October 17, 2009

Dear Program Delegate:

The Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT) is proud to announce its 5th Annual Advocacy Campaign: ImmuneWise, an advocacy effort focused on increasing national childhood immunization rates. Our 10,000 members can act to improve immunization rates in the United States by becoming more educated on immunizations and utilizing tools provided by our Section to implement change. Our members can affect change, as evidenced by the Section’s 2008-09 project: Target Tobacco, our most successful project to date. This year we partnered with the AAP’s Section for Seniors Members, who provided invaluable clinical pearls and mentorship as our Section focused on this prominent issue that affects all children in the United States.

The SOMSRFT Advocacy Subcommittee compiled resources, tools and suggested advocacy projects for implementation at the individual, program/clinic, community, state, and national/federal level.

This compiled information can be found on the enclosed CD-ROM, and is divided into four sections: 1) General, 2) Education, 3) Advocacy, and 4) Conclusion. The CD-ROM may be navigated by the tabs on the PDF file. Please start at the tab titled "General" in order to be guided through this material and to better understand the expectations SOMSRFT has for you as a program delegate.

The ImmuneWise Noon Conference presentation contains a patient case, background facts and reasons to get involved in improving immunization rates, as well as an overview of projects at each advocacy level. The presentation should be used in the noon conference setting to educate residents and residency program leaders on potential advocacy projects. In addition, there are educational morning reports and advocacy modules to help meet each residency's training needs.

Please use the Project Implementation Checklist found in the "General" tab on the CD-ROM to guide you through the advocacy campaign. It is expected that each program delegate will give the Noon Conference presentation to the residents in their program. Please use the Project Outcome Report found in the "Conclusion" tab of the CD-ROM to notify the SOMSRFT Advocacy Subcommittee of your success.

A copy of our CD-ROM will be distributed during our Annual Assembly at the 2009 National Conference & Exhibition. The material will also be available on the Section Web site at www.aap.org/ypn/r/advocacy and provided to each program director.

Sincerely,

SOMSRFT Advocacy Subcommittee
October 17, 2009

Welcome to the 5th Annual Advocacy Campaign of the Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT). This year’s project is “ImmuneWise”: an advocacy effort to educate residents on vaccines and vaccine preventable diseases with the ultimate goal of increasing national immunization rates.

Our Section aims to provide residents with tools so that each program can implement the advocacy project that they choose, at the intervention level they desire. On this CD-ROM, the SOMSRFT Advocacy Subcommittee compiled resources and suggested advocacy projects for implementation at the individual, program/clinic, community, state, and national/federal level. This letter contains examples of the CD-ROM contents as well as guidance on how to implement the suggested activities. Each opportunity is presented in more detail within the ImmuneWise Noon Conference presentation.

Individual Level: Individual advocacy describes the work you are already doing to improve the health and well-being of individual patients. This could include calling an insurance company, a school, or a social service agency on behalf of an individual patient. Individual advocacy easily translates to advocacy on other levels; at its core, each level of advocacy is about speaking out on behalf of children’s health and well-being.

Program/ Clinic Level: A program or clinical setting implements a project at this level of advocacy with one or two individual residents taking a leadership role. This category of projects requires support from fellow residents and faculty. Examples include:

- Implement a Quality Improvement Project focused on improving immunization rates in your resident clinics. Follow our step-by-step guide located under the “Quality Improvement” tab titled Quality Improvement Project in the Advocacy Section.

- Introduce the five Advocacy Modules in a series of conferences to educate your residents about principles of advocacy. These are located under the “Advocacy Module” tab in the Advocacy Section. Of note, these modules are also located on the AAP Web site for continued reference.

Community Level: A group within the community, led by one or two residents, implements this level of advocacy. This category of projects requires support from community pediatricians or other community leaders. Examples include:

- Distribute the Myth vs Fact Handout to parents in your clinic and/or coordinate the circulation of these handouts to parents of community practices. This is located in the “Handout” tab in the Advocacy Section.

- Give a presentation to PTA groups or preschool parents using the information provided in the Myth vs Fact Handout and the resources
provided in the Education Section under the Historical Perspective of Immunizations tab.

