

2004

Community Pediatrics

CURRICULUM



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ANNE E. DYSON COMMUNITY PEDIATRICS TRAINING
INITIATIVE CURRICULUM COMMITTEE

Edited by Wanessa Risko, MD, SD, Grace Chi SM & Judith Palfrey, MD

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Anne E.
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Community Pediatrics
Training Initiative

Caring All Together

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Introduction

About This Book

This book provides curricular resources for training of pediatric residents in 8 core competency areas of community pediatrics. The core competency areas are:

- Delivery of Culturally Effective Care
- Child Advocacy
- Medical Home
- Special Populations
- Pediatrician as Consultant, Partner, and Collaborative Leader
- Educational and Child Care Settings
- Community and Public Health
- Research and Scholarship

** The core competency areas were established by the Curriculum Committee of the Anne E. Dyson Community Pediatrics Training Initiative.

Each chapter opens with an essay followed by examples of curricula, tools and resources in that specific area of community pediatrics. It includes methodological suggestions for the delivery of the curricular materials, anticipated educational outcomes, examples of curricular tools and a wide array of resources: websites, books, articles and videos that we have found helpful in training residents. These resources are derived from the experience of the Anne E. Dyson Community Pediatrics Training Initiative, encompassing 12 residency programs. We encourage those using the book to be in touch with faculty and residents at each of the sites and have provided contact information.

It is our hope that this collection of methodologies, tips and resources will be helpful to medical educators as they plan the content of their residency curriculum. We see this book as the first page of a story that is unfolding everyday, and anticipate that there will be many further pages and chapters in the years to come.

Wanessa Risko and Judith Palfrey

About the The Anne E. Dyson Community Pediatrics Training Initiative

The Anne E. Dyson Community Pediatrics Training Initiative was launched in 2000 by the Dyson Foundation of Milbrook, New York. At that time, The Dyson Foundation was led by Dr. Anne E. Dyson, a remarkable pediatrician and continuity director. Dr. Dyson had personally experienced the shortcomings of the traditional medical model in addressing patients' needs; She appreciated the gap between our understanding of the issues and our ability and willingness to confront them. Dr. Dyson recognized the need to bridge this gap with a fundamental aspect of pediatrics – the engagement of families and communities in managing illness and fostering health. Through consultation with colleagues around the country, Dr. Dyson formulated an initiative to create centers of excellence for community pediatrics training around the country (Table 1).

Over half of the eligible U.S. residency programs responded to the Dyson Foundation's challenge to incorporate new principles of community pediatrics into their residency curricula. Ten proposals, encompassing 12 residency programs were chosen to receive the support of the Dyson Foundation to enhance the training of their resident in a manner consistent with the initiative's goal and objectives (Table 2).

Table 1
The Anne E. Dyson Community Pediatrics Training Initiative

Goal

To produce pediatric professionals with a greater capacity to improve the health of children in their communities.

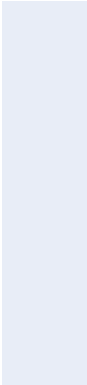
Objectives

- Equip pediatric residents with the tools and knowledge they need to become capable professionals committed to improving the health of children in their communities.
- Engage pediatric residents in the communities in which they work. Using resources from the local community provide didactic and experiential opportunities in the assessment of community goals, strengths and needs so that the residents learn to practice as Medical Home providers.
- Develop meaningful partnerships between academic departments of pediatrics (and their medical centers) and community-based organizations, community pediatricians and families in their regions.
- Enhance pediatric training through interdisciplinary collaborations with other schools and university departments.

Table 2

Anne E. Dyson Community Pediatrics Training Initiative Sites

- The Children's Hospital of Philadelphia Pediatric Residency Program
- Columbia University Community Pediatric Training Program and Harlem Hospital Center
- Indiana University School of Medicine Pediatric Residency Program
- Medical College of Wisconsin: Department of Pediatrics Pediatric Training Program
- University of California, Davis School of Medicine, Pediatric Residency Program
- University of California, San Diego Department of Pediatrics and the Naval Medical Center
- University of Florida Health Science Center/Jacksonville Pediatric Residency Program
- University of Hawaii Integrated Pediatric Residency Program
- University of Miami School of Medicine
- University of Rochester School of Medicine: Pediatric Links with the Community / Child Advocacy Resident Education (PLC/CARE) Program



Methods and Evaluations

*Beth Rezet, MD, Dean Sidelinger, MD, MEd,
& Wanessa Risko, MD, SD*

Community pediatrics has emerged as a valuable paradigm, redefining the role of pediatricians in a manner that addresses the complex nature of modern childhood health issues.

As described by the American Academy of Pediatrics: Community pediatrics embraces a perspective, recognition, synthesis and commitment to a specific way of practicing pediatrics.

A Perspective that enlarges the pediatrician's focus from one child to all children in the community.

A Recognition that family, educational, social, cultural, spiritual, economic, environmental, and political forces act favorably or unfavorably, but always significantly, on the health and functioning of children.

A Synthesis of clinical practice and public health principles directed towards providing health care to a given child and promoting the health of all children within the context of the family, school, and the community.

A Commitment to using a community's resources in collaboration with other professional agencies and with parents to achieve optimal access, quality of care and advocacy

Teaching community pediatrics to residents is a complex endeavor, as it involves a shift from the classical medical model. The patient, family and community are the center of the learning process while community based organizations and faculty facilitate, set the stage, guide and nurture the learning process. For those designing the curriculum, selecting what is to be learned, the proper cast of players and settings, and the parameters of these multiple relationships are the beginning of an educational journey.

There are a multitude of experiences that can take place outside the traditional hospital or office settings. By definition, these experiences will offer community exposure; however, exposure alone may not lead to learning. Teaching methods that match specific learning objectives and evaluation mechanisms are key to an effective curriculum. Regardless of the learning methods used, there should be ongoing sharing of information between teachers and residents, and an emphasis on nurturing partnerships.

This chapter will review a few of the many methods that can be used to teach residents about community pediatrics and to evaluate whether learning has occurred. The discussion details many of the tools presented elsewhere in this text and provides an overview and a context for the educational and evaluation methods. These methods can be employed in a variety of settings or venues, as shown in Table 1.¹⁻⁵ Evaluation tools for assessing residents' learning are discussed following the presentation of each method. The importance of learner feedback and faculty development is also discussed.

TABLE 1
Teaching Methods and Venues

Teaching Methods

- Patient care and clinical learning*
- Conferences & didactic sessions
- Problem-based learning
- Case-based learning*
- Skills workshops

- Projects*
- Service learning*
- Site visits: community organizations, government agencies, schools, etc*
- Home Visits*
- Advocacy campaigns

- Accessing community resources
- Continuous quality improvement
- Self directed learning
- Reflection and self assessment*
- Literature searches
- Observation followed by feedback*
- Interactive web sessions
- Group discussions
- Journal clubs

Venues

- Continuity clinic
- In-patient service (including ICUs)
- Noon conferences
- Grand Rounds
- Teaching rounds
- Outpatient block rotations:
 - Behavior/Development
 - Community Pediatrics
 - Adolescent Medicine
 - Others
- Research or project rotations

- Immersion experiences in the community

*Topic discussed in this chapter

Learning Community Pediatrics - Specific Methods: Clinical Learning

Learning during clinical experiences is the backbone of medical training. Clinical teaching can be a tremendous opportunity to incorporate preventive medicine and public health practices. Virtually any clinical situation can generate a discussion of the patient’s problem in the context of family, community and public policy. For example, a preceptor reviewing a newborn visit conducted by a resident can address the public health aspect of the “Back to Sleep” campaign. At a 6-year-old visit, the issue of schools and physical education can be discussed. The availability of safe community spaces for teens can be addressed during an adolescent visit.

These patient care teaching moments can be used during inpatient teaching as well. Residents learn valuable lessons by interacting with health care professionals other than physicians in the inpatient and outpatient settings. Many programs engage pediatric social workers for provision of service. Social workers can also be a great source of “sub-specialty” teaching for the residents by sharing their wealth of knowledge and expertise in case management and the process of negotiating with community-based organizations, schools, and other public systems.

Triggering a community approach during clinical experiences

Questions for discussion during inpatient rounds

How common is this condition? What are the risk factors associated with this condition? Are there interventions that could have prevented this outcome? What measures would prevent this from happening to others? Who needs to be involved in the care plan for this patient? How can communication among providers be enhanced for this patient? What community resources can be useful to this patient?

Evaluating Clinical Learning

To measure competency in community pediatrics, residents may participate in direct observation, in cases with standardized patients (SP’s) or as part of an objective structured clinical examination (OSCE). In addition to being a wealthy source of data for competency-based evaluations of residents, participation in both direct observation and in simulated experiences can provide excellent sources of further directed learning and reflection. A standardized checklist can be used for direct observation. An example of an observation tool is shown below. OSCE’s and SP’s although resource intensive, are particularly effective in assessing residents’ competency in the areas of patient care and interpersonal and communication skills in situations simulating real practice.

Pediatric Primary Care: Direct Observation				
Resident _____	Date _____			
Attending _____				
1) Patient Assessment: History	Yes	No	N/A	
A) Did you observe the resident take a medical and/or social history in an age appropriate manner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B) Was the patient or parent cooperative during the interview? Did the resident cope well with an uncooperative historian?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
C) Did the resident ask questions using lay terms (in contrast to medical terms)? Did the resident introduce him or herself to the patient and the family?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
D) Did the resident ask questions concerning sensitive issues? Was this done with a caring, non-judgmental attitude?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

E) Was the questioning open-ended?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F) Was the history complete?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Patient Assessment: Physical Exam			
A) Did you observe the resident perform a focused exam A complete exam?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Did the resident wash hands prior to exam?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Did the resident perform an age appropriate physical exam? Did the resident take into consideration issues of modesty?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Did the resident engage the patient during the physical exam?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E) Was the patient cooperative? Did the resident use skills to facilitate the exam with an uncooperative patient?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F) Did the resident perform a developmental assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Patient Assessment: Diagnosis			
A) Was the resident able to generate a differential diagnosis for a complaint?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Did the resident appropriately use lab studies, X-rays or consults?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Was the resident able to explain in lay terms his or her thoughts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Did the resident allow time &/or opportunity for questions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Patient Management			
A) Was the resident able to formulate a care plan for the patient?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Was a resident able to explain in lay terms the proposed plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Did the resident incorporate the patient and parent in the care plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Patient/Family Education			
A) Did you observe the resident teach the patient and or parent a particular skill?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Did the resident use appropriate language and give opportunity for questions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Did the resident give written/printed instructions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Did the resident engage the patient or family in discussion?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Resident Documentation Skills			
A) Were the resident's chart notes appropriate and complete?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B) Was there appropriate documentation of care plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C) Was the next visit clearly stated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D) Were the appropriate forms completed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Did the resident verbally reflect on his or her performance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) Did the resident receive immediate feedback concerning their professional competencies in each of the above 6 areas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. Rezet, MD

Learning Community Pediatrics - Specific Methods: Case-based Learning

Case-based methodology can be used to teach community pediatrics in an engaging, learner-centered manner. Cases can be used to teach about virtually any topic including non-traditional subjects such as medical care financing (state and private insurance), barriers to continuity and access to care, strategies for coordination of care and advocacy, and cultural sensitivity. Cases depict real events of professional life in a written format that students can analyze productively, usually in discussion groups with instructors and in a process that blends empathetic identification with collaborative thinking, priority setting, problem-solving, criticism, and consensus.⁹ Case-based discussions can occur in a number of settings and venues, including block rotations, noon conferences, continuity clinic core conferences, etc. The facilitator is a key determinant of a successful case-based discussion. The facilitator guides the discussion with some core questions but never dominates. He/she should promote participation, exploration, reflection, and sharing by the group. Cases can be brief or multi-faceted and encompass many features. Samples of cases are available at the Dyson Initiative website (www.dysoninitiative.org). There are many web-based resources that can be used for case-based discussions including those listed in the resource section at the end of this chapter.

Strategies to Facilitate Case-based Discussions:

- Allow adequate pauses so participants will be moved to answer questions
- Summarize and emphasize important points made during discussion
- Redirect discussion from dominant individuals
- Try to engage all participants by asking questions like, "What do others think?"
- Be aware of who does and does not participate, whether the discussion is factual or subjective, and the body language of group members
- Redirect questions asked of the leader back to the group

Steps in Developing Cases:

- Determine the scope of the case and its specific objectives
- Determine the setting and format of the experience (pre-clinic or workshop, for example, self-directed or group)
- Involve residents in the design of the subject and case format
- Provide access to information to answer case questions
- Provide context for using newly learned information
- Provide instruction to case facilitators on how to best perform their role

Evaluating Case-Based Learning

Typical evaluations examine residents' participation during the session as well as faculty's perceptions of their medical knowledge and decision-making skills.

Comparison of performance on pre and post-tests provides an easy method to evaluate learning during case-based sessions. Pre and post-testing are particularly useful in measuring changes in knowledge as a

result of a case-based discussion. Feedback on performance on pre-tests can be provided to residents to assist them in identifying strengths and weaknesses in their knowledge base thus allowing them to concentrate on areas where improvement is needed. A drawback in utilizing pre and post-tests to assess change in attitudes is that residents may complete the tests with socially appropriate answers rather than how they actually think.

Faculty may develop paper or electronic cases requiring residents to work through case vignettes, such as working with a family with limited resources. The case may present opportunities for identifying and linking families to community services. Residents may do this using their knowledge of community resources or their skills in locating these resources. Evaluation of the process of linking the family with the appropriate resources may serve as an adequate substitute for actually observing the performance of the service in clinic. Residents additionally may keep a log of patient cases documenting referrals to community resources. This can even be integrated with continuity clinic logs prompting consideration of community resources in every clinical encounter.

Learning Community Pediatrics - Specific Methods: Service Learning

The service learning model serves as a foundation for many community and public health experiences in the training of health professionals. Service learning is defined as a structured experience that combines community service with preparation and reflection. Students engaged in service learning provide community service in response to community-identified concerns and learn about the context in which service is provided, the connection between their service and their academic coursework, and their roles as citizens.⁶

Many programs offer the opportunity for motivated residents to volunteer clinical service in the community, gaining both clinical experience and knowledge about a community's distinct strengths and challenges. Coordinating multiple activities and individuals is often required during service learning. This can be a challenge, although some programs have achieved this with great success.^{10,11} Service learning opportunities may include working at a homeless health clinic, a school-based clinic, or a juvenile detention health center. Preparation is important for a successful service learning experience. Prior to or concurrent with their clinical experience, residents should be given information about the community they will serve, the nature of the service, and the goals of the experiences. This preparation can take place in many forms: lectures, literature searches, reading, discussions, and shared informational sessions. These should be coupled with debriefings after individual interactions and summative evaluation after completion of the service.

At Columbia University, in addition to providing direct services, residents learn about the context in which the service is provided, the connection between the service and their professional growth and their role as citizens. During the community and Ambulatory rotations residents read about, visit, and provide services at a variety of community sites: WIC, Riverdale Lactation Center, Temporary Assistance for Needy Families' Center visit, homeless shelter, and a domestic violence program. Before and during the service learning experiences, residents review the learning goals, complete reading assignments, and engage in reflection. These activities engage the residents as active participants and increase the yield of the field experiences. An evaluation and reflection card used after each service learning experience is included at the end of this section.

Key For Successful Service Learning:

- Determine block(s) of time for the experience
- Choose site(s) based upon both community strengths and needs as well as educational objectives
- Use community pediatrics competencies to define knowledge and skills objectives
- Prepare residents with a contextual framework and clear expectations
- Provide written contact information
- Provide mandatory debriefing or reflective exercises
- Use resident and CBO's feedback to evaluate and improve future visits

Evaluating Service Learning Experiences

A variety of methods can be used to evaluate the service learning experiences. An example of one tool used for brief evaluation and reflection is shown below. Often a combination of methods is most useful, and can easily be added to a resident learner's portfolio. The evaluation methods should aim to assess whether the curriculum's learning objectives have been achieved. Direct observation followed by completion of an observation scale can be used to assess the achievement of specific competencies. Community representatives, faculty, and the resident can complete questionnaires establishing whether specific skills, attitudes or knowledge were attained. It is particularly useful to provide means for the resident to reflect about what was learned and how to integrate it into medical practice. The self-reflective portion of the evaluation is often built into the service learning model. An additional item for the learners' portfolios from service learning can be the residents' completion of asset mapping or needs assessment before beginning their work in the community.¹² This first step in service learning is often used to identify community strengths as well as the needs of the particular community, providing an opportunity to become more familiar with the community.

Community Pediatrics Reflection / Evaluation Cards	
Name _____ PGY _____	
Site _____	
Did you attend as scheduled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did someone from the site expect you and orient you to the session's activities? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Were activities done as scheduled (talks, classes)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
If so explain why _____	
	Describe one thing that you learned at the site:
	 Describe one way you can apply the knowledge/skills learned into patient care:

*Dodi Meyer, MD & Patricia Hametz, MD
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Learning Community Pediatrics - Specific Methods: Projects

Service or research projects may be a natural extension of a resident's community experience. Residents may be given time as interns to learn about possible community projects, as juniors to design or begin a project, and as seniors to implement or complete the project. Some programs may only be able to support this process as elective time, others as a block rotation or longitudinal experiences.⁷ As with all learning endeavors, the project process will flow more smoothly if they have specific, attainable goals from the outset. Residents should play an integral part in deciding what should be learned during their projects. Yet they must be reminded that lengthy, overly ambitious projects can be discouraging to residents, community partners and faculty alike.

Projects may be carried out during block rotations and/or continuity clinic or at another protected time. Some projects require only a few hours to execute, while others are longitudinal and require multiple sessions. Some projects are designed and implemented by a single resident; others engage a group of residents over time. Some residents have used grant funding, for example, the CATCH grants through the AAP. A sample of a project proposal that may be a helpful model for assisting residents is provided below.

Although having residents design their own projects can increase resident ownership and self-directed learning, these advantages need to be weighed against the increased responsibility and time constraints. An alternative is to have ongoing community projects that involve residents at specific times. This approach provides the opportunity for resident involvement to be a consistent aspect of both the training program and the community endeavor. Either way, it is the role of project advisors to help residents set clear, reachable goals that match the strengths and needs of the community. Successful projects generally require residents to formulate realistic expectations of themselves and their projects, and to acquire skills in needs assessment, negotiation of common goals, and above all else, mobilizing the time to complete the outlined goals.

Key For Successful Projects:

- Decide if projects are to be mandatory or voluntary
- Define what is an acceptable project
- Determine a project's timeline and scheduling
- Introduce the concept of projects early in residency to initiate the thought process, reinforce expectations along the way.
- Use community assets and needs as a springboard for project ideas
- Assess funding necessity and possibilities
- Help residents establish realistic project expectations
- Provide mentorship through the faculty or community
- Create a mandatory forum to share ongoing projects and finished projects, including those that have been less successful

For more expanded discussion of projects, please see *Resident Projects Toolkit*, a companion publication by the Anne E. Dyson Community Pediatrics Training Initiative.

One example of an ongoing longitudinal project is the homeless health initiative at Children's Hospital of Philadelphia.

Several years ago this ongoing project was started by residents who provided volunteer clinical health services at a local homeless shelter. The initiative grew into a multi-faceted program involving health care institutional support, educational outreach, and legislative endeavors. One group of residents decided to do a needs assessment of the shelter and partner with the homeless center organization to answer some of these needs. Subsequent resident groups implemented a parenting curriculum, provided health insurance and managed care information and access, and engaged other health care providers (nurses, physical therapists) to offer their services. Some residents used the initial model to offer similar services at other homeless shelters. The branch projects that emanated from the initial volunteer initiative have grown over a four-year span. Many residents used a dedicated block "project" rotation or elective time, while others volunteered time throughout their three years of residency. Faculty mentorship was present but not time consuming; and was most useful during negotiations for institutional support. The residents were able to negotiate support for a part-time coordinator from the hospital. For more detailed example of resident projects, please see <http://www.dysoninitiative.org/projects.php>.

Evaluating Projects

Projects in community pediatrics provide a unique opportunity to evaluate the resident's abilities in areas such as communications skills, professionalism, and systems-based practice. The faculty and community partners working with residents on a community project become familiar with the residents' performances over time utilizing the various knowledge, attitude, and skill sets necessary to plan, implement, and evaluate projects.

As with the other methodologies discussed throughout this chapter, goals and purposes for the resident projects should be clear and discussed with residents, faculty, and community partners involved in the projects. Unlike the home visits, other site visits, and service learning discussed elsewhere in this chapter, residents will play a greater role in designing the goals of the project – within the constraints of the program learning goals for the residents.

The learner portfolio should contain the residents' project proposals – including any preliminary asset mapping or needs assessment performed. While carrying out the project, residents should maintain a log of accomplishments and challenges. Included in this log should be lessons learned and applicability to the project as well as future practice. Upon completion of the project, a summary report should be completed. All these reports can be included in the learner portfolio. In addition, any outcomes from the project, such as health education materials developed, or policies changed as a result of the project, should be catalogued for inclusion in the project report and thus the learners' portfolio. These materials may help to assess residents' competence in practice-based learning and improvement and systems-based practice.

Assessment of the residents' performances from faculty and community partners involved in projects can be part of a modified 360-degree evaluation of the resident. A traditional 360-degree evaluation is comprised of anonymous surveys completed by people in staff, colleagues, and supervisors. The people completing the surveys are familiar with a learners' performance over time and are self-selected by the learner. The evaluations are compiled by a facilitator, compared to a learner's self-evaluation, and are used to identify strengths and areas for improvement.

Senior Advocacy Project Proposal Form – The Children’s Hospital of Philadelphia

Description: Please state your broad, long-term objectives and specific aims, making reference to the health relatedness of the project. Describe concisely the project design and methods for achieving these goals. Avoid summaries of past accomplishments and the use of the first person. This description is meant to serve as a succinct and accurate statement of the proposed work and should be freestanding from the application.

Performance site: Please list, in the space provided, the site or sites where the proposed project will take place.

Key personnel: Please list all persons directly involved with the planning and execution of the proposed project.

Project Plan: Please provide a narrative of the proposed project, which should be no more than 5 pages in length. As part of the narrative, please include the following sections:

- a) Specific Aims
- b) Background and Significance
- c) Project Design and Methods (include a brief description of the target population)
- d) Budget Justification (if applicable)
- e) Evaluation Plan
- f) Literature Cited

Learning Community Pediatrics - Specific Methods: Home Visits

Home visits can teach about the patient, family, community and the role of health care professionals. They offer residents an opportunity to experience patients in their own environments while, at times, providing a clinical service. Home visits can be incorporated into continuity clinic programs as well as block rotations. Some programs have set aside an afternoon for each resident to conduct in-home patient care visits. Setting specific expectations with a community-focused physician, nurse, or social worker prior to the visit, choosing a family, and debriefing and reflecting on lessons learned afterward will frame the experience and make it more meaningful than simply going to a home and conducting a patient exam.

Goals and expectations for residents participating in home visits must be clearly stated and discussed with residents prior to participation in the visits. Families who have been previously identified must also be notified of the purpose of the home visit. Residents may be part of a previously arranged home visit – with a social worker, public health nurse, or another clinician visiting the home – or the visit may be specially arranged with the resident as the main provider. Choosing a family before the visit, coordinating resident visits, and pairing providers with educators can be a challenge to orchestrate. Once a system becomes part of the curricular framework, visits tend to run smoothly. For safety and to facilitate reflection, residents should travel with a partner—a fellow resident, an attending physician, a social worker, a nurse, or a community member.

Home visits can be linked to inpatient experiences as well. A home visit by a resident as part of the health care team prior to a patient’s discharge from the hospital can add a tremendous amount of information for discharge planning.

Key For Successful Home Visits

- Define the visit's learning goals and objectives
- Assign a block of time for the visit
- Coordinate point people to accompany the resident and to facilitate reflection
- Select a family or patient to visit
- Prepare the resident and the family for the experience by setting a time and clarifying the visit's goals and objectives
- Debrief after the visit with specific guidelines for discussion

Evaluating Home Visits

Often the home visits focus on patient care as well as interpersonal and communication skills. Competency-based evaluations of residents' performance during home visits can be assessed by direct observation or by using patient surveys. These surveys may assess patient satisfaction, resident's communication skills as well as other specific aspects of the interaction.

The social worker, public health nurse, or other clinician accompanying the resident on the home visit can complete a checklist while directly observing the resident's interaction with the patient, family, and other health professionals. These assessments, accompanied by the residents' self reflection on the home visit and some goals for further learning can be entered in the learner portfolio for assistance in assessing residents' competence in patient care and interpersonal and communication skills as a part of community pediatrics.

Learning Community Pediatrics - Specific Methods: Site Visits

Site visits provide an opportunity to get to know important aspects of the community without the emphasis of service provision. Site visits can be part of an integrated block rotation such as community pediatrics, primary care, behavior and development, adolescent, outpatient ambulatory or as part of a more focused event or mini-rotation. The most appropriate sites often involve organizations that provide key services to the community and in addition, show interest in participating in medical training. Interacting with students and staff at a juvenile center, visiting family court, assisting at an after school program, accompanying therapists for assessments of babies for early intervention can all be valuable learning experiences. Yet busy residents, accustomed to classroom learning as medical students and patient-oriented, problem-based learning as trainees, may find it difficult to engage in community-based learning opportunities. To facilitate these visits, once the sites are chosen, the residents should be provided with a clear understanding of the learning objectives along with background information, specific directions, and contact information.

It is important to clarify the goal and objectives of the training program to the CBO as well as to the residents. The goals of the program must be relevant to both residents and CBOs. Many organizations will welcome physician visits as an opportunity to educate pediatricians about their agency's mission and the services they provide to the community. Others may benefit from sharing expertise such as using pediatricians as consultants for day care or sharing of medical knowledge with school nurses and administrators. School programs may request direct service such as residents providing didactic health lectures to schoolchildren. A partnership based on mutual benefits and strengths is more likely to last.

Key For Successful Site Visits

- Define the goal, objectives and the time for the visit
- Be selective when choosing sites, concentrate upon a few community organizations
- Recruit specific individuals within these organizations to interact with the resident during visits (enthusiastic and knowledgeable about their CBO)
- Cultivate and maintain on-going relationships with these contacts at the CBOs
- Ensure all involved are aware of the goals and expectations for these encounters
- Use on-going feedback from both the residents and the CBO to adjust and improve future experiences

Evaluating Site Visits

During site visits the resident may be an observer, active participant (as a health educator, pediatric consultant, or clinician), or a combination of the two. Clearly stating the goals and objectives of the visit will help structure the resident evaluation.

Several evaluation methodologies for the site visits can be placed in the learners' portfolios for community pediatrics. These include logs of activities, residents' reflections on these activities, as well as evaluations of residents from faculty, community partners, children, and families. A log of community site visits could include the type of agencies visited, the populations served, the services provided, and the resident's role. As part of their logs, residents may include reflections on the experience including items learned as well as applications to future practice. These reflections help residents plan their own learning and assist them in the process of becoming lifelong learners.

Residents may participate in a variety of site visits, interacting with many families and health professionals, thus providing numerous opportunities for feedback to and evaluation of the residents participating. These evaluations can be combined into a modified 360-degree evaluation of residents.

These evaluations, obtained from multiple personnel interacting with residents during site visits, can be used to assess interpersonal and communication skills, professional behaviors, and some aspects of patient care, and systems-based practice. During site visits, residents have contact with multiple people including superiors (faculty), colleagues (public health nurses, social workers, and health educators), peers (fellow residents and medical students), as well as children and families. The same evaluation form, with slight modifications depending on the evaluator, can be used with all of these groups to assess the residents' performance in the eight domains of competence in community pediatrics. Residents should complete a similar survey as a self-evaluation of their performances on various site visits. These evaluations can then be compiled, summarized, and discussed with the resident by a faculty member or designee. Areas of weak performance and areas of discordance among the surveys provide residents with further learning opportunities.

Sample Site Visit Tool

HOOVER HEALTH AND SOCIAL SERVICE CENTER

WHERE:

Hoover High School
4474 El Cajon Blvd.
San Diego, CA 92115

CONTACT PERSON(S):

Site Nurse
Tel:

DIRECTIONS:

1. Take 8 EAST to 805 SOUTH
From UCSD Hillcrest Medical Center
2. Exit El Cajon Blvd
Estimated travel time: 15 –20 minutes
3. Turn LEFT on El Cajon
4. The school will be on your LEFT

SITE DESCRIPTION:

Hoover clinic is an on-campus full service clinic providing medical, dental, and mental health services for the students of Hoover High School.

Note: Please wear your medical ID, check in at school front office. Let them know you are there to work at the Hoover Clinic with Nurse A. Ask office staff for directions to the clinic. Please contact Nurse A for your assigned topic and other logistical information

LEARNING OBJECTIVES:

1. Compare health issues of infants and children treated in clinical settings to their counterparts in the community who do not access traditional health care (from individual client base to population base)
2. Describe and identify the threats to child health when children lack a regular medical home
3. Facilitate the family or child's access to regular continuous care
4. Identify child health issues which that could be influenced by physician advocacy/consulting
5. Describe eligibility criteria for services available for uninsured and/or fiscally needy children/families
6. Recognize barriers to continuous and comprehensive health care
7. Recognize the importance of family-based psychosocial barriers such as substance abuse, violence, psychiatric disorders which may influence child health
8. Understand and identify personal beliefs (social prejudice, opinions, etc.) concerning the populations

THINGS TO CONSIDER:

1. What is the role of a pediatrician in a school setting?
2. How can you communicate more effectively with school staff?
3. What are some advantages and disadvantages of providing health care through school?
4. How can you get more involved with schools for your own patients?
5. What are some of the common health concerns or questions of school staff?

READINGS:

1. Hoover H.S. handout
2. K. Hacker; G.L. Wessel; School-Based Health Centers and School Nurses: Cementing the Collaboration; Journal of School Health, 1998, 68(10), 409-414.

Program Implementation: Faculty Development, Assessment & Structure

Faculty Development

Faculty development is an essential aspect of a community pediatric curriculum. In learning community pediatrics, residents will come in contact with many individuals, each a potential source of learning. By its nature, faculty development for community pediatrics involves a great diversity of teachers, with distinct needs and goals.

As the residents gain experience in community pediatrics and advocacy, the attending faculty will need to update their own knowledge and skills. Consequently faculty development should cover the same material (and more) as the competencies proposed for residents. Providing time for faculty retreats, workshops, and CME in community pediatrics is vital. Using venues already in place such as Grand Rounds, workshops for community and continuity clinic preceptors, poster sessions, and journal clubs is practical and likely to succeed. (See the Child Advocacy Survey from Medical College of Wisconsin in “Child Advocacy” chapter.)

All those interacting with residents are potential teachers and these individuals may benefit from an understanding of the residency experience and a clear sense of the goals of their interaction. The community-based faculty may benefit from information about residency, and discussions on how to assess the learning needs of residents and how to engage them. Some programs hold separate faculty development sessions for community and clinical faculty, each with distinct goals. Community and clinical faculty can also share their experiences and expertise during combined sessions. Recognizing, rewarding, and sharing expertise encourages faculty to continue their community involvement and their roles as teachers.

Resident Feedback

Resident feedback is essential for continued improvement of any training program. While guidelines, expectations, and competencies provide a framework for developing a solid curriculum, resident input helps assure program enhancement, acceptance and ownership. Involvement, not just in the design of curriculum but also in its ongoing assessment and summative evaluation, can be in itself a learning experience for residents, providing expression for their learning needs and unique perspectives. The reflective learning, which is incorporated into the residents’ learner portfolios, can also be included in program evaluations. An example of a reflection and self-assessment tool is included below, depicting questions asked during resident exit interviews following the community pediatrics block rotation.

