

Community-based Resident Projects

TOOLKIT

a guide to

**Partnering with Communities
to Improve Child Health**

Developed by the Anne E. Dyson Community
Pediatrics Training Initiative and generously supported
by the Dyson Foundation



COMMUNITY
PEDIATRICS
TRAINING INITIATIVE

A Program of the American Academy of Pediatrics

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Introduction and Background

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“It is especially important now for pediatricians to reexamine and reaffirm their role as professionals in the community—as community pediatricians—and prepare themselves for it, just as diligently as they prepare for traditional clinical roles.”

—The American Academy of Pediatrics
1999 Policy Statement,
*The Pediatrician’s Role in Community Pediatrics*¹

Community Pediatrics Background

History of Community Pediatrics

Early in the twentieth century, Abraham Jacobi, MD (1830–1919), “the father of American pediatrics,” noted that child health was influenced by community factors. In 1968, Robert J. Haggerty, MD, defined the term “community pediatrics” as “taking responsibility for all children in a community, providing preventive and curative services, and understanding the determinants and consequences of child health and illness.”² Dr. Haggerty believed that it was essential for pediatricians to become partners with other child advocates and community leaders in order to improve the health of children.

Definition of Community Pediatrics

Community pediatrics is about providing the very best health care to children. It is about making this care available to all children, no matter what social, ethnic or cultural group they come from. Using the community approach, pediatricians not only do medical check-ups and write prescriptions, they also explore the root causes of children’s illnesses and look for the community assets that bolster development and promote health. Physicians who take the community approach to providing health care are concerned with everything that may be directly or indirectly related to health. By synthesizing clinical practice and public health principles, physicians provide comprehensive care for all children.

American Academy of Pediatrics (AAP) Community Pediatrics Policy Statement

Community Pediatrics is the following:

- 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 toward 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 use a community’s resources in collaboration with other professionals, agencies, and parents to achieve optimal accessibility, appropriateness, and quality of services for all children, and to advocate especially for those who lack access to care because of social or economic conditions or their special health care needs.
- An **integral part** of the professional role and duty of the pediatrician

The Community

Before exploring the topic of resident projects in community health, it is important to define and describe what a community is. Adapting the definition used in the field of ecology, we will say that a community is “a group of individuals living in a particular region under more or less similar conditions.” Within a community there are many groups—neighborhoods, ethnic clusters, religious organizations, and so on. Each group plays an important role and is an essential piece of what makes a community whole. There are many factors in a community that influence the health of individuals living in that community. For example, environmental pollution could increase asthma, cancer, or congenital abnormalities. Causes of disease such as this, causes that operate at the level of an entire community, may be left unaddressed if the physician focuses only on individual patients and their immediate problems.

Mandate for Curriculum Change

As of 2001, the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee for Pediatrics has mandated that “there must be structured educational experiences that prepare residents for the role of advocate for the health of children within the community.”³ The American Academy of Pediatrics 1999 policy statement, “The Pediatrician’s Role in Community Pediatrics,” notes that “the major threats to the health of America’s children—the new morbidity—arise from problems that cannot be adequately addressed by the practice model alone” and further asserts, “it is especially important now for pediatricians to reexamine and reaffirm their role as professionals in the community—as community pediatricians—and prepare themselves for it, just as diligently as they prepare for traditional clinical roles.”³ (TABLE 1)

To begin to identify and intervene in some of the important health problems facing communities, physicians need to step out of their offices and into the neighborhoods where their patients live. Community-oriented primary care is indeed an integral part of the professional role and duty of the pediatrician.

TABLE 1

AAP Steps Toward Becoming a Community Physician

- Develop a community perspective
 - Mobilize community resources
- Collaborate with community members
- Coordinate access to existing services
 - Ensure a medical home for all
 - Educate residents outside of the clinical setting

Community Pediatrics Training

During a community pediatrics rotation, residents might visit a variety of community-based organizations (CBOs) to see what people in these organizations do and what kind of impact they have on the health and well-being of children at the community level. The term “CBOs” is used here to denote nonprofit groups that are distinct from the academic medical center, government, and business, and whose mission is to build a healthier community. The local food pantry would be an example. Setting up site visits requires gradually building up connections with CBOs. The literature on this type of educational intervention indicates that CBOs are often very willing to participate even if they don’t directly gain anything from the visits because they view themselves as performing a community service by helping to educate doctors.

While the residents’ involvement may vary from site to site, active, hands-on, experiential learning is preferred over didactic teaching. Active learning gives residents the opportunity to see first-hand the effects of poverty on health and well-being. They learn about resources available for their patients and families. They may be inspired by the resiliency of children and youth and by the dedication of the community-based child advocates who serve them. Our hope for all is that the community pediatrics experience expands their knowledge of community resources, enhances their understanding of social and environmental factors that influence health, and empowers them to consider how they can partner with their communities to effect change in the lives of vulnerable children and families.

During site visits residents also gain knowledge and practice in a range of subjects, including cultural awareness and sensitivity, community-based health promotion, advocacy (letter writing, public speaking, and use of the media), research, project design and implementation, and collaboration.

Most places that have tried to do community medical education—whether for medical students or for residents—have found that an active participatory project is an important component. However, the definition of “project” can vary widely. Faculty from Dyson Initiatives across the country came up with the following definition of a project for pediatric residents: “a mentored, hands-on experience in community-linked endeavors to prepare residents to be lifelong active leaders in improving and advocating for child health in the community.”

Overcoming Barriers to Community Pediatrics Training

Although it is generally agreed that pediatricians should be active in the community, the available evidence indicates that pediatric residency training has not emphasized this area. Residency programs that have tried to institute community training have often found it difficult to integrate the concepts and skills into the already demanding and crowded residency schedule. The block nature of residency training presents a particular challenge for community pediatrics since many community

TABLE 2**Key Ingredients for Successful Resident Projects**

- Protected time for residents and faculty
 - A frame-shift: an “ah-ha” experience regarding community health
 - Rigorous (not fluffy) didactic curriculum before projects
 - Examples of practicing physicians
- Focus on process as opposed to outcome
 - Involvement of community leaders
 - Teamwork/sustainability
 - Opportunity for reflection/assessment
- A motto of “do no harm and have fun”
 - Mentoring
 - Flexibility
 - Faculty development
- Community assets (vs. deficits) paradigm
 - Lifelong skills procurement

influences play out longitudinally over weeks, months or even years. Finally, the notion of community medicine bucks up against some of the conventional practice of medicine. The call for partnership with families and communities places doctors in a new professional role that is not completely in sync with tradition. The ACGME’s new call for a re-examination of what it means to be a professional puts a new emphasis on responsibility for the care of children from all backgrounds. These new directions will be a strong incentive to new initiatives in community based resident training. There is no formula that will work for everyone everywhere. Nevertheless, the literature on this topic, as well as the experience of faculty and other individuals at Dyson Initiative sites, indicates that there are some key ingredients necessary for successful resident community experiences. **(TABLE 2)**

Community-based and preventive activities often seem irrelevant to residents who have been trained in a high-technology environment that values managing acute, rare problems. It is therefore very important to have a “mini- MPH” curriculum that establishes the importance of a broader perspective for improving the health of children in the entire population. Even when residents do accept the importance of the broader perspective, they may be intimidated by the prospect of working in the community because the environment is so alien to them, compared with the confines of the AMC. It is therefore important to gradually assist residents in developing community skills. The general approach for doing that, as well as some examples of resident experiences, is included in later chapters.

References

1. American Academy of Pediatrics Committee on Community Health Services. The pediatrician’s role in community pediatrics. *Pediatrics*, 103(6):1304-1306.
2. Haggerty RJ, Roghmann KJ, Pless IB. *Child Health and the Community*. 2nd ed. New Brunswick, NJ: Transaction Publishers; 1993.
3. Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Pediatrics. ACGME Excerpts, February 1, 1997. Available at www.acgme.org. Accessed November 19, 2004.

Resources

- Hunt R. *Introduction to Community-Based Nursing*, 2nd ed. Philadelphia, PA: Lippincott Williams & Wilkins; 2001.
- Marion R. *The Intern Blues: The Private Ordeals of Three Young Doctors*, 2nd ed. New York: Perennial; 2001.
- Wear D, Bickel J, editors. *Educating for Professionalism: Creating a Culture of Humanism in Medical Education*. Iowa City, IA. University of Iowa Press; 2000.
- Work Group on Health Promotion and Community Development. *Community Tool Box: Bringing solutions to life*. University of Kansas in Lawrence, Kansas. Available at <http://ctb.ku.edu/tools/>. Accessed November 19, 2004.



Project Development: Getting Started

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IN THIS CHAPTER

Selecting a Project

*Choosing Partners, Mentors,
and Advisors*

Time Management

Timelines and Work Plans

Selecting a Project—Creating an Awareness of Opportunity

The key to getting started on a community-based project or initiative is to consider what is important regarding the health and welfare of children and families in the community. Residents should ask themselves, “What population of children and/or health concern presents itself often during residency training?” It is important to shift the focus from the individual patient to population-based health care when choosing a project.

Residents in training are exposed to local communities through rotations in community clinics. They often become familiar with advocacy issues during sub-specialty rotations, noon conferences, grand rounds, and advocacy work-groups. Early involvement in any of these efforts can broaden the resident’s awareness of potential projects. Later, during clinical rotations, residents may find themselves becoming seriously interested and even passionate about specific diseases, conditions, or health issues that affect children and their families.

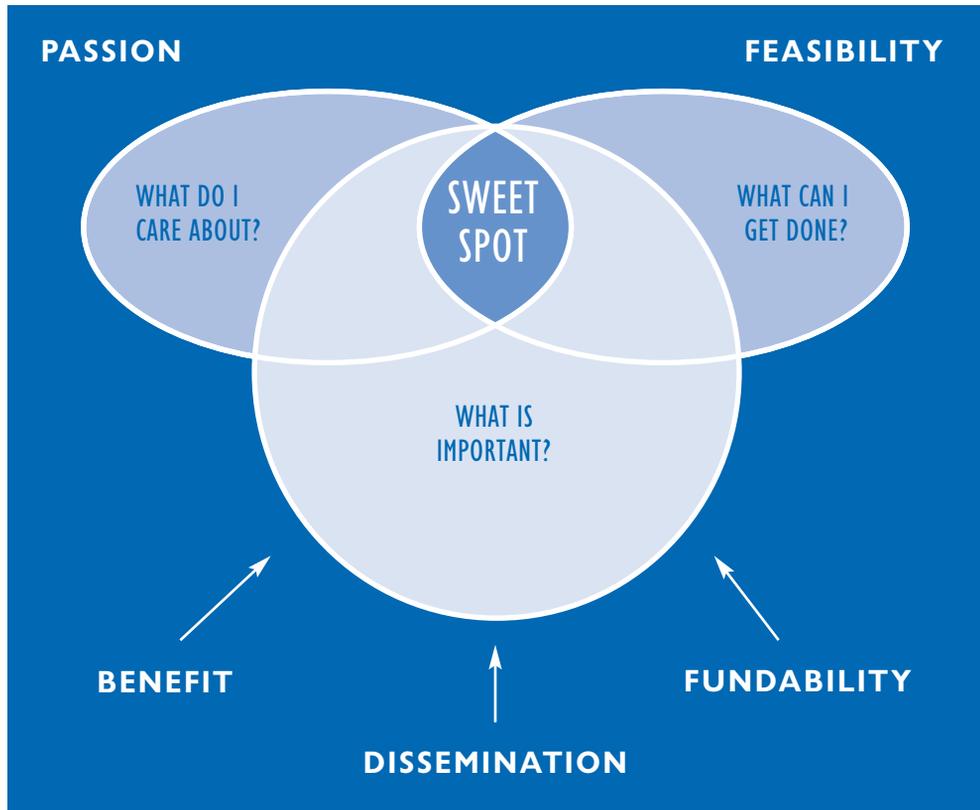
The resident may discover a system that needs to be changed (programs), or a behavior that needs to be modified or eliminated (procedures), or perhaps a desire to become involved at a state or national advocacy level (policies). Work with local public health departments, community-based organizations, private citizens, community-health related service agencies, private community pediatricians, the AAP, and other programs can give residents a “community perspective” on a possible project. The ability to learn as much as possible about specific issues and social determinants facing children and families is paramount in developing a realistic, effective community-based project.

Finding the “Sweet Spot”

The Sweet Spot Model developed by Jonathan Winickoff, MD, MPH, identifies key

IT ALL STARTS with an idea, a passion, or a mission to address a health care issue one feels the need to pursue.

components residents should consider when developing a project, such as feasibility, fundability, dissemination, and benefit.¹ While searching out project ideas, residents may discover projects that are already in the development process (by other residents or by faculty), may be recruited by faculty who have a new project in mind, or may be approached by the community to develop a new project. All of these are valid approaches. In addition, a resident may decide to develop a different aspect of an existing project. In any case, careful project planning will greatly affect the outcome of the project.



Jonathan Winickoff, MD, MPH

Selecting a Partner

Residents may not be sure which “population of children” they could work with. Fortunately, there are many resources the resident can turn to for help. For example, the resident can interview community pediatricians, faculty advisors, program managers, and other relevant professionals, as well as the community in general to explore possible populations of children and their corresponding health concerns. Many times faculty and community pediatricians participate on community boards or sit on special community-based committees targeting a specific health issue. Because faculty may not automatically share this information, residents should specifically ask what community activities faculty are currently involved in or have been involved with in the past.

KEY PLAYERS

- Residents
- Mentors
- Community-based Organizations
- Project Managers/Coordinators
- Community Health Advocates
- Principal Investigators

As residents develop a project, a team of key individuals can provide assistance and direction. The resident should seek out professionals and citizens with specialized expertise relevant to the resident's skills, interests, and population of children or project in consideration. Examples of key players include principal investigators on funded projects, faculty mentors and advisors, community stakeholders (churches, private citizen groups, community boards), community health advocates, and community-based program directors/coordinators. The most important thing to remember is that community-based projects are not completed by one person. The resident should take advantage of the experience, expertise, and willingness of others to help with the project, not only through the development phase, but also in implementing and evaluating the project.

Project Initiation

Projects can be initiated by the residents themselves or by community pediatricians, university faculty, or members of the community. More important than who initiates the project is the degree of careful planning and collaboration between all parties. Whether residents join an existing project or initiate a new project of their own, the beneficiary should be the community, and that requires the community's wholehearted acceptance and collaboration.

Mentors versus Advisors

At the outset, the resident should consider selecting a mentor rather than a project advisor. An advisor provides counsel and direction, whereas a mentor not only advises, but also provides experience. A mentor is highly regarded, guides the resident while allowing the resident to examine his/her own ideas, increases learning, and reinforces personal and professional development. Mentors serve as teachers, coaches, and role models.^{2,3} Residents should look for a project mentor within the pediatrics faculty, and/or within the community (a community pediatrician, a community health advocate, or a member of a community-based organization) who will commit to being more than an advisor. In academic programs where advisors are assigned, the resident will need to make a special effort to find a true mentor and work with both the advisor and the mentor.

