Building Health Equity Capacity at Fraser Health: Gap Analysis of Health Equity and Diversity Awareness Needs among EHS Employees

by

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Abstract

This project aimed to identify the health equity and diversity awareness learning needs among Environmental Health Services employees at Fraser Health and provide recommendations. To identify needs, a survey and focus group were conducted to measure employee's knowledge and attitudes towards the application of health equity and diversity awareness in their day-to-day work. Based on the results from both the focus group and the survey, health equity gaps were identified based on the health equity competencies developed in collaboration with the PHABC. The identified gaps were aligned with potential recommendations for Environmental Health Services to move forward with.

Keywords: health equity; diversity awareness; health authority; capacity building;

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1.1. Introduction to the public health problem

Health equity, the social determinants of health and diversity awareness are all key components to promoting upstream interventions and building healthier communities. Health inequities are a global health problem and require immediate attention (Marmot et al., 2008; Marmot, 2007). Health inequities are systematic differences in health between different groups of people and are generally avoidable through reasonable action (Marmot et al., 2008). Health inequities are present between nations and within nations, including our province of British Columbia (Marmot et al., 2008; Provincial Health Services Authority, 2016). Reducing inequities is not solely the responsibility of the health care system, but requires collaboration with all levels of government, businesses, and communities.

For the past 7 years, Fraser Health has had a strong commitment to health equity. The Health Equity and Population Health Unit (HEPHU) was created to meet the need for health equity tools for their diverse population, which was the first of its kind in British Columbia. As a health authority, Fraser Health has played a unique role in promoting healthy communities and facilitating access to necessary resources for everyone within its jurisdiction to maximize their well-being. In 2009, Fraser Health adopted a health equity and population health approach as part of their 2009/10 – 2011/12 Health Services Plan (Fraser Health Authority, 2009). Based on the strategies in this plan, the Health Equity Working Group (HEWG) was formed to bring people together across Fraser Health who are committed to health equity in their day to day work. Today, the membership of the group includes employees from environmental health, harm reduction, women's health, HEPHU, Aboriginal health, and Diversity Services.

In 2011-2012, the HEWG developed a Health Equity Assessment Toolkit (HEAT) for staff to apply an equity lens to the programs and policies they implement, which was the first tool of its kind in Canada (Fraser Health Authority, 2015). Two versions of the tool were developed to meet the needs of different staff. One tool is a longer workbook and the other is referred to as the rapid HEAT tool. The longer version of the tool was developed for program planners and managers at Fraser Health. This tool assesses current policies, programs and/or services. It assists users to identify potential strategies to address health inequities and understand the potential unintended consequences. The tool also includes an evaluation piece on collecting data to see monitor the effectiveness of strategies. The short tool is geared towards frontline staff and goes through quick questions to encourage them to consider the services they offer.

The long version of the HEAT is currently being implemented in the Population and Public Health (PPH) program.

In 2013, a Health Equity Certification Program: A Framework for Health Equity Training was developed to address the health equity needs across the health authority. This version of the certification framework has yet to be fully implemented across Fraser Health and was updated in July of 2016. In 2011, the Public Health Association of BC (PHABC) developed draft health equity core competency statements for public health professionals with invaluable input from a focus group within Fraser Health (Simces & Ross, 2011). The competencies are divided into categories: public health sciences; assessment and analysis; policy, program, planning and evaluation; partnerships, collaboration and advocacy; and, diversity and inclusiveness, communication, and leadership.

Environmental Health Services managers worked through the long version of the HEAT to identify key areas where they can improve health equity. By completing the HEAT workbook, they identified five areas for improvement. Each area is characterized by a question; available data that might answer the question; missing data; future actions; goals; and the priority of the action area. One question that was identified as a high priority and was feasible for the purpose of this project was: what are the health equity and diversity education needs of field staff?

1.2. Purpose

While the application of the HEAT is relevant to EHS, it is also relevant to health equity at Fraser Health in general. The definition of health equity used by Fraser Health is, “all people (individuals, groups and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic, and environmental conditions” (Fraser Health Authority, 2015). Within the last 3 years, Fraser Health has developed a health equity certification framework, and this project will allow an attempt at piloting parts of the Health Equity Certification framework. This aligns with EHS’s goal to provide tailored training to address staff knowledge needs relevant to the populations they serve. The purpose of this project was to identify potential knowledge gaps among EHS employees in terms of health equity, the social determinants of health and diversity awareness.

As discussed with Fraser Health (T. Patterson & K. Shaw, personal communication, November 16, 2016), EHS needs to meet the following steps for the project:

1. Apply/adapt health equity core competencies (specific to cultural awareness and diversity) to the environmental health officer (EHO) and licensing officer (LO) context.

2. Iteratively with Step 1, gain an understanding about where EHS is at in terms of health equity and diversity awareness knowledge and identify gaps in learning needs.

3. Identify and deliver suitable training based on the identified gaps.

For the purpose of my project, I will be focusing on Steps 1 and 2, with Step 3 being shaped as future recommendations for Fraser Health to move forward with. The health equity competencies, and the applicable educational resources, will assist in generating the final recommendations for the Environmental Health Services management team.

1.3. Review of the relevant literature

1.3.1. Health equity and the social determinants of health

a. Social Inequities in Health: concepts and definitions

Whitehead first proposed a definition of health inequity in 1992, which states that health inequity refers to "differences which are unnecessary and avoidable, but are also considered unfair and unjust" (Whitehead, 1992, p. 191). In addition, Whitehead suggested that inequity implies a moral connotation. The use of "unfair" in Whitehead's definition of inequity can be problematic, as "fairness" can be interpreted in different ways, depending on the individual and the context. Throughout the literature, unfair has been gradually replaced with unjust, however, there has been little variation in the definition of health inequity. While multiple definitions have been suggested, it is agreed that inequities are avoidable, inherently unjust and can be changed (Asada, Hurley, Norheim, & Johri, 2014; Braveman & Gruskin, 2003; Browne, Varcoe, Ford-Gilboe, & Wathen, 2015; Graham, 2004; Marmot et al., 2008; Savage et al., 2013; Whitehead, 1992). A difference in health status is inequitable if it is systematically associated with a social determinant of health that would further disadvantage an already disadvantaged group (Braveman & Gruskin, 2003). This definition of health equity will be used for the purpose of this project. Therefore, inequities are unjust (Braveman & Gruskin, 2003; Browne et al., 2015).

