POLICY STATEMENT

Enhancing Pediatric Workforce Diversity and Providing Culturally Effective Pediatric Care: Implications for Practice, Education, and Policy Making

COMMITTEE ON PEDIATRIC WORKFORCE

abstract

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This policy statement serves to combine and update 2 previously in-
dependent but overlapping statements from the American Academy
of Pediatrics (AAP) on culturally effective health care (CEHC) and work-
force diversity. The AAP has long recognized that with the ever-increasing
diversity of the pediatric population in the United States, the health of all
children depends on the ability of all pediatricians to practice culturally
effective care. CEHC can be defined as the delivery of care within the
context of appropriate physician knowledge, understanding, and appre-
ciation of all cultural distinctions, leading to optimal health outcomes.
The AAP believes that CEHC is a critical social value and that the knowl-
edge and skills necessary for providing CEHC can be taught and acquired
through focused curricula across the spectrum of lifelong learning.

This statement also addresses workforce diversity, health disparities,
and affirmative action. The discussion of diversity is broadened to in-
clude not only race, ethnicity, and language but also cultural attributes
such as gender, religious beliefs, sexual orientation, and disability,
which may affect the quality of health care. The AAP believes that
efforts must be supported through health policy and advocacy initia-
tives to promote the delivery of CEHC and to overcome educational,
organizational, and other barriers to improving workforce diversity.
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INTRODUCTION

This policy statement serves to combine and update 2 previous
statements from the American Academy of Pediatrics (AAP) on cul-
turally effective health care (CEHC)[1] and workforce diversity.[2] The
impetus to combine these independent policy statements comes from
the recognition that the provision of culturally effective care and
enhancing the diversity of the pediatrician workforce represent
parallel and often overlapping initiatives to improve care for pediatric
patients. This policy statement provides guidance for policy makers,
advocacy groups, medical educators, and physicians on the provision
of CEHC and enhancing the diversity of the pediatrician workforce.

CEHC can be defined as the delivery of care within the context of
appropriate physician knowledge, understanding, and appreciation of
all cultural distinctions, leading to optimal health outcomes, quality of life,

and family satisfaction.[1] For the purposes of this policy statement, the term "culture" is used to signify the full spectrum of values, behaviors, customs, language, race, ethnicity, gender, sexual orientation, religious beliefs, disabilities, and other distinct attributes of population groups. The AAP believes that "culturally effective care" is a more inclusive term than "cultural competence" because it encompasses the values of competence and, more important, focuses on the outcomes of the physician-patient or physician-family interaction.

The AAP has a distinguished history of promoting diversity within the pediatrician workforce. Of particular note is the 1994 *Report of the AAP Task Force on Minority Children's Access to Pediatric Care*,[3] which promulgated 66 recommendations covering a wide range of topics, from the health status of minority children, to barriers to accessing pediatric care, to workforce needs. Racial and ethnic diversity was also a major issue addressed by the report of the Task Force on the Future of Pediatric Education II,[4] which called for increases in the percentage of underrepresented in medicine (URM) pediatricians in practice and academic medicine to meet the needs of the ever-growing population of children from racial/ethnic minority groups.

Over the past decade, the discussion of patient diversity by the medical community has increasingly expanded beyond the traditional attributes of race and ethnicity to include cultural characteristics such as language, race, ethnicity, ancestry, national origin, immigration status, religion, age, marital status, gender, sexual orientation, gender identity or expression, and disability.[5] A broader and more inclusive definition of patient diversity consequently requires an expansion of diversity beyond race and ethnicity within the pediatrician workforce as

well. The AAP believes that it has an important leading role in applying this expanded definition of patient diversity to improve the provision of CEHC for all populations.

This statement makes the case for a diverse pediatrician workforce; explores the impact that patient attributes have on their health care; investigates CEHC education and training; and addresses health policy and implementation. These issues are complex and nuanced, and a forceful commitment from an educated leadership will be needed to fully achieve the statement's recommendations.

CASE FOR A DIVERSE WORKFORCE

The Association of American Medical Colleges' description of URM encompasses "those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population."[6] URM groups in the United States currently include black and African American, American Indian and Alaska Native, Native Hawaiian and other Pacific Islander, Hispanic and Latino, as well as any Asian other than Chinese, Filipino, Japanese, Korean, Asian Indian, Thai, or Vietnamese/Southeast Asian.[7] Some of the most compelling evidence in support of increased workforce diversity is that physicians from URM groups disproportionately practice in underserved communities and treat a greater number of underrepresented minority, Medicaid, and uninsured patients.[5,8–10] Whatever the reason for these practice patterns, the contributions of the minority physician workforce to the care of these groups of patients are therefore significant.

Numerous studies have demonstrated that minority patients suffer from significant health disparities and experience more barriers to accessing health care services than do other nonminority patients, but access to

care for minority patients is improved when the physician and the patient are racially or ethnically consentient.[5,11,12] Such congruence between patient and physician is, however, relatively infrequent.[12] This is perhaps why a 2006 study by the Health Resources and Services Administration noted that "although studies in our review suggested that interpersonal care was on balance better in race concordant patient-practitioner relationships, and that patients tended to prefer practitioners of their own race, these findings did not apply to all patients and practitioners."[13]

A study examining patient-physician social concordance using 4 social characteristics (race, gender, age, and education) showed that lower patient-physician social correspondence was associated with less favorable patient perceptions of care and lower global satisfaction ratings; conversely, stepwise patient-physician similarities were shown to improve patient perceptions of care in an additive fashion.[14] A large study looking at patient-physician congruence in adult patients with diabetes mellitus who were at high risk of cardiovascular disease concluded that African American patients who received treatment from African American physicians were significantly more adherent to taking their medications and that Spanish-speaking patients were significantly more adherent to taking their medications when their physicians were linguistically concordant.[15] Consequently, there is an ongoing need to increase racial and ethnic diversity among the pediatrician workforce in part because minority pediatricians continue to be more likely to provide care to minority children and their families in a disproportionate manner.[2]

