ORIGINAL ARTICLE

CANADIAN COLLEGE OF HEALTH LEADERS
COLLÈGE CANADIEN DES LEADERS EN SANTÉ

# Effective diversity, equity, and inclusion practices

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Healthcare Management Forum
1-4

DOI: 10.1177/0840470418773785
journals.sagepub.com/home/hmf
SAGE

**Abstract**

Demographics in Canada, and the workplace, are changing. These include population changes due to race, ethnicity, religion/faith, immigration status, gender, sexual identity and orientation, disability, income, educational background, socioeconomic status, and literacy. While this rich diversity can present challenges for patient experiences/outcomes and working environments, it can also present opportunities for positive transformation. For successful transformation to take place, strategies should focus on "Diversity, Equity, and Inclusion" (DEI) versus "diversity" alone and on creating inclusive team environments for positive staff experiences/engagement. There is a growing understanding of the relationship between the providers' work environments, patient outcomes, and organizational performance. This article leverages the principle of improving the healthcare provider's experience based on Health Quality Ontario's Quadruple Aim ("people caring for people"). Based on learnings/experiences, the top three successful practices from the organization's DEI strategy have been outlined in this article.

## Introduction

Demographics in Canada, and in the workplace, are changing. This includes trends in immigration, internationally trained professionals, languages/communication styles, religious/faith communities, a diverse Indigenous population, single parents, low-income populations, mental/physical health and lesbian, gay and transgender populations.[1] In healthcare, these trends can result in health inequities (health differences between population groups defined in social, economic, demographic, or geographic terms—that are unfair and avoidable).

From a *race* perspective alone, racism/cultural oppression have been realities for many minority groups. Nurses working across Canada speak of their experiences of discrimination, racism, and the challenges of working effectively in such environments.[2] However, "cultural diversity" goes beyond values, beliefs, practices, and customs; in addition to racial classification and national origin, there are many other faces of diversity.[3] These include age, socioeconomic status, religion/faith, immigration status, gender, sexual identity and orientation, disability, income, educational background, socioeconomic status, and literacy.

While this rich and broad diversity among population groups can present challenges for patients, working environments, and organizations, it can also present opportunities for positive transformation. For this transformation to take place, the focus of a successful and effective strategy would need to shift from "diversity" alone to "Diversity, Equity, and Inclusion (DEI)."

The recognition and embracing of diversity (the range of differences among population groups) is essential and foundational. From a patient's perspective, going beyond to include equity and inclusion can result in positively changing a patient's life, experience, and outcomes as well as an organization's outcomes. Experiences and initial research show that Osler's DEI initiatives have the potential to improve equitable access to quality and safe care, reduce (unnecessary) readmissions or emergency department visits and length of stay as well as liabilities and errors. For example, errors can occur when a patient does not speak the same language as the provider potentially resulting in miscommunication of diagnosis or prognosis.

From a staff perspective, staff training and education focused on DEI versus diversity alone within Osler is beginning to transform the work and team environment and, in turn, positively impact the patient experience. There is a growing understanding of the relationship between nurses' work environments, patient/client outcomes, and organizational and system performance.[2] This is evident from the principles of Health Quality Ontario's Quadruple Aim which states that "at its core, healthcare is about people caring for people." Evidence also shows that healthy work environments yield financial benefits to organizations in terms of reductions in absenteeism, lost productivity, organizational healthcare costs,[2] and costs arising from adverse patient/client outcomes[2] as well as staff experience and engagement.

One key learning for the organization has been that creating inclusive societies takes time and requires work beyond merely "not-excluding."[4] Another has been that it is not about "universalism and treating all the same, i.e. equality; it's about *equity*—the absence of avoidable or remediable differences among groups of people" (World Health Organization).[5] The difference between equality and equity? "Equality is giving everyone a shoe. Equity is giving everyone a shoe that fits."