Social inequities in health are essential to understanding why some people are healthier than others. Social inequalities are different from social inequities. Social inequalities refer to simple

differences between groups (such as males and females), whereas social inequities are the differences between groups that are considered unjust (Asada et al., 2014; Braveman & Gruskin, 2003; Graham, 2004; Whitehead, 1992). Inequities can be difficult to measure as it is challenging to quantify what an unfair difference in health is (Braveman & Gruskin, 2003). When Whitehead (1992) first proposed her definition, she recognized that judgment on what is considered "unfair" is context dependent. While Marmot (2007) suggests that inequities are unjust because good health should be attainable for everyone, health equity academics call for a quantifiable reason why inequities are unjust (Asada et al., 2014; Braveman, 2006).

With a renewed interest in health equity, there have been more comprehensive definitions proposed (Marmot, 2007). Braveman (2006, p. 180) suggests that inequities are: "potentially avoidable differences in health between groups of people who are more and less advantaged socially; these differences systematically place socially disadvantaged groups at further disadvantage in relation to health". Browne et al. (2015, p. 2) proposed that health inequities be understood "as socially constructed, unjust, and avoidable differences in health and well-being between and within groups of people".

Another dimension of equity that requires careful consideration is that equity is inherently ethical (Asada et al., 2014; Braveman, 2006; Braveman & Gruskin, 2003; Browne et al., 2015; Marmot et al., 2008). Asada et al. (2014) suggests that health differences due to inequities are ethically problematic. Marmot (2008, p. 1661) argues that reducing health inequities is an "ethical imperative". Braveman (2003; 2006) agrees and likens equity to principles of distributive justice (e.g., equitable allocation of resources in a given society). Browne et al. (2015, p. 2) suggests that equity in health is a "social justice goal". The WHO constitution, formed in 1946, states: "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (World Health Organization, 1946). All human rights are considered interrelated, and the right to health cannot be separated from other human rights (Braveman, 2006; Braveman & Gruskin, 2003). We have a right to health; therefore we have a right to all of the prerequisites of health. To enjoy the "highest attainable standard of health", inequities must be reduced.

b. Form and nature of social inequities in Canada

Social inequities in Canada occur along a number of dimensions. Some of the most important dimensions are: age, gender, education, income, occupation, ethnicity and region (i.e., the social determinants of health) (Grabb & Guppy, 2009; Wong, LaVeist, & Sharfstein, 2015).

Differences in power may exist in all of these dimensions and likely contribute to inequity (Grabb, 2007; Marmot et al., 2008; Marmot, 2007). Social class is central to the discussion of social inequities, as social class is an important axis on which health inequities act (Asada et al., 2014; Braveman, 2006; Grabb & Guppy, 2009; Marmot, 2007).

People living in BC generally experience good health, however, health is unevenly distributed throughout the province (Provincial Health Services Authority, 2016). Individual health status in BC depends on region, demographics, SES, Indigenous status, and gender. In 2016, the Provincial Health Services Authority, in collaboration with different health organizations across the province (including Fraser Health), released a report on health equity indicators for BC (Provincial Health Services Authority, 2016). The indicator categories in this report include life expectancy; early childhood development; adolescent health; and general population health. Measures of life expectancy serve as a good indicator of social conditions (e.g., wealth, occupation, access to healthcare and education) (Provincial Health Services Authority, 2016). In BC, life expectancy fluctuates based on an individual's sex, geographic region and SES. For example, individual's living in central and northern parts of BC have a shorter life expectancy compared to other regions in the province. Just as life expectancy varies based on sex, region and SES, so does early childhood development. For example, in different health service delivery areas, rates of language and cognitive development varied between 5.8% and 13.5% (Provincial Health Services Authority, 2016). The data presented here is only a small portion of the true extent of health inequities in BC. By continuing equity-based surveillance, Fraser Health aims to provide programs that reduce inequities.

As mentioned, health inequities are fueled by the unequal distribution of power (e.g., money, property, goods and services), which dictates how social hierarchies are formed (Braveman, 2006; Braveman & Gruskin, 2003; Marmot et al., 2008). This limits how specific social groups access the services they need (e.g., health, education) and restricts their attempts to achieve good health (Marmot et al., 2008). Inequities occur due to differences in social class. Ultimately, inequity is predicated on the notions of advantage and disadvantage (Braveman & Gruskin, 2003).

All income levels show a social gradient in health. The lower one's socioeconomic status (SES) the greater their chance of illness and poor wellbeing (Marmot et al., 2008). The social gradient does not necessarily single out those at the bottom of the gradient; rather, we are all implicated (Marmot et al., 2008). Where any given individual sits in the social hierarchy influences what

they are exposed to. Social hierarchies are entrenched in every society and not easily altered (Marmot, 2007).

c. Reducing Inequities

By defining social inequities in health, we can move towards reducing and/or mitigating these inequities through action on the social determinants of health. Reducing inequities will be challenging, as it often requires confronting harmful underlying social, economic and political structures (Braveman & Gruskin, 2003; Marmot, 2007). Health inequities are inherently complex and there is likely not one single social determinant of health that is the root cause of the inequity, as such, reducing inequities can be resource extensive (Braveman & Gruskin, 2003; Purnell et al., 2016). Ten years ago, Marmot (2007) called for an increased emphasis on "the causes of the causes", which he defined as:

> The causes of the causes are the fundamental structures of social hierarchy and the socially determined conditions these create in which people grow, work, live and age. The time for action is now, not just because better health makes economic sense, but because it is right and just. (p. 1153).

Reducing health inequities does require better access to health services, which the literature largely focuses on; however, that alone is not enough (Marmot, 2007). Empowerment is key and this extends to individuals, institutions and communities. In addition, actions on the social determinants of health is not limited to the health care system; rather, an intersectoral approach involving government, businesses, and communities must be utilized (Marmot et al., 2008; Marmot, 2007; Whitehead, 1992). An intersectoral approach emphasizes partnerships between organizations, institutions and government. Political structures are important because they have the capacity to develop coherent policy (Marmot et al., 2008). Coherent policy is a coordinated policy that extends action beyond health sectors to also include non-health related sectors. Finally, policies should not aim for equal health among all citizens, but focus on eliminating the causes of inequities (Whitehead, 1992). Differences in health (i.e., health inequalities) will always remain between different groups and individuals. By acting on the social determinants of health, we can work towards reducing inequities.