THE CHILDREN'S HOSPITAL of PHILADELPHIA
COMMUNITY PEDIATRICS AND ADVOCACY PROGRAM

Reflection and Self-Assessment
Exit Interviews: Resident Block Rotations

Resident Name: _____

Conducted By: _____

Conducted On: _____

Before you began this advocacy rotation, what was your level of interest in advocacy?

None

Neutral

Large

General questions to guide free form interview:

- What does advocacy mean to you? Did this impression change as a result of your experiences during the rotation? If so, how?
- What area of advocacy are you concentrating on, and why?
- What were your goals and expectations coming into this rotation?
- Which parts of the past month proved most beneficial in meeting those goals/ expectations? Give some concrete examples/anecdotal evidence.
- Which parts of the past month did not live up to their general description, and why? Give some concrete examples/anecdotal evidence, and suggestions for improvement.
- In general, how effective do you think the past month's training sessions and lectures were in terms of meeting your goals and the broader goals of CPAP? Give concrete examples to ground the responses, and where negative comments are made, give tangible ways to improve.
- Please list the top 3 and bottom 3 sessions in terms of how likely it is that they will assist in your understanding of the advocacy goals and objectives for the CPAP Initiative and in your own careers. (This information will remain confidential, but will be used in the aggregate to improve the quality of presentations.)

In addition, residents may complete surveys assessing the curriculum: relevance, applicability, methodology, and its implementation. This feedback may be reviewed on a regular basis to ensure that continuous improvements are made in the program activities.

Teaching Methods and Coordinated Evaluation Tools

Teaching Methods	Possible Evaluation Methods for Learner Portfolio
Home Visits	<ul style="list-style-type: none"> • Patient/family survey • Direct observation by health professional • Self assessment
Site Visits	<ul style="list-style-type: none"> • Community site visit log • Self reflection • 360 degree evaluations
Service Learning	<ul style="list-style-type: none"> • Self reflection • 360 degree evaluations
Projects	<ul style="list-style-type: none"> • Asset mapping/needs assessment • Project proposal • Project summary report • Faculty and community partner evaluations • Project outcomes • 360 degree evaluations
Case Based Learning	<ul style="list-style-type: none"> • Pre/Post tests • Continuity clinic community resource log
Clinical Teaching	<ul style="list-style-type: none"> • OSCE's • SP's

Block or Longitudinal?

Depending on the structure of each pediatric residency program, community pediatrics can either be taught in a concentrated block rotation or longitudinally. Both are feasible and effective methods to teach residents about community pediatrics; a combination of both can also be applied.

Block Rotation

During a typical 4-week block rotation, residents may experience a concentrated curriculum of didactic sessions coupled with community visits, and often a community-based project. The sessions covered during this time frame can vary from social, economic, and cultural barriers to healthcare and extend to general topics such as cultural competency. Below are two sample schedules that highlight block experiences. The first represents a five-day workshop in legislative advocacy considered for implementation at the Children's Hospital of Philadelphia. The second is a sample week from a mandatory block rotation in community pediatrics for second year pediatric residents at the Medical College of Wisconsin.

**Block Experiences — Sample Advocacy Week,
The Children’s Hospital of Philadelphia**

Monday	Tuesday	Wednesday	Thursday	Friday
Lecture: What is a bill? How it is passed? How to use CapWiz (AAP)	Workshop session: Draft issues and questions	Skill: Write a fact sheet	Skill: Role play opposing sides of same issue	Skill: Write follow up and Thank You letters
Lecture: How is medical care paid for? How is GME paid for?	Skill: Contact legislators for appointments	Skill Workshop: How to give testimony	Skill: Meet with legislators	Debriefing including discussion and plans for next steps

Sample Week from Block Rotation, Medical College of Wisconsin

Monday 5	Tuesday 6	Wednesday 7	Thursday 8	Friday 9
	8:30 - 9 a.m. Discussion with MDEP Coordinator	8:30 - 9 a.m. Discussion with MDEP Coordinator	8:30 - 11:30 a.m. Milwaukee County Children’s Court with Lindsey Draper	10 - 11:45 a.m. Experience-Based Discussion Process
	9-11:30 a.m. WIC (Women, Infants, Children) Program with WIC Coordinator	9 - 10:30 a.m. Evaluation and Assessment Tools with Evaluator	Place: 10201 W. Watertown Plank Road	Place: MCW, H3050
	Place: Wee Care WIC	10:45 - 11:45 a.m. Advocacy Basics, Family Support Model, and Working with CBOs with Program Staff		
		Place: MCW		
1 - 4 p.m. Introduction to MDEP Program Director. Intro to Milwaukee and Reflective Practice Model with Program Staff	1 - 4 p.m. Community Experience Projects	1 - 4 p.m. Community Experience Projects	1 - 4 p.m. Community Experience Projects	1 - 4 p.m. Community Experience Projects
Place: MCW	12:00 - 1:00pm Meeting 1:15 - 2:45			
	Car Tour of Milwaukee with Program Manager			

Longitudinal

Many programs incorporate their community pediatrics curriculum into all three years of pediatric training. The longitudinal design of Continuity Clinic makes it an opportunity for teaching and using advocacy tools. Noon conferences, teaching rounds, morning report, workshops and Grand Rounds are all didactic forums for teaching that offer ongoing exposure. Some programs have implemented book groups or evening rounds to meet and discuss some aspects of Community Pediatrics such as cultural competency, advocacy journal club and professionalism. Over the course of training, residents are exposed to topics in community pediatrics over all three years and may participate in community projects or service learning over a longer period of time than is allotted during a block rotation. Protecting time for the learners for this endeavor can be a challenge in a busy service program.

Sample List of Conferences, University of Florida, Jacksonville

Date	Noon Conference Topic	Noon Conference Title
6-Jul-04	Intro to Community Pediatrics	Introduction of Staff
13-Jul-04		Introduction to Community Pediatrics
20-Jul-04		Community Action Initiatives (CAI)
27-Jul-04		Forum on Introduction of Community Pediatrics
3-Aug-04	COPC	Community Oriented Primary Care (COPC) The Model
10-Aug-04		Define and Characterize the Community
17-Aug-04		Involve the Community/Pediatrician as a Leader and Partner
24-Aug-04		Develop and Intervention
31-Aug-04		Forum on COPC/Research and Scholarship
7-Sep-04	Research and Scholarship	The Basic Elements of the Research Process
14-Sep-04		Creating a Research Agenda for a Specific Health Issue
21-Sep-04		Research: Reports from the Field
28-Sep-04		Forum on COPC/Research and Scholarship
5-Oct-04	Culturally Effective Care	
12-Oct-04		The Realm of Culturally Effective Care
19-Oct-04		Resources for Characteristics of Ethnic/Religious Groups
26-Oct-04		Forum on Culturally Effective Care
2-Nov-04	Child Advocacy	Pediatrics: A Profession Born of Advocacy
9-Nov-04		Advocacy Tools for the Busy Pediatrician
16-Nov-04		Applying Advocacy to Pediatric Practice in the Real World
23-Nov-04		Legislative Advocacy: Critical Issues Impacting Florida's Children
30-Nov-04		Pediatricians Take Action: The Role of Jacksonville Pediatric Advocacy Network, Florida Pediatric Advocacy Network, and the American Academy of Pediatrics
7-Dec-04	Community and Public Health	Overview of Pediatric Environmental Medicine
14-Dec-04		Environmental History Taking in Pediatric Practice
21-Dec-04	Open/holiday	
28-Dec-04	Open/holiday	
4-Jan-05	Miscellaneous	CAI update
11-Jan-05	UN Convention on the Rights of the Child	Children's Needs and Rights/ Highlights of the UN Convention
18-Jan-05		Respecting Children's Rights in Pediatric Practice
25-Jan-05		Health Policy and Health Services

Sample List of Conferences Continued

Date	Noon Conference Topic	Noon Conference Title
1-Feb-05		The Health Professional as Advocate
8-Feb-05	Medical Home/Special Populations	Medical Home: Concept and Implementation Issues
15-Feb-05		Caring for Children in General and Medical Foster Care
22-Feb-05		Special Needs of Homeless Children and Adolescents
1-Mar-05		Special Needs of Immigrant and Adopted Children and Adolescents
8-Mar-05	Miscellaneous	CAI update
15-Mar-05	Environmental Health	Dec. 7th lecture
22-Mar-05	Environmental Health	
29-Mar-05	Miscellaneous	Legal Aid-- Rebecca Feyerik
5-Apr-05	Mental Health	Dr. Goodfriend (PTSD in Children)
12-Apr-05	Education and Child Care Settings	Early Childhood Brain Development and the Role of Child Care
19-Apr-05		The A, B, C's of IEPs, IFSP, ADA. . .
26-Apr-05		Multidisciplinary Panel on Child Care and Education
3-May-05	Mental Health	Dr. Goodfriend
10-May-05	International Health	International Health: The Epidemiological Comparison
7-Jun-05	COPC - Advanced Training	CAIs Presented - Applying the COPC Model
14-Jun-05		CAIs Presented - Applying the COPC Model
21-Jun-05		CAIs Presented - Applying the COPC Model
28-Jun-05		CAIs Presented - Applying the COPC Model

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Useful Websites

Accreditation Council for Graduate Medical Education (ACGME)

The ACGME website contains a section on the six core competencies for residency training entitled Competencies and Outcomes Assessment. The Toolbox of Assessment Methods is located here.

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

The Anne E. Dyson Community Pediatrics Training Initiative

The Competency in Community Pediatrics document is located on the Dyson website. In addition selected teaching and evaluation resources from the residency programs participating in the Dyson Initiative are linked to this website.

<http://www.dysoninitiative.org>

Association of Pediatric Program Directors (APPD)

The APPD website contains a section on Resources for Competency Evaluation. This section will be updated as the ACGME competencies are integrated into residency training.

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

Pediatrics in Practice

Pediatrics in Practice is a faculty development website to assist teaching of the seven Bright Futures core concepts. The PDF Library section of the website contains sample self assessment, patient and family survey, and preceptor structured observation forms.

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

2

Delivery of Culturally Effective Care

Cultural competence can be defined as the ability to recognize and appropriately respond to cultural issues that affect the care of your patients.¹ As in other competencies in health care, cultural competency consists of a combination of knowledge (such as familiarity with potentially harmful folk or ethnomedical remedies) and skills which in turn affect behavior (such as how to optimally work with a medical interpreter).

The relevance of cultural competence to healthcare and pediatrics

There are three main reasons that cultural competency is relevant to healthcare and pediatrics: 1) the growing diversity of our nation; 2) the persistence or worsening of racial and ethnic disparities in the U.S. for a wide variety of health issues; and, 3) failure to recognize and appropriately respond to cultural issues in health care that can adversely affect quality of care, outcomes, patient satisfaction, and costs.

The United States is experiencing explosive growth in the diversity of its population. By 2030, there will be more racial/ethnic minority children than non-Latino white children 0-18 years old, and for children 0-5 years old, minorities will outnumber non-Latino whites by 1.1 million.² In 2000, Latinos surpassed non-Latino whites as California's largest racial/ethnic group.³ There are 47 million people in the U.S. who speak a language other than English at home, and more than 21 million who are limited in English proficiency.⁴ Providing optimal care to this increasingly diverse population of children and their families will require solid cultural competency training.

Disparities in health care

Recent reports by the Institute of Medicine (IOM)⁵ and the Agency for Healthcare Research and Quality⁶ called national attention to the multiple racial/ethnic disparities that exist in healthcare. The IOM report, for example, concluded that racial and ethnic minorities in the United States receive lower quality healthcare than whites, even after adjustment for access-related factors such as insurance coverage and income. Dramatic racial/ethnic disparities in the healthcare of children persist, including substantially higher rates of infant mortality among African-Americans, higher rates of obesity among Latino and African-American children, a lower likelihood of receiving effective asthma medications among

minority children, higher rates of performing skeletal surveys and filing Child Protective Services reports among injured minority children, and lower doses of analgesics for minority children with serious long-bone fractures. Experts agree that training a more culturally-competent pediatric workforce is a critical step in the elimination of these racial/ethnic disparities.

Research also documents a wide range of adverse effects that limited English proficiency can have on health and use of health services including impaired health status, a lower likelihood of having a usual source of medical care, lower rates of preventive services, non-adherence to using medications, a greater likelihood of a diagnosis of more severe psychopathology and of leaving the hospital against medical advice among psychiatric patients, a lower likelihood of being given a follow-up appointment after an emergency department visit, an increased risk of intubation among children with asthma, an increased risk of drug complications, longer medical visits, higher resource utilization for diagnostic testing, lower patient satisfaction, and impaired patient understanding of diagnoses, medications, and follow-up.

In addition, research has shown that failure to appreciate the role of culture in pediatric care can result in a variety of adverse consequences including difficulties with informed consent, miscommunication, inadequate understanding of diagnoses and treatment plans by families, dissatisfaction with care, preventable morbidity and mortality, unnecessary child abuse evaluations, and disparities in prescriptions, analgesia, and diagnostic evaluations.¹ This growing body of literature thus indicates the impact culturally-competent pediatric care can have on the quality of care, outcomes, patient satisfaction, and costs.

– *Glenn Flores, MD*

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Teaching Residents About Culturally Effective Care

To practice culturally effective care pediatricians must acknowledge the importance and role of culture in health promotion and illness. Effective, non-judgmental communication is at the core of culturally effective care. Acknowledging their own cultural stand, pediatricians must elicit the patient's true system of care, who they consult for health issues, their vision of health and illness, and the impact of illness on the family and community. As clinical practice presents ever new challenges, pediatricians should reflect and learn best practices from patient encounters, other health professionals, and information resources (journals, websites, books, etc.). The effective and ethically appropriate use of interpreters, and the skills in accessing resources useful in delivering culturally effective care are important in delivering culturally effective care.

Following are a variety of curricula elements and tools used by pediatric residency programs to meet competency in the delivery of culturally effective care.

1. **Cultural Immersion Days and Film/Theater experiences.** *The University of California (UCSD) and the Naval medical Center (NMCS), San Diego*
2. **Rapid Assessment Process.** *University of Rochester*
3. **Using Interpreters.** *The Children's Hospital of Philadelphia*
4. **Community Walking Tours.** *Columbia University*



Cultural Immersion Days and/or Film and Theatre Experience

TRAINING RESIDENTS TO DELIVER CULTURALLY EFFECTIVE CARE

*Examples of curricula and tools from The University of California, San Diego (UCSD) and the Naval Medical Center, San Diego (NMCS) Dean Sidelinger, MD, MEd
Gregory Blaschke, MD, MPH, & Vivian Reznik, MD*

Goal:

To have residents focus on understanding core cultural issues, a patient's social context, differing cultural meanings of illness and wellness, and negotiating cultural divides.

Method:

At UCSD and NMCS, part of the community pediatrics curriculum uses field experiences to expose residents to different cultures. The curriculum uses these field experiences and subsequent reflection to help residents understand other cultures and discover their own cultural biases. Two unique methods used by UCSD and NMCS are the Cultural Immersion Days and a Film and Theater Series. See the following tool description.

Additional Culturally Effective Care Teaching Activities:

Throughout residency, pediatric residents have the opportunity to participate in other activities related to delivering culturally effective care, including:

- Completing a Self Assessment Tool
- Completing a Beliefs Worksheet
- Case-based discussions
- Analysis of videotaped bilingual interviews
- Readings
- Site/home visits

Learning Outcomes:

- Residents learn the importance of cultural differences and how these affect the clinical encounter.
- Residents understand their own cultural biases and how their attitudes shape their relationship with patients.
- The resident will become proficient in asking open-ended questions and avoid stereotyping.
- The resident learns to be respectful of the patients' ethnic backgrounds and cultural beliefs.
- The resident becomes competent in using appropriate resources including medical interpreters as well as culturally responsive patient educational materials and community-based services.

Contact

For more information on activities relating to culturally effective care for pediatric residents at The University of California, San Diego (UCSD) and the Naval Medical Center, San Diego (NMCS), please contact:

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Cultural Immersion Days

The University of California, San Diego (UCSD) and the Naval Medical Center, San Diego (NMCS D)

Occurring once every three months, a cultural immersion day consists of a 4-hour visit to a discrete cultural community. A group of 35-40 people (about 20 of them residents) leaves the medical center at lunchtime via a chartered bus and returns in early evening so the residents can take call. The activities start on the bus, where the group is told about the origins, demographics, and history of the featured community. Once the group arrives at their destination, they sample local food and music, meet and interact with representatives of the community, and discuss cultural beliefs, practices, and issues of community importance.

At these events, community members are the teachers, sharing their history, knowledge, and experience. Cultural Immersion Days are an opportunity to learn directly from members of a culture about:

- Their cultural beliefs and practices
- The issues they face and how they deal with them
- Their impressions of doctors and the health care system

Interns are required to attend these events. To ensure their presence, chief residents select the dates for these activities at the beginning of the year, avoiding holiday seasons and varying the day of the week.

A faculty member who has a relationship with the targeted community organizes the event in partnership with community members, one or more residents, and a staff member. Planning starts 2 to 3 months before the event and requires approximately four meetings between faculty and community members and 8 to 10 hours of staff time. The cost ranges between \$650 and \$1800 per event. A less expensive version could consist of a potluck dinner at a faculty or community member's home, then a presentation by community members and a follow-up discussion.

UCSD and NMCS D report that the most successful events were those that included residents in the planning process. When residents are actively involved, they convey the importance of these issues to their peers. Their enthusiasm is contagious. Another determining factor is to plan adequate time for the residents to ask questions during and after presentations.

Cultural Immersion Days have focused on the following topics: Filipino culture, African refugees and Latinos, migrant health, the military community, the Hmong community, homeless youth, the Arab world, and border health issues.

The Cultural Film and Theater Series

The University of California, San Diego (UCSD) and the Naval Medical Center, San Diego (NMCS D)

Residents are invited to attend a movie series with faculty and community members. Each of the featured films depicts important aspects of a specific culture as well as some of the issues it faces. These events occur about once every three months. They begin with dinner, usually at a faculty member's home; then the movie is followed by a facilitated discussion. Twelve to 15 individuals attend these sessions, about half being residents and the rest faculty or community members.

To increase attendance, chief residents help planners choose dates when residents are most available. The movie series is supported by a grant from the UCSD Civic Collaborative to use culture, as portrayed in theater and cinema, to enhance the residents' cultural awareness.

Movies	Discussion Leader
And the Earth Did Not Swallow Him	The Movie's Producer
Bend it Like Beckham	A Local Indian Pediatrician
El Norte	A Mexican- American Social Worker
Good Fences	An African-American Faculty Member
Monsoon Wedding	Two Indian Pediatric Fellows
The Gods Must be Crazy	A Psychologist From Kenya
The Scent of Green Papaya	A Nurse Who Flew Saigon

An Example of learning about culture by going to the Theater

Eighty pediatricians and family practitioners, faculty and trainees gathered at the San Diego Repertory Theatre to listen, laugh, and engage with the three artists of Culture Clash, an award-winning Latino comedy troupe.

“Our goal was to stimulate our physicians to think about how culture has impacted attitudes, behaviors, and ultimately their interactions with patients and families”, says Vivian Reznik, Co- Principal Investigator of the Dyson Initiative. “The play was followed by a forum with the cast. The evening proved to be a fun and interesting way to provide our faculty and trainees with an opportunity for reflection on racism, sexism and nationalism”.

(abstracted from The Dyson Initiative News, San Diego)



Addressing Culturally Effective Care: The Use of Interpreters

TRAINING RESIDENTS TO DELIVER CULTURALLY EFFECTIVE CARE

Examples of Curricula from The Children's Hospital of Philadelphia

Goal:

To help residents appreciate the nuances of using interpreters, the implications of language barriers in delivering health care and to provide residents with the necessary skills to effectively use interpreter services.

Method:

At CHOP, each resident participates in a three-hour workshop which introduces the issue of non-English-speaking families. They explore barriers to communication in the hospital and the office by discussing signage, available interpreter services and their own biases. A video depicting an English-speaking provider and a non-English speaking patient is reviewed. There is discussion about the use of various interpreters (trained professionals, office staff and family members). The residents gain hands-on experience in using the interpreter phone line while role-playing a prepared case.

Additional Culturally effective care teaching activities:

- Workshops on cultural differences and how they affect care
- Book group using cultural issues in literature to explore cultural issues in the clinical setting
- Neighborhood tours

Learning Outcomes:

Residents learn how language barriers can affect many aspects of health care and how to use various services to overcome these barriers.

Contact:

For more information relating to culturally effective care at the Children's Hospital of Philadelphia, please contact:

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Rapid Assessment Process

TRAINING RESIDENTS TO DELIVER CULTURALLY EFFECTIVE CARE

Examples of curricula and tools from the University of Rochester

Abstracted from The Leadership in Community Pediatrics: A Field Guide for Physicians.

Andrew Aligne, MD, MPH

Goal:

To help residents identify health priorities for the community by interviewing key community experts.

Method:

At the University of Rochester pediatric residents engage with individuals from the community and help to promote social change by borrowing methods used in anthropology and qualitative research. One of these methods is the Rapid Assessment Process (RAP) (an expedited version of Rapid Ethnographic Assessment), a process that helps residents absorb useful principles of inquiry and action at the community level and gather diverse input of the community's experiences by interviewing key community leaders. The RAP includes the community members as active participants who contribute in the areas of cultural differences at the community level, community health priorities, community strengths and weaknesses, as well as gaps in services.

Each resident is trained in RAP techniques early in the first year of their training through didactic lectures and small group seminars. The resident completes a RAP as part of their planning for their residency training community project. Residents are exposed to RAP techniques "hands-on" during the two-week block rotation and then, depending on their interests, use these techniques over the next two years in their longitudinal projects.

Additional Culturally Effective Care Teaching Activities:

Throughout residency at the University of Rochester, pediatric residents have the opportunity to participate in other activities related to delivering culturally effective care, including:

- Completing a self assessment tool
- Case-based discussions
- Analysis of videotaped bilingual interviews
- Readings
- Site/home visits

Learning Outcomes:

- Residents learn about community needs and assets from the point of view of community members or organizations.
- Residents learn to elicit key information, listen, and observe attentively.
- Residents develop a knowledge base of culturally appropriate resources and services useful to offer their patients.

Contact:

For more information on activities relating to culturally effective care activities for pediatric residents at the University of Rochester, please contact:

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PLC/CAKE

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Community Assets/Needs Assessment — RAP

Field Methods From Anthropology: Rapid Assessment Procedures (RAP)

by Nancy P. Chin & Julius Goepf

Traditionally, anthropologists carry out investigations of a community's culture and society over a period of one to two years by living in the study community. This results in a detailed description and analysis of many different levels of community beliefs and activities known as an ethnography. Unfortunately, health planners and development workers found ethnographies too long-winded and too littered with esoteric details to be useful in program planning. They also needed relevant data with a turn around time in weeks rather than months. Thus, Rapid Assessment Procedures or RAP grew out of a need for health planners to better incorporate local-level social and cultural data into programs, interventions, and evaluations in a timely way.

In Community Pediatrics RAP serves multiple purposes:

- A way to engage the community and build rapport
- An approach to collecting social and cultural data around a health issue
- A model for and a model of social change

Like traditional ethnography, RAP uses a holistic perspective. That is, the investigation assumes that many seemingly disparate social domains, such as religion, economics, politics, education and kinship are in fact related to one another and mutually influential.

“The community is the expert of its own experiences.”

RAP has five key components:

1. Community centered
2. Mixed team composition
3. Iterative process
4. Variety of data collection tools
5. Focused topic

Community-Centered Approach

Having the community participate in identifying their needs and posing solutions to their problems is key to success. Data is collected, not at a medical center or a clinic, but by going out into neighborhoods and talking to people on their own territory. This requires a sincere interest in what community members are doing and how they are accomplishing their self-defined goals. Consider what the community thinks is important. How is this different from the investigators' goals?

Mix Team Composition

In order to access the opinions, views and practices of a wide variety of community members, you need a wide variety of data collectors. RAP teams typically consist of 3 to 5 people. Try to get both men and women on the team. Diversify as much as possible along lines of race, ethnicity, discipline, and other social variables as needed. If doing a RAP on education, for example, you may want to recruit a teacher to your RAP team.

Iterative Process

In order to fully take advantage of the mixed team composition, the team needs to meet daily to debrief and review the results of the day's data collection. This allows for data verification and the identification of gaps, inconsistencies and contradictions leading to either their resolution or their explanation.

Variety of Data Collection Tools

In-depth Ethnographic Interviewing – Open-ended conversations in which the respondent controls the content and direction of the interview. These typically last anywhere from 30 to 90 minutes. A prepared interview guide will outline the major questions, but the core of the interview is in the follow-up probing questions. Probes help you:

- Become familiar with people's everyday actions
- Link people's actions with their ideas about the way the world works
- Uncover the meanings people attribute to actions and ideas
- Understand the emotions that people attach to these actions and ideas



What to Observe

Describe before you interpret or evaluate. What is the setting like? Characteristics of the participants: dress, age and relationships to one another. What do they see themselves as doing? NOT what is it that YOU see them doing. Ask. Who interacts with whom? Who is excluded? Who is the leader? Observe what does not happen!

Focus Groups – Group interviews of people who share a similar attribute. Conversation ideally takes place between the participants, rather than between the participants and the researcher. Take advantage of “naturally occurring” focus groups where people customarily gather, like the laundromat, the village well, the corner store or a neighborhood playground.

Participant-Observation – Observations made while accompanying people on their daily, ordinary routines as they go to work, the market, doctors' appointments, religious services, etc. This affords you the opportunity to ask questions about the inevitable gap between what people say they do (their ideals) and what actually takes place in on-the-ground action (what is possible).

Walking Tours – Walks around the neighborhood noting community assets and features of the community that will either support or deter healthy child development.

Social Mapping – Ask community members to draw a map of their neighborhood and locate important points on it. How do maps differ from one another? Compare and contrast to the official city map.

Children's Drawings – Bring crayons and paper with you. Ask children to draw pictures on the topic you are investigating. This is an idea taken from the work of child psychiatrist Robert Cole.

Focused Topic

Learn how cultures and societies operate in a specific realm. Examples include: child abuse reporting; emergency medical care; family planning; and experiences in a home visiting program for new mothers.

RAP Do's

Be non-judgmental.

Be a listener and a learner.

Critically self-reflect on your own

RAP Don'ts

Don't argue with informants.

Don't teach or lecture.

Don't break confidentiality.

Sampling Strategies

The goal in RAP sampling is not to determine the prevalence of a trait in a population (that is done by survey methodology), but to capture a wide range of experiences and ideas by talking to information-rich resources. Respect the internal diversity of the community by seeking out a range of community members whose experiences may differ. Gender always matters, but also consider religion, education level, and age. A typical RAP will bring you in contact with about 20 to 30 people.

Data Analysis

Look for themes, recurring ideas, concepts and terms. See if they link together in any particular pattern. Demographic characteristics of respondents can be placed in a table and compared with themes. Respondent verification or a "members' check" whereby you feed your data and interpretations back to the community to see if they agree, is the primary way of ensuring internal validity of the data (that is, are the data true?). External validity of the data is not an issue; the whole idea is to understand local expressions. Your findings are not intended to be generalizable to the entire population.

Returning From the Field: Re-entry Adjustments

Even though you might just be going to another part of town for a few days, coming back to your regular routine may require some adjustment. The RAP might highlight the essentially arbitrary nature of most routines and customs. This may make you impatient in your old settings. Or cranky. Or you may feel the need to institute changes. Rapidly touch base with your RAP team members frequently to discuss these challenges.

Community Walking Tour

TRAINING RESIDENTS TO DELIVER CULTURALLY EFFECTIVE CARE

Examples of curricula and tools from Columbia University

Dodi Meyer, MD & Patricia Hametz, MD



Goals:

To teach residents the impact of a patient's culture and environment on his/her health, and to teach residents how to use this understanding to deliver culturally effective care.

Method:

Culturally effective care is an integral part of training at Columbia University. As one of their three major focus areas—community health, cultural competency and advocacy- pediatric residents participate in a variety of activities around this topic with the goal to (1) understand how beliefs, culture and ethnic practice can influence health status and care for children in the community (2) demonstrate an ability to form meaningful relationships with patients from a variety of socio-cultural backgrounds (3) recognize and manage how cultural attributes and biases can affect a clinical encounter and (4) develop skills to communicate and elicit information from the patient and family about their health belief system and socio-cultural background. Concepts of culturally effective care are introduced to interns during their first week in the program during the Community Walking Tour.

Pediatricians and community partners guide a tour of the Washington Heights community, giving incoming interns an opportunity to see the neighborhood first hand. The goals of this activity are (1) to introduce residents to the local community; (2) have residents understand that the physical and cultural environment is relevant to a patient's health and well-being; and (3) to introduce residents to community asset mapping. The group visits four sites: Best Beginnings, a community-based early childhood support program intended to prevent child abuse and neglect; a community agency-based day care center; an elementary school with a Health Partnership Program with the Hospital; and a Botanica. All residents are provided with a packet including a neighborhood map, child health data profile for the community, a resource manual of community agencies and services, literature about Community Asset Mapping, and a brief description of the programs visited.

Additional Culturally Effective Care Teaching Activities:

Throughout residency at Columbia University, pediatric residents participate in other activities related to delivering culturally effective care, including:

- Home visits
- Narrative lunches (discussions with community workers of book chapter related to issues or illness and culture; books read include Anne Fadiman's *The Spirit Catches You and You Fall Down* and Lucy Grealy's *Autobiography of a Face*)
- Workshops about the role of culture in the clinical encounter
- Training on using interpreter services
- Didactic sessions

Learning Outcomes:

- Residents are familiar with community in which their patients live
- Residents become engaged by the assets and needs of the community
- Residents are able to recognize and manage any cultural issues that may affect a clinical encounter
- Residents learn how to effectively communicate with children and families
- Residents are able to demonstrate sensitivity towards a diverse patient population
- Residents become familiar with differences in health status among different populations

Contact:

For more information on activities relating to culturally effective care at Columbia University, please contact:

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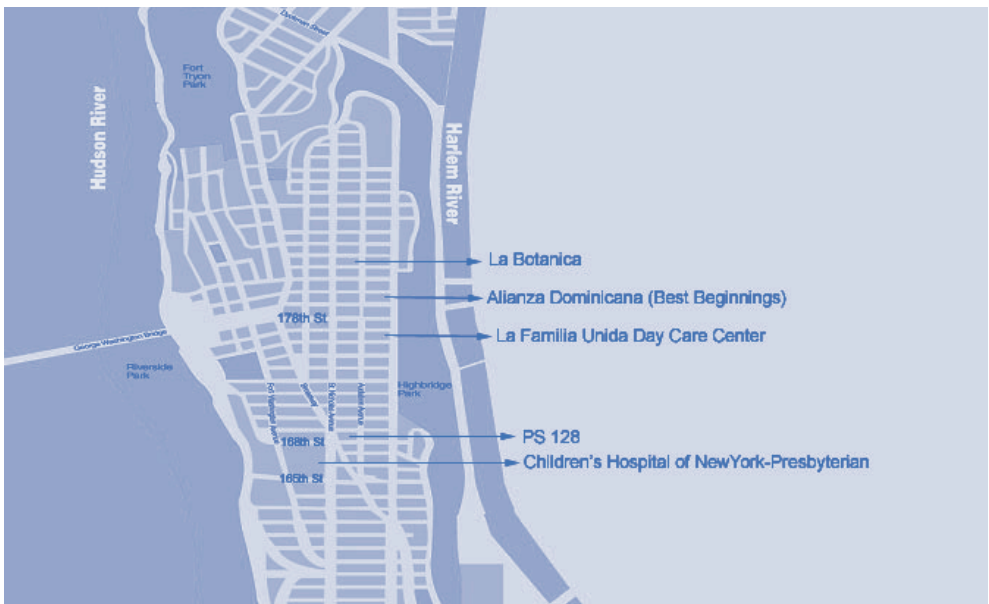
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www.communityped.org

Community Walking Tour

Dodi Meyer, MD & Patricia Hametz, MD Columbia University

Walking Tour Schedule — Friday, June 18th, 2004		
9:00 – 9:45am	Completion of National & Local Evaluation Instruments	Hoyt Conf. Room BHN 1-121
9:45 – 10:00am	“Introduction to Community Pediatrics” Speaker: Dodi Meyer, MD Director, Community Pediatrics Program	Hoyt Conf. Room BHN 1-121
10:15 – 10:45am	Site Visit to: P.S. 128	560 W. 169th St. New York, NY 10032
11:00 – 11:20am	Site Visit to: La Familia Unida Day Care Center of Alianza Dominicana, Inc.	Alianza Dominicana 176th St. & Amsterdam Ave.
11:30 – 11:50am	Site Visit to: La Botanica	182nd St. & Audubon Ave.
12:00 – 12:20pm	Site Visit to: Best Beginnings	Alianza Dominicana 2410 Amsterdam Ave. 3rd Floor
12:30 – 1:30pm	Lunch	Alianza Dominicana 2410 Amsterdam Ave. 3rd Floor
1:30pm	Return to Hospital	



**Asset-Based Walking Tour
Post Tour Evaluation**

Please write six to eight adjectives to describe the
Washington Heights and Inwood community.

