INTEGRATING CULTURAL COMPETENCE IN HEALTH ORGANIZATIONS IN ISRAEL: A CONCISE GUIDE

BY THE JERUSALEM INTERCULTURAL CENTER
CULTURAL COMPETENCE TEAM

This document will help your health organization provide services appropriate to the needs of different cultural populations in order to improve their cooperation with the proposed care, and their health outcomes. In addition to the patient's perspective, this document relates to the implications of adapting the organization to diversity among staff members.

Due to the concise format of this document, we have chosen to write it in general terms so that it can serve organizations involved in community health as well as those that provide tertiary health services. We are aware that some issues may be more relevant to one type or another of health organization, but for the purpose of convenience, we have decided to present the recommendations in a single, inclusionary document, enabling the readers to choose the actions relevant to their organization. The document presents ten principle subjects in the context of which health organizations need to adapt their services, and offers gradual implementation: the initial actions that are required, activities for implementation and activities to maintain the change.

There are various definitions to organizational cultural competency in the Israeli discourse. Some definitions overlap, and we are sometimes asked what is the best definition: "cultural competence", "cultural appropriateness", "cultural humility" or perhaps "cultural safety". This multiplicity of definitions is a typical discourse for an emerging professional field. Currently, the accepted definition elsewhere to the practical changes performed by organizations in order to provide care to diverse populations is "cultural competence", or "cultural competency" (*Kshirut Tarbutit*, in Hebrew). Cultural competence in health care describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs (definition taken from Betancourt, Green and Carillo, 2002: v).

Integrating cultural competence processes in the organization is not a one-time step, but rather a constant process, integrated in all of the organization's levels. Sharing of knowledge, methods and resources among organizations can significantly improve the successful implementation of the processes.

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Acknowledgments

We are deeply grateful to a large number of people who contributed their experience and expertise to make this guide relevant and useful. The main part of the draft is based on the Jerusalem Intercultural Center's work since 2008, in cooperation with health organizations in Jerusalem, and afterward in different places in Israel. We collected many comments to the draft from people who are working in cultural competence within the health system and in academia, in Israel and in other countries. In addition, we were assisted by cultural competence coordinators in health organizations, and by additional experts who attended a meeting about the draft document that we held in April 2013 at the Schoenbrun Nursing School in Tel Aviv.

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We received comments and ideas, many of which have been used in this version, and others will be used in more detailed expansions of different chapters, which will include much more information and practical tools. Although this document is not considered a draft any more, additional comments, suggestions and insights, which will be inserted to forthcoming versions of the guide, are welcome. They can be sent to: jicc@jicc.org.il.

With thanks,

The Jerusalem Inter Cultural Center

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Content

1. The Recommended initial steps for a culturally competent organization

As of late 2012, most Israeli health organizations have been exposed to the cultural-competence approach, either by means of the directive of the Director-General of the Israeli Ministry of Health (07/11), or in the context of previous activities in the field. For the organizations that are just starting out in this area, here are some recommendations that can help to engage the management, awaken interest in this approach throughout the organization, and begin to formulate an integrative cultural competence program.

- Appoint a staff member to be in charge of coordinating all activities related to cultural competence in the organization. (see page 6 for a detailed role description). In addition it is important to identify a senior, influential figure in the organization, who is committed to the process and will promote it, alongside the official coordinator.
- Hold an "first glance" session or workshop for the management, in which the subject and its clinical and risk-management implications will be presented.
- Convene a multidisciplinary steering committee whose role will be to map out needs, divide up tasks, obtain authorizations from the management to carry out the tasks, determine the resources needed for the change, and manage the process overall. The committee's work is ongoing and not limited to the ignition of the process. It is important that the committee include senior managers, in addition to the CC coordinator and other stakeholders.
- Define the rationale for the integration of CC in the organization, e.g: complying with legal requirements, risk management, quality of service and care, and patient and staff satisfaction.
- Map out needs and existing resources: to make the organization effectively accessible to the relevant populations, the organization must obtain a clear picture of the language and cultural groups that use its services. Further to the mapping, the needs, from which the required resources are derived, must also be defined. The mapping can be carried out using one or more of the following methods: a survey among the service providers on their experience with people from other cultures; a survey among the clients or their representatives from among the different groups; a comparison of the patterns of requesting and using the services; or a sample of clients majority and minority groups. At the same time, all the existing available solutions should be mapped out, and the outline in this guide may be helpful in this respect. The mapping will demonstrate unmet needs (e.g. language barriers, staff frustration) and presenting it will assist the management to understand the importance of the subject, and allocate resources.
- Adapt the organizational vision and policy guidelines to the cultural competence approach – the organizational vision should be examined to see if it relates to the subject of cultural competence (as well as if it contains aspects that contradict principles of cultural competence).