Diversity Services at Fraser Health is heavily involved in the HEWG. The training services they offer provide employees with the opportunity to learn about the ways in which diversity (i.e., age, gender, culture, education) occur in their day-to-day work. Given that health inequities often act

along similar axes, diversity awareness and health equity are interconnected. In addition, the health equity competencies developed in collaboration with PHABC contain a section on diversity and inclusiveness. For Fraser Health to achieve health equity, diversity and inclusiveness must be addressed.

1.3.2. Diversity Awareness Training

Diversity awareness training is becoming more common among organizations, including Fraser Health, who have developed diversity competency standards for health care providers. Diversity training can enhance organizational outcomes and capacity (Kalinoski et al., 2013). The aim of providing diversity awareness training is to change attitudes, knowledge and skills.

In 1993, Kraiger, Ford & Salas developed a framework based on the psychological literature that identifies three potential learning outcomes: affective-based outcomes, cognitive-based outcomes and skill-based outcomes. Affective-based outcomes drive our perception and behaviour, which can include attitudes, self-efficacy and intrinsic motivation (Kraiger, Ford, & Salas, 1993). Cognitive-based outcomes measure our verbal knowledge and learned strategies to act on our knowledge. Skill-based outcomes represent actual changes in our behaviour. Past studies have largely demonstrated that diversity awareness training has the largest impact on cognitive based outcomes (Kalinoski et al., 2013). The hope is that the training will encourage individuals to consider social hierarchies (which are inherently associated with inequities), as training is typically focused on race, gender, ethnicity and other facets of diversity.

Diversity training is typically divided into two categories: didactic teaching methods and methods that promote behavioral change (i.e., experiential learning) (Kalinoski et al., 2013). Kalinoski and colleagues (2012) conducted a literature review on diversity training process and outcomes. The authors took note of training medium, training duration, training source, practice spacing, setting, needs assessment, diversity training versus diversity education, choice in training, and task interdependence (Kalinoski et al., 2013). From their meta-analysis they found that diversity awareness training had small to medium effects on learning (Kalinoski et al., 2013). Factors that are critical to ensuring that diversity awareness training improves affective-based outcomes are: greater engagement between participants; a mix between active and passive forms of teaching; training that was provided through a human-instructor; and training that was longer than 4 hours. Diversity awareness training tended to be more effective when the participant was "motivated" (i.e., the educator was a manager/supervisor and not a fellow employee). In

addition, participants should understand why the training is important and how it will support them in their day-to-day work (Kalinoski et al., 2013). While diversity training generally showed positive outcomes, Kalinoski et al. (2012) acknowledge that it can be difficult to alter attitudes and biases in one training session. Ultimately, attitudes may change over time and not simply post-training.

Celik, Abma, Widdershoven, van Wijmen & Klinge (2008) aimed to investigate how diversity is integrated in current healthcare practices and to explore opportunities and barriers in the implementation of diversity awareness training. In this study, diversity is defined as, "a combination of certain dimensions of differences (e.g., biology, age, gender, culture and education) that interact and can result in dissimilar needs and preferences" (Celik, Abma, Widdershoven, van Wijmen, & Klinge, 2008, p.65). Their findings indicate that potential barriers to integrating diversity awareness training into healthcare settings include: lack of knowledge between provision of care and diversity; poor communication and difficulty understanding the patient's "story"; and health care organizations generally lack the time and resources to address diversity concerns (Celik et al., 2008).

1.3.3. Operationalizing these terms in a health authority setting

The overall goal of this project is to eventually build health equity and diversity awareness capacity among EHS and CCFL employees at Fraser Health. This aligns with Marmot's (2008) recommendations that to successfully promote change and tackle inequities, capacity needs to be developed in organizations and political will must exist to incite change. For health equity to be operationalized at Fraser Health there must be an agreed upon definition (Braveman, 2006; Braveman & Gruskin, 2003). However, the most common definition of equity has not deviated much from what Whitehead (1992) originally proposed. Braveman (2006) emphasizes that an operationalized definition of health equity must specify the role of social position in how inequities are experienced.

Health equity is a critical element of health care quality, including the services provided by EHOs at Fraser Health (Wong et al., 2015). In the past, equity has been discussed in terms of access to care rather than focusing on the underlying factors that contribute to equity in the first place. While improving access is a noble cause, it does not address the social determinants of health that contribute to inequities (Purnell et al., 2016; Wong et al., 2015). Health care organizations (i.e., Fraser Health) must understand the causes of inequitable access. In order to

improve the knowledge, beliefs and attitudes of employees at Fraser Health, health equity and diversity training programs need to be made available to all health care professionals (Celik et al., 2008).

1.4. Methods

1.4.1. Survey

To understand the health equity learning needs among environmental health services staff (Environmental Health Officers for Healthy Built Environment, Geographic, Drinking water; licensing officers (LO) for adult care, child care and the investigation team, managers, frontline leader/supervisor) a survey was developed with three EHS managers and a policy analyst in the HEPHU at Fraser Health. The survey adapted questions previously used on health equity surveys among HEPHU staff.

Through collaboration with the Public Health Association of British Columbia, Fraser Health developed new Public Health Core Competencies with a health equity lens (Simces & Ross, 2011). The aim of this project was to facilitate the effective delivery of core public health programs in BC. The 23 competency statements reflect the skills, attitudes and behaviours essential to public health staff in addressing health equity and in implementing health equity plans and programs. These competencies were developed in 2011, but have yet to be operationalized. Additional questions for the survey were developed based on these competencies and how they apply to EHS and the CCFL (Community Care Facilities Licensing) Program. A brief literature search was conducted to identify if health equity indicators exist and/or have been validated, but as this is an emerging field there was limited information available.

After two meetings with Fraser Health, a draft of the survey was developed and altered over the course of 2 weeks. Both surveys were created using the FluidSurveys platform provided by Simon Fraser University. Based on the needs of EHS at Fraser Health, two versions of the survey were developed. One version was specific to Environmental Health Officers and the other was specific to CCFL, given they have slightly different job descriptions. Both surveys contain a combination of multiple-choice questions with optional text responses. The CCFL version contains 28 questions and the EHO version contains 27 questions (i.e., the CCFL survey contains 11 competency statements whereas the EHO version contains 10 competency

statements). The general themes of the questions relate to health equity, the social determinants of health and diversity awareness, in addition to gauging employees' understanding of the PHABC health equity competencies.

