordinator, NSHA – Central Zone

Jennifer Leuschner, Manager – Early Years, Public Health, NSHA – Eastern

Andrea Johnson, Director – Talent and Organizational Development, Volunteer Services, NSHA

Past Members

Wanda Matthews, Executive Director of Zone Operations, NSHA – Western Zone

Maggie Marwah, former Senior Director of Communications and Public Relations

Sheila Rankin, former Director – Talent and Organizational Development, Volunteer Services, NSHA

Melissa Lee-Ross, former Manager – Primary Health Care, NSHA – Eastern Zone

Amy MacDonald, Interim Manager – Primary Health, IWK

Anne Feltham, Administrative Support

Sheree Walsh, Administrative Support

Appendix B

Core Concepts and Terminologies

Culture

Culture is the integrated patterns of human behaviour that includes thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups (IWK Health Centre, *Diversity and Inclusion Strategy*, 2009).

Cultural Competence

Cultural competence embraces the importance of culture; the assessment of cross-cultural relations; vigilance toward the dynamics that result from cultural differences, including issues of power, privilege and oppression; and the expansion of cultural knowledge. It enables and empowers clients to improve their lives by building on their strengths and the strengths of their communities and adapting services to meet their culturally unique needs.

It is not simply a technical skill, problem-solving approach or communication technique. It requires a fundamental change in the way we think about, understand and interact with others. Because culture is dynamic, shared and continuous, so is cultural competence. It's a process of 'becoming' not an end to be reached (Nova Scotia Health Authority, *Diversity Lens Toolkit*, 2015).

Cultural Safety

Cultural Safety is an Indigenous term that is primarily about examining our own cultural identities and attitudes, and being open minded and flexible in our attitudes towards people from cultures other than our own. The only person who can determine if services were culturally safe is the person receiving them. The provider and the system cannot claim to be culturally safe.
Therefore Cultural Safety can be defined as an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning together (Williams, R., 1999, pg 213).

It is predicated on:

- Shared historical contexts
- Acknowledges we are all bearers of culture and helps us examine what we may represent/bring to our interactions and relationships with people.
- Openly acknowledges and challenges issues of power and privilege.
- Requires and examination of personal values and beliefs associated with our cultural identity.
- Past and existing colonial relationships.
- The impact these experiences and understandings have on good/authentic relationships.
- On critical self-reflection and awareness

(Description input by Janet Pothier, Rowan Tree Consulting & Facilitation Services)

Diverse Populations

This terminology has been used in academia (Kumaran, M., 2010) and health (Alberta Heath Services, 2017), to mean people who are different from the majority and who are disproportionately impacted by diseases because of systemic barriers, policies, procedures, social determinants of health and the health system. In Nova Scotia, Indigenous people, immigrants, refugees, specific visible minorities, African Nova Scotians, French speaking Nova Scotians, people with disabilities, LGBTIQ and people experiencing poverty and homelessness may fall within this description. In higher leadership and decision making, employment, research and fund allocation, these groups are either excluded or underrepresented as compared to the statistical or cultural majority population. Other terms, such as priority populations, vulnerable groups, marginalized populations, under-served and under-represented groups, have been used to describe these groups within different contexts and by different writers and organizations in this document and elsewhere.

Diversity

Diversity is differences among people, whether they're individuals or groups. It includes but isn't limited to differences in age, ability, culture, ethnicity, gender, geographical location, language, physical characteristics, race, religion, sexual orientation, socio-economic status, spirituality and values (Nova Scotia Health Authority, *Diversity Lens Toolkit*, 2015).

Employment Equity

Employment equity refers to the provision of jobs and job conditions in a fair and unbiased manner. This requires policies, values, strategies and actions which create and foster equal access to opportunities for all. In the context of a diverse and healthy workplace, commitment to equity is evidenced by fair hiring policies and the provision of opportunities for professional development in recognition of the implications diverse backgrounds and pre-existing knowledge (or lack thereof) may have. Priorities for hiring reflect the population served (Capital District Health Authority, *Diversity in employment: policy and procedure*, 2013).

