First Steps Nutrition Modules

Module 9 – Skill-Building for First Steps Practitioners

Introduction

This module reviews some concepts and skills that are important when working with families. These skills are not necessarily specific to nutrition, but can help the clinician better understand the client's perspective. This helps in the information-gathering stage of the assessment process and is also valuable as the team works to develop intervention strategies.

Challenges to the development and implementation of an effective nutrition care plan can include cultural barriers, socioeconomic concerns, and other barriers to communication.

Estimated time to complete this module: 30 minutes.

Learning Objectives

Participants will be able to:

- Define client-centered approach
- Describe the four concepts of patient- and family-centered care
- Identify questions that use a supportive, respectful client-centered approach
- Identify some common cultural beliefs (specific to populations most commonly served) and their potential effects on food intake
- Identify potential barriers a client who is low-income may encounter, how they relate to nutrition, and how the practitioner can help to find a solution
- Identify practical examples of the principles of adult learning
- Identify referral resources

Outline

I. INTRODUCTION

II. PROVIDING CLIENT-CENTERED CARE

III. CULTURAL FACTORS AND BELIEFS

a. Cultural Competence
b. Considerations in the Nutrition Assessment
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IV. STRATEGIES FOR WORKING WITH ADULT LEARNERS

a. Principles of Adult Learning
b. Health Literacy

V. ISSUES RELATED TO INCOME

a. Food Security
   - *Read more (2): Terminology related to food security, Other actions nutrition professionals can take related to food insecurity and hunger*
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d. Stress
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VI. RESOURCES

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IX. QUIZ

Providing Client-Centered Care

Client services in First Steps are client-centered. Client-centered means that the client comes first in the service delivery relationship. It is the client, not the provider, who determines what she needs, and with the provider's help, selects services or treatments that are the most appropriate.

When providers remain non-judgmental, listen and take time to meet the client's needs, they will keep the client engaged. As the client feels heard and her needs are addressed, trust will develop and the client will want to continue to work with the provider.

Family-centered care (or patient- or client- centered care) is an approach to the planning, delivery, and evaluation or health care. The core concepts of patient- and family-centered care are:

- **Dignity and Respect**. Health care providers listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.

- **Information Sharing**. Health care providers communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.

- **Participation**. Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.

- **Collaboration**. Patients and families are also included on an institution-wide basis. Health care leaders collaborate with patients and families in policy and program development, implementation, and evaluation; in health care facility design; and in professional education, as well as in the delivery of care.

Client Responsibilities	**Staff Responsibilities**
	Explain services clearly and how you think they might meet the client's needs. Convey the value of MSS/ICM services and identify what they offer to the client
	Alert client to potential benefits associated with healthy habits
Identify her goals and make	Provide opportunities for the client to work through

decisions about behavior change	her feelings about the topic
Gain skills and knowledge to meet goals	Provide opportunities for the client to learn and develop new skills, acquire a sense that she can do it, value the new habit, and be encouraged and supported
	Develop a plan of care for incorporating client priorities
	Check in with the client on a regular basis to make sure you understand and are meeting her needs
	Document risk factors and outcomes

Tools for Client-Centered services include (See the First Steps Manual for more information):

- Active listening - First Steps Manual
- Motivational interviewing - First Steps Manual and http://www.motivtionalinterview.org/training/index.html
- Understanding Stages of Change - First Steps Manual
- Environment that is client-centered - A checklist is available at http://www.familycenteredcare.org/tools/downloads.html
- Client survey

The Institute for Family-Centered Care maintains a website with information for health care providers. Materials include tools to evaluate clinical and organizational practices and resources for improving the quality of care provided.

An additional resource, specific to nutrition is a group study module, “family-centered care.” Originally developed for nutritionists whose practices include children with special health care needs, the information provides practical applications of the principles of family-centered care. More information at http://depts.washington.edu/pwdlearn/group.htm

Cultural Factors and Beliefs

Culture plays an important role in a person's food choices, as well as in an individual's choices related to health care. Regional, ethnic, religious, and familial culture may affect a woman's approach to pregnancy and parenting, as well as the type and amount of support she and her infant may receive. Even when there is no language barrier, culture can affect communication and understanding between client and the provider.