PATIENT ATTRIBUTES AND IMPACT ON HEALTH CARE

Data from the US Census Bureau project that by 2020, 44.5% of American

children 0 to 19 years of age will belong to a racial or ethnic minority group.[16] Consideration of cultural attributes in addition to race and ethnicity would greatly increase this projection of diversity. For example, in 2010, there were 646 000 same-sex unmarried couple households in the United States, and a number of these households reported having children.[17] Data from 2008 indicate that 23% of US citizens were living in rural locations, 12% of US citizens who were living outside of residential facilities or nursing homes had a disability, and 4% identified themselves as lesbian, gay, bisexual, or transgender.[18]

According to the US Census Bureau, approximately 20% of the US population older than 5 years speaks a language other than English at home. Although the majority of these people report that they also speak English well, it is estimated that approximately 24.5 million people in the United States need some assistance with English. Approximately 62% of these people speak Spanish at home.[19]

Census data confirm the growing numbers of foreign-born immigrants residing in the United States. The US Census Bureau uses this term to refer to anyone who is not a US citizen at birth. This includes naturalized US citizens, lawful permanent residents (immigrants), temporary migrants (such as foreign students), humanitarian migrants (such as refugees and asylees), and persons illegally present in the United States.[16,20] However, obtaining accurate estimates of numbers of US foreign-born immigrants is difficult because of respondents' concerns regarding potential legal difficulties arising from participating in census activities. In addition, census data may not accurately provide information on migrant workers' children and the growing numbers of homeless children.

The pool of foreign-born immigrant children includes both legal and undocumented children as well as international adoptees. Foreign-born immigrant children often face multiple challenges, including language barriers, and in addition to the common illnesses typical of other US children, they may suffer from other diseases rarely diagnosed in the United States. Furthermore, the diversity of the US foreign-born immigrant population, manifested even in individuals from the same country of origin, is such that health needs and health literacy are extremely varied, making the delivery of care for this population still more challenging. Homeless children face higher rates of trauma-related injuries, developmental delays, neurologic problems, and asthma, among other conditions.[21] Migrant workers' children face similar health and linguistic challenges and, because of unstable living conditions, poverty, and other social constraints, are often unable to access comprehensive health care.[21]

Significant and pervasive racial and ethnic health and health care inequities persist among children with chronic health conditions, such as attention-deficit/hyperactivity disorder, asthma, autism spectrum disorder, Down syndrome, cerebral palsy, cystic fibrosis, diabetes, sickle cell anemia, obesity, traumatic brain injury, and HIV/AIDS.[22] Black and Hispanic parents of children with special health care needs report higher dissatisfaction with care and more difficulties navigating services for their children compared with their white counterparts.[23] Although *Healthy People 2020* has listed "cultural sensitivity in health care provision" as 1 of 7 key determinants of health under the heading of health disparities,[18] addressing disparities in cultural attributes and attitudes between physicians and their patients, patients' families, and/or guardians requires educational interventions to ensure that pediatricians and other

health care professionals are able to provide CEHC to a diverse patient population.[24] To better understand and overcome long-standing and minimally improving health care disparities, the Institute of Medicine in 2009 formed a Subcommittee on Standardized Collection of Race/Ethnicity Data for Healthcare Quality Improvement.[25]

Certain patient populations and communities suffer from poorer health compared with other populations. Reliable data have shown that patients who belong to racial, ethnic, linguistic, or other minority groups tend to have greater morbidity than do white, English-speaking patients.[12,26–32] Research has shown that early life events influence one's health over an entire lifetime and that there is a stepwise health gradient that is defined distinctly by socioeconomic status.[33,34] *Healthy People 2020* has outlined much broader examples of health disparities beyond race and ethnicity, with disparate health outcomes noted to be associated with gender, sexual identity and orientation, age, disability, socioeconomic status, and geographic location.[18] Although some studies have suggested that, compared with heterosexual people, lesbian, gay, bisexual, and transgender (LGBT)*[35] people face greater mental health challenges,[36] other studies have not found such mental health differences but instead simply disparities in accessing routine health care services.[37,38] LGBT patients may be reticent

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*Some support groups, community organizations, and researchers are now using the acronym LGBTQ or GLBTQ instead of LGBT. The "Q" may represent questioning or queer (in a nonpejorative way) and includes individuals who are uncertain of their sexual orientation but may still be considered a sexual minority or who self-identify as queer. However, according to the Gay & Lesbian Alliance Against Defamation, the use of the term "queer" is not universally accepted within the LGBT community, and care should be taken to avoid its use unless quoting or describing someone who self-identifies as queer.

to disclose their sexual or gender identity in a medical encounter for fear of being judged and also may believe that their physician is unfamiliar with LGBT health concerns.[39] LGBT youth face additional challenges as they navigate middle school and high school, where they may experience varying degrees of harassment, discrimination, exclusion, and isolation,[40] which may lead to increased depressive symptomatology as well as increased risk of suicidal ideation and self-harm compared with their heterosexual peers.[41,42]

CEHC: EDUCATION AND TRAINING

The AAP maintains that CEHC should be promoted through health policy and education at all levels, from premedical education and medical school through residency training and continuing medical education (CME). This task is complex; multiple languages and dialects must be addressed, requiring significant resources ranging from translation services to community linkages as well as commitment from both the learner and the educator. Nevertheless, the AAP maintains that at every level of education, pediatricians must be able to interact effectively and respectfully with patients and their families regardless of the cultural differences that may exist between them. These educational efforts should enhance the knowledge and understanding of pediatricians and other child health care professionals about the cultures of their patients and their families and increase their ability to provide care in a manner that is responsive to the individual needs of each patient. Educational programs must focus on the enhancement of interpersonal and communication skills, which are essential to nurturing the pediatrician-patient or pediatrician-family relationship and optimizing the health status of patients.

