**Anne E. Dyson Child Advocacy Award**

**2013 Recipients**

**Project Leaders:** Jessica Albright, MD and Madhavi Gavirneni, MD  
**Project Title:** ReadNPlay for a Bright Future

The ReadNPlay for a Bright Future project developed by Dr. Albright and Dr. Gavirneni aims to prevent childhood obesity beginning in infancy.

ReadNPlay encourages healthy active living for families with young children through use of a novel communication tool, the ReadNPlay Baby Book. The trademark baby book developed by the project team spans from the newborn visit to 18 months and has areas for families to write-in information obtained at well child checks as well as preprinted anticipatory guidance information supportive of the goals of the project. Posters and activity-promoting incentives distributed in the clinic and community serve as reminders to families to Play More, Play Together, Play Safely, and Fuel to Play.

**Project Leader:** Amber Loyson, MD  
**Project Title:** The Transition to a NICU Graduate Medical Home

With the rising number of infants of multiple births and the stable or increasing rate of low birth weight and premature infants, Neonatal Intensive Care Units across the US provide care for many of the sickest children. The survival rate is fortunately improving, although the South East region where Dr. Loyson is located has the highest infant mortality and morbidity rates when compared to the rest of the United States. These medically-complex children once discharged demand that primary care physicians receive excellent communication from NICU providers to ensure that they receive high quality care in the setting of a medical home, one that provides coordination of care with constant attention to their health and development as well as to their social environment.

After a complicated hospital stay, a NICU graduate is discharged from the hospital with health challenges and medical needs that differ greatly from healthy, term infants. Consequently, there are many tasks demanding attention to ensure a child’s transfer of care upon NICU discharge. Dr. Loyson realized the primary care provider needs to be able to take an active role in the coordination of care and services before the infant is discharged. As the primary care clinician plays a key role in providing continuity of treatment, Dr. Loyson concluded that a visit from the patient’s primary care physician before discharge would ensure smooth transition of care from neonatologist to primary care provider. This meeting offers a beneficial opportunity to arrange appropriate follow up for the infant, develop a management plan, and provide additional education to parents. As the primary care pediatrician plays a major role in the follow up of these patients and the eventual success of these NICU
graduates, Dr. Loyson has created a program that identifies primary care physicians early in the hospital course and that parents with an anticipated discharge from Shand’s NICU who are being followed by a primary care physician within the Shand’s network receive an educational meeting with their primary care provider before the baby is discharged. Although the baby may be seen by a different initial provider, the primary care provider will be able to establish an essential relationship with the family and become familiar with the infant’s needs.

A joint statement from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American College of Osteopathic Medicine identifies the medical home as a concept where each patient has a personal physician that knows them well and provides comprehensive care; that care is coordinated across multiple aspects of the health care system, and that quality and safety is incorporated in to all aspects care. In Dr. Loyson’s experience as a resident, she noticed that these physician ideals and concepts of a medical home were just not being met as prior NICU patients were regularly being seen in our clinic often without prior notification and without joint discharge planning. Just as physicians need to maintain their certification by getting Continuing Medical Education credits, Dr. Loyson believes that medical practices need to keep learning and improving as a whole.

Moving toward a medical home model of care for our NICU infants is desperately needed. When one thinks of patients that could benefit from this program, the clear answer are complex patients in need of multiple specialty referrals, medical equipment, therapists, and familial education. However, other infants, such as any with over a week long NICU stay, may benefit from such a program.

The implementation of primary care in the NICU includes more than just identifying who will be the baby’s primary care physician. Both before and after discharge, primary care involves a range of duties and tasks, including assessment of the baby’s growth and development, neurodevelopmental and retinopathy screening, anemia monitoring, parental education for car and home safety, and immunizations and RSV prophylaxis as necessary. In order to accomplish these goals, Dr. Loyson determined that the child’s primary care provider must be identified early in the hospital course. This allows doctors to discuss laboratory and screening results, meet the infant’s parents and provide them with education regarding their first day at home with baby, enroll the infant for Synagis as necessary, become aware of any other follow up appointments that are scheduled for the infant, and refer the infant to Early Steps early intervention program and the family to any appropriate local family support services. As outlined in the Critical Elements of Care: Nursery Discharge Guideline, doctors strive to be able to provide anticipatory guidance regarding signs and symptoms requiring urgent medical attention, how to access emergency care, daycare & infection exposure issues and SIDS risk.

The tenets of a medical home are applicable both during and after a neonatal ICU admission. By finding ways to identify future infant caretakers sooner and being able to establish a pre-discharge primary care physician visit to coordinate care, Dr. Loyson knows they will have more success in having our NICU graduates cared for in a medical home environment. Overall, understanding and implementing the
concepts of a medical home in the NICU setting will lead to improved long term medical, emotional and psycho-social outcomes of NICU patients and their families.

**Project Leaders: Jenny A. Torre, MD and Sonal Malhotra, MD**  
**Project Title: Childhood Obesity Prevention Program**

Obesity is currently the second leading cause of death in the United States. In NYS, obesity among children and adolescents has tripled over the past 30 years, with 1/3 of New York's children being obese or overweight. The obesity prevalence among 2-5 year-olds enrolled in WIC in NYS is 15%. As seen in a number of diseases, there is a large disparity in health between ethnicities and socioeconomic status, with obesity highest among people living in low-income neighborhoods. This has been linked to a number of variables including access to safe outlets for physical activity and the availability of healthy food. Access to healthy food stores has been shown to be associated with lower BMI and lower prevalence of obesity.

Albany County is failing when compared to the rest of the state. While on average in NYS Counties healthy food access is at 43%, only 26% of the zip codes in Albany County have a healthy food outlet which supplies fresh fruit and vegetables. In addition, there is less than 1 farmers market per 10,000 people, but there are 10 times as many fast-food restaurants in Albany County.