Post ImmuNeWise Posters in your clinic waiting rooms, examination rooms, and in those of community pediatricians. These are located in the “Poster” tab in the Education Section.

Write a letter to the editor of a local newspaper based on the information contained within the education materials included in the CD-ROM. The Sample Letter to the Editor is located under the “Media” tab in the Advocacy Section.

**State Level:** An individual, program or community group can utilize information within the CD-ROM to develop or implement a statewide campaign. Any AAP member can take part in state advocacy. Examples include:

Call, email or write your legislator on an issue of importance affecting childhood immunizations. Utilize the Sample Letter to the Legislator found under the “State Government Affairs” tab in the Advocacy Section to craft this letter.

You might approach state legislators regarding a statewide immunization issue or piece of legislation such as mandatory HPV vaccination. Use the information in Advocacy Module #3 on Working with Decision Makers under the “Advocacy Modules” tab in the Advocacy Section. The State and Governmental Affairs Handout under the “State Government Affairs” tab in the Advocacy Section can also be used for guidance on project implementation.

**National/ Federal Level:** An individual, program or community group can utilize resources on the CD-ROM to develop or implement a national campaign. Examples include:


Attend the AAP Advocacy Institute March 10-11, 2010 and develop advocacy and leadership skills that are instrumental in successful national projects not limited to vaccine advocacy.

Our Section has the ability to impact change on an individual, program/clinic, community, state, and federal level. This CD-ROM serves as a resource and foundation for individual residents and programs to implement the project(s) they feel will have the greatest influence on improving immunization rates across the country. Utilize the Project Implementation Checklist in the “General” tab and submit a Project Outcome Report from the “Conclusion” tab upon project completion. The SOMSRFT will recognize outstanding projects in Angles on Advocacy column published in the AAP Resident Report.

Thank you for all of your hard work each day to improve the lives and health of children.

Sincerely,

SOMSRFT Advocacy Subcommittee
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PROJECT IMPLEMENTATION CHECKLIST

Complete Survey Monkey Pre-Test. This can be done prior to arriving at the NCE, while at the NCE, or within one week of your return home.

Read the “Introduction” section found in the PDF on the CD-ROM.

Inform your program director of project and instructions from SOMSRFT Advocacy Subcommittee.

Select date for presenting the ImmuneWise Noon Conference.

Use tools provided to implement an advocacy project, see examples in “Advocacy Campaign Intro Letter.”

Submit a “Project Outcome Report”, a one page document found under the “Conclusion” tab of the PDF on the CD-ROM via email to Julie Raymond: jraymond@aap.org and to your District Coordinator.

Complete Survey Monkey Post-Test which will be emailed to you from the SOMSRFT Advocacy Subcommittee in the Spring.

Thank you and congratulations on your role as Program Delegate for your program!

SOMSRFT Advocacy Subcommittee
5th Annual Advocacy Project: ImmuneWise
Section on Medical Students, Residents, and Fellowship Trainees 2009-2010
ImmuneWise

Smart moms know the facts

FACT: Vaccines save 33,000 lives each year
Case Presentation
Case Presentation

• 4 year old female is on the illness clinic schedule
• Her mom reports 2 days of fever and decreased energy level
Case Presentation

• Review of Systems
  – Temp to 102° F
  – Mild headache
  – Eye redness
  – Mild congestion
  – Non-productive cough
  – No GI complaints
  – No rash

• PMHx
  – Healthy
  – Due for 4-5 year old immunizations

• SHx
  – Lives with parents
  – No known sick contacts
  – Recent travel to Disney World (about 10 days ago)
Case Presentation - Exam

- **General**: Cooperative, NAD but appears ill
- **HEENT**: PERRRL, bilateral conjunctival erythema and watery eyes, nares patent, MMM without lesions, neck supple, no lymphadenopathy
- **Chest**: CTA bilaterally, no wheeze/rales/rhonchi; RRR, no murmur/rub/gallop
- **Abd**: Active BS, soft, non-tender, no HSM
- **Skin**: No rash or lesions noted
Case Presentation

