

A New Formula for Child Health:

Doctors
+ Communities
Healthy Kids

*An collection of Asset-Based stories,
inspiration and tangible tips for
community—physician partnerships*

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Acknowledgements

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To the local associations and individuals not only in CPT's partner communities but in communities across the nation who dedicate each day to building connections and making positive changes in their neighborhoods. Your work is an inspiration to us.

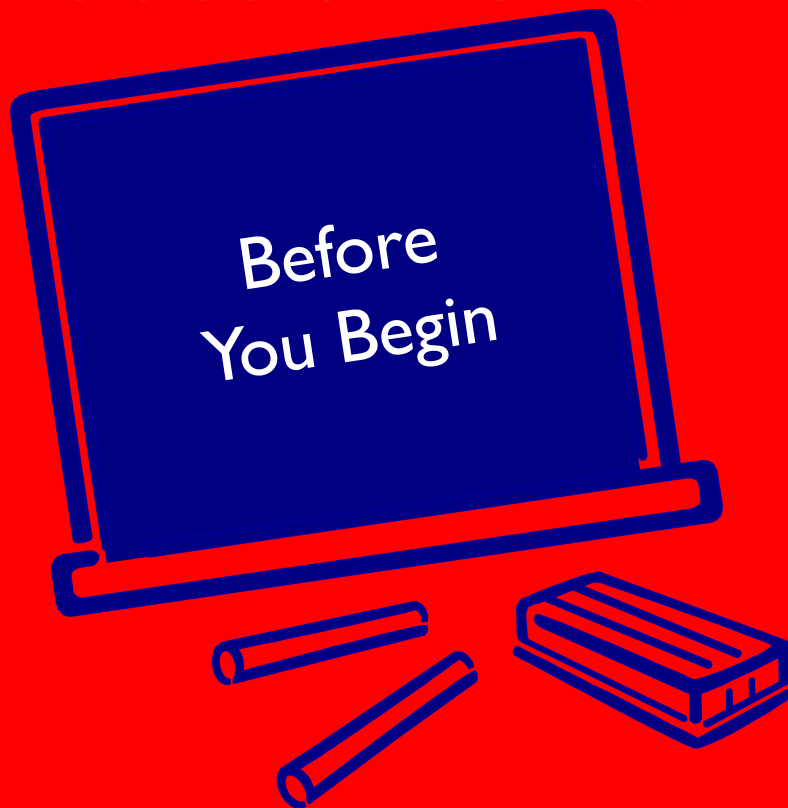
To Diane Littlefield for her vision on this project, for pushing and assisting us in making it a reality.

To the memory of Anne E. Dyson and the Dyson Family Foundation, thank you for believing in the possibility of community-physician partnerships and for helping to make them possible in ten United States communities.

To the American Academy of Pediatrics and its Community Access To Child Health (CATCH) program, thank you for allowing us to search and include a few of the stories in your database, showing that this exciting work is happening all over the country.

Finally, to the physicians – and the communities – who are working together or who hope to form partnerships with each other, we urge you to jump in with both feet, to never forget your own strengths and most importantly, never fail to recognize the assets present in all communities and all partnerships. *Good luck!*

Section One:



Foreword

By John Kretzmann, PhD

How do we create and enhance the health and vitality of our children? Eight years of rich experience by the participants in a wonderfully creative experiment called Communities and Physicians Together (CPT) have contributed to a new and promising set of answers to that question. The findings recognize that two groups of stakeholders make crucial contributions to the good health of children: medical professionals on the one hand and community residents and groups on the other. In a sense, the experience of almost 30 projects initiated over the life of CPT reveals the power of combining the assets of two worlds to co-produce the conditions which lead to healthier children. The equation might be expressed as:

Medical Professionals + Community Assets = Healthier Children

This document explores six of these projects in depth. Each resulted from the creative combination of the physician's clinical interests and expertise with the agendas and resources of the local community. The concrete results are varied and impressive – a Spanish language health fair, a children's healthy cook book, an initiative to control dog bites, a Russian language health-oriented radio show, a community-wide exercise program, a child-friendly salad bar. Each of these efforts represents the jointly developed vision of a pediatrician-in-training and local community leaders, who then unite to mobilize community assets to address the challenges of enhancing children's health.

The expertise brought to these projects by the pediatricians in training are critical, and easy to appreciate – these physicians connect a passion for children's health with a clinical understanding of the preventive measures needed to improve health outcomes. On the community side of the partnership, however, the kinds of resources or assets which could be recognized and mobilized might be less obvious. The research of the Asset Based Community Development (ABCD) Institute at Northwestern University identifies six major categories of community assets:

- * The skills and gifts of individual residents;
- * The power of local voluntary groups and associations;
- * The resources of local private, public and non-profit institutions;
- * The physical resources, such as land, buildings, transportation, etc.;
- * The economic resources – what people produce, consume, barter, etc.;
- * The stories, history and culture of a community.

Each of the projects described in this report demonstrates the unique and productive combination of local community's assets with the interest and expertise of the pediatrician in training.

But this marriage of the medical system and community assets proved quite challenging to arrange. The two worlds of medical professionals and of community residents represent very divergent understandings of basic ways of life. These two worlds speak different languages, bow to different schedules, dress differently and perceive peoples' status and importance in very different ways. They also have very different ways of looking at what constitutes "good health" and how to achieve it. These two worlds typically organize, plan and make decisions differently as well. Perhaps one thing they have in common at the outset is limited experience with the "other" world and at times, negative experiences or stereotypes that create an environment that is not very trusting.

Overcoming these profound gulfs is no easy task. In fact, addressing each of these very real differences demands patient negotiation and an understanding of how to move toward win-win resolutions.

Those who have contributed to this report believe that these cases, and the lessons learned by the creative leaders from the University of California, Davis, the community organizations, the American Academy of Pediatrics and the Sierra Health Foundation can point the direction toward powerful new strategies for the enhancement of children's health. We hope that you will read them, absorb their instructive lessons, and work to build creative connections between pediatricians – including those in training – and local community assets in your own area. Our children will be the beneficiaries.

Introduction

PART ONE: A LITTLE ABOUT COMMUNITIES & PHYSICIANS TOGETHER

Creating Communities & Physicians Together

Communities and Physicians Together (CPT) is a partnership between an academic health center and grassroots community organizations in Sacramento, California and associated non-profits and professional associations. The CPT partnership includes the University of California, Davis (UCD) Departments of Pediatrics and Community and Family Medicine, nine grassroots community organizations, and additional institutional partners including Sacramento ENRICHES (Engaging Neighborhood Resources to Improve Children's Health, Education, and Safety), a county-wide collaborative dedicated to children's health, education and safety; the American Academy of Pediatrics (AAP) including the Dyson



Foundation-funded Community Pediatrics Training Initiative and the AAP Community Access To Child Health (CATCH) program; the Asset-Based Community Development Institute; and Sierra Health Foundation.

CPT grew out of two local initiatives. In 1998, the UCD Department of Pediatrics faculty identified child advocacy as an area of emphasis for educating UCD pediatric resident physicians, and Dr. Richard Pan was recruited from Children's Hospital in Boston to the faculty to develop a training program in child advocacy. Dr. Richard has founded the AAP Resident Section CATCH program prior to coming to UCD. In addition, in 1993 the Sierra Health Foundation started the 10-year "Community Partnerships for Healthy Children" (CPHC) initiative to "promote the health and well-being of children from birth through age eight by supporting community-based efforts in northern California communities" (Center for Collaborative Planning 2000). Thirty grassroots, community-based associations in Northern California called "collaboratives" learned to identify local assets and needs, establish child health priorities and develop and implement action plans (CCP 2000).

Through a Yuba City pediatrician, Dr. Arnold Gold, and ABCD Institute faculty

member, Diane Littlefield, who were involved in CPHC, Dr. Richard met with five collaboratives in Sacramento County, and in July 1999 they began teaching eleven UCD pediatric interns about asset-based community development and health.

Over the next 8 years, CPT achieved many milestones and evolved into its current form. In 2002, CPT received a major grant from the Dyson Foundation and became part of the AAP Community Pediatrics Training Initiative and the Yuba County collaborative joined CPT. In 2005, CPT received the national Community Campus Partnerships for Health Award, and in 2007, CPT added five new community collaborative partners who were not previously involved in CPHC and expanded to include resident physicians in Family and Community Medicine. The 2007-2008 Pediatrics & Family Medicine Intern classes mark 116 future physicians who are being taught community health by CPT and its partner communities.

More importantly are the impact of CPT on the partner communities and the development of community capacity. This is best illustrated by the story of Elizabeth Sterba, who began her involvement in CPT as a youth leader at the Tahoe/Colonial Collaborative (TCC), a community that literally shared a backyard with the UC Davis Medical Center and an original CPT partner. A few years later while attending college, she became the collaborative coordinator for TCC and was responsible for guiding the education of resident physicians assigned to her community and linking them to community assets. In 2003, UCD hired Liz to be Program Manager for CPT. In addition, Liz completed a master's degree in community development at UCD while working as the program manager. She plays a critical role linking the university and community in CPT for both the resident physicians and community partners.

What Does CPT Do?

CPT teaches resident physicians how to effectively partner with communities to improve community health. Through a variety of initiatives, CPT joins the medical community together with local communities.

The foundation of CPT is teaching the application of ABCD by physicians and communities. At the beginning of their residency education, resident physicians in Pediatrics and Family and Community Medicine at UCD map their own assets and are assigned to a community collaborative throughout their three years of residency. During their first year, the resident physicians spend two week in the collaborative community performing an asset map and building relationships with community members, associations, and institutions. They participate in community activities and learn about local social service agencies and organizations from the perspective of a community member. In the second and third years of their residency education, the

Residents perform a mutually beneficial community health project in partnership with community members and organizations. Residents call on their observations and experiences from the first year rotation, as well as their own clinical and personal interests, and work with their collaborative coordinator to find an issue of equal interest to work on. After establishing the subject matter of the project, the Resident and coordinator work to discuss how to tackle the issue. Much of this work is done using a “logic model” (see Appendix C), a popular tool for thorough project planning (W.K. Kellogg Foundation 2001). In addition to the experiential training, CPT provides resident physicians an ABCD conference series, symposia, a Project Workbook, and other teaching materials that guide meaningful involvement in their communities of medical practice.

As an active partnership, CPT also conducts many activities to strengthen ties between its members. The program manager plays a critical role in communicating with the partners, coordinating CPT activities, and being CPT’s leading champion in the community. The community collaboratives meet quarterly with Dr. Richard and Liz and with their residents as well as meeting more frequently on their own. CPT also sponsors an annual Hand-in-Hand Award to recognize the contributions of community partners in resident education. CPT also provides the community collaboratives with trainings on ABCD, bridging medical and community cultures, adult learning, and program evaluation. A quarterly newsletter highlights activities in partner communities. In addition, Sacramento ENRICHES, a neighborhood advocacy organization, plays an essential role as a mediator between the university and the community collaboratives in CPT, which reduces misunderstandings and conflicts between a large institution and grassroots associations.

Out of the CPT partnership has evolved the following activities in addition to resident physician education:

- * *Child Passenger Safety Project*
CPT partnered with the UC Davis Center for Injury Prevention, Trauma Prevention Program to build community capacity for educating families about child passenger safety. Through a grant from the California State Office of Traffic Safety, the Center for Injury Prevention is working with seven CPT partner communities to provide training and resources to local parents, children, educators and other leaders on the importance and proper use of booster seats, traffic safety rules and more.

- * *School Health Program*
More than 500 fourth-grade students in five Sacramento City elementary schools receive health education lessons annually through CPT’s School Health project. Resident physicians partner with school nurses to teach state-approved

health education curricula on nutrition and other topics. The program is a joint partnership between the UC Davis Pediatric Residency Program, Sacramento City Unified School District, Health Education Council, Network for Healthy California-Children's PowerPlay Campaign and the Sierra Sacramento Valley Medical Society.

* *AmeriCorps*VISTA*

Through its partnership with Sacramento ENRICHES, CPT has recruited, trained and placed AmeriCorps*VISTAs in four of its partner communities. VISTAs spend one year living and working in a host community, building strong relationships and helping to create sustainable initiatives that engage local members in improving their own livelihood. CPT VISTAs work specifically within their respective communities to create "Healthcare Consumer Advisory Councils," which are bodies of concerned parents, youth, seniors and other community members who meet to discuss local health issues and help advise the projects carried out with CPT residents.

Commonalities in Unique Partnerships

All partnerships and collaborations are unique. They are distinctive because of the individuals, associations and institutions involved, the circumstances under which they form, and the locales in which they operate. Nevertheless, there are shared experiences across groups – similar challenges faced, like successes celebrated, comparable resources available – from which we all can learn.

CPT is no exception to these rules. CPT benefited from unique events both fortuitous and achieved. CPT was able to build on the success of the CPHC Initiative and received a sizable one-time grant from the Dyson Foundation. CPHC gave CPT a strong start, but the initiative concluded five years ago and the community collaboratives have evolved considerably since then, all with new coordinators. In addition, CPT added five new community collaboratives who were never part of CPHC. The Dyson Foundation grant accelerated CPT's development; however, CPT was founded and developed for three years prior to the grant and continues after the conclusion of the grant. Across the country and abroad, there are many other physician training programs that include community medicine, as well as numerous physicians partnering with local individuals and organizations – all without money!

Another important consideration is the "labeling" that happens to and within communities. The traditional medical model is to diagnose problems, and we cannot ignore the fact that partner communities face a variety of challenges such as poverty, crime, isolation, and neglect. The key, however, is to balance knowing that these challenges exist with the awareness of the numerous local assets available to counter

them. As John McKnight counsels, focus on the “full half” of the glass.

Perhaps the key to the success of CPT is the shared belief that we want healthy communities and that this goal can be achieved when the assets of the medical profession/university can be joined to that of the community in a reciprocal partnership. The assets need to act are usually already present, but they need to be joined.

PART TWO: USING THIS GUIDEBOOK

Bridging Cultures: Language and Names

One of the great lessons from CPT is that community-physician partnerships really bring together two very different cultures – the prescriptive culture of medicine and the collaborative culture of local communities. Understanding and appreciating the differences in these two cultures – from language used, to schedules and timing, to identification of hierarchy and even dress – has proven essential for successful partnerships and projects. As a result, community partners and their residents need to discuss perceptions and preconceptions openly and define expectations together.

We have found that in most communities, the role of the physician is highly respected and often placed on a pedestal. This elevation led to some community members’ discomfort with being open and honest with the resident physicians, or even approaching them, let alone working with them as equals. Much of the work of the collaborative coordinators is to facilitate reciprocal relationships between the resident physicians and the community members that they meet. They have discovered that using first names instead of formal titles helps this process.

Some of these cultural lessons learned are illustrated in the case studies you are about to read. One example is the way in which the people in each story are referenced. You will notice that rather than call the physician “Dr. Bob Roberts” or “Dr. Roberts,” we refer to him as “Dr. Bob.” We adopted this style in order to indicate the less formal relationship between the resident physician and the community partners while still allowing the resident physician to be easily identified. In the story, we used the prefix “Dr.” and the resident’s first name, which is how many community members have learned to refer to the residents visiting their communities.

The Story Behind the Stories

Since 1999, CPT partners completed nearly thirty resident/community health projects. We chose the following six stories to illustrate differing levels of resident and community involvement; uses of individual, associational and institutional assets;

inclusion of different cultures; and differing health issues addressed. Each story shares similarities as well as unique characteristics upon which to draw lessons learned.

- * *A Partnership that 'Cooks': The Colonial Park Healthy Kids Cookbook*
This story shows how to build strong partnerships with a local community group, especially the time required to establish trust and facilitate buy-in with youth.
- * *No Mas Barreras: The Han Vu Health Fair*
Like the previous case study, this example also shows the strong ties built between a resident and her partner community. "No Mas Barreras" also illustrates the successful inclusion of one of her partner community's cultural subgroups, the Spanish-speaking families of downtown Sacramento.
- * *From Doc to DJ: The Zdorovie Deti (Healthy Children) Radio Show*
Another good example of reaching out to a cultural subgroup within a local community, this story describes how the resident called upon her own skills and unique life experiences to educate parents through local ethnic media.
- * *Tree, Turtle, Dog: Injury Prevention for Youth & Pet Owners*
In addition to showing how yet another resident called upon her own skills to create a project, this story illustrates how a clinical issue combined with an awareness of local resources led to the development of a successful project.
- * *Rural Roadrunners: Yuba's 'Drive' to Health*
One of two projects that demonstrates how a resident can be an important behind-the-scenes player in community projects, this story also gives an example of work that can be done in a rural community nearly an hour removed from an urban Medical Center.
- * *Tossing Things Up: Frontier Elementary School Salad Bar*
A second example of the resident supporting the efforts of her community partners rather than leading the project. Also an example of how the physician *did* use her title of "doctor" for the benefit of her partners, local parents.

Finally, in an effort to make this guidebook most useful to you, our reader, we have divided each story into five subheadings:

- * *The Community Context*
A brief discussion of some of the key characteristics of the community with which the resident worked to implement the project.

- * *The Project*
A description of the planning, implementation and evaluation of the project itself, including partners and logistics.
- * *Overcoming Challenges*
A summary from the voices of the residents and community partners themselves.
- * *Successes & Outcomes*
Highlights of victories and accomplishments.
- * *Looking Back: Reflections and Advice from the Field*
Guidance from community members and physicians for others interested in working on these kinds of projects.

Keywords are also provided at the beginning of each story to identify cases that may be of particular assistance or interest to you, and are ordered alphabetically.

We hope that this guidebook serves not only as a real-world example of how very diverse communities have come together to work on a range of significant issues in partnership with physicians; we hope that it will persuade you of the limitless possibilities that exist for such partnerships, that it will inspire you to look at your own community – and its assets – differently, and that you will engage in meaningful, mutually beneficial ventures with people and organizations across professions, and across your community.