Despite some community efforts, the continued lack of access to high quality, local, inner city farmers markets is still an obstacle to accessing healthy food in order to address childhood obesity in these areas.

Through collaboration with local community based organizations, including AVillage and Youth Organics (a division of Grand Street Arts), farmers, and city officials, Dr. Torre and Dr. Malhotra are creating a weekly farmers market from July to October, located in the heart of their target population. It will be held in the South End of Albany, an identified “food desert”. By partnership with Youth Organics, they aim to have local youth grow (in community gardens) and sell their own produce at their markets combined with local farmer stands. As the cost of fresh fruits and vegetables is often noted as a significant barrier, through grant support, they strive to provide farmer market vouchers to their consumers in order to encourage both participation and access. These vouchers will be used as incentive to encourage consumers to come to the markets and try new fruits and vegetables, ultimately instilling healthy nutritional values and habits to continue after completion of the voucher stipends.

Accessibility, although a large part, is only one piece of the large puzzle of decreasing childhood obesity. Dr. Torre and Dr. Malhotra plan on addressing multiple additional factors including education, exercise, and youth empowerment. Their objectives are to educate at least 100 families on portion size and healthy diet through recipes & food preparation demonstrations with local chefs and provide exercise education with demonstrations at the local playgrounds. To empower the youth, they will be working with local inner city youth to grow, promote, and sell their own produce, learning business and social skills while doing so.
Project Leader: Eric Burlingame, MD
Project Title: Healthy Food Court

Dr. Burlingame coordinated the establishment of a cart with a vendor selling fresh fruit and produce at St. Christopher's Hospital and worked to ensure the cart provided SNAP/EBT access for low-income families. This is the first of such produce vendors specifically targeting low-income patients located within a hospital in the region.

St Christopher's Hospital sits amid the third poorest congressional district in the country with food insecurity rates of 49%, meaning around half of the families served experience hunger every year. As part of larger hospital-wide initiatives to create a "Hunger-Free Hospital", modeled off Boston's "Project Bread" model, Dr. Burlingame worked with a local nonprofit (The Food Trust) and City Health Department partnership to recruit an entrepreneur to sell produce within the hospital. The cart began selling produce in September of 2011 and obtained SNAP access in January 2012 and currently has 25-30% of weekly revenues coming from SNAP purchases.

Other objectives of Dr. Burlingame's project included:
- Referring patients and families to the cart.
- Destigmatizing the use of SNAP benefits in the hospital. Prior to this, there was no way for families to use SNAP/EBT card benefits in the hospital since Sodexho, the hospital's food contractor doesn't accept SNAP benefits.
- Working to educate families, residents and staff about the scope of the problem of hunger in the community.
- Established the Food Interest Group to sustain resident participation in this and in other coordinated hospital initiatives to combat hunger including screening for food insecurity, developing food resources, and communicating best practices for connecting needy families to those resources.
- Educating the larger public about feasible & sustainable initiatives to combat hunger in institutions (regional nutrition conference guest speaker).
- Sharing findings in larger academic forums (research day poster platform abstract submission, etc.)
- Participating in larger hunger advocacy work (e.g. Federal Farm Bill policy working group with area nonprofits).

The program is currently self-sustaining with one full-time employee with plans to expand offerings at the cart as facilities allow (wash station would allow vegetable & fruit smoothies, site may allow CSA pickups, Nutrition Services may offer cooking demonstrations, etc.)
Project Leaders: Maria Katherine Henry, MD  
Project Title: The Healthy Babies Program: A Collaborative Pilot Project to Screen Infants in Emergency Housing for Failure to Thrive

The ultimate goal of The Healthy Babies Program created by Dr. Henry is to have a trained medical professional regularly assess all infants 0 - 16 weeks of age in emergency housing in Philadelphia while developing relationships with mothers to provide education and screen for mental health concerns. The program was designed in 2011 and piloted for 8 weeks at the beginning of 2012. Following the pilot, results and recommendations were provided to the Office of Supportive Housing during the spring of 2012.

The Healthy Babies Program is a collaborative project involving social workers, nurses, and physicians at CHOP, the leadership at the Philadelphia Office of Supportive Housing, and case managers at the site of the pilot. Dr. Henry's role was to develop the medical protocols, screening forms, and summary documents for the pilot and to present the design to OSH. Dr. Henry was on call for questions from the RN during the weekly weight check visits from the 2-month pilot with additional attending support from other physicians.

The project is currently in an expansion phase. HHI hired a RN for one year to expand the program to include the 4 shelters with which HHI has preexisting relationships. In the upcoming academic year, HHI and OSH will collaborate with contracted nurses currently working at the remaining shelters in Philadelphia who have funding from Health Care for the Homeless to achieve regular screening for all young infants in Philadelphia emergency housing.

Project Leaders: Adam David Schickedanz, MD  
Project Title: The Financial Fitness Clinic: Improving Child and Family Health by Addressing Socioeconomic Determinants of Health in the Clinical Setting

The Financial Fitness Clinic (FFC) came together in late 2010 as a partnership between the UCSF pediatric clinic at San Francisco General Hospital, the UCSF family medicine clinic, a community partner from Wells Fargo interested in the financial well-being of underserved populations, and a staff member at the Mission Economic Development Agency, a community-based economic development agency in San Francisco (http://medasf.org/english/). The common goal was to remove economic barriers to better health for San Francisco's poorest children and their families and to raise awareness of economic determinants of health among patients and clinicians.