In addition, programs to enhance student, trainee, and physician awareness about their own preconceptions and cultural attributes will likely translate into more open communication with and greater appreciation of the cultural backgrounds of all patients.[43] Educational programs such as those developed through the National Center for Cultural Competence can be effective in training of students, house officers, and faculty.[44]

The literature pertaining to teaching multicultural issues to medical students is robust. Many medical educators believe that training physicians to provide CEHC should begin earlier, as part of undergraduate premedical curricula. Some medical educators have suggested that these educational endeavors should focus less on individual attitudes and the characteristics of minority groups and more on discussions pertaining to social barriers and inequities at the institutional or systems level.[45,46] Others have raised concerns about the model of addressing multiculturalism and cultural competence through lectures and occasional workshops and have argued for the incorporation of these topics as a continuum throughout medical school. Some medical schools, in an effort to better integrate these skills, have opted to identify space for these activities within existing courses on patient-physician relationships and medical interviewing and develop "thoughtfully prepared instructional material throughout the four-year curriculum."[46,47] Efforts to weave CEHC education into core pediatric clerkships in the third year of medical school have demonstrated success in increasing knowledge, enhancing attitudes, and improving clinical skills.[48]

Medical schools should choose to focus at least some of their recruitment efforts on encouraging students from underserved areas, including rural locations, to apply, and should also consider proficiency in a second language an asset in evaluating prospective medical students. Educational endeavors that merit institutional and program support are instructional sessions for students and residents on how to use to their best advantage (and how to evaluate) professional medical interpreters and translation services. At a minimum, medical school curricula and pediatric residency education programs should include educational components that elucidate the impact of low English proficiency, low literacy, and low health literacy on pediatric health care and offer strategies for remediating these problems. Furthermore, increasing the number of bilingual educational opportunities in the US at all educational levels would increase the likelihood that future physicians would be more likely to speak the same language as their patients.

Program requirements for residency education in pediatrics developed by the Pediatric Residency Review Committee call for structured educational experiences that prepare residents for the role of child health advocate within the community and inclusion of the multicultural dimensions of health care in the curriculum.[49] The Residency Review and Redesign in Pediatrics (R^3P) Committee of the American Board of Pediatrics recognizes that there is a need for some flexibility in training to allow for a variety of career choices, acknowledging that residency education is merely a segment of an educational continuum that starts in medical school and is sustained throughout the years of clinical practice.[50] Immersion experiences for pediatric trainees have used community-academic partnerships to move CEHC training into underserved communities, enhancing educational experiences and creating classrooms without walls.[51,52] A curriculum designed to foster cultural humility asks physicians to engage in self-reflection and self-critique as lifelong learners and requires the physician to

bring humility to the power balance in the physician-patient relationship.[53] This curriculum, piloted by 1 family practice program, resulted in increased patient engagement during the office visits as well as high levels of satisfaction reported by participating residents.[54] Such a curriculum could be adapted for appropriate pediatric resident outpatient practices.

Beyond residency training, pediatricians and other child health care professionals can benefit from CME to enhance the provision of CEHC. The AAP regularly incorporates CEHC into its CME programming. Other resources exist that may be helpful in identifying important components for educational activities. For example, the Culturally Effective Care Toolkit on the AAP Web site can provide guidance and resources for enhancing CEHC in practice.[55]

Educational programs may include a component that allows individual participants to analyze personal beliefs and values. Programs may focus on the communication aspects of providing CEHC by exploring how assumptions and stereotypes influence interactions between physicians and patients or their families, as well as between physicians and other clinicians. Because people are influenced by their own personal experiences and may or may not subscribe to group-assumed norms, people who share the same cultural background may think and act differently. For this reason, it is important that programs intended to address the cultural values and practices of specific groups not perpetuate stereotypes. Physicians must also be aware that the culture of medicine itself promotes certain attitudes and biases that may interfere at times with the physician-patient or physician-parent relationship.

Culture is not static; changes can and do occur over time. An appreciation of cultural change and the significance of intracultural diversity (variation among individuals within the same culture) can help to prevent cultural stereotyping.[56] Programs aimed at enhancing the provision of CEHC should be tailored to the demographics of the pediatric population or community where the pediatrician serves.

CEHC: BARRIERS AND OPPORTUNITIES

Cultural variations in verbal and nonverbal communication can be a major barrier to effective pediatric care. Although the role of culturally linked behaviors that may influence the physician-patient interaction, including eye contact, body language, and communication styles, has not been fully explored,[57] language barriers have been shown to have a major effect on health care. Parents and their children in the United States increasingly speak a language other than English at home and/or have limited English proficiency. When the pediatrician and his or her patient and the patient's family do not speak the same language with fluency, there is a potential for problems to occur, such as obtaining an inaccurate history, misunderstanding of therapies, and/or deferred medical visits.[58,59]

Pediatricians continue to struggle with recommendations to use trained interpreters and provision of appropriate language services.[60] These barriers could be addressed through the use of certified medical interpreters (or bilingual pediatricians and other pediatric health care professionals) to meet the needs of pediatric patients whose parents are not proficient enough in English to interact with members of the health care system.[61] These services, however, remain beyond the reach of many pediatricians because of their cost. In 2009, Medicaid or State Children's Health Insurance Programs in only 13 states and the District of Columbia provided reimbursement for language services, and many insurance carriers do not reimburse for such services because they expect medical practices to absorb the cost as part of their overall business expense.[62] Despite the difficulties associated with identifying and accessing appropriate language services, however, the AAP opposes the use of children and adolescents as medical interpreters for their parents and family members.

Another facet of the relationship between language and CEHC is health literacy. The Institute of Medicine defined health literacy as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[63] Although this is a particular problem for individuals with low or marginal literacy skills, health literacy can also affect patients and families with adequate language literacy. Many individuals, even those with high health literacy and for whom English is their native language, find the complex wording of insurance statements, benefits coverage, hospital admissions forms, prescription drug information sheets, and similar documents to be confusing. Low health literacy for pediatric patients and their families, similar to limited English proficiency, is a barrier to the provision of optimal pediatric health care. Whereas health literacy may not be a distinct cultural attribute, language and health literacy are greatly affected by cultural distinctions and, if low, directly contribute to unfavorable patient outcomes. A provision in the Patient Protection and Affordable Care Act of 2010 now requires that any summary of benefits and coverage be presented "in a culturally and linguistically appropriate manner."[64] Commonsense innovations such as these may alleviate some of the challenging implications of low health literacy across the patient population.

