

ARTICLE 1

Cross-cultural Communication

Over the last two years, the CCHAP newsletter has provided CCHAP-affiliated practices with 21 articles on cross-cultural communication topics like: understanding culture and its effect on health care, the various components of culture, how to adapt communication to each individual's culture, a variety of articles on what health care professionals need to know about specific cultures and information on health disparities and what you can do reduce health disparities for children.

Marcia Carteret, MS has provided introductory lunch time conferences for over 60 primary care practices, with 148 physicians and 403 staff participants in 2008 and 2009, as well as training for all of the pediatric residents and faculty in the Department of Pediatrics at UCHSC. She is getting ready to bring another conference to interested practices on specific methods of adapting communication to different cultures. These methods are organized around the eight dimensions of culture. And, to adapt our approach to other cultures, it helps to understand American culture and how it differs from others. So, this month we are reviewing the eight dimensions of culture. And, also, in preparation for 2010, please consider reviewing the following three earlier introductory articles, too:

[Introduction to Cross-Cultural Communications](#)

[Culture-Based Generalizations Vs. Stereotypes](#)

[Learn About Your Culture First](#)

Eight Dimensions of American Culture

Written by Marcia Carteret

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Cultural aspects of everyday life are often difficult for people of dominant cultures to discern because their practices, traditions, values, and understandings are taken for granted as the norm. For them, there's no apparent need to examine cultural difference, and thus, no inclination to do so. In the US, middle-class Americans are typically so unaware of their own culture they believe that American culture is a melting pot of *other* cultures. This misperception is further complicated by confusion over terms such as white, American, the dominant majority, mainstream, middle class, western, European American. For our purposes here, American means "middle-class European American" and refers specifically to the "cultural ways of the group that in recent decades has held a mainstream position in North America. These are people who are primarily of Western European descent, with a social position that is often characterized as middle class on the basis of having participated in high levels of formal schooling and associated occupations." (Rogoff 2003)

Now that we've established what the term "American" points to in this article, let's begin to look at some specific dimensions of American culture. A dimension of culture is a

recognizable point of comparison used to explain how different cultures prefer to approach and solve a universal problem. There are more cultural dimensions than we can possibly address here, so we will focus on a few that seem especially relevant to patient/provider interactions.

Time and Its Control

For Americans, time is a critical factor that is battled on a daily basis. We have an adversarial relationship to time. We talk about saving or wasting time, managing time and beating the clock. Americans invented day-timers and added the term multi-tasking to the English language. We invented fast food and made it even faster by adding the drive-thru. Now even our pharmacies offer drive-thru pick-up.

Many of the other cultures in the world have a more relaxed view of time. In a health care setting, busy practitioners may not realize that patients from different cultures often experience the rushed pace of an office visit as disturbingly impersonal. It is important to slow down enough to exchange a few words of personal conversation with patients. Ask how their family is doing. This gesture only takes a few moments. It puts patients more at ease so they can respond more openly to medical questions. If the doctor is clearly in a big hurry, patients will be even less likely to ask for clarification about treatment and medications. Establishing a conversational style also helps providers introduce conversation about cultural beliefs around illness which can be very important in diagnosing and achieving patient compliance. Physicians will succeed best with patients from different cultures when the care and the cure are experienced as inseparable.

Task vs. Relationship

Very closely related to time control is the American tendency to focus on getting things accomplished, so much so that building rapport with people gets overlooked. In more traditional cultures people focus on establishing rapport first and ensuring harmony in interactions with others. In health care settings, building trust between patient and doctor often depends on developing formal but warm interactions. In Spanish the word *personalismo* speaks to this balance of professionalism and friendliness. Taking a moment to ask about the family, a handshake that lingers just a bit longer than a business handshake - simple gestures such as these go a long way.

Comfort with Change

Americans are fundamentally optimistic and place faith in the future. As a young culture with few traditions tying us to ways of the past, our identity and inspiration are projected forward in time. Americans link change to progress, development, and growth. We like things that are “New and Improved!” Older traditional cultures consider change to be disruptive and unpredictable. In other words - *negative*. When a new medical procedure or miracle drug becomes available, Americans are likely to respond with optimism while patients from risk-averse cultures will show pessimism. Doctors who demonstrate balance in this area will gain the most patient confidence. Clearly risk-avoidance varies from person to person within a culture, and plenty of Americans prefer what’s safe and predictable too. But as a generalization, we in the US do tend to take chances and embrace change.