In February of 2011, Dr. Schickedanz organized the first Financial Fitness Clinic and has continued to hold these clinic sessions monthly since. Dr. Schickedanz had developed and implemented all of the elements of the Clinic's curriculum (a three-part interactive lecture series on financial health education, social service referral, and individual financial health coaching) and established monthly FFC sessions at their primary site (San Francisco General Hospital) by July of 2011. In the summer and fall of 2011, Dr. Schickedanz elicited input on their program from other community organizations providing financial coaching to low income clients in San Francisco.
Francisco, the San Francisco Financial Planning Association, the San Francisco Treasurers Office of Financial Empowerment, and researchers at UCSF working to develop clinical interventions to address social determinants of health. They received Institutional Review Board approval to begin measuring the impact of the FFC on families' finances and health in the fall of 2011, beginning the ongoing research efforts of the FFC in October of 2011. The FFC website (www.financialfitnessclinic.org) was created that October as well. In January of 2012, the FFC staff was joined by their first intern, a public health student with years of experience in tax preparation for underserved groups in San Francisco. By early 2012, the FFC had been awarded a clinical and translational science research grant from UCSF medical center, a small grant for materials from the San Francisco General Hospital, a grant from the San Francisco Medical Society for service to the local medical community, and recognition (the Quality Leaders Award) from the California Association of Public Hospitals for innovation in the safety net. In March of 2012, they expanded the FFC family referral network using the electronic e-Referral portal, allowing providers from every clinic in the city-wide San Francisco Department of Public Health clinic network (12 total) and San Francisco General Hospital to refer families to the FFC. In May of 2012, the FFC opened at its second site, located at the Chinatown Public Health Center. In June of 2012, they welcomed their first FFC staff volunteer from PriceWaterhouse Coopers (PwC). In July of 2012, they were among a founding group for a national collaborative of clinicians and community organizers interested in promoting clinical interventions to address economic determinants of health. Input from faculty and fellow residents was sought and incorporated throughout this timeline. As of the time of this application, over 100 patients and families have been served by the FFC and are contacted regularly by their clinic staff.

The lead Financial Fitness Clinic (FFC) staff member from their community partner, the Mission Economic Development Agency (MEDA), has stepped into a fuller leadership role in the last year and has expressed an interest in taking the reigns of the clinic in the future. Dr. Schickedanz, along with the FFC, is working with her and MEDA this year to develop a sustainable staffing structure for the FFC that would allow them to maintain the program in the years ahead.
Project Leaders: Aimee M. Grace, MD and Kristin Collins, DO
Project Title: Human Trafficking and Health Care

The goal of “Human Trafficking and Health Care” is to eradicate this form of modern slavery. Dr. Grace and Dr. Collins aim to achieve this by educating the medical field to identify and report human trafficking cases. There are 27 millions slaves in the world today, in such fields as sexual services, labor exploitation, and child slavery. Most of these are women (many of whom are parents), adolescents, and children. Data from the Family Violence Prevention Fund showed that 28% of trafficked victims in a U.S. sample came into contact with a health care provider during captivity, but went unrecognized. Locally, the San Jose Police Department estimates that 60% of local trafficked victims encountered at least one health care professional while in captivity. The cost of this missed opportunity is incalculable and must be addressed. Their advocacy project aims to do just that: mobilize physicians as key front line professionals to end this human suffering.

The San Jose Police Department (SJPD) is a national leader in addressing human trafficking, having received ongoing federal funding from the Department of Justice for these efforts, and is their community partner. Together, they have embarked on a physician educational campaign about human trafficking in the San Francisco Bay Area. Their intervention is a comprehensive Grand Rounds presentation entitled “Human Trafficking and Health Care” given jointly by a physician and police officer that empowers physicians to identify and report trafficking victims.

The presentations are being given as a part of a randomized controlled trial to determine 1) if they increase the number of human trafficking cases reported, and 2) if they change the attitudes, knowledge, and behaviors of physicians regarding human trafficking. Based on their findings, they plan to transform the requirements of physician training nationally, much in the way physicians are now trained to screen for and identify victims of domestic violence. The setting of the intervention is 20 hospitals in the San Francisco Bay Area: the sites selected were those with the largest Emergency Department volumes and highest percentage of public payers, and were randomized into intervention and control sites. Pre, immediately post, and 3 months following the presentation, attendees complete validated surveys to assess changes in health care professionals attitudes, knowledge, and behaviors. They intend to use the control group (which receives the presentations after the follow-up data has been collected from the intervention group) to control for outside factors (such as a news story on human trafficking, unrelated to the intervention) that may affect baseline awareness and action of health care providers to isolate the impact of their intervention.
While understanding the impact of the presentation on provider attitude, knowledge and behaviors is important, Dr. Grace and Dr. Collins are ultimately interested in how the change in providers translates into rescuing victims of trafficking. They are assessing this in two ways. First, they have partnered with the Polaris Project, which runs the National Human Trafficking Hotline that they promote in the Grand Round presentations. They are monitoring call volumes from zip codes in the San Francisco Bay Area and tracking them over time. They will map these volumes to their study timeline to test for correlations. Second, they ask physicians in their survey to self-report their calls on behalf of potentially trafficked victims.

If they demonstrate that training on human trafficking for health care professionals helps to rescue victims, they plan to engage in systems level and policy advocacy. With their partners at the SJPD, Dr. Grace led a breakout session about Human Trafficking and Health Care at the Freedom Summit 2011 in California, with keynote speaker Condoleezza Rice and 1,700 people in total attendance. Additionally, Dr. Grace participated in the American Academy of Pediatrics Advocacy Day in Washington, DC in January 2011, and discussed her and Dr. Collin’s human trafficking research with legislative staffers, who expressed interest in their project and are looking forward to their data. She took advantage of being in Washington to meet with the national leadership of the Polaris Project, with whom she connected at the Freedom Summit. They also plan to disseminate the data through national publications and conferences. Overall, as pediatricians, Dr. Grace and Dr. Collins aim to identify and rescue as many children and adolescents as possible victimized by human trafficking and restore their full, abundant lives that had previously been robbed from them.