At the level of the individual pediatrician, CEHC requires acquisition of knowledge, development of skills, and demonstration of behaviors and attitudes that are appropriate to care for patients and families with a wide variety of cultural attributes. Physician demographics, gender, and religious beliefs are but a few of the factors that influence (often subconsciously) medical recommendations for patients from all backgrounds.[43] As such, physician self-reflection, self-knowledge, and self-critique have been identified as critical components of competence, which can be expanded further to encompass the concept of cultural humility. Practiced over time, these specific skills, in addition to conscious realignment of inherent imbalances in power that often undermine provider-patient communications and fostering of mutually respectful and dynamic partnerships within the community in which one practices, form the foundation for practicing with cultural humility.[53] Although using these knowledge bases, skills, behaviors, and attitudes is commonly referred to as cultural competence and cultural sensitivity, these terms focus on process. CEHC focuses on outcomes and emphasizes the need for continued monitoring and documentation.

Clearly, reasons for health disparities are numerous and may also include patients' cultural beliefs about health care and healing, dietary deficiencies, insufficient exercise, barriers to access to health care resources, financial indigence, inadequate insurance coverage, and inability to communicate with English-speaking physicians and other health care professionals. Trying to communicate effectively with parents who are deaf or hard of hearing also can pose significant barriers and may lead to suboptimal health care even when the child/patient is able to hear; this may direct the pediatrician to seek

creative solutions to provide family-centered care.[65] One study evaluated 3 community-based, culturally and linguistically sensitive initiatives that demonstrated that it is possible to reduce or eliminate racial/ethnic disparities in the child health arena by engaging patients and reinforcing participant collaboration.[66] A paper on quality improvement initiatives highlighted how a patient-centered medical home serves to reduce disparities and demonstrated that family involvement and partnering with others in the community not directly involved in patient care are key components of a successful program.[67] The National Committee for Quality Assurance's Patient-Centered Medical Home 2011 Standards ask practices to assess the language needs and characteristics of their patient populations; the standards also expect practice-based care teams to be trained on effective patient communication, particularly with vulnerable populations.[68] The growing number of practices achieving Patient-Centered Medical Home recognition translates into a greater number of pediatricians who understand and appreciate the importance of CEHC.

Pediatricians should become knowledgeable about the resources available to their patients and families within their institutions (offices, hospitals), health maintenance organizations, and communities. Pediatricians who seek out opportunities to partner with institutions, such as third-party payers, hospitals, health departments, and education departments, will be better able to advocate for the specific cultural needs of their patients and thereby increase patient satisfaction and quality of health care.

WORKFORCE DIVERSITY: BARRIERS AND OPPORTUNITIES

The ethnic and racial gap between pediatricians (as well as other physicians)

and their patients persists despite efforts to increase the diversity of the pediatrician workforce. Data from the AAP Annual Survey of Graduating Residents show that the percentage of underrepresented minorities (African American, Hispanic, and Native American) who graduated from US medical schools increased from 9% in 2003 to 15% in 2009, but this increase but was not statistically significant. Approximately a third of graduating residents report having grown up in a bilingual or multilingual family (34% in 2009; 29% in 2010).[69] Although these levels of URM pediatric trainees are encouraging, the percentages are far below the current estimates of the pediatric population, and these trends are unlikely to change drastically in the near future. Also, unlike most other medical specialties (except perhaps obstetrics and gynecology), the numbers of women entering pediatric training continue to increase and currently exceed the numbers of men in pediatric training.[70] Over time, it will be important to evaluate how this trend affects the availability of male pediatricians to treat patients who have this preference, which could, among other factors, be influenced by patient gender and specific cultural norms.

Literature in support of the Supreme Court decisions related to the University of Michigan's affirmative action policies has strongly stated the case for diversity at all levels of medical education. A more diverse faculty and student body is viewed as an indispensable component of quality medical education. Nevertheless, gains in enhancing diversity may be derailed by legislative actions, such as the passage of proposition 209 in 1996 in the state of California, which eliminated race-conscious admissions at public institutions. Since then, there has been a decline in the percentage of in-state minority students accepted

to and matriculating in California medical schools, with no appreciable rebound over time.[71] Institutional diversity will increase the cultural exposure of all faculty and students, which will help to dispel stereotypes and improve cultural competence by virtue of everyday interactions. A more diverse workforce will likely lead to a more diverse medical research agenda for improving health and the delivery of health care services among racial, ethnic, and cultural minority patients. Creating such a workforce, it is argued, begins with the diversity of those admitted to doctor of medicine and doctor of philosophy educational programs. Indeed, in a modern multicultural society, promoting diversity within the medical profession to better reflect the diversity of the patient population while maintaining the high quality of the health care workforce is in keeping with the societal obligation of medical schools to produce well-trained professionals to meet the future health care needs of the country.[8,13,72] The Association of American Medical Colleges published its flagship statement in 2008 to serve as a tool for medical schools for the development of diversity-related policies and, in doing so, implored those in academic medicine to be "serious about creating and sustaining diversity in medical education, biomedical research, and the physician workforce."[73]

Financial incentives to encourage URM students to enter medical training continue to grow nationally through organizations such as the National Institute on Minority Health and Health Disparities, and through state and regional programs. These incentives, including loan forgiveness/repayment and tuition reimbursement, may help to address many financial barriers such as low family income and educational debt. Institutional programs, such as the Center of Excellence in Diversity at Stanford University, reach out to promising premedical students to help prepare them for careers in medicine.[74] Diversity programs, along with educational institutions, acknowledge the importance of minority faculty concomitantly serving as mentors to minority students, serving on admissions committees, overseeing diversity initiatives, and serving in leadership positions at all levels. To support all of these activities, there must be a simultaneous commitment to increase diversity at the highest organizational and institutional levels.