Health Equity

Health equity occurs when everyone in a population has the resources and opportunities they need to achieve their full health potential. Health equity involves: fair distribution of resources needed for health, fair access to opportunities to be healthy and fairness and appropriateness in the supports and services offered to people when they are injured or ill. Health equity means people are not held back because of factors such as racism, ethnicity, religion, gender, age, social class, socioeconomic status (Department of Health and Wellness, *Health Equity Lens: Improving social determinants of health and reducing inequities in Nova Scotia*, 2016).

Inclusion

Inclusion is the state or action of including or of being included within a group or a structure. Inclusion seeks to create an environment of belonging, involvement and respect while acknowledging the individual's unique diversity elements (IWK & Capital District Health Authority, Diversity and Inclusion Strategies)

Institutional Racism

Institutional Racism is an ecological form of discrimination. It refers to inequitable outcomes for different racialized groups. There is a lack of effective action by an organization or organizations to eradicate the inequitable outcomes. (McKenzie, K. 2017).

Priority Populations

The approach includes understanding that some population groups are healthier than others, not because of personal choice, but because of social, economic and environmental circumstances over the course of people's lives (National Collaborating Centre for the Determinants of Health, 2014).

The term priority populations is most often used to indicate a need to focus on certain population sub-groups based on surveillance, epidemiological research and social justice values (Public Health Ontario, 2015).

Appendix C

The Framework's Five Pillars: Background

1. Culturally competent person-and family-centred care and services

Accreditation Canada defines person-and family-centred care as an approach that guides all aspects of planning, delivering and evaluating services. The focus is always on creating and nurturing mutually beneficial partnerships among the organization's team members and the clients and families they serve. Providing person-and family-centred care means working collaboratively with clients and their families to provide care that is respectful, compassionate, culturally safe, and competent, while being responsive to their needs, values, cultural backgrounds and beliefs, and preferences (Accreditation Canada 2017, adapted from the Institute for Patient-and Family-Centered Care (IPFCC) 2008 and Saskatchewan Ministry of Health 2011).

Person- and family-centred care acknowledges the strength and unique characteristics of individuals and families and act on this diversity to provide appropriate care and improve health and well-being. NSHA and the IWK place strong emphasis on person-and family-centred care, recognizing the critical impacts of health equity and the social determinants of health (language, race, sexual orientation, gender identity, immigration status, income and education) on patient safety and quality improvement outcomes.

Diversity and inclusion are essential to health. Nova Scotia is a diverse province and recognizes that providing equitable healthcare to people and their families with diverse values, backgrounds, and beliefs is important to increasing access and reducing health disparities. Culturally competent care provides services that respond to historical inequities, lived realities, diverse values, beliefs and behaviours. It tailors approaches to meet the different needs of diverse populations (Department of Health and Wellness, Nova Scotia, 2015). Health equity can be achieved when the diversity of individuals and communities served is represented through our policies, programs, services, workplaces and care approaches.

When we treat people *equally*, we ignore differences. When we treat people *equitably*, we recognize and respect differences (Department of Health and Wellness, 2005). Evidence shows that people belonging to certain population groups tend to experience disparities in their health status, access to services and the quality of care received. Factors such as gender, race, language, literacy, sexual orientation, immigration status, income and education can influence a person's access to timely, appropriate and high-quality care. Equitable access to health services based on need, fairness in the distribution of health care resources, provision of culturally competent care and focus on the most health-disadvantaged groups can significantly reduce disparities in health outcomes among population groups and enhance the wellbeing of diverse populations (Centre for Addiction and Mental Health, 2012).

A welcoming and accessible physical environment is critical to meeting the needs of diverse patients and families' and supports principals of creating a safe space. The physical environment plays a significant role in promoting use and access to care services, especially for population groups who have historically been under represented. Physical environment may include everything from the physical infrastructure, literacy level and language on signage, diverse visual representation, to the variety of food served in within the organizations. During a community consultation with people with disabilities (NSHA and IWK Accessibility Report, 2016), issues on physical design of our buildings and public space were raised as barriers for those with mobility, visual and cognitive challenges. Some of the examples provided included lack of ramps for wheelchair users in some building entrances, few elevators with voice prompts and Braille, and wordy signs that limit those who are visually impaired or linguistically challenged. Universal symbols and pictorial cues were suggested to accommodate literacy and other communication challenges.