Section Two:



Stories
from the Field

A Partnership that Cooks: The Colonial Park Healthy Kids' Cookbook

Keywords: Fundraising, Local Businesses, Mentoring, Neighborhood Associations, Nutrition, Obesity Prevention, Park, Urban

The Community Context

How to convince young people to eat healthier foods? Dr. Laura Hufford discovered that fun cooking experiments and taste tests can be part of the answer. During the first year of her child advocacy rotation, Dr. Laura visited the



Colonial Park Mentoring Program. There she met Shirley Johnson: 41-year resident of Tahoe/Colonial Park and mentoring program director. Affectionately known as the park “grandmother,” when people in the neighborhood describe Shirley, they’re likely to say, “Everybody loves her.”

Shirley founded the mentoring program almost 25 years ago with the Colonial Park Arts and Recreation Effort (CARE) Neighborhood Association. In the early 1990s, CARE joined with the Tahoe Park Neighborhood Association to establish the Tahoe/Colonial Collaborative (TCC). Now, all three associations work cooperatively to improve children’s health and safety in the neighborhood.

Located a few miles from downtown Sacramento, Tahoe/Colonial Park is home to UC Davis Medical Center and the Shriner’s Children Hospital, two parks, more than a dozen churches, several schools, and a conveniently located public library.. The neighborhood’s tree-lined streets are filled with modest, well-kept homes. It is an ethnically diverse community with many families from Latino and European descent. Stockton Boulevard bounds the western side of the neighborhood. This busy commercial corridor offers local residents shopping and other services but also can be dangerous due to high rates of crime and increasing traffic. Though the community has achieved many improvements over the years, neighbors continue their efforts to reduce crime, gangs, prostitution and substance abuse.

The mentoring program is an integral part of the community’s commitment to youth and includes young people from two years old to high school seniors. The program offers activities on a drop-in basis and caters especially to “latch-key kids,” whose

parents may not be at home during out-of-school times. Twenty youth may come by on rainy, winter days while the numbers can swell to nearly 100 during the hot summers. Teens receive modest stipends to mentor younger children.

Even four and five-year-olds act as “junior mentors.” They often are the younger brothers or sisters of the older mentors and want to follow in their footsteps. “We give them T-shirts and they walk around with giant buckets and brooms and try to help,” Shirley says. “Most children at four and five years old feel alienated when they’re not allowed to participate.” Young people not only care for the park, they also raise funds to help sponsor program activities such as annual ice skating trips. Through these opportunities, the youth build their “self-confidence and self-worth.”

The Project

Dr. Laura lived in Tahoe/Colonial Park during most of her residency, which she says made it easier to establish relationships with people in the neighborhood. As Dr. Laura spent time with the children, she noticed that they typically ate snacks that weren’t very healthy – sometimes in giant-sized portions. She began to talk with the young people about healthy eating and discovered that most could not name a “healthy food.” She also learned that many of the children made dinner for themselves, often relying on prepackaged foods or the nearby Jack In The Box. A few knew the concept of a smoothie, but no one knew how to make them.

“It occurred to me that not only did they not know how bad that stuff was for them, but they really didn’t know how to make themselves something healthy without their parents,” Dr. Laura explained. “So I talked to the kids about making a cookbook. Something they could use.” While many thought it would be a fun project, there was one group of grade school boys that was very skeptical. “They basically thought healthy food didn’t taste good,” Dr. Laura recalled.

So how did Dr. Laura convince them? She went home and baked two batches of chocolate chip cookies. She prepared one the “normal” way and substituted applesauce for butter for another, low-fat version. At a taste test the next day, the boys



Shirley Johnson (blue shirt, center) with CARE Mentoring Program participants and CPT Resident Laura Hufford (white polo shirt)

couldn't figure out which ones were the "healthy" cookies. So they decided to give the project a try.

Shirley's main role was to encourage the children to participate. She says she didn't have to do much because, "Kids by nature are energetic and like to learn new things... they love to taste new things and get their hands dirty." Once they're enthusiastic, "it mostly spreads by word-of-mouth," Shirley says. The children also really enjoyed their time with Dr. Laura, who Shirley describes as soft-spoken with a great amount of patience. "She was part of them. She wasn't an outsider." Shirley says.



Mashing strawberries to create "sugarless" peanut butter & jelly sandwiches.

According to Shirley, Dr. Laura is perceived as an insider because she doesn't "stress that she's a doctor" and is "willing to let go of the physician status." Dr. Laura agrees that the title of doctor can be "almost a front" that results in some separation. "When you introduce yourself to children as a doctor, they have a definite impression of who you are and what doctor means," she explains. That image may or may not be positive. "They might think, 'there's the person who gives shots.'"

But youth in the mentoring program got to know Dr. Laura as an approachable person. "One day I brought my dog; another time I brought my little boy." And her manner ensured that "mentors weren't afraid and intimidated by the doctors," which was Shirley's biggest concern about the CPT program in the beginning.

Despite the interest, Shirley says she worried from day-to-day about participation. Because the park mentoring programs are all voluntary, she never knew how many youth would show up; it could be two, it could be fifteen. Shirley says the program is "not very regimented." She believes the playground setting is supposed to be fun. "The young people are there because they want to be. They often come and go. We have a lot of children who have problems," Shirley explains. "So, if they stay fifteen minutes doing something, that's pretty good. They may wander back in." Some might find this flexibility challenging, but Dr. Laura felt very comfortable in the park setting due to her previous experience teaching in a parks and recreation program for eight years.

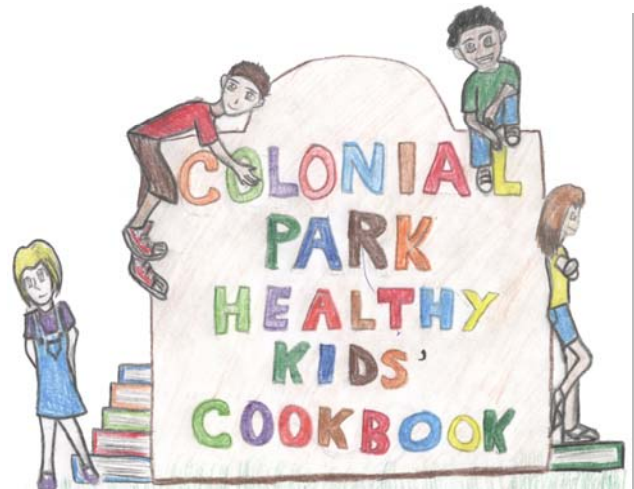
The cookbook development began with conversations about the youth's favorite foods. They talked about ingredients, what parts were healthy, and how they might alter

recipes to make them healthier. For their first experiment, Dr. Laura brought her blender and a variety of ingredients to make smoothies. “I was really surprised how well it turned out in the end,” Dr. Laura recalled. “That first day, it was really messy, the blender broke and everything went all over. I went home and asked myself, ‘What did I do?’ But the mentoring staff got really excited and took off with it.”

From a consistent group of girls who helped organize the cooking experiments to a mom on her way to recovery who encouraged the kids to draw pictures for the cookbook, “There were a lot of people who helped move things along,” Dr. Laura says. Local grocery stores were approached to help offset the cost of food, the project’s biggest expense. One store donated food, while another offered a 10% discount on groceries. Dr. Laura and the youth shopped together for ingredients a few times. Young people from the mentoring program created all the artwork for the cookbook. UC Davis printed the cookbooks and a neighborhood taqueria agreed to sell some.

Overcoming Challenges

During the creation of the cookbook, Dr. Laura learned how the assets of youth could help overcome several challenges. For example, she explains that she originally planned to use clipart to illustrate the cookbook, but encountered copyright and expense issues. Then, she realized one of the mentors had an artistic gift. “The kids kept telling me that Maijia was an artist and so she had to do the cover.” So, she drew caricatures of young people from the Mentoring Program for the cover design. Dr. Laura and Shirley agree that the drawings do look like the children.



Cover illustration for the cookbook, by Mentoring Program participant Maijia Williams

Neighborhood youth filled the remainder of the cookbook pages with drawings of fruits, vegetables and other healthy foods. “The coloring worked out so much better and added a whole new dimension,” Dr. Laura says. One thing she learned is, “If the kids can do it, then they should and you shouldn’t. You need to ask yourself, ‘Do I need to do this?’”

Time was the major challenge of this project for Dr. Laura. Originally, she intended to develop all the recipes with the children. However, finding enough 3-hour blocks of time proved difficult. So, in the end, they created about half the recipes together as a

group and Dr. Laura produced the remainder on her own. Still, she found a way for the young people to participate even if they weren't preparing the food as a group. "I



Cookbook project leaders (L to R): Dr. Laura, Alondra and Shirley

talked through with them how to alter their favorite foods," she says. For example, "They said they liked taco salad and the crunchy things on top. We talked about how that's really the unhealthy part. So they came up with what else you could put on it and what would be easy to do, like string cheese."

Amazingly, the park did not have a kitchen; just a sink, a small refrigerator and electrical outlets. But the partners made it work. Dr. Laura says she initially worried about sanitation but, "The kids really helped with clean-up. I was really impressed." They covered the wooden picnic tables with

butcher paper, lined up to wash their hands before and after, and Dr. Laura took the dishes home to wash. "The mentors and older teens helped model for the other kids and always helped with final things, like bringing supplies to my car," she said.

Alondra Morales is one such notable senior mentor who says, "Being involved with the park changed the direction of my life." Alondra began as a park mentor eight years ago, when she was 12 years old. Along with her younger sister Ruby, she also volunteers with the Collaborative's after school program. Shirley describes Alondra's role as a "go-getter for anything the program needs" and the "hands-on person who keeps the children in tow."

"I like to step back and give her the authority," Shirley says of her relationship with Alondra. Dr. Laura recalls when she became ill on the project's last day; Alondra stepped in to lead the recipe making:

"I just dropped the supplies off and Alondra worked with the kids. She just led them. They figured out how they liked the Popsicles, made them and froze them. I was really impressed because it's hard to do that at the park. They have a little refrigerator so Alondra brought them back and forth to her house until they filled the freezer. They made 100 Popsicles together."

In recognition of her contributions to the success of the Cookbook project, CPT presented Alondra with a Hand in Hand Award in April 2007.

Successes & Outcomes

The production of the cookbook generated a great deal of personal and community pride. The CPT partners hosted a celebration and invited parents, collaborative members, and other neighborhood leaders. Youth from the mentoring program taught children from the after school program how to make some of the recipes. CPT's Director, Dr. Richard Pan, brought a video camera to capture the momentous occasion and everyone enjoyed taste-testing the recipes.

"They were *so* excited and so proud," Dr. Laura recalls of the young people. "Everyone said how good it tasted." She describes it as their "shining moment" and says, "I think they were very proud of themselves. I hadn't seen that expression, that look on their face, with these kids very often."

All of the children received free copies of the cookbook. They gave away some to their favorite neighbors and also sold some as a fundraiser. Part of Dr. Laura's original idea was that the children could sell cookbooks instead of candy bars to raise money. She thought, "People would be more likely to buy them if they were produced by the kids. It would tug at their heartstrings a little more."

The youth sold cookbooks door-to-door in the neighborhood, at the annual safety fair, and to various parents, collaborative members, and local businesses. But the fundraising never really took off. Alondra says most people can afford a dollar or two for soda or candy, while the cookbook costs five dollars – a price not everyone can afford, she says. But Shirley explains another reason:

"We realized that this was more a labor of love than a fundraiser. I think Dr. Laura wanted it to be a fundraiser, but it turned out to be something that the children loved so much. We have a philosophy: we don't make money from

They Did It, Too!

Philadelphia, PA:

"Nutrition in the Kitchen"

This project was a joint effort between the Children's Hospital of Philadelphia (CHOP) Nutrition Department, residents and staff; and community groups working on obesity issues in Philadelphia's youth. Residents researched current educational materials available in CHOP out-patient clinics, from which they developed three main components of cookbook: Introduction (discussion of general nutrition topics); Recipes; and Nutritional Factoids. All recipes were taste-tested by the authors and were reviewed for cultural-sensitivity. Both recipes and 'factoids' were evaluated by CHOP nutritionists for their healthfulness and nutrition content. The cookbook was used as a 'springboard' for nutrition education session with children participating in Bartram Beacon After-school Program's Cooking Class.

-Courtesy of American Academy of Pediatrics CATCH Database
www.aap.org/commpeds/

the things we love. For example, when we have our yard sales, we give Bibles away, we don't sell them. So we gave the cookbook away to the children who were involved, we just couldn't sell them."

Shirley believes one reason for this project's success is that UCD, "asked us what we would like and I asked the children what they wanted." She compares this approach to other programs that tell you what they are going to do and says, "You may think it's a good idea, but it might not be what the neighborhood wants at all. And, if it's not what they want, they won't come. You have to find out what people want."

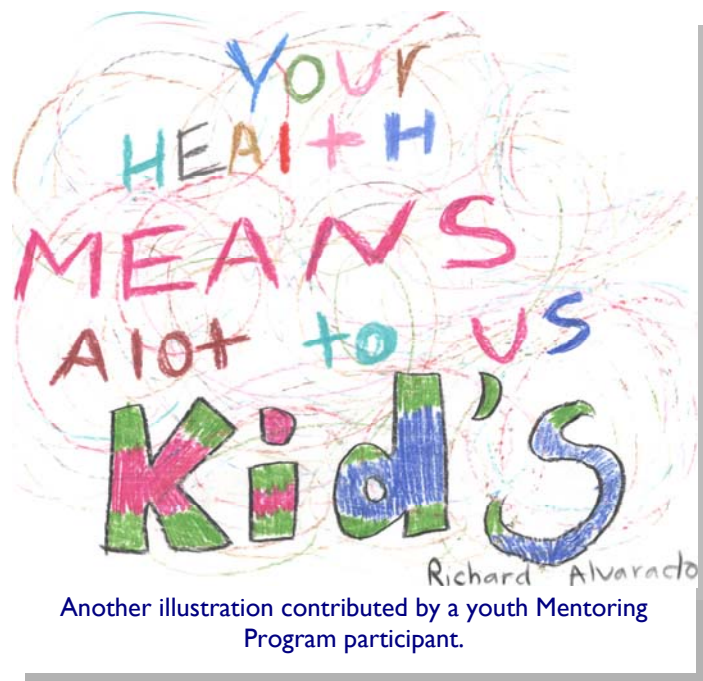
Looking Back: Reflections and Advice from the Field

For other physicians who might want to try a similar project, Dr. Laura advises them to, "Build trust by hanging out. Get to know your kids, their names, what kinds of foods they like and don't like." She says this is approach works better than announcing, "We're going to learn healthy this or that."

Shirley advises community members to "be ready" before undertaking a project. "If it's within your heart and you're willing to do what it takes to bring it to fruition, then you're ready," she says. She believes that heart and vision are inexorably linked and key to sustainability. Shirley explains:

"If you don't have the love for what you're doing, you might succeed a little but you'll never reach the full potential of what it can be. It only takes one person to have the heart. Others will follow along even if they don't have the vision. With the heart comes the vision and that's what I've always been driven by. That's why I still do what I do – because if I didn't have the heart and the vision, I'd give up."

Dr. Laura says that as a result of the CPT program, she looks at primary care and her job as a physician differently. As a hospital physician at an academic center, she doesn't have a consistent patient base. While primary care may provide more opportunity to form long-term relationships, she still sees ways that she can make a



difference by working with the community. “Even as a hospital doctor, I see what happens. Sacramento has a high rate of death from drowning. I see the effects from near-drowning on kids and the severe medical problems that can result. That’s something I could get involved with the community about.”

Her experience also gave her more insight into the context of people’s lives. She now has better appreciation for the reasons *why* patients may arrive late for appointments. Dr. Laura explains, “Knowing someone had transportation issues, we’re still quick to say, ‘We can’t see you today.’ Maybe they had to get a ride with their sister who was working another job and stop along the way to drop-off court papers for their mom’s court appointment.” Shirley says she hopes that through projects like CPT, “Communities can realize physicians are people too and vice versa. We’re not just people coming in to get examined.”

Through a physician’s lens, Dr. Laura describes how the cookbook project differs from the usual approach to improving children’s nutrition:

“Typically an obese kid would come into my office and I would tell them the healthy foods they should eat. Which I think needs to be done, but it’s not very effective. Never really do I see it work. Whereas going to where they live everyday, getting them excited about eating healthy foods, showing them how they can do this, doing it with them, and letting them be part of this creative project – they’re much more likely to try it in the long run.”

Ultimately, she believes that these experiences help to create the mindset that healthy food is good, fun and doable.

In terms of working with the community, Dr. Laura says that physicians typically, “Ask what the problems are and how can *I* fix the problems. With the CPT approach, the question is a little different,” she explains. “We ask how can *we* fix the problem. Most solutions already lie in the community. It’s about helping people to invest in themselves and in the community and really help each other. And then, how can I as a physician help with that?”

“My approach is completely different now,” Dr. Laura says as she describes how she might initiate a community-physician partnership. Before, she might begin by sharing her idea. Now, Dr. Laura says getting to know people is an important first step before deciding what to do – especially if you’re a complete outsider coming in. And of course, she now begins introductions with her first name and *then* lets people know she’s a pediatrician.

No Más Barreras: The Han Vu Health Fair

Keywords: Arts, Bilingual, Culture, Elementary/Title I schools, Flu Prevention, Health Department, Health Fair, Immunizations, Obesity Prevention, Parents, Urban

The Community Context

Dr. Han Vu was already in her third year of residency when she first met Ms. Juanita Jue, the new coordinator for Children First – Flats Network (CFFN). Though new to her position, Juanita was no stranger to the “Flats” neighborhood in midtown



**Children First
FLATS NETWORK**

Sacramento. A community resident for 28 years, Juanita first volunteered at Washington Elementary School more than 20 years ago. The school serves as a home base for the Network’s activities, including the Communities and Physicians Together (CPT) project. The school’s students represent a rich diversity of ethnicities and languages. However, many student families struggle with the barriers and health impacts that accompany poverty, low incomes or limited English language skills.

The idea for a child health and safety fair originated with Dr. Han after she participated in large health fairs sponsored by a city television network and medical center. She wanted to design a health fair that focused on children and parents in the local neighborhood, and offer fun, interactive activities that would appeal to multilingual, multicultural families.