Project Leader: Karen Maule, MD
Project Title: Button Battery Ingestion Advocacy Project

Button battery ingestions in children are resulting in increasingly frequent, devastating complications and fatalities. Public and physician awareness is poor, and many products using button batteries are not child-proofed. The majority of ingestions are not witnessed; presentations are non-specific; battery voltage has increased; the 20-to 25-mm button battery size are more likely to become lodged at the cricopharyngeal junction; and severe tissue damage can occur in 2 hours. This button battery injury prevention advocacy project, led by Dr. Karen Maule, has multiple objectives along the spectrum of prevention. The goals of this project are to advocate for child-resistant industry standards across the spectrum of consumer products using button batteries, improve public and physician awareness, optimize management by developing evidence-based multidisciplinary institutional protocols, and encourage resident-led advocacy projects to enhance and broaden understanding of child health.

In March 2011, Dr. Maule joined an expert panel of advocates in Bethesda for an informational presentation to the Consumer Product Safety Commission (CPSC) and industry representatives. Afterwards, the CPSC produced a public service announcement about button battery hazards, which was distributed during National Poison Prevention Week. In addition, multiple local media outlets, YouTube videos,
blog entries, handouts, brochures, and posters have been produced to enhance public awareness. She has also presented this advocacy project to the AAP COIVVP and the Illinois Chapter of the AAP to continue to raise physician awareness. Engineers at CPSC are also brainstorming innovative redesign to battery manufacturing to decrease the risk of injury.

Currently, members of her coalition are working with Underwriters Laboratory (UL) to author an all-encompassing voluntary standard to child-proof consumer electronic products that use button batteries. A draft of a bill on button battery safety has been introduced in the Senate Commerce Committee at the end of June, and the members of her coalition provided feedback and statements of support. The objective of the bill is to require the CPSC to promulgate consumer product safety standards to require child-resistant closures on consumer products that use batteries. Secure battery compartments could potentially eliminate 62% of pediatric battery ingestions. Given the rapid onset of injury, the only effective intervention is prevention.

This project has fueled Dr. Maule’s interest in primary care, injury prevention, and advocacy. With faculty guidance, she devised an effective approach along the spectrum of prevention. With many e-mails and conference calls, she mobilized individual advocates to form and collaborate as a national, multidisciplinary coalition. Dr. Maule represented the coalition in national meetings to change public policy and industry standards. She authored articles and presented at conferences to spread public and physician awareness. She led resident participation and helped develop more in-depth resident advocacy training in their curriculum. Individual residents from all classes have participated according to interest in specific aspects of the project. Dr. Maule plans to continue to be involved in this project after graduation and is working with the Office of Child Advocacy to include the next phases of this project among the offerings to residents seeking an elective experience in child advocacy.

**Project Leader: Ilana M. Sherer, MD**  
**Project Title: Bay Area Youth Gender Acceptance Project: A Multidisciplinary Network Improving Health Outcomes for Nonconforming Children**

Because gender variant children are at high risk for violence, bullying, suicide, and other issues starting at very young ages, Dr. Sherer initiated this project. Hormone treatments and psychological therapies exist that reduce these risks while allowing the child to express their affirmed gender. However, gender variance is poorly recognized and understood by pediatricians, and most pediatricians lack the skills to appropriately diagnose, counsel families, and provide or refer for appropriate care.

Extensive community networking and literature review revealed a need to address three pressing issues, which became Dr. Sherer’s project goals and three separate aspects of one larger project:
Goals of Project:

1. Create a setting where gender variant children can receive culturally-appropriate care for their specialty and general medical needs.
2. Educate pediatricians and other health care providers about gender issues.
3. Teach gender variant children/families the tools to self-advocacy within the medical setting

Outcomes of this project:

1. Child Adolescent Gender Center
   * Currently seeing approximately 15 patients
   * Anticipate significant increase once clinic opens officially this summer
   * First patient recently started on cross hormone therapy after 2 years of hormone blockers
   * Community partners managing dozens of referrals for mental health and advocacy needs
   * Coalition of approx 25 mental health providers associated with the Center formed
2. Award: UCSF Chancellors Award for LGBT Leadership
3. Formal and Informal Publications
4. UCSF, Community, National and International Presentations
5. Other Collaborations/Committees
   1. Content Advisor Trans Bodies, Trans Selves book project.
   2. Coalition creating Section on LGBT Issues within AAP.
   3. Advising with Planned Parenthood, Santa Cruz; Gender Spectrum, PFLAG San Francisco.

This project began as Dr. Sherer’s resident project for the Pediatric Leadership for the Underserved (PLUS) program at UCSF and has become a large collaboration of UCSF faculty, community organizations, and community mental health providers. She has been involved through every step of the planning and development of this project, and her specific contributions have been bringing together the multiple providers and community organizations into a larger network and working on developing residency curricula and educating families. In addition, several other residents have been involved. Dr. Sherer initially started this project with Raul Gutierrez, who graduated from residency while they were still in the planning stages in 2010. In addition, Ari Zadel is a current R2 at UCSF and will continue to work with Dr. Sherer to develop, test, and implement the residency curriculum as part of his primary care project within residency. One of Dr. Sherer’s overarching goals within the larger collaboration has been to ensure continued involvement and educational opportunities for residents, by providing opportunities for clinical rotations through the multi-disciplinary setting and by creating the residency curriculum.
Project Leader: Geoffrey Collins, MD
Project Title: Cyclopedia: Empowering Urban Adolescents through Bicycling

Cyclopedia (www.cyclo-pedia.org) was created by Dr. Collins and has roots in another bicycling program he ran in East Harlem (www.losaventureros-ps225.blogspot.com) during medical school in 2007-2008.

Cyclopedia is a bicycling program for urban adolescents at the Rochester Boys and Girls Club that combines physical activity with collaborative online documentation in order to give the participants not just a sense of place but also a sense of belonging. Each trip comprises mapping a route to the destination, the trip itself, photographic and video documentation, a lesson on the trip topic, and collaborative expansion of the website during the home base wrap-up. The adverse health effects of social isolation and lack of physical activity contribute to obesity, mental health issues, school violence and even teen pregnancy. Successful interventions generally have three characteristics: they involve education, activity and group participation. A child can have all of his or her immunizations and show up for every wellness visit but that will not stop him or her from becoming a teen parent, not finishing college, or developing type II diabetes. Urban health is about underlying social conditions creating poor outcomes. The key to changing the outcomes is reconnecting children with their own communities (a social connection) and with their own neighborhoods (a physical connection).