- Identify barriers in the existing policies to the realization of the cultural-competence process.
- Build a (multi-year, gradated) strategic plan to achieve the cultural competence targets. The program relates to issues of diversity, inclusion and equality, as well as to discrimination at the workplace. Among other things, the adaptation of the vision also requires setting the organizational procedures needed to implement the change. It is important that the strategic plan be public and transparent for the staff members.
- Allocate financial and human resources for the process as derived from the strategic plan.
- Launch the process gradually: in a single department/clinic or in a small number of departments/clinics, whose employees are likely to cooperate with promoting the subject so that a change regarding cultural competence will be seen on the ground and produce results.
- Learn about cultural competence from health organizations that have already undergone similar processes.
- Publish the management's (organizational) commitment to promote equality and CC - as a declaration of intent that will lead to ongoing action.

2. Cultural Competence Coordinator

The desired outcome: The coordinator of cultural competence is a senior staff member, who is committed to the subject, and has overall responsibility of the CC activities. The role includes the development, management and integration of infrastructures, and the broadening of the organization's ability to contend with language and cultural gaps.

The coordinator is responsible for the entire designated activities on cultural competence, including:

- Coordination of the cultural competence committee in the organization. (Preferably, this will be a multi-disciplinary committee, which will represent diversity of professions, units and cultural identities.) Representation the organization in relevant forums.
- Significant involvement in setting organizational policy in the area of cultural competence.
- Continual in-service training of staff members in the core issues of cultural competence.
- Overall responsibility of translation, interpreting and cultural mediation services (whether provided internally or outsourced).
- Adapting the organizational and physical environment to the clients from diverse communities.
- Maintaining ties with communities that represent the clients.

- Management of demographic data regarding the clients' languages, their cultural and social profile and the existing means within the organization to address their needs (see chapter 4).
- Addressing queries from staff regarding cultural competence issues.
- The management of the accumulated organizational knowledge on cultural competence.
- Maintaining ongoing ties with sources of information and consultation outside the organization in order to improve cultural competence and address problems that arise in this area. This includes cooperation with other health organizations, to learn about models for implementations, successes and challenges.
- Following up, keeping up to date and gaining additional expertise in the field of cultural competence, including knowledge of the accepted international standards in cultural and linguistic competence.
- The coordination of activities of the relevant units and outside parties in order to implement the requirements of the law, the directive of the governmental ministries, and the organizational policies that relate to cultural competence.
- Responsibility for assessment and quality-control mechanisms for the integration and maintenance of cultural competence in the organization.

3. Training employees

The desired outcome: The operation of basic and follow-up training that will provide staff with knowledge, awareness and skills to enable them to deliver culturally competent care and service. The cultural competence of an employee or team is an ongoing and continual process and cannot be reduced to a one-time lecture. The Israeli Director-General's directive from 2011 recommends training all the organization's employees, especially care providers, in courses dealing with cultural appropriateness. The directive does not go into the details or length of the desired training, but we recommend a full-day basic workshop followed by a number of follow-up in-service training sessions throughout the year.

Recommended initial steps:

- Hold a "first glance" workshop on the subject for the management, in order to create a buzz that will trigger the process, on behalf of the management. We recommend holding this workshop at the beginning of the organization's adaptation process in order to enlist the management in promoting it. An initial workshop that links the elimination of health inequities with cultural competence can be held to discuss the legal, organizational and economic implications that may be required for the change, and to outline steps for the continued activities in the organization. It is recommended that at the end of this kind of introductory workshop, the management of the organization release an announcement to its employees declaring its commitment to the cultural-competence process.

