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The Cultural Competence of General Hospitals in Israel

Irit Elroy ✦ Michal Schuster ✦ Ido Elmakias

The study was conducted with the assistance of the Israel National Institute for Health Policy Research

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Executive Summary

Background

The population of Israel is heterogeneous, consisting of varied religious, cultural and linguistic groups. To help promote equality in the health system, a Director-General's Circular (DGC) went into effect in February 2013 defining objectives and standards for the cultural and linguistic adaptation of health services to promote cultural competence (CC).

The CC of a health system is its ability to provide care to patients abiding by different values, beliefs and behaviors, and to adapt the care to their social, cultural and linguistic needs. In the current study, we focused on the ability of Israel's hospitals to meet these cultural and linguistic needs.

In this study, "Cultural Adaptation" refers to the process undertaken by health organizations to achieve cultural competence.

Another term used in the study is "linguistic accessibility": the steps taken by health organizations to make services accessible to people speaking different languages.

This is the first study to map the CC of general hospitals in Israel. It was conducted near the time of publication of the DGC (2013). Its timing was designed to examine the state of CC at an early stage of the roll-out for the findings to serve as a basis for further examination in the future.

Study Goals

- To evaluate the state of CC in hospitals
- To identify the factors enhancing or inhibiting the promotion of CC in hospitals
- To learn of hospitals' activities and programs to promote CC
- To examine the hospitals' needs for the promotion of CC.

Research Methods

The study surveyed 35 of the 39 general hospitals in Israel. Organizationally, the hospitals in the study had diverse affiliations; geographically, their distribution was broad. The study consisted of three components to be described below: mapping, observation and in-depth interviews.

Mapping – To evaluate the state of CC, we held an interview in each of the 35 hospitals with the Cultural Competence Coordinator or a senior administrative staff member (involved in the topic of CC). The interviews were conducted using a closed mapping tool that we developed, based on well-known international standards in the field, and on the guidelines of the DGC. The tool consisted of 75 statements grouped together into 10 topics (e.g.: the organizational policy of a hospital on CC; oral translation in the course of an examination, and training staff in CC). According to the measure of CC developed for this study, every hospital was defined as an observation and received a score (from 0 to 4) for each of the 10 topics, according to grades given by the interviewees to each statement comprising a particular topic. To calculate the measure, we computed an average score for each of the 10 topics and an overall average for all of the topics. This overall average score is the hospital's score on the CC measure.

Observation – At 10 large hospitals (in this study, a large hospital is one with more than 300 beds), we examined the linguistic accessibility of the signposting with the help of an observation tool and the measure of linguistic accessibility developed by the research team. The assumption is that linguistic accessibility increases as the proportion of signs appearing only in Hebrew decreases, and the proportion of signs with Arabic/ English/ Russian increases. In each of the 10 hospitals observed, the observations followed three routes taken by a "typical visitor": from the main entrance, the routes branched out – to the emergency room, to the department of internal medicine, and to the outpatient reception office. The hospital signs were counted using the following categories: signs in Hebrew only; in Hebrew, with Arabic; in Hebrew, with English; and in Hebrew, with Russian. The scores on the linguistic accessibility measure for signposting ranged from 0 to 1. The higher the score received (the nearer to 1), the more linguistically accessible a hospital was to the populations speaking the given languages.

In-depth interviews – At 18 hospitals, we also conducted semi-structured, in-depth interviews with the officers in charge of CC and at 9 of these, with a senior administrator as well. In-depth interviews provide a better understanding of the hospital process promoting CC, shedding light on: the attitudes to the DGC and to the question of CC; the barriers to, and facilitators of, CC; the requirements of hospitals in order to improve CC; and the plans they have in order to do so.

All the interviews were conducted between December 2012 and February 2014. The observations took place between April and June 2014.

Main Findings

a. Findings from the Mapping

- The average summary score for all the hospitals on the overall CC measure was 2.2 on the scale of 0 to 4 – a relatively low to moderate average. The range of scores was large, from 0.7 to 3.2.
- The analysis of CC scores revealed that the CC levels of the hospitals were not uniform.
  - Governmental hospitals scored the highest followed by public ones. Private hospitals received the lowest average score on the CC measure.
  - Hospitals that had completed the process of accreditation from the US Joint Commission International (which sets standards of patient care) had a higher CC level than the others.
  - Hospitals in the center and south were at a higher CC level than hospitals in the north and in the Jerusalem district.
  - A hospital's peripheral status and size had only a weak relation to the level of CC.
- A hospital's peripheral status and size correlated less with the CC level.
- An analysis of the organizational steps taken by hospitals showed that the most important ones for CC were the existence of a work program and a steering committee on the topic.

b. Findings from the Observations

The linguistic landscape of hospital signposting:

- The scores (on a scale of 0 to 1) received by 10 hospitals on the signposting measure was large, ranging from 0.14 to 0.69.
- 59% of the signs were only in Hebrew; 19% of the signs were in English as well as Hebrew; 18% were in Arabic as well as Hebrew; 4% had also Russian.