During the preceding two years of her advocacy rotation, Dr. Han had initiated relationships with some students, parents, and school personnel. She had observed kids at play in the neighborhood, noting that they often rode bikes without helmets or with their friends on the handlebars. Flu season was approaching and the school had struggled with increased student absences in past years due to rapidly spreading infections. Dr. Han’s experience in the emergency room also informed her idea. She explains,

“Seeing the effects on children who aren’t eating well and are overweight, who didn’t get a flu vaccine, and were hospitalized with the flu. In one extreme example, I saw a two-year-old child who weighed 110 pounds and was hospitalized in the Intensive Care Unit with the flu. The child couldn’t breathe

and had a tube down his throat, because he was so overweight. In retrospect, I can see that my experiences informed what preventions were needed."

The Project

Forewarned that health fairs often don't succeed because, "they don't really match with what people really want," Dr. Han and Juanita set plans in motion for an event that catered to the community. Juanita leveraged her connections to recruit parents, students from area high schools and universities, local business owners, and association members to participate. Dr. Han worked to engage volunteers from the health professions, including other pediatric residents and officials from Sacramento County Health and Human Services. "We had *one* meeting," Juanita remembers and weaves her fingers together to illustrate how the project came together. "Collaboration, coordination, asset-based - we reached the epitome of those terms with this project."

Parents had expressed concern about childhood obesity and making school lunches healthier so "healthy food and eating" became the health fair theme. A couple whose child attended the school ran a catering business and offered to host a booth to teach children and parents how to prepare healthy snacks. Other parents ran the bike helmet



L to R: Juanita (with granddaughter Lilu), Public Health Nurse Reiko Osaki, Dr. Han and Public Health Nurse Rosalinda Vizcina

and smoke detector raffle, translated for families during the flu vaccine, and helped staff the "I Want to Be a Doctor" photo booth and other health and safety games and arts booths.

Another parent was in charge of sharing information about the health fair at *Café con el Director*, a monthly bilingual opportunity for parents and the principal to discuss school issues in an informal setting.

This forum provided one venue for Juanita to "encourage parents to talk with the doctors, to break down cultural barriers between the doctors and the community." Juanita says, "Now the community knows the doctors but then I had to do a lot of work." She would tell parents, "This is your school and these are your children. You have every right to ask questions and the doctors want to know how to best help you."

Juanita and Principal Antonio Medrano also introduced the health fair idea to students through lunch time arts activities and classroom visits. Juanita explains:

“To prepare the students, we did artwork about health. They drew pictures and we had noontime discussions about what is health. We asked, ‘Is it just the food you eat? Is it just getting exercise?’ Antonio and I went into every classroom to explain the difference between a flu shot and Flu-Mist.”

Juanita and the principal acted out a bilingual skit to explain that Flu-Mist is administered by mouth and doesn’t hurt. They also translated all the permission slips and fact sheets, which were sent home attached to a bilingual flyer to announce the fair. All these activities helped get people talking about the fair because as Juanita noted, “gossip is the quickest thing to spread the word.”

Overcoming Challenges

Dr. Han recalls, “The biggest challenge was getting free flu vaccine during a shortage year. I wrote to about five or six people at the Health Department but kept getting passed from person to person.” But once she connected with the county health officer Dr. Glennah Trochet, things began to fall in place. Based on the Title I free lunch program, Dr. Trochet determined that Washington Elementary School met the eligibility guidelines to receive free vaccines. She linked Dr. Han with MedImmune, the producers of a relatively new product called Flu-Mist, and with the county’s mobile health van.

At one point, bureaucratic rules threatened the entire project. A new school district employee couldn’t find the Memorandum of Understanding (MOU) that described the agreement between the district and the County’s Health and Human Services department. Flyers and permission slips were held back while a county staffer searched through microfiche to try to locate the document. Eventually, officials at the two agencies worked out an agreement and gave permission to go forward.

Coordinating the logistics to provide the Flu-Mist added to the challenge. Because it was a live vaccine being offered on school grounds, there were a lot more restrictions and paperwork. Children had to be a certain age, without any chronic disease, immunosuppression, egg allergies, or asthma. Some required a follow-up visit for a second dose. The partners had to ensure that parents understood the process so they could provide informed consent and guarantee their child returned for the second



A Fair participant receives his free Flu-Mist treatment from a Public Health Nurse

visit. They also needed to request special parking permits for the van. Once everything was in place, the CPT partners worried that no one would come.

Successes & Outcomes

The CPT partners held the First Annual Child Health and Safety Fair on the Saturday before Halloween. About 300 people attended and almost 100 children received flu vaccine. There was a 100% return rate for those who needed a second dose. Dr. Han says, “The biggest reason for the good turnout was the involvement of the school and the parents...I couldn’t have done it without Juanita.”

Parents, students, voluntary associations, area businesses, and local institutions all contributed to help make the fair a success.



Through Juanita’s connections and Dr. Han’s constant phone calling, the CPT partners collected donations of raffle prizes, gifts, and refreshments. Sacramento State University’s Barrio Arts program, which works with neighborhood children, contributed art supplies and CSUS Art 148 students served as fair volunteers. Dr. Han contacted local stores and recalls that, “The manager of Longs (Drugstore) just gave me a bag and told me to put whatever I wanted in it from the shelves.” County Health and Human Services staff willingly rearranged their schedule to work on a Saturday. UCD pediatric residents offered body mass index (BMI) measurements, face painting, and talks on the dangers of smoking. They also ran a “Fishing for Health” game where children answered questions about home safety and health and then fished for prizes.

Because it was so successful, one of the unanticipated outcomes is that the fair became an annual event. “That’s one of the goals of CPT,” Dr. Han says. “If a project is successful, you can carry it through in the next year.” In the second year, pediatric resident Dr. Emily Scott served as coordinator and used Dr. Han’s list of contacts as a starting point for community engagement. The third year brought significant changes however. The school didn’t meet eligibility requirements for free vaccine and as a result, parents had less incentive to get involved. The current group of residents working on their child advocacy rotation had different interests and no one wanted to

coordinate the fair. So CFFN and the school hosted a scaled-down version during after school hours rather than a Saturday.

Even though the 3rd Annual Child Health and Safety Fair was not a project coordinated by current residents, once again the CPT partners overcame obstacles by working together and reaching out to community partners. Dr. Han remained involved by creating the flyer and helping set up. Current residents taught sushi-making as an example of a healthy snack while local agencies operated booths that focused on nutrition, clean air, and other health issues. CFFN's new part-time assistant solicited donations for game prizes. Dr. Gold from the Yuba Community Collaborative staffed the "I Want to Be a Doctor" activity, assisted by high school student volunteers.

As a result of this experience, Dr. Han says she learned the importance of being "open-minded and flexible on both ends." She knows that the community may not always share the same priorities as health professionals and that you can't be "so set in your ways that you don't listen." In her reflections, Dr. Han notes that medical training is very proscribed, regimented, and scheduled. But community work is different. "No one is telling you what to do." So she learned that, "It's OK to not always have set rules in order to get a community project done and be successful. It doesn't have to always be perfect."

Juanita had "never connected with institutions before in an asset-based way" and as a result of this project, her attitude has shifted. She says, "I don't like to work with institutions but with this, I don't feel I'm fighting against them. It's a collective energy, a collective movement, a collective activity." The shift she is most proud of however is the breakdown in the cultural barrier between families and physicians.

Families are now on a first name basis with the doctors and Juanita believes this is an important change because the title and role of doctor often comes with "set ideas about how it should be." Juanita explains that for parents, this can mean that, "Someone else has control over your child's health and what you say doesn't matter." The informality of first names indicates that, "You are no different, you are two individuals concerned about the same child and the same family." Consequently, families and doctors can talk about how to work together and even if they don't speak the same language, they try to understand.

Looking Back: Reflections and Advice from the Field

Both Juanita and Dr. Han emphasize that for physicians, developing an understanding of community conditions is crucial. By working in the community, doctors begin to learn about the context of their patients' lives. Dr. Han credits not just the fair, but the entire planning process and "getting to know what their lives are like outside of the 15

minutes we see them every three months.” She now recognizes that they are “not just patients,” but kids who go to school and ride their bikes around the neighborhood. She realizes what’s important to them and what their daily lives are like.

As a result, Dr. Han says she has more realistic expectations and a new appreciation of the impact of an infection. “Their parents may have to miss work. If they don’t have a car, they have to take two or three buses to get to an appointment. I understand the context of their lives and why they may not be able to follow medical advice. If I tell them to get more exercise but it’s not safe to play outside or eat more healthy food but there’s not enough money...”

For health professionals who might want to undertake a similar project, Dr. Han believes it is important to involve the community and discover what they want from doctors. She reminds them that, “No one comes without a connection.” Her message to community members also encourages participation. Dr. Han advises,

“Don’t be intimidated by the institution or doctors. A lot of times people think, ‘What can I possibly do that they can’t or how can I make a difference?’ Don’t use this as an excuse to not get involved. If it was just a bunch of doctors, we couldn’t have done it. The community provides a lot we can’t provide – connection to other community members, getting the word out, bringing their kids, and being involved.”

For anyone who wants to work with community, Juanita underscores the importance of developing trust. No matter how long it takes, it is “the key to any and all successful events and such a crucial part in capacity building.” She defines trust as, “Two big arms that embrace respect, courtesy, understanding, caring, and commitment. When you trust someone, two great forces join together and make possible what for one person seems impossible.”

They Did It, Too!

San Diego, CA:

“Hip to Be Fit Health Fair”

Dorris Miller School is located in the Murphy Canyon area of San Diego, 97% of the students are military dependents. Several meetings were held to determine the needs of Dorris Miller School—the actual project ended up being completely different than the original idea. Obesity prevention was one need identified. Establishing a mutual goal led to the creation of a Health Fair for all students of the school. Recruitment of other residents and support was needed for success. On the day of event, multiple booths each with a specific health topic related to nutrition education and physical activity were set up. Residents staffed and led activities and teaching. Give aways, incentives and educational materials were used to motivate the students. This project was very successful, over 900 kids attended!

*-Courtesy of American Academy of Pediatrics CATCH Database
www.aap.org/commpeps/*

From Doc to DJ: The Zdorovie Deti (Healthy Children) Radio Show

Keywords: Cultural Effectiveness, Ethnic Media, Health Education, Immigrant, Prevention, Radio, Slavic/Russian, Suburban, Tuberculosis

The Community Context

During her first year with the Cordova Community Collaborative for Healthy Children and Families (CCC), Dr. Inessa Gofman discovered that the City of Rancho Cordova is home to a large Russian immigrant population. Located about 12 miles east



of the State Capitol, Rancho Cordova is one of California's newest cities (incorporated in 2003). Nearly 7% of the City's population reported Russian or Ukrainian ancestry in the 2000 Census. Dr. Inessa quickly learned how she could contribute to the community's health improvement efforts.

Dr. Inessa emigrated from the Ukraine to the United States as a child and Russian is her native language. When CCC Coordinator Linda Lee read about Dr.

Inessa's background and saw that she spoke Russian, "My eyes lit up and my ears perked up" she recalls. "I knew I wanted her." As they began to work together, Dr. Inessa soon realized that she could help communicate with those not reached by mainstream health education efforts due to language and cultural barriers.

"While conducting an asset map of the community, I learned about challenges faced by the many Russian-speaking immigrants in Rancho Cordova in obtaining quality health information and care in Sacramento," Dr. Inessa recalls. "As the only Russian-speaking physician in the pediatric clinic, I also recognized the cultural divide between the immigrants and the U.S. health care system."

Though the collaborative already had an outreach project underway, "It's a very difficult population to outreach to," Linda says. "A lot of Slavic families didn't believe in Western medicine and there was a lot of fear." When she mentioned that a local Russian language radio station showed interest in airing a program on health, Dr. Inessa saw it as "an opportunity to apply my experiences as both an immigrant from

the Ukraine and as a pediatrician to demystify American medicine and build a bridge between the cultures for others in the community. “

The Project

The idea for the “Zdorovie Deti” (“Healthy Children,” in English) radio show originated from two sources. First, Linda attended a symposium sponsored by the Dyson Foundation and learned about a similar resident project in Indiana called “Preguntale al Pediatra” that targeted the Spanish-speaking community. “That’s how I stole the idea,” Linda says. “We all go to a lot of conferences and a lot of times the information never gets back to the community.” She believes one of her biggest contributions to this effort is that, “I actually took an idea back from the conference and recognized the power of social capital and community building.

Tatyana Zaremba, an outreach worker with CCC, also recognized the importance of using the media to offer parents health information in their own language. She had an existing relationship with Afisha, a Russian multimedia group that airs Russian programs on local radio station 1430AM and operates the *Diaspora* Newspaper in the Greater Sacramento region. The only group of its kind in the area, Afisha is a major source of news and information for the Russian-speaking immigrant community. Their radio shows reach approximately 14,000 listeners up and down the Sacramento Valley.



L to R: Tatyana Zaremba, Linda, Richard Pan, Dr. Inessa and Yuriy Korotkov in the on-air room at Afisha

As discussions progressed, “We were all excited about the idea,” Linda says. Afisha’s Director, David Ponomar, says that with increased trust from the Russian community comes a responsibility to serve the community. This motivated him to offer free airtime for the radio show, plus column space in the *Diaspora* newspaper. *Diaspora* editor Yuriy Korotkov helped provide presentations and call-in opportunities for Russian-speaking families on the radio show. “The Zdorovie Deti radio show provides critical health information to the community in a manner that bridges Western medicine with traditional beliefs of the community,” remarks Ponomar.

The first show aired on December 22, 2003 and featured the CPT project and the

importance of well-child visits. Dr. Richard Pan, CPT Director, appeared as a guest. Subsequent shows offered information on preventing cold and flu and discussed the importance of immunizations. One show dealt specifically with tuberculosis (TB) testing. This topic is of particular importance for the Russian/Ukrainian immigrant population because TB vaccinations are given in the former Soviet Union but not the United States. Consequently, immigrants often are reluctant to be tested for TB because they have already received a vaccination in their native country which may result in a positive TB test. Dr. Inessa's radio show focused on the reasons why new US residents should be tested when they arrive.

Overcoming Challenges

In retrospect, some might say that getting the idea together was the easy part.

Deciding what Dr. Inessa would talk about during each show, on the other hand, would prove to be more of a challenge. "Researching topics for each show requires a lot of time and effort," she said, "but that comes after choosing the topics. I had to make sure that they were relevant, since that was critical in maintaining a listener base."

Prior to every radio show, the partners met to think about topics. Linda's knowledge of the community allowed her to contribute ideas while Dr. Inessa suggested topics based on her observations from the UCD clinic where she saw some Slavic patients. They also selected topics based on seasonal changes. For example, in the summer they might do a show on sun protection or water safety. To ensure relevancy, CCC partnered with various community-based programs to organize some initial focus groups with Russian-speaking parents. This provided community members with an opportunity to discuss their concerns about health and American medicine. In addition, Dr. Inessa consulted staff working at Afisha for their ideas and feedback.

Здоровые дети

ЧТО ТАКОЕ АЛЛЕРГИЯ?

Программа "Здоровые дети", которую ведет на радио "Афиша" (волна 1690 AM) врач-педиатр в резидентуре UC Davis Medical Center в Сакраменто Инна Гофман, пользуется большой популярностью у радиослушателей. Во время прямого эфира родители имеют возможность получить профессиональную консультацию по самым разным вопросам, связанным со здоровьем их детей. Одна из последних передач, прозвучавшая в рамках программы "Друзья, отзовись!", была посвящена проблемам аллергии.

Татьяна ХРАМЦОВА
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- Что такое аллергия?
- Реакция иммунной системы на аллергены в окружающей среде. Аллергия может быть сезонной (только весной, летом, осенью) или круглогодичной. От аллергии воспаляется и



Врач-педиатр Инна ГОФМАН

опухает слизистая оболочка.

- Как выражается аллергия?
- Аллергия может быть в дыхательных путях, в кишечнике или на коже. Аллергия дыхательных путей выражается в следующих симптомах: течет из носа, заложен нос, наблюдается чихание, чешутся глаза, нос, уши, горло, слезятся глаза. Если аллергия круглогодичная, то хронический кашель может быть самым главным симптомом. Кстати, он очень похож на простудный кашель. Поэтому, если у вас появился кашель, не спешите принимать отхаркивающие микстуры, а проследите за параллельными симптомами, может, это аллергия.
Аллергия на шерсть кошек может

аллергенов: пыльца цветущих растений, маленькие клещи, живущие в пыли, сорняки, перхоть животных, плесень, сигаретный дым.

Если у ребенка понос, экзема, рвота после определенной еды, то у него может быть пищевая аллергия. Еда, которая часто вызывает аллергию: куриные яйца, арахис, орехи, молоко, соевые продукты, рыба, пшеница, горох, разные орехи. Если у ребенка экзема на коже, то это может быть связано с едой, а также с аллергенами в воздухе или даже иногда с собственным потом.

- Как можно избежать от аллергенов в доме?
Вы можете попробовать удалить аллергены из ваших домов. Вот несколько советов: не курите при ребенке и меняйте одежду, которая пропитана дымом.

Чтобы избавиться от пыли и пылевых клещей, стирайте постель в горячей воде раз в неделю. Сушите одеяла и подушки в сушилке раз в месяц, чтобы вытянуть пыль. Уберите из спальни ребенка мягкие игрушки. Пылесосьте ковры два раза в неделю.

Если у вас есть домашние животные, имейте в виду, что это - страшный аллерген. Пылесосьте чаще и мойте чехлы от диванов, т.е. те места, где постоянно лежат животные. Используйте водные пылесосы.

Тараканы также вызывают аллергию, особенно у астматиков. Плесень - это аллерген. Ее можно смыть водой с порошком и отбеливателем.

Пыльца растений - тоже сильный аллерген, поэтому постарайтесь защитить свой дом от пыли.

Мыло и духи с сильными запахами содержат также аллергены.

Если профилактика не помогает, обязательно обратитесь к доктору, который выпишет несколько рецептов, например, капли в нос, чтобы снять воспаление. Обычно эти капли начи-

Dr. Inessa's shows were transcribed and published in the local Afisha paper by a community volunteer

Another concern for Dr. Inessa and her community partners was ensuring the accuracy of information and using culturally appropriate translations. Dr. Inessa's preparation included writing drafts of her shows in English, translating them into Russian and

then asking bilingual Afisha staff to review the drafts and provide feedback. After delivering her 30-45 minute presentation on the month's selected topic with occasional assistance from cohosts Tatyana Khramtsova and/or Yuiry Korotkov, Dr. Inessa opened the show up for call-in questions and discussion from listeners.