Personal Control Over Destiny

Americans tend to believe that every individual has primary control over his or her destiny. There isn't typically a strong belief in the power of fate or karma. In many cultures there is a belief that things, including illnesses, happen because a higher power has intervened. People may show a tendency to resign themselves to bad things in a way that Americans never would. "It s God's will." This doesn't mean patients/families won't put faith in an American doctor's medicine, but there may be surprising belief systems operating around what has caused illness or how much control they can exert on the outcome. A Hispanic mother may believe that her child has *Mal d'ojo*, or has been cursed with the "evil eye." Members of the traditional Hmong culture believe a baby's soul can be detained by a malevolent spirit called a *dab* causing a number of serious illnesses including epilepsy.

Self-Sufficiency

Closely related to the American emphasis on individual control over destiny is the value of being self-sufficient. To succeed without depending on others shows supreme self-determination, self-reliance, and self-confidence. The concept of being self-sufficient, however, doesn't translate into all languages and the trait is not valued in many other cultures. People from Hispanic and Asian cultures, who have strong attachment to families and communities, emphasize a skillful use of the bonds between families and friends when making decisions and getting things done. Interdependency is a more helpful cultural adaptation in many cultures around the world. The US health care system presents all of us with a unique set of challenges, but those who are from different cultures will really struggle to demonstrate the kind of self-sufficiency we respect in America. The very nature of working together to find solutions means everyone – provider, staffs, patients, and their extended families - relinquishes self-sufficiency to some degree.

Status

In American culture we value the idea of equality. The quotation "All men are created equal..." is arguably the best-known phrase in any of America's political documents. (Thomas Jefferson first used the phrase in the Declaration of Independence as a rebuttal to the going political theory of the day: the Divine Right of Kings.) Perhaps in reality some of us are clearly more equal than others, yet egalitarianism is a defining aspect of American culture and one in which we differ from other cultures that actually embrace a set social hierarchy. Americans' insistence on collapsing social hierarchy leads to our preference for informality in social interactions, demonstrated in a well-known tendency to use first names when we address others, even with strangers. This degree of informality can make people from some other cultures uncomfortable, especially when there is a perceived status difference between people, as in patient/family/doctor interactions. It is best to rely on formal terms of address, using Mr. and Mrs., instead of first names. This will likely make people in many cultures more comfortable.

Language

Language use as a cultural dimension deserves a whole separate article, but the basics can be touched on here. Americans are low context communicators, so the words we speak

are expected to deliver everything that's important during verbal interaction. We pay far less attention to factors such as body language and the context of what is being said. In high context cultures, gesture, body language, eye contact, pitch, intonation, word stress, and the use of silence are as important as the actual words being spoken in conversation. High context cultures tend to communicate in a less direct fashion. Americans, being low context, are comfortable with very direct speech and sometimes seem abrupt to people from high context cultures. We miss the nuances of conversation. Americans appreciate communication that gets straight to the point and tend to interrupt when conversation isn't moving along. People from many other cultures do not feel they have had a chance to adequately explain their concerns until they have told "the whole story." This is important to keep in mind when communicating with people from different cultures, especially those who are relatively new to the US. Interactions with Americans who are highly verbal and direct can be challenging for someone who is accustomed to telling a story as a way of answering a question. Americans aren't the only direct/high context communicators in the world, but we certainly rank among them.

Individualism

Cross-cultural research shows US Americans score higher on this cultural value than any other culture in the world. All the values we've addressed up to this point are closely related to this one aspect of American culture. Individualism is the belief that each individual's interests should take precedence over those of the social group. Collectivist cultures, by comparison, assign value based on the role a person plays within a group. If people were stars in the sky, being one of the seven brightest stars forming the Big Dipper would be more important to someone from a collectivist culture than being the single brightest star. In American culture, where the individual is paramount, everyone wants to be the North Star.

Individualism versus collectivism is an important dimension of culture because it affects the way people live together – for example in nuclear families or extended families – and it has many implications for values and behavior. Child rearing as a whole is handled differently in collectivist cultures. The child in a collectivist culture is seldom alone, either during the day or night. Children are reared by an extended kin group that may or may not include family like ties with persons who are not biological relatives. Important health decisions are not made solely by an individual – parent or otherwise. In many collectivist cultures, the term "family" doctor points to a medical relationship that is indeed more like family. Several generations visit the same physician, establish rapport and hold certain expectations for interaction with their doctor. Compare this to searching for doctors on the Internet in the United States, or having to choose from an approved list of physicians in a managed care network. Feeling like an isolated stranger visiting a doctor's office can cause great anxiety for a recent immigrant. There's much uncertainty about how the medical system works, about insurance, about how an American doctor will relate to cultural and language barriers. All of these worries are an added burden to the actual illness that requires medical attention in the first place. So, a mother from a collectivist culture will likely bring a grandmother, aunt, or family friend for support when she visits a pediatrician. Big decisions about procedures, such as surgery, may take hours as wives ask husbands, husbands consult elder brothers, elder brothers consult the