Placement of Sign on Visitors' Route

The signposting en route to the department was the most accessible (i.e., appearing not only in Hebrew, but also in English, Arabic and Russian more so than elsewhere in the hospital). This was followed by the signposting at the main entrance and, then, in the department itself.

Type of Hospital Department

The emergency room was more accessible linguistically than the outpatient clinics or the department of internal medicine.

Type of Signposting

Directions and warning signs were more accessible linguistically than signs about what to do in case of an emergency, instructions, and prohibitions. Information signs (e.g. signs indicating visiting hours) were less accessible still.

c. Findings from the In-Depth Interviews

Attitudes to the DGC and the Question of CC:

- On the whole, the DGC was perceived as positive and to the point. It was perceived as a document presenting an appropriate goal, yet unsatisfactory because it was not backed up by financial resources for implementation.
- According to interviewees, the DCG charted the main lines for improving CC but, in part, was insufficiently detailed and did not provide clear guidelines for implementation.
- In some hospitals, the Circular was perceived as yet additional provisions to implement, i.e., as a burden on a system already overladen and coping with guidelines and procedures on other topics (e.g., preventing infection).
- The interviews revealed that some interviewees saw CC primarily as linguistic accessibility, with less attention to the broader sense of the term.
- Interviewees were in agreement that CC is an important, appropriate topic. The reasons they cited were: the quality of care and of the service, physician-patient relations, egalitarian and fair service, a humanistic approach, and a sense of service.

Factors Inhibiting the Implementation of the DGC Guidelines and the Promotion of CC:

- The absence of budgetary support and prioritization: Given that the hospitals suffer from budget deficits, they all reported a lack of funds as the main barrier to promoting the topic. In this situation,, when allocating budgets for various needs in the hospitals, cultural competence

receives lower priority. Funding is in fact the main barrier as it does not permit the hospitals to progress on the topic or cope with additional obstacles, such as a lack of staff cooperation (mainly physicians) or of knowledge of the activities necessary for purposes of meeting the standards (particularly cultural adaptation).

- The absence of a formal staff position to be in charge of CC: It is difficult to promote the topic without assigning a specific position for the purpose. The fact that the position is filled by a staff person on top of their regular jobs hampers the development of broad, continuous processes.
- Little cooperation between departments in the same hospital and between hospitals, and the absence of resource pooling: Hospitals had taken steps to promote CC even before the promulgation of the DGC, particularly with respect to aspects responding to needs in the field. Today, too, the hospitals come up with solutions, but these are local and specific (at the level of the hospital and sometimes of the department) rather than common or systematic responses. Each of the hospitals usually contends with similar challenges in an attempt to find solutions. The inefficiency of the system is reflected in this separate coping, each hospital constantly "reinventing the wheel" in their own specific solutions.
- The guidelines of the DGC on translation into assigned languages: The Circular calls for translating forms and signs into specific languages although, at times, the main target populations of the hospitals may not speak these languages.
- The promulgation of the DGC: Despite general agreement over the importance of the topic, the Circular aroused opposition because it was not accompanied by funding provisions or other resources. It was perceived as yet another Circular – one of many – to "descend" on the hospitals without backing. The manner of presentation may have provoked as much opposition as the funding problem itself.

Additional inhibiting factors were: limited time resources, the absence of a written work program, the difficulty of enlisting staff cooperation, and little awareness by staff personnel of the importance of CC.

Existing Factors Promoting the Implementation of the DGC and CC:

- Interviewees cited the important role of the DGC guidelines: the guidelines placed the topic of CC on the agenda and served as an incentive to promote CC. The Circular has been described as a mechanism for raising awareness of the importance of CC and of the obligation to follow it.
- The process of accreditation from JCI, which is incumbent on hospitals, is a prominent factor cited as accelerating the implementation of the Circular and the processes of CC.
- The enlistment and support of the hospital management were cited as a highly influlential factor in the process.
- It was noted that hospitals use available external resources such as the translated medical forms of the Israel Medical Association, or the Tene Briut telephone translation service ("Voice for Health" to respond to the immediate gaps in language and culture encountered by Ethiopian immigrants when receiving medical treatment). Staff members also participated in instruction on

CC provided by the Ministry of Health. Initiatives of this type illustrate resource pooling and the creation of infrastructure to assist hospitals provide responses.

Additional factors promoting CC: High staff awareness, an involved hospital administration, external funding from organizations and foundations, and a risk management mechanism.