The survey was distributed on Wednesday, February 8th and was left live until February 17th. The target sample for the survey was all EHO's and LO's employed at Fraser Health. A convenience sample was used and the survey was distributed by email through employees' managers to all of the target staff.

1.4.2. Focus Group

The EHS managers that I consulted with on the project expressed the need for only one focus group with EHOs regarding their knowledge and attitudes towards health equity and diversity awareness and future training programs. While a second focus group with managers was discussed, the EHS managers consulted indicated other EHS managers had a firm grasp on health equity and diversity awareness needs. Focus group participants were recruited through their respective managers, with 7 different managers being involved in this project. The managers represent different units at Fraser Health (e.g., water quality, geographic) or different regions (e.g., Surrey, Delta, White Rock).

There were 7 participants in total and the group was designed to be homogenous in that all members had similar roles at Fraser Health and came into the focus group with a working understanding of health equity and diversity awareness. The shared connections among the group (i.e., homogeneity) allowed for engaging and non-threatening dialogue. The focus group was held at Fraser Health's main office at Central City in a conference room. Fraser Health consent forms were provided at the beginning of the focus group. In total, the focus group ran for 70 minutes and was audio-recorded on two devices for convenience purposes. At the closing of the group, the facilitator (i.e., myself) provided a verbal summary of what was discussed to ensure I was correctly taking away what had been had discussed. Prior to the focus group, a comprehensive guide was developed in collaboration with two EHS managers that touched on the topics relevant to the project (e.g., health equity, diversity awareness, knowledge and training needs), however, the guide did allow for flexibility so participants could guide the discussion in engaging directions. I led the focus group discussion and by adhering to the focus group guide I minimized interviewer bias, as I only asked questions and probed when necessary.

The focus group discussion was transcribed verbatim and coded using thematic content analysis. Thematic content analysis aims to present the key themes of the focus group participants' descriptions (Green & Thorogood, 2014). Prior to identifying codes and themes, familiarization with the data was necessary. This included listening to the focus group and re-reading initial notes. From this initial process, I coded the transcript for recurring themes, metaphors and how participants described their work in terms of health equity. The initial codes were then grouped into broader themes.

1.4.3. Gap Analysis and Assessing Learning Needs

The purpose of this project was to identify potential knowledge gaps among EHS employees in terms of health equity, the social determinants of health and diversity awareness. To address these gaps, I assessed learning needs. A learning need is a gap that exists between employee's normal day-to-day work and managers desired practices (Continuing Professional Development, 2016a, 2016b). The purpose of the gap analysis was to identify if and what gap(s) exists, analyze the gap(s), and identify strategies to bridge the gap(s). The combination of the survey and focus group allowed for characterization of the size of the gap(s), whether EHS employees were aware of the gap(s), their current practices in addressing the gap(s), and if they were motivated to bridge the gap(s). From there, EHS can move forward by addressing the gaps and recommending educational resources.

In terms of health equity, EHS needs to develop organizational supports such as: shared vision, equitable policies and leadership and formal recognition that Fraser Health supports managers and their staff to address and reduce health inequities (PHABC, 2011 (Simces & Ross, 2011)).

1.5. Presentation of findings from survey & focus group

1.5.1. Results from Survey

a. Results from EHO Version

Table 1 Characteristics of Sample (n=27)

Position at Fraser Health	N (%)
EHO (Healthy Built Environment)	1(3.7)
EHO (Geographic)	19 (70.4)

EHO (Drinking Water)		3 (11.1)
Manager		1 (3.7)
PC		2(7.4)
Front Line Leader/Supervisor		1 (3.7)
Familiarity with Concepts	**Health Equity**	**Diversity Awareness**
Extremely Familiar	6 (23.1)	4 (15.4)
Moderately Familiar	9 (34.6)	11 (42.3)
Somewhat Familiar	7 (29.6)	7 (29.6)
Slightly Familiar	3 (11.5)	3 (11.5)
Not at all Familiar	1 (3.8)	1 (3.8)
Knowledge to Apply	**Health Equity**	**Diversity Awareness**
Strongly Agree	2 (7.7)	3 (11.5)
Agree	11 (42.3)	15 (57.7)
Neither agree or disagree	8 (30.8)	5 (19.2)
Disagree	4 (15.4)	2 (7.7)
Strongly Disagree	1 (3.8)	1 (3.8)
Frequency of Application	**Health Equity**	**Diversity Awareness**
Always	4 (15.4)	7 (26.9)
Often	5 (19.2)	7 (26.9)
Sometimes	10 (38.5)	7 (26.9)
Never	7 (26.9)	5 (19.2)

The majority of EHO respondents were from geographic (70.4%) or drinking water (11.1%). Most respondents indicated they were familiar with health equity and diversity awareness (57.7%). In terms of ability to apply these concepts, EHO's indicated they are more able to apply diversity awareness (69.2%) than health equity (50%). In addition, EHO's are more likely to apply diversity awareness in their day-to-day work (53.8%) than health equity (34.6%).

Based on the ten competency statements provided, there were three that EHO's expressed they were most unsure of. These included: *Able to establish trusting relationships with groups affected by health inequities to implement solutions* (59.2% expressed that they were unsure how to apply this in their daily work); *Demonstrate knowledge and understanding of Aboriginal people, immigrant populations, refugees, and visible minorities, their socio-political and historical context, in addressing health and health equity* (68.1% expressed that they were unsure of how to apply this in their daily work); *Able to adequately communication about the social determinants of health, diversity and health inequities* (68.1% expressed that they were unsure of how to apply this in their daily work).