• Diagnosed with a viral upper respiratory infection
• Supportive care was discussed with the patient’s mother
Case Presentation

- The 4 year old returns the next day with a new rash...
- Exam is unchanged except for a blotchy, blanching erythematous maculopapular rash on her face and neck
Differential Diagnosis

- Discussion
Management
Measles

Epidemiology

• Humans are the only natural host
• Transmitted by direct contact with droplets
  – may contract from airborne droplets too
• Most common in preschool and early school-aged children with a late winter peak
• Vaccine licensed in 1963
• Vaccine failure rate of 5% in those with only a single dose
Measles vaccine was licensed in 1963. Evidence suggests that measles is no longer endemic in the United States.
MEASLES

EPIDEMIOLOGY

Reported Measles Cases
Region of the Americas, 1980 - 1998

- Catch-up campaigns
- 86% coverage <1 yr old
- Follow-up campaigns

Confirmed cases (thousands)

Year

Source: PAHO/WHO, 1/99
* Provisional Data

© CDC
Measles

Clinical Presentation

• Incubation period of 8-12 days

• Symptoms and signs include:
  – Fever, malaise, cough
  – Conjunctivitis, coryza, +/- photophobia
  – Koplik spots on soft palate (often occur before the rash and are diagnostic)
  – Rash, usually day 2-3 of illness

• Contagious for 1-2 days before onset of symptoms until ~4 days after rash appears
MEASLES

CLINICAL PRESENTATION
Measles Diagnosis

• Serum sample positive for measles IgM antibody on initial presentation
  – Sensitivity varies - low in first 72 hours of rash
  – If the initial test is negative, consider repeating after the rash is present > 72 hours

• Significant rise in measles IgG in paired acute – convalescent samples

• Measles RNA in blood, throat, nasopharyngeal or urine samples (by PCR)
Measles Complications

- Complications include:
  - Otitis media
  - Croup or bronchopneumonia
  - Diarrhea

- Severe complications:
  - Acute encephalitis in 1/1000 cases
  - Death in 1-3/1000 cases
    - Usually due to respiratory or neuro complications
  - Subacute sclerosing panencephalitis (SSPE)
    - Degenerative CNS disease
**Measles Treatment**

- **Supportive care**
- **Vitamin A**
  - Give if vitamin A deficiency is endemic
  - Give in the U.S under certain conditions
    Consult Red Book
- **Ribavirin**
  - Not FDA approved, but may help those severely affected and immunocompromised
Measles Infection Control

• Vaccine given within 72 hrs of exposure may provide protection in susceptible individuals

• Immune globulin given within 6 days of exposure may prevent or modify measles
ImmuneWise

Smart moms know the facts

FACT: Vaccines save 33,000 lives each year

ImmuneWise

Advocacy
Immunewise

- 5th Annual Advocacy Project
- SOMSRFT partnered with Section for Seniors Members
- Goal: Educate providers and parents
- Goal: Improve immunization rates
- Goal: Foster advocacy interest among SOMSRFT members
Who Else?

• Within the AAP, many are concerned

Paul Offit, M.D.
What about you?

- Many levels of advocacy
  - Individual level
  - Residency program / Clinic level
  - State level
  - Federal level
Individual Level
Individual Advocacy

• Talk to the Press
  – Write a letter to the editor
  – Make yourself available to the media

• Contact your state legislators
  – Write a letter or an email
  – Provide them with information

• Discuss the issue with parents
  – Provide parents with info on *Myths vs. Facts*
  – Answer questions about vaccine components, side effects, and alternate schedules
Myths vs. Facts
Program / Clinic Level
Program-Wide Advocacy

• Implement a quality improvement project focused on improving immunization rates

• Implement an immunization education curriculum
ACGME Program Requirement on Practice Based Learning and Improvement states, “systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement. Residents are expected to participate in a quality improvement project.”
QI Project
Immunization Rates

- QI projects focused on improving immunization rates can target
  - Particular vaccine (e.g., influenza)
  - Target population (e.g., 2-24 month olds)
  - Entire population served

- An example of how to do QI for immunization rates comes from TIDE – Teaching Immunization Delivery and Evaluation
Designing QI – Step 1