- Articulating the rationale of the trainings: what will the organization save/prevent, and how it will benefit as a result of the CC training; what is the training's added value for the employees.
- Incorporate training sessions into the organization's annual work plan.
- Set the most effective training frameworks within the organization, in cooperation with the training unit/department. There are various models available for the basic training sessions and courses, for example: an entire day, two half-days, or a few short meetings. This last model is more suitable for hospitals, for example, that cannot release staff members from the various departments for more than a few hours at a time. It is, however, important to hold all the parts of the training within a reasonable period of time (no more than four months) in order to assure continuity of learning and integration.
- Determine criteria for the makeup of the participants in each workshop (by organic teams? based on a professional cross section?). We recommend interactive learning, which is effective in groups of 20 participants.
- Decide on the content – The current approach is that the basic training does not focus on specific population groups, but rather on providing the knowledge, awareness and tools to deal with diverse populations. See possible training subjects later on in this chapter.
- Decide who will deliver the training – The training can be carried out by an outside entity (which will make the necessary adjustments of the core issues to the relevant organization), or by a trained employees from within the organization.

Recommended follow-up activities:

- Adapt the training to the various sectors (e.g. medical, paramedical, administrative). At the conclusion of the process, all the employees will undergo the training, including those who do not have day-to-day contact with patients. Our working assumption is that training on the core issues of cultural competence is relevant for all the organization's employees and volunteers, including those who do not have direct contact with the organization's clients. Hence, a cultural competence approach will be assimilated throughout the entire organization.
- The basic training in cultural competence must be at least eight hours long. Our experience shows that eight hours is the minimal period to receive basic tools for cultural competence. The basic training provides general tools in the following subjects:
    - Increasing sensitivity to the intercultural differences between the patient and the provider – regarding forms of communication, culturally dependent core traits and behavioral norms, cultural dimensions and perceptions regarding health and illness.
    - Ways to create an effective patient-provider dialogue;
    - The effective use of a language and cultural mediator

- Dealing with social and political tensions and racism within the health organization.
- The potential conflict between adapting to the patient's culture and medical and ethical principles.
- Understanding the cultural biases of the staff members and how they perceive their professions.

Recommended maintenance activities

- Set up follow-up in-service training and frameworks for further training (e.g. study days, case studies, participation in staff meetings). At the in-service training sessions, the knowledge regarding specific populations, health and illness perceptions in a cultural context and the discussion of test cases that occurred in the organization can be broadened.
- Set up a mechanism for feedback and drawing conclusions from the training sessions.
- Assess the link between the training and improved treatment.

4. Gathering and managing information

The desired outcome: The health organization should collect and manage information in such a way as to enable it to provide better, culturally-competent treatment. At the culmination of the process, cultural and language information will impact cross-organizational processes. On the individual level, the information will facilitate the dialogue with the patient and improve decision-making with regard to the appropriate treatment.

Recommended initial steps:

- Map out the cultural and language needs of the organization's clients.
- Gather information regarding the patients' language and cultural profile and language preferences, as part of the registration process (as well as on previous data), in order to provide language and cultural access services and to identify changes in the demographic trends among the organization's patients. In addition to the clients' preferences, the organization can collect information regarding barriers to service and care.

Recommended follow-up activities:

- Make the information about the language and cultural profile of the patients accessible along with statistical analyses based on this information. Hence, the information on cultural competence will be more than occasional anecdotes: it will be accessible to data mining, similar to other medical or administrative information. Subsequently, the information should be distributed to employees who need it to provide culturally competent service and care.

- Link the system that registers the patient's preferred language to other relevant systems (e.g. interpreter booking, translation of forms, employee recruitment). In this regard, it is important to synchronize between the patient admission office and the other systems, regarding patient's language profile and preferences.
- Information accessible to the staff will include up-to-date data on the communities receiving services from the organization. This will include, inter alia, a list of community, cultural and religious entities that work with the relevant populations that are receiving services from the health organizations; a list of places and occasions when the community meets (clubs, religious gatherings, etc.); a list of all the official and unofficial communications channels used by those communities. If possible, specific information about certain cultural groups in the organization may be disseminated (e.g. family structures, beliefs and religious laws on the subjects of health and illness, traditional medicine) by means of the organization's intranet, pamphlets, etc.
- Maintaining information on bilingual staff-members who have undergone language screening and can provide care in languages other than Hebrew.
- Recommended maintenance activities:
- Manage information about complaints and inquiries that have a cultural context.
- Manage information about assistance from entities outside the organization on subjects related to cultural competence (consultation on issues of cultural competence in treatment, the advancement of professional development, translation services, etc.) The information should be documented and kept up to date by the organization's cultural competence coordinator in order to create an organizational memory on the subject.
- Manage information regarding incidents associated with cultural competence that have occurred in the organization and from which lessons were learned.
- Manage information regarding community activities related to cultural competence and insights gained.
- Periodically assess the availability of the information and its effectiveness in improving service.