During her initial show, Dr. Inessa had no callers, so Afisha staff quickly took to the phones, giving listeners a hint that they should call in. "The first show, we only had three callers and one was a plant," Linda recalls. The "plant" was a Russian-speaking friend of Dr. Inessa. For the next few shows, Dr. Inessa offered prizes for the 5th and 10th callers. The tactics worked Linda says, especially the plant caller. "We used her for a few more shows and then all of a sudden, after about the fourth or fifth show, we had 40 calls coming in on one show." Soon, a devoted fan base developed and Dr. Inessa received more calls than could be answered in her one-hour time slot. One listener even called to profess his dedication to the show saying, "I love you Dr. Inessa! I listen every month!"

In the Fall of 2005, Dr. Inessa successfully applied for a \$10,000 grant from the American Academy of Pediatrics' Community Access To Child Health (CATCH) program. These funds enabled the team to offset some of Afisha's costs for producing the show and newsletter; hire a Russian-speaking community member to continue conducting focus groups to evaluate and strengthen the show; and purchase supplies including an electronic Russian-English translator.

Sustaining this effort presented another challenge. When Dr. Inessa finished her residency program, the CPT partners had not identified a successor because her unique gift of being a Russian/English bilingual physician is not easy to replace. Dr. Inessa agreed to continue her monthly show via telephone. Meanwhile, she practices inpatient general pediatrics over 100 miles away in San Francisco.

They Did It, Too!

Indianapolis, IN:

"Preguntale Al Pediatría"

Riley Hospital for Children sponsors the Radio Program "Preguntale al Pediatra" (Ask the Pediatrician). This is a longitudinal service learning project using radio to promote child health and community resources to the latino community in Indianapolis and the surrounding area. The project is conducted in Spanish and entails a monthly, hour and fifteen minute radio show on 107.1 FM Radio Latina. The first portion of the show a resident reads a children's book. The next portion consists of a discussion of a particular pediatric health issue (such as discipline, immunizations, oral health, domestic violence, obesity etc). The remaining part of the show is open for callers to ask pediatric health related questions. All callers receive a free children's book sponsored by Reach Out and Read.

*-Courtesy of American Academy of Pediatrics CATCH Database
www.aap.org/commpeps/*

Still another challenge, met initially by the CATCH grant, is funding. For each free hour of radio show programming or each free column space in the newsletter that Afisha provides, this small organization loses money. CCC and interested community members searched for a continuous stream of funding and/or a sponsor for the show, but were not able to secure ongoing support.

Successes & Outcomes

Despite the challenges of sustainability, Linda says, “This is one of the projects in my entire career that I’m most proud of. We pulled together all the partners from institutions to the grassroots level. We dug into this community that was difficult to begin working with and utilized the resources we already had.” She says it was a difficult project for everyone but “we pulled it off.”

Linda believes one of the keys to success is that, “Everyone put in an equal amount of work and everyone brought something to the table. We didn’t look at it as people with titles. We all came together as equals who all have something to contribute to make the project successful.” As a result, the health message reached listeners far beyond the Sacramento area because the radio show was broadcast over the Internet and to other partner cities that have large Slavic communities.

Looking Back: Reflections and Advice from the Field

For those who might want to try a similar approach, Linda suggests they “take it step-by-step and look at the bigger picture.” Through their experience, the CPT partners learned that it is important for radio guests to speak the language. She also recommends partnering with a well-known co-host who can help the resident feel at ease on the radio and expand the listener base.

The ability to recognize people’s gifts and reframe deficits is fundamental to an asset-based approach. Dr. Inessa could have walked into the Rancho Cordova community and, like others before her, identified the Russian/English language barrier as a huge challenge for health and healthcare. Instead, for the first time, Dr. Inessa recognized that her native language was an asset and she employed it in an effort that has helped build a bridge across a cultural divide and educate thousands of people.

Tree, Turtle, Dog: Injury Prevention for Youth & Dog Owners

Keywords: After school programs, Dogs/Dog Bites, Elementary School, Ethnic Media, Injury Prevention, Park, Safety, Urban

The Community Context

Stress and physicians' training seem to go hand-in-hand. While the child advocacy rotation can add extra pressure to an already



hectic schedule, Dr. Stephanie Ryan discovered how to achieve her CPT goals with ease. Her idea for dog-bite prevention education was born after noticing common neighborhood activities and by drawing on her personal experiences as a dog owner and doctor.

During her first year with the Tahoe/Colonial Collaborative (TCC), Dr. Stephanie focused on learning about the community and putting her observational skills to work. A large park situated in the center of the community and across from an elementary school was one of the first features she noticed. "There are always kids walking home from school through the park, people walking their dogs, and dogs on their own without a leash – and you never know if they are strays or if their owner is across the park," she says. "In some of the less affluent areas of the neighborhood, it's common to see chain-link fences with dogs behind them. So, kids definitely encounter dogs in the neighborhood."

A devoted owner of a Siberian husky, Dr. Stephanie frequently walks her dog around her own neighborhood. Because her dog resembles "Demon," the star of the popular Disney movie *Snow Dogs*, "Kids are always running up, waving their arms, and yelling," she says. These types of behaviors can provoke even the friendliest canine, so when these encounters occur, Dr. Stephanie teaches children how to approach a dog safely.

Based on her Emergency Room (ER) experience, Dr. Stephanie had seen first-hand the potential consequences for children who do not know the appropriate ways to approach dogs. "I've seen kids bitten by dogs, some with minor wounds and one time, a child with bites to the face that needed stitches and would probably scar," she recalls.

Most importantly, she says that the majority of these traumatic events can be prevented. Dr. Stephanie maintains that dogs rarely bite when unprovoked. Rather, it occurs mostly because children are not usually trained how to approach a dog. Moreover, “Other children are just completely petrified the second they see a dog,” she says.

The Project

Dr. Stephanie pieced together her observations, interests and experiences into a doable project during her second year. To build on her existing knowledge and skills, she conducted some initial research to learn more about dog bite prevention education. “It was something I was already doing with my own dog, but I wanted to make sure that I was giving out the right information,” she says. While most of the research was on the Internet, she also contacted a few veterinarians and the Society for the Prevention of Cruelty to Animals (SPCA).



Led by Dr. Stephanie, children practice the “turtle” position taught to protect them should they encounter an aggressive dog

“The collaborative was essential,” Dr. Stephanie says when she describes why this project was so easy to carry out. The collaborative already sponsors educational children’s “camps,” so these groups provided a natural venue for health education. Holly Schlumpf, TCC’s program assistant, scheduled the sessions and organized the groups. The collaborative also coordinated with Tahoe Elementary school’s after school program and Colonial Park’s Mentoring Program to recruit participants. These settings “gave the doctors opportunities to test their skills and ideas,” Holly

says. Part of Holly’s role was to “initiate and encourage the participation of the pediatric residents.”

From her perspective, an important role of the collaborative coordinator is to help explain the CPT process to the pediatric residents, as well as provide space, tools, and access to the community so they can carry out their projects. She describes meetings with the CPT health professionals as an opportunity to “discuss *their* ideas about things to teach the children or possible events to hold in the community.” Additionally, Holly worked with the children to “help them see how they can put their

ideas into practice and feel proud of themselves.”

To advertise the sessions, TCC produced flyers and posted them on the elementary school fence so parents waiting to pick up their children after school would see them. Amreek Singh, the school’s Family Advocate and crossing guard, helped promote the opportunity to both parents and students. While some sessions were open to whoever wanted to come, the best turnout resulted from access to a “captive audience,” Dr. Stephanie says.

Dr. Stephanie believes that offering a short, interactive program is one key to success. “And as a bonus, the kids got to play with a dog,” she says. Rather than staying after school for a whole hour, young people participated in a 15-minute educational session and then practiced their skills with the dog. Holly says that the practice with live animals is one of the most outstanding features of this project. At first it was “really scary” for many people. “No one knew it was going to be a nice dog but we found out that it was actually gentle. It was visual and hands-on,” she recalls.

Dr. Stephanie taught the session in three short segments. First, they learned how to approach a leashed dog. Next, they talked about what to do if a strange or stray dog draws near. In the last segment, the group practiced their new skills. Interactive opportunities were built-in throughout the session. For example, she says, “If a dog approaches you, you’re supposed to stand like a tree. So we would practice standing still and letting the dog sniff.” Dr. Stephanie also demonstrated what happens when a child runs from a dog. “I have my dog on a retractable leash and I would ask one of the kids to run. Sure enough, the dog would chase, but after about 10 feet, he would come to end of his leash.” The group also practiced the “turtle position,” a protective response if someone is knocked down in a dog attack.



Dr. Stephanie (standing near the tree) engages with TCC afterschool program participants at the local elementary school while presenting her dog bite prevention program.

“Of all the projects, this was one of the best because of the hands-on teaching the children how to avoid a dog that is mad or vicious and that can save lives.” Holly believes this project is powerful because of its “real life” applicability and the opportunity for what she calls the “trickle effect.” That

is, “the children got practice in something that they will teach to *their* children or friends,” she explains.

The CPT partners also experimented with pre and post-test methods to incorporate interactivity into the evaluation process. First, they used a traditional paper and pencil multiple-choice test. Later, as a pre-test, they asked children to raise their hands in response to verbal questions while the collaborative staff counted responses. At the end of the session, the demonstrations of skills served as a post-test. Dr. Stephanie says that when they observed children teaching others, this also indicated learning. Some students attended more than one session and these repeat participants “would coach other kids on the right way to approach a dog,” Dr. Stephanie recalls. “Even in my own neighborhood, you can tell which kids I’ve taught. They hold their fist out to let the dog sniff; then they tell other kids how to approach if they want to pet the dog.”

Dr. Stephanie explained this project presented few barriers because, “it was low-tech and low-key.” The program itself was not expensive so funding did not present a challenge. Collaborative members helped promote the sessions. Dr. Stephanie held sessions in a public park and consequently, she “didn’t need a special permit or have to worry about liability inside the school.” There is not a great deal of setup required and “you don’t even need a real animal,” she says. “You can probably use puppets or a stuffed animal, especially with younger kids.”

Overcoming Challenges

Gaining involvement from other neighborhood dog owners was the biggest challenge. Dr. Stephanie spent “many afternoons approaching people in the park” and inviting dog owners to “bring their dogs and practice skills with the kids.” She also hoped that other community dog-owners would “listen to my presentation and teach other kids how to pet the dogs.” This community involvement could build connections among people in the neighborhood as well as sustain the project. “I got some but not many,” Dr. Stephanie says of her recruitment efforts, in part because many people work during after school hours.

When Dr. Stephanie experienced some challenges gaining participation from neighborhood dog owners, she turned to her fellow pediatric residents for support. Dr. Laura Hufford, who also works with TCC and owns a dog, allowed her small beagle to participate. “The beagle doesn’t look as menacing as my dog sometimes does,” Dr. Stephanie explained. The younger kids lined up to practice with the smaller dog while older, bigger children demonstrated their bravery with the big dog.

Holly agrees that this project presented minimal challenges. Overall, she says the most challenging part of CPT is getting some of the doctors to respond to phone calls and

email invitations to visit the kids or attend upcoming events. “I know they’re busy and overwhelmed with their training and some couldn’t stay in touch,” she says.

For others who may work with pediatric residents, Holly recommends that they, “Encourage them and offer help but don’t enable. They need to do their project on their own. Be available, give them access, resources and tools, and be persistent and consistent about checking in.” She also says the lines of responsibility need to be clear. “As a coordinator, I have things I need to get done too. We’re not responsible for them getting the project done but we are responsible for meeting our deadlines.”

Successes & Outcomes

The dog bite prevention workshops were “easy, fun, and served a purpose,” Dr. Stephanie says. She notes that national television news programs sometimes feature segments on what children should do if attacked by a dog. In fact, the UC Davis Medical Center’s public relations department recognized the value of featuring this project in the local media. They invited television news stations, photographers and print journalists to do a story about the CPT effort with a focus on the dog bite prevention project. TCC staff helped to organize participation for the media day. An interview with Univision gave Dr. Stephanie an opportunity to exercise her Spanish-speaking skills. As a result, a diverse range of children and adults across the region learned how to prevent dog bites.



Children pet Nanook (held by Dr. Stephanie) following her dog bite prevention lesson

One outcome of the CPT partnership with TCC is a binder that contains all the doctors’ projects. “What’s great about the book is that a program coordinator can use it to teach a lesson,” Holly says. Additionally, TCC shares this compilation of research and curricula with other community groups. In this way, the work of the residents creates that same “trickle effect” and provides a resource for sustaining projects after they leave.

Holly says one important accomplishment of the CPT program is that both children and doctors learn from the projects. “It wasn’t just the children learning or just the

doctors learning but *both* benefited,” she observes. “It was so much fun working with the doctors and see them become more community minded,” Holly says of the CPT program. “They’re trained to be in one room with four walls, to prescribe medicine for aches, pains and ‘owies.’ This gave them a chance to get out in the community and get a feel for what people like us (coordinators) engage in on a daily basis.”

Reflecting on the unique training she received at UCDCMC, Dr. Stephanie says, “In most programs, there is no formally structured time for community work. You would probably only get that experience if you pursued it on your own. CPT provided that structured time throughout our three years and forced us to do something.”

Dr. Stephanie says she learned that, “Most community groups are happy to partner with a healthcare professional and have a physician be part of and contribute in some way.” She says the success of community-physician partnerships, “Depends on expectations – the organization’s expectations of the physician and the physician’s expectation of the organization. It’s like any relationship; if discussed, then it will work.”

Though she believes the usefulness of this project is an important accomplishment, from a personal standpoint, Dr. Stephanie is most proud that, “I kind of did it myself.” She thought of the idea and carried out most of the activities. Compared to other residents who may get involved with large, technical studies with thousands of patients, a big budget and a long list of faculty who participate, Dr. Stephanie says her project is very different. She describes it as, “Not better or more important, but more grassroots and in the community.”

As a result, Dr. Stephanie says she is “more aware of the communities and the situation for some of my lower socioeconomic kids...how kids live and some of the struggles they go through.” In addition, CPT provided Dr. Stephanie with a “foundation” to build her work with the community. “I will be more likely to seek out things like the collaborative in the future. Knowing that these kinds of organizations exist, I’m more likely to try to connect with them.”

Looking Back: Reflections and Advice from the Field

For those who may want to begin a similar project, Dr. Stephanie advises people to “go for it” and stresses how easy it is to implement. For groups concerned about liability and working with live animals, Holly says its important to receive permission for participation from children’s caretakers and give children a choice whether to attend.

Holly emphasizes ways to engage young people and says, “Get down to their level. Sit down, have lunch and talk to them about what they enjoy, their favorite things, recent

movies they've seen. Get personal without getting into their personal life." Holly also recommends providing children with the opportunity to be leaders, especially the "naughty" ones. Giving them responsibility gives them "a boost," she says. "They get to feel grown-up and help others, for example the faster ones help the little ones and they learn to work as a team."

By working together, Holly says, "I learned the doctors are people, not machines. They do have compassion and heart." Despite their years of medical training and high incomes, she now realizes that she doesn't have to be "intimidated" by doctors or think of herself as "less than." Holly sums up the contributions each provided to the partnership and says, "They work really hard and do an amazing service to the community. And we were there to help them learn more about the community."

Rural Roadrunners: Yuba's "Drive" to Health

Keywords: After School Programs, Bilingual, Diversity, Elementary Schools, Faith-based Organizations, Local Business, Obesity Prevention, Physical Activity, Rural

The Community Context

During the first year of his child advocacy rotation in Yuba County, Dr. Zackary Taylor conducted an asset-mapping exercise and found inspiration at Riverside



Restoration Center (RRC), a faith-based non-profit organization. He recalls that RRC founders Mary and Michael Hunt had just restored their home next door and remembers being impressed with the environment they created right across the street from Cedar Lane Elementary school. Located about 45 miles from Sacramento, the Linda neighborhood is home to many Hmong and Latino families. In past years,

neighbors worked with the Yuba Community Collaborative for Healthy Children (YCCHC) to build a community garden. Their efforts have helped overcome the stigma associated with the area's high rates of poverty, child abuse, and substance abuse.

Because of the distance from Sacramento, Dr. Zack's presence in the community was limited. So when he began project planning in his second year, he wanted to do something fun that would generate enough enthusiasm so people could operate in his absence. The previous year, he participated in roundtable talks with local parents, organized by YCCHC member Dr. Arnold Gold.

From these discussions, Dr. Zack remembered that more after school activities were high on parents' wish list. He also knew area parents had concerns about child nutrition and obesity, based on a recent survey conducted by pediatric resident Dr. David Petersen. After learning about Home Run for Health, a successful CPT project in Sacramento that featured exercise contests, Dr. Zack began to think about how to adapt the idea. He decided to design a project that would encourage school-aged children to exercise by combining fun, education, and rewards.

RRC "seemed like a good fit," explained Ms. Theresewynn Rodgers, former YCCHC

Coordinator. They already ran an after-school program to help children stay off the street and had an open field that could be used for exercise. RRC offered homework support, a computer room, air hockey, and snacks. Adding a health component made sense. They had the “place and space” without the “red tape” barriers of the school. And they had Mary, who Dr. Zack describes as “actively engaged,” “enthusiastic,” and “willing to do anything for the kids.”

Mary says she has “the heart for the kids” because she sees how they live and grow up. Drug abuse is a long-standing neighborhood issue, with methamphetamine sold at nearby homes and the river bed. “Some are street kids. They’re not able to go home too much because of drug activity. After school, they become bored and that’s when they get into trouble.” RRC offers safe, drug-free activities and “meets them right where they are.” Mary explains her motivation and approach,

“We serve the community we live in and we build friendships with the people here. Working with the poor is something that we’re called to do and we look at it from a different perspective. We work from the inside out, not the outside in... We have a building, but we’re outside the walls.”

