Culturally Effective Care Toolkit

Introduction
The care that pediatricians provide to an increasingly diverse child and adolescent population should encompass medical home principles; it should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The American Academy of Pediatrics (AAP) defines culturally effective care as “the delivery of care within the context of appropriate physician knowledge, understanding, and appreciation of cultural distinctions leading to optimal health outcomes.” Such understanding should take into account the beliefs, values, actions, customs, and unique health care needs of distinct population groups.

This Culturally Effective Care Toolkit is a practical, hands-on resource to help practicing pediatricians and their office staff provide culturally effective care to their patients and families.

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Chapter 1: What Is Culturally Effective Pediatric Care?
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Chapter 3: Nutrition, Feeding, and Body Image Perspectives
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Pediatricians can turn to the AAP for culturally effective care resources.

The policy statement “Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy” defines culturally effective health care and describes its importance for pediatrics and the health of children.

The policy statement “The Medical Home” defines the medical home concept in detail.

The AAP News article “Culturally Effective Care Resources” provides information about where to find resources on the AAP Web site about delivering culturally effective care.
Culturally Effective Care Toolkit

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The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. This toolkit is for informational purposes only. It is not intended to constitute legal advice. An attorney should be consulted if legal advice is desired.

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Chapter 1: What Is Culturally Effective Pediatric Care?

In the policy statement “Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy,” the American Academy of Pediatrics (AAP) defines culturally effective care as “the delivery of care within the context of appropriate physician knowledge, understanding, and appreciation of cultural distinctions leading to optimal health outcomes.” Such understanding should take into account the beliefs, values, actions, customs and unique health care needs of distinct population groups. Providers will thus enhance interpersonal and communication skills, thereby strengthening the physician-patient relationship and maximizing the health status of patients.

The demographic changes in the United States over the last decades have significantly altered the clinical milieu such that many pediatricians are providing care to an increasingly diverse population. It is estimated that by the year 2050, the percentage of racially and ethnically diverse populations will have increased to a pivotal turning point, such that historically minority populations will exceed 50% of the overall population and will become a majority. In several states in the United States, this transition has already occurred.

Pediatricians strive to provide high-quality clinical services, defined by the Institute of Medicine (IOM) as being patient-centered, effective, efficient, timely, safe, and equitable. The IOM quality pillar, equity, involves “providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.”

Within this quality framework, physicians in general and pediatricians specifically need to be equipped to deliver health care services to increasingly diverse children and families. The term diversity should be viewed in the broadest sense, extending beyond race and ethnicity to include religion, sexual orientation, disability, geographic location, education status, socioeconomic status, and other factors.

Guiding Principles for Cross-Cultural Health Care Delivery

As pediatricians provide health care services within a medical home to a growing population of diverse patients, general principles can be helpful in cross-cultural encounters. For example, rather than identifying and focusing on patients’ culturally-bound beliefs or behaviors, pediatricians can

- Communicate, by their attitude and behavior, an openness to different cultures.
- Be willing to adapt, if possible, their clinical practice to acknowledge patients’ and families’/caregivers’ culture.
- Demonstrate a commitment to professional development aimed at acquiring new cultural competence knowledge and skills.
- Consider that often the variability within cultures (eg, between affluent and poor African Americans) may be more pronounced than between cultures. For example, poor inner-city African Americans and poor whites from Appalachia may face more similar socioeconomic barriers and challenges that those faced by wealthy African Americans. There is also significant variability between recent immigrants and those that have been in the United States for one or more generations. Cultural assimilation, to include acquisition of English-language skills, often increases with time spent in the United States.

This toolkit aims to provide practicing pediatricians with resources to deliver culturally effective and linguistically competent health care services within their medical home. The toolkit was developed in response to a recommendation to the AAP Board of Directors asking for more practical information, resources, and tools for pediatricians in practice. The content is informed
by a 2009 AAP needs-assessment survey and the chapters were written based on questions and issues raised by pediatricians.

Reference

Chapter 1 Tools and Resources

Tool 1A: US Department of Health and Human Services Office of Minority Health: A Physicians’ Practical Guide to Culturally Competent Care
This free online CME activity is based on practical case studies a physician may encounter when providing culturally effective care.

Tool 1B: National Initiative for Children’s Healthcare Quality: Expanding Perspectives: Improving Cultural Competency in Children’s Health Care
Using quality improvement and care model framework, this report focuses on a practical set of changes to improve cultural sensitivity and effectiveness of care in a practice setting.

Tool 1C: National Center for Cultural Competence, Georgetown University Center for Child and Human Development: Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs
This Web site provides information about cultural brokers and implementing sustaining cultural broker programs.

