

Healthcare for Immigrants and Refugees

By Marcia Carteret

The term culture shock was first introduced in the mid-1950s to describe the anxiety produced when a person moves to a completely new environment and experiences discomforting levels of disorientation. When normal guidelines for appropriate social interaction disappear and self-sufficiency is severely challenged, it is natural for human beings to become very stressed. The process of overcoming culture shock is called acculturation, and, depending on an individual's specific circumstances, it can be a long and arduous process indeed. The level of stress endured throughout the acculturation process by an individual may vary from a small amount to the point where it "virtually destroys one's ability to carry on." (Berry, 1990).

With the changing demographics in Colorado, healthcare providers across the state will continue to see significant numbers of individuals and families who have immigrated to the U.S. or applied for refugee/asylee status here. Many of these newcomers are from countries where the national culture is dramatically different from that of the United States. It is important for healthcare providers to understand the special challenges some of these patients present due to the stresses they may have endured before coming to the US and the extreme hardships many face in trying to establish themselves in this country. Awareness of common immigrant/refugee health considerations, including acculturation stress, can help eliminate health disparities among certain immigrant and refugee populations.

Immigration Status Basics

Immigrant: A person who comes to a country to take up permanent residence who does not fit the definition of a refugee or asylee. <http://en.wikipedia.org/wiki/Immigration>

Refugee: Any person who is outside his/her country of nationality or, in the case of a person having no nationality, is outside any country in which he/she last habitually resided, who is unable or unwilling to return to such country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. Refugees are a category of immigrants who arrive with legal resident status in the United States and as such are entitled to all of the rights and responsibilities of legal residents. Refugee status is determined by the Department of Homeland Security *before* a person is eligible for resettlement in the United States. Refugees are eligible for refugee health services for a period of eight months from the date they entered the United States.

Asylee: An individual who has received permission to remain in the United States, under Section 208 of the Immigration and Nationality Act (INA), based on a "well founded fear of persecution" should the alien return to their native land. A prospective asylee applies for this permission from within the United States, unlike a refugee who applies from abroad. Asylees of all nationalities are eligible for Refugee Health Assessment Program services within 90 days of US entry.

Immigrant and Refugee Acculturation Stress

Acculturation refers to the changes that groups and individuals undergo when they come into contact with another culture (Williams & Berry, 1991). Acculturative stress is a more specific term that refers to the stress that directly results from and has its source in the acculturation

process (Berry, 1990). Immigrants and refugees who experience intense feelings of loss after leaving their native country may go through a period of cultural bereavement which can compromise their ability to make necessary adaptations. Multiple stressors that are often part of their new environment include discrimination, language barriers, unemployment and/or low income, feelings of not belonging in the host society, and a sense of anxious disorientation in response to the unfamiliar environment. Acculturating individuals may also feel pulled between traditional values, norms, and customs and those in the new society (e.g., parent--child conflict related to the child's encountering the new culture through school; role conflict related to a mother's having to work).

The degree of acculturative stress an individual experiences is greatly reduced when certain favorable conditions exist. The presence of immediate and extended family networks is crucial, as is social support from outside the family in the new community. Favorable socioeconomic status, education and income also ease the acculturation process. Studies also suggest that individuals adapt differently to acculturation stress based on variables such as self-esteem, resilience, knowledge of the new language and culture, realistic/positive expectations for the future, and a high degree of tolerance for and acceptance of cultural diversity in their newly adopted society.

Due to their experiences throughout the resettlement process, some immigrants and many of the refugees arriving in the United States require comprehensive medical services. Refugees have to have overseas pre-departure screenings as well as health screenings within 30 days of arrival in the U.S., but neither replaces reliable health data and complete medical histories which are scarce among many of the incoming populations. Common health considerations include immunizations, treatment for infectious and parasitic diseases, HIV/AIDS care, oral health care, lead screening, nutrition and diet, and mental health services. Additionally, health considerations specific to children include diarrheal diseases, acute respiratory infections (ARI), and malnutrition.

Preparing for Medical Consultation with Refugees

It is most common for people from refugee backgrounds to have gone without access to comprehensive health care for years. Their initial contact with US health care providers may be the first opportunity in their lives to receive client-focused, high quality health care. At the same time, building a relationship and providing optimal care to refugees can be a challenge for health professionals. Refugees often lack knowledge of English, leading to feelings of isolation and mistrust. The health system will often seem very complicated to refugees and they may need assistance with acquiring prescriptions and other tasks. Many may be suffering from serious mental illnesses due to trauma and grief and may be stigmatized by their society. There may be shame associated with certain contracted diseases such as HIV. Additionally, women may often prefer a female practitioner and may experience strong emotional and psychological responses during gynecological exams due to past sexual abuse.¹

Health-Related Cultural Practices

Body modification

Virtually all cultures engage in some sort of body modification, such as tattooing or piercing.