• Assess Immunization Rates (“Plan”)
• Assessment methods:
  – Chart method
  – Active method
  – Consecutive method
• Record the assessment data collected
  • There is a sample to download
Designing QI – Step 2

- Implement Change (“Do”)
  - Describe and analyze key office routines related to immunizations using an office immunization practices questionnaire
    - There is a sample to download
  - Based on findings…
    - Select an intervention likely to improve immunization rates
    - Focus on the “vital few” interventions rather than the “useful many”
### Office Immunization Practices Questionnaire

<table>
<thead>
<tr>
<th>Factor</th>
<th>Office Practice</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Describe behaviors; check if yes</td>
<td>Select system change by checking box</td>
</tr>
<tr>
<td><strong>Assess</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment and feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are practice immunization rates assessed regularly?</td>
<td>✔</td>
<td>□ Assess immunization rates in the practice on a periodic schedule using a valid method.</td>
</tr>
<tr>
<td>Is feedback of immunization rates given to providers?</td>
<td>✔</td>
<td>□ Give immunization providers specific feedback about their rates and comparison to other rates</td>
</tr>
<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Record is always available, prompts for providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical record is available</td>
<td>✔</td>
<td>□ Record available at each visit</td>
</tr>
<tr>
<td>Record of immunizations available</td>
<td>✔</td>
<td>□ Immunizations recorded in one easy to locate place in chart</td>
</tr>
<tr>
<td>Immunizations systematically checked at all visits?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization prompts for providers at the time of visits?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient-held immunization record/card?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Opportunities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunize at both sick and well visits?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraindications to immunizations are appropriate and consistent?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All immunizations due administered simultaneously</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there standing orders for</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Institute standing orders</td>
</tr>
</tbody>
</table>
Designing QI – Step 3

• Assess the Effects of Change ("Study")
  – Assess the immunization rates again (after a set period of time)
  – Continue to improve your effort after noting barriers / set-backs
  – Celebrate successes
Community Level
Community Advocacy

- Find community supporters and leaders
- Speak to parent groups
- Post ImmuneWise posters in key locations
- Utilize national PSAs at the local level

FACT: Vaccines save 33,000 lives each year
PSA

Every Child By Two
State Level
Each state has their own reimbursement issues

= States where insurers are required to cover some or all childhood immunizations
State Advocacy

• Statewide campaigns are an opportunity to partner with AAP Chapters
• The activities available/needed vary by state, so for more information turn to:
  – ImmuneWise CD-ROM
  – AAP Committee on State Government Affairs
National / Federal Level
National Advocacy

- National media campaigns underway
  - Every Child by Two
  - The Vaccinate

Your Baby Web site:

www.vaccinateyourbaby.org
Federal Advocacy

• Other opportunities for involvement:
  – Attend AAP Advocacy Institute
    • March 10-12, 2010 in Chicago
  – Familiarize yourself with AAP position papers
  – Become a Key Contact for the AAP Federal Affairs Advocacy Network (FAAN)
You Can Make a Difference!

- Find out the special needs of your clinic or community
- Develop a project YOU have a passion for
- Return the Project Outcome Report for ImmuneWise. This will help us improve future advocacy projects!
- Let us know what you have accomplished. We want to recognize you in district newsletters and Resident Report!
Brought to You By:

- SOMSRFT Executive Committee
  Advocacy Subcommittee
  - Co-Chairs
    • Drs. Katie Snyder and Jennifer Williams
  - Members
    • Drs. Shawn Batlivala, Clara Filice, Jenni Linebarger, Christina Robinson, Sara Slovin, Josh Smith, Amy Starmer, David Tayloe
  - Other Contributors/Supporters
    • Lucy Crain, MD, FAAP, Buz Harlor, MD, FAAP, Michael Warren, MD, FAAP, Julie Raymond, Ian Van Dinther
Welcome to the 5th Annual Advocacy Campaign of the Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT). This year’s project is “ImmuneWise”: an advocacy effort to educate residents and parents with the goal of increasing national immunization rates. Our Section’s goal is to provide residents with tools so that each program can implement the advocacy project that they choose, depending on the level of advocacy they desire.