An exhaustive list of beliefs, attitudes, and practices toward pregnancy with a cultural basis is not practical. Instead, it seems reasonable to have a general understanding of some of the influences that culture can have, and approach each client as an individual, determining what influences her health care decisions.

Cultural Competence

What is cultural competence? If you can recite all of the foods that a person from the Philippines might eat and can describe the political climate of Argentina, are you culturally competent? No, just memorizing facts about another culture or country does not make a person culturally-competent.

A component of cultural competence actually begins with an awareness of your own cultural beliefs…and then the realization that other people may not share your beliefs. Understanding that beliefs may differ and that "acceptable and unacceptable" is measured by a different standard is key. Not placing value judgments on someone else's behavior is an important step in practicing cultural competency.

For example, traditional Western thought is that there is a scientific reason (such as bacteria or viruses) for disease and illness and that it is desirable to use science to treat the illness and eliminate disease. In another culture, it may be believed that illness is caused by thinking or doing something evil. This can have an impact on the approach to treatment.

Differences in the meanings of household objects can exist and have an impact on medical care. An example: A Laotian patient is told to give her child one teaspoon of medicine every 4 hours. The only spoon in her house is a porcelain soup spoon and the medicine runs out long before the prescribed 10 days.

Finally, it is important to understand that there may be differences based on culture…but it's also important to realize that there may NOT be differences based on culture. In other words, a person from another culture may be willing to or have already laid aside his or her own cultural practice and adopted the western or US way of doing things. For example, although a woman from Vietnam may feed her infant soup and rice as a first food in Vietnam, once in the US she may prefer to offer rice cereal.

For the health care provider, cultural competence begins with an awareness of his or her own taken-for-granted cultural beliefs and practices, and recognition that people from other cultures may not share or understand them. Thus, it means more than speaking another language or recognizing the cultural icons of a people; it means changing one's own pre-judgments or biases of a people's cultural beliefs and behaviors.

Steps toward cultural competence include being:

- aware of and knowledgeable about cultural differences and their impact on health-related attitudes and behaviors
- sensitive, understanding, non-judgmental, and respectful in dealing with people whose culture is different from your own
- flexible and skillful in responding and adapting to different cultural contexts and circumstances

Considerations in the Nutrition Assessment

When completing a nutrition assessment, consider the following influences:

- The role of family members (including extended family), especially in making health care decisions
- Barriers posed by language, including the need for an interpreter, cultural attitudes related to body language and eye contact
- Attitudes toward health care (especially Western medicine) and trust (or distrust)
- Roles of traditional healers (e.g., curanderas in Mexican culture), and any therapies prescribed or food suggested or discouraged
- Use of "hot" or "cold" foods [link] during different stages of pregnancy and lactation
- Religious influences on approach to health care, food choices and behaviors
- Superstitions (e.g., protecting infants from the "evil eye" can be common among people from Mexico, Somalia, and some parts of India)
- Use of alternative and/or complementary medicine or treatments
- Regional traditions within the US (e.g., Southern cooking)

Read more about the concepts of hot and cold

Although practices may be different between people from different areas, the concept of "hot" and "cold" influences health care decisions and food choices. The thought behind these beliefs is that illness is a result of imbalances and that correction of the imbalances will restore health.

For example, for many people from China, pregnancy is a "hot" condition or state. Blood loss associated with childbirth makes woman cold, so she should eat "hot" food to replenish energy. Which foods are considered "hot" can vary between geographic areas and may not be related to temperature, flavor, or texture of the food. In addition to food choices, these beliefs can affect other behaviors (e.g., after childbirth, women may stay at home for an extended time or dress warmly).

People from the following countries may make decisions based on the concepts of "hot" and "cold:" China, Hong Kong, Taiwan, Vietnam, Japan, Korea, Mexico, India, Philippines, and Cambodia, as well as some Arab and African countries.

Encourage those clients with healthy cooking and food practices to continue those practices. Don't quit utilizing all of the wonderful fresh produce that is inherent in some traditional diets.