Table 2 Priority of Training

Priority of Training to Daily Work	Health Equity *n* (%)	Diversity Awareness *n* (%)
Essential priority	2(9.1)	4 (18.2)
High priority	7 (31.8)	12 (54.5)
Moderate Priority	9 (40.9)	3 (13.6)
Low Priority	2 (9.1)	3 (13.6)
Not a priority	2 (9.2)	0

In terms of health equity, the majority of respondents indicated that training was a moderate priority (40.9%), compared to diversity awareness where majority indicated that training was a high priority (54.5%).

b. Results from CCFL Version

Table 3 Characteristics of Sample (n=11)

Position at Fraser Health	N (%)
LO (Adult Care)	5 (45.5)
LO (Child Care)	0 (0)
LO (Investigation Team)	4 (36.4)
Manager	1 (9.1)
Front Line Leader/Supervisor	1 (9.1)

Familiarity with Concepts	Health Equity	Diversity Awareness
Extremely Familiar	4 (36.4)	5 (45.5)
Moderately Familiar	3 (27.3)	3 (27.3)
Somewhat Familiar	3 (27.3)	3 (27.3)
Slightly Familiar	1 (9.1)	0 (0)
Not at all Familiar	0 (0)	0 (0)
Knowledge to Apply	**Health Equity**	**Diversity Awareness**
Strongly Agree	3 (27.3)	4 (36.4)
Agree	5 (45.5)	5 (45.5)
Neither agree or disagree	2 (18.2)	2 (18.2)
Disagree	1 (9.1)	0 (0)
Strongly Disagree	0 (0)	0 (0)
Frequency of Application	**Health Equity**	**Diversity Awareness**
Always	3 (27.3)	4 (36.4)
Often	4 (36.4)	3 (27.3)
Occasionally	4 (36.4)	4 (36.4)
Never	0 (0)	0 (0)

The majority of LO respondents were from adult care (45.5%) or the investigation team (36.4%). Most respondents indicated they were familiar with health equity (63.7%) and diversity awareness (72.8%). In terms of ability to apply these concepts, more CCFL employees indicated they knew how to apply diversity awareness (81.9%) than health equity (72.8%) in their day-to-day work. In addition, CCFL employees are likely to apply both diversity awareness and health equity (63.7%) in their day-to-day work.

Based on the eleven competency statements provided, there were four that CCFL employees indicated they were most unsure of. These included: *Able to establish trusting relationships with*

groups affected by health inequities to implement solutions (70.0% indicated that they were unsure how to apply this in their daily work); *Demonstrate knowledge and understanding of Aboriginal people, immigrant populations, refugees, and visible minorities, their socio-political and historical context, in addressing health and health equity* (60.0% indicated that they were unsure of how to apply this in their daily work); *Able to adequately communicate about the social determinants of health, diversity and health inequities* (70.0% expressed that they were unsure of how to apply this in their daily work); *Able to identify and provide information needed to conduct a health equity assessment* (62.5% indicated they were unsure of how to apply this in their daily work.

Table 4 Priority of Training

Priority of Training to Daily Work	Health Equity *n (%)*	Diversity Awareness *n (%)*
Essential priority	2 (20.0)	2 (20.0)
High priority	1 (10.0)	2 (20.0)
Moderate Priority	6 (60.0)	4 (40.0)
Low Priority	1 (10.0)	2 (20.0)
Not a priority	0 (0)	0 (0)

In terms of health equity and diversity awareness, the majority of respondents indicated that training was a moderate priority (60.0% and 40%, respectively).

c. Open Text Responses from Both Surveys

Both versions of the survey contained 8 questions with an optional open-text response. The first question asked was “In what ways do you see health equity occurring in your work?”. The two main categories that emerged from this question were the concept of legislation and conflation of equity with equality. The notion of legislation, mandate and regulation was a recurring theme and can be seen in the following answer:

> *“Our mandate is to enforce legislation, which doesn't seem to take health equity into consideration”*

An additional theme was respondents confusing equity with equality, which can be seen in the following answer:

> *"The population receives the same level of care regardless of class, incomes, or cultural background."*

When participants were asked the same question regarding diversity awareness, the majority of the answers referred to notions of cultural awareness and being sensitive to different cultures they may interact with. A few participants referred to being "culturally curious".

> *"Being curious about different cultures and assessing how different cultural practices still meet compliance standards. Being open to seeing compliance from a different lens."*

The final open-text questions with particular importance to this project regarded what training was needed to effectively apply health equity and diversity awareness in their everyday work environments. The responses were relatively similar across both surveys and both questions and included: workshops or certification where management is included; easy access to online resources; webinars; applicable examples of health equity and diversity awareness; modifying the mandate to allow for health equity and diversity awareness work; training on culturally safe interactions; training on how to apply health equity in terms of guiding regulation.

1.5.2. Focus Group Results

One focus group was conducted with a total of seven participants (three males and 4 females). The group was comprised of all EHOs across different Fraser Health regions. Overall, all participants had a working understanding of health equity and diversity awareness and came prepared with plenty of examples of how they see this in terms of their day-to-day tasks. The consensus from the group was that they felt limited, to a certain extent, by their job description in their ability to act on health inequities.

The focus group touched on several key themes identified in the literature, such as interpersonal collaboration; the need to make judgment calls; advocacy; upstream actions; resource intensiveness; and effective policy changes. The group also discussed additional topics, which are divided into themes. These key themes are developed further below, with enlightening, verbatim quotations where appropriate.

a. Organizational Barriers (i.e., "I don't have the legislative teeth")

Overall, the majority of the group expressed feeling limited, to some extent, with not having the mandate, regulatory authority, resources or legislative authority to adequately address health

inequities. For example, participants expressed having to justify the time they spent on tasks and if addressing health inequity was not included in their job description then their "hands are tied". While the group reported generally recognized inequities when they saw them, they expressed that reducing or mitigating those inequities, while well intended, was an "extra" task.

> "*It's hard when someone calls with an issue and says, but aren't you the health department? And you say yes, but I don't have the legislative teeth to get involved…What's the intent of the legislation? And that intent is a grey zone. Things are not black and white."*
>
> *"We can have all of these great ideas [to reduce inequities], but you have to bring money or some way to force people to do it. What's going to make people [reduce inequities] if it's easier to not [reduce inequities]?"*

In addition, many participants indicated they were "silo'ed" into their individual departments. Participants emphasized that better communication between departments may be an effective way to reduce inequities as well as an expansion of their job description that includes health equity work.

b. The Public vs. Individual Need

Many of the participants expressed that they often wanted to help individuals in inequitable situations, but the ultimate purpose of their job was to enforce regulation, no matter the situation. A few participants spoke to the notion of "bending but not breaking the rules", in that they felt more flexibility would allow them to reduce inequities without compromising the purpose of their role as an EHO. This theme also teased out a feeling of guilt for enforcing regulation on operators in inequitable situations.