Another approach to increasing the recruitment of minority students into the health professions is to focus on reaching out to individuals in earlier educational stages, such as elementary and high school. To maximize the effectiveness of these programs, appropriate support structures for these individuals within their communities, schools, postsecondary institutions, health care organizations, medical societies, and other entities need to be established. These support structures include financial incentives, mentoring and shadowing programs, adequate staffing for diversity programs, and educational and other initiatives related to cultural effectiveness and diversity. Holistic review of college and medical school applications may further bolster the numbers of URM students admitted to institutions of higher learning. Giving weight not only to the applicant's academic credentials but also to leadership potential, ability to work within a team, and interpersonal and communications skills, while taking into account personal circumstances, may provide more opportunities for outstanding students with essential nonacademic qualifications to succeed. There is clearly a need to pursue active recruitment of minority candidates for health-professions education programs. To increase the small number of minority individuals entering pediatrics without negatively affecting the number entering other specialties, the total number of minority individuals entering medical school must first be increased.

Workforce diversity and CEHC may also be enhanced by increasing minority representation in hospital governance and leadership positions, which can heighten the institution's efforts to reduce health care disparities and promote diversity in management and leadership. For example, minorities comprise 29% of the patient population nationally, yet they represent only 14% of hospital board members, 14% of executive leadership positions, and 15% of first- and mid-level management positions.[75] Such data illustrate an opportunity to foster programs that promote minority representation in hospital decision-making roles.

HEALTH POLICY AND IMPLEMENTATION

Although mandates from government agencies and regulatory bodies have served as important policy leverage or motivation to promote the provision of CEHC, these mandates have been largely unfunded, implying that academic institutions, hospitals, pediatricians, and other physicians must defray the costs of their implementation.[76] Decreasing payment to physician practices for clinical care and decreasing hospital operating margins have rendered these mandates largely impractical. Additionally, financial and other incentives from insurers, government agencies, and other payers to reward physicians and hospitals for delivering CEHC have been meager and, hence, have not supplied the impetus and support to encourage fundamental systemic changes, which are often costly.

In an era when cost containment is an urgent priority for the health care

community, research plays a pivotal role in changing the societal value of CEHC. The AAP regards CEHC as vital and a critical social value. However, many health care payers, employers, institutions, and others fear exacerbating current financial pressures and hardship when trying to provide such care. Many estimates of costs associated with poor child health do not take into account lifetime costs resulting from loss of productivity and earning potential; those who would contend that improving eligibility for health insurance will adequately address child health disparities need also to consider barriers such as insurance enrollment and access to care while recognizing the burden of certain chronic health conditions that disproportionately impact underserved children.[77] Reliable and timely data to demonstrate long-term decreases in health care costs, appropriate use of health care services, and improved patient health outcome measures would provide a solid foundation for addressing valid concerns about the financial implications of providing CEHC. To this end, culturally effective knowledge and skills need to be applied to research development and implementation. From a quality-of-care perspective, moreover, this research would allow policy makers to identify at-risk patient populations and to develop strategies to address health disparities on national, regional, state, and local levels.

Although Medicaid and other public insurers are placing increased emphasis on "cultural competence" and quality care,[78] few tools exist for health care payers to measure the outcomes of processes implemented to ensure CEHC. The use of patient-satisfaction scoring systems that assess shared decision-making, mutual respect, trust, and other culturally sensitive parameters should be encouraged. Survey instruments should use quality measures that are within the scope of responsibility of the health care professional, and the results of these surveys should be used to identify priorities for continuing education. When carefully designed to reflect the health and wellness values of the specific community being surveyed, such outcomes-driven efforts will allow greater focus on the effectiveness of interventions designed to monitor and ensure quality care.

Sponsors of diversity initiatives must likewise be able to track their progress in reaching specific targets and goals through research and data-driven outcome measures. For instance, institutional goals and metrics that are established for the purpose of recruiting and retaining minority trainees and faculty could be used to assess effectiveness. It is difficult to improve what we cannot measure. Limited data on cultural minorities in medicine hamper the ability of the profession to evaluate the current status of diversity, implement activities to enhance it, and measure the outcomes of these activities. The AAP has begun to address this concern by compiling more data regarding better tracking of attributes other than race and ethnicity through research generated by its Annual Survey of Graduating Residents, its new Pediatrician Life and Career Experience Study, its membership surveys, and collaborations with external organizations. However, more must be done to measure progress in improving diversity within medicine and pediatrics.

CONCLUSIONS

Since adoption of the *Report of the AAP Task Force on Minority Children's Access to Pediatric Care,*[3] the AAP has strengthened its commitment to ensure that all infants, children, adolescents, and young adults have access to optimal CEHC, ideally through a medical home.[80] Additionally, the AAP acknowledges that CEHC is multifaceted, complex, and often costly. The AAP believes that the education of pediatricians about cultural attributes and about the importance of implementing culturally effective practices and policies is essential. Because pediatricians are committed to life-long learning, education that will enhance the provision of such care must be available at all levels, from pre-medical education and medical school through residency training and CME.

The medical community has made insufficient progress in diversifying its workforce. Improving diversity within the pediatrician workforce will require proactive leadership from the medical community in a number of areas, including recruitment, mentoring, education, organizational support systems, and financial incentives. Success will also depend on the collaboration and cooperation of many stakeholders, including the AAP, with respect to initiatives designed to promote diversity within the health professions. Pediatricians are not alone in seeking solutions to improve the delivery of pediatric health care to the neediest patients. Pediatricians, other health care professionals, hospitals, universities, community groups, health care payers and insurers, regulatory and accrediting bodies, legislators, and others have significant roles to play in ensuring CEHC and will have to participate in health policy deliberations on this topic. Broad-based participation will ensure that a pediatric focus and perspective are brought to bear on decisions that have a direct effect on the quality of care that is delivered to children. In particular, stakeholders will have to advocate for necessary financial, regulatory, and other support among decision-makers to implement appropriate changes to the US health care delivery system.

Individual pediatricians need educational tools; the pediatric community needs the results of outcomes research to bolster, validate, and sustain its effort; institutions need support and encouragement to provide appropriate and effective education and training; foundations and other organizations need to have a pediatric perspective in all health care and policy development considerations; and legislative bodies, including federal and state agencies, need to provide the funding and infrastructure necessary to implement and evaluate mandates. The AAP has played, and must continue to play, a pivotal role in all of these important health policy deliberations.