Resources

Web Sites

Agency for Health Care Policy and Research

<http://www.ahcpr.gov/clinic>

CLAS — The Culturally and Linguistically Appropriate Services
Early Childhood Research Institute

<http://www.clas.uiuc.edu>

Diversity RX

<http://www.diversityrx.org>

American Medical Association Cultural competence Initiative

<http://www.amaassn.org/ama/pub/category/2661.html>

Community Toolbox

<http://ctb.ku.edu/>

CulturedMed.

<http://www.sunyit.edu/library/html/culturedmed/index.html>

Ethnic medicine information from Harborview Medical Center

<http://ethnomed.org/>

Holistic Kids. Pediatric Integrative Medicine Education Project

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

National Center for Complementary and Alternative Medicine

<http://altmed.od.nih.gov/>

M.D. Anderson Cancer Center's/Complementary Integrative Medicine

<http://www.mdanderson.org/departments/cimer/>

Resources in Cultural Competence Education for Health Care. 2003

www.calendow.org

Simulation Training Systems. 2001

<http://www.simulationtrainingsystems.com/schools/bafa.html>

The Cross Cultural Health Program

<http://www.xculture.org>

Videos

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Kraut AM. Healers and strangers. Immigrant attitudes toward the physician in America—a relationship in historical perspective. *JAMA* 1990;263(13):1807-11.

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Pachter LM. Culture and clinical care. Folk illness beliefs and behaviors and their implications for health care delivery. *JAMA* 1994;271(9):690-4.

Pachter LM, Bernstein B, Osorio A. Clinical implications of a folk illness: empacho in mainland Puerto Ricans. *Medical Anthropology* 1992;13(4):285-99.

Peterson ED, Shaw LK, DeLong ER, Pryor DB, Califf RM, Mark DB. Racial variation in the use of coronary-revascularization procedures. Are the differences real? Do they matter?[see comment]. *New England Journal of Medicine* 1997;336(7):480-6.

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3

Child Advocacy

Advocacy is many things. It is speaking out, speaking up, speaking for. In its simplest and most profound form, advocacy is giving voice to the questions, “What is wrong here? Couldn’t we do better?” Advocates witness and bring to light abuses and inequities, unfair practices and dangerous conditions. Advocates take unpopular positions by questioning the status quo. They ask, “Why?” when others assert, “We have always done it this way.” Some advocacy involves taking serious risks, caring enough about a cause to question authority and even to court personal repercussion. But other advocacy work is quiet, reformative, and constructive. Advocates who don’t simply wag their fingers and cry foul but figure out new ways of addressing serious problems can make a significant difference.

The relevance of child advocacy for pediatrics

Today many of the issues affecting the health of children and families are complex; they involve a multitude of biological, social, psychological and environmental factors. Many of these problems cannot be addressed by simply prescribing a medication. To improve health, the pediatrician must be able to identify needs and facilitate access to resources for patients, families and communities. Advocacy is one way to mediate this process. Despite vast expenditures on health care, eight million children do not have health insurance coverage,¹ children and youth who need to see a mental health professional are limited in the visits they can receive² and adequate dental care is unavailable to most poor children.³ Thirteen percent of the children in the United States have a chronic illness or disability and their parents report that they cannot get the help they need for their children’s care.⁴ Several serious health conditions are on the rise including autism, ADHD, asthma, obesity, diabetes, and serious mental health conditions.⁵

At least part of the increase in these problems is attributed to lifestyle and community concerns. Ill health is unequally distributed among children in the United States. Black children have low birth weight and infant mortality rates twice that of whites; they are two to three times as likely to die from various childhood health concerns as their white peers.⁵ Health care services are vastly different for non-English speaking families than from those delivered to native English speakers.^{6,7} All of these facts raise the stakes for children and families in the United States and lead to a need for advocacy by pediatricians.

Ways to advocate for patients and families

There are very concrete ways that pediatricians can advocate. Child health advocacy can be conceived of as having four subtypes: clinical advocacy, group advocacy, legislative advocacy, and professional advocacy. Pediatricians can involve themselves in some or all of these activities.

Clinical advocacy targets activities to improve day-to-day care for children and families in the practice setting. The practitioner works to assure that the voice of each child and each family is heard during the process of delivering care. The clinician works to understand the context and culture that the child and family live in and to mobilize community-based resources to assure the optimum growth and development of the child according to the hopes and aspirations of the family.

Group advocacy is the creative response to encountering a similar problem or set of circumstances over and over again. The practitioner identifies an issue affecting a population and makes plans to address it. By designing a teen-tot model for adolescent parents or a foster care clinic or a NICU follow-up program, child health clinicians concentrate resources and expertise and are able to explore and address the causes for and the solutions to problems at hand.

Public policy and legislative advocacy bring systems-level problems into public view for response and legislative action. Speaking up about what they have seen, pediatricians can add authority and hard data to the arguments for increased local, state, and federal services and for funding for children. This advocacy can be in the health realm, but can also be equally important in other arenas such as housing, education, daycare, and welfare policy.

Professional advocacy ensures that nothing is getting in the way of child health care providers carrying out their work in the most effective way. Such advocacy helps pediatricians receive adequate training, supports, funding, and recognition for their work assuring optimal health and developmental outcomes for children and families.

No one can do it alone

One view of the advocate is a loner, a Joan of Arc marching out ahead of the crowd, forging a new path. That may have worked in 15th century France, but fighting barehanded and solo does not win the day in the 21st century. Child health advocacy is best practiced by the careful crafting of alliances among between clinicians, families, community-based organizations, public officials, and, if possible, the business community.

To be an effective modern advocate involves as much listening as speaking, following as leading, waiting as doing. Successful advocacy outcomes take patience and perseverance as well as collaboration and humility. Once the families and communities have been heard and the sharing has occurred and the planning has been done, the effect of the combined effort of many is stronger and more powerful and guarantees a much higher likelihood of success than any individual effort alone.

Judith Palfrey, MD

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7. **Flores G, Rabke-Verani J, Pine W, Sabharwal A.** The importance of cultural and linguistic issues in the emergency care of children. *Pediatr Emerg Care 2002;18(4):271-84.*

Teaching Residents About Child Advocacy

Pediatricians are trained to advocate for children and their families in the clinical setting. However, pediatricians should also advocate for children's health and well-being beyond the individual patient's clinical circumstance and understand the role they can play in addressing community and population health concerns. They must develop the advocacy skills necessary to inform the legislative process at all levels -local, state and federal - in support of system change and the well being of children and families.

Following are a variety of tools used by residency programs to meet pediatric competency in child advocacy:

- Letter Writing Campaign and Advocacy Journal Club - *The Children's Hospital of Philadelphia*
- Child Advocacy Survey - *Medical College of Wisconsin*
- Child Advocacy Library - *University of Rochester*
- Key Steps in Doing Effective Advocacy - *American Academy of Pediatrics*
- Five Critical Steps for Successful Advocacy - *Nancy Amidei*



Letter Writing Campaign and Advocacy Journal Club

TEACHING RESIDENTS ABOUT CHILD ADVOCACY

Curricula and Tools from The Children's Hospital of Philadelphia (CHOP)

Beth Rezet, MD & Cara Vivarelli-O'Neill, MPH

Goal:

To increase resident's knowledge of the legislative advocacy process and raise their comfort level in taking a pro-active role in the process.

Method:

At The Children's Hospital of Philadelphia (CHOP), residents learn about child advocacy in a three-year curriculum integrated into preexisting clinical rotations and conferences. Child advocacy education consists of a combination of required and elective activities. The required activities include 4-week block rotations (1st and 2nd year), advocacy community projects as well as didactic learning opportunities reinforced by related skills-based workshops. In addition, some of the elective activities at CHOP include Letter-Writing Campaigns and Advocacy Journal Club.

Monthly noon conferences and Grand Rounds serve as loci for residents, hospital staff, and community advocates to interact around issues concerning child advocacy. The Letter-Writing Campaigns are held in conjunction with these teaching opportunities at CHOP (see activity details below).

For the Advocacy Journal Club, CHOP invites residents to participate in this multi-disciplinary group of faculty, legal advocates, social workers, nurses and others and serves as a forum to review and discuss how policies impact the care and health status of children (see activity details below with a sample of topics).

Additional child advocacy teaching activities:

Throughout residency, pediatric residents have the opportunity to participate in other activities related to child advocacy, including:

- Volunteering at a homeless shelter
- Community health events
- Community experiences and projects
- American Academy of Pediatrics Advocacy Day on Capitol Hill
- Book Club
- Workshops

Learning outcomes:

- Residents increase their ability to identify important advocacy issues affecting the families they serve.
- Residents develop the confidence to participate in the legislative process and understand the importance of their role in this process.
- Residents learn how to access information that will help them understand how policies and socioeconomic issues affect the care and well being of children.

Contact:

For more information on activities relating to child advocacy activities for pediatric residents at The Children's Hospital of Philadelphia (CHOP), please contact:

Jill Triumpho, MEd

Program Coordinator

Community Pediatrics and Advocacy Program

Children's Hospital of Philadelphia

Adolescent Med., Room 9408

34th St. and Civic Center Blvd

Philadelphia, PA 19104

Phone: 215-590-0661

E-mail: Triumpho@email.chop.edu

www.cpap.phillypeds.com

Letter Writing Campaigns

Children's Hospital of Philadelphia

These campaigns, frequently co-sponsored by such organizations as the Department of Social Work or the League of Women Voters, take place before and after the Department of Pediatrics Grand Rounds and other special events. Each campaign addresses a discrete issue, often to support or oppose a specific bill or proposal. Campaigns offer education on the merits of the proposal, a letter-signing/email campaign, and a follow-up on the effects of the letters/emails. As a result, there is advocacy activity on a weekly basis; the majority is educational, with a letter-signing/email effort once every 4 to 6 weeks.

Over the last few years, campaigns have focused upon such topics as access to care, children's mental health, statewide hospital budget cuts, graduate medical education, education for children with disabilities, and childhood lead poisoning.

Typically, a faculty member and an administrative assistant standing outside the room holding Grand Rounds will ask attendees to review a flyer and perhaps sign a petition or letter. The flyer describes the issue and the initiative being organized. Multiple clipboards with pens are available when signatures are being collected. These materials are also posted in the residents' lounge.

Before implementation, all campaigns are reviewed by the hospital's director of government affairs as well as the chair of pediatrics, to ensure that the action is consistent with the hospital's policies and vision.

The Paul Wellstone Mental Health Equitable Treatment Act of 2003

What is Mental Health Parity?

- Mental Health Parity legislation would provide equal access to mental health services for Americans with health insurance (www.nmha.org).
- The Paul Wellstone Mental Health Equitable Treatment Act of 2003 strives “to provide for equal coverage of mental health benefits with respect to health insurance coverage unless comparable limitations are imposed on medical and surgical benefits”.
- This Act will require full parity for all categories of mental health condition listed in the DSM (Diagnostic and Statistical Manual of Mental Disorders).
- In 1996 Congress passed a temporary and limited Mental Health Parity Act
- It eliminated annual and lifetime dollar limits for mental healthcare.
- BUT, many employers have been able to work around the law by placing new restrictions on mental health benefits such as additional limits on outpatient office visits and number of days for inpatient care. (www.nmha.org)

Why should YOU support Mental Health Parity?

- Mental Health Parity is affordable! Several studies in states with parity have found that it only raises costs between one and four percent.
- PricewaterhouseCoopers found that Maryland's comprehensive parity law resulted in an increase of less than one percent in total premiums.
- In North Carolina, mental health expenses have decreased every year since comprehensive parity for state and local employees was passed in 1992. (www.nmha.org)
- The lack of parity costs the nation.
- The Surgeon General found that costs of mental illness accounted for a \$79 billion loss on the United States economy in 1990 (www.dhhs.gov).
- Current mental health coverage is discriminating.
- Limiting parity coverage to “severe mental illnesses” discriminates against children, adolescents and those whose illnesses fall outside of this category.
- Disorders often excluded from this category include: eating disorders, substance abuse disorders, post-traumatic stress disorder, and childhood disorders such as serious mental and emotional disturbances (www.nmha.org).

Support Mental Health Parity Next Week During CPAP's Letter Writing Campaign!

November 19, 2003

Senator Rick Santorum
511 Dirksen Senate Office Building
Washington, D.C. 20510

RE: S.486 / H.R. 953 – Wellstone Mental Health Equitable Treatment Act

Dear Senator Santorum:

As a healthcare professional and child advocate I call on you to endorse federal legislation S.486 / H.R. 953, the Wellstone Mental Health Equitable Treatment Act. The Wellstone Mental Health Equitable Treatment Act is legislation to end insurance discrimination against people who need mental health care.

Mental illness is the second leading cause of disability and premature mortality in the United States. Yet every day families with adequate physical health insurance discover that their loved ones who have mental health problems cannot get needed care because their private health insurance sets strict limits on mental health treatment. There are commonly no such limits on treating any physical illness. According to the 1999 Surgeon General's Report, mental illnesses are reliably diagnosed and for virtually every mental disorder, there is a range of treatments and services that have been shown to be effective.

Untreated mental illness costs our economy about \$80 billion each year -- in lost productivity, sick leave and unemployment. American families need a solution NOW. The solution is bipartisan legislation that would require parity between mental health benefits and the benefits provided to treat any other illness or injury. This simple, fair step will save lives and strengthen families. Mental health parity legislation will not lead to a significant increase in insurance premiums or in the number of uninsured Americans. But the costs of NOT enacting parity are high, and will fall most heavily on taxpayer-funded public programs affecting our economy and the well-being of American families and their communities.

Please make passage of a strong mental health parity bill a top priority. It is vital to provide access to treatment for the many children, adolescents and families in the nation who have mental health needs.

Sincerely,

Signature:

Print Name:

The Children's Hospital of Philadelphia
34th St. & Civic Center Blvd.
Philadelphia, PA 19104

Advocacy Journal Club

Children's Hospital of Philadelphia



CHOP invites all residents to participate in the Advocacy Journal Club, a multi-disciplinary group of faculty, legal advocates, social workers, nurses and others which serves as a forum to review and discuss how policies and research data impact the care and health status of children.

The Advocacy Journal Club:

- Identifies current research related to policy and socioeconomics to investigate its effects on health care delivery and outcomes.
- Identifies an advocacy related topic for each meeting with a related article to serve as a focus for discussion
- Uses the session as an opportunity to explore possibilities for action by health care providers and child advocates and develop a plan for implementation

Sample of topics for discussion for Advocacy Journal Club

in 2002 – 2003 were:

- Changes in Use of Health Insurance and Food Assistance Programs in Medically Underserved Communities in the Era of Welfare Reform: An Urban Study
- Researching Priorities for the Reduction of Perinatal and Neonatal Morbidity and Mortality Weekly Report
- Racial Difference in the Evaluation of Pediatric Fractures for Physical Abuse



Child Advocacy Reading List

TEACHING RESIDENTS ABOUT CHILD ADVOCACY

Curricula and Tools from University of Rochester

PLC / CARE Program

Goal:

To provide residents with a comprehensive list of resources on various topics in child advocacy.

Method:

At the University of Rochester, residents participate in activities related to child advocacy in a number of ways. During their intern year, they engage in a two week-long community immersion program, Pediatric Links with the Community (PLC), where they have the opportunity to become familiar with a wide range of community-based organizations. In the 2nd and 3rd years, the residents have the option of participating in a specialized track, specifically designed for those interested in learning more about community pediatrics, the Child Advocacy Resident Education Program (CARE) Track. Throughout their training, the residents at the University of Rochester are expected to become familiar the literature that speaks to issues related to child advocacy. The PLC/CARE Child Advocacy Library is a comprehensive list of books, articles and multimedia resources that allows residents to easily access important information related to child advocacy and community pediatrics. (A sample of their library is included)

Additional Child Advocacy Teaching Activities:

Throughout their residency, residents in the PLC/CARE Program have many opportunities to learn more about child advocacy.

- Didactic seminars
- Visits to community organizations
- Community-based projects

Learning Outcomes:

- Residents are able to identify and utilize resources to allow them to better advocate on behalf of children and families
- Residents learn important background information on previously collected data and interventions so as to better design their own community projects
- Residents have the ability to gain and demonstrate knowledge in child advocacy when communicating to effect change to improve child health

Contact:

For a complete copy of the child advocacy library and more information on activities related to child advocacy at the University of Rochester, please contact:

Santina Tu

PLC / CARE Project Manager

University of Rochester

Department of General Pediatrics

601 Elmwood Avenue

Pediatrics - Box 777

Rochester, NY 14642

Phone: 585-273-3737

E-mail: santina_tu@urmc.rochester.edu

<http://www.plccare.org>

Child Advocacy Library

PEDIATRIC LINKS WITH THE COMMUNITY/CHILD ADVOCACY RESIDENT EDUCATION (PLC/CARE) PROGRAM

Pediatric Links with the Community (PLC)

Alicea, Gil C. and Carmine Desena. *The Air Down Here: True Tales From A South Bronx Boyhood.* San Francisco, CA.: *Chronicle Books.* 1995.

Baldwin, James. *The Fire Next Time.* New York, NY.: *Vintage Books.* 1993.

Berrick, Jill Duerr. *Faces Of Poverty. Portraits Of Women And Children.* New York, NY.: *Oxford University Press.* April. 1997.

Canada, Geoffrey. *Fist Stick Knife Gun: A Personal History Of Violence In America.* Boston, MA.: *Beacon Press.* 1995.

Canada, Geoffrey. *Reaching Up For Manhood: Transforming The Lives Of Boys In America.* Boston, MA.: *Beacon Press.* 1995.

Chase-Lansdale, P. Lindsay, and Jeanne Brooks-Gunn. *Escape from Poverty, What Makes a Difference for Children?* New York, NY: *Cambridge University Press;* 1997.

Child Advocacy Resident Education Program (CARE)

Aday LA. *At Risk in America The Health and Health Care Needs of Vulnerable Populations in the United States.* San Francisco, CA: *Jossey-Bass Publishers;* 1993.

Aday LA, and Andersen, R. *Development of Indices of Access to Medical Care.* Ann Harbor, MI: *Health Administration Press;* 1995.

Albom M. *Tuesdays with Morrie.* New York, NY: *Doubleday;* 1997.

Altschule M. *What Medicine is About.* Boston, MA: *The Francis Contway Library of Medicine;* 1975.

Alvarez J. *¡Yo!.* New York, NY: *Plume Books;* 1997.

American Academy of Pediatrics. *A Pediatrician's Guide to Proposal Writing.* *An American Academy of Pediatrics Publication;* 2000.

American Academy of Pediatrics. *Community Pediatrics: An Annotated Bibliography.* *An American Academy of Pediatrics Publication;* 2002.

American Academy of Pediatrics, and Department of Community Pediatrics and Coalition Community Foundation's for Youth. *A Planning Guide for Alliance for Healthy Children.* *An American Academy of Pediatrics Publication;* 2001.

Pediatric Links with the Community/Child Advocacy Resident Education

The Annie F. Casey Foundation. *Kids Count Data Book: State Profiles Of Child Well-Being.* Baltimore, MD.: *Annie F Casey Foundation.* 1998.

Bravenman, P. and Bennett, T. *Information For Action: An Advocate's Guide To Using Maternal And Child Health Data.* Washington, DC.: *Children's Defense Fund Publication.* 1993.

Bithoney, W. Et. Al. *Training Residents To Serve The Underserved: A Resident Education Curriculum.*

Ambulatory Pediatric Association and American Pediatric Association. Arlington VA.: *National Center for Education in Maternal and Child Health*. April. 1993.

Center For Community Change. How And Why To Influence Public Policy: An Action Guide For Community Organizations. Washington, DC.: *Center For Community Change*. 1996.

Center For The Future Of Children. The Future Of Children: Protecting Children Form Abuse And Neglect. vol. 8. no. 1. Los Altos, CA.: *The Center For The Future Of Children. The David And Lucile Packard Foundation*. Spring. 1998.

Center For The Future Of Children. The Future Of Children: Children And Poverty. vol. 7. no. 2. Los Altos, CA.: *The Center For The Future Of Children. The David And Lucile Packard Foundation*. Summer/Fall. 1997.

Center For The Future Of Children. The Future Of Children: Welfare To Work. vol. 7 no. 1. Los Altos, CA.: *The Center For The Future Of Children. The David And Lucile Packard Foundation*. Spring. 1997.

Videos

"Families Talk About..." Video Series. Rose Films. Rochester Area Foundation. Active Parenting Publishers, Inc. 1996. Created by: Sayre, James. MD. Clinical Professor of Pediatrics. University of Rochester.

Video 1 - Bonding With Your Baby

Video 2 - Education Starts At Home

Video 3 - Wise Words On Discipline

Child Advocacy & Access Conference Series

"Cross-Cultural Issues in the Delivery of Care"— Children's Hospital at Strong. University of Rochester. Pediatrics Grand Rounds. January 10, 1996.

Presented by: Alexis Abernathy, MD Clinical Associate Professor Department of Psychiatry, Ambulatory Services, University of Rochester; Jose M. Bayone, MD Assistant Professor Department of Family Medicine. University of Rochester; Lynn Bickley, MD Associate Professor Department of Medicine, General Medicine Unit, University of Rochester.

"Myths about Street Violence"— Children's Hospital at Strong. University of Rochester. Pediatrics Grand Rounds. March 27, 1996.

Presented by: Peter Stringham, MD Assistant Professor of Clinical Pediatrics. Boston University's Medical School.

"After Health Care Reform: Mothers and Children"— Children's Hospital at Strong. University of Rochester. Pediatrics Grand Rounds. April 10, 1996.

Presented by: Michael Simmons, MD Professor of Pediatrics. Dean of University North Carolina. Chapel Hill School of Medical.

Ray Kroc Lecture

"Community Activism: A Front Line Perspective"— Children's Hospital at Strong. University of Rochester. Pediatrics Grand Rounds. April 23, 1997.

Presented by: Reverend Martha Overall. (Featured in *Amazing Grace: The Lives Of Children And The Conscience Of A Nation*).



The Child Advocacy Survey

TEACHING RESIDENTS ABOUT CHILD ADVOCACY

Curricula and Tools from the Medical College of Wisconsin

Earnestine Willis, MD, MPH, Karen Wendelberger-Marcidante, MD Dawn Bragg, PhD

Goals:

To identify faculty and residents who are already involved with advocacy efforts and to garner support for these efforts to use them as teaching opportunities.

To increase awareness of local and statewide advocacy issues and methods for both residents and faculty to involve themselves with the legislative process.

Method:

The chair of the Department of Pediatrics at the Medical College of Wisconsin requested that all pediatric faculty complete a two page survey, Departmental Activities in Child Advocacy (see sample below). The survey covers two core components: understand the faculty's level of experience using legislative tools and activities as well as compile current faculty advocacy focuses. The administration compiled the information and makes it available to residents. The department encourages residents to identify advocacy topics of interest to them and connect with the appropriate faculty member in an effort to support them with their advocacy initiatives.

Additional Child Advocacy Teaching Activities:

Throughout residency, pediatric residents have the opportunity to participate in other activities related to child advocacy, including:

- Residents complete a survey on their past community and advocacy activities
- Didactic sessions on advocacy provided by community and state representatives and Children's Hospital of Wisconsin lobbyist
- AAP Lobby Day in Washington, DC
- Statewide Pediatrics Advocacy Day
- Community visits with local advocacy agencies

Learning Outcomes:

- Residents become knowledgeable about current pediatric advocacy issues that affect child health policy
- Residents acquire competency in advocacy basics inclusive of the legislative process and how to develop their role in advocacy.
- Residents learn the various legislative tools (Capwiz) available and how to utilize them.
- Residents develop a greater exposure to the legislative process and become an active participant within their own time limits.

Contact:

For more information on curricular activities relating to child advocacy activities for pediatric residents at Medical College of Wisconsin, please contact:

Tiffany Frazer, MPH

Program Manager

Medical College of Wisconsin

Department of Pediatrics

MACC Fund Research Center

8701 Watertown Plank Road

Milwaukee, WI 53226

Phone: 414.456.4609

E-mail: tfrazer@mail.mcw.edu

www.mcw.edu/peds/program/mdep

The Chairman's Child Advocacy Survey of Faculty and Staff

Robert M. Kliegman, MD

Department of Pediatrics Medical College of Wisconsin

Departmental Activities in Child Advocacy

Too often children's causes go unheard and unmet because children do not vote. A child advocate has been defined as a person who speaks up for the cause of children. Child Advocacy within the Department of Pediatrics is occurring continuously by faculty and staff to improve the health and well being of children. Unfortunately, our residents often do not see these efforts and do not realize how easy it is to get involved or how powerful a voice they can have.

It would be most helpful to share with us any advocacy efforts that you have undertaken which might last days, months, or years, depending on the issue(s) that you are trying to affect. Whether you are advocating within the legislative arena, regulatory bodies, before the courts or in any other way, all of us champion children and youth. Creating an inventory of advocacy activities conducted by faculty within the Department would help to make those activities teaching opportunities for residents. Below is a list of questions that will enable us to begin the task of creating the above-mentioned inventory.

Please answer each question by checking the responses provided.

I. From the list below, please check all child advocacy activities in which you have been involved in the past.

- Educating elected/appointed officials (e.g. serving on advisory boards)
- Educating community through radio and TV
- Educating community through newspaper
- Working with/for children and youth groups
- Teaching older children to advocate for themselves
- Mobilizing groups/individuals around child health issues
- Organizing neighbors to support children
- Spearheading letter-writing or phone-calling campaign
- Testifying at public hearings

2. From the list below, please check all child advocacy activities in which you are currently involved.
 Educating elected/appointed officials (e.g. serving on advisory boards)

- Educating community through radio and TV
- Educating community through newspaper
- Working with/for children and youth groups
- Teaching older children to advocate for themselves
- Mobilizing groups/individuals around child health issues
- Organizing neighbors to support children
- Spearheading letter-writing or phone-calling campaign
- Testifying at public hearings

3. Are you currently involved in activities for which you would be willing to have an interested resident involve?

- Yes
 No

4. Please list those activities and the kinds of resident involvement desired:

Activity	Kind / Nature of Involvement	Expected Duration

5. How can the Department of Pediatrics help to further/support your involvement in child advocacy activities?

Contact

If you need further clarification, please contact

Earnestine Willis, MD, MPH
 Phone: 414-456-4131



Key Steps in Doing Effective Advocacy

Karen Hendricks, J.D.

Assistant Director, Department of Federal Affairs, American Academy of Pediatrics

Additional Tools for Teaching Child Advocacy

Make a Visit to the Hill

- Be prepared!
- Coordinate your presentation
- Present the most important points first
- Present the facts concisely
- Share your expertise
- Be constructive, be honest, and be familiar with the opposition
- Leave fact sheets on your issues
- Follow up your visit!

Advocacy Skills

- Presentation-brief and clear
- Be firm and persuasive not confrontational or abrasive
- Personalize your message, share anecdotes
- Know the opposition's arguments

Leaving a Phone Message

- Identify yourself and indicate you are a constituent
- State the bill(s) you are calling about and your position on the bill(s)
- Leave a substantive, short message- don't get too technical
- Provide contact information so they can call or write you

Advocacy Strategies

- Writing letters
- Voter education
- Filing a lawsuit
- Testifying before a state or federal legislative body
- Focus groups
- Write an editorial or letters to the editor
- Press conference
- Invite celebrities to join the efforts

Five Critical Steps for Successful Advocacy

Nancy Amidei

1. Identify your issue and goal(s)
2. Get the facts
3. Develop a strategy
4. Get to know the decision-makers and their staffs
5. Broaden your base of support

Resources

Useful Websites:

Agency for Health Care Policy and Research

<http://www.ahcpr.gov/clinic>

Centers for Disease Control and Prevention

<http://www.cdc.gov>

Congressional Record

<http://www.gpoaccess.gov/crecord/index.html>

Health Care Financing Administration

<http://www.hcfa.gov>

Health Finder

<http://www.healthfinder.gov>

Library of Congress

<http://lcweb.loc.gov> or <http://thomas.loc.gov>

National Institutes of Health

<http://www.nih.gov>

United States Department of Health Resources and Service Administration

<http://www.hrsa.gov>

United States Department of Health and Human Services

<http://www.os.dhhs.gov>

United States Department of Health and Human Services Maternal and Child Health Bureau

<http://mchb.hrsa.gov>

United States Department of Health and Human Services Administration for Children and Families

<http://www.acf.dhhs.gov>

United States House of Representatives and US Senate

<http://www.house.gov> or <http://www.senate.gov>

White House

<http://www.whitehouse.gov>

National Organizations and Other Resources

American Academy of Pediatrics

<http://www.aap.org>

Anne E. Casey Foundation: Advocacy and KidsCount

<http://www.aecf.org>

<http://www.aecf.org/publications>

Anne E. Dyson Community Pediatrics Training Initiative

<http://www.dysoninitiative.org>

C-Span

<http://c-span.org>

Child Welfare League of America

<http://www.cwla.org>

Children Now: Child Advocacy

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

Children's Defense Fund

<http://www.childrensdefense.org>

Congressional Quarterly

<http://www.cq.com>

David and Lucile Packard Foundation: The Future of Children

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

Gallup Organization

<http://www.gallup.com>

National Association of Children's Hospitals

<http://www.childrenshospitals.net>

On the Issues

<http://www.policy.com>

Pediatrics in Practice

<http://www.pediatricsinpractice.org>

Politics Now

<http://www.politicsnow.com>

Project Vote Smart Website

<http://www.vote-smart.org>

Roll Call- Official Newspaper of Capitol Hill

<http://www.rollcall.com>

Stand for Children

<http://www.stand.org>

The National Children's Advocacy Center

<http://www.nationalcac.org>

United States Congress

<https://www.congress.org>

Voices for America's Children

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

Manuals, Guides, and Newsletters

Amidei N. So You Want to Make a Difference: Advocacy is the Key. 13th Ed. Washington, DC: OMB Watch; 1991.