Resource 1A: AAP Committee on Pediatric Education and Committee on Pediatric Workforce: Resources for Medical Education on the Provision of Culturally Effective Care
This Web site provides a list of resources related to the provision of culturally effective care.

Resource 1B: The Commonwealth Fund: The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality
This paper focuses on how patients and providers interact at the interpersonal and health care system levels.

Resource 1C: National Women’s Health Information Center, US Department of Health and Human Services Office on Women’s Health: Health Professionals: Your Role in Women’s Health: Cultural Responsiveness
This Web site includes links to resources, publications, and tools for providing culturally effective care.

Resource 1D: Georgetown University Maternal and Child Health Library: Racial and Ethnic Disparities in Health Knowledge Path
This Web site provides a bibliography of current, high-quality resources about preventing, identifying, and eliminating racial and ethnic disparities in health.

Resource 1E: “The Importance of Cultural Competency in General Pediatrics”
Resource 1F: “Culture and the Patient-Physician Relationship: Achieving Cultural Competency in Health Care”

Resource 1G: “The Importance of Language and Culture in Pediatric Care: Case Studies from the Latino Community”
Chapter 2: Health Beliefs and Practices
Many variables such as culture, socioeconomic factors, generational practices, and current trends affect patients’ and families’ health beliefs and practices. Routine and accepted US health care system processes, structures, and norms may be unfamiliar to patients and families from other countries or cultures. Following are some of the areas in which pediatricians are most likely to encounter differing (or a range of) perspectives.

Clinic and Emergency Department Use
Pediatricians understandably expect patients to comply with a predictable and scheduled appointment format. However, patients from other countries or cultures may be accustomed to different processes. In certain countries in Latin America, for example, patients are expected to walk in to a clinic or practice, take a number, and wait for the provider, instead of being scheduled for a specific time. Likewise, patients may favor using emergency services for non-emergent complaints rather than accessing a primary care provider. Some patients may use the emergency department as a medical home because of perceived advantages in accessibility, availability of ancillary laboratory and radiology services, and even availability of interpretive services. Pediatricians should clarify the scheduling process in their practices.

Pain and Analgesia
The expression of pain and the health-seeking behavior centered on the relief of pain varies from culture to culture. For example, in some cultures it is considered honorable and desirable to stoically tolerate pain, while these same behavior expectations are not shared by other cultures. While there are culturally associated variations in patients’ expression of pain, physicians’ analgesic prescribing responses to patients of different cultures also may vary. Although some research studies have demonstrated that physicians may prescribe less analgesia to ethnic and racial minority populations, there is evidence to suggest that the disparity has lessened over time.¹

Traditional Practices, Alternative Medicine, and Indigenous Healers
It is increasingly recognized that some patients from the United States or other countries use alternative or traditional practices, medicines, or healers. Families may use these options prior to, in combination with, or after seeking medical care from the pediatrician. In some cultures, the concept of a “folk illness” is embraced and there is a strong belief in a definite constellation of symptoms and treatments associated with the folk illness. Pediatricians should respect patients’ health beliefs that may not be consistent with a biomedical model of disease etiology. For example, some Latino/Hispanic families believe in folk illnesses such as empacho (gastrointestinal discomfort), susto (a form of panic attack), or mal de ojo (evil eye). Many traditional practices used to treat these and other folk illnesses may be entirely benign, while others have been associated with adverse health outcomes. Folk medicines such as greta and azarcon, often used by Mexican Americans, may contain elevated lead levels and have been associated with lead poisoning in children.

Bed Sharing and Sudden Infant Death Syndrome
Since the American Academy of Pediatrics (AAP) Back to Sleep campaign to decrease the incidence of sudden infant death syndrome (SIDS), there has been a substantial increase in the percentage of mothers that place their babies to sleep on their back or sides. However, in some minority populations, this public health campaign has not been as effective. African American mothers, for example, are more likely to share beds with their infants and place them in a prone position to sleep, both risk factors for SIDS. Co-sleeping is considered a culturally acceptable, if not desirable practice in some communities. Additionally, in large families with few resources, co-sleeping can be viewed as a necessity rather than an option.
Birth and Early Infancy
At birth and immediately after birth, different cultural groups may have specific norms regarding the amount of postpartum time mothers are to remain indoors, the care of the umbilicus, early feedings, co-sleeping, circumcision, and others. In some cultures, for examples, mothers and newborns stay secluded indoors for a defined period. In other cultures, because of limited resources or cultural practices, newborns sleep in the same bed with their mother. Another example of a culturally bound practice involving newborns and babies centers on covering their heads, even if in tropical climates.