Key practices from Osler's DEI strategy have been outlined in this article with a focus on the healthcare provider/work environment:

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1. Leadership commitment
2. The DEI training/development for inclusive teams and the work environment
3. Staff engagement to leverage champions for positive change

## Leadership commitment

Commitment "from the top" has been essential to the success of Osler's DEI strategy. Senior leadership understands that "sensitivity to diversity issues at the senior executive level has an effect on diversity management practices used by hospitals."[6] Successful leadership practices at Osler include:

- A leadership team that understands the value and impacts of health equity, inclusion, and social justice.
- Osler's corporate values—Respect, Excellence, Accountability, Diversity, and Innovation—aligned with DEI.
- Senior leadership commitment to a DEI portfolio with human and financial resources.
- Osler's DEI plan has been developed in close collaboration with, and monitored by, senior leadership.
- The plan aligns with Osler's corporate strategic plan/priorities and has clear goals, objectives, indicators, and defined metrics.
- Accountabilities are defined and shared across the organization including mechanisms for raising and addressing DEI issues. For example, at Osler, senior leaders from patient experience, legal, human resources, health equity and inclusion, and ethics collaborate and provide consultation on issues related to Performance, Accommodation, Harassment and Human Rights (PAHHR).
- The DEI is incorporated into Patient and Family Advisory Councils that are diverse in membership. Patients provide insights and guidance on creating tipping points for positive change.

## Diversity, equity, and inclusion training/development for inclusive teams and work environments

Similar to other organizations with "diverse" workforces, Osler's management is faced with handling requests for which there is limited precedence. For example:

> Appropriate learning opportunities will yield positive outcomes and a workforce composed of nurses who are open-minded, inclusive, and respectful of all colleagues and recipients of nursing services. Individual members of the workforce identify and are cooperative with one another to address barriers to equity and diversity and build practice environments in which every person's contribution is valued thus allowing the full potential of all to be maximized. These individuals refuse to participate in discrimination, harassment, or bullying and address the issue in a way that will effect change. *Registered Nurses Association of Ontario.*[2]

- Staff requesting time to pray several times daily.
- Being excused from working in areas where religious items may interfere with imaging equipment.
- Being excused from mask-fit testing as beards cannot be trimmed on religious grounds.
- Requesting to finish work early because of young children.
- Requesting more time to prepare reports, or having workspaces modified, to accommodate disability.
- Refraining from working with colleagues who make derogatory comments/jokes about their community/cultural groups.
- Requesting different assignments because colleagues converse in a language not understood.
- Patients/families requesting different providers (potentially due to discrimination).

Understanding and meeting diverse needs and creating inclusive environments stems from being culturally competent. Campinha-Bacote[3] states that to meet the needs of culturally diverse groups, healthcare providers must engage in the process of becoming culturally competent—*a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations*.

*How* managers respond and address the above kinds of requests have resulted in either inclusion/alienation. Successful DEI training/development at Osler includes the following:

### *Creating safe spaces for employees to have a dialogue and share experiences*

This informal, "self-managed" approach invokes understanding and appreciation. *Mandatory* diversity training (what does this look like anyway?) is a requirement at Fortune 500 companies. But a substantial body of research shows that this training is not particularly effective at encouraging people to confront their biases. In fact, it can provoke the opposite effect. "People, not surprisingly do not like to be told what think."[4,7] Another reason why self-managed teams may be more successful is when programs are not actually branded "diversity efforts."[8] Thus, Osler has a substantial focus on creating safe spaces and opportunities for employees to voluntarily share experiences.

Stories shared by colleagues have invoked compassion, empathy, and understanding. For example, struggles of those who have a disability are new to Canada and/or are low income or vulnerably housed. Or, after feeling safe to share they were gay or lesbian, struggles with bias/discrimination.

Creating safe spaces has enabled participants to open up their hearts and minds to compassion and new learning. Some admitted that, in their limited understanding of diversity/diverse groups, they had made incorrect assumptions about some of their colleagues resulting in negative stereotypes.