OMB Watch. Through the Corridors of Power: A Guide to the Federal Rulemaking Process. OMB Watch, 1731 Connecticut Ave, N.W., Washington, DC 20009; 1986.

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4

The Medical Home

Due to the successes of biomedical sciences, the survival rate for children with chronic conditions is greater today than ever before. To survive and develop optimally, children with chronic medical conditions need comprehensive and often intensive medical services as well as other social supports. The identification of children with special health care needs (CSHCN) has evolved from diagnosis or condition-based to a more broadened definition to include specific diagnoses, impaired functional status, or increased need or utilization of health resources.^{1,2,3} Nationally representative surveys using the broader conception and definition of CHSCN identify between 14.6% and 18% of children as being CSHCN.^{4,5}

The Genesis of the Medical Home Model

Developing a system of services for CSHCN is a significant challenge for families, pediatricians and state and federal agencies. State Title V CSHCN programs are responsible for developing systems of care that work for all children with chronic illness. In response to the population's changing needs and due to changes in health care financing, social and education policies, systems of care for CSHCN have become increasingly complex. The combination of a growing population of children with multiple needs and an increasingly complex system has greatly increased the potential that CSHCN and their families fall through the cracks and have unmet health, educational and social needs.

As a result, professionals and policy makers have developed a new model of care to optimize health care delivery and improve health outcomes for children with special needs and their families. The Maternal Child Health Bureau and the American Academy of Pediatrics collaborated to develop a new set of organizational principals to guide and define this new child health care system for all children, especially those children with special health care needs. The Medical Home was formally defined in a Policy Statement published by the American Academy of Pediatrics in 2002.⁶ In this statement the AAP describes the seven characteristics of the Medical Home as:

- Accessible: care is provided in the child's community, all insurance, including Medicaid, is accepted and changes are accommodated
- Family centered: recognition that the family is the principal caregiver and the center of strength and support for children. Unbiased and complete information is shared on an ongoing basis.
- Continuous: same primary pediatric health care professional are available from infancy to adolescence. Assistance with transitions (to school, home, adult services) is provided

- Comprehensive: health care is available 24 hours a day, 7 days a week. Preventive, primary and tertiary care issues are addressed.
- Coordinated: families are linked to support, educational, and community-based services. Information is centralized.
- Compassionate: concern for the well-being of the child and the family is expressed and demonstrated.
- Culturally effective: providers recognize value and respect the family's culture, beliefs, rituals and customs.

Implementing the Medical Home Model

Among the Healthy People 2010 goals and objectives for the nation, it was made a priority that “all children with special health care need will receive regular ongoing comprehensive care within a Medical Home”⁷. The Medical Home model of care requires a care coordinator and a primary care provider working as a team to coordinate care for children and families. The Medical Home also creates a space in which the families can be partners in the care of their children and voice their preferences for care at all levels, including the primary care office level.

A number of efforts are underway at the state and local level by Title V agencies and local chapters of the American Academy of Pediatrics to help both Title V agencies and primary care providers adopt the Medical Home model of care. The goal is to bring together local and State Title V CSHCN directors with primary care providers to learn how to foster Medical Homes. One approach is for the local Title V programs to supply practices with support nurse care coordinators to co-manage the CSHCN, to help the practices improve internally and improve integration with services and agencies outside the walls of the practice. The practices proactively identify their population of CSHCN, create patient care plans for each CSHCN and manage the population of CSHCN using practice-based registries. The practices adopt a team approach with nurse care coordinators and parents as equal partners in the management of CSHCN. Moreover, the Medical Home model requires the practices to develop a greater understanding of community resources and how to help families access these resources.

To achieve all of these goals the practices must use continuous quality improvement over an extended period of time. Moreover, the practices commit to measuring their progress by assessing themselves on the critical domains of the Medical Home using validated measurement tools such as the Medical Home Index.⁸ In addition, some states are using standardized patient surveys to evaluate and give feedback to the practices, which is also incorporated into a quality improvement framework, to promote change toward the Medical Home model of care.

The ultimate reason for implementing a Medical Home model of care is to improve the quality of health care services and the health outcomes for all children, especially those with chronic conditions and their families. The impact and success of the Medical Home model of care is being evaluated in Florida, Massachusetts, California and many other states. Feedback from these evaluations should help to shape the structure of health services for children in the coming decades.

David Wood, MD, MPH

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Teaching Residents About the Medical Home Model

Pediatricians must be able to provide medical care that is knowledgeable, accessible, compassionate, culturally sensitive, family centered, coordinated, continuous, and comprehensive. To do so, pediatricians must acknowledge the crucial role of caretakers, the family, and the community in shaping health outcomes. Competencies in the areas of communication, professionalism, patient care, medical knowledge, practice-based systems, and practice-based learning and improvement, all come into play in delivering care that meets the medical home criteria

Following are a variety of curricular elements and tools used by residency programs to meet competency in medical home.

1. Resident Performance Checklist, Preceptor Prompt Card & Resident Attitudinal Scale - *University of Hawaii*
2. Project DOCC Home Visiting Program - Evaluation Form and Questionnaire - *Columbia University*
3. Medical Home Measurement Tools - *Indiana University & The Center for Medical Home Improvement*



Resident Performance Checklist

TEACHING RESIDENTS TO DELIVER THE MEDICAL HOME

Examples of curricula and tools from The University of Hawaii

Meta Lee, MD, MEd & Louise Iwaishi, MD

Goal:

For pediatric residents to learn and apply principles of the Medical Home in the continuity care clinic.

Method:

Residents at the University of Hawaii must complete a web-based Medical Home training module which requires residents to learn and apply key medical home concepts through: 1) independently reviewing didactic case reviews on PowerPoint slides available by internet access, 2) completing chart reviews of their patients using a Medical Home Chart Review Checklist, 3) completing a self-assessment exercise, “My Best Medical Home Practice Performance,” 4) receiving feedback on patient interactions from a faculty observer using a Medical Home Performance Checklist, 5) completion of pre and post-module exams 6) self-assessment of confidence following training using a Medical Home Attitudinal Scale. Entries are compiled into a portfolio, which is reviewed with an assigned faculty preceptor.

Additional Medical Home Activities and Tools:

Throughout their pediatric residency, Hawaii residents are taught about the Medical Home through a variety of structured activities. In addition to the training module described above, senior residents inspire junior residents by presenting their most exemplary Medical Home case experience at Medical Home noon conferences. Residents at all levels also participate in community-based activities and have been successful in establishing their own initiatives through Community Access To Child Health (CATCH) support. This is Hawaii’s attempt to go beyond the traditional emphasis on continuity in a resident’s ambulatory care practice to focus on other non-cognitive skills needed for effective community-based practice.

All of these combined tools used in Hawaii’s Medical Home Training create the individual Medical Home performance portfolio.

- Preceptor Prompt Card (provided)
- Medical Home Performance Checklist (provided)
- Resident Attitudinal Scale (provided)
- Chart Review Checklist
- Multiple choice exam questions
- Self-reflective essay describing a best Medical Home practice example

Learning Outcomes

Through these activities, the residents at the University of Hawaii not only become familiar with Medical Home principles, but are also able to identify personal areas of strengths and weaknesses with regard to their application of Medical Home principles to their Continuity Clinic practice. They become adept in partnering with families and other health care professionals in providing care that is tailored, comprehensive, and comprehensive. Upon completion of this medical home training, residents are able to objectively demonstrate to faculty, through their portfolio, their competence in the ACGME categories of Patient Care, Knowledge, Interpersonal Communication, Professionalism, Practice Based Learning and Systems Based Practice.

Contact:

For more information on activities related to Medical Home at the University of Hawaii, please contact:

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Medical Home Principles at the Individual Level - Resident Performance Checklist

Preceptor Medical Home Performance Checklist

Resident Name: _____

Preceptor Name: _____ Date of Visit: _____

Check the box “met”, “not met” or “N/A” to self-assess your resident’s clinic performance. Review your completed checklist with your resident. Add your resident’s completed checklist and this completed checklist to your resident’s Medical Home Portfolio.

I. PATIENT CARE	Met	Not Met	N/A	Comments
Family Centered Care 1. Ask open-ended questions to identify patient and or family concerns and address concerns effectively 2. Consider patient and or family members in the decision making process for management and treatment				
Accessibility 3. Inform the patient/family how to access me as their primary care provider 4. Offer a plan for after hours care to ensure accessibility to my patient’s healthcare needs				
Coordinated Care 5. Review correspondence from ancillary health care documents with the patient and family 6. Review plans with consultants, agencies, and or organizations involved in the patient’s care				
Continuous Care 7. Provide care that enables the patient to smoothly transition between health care providers (clinic to consultant, etc). 8. Discuss long term plans with the caregiver of my patient with chronic or special health care needs				
II. INTERPERSONAL COMMUNICATION				
Compassion 9. Ask questions to encourage understanding 10. Demonstrate compassion by using appropriate verbal and non-verbal communication to ensure all questions are addressed or answered				

III. SYSTEMS BASED PRACTICE	Met	Not Met	N/A	Comments
Comprehensive 11. Consider financial and social needs in patient's management plan to improve access to care and follow-up				
12. Enlist appropriate community resources for infant, child, and adolescent health needs				
IV. PROFESSIONALISM				
Culturally Effective Care 13. Explain the medical rationale for plan of care in understandable language to the child and family				
14. Acknowledge differences of opinion related to cultural and religious practices				

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Medical Home Principles at the Individual Level - Preceptor Prompt Card

The Preceptor Prompt Card is pocket-sized and is used following resident-preceptor interactions in the Continuity Clinic, as well as other outpatient specialty services and inpatient units.

PRECEPTOR MEDICAL HOME PROMPT CARD

Community Pediatrics Attending Physician
Continuity Care Clinic Program
Medical Home Competencies

When Resident is presenting to you:

- Did the Resident identify access, continuity, and comprehensive care issues for this patient?
- Did the Resident know the community resources for the child's care coordination that need to be involved?
- Did the Resident identify any cultural aspects or concerns?
- How family/patient-centered was the Resident's communication?
- Did the Resident demonstrate use of evidence to justify their care of the child's particular pediatric health care issues?

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Medical Home Principles at the Individual Level - Resident Attitudinal Scale

The Resident Attitudinal Scale is a self-assessment tool that also evaluates the Continuity Clinic Medical Home teaching experiences.

RESIDENT MEDICAL HOME ATTITUDINAL SCALE

Directions: Please circle the response that best describes your feelings. The following scale is defined:

1= strongly disagree (SD) 2= disagree (D) 3= neutral (N)
4= agree (A) 5= strongly agree (SA)

	SD	D	N	A	SA
1. I understand the concept of the Medical Home.	1	2	3	4	5
2. I feel confident describing the seven principles of the Medical Home.	1	2	3	4	5
3. I utilize Medical Home principles in daily patient practice.	1	2	3	4	5
4. The majority of my patients identify me as their primary care provider.	1	2	3	4	5
5. My preceptors encourage me to utilize Medical Home principles in daily patient practice.	1	2	3	4	5
6. My preceptors routinely provide me with feedback regarding my clinical performance in continuity clinic.	1	2	3	4	5
7. The level of teaching in continuity clinic is optimal.	1	2	3	4	5

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Project DOCC Home Visit / Parent Questionnaire

TEACHING RESIDENTS TO DELIVER THE MEDICAL HOME

Examples of curricula and tools from Columbia University

Goal:

To utilize home visits so that residents can gain an understanding of life outside of the hospital for children with chronic special health care needs, and for residents to see the importance of 'chronic care' planning, accomplished by an alliance between physicians and parents to improve the quality of life and educational opportunities for these children.

Method:

During their 3rd year at Columbia University, pediatric residents participate in Project Docc (Delivery of Chronic Care), a program designed by parents to educate physicians about children with chronic disease and disability. Residents participate in a home visit to a family with a child with special needs and interview the caregiver, questionnaire included. The home visit is not meant to be medical, but to provide the resident with a sense of daily life in the family. During the hour-long parent interview, the resident meets with the parents to explore issues from pregnancy to the present day. The interviewer poses questions about care providers and insurers, family and marriage, dealing with equipment and procedures, spirituality and education, and the parent's sense of control and satisfaction with care.

Additional activities related to Medical Home at Columbia University:

At Columbia University, the residents are exposed to principles of the Medical Home and Children with Special Health Care Needs in a variety of ways:

- Didactic sessions on Medical Home and Children with Special Health Care Needs
- Medical Home Assessment Questionnaire for Physician and Families
- Residents choose 2 patients from their patient population and complete the Children with Special Health Care Needs Care Coordination Patient Review Form
- Residents give lecture to their Continuity Clinic Group related to findings from the above Patient Review Form on specific aspects of caring for CSHCN.

Learning Outcomes:

Through these activities, the pediatric residents at Columbia University become competent in providing a Medical Home for children and families with special health care needs, both in the clinic and in the home. They gain a clear understanding of how to coordinate comprehensive and compassionate care, and how to connect them to resources in their local community.

Contact:

For more information on activities related to medical home and children with special needs, please contact:

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Project DOCC

Project DOCC (Delivery of Chronic Care) improves the quality of care for severely chronically ill children by educating pediatricians-in-training about their special needs from a parent's perspective.

Founded in 1994 by Maggie Hoffman, Donna Appell, and Nancy Speller— themselves parents of disabled children—Project DOCC brings doctors out of the hospital and into the home to learn first-hand how families deal with the long-term care of chronically ill children.

Project DOCC is now a part of the training of over 800 medical residents at 20 hospitals in the United States and Australia. It has trained hundreds of family members to act as “family faculty,” educating young physicians through home visits, parent interviews, and grand rounds presentations.

Beginning in 2003, Project DOCC will work with the United Hospital Fund, which provided early grant support for the program, to refine and evaluate the current pediatric program; develop, test, and launch a similar program for children with special health care needs who are aging out of the pediatric system and into adult medicine; and devise an independent, long-term organizational structure to increase Project DOCC's national prominence and effectiveness; and seek significant foundation grants to support these efforts.

Mission

Project DOCC's mission is to promote an understanding of the issues involved in caring for a family living with special health care needs regardless of age, diagnosis, or prognosis; to put the family at the center of the health care system.

How Project DOCC Works

Medical centers and family members form teams to implement Project DOCC. The curriculum is integrated into an existing rotation (e.g., general pediatrics or internal medicine) and is required for all residents and/or medical students during their training. Teaching videos, manuals, and slides are free. Each team must complete a two-day training workshop. Project DOCC encourages each hospital to pay a stipend to every family member who participates in teaching.

Pediatric Program

The Project DOCC curriculum is taught by parent teachers and made up of three components:

- Grand rounds panel presentation (one hour)
- Home visit (two hours)
- Parent interview using the Chronic Illness History (two hours)

Transitions Curriculum

Project DOCC is developing a transitions curriculum, which will focus on children with special needs as they mature into adulthood, and prepare doctors and nurses, parents, and the young adults themselves for the transition to adult medical and community services. The curriculum's target audiences are pediatricians and pediatric nurses; parents of emerging adults; teens and young adults; and physicians in adult medicine.

Contact

For more information or to learn how to participate in Project DOCC, contact

Maggie Hoffman

212-494-0746

mhoffman@uhfnyc.org or projdocc@aol.com.

www.projectdocc.org

Medical Home Index

TEACHING RESIDENTS TO DELIVER THE MEDICAL HOME

*Examples of curricula and tools from Indiana University and
The Center for Medical Home Improvement, Dartmouth University
Nancy Swigonski, MD, MPH and Stephen Downs, MD, MS*

Goal:

For residents to assess their continuity clinic practices in relation to the principles of the medical home model.

Method:

Pediatric residents in the second year at Indiana University participate in assessing their continuity clinic in relation to the tenants of the medical home. They complete this exercise after didactic sessions that introduce them to the topic of the Medical Home. Under the guidance of one of the clinic preceptors and a family advocate, the residents complete the Medical Home Index based on their clinic experience. After they have completed the tool, the residents meet to discuss aspects of the clinic that related, or didn't, to the tenants of a Medical Home. The Medical Home Index can be downloaded at www.medicalhomeimprovement.org. The first few pages of the tool are provided here.

Additional Medical Home Activities:

In addition to completing the Medical Home Index, the residents at Indiana University are also exposed to aspects of caring for children with special health care needs by:

- Residents in selected clinics use a comprehensive electronic pediatric health care system based on recommendations from the AAP's Bright Futures guidelines. The computer system is an extension to the electronic medical record. Families complete tailored paper questionnaires about concerns and risk factors. These are scanned into the computer, which generate a worksheet reminding the resident of important care management topics. The system also produces tailored handouts for parents that link them to community resources.
- Resident physicians also utilize clinical toolkits. These are "fingertip" resources containing problem specific guidelines, parent handouts, form letters, charting tools and other materials to improve and systematize care of CSHCN. There are toolkits available for topics such as attention deficit and hyperactivity disorder; Down Syndrome and domestic violence
- The continuity clinic curriculum includes didactic sessions that are made available to multiple clinic sites on the World Wide Web. These sessions include a medical home segment that promotes community linkages or quality improvement.
- The IU pediatric residency program has partnered with community organizations to improve community linkages. For example, the Indiana Parent Information Network, an organization dedicated to families of children with special needs, provides resources to help link families with legal, educational, or care resources.

**Learning Outcomes:**

By completing the Medical Home Index and participating in the other activities, residents at Indiana University become adept in providing a medical home at a systems level. They gain a good understanding of how to set-up a clinic that serves as a medical home to all families, and have the opportunity to suggest change if certain Medical Home criteria are not met. They learn how to immediately link patients to necessary resources and ensure that all patients that who come to that clinic are fully connected to programs in their community.

Contact:

For more information related to Medical Home activities at Indiana University, please contact:

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Medical Home Measurement Tools: The Medical Home Index and the Medical Home Family Index

Center for Medical Home Improvement

The Medical Home Index (MHI) is a validated self-assessment and classification tool designed to translate the broad indicators defining the medical home (accessible, family centered, comprehensive, coordinated, etc.) into observable, tangible behaviors and processes of care within any office setting. It is a way of measuring and quantifying the "medical homeness" of a primary care practice. The MHI is based on the premise that "medical home" is an evolutionary process rather than a fully realized status for most practice settings. The MHI measures a practice's progress in this process.

The Medical Home Family Index is a companion survey intended for use with a cohort of families of children with special health care needs who receive care in a designated practice. This tool provides the practice with a valuable consumer perspective while allowing family corroboration of the practice's self-assessment (as reported on the Medical Home Index).

Guidelines

We make the following three requests for those who wish to use these tools:

1. That you inform CMHI in writing (e-mail is fine) of your intended use of these tools
2. That you agree to use both tools in combination, the Medical Home Index and the Medical Home Family Index, to assess "medical homeness". We feel strongly that "medical homeness" of a primary care practice cannot be measured without including the family perspective.
3. We would appreciate the sharing of your practice and family data with us (in a confidential fashion). Most programs have done this by sending us Medical Home Index copies of completed tools with all practice and personal identifiers removed. (Future website capacity will allow users to complete the tools online). Ultimately we hope to compile a national data set from users of both tools, which will offer benchmarks and help to begin testing the hypothesis that strong medical homes for children with special health care needs will result in better care and outcomes for children and families.



THE MEDICAL HOME INDEX:

Measuring the Organization and Delivery of Primary Care for Children with Special Health Care Needs

This tool defines, describes, and quantifies activities related to the organization and delivery of primary care for *Children with Special Health Care Needs (CSHCN)*. You will be asked to rank the level of your practice in six domains: organizational capacity, chronic condition management, care coordination, community outreach, data management and quality improvement/change. Most practices may not function at many of the higher levels (Levels 3 and 4). However, these levels do represent care matched to the kinds of services and supports that families of *CSHCN* report that they need. A frank assessment of your current practice is desirable; this will best define practice and help to identify the supports needed by pediatric practices to better serve *CSHCN* in their communities. Families will complete a companion instrument commenting on their experiences with your practice.

Name: _____ Title/Position/Role: _____

Address/Phone/e-mail/fax: _____

Describe Your Practice Type/Model: _____ Number of Providers: MDs _____ ARNPs _____ PA's _____ Other _____

Is there a care coordinator working at your practice who supports *CSHCN*/families? Yes No {Use other side of sheet to explain,}

What is the estimated number of children that your practice cares for? _____ What is your patient panel size? _____

Can you estimate the percentage (Total should = 100%) of children you care for who have:

- 1) _____% Public insurance only (Medicaid/CHIP) 2) _____% Private & Medicaid
3) _____% Self/No pay 4) _____% Private insurance only 5) _____% Other?

How familiar/knowledgeable are you about the concept of a medical home as defined by the American Academy of Pediatrics?

- 1) No knowledge of the concept 2) Some knowledge/not applied
3) Knowledgeable/concept sometimes applied in practice 4) Knowledgeable/concept regularly applied in practice

How familiar/knowledgeable are you with the elements of family-centered care as defined by the Institute on Family Centered Care?

- 1) No knowledge of the concepts 2) Some knowledge/not applied
3) Knowledgeable/concepts sometimes applied in practice 4) Knowledgeable/concepts regularly applied in practice



THE MEDICAL HOME INDEX:

Measuring the Organization and Delivery of Primary Care for Children with Special Health Care Needs

DEFINITIONS OF CORE CONCEPTS *

Children with Special Health Care Needs (CSHCN):

Children with special health care needs are defined by the *US Maternal and Child Health Bureau* as those who have, or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally (USDHHS, MCHB, 1997).

Medical Home according to the American Academy of Pediatrics (AAP):

A community-based primary care "medical home" is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent.

Elements of Family-Centered Care (Institute on Family Centered Care, Bethesda, Maryland):

- 1) Recognizing that the family is the constant in a child's life, the service systems and personnel within those systems fluctuate
- 2) Facilitating family-professional collaboration at all levels of health care
- 3) Honoring the racial, ethnic, cultural and socioeconomic diversity of families
- 4) Recognizing family strengths and individuality and respecting different methods of coping
- 5) Sharing with parents, on a continuing basis and in a supportive manner, complete and unbiased information
- 6) Encouraging and facilitating family-to-family support and networking
- 7) Understanding and incorporating the developmental needs of infants, children, and adolescents & families into health systems
- 8) Implementing comprehensive policies and programs that provide emotional and financial support to meet the needs of families
- 9) Designing accessible health care systems that are flexible, culturally competent, and responsive to family-identified needs

* Words referenced here will be in italics throughout the document.



THE MEDICAL HOME INDEX: Measuring the Organization and Delivery of Primary Care for Children with Special Health Care Needs

GLOSSARY OF TERMS*

Care Coordination Activities:

- Care and services performed in partnership with the family and providers by health professionals to:
- 1) Establish family-centered community-based "**Medical Homes**" for *CSHCN* and their families.
 - Make assessments and monitor child and family needs
 - Participate in parent/professional practice improvement activities
 - 2) Facilitate timely access to the *Primary Care Provider (PCP)*, services and resources
 - Offer supportive services including counseling, education and listening
 - Facilitate communication among PCP, family and others
 - 3) Build bridges among families and health, education and social services; promotes continuity of care
 - Develop, monitor, update and follow-up with care planning and care plans
 - Organize wrap around teams with families; support meeting recommendations and follow-up
 - 4) Supply/provide access to referrals, information and education for families across systems.
 - Coordinate inter-organizationally
 - Advocate with and for the family (e.g. to school, daycare, or health care settings)
 - 5) Maximize effective, efficient, and innovative use of existing resources
 - Find, coordinate and promote effective and efficient use of current resources
 - Monitor outcomes for child, family and practice

Chronic Condition Management (CCM):

CCM acknowledges that children and their families may require more than the usual well child, preventive care, and acute illness interventions. CCM involves explicit changes in the roles of providers and office staff aimed at improving:

- 1) Access to needed services
- 2) Communication with specialists, schools, and other resources, and
- 3) Outcomes for children and families.

***Words referenced here will be in italics throughout the document.**



THE MEDICAL HOME INDEX: Measuring the Organization and Delivery of Primary Care for Children with Special Health Care Needs

GLOSSARY OF TERMS* (continued)

Quality:

Quality is best determined or judged by those who need or who use the services being offered. Quality in the medical home is best achieved when one learns what children with special health care needs and their families require for care and what they need for support. Health care teams in partnership with families then work together in ways which enhance the capacity of the family and the practice to meet these needs. Responsive care is designed in ways which incorporate family needs and suggestions. Those making practice improvements must hold a commitment to doing what needs to be done and agree to accomplish these goals in essential partnerships with families.

Office Policies

Definite courses of action adopted for expediency; "the way we do things"; these are clearly articulated to and understood by all who work in the office environment.

Practice:

The place, providers, and staff where the PCP offers pediatric care

Primary Care Provider - (PCP):

Physician or pediatric nurse practitioner who is considered the main provider of health care for the child

United States Maternal and Child Health Bureau - (USMCHB):

A division of Health Resources Services Administration

Requires both MD and key non-MD staff person's perspective - you will see this declaration before select themes; the project has found that these questions require the input of both MD and non MD staff to best capture practice activity.

***Words referenced here will be in italics throughout the document**

Medical Home Index instructions begin on the next page...



THE MEDICAL HOME INDEX:

Measuring the Organization and Delivery of Primary Care for Children with Special Health Care Needs

INSTRUCTIONS:

The Medical Home Index has six domains that include:

Organizational Capacity Chronic Condition Management Care Coordination
Community Outreach Data Management, and Quality Improvement

Each domain has anywhere from 2-7 themes, these themes are represented with a progression of care and are expressed as a continuum from Level 1-Level 4. For each theme please do the following:

- First:** Read each theme across its progressive continuum from Levels 1 to Level 4. Then,
Second: Select the LEVEL (1, 2, 3 or 4) which best describes how your *practice* currently provides care for CSHCN.
Third: When you have selected the Level, then indicate whether *practice* performance within that level is: "PARTIAL" (some activity within level) or "COMPLETE" (all activity within that level).

For the example below, "Domain 1: Organizational Capacity, Theme 1.1 "The Mission..." the score for the *practice* is: "Level 3", "PARTIAL".

Domain 1: Organizational Capacity: For EXAMPLE and Their Families				
THEME:	Level 1	Level 2	Level 3	Level 4
#1.1 The Mission of the Practice	Primary care providers (PCPs) at the practice have individual ways of delivering care to children with special health care needs CSHCN; their own education, experience and interests drive care quality. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	Approaches to the care of CSHCN at the practice are child rather than family-centered; office needs drive the implementation of care (e.g. the process of carrying out care). <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	The practice uses a family-centered approach to care (see page 2), they assess CSHCN and the needs of their families in accordance with its mission; feedback is solicited from families and influences office policies (e.g. the way things are done). <input checked="" type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 3, a parent/ practice advisory group promotes family-centered strategies, practices and policies (e.g. enhanced communication methods or systematic inquiry of family concerns/priorities); a written, visible mission statement reflects practice commitment to quality care for CSHCN and their families. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE

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Domain 1: Organizational Capacity: For CSHCN and Their Families				
THEME:	Level 1	Level 2	Level 3	Level 4
#1.1 The Mission of the Practice	Primary care providers (PCPs) at the practice have individual ways of delivering care to children with special health care needs CSHCN; their own education, experience and interests drive care quality. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	Approaches to the care of CSHCN at the practice are child rather than family-centered; office needs drive the implementation of care (e.g. the process of carrying out care). <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	The practice uses a family-centered approach to care (see page 2), they assess CSHCN and the needs of their families in accordance with its mission; feedback is solicited from families and influences office policies (e.g. the way things are done). <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 3, a parent/ practice advisory group promotes family-centered strategies, practices and policies (e.g. enhanced communication methods or systematic inquiry of family concerns/priorities); a written, visible mission statement reflects practice commitment to quality care for CSHCN and their families. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE
#1.2 Communication/ Access	Communication between the family and the PCP occurs as a result of family inquiry; PCP contacts with the family are for test result delivery or planned medical follow-up. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 1, standardized office communication methods are identified to the family by the practice (e.g. call-in hours, phone triage for questions, or provider call back hours). <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	Practice and family communicate at agreed upon intervals and both agree on "best time and way to contact me"; individual needs prompt week-end or other special appointments. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 3, office activities encourage individual requests for flexible access; access and communication preferences are documented in the care plan and used by other practice staff (e.g. fax, e-mail or web messages, home, school or residential care visits). <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE
#1.3 Access to the Medical Record <i>Requires both MD & key non-MD staff person's perspective.</i>	A policy of access to medical records is not routinely discussed with families; records are provided only upon request. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 1, it is established among staff that families can review their child's record (but this fact is not explicitly shared with families). <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	All families are informed that they have access to their child's record; staff facilitates access within 24-48 hours. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE	In addition to Level 3, practice orientation materials include information on record access; staff locate space for families to read their child's record and make themselves available to answer questions. <input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE

Instructions: A) Please select and circle one level from Levels 1, 2, 3, or 4 for each theme above (circle one).

B) Then indicate whether you place your practice at a PARTIAL or COMPLETE ranking within that level (circle one).

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Resources

Websites

American Academy of Pediatrics

www.aap.org - click on community pediatrics, then click children with special needs

American Academy of Pediatrics-Emergency Preparedness for Children with Special Health Care Needs: <http://www.aap/prg/advocacy/emergprep.htm>

Beach Center on Family and Disability: www.beachcenter.org

Center for Medical Home Improvement, Hood Center for Families and Children;

Children's Hospital at Dartmouth-Hitchcock Medical Center:

<http://www.medicalhomeimprovement.org/index.htm>

Exceptional Parent resources Guide, January 2002 Edition. Exceptional Parent, www.eparent.com

Family Village — A global community that integrates information, resources, and communication opportunities on the Internet for persons with cognitive and other disabilities, for their families, and for those that provide them services and support. www.familyvillage.wisc.edu/index.html

Institute for Child Health Policy: <http://www.ichp.edu/>

Island Parents educational Support & Training Center (IPEST): Trains parents and other caregivers to become active participants in the educational process of their child/children with a disability.

www.ipest.org

The National Center of Medical Home Initiatives for Children with Special Health care Needs;

American Academy of Pediatrics (AAP), <http://www.medicalhomeinfo.org/index.html>

National Dissemination Center for Children with Disabilities

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

Books, guides, and monographs

American Academy of Pediatrics. The Medical Home and Early Intervention: Linking Services for Children with Special Needs. Elk Grove Village, IL: *American Academy of Pediatrics*; 1995

Batshaw ML. When your child has a disability. 2nd ed. Baltimore, MD: *Brookes Publishing Company*; 2000.

The Children with Special Health Care Needs (CSHCN) Screener: Developed in Collaboration with: AHRQ, NCQA, The Association of Maternal & Child Health Programs, FAMILY VOICES, New England SERVE, The Child and Adolescent Health Measurement Initiative, Foundation For Accountability.

Cooley WC, McAllister JW. Assessing the Quality of Primary Care Medical Homes for Children with Special Health Care Needs. Lebanon, NH: Hood Center for Children and Families; 2000.

Every Child Deserves a Medical Home: Facilitator Training Manual. Elk Grove Village, IL: American Academy of Pediatrics; 2000.