Cultural competence requires a fundamental change in the way we think about, understand and interact with others. Because culture is dynamic, shared and continuous, so is cultural competence. It's a process of 'becoming' not an end to be reached (Nova Scotia Health Authority, 2015). To create a culturally competent environment, commitment from the entire organization at all levels of leadership is needed. Investment in education and building cultural competence and cultural safety skills is essential. According to Brown and Lewis of National Center for Cultural Competence (2003), health care providers' bias, stereotypes, prejudice and clinical uncertainty contribute to racial and ethnic disparities in health care. Brown and Lewis further state that the "delivery of high quality primary care that is accessible, effective and cost efficient requires providers to have a deeper understanding of socio-cultural background and linguistically competent primary care. A culturally and linguistic competent care increases patient satisfaction, health outcomes and higher levels of preventative care."

2. Diverse Workforce

Having a diverse workforce is about the provision of jobs and job conditions in a fair and unbiased manner, to achieve a healthy, high-performing workforce that will create a positive and healthy organizational culture. Studies have shown that diversity in the workforce "provides opportunities to deliver quality care which promotes patient satisfaction and emotional well-being" (Ayoola, 2013). Improvements in health services are more effective with a diverse workforce that represents the communities it serves. As defined in the *Employment Equity Act* (Gov. of Canada, Justice Laws, E.E. Act S.C. 1995, C.44), Employment Equity requires employers to engage in proactive employment practices to increase the representation of designated groups and rectify some of the employment hardships faced by members of these groups. According to *Nova Scotia Human Rights Act*, the designated groups are; visible minorities, Aboriginal peoples, persons with disabilities and women. NSHA and the IWK need to collect data to determine which groups are underrepresented to suitably address the current realities. Though some of the health system's programs are heavily populated with women, it should be understood that underrepresentation translates differently in various disciplines.

Similarly, there are traditionally underrepresented racial groups that should be considered a priority in creating a diverse workforce. Recruiting volunteers from diverse backgrounds is also important in ensuring that the workforce reflects the communities we serve.

The ongoing demographic shift, coupled with health disparities and poor accessibility to care services, warrants a critical look into employment equity practices. Through conversations and various feedback outlets by the IWK and NSHA, diverse communities have voiced that the lack of visible representation of service providers who look like them presents a challenge in how they access services. According to Phillips and Malone (2014), enhancing diversity and successfully addressing this issue will positively affect the reduction of health disparities and achieve positive health outcomes. Study-based evidence continues to support the relationship between a diversified workforce and improved health outcomes. Culturally and linguistically competent health professionals can advocate and facilitate for outreach efforts that are culturally appropriate for diverse populations (NACNEP, 2013).

NSHA and the IWK will actively engage in equitable hiring and recruitment practices of staff and volunteers using an employment equity lens; creating a welcoming workplace where every employee feels a sense of belonging; enhancing positive experiences; and supporting the advancement of members of diverse backgrounds on the promotion ladder.

3. Engagement and partnership with diverse communities

Partnering with and engaging diverse communities are essential in creating a culturally competent health system, especially where health equity is the anticipated outcome. Engagement involves the transparent exchange of information, and seeks common ground and understanding that leads to trust-based sustainable relationships. Meaningful community participation and engagement promotes understanding communities' needs, strengthens relationships and supports equitable resource allocation. This allows communities to achieve their full health potential. It is through engagement, participation and partnership that communities can effectively discuss and articulate appropriate, inclusive and responsive services that would work for their communities. In turn, communities are empowered to address their health priorities and identify solutions to their own health problems. Health organizations could be held accountable for the provision of quality services and mutually agreed upon health outcomes.

The IWK's and NSHA's approach to engagement is based on the International Association for Participation Canada (IAP2). One of the principles of this approach is equity and inclusion, which encourages designing the engagement process to be culturally safe, relevant and responsive. Health care organizations must have meaningful and flexible processes for community representation and feedback, such as focus groups, advisory committees and board representation. Wyatt R, Laderman et al, (2016) acknowledges the added benefit in working with community partners to address the social determinants of health that are beyond the reach of health care. Community-based organizations already know their own communities and their needs, and are often already engaged in related work in the community.