Strategies for Working with Adult Learners

Principles of Adult Learning

Much of the research that has been done about adult learning in the classroom also applies to the adult who is learning in the clinic setting. Some principles of adult learning are summarized below. These guidelines apply to adult learners in any income level. (Adapted from: Principles of Adult Learners, online: http://honolulu.hawaii.edu/intranet/committees/FacDevCom/guidebk/teachtip/adults-1.htm. Accessed 26 October 2006.)

- **Adults are people with years of experience and a wealth of information**. Focus on the strengths of the individual, not just gaps in her knowledge. Provide opportunities for dialogue and tap into her experiences.

- **Adults have established values, beliefs and opinions**. Demonstrate respect for differing beliefs, religions, value systems and lifestyles.

- **Adults are people whose style and pace of learning has probably changed**. Use a variety of teaching strategies and methods, such as problem solving and discussion.

- **Adults relate new knowledge and information to previously learned information and experiences**. Assess the specific learning needs of the client. Present single concepts and summarize frequently to increase retention and recall. New information must be relevant to the client's goals.

- **Adults have pride**. Support the client as an individual. Self-esteem and ego are at risk, especially around personal issues such as pregnancy, nutrition, and food choices, when the environment is not perceived as safe or supportive. People will not ask questions or participate if they are afraid of being put down or ridiculed. Allow people to admit confusion, ignorance, fears, biases and different opinions.

Health Literacy

Health literacy is "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." People who are most likely to have poor health literacy include those with low incomes, from other cultures, and from certain races and ethnic backgrounds. Health literacy may be a problem even for individuals with good literacy skills, because of the personal nature of health-related information.

Problems with understanding health information can lead to incorrect administration of medication (e.g., timing, dose, duration), missed appointments, decreased compliance with recommendations, and late diagnosis of conditions.

Health care providers can improve communication with clients by recognizing areas where miscommunication is common:

- Use of language – interpretation of words, identification of concepts (e.g., "normal range") and value (e.g., "excessive urination")
- Understanding of science behind recommendations (e.g., why it is important to continue with the full course of antibiotics after the client feels better)

Some strategies to improve communication and enhance health literacy are reviewed in the table below. These include simplifying messages, using of visual aids, and including family and friends.

Ways to Improve Understanding in Patients with Low Health Literacy	
Slow down	Take time to assess patients' health literacy skills
Use "living room" language instead of medical terminology	Use language that patients can understand
Show or draw pictures	Visual aids enhance understanding and subsequent recall
Limit information given at each interaction and repeat instructions	
Use a "teach back" or "show me" approach to confirm understanding	Ask patients to demonstrate their instructions to ensure that instruction has been adequate Never ask "do you understand?" Typically, patients will say yes even if they don't understand
Be respectful, caring, and sensitive	This attitude reassures patients and helps them to improve participation in their own health care
Reproduced with permission from Williams MV. Recognizing and overcoming inadequate health literacy, a barrier to care. Cleveland Clinic Journal of Medicine. 2002;69(5):415-418.	

Issues Related to Income

Low income has been shown to be a nutrition risk factor. (Laraia, 2006) Families with low incomes have fewer job benefits, including employer-provided health insurance, paid vacation or sick leave. Food insecurity and housing hardships are also more common, even among families with at least one full-time worker. One survey reported that 40% of working, low-income families reported food and housing hardships. (Urban Institute, 2005) Child care is a major expense for all families; for low-income families, an average of 12% of total income goes toward childcare expenses. (Urban Institute, 2005) Other issues that are often associated with low income include transportation, literacy, support, and overall stress.

Food Security

In general, food security is consistent access to nutritious and safe foods. Situations in which nutritionally adequate and safe foods are not available (or their availability is uncertain) are considered examples of "food insecurity." A family who relies on food banks for food is considered to have food insecurity. "Food insufficiency" is defined as an inadequacy in the amount of food consumed due to a lack of resources to provide enough access to food.