The reasons for this are complex and may relate to personal enhancement, hygiene, rites of passage, traditional healing and other sociological reasons. Some of these practices are temporary, such as henna paintings on the extremities, which are considered by some Middle Eastern groups to have healing properties. Other procedures such as scarification are permanent and may involve procedures such as cutting, burning or piercing.

Body modification procedures may include:

- “Coin Rubbing” and “Fire Cupping” are common among Southeast Asian cultures. Both are traditional healing methods. In coining, the edge of a coin is rubbed over the skin which creates a red stripe. In fire cupping, heated suction cups are used on the skin which leaves red marks.
- Artificial penile nodules in Southeast Asian men – foreign bodies are implanted under the skin of the penis to enhance sexual performance.
- Scars or lesions, especially in African cultures – found on the trunk of face, and other parts of the body; the cutting or burning procedures producing the scars or lesions may be done for ritual reasons, body enhancement, or for traditional healing.
- Male circumcision, particularly among Muslim males.
- Amputation of the uvula in some African groups – a traditional healing practice. Female genital cutting (FGC), also called female circumcision or female genital mutilation (FGM). Common in parts of Africa, the Middle East, and Asia, FGC/FGM is illegal in the United States.

Refugee groups may delay medical treatment because they will first resort to traditional diagnosis (either herbal or spiritual). This may cause a serious delay resulting in disease or death. Thus, they may seek medical care late in an illness. It has been observed by refugee camp aid workers that mothers do not seek medical care in good time, bringing their children in when they are already at a critical stage. There may also be problems of adherence to treatment regimes that require long-term sustained use of medicine. Doctors should stress the importance of regular check-ups for pregnant mothers and children (especially well-baby check-ups). Providers as well as nurses will be required to explain the significance of “prevention” since refugees may not be familiar with this concept.

Trauma among Refugees

Most refugees arriving in this country will have been exposed to traumatic events. These may include:

- The experience of being transplanted from their country of origin to a highly industrialized country where technology is unfamiliar
- Threats to their own lives or those of their family or friends
- Witnessing death squad killings, mass murder and other cruelties inflicted on family and friends
- Disappearances of and separation from family members or friends
- Perilous flight or escape with no personal protection
- Forced marches
- Extreme deprivation – poverty, unsanitary conditions, hunger, lack of health care
- Persistent and long-term political repression, deprivation of human rights and harassment
- Removal of shelter or forced displacement from homes

- Refugee camp experiences involving prolonged squalor, malnutrition, physical, psychological and sexual abuse, absence of personal space, and lack of safety

Major Psychosocial Issues in Resettlement

- Housing in countries of second asylum is usually very different from the refugee's place of origin. They may not be used to having hot and cold water, and flush toilets, hence they may need instructions on related safety issues.
- Transportation: A major reason for noncompliance with health care for refugees is lack of transportation to the clinics.
- Difficulty learning a new language creates a great deal of the stress associated with relocation. Most communities offer ESL (English as a Second Language) classes. However learning a new culture, means of livelihood, and all the other new experiences make learning the language very difficult for many. Older people, in particular, have great difficulty surpassing language barriers.
- Customs and protocols: Everything in the host country is new, from obtaining food and registering for school, to childbirth and money matters. The issue of medical insurance or benefits is foreign to refugees in the U.S.
- Technology: Items we take for granted, such as washing machines, televisions, VCR's, telephones, microwaves, and computers are rare in the refugees' countries of origin.

Conclusion

This newsletter is only intended as an overview of health considerations related to immigrant and refugee populations in the United States. Suggested links for further reading are provided below. There are a number of organizations in the Denver area working closely with immigrants and refugees. They can be excellent resources and links to their websites are also provided here.