The 5th Annual Advocacy Campaign: ImmuneWise is an advocacy effort to educate residents and parents with the goal of increasing national immunization rates. Our 10,000 members can improve immunization rates in the United States by becoming more educated on immunizations and utilizing tools provided by our Section to implement change. Today I will present a case and educational point related to it. Next, we will discuss the different levels of advocacy available for you to get involved in.

The picture you see depicts the conjunctival erythema and watery eyes

What is our differential diagnosis at this point? Let’s discuss findings of the presentations and rashes of the potential etiologies:

Scarlet fever (streptococcal) - Most commonly associated with pharyngitis and impetigo. Exanthem appears within 12 to 48 hours and rapidly generalizes, usually beginning on the trunk and spreading peripherally, but sometimes cephalocaudally. The remaining skin becomes diffusely erythematous and is covered by tiny pinhead papules, giving the appearance of sunburn with goosebumps. It is sandpapery to palpation and blanches with pressure.

Roseola infantum (Exanthem subitum)- affected ages 6 months to 36 months caused by herpesvirus 6. Begins with rapid temperature elevation and occasionally a febrile seizure, and is associated with anorexia and irritability that subsides at 72 hours. Usually an erythematous, maculopapular exanthem appears simultaneously with defervescence – lesions are discrete rose-pink macules or maculopapules that begin on the trunk and spread rapidly to extremities, neck, face, and scalp. They last several hours to 1-2 days before resolution.

Infectious mononucleosis – Prodrome 3-5 days, fatigue, malaise, anorexia with possible headache sweats and chills. Acute phase with fever, pharyngitis, cervical node enlargement, Tonsilar and adenoidal enlargement has range of severity. Exantheme is seen in 5% of population: but increased in patients treated with amoxicillin or ampicillin. Erythematous, maculopapular rubelliform rash but can be morbilliform, scarlatiniform, urticarial, hemorrhagic and even nodular.
**Erythema infectiosum** - Fifth disease is mildly contagious caused by parvovirus B19 usually affects preschool age or young school age children. It is characterized primarily by the exanthem. Rash begins on the face, with large, bright red, erythematous patches appearing on both cheeks. Patches are warm and nontender with circumscribed borders that are usually macular but may be slightly raised. Fever and constitutional symptoms are rare.

**Coxsackievirus** - Hand, Foot, Mouth disease is this distinctive exanthem. Brief prodrome of low grade fever, malaise sore mouth and anorexia with no lesions, within 1-2 days, oral lesions occur then skin lesions. Oral usually yellow, shallow ulcers surrounded by red halos, Cutaneous lesions begin as erythematous macules on the palmar aspects of the hands and fingers, plantar surfaces of feet and toes and interdigital surface.

**Varicella** - Brief prodrome of low grade fever, URI symptoms, and mild malaise followed by 3 crops of lesions. Initially involve the trunk and scalp then distributed more peripherally - in centrifugal mode. The scalp lesions can be helpful in diagnosis. Lesions start as erythematous papules that rapidly enlarge to thin-walled central vesicles surrounded by red halos. The vesicular fluid changes from clear to cloudy and then drying/crusting occurs. *Enanthem* consists of thin walled vesicles that rapidly rupture to form shallow ulcers. Other mucosal areas may be affected and painful, while those on the skin are pruritic.

**Drug rash** - Various presentations: *Exanthematous drug eruption* is symmetrically arranged, brightly erythematous macules and papules, discrete in some areas and confluent in others (commonly with penicillin class, carbamazepine, allopurinol, gold salts, less commonly with Sulfonamides, NSAIDS, hydantoin class, isoniazid, chloramphenicol, erythromycin, streptomycin.

Fixed drug eruption – appearance similar to TEN confluent, violaceous-red oval areas which may later become bullous.