Death and Dying
Death rituals are often shaped by culture. In dying or severely ill patients, the amount of information that physicians and families share with the patient about his or her prognosis, the patient and family members’ expression of grief, the use and acceptance of hospice care, the termination of life support systems, the integrity of the body and burial, and other end-of-life issues pose significant cross-cultural and bioethical challenges for pediatricians. Koenig and Gates-Williams² offer the following helpful guidelines in dealing with these complex situations:

- Determine who controls access to the body and how the body should be approached after death.
- Consider the relevance of religious beliefs, particularly about the meaning of death, the existence of an afterlife, and belief in miracles.
- Assess how hope for a recovery is negotiated within the family and with health care professionals.
- Assess the degree of fatalism versus an active desire for the control of events into the future.

Role of Women
The culture-specific roles of women and men have the potential to affect the care of pediatric and adolescent patients. In some cultures, for example, women are expected to defer important decisions to and, in some instances, to communicate through the male figure. The concept of machismo in Hispanic cultures often portrays the masculine figure as a protector, provider, and decision-maker. Whereas the cultural connotation may be one of masculine honor and respect, it can be viewed as disempowering toward women. Men in some cultures, for example, may exert power and control over women. If men are viewed as final decision-makers on health matters, this may affect pediatricians’ ability to empower female adolescent patients. This culturally bound and potentially disempowering role of women can adversely affect their ability to successfully negotiate condom use with a male sexual partner.

Role of Family
Given the cultural variability of the role of the patient’s family in medical decision-making as well as healing processes, the pediatrician should respectfully ask questions with the goal of fully understanding these important issues. In some cultures, the family (nuclear and extended) is the main social unit and family members are actively engaged in all aspects of the care of the patient. In dealing with hospitalized patients, for example, pediatricians should anticipate the possibility of a large number of family members during visiting hours and the possibility of exceeding the hospital’s allowable visitors’ quota. Immigrant families may be divided between the United States and the country of origin, posing an added stressor in family-centered cultures.

References


Chapter 2 Tool and Resources

Tool 2A: AAP Healthy Child Care America: Back to Sleep Campaign
This Web site includes free, downloadable patient information materials in English and Spanish.

This Web site provides additional tips and helpful resources to relate and interact with patients’ families.

This section of an Institute of Medicine publication provides summary of research studies on analgesia in minority populations.

Resource 2C: National Women’s Health Information Center, US Department of Health and Human Services Office on Women’s Health: Health Professions: Your Role in Women’s Medicine: Ethnomedicine
This Web site provides links to additional information and resources about traditional practices, alternative medicines, and indigenous healing.

Resource 2D: “Sleep Arrangements and Behavior of Bed-Sharing Families in the Home Setting”

Resource 2E: Transcultural Aspects of Perinatal Health Care: A Resources Guide
Chapters cover health and illness, pregnancy and prenatal care, labor and delivery, postpartum and newborn care, and more.

Resource 2F: Culture & Clinical Care
Lipson JG, Dibble SL, eds. San Francisco, CA: UCSF Nursing Press; 2005
This book provides information about cultural and ethnic-specific practices, beliefs, and norms, including birth and death rituals and the care of newborns and mothers.
Chapter 3: Nutrition, Feeding, and Body Image Perspectives

Breastfeeding, Bottle-feeding, and Introduction of Solid Foods

There is a great deal of cultural variability in terms of acceptable feeding practices and behaviors. Intergenerational factors contribute to patients’ and families’ eating and feeding practices. These cultural and generational contributing factors are pronounced during infancy and early childhood. It is during this period that decisions are made about breastfeeding or bottle-feeding, parental responses to crying cues in preverbal infants are formulated, and decisions are made regarding the introduction of solid foods. The timing and type of food that is introduced may be affected by the parents’ and extended family’s beliefs and cultural practices. Pediatricians should inquire about these issues and should try to elicit any dissonance between the parents’ and extended family’s food-related expectations.