The Project

With the main partners in place, YCCHC prepared a bilingual flyer and permission slip to announce the program and invite students to participate. They also used the opportunity to collect more data and attached the nutrition survey. About 40 children joined the project. It was a diverse group, with students from grades K-6 and a variety of ethnic backgrounds. They divided into teams and for two days each week, from October through May, the students exercised for about 30 minutes in the activity of their choice. Basketball, soccer, and running games were common, but jump rope proved to be a surprising favorite.

The original concept included an educational component so



Children at the Riverside Restoration Center’s after school program get excited about exercise, using hula hoops and other equipment

children could learn by doing while having fun. Dr. Zack explains, “The idea is that kids learn how to exercise and stay healthy while they’re actually doing it, not just sitting in a classroom listening...or out exercising and having fun without knowing why.”

Dr. Zack procured donated pedometers and created a super-sized map to help track their steps. The goal was to log enough steps to walk from California to Oregon and back. Certain milestones, such as 25,000 steps, were converted into miles and marked on the map so students could compare their distance to major geographic landmarks such as San Francisco’s Golden Gate Bridge. Theresewynn tallied the students’ steps on a daily basis. When teams reached a new milestone, such as 25,000, 50,000 or 75,000



Dr. Zack and Theresewynn (center) play a game with participants at the Yuba’s Drive to Health Celebration

steps, they earned a prize to help them continue their activities. Donations from area chain retailers allowed the project to purchase basketballs, air pumps, and other supplies.

In addition to tracking steps to measure progress, Dr. Zack integrated other health indicators into the program. Ms. Carlene Brown, a school nurse, recorded the initial height and weight measurements using a donated scale. They also monitored blood pressure and asthma symptoms. Later, the first year CPT residents undertook this task in order to be introduced to the project and to get to

know the children. Project organizers also hoped the interaction would build buy-in and generate interest among new residents.

Through Dr. Gold, the CPT partners learned about funding offered by Gweke Ford. Dr. Zack applied for the funds and with Theresewynn, made a presentation to the sales team. After receiving a mini-grant, they named the project in honor of the auto dealership’s contribution and used the funds to reward the children’s efforts with an end-of-the-year celebration.

By the end of the project, students combined steps totaled 373,367. Originally, Theresewynn recalls that they intended to have a parade to celebrate but, “concerns about liability and permits made this unworkable.” So the project opted to host a field day instead. The celebration offered healthy food and a variety of activities such as a water balloon toss and tug-of-war. The Yuba County Health Department and other

CPT collaboratives donated prizes. All children received a T-shirt and a certificate. The highest twelve steppers were awarded a new pair of shoes, purchased by Dr. Zack. “The tennis shoes were a big deal to the kids in this neighborhood. It was a great reward plus encouraged physical exercise,” Mary recalls.

In the final year of his child advocacy rotation, Dr. Zack worked with Theresewynn to evaluate the project. He designed a survey that Theresewynn administered in a focus group with 18 children who had regularly attended the program. They all could identify reasons to exercise and describe different types of physical activity. And, most importantly says Dr. Zack, they all had fun. Mary observed that all the children enjoyed a little competition and the opportunity to win a prize provided motivation. She also says the project helped them feel good about getting exercise and to “get their energy out” so they could sleep well at night.

Overcoming Challenges

Despite the success, the CPT partners encountered several challenges. Area families moved frequently and because of the high mobility, Theresewynn says it “was like a revolving door” for a lot of the children. This made it difficult to keep students in teams so they adjusted by switching to individual accumulation of steps and based the competition on individual rather than team effort.

Engaging parents and other volunteers also proved more difficult than the CPT partners anticipated. Initially, they thought parents would attend the program and exercise with their children. However, the CPT partners suspect that parents were often unavailable during the hours after-school. Mary recruited a few volunteers from the church community, but they were unable to establish consistent participation.

Inconsistency also occurred in the data tracking process. To “see if we made a difference,” Dr. Zack attempted to determine if there were objective improvements in the children’s weight measurements. But there wasn’t enough data at the end of the year because all the measures didn’t get taken. In his reflection, Dr. Zack says,

“I think some of the intention got lost in translation. It’s a fine line between harping on people to do things and getting them disillusioned. I think you have to be cheerleaders sometimes. Encourage people and then maybe gently remind them, ‘Did you remember to chart height and weight?’ You have to remember, they’re not getting paid to do this.”

Coordination and sustainability remain the greatest challenges for the project. Dr. Zack graduated, the new residents pursued different interests, and YCCHC experienced several organizational changes. After the executive director left for a new position,

Theresewynn no longer had time to monitor the children's progress. To cope with the changes, they reduced the program to 4 months and trained a community volunteer to keep time and track steps. But the volunteer was unable to continue. Then, expecting a child, Theresewynn resigned. This marked another turning point for YCCHC. The collaborative hired a new Coordinator, but she focused her efforts on administration rather than direct involvement with program activities.

"It was a big disappointment that it wasn't sustained," Theresewynn says. To make it work, they "needed more community volunteers and a project organizer." Dr. Zack believes that the project relied too much on the pediatric residents and that there must be someone willing to work with the kids on a daily basis. He says he learned that, "You have to have one central person or this doesn't work. And, that person must be invested." When he tried to engage other residents who wanted to pursue their own ideas, Dr. Zack found that passing on enthusiasm to others presents additional challenges.

Mary concurs and remarks, "It's hard when you have to work with volunteers who do things on their own time." She's tried to keep a scaled down version of the program going. However, RRC's after school program is different now too. It's less structured and operates more on a drop-in basis. Attendance is down since the school began offering their own after-school program. About 20 children continue to exercise 15 minutes a day. The children still have access to the pedometers and Mary continues to track their steps. RRC laid cement in front of the building so the children can jump rope and is working with the schools to locate a standard jump rope, which are difficult to obtain locally. As the program runs out of Velcro ankle bracelets for the pedometers, Mary is not sure how they will replace them. Though it's not expensive equipment, there is a cost.

Successes & Outcomes

Throughout the community, there continues to be a focus on providing healthy activities for children. YCCHC has since merged with Harmony Health Resource Center, a nonprofit family resource center located in Linda. Members include agencies, businesses, and neighborhood residents. Director Rachel Farrell explains, "The goal is to create a community where people are self-sufficient and civically engaged, to let people know that their voice counts, to get their ideas about how they want their neighborhood to look, and to help *them* learn how to do it."

A community volunteer now coordinates monthly meetings and collaborative members choose a project to carry out. On *Make a Difference Day* more than 100 people revitalized a park in East Linda, including laying a new basketball court. YCCHC organized volunteers from Girl Scouts, Club Live, Youth Build and Beale Air Force

Base and recruited corporate sponsors, local politicians and donations. The Collaborative also sponsored a series of cooking classes. Gardening and sports are next on their agenda. Rachel hopes new volunteers can be recruited for Yuba's Drive to Health.

CPT residents continue to work with Harmony Health Resource Center/YCCHC to implement health improvement projects. Rachel says, "Having the residents involved has been fabulous for them and for me. I get to see things in the County that I wouldn't normally take the time to see, places I don't usually frequent like schools and churches."

Looking Back: Reflections and Advice from the Field

To replicate a project like Yuba's Drive to Health, Rachel advises people to plan for sustainability by engaging the community or selecting a project that has a defined endpoint. For example, one of the current pediatric residents plans to work with school children to design a mural. This type of project creates a long-term visual reminder but doesn't require continual time and energy. Mary suggests that project planners think about who will take over if a key person leaves.

"Having fun is the most important part of sustainability," Dr. Zack says. He encourages project planners to explore their community to discover with whom they best connect. Dr. Zack believes that one of the successes of the project is that "everyone really had fun and got along." The experience taught him to "look at communities with fresh eyes." He recalls that, "Before I did the advocacy rotation, I didn't really know what was available in the community. People say they want to do things, but you never really know. But I learned that they really would come forward."

All involved agree that project sustainability not only requires a designated person to coordinate activities, but also clear expectations among all the partners. In this case, there wasn't a common understanding of roles and some

They Did It, Too!

Boothbay Harbor, ME:

"Fit for Kids"

Fit For Kids is an after school program designed to promote behaviors that assist in developing and maintaining cardiovascular health in school-age children ages 5 to 10 years old (K - 5th grade). There are four program components, food service (Eat Smart), physical education, classroom, and family which are implemented together in a coordinated approach to child health. This project is a collaboration between St. Andrews Hospital and Health Care Center, the Boothbay YMCA, and the Boothbay Schools.

*-Courtesy of American Academy of Pediatrics CATCH Database
www.aap.org/commpepd/*

of the underlying philosophical concepts. Rachel says she's not sure that everyone understood the concept of what CPT residents do. "They're only here for two weeks. Their role is to facilitate a project that can continue in their absence." And while Theresewynn went above and beyond expectations for a coordinator, Rachel expected that her duties would be assumed by a RRC volunteer.

Rachel says, "Even though we offered training in asset-based community development, it's like speaking a different language," especially when cultural and language barriers exist. To truly develop understanding, people need to "hear it more than once." She believes that ABCD needs to become a way of seeing the world, especially for the residents. "It needs to be a concept they live and breathe by in their lives and in their practice. It's a big paradigm shift." Rachel explains,

"It's a very different approach. Taking a step back to allow a project to become; by the people who come. You can't try to control it and that's very difficult for people in power. You've got to allow the people in the collaborative to create their own vision and then do what you can to support it."

Tossing Things Up: The Frontier Elementary School Salad Bar

Keywords: Alumni Associations, Food Service, Nutrition, Obesity Prevention, PTA, Policy Change, School Lunch programs, Suburban, Title I schools

The Community Context

Sometimes, it's all about timing. In North Highlands, organized people, a climate ripe for change and a physician's motivational presentation helped community "readiness" reach the tipping point. Former CPT resident Dr. Uyen Truong says she can't take



*Sacramento Head Start
Alumni Association*

much credit for instituting healthier lunches at Frontier Elementary School. But her presentation to parents and administrators helped inspire the Parent Teacher Association (PTA) to immediately begin fundraising for salad bar equipment. Within about three months, they raised \$5000 and students gained access to a new lunchtime option.

Though progress seemed swift, the salad bar project is one outcome of a longer-term effort to address childhood obesity in Sacramento County. John Berchielli, coordinator of the Sacramento Head Start Alumni Association, says that the introduction of salad bars in the Rio Linda Union School District responded to a community need.

At the same time school districts in California experienced serious budget cuts that eliminated funding for physical education, the issue of childhood obesity was drawing increased attention. During a local Maternal Child Adolescent Health meeting, John recalls that Sacramento's health officer described childhood obesity as the greatest preventable epidemic for children in the county. However, because there was no money to address the issue, any response would need to be community-driven.

As a long-time advocate for children's health, John maintains connections to many key leaders in the area. This is especially important for his North Highlands community where about 30% of the population is below the age of 18 and most families earn well below the State's median income. He helped establish the Sacramento Head Start Alumni Association to help facilitate parents supporting each other in the journey toward financial independence. Since first forming, John says, "A lot of Alumni have progressed in their lives. Now they are Head Start staff; others are county employees.

Most have evolved from dependence on the system to self-reliance and independence.”

Assisted by John, CPT resident Dr. Thao Doan helped bring together stakeholders to form a countywide Obesity Prevention Task Force. Al Schieder, Director of Food Services for the Folsom-Cordova Unified School District, attended the initial meeting. “He had just been recognized nationally as a best practice model for school food service.” John recalls. “He had come from private industry and completely turned the cafeteria around. He made the cafeteria look like a mall food court. Every day they offer several different options, including vegetarian.”

Mr. Schieder’s redesign of the school lunch menu eliminated soda, junk and ala carte foods while increasing revenues and participation in the school lunch program. One of the many innovations included the addition of a “garden bar” with fruits and vegetables in every elementary school. John recalls another impressive outcome: the district “went from one of the lowest sellers of milk in the State to the highest.” Following the meeting, “We went back to the Rio Linda Union School District and shared the information that we learned. Then we sent representatives to visit the Folsom program to see what could be duplicated.” John explains.

The Project

By this time, Dr. Uyen Truong had begun her placement with the Head Start Alumni Association and had completed her orientation within the North Highlands community. She accompanied the group on the site visit to observe the Folsom-Cordova program. She recalls, “The first time I went to see the salad bar, John introduced me to the food services staff. They were so enthusiastic and excited about everything.”

The group returned and reported their observations to the Rio Linda Union School District Parent District Advisory Committee (DAC). Of all the strategies they observed, John says the site visit group recommended the salad bar idea because it would be the “easiest to implement first.”

However, buying new equipment was not an option for the District during a period of budget cuts. “If we wanted to do the salad bar, schools would need to raise the money to buy the equipment. Enter Dr. Uyen Truong,” John says.

Dr. Uyen introduced the idea of the salad bars in presentations to both the PTA and Site Council at Frontier Elementary School. She discussed the need to address child nutrition from a community rather than a clinic setting. “Parents and the administrators had lots of questions about the potential benefits versus the costs of the salad bar and whether or not the kids would use it,” John remembers. “Because she’s a

pediatrician, they responded to Dr. Truong's endorsement of the salad bar as a way to improve health."

Two other elementary schools in the district were the first ones to raise enough money to implement salad bars. The Madison school kitchen staff developed the menus, including figuring out the best way to prepare the foods to encourage kids to try different fruits and vegetables. For example, they discovered that sliced apples and quartered oranges were more popular than whole fruit. Madison Elementary offered a full salad bar option where students could either choose a traditional hot lunch or make their own salad. Hillsdale Elementary offered the salad bar as an optional side to the standard hot meal.

Dr. Uyen accompanied leaders from the Frontier Elementary PTA and Site Council on tours of these schools to observe the salad bar programs. It quickly became apparent that students preferred the option of making their own salad. Because children need to be supervised in order to ensure they take the proper number of food servings, Madison had divided the cafeteria so that students who chose the salad bar sat on one side. "We saw more than 85% of the kids choose to make their own meal at the salad bar versus getting a hot meal," John recalls. "The biggest surprise of all was for the custodian who noticed a big reduction in lunch waste and had a lot less food to throw away." The group also saw a "dramatic difference in the way the kids looked, the liveliness, and interaction."

Based on observations from the group's site visits and Dr. Uyen's recommendations, the school decided to try the salad bar. "From then on," Dr. Uyen says, "the PTA took the idea and went forward. They did all the fundraising. I take very little credit." She believes the implementation occurred so easily because, "The community had already recognized the need for better nutrition. There were already school gardens happening and the desire for better, fresher fruits and vegetables." Despite Dr. Uyen's protests, John says her contribution "validated that eating healthier foods leads to better results and the salad bar is one way to accomplish that goal."

Overcoming Challenges

Like many other CPT residents, Dr. Uyen says time was the most challenging aspect of the project. "There are so many other obligations versus the desire you have to contribute more," she says. Time also is a hurdle from the community group's perspective. John describes the biggest challenge as scheduling and limited access to residents. "You can't get residents when you need them," he says. "Only when they're available and even during their community rotation, the residents are not totally free."

Though John acknowledges that Dr. Uyen's involvement was limited, he says this

project probably has had the biggest impact of all CPT projects. He explains,

“After Frontier Elementary implemented the salad bar and duplicated the results from other schools, we shared that with the DAC parents, who encouraged the District to pick up the tab and replicate the salad bar at other schools. The District couldn’t do it, but said if you can raise the money, then the food service department will support you. So, other schools started salad bars. Then, the ‘Feds’ required all Title I schools to develop a health and wellness policy. The wellness policy the school board adopted in 2006 says that all schools in the District will have salad bar programs within two years. So, the salad bar is no longer voluntary. This affects 10,500 kids.”

Next year, that number may increase to 30,000 students if voters adopt a proposed reorganization plan to combine five school districts.

From the standpoint of a busy physician, Dr. Uyen believes this experience proves you don’t have to be “a one-man show” or “deeply involved every step of the way” in order to accomplish a project. “There were contributions and work from many levels of the community, whether it was a student, teacher or parents. So that even with the hectic schedule of a physician, you can help a community to do something for the kids,” she says.

Aside from time, there are differences in the work environment of physicians and community groups that can present challenges to pediatric residents. Dr. Uyen says, “When you come from a very structured educational environment and suddenly there is no schedule to tell you what you need to accomplish by when...that can be very hard for those of us who have a particular mindset.” Goal-oriented physicians who are accustomed to achieving clearly defined objectives sometimes may find working in an unstructured environment “inhibiting,” Dr. Uyen explains. “For example in your first year, you are supposed to accomplish something, but you’re not sure what.” She says in contrast, people who have worked in a community setting for a long time are “very patient and willing to wait for laws to pass and things to come together.”

In terms of sustaining the salad bar, a big challenge is finding monitoring staff. The state requires salad bar monitors to ensure children have a minimum serving from the different food groups. John describes current employees as “stretched to their limits” and even if the school district had a designated position for “salad bar monitors,” it would be difficult to hire staff for only 45 minutes a day.

So far, the district seems to have found a creative solution. Recently, the half-day kindergarten program converted to a full-day program, freeing up bus drivers during the middle of the day. “So we’re training them to be salad bar monitors and they are

able to keep full-time positions, along with their benefits,” John explains. “We need to develop a training mechanism or constantly recruit new volunteers, or integrate by training older students to be monitors for younger students.” He says they are still trying to figure out the best model.

Successes & Outcomes

The Obesity Prevention Coalition has grown and gathered momentum across the county since the initial meeting Dr. Thao helped organize. “This year it’s hosted by Kaiser Permanente,” John says. “They provide meeting space and mini grants for Coalition pilot projects.” The Coalition is also now a formal subcommittee of the county’s Public Health Advisory Board. According to John, this is the first time a non-mandated, unfunded grassroots group has gained this status. John now serves as the Coalition’s vice chair. Reflecting on his evolving role, he says, “Don’t be surprised if a project turns into a lifelong career.”

So what did the partners learn during the process of creating partnerships between community groups and physicians? “When you bring the two together, you discover previously unknown solutions,” John explains. He also notices a change in how community members perceive doctors. “Whenever I introduce residents, it’s a new revelation to the community members to learn that the health professionals are interested in advocacy and not just treatment,” he says. As a result, “People see doctors in a different light – as people who actually care about the community. It shows that doctors care about you as a person, not just about making money.”