Role Negotiation

It is critical to take into consideration the resident's demanding schedule when developing, implementing, and evaluating a community-based project. Everyone contributing time to the project needs to be realistic about the amount of work the resident can handle. Toward this end, the resident should develop a timeline and use a role negotiation tool to assign responsibilities and deadlines (additional examples can also be found online)⁴. Not only does this protect the resident from taking on too much, it also helps clarify the importance of teamwork.

Developing a Work Plan

Once the resident, mentor, and community have decided on a project, the resident should develop specific goals, objectives, and an evaluation plan. An experienced project manager can assist the resident with the following:

WHO HAS TIME?

- When will the project start and end?
- How much can the resident realistically commit to?
- What are other partners responsible for?
- Has a timeline been developed?

- **Developing a clear problem statement** using what has been found in the literature and census data
- **Outlining the project and population of children and/or health concern that will be addressed** in the context of a concept paper, or as a formal work plan
- **Defining the type of project this will be: research, intervention, system change or policy/advocacy change** or a combination
- **Developing specific goals and objectives, and an evaluation plan** with measurable objectives

It is best if the resident chooses one primary objective as a focus, considering time limitations. And of course, it is essential that the resident use a role negotiation tool so that all parties agree on work assignments.

A Word About IRB *(Institutional Review Board)*

Should the selected project include collecting personal health information from participants or take the form of a research project in which data is collected, consult your institution's Institutional or Internal Review Board early on in the process. For more information, visit the Department of Health and Human Services Web site: <http://www.hrsa.gov/quality/hsrtraining.htm>.

For more information on IRBs, see Chapter 8: Evaluating Resident Projects.

Funding Projects

The subject of funding is sure to arise during project development. Residents and the community, as partners, may wish to consider applying for grant monies. The American Academy of Pediatrics offers Community Access to Child Health (CATCH) grants to community pediatricians and residents, and offers residents an excellent opportunity to gain experience in writing grant applications. Many local foundations offer mini-grants with less cumbersome application processes than those for larger, federal grants. Small grants may easily suit the needs of resident and community-based projects. Many communities have resource books available that list local foundations and their contact information. Also, going online to search for corporate grants is an excellent option. For additional information on federal funding opportunities, visit the US Department of Health and Human Services Health Resources and Services Administration (HRSA) Web site at www.hrsa.gov or the Center for Disease Control and Prevention (CDC) Web site at www.cdc.gov. To apply for a CATCH grant, go to the AAP Web site, www.aap.org, and look under Community Pediatrics for CATCH.

Additional funding information can be found at the end of this toolkit, in Chapters 8 and 9.

Residency Programs and Resident Projects

Residency programs should act as the foundation for community-based projects. A systematic approach to project development includes proper training, education, and support provided by the residency program. Some residency programs take a longitudinal approach, expecting projects to be developed over the entire residency; other programs employ block rotations, or have residents complete portions of projects during their community rotation; still others allow residents to complete projects in their senior year.

TABLE 1 illustrates a three-year community pediatrics training program in which residents develop projects over the course of their residency.

TABLE 2 (on following page) is an example of a month-block rotation timeline that may be helpful to residency programs in developing a community project component.

TABLE 1

A Three-Year Training Schedule in Community Pediatrics

RESIDENT YEAR	ELEMENTS	GUIDELINE TO COMPLETION DATES
PGY1	<ul style="list-style-type: none"> • Attend noon conferences • Historical perspective of community pediatrics • Requirements of the project • Introduction to community pediatric noon conferences (curriculum) • Introduction to COPC* model or ABCD** model • Resident committees • Introduction to possible projects • Interview program manager/faculty • Population of children selected 	<ul style="list-style-type: none"> • Throughout residency • July of intern year • By end of December in the intern year • By the end of the intern year
PGY2	<ul style="list-style-type: none"> • Faculty mentor selected • Implementation of COPC model/ABCD • Attend community meetings • Community assessment • Identify community health advocate • Develop work plan (approved) • Role negotiation • Grants applied for (where applicable) • Data collection (where applicable) • Intervention (where applicable) • Document/utilize portfolio • Present project progress, where appropriate 	<ul style="list-style-type: none"> • Beginning of PL2 year • Middle of PL2 year • Middle to end of PL2 year • By the end of the PL2 year
PGY3	<ul style="list-style-type: none"> • Continue data collection, and/or intervention • Continue community meetings • Finalize findings • Mentor new interns • Provide presentations • Submit abstracts to appropriate journals, conferences, and research day • Submit portfolio (where appropriate) 	<ul style="list-style-type: none"> • Beginning of PL3 year • Middle of PL3 year • Prior to graduation

*COPC: Community-Oriented Primary Care

**ABCD: Asset-Based Community Development

C. Kalynych, 2004

No matter which type of model is adopted, the residency program must provide ample time, education, and support so that the resident develops skills in community pediatrics (for examples of competencies in community pediatrics, visit www.dysoninitiative.org.)

TABLE 2

Month-Block Rotation Community Experience Project Timeline

First week

- Team process orientation
- Roles, responsibilities, and expectations of team members
- Introduction to CBO
- Implementation of community assessment tool
- Brainstorming on project direction
- Establish work plan and task assignments

Second week

- Literature review; research health topic
- Establish project goals and objectives
- Identify system change, product, or intervention to implement within the CBO's community

Third week

- Implement intervention

Fourth week

- Analyze results
- Preparation for team presentation
- Present project to college faculty, peers, and CBO staff

Project Development at a Glance

Residency programs should ensure that residents understand the terminology they will need to know to complete a community-based project such as, social determinants, population-based health, core public health functions, the ability to define community, etc.

Residents should:

- 1 Complete a community assessment using a logic model such as Community Oriented Primary Care (COPC) or Asset-Based Community Development (ABCD).**
- 2 INVOLVE THE COMMUNITY IN ALL ASPECTS OF PROJECT DEVELOPMENT.**
- 3 Identify a faculty mentor.**
- 4 Identify a community health advocate.**
- 5 Develop specific goals and objectives.**
- 6 Develop a realistic timeline regarding clear goals and objectives, and develop an evaluation plan.**
- 7 Complete a role negotiation.**

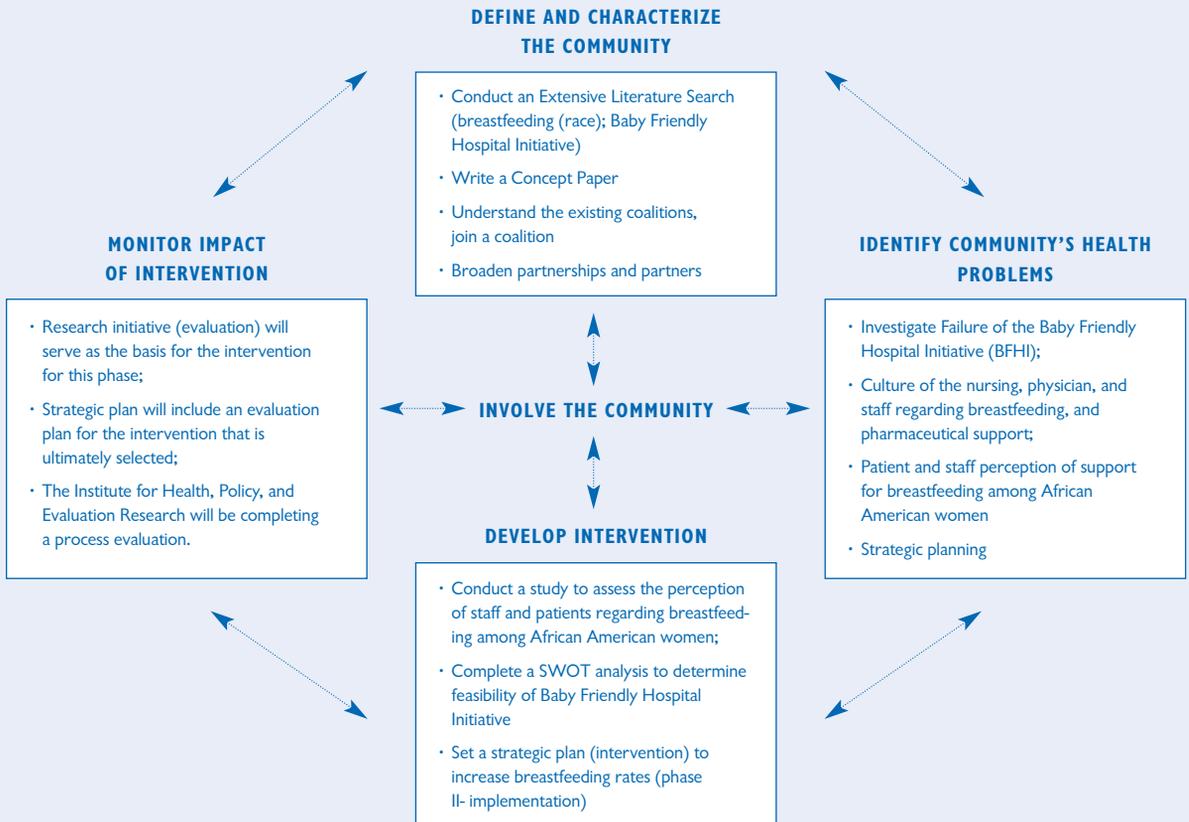
As an example, the following resident project regarding breastfeeding was developed, implemented, and evaluated using the COPC model.

Community Primary Care Model (COPC)



Example Project:

Increasing Breastfeeding Rates Among African American Women



References

1. Winickoff J. The Sweet Spot. For the Anne E. Dyson Community Pediatrics Training Initiative. Anne E. Dyson Community Pediatrics Training Initiative 2nd Annual Symposium: Rochester, NY; September 2002.
2. Peterson R. Handbook for Mentors, second edition of The New Mentor Handbook: University of California; 1989. Adapted by the Department of Educational Administration for use at California State University, Fullerton. Available at <http://www.gse.uci.edu/doehome/EdResource/Publications/MentorTeacher/Contents.html>. Accessed December 28, 2004.
3. University of British Columbia, College of Health Disciplines. Preceptor & Mentor Initiative for Health Sciences in BC. Managing Programs: Mentorship Roles; July 2003. Available at <http://www.health-disciplines.ubc.ca/pm/managingprograms/mentorshiproles/overview.htm>. Accessed December 28, 2004.
4. Heap N. Role Negotiation. Available at <http://homepage.ntlworld.com/nick.heap/Rolenegotiation.htm>. Accessed December 20, 2004.

Resources

American Academy of Pediatrics Community Access to Child Health (CATCH) Program
www.aap.org/catch

Asset-Based Community Development
<http://www.northwestern.edu/ipr/abcd.html>

Centers for Disease Control and Prevention
www.cdc.gov

Community Tool Kit. Bringing Solutions to Light. Kansas University. Available at <http://ctb.ku.edu/>. Accessed November 19, 2004.

Greater Los Angeles Council on Deafness (GLAD)
<http://www.gladinc.org/cpmmadv.htm>

HealthLink, Medical College of Wisconsin. Community Advocate Programs Improve Accessibility and Quality of Health Care; October 2001. Available at <http://www.healthlink.mcw.edu/article/963412354.html>. Accessed November 19, 2004.

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, Department of Health, Education & Welfare. The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research.

Rhyne R, et. al. Community-Oriented Primary Care: Health Care in the 21st Century, American Public Health Association;1998.

US Department of Health and Human Services, Health Resources and Service Administration.
www.hrsa.gov

2

Evidence-Based Public Health

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IN THIS CHAPTER

*Blunders in the
Absence of Evidence*

Getting Evidence

Determinants of Health

National Health Priorities

Health and Wealth

*Activities, Resources,
and References*

“Our lack of greater progress in tobacco control is more the result of failure to implement proven strategies than the lack of knowledge about what to do.”

—Reducing Tobacco Use. A Report of the Surgeon General, 2000¹

Blunders in the Absence of Evidence

Bloodletting, which seems obviously insane now, was the standard of care in this country about a hundred years ago. Practicing in the absence of evidence is like driving blindfolded: you might get to your destination safely, but you’re more likely to end up harming someone. In the absence of clinical evidence, medical history records a series of horrendous disasters rationalized by good intentions and pathophysiologic theories.

What is true for clinical medicine also applies to public health practice. This is revealed in the true story of a health department that decided to do something about the large number of people drowning each year in their community. They assumed, quite reasonably, that people drown because they don’t know how to swim. Therefore, they launched a huge program to teach swimming. Not only did drownings not go down, they went up. Eventually, the health department devised an effective plan that decreased drowning, but it might have been better to start with an evidence-based approach and the concept of “first do no harm.”

Getting Evidence

It is very important to avoid wasting time and energy by reinventing the wheel. It is even more crucial to avoid repeating interventions that have already been demonstrated to be ineffective or harmful. Fortunately, for most community health problems, the resident does not need to do primary research. There’s already a lot of information available that can identify causes and effective solutions. A good place to start is the online *Guide to Community Preventive Services: Systematic Reviews and Recommendations*, at www.thecommunityguide.org.²

Determinants of Health

The health of a community only partially depends on accessible medical services. Other significant determinants of health include genetic predisposition to particular diseases, the physical environment, the social environment, each individual's active and passive behaviors, and the public policies and interventions that influence all of these factors. When thinking about potential interventions for improving individual or public health, the resident should focus on important problems with *modifiable risk factors*.

National Health Priorities

The federal government uses the leading health indicators to measure the health of the nation. The health indicators were selected on the basis of their ability to motivate action, the availability of data to measure progress, and their importance as public health issues.³

TABLE 1

National Health Priorities (From <i>Healthy People 2010</i>)			
THE LEADING HEALTH INDICATORS	EXAMPLES OF OBJECTIVES	CURRENT STATUS	GOAL FOR 2010
Physical Activity	Adolescents: 20 min. exercise; 3x/week	64%	84%
Overweight and Obesity	Reduce # of overweight/obese children/adolescents	11%	5%
Tobacco Use	Reduce teen smoking	36%	16%
Substance Abuse	Increase # of teens not using drugs/substances during past month	77%	89%
Responsible Sexual Behavior	Increase # of teens who are abstinent or use condoms	85%	95%
Mental Health	Increase # of adults w/ known and treated depression	23%	50%
Injury and Violence	Reduce vehicular deaths	15.8/ 100,000	9.0/100,000
Environmental Quality	Reduce # of non-smokers exposed to environmental tobacco smoke (age 4 +)	65%	45%
Immunization	Increase # of children who get all universally recommended vaccines	73%	80%
Access to Health Care	Increase # of people with health insurance (all ages)	86%	100%

Looking at **TABLE 1**, we can see that, for the most part, the indicators are not influenced by how physicians deliver medical care. Therefore, effective interventions in these areas may need to occur outside the hospital and doctor's office. Another salient point is that behaviors generally established before adulthood (smoking, overeating, inactivity, violence, etc.) have an important impact on adult health. In other words, improving health in adults means changing behaviors in children. In some ways, one can say, "everything is pediatrics."