Project Leaders: Sarah E. Libecap, MD and Julie O'Brien, MD
Project Title: Beyond Immunizations: Improving Well-Child Visits through Parent Education

While pediatricians view well-child visits as a venue for anticipatory guidance, developmental screening, parenting tips and advocacy, parents often do not share these goals. The limitations and complexities of well-child care have been documented, and the need to rethink and restructure the traditional primary care visit has been established. Lower income families, living in resource-poor neighborhoods, are even less likely to take advantage of preventive primary care services. Studies show these families are 2-4 times more likely to be dissatisfied with the care their children receive, particularly in the areas of the child’s growth and development. In 2009, Pediatrics published two studies which identified parent and physician driven strategies to improve the effectiveness of well-child care: individualizing and improving transparency of each visit and utilizing community resources.
Motivated by this research and working with underserved families in their clinic, Dr. Libecap and Dr. O'Brien’s project aims to improve the quality and use of primary care visits by expanding the primary care model outside of the clinic, promoting positive parenting skills, increasing awareness of child development, and helping parents prepare individualized questions for their child’s pediatrician. Through a partnership with a community-based organization, Parent University, Dr. Libecap and Dr. O’Brien have established monthly Pediatric Wellness Workshops in one of San Francisco’s poorest communities, Bayview Hunters Point (Bayview). These workshops focus on pertinent health topics and provide anticipatory guidance to parents with children ages 0-5 years in Bayview. Based on the principle that an informed parent is more likely to be an inquisitive, active member in shared decision making with their physician, each workshop aims to encourage parent engagement in the well-child visit. This project is unique in partnering with a community organization to empower parents to become active participants and use well-child care more effectively. These workshops address needs identified by both parents and pediatricians: they help parents understand the purpose of their well-child visits, empower parents to individualize their visit, build upon community resources and use time outside the physicians office to increase awareness and ultimately strengthen the medical home.

**Project Leaders: Kevin E. Nelson, MD and Robyn Nolan, MD**  
**Project Title: Pediatricians Against Secondhand Smoke: Protecting Children from Secondhand Smoke**

"Pediatricians Against Secondhand Smoke (PASS): Protecting Children from Secondhand Smoke" is a resident-driven project started in January 2009 to decrease the exposure of Utah children to secondhand smoke (SHS). PASS is a resident-formed, grassroots advocacy group created to bring together residents, interdisciplinary child healthcare providers and community anti-tobacco advocates.

The PASS Initiative works to provide a sustainable intervention to address the following specific objectives for Utah children and pediatricians:

1. Assess the needs of Salt Lake Valley community pediatricians in providing effective, culturally sensitive smoking cessation interventions.

2. Develop generalized pediatrician smoking cessation intervention curriculum that may be tailored to specific needs of each pediatric practice based on a baseline needs assessment survey.

3. Assess pediatrician smoking cessation practice behaviors following an educational intervention by using baseline and follow up surveys in each practice to determine self-reported changes in attitudes and practice behaviors.

4. Provide sustainable systems change measures to improve pediatrician smoking cessation best practices in pediatric office settings.
5. Provide community pediatricians and pediatricians in-training with appropriate smoking cessation training.

6. Support programs that may decrease the burden of SHS on Utah children.

During the planning stages of the PASS Initiative, PASS residents provided resident education and support for legislative advocacy. To date, PASS residents have developed a community pediatrician needs assessment survey, built a resident-led anti-tobacco coalition, developed a curriculum for pediatrician smoking cessation intervention, and partnered with local health departments in developing clinic/systems change resources. Education efforts have included didactic instruction to residents and community organization regarding the health effects of SHS and need for pediatrician intervention with parents who smoke. During the 2010 Utah Legislative Session, efforts also included advocacy for legislation supporting smoking bans in private vehicles when children are present.
Anne E. Dyson Child Advocacy Award  
2009 Recipients

**Project Leader Name:** I.J. Brenda Anosike, MD  
**Project Title:** Young Leaders of Medicine Mentoring Program (YLOM)

The Young Leaders of Medicine Mentoring Program was a community/hospital-based program that was started in the summer 2007. YLOM takes place at the Hasbro Children’s Hospital in Providence, Rhode Island. It was designed to work with selected high school students (grades 9-12) in the Providence community who are interested in the health/medicine career and community service. Each month the students meet with pediatricians to discuss different diseases that affect children with an associated adolescent issue. As apart of this program, the students get the opportunity to work with elementary students and meet with doctors and nurses to learn about the body. As a final project, the students set-up a charity health fair in Providence in order to bring care and resources to our families that cannot otherwise see their doctors due to time or financial constraints. In these difficult times, however, it has been hard for a great deal of our neighboring families and even for the student, themselves. The ultimate objective of the health fair is to bring awareness and care to the community.

**Project Leader Name:** Ananya Guha, MD  
**Project Title:** Familias Fuertes

Familias Fuertes is a resident-initiated, community based outreach program combating obesity in families in the International District of Albuquerque through supervised physical activity, nutritional education, and health promotion. Children of the International District of Albuquerque, an impoverished Hispanic immigrant community in Albuquerque, have an increased risk of obesity and associated health consequences. Not only do children suffer in this community from poor nutritional choices, but the violence which has earned this area the nickname “War Zone” prevents most children from participating in outdoor activities and routine physical exercise.