The African Community Center

<http://www.africancommunitycenter.net/>

Jewish Family Service

<http://www.jewishfamilyservice.org/>

The Asian Pacific Development Center

<http://www.apdc.org/>

Lutheran Family Services

<http://www.lfsc.org/>

Related Links for Further Reading

- Culture Med <https://culturedmed.sunyit.edu/index.php/home>
- Rhode Island has a really good site for refugee services:
<http://www.health.state.ri.us/chew/refugee/>

- US Department of Health and Human Services, Office of Refugee Resettlement
<http://www.acf.hhs.gov/programs/orr/benefits/health.htm>

References:

1. Refugee Health Care: A Handbook for Health Professionals, The Consultation – Communicating Effectively with Refugee Clients, Minister of Health, New Zealand, November 2001

We gratefully borrowed the following portions of this article from The Refugee Health Providers Manual, Refugee Health Program, Office of Minority Health Rhode Island Department of Health, May 2007: *Preparing for Consultation with Refugees, Health-Related Cultural Practices, Trauma Among Refugees, and Major Psychosocial Issues in Resettlement.*

Colorado Medicaid is Proposing A New Pilot Program To Reform Medicaid

As mentioned in last month's newsletter, The Colorado Dept. of Health Care Policy and Financing (HCPF), which administers Medicaid and CHP+, is proposing a pilot program to improve the health and health care of Medicaid recipients. HCPF has solicited the input of the Legislative Committee and Executive Committee of the Colorado Chapter of the American Academy of Pediatrics, the leadership of Colorado Academy of Family Physicians and the Colorado Medical Society. These organizations have been actively involved over the past several weeks in adaptations of the plan to ensure that the needs of the children in your practice are being met and that your current efforts are acknowledged and supported.

CCHAP sees Health Care Reform as an important step in improving children's health care and wants to be sure that children's needs are treated as a priority within the plan. But, HCPF acknowledges that the proposal is a work in progress, so.....**Your input will be crucial to be sure that the needs of children and their providers are met.**

A full description of the proposal will be made public in the next couple of weeks. We will send you a special edition of the CCHAP newsletter describing their proposal and tell you how you can easily provide your response directly to state Medicaid planners electronically.

Rest assures that the Legislative Committee and Executive Committee of the Colorado Chapter of the American Academy of Pediatrics, the leadership of Colorado Academy of Family Physicians and the Colorado Medical Society will continue to be actively involved in representing Medicaid recipients and their providers.

You can begin to learn more about the proposal on the HCPF website:

<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1233759745246>

There are public forums that are open to all interested parties to describe the plan and answer questions:

April 20, 2009 at 4:00 - 7:00 pm	225 E. 16th Street, Denver, CO 80203. 1st Floor Conference Room. or via WebEx (see web site)
May 12, 2009 at 9:00 - 12:00 pm	225 E. 16th Street, Denver, CO 80203. 1st Floor Conference Room. or via WebEx (see web site)
June 11, 2009 at 2:00 - 5:00 pm	225 E. 16th Street, Denver, CO 80203. 1st Floor Conference Room. or via WebEx (see web site)

If you want to be on the email list to receive updated information and invitations to the public forums, please email baltazar.rocha@state.co.us

PROVIDER RESOURCE HELPLINE

To Assist You In Connecting Your Patient with a Chronic Health Condition or Special Needs
And Their Families
With Appropriate Services and Resources

Call 1-877-731-6017

Fax: 303-733-3344

Email: providerhelpline@familyvoicesco.org

The PROVIDER RESOURCE HELPLINE (PRH) assists providers in identifying appropriate services and resources for children with chronic illness or special needs and for their parents:

- Specialized services, resources, programs, medical equipment, therapies
- Parent/patient education about chronic illness / special needs
- Parent/patient support services
- Case management
- Care coordination
- Help in finding funding for uncovered services

Examples:

- You are seeing a new patient (new to Colorado) who is an infant with 22q Deletion Syndrome, congenital heart disease, cleft palate and an oxygen requirement of undetermined etiology. Parents want to link up with all of the support services and a parent group like they had where they used to live.
- A child with multiple developmental delays also has behavioral problems. The parents are not sure they are getting all the help their child is entitled to and they want a parent support group and they are asking for counseling.
- A parent with a disabled child wants your help in applying for some sort of waiver that you aren't familiar with.
- One of your patients has heart disease and is failing to thrive. Surgery can't be done until the child is larger. You need someone to weight the child each week, provide feeding guidance and support the parents.

PRH Hours of Operation:

Monday thru Friday from 8 AM to 4 PM
Voicemail available 24/7

We can provide the information to you or your staff for you to give the patient....
Or we can work directly with the patient and family.....your choice.
The helpline will provide follow-up to your office on how the patient and family are doing

If the information on appropriate resources is not immediately available, we will research your question or case and provide the information to you and the family as soon as possible in whatever manner you and the family wish (via phone, fax, or email).