RECOMMENDATIONS

The AAP believes that increasing the diversity of the pediatrician workforce and enhancing the provision of culturally effective care to the pediatric population will help achieve the AAP mission of promoting optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. Thus, the AAP is committed to working in collaboration with AAP chapters and other groups, including but not limited to medical societies, hospitals, universities, health care payers and insurers, federal agencies, and policy makers, to achieve greater workforce diversity and promote the provision of culturally effective pediatric care and recommends the following:

1. Pediatricians should assume a leadership role in advocating for a diverse workforce. Diversity in this context includes a wide spectrum of racial, ethnic, and cultural attributes, which include values, behaviors, customs, language, sexual orientation, religious beliefs, socioeconomic status, and other distinct population attributes. Many individuals exhibiting such a broad range of perspectives and attributes are URM compared with their presence in the general population.

2. The AAP should support the development of sequentially staged programs that prepare URM students to pursue careers in health professions, including pediatrics. URM medical student, resident, or physician groups would encompass those individuals from ethnic and racial populations that are underrepresented in the medical profession relative to their numbers in the general population as a whole.

3. Medical student, resident, and faculty recruitment activities should support and advocate for the full spectrum of diversity as described in Recommendation 1.

4. Affirmative-action programs should be supported because they promote the entry of URM students into medical school.

5. Financial assistance should be broadened for URM students, including federal funding for diversity programs, Title VII funding, loan-forgiveness/repayment programs, and tuition reimbursement.

6. Educational and health care institutions and organizations must employ individuals who are primarily responsible for the implementation, management, and evaluation of diversity programs that address the full spectrum of diversity as described in Recommendation 1.

7. Institutional commitment to improve workforce diversity must include formal programs or mechanisms to ensure that individuals of diverse backgrounds can rise to leadership positions. Furthermore, commitment from a number of groups (including institutions, the AAP, AAP chapters, medical societies, federal agencies, and policy makers) is necessary to ensure the provision of CEHC.

8. Pediatricians should assume a leadership role in advocating for CEHC for all infants, children, adolescents, and young adults.

9. The AAP, along with health care organizations at all levels, should continue to participate in the development and assessment of effectiveness of educational programs that promote CEHC. The curricula should address issues including but not limited to the patient's and one's own cultural beliefs, values, behaviors, customs, language, sexual orientation, religious beliefs, disabilities, and other distinct attributes.

10. Pediatricians must continue to work locally with hospitals, offices, and managed care organizations as well as commercial and government insurance payers to develop policies and programs that address health care needs specific to their communities.

11. Mandates from both the government and insurers to improve the provision of CEHC must be accompanied by funding or payment to support the infrastructure necessary to implement these programs and assess their effectiveness.

12. Public and private incentive programs must be established to encourage the implementation of national, regional, state, and community-based initiatives to improve the delivery of CEHC.

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REFERENCES

1. Britton CV; American Academy of Pediatrics Committee on Pediatric Workforce. Ensuring culturally effective pediatric care: implications for education and health policy. *Pediatrics.* 2004;114(6):1677–1685

2. Friedman AL; American Academy of Pediatrics Committee on Pediatric Workforce. Enhancing the diversity of the pediatrician workforce. *Pediatrics.* 2007;119(4):833–837

3. American Academy of Pediatrics. *Report of the AAP Task Force on Minority Children's Access to Pediatric Care.* Elk Grove Village, IL: American Academy of Pediatrics; 1994

4. American Academy of Pediatrics, Task Force on the Future of Pediatric Education. The future of pediatric education II. Organizing pediatric education to meet the needs of infants, children, adolescents, and young adults in the 21st century. A collaborative project of the pediatric community. *Pediatrics.* 2000;105(1 pt 2):157–212

5. Cooper LA, Powe NR. *Disparities in Patient Experiences, Health Care Processes, and Outcomes: The Role of Patient-Provider Racial, Ethnic, and Language Concordance.* New York, NY: Commonwealth Fund; 2004

6. Association of American Medical Colleges. Definition of the term "underrepresented in medicine." Available at: https://www.aamc.org/initiatives/urm/. Accessed December 11, 2012

7. US Department of Health and Human Services, Health Resources and Services Administration. *Transforming the Face of Health Professions Through Cultural and Linguistic Competence Education: The Role of the HRSA Centers of Excellence.* Washington, DC: US Department of Health and Human Services, Health Resources and Services Administration. Available at: www.hrsa.gov/culturalcompetence/cultcompedu.pdf. Accessed December 11, 2012

8. Cohen JJ. The consequences of premature abandonment of affirmative action in medical school admissions. *JAMA.* 2003;289(9):1143–1149

9. Grumbach K, Hart LG, Mertz E, Coffman J, Palazzo L. Who is caring for the underserved? A comparison of primary care physicians and nonphysician clinicians in California and Washington. *Ann Fam Med.* 2003;1(2):97–104

10. Basco WT, Jr, Cull WL, O'Connor KG, Shipman SA. Assessing trends in practice demographics of underrepresented minority pediatricians, 1993–2007. *Pediatrics.* 2010;125(3):460–467

11. Toomey SL, Chien AT, Elliott MN, Ratner J, Schuster MA. Disparities in unmet need for care coordination: the national survey of children's health. *Pediatrics.* 2013;131(2):217–224

12. Collins KS, Hughes DL, Doty MM, Ives BL, Edwards JN, Tenney K. *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans—Findings from the Commonwealth Fund 2001 Health Care Quality Survey.* New York, NY: Commonwealth Fund; 2002

13. US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. *The Rationale for Diversity in the Health Professions: A Review of the Evidence.* Rockville, MD: Bureau of Health Professions, Health Resources and Services Administration; 2006. Available at: http://bhpr.hrsa.gov/healthworkforce/reports/diversityreviewevidence.pdf. Accessed December 13, 2012