Obesity

Minorities share a disproportionate burden of overweight and obesity. Specifically, the prevalence of overweight and obesity is highest among Hispanic/Latinos, American Indians, and African Americans. While some data do suggest that the obesity epidemic has stabilized in some communities, the health disparity between minorities and nonminorities has persisted. The length of time that immigrant mothers have lived in the United States and their degree of acculturation may adversely affect the rate of childhood obesity. Specifically, as families live for longer periods in the United States and become more acclimated to the American lifestyle, these immigrant families tend to acquire a more sedentary lifestyle, consume less wholesome diets, and purchase more fast foods. In addition to encouraging exercise and low-fat diets, pediatricians should consider the added barriers to healthy lifestyles, such as the availability of affordable fruits and vegetables in minority or inner-city urban populations, the built environment (safe parks and “green spaces”), availability of junk food in school vending machines, and cultural food preparation practices. Pediatricians should also inquire about the preparation method (eg, baked, fried, deep-fried) of culture-specific or traditional foods.

Food Insecurity

Poor, minority, migrant, homeless, and other underserved populations are at risk for being food insecure (having a limited or uncertain supply of food) and the associated child health sequelae. Researchers have reported a relationship between food insecurity and overweight; developmental, behavioral, or academic problems; and other adverse health consequences. Immigrant families that lived in poverty in their country of origin may consider buying fast foods or purchasing food in abundance as a newly acquired privilege for themselves and their children. In some instances, the pendulum swings from food insecurity to more abundant but unhealthy foods. Pediatricians should screen all children (with or without weight loss or history of hunger) for the presence of food insecurity as a pediatric risk factor. Prompt referral to Women, Infants, and Children services; Supplemental Nutrition Assistance Program (formerly food stamp program); or other social services is recommended.

Body Image Perceptions

Parents’ and patients’ perception of body image and specifically what they consider normal or overweight body size is influenced by their culture. In Hispanic cultures, for example, parents often view overweight or obese babies and children favorably and consider them to be “healthy.” Pediatricians should be aware that these perceptions or hunger-related past experiences exist and discuss healthy weight-to-height standards with parents.

Reference

Chapter 3 Resources

Resource 3A: Book chapter: “Promoting Healthy Nutrition”

Bright Futures provides detailed information on well-child care for health care practitioners. This chapter specifically focuses on food and nutrition behaviors that are influenced by myriad environmental and cultural forces.

Resource 3B: White House Task Force on Childhood Obesity: Solving the Problem of Childhood Obesity Within a Generation
This report provides data addressing breastfeeding rates among minorities.

Resource 3C: “Influence of Race, Ethnicity, and Culture on Childhood Obesity: Implications for Prevention and Treatment: A Consensus Statement of Shaping America’s Health and the Obesity Society”
Chapter 4: Behavior and Child Development

An understanding of parents’ and families’ culturally bound perceptions and beliefs about child development and mental health norms as well as accepted discipline practices is of paramount importance to the practicing pediatrician.

Because of potential stigma associated with mental health diagnoses or general mistrust of the health care system, patients from some communities may minimize, devalue, or ignore important mental health referrals.

Chapter 4 Tools and Resources

Tool 4A: Addressing Mental Health Concerns in Primary Care: A Clinician’s Toolkit
The toolkit contains ready-to-use resources and tools on one instant-access CD-ROM including screening and assessment instruments, quick-reference care management advice, step-by-step care plans, time-saving documentation and referral tools, coding aids, billing and payment tips, parent handouts, community resource guides, and more. There is a cost for this publication.

Tool 4B: Bright Futures Tools and Resource Kit
Designed to accompany and support Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition, this tool and resource kit includes forms to streamline health supervision visits, documentation forms for well-care visits and work done, practice management tools, tools designed to aid in screening and developing community linkages, and patient and parent handouts. There is a cost for this publication.

Tool 4C: Bright Futures in Practice: Mental Health—Volume II, Tool Kit
Designed to accompany Bright Futures in Practice: Mental Health—Volume I, this toolkit includes hands-on tools for health professionals and families for use in screening, care management, and health education. This publication is freely available online.

Resource 4A: Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition
This publication provides detailed information and guidelines on well-child care from prenatal to age 21 for health care practitioners. There is a cost for this publication.

Resource 4B: Bright Futures in Practice: Mental Health—Volume I, Practice Guide
Highlighting the mental health of children in a developmental context, this manual presents information on early recognition and intervention for specific mental health problems and mental disorders. It is freely available online.
Chapter 5: Interpretive Services

A critically important component involved in creating a culturally effective pediatric practice centers on identifying and responding to limited English proficient (LEP) patients’ language preference.