When contacting us, please provide us with the following information:

1. Your provider office and PCP name
2. Name of Child
3. Date of Birth
4. Medical Condition / Primary Disability
5. Type of insurance
6. Resource or service requested
7. Who we should contact with information
8. Family Contact Information
9. How is it best to provide information back to you: phone, fax, email or voicemail

TO DOWNLOAD A REFERRAL FORM SEE END OF CHAPTER OR [CLICK HERE \[jeff see below\]](#)

Next time you see a child with any chronic health problem or a special needs child, call us to see how we can help.

Questions about the helpline? Call 1-877-731-6017

**The Provider Resource Helpline Is Sponsored By
[Family Voices](#) and [CCHAP](#)**

CLARIFICATION:

Contact Erlinda or Lorena with CCHAP at 720-744-5552 (phone) or 303-751-9048 (fax) when you are only concerned about socio-economic issues like food stamps, housing, Medicaid eligibility, legal aid, abuse, etc. Contact the hotline for clinical referral needs.

[Jeff - the Referral fax form is attached to the email.]

Childhood Bullying: A Guide for Pediatric Practices

This article is submitted by Creating Caring Communities, non-profit organization

Approximately 10% of all children attending school are frightened and afraid through much of the school day. Some of these children avoid lunch, recess and playtime out of fear that they will be humiliated or picked on by bullies. Often they present in the nurse's office complaining of a headache, stomach ache or of not sleeping well. Rarely do they say that the problem is bullying out of fear and an inability to defend themselves.

Health professionals play a critical role in recognizing and addressing this problem early. The consequences of growing up as a victim or a bully can be serious. Victims may suffer from anxiety, low self esteem and depression as well as lowered academic achievement. Some victims may attempt suicide out of desperation. Bullies, on the other hand, are at risk for conduct disorders and for serious antisocial and criminal behavior by early adulthood. Most remain bullies throughout their lives, enjoying their power and the control over others that their behavior evokes. They are at risk to drop out of school, fail to hold a job and never develop or sustain a close, intimate relationship. Finally, the children who are neither bullies nor victims, who watch but are not targeted, report feeling guilty for not intervening but too frightened of being targeted themselves to do anything.

Even though bullying takes place in school, pediatricians and health care professionals have a vital role to play in spotting children in trouble and suggesting interventions that can help. Bullying may present in a pediatric practice in a number of ways:

- school avoidance
- persistent symptoms (i.e. headache, stomach ache, sleep problems)
- depression and behavior problems.

There are tools you can use to identify bullies and victims. *See the following screen*

Spotting the victims

A child who comes into the office with a withdrawn or shy demeanor, whose speech is soft, perhaps barely audible when asked about social experiences or friendships, may be a victim. Some will have distinguishing physical characteristics as well: overweight, underweight, too tall, too short, physical disability, coordination difficulties or even bruises on their bodies from abuse. Children with learning differences may have problems with organization, visual planning, and integration that leave them vulnerable on the playground and during team sports. Many of them are not adept at sizing up social situations and, for that reason, are easy to tease or ridicule. Special needs children who are mainstreamed are typically at risk unless the school has put in place protective measures.

Many victimized children have anxiety-based symptoms that present as somatic complaints. When they are in school, they frequently take refuge in the nurse's office, complaining of headaches or stomachaches. They are so frightened that their fear manifests as physical symptoms. Some avoid school all together.