Drug Hypersensitivity syndrome – Symmetric, bright red, exanthematous eruption confluent in some sites can be seen in the first 2 months after initiation of a drug. May have lymphadenopathy, hematologic and organ involvement. Can be known as DRESS (drug rash with eosinophilia and systemic symptoms)

**Rubella** - Exanthem is discrete, pinkish red, fine maculopapular eruption, which like measles begins on face and spreads cephalocaudally. Lesions become confluent on cheeks while clearing on forehead. Clinical course 1-5 days low grade fever, mild malaise, posterior cervical adenopathy.

**Measles** - *Yes, this is a case of measles* Exanthem is first seen on day 3-4 as the prodromal symptoms and fever peak in severity. It is blotchy, erythematous, blanching, maculopapular eruption that begins at the hairline and spreads cephalocaudally over 3 days usually involving the palms and soles. Once generalized becomes confluent over proximal areas, but discrete over distal areas.

**Slide 10**
Do you know the Red Book recommendations for the management of measles? Let’s start at the beginning; we will discuss the recommendations in a few slides.

**Slide 11 Follow bullet points**
The measles vaccine was licensed in 1963. Evidence in 2006 suggested that measles was no longer endemic in the US.

This graph depicts the number of cases each year from 1985 until 1998 in yellow which decline as the Coverage by immunizations increase. From 1989 until 1991 the incidence of measles in the US increased because of low immunization rates in preschool-aged children, especially in urban areas. From 1997-2004 the incidence of measles has been low (37-116 cases per year) which is consistent with absence of endemic transmission. Of note, cases are considered international importations if the rash onset occurs within 18 days after entering the US. Almost half of the imported cases occur in US residents returning from foreign travel.

Follow bullet points

Koplik spots: small red irregular spots with blue - white centers on mucosal surface of oral cavity

Measles virus infection can be diagnosed by a positive serologic test result for measles immunoglobin (Ig) M antibody, a significant increase in measles IgG antibody concentration is paired acute and convalescent serum specimens by any standard serologic assay, or isolation of measles virus from clinical specimens such as urine, blood, throat or nasopharyngeal secretions. The state public health laboratory or the CDC Measles Laboratory will process these samples.

Otitis, croup, and diarrhea affect young children. SSPE is a rare degenerative central nervous system disease characterized by behavioral and intellectual deterioration and seizures. Widespread immunization has led to virtual disappearance of SSPE in the United States.

No specific antiviral therapy is available. The WHO and the United Nations International Children’s Emergency Fund recommend administration of vitamin A to all children diagnosed with measles in communities where vitamin A deficiency is a recognized problem. This has been associated with decreased morbidity and mortality. Consult Red Book for specific recommendations for hospitalized patients. Measles virus is susceptible in vitro to ribavirin given by the IV and aerosol routes to treat severely affected and immunocompromised children with measles. However no controlled studies have been performed and are not currently approved by the Food and Drug Administration.
Slide 19
The second half of this presentation is designed to educate medical students, residents, and fellows on how they can impact vaccine rates for children in their community, and at the state and federal level. SOMSRFT has put together tools to use to develop and implement an advocacy project to meet the specific needs of their program.

Slide 20 Follow bullet points

Slide 21
Why is it important to get involved? Because YOU need to be the source of information for your parents. Jenny McCarthy and other celebrities have been provided media coverage on television programs like CNN, Oprah, and Larry King Live. She has authored and co-authored books: “Mother Warriors” and “Healing and Preventing Autism”. The later written with Jerry Kartzinel, M.D.

Please listen to this clip from Jenny McCarthy on CNN as she makes the following statements 1. “Vaccines “triggered” her son’s autism 2. When asked by the commentator why do you think the AAP continues to deny a link between vaccines and autism McCarthy states “there is a huge business in pharmacuticals” 3. The commentator states to McCarthy “technically you are not a doctor...” McCarthy replies “I am not compounding medicine in my kitchen but “greed” (of doctors) has made it hard to change the vaccine schedule. She claims that her son is “fully recovered” from autism using biomedical treatments. Please watch the clip embedded from Larry King Live where she discusses anecdotal information and the vaccine schedule in this clip AAP president Dave Tayloe sits on the panel discussion regarding vaccine safety. Please watch this and other widely publicized talks by McCarthy on Oprah and The View. Larry King Live.