Specific guidelines outlined in the National Standards on Culturally and Linguistically Appropriate Services (CLAS) can be used to make an individual practice more culturally and linguistically accessible to diverse patient populations. The CLAS standards were developed by 2 national project advisory committees that completed a thorough analytic review of relevant laws, regulations, contracts, and standards. In addition to federal, state, and payer requirements to provide linguistically appropriate services, a growing body of scientific literature has identified risk of medical errors if linguistic barriers are not addressed in the clinical setting.1

Options for Providing Interpreter Services

If the pediatrician does not speak or is not fluent in the LEP patient’s primary language, there are several viable options to provide office- or hospital-based interpretive services such as language lines and trained independent interpreters. Using children, other family members, or untrained staff is not desirable in that these individuals may be unfamiliar with technical or scientific language, may inadvertently commit interpretive errors, or may editorialize patients’ responses. Some community-based organizations provide a lower cost interpretive services option.

Pros and Cons Associated With Different Options

The cost associated with interpretive services is cited as a significant challenge in providing linguistically appropriate services to diverse patient populations.

- **Language lines** charge by the minute and depending on the length of the visit, may be the most expensive alternative. The lack of physical presence and visual contact of a telephonic interpreter can be viewed as problematic by some clinicians. On the other hand, if the pediatrician provides services to monolingual families from several different countries, language lines usually have a large cadre of multilingual interpreters available to provide needed language services. Finally, if the anticipated need for interpretation is only a few minutes in length or if the language is uncommon, language lines may be the most cost-effective option.

- **Trained independent interpreters** usually charge by the hour and would be more cost-effective if several patients needed interpretive services during a given block of time.

- **Newer videoconferencing and mobile computer technology methods** available in some hospitals offer promising options but are not yet widely available in office-based practices.

- **The on-site interpreter’s** physical presence is often favored by providers and can be instrumental in assessing the patient’s nonverbal language and visual cues.

Some community-based organizations offer training programs for laypersons to be certified as medical interpreters. Additionally, there are community-based programs that prepare individuals to serve as cultural brokers or patient navigators.

Beyond filling the immediate need for an interpreter, these community members (cultural brokers/patient navigators) can be instrumental in providing important information about cultural beliefs, customs, and trends. Trained interpreters from community- or faith-based organizations often offer a less costly option for interpretive services.
**Cost and Payer Payment**
In the United States, most payers do not pay physicians for the cost of interpretive services. Interpreter services are allowable Medicaid services. There is, however, variability in that some state Medicaid and Children’s Health Insurance programs (CHIP) do pay the provider or contract directly with the interpreter.

Pediatricians will need to contact individual private and public payers to determine the scope of covered services in their state. If the interpreter expense is not covered by private or public payers, the pediatric practice pays for the services. Pediatricians can contact local hospitals to try to negotiate a discounted rate for interpreter services. Alternatively, practices can form physician networks to negotiate a more favorable rate.

**Integrating Interpreter Services Into Office Systems and Practice**
Using interpreters, whether telephonic or in person, is likely to increase the amount of time needed for a patient visit. However, anticipatory planning can minimize disruption and delays in clinical practice. Scheduling interpreter-assisted visits as the first visit of the clinical session allows the practice to set the exact time when the interpreter will be needed. Patients and families should be advised to arrive at least 30 minutes prior to the interpreter’s arrival time.

**What to Look for in Hiring/Contracting for Interpreter Services**
While there are currently no federal health care interpreter certification standards, pediatricians should inquire about the level of interpreter training, qualifications, and years of experience. At least one state (Washington) provides state-level certification. Additionally, preliminary steps have been taken toward the development of national standards.

**Pitfalls to Avoid**
Using untrained interpreters, including family, friends, and staff, can result in medical errors such as omissions, substitutions, or inaccuracies. Additionally, untrained interpreters may choose to editorialize sensitive information (eg, sexually transmitted infections, domestic violence). Using children as interpreters adds another set of challenges in that they are not mature enough and can be adversely affected by the clinical information being discussed.

Using untrained interpreters, including trainees who have superficial knowledge of a specific language, may result in a dangerous and false sense of security that accurate interpretation and meaningful physician-patient communication is actually taking place.

**Tips for Working Effectively With Interpreters**
- If possible, give the interpreter a quick summary of or an introduction to the patient and briefly share what is anticipated and will be covered during the visit.
- Even though the tendency is to establish eye contact with the interpreter, maintain eye contact with the parent or patient.
- Speak slowly.
- Use simple and easy-to-understand words and phrases; avoid jargon.
- Avoid interrupting the interpreter once the session has started.
- Invite the interpreter to share specific cultural practices or challenges that may arise during the encounter.

**Assessing the Need for Interpretive Services**
To determine the patient’s or family’s language of preference, they can be asked to read a brief “I Speak” document containing a single sentence in many different languages. Additionally, if
patients say very few words during the clinical encounter and use a lot of nonverbal communication, such as nodding, pediatricians should suspect that there is a problem with language comprehension or literacy level.