5. Language accessibility of treatment and services: Oral interpreting

The desired outcome: High-quality accessibility to health services and health information for non-Hebrew-speaking populations so that the care they receive will lead to similar health outcomes of the Hebrew speakers. The care providers should make use of the appropriate accessibility tools, including face-to-face or remote interpreting. It should be ascertained that that language mediators of all kinds have received adequate training in medical interpreting, and their work should be quality controlled. The organization should prohibit the use of minors, family members or staff who has not gone an interpreting training. Using them to interpret significantly

hampers the quality of care, and is unethical. Apart from interpreting, linguistic access to health care also includes patient-provider language concordance, where this match does not affect the quality of care.

Recommended initial steps:

- Map out gaps – The organization should gather data regarding the languages spoken by the clients. We recommend checking (by means of surveys or interviews) the service and healthcare areas in which most severe communication gaps exist.
- Define the existing solutions – the means of language accessibility that the organization currently uses, for which languages, at what frequency, where and at what hours.
- Define the scope of the desired solution – Analyze the needs and solutions to determine the desired responses: Does the percentage of clients turning to the organization require the employment of in-house staff interpreters, remote language access (by telephone/video) or the use of bilingual employees that have undergone adequate medical interpreting training?

Recommended follow-up activities:

- Establish a pool of interpreters – language access will be achieved through the use of one or more of the following ways: the employment of interpreters; contracting with interpreting services, or; use of bilingual employees and volunteers who received adequate training in interpreting. The fundamental principle is that every individual who functions as an interpreter (whether in addition to their regular work, as their principal function or as an outsourced interpreter) must undergo screening and assessment to determine their level of knowledge, skill and commitment to the role.
- When an outside interpreter is used, or when interpreters are hired, it must be ascertained that the interpreters have been given specific training as medical interpreters, and that their work meets the quality and ethical standards that apply to the medical interpreting profession.
- Set up a mechanism and procedure for booking interpreters and maintain data management on the subject (who did the booking, how long was the session, the subject, was it held/canceled, etc.).
- Establish and integrate policy to encourage the use of trained (face-to-face or remote) interpreters, and minimize the use of other solutions.
- Disseminate knowledge regarding language access to all employees, as well as to all who request services (within and outside the organization using the relevant communication channels). It should be ascertained that signage regarding the availability of interpreters can be found in all parts of the organization that clients visit. Clients should be informed that they are entitled to interpreting services free of charge.

- Employees should be trained in the proper use of the interpreter – in the context of the basic training for cultural competence and in all orientation sessions for new employees.

Recommended maintenance activities:

- Continually assess the availability of language access relative to demand. Assess the impact of the various means of language access on the effectiveness of treatment.
- If possible – assess the quality of the interpreting, by professional interpreters.
- Monitor the actual use of interpreting upon the patient's request and in every case of a language gap.
- Setting a feedback and control mechanism of the interpreters' work.

6. Language access for service and treatment: Written translation

The desired outcome: All forms requiring the patient's signature will be available in the most common languages in the organization (in addition to the requirements of the director-general's directive, which mandates translation into English, Arabic and Russian). All administrative material related to the organization will be available in the common languages, and all the health material will be published in these languages, after introducing the necessary cultural adaptations (It should be borne in mind that in certain languages, speakers' reading and writing level may be relatively lower, and consequently, the written material cannot replace oral language accessibility). It is important that the translation be carried out by expert medical translators. The members of the medical staff and even medical interpreters may not necessarily possess the skills needed to translate written materials, although some may take part in the quality control of the translation of these materials.

Recommended initial steps:

- Map out all the forms in the organization in order of importance to the patients: forms to be signed by patients, personal medical information, general health information and advertising material.
- Classify the forms according to how crucial they are to the patient (crucial/important/nice to have).
- Identify potential translation professionals – i.e. entities, companies or individual professionals that specialize in medical translations. Untrained bilingual employees or oral interpreters should not be given written material to translate unless the translation undergoes quality control by a certified translator.
- Locate forms and documents that had been translated by other entities, and can be adapted to the health organization. Translation of forms is an expensive and complex process, and can be more effective by resource-sharing among similar organizations.

- The original, Hebrew materials should be adapted to the level of the target audience's medical literacy, using plain language as much as possible. The style and appearance should also be adapted to the target culture.