Slide 22
In addition to Dr. David Tayloe (AAP President 2009) others are speaking out: One of the most vocal is Paul Offit, M.D., who along with Fred Clark invented the vaccine for Rotavirus (RotaTeq). He is the author of “Autism’s False Prophets” and numerous articles. Listen to his discussion (less than 3 minutes) on the harm done by those who attack vaccines and the vaccine schedule. The ImmuneWise CD-ROM has the “Myth vs Fact” handout that addresses many of the responses made by Dr. Offit to the alternative schedule of Robert Sears, M.D., who refers to himself as “Dr. Bob”. Please read his Pediatrics article (The problems with Dr. Bob’s Alternative Vaccine Schedule) which can be found at the AAP website and on the ImmuneWise CD-ROM.

Slides 23-24 Follow bullet points

Slide 25
Materials to guide anyone interested in these opportunities are on the CD-ROM and on the SOMSRFT website.

There is a sample letter to the editor and hints for how to make your own... see the Media section of the CD-ROM.

There are materials to share with the media or with legislators to make sure they get the facts straight... see the State Government Affairs section of the CD-ROM.
And there is a handout on Myths vs. Facts for parents, and summary presentations on vaccine components, vaccine adverse effects, and alternate schedules... see the Advocacy Handouts section of the CD-ROM.

**Slide 26**
This handout is available for downloading. Feel free to distribute.

**Slides 27-28 Follow bullet points**

**Slide 29**
The ACGME Program Requirements for Graduate Medical Education in Pediatrics requires each pediatric resident to participate in a QI project as part of their training in Practice Based Learning and Improvement (effective July 1, 2007).
Many utilize a Plan – Do – Study – Act cycle for performing quality improvement.

**Slide 30**
The ideas used in the following QI Project description are from "Teaching Immunization Delivery and Evaluation," also known as TIDE, and can be found at the website: http://www2.edserv.musc.edu/tide/reg/main.las

**Slide 31**
1. The Chart Method is the most widely used method. For this, the reviewer randomly selects a set number of patient charts to review. One disadvantage is that this method may give falsely low estimates of a practice’s immunization rate because data on children who are no longer active patients are included and their records may not be complete.
2. Active Method uses the Chart Method and a phone call. The advantage of this method is that it can (1) determine if the patient is still an active patient and (2) provide data on additional immunizations not included in clinic's medical record. This method is very accurate but also time-consuming and expensive.
3. The Consecutive Method works in the following manner: screen 30 consecutive patients for immunization status during their visits (both acute visits and well-child care are included). For example, start at 10 AM on a particular day and screen every child until you have 30. While this method is the easiest, the disadvantage is that frequent clinic patients are oversampled, often leading to an over-estimation of immunization rates.

**Slide 32**
1) One can use a tool, such as the Immunization Practices Questionnaire as exemplified by the TIDE Program, to identify areas of improvement. The components of this questionnaire can be summarized using the mnemonic ARORA and are as follows:
   - **A** - Assessment and Feedback: Are practice immunization rates assessed, and is feedback given to providers?
   - **R** - Records: Are medical records/immunization records always available, are immunizations always checked, are there immunization prompts on record, and do patients have immunization records?
O- Opportunities: Are immunizations given at both sick and well visits, are contraindications to vaccines appropriate, are all indicated vaccines given at visit, and are there standing orders for immunizations?

R- Remind: Are there patient reminders for appointments? Is there a recall system for patients?

A- Assess again

2) The Pareto Principle is used in QI efforts and allows one to identify the “Vital Few” interventions that would have the greatest impact on vaccination rates. For example, if vaccines are not given at both sick and well visits in a particular setting and these missed opportunities account for 25-30% of immunization errors, then this would be one of the important vital few areas to focus on in a QI project. It is important to identify and choose the “Vital Few” interventions likely to have the greatest impact on immunization rates rather than focusing on the “Useful Many.”