Health and Wealth

Socioeconomic status (SES) is generally considered the most important social determinant of health. SES is a complex concept related to income, wealth, class, education level, and location of residence, among other factors. Essentially it comes down to the fact that money and health are related. For example, in England, where health data are collected by social class, all-cause morbidity in adults is clearly related to class, with the risk of dying before age 64 almost four times higher in blue-collar workers than in their white-collar bosses.⁴ Compared with their non-poor peers, poor children in the United States have twice the rate of accidental injury and greater than four times the risk of assault, with an increased morbidity from chronic disease, and an increased risk of growth and developmental delay.

As a result of centuries of virulent racism, systematic differences in the economic experiences of blacks and whites persist. For example, the average household wealth of blacks in 1995 was \$200, compared with \$18,000 for whites.⁵ And wealth is probably more important to look at than income when measuring SES. Studies that control for income but ignore wealth aren't really controlling for SES.

In another example, high social status is associated with objective biochemical markers of health, such as lower HDL cholesterol. Therefore, poverty can contribute to poor health by altering health behaviors and hence actually changing a person's physiology, especially if poverty leads to lower social status and lowered perceived autonomy. In addition, poverty can damage health by forcing people to live in polluted neighborhoods. For example, lead dust exposure is a problem mainly for poor children. Although the elimination of lead from gasoline has led to a dramatic decrease in the average blood lead levels, higher lead levels are now concentrated in neighborhoods with housing that has high lead-dust concentrations.

Poverty is modifiable. Child poverty rates have changed over time, with the lowest rates in recent history seen around 1975. Until the 1960s, the elderly made up the age group most likely to be poor; today it is children, with a poverty rate double that of the elderly (20% vs. 10%). Moreover, child poverty rates are much higher in the United States than in other industrialized countries.

Activities, Resources, and References

- 1 **Why is the age of menarche decreasing? Why is height increasing? Why are such changes not likely due to genetic factors?**
 - 2 **What is a "risk factor"?**
 - 3 **What kinds of things need to be happening in terms of policies and interventions at a local, state, and national level in order to improve the health status of the American people?**
- **Please pick one of the ten Leading Health Indicators and using the library or other resources, find examples of things that work for achieving one or more of the goals in "Healthy People 2010."**
 - **Become familiar with Medline, Psychlit, the Cochrane site, and the Community Guide site.**

Drowning Prevention

In an anecdote told in this chapter, swimming lessons increased drownings. Why would that happen? What are risk factors and protective factors for drowning? What could you do to find out what works to decrease drowning at a population level? What would work to decrease drownings?

EXAMPLE: In five minutes, find out what works for drowning prevention.

- Go online to **PUBMED**, the free version of Medline (type “pubmed” in Google).
- Search the site for “drowning/ep, pc” (for epidemiology, prevention and control: These are official Medline abbreviations for subheadings).
- **QUICKLY SCAN** the article titles. For example, a recent systematic review done for an AAP policy statement may seem particularly relevant.
- Click on that entry to see a full text version of the article. **DISCOVER** there is no evidence for swimming lessons (which may indeed actually be harmful at a population level) and that there is decent evidence for pool fences (though not necessarily for mandating them by law).
- Notice that there are other valuable resources, such as a journal that recently devoted an entire issue to drowning prevention.
- Click on “**RELATED ARTICLES**” to focus the search results, if necessary.

Recipe for Evidence-Based Community Pediatrics Projects

- 1 **DEFINE** the issue using tools from other chapters (e.g., project development).
- 2 **IMAGINE** that someone has already tried to deal with the issue, and that they have learned some lessons that could help the resident’s project.
- 3 **LOOK** at some of the Web sites (e.g., www.thecommunityguide.org) that rank the effectiveness of interventions.
- 4 **REVIEW** the literature briefly. A medical librarian can help the resident effectively search the Internet, and particularly Medline.
- 5 **REPLICATE** what works; don’t reinvent the wheel.
- 6 **AVOID** what is already proven to be harmful or ineffective.
- 7 If there is really nothing known about the issue, or about the proposed intervention, **STOP** and return to Step 1. When everything about a potential project is completely innovative, the project is not really concerned with community service. Instead it is a proposal to do primary research on human beings. Please see Chapter 8, Evaluating Resident Projects.

References

1. US Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta, Georgia: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Control and Prevention and Health Promotion, Office on Smoking and Health, 2000. Available at http://www.cdc.gov/tobacco/sgr/sgr_2000/. Accessed December 29, 2004.
2. Centers for Disease Control and Prevention, Task Force on Community Preventive Services. Guide to Community Preventive Services: Systematic Reviews and Recommendations. www.thecommunityguide.org.
3. Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Healthy People 2010. Available online at www.healthypeople.gov.
4. Berkman LF, Kawachi I, editors. Social Epidemiology. New York: Oxford University Press; 2000.
5. Heintz J, Folbre N, the Center for Popular Economics, et al. The Ultimate Field Guide to the U.S. Economy: A Compact and Irreverent Guild to Economic Life in America. New York: The New Press; 2000

Resources

Agency for Health Care Research and Quality, U.S. Department of Health and Human Services. <http://www.ahrq.gov/clinic/cps3dix.htm>.

American College of Preventive Medicine and Association of Teachers of Preventive Medicine. *American Journal of Preventive Medicine*, Special supplements. Available online at <http://www-east.elsevier.com/ajpm/>.

Bloom DE, Canning D. The health and wealth of nations. In Basiro D, Gray A, Seale C, editors. *Health and Disease: A Reader* (3rd ed.). Philadelphia: Open University Press; 2001.

Centers for Disease Control and Prevention. MMWR Recommendations and Reports. Available online at http://www.cdc.gov/mmwr/mmwr_rr.html.

The Cochrane Collaboration; <http://www.cochrane.org>.

Gwatkin DR. Health inequalities and the health of the poor: What do we know? In Basiro D, Gray A, Seale C, editors. *Health and Disease: A Reader* (3rd ed.). Philadelphia: Open University Press; 2001.

Medical Services Study Group. Deaths under 50. In D. Basiro, A. Gray, C. Seale, editors. *Health and Disease: A Reader* (3rd ed.). Philadelphia: Open University Press, 2001.

U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services* (2nd ed.)

Sagan LA. *The Health of Nations: True Causes of Sickness and Well Being*. New York: Basic Books; 1987.

Stolley PD, Lasky T. *Investigating Disease Patterns: The Science of Epidemiology*. New York: Scientific American Library; 1995.

Wilkinson R. The psychosocial causes of illness. In Basiro D, Gray A, Seale C. (eds.), *Health and Disease: A Reader* (3rd ed.). Philadelphia: Open University Press; 2001.

3

Asset-Based Community Development (ABCD)

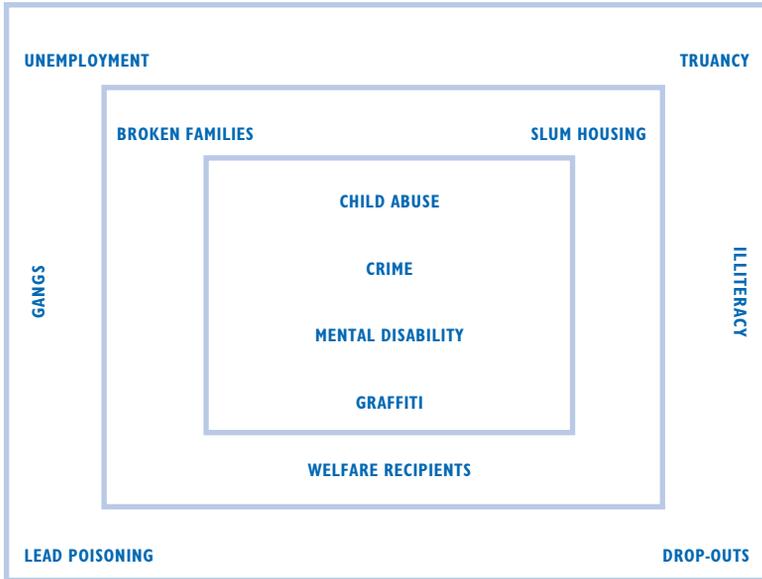
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Sections of this chapter have been adapted from Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets by John P. Kretzmann and John L. McKnight.

Definitions

Asset-Based Community Development (ABCD) is based on the idea that communities can be improved by building from within: that the community's citizens can improve their status by mobilizing their own skills and talents. A community that can emphasize what the citizen individually and coherently brings to the table, rather than focusing on deficiencies, will equip itself with more effective tools. This is the essence of ABCD: believing that the glass is half full rather than half empty. John Kretzmann and John McKnight have written extensively about this in *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*.

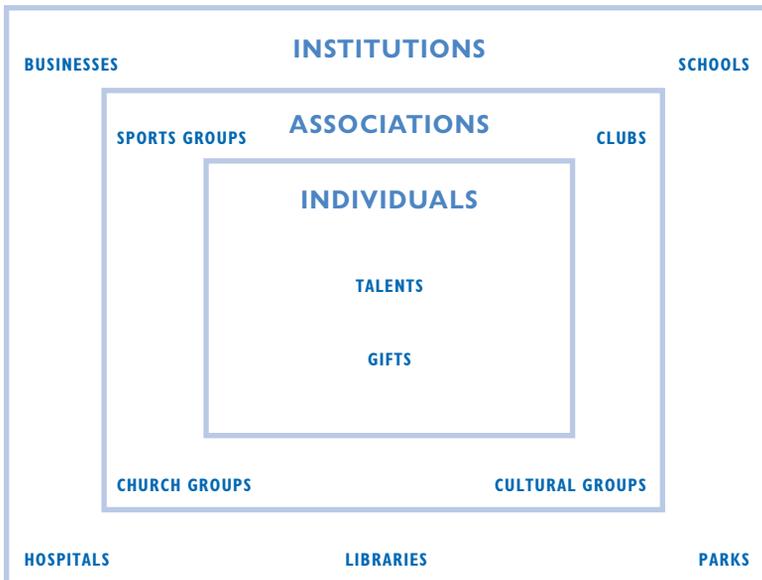
The traditional community map often focuses on its deficiencies rather than its assets. These might include high rates of poverty, gangs, failing schools, and homelessness. Emphasis on these things, however, can have significant negative consequences—residents of the community may acquire a poor self-image, and those outside the community may come to judge it based on its deficits alone. The people in the community then appear only to be clients, unable to take care of their problems and with no say in the solutions. Highlighting the assets of a community, on the other hand, allows it and those supporting it to positively improve their environment on their own terms.



NEIGHBORHOOD NEEDS MAP

This map focuses on the deficiencies of the community, highlighting negative aspects such as crime, unemployment, and school dropout rates.

VS.



COMMUNITY ASSETS MAP

This map shows the community's assets, on which it can build its future, from the institutions and associations, to individuals. All levels have positive traits that contribute to a community.

ABCD in Action

Pediatric residents can focus their projects on promoting connections between community members and the groups that make up a community—associations and institutions. Each of these has a bounty of assets that can be mobilized toward a successful project. Professionals, especially from outside the community, tend to concentrate on institutions—hospitals, clinics, schools and health departments—for collaboration in health programs. The ABCD concept argues that individuals and associations represent large, untapped resources.

SEEKING OUT each individual's skills and talents is known as taking a **capacity inventory**.

AN INDIVIDUAL'S STORY

John is a quarterback on the high school football team, but he also has asthma and requires daily medication.

Do you measure John by his physical disability and look at him as deficient? Or do you look at him as someone who has unique talent, who can help his teammates and honor his school?

SOCIAL CAPITAL

The interdependence of the community's social organizations (the associations, institutions, and individuals), their members' ability to network, and their ability to trust each other facilitate coordination and cooperation for mutual benefit of the entire community.

The community's social organization offers a broad collaborative alignment instead of the usually narrow approach of government and its programs. Community building is the way to build social capital.

If all the groups and individuals cooperate and collaborate with each other, the community will thrive.

Individuals

Individuals are the community's basic, and most valuable, building block. Everyone in the community has a talent or gift, and the use of those talents is what makes the community stronger. These talents are the raw materials from which the community is built; these individuals can directly improve the health of the community's children. Seeking out each individual's skills is known as taking a **capacity inventory**. By focusing carefully on each person's individual skills and talents, such as professional and personal skills, the resident will find many talents that can be mobilized into a successful collaborative project. These talents can be brought together to support the evolution of project planning and implementation.

This is a good asset model to use with patients and families, seeking their strengths and seeing beyond their deficiencies. All residents in a community have some talent that can be used to improve the neighborhood. Defining these assets is the first place to start.

Associations

An association is a group of two or more residents joined together around a common activity, sharing a common vision. The members who collectively work toward achieving the goal often do more than the association was formed to do; the assembly of talents and gifts in the association allows it to accomplish more as a whole than the members could accomplish individually. Some associations have paid staff; some are run by volunteers. All associations have some impact on local citizens. Examples of associations include sports groups, church groups, neighborhood groups, art groups, political groups, and service groups.

Associations may be highly organized, like the Rotary Club, with some paid staff, or loosely held together, like a women's knitting club that meets once a week. The visitor to a community can uncover what associations exist by asking individuals what groups they belong to or by reading the bulletin boards at churches and grocery stores. The more established groups may even publish ads in the local paper or phone book.

Story Point...

- A church group formed for Bible study finds some of its members unable to attend for lack of transportation. They purchase a bus and drive their members to the meeting. The group has gone beyond their original focus.
- A restaurant organizes a softball team to play against other local teams. They notice how unsightly the roads are on the way to their games. The team decides to join Adopt-a-Highway and clean the roads around their town. The group goes beyond their original mission and has a positive impact on the community.

Institutions

Institutions are more formal. Organizations such as schools, libraries, churches, health departments, hospitals, parks are all either government-run or not-for-profit. When pediatric residents think of working with communities, it's likely that they will think to collaborate with one of these entities. Institutions have a large number of resources but often have fewer community members than associations. They frequently take direction from leaders outside the community and therefore do not always represent the community's most pressing needs.

Discovering the Assets of a Community

There are many ways residents can discover the assets of a community. Here are just a few ideas:

- Speak with individuals, look in the telephone directory, read advertisements in the local paper, and check grocery or church bulletin boards to get a feeling for the general make-up and assets of the community.
- Conduct a survey of the community associations, by mail or by phone.
- Have fellow residents list the associations they belong to and the skills they could offer a health project that may be outside of the main mission of their employer.
- Use all of the above information to develop a community assets map (pg. 19)!

Sample Project

A Windshield Survey or Community Snapshot

Ride through the neighborhood and write down what you see that could be a community asset. Look for churches, schools, childcare facilities, and the like. Take notes and photos. Research the names of key personnel such as superintendents, pastors, and industry leaders. If possible do this drive-by with your community mentor and discuss what is available to community members. Try to see what is or is not available to children. Put together a list of what community members see every day.

Things to think about while looking:

- **HOUSING.** Are there apartments or separate homes? What is their age and condition?
- **TRANSPORTATION.** How heavy is the street traffic? What kind of vehicles? Are there sidewalks? Is public transportation available, frequent, and safe?
- **PARKS AND RECREATION.** Where are the parks? What type of recreation is available in the parks? What cultural facilities, such as museums and theaters, are there?
- **SCHOOLS.** What is the condition, location, and size (in terms of student body and student-teacher ratio) of the schools?
- **GOVERNMENT.** Are police visible? Is there a fire department in the community? Where are the nearest government offices?
- **BUSINESSES.** Are there grocery stores and pharmacies in the community? Do the liquor stores outnumber the grocery stores? What is the language of signage? What businesses are missing?
- **SERVICES.** Where are the medical and dental offices? Hospitals? Child-care centers? WIC?
- **PEOPLE.** What races and ethnic groups are present? Are there children? Families? Are races comingled or living separately?