> *"At the end of the day, you need to have a good sleep, because you know you did the best you could in that circumstance. The community is safe. They're protected from health and safety issues. You can't cross that line. We bend over backwards as much as we can, but at the end of the day, [the] community has to be kept safe"*

c. Conflating Equity with Equality

While overall the group had a working knowledge of equity, the social determinants of health and diversity awareness, and how to apply and/or identify these concepts in their day-to-day

work, the group generally used equity and equality interchangeably. The group recognized that inequities are unfair. However, many participants indicated that reducing inequities involved treating everyone the same.

> *"We need to make it fair and equitable. Regardless of how poor you are, your level of education or English, you get the same treatment."*

d. Advocacy

Many of the participants spoke about feeling passionate about reducing inequities, and therefore felt compelled to advocate on behalf of disadvantaged populations. Some of the EHO's expressed that when they came into contact with disadvantaged populations (e.g., refugees, new immigrants), they invested more of their own time to ensure the situation was dealt with correctly, and to the best of their ability. The bulk of EHO's job description is focused on enforcement related activities; however, a few participants indicated that they had the skills to advocate for and with disadvantaged populations.

> *"…because I could tell they felt like they didn't have a voice, I put in a little bit more [work]. I had to ask a few more questions. I had to do that. Just to make sure we were handing it off properly. I knew this population was disadvantaged."*

e. Training Requirements

Prior to the focus group, an EHS manager suggested that I ask the participants whether they were aware of the health equity work going on at Fraser Health and the resources available to them. When asked if they knew about the Health Equity and Population Health Unit I was greeted with surprise. Only one of the participants was aware of the equity work and training available at Fraser Health. In terms of health equity and diversity training, all of the participants expressed interest in receiving some sort of training that would enable them to effectively identify and mitigate inequities in the field. The group suggested a combination of online modules and in-person workshops would be helpful, and that to do this they would appreciate the support of their managers. Another participant suggested that a short module on health equity and diversity awareness be included in the new employee orientation required by all EHO's.

> *"Having health equity workshops and the diversity awareness modules are really helpful. A lot of us come from different backgrounds and we might only have one particular idea*

of what health equity or diversity awareness is. I learned a lot from the module. It helped me think outside of the box."

1.6. Discussion of results and limitations

The overall purpose of this project was to gain an understanding about the health equity and diversity awareness needs among EHS staff (e.g., EHOs & LOs) and to ultimately answer the following question: what are the health equity and diversity education needs of field staff?

Both the results from the surveys and focus group aligned with key themes in the literature, such as: intersectoral collaboration; the moral dimension of health equity; the resources required to reduce inequities; advocacy; and the difficulty of health equity work. In addition, both the focus group and the surveys indicated the need to include health equity and diversity awareness in EHS employees' job descriptions. Arguably, the most important result from this exercise is that an interest to pursue health equity and diversity awareness training exists among EHS employees. While the survey results indicate that CCFL employees are generally more comfortable with health equity and diversity awareness than EHO's, both groups of employees expressed that additional training in these areas was a priority.

The results also demonstrate, to some extent, an internal conflict. For example, participants expressed wanting to attend to health inequities, but found themselves prioritizing their day-to-day targets. The focus group participants recognized that while they might not have the tools to reduce inequities, they felt compelled to do something. This aligns with Celik et al.'s (2008) findings regarding the barriers and opportunities to implementing diversity awareness in a healthcare setting. Celik et al. (2008, p.65) identified "an emerging sense of urgency to attend to diversity" among healthcare employees. This notion of an "emerging sense of urgency" aligns with more so with the concerns expressed by the focus group participants, but also came through in the survey as well.

Identification of Gaps among EHS Employees

Based on the surveys, focus groups and gap analysis, the learning needs of EHS employees are largely defined as self-recognized or perceived needs (i.e., I know what I want and need to know) (Continuing Professional Development, 2016b). The following gaps, in terms of competencies and barriers to change have been identified.

Based on the results from the survey, EHS employees are unsure how to establish trusting relationships with groups affected by health inequities in order to implement solutions; they could improve their knowledge and understanding of Aboriginal people, immigrant populations, refugees and visible minorities, their socio-political and historical context, in addressing health and health equity; and they are unsure how to adequately communicate about the social determinants of health, diversity and health inequities. The root causes of these gaps are mostly lack of knowledge and skill; however, the attitudes among EHS employees toward change are largely positive. Additional gaps related to the health equity competencies emerged during the focus group. Based on the discussions among participants, EHS employees could have a stronger understanding about what health equity and health inequity mean and how these differ from health equality and health inequality/disparity. EHO's also expressed an interest in advocating for the populations they work with.

In addition to knowledge and skill based gaps, organizational barriers exist within Fraser Health that may make health equity and diversity awareness work more difficult. Participants from both the surveys and the focus group indicated the need for direction from their managers as to what is expected from them in terms of health equity and also the expansion of their job descriptions (i.e., mandate, jurisdiction, regulation) to allow them to fit health equity work into their daily tasks. However, if employees receive health equity training, they may find that they are able to effectively identify and reduce inequities without their job descriptions being altered.

Limitations

Several limitations exist in this project. In terms of the survey, the EHO version received 35 responses and the CCFL version received 13 responses. Among these responses, there was a 72% completion rate. In addition, information regarding how many EHOs and CCFL employees work at Fraser Health is restricted. Based on my conversations with EHS managers, it appears that the response rate to the surveys is over 50%. Since participants could choose whether they were going to complete the survey or not, selection bias may have been an issue.

Additionally, the participants for the focus group were specifically chosen by their managers, assuming that these employees would have a heightened interested in health equity and diversity awareness. This came through in the focus group discussions, as all participants were aware of health equity and passionate about it. Therefore, the results from the focus group may not be generalizable to the entire EHS department at FHS.

1.7. Potential Recommendations for Fraser Health

1. Prioritize health equity and diversity awareness training for EHS employees with a particular focus on EHOs in all settings.

2. Adapt a definition of health equity and diversity awareness that fits with the vision of EHS at Fraser Health. In addition, develop health equity and diversity awareness competencies, which can guide employees in applying a health equity lens in their day-to-day work. This will bring clarity to the link between health equity and EHS employees' job description.