Read more about terminology related to food security

The US Department of Agriculture has classified food security and related terms (Bickel, 2000):

- ***Food secure**: "Households show no or minimal evidence of food insecurity."*
- ***Food insecure without hunger**: "Food insecurity is evident in household members' concerns about adequacy of the household food supply and in adjustments to household food management, including reduced quality of food and increased unusual coping patterns. Little or no reduction in members' food intake is reported"*
- ***Food insecure with hunger (moderate)**: "Food intake for adults in the household has been reduced to an extent that implies that adults have repeatedly experienced the physical sensation of hunger. In most (but not all) food-insecure households with children, such reductions are not observed at this stage for children"*
- ***Food insecure with hunger (severe)**: "At this level, all households with children have reduced the children's food intake to an extent indicating that the children have experienced hunger. For some other households with children, this already has occurred at an earlier stage of severity. Adults in households with and without children have repeatedly experienced more extensive reductions in food intake"*
- ***Food insecure with hunger among children**: "At least one child in the household (age 0-17) has been hungry during the year because of constrained household resources. [All children were not necessarily hungry. For example, only an older child experienced hunger, with younger children being shielded from hunger]"*

Food insecurity is probably the first income-related barrier that comes to mind when considering nutritional status during pregnancy. Lack of access to nutrient-dense foods contributes to compromised nutritional status during pregnancy and in the postpartum period. (George et al, 2005) Children from families with food insufficiency may have compromised health and nutritional status as well. (Casey et al, 2001)

Here is one example of how a practitioner can follow the "Evaluate – Inform – Act – Follow-up" cycle with one risk factor:

Evaluate issues related to food security:

- Urgency of issue and client's awareness of community resources for food or other necessities. Has the client used a food bank? Applied for food stamps? Is she on WIC?
- Is the food the client receives from the food bank nutritious and/or does she know how to prepare it? Can she exchange those food items she can't use with someone for ones she can use?
- Where does the client eat most of her meals?
- Who prepares meals and snacks? What does she prepare for herself?
- What equipment is available for cooking?
- Is lack of knowledge or skill in food preparation, budgeting, and meal planning a factor?
- What is available for food storage? Refrigerator? Freezer? Containers?
- Are containers "raid-proof" from persons and/or vermin?
- How knowledgeable is the client about disease-carrying insects and vermin?
- What barriers to resources exist – transportation, cultural issues, client beliefs around using resources?
- Other things to consider include: gardening practices, other means of acquiring foods (hunting/fishing)

Knowledge of the culture of the local community will help determine appropriate questions and/or information to include about food and nutrition security during the nutritional care process. (Holbren, 2006)

The American Dietetic Association suggests screening using a single-item food sufficiency question, "Which of the following statements best describes the food eaten in your household:

1. Enough of the kinds of food we want to eat
2. Enough but not always the kinds of food we want to eat
3. Sometimes not enough to eat
4. Often not enough to eat" (Holbren, 2006)

While this is not adequate for a complete discussion when food insufficiency or insecurity is present, it is a good place to start.

Inform

- Share information about local food resources. This may involve networking with organizations and programs in the community, including food and nutrition assistance programs, emergency food and meal programs, farmers markets, community gardens, anti-hunger advocacy organizations, and food cooperatives.
- Share information about the availability and benefits of Federal and non-Federal resources available in the community.
- Review options for food storage or preparation.
- Introduce local resources to address barriers such as transportation.

Act

- Document risk factor on care plan.
- Work with client on developing meal preparation and budgeting skills.
- Refer to community resources for emergency food if needed.
- Explore and help to identify opportunities for cooking and storing food on a temporary basis.
- Explore other housing options, if this is the issue.
- Work with the client to decrease barriers to access and storage of food.
- Case conference with team members.

Follow-up and outcomes

- Identify adequacy of food resources, cooking equipment and storage.
- Identify changes in the client's knowledge of budgeting and cooking.
- Follow-up on barriers to food access.
- Document outcomes in the care plan, and if no changes occurred since the risk factor was identified, note the reason.