father or perhaps even a community healer. This can create confusion and frustration for western doctors, but collectivism is a deeply rooted value. The classic American individualist who stays aware of how collectivist cultures operate will be much more skillful in cross-cultural interactions. Being group-oriented isn't better or worse than being more individualistic. Both ways of approaching life have advantages. As with all the dimensions of cultures, awareness of difference without judgment is the path leading to happier healthier patients and successful providers.

Summary

This article has introduced eight key dimensions of American culture. Learning about our own cultural patterns provides us with a baseline for comparing cultures that are different. As we develop self-awareness around cultural experience, we are able to observe without leaping to judgment. We realize there's a difference between what we actually observe and how we label our observations based on our own cultural programming. In the process of becoming more aware of interactions with culturally diverse patients, providers hone communications skills that benefit all patients. Increased patient satisfaction and health outcomes lead to happier providers and more successful practices. Certainly within the medical culture, that's seen as a win-win situation of great value.

References

[The Cultural Nature of Human Development](#) by Barbara Rogoff 2003)

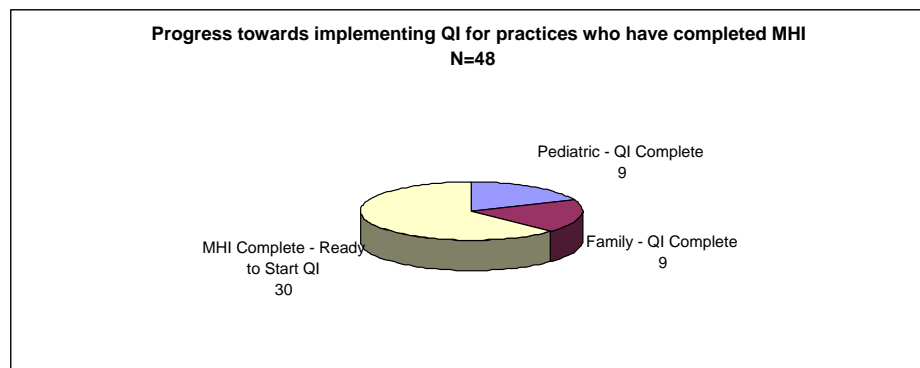
ARTICLE 2

Quality Improvement UPDATE

CCHAP 2009 Quick Stats ...

In 2009, 48 practices completed the Medical Home Index (MHI) (31 pediatric practices, 17 family practices). Currently, 18 of those practices are either planning or have implemented 21 different Quality Improvement projects:

- 52% of QI projects involve age appropriate preventative care and screening
- 33% of QI projects involve improving practice family centered-ness



In 2009, CCHAP worked with 11 practices that began QI projects to assess their effectiveness in administering the Ages and Stages Questionnaire (ASQ) as their developmental screening. The number of developmental screens completed by these 11 practices during the first three quarters of 2009 has steadily increased, which of course means their reimbursement for developmental screening has also increased.

CCHAP is Available to Help Your Practice To Make Whatever Changes You Wish

Did you know that all board certified pediatricians and family physicians, which they go through recertification, will be required to do a QI project? Let us help. Angie Goodger is available to help your practice select something you want to improve and to coach your practice through the process of setting up a QI project to make the improvement you select. You can reach her at Angie@cchap.org.

Quality Improvement Tips Measurement

A vital piece of Quality Improvement is measurement of progress. In order to measure progress, you need to first clearly define what you want to change and what outcome

you want to have happen. The next step is to measure where you are now: what is your baseline level. Then, you create your plan and implement it. At the end you measure where you are again, to determine whether or not your specific change has actually led to an improvement.

So, key first steps of QI are to decide what you want to have happen, how you will measure it and then measure where you are at the beginning. When defining your measurements, keep the following in mind:

- Keep it simple: gather just enough data to learn what you want to learn.
- Don't rely only on hunches.
- Look at data that you are currently using to see if that will meet your needs.
- How can data be collected most easily, concurrently?
- What data is easily available from other sources?