Reference

Chapter 5 Tools and Resources

Resource includes practical tips for communicating with patients in person or on the phone.

Tool 5B: National Health Law Program: Language Services Resource Guide for Health Care Providers
This publication has a variety of tools and resources for implementing interpretive services including assessment and evaluation tools, language service plan development, state and local interpreter services, interpreter testing resources, Medicaid and CHIP payment, and translated health promotion materials.

Tool 5C: National Council on Interpreting in Health Care: Guide to Initial Assessment of Interpreter Qualifications
This guide explains how to assess interpreter qualifications.

Tool 5D: Rhode Island Health Literacy Project: Tips for Locating Interpreter Services
One-page guide provides tips for locating interpreter services for patients.

Tool 5E: “I Speak” Language Identification Flashcards
Tool used to assess primary language spoken by patients and families.

Tool 5F: Health Industry Collaboration Effort: Better Communication, Better Care: Provider Tools to Care for Diverse Populations
Toolkit provides resources and tools for communications issues.

Resource 5A: US Department of Health and Human Services Office of Minority Health: National Standards for Culturally and Linguistically Appropriate Services in Health Care: Executive Summary
This report describes 14 national standards for providing culturally and linguistically appropriate services.

Resource 5B: La Clinica del Pueblo
This Web site provides a community-based example of a clinic providing interpretive services.

Resource 5C: The Commonwealth Fund: Providing Language Interpretation Services in Health Care Settings: Examples From the Field
Detailed information of model state, local, managed care, community, and hospital-based programs can be found in this online publication.

Resource 5D: National Council on Interpreting in Health Care
This Web site offers multiple resources for implementing interpretive services.

**Resource 5E:** “The Importance of Cultural Competency in General Pediatrics”  
Brotanek JM, Seeley CE, Flores G. *Curr Opin Pediatr.* 2008;20:711–718

**Resource 5F:** Management Sciences for Health: *The Provider’s Guide to Quality & Culture: Working with an Interpreter*  
Specific tips for clinicians to effectively work with interpreters.

**Resource 5G:** *What’s in a Word? A Guide to Understanding Interpreting and Translation in Health Care*  
This guide describes the differences between oral interpreting and written translation, including the skills needed to competently undertake each.
Chapter 6: Literacy and Health Literacy

Health literacy has been defined as “the degree to which individuals have the capacity to obtain, process and understand basic health information needed to make appropriate health decisions and services needed to prevent or treat illness” (www.hrsa.gov/healthliteracy). Patients with a low literacy level may have difficulty understanding verbal and written instructions, understanding and managing chronic diseases, completing medical history or insurance forms, accessing health care services, and understanding the importance and consequences of high-risk behavior. Studies have demonstrated an association between high literacy level and knowledge of the use of health services such as emergency department instructions, childhood health maintenance procedures, and informed consent. Additionally, researchers have identified a positive relationship between high literacy level and knowledge of asthma, HIV/AIDS, postoperative care, and others (www.hrsa.gov/healthliteracy).

Assessment of Literacy Levels

To determine a patient’s or family’s health literacy level, providers can use one of many assessment tools. The severity or chronic nature of the patient’s clinical scenario are factors that modulate the emergent need for health literacy assessment and the long-term effect of literacy level on medication adherence, disease management, and ultimately, health outcomes. Because health literacy involves not just patients’ ability to read but also to understand messages relating to health and health care, providers should assess all patients’ health literacy levels to provide the best care. Pediatricians need to communicate with all patients and parents, but particularly those with low literacy, at a level they can understand. Specific communication techniques such as asking the parent to say in their own words what they understood and posing inviting questions to the family are encouraged.

Chapter 6 Tools and Resources

Tool 6A: Plain Language Pediatrics: Health Literacy Strategies and Communication Resources for Common Pediatric Topics
This book provides the framework for implementing a plain language approach to communication in your office and specific steps you can take to ensure the information you present to patients and their parents is clearly understood. Included are 25 reproducible plain language patient education handouts in English and Spanish. There is a charge to purchase this publication.

Continuing medical education (CME)-bearing opportunity features practical tips and checklists for practice operations, assessment, patient materials, and additional resources for practicing physicians.

Tool 6C: Health Literacy Assessment Tool: Rapid Estimate of Adult Literacy in Medicine (REALM)
The REALM is a medical-word recognition and pronunciation test for screening adult reading ability in medical settings. It can be administered and scored in less than 3 minutes by personnel with minimal training, making it easy to use in clinical settings. It is available in English only. There is a cost associated with administering this tool.