As residents come to understand the assets approach, they should consider how their own talents can become an asset for the community. The resident must be realistic about his or her available time and energy, and find allies among individuals, associations, and institutions, and bring them on board. It should be an enjoyable experience for all involved (See Chapter 1, Project Development).

Sample Project

A Day in the Life

Pediatric residents may be aware that many of their patients are economically challenged and have specific difficulties with everyday activities. “A Day in the Life” asks residents to experience the day the way their patients and families do.

Understanding patients’ problems firsthand will make it easier for the resident to decide how to start the project. It will also enable residents to meet community leaders and learn how community leaders have solved their own difficulties outside the medical center’s walls.

1 Shop for food.

- a Walk or take public transportation.
- b If there are no chain stores in the community, choose between high prices at a convenience store or traveling outside the community.

2. Get help for a sick child.

- a Find the office of the nearest physician. Choose between traveling outside the community and visiting the local clinic or emergency room.
- b Research the average length of a wait at the local hospital ER at various times of day and days of week or month.
- c Decide what to do with the sick child’s siblings (leave them alone, pay for a sitter, leave them with a relative, bring them along).

3 Experience limited financial resources.

- a Sign up for Medicaid.
- b Sign up for WIC.
- c Find the appropriate government offices.
- d Negotiate an activity in an unfamiliar language.

4 Send a child to school.

- a Research the average, and greatest distance from home to school. Ask about transportation (school bus, public transport, carpooling, walking).
- b Assess the safety of a child’s walking to school. Consider age of child, traffic, crime, and so forth.
- c Investigate the activities available for the child before and after school. Is childcare available for working parents? What is the cost? What are the penalties for late pickup? How crowded are the facilities? How qualified are the teachers?

As you can see, this activity can be expanded almost infinitely. The more tasks the resident is set, the better he or she will understand the difficulties community members face. A Day in the Life will also give residents an opportunity to meet community leaders and discuss the challenges the community faces.

Resident Project Example

(Presented at the Pediatric Academic Societies Meeting in May 2004)

One pediatric resident at the University of California, Davis, was working in the hospital's emergency room. She noted an unusually large number of dog bites coming through the ER during her rotation.

She traced many of these incidents to one neighborhood and specifically to a park in that neighborhood. This was where most of the children in that neighborhood played during the day, but also where most of the dog owners ran their dogs.

The resident met with the local residents, who were represented by a neighborhood association, the Tahoe-Colonial collaborative. She explained her findings and suggested that they organize a course for interested parents and their children on how to behave around dogs. The collaborative recruited community members to put signs up in the neighborhood as well as contact as many

parents as they knew whose children used the park. The pediatric resident volunteered to deliver the lecture on how to approach a dog and what to do if a dog, off leash, approaches a child.

The course was a success. One fine Saturday a number of children and their parents learned to stand like a tree when a dog approached, without a leash, and how to speak to a dog to keep it calm and friendly. What was even more exciting was that many dog owners came with their animals to hear the lecture and to volunteer to work with the children.

This is an example of collaboration between pediatric resident and the local neighborhood. It improved child health and everyone involved pooled their resources to make their neighborhood a better and safer place to live.

Resources

McKnight J, Pretzman P. *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*. Chicago: ACTA; 1997.

Littlefield D. *Asset Based Community Development in Practice*. Lecture series at the Center for Collaborative Planning, Sacramento, CA; October 22–23; 2001.

McKnight J, Pandak C. *New Community Tools for Improving Child Health: A Pediatricians Guide to Local Associations*. Oak Brook, IL: Asset-Based Community Development Institute, Institute for Policy Research, Northwestern University, and the American Academy of Pediatrics; 1999.

Community and Physicians Together, University of California, Davis. <http://www.CPT-online.org>

4

Working with Community-Based Organizations

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IN THIS CHAPTER

What is a CBO?

CBO expertise

Partnerships

Decision-making

The Community-Based Organization (CBO)

A community-based organization is a locally controlled and consumer-oriented agency that fosters self-reliance and self-sufficiency in the overall advancement of human welfare and reflects the values of the community in which it resides. Some community-based organizations focus on a particular geographic area, working to provide services and support to the residents of a particular neighborhood.

CBO Expertise

The CBO has expert knowledge in community needs, community credibility, resources, culture of the clients they serve, funding streams, and unique advocacy opportunities. Each CBO has a mission statement to serve a defined group of individuals with a set of programs or services to meet some of the needs of the community. While CBOs may have a narrow or broad focus of the human services provided, most agencies by their nature are flexible and resourceful in assisting individuals in crisis. The CBO often has the infrastructure to tap into community opinion. Many are grassroots organizations unaffiliated with national or international groups. Most CBOs have representation from the clientele they serve, either as directors on their board, or on committees or advisory boards. Most CBOs operate as nonprofit organizations (NPO).

Nonprofit Organizations

Nonprofit organizations are organized and operated exclusively for a charitable purpose as set forth in IRS Code 501. Major subcategories include charities, foundations, social welfare organizations, and professional and trade associations. A major source of income is from governmental funding (federal and/or state), but many NPOs also have significant funding through private, local donations. Some nonprofit organizations may also receive membership fees, corporate support, or United Way support (e.g., the YMCA).

Example of a Non-profit CBO

Next Door Foundation, Milwaukee, WI

The Next Door Foundation (NDF) began with a youth outreach program in 1969 at Our Savior's Lutheran Church in Milwaukee and received nonprofit status the next year. Innovative programs continued to develop over the years. The NDF partnered with schools (St. Olaf and Carthage colleges and Milwaukee Public Schools). They opened the Cornerstone Children and Youth Center at Reformation Lutheran Church.

Over the years, they have provided programs for drug and alcohol rehabilitation, an alternative high school, and an adult basic education/ GED program.

In 1995, strategic planning focused attention on children from birth to 12 years of age. Programs included early Head Start and Head Start for 3- to 5-year-olds as well as kindergartens for 4- and 5-year-olds.

Their vision statement clearly stands for what pediatricians want: "The Next Door Foundation will position Central City Milwaukee kids to succeed." The NDF Mission is "We support the intellectual, spiritual and emotional development of children, so they become self-sufficient and contributing members of the community."

NDF is positioned to provide optimal educational preparedness and

development for children as well as promote adult literacy and strengthen parenting skills. Furthermore, the NDF now houses a pediatric clinic to provide health care.

The Next Door Foundation has been community-based since its inception. It continues to respond to the needs of those families in the community. The NDF has a broad base of financial support, with 35% of its funding coming from private sources (United Way, congregations, businesses, individuals, and foundations) and 65% from public programs (federal, state, local public schools, and the City and County of Milwaukee).

Partnerships

Each member is equal and brings unique, complementary skills. The CBO must feel a part of the academic community, and the resident must immerse himself or herself in the lives of the CBO and its clients.

Starting a Project

The idea for a project can originate from any of three sources: the CBO staff, the resident, or a faculty member. To be successful, however, there must be buy-in from all involved individuals. Residents must see the need for their particular expertise and that the project directly relates to pediatric patients. The CBO must see that its expertise is needed and that the project will directly benefit its clients.

On the following page is an example of a CBO initiated project and a true partnership that led to a successful project.

HOW TO PARTNER WITH A CBO

- 1 Identify an area of interest or passion (e.g., Latino health).
- 2 Seek out a faculty advisor to help direct the resident to a CBO.
- 3 Meet with the leadership of the CBO.
- 4 Spend time getting to know the staff, the clients, and the culture of the CBO and the community it serves.
- 5 Find out the CBO and community's interests and needs.
- 6 Allow the CBO to get to know the resident by sharing experiences, situation, and interests.
- 7 Mutually realign the resident's interests with those of the CBO.
- 8 Together plan and carry out the project.

Filling the Cavities Between Children and Oral Health

The inspiration for this project came from the staff at the Next Door Foundation (NDF), a community-based organization in Milwaukee.

NDF recognized an urgent need among its clients—dental care. Severe dental disease was evident in children attending Head Start; the children were not getting needed dental care. Preliminary survey results showed that only 98 of 207 children in Head Start had received the required annual dental visit. 44 of the 98 examined children had significant dental caries but no children had had their cavities repaired.

Even though the pediatric residents were not dentists, they had seen the adverse effects of severe dental caries while caring for children in multiple settings (the clinic, the emergency department, and the hospital) and were aware of the long delays in accessing dental care for this population.

Project Goals

Four pediatric residents partnered with the Next Door Foundation in this project. Their objectives for this one-month block rotation were to:

- **Explore barriers to oral health.**
- **Increase awareness through education.**
- **Integrate oral health into health supervision visits.**
- **Advocate for increased access and education.**

With the collaboration of the staff at NDF, the residents held focus groups to assess knowledge about oral health and barriers to care. They then pilot-tested a survey tool. They met with the leadership of the Children's Health Alliance and the Wisconsin Oral Health Coalition. They contacted local dentists to assess Medicaid acceptance and waiting periods.

Accomplishments

- **An oral health workshop for parent educators at the NDF**
- **Dental tips and activity pages for teachers**
- **Letters to dentists advocating increased participation in Medicaid**
- **Survey tool and an oral health care fact sheet for parents**

Conclusion

Subsequently residents presented their results to the Executive Committee of the Wisconsin Chapter of the American Academy of Pediatrics, who not only endorsed the concepts but also aided in lobbying state legislators for enhanced dental care for children. Through the combined efforts of NDF, the pediatric residents at the Medical College of Wisconsin and other dedicated individuals, primary care providers now receive reimbursement for fluoride varnish application for children. In addition, educational programs are in place to inform parents about oral health issues and to speed the referral process to pediatric dentists.

GETTING TO KNOW YOU

Most CBO staff members have no idea that residents may work 30 consecutive hours.

Likewise, most residents do not appreciate the wide range of services provided by each CBO in the community.

Definition of a Team

"A team is a small number of people with complimentary skills who are committed to a common purpose, set of performance goals, and approach for which they hold themselves mutually accountable."¹

Relationship building

In order to get to know team members, the resident and the staff of the CBO will need to learn about each other's culture while sharing their own. Team members will need to devote adequate time to getting to know each other in order to develop mutual trust and lessen the likelihood of misperceptions.

Team Decision Making

Consensus is agreement where all legitimate concerns have been raised and addressed. It is the collective opinion that all members understand and support publicly. True consensus takes time but will lead to the highest quality decisions.

BEWARE the trap of American democracy where the majority vote wins. The minority may not support the efforts of the “team decision.”

Conflict Negotiation

Conflicts create an opportunity for higher-order collective thinking and listening in order to seek a win-win solution, not just a compromise. Both the CBO’s and the resident’s interests are high priorities. Each must know its position so well that each is able to focus on the interests of the other party.

BEWARE the “I am the doctor and I know what’s best” mentality.

How to Negotiate Conflict ²

(adapted from Holtom BC)

Identify and define the problem in a clear and simple manner.

- Define the problem in a way that is mutually acceptable to all parties.
- State the problem as a goal.
- Depersonalize the problem.
- Separate the problem from the solutions.

Understand the problem fully and identify interests.

- Interests include substantive issues, process, relationships, and principles.

Generate alternative solutions.

- Redefine the problem.
- Expand the pie (look for additional possibilities: you prefer the center of the pie and I prefer the crust).
- Logroll (trade off multiple issues: I win one, you win one).
- Find a bridge solution.
- Use brainstorming techniques to find new options.

Evaluate and select alternatives.

- Agree to the criteria ahead of time.
- Be willing to justify personal preferences.
- Be alert to the influence of intangibles.
- Evaluate solutions based on quality and acceptability.
- Take time off to cool off.
- Keep decisions tentative until all aspects are complete.

THE TWO SIDES OF CONFLICT

Negative	Positive
Status Quo	Creativity
Zero Inertia	Higher Order Thinking
Avoidance	Listening
Immobilization	Change

FOCUS ON community assets, not deficits.

References

1. Katzenbach JR, Smith DK. The discipline of teams. *Harvard Business Review* (March–April) 1993: 111–120, Reprint number 93207.
2. Holtom BC. Seminar on Managing People I: Effective Negotiations. Presented in Milwaukee, WI. October 22, 2002 with permission.

Resources

Fisher R, Ury W, Patton B. *Getting to Yes: Negotiating Agreement Without Giving In*. New York: Penguin Books; 1991.

5

Cultural Competency

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IN THIS CHAPTER

What is Cultural Competency?

The Impact on Pediatric Medicine

Cultural Competence Survey

Cultural Competency and Project Development

Cultural Comparison Didactic

All good quality healthcare is cross-cultural healthcare, in that it views illness within the contexts of social, emotional, political, cultural, spiritual and psychological beliefs.

The concept of cultural competency is central to working with families and communities to improve child health. Given the ever-changing diversity of our neighborhoods and increasing healthcare disparities, cultural competency is essential to successfully improving the health of families.

What Is Cultural Competency?

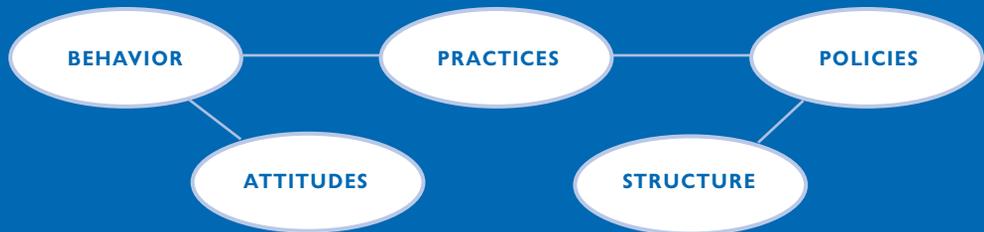
Cultural competency can be defined as a congruent set of behaviors, attitudes, and policies that allow a system, agency, or profession to work effectively in providing a service to others in cross-cultural situations. There are many ways to explore what culturally effective care means for the resident and what role it should play in pediatrics practice.

The American Academy of Pediatrics defines culturally effective care as, “the delivery of healthcare within the context of appropriate physician knowledge, understanding and appreciation of cultural distinctions. Such understanding should take into account the beliefs, values, actions, customs and unique healthcare needs of distinct population groups. Providers will thus enhance interpersonal and communication skills, thereby strengthening the physician-patient relationship and maximizing the health status of patients.”¹

Woven into cultural competency are these following basic definitions:

- **Race:** a classification of individuals who possess distinctive physical characteristics that are genetically transmitted

- **Ethnicity:** races or groups of people who are classed based on common backgrounds, languages, traits, customs, or appearance
- **Culture:** any group of people who share experiences, language, and values that permit them to communicate knowledge not shared by those outside of the group
- **Competence:** a capacity equal to requirement



CULTURAL COMPETENCE requires that organizations have a clearly defined, congruent set of values and principles, and demonstrate behaviors, attitudes, policies, structures, and practices that enable them to work effectively cross-culturally.