It's important to ensure validity of monitoring data. During your planning, be sure to consider:

- Who will collect the data?
- How will the data be collected and how often?
- Are data consistent with reality?

At its core, Quality Improvement is a factual, data driven approach to see if changes in care practices, or process, make a difference in outcomes.

And remember, Angie Goodger is available to help you through the process.
Angie@cchap.org

ARTICLE 3

PRACTICE MANAGER MEETING

Live Web Cast!!

Wednesday, January 13th

11:30 – 1:00 PM

Medicaid Billing Presentation

Gina Robinson, Program Administrator with the Office of Client and Community Relations at HCPF will be our guest speaker. Gina will address many of the most common questions and issues that practices face when billing Medicaid.

We are also excited to announce that this presentation will be done as a live WEB CAST so that all of our practices state-wide will be able to view the meeting over the internet...or attend in person for a free lunch!

More details about access to the web cast will be sent to practice managers this week. Please mark your calendars for this special event!

ARTICLE 4

Practice Manager's Corner

MEDICAID PATIENT LIST REQUEST (REMINDER)

We have heard back from about 30% of CCHAP practices that have sent us their Medicaid patient ID lists. If you have not yet sent us your list, please take a few minutes to get us your report no later than January 15th. Generating this list is not difficult for most practices and we can help you. Please see the **Options** below for guidelines.

Health Care Policy and Financing (HCPF) relies a great deal on CCHAP to assist them with determining how many Medicaid children are being served by Medical Home practices like yours and then how many more Medical Homes are needed to serve the needs of children throughout the state. With the climate of economic instability within the state budget, services and reimbursements are at risk. The more information that we can provide to HCPF regarding the number of children being cared for by private practices, the better prepared they will be to support the current level of Medicaid reimbursement for providers to Medicaid children and avoid any further cuts in reimbursement.

Last April we contacted our current CCHAP affiliated practices to get a count of how many patients you thought made a Medical Home with your practice. This data was extremely helpful and **we are asking for your help again now.**

The data we need from you is a report that lists all unique Medicaid patients (just their Medical ID number – no names and no duplicates) who have been seen by a provider in your practice sometime within the past 2 years. We anticipate that we will need to collect this data from each of you approximately every 6 months, so if you can design a report that produces this data and then send it to us in an Excel spreadsheet, we would be most grateful. Please try to get me this data by year end.

Options:

1. If you enter all Medicaid claims on the Medicaid Provider Portal, you can generate this list easily as follows:
 - Log in to the provider portal > Go to the data maintenance tab > then the client maintenance sub-tab > Options are available to sort (by DOB to eliminate older patients), print and **download to Excel.**
2. If you use an EDI and clearinghouse system to submit claims, here are some basic guidelines to generate a report. Since all systems have unique reporting capabilities, please call Kevin if you need help. We want to make this as easy as possible for you:
 - Constrain on Medicaid only
 - Constrain on DOS within past 2 years
 - Constrain on DOB < 21 years of age.

- Report Medicaid ID number of patient (this is the only column of data that we need on this report)
- Report only one instance of the ID to avoid duplicates
- Download report to Microsoft Excel, if possible

Please email the Excel file to heckman.kevin@tchden.org and please call me for help on this request. I can be reached at 720.777.6309. I want to make this as easy for you as possible!

YOUR VOICE WAS HEARD Update On Medicaid Reform in Colorado

Below is an update of the Accountable Care Collaborative activities.

As you recall, Colorado Medicaid proposed to conduct a pilot program in late 2010 for one year in which new regional care coordination organizations would be formed to do many things that a managed care organization would do to help Medicaid recipients and providers. And if the pilot is successful, then this approach would be expanded statewide to all Medicaid recipients and providers probably in 2012. You may recall that one concern that private practices had was that the payment to providers was going to be basic Medicaid reimbursement plus a possible distribution of some portion of shared savings at the end of the year. Many CCHAP practices expressed concern that this approach would not adequately cover their costs. CCHAP-affiliated practices were worried that they would not continue to receive the current higher reimbursement for meeting the medical home standards and providing preventive care that they currently receive. Colorado Medicaid heard your voice and recently issued that following public statement.

“Colorado Medical Homes for Children practices, including the Colorado Children's Healthcare Access Program (CCHAP), serve as medical homes for a large number of children who are enrolled in Medicaid. The Department expects that these practices will continue to deliver comprehensive health care services to children in a similar way when the ACC is implemented. The existing Pay for Performance payment structure for these participating providers will not change under the ACC.”