Recommended follow-up activities:

- The organization must translate all forms that require the patient's signature into the languages required by the Ministry of Health's directive, as well as to the most frequently-used languages. This includes informed consent forms, payment forms and in the relevant institutions also hospitalization forms.
- In order to facilitate the work with the translated forms, the format of the form can be adapted to the way in which it is filled out, e.g. for forms in which the answers are closed (yes/no or checking a box), the original text can be positioned opposite the translation and the data can be fed in directly from the translation. Forms that require filling in text, for example, will need to be translated back into Hebrew, or translated by an interpreter, with his/her signature on the form next to that of the patient. Please note: The interpreter cannot fill in the form instead of the patient, but can only translate what the patient says to him/her.
- The organization will enable every patient to choose the language of the form they sign (i.e. Hebrew or one of the translation languages).
- Every new form relevant to the target audience will be sent for translation into the target languages relevant for the organization.

Recommended maintenance activities:

- It should be ascertained that the translated documents are available on an ongoing basis in every branch, clinic or hospital in accordance with the relevant activities at each site.
- All the translated documents should be easily accessible from the organization's data systems. In addition, we recommend sending copies of all the translated material to the interpreters (in-house or outsourced) as well as to the bilingual service representatives so that they can become familiar with the content, can help when orally interpreting a written document and can sum up the contents of the document should a client that expresses an interest in the information in the forms and pamphlets call.
- Ongoing monitoring of the availability of the translated material should be conducted.
- It should be considered whether to translate personal information related to the patient, such as discharge letters (addressed to an attending physician who may not read Hebrew), recommendations for continued treatment, etc. This translation will improve the follow-up treatment in the community as well as the patient's compliance with the recommendations.

7. Cultural mediation of the medical service and care

Cultural mediators are often called "cultural brokers". Their role is to identify and offer solutions in such instances where cultural gaps are formed in the broader context of the health services. For the most part, they belong to the cultural community of the patients in question, and also have significant insight into the culture of the hegemonic community, as well as into the culture of the health services. They often assist when language gaps exist, but their main task is to reduce barriers, even when language does not pose any obstacle for offering treatment and rendering services. In a health care environment, their role sometimes includes aspects of health education and promotion, by providing information, assisting people in finding their way around the health system, and acting as mediators when conflict arises. Cultural mediators will be capable of assisting the cultural competence coordinator in connecting patients to the community, and in locating authoritative and assisting bodies within the community. Regarding healthcare professionals, the role of the mediators will be to explain the community's culture and how it perceives health and illness. In contrast to interpreters, they can work with either the clients or the health care professionals (individually or in groups) even when one of the parties is absent.

The desired outcome: institutionalizing and integrating a mediating factor into the health system, which will help reduce barriers and intercultural misunderstandings, as well as provide intercultural communication between the professional teams and those seeking services. Cultural mediation services will be available to all health care providers, as well as all those receiving services or treatment in the health system, as is deemed necessary, and those providing the service will operate in accordance with work rules and directives that will allow for the most ethical and efficient exercise of such services. Cultural mediators will have undergone sufficient training in their field. They will participate in in-service training courses and workshops, and will be subject to quality assessment.

Recommended initial steps:

- Mapping out gaps – the organization will collect and process data relating to the various cultural communities (such as origin, number of years in Israel in the case of immigrants, age, gender and other medical criteria) that utilize the services of the organization. In the case of exceptionally large communities or in such cases where a rise in the number of applicants is clearly visible, or where there is reason to believe that significant cultural gaps undermine the quality of the health care services provided, the employment of a cultural mediatory should be considered.
- Define the scope of the desired response: by analyzing the needs and the available responses, one might determine which communities would be best in providing mediators, and how many work hours are necessary for each position. In this matter it

would be best to consult with people who have experience in the field, and have either employed and/or trained cultural mediators.

Recommended follow-up activities:

- Recruiting – Potential personnel for work in cultural mediation must undergo screening and evaluation, in order to determine the level of the candidate's knowledge, proficiency and commitment to his/her job. Each candidate's background must be thoroughly examined, including the individual's standing in his/her community, the level of trust placed in him/her by the community, the extent of the said individual's verbal and emotional proficiency and the motivating factor behind their desire to man this particular position. Cultural brokers and mediators must be prepared to operate "between Scylla and Charybdis" i.e. in such situation where they are stuck in the middle of two opposing forces - the community, on the one hand, and the health system, on the other, and still able to contend with the complexity of the very role they have chosen to undertake, whilst adhering to the required rules of ethics. The evaluation can be carried out by the cultural competence coordinator, within the framework of his/her ties with the community.
- Formulate a job definition, interface points and a job framework – often the role of the cultural mediator is vague, resulting in misunderstanding and tension. Since the mediation takes place when there are gaps and disagreements between two parties, the latter tend to challenge the mediator and push him/her to the limit. It is therefore necessary to define the scope of authority given to the mediator in various contexts – e.g. when mediating in the doctor's room; when explaining the guidelines for treatment; when operating within the community; when assisting the cultural competence coordinator in his/her work with the community etc.
- Define the mediators as part of the organizational team. It is essential that the mediators be defined as an integral part of the organization's personnel (definition of subordination included), and thus take part in ongoing activities like staff meetings, planning sessions for health promotion, locating populations for focused health care etc.
- Create a training model suitable for the job definition, within the framework of the organization, or any other organization that has the knowhow to do this. Mediators will undergo training before taking up the position, as well as in-service training.
- Define the formal procedure of cultural mediation services, which will relate to when and how cultural mediation services are rendered, and also how these are recorded etc.
- Adopt a policy that will encourage the use of cultural mediators in the health system, and instructing the staff to use them correctly. In such case where the services of an interpreter (via face to face or remote interpreting) are also available, the staff must be advised of the criteria for choosing the most appropriate assistance for the situation at

hand, by understanding the essential difference between the two positions and how each can be best utilized.

- Disseminate information to the relevant staff and community members about the possibility of using cultural mediators, including the set up of proper signage within the organization's premises to the effect that cultural mediators are available.

Recommended maintenance activities:

- Constantly evaluate the availability of cultural mediators in relation to the demand. Furthermore, evaluating how the efficiency of the treatment was impacted by the intervention of a cultural mediator.
- Set a mechanism which will provide feedback and monitor the work of the cultural mediator, including designated indices and benchmarks to evaluate his/her work.
- It would be best to either integrate the cultural mediators into an existing professional framework, or create one especially for them, which would make it possible for them to consult with others, share dilemmas and receive constructive advice and support for dealing with complex situations.

8. Adapting the work environment

The desired outcome: The health organization will adapt the organization's physical environment, including signage and accessories, to the target cultures visiting it. The organization will undertake a constant monitoring of the organization's physical space (which is best done with the help of a professional translator and representatives of the communities using the services) in order to ascertain that every new accessory or sign is translated and/or culturally adapted. The health organization will enable all patients of all the various religions to observe their religious practices in a proper and dignified manner.

Recommended initial steps:

- Gather data and map out the existing situation within the health organization (e.g. what signage exists and in what languages, how is the translation monitored, what kinds of prayer rooms exist, what type of programs are shown on the television screens).
- Explore alternatives for making the organizational environment linguistically and culturally accessible used in other health organizations, both in Israel and the world, e.g. – a multi-lingual orientation map or multi-lingual digital signage that can be changed and adapted at low cost.
- Make decisions regarding the languages of the signage and the way to find one's way around the health organization (in accordance with the director-general's directive and patients' main languages).

- Take price quotes for the professional translation of signage and the organization's Internet site.
- Recommended follow-up activities:
- Designate the necessary activities to adapt the organization to patients from different cultural backgrounds (e.g. choosing what will be screened on the television and information screens in the waiting rooms, checking the opening hours and adapting them to the various population sectors treated by the organization).
- Decide on the most effective means of communication between the organization and its patients from different cultural backgrounds (there may be a number of different ways to be used at the same time – letters, text messages, a health mediator).
- Contract with an appropriate professional and launch a gradated change of all the signs and orientation maps in the organization. It should be ascertained that both the inner spaces in the organization (e.g. signs at the doors, crucial information in the department/clinic) as well as the outer spaces are linguistically and culturally accessible.
- Have the signage quality controlled by a professional translator (and if possible, by a representative of the community).
- Adapt the therapeutic and organizational spaces to the different cultures. The signs should be made culturally and linguistically accessible, along with the pictures and television screens in the waiting rooms. These adaptations will send patients the message that they are welcome in the organization and that thought has been given to their needs.
- Explore alternatives for the designation of proper prayer rooms appropriate to patients of different religions. In this context, we recommend consulting with religious authorities in order to receive the proper religious guidelines for prayer arrangements. An appeal may be sent out to members of the community for contributions and to announce the presence of the prayer area.
- Adapt the catering services to the different religious and cultural sensitivities and offer specific solutions (e.g. catering from an outside source) for patients who have special food requests.
- Hold a discussion with the employees about a dress code that is binding on all the employees of the organization in order to show respect to patients from all the different religions and cultures.