Familias Fuertes began as a pilot project last year, with weekly two hour sessions where women and children stretch, play, exercise, and eat healthy food together. Women also get the opportunity to work out in a gym while children engage in a mixture of supervised structured and unstructured play. The program teaches children to model parent’s healthy behavior and teaches parents that their children can enjoy healthy food and activity. With the positive response and consistent participation from the community, we aim to create formal exercise, nutrition, and health curricula, study the effectiveness of the health curricula to improve lifestyle and health outcomes, and expand the number of families enrolled in the program.
In addition to covering health topics, health education sessions will include information and enrollment assistance for available government programs, including Medicaid, Food Stamp, and WIC programs. In addition, health education sessions will address how to navigate the complex medical system to find a medical home for their children at either Young Children’s Health Center or the University of New Mexico, and advocate for their child during health visits. With these various components, Familias Fuertes utilizes and augments existing community resources and social capital to promote a comprehensive culturally-appropriate healthy lifestyle curriculum for families in the International District.

**Project Leader Name:** Richard P. Hobbs, III, MD  
**Project Title:** Healing for Homeless Children

The Samaritan Health Center’s Healing for Homeless Children (HHC) program is based in the Durham Rescue Mission, the area’s largest homeless shelter. The Samaritan Health Center provides comprehensive, free medical care for homeless adults and children in Durham, North Carolina.

Healing for Homeless Children is a clinic initiative that seeks to provide a temporary medical home for these often transient, resource-poor children. Specifically, HHC screens all new children to the Mission, assesses and treats chronic and acute medical conditions, coordinates care with local case workers, refers for specialty services, and promotes literacy by providing books through Reach Out and Read. After initial evaluation, children receive preventative, chronic and acute care while the family resides at the homeless shelter, and longer if necessary.

The primary goal of HHC is to advocate for the medical needs of these children, who often fall through the cracks of a difficult to navigate medical infrastructure. Above and beyond providing needed medical care, however, the HHC seeks to link these children with ongoing community resources to meet behavioral, educational, nutritional, social and spiritual needs. All the care is free and provided by volunteers, including University of North Carolina and Duke University attendings, residents, medical students, and other allied health providers.
Anne E. Dyson Child Advocacy Award
2008 Recipients

Project Leader Name: Mana Golzari, MD
Project Title: Medical Homes for Youth Exiting Juvenile Detention

Medical Homes for Youth Exiting Juvenile Detention aims to create a partnership between the county juvenile hall and the UCSF pediatrics residency program in order to create medical homes for youth upon release from detention.

An estimated 120,000 adolescents under 18 years of age go through county juvenile halls (JH) as part of the California juvenile justice system each year. In 2005, there were 1,831 detentions in San Francisco’s juvenile hall and an average of 100 youth in residence at any given time. These minors have substantially higher rates of morbidity and mortality compared to their peer group in addition to higher rates of co-occurring health-risk behaviors. Their time of incarceration often represents their only significant contact with a health care provider outside of an emergency setting. Although it is currently mandated that incarcerated youth receive health care services during their time in JH, the majority of this care is in the form of acute care services. These services are abruptly discontinued upon the youth’s discharge back into the community. There is currently no system in place to ensure medical follow-up for youth exiting detention.

The AAP issued a policy statement in 2001 stating that children and adolescents confined to correction care facilities should have special attention focused on, among other things, the establishment of a medical home before release. The goal of our project is to create a partnership between our county juvenile hall and our pediatrics residency program in order to create medical homes for youth upon release from detention.

Project Leader Name: Lisa M. Guetzko, MD and Roxanna Eftekhari, MD
Project Title: Outreach for Refugee Children in Tampa Bay

Outreach for Refugee Children in Tampa Bay aims to address the primary health care needs of children of refugees and asylum seekers in the Tampa Bay area. This population is particularly in need of health care assistance because they typically do not have health insurance or permanent Medicaid coverage, having chosen or been forced to move from their native countries to seek asylum in the United States. The obstacles to obtaining health care for this population include not only a lack of funding, but also language, cultural, intellectual and social resources such as transportation. They provide well child checks, sports physicals, health information, fluoride dental varnishes, prescriptions, specialist referrals, general health information and academic counseling to refugee children, adolescents and families. They work with local non-profit and humanitarian organizations to identify and address the specific needs of the populations we serve. By forming partnerships with
well-established community outreach centers, they promote sustainable health care options for those who have fled their home countries to escape torture, oppression, violence, and the unimaginable. With the knowledge and assistance of their various partners, they are not only teaching their patients how to improve their health, they are also learning invaluable lessons from them about the amazing resiliency of the human spirit.

**Project Leader Name:** Alexander S. Zusman, MD, Tricia Michels Tayama, MD and Kajal Khanna, MD, JD  
**Project Title:** Media Advocacy for Youth Violence

Media Advocacy for Youth Violence is a community-based child advocacy project that uses media to address the problem of youth violence in the city of San Francisco. The group began by collaborating with the Wraparound Project, an academic-community partnership that strives to reduce recidivism (return to the hospital for violent injuries) among youth in San Francisco. The focus of the Wraparound project at San Francisco General Hospital (SFGH) is culturally sensitive case management services for youth who have been injured by violent crime. So far this approach has effectively lowered the recidivism rate to 3% from 35%. Last year, firearms were involved in 85% of all youth killed in San Francisco creating a tremendous need to raise awareness and generate solutions around the problem of youth violence.

Through a close relationship with their community partner, the group realized that a film could have tremendous potential to increase awareness surrounding youth injured by violence. In 2007, they created a documentary film that portrays youths’ stories of recovery and re-integration following serious violence related injury. By sharing these stories, they anticipate their film will be a powerful and unique advocacy tool that can reach youth, local community-based organizations, and health care providers. Their plan is to generate collaboration, discussion, and new solutions by distributing this film through community screenings followed by panel discussions on the topic of youth violence. Thus far, they have been invited to present their film at the annual Juvenile Justice Summit in San Francisco and have subsequently been asked to show the film in the local public schools and at the quarterly UCSF Division of General Pediatrics meeting.
Project Leader Name: Joshua M. Dower, MD and Raveen Raviendran, MD
Project Title: “Literacy for End-of-Life”

“Literacy for End-of-Life” is a project targeting children and families who face terminal illness, life altering experiences including acute injuries, and fetal demise. The project will attempt to provide age-appropriate resources for individuals coping with end-of-life issues. Through books and other resources this program will give families a library of tools to attain answers to questions surrounding death and the grieving process. This will provide an opportunity to address feelings of guilt, anger and loneliness. It will also be an occasion to have a celebration of life and explain death as a natural process.