3. Improve communication between EHS managers and field staff as to what is expected of employees in terms of health equity and diversity awareness.

4. Based on the gap analysis, the following modules/workshops are recommended:

Table 5 Suggested Modules and Workshops for Staff

Observed Gaps	PHABC Competency Statements	Fraser Health Course	External Course
Definition of health equity and health inequity and how these differ from health equality and health inequality/disparity	Understand what health equity and health inequity mean and how this differs from health equality and health inequality/disparity.	Vulnerable Populations Module 1	Community Approaches to Advance Health Equity Course; Monitoring Trends in Health Inequalities in Canada Course; SickKids Hospital: Social Determinants of Health
Unsure how to establish trusting relationships with groups affected by health inequities in order to implement solutions	Able to establish effective relationships (e.g., trusting, non-judgmental/respectful, sustainable, collaborative) with population groups affected by health inequities to jointly assess needs, test and implement solutions.	Vulnerable populations, Module 4: Relational practice	Collaborative Decision-Making With Communities Course
Interest in advocating for the populations they work with	Able to advocate on behalf of and with populations affected by health inequities.	[--gap--]	Health Compass: Advocacy
Little knowledge and understanding of Aboriginal people, immigrant populations, refugees and visible minorities, their socio-political and historical context, in addressing health and health equity	Demonstrate knowledge and understanding of Aboriginal peoples, their socio-political and historical context, and jurisdictional issues, in addressing health and health equity.	Indigenous Cultural Competency Training	

Adequately communicate about the social determinants of health, diversity and health inequities	Able to use best practices in framing and communicating about social determinants of health and health inequities.		Community Tool Box: Module 7: Developing an Intervention

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Appendix A: Survey Questionnaire

Health Equity and Diversity Education in EHS

Thank you for agreeing to take part in this survey, which has been designed to gain a better understanding of staff's knowledge and attitudes towards health equity and diversity, to identify what skills staff already possess and what they require further training for. The information collected here will be used to help better understand the cultural awareness and diversity education needs of field staff working within EHS. It is hoped that by having a better understanding of our work related cultural climate, we can better shape our policies and practices to improve the care and services we provide to the public.

This would not be possible without your valuable input and participation. Thank you for taking the time to contribute to this work and help us improve the services we provide to the public.

This survey should take no more than 10-15 minutes to complete. All responses are treated as confidential. No identifying information is connected to your survey answers other than what you answer in the survey. In no cases will responses from individual participants be identified. Your answers from this survey will be combined with others' answers and reported in combined form only. The results of this pilot testing of this survey will be reported in a class assignment. No identifying information, such as your name, will be released or included in the class assignment.

This survey is being hosted by FluidSurveys, which stores the survey data in a secure server located in Canada. FluidSurveys is a commercial provider external to Simon Fraser University. Their parent company is owned and operated in the United States and in extraordinary circumstances staff in the United States may access the surveys and survey data hosted in Canada.

Questions in this survey are related to the concepts of health equity and diversity/cultural awareness. Please consider these concepts in the context of carrying out your work in:

- Enforcing applicable regulations and by-laws
- Identifying all factors detrimental to community and environmental health

- Performing education, research, assessments, analytical tasks
- Facilitating community engagement and community capacity building to optimize planning and implementation of provincial population health strategies
- Advocating for healthy public policies that contribute to population health of a community
- Investigating complaints

These concepts are defined as:

Health equity: The concept of health equity refers to eliminating unfair and unjust gaps in health outcomes for various groups and communities that stem from avoidable socioeconomic or sociological disparities.

Social determinants of health: The social determinants of health are defined as "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness" (WHO, 2013). The health of our communities is influenced by the social, environmental and economic conditions in which we live. These are often called the social determinants of health and include factors such as: education, income, gender, race or ethnicity, supports during early child development, and access to safe and affordable housing.

Diversity Awareness: Diversity is any dimension that can be used to differentiate groups and people from one another. It means respect for and appreciation of differences in ethnicity, gender, age, national origin, disability, sexual orientation, education, and religion.

If you have any questions or difficulties during the survey, please contact:

Cheyanne Stones

cstones@sfu.ca

Cell: 604-868-3346

Ken Shaw

Shawken.shaw@fraserhealth.ca

If you agree to participate in this questionnaire, click on the "I Agree" button on the bottom right of this page to begin:

1. Which of the following best describes you?

- ○ EHO - HBE
- ○ EHO - Geographic
- ○ EHO - Drinking Water
- ○ LO - Adult Care
- ○ LO - Child Care
- ○ LO - Investigation Team
- ○ Manager
- ○ PC
- ○ Frontline leader/supervisor
- ○ Other, please specify... _____

2. How would you describe your familiarity with these concepts?

	Extremely familiar	Moderately familiar	Somewhat familiar	Slightly familiar	Not at all familiar
Health Equity	○	○	○	○	○
Social Determinants of Health	○	○	○	○	○
Diversity Awareness	○	○	○	○	○

3. Do you understand the relationships between health equity, social determinants of health, and diversity awareness?

- ○ Strongly agree

○ Agree

○ Neither agree or disagree

○ Disagree

○ Strongly disagree

4. In your current position, how important are the following concepts?

	Not at all important	Somewhat important	Neutral	Important	Very important	Not applicable
Health Equity	○	○	○	○	○	○
Social Determinants of Health	○	○	○	○	○	○
Diversity Awareness	○	○	○	○	○	○

5. Do you know how to apply these concepts in your work?

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
Health Equity	○	○	○	○	○
Social Determinants of Health	○	○	○	○	○
Diversity Awareness	○	○	○	○	○

6. How often do you apply these concepts in your day to day work?

	Always	Usually	Occasionally	Never
Health Equity	○	○	○	○

Social Determinants of Health	○	○	○	○
Diversity Awareness	○	○	○	○

7. Do you have any examples of how you apply health equity in your work?

8. Do you have any examples of how you apply the social determinants of health in your work?

9. Do you have any examples of how you apply diversity awareness in your work?

For the questions below, please review each and choose the statement below that best describes your understanding of the question, and how important this is in your work.

10. Question 1: demonstrate how health equity is associated with the social determinants of health. How do you rate your understanding in this area?