Completed pre/post assessments have demonstrated an upward trend of learning and appreciation/understanding of differences. Written feedback included heartwarming responses to "what will I do differently" or "which behaviour will I

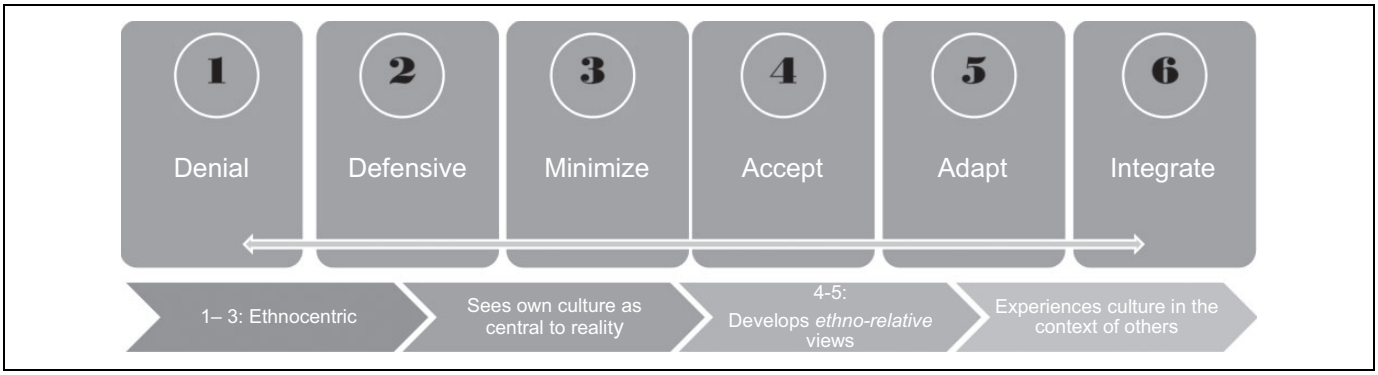


**Figure 1.** The Bennett Scale: developmental model of intercultural sensitivity.

change as of today" including being more open and understanding of staff and patients' differing practices/beliefs.

A foundational tenet included in this training is from Dr. Jean Watson, PhD: "To care for someone, I must know who I am. To care for someone, I must know who the other is. To care for someone, I must be able to bridge the gap between myself and the other."

## *Focusing on self-awareness, self-reflection, and reduction of bias, perceptions, and assumptions*

> All of us, despite the best of all possible intentions, are affected by unconscious processes.
> *-Dr. Michelle van Ryn, PhD, Mayo's Research Group*

Osler's DEI training/education has a significant focus on self-awareness, self-reflection, and bias. Significant research demonstrates that *all* humans engage in conscious and unconscious processes based on images stored in memory (note 1). *Unconscious* bias affects healthcare providers every day; it can reduce the quality of care and increase errors.[9] And that there are higher levels of racial bias among clinicians directly linked with biased recommendations (note 2).

The years of subconscious associations affect what we think we see, how we react, how we feel, and how we behave. *"Any effort to build inclusion . . . has to address our perceptions (and biases)*. This takes time . . . but is also more like to endure."[4]

A tool used in the training includes one developed by Dr. Milton Bennett: the Developmental Model of Intercultural Sensitivity (Figure 1). It has helped staff understand the process by which they can learn to value and respond respectfully to people of all cultures. Participants are asked to pause and self-assess where they are on the scale and then to reflect what they can do to do better to move from ethnocentrism to being more ethno relative.