Picking out the bullies

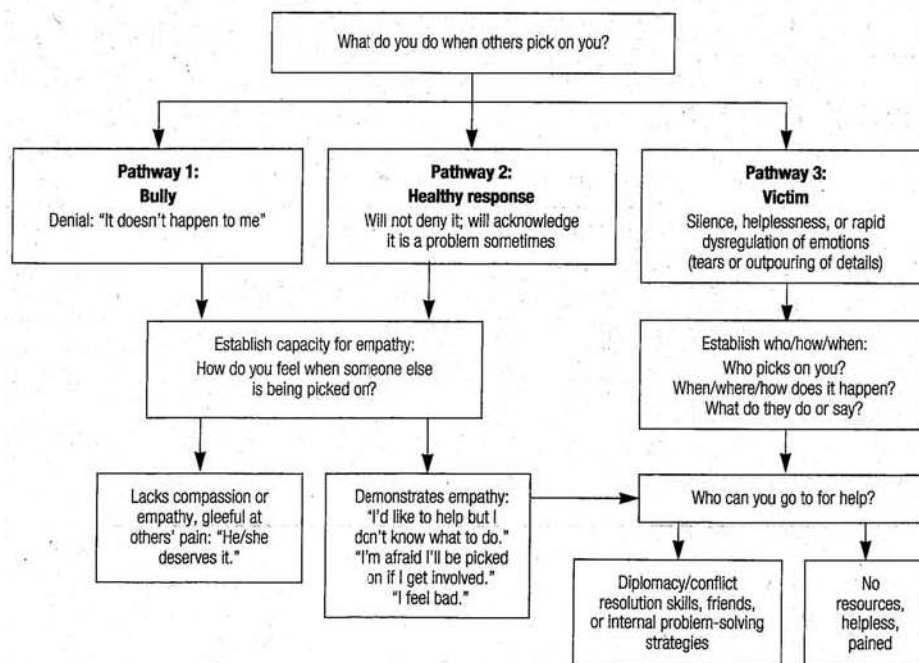
Bullies are more difficult to detect than victims. They are adept at hiding the way they treat others. In the bully's belief system, victims deserve what they get. The bully does not empathize with other children's feelings and feels justified in picking on children who appear weaker or different. Bullies often present as cocky, arrogant and self assured. Many do not accept adult authority and are disdainful when asked questions. Some are smoother talking and good at reading the social demands of the situation and giving the answers the questioner wants to hear. Family history may help identify them since most experience considerable discord with their parents. Sibling aggression is not uncommon as children who bully others at school also use intimidation and fear in other relationships.

How you can help

When you suspect or discover victimization or bully behavior, address it immediately. As bullies and victims get older, the dynamics of their roles become more entrenched and solutions become harder to find. The problem needs to be addressed within the school environment and with families. There are programs available. *Bully Proofing Your School* was developed in Colorado and is a comprehensive program with training materials from early childhood through high school. Training on implementation of this program is available to schools through Creating Caring Communities, a local non-profit. Creating Caring Communities is also making training available specific to pediatricians and nurse practitioners. You may also be interested in providing resources for families to help them better understand how they can support their children. *Bully Proofing Your Child: First Aid for Hurt Feelings* is a useful tool which you may wish to provide in your waiting room. For more information about the program, training manuals and parent guides can be found at www.bullyproofing.org or you may contact CCC directly at 720.941.0700.

Adapted from Garrity, C. and Baris, M. (1996), Bullies and Victims: A guide for pediatricians. *Contemporary Pediatric*, 13(2), 90-114.

Brief screen for bully/victim problem



Announcing an Interactive Cross-Cultural Communications Website Designed Especially for Healthcare Professionals

dimesionsofculture.com

**Register now! Click the link above and get full access
with your own secure login and password!**

A Website to Support On-going Training for Healthcare Professionals in Colorado

Because culture can have important clinical consequences, this website is devoted to supporting the self-development of healthcare professionals in basic cross-cultural communication competencies that impact health outcomes for patients. In place of the typical "diversity training" approach, practical communication strategies are emphasized that can be put to use immediately in private practices, clinics, and hospital settings.

An Interactive Website for Building a Learning Community

The content of this cross-cultural communications website focuses on reinforcing key concepts presented in cross-cultural communication trainings by Marcia Carteret. Additionally, this site presents the opportunity for physicians and staffs in multiple healthcare settings to interact with one another through threaded discussions. Because nothing can replace real life experience in the learning process, a virtual learning community will make it possible to share true stories and post useful questions while culture and medical experts facilitate discussions.

Website Features

Listed here are the pages that currently make up dimensionsofculture.com. Please note that *some pages require a login and password because only select groups of healthcare professionals, including all CCHAP pediatric practices, will have full access to the "community" pages.*

Public Pages

- [Home Page](#)
- [Greetings from the Site Editor](#)
- [Culture Calendar](#)- Monthly religious and cultural holidays
- [Culture Quest](#) – Information about cultural happenings in our community, as well as statewide and nationally.

Healthcare Community Pages (Login/Password Protected)

- ⊕ *Newsletters* – Monthly articles addressing key cross-cultural communication topics written by Marcia Carteret and other guest contributors.
- ⊕ *Interactive Forums* – an interactive on-line community dialogue between healthcare professionals about communicating with patients from different cultural backgrounds.
- ⊕ *Provider Profiles* – An ongoing series of profiles introducing some of the dynamic and culturally diverse doctors working in the CCHAP network of pediatric practices
- ⊕ *Culture Ambassadors* – A panel of representatives from cultures around the globe, with a strong focus on the cultures most heavily represented across our state.