CULTURE is akin to being the person observed through a one-way mirror; everything we see is from our own perspective.

ONLY WHEN we join the observed on the other side is it possible to see ourselves and others clearly. But getting to the other side of the glass presents many challenges.

The Impact on Pediatric Medicine

Before the resident takes the above definitions and ventures into the community he or she should consider each of these introspective questions:

- What qualities do I need to become a good physician?
- What has my experience been like in my community? In other communities?
- What impact do culture and ethnicity have on patient care in this community?
- What is the role of culture and ethnicity in the physician-patient relationship?

The answers to each of these questions will affect the approaches residents take in exploring the community surrounding their medical center. Cultural competency involves a careful discovery and appreciation not only of a person's environment, but also of their inherent beliefs. Prior personal experiences, whether negative or positive, with other individuals and groups may or may not unconsciously affect a person's actions and thoughts. It is crucial for residents to gain a clear understanding of their biases and how to best work around those biases.

The survey on the following page may help the resident understand his or her experiences in interacting with other cultures. The questions will help residents reflect on their experiences and how those experiences shaped the residents' attitudes and perceptions of others.

How do you Identify Yourself in an Ethnic or Cultural Way?

Answer the following based on a Likert scale of 1 to 4, with 4 meaning “agree” and 1 meaning “not at all.”

- 1 I recognize the influence of my own culture(s) on my actions and thoughts.
- 2 I am aware of my life experiences as a person related to a culture, or multiple cultures.
- 3 I have felt excluded from participating in activities because of my ethnicity/culture; my age; my gender.
- 4 I am aware of some traditional explanations used by cultural/ethnic groups to describe or make sense of health, illness, disease, or death.

- 5 I am aware of major barriers for pediatricians in providing health services to different cultural or ethnic groups.
- 6 I possess strengths that allow me to work cooperatively with people who are culturally/ethnically different from me.
- 7 I am uncomfortable when working with people who are culturally ethnically different from me.
- 8 I recognize the need to increase my multicultural competence.

Answer the following based on a Likert scale of 1 to 4, with 4 meaning “frequently,” and 1 meaning “never.”

- 9 I have assessed my involvement with persons of other cultures.
- 10 I have contact with individuals, families, and groups of people reflective of other cultures.

Answer the following based on a Likert scale of 1 to 4, with 4 meaning “strongly” and 1 meaning “not at all.”

- 11 I agree with the following statement: My ethnic group is considered good by others.

Adapted from: Cox, NS. (1999). Multicultural Competency Self-Assessment for Prevention Service Providers. (Available from Wisconsin HIV Prevention Training System, www.wihivpts.wisc.edu.)

Cultural Competency and Project Development

Cultural competency becomes enveloped in each aspect of resident project development by facilitating:

- the selection of a **community** of children and their healthcare needs;
- the identification of a **community-based organization**, or other community stakeholder, who can collaborate with the resident on needs assessments and service delivery;
- the selection of a **mentor or project director**, who may have community-based relationships and/or similar community interests;
- the interpretation of **clinical evidence and methodologies** that may aid the design of future community-based interventions;
- the tailoring of **language** for the dissemination of public health messages and/or study results;
- the clarification of **language** necessary to advocate for improved funding of services by public officials;
- relationship-building between **local, regional, and national figures** with similar interests.

Providers who are culturally competent affect every aspect of the healthcare system by:

- developing **partnerships** with healthcare experts and community-based consumers;
- facilitating **projects** that address a community’s unmet healthcare needs;
- **advocating** for increased community-based services;
- developing community-based health **curriculums** for at-risk children;
- ensuring critical **evaluation** of all community-based service programs and assessments;
- fostering **resident** education by interacting with diverse community stakeholders; and
- working with medical, governmental, and private sources to ensure **sustainability** of effective community-based programs.

CLINICAL CULTURAL COMPETENCE

Healthcare providers must:

- Be aware of social and cultural factors on health beliefs and behaviors;
- Assess how these factors affect families;
- Have the tools and skills to manage these factors; and
- Empower patients to be active partners and to negotiate ethno-cultural beliefs and practices of the patient and those of the culture of biomedicine.

Resident Project Example

Need for Cultural Competence for Success

Name of Project

Reach Out and Read in
Native American Country

Purpose

- To promote literacy in an Native American population
- To seek culturally appropriate children's books for dissemination

Why Cultural Competency is Essential for this Resident Project

- It will be necessary to have a native collaborator to sell the idea to staff and patients.
- One will have to be patient and willing to work on "Native American time."
- It is essential not to talk about "investigation," "study," or "research" but rather about outcomes and program evaluation.

Resident Project Example

Improving Cultural Competency in a Clinic

Name of Project

An Assessment of Available Resources for Language Discordant Families in a Pediatric Ambulatory Care Center

Purpose

To assess:

- parental knowledge of the availability of interpreter services;
- parental satisfaction with the delivery of healthcare to their children; and
- the varieties of languages spoken at the Columbia University-Harlem Hospital Center Pediatric outpatient clinics.

Outcome Measures

- Percent of parents aware of clinic-based interpreter services
- Percent of parents satisfied with healthcare delivery

Initial Lessons Learned

- Most parents and providers speak in English (even if it's not parent's primary or native language)
- Parents unaware of interpreter services
- Providers generally use available interpreter services
- Parents generally satisfied with child healthcare (even if language discordance present)

Next Steps

- Advocate for increased clinic-based interpreter services.
- Create study of effect of patient-provider language discordance and specific health indicators (e.g., immunizations, lead screening, body mass index evaluation).

Cultural Comparisons

As the resident works in cross-cultural settings, he or she should consider the following categories of broad comparisons designed to increase understanding of the potential diversity of cross-cultural beliefs. These examples by no means typify all people within the same culture or exhaust the range of cultural behaviors.

TRADITIONAL CULTURAL VALUES	CONTEMPORARY EURO-AMERICAN VALUES
Cooperation	Competition
Group emphasis	Individual emphasis
Humility/modesty	Self-importance
Passivity/calmness	Activity/restlessness
Sharing	Saving
Respect for age	Respect for youth
Nonmaterialism	Materialism
Orientation to present	Orientation to future
Religious beliefs as a way of life	Religious beliefs as a segment of life
Listening/observational skills	Verbal skills
No direct eye contact	Direct eye contact
Respect for tradition	Progress oriented
Character as source of status	Academic degree as source of status
Illness as imbalance	Illness as physical issue

Adapted from: Coyhis, Don. Culturally specific addiction recovery for Native Americans. In Jo-Ann Krestan (ed.), *Bridges to Recovery: Addiction, Family Therapy and Multicultural Treatment* (pp. 94–95). New York: The Free Press, 2000.

References

1. American Academy of Pediatrics, Committee on Pediatric Workforce. Culturally effective pediatric care: Education and training issues. *Pediatrics* 103(1): 167–170.

Resources

Ambulatory Pediatric Association, 1996 Educational Guidelines for Residency Training in General Pediatrics . Available online at <http://www.ambpeds.org/guidelines/index.cfm>.

American Academy of Pediatrics, Report of the Task Force on Minority Children's Access to Pediatric Care. Elk Grove Village, IL: AAP; 1994:16.

Brach C, Fraser I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review*, 57(1):181–217.

Fadiman, Anne. *The Spirit Catches You and You Fall Down*. New York: Farrar, Straus and Giroux; 1997.

Flores G. Culture and the patient-physician relationship: Achieving cultural competency in health care. *Journal of Pediatrics* 136(1):14-23.

Flores G, Laws MB, Mayo SJ, Zuckerman B, Abreu M, Medina L, Hardt EJ. Errors in medical interpretation. *Pediatrics* 111(1), 6-14.

Green AR, Betancourt JR, Carrillo JE. Integrating social factors into cross-cultural medical education. *Acad Med*;77(3):193-7.

Kinsman S, Mitchell S, Fox K. Multicultural issues in pediatric practice. *Pediatrics in Review* 17(10), 349-354.

Kleinman A, Eisenberg L, Good B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine*. 88(2):251-8, 1978 Feb.

Smedley BD, Stith AY, Nelson AR, editors. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington D.C.: National Academies Press; 2003.

American Medical Association Cultural Competence Initiative
<http://www.ama-assn.org/ama/pub/category/2661.html>

Cancer Center
<http://www.mdanderson.org/departments/CIMER/>

Complementary/Integrative Medicine at the University of Texas MD Anderson

Cross-Cultural Health Care Program
www.xculture.org

CultureMed
www.sunyit.edu/library/culturemed/index.html

Ethnomed
<http://ethnomed.org>

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

National Center for Contemporary and Alternative Medicine
<http://altmed.od.nih.gov>

National Center for Cultural Competency
<http://www3.georgetown.edu/research/gucchd/nccc/index.html>

6

Media Relations: How to Advocate Effectively and Promote Health Education

DIANNA FOX, MD
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IN THIS CHAPTER

Understanding the Media

The Media in the Community

Strategies for Effective Interviews

Troubleshooting Difficult Situations

Sections from this chapter have been adapted from the American Academy of Pediatrics Communications Handbook produced through the AAP Office of Public Relations.

Understand the Media

The media is a powerful tool for getting a message into the community. The public looks to physicians for expert advice, as do reporters. For reporters, time is essential. Reporters, like physicians, are constantly responding to deadlines. Therefore, reporters need to know the facts. They organize stories based on the five Ws and one H theory: **Who, What, When, Where, Why, and How.** Information given outside of this theory may be easily cut from the story. Physicians need to be well informed before the interview and prepared to answer the five Ws and one H with ease.

Reporters also look for dramatic and timely stories. For example, when the American Academy of Pediatrics announces new guidelines for the treatment of a medical illness, a physician's office should be prepared to respond quickly and accurately to the media's request. Reporters appreciate quick responses, and this helps to build relationships with reporters for future health education related topics. Reporters will likely view the physician as honest and accessible, and treat the physician as a valuable community resource.

The media operates through print, broadcast, and the Internet. Print media reporters expect specific, well-explained details to give the story depth. In broadcast media, the interviewer expects a few dynamic points spoken clearly. The Internet media is rapidly expanding and is an excellent way to access information from known authoritative resources, such as the American Academy of Pediatrics, American Academy of Family Physicians, American Academy of Emergency Medicine, and the American College of Physicians.

- WATCH** the local news
- READ** the newspaper
- TALK** to colleagues about the types of stories reporters covered in your area
- TALK** to community leaders

No matter which media is used to document a story, physicians need to know that everything said or written for an interview is fair game for publication or broadcast. There is no such thing as “off the record.” One way to remember this is to imagine that everything said will be published on the front page of the local newspaper or broadcast on the local evening news. Physicians need to control what they say and how they say it.

The Media in the Community

Reporter assignments vary. Some reporters may be better informed than others and thus better able to report about certain issues. Reporters work in a world of strict deadlines. For television commentaries, deadlines are today, within one to four hours. Newspaper and magazine reporters may be working on deadlines of hours, days, or weeks. Therefore physicians must get to know the reporters in their area and the type of stories they cover.

Before physicians approach reporters, they should consider the following questions:

- Will the story have an impact on people in my community?
- Is the story new, timely, or controversial?
- Is the media already covering the story? If so, what is missing from the story? Can I offer a reporter a new angle on the story?
- Does the story relate to current legislation?
- Does the story relate to current health objectives in the community? In the state? In the nation (Healthy People 2010)?
- Does the story require an expert opinion? An opposing opinion to balance the story?
- What message do I want to convey?

Once they have answered these questions, physicians can take a proactive approach to the media. Physicians can offer help to the media when health-related issues come to the forefront. Contacting the media first, rather than waiting for the media to address the issue, helps the physician build a relationship with the media. For example, physicians can capitalize on observances such as “National Domestic Violence Awareness Month” (October) or “Breastfeeding Awareness Month” (August) to provide reporters with information on statistics, local trends, and education.

Community leaders can provide additional current statistics and insight into trends within the community. When community leaders and physicians combine to send a single, unified health education message through the media, they are helping to build future partnerships for health education in the community. Sending health education messages in a national context can strengthen the local message and the physician’s role as an advocate for children and a partner in the community.

“Preguntale al Pediatra”—“Ask the Pediatrician” Radio Show, Indianapolis, Indiana

Indianapolis has a rapidly growing Latino population. Many Latinos tune into the local Spanish station, Radio Latina 107.1 FM. In 2003, Dr. Deanna Reinoso and Dr. Sarah Stelzner partnered with the Hispanic Education Center to start a service learning project using the radio to promote child health in the Indianapolis Latino community.

Pediatric resident physicians-in-training host the one-hour show,

in Spanish, monthly along with Dr. Reinoso. Each month pediatric health education issues and resources are discussed. Topics range from discipline and oral health to immunizations and domestic violence.

At the beginning of each show, pediatric residents read a bilingual book to promote literacy. “Reach Out and Read” of Indiana donates the books for the show. During the latter part of the show, physicians

accept listener questions and comments. Each caller receives a free book from the national “Reach Out And Read” program.

At the end of the show, community events are announced and referrals made to individual callers. Shows are reviewed and community surveys are conducted as part of an ongoing assessment of health topics important to the Indianapolis Latino community for future shows.

Handling the Media: Strategies for Effective Interviews

Before the Interview

Before any media interview, the physician should act on the following checklist:

- Prepare, prepare, prepare!
- Practice
- Know the audience
- Dress professionally

The physician should review all the current statistics and facts about a particular topic before the interview, including current Academy guidelines. He or she should research the target audience for the story or broadcast, and finally, dress professionally, even for a telephone interview.

During the Interview

The physician should review the following guidelines just before the interview:

Send a Single Message

- State the most important facts at the beginning (The five Ws and one H).
- Use examples (but not names or identifiable specifics) to help readers or listeners relate to your message.
- Stick to a single health education message
- Follow AAP or national guidelines for sending a health education message.
- Be prepared to state your message in different ways.
- Provide up-to-date resources and referral numbers.

Maintain Positive Energy

- Smile and keep your energy high.
- Be confident.
- State the positive, don't argue.

Speaking Tips

- Speak in short, quotable "sound bites."
- Speak in lay language, not medical jargon.
- Refer to your notes when necessary.
- Don't speak just to fill a silence.
- Correct mistakes immediately.
- Suggest something specific the public can do to help.

Confident body language and a smile convey a more positive message than words. If the physician happens to disagree with the reporter, he or she should resist the temptation to argue and instead state the positives and share facts and statistics. This will reinforce the physician's point of view as well grounded in logic, not based on personal opinion. Because most people find silence uncomfortable, reporters often allow long periods of silence after an answer, hoping that the interviewee will respond by saying more than he or she had planned, or should. The physician should be aware of this and wait quietly for the next question.

Personalized examples help readers and listeners relate to a message. Examples give statistics a human face. However, the physician should have express permission to share any patient's story publicly, or keep the details vague enough so that the patient cannot be identified. Patient confidentiality is important. The physician should also be clear with the reporter about what can and cannot be discussed, and if the reporter starts to probe, the physician should respectfully decline to respond and turn the conversation back to the health education message.