## *Focusing on cross-cultural communication*

Communication styles can negatively affect relationships. It is imperative to be aware of other's differing communication styles as well as one's own. Intercultural communication is influenced by factors including how power and authority are shared in the culture, values of individualism and collectivism, and the role of context in communication. Edward Hall proposed a continuum of low to high context with respect to contextualizing the messages sent and received. Low-context cultures (such as Canadian) emphasize the words with less emphasis on the context such as who says it and how it is said. In high-context cultures (such as Asian), the context of the message is just as important as the words used and influences how the message is understood.[10] For example, Communication becomes a key issue in developing collegial relations in the team. The literature demonstrates a strong association between racial diversity and difficulties with communication and conflict resolution in teams. Research highlights a significant association between diversity, group conflict, and communication difficulties.[11] *There is a strong business case for initiating communication about culture as a platform for change.*[11]

Leaders who validate different perspectives and demonstrate a willingness to talk about differences achieve a positive outcome.[2] This involves listening, reflecting, and nonjudgemental approaches and focusing on nonverbal communication. *We've often "spoken" volumes without saying a word.*

## *Building capacity of employees to understand legal implications*

Legal obligations and implications are essential to incorporate into DEI training. Whether we "agree" with different practices or not is a moot point in situations superseded by law, for example, the Ontario's Human Rights Code. This code recognizes the dignity and worth of every person in Ontario and provides for equal rights and opportunities and freedom from discrimination, such as disability, creed, family status, sex, and gender identity. Employers have a legal duty to accommodate the code-related needs of people who are adversely affected by a requirement or standard.

## *Achieving organizational expectations through living the organization's core values*

Not leaving anything to chance, that respecting each other's differences is the "right thing to do," also include a component

that speaks to the organization's values and expectations. Osler's values—respect, excellence, accountability, diversity, and innovation—are an integral part of DEI training and performance development.

Through manager engagement, a "Diverse and Inclusive Teams" module has been developed and is delivered in person to groups. The curriculum includes organizational and individual values, self-assessment/reflection, value-based exercises, Osler's code of conduct, anti-harassment and discrimination, cross-cultural communication, and bias (implicit and explicit). The results/impacts, through pre/post assessments and evaluations, are remarkable.

## Staff engagement to leverage champions for positive change

Change champions are key to creating tipping points and cultural shifts to embracing DEI initiatives. In the *Journal of Applied Social Psychology*, using a sample of 4,597 healthcare sector employees, research indicated that diversity practices are associated with a trusting climate that, in turn, is positively related to employee engagement.[12] Key staff engagement mechanisms that have invoked DEI change at Osler:

- *The Diversity Advisory Council*: Interdisciplinary staff learn about, and work on, impacts and issues related to DEI.
- *The Accessibility Advisory Committee*: Internal staff/volunteers and external community members ensure barriers are reduced for patients, staff, physicians, volunteers, and visitors with physical and/or mental health issues.
- *The Women of William Osler Committee*: Members foster a collaborative environment that is gender-inclusive, respectful, equitable, and accessible whilst enabling personal and professional growth through a lens of gender equity.
- *The Lesbian, Gay, Bisexual, Transgender, Queer, 2-Spirited, Intersex, Asexual, and Allies Committee*: Members foster a collaborative, welcoming and safe environment that is informed, inclusive, respectful, equitable an accessible for all patients, families, staff, physicians, and volunteers.
- *Performance, Accommodation, Harassment, and Human Rights Task Force*: Senior leaders from patient experience, human resources, legal counsel, ethics, and equity and inclusion discuss/provide recommendations that stem from PAHHR.

## Conclusion

*Change must begin with senior leadership with accountabilities being shared among middle management*. We cannot, however, underestimate the power of including and engaging all staff/individuals for positive transformation. Each of us must serve as culturally competent role models and share our skills and knowledge with others and we must engage in discussions and challenge questionable behaviours or institutional practices.[13]

The initiatives and practices shared have demonstrated positive outcomes impacting individual employees, the team/work environment, the organization as a whole, and patients/families. The DEI initiatives are no longer departmental based initiatives or projects but essential for cultural transformation.

### Notes

1. Dr. Michelle van Ryn, PhD, Mayo's Research Group.
2. David Williams, PhD, MPH, Ronald Wyatt, MD, MHA.

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