14. Thornton RL, Powe NR, Roter D, Cooper LA. Patient-physician social concordance, medical visit communication and patients' perceptions of health care quality. *Patient Educ Couns.* 2011;85(3):e201–e208

15. Traylor AH, Schmittdiel JA, Uratsu CS, Mangione CM, Subramanian U. Adherence to cardiovascular disease medications: does patient-provider race/ethnicity and language concordance matter? *J Gen Intern Med.* 2010;25(11):1172–1177

16. US Census Bureau. Projections of the total resident population by 5-year age groups, race, and Hispanic origin with special age categories: middle series, 2016 to 2020. Washington, DC: US Census Bureau; 2000. Available at: www.census.gov/population/projections/files/natproj/summary/np-t4-e.pdf. Accessed December 11, 2012

17. US Census Bureau. 2010 Census Briefs. Households and Families: 2010. Washington, DC: US Census Bureau; 2010. Available at: www.census.gov/prod/cen2010/briefs/c2010br-14.pdf. Accessed June 22, 2013

18. US Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Healthy People 2020. Available at: http://wcww.healthypeople.gov/2020/about/default.aspx. Accessed June 20, 2012

19. US Census Bureau, American Community Survey Reports. Language use in the United States: 2007. Available at: www.census.gov/hhes/socdemo/language/data/acs/ACS-12.pdf. Accessed December 12, 2012

20. US Census Bureau. International migration. Frequently asked questions. Available at: www.census.gov/population/intmigration/about/faq.html. Accessed June 11, 2013

21. DuPlessis HM, Cora-Bramble D; American Academy of Pediatrics Committee on Community Health Services. Providing care for immigrant, homeless, and migrant children. *Pediatrics.* 2005;115(4):1095–1100

22. Berry JG, Bloom S, Foley S, Palfrey JS. Health inequity in children and youth with chronic health conditions. *Pediatrics.* 2010;126(suppl 3):S111–S119

23. Ngui EM, Flores G. Satisfaction with care and ease of using health care services among parents of children with special health care needs: the roles of race/ethnicity, insurance, language, and adequacy of family-centered care. *Pediatrics.* 2006;117(4):1184–1196

24. Stoddard JJ, Back MR, Brotherton SE. The respective racial and ethnic diversity of US pediatricians and American children. *Pediatrics.* 2000;105(1 pt 1):27–31

25. Ulmer C, McFadden B, Nerenz D, eds. *Race, Ethnicity, and Language Data: Standardization*

for Health Care Quality Improvement. Washington, DC: National Academies Press; 2009

26. Betancourt JR, Green AR, Carrillo JE. *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches*. New York, NY: The Commonwealth Fund; 2002

27. Collins KS, Tenney K, Hughes DL. *Quality of Health Care for African Americans*. New York, NY: The Commonwealth Fund; 2002

28. Doty MM. *Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English*. New York, NY: The Commonwealth Fund; 2003

29. Doty MM, Ives BL. *Quality of Health Care for Hispanic Populations*. New York, NY: The Commonwealth Fund; 2002

30. Hughes DL. *Quality of Health Care for Asian Americans*. New York, NY: The Commonwealth Fund; 2002

31. Perot RT, Youdelman M. *Racial, Ethnic, and Primary Language Data Collection in the Health Care System: An Assessment of Federal Policies and Practices*. New York, NY: The Commonwealth Fund; 2001

32. Flores G; Committee On Pediatric Research. Technical report—racial and ethnic disparities in the health and health care of children. *Pediatrics*. 2010;125(4). Available at: www.pediatrics.org/cgi/content/full/125/4/e979

33. Braveman P, Barclay C. Health disparities beginning in childhood: a life-course perspective. *Pediatrics*. 2009;124(suppl 3):S163–S175

34. Guyer B, Ma S. Conceptualizing health disparities: panel reflections. *Pediatrics*. 2009;124(suppl 3):S212–S213

35. Gay & Lesbian Alliance Against Defamation, Inc. *Media Reference Guide*. 8th ed. Available at: www.glaad.org/reference. Accessed June 20, 2012

36. Burgess D, Tran A, Lee R, van Ryn M. Effects of perceived discrimination on mental health and mental health services utilization among gay, lesbian, bisexual and transgender persons. *J LGBT Health Res*. 2007;3(4):1–14

37. Berg MB, Mimiaga MJ, Safren SA. Mental health concerns of gay and bisexual men seeking mental health services. *J Homosex*. 2008;54(3):293–306

38. Hiestand KR, Horne SG, Levitt HM. Effects of gender identity on experiences of health-care for sexual minority women. *J LGBT Health Res*. 2007;3(4):15–27

39. Mayer KH, Bradford JB, Makadon HJ, Stall R, Goldhammer H, Landers S. Sexual and gender minority health: what we know and what needs to be done. *Am J Public Health*. 2008;98(6):989–995

40. Kosciw JG, Greytak EA, Diaz EM. Who, what, where, when, and why: demographic and ecological factors contributing to hostile school climate for lesbian, gay, bisexual, and transgender youth. *J Youth Adolesc*. 2009;38(7):976–988

41. Almeida J, Johnson RM, Corliss HL, Molnar BE, Azrael D. Emotional distress among LGBT youth: the influence of perceived discrimination based on sexual orientation. *J Youth Adolesc*. 2009;38(7):1001–1014

42. Russell ST, Ryan C, Toomey RB, Diaz RM, Sanchez J. Lesbian, gay, bisexual, and transgender adolescent school victimization: implications for young adult health and adjustment. *J Sch Health*. 2011;81(5):223–230

43. Berger JT. The influence of physicians' demographic characteristics and their patients' demographic characteristics on physician practice: implications for education and research. *Acad Med*. 2008;83(1):100–105

44. Georgetown University Center for Child and Human Development. National Center for Cultural Competence. Available at: http://www11.georgetown.edu/research/gucchd/nccc/. Accessed December 13, 2012

45. Green AR, Betancourt JR, Carrillo JE. Integrating social factors into cross-cultural medical education. *Acad Med*. 2002;77(3):193–197

46. Wear D. Insurgent multiculturalism: rethinking how and why we teach culture in medical education. *Acad Med*. 2003;78(6):549–554