Recommended maintenance activities:

Mark the holidays and red-letter days of the different religions and consider solutions to the sensitivities related to celebrating them.

Distribute information leaflets to the patients and provide information during orientation days to employees about the cultural issues that may come up in the organization, e.g. behavior on Shabbat, festivals, issues related to kosher food, etc.

9. Relations with the community

The desired outcome: The health organization will make proper and continual use of the relations with representatives of the communities relevant to the organization in order to improve the service given to the patients of the various communities, and to resolve problems and crises bearing a social or cultural context that may arise in with patients.

Recommended initial steps:

- Gather demographics about the communities that use the organization's services.
- Create a source list of contacts for each of the various communities, e.g.: religious figures, community leaders, social and municipal services, health promoters, case managers and aid agencies.
- Hold meetings with the relevant position holders in the health organization that maintain ties with the community (social services, customer service).
- Gain a basic understanding of the system of ties that existed in the past with the various communities and identify the barriers and challenges that characterized this relationship.

Recommended follow-up activities

- Identify the main interfaces between community leaders and the key figures in the health organization.
- Identify health and illness concepts and behaviors in the various communities (e.g. preference for specific medications among certain populations, ways to deal with chronic diseases).
- Create forums for effective and ongoing dialogue between the community leaders (e.g. a committee of rabbis or Muslim religious leaders) and the management of the health organization or organizational units. Build strategic programs for ongoing ties with the community, including quarterly meetings with community leaders to identify barriers and difficulties on the part of the community in utilizing the organization's services, build programs to mark important dates to the members of the various religions and cultures, etc.
- Form an advisory board on the subject of language and cultural access that includes community representatives (neighborhood committees, civil society organizations, patient associations, etc.). These representatives will provide feedback on the forms, signage, health information leaflets, interpreting services and client satisfaction.
- Create a procedure of communicating with the community during crises. The procedure will be based on the ties formed at routine times and will set out guidelines for the steps that the coordinator of cultural competence should take at a time of crisis.

Recommended maintenance activities:

- Examine cultural elements in service and care in client satisfaction surveys. Particularly, check to see if there are barriers to the use of the services among the different groups. These data can be also obtained unofficially, through discussions with community leaders.
- Strengthen ties with the relevant organizations and spiritual leaders, e.g. hold regular meetings with religious leaders, to help in complex medical cases in which there is no direct or productive dialogue with the patient or his family.

10. Human resources and cultural competence in the organization

The desired outcome: The health organization will outline and integrate policy guidelines related to the management of human resources in order to make sure that employees from diverse groups are hired. The human resources unit will be involved in the organizational procedures involving language and cultural adaptation. The human resources unit will perform the changes related to hiring, starting from employee recruitment to employee assessment.

Recommended initial steps:

- Set human resources policies that promote the correspondence of the patients' demographic profile to that of the medical staff (at all levels and professions) by means of a multi-year program. The program will promote parity between the cultural cross section of the staff and that of the patients.
- Match the management of human resources in the organization to the policy as consolidated and taking all the actions needed to put together teams, at all levels, that reflect the demographic, cultural and language profile of the patients.
- Give priority to finding personnel from diverse cultural groups and staff that have undergone cultural competence training. The identification of appropriate personnel can be carried out, for example, by means of advertising in the media of the various cultural groups.
- Advertise available jobs that address the cultural disparities and disseminate information about jobs in a manner that is appropriate to the various cultural groups.
- Culturally adapt the mechanisms used to screen and hire new employees:
    - Word the job and skills description so as not to discriminate against potential candidates from different populations.
    - Advertise available jobs in different languages, worded to be multicultural and nondiscriminatory.
    - Advertise available jobs in the media used by the members of the different communities.

- Hold job interviews by means of a committee that includes representatives of the different cultural groups or individuals who have been given training in the cultural adaptation of interviews and screening tests.

Follow up activities:

Integrate work skills in a multicultural environment in hiring procedures.

Make aspects of cultural competence part of employee assessment.

Recommended maintenance activities:

- Create mechanisms to retain employees from different cultures, for example by adapting the organizational environment to these cultures and creating an organizational culture that encourages diversity.
- Give expression to the features of the religion and culture of the employees from different cultures along with consideration for the holidays and red-letter days of the different cultural groups in the ongoing practices of the hospital (e.g. make sure that in-service training sessions are not given on a Muslim holiday).