Dr. Uyen says the CPT experience “definitely changed my perspective on the role of the physician in a child’s life. Physicians should be more involved with children outside of the clinic or hospital setting,” she says. In contrast to the “usual approach” to obesity prevention that involves “educating and telling,” Dr. Uyen describes the role of the physician in a community setting as a

They Did It, Too!

San Diego, CA:

“School Board Advocacy”

The resident involved with this project presented/testified at school board meetings to educate school board members about how obesity affects school performance, self-esteem, and physical/mental health with the goal of changing/modifying school policy regarding what foods are served through the school lunch program. This project focused on one school district.

-Courtesy of American Academy of Pediatrics CATCH Database
www.aap.org/commpepd/

“physician observer” and says,

“When you’re in the community, it’s easier to see what is at the root of the problem and what the issues really are. Then you can begin to understand why the problem exists. Is it because grocery stores are not accessible? Is it that the community only has access to low-quality groceries and therefore chooses to eat other things?”

She contrasts this to working with children and families in a clinic setting.

“It’s really frustrating to talk to the family for 45 minutes or an hour about the dangers of obesity and what can happen if the child doesn’t lose weight. Families want a specific plan and want your help to map it all out: what to eat, how much to eat, how much exercise to get and that kind of thing. But in between visits, there’s no weight loss because they’ve gone back to their usual behaviors and approach to eating. If you work with the community to alter the environment so that kids have better options and fresh food, and you actually change the environment, it makes a bigger difference to address obesity.”

Looking Back: Reflections and Advice from the Field

“Take the time to go observe a community that is practicing what you’re thinking about implementing,” John suggests. He cautions others who want to try a similar project to start small and “try it before you buy it” because the same approach may not work in every community. He also recommends developing a good relationship with the county health officer. John credits the Sacramento County Health Department with their willingness to share staff resources despite a lack of funding for obesity prevention. “We work together to pursue health grants,” he says. “If you don’t bring all players together, you won’t be successful. A fragmented approach results in fragmented results.”

Finding “someone who intimately knows the community” is essential for physicians interested in an asset-based community approach to health improvement. “Be sure that the idea comes from them and work from the inside out,” Dr. Uyen says. She also recommends that community members target residents because, “They’re idealistic and want to change the world. They also have the most up-to-date information. These can be great assets for community projects.” However, the drawback is that physicians are in residency for a very short time.

By working together, health professionals, school personnel, parents and community groups successfully altered the food environment for thousands of young people. School lunches now provide students with more nutritious, culturally appropriate choices. In the process, one pediatrician learned how a small investment of time can

Section Three:



Lessons Learned About Creating Community Health Partnerships

After more than five years and dozens of child health improvement projects, the Community-Physicians Together (CPT) program has amassed a treasure-trove of wisdom. Some common successes, challenges and lessons learned are presented to help inform others who would like to establish similar efforts in their own communities.

PROUDEST ACCOMPLISHMENTS

Among all the successes, physicians and collaborative coordinators alike frequently point to two areas of accomplishment of which they are most proud: the collaborative effort and the young people. A third area includes the ability to bridge cultural divides. Learning is embedded in all of these successes: learning to see people in new ways, to work together effectively and create new opportunities for young people to positively impact their health.

Collaboration

For most CPT participants, the collaboration itself is a major accomplishment that allowed multiple partners to join forces, overcome barriers, and establish a sense of equality where all contributions are valued. The ability to be creative and have fun is too important to overlook – especially when working with children and volunteers. Physicians and community members alike often noted how much fun they had working on CPT projects.

As a result of working collaboratively, the CPT partners developed cost-effective projects that impacted dozens, if not hundreds or thousands, of children and their families. Their ability to involve people from diverse sectors – especially the grassroots – and leverage resources surprised several pediatric residents and even some seasoned collaborative coordinators. As one former CPT resident recalls, “People donated time, products, prizes and I didn’t have to spend my own money. It really was grassroots and included people from all aspects of the community. Looking back, it was a huge collaborative effort. Wow, we got a lot of people involved.”

Likewise, working together to create new opportunities and choices for young people also is a source of pride. Whether at home or school, hundreds of young people now have more options to choose nutritious food. “They learned a whole new way of doing things that is healthy and tastes good,” says one collaborative member.

Contributions and Accomplishments of Young People Through Hands-On Learning

Community members and physicians frequently say that the most satisfying outcome was seeing children acknowledged for their contributions and participation. Through their involvement in CPT projects, many youth experienced a sense of personal accomplishment and pride – for example, when they produced their own cookbook and prepared their own recipes for visiting dignitaries or took more than 10,000 steps to complete an exercise challenge. Witnessing the young people’s pride and being a part of their “shining moment” made the effort extremely worthwhile for many of the CPT adult partners.

Learning also is an important outcome for CPT participants – young people and adults alike. Most CPT projects used an interactive, culturally competent, and participatory approach to health education to cover topics such as injury prevention, nutrition, and immunizations. A particular source of pride is the *hands-on* approach to learning that created a ripple (or “trickle”) effect among youth and within the community. Some knowledge will be shared through personal networks; for example, one young person teaching another how to approach a strange dog or prepare a fruit smoothie. In other cases, the ability to replicate the education is more structured such as the new salad bars offered in school lunch programs or the health education curricula developed by pediatric residents and shared with groups throughout the region.

Bridging Diverse Cultures & Engaging the “Grassroots”

By connecting physicians and community members, the CPT partnerships helped build new relationships and understanding between people who typically don’t relate outside of the formal roles of doctor and patient. In most cases, these projects were the first time community members and doctors interacted on equal ground. Working together to plan a health fair, deliver a radio show, or develop new food options enabled the partners to creatively include segments of the community that often are left out or “hard to reach.”

This is especially true for youth, as well as people who have low incomes or do not speak English. From bilingual flyers and Slavic community focus groups to the involvement of culturally diverse businesses, media and nonprofit organizations, pediatric residents learned how to effectively cooperate with people from Latino, African American, Hmong, Slavic, Asian American, and Caucasian ethnic groups. In turn, community members began to see doctors as accessible, approachable people who are genuinely interested in the well-being of children and their community.

OVERCOMING BARRIERS TO CHANGE PERCEPTIONS AND ROLES

There are some differences between community and university-physician cultures that can present challenges for a partnership. Pediatric residents are immersed in a very structured educational environment. “We’re always told what to do verses in the community, no one is telling you what to do and it’s very scary,” says one doctor. Working in the relatively fluid and unpredictable community environment is a entirely new experience for many doctors. Consequently, there is a learning curve when it comes to understanding their role and what they may be able to accomplish during their placement.

On the flip side, collaborative coordinators often described barriers related to the perceptions community members commonly hold about doctors. Frequently, there is an “intimidation” factor operating and community members may feel a difference in status that prevents them from engaging as equal partners.

One of the most important outcomes of community-physician partnerships may be that it “changes how a community views doctors.” Children and parents alike begin to see doctors as “normal people.” Participants also believe that interactions with the pediatric residents may ultimately impact how young people perceive doctors. As one pediatrician notes, “Over the long-term, they probably see their doctor as a more approachable person in general and maybe the medical profession as more accessible.”

Its All In A Name

Often, this shift is facilitated by dropping the formality of the title of “doctor” and instead, inviting people to call physicians by their first names. The ability to talk on a first name basis helps break through some cultural barriers and allows community members (including young people) to look beyond the title and see doctors as people. Additionally, this process helps to establish an atmosphere of equality – where the gifts and contributions of all participants are valued. Some reflections from collaborative coordinators highlight how perceptions change:

“I learned everyone brought something to the table. We didn’t look at it as people with titles. We all came together as equals and we all have something to contribute to make the project successful.”

“It’s a new revelation to the community members to learn that the health professionals are interested in advocacy and not just treatment. People see doctors in a different light – as someone who actually cares about the community. It shows that doctors care about you as a person, not just about making money.”

“Physicians are just like us if you can get through their persona. My biggest concern was making sure the mentors weren’t afraid and intimidated by the doctors. If I could get through to the kids that they are people who genuinely do want to help you, then that helps them not be intimidated.”

“I learned the doctors are people, not machines. I was just very intimidated at first. I looked up to them and looked at them as higher than me. They make the big bucks and go through all those hours of medical school. I learned I didn’t have to be intimidated and I don’t have to think of myself as less than. They do have compassion and heart, especially the ones we work with because they’re working with children.”

People, Not Patients: Understanding the Community Context

Likewise, through their child advocacy rotation, pediatric residents learn to see children within the full context of their lives, not just as patients. That is, they observe children as real people who go to school, play, and ride bikes. As the pediatric residents work in partnership with community members, they often develop a deeper appreciation and understanding of the challenges encountered by people with limited incomes.

Through their community observations and interactions, pediatricians learn how neighborhood conditions affect children’s health and their families’ ability to support a healthy lifestyle. As a result, they have a better appreciation for the reasons why someone arrives late for an appointment or is unable to follow through with medical advice. Comments from several pediatricians illustrate what they learned:

“Now I have better insight, if somebody is late, why they’re 30 minutes late for an appointment. Sometimes people have really good reasons.”

“I’m more aware of the situation for some of my lower socioeconomic kids. I’m more aware of how kids live and some of the struggles they go through.”

“They’re not just patients. Getting to know what their lives are like outside of the 15 minutes we see them every three months, I have more realistic expectations. I understand the context of their lives, why they may not be able to follow medical advice if I tell them to get more exercise but it’s not safe to play outside or eat more healthy food but there’s not enough money.”

Several doctors said they were surprised to learn that community members often are willing and happy to partner with a physician. In addition, the doctors’ CPT experience enabled them to learn about what is available in communities and as a result, say they are more likely to work with community groups in the future.

"Knowing that these kinds of organizations exist, I'm more likely to try to connect with them."

"It was very surprising to me that health-care professionals are so very welcome into communities and that our thoughts and ideas are well received."

"The enthusiasm is there if you have the time to take advantage of it. If you're willing to work with the community, they're more than willing to work with you... Before I did the advocacy rotation, I didn't really know what was available in the community. People say they want to do things, but you never really know. But I learned that they really would come forward."

CONTRASTING APPROACHES FOR CHILD HEALTH IMPROVEMENT

CPT participants identified several ways that an asset-based community development (ABCD) approach differs from the usual approach to improving children's health. Typically, the physicians' role take place within the context of providing healthcare services in an office or hospital setting. The doctor asks, "What are the problems and how can I fix the problems?" As the 'expert,' the physician tells patients what to do to improve their condition. As one pediatrician explains, "The usual approach involves educating and telling." Another says that the usual approach "is not really geared to teaching children about their own health" because the information is typically presented in a lecture format that is disconnected from the child's actual experience. This may be partially explained by the training physicians receive because usually "there is no formally structured time for community work."

In contrast, CPT provides structured time to work in the community throughout the three years of residency. Working with the community requires physicians to be "participant observers" and to use "a mutual give-and-take" style in working with families. "The role of a physician when entering a community is to no longer take on the role of dictating what should and should not happen," says one former CPT pediatric resident. Motivation for projects often develops based on the residents' observations of the community combined with their own interests, skills and passions. As they begin to build relationships and develop an understanding of community conditions, shared interests emerge.

An ABCD approach does not require a physician to "know it all," "be perfect" or operate as "a one-man show." Rather, doctors enter the community with an open mind so they can discover what people in the neighborhood want. Both collaborative coordinators and CPT doctors emphasized the importance of getting to know the community *before* offering ideas for solutions. Observing, listening and taking time to build trusting relationships are key. One former CPT resident recommends flexibility

and offers this advice, “The community may not share our priorities. Don’t be so set in your ways and what you want that you don’t listen.”

The questions a physician asks change as well, for example, “How can *we* fix the problem within the community?” The physician’s role is to recognize that “most solutions already lie in the community” and to ask, “How can I help people to invest in themselves and in the community and really help each other?” As one community-based physician explains,

“It’s a very different approach, a paradigm shift. Taking a step back to allow a project to become... by the people who come. You can’t try to control it and that’s very difficult for people in power. You’ve got to allow the people in the collaborative to create their own vision and then do what you can to support it.”

Size and scope are other areas in which an ABCD approach differs from the usual approach to improving health. Several former CPT residents contrasted their projects with other health improvement efforts and described them as “smaller,” “more grassroots,” and “community focused.” For example, Han Vu’s Child Health and Safety Fair concentrated on a specific population and advertised through the school and by word-of-mouth. In contrast, a health fair sponsored by local health organizations drew people from across the Sacramento region and used major media outlets to advertise. Likewise, Dr. Stephanie Ryan discovered that her project differed greatly from most others that were presented at a physicians’ professional conference. Her project did not involve “50,000 patients and a big budget.” Rather, it was “more grassroots and in the community.” She concludes, “I’m not saying it was better or that the other projects weren’t important; mine was just very different.”

The CPT experience introduces new possibilities for the role of a physician in health improvement. Several former residents say that as a result of CPT, they recognize more possibilities for working in partnership with the community. While some believe this may be easier for physicians who have regular patients, others acknowledge that “there is definitely a role for doctors to play outside of the hospital.” Several physicians describe the impact of the CPT experience on how they work as a physician:

“It definitely changed my perspective on the role of the physician in a child’s life.”

“I look at primary care differently.”

“My approach is completely different now.”

FREQUENT CHALLENGES: TIME CONSTRAINTS AND COMMUNITY ENGAGEMENT

Time is one of the biggest challenges encountered by pediatric residents during their child advocacy rotation. “It’s so busy in residency it’s hard to find the time,” says one former resident who worked 80 hour weeks while also coordinating a community project. Residency already demands a major investment of time and energy in order to master medical interventions so finding time to collaboratively plan and implement a project presents a hurdle. Several residents expressed regret that they couldn’t spend more time with the community, especially interacting with children. “There are so many other obligations versus the desire you have to contribute more,” one doctor explained.

Collaborative coordinators also recognize the time pressure resident doctors face because they sometimes experience challenges trying to communicate and schedule time with them. One way to overcome these challenges is to encourage residents to design projects that build on an existing area of interest or activity in which they already engage. This can help minimize research and preparation time as Dr. Stephanie Ryan discovered with her dog bite prevention project. For community members who work with pediatric residents, realistic expectations and regular communication may help. It’s important to remember that residency itself is time-limited. Community groups need to be prepared for relatively short-term participation from the doctors. Once their residency is complete, many go on to work in other communities.

Engaging the community presents challenges for pediatric residents new to this work and seasoned community developers alike. Recruiting parent volunteers, youth participants, or local businesses can be more difficult than it first seems. Even well-connected community groups experience challenges getting people involved. As they planned and implemented projects, both pediatric residents and collaborative coordinators frequently worried whether they would get enough participation.

Time is a factor that comes into play here as well. Projects may take place after school – a good time for youth but not necessarily a time when many parents or working adults are available. As one pediatric resident says, “If you want other parts of the community involved, start early. It takes time, more time than I thought.”

Of course, doctors are not the only ones with busy schedules. Collaborative coordinators and community-based staff are equally challenged to find extra time. They are typically multi-taskers with a variety of responsibilities. “I’m going in a million directions,” says one. And if there isn’t enough community engagement, “It falls back on me but there’s not enough of me. It’s hard when you have to work with volunteers who do things on their own time.”

Creativity and persistence can help gain involvement. For example, Dr. Laura Hufford's "taste test" method captured the interest of reluctant youth participants while Dr. Stephanie Ryan's willingness to spend "many afternoons approaching people in the park" resulted in some participation from neighborhood dog owners. Flexibility and a willingness to change the approach also can help overcome many challenges. For example, when logistics and liability concerns presented too many hurdles to sponsor a celebration parade, Yuba's Drive to Health project hosted a field day instead.

Understanding what potential hurdles may lie ahead can help new partnerships effectively troubleshoot anticipated challenges. This is especially important when planning for sustainability.

WHO WILL DO WHAT FOR HOW LONG? THINKING ABOUT ROLES & SUSTAINABILITY

CPT projects involved a wide range of participants – from neighborhood young people to local businesses, ethnic media and faith-based nonprofit organizations. Institutions such as the university hospital, schools, and county health departments also were essential partners. And, when they needed help implementing their projects, pediatric residents did not overlook their own community. Most gained assistance from their fellow classmates and in some cases, found an up-and-coming resident who was interested in continuing the project.

However, sustaining the CPT projects frequently presented a challenge. Because the projects draw upon individual doctor's specific interests and skills, they are not easily replaced. For example, a Russian-speaking pediatrician who can host health shows on the radio is a very unique situation. Additionally, though the passion of an individual resident may initially drive a project, this is not easily replicated or sustained. Once residency is complete, doctors often relocate and financial resources may be required to continue their work.

Some projects more easily lend themselves to community leadership and may not require a physician's involvement in order to continue. For example, teaching young people to prepare healthy recipes or training adult volunteers to track the number of steps children take in an exercise program. Yet, it's important to recognize the "value added" by a physician's participation. Doctors bring a certain authority about health that community decision makers may be more willing to listen to – for example, when the school district and PTA heard Dr. Uyen endorse salad bars as one avenue to providing more nutritious food in school lunches.

In collaborative projects, there is usually plenty of work. However, it takes time to get

to know people, their unique gifts and how they might contribute to the effort. This may be even more true when working with youth. The talents of young people often are discovered in the process of “hanging out” and talking while coloring in the park, preparing food together, or playing a game. But in order for young people to come forward, adults may need to “step back.” In Dr. Laura Hufford’s words, “If the kids can do it, then they should and you shouldn’t.”

Potential Skills & Tasks

To begin planning a sustainable health improvement project in your community, consider the various skills and tasks any community-physician partnership may require and who might fulfill these roles. To begin, consider tasks or roles that may need to be filled:

- * Provide vision and “heart”
- * Help generate ideas
- * Coordinate logistics
- * Share knowledge of the community
- * Develop programs and curricula
- * Create outreach materials
- * Raise funds or request donations
- * Encourage participation
- * Research health issues
- * Educate/train participants
- * Translate written materials
- * Interpret during meetings or
- * Education sessions
- * Troubleshoot
- * Network and connect people
- * Orient new participants
- * Observe
- * Track health status (e.g., weight and height measurements, immunizations)
- * Catalyze new activities
- * Implement activities
- * “Cheerlead” (i.e., enthusiasm for the group effort, especially when challenges arise)

Potential Partners

Consider the types of individuals and groups that may have an interest in supporting children’s health improvement efforts. Before approaching a potential partner, think about their perspective – why would they want to get involved? Use the chart on the next page to identify possible ways to begin.