47. Taylor JS. Confronting "culture" in medicine's "culture of no culture." *Acad Med*. 2003;78(6):555–559

48. Paul CR, Devries J, Fliegel J, Van Cleave J, Kish J. Evaluation of a culturally effective health care curriculum integrated into a core pediatric clerkship. *Ambul Pediatr*. 2008;8(3):195–199

49. Mulvey HJ, Ogle-Jewett EAB, Cheng TL, Johnson RL. Pediatric residency education. *Pediatrics*. 2000;106(2 pt 1):323–329

50. Jones MD, Jr, McGuinness GA, First LR, Leslie LK Residency Review and Redesign in Pediatrics Committee. Linking process to outcome: are we training pediatricians to meet evolving health care needs? *Pediatrics*. 2009;123(suppl 1):S1–S7

51. Sidelinger DE, Meyer D, Blaschke GS, et al. Communities as teachers: learning to deliver culturally effective care in pediatrics. *Pediatrics*. 2005;115(suppl 4):1160–1164

52. Zúñiga ML, Sidelinger DE, Blaschke GS, et al. Evaluation of residency training in the delivery of culturally effective care. *Med Educ*. 2006;40(12):1192–1200

53. Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved*. 1998;9(2):117–125

54. Juarez JA, Marvel K, Brezinski KL, Glazner C, Towbin MM, Lawton S. Bridging the gap: a curriculum to teach residents cultural humility. *Fam Med*. 2006;38(2):97–102

55. American Academy of Pediatrics. Culturally effective care toolkit. Available at: http://practice.aap.org/content.aspx?aid=2990. Accessed December 13, 2012

56. Pachter LM, Harwood RL. Culture and child behavior and psychosocial development. *J Dev Behav Pediatr*. 1996;17(3):191–198

57. Cooper-Patrick L, Gallo JJ, Gonzales JJ, et al. Race, gender, and partnership in the patient-physician relationship. *JAMA*. 1999;282(6):583–589

58. Flores G, Laws MB, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics*. 2003;111(1):6–14

59. Flores G, Abreu M, Olivar MA, Kastner B. Access barriers to health care for Latino children. *Arch Pediatr Adolesc Med*. 1998;152(11):1119–1125

60. Kuo DZ, O'Connor KG, Flores G, Minkovitz CS. Pediatricians' use of language services for families with limited English proficiency. *Pediatrics*. 2007;119(4). Available at: www.pediatrics.org/cgi/content/full/119/4/e920

61. Weinick RM, Krauss NA. Racial/ethnic differences in children's access to care. *Am J Public Health*. 2000;90(11):1771–1774

62. Youdelman M. *Medicaid and SCHIP Reimbursement Models for Language Services (2009 Update)*. Washington, DC: National Health Law Program; 2009

63. Institute of Medicine. In: Nielsen-Bohlman L, Panzer AM, Hamlin B, Kindig DA, eds. Health Literacy: A Prescription to End Confusion. Washington, DC: The National Academies Press; 2004

64. Patient Protection and Affordable Care Act Title I, Subtitle A, Part A, Subpart ii, Section 2715, Pub. L. 111-148, 124 (2010)

65. Swota AH, Hester DM. Ethics for the pediatrician: providing culturally effective health care. *Pediatr Rev*. 2011;32(3):e39–e43

66. Flores G. Devising, implementing, and evaluating interventions to eliminate health care disparities in minority children. *Pediatrics*. 2009;124(suppl 3):S214–S223

67. Chin MH, Alexander-Young M, Burnet DL. Health care quality-improvement approaches to reducing child health disparities. *Pediatrics*. 2009;124(suppl 3):S224–S236

68. National Committee for Quality Assurance. *Standards and Guidelines for NCQA's Patient-Centered Medical Home (PCMH)*. Washington, DC: National Committee for Quality Assurance; 2011

69. Frintner MP, Cull WL. Pediatric training and career intentions, 2003–2009. *Pediatrics*. 2012;129(3):522–528

70. American Academy of Pediatrics. AAP Graduating Resident Surveys, 1997–2012. Trends in the proportion of graduating pediatric residents who are women (1997–2012). Available at: www.aap.org/en-us/professional-resources/Research/pediatrician-surveys/Documents/Graduating_Residents_Survey_Trend_Data-Gender.pdf. Accessed May 20, 2013

71. Association of American Medical Colleges. *After Affirmative Action: Diversity at California Medical Schools*. Washington, DC: Association of American Medical Colleges; 2008

72. Smedley BD, Butler AS, Bristow LR, eds. *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*. Washington, DC: National Academies Press; 2004

73. Association of American Medical Colleges. *Roadmap to Diversity: Key Legal and Educational Policy Foundations for Medical Schools*. Washington, DC: Association of American Medical Colleges; 2008

74. Stanford School of Medicine. Center of Excellence in Diversity in Medical Education. Available at: http://coe.stanford.edu/. Accessed December 13, 2012

75. American Hospital Association and Institute for Diversity in Health Management. *Diversity & Disparities: A Benchmark Study of U.S. Hospitals*. Chicago, IL: American Hospital Association; 2012

76. US Department of Health and Human Services, Health Resources and Services Administration. *HRSA CAREAction. Mitigating Health Disparities Through Cultural Competence*. 2002. Available at: www.ask.hrsa.gov/detail_materials.cfm?ProdID=1655. Accessed December 13, 2012

77. Currie J. Policy interventions to address child health disparities: moving beyond health insurance. *Pediatrics*. 2009;124(suppl 3):S246–S254

78. Federal Register. 42 CFR Part 400 et al. Medicaid program; Medicaid managed care; proposed rule. 1998;63(188):52022–52092. Available at: www.gpo.gov/fdsys/pkg/FR-1998-09-29/html/98-26068.htm. Accessed December 13, 2012

79. American Academy of Pediatrics, Medical Home Initiatives for Children with Special Needs Project Advisory Committee. The medical home [reaffirmed May 2008]. *Pediatrics*. 2002;110(1):184–186

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