Lavin A, Rappo P, Vanchiere C. Managed Care and Children With Special Health Care Needs: CPT Coding and the Medical Home. Chicago, IL: *American Academy of Pediatrics*; 1997.

The Medical Home Index: Measuring The Organization and Delivery of Primary Care for Children with Special Health Care Needs. *Lebanon, NH*; 2001.

Porter S, Freeman L, Griffin LR. Transition planning for adolescents with special health care needs and disabilities: a guide for health care providers. Boston, MA: *Institute for Community Inclusion, Children's Hospital Boston*, 2000.

Silva TJ, Sofis LA, Palfrey JS. Practicing Comprehensive Care: A Physician's Operation Manual For Implementing a Medical Home for Children with Special Health Care Needs. Boston, MA: *Children's Hospital, Institute for Community Inclusion*; 2000. www.communityinclusion.org/publications/compcare.html

Small steps...big differences: The medical home partnership: practical tips for physicians caring for children with special health care needs. *New England SERVE*. Available at <http://www.medicalhomeinfo.org/resources/state/Downloads/MA%20Info/Provider%20Brochure.pdf>.

What do Families Say About Health Care for Children with Special Health Care Needs? Your Voice Counts! Boston, MA: Family Voices; 2000.

Articles

American Academy of Pediatrics Ad hoc Task Force on Definition of the Medical Home. The medical home. *Pediatrics*. 1992; 90(5): 774.

American Academy of Pediatrics Committee on Children with Disabilities. Care coordination: integrating health and related systems of care for children with special health care needs. *Pediatrics*. 1999; 104(4): 978-981.

American Academy of Pediatrics Medical Home Initiatives for Children with Special Needs Project Advisory Committee. The medical home. 2002. *Pediatrics*. 110(1): 184-186.

Bergman AB. The practice of political medicine. *Pediatr Ann* 1995;24(8):405-8.

Cooley WC, McAllister JW, Sherrieb K, Clark RE. The Medical Home Index: development and validation of a new practice-level measure of implementation of the Medical Home model. *Ambulatory Pediatrics*. 2003; 3(4): 173-80.

McPherson M, Arango P, Fox H, Lauver C, McManus M, Newacheck PW, et al. A new definition of children with special health care needs.[comment]. *Pediatrics* 1998;102(1 Pt 1):137-40.

Rappo PD. The care of children with chronic illness in primary care practice: implications for the pediatric generalist. *Pediatr Ann* 1997;26(11):687-95.

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Sia CC. 2001 Job Lewis Smith award acceptance address. *Pediatrics* 2002;109(3):509-10.

Tonniges TF, Palfrey JS, Mitchell M. Introduction (Medical Home Supplement). *Pediatrics* 2004;113:1472 (5 Suppl).

Other

Every Child Deserves a Medical Home Training Curriculum. American Academy of Pediatrics, Family Voices, Maternal and Child Health Bureau, National Association of Children's Hospitals and Related Institutions, Shriners Hospitals for Children; 1997. Available at <http://www.medicalhomeinfo.org/training/index.html>

5

Special Populations

Children who experience health risks due to challenging conditions that complicate their lives are identified as “special populations.” These conditions include physical, emotional, or behavioral illnesses and social circumstances, economic challenges, and developmental stages associated with risk-taking behaviors. Special populations include adolescents, children who have chronic conditions, immigrants and refugees, those in substitute care, homeless youth, and those at risk of violence. Failure to acknowledge the potential for morbidity and mortality in these special populations can result in substandard care for some of the most vulnerable children we encounter.¹

The literature now indicates that information previously documented only in a “social history” or “past medical history” section of the medical record may, in fact, belong in the chief complaint and be crucial to diagnosis and treatment. Placement in foster care, homelessness, chronic illness, drug addiction, unintended pregnancy, immigration, adoption and exposure to domestic violence reflect not only social situations, but also health risk factors which children may be imperiled children.^{2,3} Most of these children have some combination of increased environmental exposures, economic disadvantage, and stress with decreased exposure to preventive care, age - appropriate stimulation, and nurturing attachments.^{3,4,5} Without an appreciation of these issues, the health care provider is likely to overlook needs, misinterpret symptoms, and/or apply inappropriate or unachievable treatments.^{3,6,7}

To understand and best care for these children, the health care provider must recognize that his/her role will often extend beyond the reach of the stethoscope. Clearly clinical acumen is crucial; many of these children will present with poorly developed histories and little to no health documentation. They will have untreated or under-treated illness, and the resultant acute or chronic disability be uncovered and addressed.^{5,6,7} However, accessing information, achieving accurate diagnosis, and ensuring appropriate treatment are not likely to occur unless the health care provider is able to harness “non-traditional” resources. Facility with the legal, educational, and behavioral health systems as well as the health care financing and delivery systems is required of those who care for children in these special populations.^{1,4,5,6}

Like all children, those in special populations deserve to live happy, healthy childhoods and grow to adulthood regardless of their setting. Because of their circumstances, uncertainties, and conditions, such individuals and their families are unlikely to be able to meet their health needs without community support. This requires the physician to participate in a variety of professional partnerships to best serve the child and his or her family.,^{1,4,5,6} More than most, these children require comprehensive, coordinated, cost-effective, community-based care.

Heather C. Forkey, M.D.

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2. **Pearce JW, Pezzot-Pearce TD.** Psychotherapeutic approaches to children in foster care: guidance from attachment theory. *Child Psychiatry Hum Dev* 2001;32(1):19-44.
3. **Werner EE, Smith RS.** Overcoming the odds: High Risk Children From Birth to Adulthood. *Ithaca, NY: Cornell University Press; 1992.*
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6. **Simms MD, Dubowitz H, Szilagyi MA.** Health care needs of children in the foster care system. *Pediatrics* 2000;106(4 Suppl):909-18.
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Teaching Residents About Special Populations

Pediatricians need to understand the social determinants that influence the child's health and well-being. They must identify those children who are vulnerable to greater health risk, and intervene to diminish the possibility of negative health outcomes. To do this, pediatricians need to understand the working of the various systems (legal, foster care, public policies, etc) and how to collaborate with these entities.

Following are a variety of tools used by residency programs to meet pediatric competency in working with special populations:

- **Child Welfare Block Rotation** - University of Hawaii
- **Partnership with Julian Center Passport Tool** - Indiana University
- **Community Collaboration focused on young parents** – University of Florida and Beulah Beal Young Parents Center

Child Welfare Block Rotation

TEACHING RESIDENTS ABOUT SPECIAL POPULATIONS

Curricula and Tools from the University of Hawaii

Victoria Schneider, MD & Louise Iwaishi, MD



Goals:

- Demonstrate proficiency in the conduct of a thorough history and physical examination in cases of suspected abuse and neglect.
- Understand the psychosocial evaluation and treatment of the abused/neglected child and family.
- Be able to describe and identify the community services available to serve the population of abused, neglected, and at-risk children and families.
- Demonstrate an ability to assume the role of the pediatrician as child advocate in the community.

Method:

The University of Hawaii implemented a four-week block rotation focusing on child welfare, and the special at-risk populations involved in the child welfare system. The University collaborates with the state's Healthy Start, Child Protection Services (CPS) and Child At-Risk Evaluation (CARE) Clinic to ensure a well-rounded learning experience for the residents.

At Healthy Start, the resident works with a social worker and accompanies the social worker on home visitations. The resident also reviews select cases at both the beginning and end of the rotation and makes appropriate recommendations to the social worker.

At CPS, the resident follows a social worker as he or she works with a family. The resident collects medical information for team conferences, observes the process of a child being moved from a home foster care, takes part in case reviews involving children with medical or developmental problems, participates in home visits, attends at least one court hearing, and conducts pre-placement medical examinations.

At the CARE Clinic, the resident collects health information on the foster children, carries out a thorough medical evaluation of each child, and conducts developmental and behavioral assessments as indicated.

While residents engage in these learning experiences they also partake in didactic sessions during the 4-week block rotation. Each week focuses on a different topic (table for details).

Week 1: General

- 1) Magnitude of problem/role of the child abuse & neglect expert in the community/role of the pediatrician in the community
- 2) Reporting law requirements
- 3) Community resources
- 4) Risk factors for child abuse & neglect
- 5) Long term sequelae of child abuse & neglect
- 6) Cultural/ethnic issues
- 7) General guidelines on history taking, documentation
- 8) Court testimony

Week 2: Physical Abuse

- 1) Presenting symptoms in the outpatient setting and inpatient setting
- 2) History Taking
- 3) Physical exam
- 4) Differential diagnosis
- 5) Appropriate lab studies
- 6) Abusive patterns: Shaken Baby Syndrome; Battered Child Syndrome; abusive bruises; Munchausens by Proxy; burns

Week 3: Sexual Abuse and Neglect

- 1) Presenting symptoms in the outpatient setting
- 2) Normal vs. abnormal prepubertal genital anatomy
- 3) The role of the physical exam in the diagnosis of sex abuse
- 4) Nonabusive abnormalities of the genitalia
- 5) History taking
- 6) Physical exam
- 7) Appropriate lab studies

Week 4: Neglect

- 1) Failure to thrive
- 2) Emotional neglect
- 3) Medical neglect
- 4) Physical neglect

Additional Special Population Teaching Activities:

Throughout residency, pediatric residents have the opportunity to participate in other activities related to working with children of special populations, including

- Hospital consultations in cases of suspected child abuse and neglect
- Participation in the State Child Death Review Board
- Participation in other child welfare-related activities, such as conferences, legislative sessions, community board meetings
- Throughout the month, the resident meets with faculty to review their experiences and cases, and for tutorials and slide reviews.

Learning Outcomes:

- Residents become proficient at identifying children of special populations and developing a comprehensive care management plan in response to their special needs.
- Residents learn to work collaboratively and within the child welfare system and understand how the system influences the care of the child.
- Residents learn about resources useful to these special children and how to access them on their behalf.

Contact:

For more information on activities relating to special population training activities for pediatric residents at the University of Hawaii, please contact:

Sharon Taba, MEd

Program Director

University of Hawaii

Department of Pediatrics

1319 Punahou Street

Honolulu, HI 96826

Phone: 808-983-8196

E-mail: sharontab@kapiolani.org

<http://hawaiiimed.hawaii.edu/uhpeds/uhpeds.html>



Partnership with the Julian Center - Passport to Self Directed Learning

TEACHING RESIDENTS ABOUT SPECIAL POPULATIONS

Curricula and Tools from the Indiana University

Nancy Swigonski, MD, MPH, Sarah Stelzner MD,

Dianna Fox, MD & Carleen Miller, MA, LMFT, LMHC

Goal:

To provide the resident with a comprehensive real-life learning experience focused on teaching the unique needs of youth affected by violence in transitional situations.

Method:

With a focus on domestic violence, Indiana University has cultivated a partnership with The Julian Center, a United Way community-based organization which provides services and shelter to women and children who are victims of domestic violence. Through this partnership, residents learn about the health concerns and special needs specific to children and families living with domestic violence.

The residents work in collaboration with The Julian Center staff to provide care, education and support to the families and their children. For example, one resident reviewed The Julian Center's statistics and noted the majority of women at the shelter were young mothers. In response, another resident developed a toolkit of resources for young mothers and their children with emphasis on physician and domestic violence advocates' needs.

An important component of this learning experience is **Indiana University's Passport**, a form that residents take with them when they visit The Julian Center. The form (see below) provides guidance,, names learning goals and objectives for the visit, and asks residents to evaluate their community experience.

Additional Special Population Teaching Activities:

Throughout residency, pediatric residents have the opportunity to participate in other activities related to working with children of special populations, including:

- Residents view a video documentary on children and domestic violence
- Residents participate in discussions about accessing community resources
- Residents review developmentally based screening guidelines for children regarding domestic violence

Learning Outcomes:

- Residents become very involved with the day-to-day trials and tribulations of children who are victims of domestic violence and develop a good understanding of the major issues for families in crisis.
- Residents become proficient in interacting with families and in appropriately addressing the issues surrounding domestic violence.
- Residents are able to develop a positive patient - doctor relationship with families in transition to support a more permanent transition to a medical home.
- Residents learn to work effectively with community-based organizations and their staff.

Contact:

For more information on activities relating to special populations at Indiana University, please contact:

Cathy Luthman
Program Manager

Partnerships for Change—Dyson Initiative

Indiana University
Department of Pediatrics
Children's Health Services Research
699 N. West Dr.
Indianapolis, IN 46202

Phone: 317-278-4514

E-mail: cluthman@iupui.edu
<http://www.ichsr.org/>

Passport to Self-Directed Learning

Community I – Domestic Violence: Screening, Epidemiology, and Services

Competency: Medical Knowledge

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

Objective 1:

Become aware of effective screening tools for domestic violence that health care providers should use.

Instruction:

1. Review the Domestic Violence Screening Tool for Developmental Stages located on Angel.
2. Read "Scars That Won't Heal: The Neurobiology of Child Abuse" from Scientific American, Vol 286, Issue 3, Mar 2002. located on our website.

Evaluation:

1. Thinking about the patients in your clinic, how could you incorporate age specific domestic violence screening tools into your practice?
2. Knowing the long-term effects of child abuse, what can you do in your clinic to help a patient deal with these lasting effects as they transition through different stages of life?

Competency: Practice-Based Learning and Improvement

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

Objective 1:

Understand the cycle of violence and wheel of power from cultural, economic, psychological, and legal viewpoints.

Instruction:

1. Review the cycle of violence and wheel of power handout located on our website.
2. Read the AAP Policy Statement "The Role of the Pediatrician in Recognizing and Intervening on Behalf of Abused Women" from Pediatrics Vol 101, No 6, June 1998 at <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;101/6/1091.pdf>

Evaluation:

Knowing some of the major components of domestic violence and your role as a pediatrician, how will you recognize and intervene on behalf of your patients and caregivers?

Competency: Systems-Based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

Objective 1:

Understand the importance of immediate support services and advocacy for women and children affected by domestic violence.

Instruction:

Read “Community-Based Domestic Violence Services” by Amy J. Saathoff and Elizabeth Ann Stoffel from *The Future of Children: Domestic Violence and Children* Vol 9, No 3, Winter 1999 at http://www.futureofchildren.org/usr_doc/vol9no3Art7.pdf

Evaluation:

Using community-based services for domestic violence as a model, what services are most important to families affected by violence and why?

Objective 2:

Understand the team approach to caring for families affected by domestic violence

- Instruction: Review “Table 1: A Public Health Model for Domestic Violence Prevention” located on our website.
- Evaluation: In what ways do you envision your clinic being able to work with other primary, secondary, and tertiary modes of care in order to provide optimal care for those affected by domestic violence?

Reflection:

1. How will you incorporate what you learned into your continuity clinic practice?
2. What did you learn from this exercise that most surprised you?

Contact:

Carleen Miller, M.A., LMFT, LMHC
Director of Julian Center Shelter

Dianna Fox, MD
Assistant Professor of Clinical Pediatrics.

Phone: 317-941-2219

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Community Collaboration Focused on Young Parents

TEACHING RESIDENTS ABOUT SPECIAL POPULATIONS

Curricula and Tools from the University of Florida, Jacksonville

Goal:

For residents to develop skills in working with pregnant and/or parenting adolescents in an urban alternative high school. In addition, the residents contribute to the improvement of the health and well being of these teen parents and their offspring.

Method:

The University of Florida in Jacksonville has developed a strong partnership with the Beulah Beal Young Parents Center. The Center is an alternative high school offered by the Duval County Public School System to respond to the special needs of pregnant and parenting adolescents. During the Community Rotation experience, the pediatric resident visits the school, interacts with the teens and their offspring in the classroom and nursery, assesses the teens' concerns and beliefs through focus group discussions, and provides health education classes on topics selected by the adolescents. In addition, the residents interact with staff, answer questions about babies' health, and observe how teen parents are taught child-care skills. At least twelve residents rotate through this site annually. The health education classes that the residents provide are evaluated by the Community Rotation Director using a specific instrument (attached).

Additional special population teaching activities:

Throughout residency, pediatric residents have the opportunity to participate in other activities related to working with children of special populations, including:

- Residents will also have the opportunity to visit Beulah Beal's daycare center including the breastfeeding room
- Residents are sometimes assigned a faculty mentor at the Florida School for the Deaf and Blind (boarding school for hearing and/or visually impaired children pre-school to 12th grade) where they get hands on experience assessing and providing health information to visually and hearing impaired children.

Learning outcomes:

- Residents learn to define the health education needs of the targeted special population.
- Residents enhance their knowledge and understanding of the multiple issues faced by teen parents and the constellation of services that can be made available to them when community agencies collaborate.
- Residents learn to work collaboratively with the staff, supporting them in their efforts to care for children in high-risk situations.
- Residents learn to identify common environmental and/or cultural variables that contribute to early pregnancy among girls and young women.

Contact:

For more information on activities relating to special populations for pediatric residents at the University of Florida, Jacksonville, please contact:

Joy Burgess, RN, MSN
Program Manager

Department of Pediatrics / Dyson Initiative
University of Florida
Shands Clinical Center, 5th Floor
Jacksonville, FL 32209

Phone: 904-244-4295

E-mail: joy.burgess@jax.ufl.edu

<http://www.hscj.ufl.edu/peds/pr/dyson.asp>

Beulah Beal Young Parents Center

History and Purpose of the Educational Lecture Series

In 2001, University of Florida, Department of Pediatrics started a monthly health educational lecture series for teen parents of Beulah Beal. Under the leadership of Dr. Nicole Mark, a Senior Pediatric Resident during that time, the first presentation started in September 11, 2001. Monthly presentations followed after that and topics have concentrated primarily on infant and children's health issues.

The Educational Lecture Series was started in response to requests from Beulah Beal's teen parents. Many of Beulah Beal's babies are patients at Shands Pediatric Clinic. Pediatric Residents' monthly interaction with Beulah Beal's student population enhances the doctor -patient relationship. It also provides a better environment for giving anticipatory guidance compared to being at the doctor's office when parents are easily distracted by their babies. The interactive nature of the Educational Lecture session also encourages good rapport between provider and parent, and it promotes the importance of regular primary care office visits for the baby.

Directions from Shands Hospital

Travel East on 8th Street from Shands Hospital. Turn North (Left) onto Boulevard Street. Turn Right (East again) onto 9th Street. Beulah Beal Center will be on your right at 330 West 9th Street.

Contact:

Ms. Lee Marshall, Principal
Ms. Susan Schultz, Supervising Teacher

330 West 9th Street
Jacksonville, FL 32206

Background Information

Operated by Duval County Public Schools

Beulah Beal Young Parents Center is an alternative placement offered by Duval County Public School System to provide a school setting for pregnant and parenting adolescents. The Duval County Public School System has maintained a program for pregnant and parenting teens for more than 25 years. The program was previously located at the Darnell Cookman Counseling Center on Davis Street in downtown Jacksonville. In 1990, the program was moved to its current location at Beulah Beal.

Beulah Beal currently collaborates with several community business partners that bring valuable resources to the school. The Educational Community Credit Union has been the school's business partner and provided a variety of resources to the school.

Students

Each year approximately 350 pregnant or parenting students aged 11-19 enroll at the school. At any given time, there are approximately 200 students enrolled at the school. Although the majority of the students are female, male students can also attend. Approximately 30% of the students are two to three years over age for the assigned grade level. Students attend the school for one academic year and are enrolled in courses to meet promotion and graduation requirements of Duval County Public Schools.

Many of the students who attend Beulah Beal have been identified as adolescents who live in areas designated as Health Professional Shortage Areas (HPSA) and Medically Underserved Areas (MUA). Beulah Beal finds that it must address and educate its students about the community issues of teen pregnancy, infant mortality, low birth weight babies, HIV infection, drug use and sexually transmitted diseases.

Daycare Center

A daycare center is provided for the infants of students who attend Beulah Beal. Infants range in age from two weeks to twelve months. Students take courses in Parenting and Childcare. An on site clinic is provided for the students staffed by a full time nurse from the Duval County Health Department. For years the University of Florida Family Health Center and Shands Jacksonville have been involved with teaching students about important health issues.

Beulah Beal Young Parents Center

Goal

Contribute to the improvement of health among teen parents, their offspring, and the staff who work with them in a special school-based setting offering daycare and other services.

Objectives

1. Define the health education needs of the student population and the school daycare workers.
2. Enhance knowledge and promote positive attitudes toward preventive health practices among the teen student population, teachers, and daycare workers.
3. Identify common environmental and/or cultural variables that contribute to early pregnancy among girls and young women.
4. Understand the multiple issues faced by teen parents and the constellation of services that can be made available to them when community agencies collaborate.

Learning Activities

1. Interact with teen parents to learn about their health education needs, and their needs for multiple community-based services, as well as their reactions to their environments, their children, and the teaching of childcare skills.
2. Interact with staff and/or the Principal to identify priorities for health education among the staff.
3. Conduct monthly health teaching sessions with emphasis on newborn and infant care.
4. Emphasize communication of information about immunizations, nutrition, and injury prevention, especially at the daycare center for teen parents' children.
5. Act as a resource and advocate for teen parents seeking full primary and specialty pediatric care for their children.

What to Expect

You are expected to give a health presentation to the teen parents and staff of Beulah Beal Center. You should consult with Dr. Ravago in advance about your topic and your plans for your presentation.

You will also have the opportunity to visit Beulah Beal's daycare center including the breastfeeding room. In addition, you will interact with staff, answer questions about babies' health, and observe how teen parents are taught childcare skills.

Resources

Youth in Substitute Care

Websites

Violence Policy Center. Available at: <http://www.vpc.org/>. Accessed August 13, 2004.

Children's Defense Fund. Available at: <http://www.childrensdefense.org/>. Accessed August 13, 2004.

The Children's Bureau. Available at: http://www.acf.dhhs.gov/programs/cb/publications/rpt_abu.htm. Accessed August 13, 2004.

National Clearinghouse on Child Abuse and Neglect Information. Available at: <http://nccanch.acf.hhs.gov>. Accessed August 13, 2004.

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Homeless Youth

Websites

National Coalition for the Homeless
<http://www.nationalhomeless.org/index.html>

Safe Horizon
<http://www.safehorizon.org/>

US Department of Housing and Urban Development
<http://www.hud.gov/>

Manuals, Guides, Newsletters

Alone Without a Home: A State-by-State Review of Laws Affecting Unaccompanied Youth. (2003). National Law Center on Homelessness & Poverty and National Network for Youth. Washington, D.C.

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Youth with Chronic Conditions

Websites

Brave Kids

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

Family Voices

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

Association of Maternal and Child Health Programs

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

Manuals, Guides, Newsletters

AMCHP Fact Sheet: Protecting Children with Special Health Care Needs - March 2003 [PDF]

<http://www.amchp.org/aboutamchp/publications>

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Adolescents

Websites

Centers for Disease Control and Prevention
<http://www.cdc.gov/health/adolescent.htm>

Monitoring the Future
<http://www.monitoringthefuture.org/>

National Adolescent Health Information Center
<http://youth.ucsf.edu/nahic/>

National Campaign to Prevent Teen Pregnancy
<http://www.teenpregnancy.org/>

Substance Abuse and Mental Health Services Administration
<http://www.samhsa.gov/index.aspx>

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Other

What Docs Should Know About...The Impact of Teen Pregnancy on Young Children.
Available at: <http://www.teenpregnancy.org/resources/reading/pdf/tots.pdf>

Immigrants and Refugees

Websites

Children's Defense Fund

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

Harvard Program in Refugee Trauma

<http://hpvt-cambridge.org/>

International Rescue Committee

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

National Immigration Law Center

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

Office of Refugee Settlement

<http://www.acf.hhs.gov/programs/orr/>

U.S. Committee for Refugees

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

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Articles

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Youth who are Adopted

Manuals, Guides, Newsletters

National Council for Adoption. National Adoption Report (NAR). Available at http://www.ncfa-usa.org/pub_NAR.htm

Books & Monographs

Brodzinsky DM., Schechter MD., Heinz, RM. *Being Adopted: The Lifelong Search for Self.* New York: Doubleday, 1992

6

Pediatricians as Collaborative Leaders

What roles are available to pediatricians as consultants, leaders, and partners in the community? And what kind of curricular experiences, exposure to expertise, and competencies can be employed throughout a residency training program to better prepare graduating residents for the successful practice of these roles in their community of choice?

The pediatrician's primary consultant role is directed toward the child and the family, especially those families of children with ongoing, chronic illness. This consultant role is very much needed. It is estimated that at least 10 percent of the United States' child population has significant, recognized chronic illness that requires additional care or expertise above the norm. This percentage increases dramatically in many other countries, especially those within the developing world.

During their training, pediatric residents should be exposed to those families and their needs both inside and beyond the traditional medical setting. Working in the home setting and special schools, working with interdisciplinary teams of providers and the families themselves – these all are important experiences to include in a residency training program so learners can appreciate the needs and strengths of family. Desired competencies in advocacy, knowledgeable interventions, meaningful follow-up, and governmental (local, state and federal) programmatic interfaces can be emphasized during these experiences. Multidisciplinary and parent faculty with those areas of expertise are well-suited teachers for residents.

Once knowledge has been acquired and behavior affected, the resident can serve as a consultant, teacher, and leader for medical students and younger residents who are at an earlier stage of learning.

In addition to their primary consultant role to families, pediatricians should also play a consultant role in organizations and places that focus upon children, even when the venue is not purely a medical one. These organizations include, but are not limited to, child care centers, schools at all levels, community-based organizations, and policy-setting institutions that impact children. Teaching about these areas will require different faculty and a multidisciplinary team so residents can best appreciate the importance of the pediatrician in these settings and teams.

During all these experiences as a consultant and teacher outside the strict medical environment of the hospital, ambulatory site or nurseries, the pediatric trainee should be introduced to key elements and rewards of leadership. These elements include:

- Serving as role models in community-based training; Becoming an advocate for children and families in different community settings;
- Contributing positively to collaboration and the synergy that occurs when multiple providers work together in different settings;
- Advocating for better appreciation of multi-cultural contributions to children's health;
- Conveying positive commitment to these aspects of care for children and families; and
- Lifelong learning, the appreciation of this as a strategy for career fulfillment and the ability to convey that to a young trainee.

The pediatrician with a full breadth of that expertise is not limited to the pure medical setting. To develop the pediatrician as leader, consultant, and partner to the larger community where children and families live is the broader challenge for the next generation of pediatric residency programs.

Learning the skills of partnering and collaborating is a lifelong process. Teaching humility and respect for other's experience and perspective may be learned in many areas of medical training. Providing the opportunity to step outside of the medical center may encourage this process. Each training program will need to determine how and where these experiences can be incorporated to maximize these learning opportunities. This is dependent on available settings, needs, strengths, community-based resources, and the level of commitment and communication with those outside hospital sites and settings. The families and communities we care for will surely affirm the strength and importance of broadening these educational expectations for our future pediatricians.

Steven P. Shelov, MD, MS

Teaching Residents to function as Consultants, Collaborative Leaders, and Partners

Pediatricians hold important collaborative and leadership roles, both within and outside the traditional medical setting. While keeping the child and his/her family at the center, the pediatrician must work in partnership with key individuals, organizations and systems that affect the child's wellbeing. Pediatricians should be able to function as productive members of the health care team; demonstrating the ability to collaborate, lead or provide guidance and information to other professionals whose work impact on the wellbeing of children. The ability to listen carefully, to value the contributions of others, to negotiate conflict resolution, as well as the skills to mobilize information and communicate effectively to a variety of constituencies are key to the successful practice of community pediatrics.

This chapter will outline several teaching methods and tools used to train residents to serve as Consultants, Collaborative Leaders, and Partners. Included are:

- **Resident Asset Map** – *University of California, Davis*
- **Individual Professional Development Plan** – *Indiana University*
- **Community Agency Assessment Form** – *Medical College of Wisconsin*



Resident Asset Map

TEACHING RESIDENTS TO FUNCTION AS CONSULTANTS,
COLLABORATIVE LEADERS, AND PARTNERS

Curricula and Tools from Communities & Physicians Together (CPT)

at the University of California, Davis

Richard Pan, MD, MPH and Peggy Tapping

Goal:

To help residents see themselves as part of a larger picture, and to understand the assets and capacities that they bring to the table when collaborating with communities around improving child health.

Method:

The Resident Asset Map is completed by interns before they begin with the Residency Program, and returned to the CPT Program Manager. The Program Manager uses these maps to help assign incoming residents to their Collaborative Communities, with which they will be partnered throughout their three years of residency. Collaborative Coordinators – or leaders of the partnering CBOs – also use the Resident Asset Map to familiarize themselves with the resident and identify the gifts and talents coming to their community.

Additional teaching activities:

Throughout residency, pediatric residents have the opportunity to participate in other activities related to Pediatricians as Consultants, Collaborative Leaders, and Partners, including:

- Completing a Windshield Survey (see attached tool)
- Partner with a Community Collaborative (a group of community - based organizations that work together)
- Provide health education to elementary school students through the School Health program

Learning outcomes:

- Residents learn to reflect on their personal experiences and assess their potential contribution to the community
- Residents learn to identify personal professional interests as opportunities to work with key community groups and therefore increase community collaboration.
- The resident learns to identify skills and strengths they share with community members and define areas for further learning and growth through community experiences – learn from others

Note – This tool is tailored to the program at the University Of California, Davis where they adopted the McKnight and Kretzman model of Asset-Based Community Development (ABCD) in their collaborative work at the community level. The focus is on the assets of the community and its organizations and residents as they seek to address urban problems. For more information on ABCD, please go to <http://www.northwestern.edu/ipr/abcd.html>.

Contact:

For more information on activities relating to pediatricians as consultants for pediatric residents at University of California, Davis, please contact:

Elizabeth Sterba

Program Manager

Communities & Physicians Together

UC Davis Children's Hospital
Department of Pediatrics
2516 Stockton Boulevard, Suite 217
Sacramento, CA 95817

Phone: 916-734-2156

E-mail: elizabeth.sterba@ucdmc.ucdavis.edu

Website: www.cpt-online.org

Communities & Physicians Together Resident Asset Map

Name: _____

Medical School: _____

Hometown: _____

Zip Code of Sacramento Residence: _____

Languages: (Please list proficiency) _____

Hobbies: _____

Membership or Involvement in Associations (past and current):
(see attached list from CATCH Guide for reference) _____

Previous Involvement in Community Projects (describe): _____

Please check the areas that interest you and that you'd like to have some involvement in as part of your advocacy experience.

- | | | |
|---|---|---|
| <input type="checkbox"/> Access to Health Care | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Special Needs Children |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> Safety/Injury Prevention | <input type="checkbox"/> Health Promotion |
| <input type="checkbox"/> Recreation/Physical Activity | <input type="checkbox"/> Cultural Awareness | <input type="checkbox"/> Oral Health |
| <input type="checkbox"/> Adolescent Health | <input type="checkbox"/> Nutrition | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Literacy | <input type="checkbox"/> Schools | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Rural Health | <input type="checkbox"/> Health Education | <input type="checkbox"/> Parenting |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Obesity | <input type="checkbox"/> Tobacco Cessation |

Other: _____

How familiar are you with the following (circle response):

	Never Heard of it!	Unfamiliar	Familiar	Very Familiar
Sierra Health Foundation Community Partnerships for Healthy Children Initiative	1	2	3	4
Asset-Based Community Development	1	2	3	4
AAP CATCH Program	1	2	3	4
Social Capital	1	2	3	4

Windshield Survey

Housing

Describe the buildings people live in (apartments or detached homes, age, condition). Are there front porches? fences? dogs in the yard? window bars? security systems? Vacant homes or buildings? Trash/junk in yards? Parking?