- ○ I am skilled in this area and regularly apply it in my work
- ○ I have some skills in this area and am looking for opportunities to apply it in my work
- ○ I have some skills in this area, but am not sure how to apply them to my work
- ○ I am not skilled in this area and am unsure how to apply it in my daily work

11. Question 2: Able to appropriately address identified health inequities. How do you rate your understanding in this area?

- ○ I am skilled in this area and regularly apply it in my work
- ○ I have some skills in this area and am looking for opportunities to apply it in my work
- ○ I have some skills in this area, but am not sure how to apply them to my work

○ I am not skilled in this area and am unsure how to apply it in my daily work

12. Question 3: Able to provide services designed to prevent and/or reduce health inequities. How do you rate your understanding in this area?

○ I am skilled in this area and regularly apply it in my work

○ I have some skills in this area and am looking for opportunities to apply it in my work

○ I have some skills in this area, but am not sure how to apply them to my work

○ I am not skilled in this area and am unsure how to apply it in my daily work

13. Question 4: Able to engage in partnerships with diverse stakeholders to reduce health inequities. How do you rate your understanding in this area?

○ I am skilled in this area and regularly apply it in my work

○ I have some skills in this area and am looking for opportunities to apply it in my work

○ I have some skills in this area, but am not sure how to apply them to my work

○ I am not skilled in this area and am unsure how to apply it in my daily work

14. Question 5: Able to utilize the strengths that EHS, CCFS and other components of Fraser Health can bring to addressing health inequities. How do you rate your understanding in this area?

○ I am skilled in this area and regularly apply it in my work

○ I have some skills in this area and am looking for opportunities to apply it in my work

○ I have some skills in this area, but am not sure how to apply them to my work

○ I am not skilled in this area and am unsure how to apply it in my daily work

15. Question 6: Able to establish trusting relationships with groups affected by health inequities to implement solutions? How do you rate your understanding in this area?

○ I am skilled in this area and regularly apply it in my work

- ○ I have some skills in this area and am looking for opportunities to apply it in my work
- ○ I have some skills in this area, but am not sure how to apply them to my work
- ○ I am not skilled in this area and am unsure how to apply it in my daily work

16. Question 7: Able to advocate (i.e., support and promote the rights of individuals) on behalf of and with populations impacted by health inequities. How do you rate your understanding in this area?

Example: An organization conducted a survey on waste issues in five neighbourhoods. The focus of the advocacy campaign was the management of household waste in these neighbourhoods. They worked with 8 neighbourhoods to implement a household waste collection process to deal with a lack of services from the municipality in this area (Candian Public Health Association, 2009).

- ○ I am skilled in this area and regularly apply it in my work
- ○ I have some skills in this area and am looking for opportunities to apply it in my work
- ○ I have some skills in this area, but am not sure how to apply them to my work
- ○ I am not skilled in this area and am unsure how to apply it in my daily work

17. Question 8: Able to understand the influence of diversity on health equity (e.g., where diversity includes unique values, social, political, historical, physical, spiritual, mental, gender, economic, environmental and cultural experiences). How do you rate your understanding in this area?

- ○ I am skilled in this area and regularly apply it in my work
- ○ I have some skills in this area and am looking for opportunities to apply it in my work
- ○ I have some skills in this area, but am not sure how to apply them to my work
- ○ I am not skilled in this area and am unsure how to apply it in my daily work

18. Question 9: Demonstrate knowledge and understanding of Aboriginal people, immigrant populations, refugee's, and visible minorities, their socio-political and historical context, in addressing health and health equity. How do you rate your understanding in this area?

- ○ I am skilled in this area and regularly apply it in my work
- ○ I have some skills in this area and am looking for opportunities to apply it in my work
- ○ I have some skills in this area, but am not sure how to apply them to my work
- ○ I am not skilled in this area and am unsure how to apply it in my daily work

19. Question 10: Able to adequately communicate about the social determinants of health, diversity, and health inequities. How do you rate your understanding in this area?

- ○ I am skilled in this area and regularly apply it in my work
- ○ I have some skills in this area and am looking for opportunities to apply it in my work
- ○ I have some skills in this area, but am not sure how to apply them to my work
- ○ I am not skilled in this area and am unsure how to apply it in my daily work

20. How much of a priority is health equity training to you and your work?

- ○ Essential priority
- ○ High priority
- ○ Moderate priority
- ○ Low priority
- ○ Not a priority

21. In what ways do you see health equity occurring in your work?

22. What do you need in terms of training to be able to comfortably identify health inequities?

For example: health equity workshops, online courses, health equity certification, or easy to access resources?

23. How much of a priority is diversity awareness training to you and your work?

- ○ Essential priority
- ○ High priority
- ○ Moderate priority
- ○ Low priority
- ○ Not a priority

24. In what ways do you see diversity awareness occurring in your work?

25. What do you need in terms of training to be comfortable with diversity awareness?

For example: diversity training workshops, online courses, diversity awareness certification, or easy to access resources?

26. Thank you for agreeing to take part in this survey. Is there anything else you think we should know?

Appendix B: Focus Group Guide

Questions:

1. What are your thoughts about health equity and diversity awareness in how they apply to your work?
2. What are some ways that health equity is different from diversity awareness?
    a. What ways are they the same?
    b. Is one concept more applicable in your work?
3. What are the groups you work with that may be marginalized or experiencing inequities?
    a. What information would you need to make these groups easier to identify?
        i. 2 page fact sheet on populations?
        ii. Tips on identifying potential inequities?
4. What groups /populations would you like to learn more about for your day-to-day jobs?
5. What do you need to make inequities easier to address or mitigate?
    a. Online resource?
    b. Rapid HEAT?
    c. Are you aware of the training offered by diversity services? Or the HEAT developed at Fraser Health? If you were aware of these services, would you use them?
    d. What features need to be included in a resource if you were to use it?
6. What are some ways you currently apply these concepts in your work?
    a. Populations you work with?
    b. Investigating complaints?
7. How comfortable do you feel applying these concepts in your day-to-day work?
    a. Why do you feel that way?
    b. Is there one concept that you feel more comfortable with?
8. What sort of training would be the most helpful for you to better be able to apply health equity and diversity awareness?
    a. What current training do you have to complete for your job? BCIT?
    b. Are you aware of the current training in health equity and diversity awareness at Fraser Health?
    c. What do you like/not like about it?
    d. Face-to-face workshops? Online modules? Conferences?