The physician should choose two to four major points to try to get across during the interview and stick to them. He or she may need to restate the message in several ways, but sticking to the central theme is the most important thing. Short, quotable "sound bites" will give readers, listeners, and viewers something they can easily remember after the interview. Referencing AAP or national guidelines is a good way to emphasize an issue's importance. Keeping terminology simple and straightforward will help the interviewer, readers, and listeners understand more easily, so the physician should avoid medical jargon and speak in lay language. During the interview, the physician should feel free to refer to notes and references. If the physician doesn't know an answer to a question, he or she may say "I can get that information for you after the interview" and follow up with the reporter.

Any mistakes made during the interview, should be admitted and corrected immediately. Information given out should be up-to-date, especially addresses and phone numbers. Last, the physician should suggest something the public can do to help promote their own health or health in their community.

After the Interview

A few days after the interview, the physician should send a thank you note to the interviewer, summarizing his or her key points.

Maintaining a good relationship with the media is key for future health education messages and partnerships. A thank you note helps build this relationship.

Thanking involved community partners as well helps to solidify their role as advocates for children.

Troubleshooting Difficult Situations

The Controversial Reporter

Just as a good interviewer rehearses in advance, the physician should prepare for difficult questions ahead of time and practice a response. Interviewers are sure to ask questions about controversial subjects. The physician's response should be controlled and consistent. Thinking out a clear, concise answer that includes a logical progression of facts can help the physician avoid being drawn into making incorrect statements or conclusions. Often the interviewer will repeat a question to force a controversial response. Repeating the original answer is acceptable. Most importantly, the physician should stick to positives and never become defensive or angry. Arguing with a reporter is a sure way to push the story to the front page, or cause it to be dropped. If the situation becomes hostile, the best strategy is to offer to get back to the reporter with a response later. In these situations, a response letter may be the most peaceful solution.

The Bored Reporter

Reporters are often asked to cover stories they may not personally find interesting or that are outside their normal beat. Some reporters may be uninformed about a topic prior to the interview. One way to counter this is to tie statistics and data to topics in the news and to supplement them with real-life examples. Terms like “new data show...” and “current reports state, but...” are sure to pique the interest of the reporter. A confident and dynamic presence will also help; a genuine interest in the topic will communicate itself to the reporter.

Nervousness

Any interview can bring about feelings of nervousness or a fear of “saying the wrong thing.” Preparation and practice can help alleviate these feelings. Before the interview, the physician should meet with the reporter to get an idea of the reporter's style and the types of questions he or she might ask. Reporters may have just a few minutes, but take advantage of the opportunity. During the interview, the physician should maintain eye contact with the interviewer, smile, and act confident. Off-hand comments during commercial breaks or during pauses should be avoided.

“I Don't Know”

Everyone has limits, even an expert. If the physician doesn't know the answer, he or she should offer to get back to the reporter later. This gives the physician the oppor-

tunity to think of an appropriate response and to review Academy guidelines on a particular issue. If the physician's personal opinions are at odds with Academy guidelines, he or she should make this clear to the reporter and explain the differences.

Misquotes

Being misquoted is not necessarily a disaster. Before taking action, the physician should consider the following questions:

- Does the story contain information dangerous to patients and families?
- Is the story balanced? Does it contain wrong information?
- Does it undermine the credibility of physicians in the area?
- Could a response result in a backlash?

If the answer to any of the first three questions is yes, the physician should try to remedy the misquote while the issue is fresh in the minds of readers, listeners, viewers, and the reporter. If the answer is no to these questions, a response is probably not warranted. Finally, the physician should consider whether a response would cause more harm than good. Correcting a misquote must always be in the best interest of the community, not simply a matter of personal or professional pride.

Summary

In summary, a successful interview adheres to the three Cs:

1. **Communicate key points:** between two and four
2. **Cooperate with the news media:** disagree, but never argue
3. **Control the interview:** be positive and prepared, and know your limits

Most importantly, the physician can enjoy knowing that good media skills promote the health of children.

Resources

American Academy of Pediatrics. AAP Office of Public Relations Communications Handbook. Available online at www.aap.org/moc/pressroom/handbook.htm. (AAP Members only)

Goldberg RK. Media Works: Just Avoid These Common Mistakes. *Physicians Practice*, May 2004, pp. 41–42.

Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. Healthy People 2010. Available online at www.healthypeople.gov.

American Academy of Pediatrics
www.aap.org

Physicians Practice
<http://www.physicianspractice.com/>

Centers for Disease Control and Prevention, Entertainment Education
www.cdc.gov/communication/entertainment_education.htm



Legislative and Social Advocacy

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IN THIS CHAPTER

The Goals of Child Advocacy

Building Relationships

Letter-Writing

Phone Calls

Visiting a Legislator

Adapted from the Hospital and Healthsystem Association of Pennsylvania and The Community Pediatrics and Advocacy Program Curriculum

What Is Child Advocacy?

Child advocacy is any idea, strategy, or action that has the specific goal of improving the physical, emotional, or environmental condition of an individual child or adolescent, their family, or their community.

The goals of child advocacy include achieving social justice for youth, empowering families, and assisting communities to support the healthy development of children and adolescents.

The role of the advocate is to speak on behalf of youth and to empower them to speak for themselves. Advocates work to affect the condition of an individual, either directly or indirectly, by fostering the health of families, communities, and populations.

Children and adolescents, in particular, need strong advocates. It is well documented that children and adolescents are biologically and behaviorally susceptible to disease, cannot vote and therefore have no political voice, and often have little to no control over their environments. Therefore, advocates are needed to maintain and enhance vital health and educational services, resources, and entitlements for children and adolescents.

Building relationships with elected officials takes time and effort, and is as important as intense advocacy on any single legislative issue. The goal of grassroots advocacy involvement is to develop a relationship with members of Congress, state senators and representatives, and their respective staffs, so that the advocate is viewed as a credible source of information on health care issues whose input is valued and sought, and whose calls get returned.

GRASSROOTS ADVOCACY:

Attempting to influence the actions of elected officials through communications from the electorate

The advocate's most meaningful contacts with elected officials should not occur when lawmakers are embroiled in a critical health care debate. The advocate needs to build partnerships on a strong, nonadversarial foundation. A partnership based on mutual respect and trust is a valuable asset when the advocate needs to turn to legislative leaders for support and assistance regarding health care policy.

The Importance of Advocacy to Pediatricians

Pediatricians, regardless of specialty, advocate for children and adolescents every day. The American Academy of Pediatrics defines pediatricians as physicians who strive to attain optimal physical, mental, emotional, and social health and well-being for all infants, children, adolescents, and young adults. Pediatricians have a unique opportunity to address all aspects of health and wellness, not just those that can be achieved by medical treatment alone.

Getting Involved

Only the pediatrician can effectively explain to senators and representatives the specific consequences of healthcare legislation. Most legislators are not experts on healthcare. They need information to make good decisions on pending legislation. With so many issues before them, elected legislators cannot seek out constituents' views on every matter. It is the pediatrician's responsibility to ensure that government does not operate in a vacuum when it comes to children's health.

Professional lobbyists in Washington and at the state level play a vital role in advocacy efforts, but they cannot do the job alone. Lobbyists can communicate a hospital's message, analyze the impact of proposals on categories of hospitals, provide extensive data and information to legislators and their staffs, and build coalitions with other state and national groups with similar goals. But the pediatrician's involvement, as a constituent and community leader, is essential to making the senator or representative listen to the arguments, pro or con, and take a position. Legislators want to know what the people think about an issue before they take a position on it.

Building Relationships

Legislators

The first step of effective advocacy is getting to know who represents the community at the state and federal levels. Visiting www.senate.gov, www.house.gov, and the Web site for state legislature should provide names, addresses, telephone numbers, and usually e-mail addresses.

Issues

The next step is staying current with the relevant issues. There are many organizations that exist solely to advocate for children, and they send out alerts to their listserv subscribers when important issues are in Congress and when action is needed. Here are a few key organizations:

- **The American Academy of Pediatrics**, www.aap.org
- **Voices for America's Children**, www.childadvocacy.org
- **The Children's Defense Fund**, www.childrensdefense.org
- **Docs for Tots**, www.docsfortots.org
- **Families USA**, www.familiesusa.org
- **National Association of Children's Hospitals and Related Institutions**, www.childrenshospitals.net

Where Legislators Stand on the Issues

To find out how a particular representative is voting, visit the nonpartisan Web site, www.vote-smart.org. Many of the child advocacy organizations listed above also post a voting scorecard for Congressional representatives each year. The child advocate should subscribe to a couple of organizations and keep an eye on how state and federal representatives are voting.

Letter-Writing

A written communication—a letter—remains one of the most effective ways to express concerns or deliver information to a state or federal representative. What's new is that the message can now be delivered by fax as well as by mail. However they arrive, letters and other forms of written personal communications remain the most effective communication tool, short of personal visits. Letters from constituents that are well written and that briefly explain the issue and the legislation's impact will be noticed in a congressional office.

What to Include in an Advocacy Letter

Dear Senator/Representative

Opening paragraph:

- States the subject of the letter
- Gives the bill number or name, if available
- Identifies the writer and his or her hospital or health system (institutions may have rules regarding identification.)

Body of letter:

- Explains the issue simply and factually at a level the senator or representative can understand
- Gives a local example of potential effects, to make the legislator care
- Clearly states support for or opposition to the bill or provision in question
- Is polite and non-threatening
- Thanks the senator or representative for his or her attention to the issue
- Offers to provide more information on request
- Asks for a reply

LETTER-WRITING TIPS

- Target the appropriate legislators.
- Limit the letter to two pages or less.
- Avoid ready-made letters or modify them to deliver a unique message.
- Give credentials when appropriate.
- Express appreciation for past or future support.
- Ask for a reply.
- Fax the letter if the time for action is short.

PHONE-CALLING TIPS

- Ask to speak to the senator or representative if a relationship has already been established
- Or ask to speak with the legislative assistant who handles the issue
- If necessary, leave a concise message

Phone Calls

Phone calls are often an effective means of communicating with officials. A call is most likely to receive attention if the advocate has developed a personal relationship with the legislator or staffer. Often, calls are logged as for or against a particular issue and the caller may not get past the assistant. Nonetheless, making a well-timed call can be particularly important, especially when coordinated with calls from colleagues.

Face-to-Face Meetings

Face-to-face meetings are the most effective method of communicating with senators, representatives, and their staff. In order to be successful, such meetings require extensive planning, an understanding of the needs of legislators, and, perhaps, a rehearsal.

Face-to-face meetings need not take place at the representative's office. Legislators will usually be interested in visiting a hospital, and their staff is often searching for opportunities to use the legislator's time at home most effectively. Therefore, a visit to the hospital could serve everyone's interests.

Community visits are planned for legislative recesses, when representatives have fewer distractions. Congressional recesses are generally scheduled around holidays and for most of August. Congress normally adjourns for the year in mid-to-late fall.

There are times when meetings are appropriate in legislators' offices during a legislative session. These meetings may be tied to critical legislative action or advocacy events in Washington or in the state capital.

The American Academy of Pediatrics offers an advocacy day two times each year, during which resident physicians can learn about legislative advocacy and visit their Congressional representatives. The AAP also hosts an annual legislative advocacy conference. Visit www.aap.org for more information on these events.

Requesting a Meeting

- Contact the senator's or representative's local or Washington office to speak with the appointment secretary/scheduler.
- Offer credentials and explain the reason for the meeting.
- Ask the scheduler how a meeting can be arranged. The advocate may be referred to the district office for a meeting in the district.
- If appropriate, the advocate should state that he or she is a constituent.
- Be prepared to fax a written request.

MEETING TIPS

- Frame the issue as it affects the legislator
 - Listen
- Work with staff
 - Be flexible
- Say thank you, and follow up

Meeting a Member of Congress

Frame the Issue as it Affects the Legislator

- The advocate should be sensitive to particular peculiarities of districts. For example, it's hard to ask a legislator to oppose a piece of labor legislation if there is a significant number of union members in the district.
- Present the issue as the legislator and staff see it.
- Acknowledge difficulties legislators may have. Legislators are more likely to fight for a cause if they know the advocate understands what's at stake for them.
- Try to create a win-win situation and be open to compromise.

Listen

- Being a good listener is crucial because it will promote better dialogue and help avoid misunderstandings.

- Learn to decode polite phrases. For example, "I want to be with you on this," does not mean "I am with you on this," and "I want to help you" does not mean "I will help you."
- If necessary, follow up with specific, focused questions that clarify everyone's position. Never be confrontational.

Work with Staff

- Never view staff as a second resort. Legislators depend heavily on their staff.
- Get to know key staff people in an office—receptionist, chief-of-staff, administrative assistant, health legislation assistant.
- Understand that over time, staff tend to take on the traits, outlook, and judgment of their employer.
- Learn the needs of staff, as well as their style, and be willing to work with them as well as the legislator.

Be Flexible

- Visits rarely go exactly as planned. Legislators may be delayed in a committee hearing or a roll call vote may interrupt the meeting. If the advocate stays flexible and positive, the visit will be much more successful and pleasant.

Thank and Follow up with the Legislator in a Timely Fashion

- Legislators hear complaints all the time and, just like anybody else, they feel rewarded when they're shown appreciation.
- Write a thank-you note that includes a brief summary and repeats the major points or specific requests for action discussed during the meeting.

Putting the Model into Action

There are many examples of residents who have put this model into action. Twice each year the American Academy of Pediatrics hosts a Legislative Advocacy Day, where residents from around the country come to Washington to learn how to interact with their legislators. They then go to Capitol Hill to advocate for children's issues.

A more common example is for residents and other staff to get involved in writing letters to legislators and helping to get these letters signed. An example of a letter written by a Children's Hospital of Philadelphia Pediatric Resident is featured on the following page. This letter was presented before grand rounds and was signed by over 100 physicians and other healthcare professionals.

March 26, 2003

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

RE: Stop Proposed Medicaid Cuts

Dear Senator Santorum,

As pediatric health care professionals, we are deeply disappointed by the proposed cuts in Medicaid for 2003–2004. These cuts threaten to unravel both Medicaid and Children’s Health Insurance Program (CHIP)—the safety nets of healthcare for our State’s children.

On a broad scale, Medicaid and CHIP ensure that every child has an equal and healthy start. With these proposed cuts, approximately 1 out of every 3 of the nearly 30 million children supported through these health care coverage plans would have no health insurance and thus limited, or no access to basic health-care services.

The current plan merges Medicaid and CHIP funding into a capped block grant which poses Pennsylvania with a dilemma: either continue the current Medicaid program as is without any supplementary financial assistance from the federal government, or combine the Medicaid and CHIP funding into a capped, consolidated block grant to be divided among children, the elderly, and the disabled. The consequences of this plan will create competition amongst vulnerable populations for limited dollars. As a result, children are at greater risk of losing healthcare for several reasons:

- 1) Capped federal assistance will force states into financial trouble with rising medical costs and more families in need of health care;
- 2) Children will lose comprehensive health services (i.e. immunizations, hearing, vision, dental care) because the divided funds will decrease the amount allotted to children and not to mention, increase costs in the future; and
- 3) Low-income children families dependent on CHIP will not be able to afford coverage for their children as states are forced to increase co-payments because of the capped funding.