This website is designed to meet the needs of the healthcare community served by Colorado Children's Healthcare Access Program. If you are a participating CCHAP provider or staff member and have suggestions for the website, please contact Marcia Carteret at mcarteret@gmail.com or 720-777-3124. Your comments and suggestions will help make dimensionsofculture.com an effective tool for learning and community building.



Abe Grinberg MD, FAAP MPH

Language as a Communication Barrier in Medical Care for Hispanic Patients

Communication with patients and their families is essential in providing quality medical care. Cultural and language barriers create a void in the delivery of safe health care, customer satisfaction and quality of care. The public debate on how to bridge cultural and language barriers has a long history. The use of formal interpreters and translators is associated with the ability to eliminate these barriers; however, the ability to communicate directly with health professionals in a common language is associated with an increase level of trust in medical settings.

There are 7 important points to have in mind when addressing cultural and language barriers with the Hispanic patients and their families:

- I. The number of people speaking a language other than English at home and the number of Americans Limited in English Proficiency (LEP) in the United States is significant. It is expected that the total number of people in these two groups will continue to increase at a faster rate than the one of the general population in the USA. About two thirds of them are Spanish speaking individuals () ().**
- II. Multiple studies document that quality of care can be seriously compromised when Spanish LEP patients need but do not get translation and interpretation services () ().**
- III. Studies also document that the quality level of interpretation offered by bilingual providers and professional hospital interpreters is high. However, the quality of interpretations offered by hospital employees who are not professional interpreters, family members, relatives, friends, and ad-hoc translators are many times incorrect and of poor quality (5).**

- IV. Interpretation errors are common. About 60% of the errors have potential clinical consequences. Even professional interpreters commit significant errors about 50% of the time (5).
- V. Patients, who interact with a bilingual provider, frequently rate them as more friendly, respectful, and concerned when compared to those who interact with a translator or interpreter. Patients and families who are taken care by a provider who speaks their own language frequently have a more accurate recall of critical information about the encounter than those who interact with a provider who uses a translator or an interpreter(6)(7).
- VI. There are data that suggest that the length of hospital visits, the incidence of any testing, the cost per visit and the number of hospital admissions are decreased in those patients who interact with a provider who speaks their own language when compared to those providers who use a translator or interpreter during the course of the medical encounter (8).
- VII. There is evidence that courses in Medical Spanish can help health care professional achieve fluency in Spanish at the functional level and promote cultural awareness that strengthen communication skills. The promotion of such courses is associated with decreased interpreter use and increased patient and family satisfaction (9).

Bear in mind that Hispanics embrace people when they make an effort to speak their own language. They tend to be tolerant and have a tendency to develop relationships that are based on friendship and respect. You will make them feel comfortable and help them feel that you are concerned about their medical care.

“Dele a un hombre un pescado y él comerá por un día. Enséñele cómo pescar y comerá por el resto de su vida” (Lao Tzu. Filósofo Chino).

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5. Flores G., M.B. Laws., S.J. Mayo., B. Zuckerman., M. Abreu., L. Medina and E. J. Hardt. 2003. Errors in clinical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics* 111: 6-14

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8. Hampers, L. C and., McNulthy, J.E. 2002. Professional Interpreters and Bilingual Physicians in a Pediatric Emergency Department. *Arch Pediatr Adolesc Med. 156:1108-1113.*
9. Suzan S. Mazo., Louis C. Hampers., Vidya T. Chande. Steven E. Krug. (2002). Teaching Spanish to Pediatric Emergency Physicians: Effects on Patient Satisfaction. *Arch Pediatr Adolesc Med 156: 693-695*

Course in Medical Spanish customized for pediatric care providers. Once a week for 12 weeks (2 hour class), includes also 6 month internet access to “Spanish for health care course”. Flexible schedule to accommodate participants’ preferences; Classes take place at the providers’ office for groups of 8-12 students.

\$ 389 dollars per student. Includes 6 month internet access to the on line training course.