Transportation

How much traffic is on the streets? What kind of vehicles? Public transportation (bus, light rail) stops nearby? Sidewalks and crosswalks?

Parks and Recreation

Where are parks in the neighborhood? Describe the parks (condition, trees and/or grass, children playing). What recreational facilities are available (playground, pool, ball fields, etc; condition) Where are cultural facilities (museums, library, theaters, etc)? Public art?

Schools

Describe the schools in the neighborhood? Grade levels? Size? Condition? After-school activity? Healthy Start or other programs? What school district is the neighborhood in?

Government

Are the police visible? In cars, bikes, walking? Any government offices in the neighborhood?

Businesses

Describe the businesses in the neighborhood. (Grocery stores, drug stores, restaurants, liquor stores, payday stores) Who are the major employers in the neighborhood? Signage in other languages? What businesses are missing?

Services

Where are physician and dentist offices? Hospital? Chiropractors? What child care facilities are available? Social service offices? Family resource center? WIC? Community centers? Community organization offices? Shelters for homeless, abused spouses? Houses of worship? Religions/ denominations? Activity on weekdays?

People

Who do you see in the streets? Where do people hang out? Teens? Families with children? What activities are available for children (sports, arts & crafts, etc.)? What race/ethnicity? Do people of differing ethnicity interact? Live in separate areas?



Individual Professional Development Plan

TEACHING RESIDENTS TO FUNCTION AS CONSULTANTS,
COLLABORATIVE LEADERS, AND PARTNERS

Curricula and Tools from Indiana University

Sarah Stelzner, MD & Nancy Swigonski, MD, MPH

Goal:

To help residents identify areas of interest and potential professional growth as advocate, consultant, community leader, volunteer

Method:

A faculty member meets with the resident and administers the questionnaire (see below). Residents are guided through a process of reflecting on their own experiences, interests, and goals, and are asked to identify how this will inform their training experience and ultimately their practice. The interview takes about 5 minutes and helps to guide faculty and resident to tailor the second community month to interests, learning style and future plans and find the best fit for the Community Project. Faculty also utilize the interview to inform the resident about community experiences that they can choose to pursue through the program at a later point.

The Individual Professional Development Plan is administered at the END of the first Community Pediatrics rotation during internship and revisited again at the START of the second Community Pediatrics rotation during second year.

Additional teaching activities:

Throughout residency, pediatric residents have the opportunity to participate in other activities related to Pediatricians as Consultants, Collaborative Leaders, and Partners, including:

- Organizing community clinic health fairs
- Advocating for children through AAP legislative activities
- Producing monthly radio show programs on health education topics
- Staffing domestic violence center's clinic
- Developing toolboxes for clinic and patient use
- Participating in Grand Rounds panels on legislative advocacy, gun violence prevention, parenting roles, etc.
- Interviewing subspecialists on transitions' issues
- Providing voters' registration and key issues information
- Meeting with parent liaisons for children with special health care needs and advocates for victims of domestic violence
- Assessing needs of the underserved population through annual surveys

Learning outcomes:

- By reflecting on personal experiences the resident identifies personal professional interests, and pursues these interests as opportunities for collaboration with key community groups

Contact:

For more information on activities relating to pediatricians as consultants at Indiana University, please contact:

Cathy Luthman

Program Manager

Partnerships for Change—Dyson Initiative

Indiana University

Department of Pediatrics

Children's Health Services Research

699 N. West Dr.

Indianapolis, IN 46202

Phone: 317-278-4514

E-mail: cluthman@iupui.edu

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

Individual Professional Development Plan

Indiana University

Introduction by the faculty member

The goals of the community pediatrics rotation are to ...(insert your program philosophy).... But we realize everybody comes with different interests and experience so we want to ask you 5 questions that will take about 5 minutes so we can make a better fit with your own personal goals.

To be delivered in person or over the phone by faculty

1. What are your plans for your future practice?
2. What community experiences have you had during college, medical school or residency?
Probe: Partnering with CBOs, advocacy, volunteerism, school based care
Probe: What was your specific role in that experience?
3. How can you imagine yourself being an advocate or community leader when you are out of training?
4. What do you need to learn on this rotation to reach those goals?

Faculty member goes on to explain Community II rotation

During the community II rotation, residents are given the chance to work more intensely with one of three community-based organizations. I want you to think about some of the things we just talked about like your own interests and experiences or things you think will be especially helpful in the future and choose one of the three organizations. Let me describe them briefly....

- Faculty will then introduce CBOs and projects and that we would like to make a compatible match of resident with a CBO.
- Faculty will give a sentence about CBOs and projects then pause for resident to choose.

Decide on CBO and focus of Longitudinal Project:

(must be chosen by 2 months prior to Community II rotation)

List of possibilities for further advancement:

To be filled out at the end of Community I and then revisited at the beginning of Community II

- Developing a Medical Home in Your Practice
- Partnerships with Schools
- Continuous Quality Improvement
- Advocate for Vulnerable Populations (families exposed to violence, recent immigrants, families affected by HIV/AIDS, Children with Special Health Care Needs, youth in juvenile justice system, children and youth in foster care, sexual minority youth, families with mental health issues)
- Legislative Advocacy
- Linguistic and Cultural Competency
- Elimination of Racial and Ethnic Disparities in Health Care
- Systems Based Health Care
- Practice Based Learning

Chosen Areas of Expertise:	Methods to Achieve Competency:	Venue (CBO, continuity clinic, NB nursery, etc.)	Date Accomplished	Faculty Signature

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Community Agency Assessment Form

TEACHING RESIDENTS TO FUNCTION AS CONSULTANTS,
COLLABORATIVE LEADERS, AND PARTNERS

Curricula and Tools from the Medical College of Wisconsin

Earnestine Willis, MD, MPH, Karen Wendelberger-Marcadante, MD, Dawn Bragg, PhD

Goal:

To assist residents in developing skills to understand structures of community-based organizations (CBO).

Method:

During a mandatory block rotation, second- year residents complete a Community Agency Assessment Form. It is conducted through an informational interview- with key CBO staff (executive director, chief financial officer, development officer, etc.) at the agency where residents have chosen to do a month-long project. This form assists in guiding residents to forge a working relationship with the CBO through the development of a community-based project. The assessment process takes approximately 45 minutes. To enhance the working relationship, each resident completes the form face-to-face with staff members. Upon filling out the worksheet, residents debrief with the community pediatrics program director and shares how this experience facilitates their understanding of the organization.

Additional teaching activities:

Throughout residency, pediatric residents have the opportunity to participate in other activities related to Pediatricians as Consultants, Collaborative Leaders, and Partners, including:

- Monthly noon conferences for discussions with first year residents pediatric dental residents, and nursing students led by community-based faculty
- Skill building in advocacy during the yearly statewide pediatric advocacy day and AAP advocacy day in Washington, DC
- Collaborating at community-based organizations fundraisers and community events for children
- Quarterly noon conferences for third - year residents on current community pediatrics topics
- Interactions with trained cohort of parents who face healthcare barriers during month-long rotation in community pediatrics for second - year residents to share personal experiences and resiliencies in overcoming those barriers.

Learning outcomes:

- Residents develop a working knowledge of the community-based organizations' mission, vision and services offered.
- Residents learn communication skills and partnership styles at the community level.
- Residents assess community health needs to be addressed in their community initiative.
- Residents identify common goals for collaboration and recommend ways to complement community's strengths in the partnership process.
- Residents discover future opportunities for service collaboration.

Contact:

For more information on curricular activities relating to pediatricians as consultant at the Medical College of Wisconsin, please contact:

Tiffany Frazer, MPH
Program Manager

Medical College of Wisconsin
Department of Pediatrics
MACC Fund Research Center
8701 Watertown Plank Road
Milwaukee, WI 53226

Phone: 414-456-4609

E-mail: tfrazer@mail.mcw.edu

<http://www.mcw.edu/peds/program/mdep/>

Community Agency Assessment Form

MULTI-DIMENSIONAL EDUCATION PROGRAM

Worksheet

Use the following set of inquiries during the interview to gain insight into a Community-Based Organization (CBO). Several (3-5) key persons of the CBO, as listed below, would be worthwhile to interview. **Note:** Make sure that at least one of the key persons is CEO/President/CFO.

- President, Board of Directors
- Chief Executive Officer (CEO)
- Chief Financial Officer (CFO)
- Development Officer (Optional)
- Human Resource Officer (Administrator)
- Chief of Technology
- Legal Advisor

Community-Based Organization (CBO)

Name: _____

Inquiries	Comments
History of CBO	
Mission of CBO and Goals	
Define Governance Structure and Management (Request Organizational Chart and Staffing)	
What is the Product-line(s) in CBO?	
History of CBO	
Mission of CBO and Goals	

Inquiries	Comments
Define Governance Structure and Management (Request Organizational Chart and Staffing)	
What is the Product-line(s) in CBO? Targeted Population(s)	
Demographics of Population	
Define other Assets in Community	
List of Services Provided by CBO	
Waiting Time for Services	
CBO's Abilities to Balance Planning and Opportunities	
Give Examples of Innovativeness/Creativity of CBO	
Abilities to Create New Opportunities in Governance of CBO i.e. consumers-oriented, staff and Board	
CBO's Abilities to be Efficient	
Outreach Efforts of CBO to the Community (ies)	
Evaluation of Program: a. Process Measure b. Outcome Measures	
Evaluation Results...Effectiveness	

Inquiries	Comments
CBO's Ability to Accept Risks	
Programmatic Efforts to Reduce Emphasis on Paper in CBO	
Current Challenges for CBO	
Urgent Change Desired in CBO	
CBO Processes to Create Sense of Urgency for Needed Changes e.g. In-service, Recruitment	
CBO's Ability to Align Incentives with Productivity	
Agency Self-reliance based on Services	
Self-Sufficiency based on Philanthropy/Endowment	

Resources

Websites

The American Academy of Pediatrics: Department of Community of Pediatrics

<http://www.aap.org/sections/socp/index.html>

The Asset Based Community Development Institute

www.northwestern.edu/ipr/abcd.html

Children's Defense Fund

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

Community Access to Child Health (CATCH)

<http://www.aap.org/catch/>

Community Toolbox

<http://ctb.ku.edu/>

Healthy Tomorrows Partnership for Children Program

<http://www.aap.org/compeds/htpcp/index.html>

Task Force on Community Preventive Services

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

Manuals, Guides, Newsletters

Section on Community Pediatrics Newsletter

<http://www.aap.org/sections/socp/publications.html>

Articles

American Academy of Pediatrics Committee on Community Health Services. The pediatrician's role in community pediatrics. *Pediatrics*. 1999; 103(6): 1304-1306.

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Grason H, Aliza B, Hutchins VL, Guyer B, Minkovitz C. Pediatrician-led community child health initiatives: case summaries from the evaluation of the community access to child health program. *Pediatrics*. 1999; 103(6 Pt 3): 1394-419.

Guyer B. Promoting Community Pediatrics: recommendations from the Community Access to Child Health Evaluation. *Pediatrics*. 1999; 103(6 Pt 3): 1370-2.

Other

American Academy of Pediatric Mentorship and Technical Assistance Program (MTAP)

<http://www.aap.org/sections/socp/mtap.html>

Please see Resources in the Community and Public Health and Special Populations Chapters



Educational and Child Care Settings

What is School Health?

School Health is the planning and execution of activities aimed at enhancing the physical, mental, and social well-being of youngsters in their own educational settings. In the past, school health has included nutritional supplementation, health and dental assessments, vision and hearing screening, as well special educational services for children at high risk for school failure. With time, school health activities have broadened in nature and scope. The Institute of Medicine has defined School Health as: “...an integrated set of planned, sequential, school-affiliated strategies, activities, and services designed to promote the optimal physical, emotional, social, and educational development of students.” Thus school health activities can be both school-based or school-linked—not necessarily on school property, but related directly to the school.

Today, generalists and specialists can participate in school health activities, as children spend a large proportion of their time in educational settings such as daycare, schools, early childhood programs, after school and other organized out of home activity. To do school health effectively requires competencies in patient care, medical knowledge, practice learning and improvement, interpersonal and communication skills, professionalism, and systems based practice. School Health also is an arena where the topics important to community pediatrics are easily identifiable: culturally effective care, child advocacy, medical home, special populations, the pediatrician as consultant, partner, and collaborative leader, educational and child care settings, community and public health and research and scholarship.

School Health Activities

School Health activities in this country are marked by disparities in funding, staffing, and scope. This is in contrast to many other countries, where School Health is an integral part of the community health system and consistent planning and execution of activities exists. Traditionally, three components have been identified: health services, health education, and the health environment – physical and emotional of the school.

In the past decade, the CDC has set forth 8 component areas for school health: health services; counseling and support; healthy environment; family, school and community partnerships; staff wellness; physical education; health education; and nutrition. The American Academy of Pediatrics has enunciated 7 Goals for a School Health Program: 1) Assure all students access to primary health care (medical home); 2) Provide a system for dealing with crisis medical situations in the school; 3) provide mandated screening and immunization monitoring; 4) Provide systems for identification and solution of students' health and educational problems; 5) Provide comprehensive and appropriate health education; 6) Provide for a healthful and safe environment that facilitates learning, and 7) Provide a system of evaluation of the effectiveness of the school health program. Schools are being recognized as places where encouragement and monitoring of key health behaviors, such as diet, activity, smoking, and substance use, can be addressed.

What is the Role(s) of the Pediatrician in School Health?

The pediatrician can play two distinct roles in relation to school health. The first role is as a particular child's physician, advocating for the assistance needed to help the child deal with a specific acute or chronic health or learning problem. This includes skilled communication with key school personnel as well as, telephone and sometimes in- person attendance at school special education meetings. Knowledge of medical issues and education laws, requirements and policies are mandatory for the pediatrician to be effective. In addition, professionalism will dictate recognition of other professionals' key roles in evaluation and treatment. Modification of regular school activities may be required, or medication may need to be arranged. Peer reactions to a given child's conditions may need to be handled with the teacher and other school personnel. Regular feedback from the school on progress, school behavior, attendance, possible side effects of treatment, and even assistance in provision of treatment- for example intervention in an acute asthma attack- may also be a part of the pediatricians' role. It is clear that all pediatricians are likely to have some interaction with educational settings in relation to their patients.

The second role a pediatrician can play is as a consultant to a school or school district. It is important for the pediatrician to be aware of the distinction. When the physician is a consultant, paid or volunteer, the school or district is the "client", and the pediatrician deals with systems of care rather than taking on the medical management of a given child. Instead, policies and procedures are established for dealing with health and educational issues for groups of children, such as children with special needs, medically fragile children. These include emergency care protocols, outbreaks of infectious disease, incidents of school violence, setting up ways to help families get access to health insurance, and optimizing the health of school athletes – to mention just a few. Many pediatricians have found this type of activity professionally rewarding.

Philip R. Nader, MD

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Teaching Residents About Educational and Child Care Settings

To achieve competency in educational and child care settings, pediatricians should be comfortable working with schools and child care to improve the health of children. This involves both an understanding of local policies relating to children with special educational needs and an ability to screen and refer children for appropriate services. Pediatricians must be able to interact with school nurses, teachers and educational staff in coordinating care for children, ensuring that children have appropriate assistive technology, medications and health plans while in school and child care.

Following are a variety of tools used by residency programs to meet pediatric competency in educational and child care settings.

- 1) **School Health Teaching Experience**- *University of Miami*
- 2) **Communities & Physicians Together School Health Program**- *University of California, Davis*
- 3) **Education Module: Understanding programs and services for students with disabilities** - *The Children's Hospital of Philadelphia*
- 4) **School Health Needs Assessment** - *Judith S. Palfrey, MD*



School Health Teaching Experience

TEACHING RESIDENTS ABOUT EDUCATIONAL AND CHILD CARE SETTINGS

Curricula and Tools from the University of Miami

Goal:

To provide residents an opportunity to develop effective teaching strategies and lesson plans on various health topics for school children.

Method:

The elementary school teaching experience is required of all 2nd & 3rd year pediatric residents at the University of Miami. Under the guidance of a nurse practitioner, 2nd & 3rd year residents spend _ day teaching pre-k through 5th graders at partnering elementary schools about exercise, nutrition, tobacco, personal and dental hygiene. Prior to visiting the schools, the residents meet with the nurse practitioner to discuss developmentally appropriate teaching methodologies and go over the lesson plan. Materials for the school visits are obtained from the Children's Health Fund (www.childrenshealthfund.org). Samples are included in the following pages.

Additional School Health Activities:

The School Health Teaching Experience complements other educational and child-care setting activities that are part of the Community Pediatrics Training Initiative at the University of Miami. Examples of other activities include:

- A half-day visit with the director of a community-based child care center;
- Working at a high school-based clinic;
- Participating in school health advisory committee meetings;
- Volunteering at after-school programs;
- Visiting programs for children with disabilities; and
- Providing primary care for uninsured children at various public schools through a mobile clinic.

Learning outcomes:

- Residents have an opportunity to interact with children, teachers and other school personnel to improve their health education teaching skills;
- Residents develop an appreciation of what the role of a pediatrician can be when collaborating with schools;

Contact:

For more information on activities relating to educational and child care activities for pediatric residents at the University of Miami, please contact:

Brian Guerdat, MPH
Project Manager

University of Miami, Child Health Advocacy for Miami Pediatricians
Department of Pediatrics
Ste 4040 (D820)
Miami, FL 33136

Phone: 305-243-3528

E-mail: bguerdat@med.miami.edu
<http://www.um-jmh.org/body.cfm?id=187>

The Food Guide Pyramid
can help you make good food choices

Do you know why children are different sizes?
Your size depends on many things:

- What you eat and drink
- The kind of work or play you do
- The size of your mother and father

Is a small child more healthy than a large child?
■ Size is not the same as health

- Children of different sizes can be healthy
- To be healthy, eat good foods and keep active

Should overweight children go on a diet?
■ A weight loss diet is not a good idea for growing children

- Eating healthy helps you be the size that is right for you

Making fun of someone's size is not ok. You can be a healthy child at any size!

Why is it cool and smart to eat good foods?
■ To make your body strong
■ To help you grow
■ To let your brain learn
■ To give you energy to play
■ To help your body to heal

Foods to choose to be a healthy child at any size!

- Eat many kinds of foods from the Food Guide Pyramid
- Eat most food from the groups at the bottom of the pyramid
- Drink low-fat or skim milk
- Eat at least 5 servings of fruits and vegetables each day
- Eat sweets and chips for a treat only
- Drink more water and less juice and less soda

How to eat healthy and smart:

- Eat breakfast, lunch and dinner every day
- Eat no more than 2-3 snacks a day
- When at home, eat with your family
- Turn off TV while eating
- Take time to sit down to eat
- Eat slowly and stop eating when there is still a bit of room in your stomach

Be cool, eat smart and feel great!

Healthy B.A.S.I.C.S.
(Building Active Strategies to Inform Children in School)

is a project devoted to bringing simple, engaging and culturally relevant health materials to elementary and middle school children.

The English and Spanish brochures were created by clinicians of the National Children's Health Project Network of The Children's Health Fund.

For additional information, contact:
The Children's Health Fund
Healthy B.A.S.I.C.S.
317 E. 64th Street
New York, NY 10021
www.childrenshealthfund.org

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MetLife Foundation

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Healthy B.A.S.I.C.S.
Cool Kids Eating Healthy Food



Communities & Physicians Together School Health Program

TEACHING RESIDENTS ABOUT EDUCATIONAL AND
CHILD CARE SETTINGS

Curricula and Tools from the University of California, Davis

Goal:

To provide residents an opportunity to engage in local schools through visits, participation in Multidisciplinary Teams (MDT's) and Individualized Education Plans (IEP's); and partner with school staff to educate children on various health topics.

Method:

Residents at the University of California, Davis, partner with five community collaboratives and five local elementary schools to participate in a school health program where they visit local elementary schools and teach students from various health curricula including the American Heart Association's "HeartPower!" curricula and the Health Education Council's "5-a-Day Power Play" curricula. Topics include nutrition and physical activity, heart health, drug and alcohol abuse, making healthy choices and media messages. Approximately one week prior to the resident's assigned school health visit date, they receive materials that include a lesson plan, visit schedule and driving directions. The day before their visit, they receive a school health kit which includes again the lesson plan, visual aides such as posters, and activity materials including stethoscopes, fat and muscle models, food packages and more. A key component included in this program is a Noon Conference lecture on classroom management/teaching children, developed and given by the principal of a participating school. This noon conference introduces first year residents to the curriculum being taught that academic year, and refreshes all residents on how to lead the class through fun, interactive and educational dialogue and activities.

Additional School Health Activities:

Observation/participation in Multidisciplinary Teams (MDT's) and Individualized Education Plans (IEP's): when available, residents are given the opportunity to sit in on MDT and IEP meetings regarding students at each school. The MDT offers residents a chance to see how different facets of a community – parents, teachers, principals, counselors, mental health clinicians, and physicians – work together in a holistic way to improve a child's academic and social behaviors. Giving residents an opportunity to see the IEP process is also important, as many physicians are those responsible for requesting IEP's yet do not know what or who is involved.

Learning outcomes:

- Residents have the opportunity to interact with school nurses, teachers and administrative staff regarding the health of students
- Residents gain knowledge of educational and environmental interventions that can improve child health most effectively through collaboration
- Residents have the chance to act as a consultant to the school on various health topics
- Residents are able to become more familiar with his/her patient population outside of the medical setting.

Contact:

For more information on activities relating to educational and child care activities for pediatric residents at the University of California, Davis please contact:

Liz Sterba

Program Manager

Communities & Physicians Together

Department of Pediatrics

UC Davis Children's Hospital

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Fax: 916-734-0342

E-mail: elizabeth.sterba@ucdmc.ucdavis.edu

www.cpt-online.org



Presents

Introduction to School Health Noon Conference

Monday, October 4, 2004 • 12:00PM • UCDMC, Davis Tower 7705

Topics Covered:

- Essentials of Classroom Management
- NEW Curriculum for 2004 – 2005!
- New Procedures

Presenters:

- Mary Greeson
Principal
Ethel Phillips Elementary School
- Dawn Dunlap
Nutrition Specialist
Sacramento City Unified School District

**It's just
what the
Doctor
ordered!**



Funded by the Anne E. Dyson Community Pediatrics Training Initiative



Communities & Physicians Together School Health Program

School Health Procedures

1. Approximately one week prior to your School Health visit date, the Child Advocacy Program Manager (Liz Sterba) will email you your lesson assignment, visit schedule and driving directions. Also included will be the curricula you are teaching. Be sure to review the lesson and make note of places you can interject your own expertise, experiences and interests.
2. After 12:00 Noon on the DAY BEFORE your scheduled visit, come to Liz's office (Ticon II, Room 217) and check out your School Health Kit
3. On the day of your visit, be sure to look as "doctorly" as possible – wear your coat, name badge, stethoscope, etc. Go to your school and check in with your school nurse at the time specified. GET EXCITED and do your presentation with ENTHUSIASM!
4. Return the School Health Kit to Liz's office DIRECTLY AFTER YOUR PRESENTATION – DO NOT WAIT! OTHER RESIDENTS MAY NEED YOUR KIT!
5. Provide Liz with feedback on your visit so she can pass it on to the School Health Committee

Partners of the School Health Program are:



Health Education
Council



Sacramento City Unified
School District

Adopt-a-School



"Physicians donating expertise to the community"

Adopt-a-School
Program

UC DAVIS
CHILDREN'S HOSPITAL

UC Davis
Children's Hospital



Education Module & Case Studies:

TEACHING RESIDENTS ABOUT EDUCATION LAW AND POLICIES
Curricula and Tools from The Children's Hospital of Philadelphia

Goal:

To teach pediatric residents about the educational laws and policies for children with disabilities from early childhood education to transition to adulthood

Method:

Education and early intervention are two of many core advocacy areas that the residents at The Children's Hospital of Philadelphia (CHOP) Community Pediatrics and Advocacy Program master during their training. During their 1st year of residency, residents participate in an education module that is led by one of the program's partners, the Education Law Center. The module covers a wide array of topics, including:

- A. Exits, Entrances, and Transitions in Public Education in Pennsylvania
- B. Definitions of Disabilities in Special Education and Preschool Early Intervention
- C. Individualized Education Programs (IEP)
- D. Transition to Adult Life for Students with Disabilities
- E. Graduation Requirements for Special Education Students
- F. Laws: Individuals with Disabilities Education Act, American with Disabilities Act Section 504

The residents at CHOP become familiar with these topics through didactic presentations, hands-on activities and case studies (included) that highlight aspects of education law. The case studies are discussed under the supervision of an attorney at the Education Law Center after the residents have prepared their own ideas.

Additional Activities Related to School Health

- Visiting local schools in the area, including a school for children with cerebral palsy

Educational Outcomes:

The residents at CHOP become competent in many areas of education and child care. They are extremely familiar with education laws and policies and have the knowledge to serve as consultants for parents and teachers of students. The residents have a working knowledge of how to refer children for services, as well as what services are available in their community. Lastly, with such comprehensive knowledge of the programs available for students, they can serve as advocates..

Contact:

For more information on activities at CHOP, please contact:

Jill Triumpho, MSEd

Program Manager, Community Pediatrics and Advocacy Program

Children's Hospital of Philadelphia

Adolescent Med., Room 940834th St. and Civic Center Blvd
Philadelphia, PA 19104

Phone: 215-590-0661

E-mail: Triumpho@email.chop.edu

<http://cpap.phillypeds.com/>

Educational Module Case Studies

Case Study #1

Nathan is two years and 10 months old and is receiving early intervention services from Bucks County MH/MR. He has CP, and uses a walker and has braces on his legs. He is not cognitively impaired. The only service on Nathan's IFSP is physical therapy 3 times per week.

Since he will turn 3 shortly, the County convened a transition meeting that was attended by Nathan's parents, the County, and representatives of the Bucks County IU, which administers the preschool program for children with disabilities. The IU's position is that, since Nathan has no intellectual deficits and does not need special education, he is not eligible for early intervention preschool services.

- Is Nathan eligible for EI services from the County?
- While Nathan's family and the IU fight about this, what happens to Nathan's services?
- How would Nathan's family challenge the IU's decision that he is not eligible, and its refusal to provide services in the meantime?

Case Study #2

Sam has retardation, and has been receiving special education services from his school district since he entered school. He is now in 12th grade, and attends a full-time learning support class. For the past several years, whenever his family discussed Sam's transition plan, they made clear that they expected Sam to continue in school until he is 21 (although they want the program reshaped to focus on vocational experiences services in the community, with some academic support in the District). The family thought that the District agreed with this plan.

But at a recent school meeting the Special Education Director said that Sam would be graduating with his class at the end of the School Year, and that his right to services would end at that point. The District also told them that, if they press the issue and refuse the diploma, Sam cannot march in the graduation ceremony with his classmates – which will break his heart.

- Whose decision is it whether Sam should graduate?
- What can Sam's family do about this?
- Can Sam not take the diploma and still go through the graduation ceremony with his classmates?
- How could Sam's parents have avoided this problem?

Case Study #3

Sandra is approaching her 16th birthday. She is a 10th grade student with a learning disability. She attends a regular school for most of the school day, with a resource room for language arts courses. Sandra's reading levels are well below grade level. The school district has informed Sandra's family that, at the next IEP meeting, they will be discussing how to plan for Sandra's post-school life – they call it transition planning. The District has also invited Sandra to the meeting to find out about her long-term goals. Sandra and her family want her to go to college.

- What are some of the things that her family should think about as they prepare for this meeting?
- What happens if the family and the District don't agree that Sandra's plans are realistic?
- Are these answers different if Sandra is attending a public charter school?

Case Study #4

Juan was recently diagnosed with cancer. He is 8 and in 2nd grade. After he was diagnosed, Juan received chemotherapy, which caused nausea, but which did not prevent him from attending school. However, his district told his mother that he could come only if she came with him, and cleaned up after him if he vomited after eating in the lunchroom. Juan's mother did go to school with him (and her baby) each lunch hour for 6 months, but then had to stop.

- Could the District keep Juan out of school?
- What options did his mother have?

Later in his treatment, Juan was able to go to school, but he needed several accommodations. For one thing, he had to stay in during recess (and he needed someone to stay with him). He also needed to be able to go to the school nurse whenever he felt ill. When Juan's mother explained this to the District, they said that they couldn't make special rules for Juan – he had to attend on the same basis as other students.

- Was the District correct?
- What rights did the family have to these "accommodations"?
- If the family and the District couldn't agree, what could the family do? What happens in the meantime?

Juan had a bone marrow transplant, which has permanently compromised his immune system. He now misses school for months at a time during flu season, or when a classmate has or has been exposed to a contagious disease. Also, the transplant and medication damaged Juan's lungs, and, even when he doesn't have these long term problems, he missed school intermittently.

- What help does the District owe Juan?



Additional Tools: School Health Needs Assessment

TEACHING RESIDENTS ABOUT EDUCATIONAL AND CHILD CARE SETTINGS

Judith S. Palfrey, MD

When working with school systems, child health professionals should view the school as a small community or neighborhood and develop a plan to systematically address health concerns. This involves: (1) a needs assessment (2) finding allies (3) assuring the basics (4) planning innovations (5) securing funding/resources (6) implementing interventions and evaluating their effectiveness. Below is a sample needs assessment.

School Health: The Needs Assessment

1. Who attends the schools(s)?

- Ages
- Ethnic/racial backgrounds
- Immigration statistics for the community
- Health problems of the children
- Educational status of the children
- Primary care providers
- Absenteeism rate/reasons for absences
- Common reasons for health room visits

2. Documentation of health related-practices in the schools(s)

- Nutrition program: school breakfast/lunch
- What is the exercise regimen?
- What is the environment/schedule?
- Is there a health curriculum? Is it emphasized?
- What is the school smoking policy?
- Is there a teen pregnancy prevention effort?
- Is there a stress reduction/suicide prevention plan?
- What community resources are available?

3. What do teachers, students, and administrators consider the most serious health problems/hazards in the school?

- Health problem #1
- Health problem #2

4. How does the school health program now operate?

Is there a full-time nurse?

If not, who does the nursing functions?

How is the time spent?

What is the annual yield of screenings?

What resources would be needed to move toward innovation?

Standard School Health Procedures

- Screenings
- Physical examination
- Sports physicals
- Periodic height and weight checks
- Immunization monitoring
- Vision and hearing
- Infection Control
- Emergency Preparedness

Resources

Websites

Americans with Disabilities Act
<http://www.ada.gov/>

Caring for Our Children, 2nd Edition (HTML)
<http://nrc.uchsc.edu/CFOC/HTMLVersion/TOC.html>

Centers for Disease Control & Prevention Kids Page
<http://www.bam.gov/health/index.htm>

Child Care and Early Education Resource Connections
<http://www.childcareresearch.org/discover/index.jsp>

Disability Info
<http://www.disabilityinfo.gov/>

Healthy Child Care America
<http://www.healthychildcare.org/>

Manuals, Guides, Newsletters

American Academy of Pediatrics. The Pediatrician's Role in Promoting Health and Safety in Child Care. *Elk Grove, IL: American Academy of Pediatrics; 2001.*

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Terman DL., Larner MB., Stevenson CS., Behrman RE. Special Education for Students with Disabilities: Analysis and Recommendations. *Future of Children*. 1996; 6(1): 4-24.

Other

Mills v. Board of Education, 348 F. Supp. 866 (1972). Establishes the Constitutional right to a free, appropriate public education, regardless of disability.