We write to you as a leader and our representative in the Senate. The children of Pennsylvania need healthcare coverage. While children are more than half of the Medicaid enrollees, they account for less than one-quarter of Medicaid spending. In addition, children’s expenses are only one-sixth the costs of older and disabled beneficiaries. Yet, Medicaid is the single largest provider of public assistance for children’s health care delivered by Children’s Hospitals. We cannot let children suffer in order to avert a fiscal crisis. We hope that you will consider joining Senator Arlen Specter in rejecting the inclusion of any Medicaid cuts as part of the FY 2004 Final Budget Resolution as proposed by Senate Finance Committee Chair Charles Grassley.

Best regards,

Signature:

Print Name:

The Children’s Hospital of Philadelphia
34th and Civic Center Boulevard, Philadelphia, PA 19104

Resources

Amidei N. So You Want to Make a Difference- Advocacy Is the Key. OMB Watch, 2nd Edition; 2003.

Docs for Tots. What Every Doc Should Know about Child Advocacy. Available at www.docsfortots.org. Accessed December 2, 2004.

Meredith JC, Meyer L. Lobbying on a Shoestring. Massachusetts Continuing Legal Education, Boston, MA. 2000.

American Academy of Pediatrics Department of Federal Affairs
<http://www.aap.org/advocacy/washing/dcenter.htm>

The Children's Hospital of Philadelphia Community Pediatrics and Advocacy Program
www.cpap.phillyped.com

Docs for Tots
www.docsfortots.org

Hospital and Health System Association of Pennsylvania
www.haponline.org

8

Evaluating Resident Projects

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IN THIS CHAPTER

Where to Start
What's a Good Idea?
Measuring Outcomes
Time and Support
Presenting Your Work

For a resident, deciding to undertake a community research project is at once exciting and daunting. An area or question has piqued the resident's interest enough to step outside the walls of the hospital and clinics. Because time is limited, the project must be designed to meet its goals efficiently. To ensure this outcome, the resident must know what to evaluate, how to proceed with the evaluation, who can help, and when and where to submit the results.

In CHAPTER 1, PROJECT DEVELOPMENT: GETTING STARTED, we introduced the Sweet Spot Model for project development, which incorporates feasibility, fundability, dissemination, and benefit in project planning. All projects should include a way to monitor the benefit they may have for the community. In the "Breast Feeding Rates Among African American Women" Project on page 11, the impact of the intervention was assessed by evaluating the intervention given by physicians and staff to improve breastfeeding rates. The pediatric resident from UC Davis measured the success of her project to reduce dog bites by the number of parents and children participating in a dog behavior program in a neighborhood park. Both projects were able to demonstrate clear benefits for their communities. However, when the resident wants to publish results of a project that consists of programs or interventions, the project must be structured in a research design model with a child-health related outcome.

The Research Question

The research question should address a community health issue that the researcher wants to solve. A "good" question should take into account what is relevant or important to the community. In other words, the answer to the question should matter to the community group it addresses. It should also matter to the resident group that will learn from the project and the faculty who will oversee and/or evaluate it. Each of these may value different outcomes. In dealing with communi-

ties, attentiveness to the needs and uncertainties of the group will often drive the research question. For example, a project that looked at breastfeeding rates among low-income Latinas in Miami required significant input from peer counselors who could persuade mothers to attend prenatal sessions. These mothers might not otherwise have trusted the researchers.

Preliminary Research

There's no need to reinvent the wheel. A local mentor can answer a few fundamental questions that will help the resident avoid wasting time: Has something similar been done before? Has the same group or community been evaluated for the same reason? Have screening methods or surveys already been tested in this group or for this question?

The next step is for the resident to become well informed. This should include a complete search of the medical and public health literature through Medline. With the help of a reference librarian, the resident may also review the social science literature. The CDC's Community Guide (www.Communityguide.org) is another invaluable resource.

Other relevant sources of data include the U.S. Census, the local health department, the state WIC office, United Way, and city and state government offices. A mentor may also steer the resident to other information resources, such as published studies, advocacy groups, community organizations, and Web sites. All of these in combination will give the resident a solid background in the research area, which will both save time and enhance the project.

Experts in the field should also be sought out and consulted to provide information about the research issue and serve as a networking tool for the resident in the future. Once the preliminary research is done, the resident should reframe the question.

Characteristics of a Good Research Question

Hulley and Cummings describe the characteristics of a good research question with the mnemonic **FINER**.¹

FEASIBLE: Is the question practical? Is the scope, cost, time, and logistics involved in getting to the answer something within reach?

INTERESTING: Is this something the resident wants to do?

NOVEL: Will the answer to this question provide new information? A novel research question is more likely to lead to a study whose conclusions are reportable in a peer-reviewed journal. A research question that is not novel—that is modeled on a previous study, for example—may not be published but may still lead to a study that helps apply a successful project to the community.

ETHICAL: Will the project create an unacceptable risk or violation of the privacy of participants?

RELEVANT: Will the outcome affect clinical practice or policy? Or in the case of advocacy, is the project community responsive?

GETTING STARTED TIPS

- Identify a mentor.
- Consult the literature.
- Call the experts.
- Reframe the question.

A GOOD IDEA IS:

- Feasible
- Interesting
- Novel
- Ethical
- Relevant

Measuring the Outcome

Surveys

The majority of clinical studies rely on information gathered from surveys. These can be in the form of self-administered questionnaires or interviews. Any such instrument should be simple, easy to read, and in the participants' first language.

In general, the following guidelines will improve a survey.

1. Use close-ended (yes-or-no) rather than open-ended questions.
Close-ended questions are easier to analyze.
2. Try to use existing instruments that have been validated.
3. Pretest questions so that they make sense to the group being studied.
4. Code answers in advance to make data entry easier.

Specific surveys are included in the reference section.

Sample Size

The power of a study—that is, the probability you the user will be able to detect a meaningful difference, or effect, if one were to occur—will depend on the sample size, or the number of people in the study. It is important to determine the sample size at the onset of the project, as this will affect the time, money, and effort required.

To get an accurate estimate of sample size, the resident should spend an hour with a statistician. The statistician can review the research question and the projected main outcome measure. While it is difficult to generalize, most community-based studies require at least 120 subjects for participation in order to generate sufficient power.

IRB Requirements

Before starting on any project, we must once again refer to the FINER criteria and think about the ethics involved. No unacceptable risk or breach of privacy for subjects enrolled in the study can be allowed. Institutional review boards (IRBs) at research centers ensure adherence to federal, state, local, and institutional regulations concerning the protection of human subjects in research. IRB review and approval is required before any project can be implemented. Most IRBs also require that all research staff complete a human subjects certification course (www.miami.edu/citireg). The time required for staff training in human subjects research and IRB committee approval of the study should be allocated for in the resident's schedule and time line on the project.

Project Checklist

For residents, time is everything. The opportunity to become involved in a research project will require a resident with a keen interest in a research question, commitment to answering this question, and an ability to organize a schedule. A time line that can be flexible enough to accommodate a resident's schedule is helpful.

SAMPLE CHECKLIST

Community-Based Research Projects University of Miami Pediatric Residency Program, 2003–2004			
✓	TASKS	RESOURCES	DEADLINE
	Meet with mentor and statistician to discuss study design and data management	Contact info.	9/30/2003
	All research staff complete CITI Human Subjects Certification Course	www.miami.edu/citireg	9/30/2003
	Submit completed human subjects committee forms to research director: • Expedited or full protocol • Informed consent		9/30/2003
	Submit project time line to mentor/research director***		10/31/2003
	Submit research assistant request (responsibilities, language and transportation prerequisites, days and times needed)		10/31/2003
	Meet with Resident Co-PI, mentor, research director every other month to discuss progress		First meeting by 10/31/2003
	Prepare bibliography for background material (to be used in final manuscript)	EndNote software	
	Translate informed consent forms and study materials as appropriate		
	Submit abstract of study findings		9/30/2004
	Submit abstract of study findings to a national meeting		9/30/2004
	Submit first draft of manuscript describing study findings to mentor		11/31/2004

Finding Time and Support

Effectively evaluating any community-based project is quite difficult. Doing so in the context of a busy clinical and teaching schedule, as a junior faculty member, is even more trying. Accomplishing such a task as a pediatric resident is heroic. Breaking down the task into the following steps can make it more manageable.

1. Seek funding and technical support from the AAP's CATCH program or AAP resident research grants. Most communities have local foundations, such as United Way chapters, community funds, or family foundations that offer technical assistance toward the proper design and execution of needs assessments and program evaluations, as well as funding.
2. "Map" the academic institution for people with experience in statistics, survey design, program development, or community relations. Seek help early and often.

HOW do heroes do it? Not alone.

3. If the community group is truly interested in the research question, they may be able to help recruit people. Seek undergraduates or community members as research assistants.
4. Insist on high standards. Advocate in the residency program for more time and more value to be placed on community-based independent study.

Presenting the Outcome

Following the outline above, the resident should be able to present results as an abstract, poster, or manuscript. In many instances, the resident can start off within his or her own institution, presenting at grand rounds or resident noon conferences. The resident can also look for specific resident programs at pediatric conferences, such as the Pediatric Academic Societies (PAS), AAP, or CATCH meetings. Usually there submission dates are as follows:

PAS:	Abstract Submission: December	Meeting: May
AAP:	Abstract Submission: Jan-April	Meeting: October
CATCH:	Abstract Submission: Feb/March	Meeting: July

The resident can also become involved in state and local organizations that may organize conferences or distribute regular scientific newsletters.

An online search may also reveal organizations that would find the research pertinent. Many of these hold national meetings and call for abstracts.

On the following page is a sample poster for a resident project. Posters for presentation are structured to follow the outline of an abstract: background, objectives, methods, results, and conclusion. For community projects, the background and objectives should address the needs assessment of the community partner. The methods will often be a description of the intervention. The results section should have a measured outcome but should also consist of lessons learned and next steps.

The Effect of Postpartum Depression on the Breastfeeding Rates of Low-income Hispanic Women in East Little Havana

Faculty: Lourdes Quintana Forster, MD, Resident: Jessica Capote-Dishaw MD, Research team: Saribel Ceballos ARNP, Amalia Castro, Research Advisor: Lee Sanders MD

Faculty Demonstration Project: The Dyson Initiative for Residency Education in Community Pediatrics, University of Miami

Issue Background

- Postpartum depression affects 10-20% of new mothers.
- Maternal depression has been identified as a barrier for breastfeeding successfully.
- Latin women face multiple unique problems associated with multiple risk factors that already decreases their likelihood of breastfeeding upon arrival to this country.
- Breastfeeding rates dwindle upon arrival to this country as have been shown to decline as acculturation increases.

Advocacy Project History/Design

- Design is a longitudinal, descriptive study embedded in a culturally sensitive, community-based intervention to educate mothers on the importance of breastfeeding
- Participants are screened for postpartum depression and referred as necessary to appropriate care.
- Primary outcome measures: 1) Prevention of postpartum depression in the community, 2) Determine differences in duration of breastfeeding (months) between depressed (postpartum) and not depressed, 3) Identify prenatal risk factors for postpartum depression in these women, 4) Identify other barriers that limit breastfeeding duration among these women.

Community Partners

- Little Havana is a community with 86% Latin population.
- Abriendo Puertas is a community center providing family-centered, culturally competent, interdisciplinary services to families in this area through a neighborhood-driven approach and the assistance of *madrinas*.
- Women considered at risk for depression based on the Edinburgh Postnatal Depression Scale are referred to Miami Behavioral Health Center for services.
- The Rafael Penalver Clinic is a partner in this research, where women are being screened and entered into the study.

Resident Experiences

- Designed curriculum for prenatal course on breastfeeding for Latin women attending Abriendo Puertas Community Center.
- Teaching multiple classes for mothers in prenatal period on breastfeeding (2 classes provided per month, 10 classes to date, serving 47 women).
- Assisted in creating a policy for Miami-Dade County/WIC Breastfeeding Task Force.
- 2 prenatal classes provided in conjunction with Miami-Dade County WIC.
- Administered screening tool for maternal depression at sessions and recruited mothers into the study from Abriendo Puertas

Community Center and Rafael Penalver Clinic.

- Assisted in study design and follow-up.
- Presented topic being studied at Florida Pediatric Society Meeting (June 2003) in Orlando, FL.

Breastfeeding Beliefs and Practices/Cultural References

- “El colostro es leche danada y se debe botar”—Mexico
- “No se puede tomar antibioticos mientras das leche materna” — various countries
- “A las mamas le da fiebre cuando le empieza a bajar la leche” — Dominican Republic
- “El nino semalcria si toma leche materna despues del ano.” — Honduras

Lessons Learned

- Latin women have unique challenges when transitioning to American culture
- Breastfeeding education is an important component of prenatal care especially in immigrant women when faced with so many formula choices.
- Postpartum depression is known to be a risk factor for poor breastfeeding duration, and it is important for depression to be identified and treated.
- Postpartum depression is particularly common in the Latin women (from preliminary data obtained).
- In this community, it would be particularly important for the pediatrician to provide support and services needed in order to ensure a healthy environment for the pediatric patient.

List of Important References (Complete List Available upon Request)

1. Alder E and Cox JL. Breast Feeding and Post-Natal Depression. *Journal of Psychosomatic Research* 1983; 27(2):139-144.
2. Buxton Karen E, et al. Women Intending to Breastfeed: Predictors of Early Infant Feeding Experiences. *Am J Prev Med* 1991; 7(2):101-106.
3. Cox JL, Holden JM and Sagovsky R. Detention of Postnatal Depression. *British Journal of Psychiatry* 1987; 150:782-786.
4. Denman-Vitale S and Krantz E. Effective Promotion of Breastfeeding among Latin American Women Newly Immigrated to the United States. *Holistic Nursing Practice* 1999; 13(4):51-60.
5. Field T, Hernandez-Reif M and Feijo L. Breastfeeding in Depressed Mother-Infant Dyads. *Early Child Development and Care* 2000; 00:1-7.
6. Zuckerman BS and Beardslee. Maternal Depression: A Concern for Pediatricians. *Pediatrics* 1987; 79: 110-117.

Next Steps

- Plans for teaching conferences for pediatric residents in areas of postpartum depression and breastfeeding education.
- Extension of formal screening in resident community clinic.

References

1. Hulley SB, Cummings SR, Browner WS, Grady D, Hearst N, Newman TB. *Designing Clinical Research: An Epidemiological Approach*, 2nd ed.. Baltimore: Lippincott Williams & Wilkins; 2001.

Resources

AAP CATCH Grants Guide

www.aap.org/catch/2005residentguide.pdf

Community-Campus Partnerships for Health

<http://depts.washington.edu/ccph/index.html>

The Community Guide

www.communityguide.org

Pediatric Academic Societies

www.pas-meeting.org

Surveys

Hollingshead A. Four Factor Index of Social Status. New Haven, CT: Yale University, Dept. of Sociology, 1975. Unpublished manuscript.