Contact: Abe Grinberg MD (720) 748-7669.

abe@bilingualmed.com my web-site www.bilingualmed.com

Postpartum Depression Screening For Mothers And Training For Your Practice

Postpartum Depression is a significant public health issue affecting 1 out of 8 new mothers. In Colorado, it is underidentified and undertreated. The Rose Community Foundation has funded Dr. Brian Stafford and The Kempe Center's Postpartum Depression Intervention Program to provide Free Medical Education and On-Site assistance to practices in the Denver Metropolitan area in order to assist their identification, education, treatment, and referral for women with this condition. Practices will receive a free talk as well as a free tool kit and fliers and brochures to assist them. This provider education is paired with a public awareness campaign on this issue titled, 'Oh baby, this isn't what I expected.' Interested practices or practitioners should contact the Kempe Center at 303-864-5845 or Dr. Brian Stafford at Stafford.brian@tchden.org to schedule the on-site pre-clinic or lunchtime training.

Child Psychiatrist Available to Provide Conferences for You In your Office

Rick March, MD is a child psychiatrist at the Mental Health Center of Denver. He is available to provide teaching on a variety of child Psychiatry topics (below) in your office. He is also willing to discuss cases with you, as well. Please contact him to take advantage of this wonderful opportunity.

He can be reached at Rick.March@MHCD.org

Here are some of the topics he can cover for you.

- Diagnosing Depression in Children and Adolescents
- SSRI's and Black Box warnings
- Suicide and self-abuse
- Diagnosing Bipolar Disorder in Children and Adolescents (including differential diagnosis)
- Atypical Antipsychotics
- Mood Stabilizers and Antidepressants
- Pediatric Psychopharmacology and the FDA
- Kid with ADHD who don't get better on stimulant medication
- Psychosis in Children and Adolescents

And, remember there is a child psychiatrist on call available by phone for your Medicaid children.....

The Cross-cultural Curriculum for the Department of Pediatrics
The syllabus is now available for you and your practice

There is a syllabus available on the CCHAP web site that covers a variety of topics related to cross cultural health care. The following topics are covered:

- Demographics of Colorado's Children – page 4

- Health Disparities among Colorado's Children – page 5

- Health Disparities – Contributing factors page 8
 - Poverty – page 9
 - Genetics - 15
 - Environmental exposures - page 16
 - Life style behaviors – page 16
 - Provider's ability to understand/accommodate the patient's / parent's culture – page 17
 - Provider's ability to communicate well with families – page 17
 - Patient's / parents limited English proficiency - page 17
 - Patient's / parent's limited health literacy - page 17
 - Discrimination – page 19

- What can Providers do to improve outcomes? – page 20

- Race, Ethnicity and Culture (Definitions) – page 22

- Cross-cultural Communication – page 26
 - Generalization versus stereotyping – page 27
 - What providers need to know about culture? (Dimensions of culture) – page 29
 - Basics of cross-cultural communication – page 33

- How to communicate with and help families with Limited English Proficiency – page 37

- How to communicate with and help families with Limited Health Literacy – page 46

- The Cross-cultural Health Care toolkit – page 49
 - Keys to success in cross-cultural communication – page 49
 - LEARN mnemonic – page 50 and page 57
 - Cross-cultural health care Review of Systems – page 50

- Case Studies – page 59 and page 62

- Examining our Own Personal Biases – page 64

- 8 Steps You Can Take to Enhance Your Skills in Cross-cultural Health Care – page 66

- The Institute of Medicine's Guidelines – page 68

- The CLAS Standards (Guidelines for organizational change) – page 69

- References – page 72

Child Psychiatry Telephone Consultation on Medicaid Children

The Behavioral Health Organizations and the Mental Health Centers in the greater metro area have very generously made available telephone consultation by child psychiatrists to help providers in CCHAP – affiliated practices manage their Medicaid children with complicated mental health issues or complicated medication regimens. These child psychiatrists are also willing to come visit your practice to get to know you and even to discuss cases. We are very grateful for this very generous support for your Medicaid children.