ARTICLE 5

All CCHAP-affiliated Practices Now Can Receive TELEPHONE CONSULTATION ON MENTAL HEALTH ISSUES FOR CHILDREN ON MEDICAID

Rick March is a child psychiatrist who has received grant monies to provide phone consultation regarding children and adolescents with mental health problems throughout Colorado. He has over twenty years experience in child psychiatry and is available weekdays during regular business hours. If you do not reach him directly, he would be able to speak with you, at the outside, by the next business day. Dr. March is at the Mental Health Center of Denver which provides services for children who live in Denver County. However, he may be able to arrange to see other patients outside this catchment area, possibly in your practice in very difficult cases. He is also available to provide educational presentation for your providers on a wide variety of mental health topics.

His direct line is 303-504-1500

So, telephone consultation from a child psychiatrist for Medicaid children cared for in a CCHAP-affiliated practice is now available in all counties in Colorado.

For Boulder and Jefferson Counties – Don Bechtold, MD – 303-432-5172

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

For all other counties (including Denver) – Rick March, MD – 303-504-1500

ARTICLE 6

INTRODUCING THE CCHAP QUICK REFERENCE LINK!

Do you need to know the one telephone number to call for a Medicaid mental health referral? Want to reach the CCHAP social worker? Need help in finding resources for a special needs child? Having trouble remembering all of the 14 support services CCHAP provides for your practice? We have a quick reference link for your desk top! For these things and many more...

Recently, our advisory group of physicians and practice administrators suggested an idea for a quick and easy way to access CCHAP affiliated resources for frequently used contacts and services. We liked the idea and have developed a web link that will quickly access a single page that contains contact information as well as additional links to documents and web pages. The goal is to have a computer desktop shortcut that, with just a click or two, will provide CCHAP affiliated providers and staff with the information you need, when you need it.

Because this new tool is for you, we want it to be pertinent and efficient. So please, if you have ideas as to how to improve on this, contact Kevin Heckman heckman.kevin@tchden.org or 720.777.6309, our Program Administrator, with your feedback and suggestions. Thanks!

INSTRUCTIONS:

1. Click on this link <http://www.cchap.org/qr/> to open the Quick Reference Link web page (Note: you can also type this address into a web browser manually).
2. In your browser window menu (upper left corner) click File>Send>Shortcut to Desktop.
3. The Quick Reference Link is available from any computer with internet access.

Kevin C. Heckman
Program Administrator
CCHAP
720.777.6309

ARTICLE 7



Cavity Free at Three is a statewide effort aimed at improving oral health in children and pregnant women. We are working with CCHAP to offer our program model to interested participants. Recent Medicaid guidelines allow primary caregivers to provide oral health counseling along with fluoride varnish application and receive reimbursement for these services. In order to participate, the medical provider as well as staff members involved in this provision of care should complete online training through the Smiles for Life Curriculum.

Simply visit <http://www.smilesforlife2.org>, and complete Module 2:Child Oral Health and Module 6: Fluoride Varnish. After the online process is completed, we plan a coordinated effort for site visit based training opportunities offering hands on demonstrations as well as follow up and support of our program.

We are in the process of coordinating training opportunities throughout the state of Colorado beginning early 2010. This will allow for representatives from your group to attend trainings in your area. If you are interested in hosting a training, or learning more about Cavity Free at Three opportunities, please contact Anita Rich at rich.anita@tchdenver.org. If you have questions specific to our program, please contact karen.savoie@ucdenver.edu or visit <http://cavityfreeatthree.org>. Thank you.

ARTICLE 8

Medical Home Certification

Around 50 of the 150 pediatric and family practices that CCHAP currently works with are in the process of obtaining “medical home certification.” The Colorado Department of Health Care Policy and Financing (HCPF), which administers Medicaid in Colorado, is directed by Senate Bills 07-130 and 07-211 to document that children on Medicaid receive care in a quality medical home. So, HCPF is asking practices that are receiving the enhanced reimbursement (as a CCHAP – affiliated practice) to obtain Medical Home Certification to document the quality of the medical home they provide to children on Medicaid. Practices that have affiliated with CCHAP in the past 8 months have already begun the certification process. The remaining CCHAP-affiliated practices will be asked to begin the certification process very soon.