11. Providing client services and addressing inquiries from the public

The desired outcome: The health organization's call centers (to make appointments, respond to public inquiries, provide information, etc.) will respond to telephone inquiries in the languages relevant to the target audiences. The telephones will be answered by operators who have undergone designated cultural competence training. In addition, written inquiries will be answered in the languages relevant to the target audiences. In those cases in which it is necessary for legal reasons to respond in one of Israel's official languages, it should be noted in a number of other languages that it is possible to communicate orally in other languages too. The translated answers to inquiries should undergo quality control.

Recommended initial steps:

- Map out the cultural and language needs for the provision of services by the call centers.
- Define the scope of the response – the organization's management needs to decide how the written translation and oral interpretation will be carried out at the call centers and explore alternatives, either by means of existing staff members or by hiring suitable people from outside the system.

Recommended follow-up activities:

- Create infrastructures for multilingual routing in the organization's telephone system so that callers who speak the principal languages will be able to reach the various departments and clinics as quickly as possible.

- Hire bilingual operators that will make appointments and provide medical information and information about patients' rights. The response at the call center will be provided in all the relevant languages based on the mapping conducted. At a later stage, the call center personnel should be planned so as to preserve the language diversity over the long term.
- Train employees in the call centers on subjects related to intercultural communications, patients' rights and programs for the populations that require specific attention (new immigrants, work migrants, etc.) We recommend holding training sessions on these subjects once per quarter. The call-center staff may participate in the organization's general in-service training and also receive designated training in their area of service.
- Provide an immediate telephone response in Hebrew, Arabic, Russian, English and Amharic in the emergency centers in order to exercise the right of all individuals to receive these services.
- Create the option to add an interpreter to the call, if needed.
- Plan the health organization's Internet site so that it is accessible and culturally appropriate (including content and pictures) to readers the main relevant languages (Hebrew, Arabic, Russian, English and other languages as needed). Create easy access to vital information such as core services, addresses for inquiries and basic rights. It should be ascertained that the content suits the health literacy level not only of the Hebrew speakers, but also of readers of other languages. The pages in the relevant languages should contain information regarding the language access measures available. (e.g. response to inquiries, option to send letters in a language other than Hebrew, making an appointment and the use of an interpreter)

Recommended maintenance activities:

- Include the subject of cultural competence in the monitoring of the call-center personnel.
- Integrate aspects of cultural competence in the client satisfaction surveys.

12. Assessment

The desired outcome: Aspects of cultural competence will be included in all aspects of assessment: on the organizational level (macro), on the level of procedures and specific programs (meso) and on the individual and staff level (micro). The integration of cultural competence principles for the purpose of assessment will be carried out in a gradated fashion, in accordance with the organization's progress and in consideration of the changing organizational climate.

Recommended initial steps:

- Investigate all the principal monitoring tools that have been used in the organization to assess activities, such as employee assessment, assessment of the level of service and client satisfaction, and ongoing quality control processes.
- Formulate the indices of cultural competence that can be easily integrated into the existing control tools, e.g. aspects of language and cultural accessibility in client satisfaction surveys, in risk management controls, in annual employee assessments, etc.
- Recommended follow-up activities:
- Mark out the areas for assessment in the organization: e.g. the organization's ties with the communities that use its services, inter-team relations, patient-provider relationship.
- Get to know the (individual and organizational) assessment tools that are already available today. Passing the monitoring criteria of the Health Ministry and other organizations in aspects of cultural competence.
- Develop designated assessment tools to measure the level of cultural competence. Numerous tools for self-assessment or monitoring of the principals of cultural competence exist in the world. With the growing accumulation of knowledge and experience in the subject, the relevant parties in the area of training and quality of care can develop and integrate these tools into the organization. Questionnaires, interviews, focus groups and observations ("mystery patient") or a combination of these tools may be used. When conducting inter-organizational assessment, it is important to include employees from all the professions and hierarchies.
- Develop tools to assess the extent of the integration of the principles of cultural competence and of the effectiveness of the activities derived from them (including interpreting services, accessibility of services, employee training, etc.).

Recommended maintenance activities:

- Use the data to identify success and barriers to the integration of cultural competence.
- Conduct an ongoing analysis of the data from the various monitoring tools and the integration of the conclusions in the organizational policies, the various programs and the relevant procedures, including performing necessary organizational changes.
- Make the assessment results public with full transparency for the various sectors in the organization.