Denver County – Rick March, MD – 303-504-1520

Jefferson County – Don Bechtold, MD – 303-432-5172

Adams, Arapaho and Douglas Counties - Joe Pastor, MD – 303-853-3888

Integrating Developmental Screening Into a Pediatric Practice

- The Colorado Assuring Better Child Health & Development (ABCD) project has received a three year grant to provide training and technical assistance to providers to implement a “validated” developmental screening tool at well child visits for infants/toddlers birth to five.
- The ABCD project is partnering with CCHAP to provide training and support to pediatric practices to implement developmental screening.
- **Medicaid will reimburse \$34.00 to providers if you use a standardized, validated developmental screening test at an EPSDT visit.**
- The Colorado Chapter of the AAP supports the ABCD project.
- Early detection and intervention improves outcomes. Many delays in children’s development are missed in the first 4-5 years of life without a standardized, validated screening test.
- The **most time-efficient tool** is one in which the parent completes a questionnaire.
- **To comply with 2010 recertification guidelines by the American Board of Pediatrics**, documentation will be required to show levels of involvement in practice improvement initiatives. By implementing the use of a **“validated” developmental screening with a sensitivity and specificity rating of 70% or greater like the ASQ or PEDS**, practices are taking steps to integrate quality improvement into their practices.
- What are providers saying about implementing either the ASQ or the PEDS parent questionnaire developmental screening tool:
 - **It takes 1-2 minutes for an MA, LPN or RN to score.**
 - **It takes less than a minute of the provider’s time if the MA, LPN or RN scores the questionnaire.**
 - In many instances, it reduces the length of the visit.
 - It helps providers concentrate on the concerns/priorities of the parents.
 - It reduces the number of concerns that come up as you are walking out the door at a well care visit.
 - It improves patient satisfaction.
 - It promotes positive parenting practices.
 - It increases provider confidence in decision-making for when to refer a child for further developmental evaluation.
- Eileen Auer Bennett, the Colorado State ABCD Coordinator and her team are available to assist providers in getting started. Training and technical assistance will be provided to practices to implement a standardized tool such as the ASQ or PEDS. Support will also be given to office staff on how to incorporate a standardized developmental screening tool into the current office work flow.

For more information, please contact:

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The Ages & Stages Questionnaire (ASQ)

The Ages & Stages Questionnaire (ASQ) is a well respected screening tool. It has the best sensitivity and specificity. It is standardized across various common minorities. Health care providers have identified the following advantages:

- Parent completed—Parents are partners in their child’s assessment and intervention activities.
- Serves as a talking guide with parents identifying a child’s strengths as well as things the child is not doing yet.
- Practical—Scoring takes 1-2 minutes and can be done by paraprofessionals.
- Cost-efficient—May be photocopied repeatedly.
- Scoring is simple—Only three responses:
 1. Sometimes, occasional or emerging response from child = **5 points**
 2. Yes, child performs specified behavior = **10 points**
 3. Not Yet = **0 points**
- If the child’s total score falls in a shaded area of the bar graph for any developmental area, further diagnostic assessment is recommended.

Visit www.brookespublishing.com to view and order the ASQ tool online.

The Parents’ Evaluation of Developmental Status (PEDS)

PEDS is another tool commonly used by practices involved in a pediatric surveillance program. Provider feedback has been positive. “The PEDS is nice because physicians value knowing the issues parents want to address before going into the room.”

Below are other advantages outlined in an article by Frances Glascoe, PhD, Associate Professor, Division of Child Development, Vanderbilt University School of Medicine:

- Developed out of four cross-validation studies on a nationally representative sample of families.
- Uses parent concerns or judgments about the child’s development and behavioral status.
- Easy to score—two minutes to elicit and interpret.
- Enables health care providers to determine the need to refer and where.

Visit www.pedstest.com to view and order the PEDS tool online.

Spanish Interpretation Training for Pediatric Practices

CCHAP offers a convenient, time-efficient, cost-efficient medical Spanish interpretation training program for pediatric office staff and providers. It is provided as a telephone conference, during practice office hours at lunch time.

Training in medical Spanish interpretation includes:

- Medical (pediatric) terminology
- Subtle differences in the two languages in word selection and grammar
- Culturally appropriate communication skills
- Professionalism and etiquette of interpretation
- Confidentiality and HIPPA issues

Who: This program is for people in the practice who already speak Spanish and English

How: The sessions will be conducted via telephone, using handout materials and the Internet, and will also include role-playing.

When: Wednesdays from 12:15 to 1 pm. The next session will begin as soon enough people are interested in attending.

How long: 45 minute sessions weekly for 6 weeks

Registration: Email the information below to ilssoto@aol.com.

Name of student:

Job title:

Pediatric practice name:

Work phone number:

Home phone number:

Is your first language English or Spanish?

If Spanish is your second language, how long have you been speaking it?

What time is your usual lunch hour?

What is your goal in enrolling in this class?

Price: \$20 per session.

After your registration and start date is confirmed, please send a check for \$120, payable to International Language Services
12572 West Brandt Place, Littleton CO 80127.

An assessment of each individual's skill level will be done during a 5-10 minute phone call prior to first telephone conference/class. Maria will contact you to schedule this initial individual telephone call upon receipt of your registration email. A certificate of completion will be given after completion of all 6 sessions. The faculty is Maria Soto, a certified Spanish interpreter and trainer with International Language Services.