Tool 6D: Health Literacy Assessment Tool: Test of Functional Health Literacy in Adults (TOFHLA)
The TOFHLA includes a 17-item test of numerical ability and a 50-item test of reading comprehension. It takes up to 22 minutes to administer. It is available in English only. There is a cost associated with administering this tool.

**Tool 6E:** Health Literacy Screening Tool: [Newest Vital Sign](#)
This tool identifies patients at risk for low health literacy. The tool’s main advantages in the clinical setting are that it can be administered in 3 minutes, it is available in English and Spanish, and it can be ordered at no cost.

**Tool 6F:** Health Resources and Services Administration: [Unified Health Communication (UHC): Addressing Health Literacy, Cultural Competency, and Limited English Proficiency](#)
Online CME-bearing opportunity is designed to help providers improve communication with their patients.

**Tool 6G:** Rhode Island Health Literacy Project: [Health Literacy Toolkit: Better Communication for Better Care](#)
Toolkit includes tips and resources for providers to address health literacy in practice, as well as resources for patients.

**Tool 6H:** Children’s Health Fund: [Health Education Materials](#)
This Web site provides health education materials for low literacy patients and families. Materials are available in English and Spanish.

**Resource 6A:** Center for Health Care Strategies: [What is Health Literacy? Fact Sheet](#)
Fact sheet provides practical tips for assisting patients and families with low literacy.

**Resource 6B:** Institute of Medicine: [Healthy Literacy: A Prescription to End Confusion Literacy Consensus Report Brief](#) and [Full Report](#)
Report provides an overview of health literacy.

**Resource 6C:** The Commonwealth Fund: “[Health Literacy Practices in Primary Care Settings: Examples From the Field](#)”
This report describes several promising practices for implementing health literacy in primary care practices.

**Resource 6D:** [Teaching Patients With Low Literacy Skills](#)
This book covers a wide range of topics, including educational theories, tests for literacy skills, assessments of the suitability of materials, as well as discussion and examples of understandable visuals.
Chapter 7: Medical Education

Researchers suggest that a multicultural learning environment can be beneficial in that it “exposes students to a broad array of ideas, experiences and perspectives, and thereby better prepares them to meet the needs of a multicultural American populace.”1 In addition to fostering a diverse educational and clinical climate regarding race, ethnicity, gender, and physical disability, for example, other learner-associated factors such as the inclusion and respect of foreign medical graduates should be explicitly addressed. These diverse educational learning environments coupled with robust cross-cultural curricula optimally will foster the development of pediatricians equipped to deliver effective cross-cultural care.

Reference

Chapter 7 Tools and Resources


This tool assists in meeting the community pediatrics and advocacy requirements of the Accreditation Council for Graduate Medical Education. The first goal is related to providing culturally effective care.

**Tool 7B:** AAP Community Pediatrics Training Initiative: *Community Pediatrics Curriculum*

Curriculum for residency education includes methodologic suggestions for the delivery of the curricular materials, anticipated educational outcomes, examples of curricular tools, and a wide array of resources—Web sites, books, articles, and videos. There is a chapter about delivering culturally effective care.

**Tool 7C:** AAP Community Pediatrics Training Initiative: *Community-based Resident Projects Toolkit*

This toolkit assists in the development and implementation of resident community pediatrics projects. There is a chapter on cultural competency.

**Resource 7A:** AAP Committee on Pediatric Education: *Educational Goals and Objectives for Culturally Effective Pediatric Care for Residents in Pediatrics*

This document presents a set of goals outlining strategies for incorporating culturally effective care into the six areas of general competence for graduate medical education.

**Resource 7B:** “Integrating Social Factors into Cross-cultural Medical Education”

**Resource 7C:** “The Teaching of Cultural Issues in US and Canadian Medical Schools”

**Resource 7D:** “Components of Culture in Health for Medical Students’ Education”
Tervalon M. *Acad Med.* 2003;78:570–576

**Resource 7E:** “International Medical Graduate-Patient Communication: A Qualitative Analysis of Perceived Barriers”
Resource 7F: “Should the Residency Programs Train International Medical Graduates in Certain Communication Skills?”
Chapter 8: Tips, Tools, and Resources for Implementation

**Tips for Busy Practices**

The delivery of culturally effective and linguistically appropriate health care services is integral to high quality of care. The added time demands that may be associated with pediatricians’ unfamiliarity with a specific culture or language can be minimized or managed by:

- Having a diverse clinical, nursing, and administrative staff that is reflective of the local patient population and can potentially serve as cultural brokers.
- Becoming familiar with local community-based organizations that can serve as a valuable resource for specific areas of need such as interpretive services.
- Adding a few key questions to the medical history questionnaire (Has the patient or parent consulted a traditional healer or used medicines/herbs that the pediatrician did not prescribe? What does the patient/parent believe is the cause of the illness?).
- Considering group visits of monolingual or limited English proficient parents, families, and patients as an option to minimize interpreter-associated expenses.
- Anticipating and allowing for extra time that may be necessary with interpreter-assisted patient encounters.