Considering Children with Disabilities and the State Children's Health Insurance Program
Available at: <http://aspe.hhs.gov/daltcp/reports/kidbroc.htm>

Promoting Language and Literacy in Early Childhood Care and Education Settings: Literature Review.
Child Care & Early Education Research Connections; April 2004.
Available at: <http://www.childcareresearch.org/discover/viewPdfFile.jsp?resourceId=3261&type>

8

Community and Public Health

The demographic characteristics of children in the US and the nature of their health issues have changed greatly over the past several decades. Some of these important changes include increased cultural and ethnic diversity, a greater number of families with dual wage earners and fewer social supports, a rise in chronic childhood conditions, behavioral and developmental problems, and the rise of injuries as a major cause of death and morbidity. These changes call for a similar transition in Pediatric care and the roles and functions of Pediatricians.^{1,2,3}

Given the impact of social and environmental determinants on child health, the traditional, office-based practice of Pediatrics is inadequate to meet the health challenges faced by many children, perhaps the majority of US children and families. As a result of these trends, the community is increasingly being identified as the venue in which Pediatrics will be practiced in the future, and Community Pediatrics is rapidly evolving as the framework that will support this practice.⁴ Although the theory and vision of Community Pediatrics is rooted in other “transforming” movements in Pediatrics,⁵ and has been grounded in such AAP documents as the Statements on Community Pediatrics⁶ and the Medical Home,⁷ translating theory into practice will require envisioning a new future for Pediatrics — one that will be in part defined by the intersections of Pediatrics, Public Health and the Community.^{8,9,10,11}

The generation of new knowledge, the development of new practice skills and revisions in undergraduate and graduate medical education will be required to sustain this transformation. The questions we face as a profession are complex, numerous and tangible. Who are American children? What are the determinants of their health status? What is the evidence - base for the practice of Pediatrics and what is its relevance to these determinants? What health disparities exist among children in the US? What new skills are required by pediatricians to meet these health challenges? What other disciplines are required to effect positive health outcomes for children and how are they to be integrated into the practice of Pediatrics? Are there other relevant models of Pediatric practice and how can they be financed? What are the consequences and impact of public policies on Pediatric practice? Is there a role for considering social justice, children’s rights and equity within the perimeter of Pediatric practice, and if so, how can these be taught? How can Community Pediatrics be integrated into medical education curricula?

The synergies created by the collaboration of Pediatrics, Public Health and the Community will contribute to the development of a new practice of Pediatrics. The framework for this new practice has been well articulated by the AAP Statement on Community Pediatrics.⁶ With respect to Public Health, the Core Functions of Public Health — Assurance, Assessment and Policy, combined with the discipline's¹⁰ Essential Functions,¹² expand and strengthen the framework for this new practice of Community Pediatrics.

The vision of the Dyson Initiative for the future of Pediatrics validates the relevance of this interface between Pediatrics and Public Health.¹³ The principles developed by the Initiative and others establish the strategies to effect this integration.^{9,10,13,14,15,16}

- Improve children's health care by identifying and addressing the leading causes and determinants of health, and by providing access to clinicians to "wraparound," outreach, and social services
- Improve access to care by implementing strategies to provide care to the un- or under-insured
- Improve the quality and cost-effectiveness of care by applying a population-based perspective to medical practice, and develop new approaches to address emerging child health issues
- Engage pediatricians and Public Health practitioners in collaborative health practices
- Strengthen health promotion and disease prevention by mobilizing community partnerships
- Shape the future direction of health systems by collaborating in health policy development, advocacy, health profession training and research
- Contribute to the education and workforce development of pediatricians and Public Health professionals
- Establish a platform for translational, community-participatory health services and population-based research, and contribute to the evidence base for Pediatrics and Public Health
- Link the assets and resources of Academic Health Centers with Public Health Departments to contribute to the capacity, financial base and sustainability of both sectors
- Define an ethical basis and set of principles to establish the legitimacy and necessity of this collaboration and to ensure its integration into the culture of both Pediatrics and Public Health

There is no medical discipline for which this linkage between Medicine and Public Health is more important. Ultimately, we will be judged by our success in establishing a new model for child health practice and research that utilizes and integrates the assets of the entire community to improve and ensure equity in the health and well being of all children and families.

Jeffrey Goldhagen, M.D., M.P.H

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Teaching Residents About Community and Public Health

Pediatricians need to understand the interface between public health principles and community pediatrics in addressing child health issues. An understanding of population health indicators, principles of epidemiology, disease prevention and health education are essential for the practicing clinician. Pediatricians must be knowledgeable in accessing and using data to inform their clinical practice and collaborative efforts with the community.

Following are a variety of tools used by residency programs to meet pediatric competency in community pediatrics and public health:

- **Understanding Entitlement Programs** - *Columbia University*
- **Patient Simulation Exercise** - *University of Florida, Jacksonville*
- **Pediatric Mobile Clinic** - *University of Miami*



Understanding Entitlement Programs

TEACHING RESIDENTS ABOUT COMMUNITY AND PUBLIC HEALTH

Examples of Curricula and Tools from Columbia University

Anouk Amzel, MD & Hetty Cunningham, MD

Goal:

For residents to develop a basic knowledge of government entitlement programs and how these programs affect the health and well being of the families that the residents serve.

Method:

At Columbia University, the second - year residents go through a one - month Community Pediatrics Block Rotation. This block rotation is focused on two themes – maternal child health and culturally competent care. Through a combination of service learning opportunities, community projects, and didactic sessions, the residents are exposed to the principles of public health and culturally competent care.

During the Community Pediatrics rotation the residents participate in a lecture focused on entitlement programs and following the session the residents complete an assignment answering six questions on two entitlement programs of their choice. A copy of the Power Point seminar presentation and the assignment worksheet follows. The assignment consists of an interactive inquiry using electronic resources to answer basic questions.

Additional community pediatrics and public health teaching activities:

Throughout residency, pediatric residents have the opportunity to participate in other activities related to public health, including:

- A two-hour neighborhood tour led by a community representative and faculty member
- A presentation on mortality and morbidity statistics of a 20 - block neighborhood in Harlem
- Home visits

Learning outcomes:

- Residents will gain a population perspective when facing child health issues
- Residents can identify the major causes of morbidity and mortality within the community that they serve and understand how the socio-economic health of the family affects the child's well being.
- Residents develop an appreciation for the notion of prevention and how to best work with the community and the families to implement prevention and education activities.

Contact:

For more information on activities relating to community and public health activities for pediatric residents at Columbia University, please contact:

Martha Bolivar

Project Manager

Columbia University

Department of Pediatrics

VC 4-402

622 West 168th Street

New York, NY 10032

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

Government Assistance Power Point Presentation
“Understanding Government Assistance”
Columbia University

WIC, Medicaid, Welfare:
Understanding Government
Assistance

Anouk Amzel, M.D.
Hetty Cunningham, M.D.


2/16/05

Goals and Objectives: To develop
a basic knowledge of government
assistance programs

- Understand eligibility levels for programs
- Define entitlement program
- Where can families get help?

2/16/05


2



Philosophy: Why is this important?

- This talk is part of a series of Community Pediatrics presentations based on child advocacy. Good medicine is not practiced in a vacuum. In order to be an effective pediatrician (generalist or specialist), one needs to consider the cultural and environmental context in which their patients live. This includes thinking about people's cultural background, home and community environment, educational opportunities, and economic realities – all with the goal of improving the overall health of children on a one-to-one, community, state, and national level.

2/16/05



Government Assistance

- Welfare
- Food Stamps
- WIC
- Medicaid
- SCHIP
- SSI

2/16/05

4

How do our families survive?

Expenses

■ Rent	\$600 (usu. for a rented room)
■ Food	\$350
■ Clothes, etc	\$120
■ Phone	\$30
■ Gas/Electric	\$50

■ **Total Out:** \$1150
(numbers calculated in 2002)

2/16/05

How do our families survive?

Income (not working)

■ TANF	\$577
■ Food stamps	\$345
■ EITC*	0
■ WIC	~\$50

■ **Total in** \$972

■ **Total out** \$1150

*EITC=Earned Income Tax Credit

2/16/05

6

Government Assistance Guiding Questions

Columbia University

Assignment Instructions:

Visit the websites below, and answer the questions about 2 of the government assistance programs.

Government Assistance Programs:

- Section 8 housing
- Public Housing
- Public Education
- Temporary Assistance to Needy Families (TANF)
- Food stamps
- SCHIP
- Medicaid

Questions:

1. Who pays for the assistance (State, federal, etc)
2. Who is eligible?
3. What services are provided?
4. Where can someone go to get assistance?
5. Where can someone go if they feel have been denied services unfairly?
6. Entitlement Program? **Yes** **No** (circle one)

Websites:

<http://www.lawhelp.org/ny/> - Rights, eligibility, and assistance information regarding all forms of government assistance.

<http://www.insideschools.org> - What to do if a child needs tutoring? What is the "No Child Left Behind" program? What can you do to get your child extra help in school? What to do if the child's class is overcrowded? How to advocate for your child's special needs.

www.kff.org - Keiser Family Foundation – excellent resource on Medicaid and SCHIP
"The state-by-state data available on the site cover a wide variety of health policy topics including health insurance coverage and characteristics of the uninsured, minority health - including breakdowns of data by racial/ethnic group, enrollment and spending for Medicare, Medicaid and the S-CHIP program, population demographics, and health status measures. State Health Facts Online can be accessed at www.statehealthfacts.kff.org or through the Foundation's primary website at www.kff.org, where users can access all of the Foundation's reports and analyses on health issues."

www.cmwf.org - The Commonwealth Fund - Health care for minority populations and publication relating to the quality of care for children comparing Medicaid managed care to commercial managed care.

www.urban.org - The Urban Institute - A data base site where one can review stats from around the country concerning welfare rules. Publication on "Teens and welfare reform", and area entitled "Assessing the New Federalism" – uses statistics to report on how people are faring under the new welfare laws.



Patient Simulation Exercise

TEACHING RESIDENTS ABOUT COMMUNITY AND PUBLIC HEALTH

Examples of Curricula and Tools from the University of Florida, Jacksonville University of Florida, Jacksonville, Department of Pediatrics, Community Pediatrics Training Initiative

Goal:

To increase the resident's awareness of the impact of the structure and financing of public health resources on their patients and families, especially those from underserved communities.

Method:

At the University of Florida in Jacksonville, residents have the opportunity to experience a “real life” immersion activity by assuming the role of a parent profile that is reflective of the families they serve through their continuity clinic. University of Florida has developed two different scenarios for the residents to choose from. Below you will find one of the scenarios – The Jones Family.

The resident must review the scenario, compile a list of concerns for the family and develop an action plan for addressing these concerns. Following the action they have developed, the resident then sets out – impersonating the parent in the scenario – to resolve the issues. Along the process the resident must keep a detailed log and prepare a written summary for discussion at the end (more detailed instructions are included in the attached tool).

Additional community pediatrics and public health teaching activities:

Throughout residency, pediatric residents have the opportunity to participate in other activities related to public health, including:

- Continuity Clinics within the Department of Health
- 30 - day Community (block) Rotation, where residents work with numerous community-based organizations
- Involvement in Community Action Initiatives (CAI's) – a two - year longitudinal experience where residents work with specific populations of children in community pediatrics
- Integrating Medical-Legal Aid issues that impact families into residency training
- Multidisciplinary faculty from diverse backgrounds (public health, anthropology, epidemiology, nursing, medicine, social work, etc.) provide expertise and teach epidemiology, environmental health, health policy, health promotion etc

Learning outcomes:

- Residents develop empathy for families and the multiple barriers they face in accessing health services and navigating the health care system
- Residents develop skills in identifying and prioritizing key issues impacting the families they serve
- Residents learn to identify the resources available in the community and the steps necessary to access them
- Residents enhance their ability to communicate with parents about available resources
- Six residents develop skills and expertise in providing culturally effective care to underserved at-risk populations

Contact:

For more information on activities relating to community and public health activities for pediatric residents at the University of Florida, Jacksonville, please contact:

Joy Burgess, RN, MSN

Program Manager

Department of Pediatrics

University of Florida

Shands Clinical Center, 5th Floor

Department of Pediatrics/Dyson Initiative

Jacksonville, FL 32209

Phone: 904-244-4295

E-mail: joy.burgess@jax.ufl.edu

<http://www.hscj.ufl.edu/peds/pr/dyson.asp>

Patient Simulation Exercise: Instructions for Jones Family Scenario

You ARE THE PARENT in this scenario. Considering your resources and assets AS THIS PARENT, you are to seek and obtain the services necessary to resolve as many of your highest priority problems as possible during the Community Rotation.

When you contact agencies by phone or in person, DO NOT introduce yourself as Dr. X, a resident physician at University of Florida, Jacksonville. In other words, do not present yourself as a 'student' who is just trying to learn about their agency and its services. Avoid dressing in your best leather jacket, suit, or other upscale clothing that makes you stand out as a non-client who does not belong in a social agency office seeking services.

At agencies, you, THIS PARENT, will be required to wait in line for applications, etc. You will, of course, not actually submit applications but will have to become familiar with what information is required to fill them out completely and what happens to clients when information is not complete. Because we know your time is limited, you may use the Internet to seek information about services.

After you have finished reading these instructions,

1. Review the brief scenario below.
2. Make a list of your family's biggest problems in living (FROM PERSPECTIVE OF YOUR ROLE AS PARENT) in a notebook.
3. List your highest priority goals for the next days and weeks followed by goals that would require a longer time period to achieve.

In addition to the list of the patient/family's problems and highest priority goals, and the more long-term goals, please document in your notebook:

1. A Chronological Log with a page for each of your contacts with various agencies and personnel. Each Log page should contain:
 - a. Date of contact, name of agency and person you spoke with and his/her roles as you know it.
 - b. Describe briefly what you were trying to accomplish with the contact or visit and whether you were successful.
 - c. State briefly what the experience was like and how you felt during and afterward.
 - d. Note how many hours/minutes you spent accomplishing what you did in this contact or visit, including transportation, and finding out whom you should contact or visit in the first place.
 - e. Identify the barriers you encountered in the role for this scenario. What solutions were you able to develop that addressed any of these barriers? Are there community-level solutions that would better address the barriers for families with similar problems in the future?
 - f. Note any key insights that may affect the way you practice pediatrics or that you want to explore with your mentor(s).

2. At the end of your Community Rotation, referring to the information in your log, please prepare a Written Summary that
 - a. Identifies all the problems in living that you worked on, what you were able to accomplish toward addressing each, and which community agencies and services helped you to accomplish what you did.
 - b. Identifies the remaining key problems for this family and what services are still needed to address them. (You do not need to know the names of all the additional agencies).
 - c. Describes the extent to which the scenario-based learning experience helped you to achieve the Community Rotation learning goals. Cite examples of why/why not.
3. Discuss your Summary as well as your insights from your Log with the Course Director; and, if available, the Community Services Professional with whom you worked most closely.

Scenario for the Jones Family

You are Pearl Jones, a divorced mother, age 30, who has recently relocated to Jacksonville with your two children. Cassandra, your 7 year old daughter has been diagnosed with sickle cell disease, with recurring acute chest syndrome. She barely passed the first grade in her previous school, is in the second grade here, but struggles to keep up with classmates in her new school. In Atlanta she was cared for at a Sickle Cell Clinic.

Your 9-year-old son, Tyrone, has chronic ear infections that require visits to the ER and medicines, too. He's a rough and tumble boy who'd rather be outside playing with the older boys than doing his chores or his homework. You worry about finding a program that can offer him supervised after-school activities, when you go back to work.

In Atlanta, you worked as a hotel housekeeper until the children's frequent illnesses caused you to lose your job due to excessive absences. You quit high school in the 10th grade to work as a waitress, later as a convenience store clerk, and then as a hotel housekeeper. You'd like a better job, but know that your income prospects are limited as a result of not having a high school diploma. You haven't seen nor received child support from the children's father in several years.

You and the children are staying with your older sister and her family temporarily in their apartment. You think if you can just get a Section 8 certificate, you could all move into a house large enough for your entire family, and your sister would take care of Cassandra while you work days or go to school. No one in the family has a car.

You and the children lost health insurance coverage when your ex-husband left town. Your previous job didn't pay enough for you to afford health insurance. You have never applied for welfare. According to your sister, there are numerous job opportunities in Jacksonville. Cassandra has just been released from the Shands ER after treatment for a sickle cell crisis. She has been referred to the Sickle Cell Clinic at 555 West 11th Street, where you will meet Selena Webster-Bass, MPH, and the specialists who will care for her. Ms. Webster-Bass can be reached at XXX-XXXX to set up an appointment.

For Scenario #1, The Jones Family

This Information for Rotation Staff and 'Mentors' ONLY

This information is used as a reference when discussing this scenario with the resident at the end of the Community Rotation

Problem / Need / Goal	Agency / Service(s)	Our Contact Person
1. 7 yr old daughter's sickle cell disease with recurring acute chest syndrome (ACS).	Sickle Cell Clinic, Shands	XXX
2. 7 yr old may be eligible for SSI on basis of functional limitations caused by her sickle cell disease and family's otherwise non-existent income	SSA Supplemental Security Income, (SSI) Northside JAX Office	TBA
3. Health insurance; immediate income; and Food Stamps	Medicaid, TANF and Cash Assistance; Dept of Children and Families	XXX
4. Child support payments	Jacksonville Legal Aid	XXX
5. Schooling for daughter with sickle cell; homebound instruction might possibly be needed	Children's Medical Services	XXX
6. GED preparation to qualify for high school equivalent diploma	Worksource; or JAX Public Schools; or FCCJ	XXX
7. Vocational Assessment and job training for mother	WorkSource	XXX
8. After School program/child care for 9 yr old son	Worksource, if public school or YMCA programs are unable to enroll the child; possibly Community Partnerships for Protection of Children (available at full-service schools). Boys and Girls' Club? Jacksonville Children's Commission City of Jacksonville Parks and Recreation Services	XXX
9. Pediatric care for 9 yr old son with chronic ear infections	Shands Pediatric Clinic; ENT Clinic would refer to Audiology and possibly psycho educational evaluation, if hearing or learning might be impaired by hearing deficit or learning disability	
10. Section 8 Housing availability and eligibility	Jacksonville Housing Authority	
Other?		

Miami Pediatric Mobile Clinic

TEACHING RESIDENTS ABOUT COMMUNITY AND PUBLIC HEALTH

Examples of Curricula and Tools from the University of Miami

Arturo Brito, MD, Brian Guerdat, MPH, Julie Belkowitz, MD & Mavara Mirza, MD



Goal:

To provide residents with an opportunity to learn about the challenges of providing comprehensive primary care to an underserved and uninsured community.

Method:

Pediatric residents at the University of Miami have the unique opportunity to spend four weeks on the University of Miami Pediatric Mobile Clinic. During this time, residents are exposed to a diverse population of underprivileged children and families, most of whom lack medical insurance and face other socioeconomic and socio-cultural barriers. Prior to starting their rotation, residents are provided with a Pediatric Mobile Clinic Manual that highlights important aspects about the community that will assist the resident in providing culturally effective and comprehensive primary care. These include a demographic description of the community, helpful hints, and community and medical resources. Residents are required to become familiar with the contents of their manual prior to starting the rotation, and are able to access it during their rotation.

Additional community pediatrics and public health teaching activities:

- An elementary school teaching experience is required of all 2nd & 3rd year pediatric residents at the University of Miami. Under the guidance of the Nurse Practitioner, 2nd & 3rd year residents spend day teaching pre-k through 5th graders at partnering elementary schools about exercise, nutrition, tobacco, personal and dental hygiene.
- Pediatric Mobile Clinic patients are also referred to on-site University of Miami law school students and, under the supervision of an assigned attorney, develop individualized action plans.
- Residents and students work with an on-site psychologist who provides ongoing behavioral management guidance, including teaching parents how best to advocate for their children.

Learning outcomes:

- Resident become familiar with the needs and assets of an underserved community, and how to match those needs and assets with available resources.
- Residents learn about how culture and ethnicity may affect a child's health status and ability to access care.
- Residents are able to identify child health care services in the community for children and families of different socioeconomic backgrounds.
- Residents become adept in providing primary care in a community-based practice.

Contact:

For additional information on community and public health activities at the University of Miami, please contact:

Brian Guerdat, MPH

Program Manager

University of Miami

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Child Health Advocacy for Miami Pediatricians (CHAMP)

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Miami, FL 33136

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<http://www.um-jmh.org/body.cfm?id=187>

Pediatric Mobile Clinic Manual

To: Residents and Students

From: Arturo Brito, M.D./ Mavara Mirza, M.D.

Re: Community Pediatrics

Welcome to the University of Miami Pediatric Mobile Clinic. The mission of our clinic is to help uninsured and underinsured children access quality comprehensive primary health care. We accomplish this by providing services directly and by guiding families to affordable and efficient programs in the community.

This rotation provides an opportunity to learn about the challenges of providing primary care within the community to children living with limited resources. To maximize your educational experience, it is imperative that you read your personal calendar and orientation manual thoroughly before the beginning of your rotation. If there are any potential problems, please let us know as soon as possible.

Once again, we welcome you and look forward to meeting with you. We hope that you will find this a very useful and fulfilling experience.

Sincerely,

*Arturo Brito M.D.
Associate Professor
Medical Director, Pediatric Mobile Clinic*

*Mavara Mirza, M.D.
Assistant Professor*

The University of Miami Community Pediatrics rotation is a unique opportunity for residents and students to provide comprehensive care to underprivileged children in culturally diverse settings. The Pediatric Mobile Clinic (PMC) has been providing primary care to predominantly underserved, minority patients throughout Miami-Dade County for the past twelve years. This includes children lacking health insurance, as well as those having difficulty accessing their assigned health care providers because of socioeconomic and geographic barriers.

The Pediatric Mobile Clinic is more than a 34-foot long doctor's office on wheels. There is actually a laboratory/treatment area and a pharmacy on board. The clinic maintains continuity of care through regularly scheduled appointments at set locations on a monthly basis. Like most private pediatric practices, patients are provided with well-child care, including the AAP recommended screening services, anticipatory guidance, physical examinations and immunizations. Many patients utilize the clinic's services for the management of chronic problems such as allergic rhinitis and asthma, as well as acute problems such as otitis media and pharyngitis. The challenge in caring for patients on the PMC lies in truly understanding the patient's medical, socioeconomic, cultural and physical needs and devising a collaborative care plan. As a result, emphasis is placed on the quality and thoroughness of the care provided, rather than the quantity of the patients seen.

Residents and students on the Pediatric Mobile Clinic provide in-depth medical and preventive care services and learn cost-effective strategies in providing pediatric care to uninsured and under-insured children. In order to help in the early detection of illness, residents/students are taught techniques to hone their pediatric clinical skills. They are strongly encouraged to devise an assessment and plan for each patient seen, utilizing evidence-based medicine when possible and distinguishing it from anecdotal treatment plans.

Residents and students learn about the role of a physician not only as a physical healer, but also as a lifelong advocate for his/her patients. They begin to understand the challenges of caring for immigrant and/or economically disadvantaged families and acquire knowledge about the community resources available to match their patients' needs. They learn about the critical importance of patient advocacy in caring for underserved individuals. Beyond comprehensive medical care, residents and students work collaboratively with a Nurse Practitioner, law school students and psychologists in three affiliated projects:

- An elementary school teaching experience is required of all 2nd & 3rd year pediatric residents at the University of Miami. Under the guidance of the Nurse Practitioner; 2nd & 3rd year residents spend _ day teaching pre-k through 5th graders at partnering elementary schools about exercise, nutrition, tobacco, personal and dental hygiene.
- Pediatric Mobile Clinic patients are also referred to on-site University of Miami law school students and, under the supervision of an assigned attorney, develop individualized action plans.
- Residents and students work with an on-site psychologist who provides ongoing behavioral management guidance, including teaching parents how best to advocate for their children.

An ongoing focus of this rotation has been to increase residents' and students' awareness of the ethnic disparities that exist in healthcare. Emphasis is placed on understanding how culture and ethnicity may affect a child's health status and ability to access medical care.

The PMC presents residents/students with an opportunity to increase their clinical acumen and understanding of the challenges facing many underprivileged children in accessing basic healthcare service. Over the past decade, the Pediatric Mobile Clinic has identified ongoing barriers to healthcare and developed alliances with community organizations to help its patients overcome those barriers. The experiences on the PMC allow residents and students to develop their clinical acumen as well as their understanding of the challenges facing many underprivileged children in accessing basic healthcare services, and an appreciation for how legal, psychological, cultural and socioeconomic factors can impact the health of children.

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Pediatric Mobile Clinic Goals

Goal I: Child Healthcare Access. To learn about safety net insurance programs for low-income and/or uninsured children living in South Florida.

- a. Describe qualification criteria for state's SCHIP Program, Florida KidCare, and each of its four components: Healthy Kids, MediKids, Medicaid and Children's Medical Services.
- b. Describe the American Academy of Pediatric's Medical Home Policy statement and how it relates to the above and the Pediatric Mobile Clinic.

Goal II: Cultural Influence on Health. To recognize the importance of understanding cultural diversity and how to incorporate this knowledge into developing the most effective prevention and treatment protocols.

- a. Learn specific health disparities data for populations served by the Pediatric Mobile Clinic.
- b. Illustrate how culturally appropriate and inappropriate interactions can impact children's health through the use of actual clinical cases.

Goal III: Clinical Skills in a Community Setting. To learn the most cost-effective strategies for providing pediatric primary healthcare to uninsured and under-insured children in the community setting.

- a. Learn how to develop collaborative care plans between families and healthcare providers to help optimize adherence with prevention and treatment recommendations.
- b. Describe the importance of adhering to screening practice guidelines, particularly for under-served populations, for the health issues listed below, and understand the potential impact on public health outcomes when these standards are not met.
 1. immunizations
 2. vision
 3. hearing
 4. lead
 5. hemoglobin
 6. dental
 7. developmental
 8. tuberculosis
 9. urinalysis

Goal IV: Community Sub-Specialty and Family Support Services. To learn about sub-specialty and family support service options for underserved children and their families living in South Florida. These services include, but are not limited to: medical sub-specialties, dental care, legal counseling, mental health services, and community healthcare clinics for low income and/or uninsured adults.

a. To learn the qualification criteria for sub-specialty and family support services most commonly used by PMC staff.

b. To learn the referral procedure for sub-specialty and family support services most commonly used by PMC staff.

Goal V: Pediatric Residents Teaching Medical Students in the Community Setting. To learn to model the role of a community pediatrician.

a. To teach medical students how best to evaluate and manage underserved pediatric patients in the community setting by using evidenced-based medicine when it exists and to recognize the best commonly accepted practices in its absence.

b. To demonstrate how to effectively communicate with patients, families, community organizations, sub-specialists and advocacy groups.

Resources

Websites

Agency for Health Care Policy and Research
<http://www.ahcpr.gov/clinic>

Centers for Disease Control and Prevention
<http://www.cdc.gov>

Health Care Financing Administration.
<http://www.hcfa.gov>

Health Finder
<http://www.healthfinder.gov>

National Institutes of Health
<http://www.nih.gov>

U. S. Department of Health Resources and Service Administration
<http://www.hrsa.gov>

U. S. Department of Health and Human Services Maternal and Child Health Bureau
<http://mchb.hrsa.gov>

U. S. Department of Health and Human Services Administration for Children and Families
<http://www.acf.dhhs.gov>

American Academy of Pediatrics
<http://www.aap.org>

Anne E. Dyson Community Pediatrics Training Initiative
<http://www.dysoninitiative.org>

Books, monographs, manuals:

Huffman LC, Mehlinger SL, Kerivan AS, Cavanaugh DA, Lippit J, Moyo O. Off to a Good Start: Research on the Risk Factors for Early School Problems and Selected Federal Policies Affecting Children's Social and Emotional Development and Their Readiness for School. Washington, DC: Department of Health and Human Services; 2001.

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Firearm-related injuries affecting the pediatric population. Committee on Injury and Poison Prevention. American Academy of Pediatrics. *Pediatrics* 2000;105(4 Pt 1):888-95.

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Moss N, Carver K. The effect of WIC and Medicaid on infant mortality in the United States. *Am J Public Health* 1998;88(9):1354-61.

Policy on the development of immunization of tracking systems. American Academy of Pediatrics Committee on Practice and Ambulatory Medicine. *Pediatrics* 1996;97(6 Pt 1):927.

Romero D, Chavkin W, Wise PH, Hess CA, VanLandeghem K. State welfare reform policies and maternal and child health services: a national study. *Maternal & Child Health Journal* 2001;5(3):199-206.

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9

Research and Scholarship

Among the fundamental core skills taught as part of a medical education are: learning to interpret what one observes, using data to support that clinical intuition, and then learning to effectively communicate this clinical information. Yet observation skills education hardly begins when a student first encounters a patient; it is taught to each of us from infancy. A fundamental goal of medical education generally, and pediatric education specifically, then, is to teach the future physician to be ever more rigorous when observing in clinical settings.

Similarly, each clinician enters training with previously developed intuition. Part of it has come from undergraduate science education, part from life experience, part from parents, family, and friends. As medical educators, we reshape and challenge this “native” intuition, teaching students to make fewer assumptions and more “reasoned guesses.” Observation thus informs intuitive thinking.

Finally, learning to summarize observations and intuitive thought in disciplined ways and follow the traditions of medical reporting helps each young physician and pediatrician to become an even better observer and thinker.

Community pediatrics teaches that the rigorous training of pediatric residents in how to observe communities, interpret the impact of context on child health, summarize these observations and interpretations, and report them, is a fundamental part of pediatrics. The most rigorous applications of these skills come after formal education in research methods and in scholarship.

Every pediatrician works in a community context. These communities differ in geography, ethnicity, population density, climate, history, and many other factors. To understand the functioning and health of children, we must understand how and why they interact within their various contexts. To accurately understand these interactions, every pediatrician must have some fundamental understanding of the “basic sciences” of community health: epidemiology, statistics, bioethics, and political and other social science methods.

These sciences are learned by young pediatricians-in-training. Their application in community pediatrics is in understanding how communities impact child health. When a child comes into the office with otitis media, we want a trainee to know not only how to diagnose and treat the condition, but also to consider the known community factors that can affect the natural history of the condition. Does having health insurance affect a family's ability to obtain needed medication? Yes. Does a grandmother in the household whose health beliefs are non-Western affect the likelihood that a child will listen to the pediatrician's advice? Perhaps. Does living near a trash processing plant that produces substantial particulate material affect the likelihood that this child will develop recurrent infection? We will only know if these questions are posed and answered. The pediatricians we train today may be the scientists who help get these kinds of questions answered.

When an adolescent refuses to attend school because of fear of violence, a trainee needs to understand that giving the teen strategies for being safe is being a good pediatrician. Also important is being able to speak in an informed way to teachers, principals, members of the board of education, and legislators, among others, to make schools safer. This kind of communication may be enhanced by clinical vignettes, but often needs real data to make an impact. Learning how to generate data, how to summarize it, and how to report it becomes central to patient advocacy.

Finally, the field of pediatrics needs a cadre of people who are able to rigorously pose and answer questions that assess the impact of communities on children's health. Academics and scholars who can study issues in community pediatrics and communicate their findings to other pediatricians are in short supply and need to increase in number.

As we come to understand the human genome, we will increasingly understand the interplay between genes and environment. We need to be able to measure environments and track their changes over time. Furthermore, we need to know who to assist in helping environments change in planned ways that can improve children's health. This sort of change requires pediatric researchers who can methodically identify modes of changes, implement these changes in standardized, ethically-sound and replicable ways using rigorous study designs, and evaluate not only the primary but any secondary impacts of tinkering with children's environments.