What would help the hospitals promote CC and what are their plans for the future?

- Funding earmarked to promote CC – Since one of the main barriers to promoting CC is financial, interviewees were unanimous about the need for funding, preferably a dedicated budget. The tendency of the respondents was to propose solutions to problems of linguistic accessibility (e.g., signposting and translating forms). These solutions are seen as relatively simple since they do not require staff cooperation. However, they do involve high costs. According to the interviewees, these topics will not be promoted unless there are dedicated budgets.
- Raising awareness of the importance of CC – Activities among the staff to help promote CC within a hospital would include training and in-house sessions for various types of personnel to help them understand the significance of CC – from a component of appropriate care to risk management in medical treatment. Currently, due to the lack of resources (finances and time), training is held on a small scale. In the opinion of the interviewees, there should be training frameworks to provide staff with the proper knowledge and tools. One recommendation was to integrate the CC content into the professional training of staff personnel. In this context, it might be beneficial to use the CC training kit developed by the Ministry of Health and introduced into several health organizations.
- A formal fulltime position for a CC officer – Although most hospitals do have a staff member in charge of CC, in every case their CC duties are imposed in addition to their official jobs.
- Sharing resources and knowledge, and receipt of training – For instance, to promote the topic, hospitals with the same organizational affiliation might share experiences and ideas with one another by having the CC officers hold regular, joint meetings in a given period. This is a form of peer learning. Since the field is new to all the officers, they also expressed a need for additional, more long-term training. They said that apart from the knowledge gained, the training branded the officers since it denoted recognition of the topic.
- Overall broad support – The hospitals reported a need for support for a range of CC aspects in order to promote the topic in their organizations. This need arose mainly in the context of implementation on a large scale, such as signposting, translation of forms and staff training. Hospitals asked that the support be given not only at the Ministry level but also at the hospital affiliation level (for example, Clalit hospitals).

Policy Implications and Programmatic Directions

A number of programmatic directions might promote CC:

a. ***Publication of appendices to the Circular*** – Given the difficulties of hospitals to translate some of the DGC guidelines into practice, it is important to publish the appendices with clear definitions and guidelines to implement the standards. They should relate to topics of quality,

standardization and control to help the officers in charge implement the standards and offer clearer, more detailed directions.

b. ***Translation for target populations*** – The Circular speaks of obligatory languages for translation although every hospital has different target populations. It would seem more appropriate to translate signs and forms into the languages of the populations requiring a response in each hospital.

c. ***Preparing a yearly work program and appointing a steering committee*** – These two provisions were found to be positively associated with a high level of CC. It is therefore suggested that they be adopted by every hospital to help promote the topic.

d. ***Allocation of dedicated resources*** – It is important to earmark specific resources solely for the promotion of CC, such as an assigned budget, training, formal job positions for CC officers, and the translation of forms.

e. ***Resource pooling and streamlining*** – The hospitals require an apparatus to pool resources on topics that are crosscutting and widely applicable. Resource pooling could enhance system efficiency in resolving such issues as the translation of forms, an interpreter service, signposting and training. Among other things, it could help create broad infrastructure to promote CC. Examples are the establishment of a telephone translation service and the preparation of an instruction kit on the topic developed by the Ministry of Health.

f. ***Branding CC as a stamp of quality of hospital care and services*** – Branding could raise awareness of the importance of CC while emphasizing its short- and long-term benefits could act as an incentive to its implementation.

g. ***Regulation, control and enforcement*** – The hospitals require direction and constant reminders for CC to remain on the agenda. The regulator has a role to play in supervising and enforcing the guidelines of the Circular. Measuring hospitals by structured standards and indices of quality, and making CC a condition of their licensing could help promote the topic.

h. ***Consistent ongoing peer learning*** – This sort of learning at conferences and on seminar days (of the kind that the Health Ministry has initiated in other areas), may also promote the CC and the professionalism of the staff in charge. Hospitals may be able to learn from the experience of counterparts who are leaders in this respect.

i. ***Awareness of the cultural needs of patients from the majority population*** – In the inter-cultural encounter of patient and caregiver, there should be more awareness of the cultural needs of the majority population that comes into contact with caregivers from a different culture. It is also important to raise the awareness of special needs populations with physical or intellectual disabilities.

j. ***CC as an additional aspect of service provision*** – Integrating the topic of linguistic and cultural accessibility into workshops on service provision might help enlist the commitment of staff members who show little devotion to CC (mainly physicians).

k. ***Performing a repeat mapping in the future*** – This study examined the state of CC of hospitals at the time that the DGC went into effect. It would be important to repeat the mapping of CC in another two years to see the extent to which the hospitals have progressed in implementing the guidelines of the Circular.

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