In rural areas, clinicians and institutions lack training and resources for end-of-life care. Reading opens a window for discussion of challenging psychological issues. We see reading as a form of respite care. It is an opportunity for caregivers and children to receive a break from their difficult situation and enter a world of opportunities for self-exploration and camaraderie.

Family reading time helps preserve and strengthen families and is important to the overall health of families and children with chronic conditions. Furthermore, implementing this program at WVU Children’s Hospital, serving as a regional referral center, allows collateral benefits to flow into the surrounding rural communities. The long term goal will be to establish a comprehensive lending library and make the books available to children and families across the State of West Virginia.

Project Leader Name: Kitty O'Hare, MD and Manisha Shanbhag, MD
Project Title: Working Initiative for Special Health Education Services (WISHES)

WISHES is a group project of the Medicine-Pediatrics residency at the University of Pennsylvania (Penn) and Children's Hospital of Philadelphia (CHOP). Our goals are to: 1) create and administer a health care curriculum pertinent to adolescents with special health care needs (SHCN); 2) facilitate the transition of adolescents with SHCN from pediatric to adult medical providers; and 3) train Med-Peds residents as primary providers for adolescents with SHCN. In line with the goals of Healthy People 2010, WISHES seeks to remove barriers to health care for patients with disabilities.

WISHES collaborates with Widener Works and REACH, two programs for adolescents with SHCN developed by Children's Hospital of Philadelphia. The Widener School is a Philadelphia public school for children with severe disabilities. Selected seniors at Widener spend part of the week at CHOP in job readiness training. Job skills assessments are performed by specialists in physical therapy, occupational therapy, speech therapy, and neuropsychology. Over time, students are matched with job coaches and perform job trials in
various departments at CHOP. Ultimately, after successful completion of the training program, students are hired into the CHOP workforce. Students and families from Widener and other schools attend weekend support sessions conducted by the REACH group.

WISHES specifically addresses the health care needs of participants in Widener Works and REACH. Med-Peds residents review the medical record of each student, then work with the students to draft a personal health history. These durable medical summaries serve as a foundation for transition to adult providers. Further, residents try to identify adult providers for any students who have not yet transitioned to adult medicine. In 3-4 sessions, residents meet with the entire senior class at Widener to present a *Healthy Choices* curriculum. Topics include sexuality, relationships, nutrition, exercise, and substance abuse. Residents participating in WISHES report back to the Med-Peds residency program in monthly conferences. Through quarterly specialty conferences, Med-Peds residents will educate their colleagues in Pediatrics and Internal Medicine about topics related to transition and adult followup of chronic disease. In addition, Med-Peds residents are encouraged to rotate through specialty clinics addressing chronic disease, such as Penn's programs for Adult Cystic Fibrosis and Adult Congenital Heart Disease.

Funding from the Dyson Advocacy Award will be used to create and print customized health summaries for WISHES students. Also, funds will be applied toward materials used in the classroom health education sessions, including multimedia teaching tools accessible to students with a variety of sensory impairments. For example, specialized teaching materials are needed for students who are blind or with poor reading skills.

**Project Leader Name:** Alenka Zeman, MD, Anna Rosenquist, MD and Katharine Zuckerman, MD  
**Project Title:** Massachusetts Pediatric Residents and Fellows Day at the State House

This project was created entirely by pediatric residents at Mass General Hospital for Children with the goal of bringing together residents and fellows from across Massachusetts to the state house in order to learn how to be child advocates. We as residents felt that there were a lot of important child health issues being debated by legislators, but we did not know how to go about making our voices heard or did not know that we could be lobbyists. Instead of just watching these issues affect the health of children we cared for in the hospital daily, we wanted to make a difference. With these ideas in mind, we created the Massachusetts Pediatric Residents and Fellows Day at the State House last year and it has been met with great success for the past two years.

Our main goal of this project is to teach residents how to promote policy and to discuss current child health issues that are actively being debated. One day a year we gather about 70-100 residents at the state house and create a day
filled with many events. The morning consists of a number of talks including, for example, speeches from: Dr. Bigby (the secretary of health and human services), Dr. Palfrey (a well known pediatrician and child advocate) and interactive workshops from Alex Calcagno and Ed Brennan (lobbyists) who role play how to be an effective lobbyist. We take time to discuss three important child health issues each year that are currently up for review by legislators. For example, this summer we discussed the new mental health care bill (H.1872) that would provide children better access to mental health facilities, the school nutrition bill (H.2168) that allow schools to provide children with healthier food options and finally discussed funding three new vaccinations: the meningococcal, rotavirus and HPV vaccine as part of the state budget. In the afternoon, we set up individual appointments for each resident to meet with his or her representative and senator so that he or she can personally discuss their support of these bills. Our goal is to have pediatric residents and fellows from across Massachusetts meet other people interested in advocacy, learn about pediatric health care issues, and personally realize that as pediatricians we have a duty to let our opinions regarding these issues be heard.
The MGH legislative advocacy group (LAG) had the idea to create this day last year and so far we have planned two very successful days at the state house. In fact, this year we doubled our participation and had almost 100 residents, fellows and faculty from all five of the Massachusetts pediatric residency programs (MGH, Children's/BMC, Baystate, Umass and Tufts) attend. Due to the amount of success that we have had, we are definitely planning on continuing this as an annual event. This one day takes about 9 months of planning to create each year, but is definitely worth the amount of work when we hear the feedback both from participants and legislators. The enthusiasm that this project has created for child advocacy really is unparalleled.
The Pediatric Refugee and Immigrant Health Clinic frequently encounters families that struggle with multiple barriers to health care as a result of their immigration or refugee status including: poverty, cultural and language barriers, fear of apprehension by immigration authorities, as well as simple lack of documentation for health care financial coverage. Interest in partnering with the Settlement and Integration Services Organization (SISO) of North Hamilton came from a desire to overcome some of these barriers and work specifically with immigrant and refugee children. SISO is a “community based organization that provides essential services and programs to facilitate and support early settlement and integration of immigrants and refugees in Hamilton”. Dr Hunter and others have designed and implemented a pediatric clinic in partnership with SISO to provide comprehensive initial health assessments for children newly arrived to Canada, and to assist in the integration of these children and their families into the Canadian health care system. The SISO pediatric clinic has provided an opportunity for residents to improve the services for a marginalized population within our community, gain knowledge in tropical medicine and enact our important role as health advocates.