Medical home certification is a three step process. The CCHAP orientation is step one. The following **two steps** also need to be for practices that were oriented in the past and are already receiving the enhanced reimbursement. Each CCHAP-affiliated practice will be asked to:

- Conduct a self-assessment survey of practice staff and providers called the Medical Home Index. This brief survey seeks to determine your perception of how well you are doing in providing a medical home. The survey also will be given to some parents in your practice.
- After reviewing your survey results, you will be asked to select some aspect of “medical home-ness” to improve using a quality improvement process. CCHAP staff is available to coach you through the quality improvement process if you wish and we have QI projects already prepared for you to implement easily in your practice if you wish. You may already have QI projects going, which will likely meet this objective.

Medical Home

The American Academy of Pediatrics and the American Academy of Family Practice have promoted the concept of a medical home for many years now. A recent combined statement by the two academies reaffirmed their support of the concept. The Academies believe that all children should have a medical home where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. For a reminder of the American Academy of Pediatrics and the American Academy of Family Medicine description of a medical home for children, [click here](#).

Jeff - Attached to this article last month is the Medical home policy statement as a pdf.

And if you want someone to come to your office to present a more description of what a medical home is and does, please contact: Anita Rich (Rich.Anita@tchden.org) or Angie Goodger (angela@cchap.org) for more information.

Medical Home Index

Starting in April 2009, recently oriented CCHAP practices began the process of Medical Home Certification. The Medical Home Index is completed at a group meeting of your

practice with as many of the practice staff and providers as possible. During this meeting the group will complete a Medical Home Index self-assessment, discuss how each indicator rated relates to a quality Medical Home. The facilitator will conduct informal interviews of families coming to your practice that day asking them to assess the practice's medical "homeness." For a look at the medical home index, [click here](#). [\[Jeff – attached to last month's article is a sample of the MHI\]](#)

Quality Improvement Projects

Within a few weeks after the practice takes the MHI, you will be contacted by a Quality Improvement Coach with CCHAP. At that time, you will receive your Medical Home Index results, as well as guidance as to how to interpret the results. HCPF asks that you select an element of being a medical home that your practice wishes to work on. The Quality Improvement Coach from CCHAP – at no cost to your practice – is available to help you decide what your practice would like to work on, develop strategies for making the changes you want to make, and measure the effectiveness of the resultant changes.

The higher reimbursement practices receive for preventive care is the reward for your practice's commitment to providing a quality Medical Home for children on Medicaid.

AAP and AAFP Board Certification for pediatricians and family physicians

Both the AAP and the AAFP require that all physicians, when they recertify, develop a quality improvement project in their practice as part of their recertification. So, CCHAP is helping you obtain both professional board certification and Colorado Medicaid medical home certification.

For more information

Shortly, we will be expanding the Medical Home Certification process to all CCHAP practices. More information will follow. You may also contact Anita Rich (Rich.Anita@tchden.org) or Angie Goodger (angela@cchap.org) for more information.

Jeff – Please make this a regular addition to the services/programs people can click on attached to the newsletter

The Colorado Pediatric Postpartum Depression Screening and Referral Toolkit

Developed by Brian Stafford, MD, MPH
Medical Director, Perinatal Mental Health Program, The Children's Hospital

Click here to download the complete toolkit to enable a primary care practice to recognize and refer women with post-partum depression. [Click here](#)

Why should every pediatric and family practice implement this toolkit?

- ▶ Postpartum depression is a serious medical and psychiatric illness and a significant health concern.
- ▶ Approximately 12% of all new mothers develop symptoms consistent with a major depression in the post-partum period.
- ▶ If left untreated, half of these mothers, about half will continue to have symptoms that last greater than 1 year.
- ▶ These symptoms include sadness, lack of energy and pleasure, irritability, guilt, anxiety, as well as thoughts of wanting to harm the infant.
- ▶ Several lines of research have shown that post-partum depression has significant risk for the child's cognitive, social, and emotional development and may impact school readiness.
- ▶ In addition, the depressive symptoms lead to difficulties in the mother-infant and parental relationship.
- ▶ The depressive symptoms are also associated with excessive urgent care and emergency room visits as well as missed scheduled routine pediatric visits.
- ▶ Providing pediatric anticipatory guidance to a depressed caregiver does not change any parental behaviors in regard to safety, sleep, nutrition, reading, and interaction.
- ▶ Pediatric care providers of infants are in a strategic position to screen and refer depressed mothers for behavioral health evaluation and support.
- ▶ Pediatric provider inquiries about maternal health have been viewed as appropriate by mothers.
- ▶ Pediatricians, historically, like other primary care providers, have low rates of detecting maternal depression and few pediatricians have a systematic approach to screening for maternal depression.