Table One: Potential Project Partners, Interest and Roles

Potential Partner	Potential Interest
EDUCATION SECTOR	
Schools	Healthy kids → Improved learning and better school attendance. Consider school nurse, food service department, principal, teachers
PTA, parent groups	Better conditions for children in school and the neighborhood or community
After School Programs, Resource Centers	Engage children and parents in educational and enrichment activities; increase volunteers
Student / Youth Groups	Contribute to community; gain work experience; help peers/younger children; complete service learning requirements
Colleges, Universities, Trade Schools	Educate and provide students with “hands-on” experience; research new health improvement methods; promote university programs; fulfill public service mission. Consider physician/nursing programs, arts program, public relations department.
HEALTH SECTOR	
Pediatricians	Impact children’s health beyond office visits; solve underlying causes of poor health; build connections/reputation in community
Public Health Department / Officer	Improve population health especially in low-income areas; outreach to new populations; access to community for participation in existing health programs
Professional Medical Associations	Volunteer support, access to information and resources
Pharmaceutical Companies	Positive public relations; introduce new products to physicians and patients; increase product sales
Hospitals & Clinics	Volunteer support; access to information and resources
OTHER COMMUNITY SECTORS	
Nonprofit Organizations	Fulfill mission to support children and families; collaborate with others to submit grant applications or carry out projects
Neighborhood Associations	Improved neighborhood conditions: kids engaged in healthy activities → less crime, vandalism, drugs abuse, and gang activity
Local Ethnic Media	Reducing health disparities among ethnic minorities; serve audience interests; increase audience and sponsorships
Local Business	Gain customers and good will; advertise services
Faith-based Associations	Support families; contribute to local social justice efforts; raise awareness of spiritual principles and opportunities for involvement in an organized faith
Arts Groups	Art as a means to engage participation; improve health and educate; raise visibility and importance of arts
Elected officials	Serve constituent needs; gain support for election campaigns

WANT TO TRY? ADVICE FOR BUILDING COMMUNITY-PHYSICIAN PARTNERSHIPS

Whether you're a physician or other community member, here is some advice to consider if you'd like to launch a partnership to improve health.

For Doctors Who Want to Partner with Others in the Community

- * *Understand the community context*
Observe the neighborhood. Don't underestimate the power of observation to inform potential projects (see windshield survey for one tool). Visit the neighborhood and talk with people who live there and other community leaders.
- * *Discover what the community wants*
Work closely with someone who knows the community inside-out. Ask for people's ideas and use this information to identify shared interests, recruit volunteers, and engage participation. Projects built on community interests are more likely to be sustained.
- * *Build trusting relationships*
This often involves "hanging out," learning people's names and talking together in informal settings. Encourage people to call you by your first name – this helps create an atmosphere of equality. Explore potential partnerships with several different organizations until you find the right match, which includes having fun.
- * *Take a step back*
Relinquish the need to control the project. Instead, use your gifts and talents to support the community's vision. Ask yourself, "Do I need to do this?"
- * *Recognize your assets*
Each individual offers unique talents, experience and skills. Look beyond your medical training to your hobbies, passions and past work experience. You never know when your talent for soccer, cooking or a second language may come in handy.

For Community Members Who Want to Partner with Physicians

- * *Identify physicians who live or work near your neighborhood*
Interest and investment may be greater for physicians that reside in your area. Invite them to a meeting or neighborhood event to learn more about your

efforts. Be sure not to overlook the county health officer.

* *Overcome the “intimidation” factor*

Doctors are people too. Everyone’s contributions are valuable so don’t underestimate yours just because you may not have a medical degree. Communities need the gifts and talents of *all* its members in order to thrive.

* *Involve physicians in training*

Medical students and physicians in residency are typically young, idealistic and interested in changing the world. They also have the most up-to-date information and can be great assets for community projects.

* *Understand the culture of physicians*

Doctors, especially those in training, have very intense schedules and often leave the area once they’ve completed their program. They are accustomed to working in very structured environments so may find the flexibility of community-based approaches challenging.

* *Provide orientation to your community*

Assist doctors with their learning process. Introduce them to your neighborhood and key leaders. Help them understand the local context. Consider taking them on a tour and point out all the local assets.

Collective Wisdom for Successful Projects

For anyone – hospitals, university schools of medicine, physicians or community groups – that may want to try an asset-based, collaborative approach to improving children’s health, participants from the Communities & Physicians Together program offer the following collective wisdom for creating successful projects:

1. Follow your passion
2. Understand ABCD – work from within the community
3. Build trust and relationships – this often takes time
4. Observe others – then improvise and make it your own
5. Be ready
6. Start early, especially in identifying partners and volunteers.
7. Word-of-mouth is a very effective community outreach tool
8. Offer youth choices and leadership opportunities

9. Take it step-by-step – assess progress along the way
10. Establish clear roles and expectations
11. Plan for sustainability
12. Practice persistence
13. Just do it
14. Have fun and celebrate!

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Appendices

* *Appendix A: CPT Glossary*

This document was created by residents and community members in an effort to share their respective languages and cultures. The CPT Glossary has become a helpful tool for incoming residents and community partners new to the project. Some of the terms are used throughout this guidebook, and may be helpful to any community-physician partnership.

* *Appendix B: Day-in-the-Life Activity*

Developed by a community member in Rancho Cordova, California in 2003 this activity gives residents a taste of the local experience. Since its development each CPT partner community has adopted the activity. Some partner groups now use this activity to orient incoming social workers and other new employees to the community as well. The example included in this appendix is from the Tahoe/ Colonial Collaborative.

* *Appendix C: Logic Model*

In creating its *Project Workbook* for residents, CPT wanted to include this project planning and evaluation tool whose popularity continues to increase among philanthropic and government agencies. The logic model included in this appendix is an excerpt from the CPT *Project Workbook*, borrowed from the W.K. Kellogg Foundation.

* *Appendix D: Resident Asset Map*

Sent to incoming residents with their department orientation packets, the Resident Asset Map is the residents' first encounter with CPT. Residents are asked to describe their skills, hobbies, interests and experiences. The Resident Asset Map is helpful in pairing residents with the community collaboratives and also allows coordinators to better integrate the resident as an individual to the community.

* *Appendix E: Windshield Survey*

Called a "Windshield Survey" because in many larger communities it is completed while driving around in a car, this tool helps residents make subjective observations about the local environment of their partner community. Some smaller CPT communities, such as the Children First - Flats Network of downtown Sacramento use the Survey twice - once while walking around during the day, and again while driving at night - to see how the community changes depending on the time of day.

Appendix A



CLOSING THE LANGUAGE GAP: A CPT DICTIONARY FOR COMMUNITY MEMBERS AND PHYSICIANS

Compiled by Elizabeth Sterba, MS

CPT-WIDE TERMS

AAFP (American Academy of Family Physicians): The national association of family doctors. It is one of the largest national medical organizations, with more than 94,000 members in 50 states, D.C., Puerto Rico, the Virgin Islands, and Guam. Until October 3, 1971, it was known as the American Academy of General Practice. The name was changed in order to reflect more accurately the changing nature of primary health care.

The Academy was founded in 1947 to promote and maintain high quality standards for family doctors who are providing continuing comprehensive health care to the public. Realizing that the family doctor's effectiveness depends on sound, up-to-date continuing education, the founders wrote into the Bylaws the requirement that members in the Active membership category must complete a minimum of 150 hours of approved continuing education every three years to retain membership. This requirement may be met through continuing education programs, publication or presentation of original scientific papers, medical school or postgraduate teaching, residency training, etc. Accurate and current records are kept to ensure that individual requirements are met; if they are not, the member is dropped from the rolls. The requirement, unique at its time of origin, has, through the years, become a standard for an increasing number of other medical groups.

Source: <http://www.aafp.org/online/en/home/aboutus/theaafp/aafpfacts.html>

AAP (American Academy of Pediatrics): Founded in 1930 as a not-for-profit organization. The founding members, a group of 60 physicians who specialized in children's health, chose the name American Academy of Pediatrics to reflect their commitment to the interests of children and the pediatric specialty. The action demanded that the medical community acknowledge the difference between adult and child care.

Since 1930, the AAP has grown to a membership of 60,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. The AAP staff, 350 dedicated individuals, works on behalf of children's health at offices in Elk Grove Village, IL, and Washington, DC. While the purpose of the AAP has not changed in more than 70 years, the environment in which the AAP serves children and members has changed with the times. A Board of Directors, consisting of district chairs elected by AAP members in 10 geographic districts, oversees the governance of the AAP. AAP chapters are organized groups of pediatricians and other health care professionals working to achieve AAP goals in their communities. There

are 59 chapters in the United States and 7 chapters in Canada.
Source: <http://www.aap.org/75/profile/history.pdf>

ABCD (Asset-Based Community Development): Instead of focusing on a community's needs, deficiencies and problems, asset-based community development helps them become stronger and more self-reliant by discovering, mapping and mobilizing all their local assets. Few people realize how many assets any community has: (1) the skills of its citizens, from youth to disabled people, from thriving professionals to starving artists; (2) the dedication of its citizens associations -- churches, culture groups, clubs, neighborhood associations; and (3) the resources of its formal institutions -- businesses, schools, libraries, community colleges, hospitals, parks, social service agencies.
Source: <http://www.co-intelligence.org/P-assetbasedcommdev.html>

CATCH (Community Access To Child Health): national program of the American Academy of Pediatrics (AAP) designed to improve access to health care by supporting pediatricians and communities that are involved in community-based efforts for children. The CATCH Program began in 1991 under a grant from the Robert Wood Johnson Foundation. Provides Pediatricians with training, technical assistance, peer networking opportunities and funding opportunities.
Source: <http://www.aap.org/catch/>

CPT: Communities & Physicians Together. A partnership between the Departments of Pediatrics, and Family & Community Medicine at UC Davis Medical Center; Sacramento ENRICHES; and nine grassroots, community based organizations, all dedicated to engaging future physicians in hands-on community experiences.

Dyson Grant: The goal of the Community Pediatrics Training Initiative of the Dyson Foundation is to establish pediatric residency training programs that will train pediatricians who have greater skills and interest in community-based medicine, advocacy, and who are better able to improve the health of children in their communities. Proposals are not accepted and no new funding is available from this program. Two competitive selection rounds were conducted, the first beginning in 1999 and the second in 2001. Over 130 proposals were received, and after a rigorous review process, a total of ten pediatric departments throughout the United States were selected to receive awards. Each department is receiving a five-year grant ranging from \$1.7 to \$2.5 million.

The *Anne E. Dyson Community Pediatrics Training Initiative* is managed by a national program office at the American Academy of Pediatrics. The Women's and Children's Health Policy Center at Johns Hopkins University School of Public Health, Department of Population and Family Health Sciences is conducting a cross-site evaluation to assess the short- and long-term outcomes of the Initiative.

Source: http://www.dysonfoundation.org/programareas/programareas_list.htm?attrib_id=787

Sustainability: the quality of a development effort wherein the results/benefits of that effort continue to perpetuate themselves after the initial external inputs have been removed
Source: http://www.hcpartnership.org/Publications/comm_mob/htmlDocs/glossary.htm

Symposium: a convivial party; a social gathering at which there is free interchange of ideas; a formal meeting at which several specialists deliver short addresses on a topic or on related topics.
Source: www.nhchc.org/Advocacy/Glossary.pdf

COMMUNITY TERMS

Advocacy: is the act or process of defending or maintaining a cause or proposal. The strategic presentation of information to a targeted audience in order to persuade that audience to action. Advocacy is often directed towards media groups and legislators, and differs from outreach in that it seeks to educate and influence those whose decisions either prevent or perpetuate disparities in health care and health education, not those who are affected by such decisions
Sources: envision.ca/templates/profile.asp and <http://www.connecticuthealth.org/glossary/glossary.html#1>

Affordable: (as in "affordable health care" or "affordable housing") – 1. [In health care] care which is reasonably

priced for an individual or family such that care is financially available; care that is subsidized for those with very low incomes; 2. [In housing] The Federal Department of Housing and Urban Development (HUD) defines “housing affordability” as paying no more than 30% of an individual’s or family’s adjusted gross income on housing and related costs (rent/mortgage plus essential utilities).

Source: www.nhchc.org/Advocacy/Glossary.pdf

Assets-based approach: an approach in which community members inventory their community strengths and resources so that they can use and build on those strengths and resources to address a health or other issue

Source: http://www.hcpartnership.org/Publications/comm_mob/htmlDocs/glossary.htm

Board of Directors: (also called a “Board”); governing body of a nonprofit or for-profit corporation; the board has specific legal and ethical responsibilities to the organization

Source: <http://www.createthefuture.com/Glossary.htm>

CBO: Community-Based Organization. A private non-profit organization which is representative of a community or significant segments of a community and which provides educational or related services to individuals in the community

Source: www.state.nj.us/njded/grants/glossary.shtml

Community: a distinct group within a population defined by a shared geographic, ethnic, or ideological identity.

One community may be distinguished from another by a variety of criteria, including physical, historical, legal, cultural, socioeconomic, or self-imposed distinctions.

Source: <http://www.connecticuthealth.org/glossary/glossary.html#1>

Community-based: takes place at the physical geographic locations of community centers and homes, rather than in traditional health care setting such as hospitals and clinics

Source: <http://www.connecticuthealth.org/glossary/glossary.html#1>

Community capacity: the skills, knowledge, and expertise of community members which individually and collectively constitute a community's ability to identify and address its needs

Source: http://www.hcpartnership.org/Publications/comm_mob/htmlDocs/glossary.htm

Community Development: Refers to the process of facilitating the community's awareness of the factors and forces that affect its health and quality of life, and ultimately helping to empower the community with the skills needed to take control over and improve those conditions. It involves helping communities to identify issues of concern and facilitating their efforts to bring about change in these areas.

Source: <http://www.biaq.com.au/Be-Real/content/glossary.htm>

Goal: broad, general statement about what will be accomplished by a project and how it will be done.

Source: http://wphf.med.wisc.edu/how_to_apply/glossary.php

Grant: Money given by a government or by a foundation or charity. A grant is usually given for the accomplishment of specific activities or goals

Source: <http://www.ddc.wa.gov/Glossary.htm>

Grassroots: The involvement of common citizens. People or society at a local level, rather than at the center of major political activity.

Sources: www.co.arlington.va.us/Departments/VoterRegistration/VoterRegistrationTermsTrivia.aspx and www.edu.gov.nf.ca/curriculum/teched/resources/glos-biodiversity.html

Holistic care: comprehensive approach to service delivery and treatment where coordination of client's needs and total care takes priority

Source: <http://www.biaq.com.au/Be-Real/content/glossary.htm>

HUD: Housing & Urban Development. The primary governmental agency responsible for providing affordable

housing opportunities and for administering Stewart B. McKinney Homelessness Assistance Act programs. Key programs include Public Housing, the Housing Choice Voucher (formerly Section 8) program, the Supportive Housing Program, Shelter Plus Care, Housing Opportunities for Persons with HIV/AIDS, the Emergency Shelter Grant (ESG) and others.

Source: www.nhchc.org/Advocacy/Glossary.pdf

IEP: Individual Education Plan. The written plan documenting eligibility, programs and services for special education students. Physicians may recommend or require these for patients and should be in touch with patients' school officials if an IEP is in place.

Source: <http://www.ddc.wa.gov/Glossary.htm>

Indicator: quantitative or qualitative measure that provides a basis for assessing achievement, change, or performance over time.

Source: http://wphf.med.wisc.edu/how_to_apply/glossary.php

Living Wage: a wage sufficient for a worker and family to subsist comfortably.

Source: www.nhchc.org/Advocacy/Glossary.pdf

MDT: Multidisciplinary Team. Any team of three or more persons involved in the provision of services, treatment, or both, to a child and the child's family and who meet to assess the progress on the treatment/service plan

Source: www.policy.okdhs.org/ch75/Chapter_75-6/340-75-6/340_75-6-4._Definitions.htm

Non-profit: may refer to an organization or the entire sector. Non-profit means not conducted or maintained for the purpose of making a profit. Instead, it operates to serve a public good. Any net earnings by a non-profit organization are used by the organization for the purposes of which it was established. As an entire sector, non-profits include hospitals, universities, trade organizations, voluntary associations and religious organizations

Source: envision.ca/templates/profile.asp

Objectives: Concrete, specific, measurable project accomplishments.

Source: http://wphf.med.wisc.edu/how_to_apply/glossary.php

Outcome: The result of project activities, often expressed in terms of changes in behavior, norms, decision-making, knowledge, attitudes, capacities, motivations, skills, or conditions on individuals, families, households, organizations, systems, or communities. Together, the full set of project outcomes should achieve the overall project goal.

Source: http://wphf.med.wisc.edu/how_to_apply/glossary.php

RFP/RFA: Request for Proposal/Request for Application: the funder's request that includes the guidelines (instructions) and forms necessary for the applicant to submit a proposal for funding

Source: www.broward.k12.fl.us/grants/html/resources/definitions.html

Social capital: (also known as "community connectedness") refers to social networks and the norms of reciprocity that arise from them. A growing body of hard-nosed literature over the last several years shows that social capital, and the trust, reciprocity, information, and cooperation associated with it, enables many important individual and social goods. Communities with higher levels of social capital are likely to have higher educational achievement, better performing governmental institutions, faster economic growth, and less crime and violence. And the people living in these communities are likely to be happier, healthier, and to have a longer life expectancy

Source: <http://uclaccc.ucla.edu/commglossary.php>

Social entrepreneur: someone who uses the methods of business entrepreneurs to achieve social goals, such as creating new jobs or helping disadvantaged communities

Source: <http://www.kauffman.org/>

Socioeconomic status: A relative position in the community as determined by occupation, income and amount of education

Source: <http://www.biaq.com.au/Be-Real/content/glossary.htm>

RESIDENCY TERMS

Thank you to Lindsey Albrecht, MD, for her contributions to this section.