The primary objective of Project TEACHER is to decrease teacher reports of disruptive classroom behavior, decrease visits to the principal’s office for problem behaviors, and improve children’s grades and attendance. In the fall of 2004, four residents recognized their common interest in effective school-associated interventions aimed at reducing aggressive and disruptive behaviors in children. That same fall, they started researching existing programs to address their primary objective. The Coping Power Program (created by Dr. John Lochmann) met their criteria and was selected for implementation. The residents partnered with the local YMCA and Pinnacle School No. 35, applied for grant funding, screened for behavior problems in 3rd through 5th grade students at the school, and hired staff during the spring/summer of 2005. The Coping Power Program was implemented in October 2005 for 16 high-risk students and successfully finished its pilot year in June 2006.
**Project Leader Name:** Gary Maslow, MD  
**Project Title:** The Adolescent Leadership Council of Hasbro Children's Hospital

Gary Maslow, MD, started TALC in September of 2005 following an AAP CATCH Grant. The Adolescent Leadership Council of Hasbro Children’s Hospital (TALC) was created to provide adolescents with chronic illness a social support network and a voice to improve the care of children with chronic illness in the state of Rhode Island. TALC is a group of 10 teenage patients with chronic illnesses and 10 Brown University student mentors also with chronic illnesses that meets on a monthly basis. The teens and Brown University student mentors have a diversity of conditions including Crohn’s Disease, Cancer, Diabetes Mellitus, SLE, Ehlers-Danlos, and Migraines. The group provides social support and mentoring for teens with chronic illness while also providing a forum for these adolescents to become leaders who actively work to improve the experience of other children treated at Hasbro Children’s Hospital. Beyond attending monthly meetings, participants in TALC produced a newsletter discussing various aspects of chronic illness which has been distributed throughout the community, presented at Pediatric Grand Rounds, and have done outreach to local schools in an effort to educate teachers and other students about the school issues surrounding chronic illness.
The 2005 Anne E. Dyson Child Advocacy Awards went to Jonathan Lee-Melk, MD and Paul Mullan, MD. Congratulations to the both of them on their outstanding work for children! Their projects are highlighted below.

Jonathan Lee-Melk, MD  
**Project name: The Rosa Vera Fund**

Bolivia, the second poorest nation in the Western Hemisphere (behind Haiti), routinely witnesses a high level of pediatric morbidity and mortality that is entirely preventable. Particularly difficult conditions to treat include any illness or circumstance that requires an upfront expenditure or chronic care, as the resources required are simply not available to the majority of children. The Rosa Vera Fund (RVF) is an ongoing collection of donations that is guided to provide preventative, medical and/or social interventions for children of Montero, Bolivia, that would not have otherwise been possible. Since its initiation in May 2003, the RVF has successfully provided life-altering and life-saving interventions to numerous children and their families at a surprisingly minimal cost. Through collaboration with non-profit American and Bolivian partner organizations (“Curamericas” and “Rural Andean Health Committee” respectively), the RVF is working to achieve its mission through Prevention Services and Treatment Services. Key to understanding the RVF is illumination of the fact that completing pediatric preventative/medical/social work in Bolivia with the American dollar is exceedingly inexpensive.

Dr Lee-Melk’s principal role is to fundraise and promote the RVF among his friends, family, and colleagues, whom provide the sole funding for the RVF. His responsibilities include development of promotional materials, monthly updates, and reaching out to as many people as possible to express the goals, innovations, and effectiveness of the RVF.

Paul Mullan, MD  
**Project name: Camp Phoenix**

Camp Phoenix is a group founded in 2000 by the medical students of Cornell University to provide a free, safe, nurturing, and stimulating environment for pediatric burn survivors (ages 6-15) who have been discharged from the hospital. Prior to Camp Phoenix, a local program did not exist that provided continued contact with the patients once their physical wounds had healed. They interact with the children throughout the year in a series of fun-filled events, culminating in a June trip to a local overnight camp for a weekend of camp-related activities. Camp Phoenix activities are designed to build self-confidence, to emphasize teamwork, to initiate friendship, and to have fun. The camp provides a setting for children to experience those activities that every child deserves but may not have the opportunity to experience. Positive interactions with other children who are having similar emotions help replace a child’s feelings of isolation and resentment with encouragement, understanding, and comfort about their situation. The interactions with the children can also create a healthy relationship of caring, role modeling, and future goal-setting. The name of the camp was conceived because the phoenix has historically symbolized a bird that has overcome adversity and prospered after rising out of the flames of hardship.
Dr Mullan is currently director of the fundraising board, overseer of the website, chief advisor to the medical student leaders, and he continues to attend and lead events with the children. Other residents from New York Presbyterian Hospital and the Children's Hospital of Philadelphia continue to return to the events to act as camp counselors and also advisors to the current medical student volunteers.