Residency programs must kindle excitement in young pediatricians to pursue this kind of career. Giving examples and pushing trainees to formulate questions that can be answered over a lifetime's partnership with communities is an urgently needed task that we must all undertake.

Don Schwarz, M.D., M.P.H., M.B.A.

Teaching Residents About Research and Scholarship

Identifying relevant inquiry and devising a plan to approach it are essential abilities for practicing pediatricians. Whether the issue pertains to a single patient or a community, it is the task of the pediatrician to seek, to understand and to communicate current evidence,- transforming truth into action. Pediatricians in the 21st century must be skilled in seeking evidence-based data, and understanding basic principles of statistics and epidemiological analysis. In addition, pediatricians should be able to communicate effectively with a variety of audiences about the results of research relevant to them. These are among the tools used by residency programs to meet pediatric competency in research and scholarship.

- 1) **Competitive Grants Application and Research Project Timeline** - *University of Miami*
- 2) **Leadership in Community Pediatrics:A Field Guide for Physicians** - *University of Rochester*
- 3) **Project Development** - *University of California, Davis*
- 4) **Poster Presentation Forum** - *The Children's Hospital of Philadelphia*



Teaching residents About Research and Scholarship

Curricula and Tools from the University of Miami

Lee M. Sanders, MD, MPH, F. Daniel Armstrong, PhD, Arturo Brito, MD

Goal:

To teach pediatric residents about the development and execution of community-based pediatric research.

Method:

At the University of Miami, the Department of Pediatrics has made community-based research and scholarship a focal point of its residency program curriculum. In partnership with faculty and community-based organizations, residents apply for competitive internal grants process to fund their community-based projects. Residents must work alongside the faculty member to choose a topic of interest, design a study, and write a grant proposal. Projects are to last one year and grants are awarded in the range of \$10,000 - \$30,000. Proposals are reviewed and scored by an advisory board that considers the study design, community needs, feasibility, and the evaluation. Once grants are awarded, residents meet every other month with a faculty mentor to report on the study's progress. Residents are expected to submit an abstract of their research findings to a national meeting. Faculty and/or residents are expected to submit a manuscript of the findings for peer-reviewed publication. Sustainability through further extra-mural grant support is encouraged. Each project is expected to be discussed in at least one public forum including fellow residents, faculty, the CBO representative, and the CBO's clients.

Additional Activities Related to Research and Scholarship:

- To encourage participation in community-based research, each resident is introduced to a CBO of their choosing during an advocacy module of 5 days embedded in the behavior/development rotation in the PL1 year. At the end of this rotation, residents present an oral, evidence-based review of their advocacy action plan to fellow residents.
- Residents are also exposed to CBOs and community-based research through a series of didactic sessions throughout the year, community-based experiences during other ambulatory rotations, and a monthly, required session in evidence-based medicine facilitated by the CHAMP Research Director.

Learning Outcomes

- The grant application process gives residents an opportunity to learn by doing. Residents learn to identify a community need and subsequently develop a research question.
- Residents become more knowledgeable about the requirements of human subject research and have the opportunity to apply basic statistics.
- Residents present their work in a clear and professional manner to their colleagues.

Contact:

For more information on activities related to research and scholarship at the University of Miami, please contact Lee M. Sanders, MD, MPH, Research Director, or Brian Guerdat, Project Manager:

Brian Guerdat, MPH

University of Miami

Department of Pediatrics

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Miami, FL 33136

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<http://www.um-jmh.org/body.cfm?id=187>

Competitive Grants for Community-Based Projects

*The Child Health Advocacy for Miami Pediatricians (CHAMP) Program
At the University of Miami*

Request for Proposal

Instructions

The goals of these grants are (1) to encourage innovative partnerships between pediatricians and community-based organizations (CBOs), (2) to support advocacy activities that develop skills of residents and faculty that lead to meaningful change in the community, and (3) to develop faculty and resident research skills that support the development of an academic and evidence-based foundation for community pediatricians. For the purpose of these grants, a CBO is defined as any group that serves children and adolescents and their families in Miami-Dade County; this includes but is not limited to grassroots associations, parent groups, faith-based groups, health service agencies, schools, housing projects, and community centers. Preference will be given to projects that work with CBOs serving primarily underserved neighborhoods. The faculty advisor must be a full-time faculty member at the University of Miami.

Each Project Must:

1. Engage at least one resident from the Pediatric or Med/Peds programs at JMH as the project leader.
2. Involve a meaningful partnership with a CBO.
3. Aim to improve child health in the South Florida community.

Complete the following sections using the amount of space suggested. Limit your project description to 4 pages or less, double-spaced. The budget justification and references may be added as appendices, which are not subject to the 4 page limit. Save your completed proposal and submit electronically to Dr. Armstrong (darmstrong@miami.edu) by Midnight on Thursday, March 31, 2005. A Review Committee that includes a general pediatrician, a specialist pediatrician, and a CBO representative will review each application and will provide written feedback to the investigators, along with a funding decision. The Review Committee will make final decisions on budget allowances, based on justification to the project and the total availability of funds. Request for revisions will be returned to the PI by May 1, 2005. Accepted proposals will be awarded for a 12-month period, beginning July 1, 2005.

I. Personnel ($\frac{1}{2}$ page)

List name, title, and contact information (street address, email address, telephone number) for the Faculty PI, the Resident Co-PI, the CBO, and the CBO representative. Include a brief description of the CBO's activities, its mission, and the number of children served per year by the CBO. You may also list other participants in the project, including other resident participant(s), faculty co-investigator(s), consultants, or collaborating CBOs.

II. Primary Aim

This should be expressed in a single sentence. (e.g., "The primary aim is to understand maternal perception of child weight status in the preschool setting.")

III. Target Population, Specific Objectives, and Hypotheses (½ page)

- A. What specific population do you intend to reach? (e.g., “100 mothers of children aged 2-5 years enrolled in 4 subsidized childcare centers in Allapattah and Miami Beach”)
- B. What are the project’s 1 to 4 specific objectives? (e.g., “1. To enhance the existing partnership between pediatric residents and the parents and staff at the childcare centers. 2. To assess the prevalence of overweight and obesity in this population; 3. To assess the accuracy of each mother’s perception of her child’s weight status; 4. To determine the maternal and child factors associated with that accuracy”)
- C. What are your hypotheses? (e.g., “1. Maternal accuracy will be greater among African American and non-Latina mothers than among Latina Mothers. 2. Maternal accuracy will increase with maternal age and maternal years of education, and will decrease with maternal years in the US.”)

IV. Proposal Summary (1 page)

- A. How will you accomplish the specific objectives?
- B. How will you measure the primary outcome(s)? (e.g., “Maternal Accuracy is the primary outcome. It will be calculated as the difference between two variables: (1) Maternal Estimation and (2) Child Weight Status. Maternal estimation will be calculated by using a validated, linear scale that asks the mother to estimate her child’s weight on a spectrum from underweight to overweight. Child Weight Status will be calculated by body mass index percentile, or z-score (according to CDC standardized tables).”)
- C. How will you measure the primary predictor or independent variable(s)? (e.g., “Maternal and child factors will include the following: maternal age, child age, ethnicity, place of birth, years in US, history of breastfeeding, maternal BMI, years of maternal education, and childcare center. These will be measured by maternal report as part of a structured, 10-minute interview and by direct weight and height measurements of the mother.. Standardized questions, from the CDC and NIH, will be used to solicit the demographic information.”)

V. Relevance to Child Health (½ page)

- A. What is the child health problem you hope to address?
- B. How will this project add new knowledge to our understanding of this problem for children in Miami and for children the U.S.?
- C. How will this project improve the health of children in our community?

VI. End Date

Provide the date by which you expect the project to have been completed.

VII. Partnership with the CBO (½ page)

Describe the nature of the faculty’s and resident’s previous experience with the CBO. (Examples: formal or informal health assessment at CBO; previous volunteer experience at the CBO; meetings with CBO director, staff, and/or clients.) How will you partner with the CBO?

VIII. Literature Cited

Include any references from the medical literature that you cite in Parts IV and V.

IX. Letters of Support

Include at least one letter of support from the CBO with whom you propose this project. The letter should specify the nature of the relationship between the CBO and the project, what the CBO will provide to the project, what the project will provide to the CBO, and a statement of agreement about how credit for products (e.g, publications, brochures) will be assigned among the participants.

X. Estimated Budget

Complete the attached budget spreadsheet. In the text of the application, state the total amount requested, and provide written justification for each budgeted item.

1. Maximum total budget is \$3,000 without personnel, \$30,000 with personnel.
2. Budgets should not include (cumulatively) more than 10% of faculty salary.
3. Research assistant (RA) effort should be carefully considered. Please provide clear justification if required RA effort is expected to exceed 19 hours per week. Allow eight hours of time in the budget for your research assistant to complete the CITI (human subjects research) online certification, with relevant HIPAA training included.
4. Compensation for resident participation (e.g., supplies, parking, meals when away from campus) should be included in the budget. These should be included in the Materials/Supplies category.
5. CBO costs and compensation for participation are legitimate budget items.

Faculty P.I. Checklist Community-Based Research Projects 2004 - 2005

	Resources	Deadline
All research staff complete CITI Human Subjects Certification Course	www.miami.edu/citireg	By Nov. 30, 2004
* Meet with Dr. Jay Wilkinson, MD, MPH to discuss study design and data management	305-243-3022 jwilkins@med.miami.edu Page 3 of this checklist	By Dec. 15, 2004
* Submit protocol, informed consent and study materials (in MS Word format) for review and translation — before submission to HSRO	Katya Miloslavich, MS, CCRC 305-243-2245 Miloslavich@med.miami.edu	By Nov. 30, 2004
Submit completed forms to Human Subjects Research Office (HSRO) through eProst	https://hsro.med.miami.edu/	By Dec. 15, 2004
Submit Research Assistant Requests to Brian Guerdat (Responsibilities, Language, Days and Times Needed)	bguerdat@med.miami.edu 305-243-3528	By Dec. 15, 2004
Prepare bibliography for background material (to be used in final manuscript)		By Jan. 30, 2005
Document monthly meeting with Resident Co-PI to discuss progress		Monthly
Document at least 4 meetings during the project year between PI and CBO partner		Quarterly
Discuss interim data analysis and revised study timeline with Dr. Wilkinson		March 1 to May 1, 2005
* Present preliminary findings to the CHAMP Research Forum	CBO partner(s) are strongly encouraged to attend	By Nov. 1, 2005
* Submit abstract of study findings to a national or regional meeting, as approved by Dr. Armstrong		By Nov. 1, 2005
* Submit first draft of manuscript describing study findings to Dr. Wilkinson		By Nov. 1, 2005
* Submit plan for future project funding to Dr. Armstrong		By Nov. 1, 2005

CHAMP Research Forums will be held regularly every month in the in the Division of Clinical Research, Bachelor Children's Institute. These Forums are designed to provide formal, constructive feedback to each PI and research team on issues of design, analysis, and presentation. Drs. Armstrong, Wilkinson, Miller and Sanders serve as the core steering committee for the Research Forum.

While some projects are resident initiated, the primary responsibility for all aspects of each project, including those in the checklist above, resides with the faculty P.I. Starred items (*) are required.

Resident PI Responsibilities

While residents (at their own initiative) may assume greater responsibility for the project and/or its research components, the only expected responsibilities are noted below:

Attend monthly meetings with the Faculty PI. This may require creative scheduling, as well as the understanding of teaching faculty during required rotations.

Regular on-site communication with the CBO Partner to seek feedback on the project's progress from the CBO perspective. Residents are expected to visit with the CBO at least 4 times during the project year; these visits may be in conjunction with, or separate from, the faculty PI's visits.

Provide input to project design, study design, abstract preparation, and manuscript preparation. While awaiting HSRO approval, we recommend that residents prepare a complete 1-3 page "Introduction Section" or "Bibliography" for the final manuscript. This introduction should include a complete review of the literature relevant to the primary research question.

Present project design and findings in one on-campus setting (e.g., noon lecture, research forum) and one off-campus setting (e.g., national or regional meeting, national or regional publication). Travel to a specific meeting should be planned well in advance and approved by Dr. Armstrong.

CBO Participation in Research

Before data collection begins, seek advice from at least one CBO representative and at least one CBO client on the final, revised protocol and study materials (e.g., surveys). Ask the critical leading question: "Are we missing something?"

After data collection and analysis are complete, share results with the CBO representative(s) and client(s). Seek feedback on next steps for existing programs, new projects, and/or new research. (CBO representatives and clients should be strongly encouraged to join the PI at the presentation of these results to be held in summer/fall of 2005 in the Bachelor Building.)

BEFORE your first meeting with Jay Wilkinson, please complete the following:

1. **What is your Study Population?** (e.g., "100 mothers of children aged 2-5 years enrolled in 4 subsidized daycare centers in Allapattah and Miami Beach")
2. **What is your Primary Aim?** (e.g., "To understand maternal perception of child weight status in the preschool setting.")
3. **What are your Research Questions?** (e.g., "1. To assess the prevalence of overweight and obesity in this population; 2. To assess the accuracy of each mother's perception of her child's weight status; 3. To determine the maternal and child factors associated with that accuracy")
4. **What are your Measures for your Primary Outcome(s)?** (e.g., "Maternal Accuracy will be calculated as the difference between two variables: 1. Maternal Estimation. A non-validated, linear scale that asks the mother to estimate her child's weight on a spectrum from underweight to overweight; 2. Child Weight Status. Body mass index percentile (calculated by weight, height, and CDC standards)")

5. **What are your Measures for your Primary Predictor(s)?** (e.g., “Maternal and child factors will include the following: maternal age, child age, ethnicity, place of birth, years in US, history of breastfeeding, maternal BMI, years of maternal education, and childcare center.”)
6. **What are your Hypotheses?** (e.g., “1. Maternal accuracy will be greater among African American and non-Latina mothers than among Latina Mothers. 2. Maternal accuracy will increase with maternal age and maternal years of education, and will decrease with maternal years in the US.”)



Leadership in Community Pediatrics: A Field Guide for Pediatricians

TEACHING RESIDENTS ABOUT RESEARCH AND SCHOLARSHIP

Curricula and Tools from the University of Rochester

Andrew Aligne, MD, MPH

Goal:

To provide residents with a comprehensive manual in community pediatrics.

Method

After their intern year, residents at the University of Rochester have the opportunity to participate in a specialized track in community pediatrics, the Child Advocacy Resident Education (CARE) Track. This two-year track provides residents with allotted time to develop longitudinal relationships with community-based organizations in Greater Rochester, as well as focused training in various aspects of community pediatrics. At the start of the track, each CARE track resident receives the *Leadership in Community Pediatrics: A Field Guide for Physicians*. This comprehensive manual provides them with expert information and advice on how to best work with the community to improve child health.

Additional Activities Related to Research and Scholarship

Throughout their three years at the University of Rochester, the pediatric residents have ample opportunity to become adept in research and scholarship.

- Community-based resident projects
- Poster presentations in public forums
- Opportunity to apply for resident grants

Learning Outcomes

- Residents are equipped with the tools to design and implement an effective intervention to improve child health.
- Residents understand the importance of evidence-based medicine.
- Residents are able to demonstrate and communicate their ideas in a clear and concise manner.
- Residents gain an understanding of how community pediatrics fits into their role of being a pediatrician.

Contact:

For more information on activities related to research and scholarship at the University of Rochester, please contact:

Santina Tu

Program Manager

PLC/CARE

University of Rochester
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601 Elmwood Avenue
Pediatrics - Box 777
Rochester, NY 14642

Phone: 585-273-3737

E-mail: santina_tu@urmc.rochester.edu

<http://www.plccare.org/default.html>

Leadership in Community Pediatrics: A Field Guide for Physicians

Andrew Aligne, MD, MPH, Editor and Principal Author Director of the CARE (Child Advocacy Resident Education) Track and Co-Director of the PLC/CARE Program, Rochester Dyson Initiative

Introduction: The Beatles Were Wrong

In 1970, the Beatles recorded “Let it be” with the following lyrics, written and sung by Paul McCartney.

When I find myself in times of trouble, Mother Mary comes to me,

Speaking words of wisdom, “Let it be. Let it be.”

When broken hearted people living in the world agree,

There will be an answer, “Let it be. Let it be.”

This guide for Leadership in Community Pediatrics, directed to pediatricians in training and in practice, clearly demonstrates that we find ourselves in times of trouble in the delivery of health care to most children and their families, leaving them, and most of the rest of us, living in the world, broken hearted. The words “Let it be” are not the words of wisdom in this instance nor are they the answer to the trouble and heartbreak we are experiencing.

There is much to learn and much to do to make the world a better place to be, particularly for the underprivileged and the medically underserved among us. We cannot just “Let it be.” So, read on. The “words of wisdom” about and the “answers” to our problems can be found herein.

*Robert A. Hoekelman, M.D.
Professor and Chairman, Emeritus
Department of Pediatrics
University of Rochester School of Medicine and Dentistry*

Overview

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Chapter 2: Socio-Cultural Aspects of Community Health Practice

Chapter 3: Social Determinants of Health

Chapter 4: The Role of Medicine

Chapter 5: Going Upstream: How to Start Thinking About Health Problems Before Designing a Project

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- V. Activities; Resources; References



Community-Based Projects

TEACHING RESIDENTS ABOUT RESEARCH AND SCHOLARSHIP

Curricula and Tools from the University of California, Davis

Goal:

To provide residents with a hands-on experience in working with community organizations to design, implement and evaluate a community-based intervention.

Method:

Residents in their second year at the University of California, Davis participate in community-based resident projects. Choosing a Resident Advocacy Project is a team effort that includes a Faculty member, the Community Pediatrics Training (CPT) Program Manager, the community partner (Collaborative Coordinator) and the resident. The resident is asked to consider three items when choosing a project: What topics am I interested in? What is the community interested in? Is this idea do-able? Once these basic questions have been answered the team discusses details of the possible project and the residents carefully think through various aspects of their project that cover the next set of key questions: (1) What do we want (2) What do we have (3) How do we use what we have to get what we want (4) What will happen when we do? Residents are required to complete various 'activities' that force them to think about why their project might be important to the target community, who in the community they will collaborate with, what are their goals and objectives, what is their intervention, and what will be the potential outcomes. To complete this thought process, residents complete a logic model to outline their project. The Logic Model is borrowed from the Center for Disease Control and is explained in detail in the CPT Project Workbook.

Additional Activities Related to Research and Scholarship:

Once the residents complete their projects, they have the opportunity to present them in a public forum, from smaller, more intimate settings like the Resident Noon Conferences, to larger audiences such as the CPT Annual Resident Child Advocacy Symposium. (An example from another program follows later in the chapter.) This provides the resident with an opportunity to share their work and answer questions related to their project, presentations almost always done in tandem with the Collaborative Coordinator (community member) with whom they work to plan, implement and evaluate the project. In many instances, residents may also be presenting at national conferences. Providing them with a more intimate setting is wonderful practice.

Learning Outcomes

Community-based resident projects are a wonderful way for pediatricians to gain valuable hands-on experience both in working with community organizations and study design. In carefully thinking through how to best work with the community to achieve a desired outcome, residents gain skills in how to design interventions, research necessary background information and evaluate outcomes.

Contact:

For more information on activities related to research and scholarship at the University of California, Davis, please contact:

Elizabeth Sterba

Program Manager

Communities & Physicians Together

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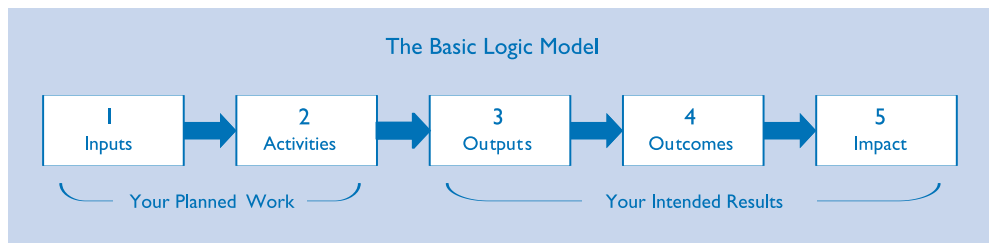
Building a Logic Model

*Taken from The Logic Model Development Guide,
W.K. Kellogg Foundation, Updated December, 2001. Chapter 1.*

The logic model is defined as a picture of how your project is going to accomplish its task – the theory and assumptions underlying the project. A project logic model links outcomes (both short- and long-term) with project activities or processes and the theoretical assumptions of the project.

Learning and using tools like logic models can serve to increase the practitioner's voice in the domains of planning, design, implementation, analysis, and knowledge generation. The process of developing the model is an opportunity to chart the course. It is a conscious process that creates an explicit understanding of the challenges ahead, the resources available, and the timetable in which to hit the target. In addition, it helps keep a balanced focus on the big picture as well as the component parts.

In general, logic modeling can greatly enhance the participatory role and usefulness of evaluation as a learning tool. Developing and using logic models is an important step in building community capacity and strengthening community voice. The ability to identify outcomes and anticipate ways to measure them provides all program participants with a clear map of the road ahead. Map in hand, participants are more confident of their place in the scheme of things, and hence, more likely to actively engage and less likely to stray from the course – and when they do, to do so consciously and intentionally. Because it is particularly amenable to visual depictions, logic modeling can be a strong tool in communicating with diverse audiences – those who have varying world views and different levels of experience with project development and evaluation. The Basic Logic Model 1 Inputs 2 Activities 3 Outputs 4 Outcomes 5 Impact Your Intended Results Your Planned Work



The most basic logic model is a picture of how you believe your project will work. It uses words and/or pictures to describe the sequence of activities thought to bring about change and how these activities are linked to the results the project is expected to achieve. The Basic Logic Model components illustrate the connection between your planned work and your intended results. They are depicted numerically by steps 1 through 5.

Your planned work describes what resources you think you need to implement your project and what you intend to do:

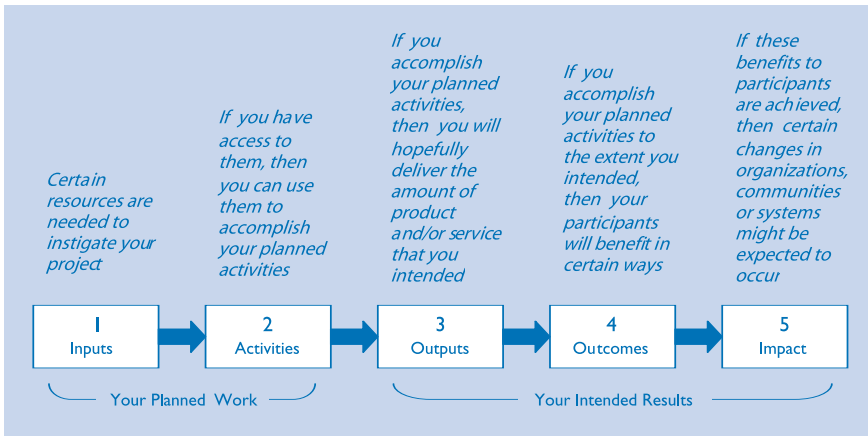
1. Inputs (Resources) include the human, financial, organizational, and community resources a program has available to direct toward doing the work. Sometimes this component is referred to as Inputs.
2. Activities are what the project does with the resources. Activities are the processes, tools, events, technology, and actions that are an intentional part of the project implementation. These interventions are used to bring about the intended changes or results.

Your intended results include all of the project's desired results.

3. Outputs are the direct products of project activities and may include types, levels and targets of services to be delivered by the project.
4. Outcomes are the specific changes in participants' behavior; knowledge, skills, status and level of functioning. There are both Short-term outcomes and Long-term outcomes.
5. Impact is the fundamental intended or unintended change occurring in organizations, communities or systems as a result of project activities.

Reading a Logic Model

When “read” from left to right, logic models describe project basics over time from planning through results. Reading a logic model means following the chain of reasoning or “If...then...” statements which connect the project's parts. The figure below shows how the basic logic model is read.



Building a Logic Model by Basic Project Components

As you conceptualize your project, begin by describing your basic assumptions and then add the following project components in the order that they should occur.

1. **Inputs** (or Factors) are resources and/or barriers, which potentially enable or limit project effectiveness. Enabling protective factors or resources may include funding, existing organizations, potential collaborating partners, existing organizational or interpersonal networks, staff and volunteers, time, facilities, equipment, and supplies. Limiting risk factors or barriers might include such things as attitudes, lack of resources, policies, laws, regulations, and geography.
2. **Activities** are the processes, techniques, tools, events, technology, and actions of the planned project. These may include products—promotional materials and educational curricula; services—education and training, counseling, or health screening; and/or infrastructure—structure, relationships, and capacity used to bring about the desired results.
3. **Outputs** are the direct results of project activities. They are usually described in terms of the size and/or scope of the services and products delivered or produced by the project. They indicate if a project was delivered to the intended audiences at the intended “dose”. A project output, for example, might be the number of classes taught, meetings held, or materials produced and distributed; project participation rates and demography; or hours of each type of service provided.
4. **Outcomes** are specific changes in attitudes, behaviors, knowledge, skills, status, or level of functioning expected to result from project activities and which are most often expressed at an individual level.
5. **Impacts** are organizational, community, and/or system level changes expected to result from project activities, which might include improved conditions, increased capacity, and/or changes in the policy arena.

Thinking about a project in logic model terms prompts the clarity and specificity required for success. Using a simple logic model produces (1) an inventory of what you have and what you need to instigate your project; (2) a strong case for how and why your project will produce your desired results; and (3) a method for project management and assessment. *Communities & Physicians Together*

Poster Presentations

TEACHING RESIDENTS ABOUT RESEARCH AND SCHOLARSHIP

Curricula and Tools from Children's Hospital of Philadelphia



Goal:

To provide a public forum where residents can present their projects.

Method:

Many pediatric residency programs funded by the Dyson Initiative sponsor “Dyson Days” – annual symposia where residents present projects and research in both poster and oral formats. At the Children’s Hospital of Philadelphia (CHOP), resident poster presentations are part of a day-long symposium. The day focuses on a theme – such as adolescent health and culture – and includes grand rounds, a prominent guest speaker, panel discussion, and the poster presentations. Prominent practitioners and scholars attend, which gives the residents a high-level professional audience for their work.

Additional activities related to research and scholarship:

- Some residents have conducted scholarly research in community advocacy. This often requires submission of the proposal to the Internal Review Board (IRB) and learning the rigors of this process and approval.

Learning Outcomes:

Requiring residents to present their work in these traditional scholarly forms enables residents to synthesize and analyze their experience, using statistics if applicable; show their work’s relevance to child and family health issues; model their methods for other residents; and participate in a professional forum in which they will be evaluated by scholarly standards.

Contact:

For additional information on activities related to research and scholarship at the Children’s Hospital or Philadelphia, please contact:

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Program Coordinator

Community Pediatrics and Advocacy Program

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Philadelphia, PA 19104

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E-mail: Triumfo@email.chop.edu

<http://cpap.phillypeds.com/>

The Community-Based Pediatrics & Advocacy Program (CPAP)
at The Children's Hospital of Philadelphia (CHOP) invites you
to

SAVE THE DATE



May 21, 2003

for the Annual CPAP Symposium

The symposium exists to showcase pediatric resident's advocacy initiatives
& to foster dialogue on specific child and adolescent health issues. This
year's theme is:

“Cultural Dynamics in Healthcare: Practice, Research, & Advocacy”

Please come & participate in this exciting event! The Symposium will officially
kick-off with morning Grand Rounds in Stokes Auditorium, here at CHOP. Our
special guest speaker will be Dr. Vanessa Northington Gamble MD, PhD, an
internationally recognized expert on the history of race and racism in American
medicine & a regular Wednesday medical commentator on the Tavis Smiley Show
on National Public Radio.

The Symposium presentation & interactive panel discussion, Residents' Poster
Session,

and Advocacy Workshops will follow. Look for more details to come...

For more information, please contact our Resource Coordinator, at
XXX-XXX-XXXX or xxx@email.chop.edu

Sponsored in part by The Dyson Foundation & The Joseph Stokes Jr. Research Institute

Symposium Agenda

8:00 am — Grand Rounds, Stokes Auditorium

“Core Elements of Effective Pediatric & Mental Health Practice”

Gordon Hodas, MD - Statewide Child Psychiatrist Consultant to the Pennsylvania Office of Mental Health & Substance Abuse Services

9:15 am — Plenary Session, Stokes Auditorium

“Preparing Pediatricians for their Role in the Mental Health System”

- Opening remarks by Dr. Jon Pletcher, CPAP Medical Director
- Presentation by Dr. Molly Garza & Dr. Sonal Thakkar, CPAP Third Year Residents

Response by Mental Health Panel:

- Dr. Marc Forman - Physician Advisor, Community Behavioral Health
- Ms. Glenda Fine - Director, Division of Child, Adolescent, and Family Services, Mental Health Association of Southeastern Pennsylvania
- Dr. Anne Kazak - Director of Psychology, The Children's Hospital of Philadelphia

- Dr. Tina Master - Assistant Director of Pediatric Residency Program, The Children's Hospital of Philadelphia
- Dr. William Carey - Physician, General Pediatrics, The Children's Hospital of Philadelphia
- Dr. Stephen Munson - Director of Child Psychiatry Residency, The University of Rochester, School of Medicine

Panel Discussion

- Closing remarks by Dr. Jon Pletcher

11:45 am — Networking Poster Session, Rotunda (outside of Stokes Auditorium)

12:30 pm — Transition to Biomedical Research Building at The University of Pennsylvania for Workshop Sessions & Lunch (See included map.)

1:00 pm — Workshop Sessions*, Biomedical Research Building

1. Pediatricians and Children's Mental Health & Illness: Room 252
2. Cultural Dynamics in Healthcare: Room 301
3. Health & Safety in Educational Settings: Room 1412
4. Child Maltreatment & Substitute Care: Room 501
5. Homeless Health Initiative: Room 901

Resources

Websites

American Pediatric Society and the Society for Pediatric Research

<http://www.aps-spr.org/>

Center for Child Health Research

<http://www.urmc.rochester.edu/cchr/>

General Pediatrics

<http://www.generalpediatrics.com/CommonProbProf.html>

PediaLink

<http://www.pedialink.org>

Pediatric Research in Office Settings (PROS)

<http://www.aap.org/pros/>

Pediatrics in Practice

<http://www.pediatricsinpractice.org/curriculum.html>

Books & Monographs

Hulley SB, Cummings SR, Browner WS, Grady D, Hearst N, Newman TB. Designing Clinical Research: An Epidemiologic Approach. 2nd Ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2001.

Cabera J, Paul L, Rice MA. A Pediatrician's Guide to Proposal Writing. Elk Grove, IL: American Academy of Pediatrics; 2000.

Available at http://www.aap.org/compeds/state_resources/ProposalWriting.pdf

Articles

American Academy of Pediatrics Committee on Pediatric Research. Promoting education, mentorship, and support for pediatric research. *Pediatrics*. 2001; 107(6): 1447-1450

Jobe AH, Abramson JS, Batshaw M, Boxer LA, Lister G, McCabe E, Johnston R; Work Groups on Research, American Pediatric Society. Recruitment and development of academic pediatricians: departmental commitments to promote success. *Pediatr Res*. 2002; 51(5): 662-4.

Salant P, Dillman D. How to Conduct Your Own Survey: Wiley, John & Sons, Inc.; 1994.

Please see the Resources in the Community and Public Health and other chapters.