Read more: about other actions nutrition professionals can take related to food insecurity and hunger

- *Continue to learn about food insecurity and its consequences on individuals, households and communities, and communicate this information to other professionals, legislators, policy makers, and community members to increase awareness about food insecurity and its effects on health and well-being.*
- *Develop a database and/or website of food and nutrition assistance organizations for providing information related to community food security assistance programs, food assistance client referrals, client history, food donation, and nutrition education may be useful.*
- *Develop innovative programs that provide nutrition education and build skills in order to improve the food security of individuals, households, and communities, including programs highlighting the benefits of local, seasonal, and sustainably-grown foods, focusing on the development of effective household management strategies and*

food preparation, and creating food-based projects that foster economic development.
- *Conduct or collaborate on food insecurity and hunger-related research, including projects that map community processes, document the nutritional value of emergency foods, investigate the causes of food insecurity and its effects on health, nutritional status and wellbeing of special, at-risk population groups, and the impact of food system issues, such as seasonal variation in food availability, on food insecurity in the community.*
- *Participate in evaluating innovative, community-based programs designed to address food insecurity.*
- *Support legislative and regulatory processes that promote uniform, adequately funded food and nutrition assistance programs, nutrition education, and programs that support the economic self-sufficiency of individuals and families.*
- *Serve as advocates for the nutritionally vulnerable and those groups at increased risk for food insecurity.*
- *Assist in efforts to improve food access and acquisition by individuals and reduce edible food loss through food recovery and gleaning.*
- *Partner with local and state antihunger advocacy organizations.*
- *Serve on a local food policy council, which examines local food systems and provides recommendations for social and public policy changes.*

Reproduced with permission: Position of the American Dietetic Association: Food Insecurity and Hunger in the United States. Journal of the American Dietetic Association. 2006; 106(3): 446-458. The entire position paper can be found at: http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/advocacy_adar1202_ENU_HTML.htm.

Selected resources related to food security are listed at the end of this module.

The field of nutrition provides opportunities for professionals to serve as advocates.

- Become familiar with the types of foods that are offered to individuals and identify some ways that they can use the foods (for example, what to do with instant rice or canned tomatoes)
- When possible, become familiar with when certain foods are distributed – are fresh fruits and vegetables more often available earlier in the week?
- If this becomes a special interest of yours outside of work, consider working with food banks and other emergency food organizations to provide nutrition education to clients so they can make better choices. Identify some healthy substitutions for some of the highly-processed foods that are often provided to individuals.

Access to Follow-up Medical Care

Lack of insurance or medical coverage may be a primary reason for lack of adequate follow-up with medical and ancillary care. Other barriers, such as co-pay fees, deductibles, and other costs associated with obtaining health care may be present. Referrals for health insurance and identification of resources to help with costs may be helpful.

Transportation

Lack of transportation to medical and other appointments, or for grocery shopping increase a client's nutritional risk. The dietitian can obtain resources to coordinate transportation and/or schedule appointments to minimize the number of trips a client must make.

Stress

Stress is a barrier to health care in and of itself. If a person is stressed with daily life they will choose behaviors that offer comfort and/or relief even if these behaviors are not considered healthy (e.g., smoking, eating comfort foods, not following through with medical appointments).

The Behavioral Health Specialist can work with a client on stress management and provide resources. Dietitians should identifying stress related in eating habits and identify habits that may actual contribute to the stress and then work with the client on ways to address these issues.

Literacy

Literacy can affect the client's ability to follow through with instructions; consider this in nutrition education when choosing words and/or materials that match the literacy level of the client. Nutrition education is a great way to get the children in the household involved. By using health education materials that are geared toward children and including them in the teaching (if possible), the client doesn't have to be embarrassed if her literacy level is not what the dietitian expected. It's also a good way for a monolingual non-English speaker/reader to begin learning some words in English.

Support

Support can come from family, friends, and organized groups. Ask about the help available to the client and become familiar with resources in the community. Without a support system people can become overwhelmed with life's details and even small tasks, such as calling the WIC office for another appointment, can seem impossible.