Attending: The physician in charge of supervising the residents. This person has completed residency and possibly subspecialty training. We also call them "faculty members."

Block: A four-week period of training time, spent on a "rotation". There are 13 of these in a given calendar year at UC Davis. For example one resident might do their ward rotation during block 1, while another resident might do their ward rotation in block 4. The Block is the hospital's system of scheduling Residents not just in pediatrics but in all of the subspecialties, so that the hospital can run smoothly. Residents do not usually get to choose on which Block they do what, and the two weeks of vacation that they get each year are assigned to them as well, through the block system.

Call: A person is considered to be "on call" when they are assigned to admit any new patients to the hospital. Traditionally, this period of call lasted 30 hours and included spending the night in the hospital (yes, all in one shift!). However, in recent years, the increments of time to be on call have gotten shorter on some of the rotations (though not all). Residents still work when they are not on call.

Clinic: A place where kids come to have appointments with their doctor that is outside the hospital. Every resident has one afternoon a week of clinic time where they take care of general problems that a child may have (needing vaccines, poor growth, etc.).

ER: The emergency room, or emergency department. It is another place that all pediatrics residents rotate through.

Grand Rounds: The weekly departmental conference, which occurs on Friday mornings in Pediatrics and Tuesday afternoons in Family & Community Medicine. These are attended by almost everyone in the department and many community members as well. Each year, all of the third year residents are required to present a topic of their choice during grand rounds (a one hour talk that requires intensive research and provokes a lot of anxiety!).

Inpatient care: Care that requires a stay in the hospital.

Intern: The confusing name given to a resident in the first year of residency (perhaps to make it clear to all that they are relatively inexperienced!). We also call these people "R1s" (meaning 1st year resident).

NICU: The neonatal intensive care unit. This is a place for the sickest newborn babies, often those that are born prematurely. It tends to be one of the busiest areas of pediatrics!

Noon Conference: The daily resident teaching conference, which lasts from noon to 1pm. Faculty members (or "attendings") lecture on important topics. It is also a time to hold meetings of various sorts. CPT hosts four "Quarterly" noon conferences, where Residents get a chance to visit with their Collaborative Coordinators. In addition, CPT hosts a series of noon conferences on community-medicine related topics.

Outpatient care: Like an appointment or visit to the clinic or doctor's office.

PICU: The pediatric intensive care unit. Critically ill children (but not usually newborns) are taken care of here. They often require ventilators ("breathing machines") and other aggressive methods of care. This is also a very busy place in the hospital!

Primary care: In the health sector generally, 'primary care' services are provided in the community by generalist providers who are not specialists in a particular area of health intervention
Source: <http://www.biaq.com.au/Be-Real/content/glossary.htm>

Resident: Immediately following four years of Medical School, a physician goes into residency, or training in a particular subspecialty (ie: dermatology, internal medicine, pediatrics, surgery, etc.). Length of residency depends on the particular subspecialty, but most (including pediatrics) are 3-year programs.

Rotation: Residency is divided into various segments which are called "rotations." This allows pediatric residents to receive standardized training in all of the areas of pediatrics (ie: the Ward, NICU, PICU). Each resident rotates through the various experiences in a different order, since their training is also staffing the hospital. Pediatric residents only rotate through pediatric specific rotations and do not undergo training in areas such as surgery or psychiatry.

Senior: In pediatrics, a second (R2) or a third year (R3) resident. These residents help supervise the interns in addition to completing their training through practicing on patients.

Ward: The setting of inpatient care. Hospitalized children are cared for by a team of people in this setting (ie nurses, residents, attendings, medical students).

Appendix B



"A Day in the Life..." Activity Adapted from the Cordova Community Collaborative

Instructions

You will be taking on the character of the person in each of the following five scenarios. Each of these characters provides you with an example of the lives of many people in the Tahoe/Colonial community.

You will take on the character of that person act out each scenario – if you are asked to use public transportation, you must physically ride the bus to the named destination(s). Use the provided “Resources for Families in the Tahoe/Colonial Community” sheet given to you (a partial listing of resources in the community) to navigate your way through “the system” and take care of your family. *Please be sure to keep notes and information on each resource provided on this sheet; and ensure that you can answer all questions asked in each scenario.* Please remember that this is only ONE day in your life... but this is just another day in the life of many families in our community!

Scenario One

Put yourself in the shoes of a mom/dad with a sick toddler, no insurance and very little money. How would you seek out services for your child and where? And oh yes, you have no car. Since you do not have transportation, you must walk or ride the bus. How much does this cost? What types of health services are available in the Tahoe/Colonial community? If there are no accessible services in Tahoe/Colonial, what are your options in Greater Sacramento County area?

Scenario Two

You would like to improve your life by getting more training. If you would like to access job training skills, where could you go? What types of job training skills are offered? Who can you contact for low-cost classes that you could either attend while your children are in school or in the evenings? Also, there are a few barriers: you are not an American citizen so where would you go to get information on citizenship/a working permit/a visa?

Scenario Three

So while you're receiving job training during the afternoon, what are some school-based programs you could access for your children aged 3, 8, 12 and 16? Please talk about those programs and the services they offer as well as if there are any fees.

Scenario Four

You have just moved to the Tahoe/Colonial Community and would like to enroll your child in school, but the school nurse tells you that your child cannot come to school until his/her immunizations are up to date. Your Medi-Cal has not been transferred yet, where can you go for shots?

Scenario Five

You have only \$80.00 left to feed yourself, your toddler and your infant. You will not be getting another aid check for a week and a half. The toddler and infant are still in diapers; the infant is still on formula. Where are the cheapest places to shop and what agencies will help you out? What important items would you get for the amount of money you have available until your next check?

Appendix C

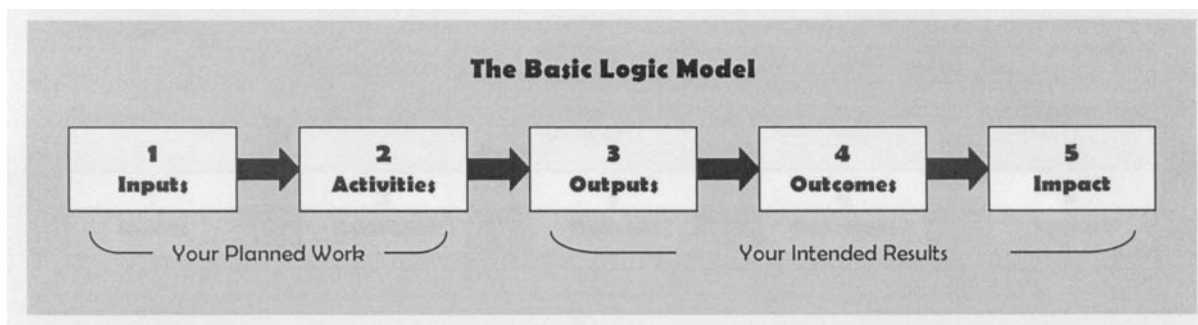
Building a Logic Model

Taken from *THE LOGIC MODEL DEVELOPMENT GUIDE*,
W.K. Kellogg Foundation, Updated December, 2001. Chapter 1.

The logic model is defined as a picture of how your project is going to accomplish its task – the theory and assumptions underlying the project. A project logic model links outcomes (both short- and long-term) with project activities or processes and the theoretical assumptions of the project.

Learning and using tools like logic models can serve to increase the practitioner's voice in the domains of planning, design, implementation, analysis, and knowledge generation. The process of developing the model is an opportunity to chart the course. It is a conscious process that creates an explicit understanding of the challenges ahead, the resources available, and the timetable in which to hit the target. In addition, it helps keep a balanced focus on the big picture as well as the component parts.

In general, logic modeling can greatly enhance the participatory role and usefulness of evaluation as a learning tool. Developing and using logic models is an important step in building community capacity and strengthening community voice. The ability to identify outcomes and anticipate ways to measure them provides all program participants with a clear map of the road ahead. Map in hand, participants are more confident of their place in the scheme of things, and hence, more likely to actively engage and less likely to stray from the course – and when they do, to do so consciously and intentionally. Because it is particularly amenable to visual depictions, logic modeling can be a strong tool in communicating with diverse audiences – those who have varying world views and different levels of experience with project development and evaluation.



The most basic logic model is a picture of how you believe your project will work. It uses words and/or pictures to describe the sequence of activities thought to bring about change and how these activities are linked to the results the project is expected to achieve. The Basic Logic Model components illustrate the connection between *your planned work* and *your intended results*. They are depicted numerically by steps 1 through 5.

YOUR PLANNED WORK describes what resources you think you need to implement your project and what you intend to do:

1. Inputs (Resources) include the human, financial, organizational, and community resources a program has avail-

able to direct toward doing the work. Sometimes this component is referred to as Inputs.

2. **Activities** are what the project does with the resources. Activities are the processes, tools, events, technology, and actions that are an intentional part of the project implementation. These interventions are used to bring about the intended changes or results.

YOUR INTENDED RESULTS include all of the project’s desired results.

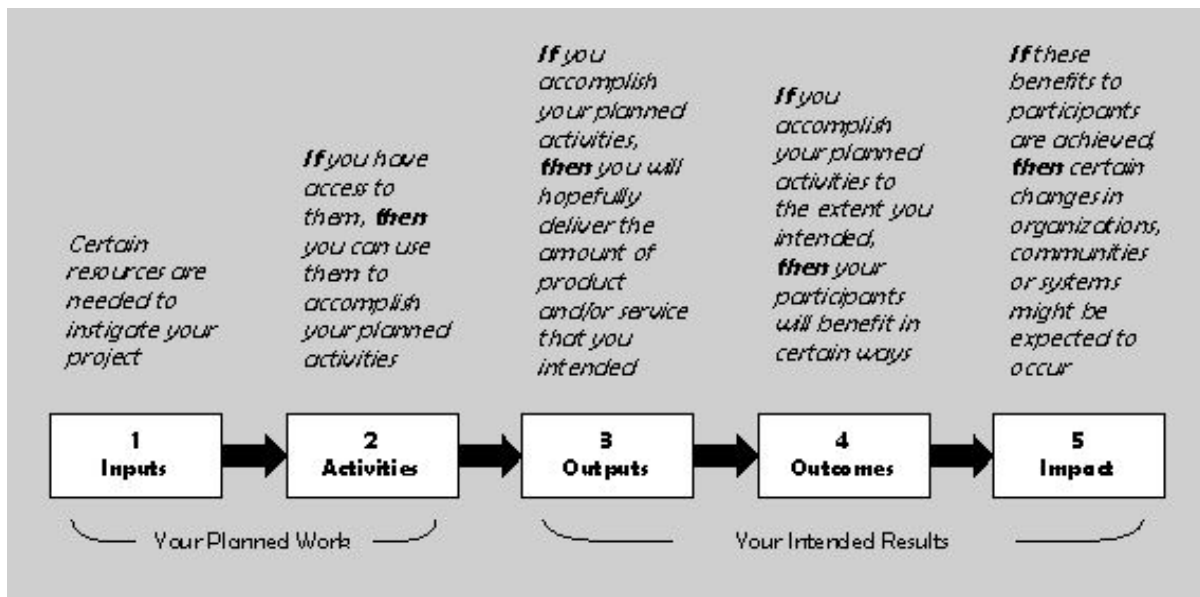
3. **Outputs** are the direct products of project activities and may include types, levels and targets of services to be delivered by the project.
4. **Outcomes** are the specific changes in participants’ behavior, knowledge, skills, status and level of functioning. There are both Short-term outcomes and Long-term outcomes.
5. **Impact** is the fundamental intended or unintended change occurring in organizations, communities or systems as a result of project activities.

READING A LOGIC MODEL

When “read” from left to right, logic models describe project basics over time from planning through results. Reading a logic model means following the chain of reasoning or “*If...then...*” statements which connect the project’s parts. The figure below shows how the basic logic model is read.

BUILDING A LOGIC MODEL BY BASIC PROJECT COMPONENTS

As you conceptualize your project, begin by describing your basic assumptions and then add the following project components in the order that they should occur.



1. **Inputs (or Factors)** are resources and/or barriers, which potentially enable or limit project effectiveness. Enabling *protective factors* or *resources* may include funding, existing organizations, potential collaborating partners, existing organizational or interpersonal networks, staff and volunteers, time, facilities, equipment, and supplies. Limiting *risk factors* or *barriers* might include such things as attitudes, lack of resources, policies, laws, regulations, and geography.
2. **Activities** are the processes, techniques, tools, events, technology, and actions of the planned project. These may include *products*—promotional materials and educational curricula; *services*—education and training, counseling, or health screening; and/or *infrastructure*— structure, relationships, and capacity used to bring about the desired results.
3. **Outputs** are the *direct results* of project activities. They are usually described in terms of the *size and/or scope* of the

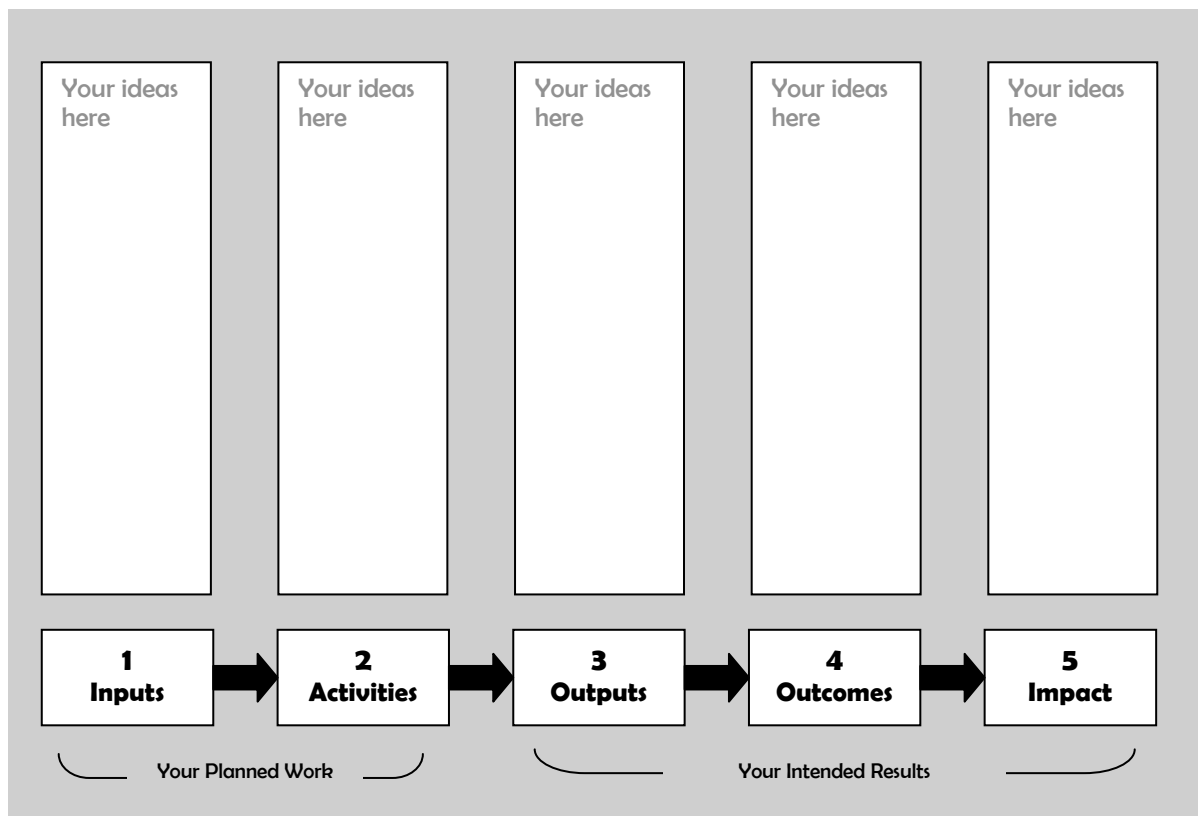
services and products delivered or produced by the project. They indicate if a project was delivered to the intended audiences at the intended “dose”. A project output, for example, might be the number of classes taught, meetings held, or materials produced and distributed; project participation rates and demography; or hours of each type of service provided.

4. Outcomes are specific changes in attitudes, behaviors, knowledge, skills, status, or level of functioning expected to result from project activities and which are most often expressed at an individual level.
5. Impacts are *organizational, community, and/or system level changes* expected to result from project activities, which might include improved conditions, increased capacity, and/or changes in the policy arena.

Thinking about a project in logic model terms prompts the clarity and specificity required for success. Using a simple logic model produces (1) an inventory of what you have and what you need to instigate your project; (2) a strong case for how and why your project will produce your desired results; and (3) a method for project management and assessment.

ACTIVITY: Create a *Draft* Project Logic Model

Now that you have an understanding of what a Logic Model is and how it can be useful in developing a community project or intervention, practice using the following blank Model by brainstorming ideas for your own project. *Note that these may be just ideas!



Appendix D



Resident Asset Map

Name:

Medical School (name and location):

Hometown:

Zip code of Sacramento residence:

I am a Resident Physician in (check one):

Family & Community Medicine

Pediatrics

Internal Medicine

Languages:
(Please list proficiency)

Hobbies:

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

Previous Involvement in Community Projects (describe):

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

- | | | |
|-----------------------|------------------------------|-------------------------------|
| Access to Health Care | Immunizations | Safety/Injury Prevention |
| Adolescent Health | Literacy | Schools |
| Child Care | Mental Health | Sports Medicine |
| Cultural Awareness | Nutrition | Special Needs Children/Adults |
| Geriatrics | Obesity | Substance Abuse |
| Health Education | Oral Health | Tobacco Cessation |
| Health Promotion | Parenting | Underserved Populations |
| Housing | Recreation/Physical Activity | Women's Health |
| HIV/AIDS | Rural Health | |

Please feel free to list other interests you have:

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

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

Appendix E



Windshield Survey

Housing

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

Transportation

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

Parks and Recreation

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

Schools

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

Government

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

Businesses

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

Services

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

People

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



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