**Community Resources**

Community partnerships and resources are instrumental in helping pediatricians deliver culturally effective care to diverse patient populations. For example, partnerships and programs developed or enhanced through American Academy of Pediatrics (AAP)-supported Community Access to Child Health and Healthy Tomorrows Partnership for Children Program grants can provide the infrastructure, partners, and venues to collaboratively address persistent diversity-related challenges and explore opportunities for practice improvement. Likewise, community-immersion or community-centered educational experiences for trainees and pediatricians alike can increase cross-cultural awareness and understanding.

**Organizational and Individual Cultural Assessment Tools**

In a new or existing pediatric practice, it is helpful to understand and quantify the individual pediatrician’s or practice’s readiness to provide culturally effective care to diverse populations. There are multiple self-assessment and organizational assessment tools that are helpful not in “grading” the pediatrician or practice but in identifying opportunities for professional development or practice improvement.

**Chapter 8 Tools and Resource**

**Tool 8A:** Healthy Roads Media: Patient Education Materials in Multiple Languages

These general health education materials are available in multiple languages.

**Tool 8B:** Patient Education for Children, Teens, and Parents, 3rd Edition

This book provides more than 150 AAP patient education handouts spanning infancy through adulthood. It is available in English and Spanish as well as online.

**Tool 8C:** MD Consult: Patient Education

This Web site provides a large volume of patient education materials in English and Spanish.

**Tool 8D:** Health Resources and Services Administration: Cultural Competency and Health Literacy Resources for Health Care Providers

This Web site provides a variety of tools and resources related to health literacy and cultural competency for health care providers.
**Tool 8E:** Center for Cross-Cultural Health: *Cultural Competency Organization Assessment*
This tip sheet provides basic information about types of organizational assessment.

**Tool 8F:** National Center for Cultural Competence: *Tools and Processes for Self-Assessment*
This Web site provides links to tools and assessment instruments for organizational and individual self-assessments.

**Tool 8G:** National Center for Cultural Competency: *Various Organizational Self-assessment Instruments, Guides, and Planning Tools*
This Web site provides links to checklists to assess organizational self-assessment in English and Spanish. Also included are links to guides and planning tools for implementing cultural competency into a practice.

**Tool 8H:** MedlinePlus: *Interactive Health Tutorials*
This Web site provides interactive patient education tutorials and handouts with animated graphics of diagnoses, procedures, and tests.

**Tool 8I:** National Quality Forum: *Endorsing a Framework and Preferred Practices for Measuring and Reporting Cultural Competency*
Reporting provides a framework and 45 practices to guide health care systems in providing care that is culturally appropriate and patient centered. The comprehensive framework for measuring and reporting cultural competency covers issues such as communication, community engagement, and workforce training.

**Resource 8A:** National Center for Cultural Competence: *A Guide to Planning and Implementing Cultural Competence Organizational Self-Assessment*
Rationale, elements, benefits, planning, and implementation of organizational self-assessment are provided here.
Chapter 9: Continuing Medical Education Opportunities

Learning to deliver culturally effective care is considered by many to be a lifelong journey. Each cross-cultural clinical encounter offers the opportunity to increase pediatricians’ knowledge and fine-tune cross-cultural communication skills. Importantly, a wealth of Web-based continuing medical education (CME) resources are readily available to support pediatricians’ professional development process.

Chapter 9 Tools

**Tool 9A:** Management Sciences for Health: *The Provider's Guide to Quality and Culture*
This comprehensive professional development Web site is focused on clinicians.

**Tool 9B:** American Academy of Family Physicians: *Quality Care for Diverse Populations*
This Web site features a CME-bearing video series about providing quality, culturally competent care.

**Tool 9C:** American Institutes for Research: *A Family Physician’s Practical Guide to Culturally Competent Care*
This curriculum guide is for providing culturally effective care.

**Tool 9D:** Diversity Rx Web Site
This Web site provides tools and resources to improve the accessibility and quality of health care for minority, immigrant, and indigenous communities.