Case Examples

Case Example: Cherise

Here is one example of how an interaction with a client can be made more client-centered:

Cherise is a 20-year old woman who initially came to the program looking for food assistance. She works part-time for minimum wage, and is 5 months pregnant. She says she usually eats 1 big meal each day, and munches throughout the rest of the day. The dietitian takes a diet history and tells Cherise, "You need to eat foods that are high in iron. Eat lots of beef and be sure to take a good multivitamin with iron. You need to eat more often; make sure to eat breakfast, lunch, and dinner every day."

Take a look at each of the dietitian's statements:

- *"You need to eat foods that are high in iron. Eat lots of beef and be sure to take a good multivitamin with iron."*

  A better way to say this might be, "You and your baby need iron …. What you are eating now is not giving you enough iron. These are foods that are high in iron (show a list). Could you work any of these into your food pattern? A prenatal vitamin will also give you iron. Would you be willing to take a prenatal vitamin? Why not? Medical coupons will cover the cost of a prenatal vitamin. I can help you set this up."

- *"You need to eat more often; make sure to eat breakfast, lunch, and dinner every day."*

  A better way to say this might be, "Your body uses food better if it is divided up evenly throughout the day. What is your usual schedule like? How can we work out a plan so you can eat 3-6 times each day?" This discussion could include access to food at work and other times during the day.

Case Example: Minh

Minh is a 24-year old woman who moved to the US 3 years ago from Vietnam. She speaks English at work, but usually speaks her native language at home. Minh is 28 weeks pregnant, and her glucose tolerance test indicated that she has gestational diabetes. She is meeting with the dietitian to learn about changes she can make to her food pattern before trying insulin.

The dietitian tells her, "I see you have gestational diabetes. As you know, the potential complications associated with gestational diabetes include macrosomia and the development of type 2 diabetes for you later in life."

The dietitian takes a diet history, and asks about the use of traditional foods. She provides a standard handout that describes a food pattern of 6 meals and snacks each day and 250 grams carbohydrate. She tells Minh, “Try not to eat so much rice.”

What did the dietitian do well?

The dietitian did make an attempt to provide client-centered information; she asked about the use of traditional foods.

How could the encounter have been more client-centered?

In general, the dietitian did not tailor the assessment process or the development of the intervention to the individual needs of the client. Some suggestions for making the interaction more client-centered include:

Find out what the client knows:

- Can you tell me what your doctor/midwife told you about gestational diabetes?
- Did what s/he said make sense to you?
- Do you have questions for me?

Find out what the client is already doing:

- What foods do you usually eat? (If the dietitian is unfamiliar with these foods, ask questions about them)
- What is your usual food pattern? When do you eat? Do you eat certain foods only on certain days of the week? Or at specific times of day?
- What is the traditional food pattern? (Some cultures define meals and snacks by the time of day or type of food; for example, is it considered a "meal" if there is no rice served?) Does the client follow the traditional food pattern?

Work with the client to identify changes:

- What is the client willing and able to modify?
- Does she understand why the changes are important?
- For this client, it might be identifying sources of carbohydrate in her food pattern and modifying (if necessary) the portion sizes

References and Resources

References

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References and Resources

Resources

Some resources are listed below. You may know of additional resources in your community. To share these with other providers, post information to the message board: https://catalyst.washington.edu/webtools/epost/register.cgi?owner=bogata&id=18649 or send a summary via email to pwdlearn@u.washington.edu. (You will need to register with Catalyst the first time you sign on to the message board.)

Related to Food Security

A summary of **Federal food assistance programs**, and links is included on this website: http://www.nutrition.gov/index.php?mode=subject&subject=ng_assistance&d_subject=Food%20Assistance%20Programs

The **Family Food Line** is a resource hotline for families in Washington State. It is a project of WithinReach (formerly Healthy Mothers Healthy Babies) and can connect families with local programs and resources. http://www.familyfoodline.org/ WithinReach provides information and referral for social and health services across Washington State, including health insurance, prenatal resources, nutrition and food resources, breastfeeding, immunization, family planning, child care, children with special needs, child development, and parent/sibling support.