To acknowledge the existing strengths and capacities within our communities and to build partnerships with community-based organizations would be a step in the right direction. It is expected that through engagement of diverse communities, all citizens are engaged in making decisions on policies and programs that impact their health and well-being.

4. Organizational leadership, decision-making and policy

A committed leadership, shared responsibility and individual accountability are essential to succeeding in diversity and inclusion efforts. Without clear leadership support frontline employees feel isolated. As stated in the Winnipeg Regional Health Authority's *Framework for Action*: *Cultural Proficiency &Diversity*, "If leadership is not convinced of the importance and is not committed to a culturally-competent organization, it will be difficult to get the rest of staff to embrace the values and principles of diversity and inclusion." (2012).

Leadership could demonstrate commitment through policies and organizational standards, as well as by bringing diversity through organizational strategic and business plans in clear and explicit terms. Without a clear voice from leaders, change in the area of diversity is often difficult and trust is minimal for meaningful engagement with diverse communities.

NSHA and the IWK have adopted the LEADS leadership framework: lead self, engage others, achieve results, develop coalitions, and system transformation. This model fits neatly with our diversity framework and the way both the IWK and NSHA have been working in diversity over the years. Lead self: each leader will take responsibility for their own biases, their own learning about diversity and about the health of our diverse communities. Engage others: each leader will make the best use of the resources available to them by engaging within the organization and by creating partnerships and reaching out to community when needed. Achieve result: each leader will lead their department, unit, team, zone etc. to achieving real health outcomes for our communities beyond just engaging or implementing programs. Develop coalitions: each leader will purposefully build coalitions and partnerships to achieve results. System transformation: each leader will ask difficult questions about diversity in a top-down approach to ensure everyone lives our organizational diversity values; leaders will question the inclusiveness of our current policies, standards, practices, plans and strategies, education curricula and all system tools, with courage, and use a diversity and inclusion lens for changes that are best suited to the health and wellbeing of all Nova Scotians.

5. Equity through data collection and research

To fully address health and health care disparities across our communities, especially among the already vulnerable populations, health-system research infrastructure for quality measurement and improvement is required (Agency for Healthcare Research and Quality, 2014). Existing data collection and quality reporting efforts should expand on how they collect and report socio-cultural identifiers/characteristics. These identifiers include, but are not limited to, race, ethnicity, language preference, socio-economic status, education, income, abilities, gender identity and sexual orientation. Health information technology, with clearly outlined identifiers, can help provide baseline data to facilitate tracking, understanding and addressing various needs of our populations.

Understanding who uses care services and how they use them can strongly affect the way care services are resourced and improved. Engaging and partnering with diverse communities is important. It's also imperative to reflect these communities in data collection and reporting systems to demonstrate inclusivity. A robust and meaningful data collection and review of these socio-cultural identifiers allows for comparability with population statistics and identifies population groups not being served. It also helps to understand patterns of health system use within diverse communities, thus supporting the development and creation of targeted interventions (Hasnain-Wynia and Rittner (2008). Nova Scotia's diverse communities have repeatedly indicated the need for health organizations to collect health data to assist in facilitating and tracking the social determinants of health, and to understand disease prevalence for individualized interventions. Though some health clinics do their best to collect relevant data to support patients and families, population groups like the GLBTQ+ have indicated some discrepancies in data collection where there is no provision for preferred gender and/or name. This has resulted in frustration with the health system by some populations, who then only access care when their health condition worsens.

Health organizations could promote academic research, focused on diverse communities, to increase understanding of their health and to maximize their quality and accessibility to care. While education and justice sectors in Nova Scotia have race-and ethnic-specific data, there is minimal similar research in Nova Scotia to help the health system fully understand the social determinants of health and accessibility challenges for minority populations. Through research and data collection, the impact of institutional or structural racism can be better understood. This research can also highlight the best approaches to address these impacts. Racial disparity has been identified, through community conversations and anecdotal feedback, as a strong element that negatively impacts how communities access care services. It will be imperative for NSHA and IWK to deploy more racially focused research efforts to build a better understanding of this issue and to develop mechanisms and supports to address it.

It is important to also note that targeted research would provide insights in understanding how a diverse workforce, patient and family-centred care, engagement and partnerships all come into play in influencing how communities use care services.

Appendix D

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