Agency for Healthcare Research and Quality (AHRQ) Child Healthcare Quality Toolbox

<http://www.ahrq.gov/chttoolbox/>

Seid M, et al. Parent's perception of primary care: Measuring parents' experiences of pediatric primary care quality. *Pediatrics* 108(2): 264–270.



Sustainability

GRACE W. CHI, SM

Dyson Initiative National Program Office

IN THIS CHAPTER

Sustainability

Ways to Sustain a Project

Funding

There are many benefits to sustaining a community-based project. Ideally, the resident should think about sustaining the project during development and implementation. If key partners are involved from the beginning, they are more likely to be interested in carrying on the project.

Benefits of Sustaining the Project

Residents invest a great deal of time and hard work into their projects. Sustaining a project after the resident is no longer available to work on it protects that investment. It also confirms for the resident the value of everything he or she learned about community pediatrics and working with a community toward a common child health goal.

Sustaining a project is also important for other residents who can learn from and possibly build on the projects of those who have gone before them. Sustaining the project allows the relationship between the residents and the community organization to continue to develop. Other community projects may grow out of or be inspired by the project. Developing a strong and trusting relationship with a CBO may take some time—possibly more time than the individual resident has available to give. However, if the project continues, someone else can take over developing the partnership.

Finally, sustaining a project benefits the community. Keeping a project going increases the chances that its child health goals will be met or magnified.

Ways to Sustain a Project

Community and Community Organization Involvement

Linking with the community and the needs and assets of the community will most surely preserve a project. If the project has been developed with community input

REASONS FOR SUSTAINING A PROJECT

- Project as an investment
- Project as a teaching tool for other residents
 - Project as a way to develop a stronger relationship with the CBO
- Project as a way to improve child health

each step of the way, chances are likely that the community or community organization will feel a sense of ownership and adopt the project as its own. Thus, at the beginning stages of project development the resident should involve the community members and CBO leaders by asking for their input and mentorship. These people understand the community in ways that only its citizens can. Developing and implementing the project in a way that fits their needs will make it easier and worthwhile for community members to carry on the project.

Faculty Mentors and Community Pediatrician Involvement

Working with mentors, either at the institution or in the community, is a great way to ensure sustainability of a project. A physician who is knowledgeable about the neighborhood and familiar with its leaders is a wonderful person to involve in a project. This person knows which CBOs nurture the neighborhoods and is aware of the resources available at community institutions. Obviously he or she will be eager to improve child health within that community and thus will be excited about carrying on the project.

Working with a community pediatrician can save the resident valuable time by directing the resident to resources and by helping the resident strategize how best to implement an intervention. As the resident and physician work on the project together, chances are the community pediatrician will feel ownership and plan to carry the project on after the resident has left.

The community pediatrician forms a perfect link between the academic medical community and the lay community. The pediatrician's connection to the medical residency program will allow him or her to share the value of the project with other residents and faculty.

Peer Involvement

Involving other residents in a project is a wonderful way to guarantee sustainability of the project. Not only does involving residents distribute the workload and increase available expertise, it also makes it possible for the project to be carried on from one year to another. Many residents conduct community projects in groups, where residents of different years work together. Thus, a PL3 who led the project one year and may pass the leadership on to a PL2 who has been involved. This 'passing the baton' encourages residents to learn from and teach each other. Mutual learning and sharing pave the way for a successful project.

Funding

In addition to involving the right players from the beginning, it is important to think about how a project can be sustained *financially*. There are many organizations that can provide resources to fund a project—some will exist within the educational institution and in the local community, and others can be found at the national level. Following are some places to look:

Within the Educational Institution

Often funding is available for resident projects within the academic institution.

People and departments to talk to include

- **Residency director**
- **Office of child advocacy/community relations**
- **Faculty mentor**
- **Department of community pediatrics**

Within the Local Community

Various community organizations may have resources available to support a project. It is even possible that the CBO the resident partners with will have funds to support the work. The resident should explore the following.

- **Service organizations**
- **Community-based organizations**
- **Local foundations**

At the National Level

At the national level, funds are available through professional health organizations. Some funding is specific to community projects, while other sources focus on specific issues. An example of this is the American Academy of Pediatrics CATCH Program/Resident CATCH Grants

For more information on resources, please see RESOURCES at the end of the Toolkit.

A Final Word

Working with a neighborhood and a community-based organization is an essential part of pediatric training. The lessons the resident learns will undoubtedly enhance his or her ability to care for children and families.

10

Social Action for Busy Professionals: Changing the World in an Hour

ANDREW ALIGNÉ, MD, MPH
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IN THIS CHAPTER

Activities that take:

- *less than an hour/month*
- *an hour/month*
- *more than an hour/month*

Resources

Lifelong use of skills learned by doing community pediatrics

Many pediatricians spend time working with their communities on various projects or serving as a volunteer, either through the local schools or other community organizations. Perceived time constraints and a lack of adequate funding may keep some pediatricians from participating more, others may feel that they do not have enough time to make a valuable impact. However, it is very possible to contribute toward a larger cause even with very small investments of time or money. Setting priorities and identifying easy ways to participate in community activities can be a pediatrician's first step toward a more invested relationship with the community.

Practice Passive Activism

Some forms of action on behalf of kids take virtually no time at all. This is called passive activism. Passive activism involves making a simple lifestyle choice.

- Lookout for programs through your bank, credit card, or telephone company that contribute to a good cause. For example, it is possible to purchase personalized checks that contribute to organizations such as Save the Children or credit cards that give a certain percentage to childhood cancer research. Just by doing everyday activities that you normally do, it is possible to contribute toward improving child health.
- Vote with Your Shopping Dollars. All consumer choices have social implications. What kind of car you drive affects air pollution, dependence on foreign oil, and so on. Where you buy a house determines where your property taxes go. Some clothes are made in sweatshops that exploit children, while others are not. Where you shop determines where your sales taxes will go: rich outer suburbs or needier urban areas, for example. The political implications of your purchases can't be the only factor in your spending decisions, but being aware of them can sometimes offer pain-free ways of making a difference that takes zero extra time.

Activities that Take Less than an Hour a Month

- Vote! Even if by absentee ballot!
- Donate to a political campaign or a nonprofit organization. Donating will obviously cost you money, but takes no time. And donations to nonprofit groups are generally tax deductible.
- Put together a resource guide of CBOs in your community that you can refer your patients to as needed.
- Use the media wisely: What do you listen to on the radio? Watch on TV? Subscribe to? Consider subscribing to a pediatric journal or listening to a local radio station that informs listeners of local community events.
- Sign up for listservs. Make the local newspaper's Web site your home page, so that you can get quick updates on what's going on in your community easily and for free.
- If you own any stocks, vote your proxy ballots in a socially responsible way. Reduction of mercury pollution is one example of a shareholder campaign that has improved the health of children.
- Power Letter Writing. The easiest way to write a letter to a government representative is to have someone else write it but you sign it yourself, and send it by clicking a button. Signing up for the e-mail listserv of an organization you support easily sets up such a service. The organization will keep track of important issues and do much of the work for you.

There are a variety of community health resources available. **TABLE 1** lists commonly found CBOs.

Activities That Take About an Hour a Month

Write a Letter to a Public Official

Write a Letter to the Editor

Testify Before Official Bodies: Courts, Legislatures, Etc.

- Being willing to write or to speak out can be very important. One example of this took place in Rochester, NY. Recently, the county executive tried to cut various social services for kids while increasing subsidies to businesses. The public outrage from citizens, including many pediatricians, led to the executive's own party overriding his budget veto and saving the children's services.
- Writing letters to the editor on a provocative issue can draw needed attention and press. For example, a Miami pediatrician regularly writes editorials in the *Miami Herald*. Over the past few years, she has highlighted important issues such as teenage pregnancy, youth violence, and child health insurance. By writing about these important topics in the local press, this pediatrician has been able to both educate the public as well as draw attention to specific issues around each topic.
- Testifying at a county legislative meeting can take anywhere from just a few minutes to a couple of hours. And the impact is tremendous. A pediatrician's expert testimony can lead to the passing of an important bill that positively affects child health.

TABLE 1:

Community Health Resources

Social service agencies

Child welfare agencies

Children with special health care needs program

Early intervention program

Maternal and child health program

Immunization and well child clinics

Lead poisoning prevention and screening programs

School health programs

Community-based organizations relating to children

To contact a government agency, use the **BLUE** pages at the front of the phone book.

Activities That Take More Than an Hour a Month

Speak Out

People pay attention to a physician who takes the time to meet with a legislator or speak at a public hearing. By participating with a CBO, the resident can become informed about important legislation and boost the CBO's lobbying efforts. An example of this is a resident who became a local media expert on children's nutrition just because she was a doctor volunteering with a food bank. It didn't take her much time to talk to reporters, but the publicity was a huge boost for her CBO's cause.

Campaign

The next time an election comes around, don't simply sit back and watch from a distance. Get involved! Study the candidates and their issues by reading and watching their debates. Then choose a candidate and volunteer.

Register Voters

In some communities, residents can check out a registration book and register voters on the spot. Residents can also let people know about absentee ballots. Pediatricians can get many parents registered by putting the forms in the clinic waiting room.

Apply for Grants

Most projects of substance need financial support. A surprising amount of grant money is available for those who take the time to research and apply. Writing grant applications is a skill that improves with practice and can be a valuable tool throughout life.

Gaining Representation on Boards and Councils

To gain representation on a community board or council, first find the agency or council that supports members' having a voice in governing. Ask about becoming an advisor to the program. Boards of agencies often meet for about one hour every three months.

Other Actions You Can Take: Advanced Activism

- Volunteer.
- Work at a free clinic.
- Start an organization for a cause that needs one.
- Become a philanthropist.
- Run for office!

While the activities at the end of this chapter may be very demanding, the ones at the top are within everyone's reach. You can make a difference.

Resources

Lewis BA. *The Kid's Guide to Social Action: How to Solve the Social Problems You Choose—And Turn Creative Thinking into Positive Action*. Minneapolis, MN: Free Spirit Publishing Inc., 1998.

Community Toolbox: Work Group on Health Promotion and Community Development.
Community Toolbox: Bringing solutions to life. University of Kansas in Lawrence, Kansas.
<http://ctb.lsi.ukans.edu/>

Grants Web

www.research.sunysb.edu/research/kirby.html

Nonprofit Gateway: Federal Citizen Information Center, Office of Citizen Services and Communications. FirstGov for Nonprofits. www.nonprofit.gov

The Foundation Center

www.fdncenter.org

Quick and Comprehensive Resources to Jump-Start a Community Project

LOUISE IWAISHI, MD
University of Hawaii

There are well-established organizations that promote community partnerships and collaborative projects. In community pediatrics there are public and private stakeholders who provide both technical and financial support.

1. American Academy of Pediatrics: CATCH Program

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

“The Community Access to Child Health Program is a national program of the American Academy of Pediatrics that increases children’s access to health services, especially a medical home. CATCH supports pediatricians and communities who are involved in community-based efforts for children. A key concept is that “one pediatrician can make a difference by working with the community to solve their local problems using local resources.” (AAP Policy Statement, *The Pediatrician’s Role in Community Pediatrics*, 1999)

CATCH provides pediatricians and pediatric residents with peer support and networking opportunities (trained local AAP Chapter facilitators and district AAP Resident Liaisons), technical assistance (national staff support and resources) and funding opportunities (May to July - during CATCH Planning Funds grant cycle and November to January - during CATCH Implementation Funds grant cycle)

Specifically the CATCH Resident Funds Program supports pediatric residents in the planning and implementation of a community-based project that addresses local needs of children. As of 2004, Resident CATCH grants of up to \$3,000 are available twice a year.

Contact your **Resident CATCH Liaisons** for technical assistance and grant writing hints.

Visit the **Resident Section Web page** research for previously funded grants.

2. Community-Campus Partnerships for Health

<http://depts.washington.edu/ccph/index.html>

The Campus Partnerships for Health (CCPH) is a nonprofit organization that promotes health through partnerships between communities and higher education institutions. Members collaborate to promote community-based teaching, research and service to improve health professional education, civic responsibility and the health of the community.

Service-learning projects allow residents to 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. Service-learning is a structured learning experience that combines community service with preparation and reflection.

Citation: Seifer SD. (1998). Service-learning: Community-campus partnerships for health professions education. *Academic Medicine*, 73(3):273-277.

3. US Department of Health and Human Services Health Resources and Services Administration Maternal and Child Health Bureau (MCHB)

<http://mchb.hrsa.gov/about/default.htm>

Title V of the Social Security Act authorizes maternal and child health service programs and provides a structure to assure the health of mothers and children in the U.S.

MCHB's vision: "A future America in which the right to grow to one's full potential is universally assured through attention to the comprehensive physical, psychological and social needs of the maternal and child health population. We strive for a society where children are wanted and born with optimal health, receive quality care and are nurtured lovingly and sensitively as they mature into healthy, productive adults. MCHB seeks a nation where there is equal access for all to quality health care in a supportive, culturally competent, family and community setting."

MCHB provides programs, data, resources, publications and funding opportunities based on public health principles. It supports collaborative, community-based projects which seek to improve overall maternal and child health and to reduce their health disparities.

4. National Initiative for Children's Healthcare Quality

<http://www.nichq.org/about/>

The National Initiative for Children's Healthcare Quality (NICHQ) is an education and research organization which is dedicated to improve children's health care quality and outcomes. NICHQ promotes professional and public awareness of quality issues, develops tools and methods to improve systems of care, conducts research to identify best practices in pediatric health care and provides educational services which include a regional learning collaborative of 40+ practices. NICHQ

collaborates with providers and organizations that care about children with those who are experts in improvement.

5. Other Resources

Many residents chose to work on projects that involve special populations. These can, but are not limited to, special populations, immigrants, children with special health care needs, etc. There are a wide array of resources available for you to gain an general background understanding of these special populations. Good places to look are:

- **Journals:** using databases such as Medline and PubMed
- **Internet:** many organizations that serve special populations have their own website, or you can access websites of larger health organizations such as the Centers for Disease Control and Prevention (www.cdc.gov) or the Maternal and Child Health Bureau (<http://www.mchb.hrsa.gov/>).
- **Local Library**
- **Mentors and Colleagues**

Resident Projects Toolkit

Feedback Form

Thank you for reviewing the Resident Projects Toolkit that was developed by a national working group of the Anne E. Dyson Community Pediatrics Training Initiative. We hope that you have found the Toolkit to be a valuable resource and will use it in your own practice or your pediatric training program.

We would love to hear your thoughts and suggestions regarding the Toolkit. Please take a moment to fill out the form below and return it to **847.228.6432 (fax)**. If you have any other questions or comments, please feel free to contact **800.433.9016, ext. 4837 (phone)** or **cpti@aap.org (email)**. Thanks!

Suggestions for Chapter _____ :

Suggestions for Chapter _____ :

Please add/omit the following to/from the Toolkit:

NAME _____

INSTITUTION _____

ADDRESS _____

EMAIL _____

- I plan to use the Toolkit in my program
- I do not plan to use the Toolkit
- Please send me the next edition of the Projects Toolkit