The Seattle Community Network lists food-related resources in the Seattle area. http://www.scn.org/services/food/

TEFAP Commodity Fact Sheets with Recipes provides information about the http://www.fns.usda.gov/FDD/facts/hhpfacts/hp-tefap.htmfoods that are available through the Commodity Food Program.

Related to Culture

Ethnomed - a resource from Harborview Medical Center, Seattle, WA http://www.ethnomed.org – resource from Harborview Medical Center, Seattle, WA

Culture Clues - these tip sheets for clinicians that are designed to increase awareness about concepts and preferences of patients from the diverse cultures served by University of Washington Medical Center. http://depts.washington.edu/pfes/cultureclues.html

National Center for Cultural Competence at Georgetown University Center for Child and Human Development, University Center for Excellence in Developmental Disabilities – website includes models, definitions, and self-assessment tools. http://gucchd.georgetown.edu/nccc/

The Provider's Guide to Quality and Culture - a self-study module for health care professionals. http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English

Ohioline - Food - features materials for professionals and families, including "Cultural Diversity - Eating in America" profiles for several ethnic groups http://ohioline.osu.edu/lines/food.html

Cultural Food Pyramids/Complementary Nutrition Archives - Cultural food pyramids created by the Southeastern Michigan Dietetic Association - http://www.semda.org/info/

University of Chicago Hospital Academy's Cultural Tapestry Guides - an overview of 18 different cultures including interpersonal preferences, preferences in decision making, meaning of gestures, medical treatment preferences, important holidays. To

access, click in sequence: Library, Academy Connect Library, Cultural Diversity, Tapestry Card Collection http://academyconnect.uchospitals.edu/v1/index.html

Related to Income

Eastside Baby Corner - a nonprofit organization operated out of Issaquah, WA. Eastside Baby Corner collects items used by children from birth to age twelve and distributes them to service providers (shelters, food banks, public health nurses, social workers, and others). http://www.babycorner.org

Communication Across Barriers – A website that includes resources about generational poverty - http://www.combarriers.com/about_donna.php

aha! Process, Inc. - http://www.ahaprocess.com/

Quiz

1. The core concepts of family- (or patient- or client- centered care) include all of the following, EXCEPT:

a. dignity and respect
b. information sharing
c. participation
d. cooperation

2. Which of the following is an example of family-centered information sharing:

a. “You need more iron and should take this supplement.”
b. “Iron is important to your developing baby and to your body. You should eat more meat.”
c. “Iron is important to your developing baby and to your body. Here are some ideas for increasing iron in your food pattern; which is reasonable for you?”
d. All of the above

3. Traditional Western thought is that:

a. Illness and disease are caused by thinking or doing something evil
b. illness and disease are caused by the acts or wishes of other people or supernatural beings and forces
c. there is a scientific reason for disease and illness and it is desirable to use science to treat the illness and eliminate disease
d. illness and disease can be caused by many things, and the best treatment approach depends on the actual cause

4. Steps toward cultural competence include all of the following, EXCEPT:

a. being aware of and knowledgeable about cultural differences and their impact on health-elated attitudes and behaviors
b. having an understanding of the food patterns of clients from all potential cultures
c. using a sensitive, understanding, non-judgmental and respectful approach
d. being flexible and skillful in responding to and adapting to different cultural contexts and circumstances

5. True or false: Health literacy is not a problem for individuals with good literacy skills.

a. true
b . false

6. True or false: One good example of the "teach back" or "show me" approach to confirming understanding is to ask the client if she understands what you said.

a. true
b. false

7. Which of the following families would be considered to have "food insecurity":

a. family relies on food banks for food
b. parents reduce their intake at the end of the month
c. parents are concerned about the adequacy of the household's food supply
d. all of the above*
e. a and b only

8. Which of the following is a potential nutrition-related problem that is often related to low income:

a. food security
b. transportation
c. high stress
d. low literacy level
e. a, c, and d
f. all of the above

9. Which of the following is an action that the dietitian can take, related to helping clients manage stress:

a. make a referral to the Behavioral Health Specialist
b. identify eating habits that are related to stress and help the client to address these issues
c. all of the above
d. none of the above; this is out of the dietitian's scope of practice