Slide 33
The Office Immunization Practices Questionnaire can be used to assess current office practices and to select interventions to address in your QI Project. This form can be found at the following site: http://www2.edserv.musc.edu/tide/modulec/roar.pdf

Slide 34
Any good QI Project requires the participation of the key players: administrative staff, clerical staff, nurses and nurse aides, and providers. Therefore, incentives for participating in QI Project as well as awards for achieving excellent results are vital: some examples are free lunches/parties, extra time off, gift cards, certificates, etc.

Slides 35-36 Follow bullet points

Slide 37
This is a public service announcement from the Vaccinate Your Baby website: vaccinateyourbaby.org

Slides 38-39 Follow bullet points

Slide 40
An example may include: Approach state legislators regarding a statewide immunization issue or piece of legislation such as mandatory HPV vaccination. Use the information in the Advocacy Module #4 on Working with Decision Makers under the “Advocacy Modules” tab in the Advocacy Section. The State and Governmental Affairs Presentation under the “Presentations” tab in the Advocacy Section can also be used for guidance on project implementation.

Slide 41 Follow bullet points

Slide 42
Every Child By Two (ECBT) was founded by former First Lady Rosalynn Carter and former First Lady of Arkansas Betty Bumpers in 1991 as a result of the measles epidemic that
killed nearly 150 people. Carter and Bumpers have been working on immunizations since their husbands were governors in the early 70’s and have been credited with the passage of laws mandating school-age vaccination requirements in every state. The goals of ECBT are to raise awareness of the critical need for timely immunizations and to foster a systematic way to immunize all of America’s children by age two. **Amanda Peet is generously volunteering her time to support this cause and does not receive compensation for her time and effort.**

**Slide 43 Follow bullet points**

**Slide 44**
Our section has the ability to impact change on an individual, program, community, state and national level. This CD-serves as a resource and foundation for individual residents and programs to implement the project(s) they feel will have the greatest influence on improving immunization rates across the country. Utilize the *Project Implementation Check-List* in the “Introduction” tab and submit a *Project Outcome Report* in the “Conclusion” tab upon project completion. The SOMSRFT will recognize outstanding projects in “Angels on Advocacy” piece published in the Resident Report.

**Slide 45 End**
The Childhood Immunization Schedule: Why Is It Like That?

Q1: Who decides what immunizations children need?

A: Each year, top disease experts and doctors who care for children work together to decide what to recommend that will best protect U.S. children from diseases. The schedule is evaluated each year based on the most recent scientific data available. Changes are announced in January, if needed. The schedule is approved by the American Academy of Pediatrics, the Centers for Disease Control and Prevention, and the American Academy of Family Physicians.

Q2: How are the timing and spacing of the shots determined?

A: Each vaccine dose is scheduled using 2 factors. First, it is scheduled for the age when the body’s immune system will work the best. Second, it is balanced with the need to provide protection to infants and children at the earliest possible age.

Q3: Why are there so many doses?

A: Researchers are always studying how well vaccines work. For many vaccines three or four doses are needed to fully protect your child. The doses need to be spaced out a certain amount to work the best.

Q4: Why is the schedule “one size fits all?” Aren’t there some children who shouldn’t receive some vaccines?

A: Your child’s health and safety are very important to your child’s doctor. The schedule is considered the ideal schedule for healthy children but there may be exceptions. For example, your child might not receive certain vaccines if she has allergies to an ingredient in the vaccine, or if she has a weakened immune system due to illness, a chronic condition, or another medical treatment. Sometimes a shot needs to be delayed for a short time, and sometimes not given at all.

Your pediatrician stays updated about new exceptions to the immunization schedule. This is one reason your child’s complete medical history is taken at the pediatrician’s office, and why it is important for your child’s health care providers to be familiar with your child’s medical history.

Q5: Why can’t the shots be spread out over a longer period of time? There are 25 shots recommended in the first 15 months of life; why not spread these out over 2 or 3 years?

A: First, you would not want your child to go unprotected that long. Babies are hospitalized and die more often from some diseases, so it is important to vaccinate them as soon as it is safe. Second, the recommended schedule is designed to work best with a child’s immune system at certain ages and at specific times. There is no research to show that a child would be equally protected against diseases with a very different schedule. Also, there is no
scientific reason why spreading out the shots would be safer. But we do know that any length of time without immunizations is a time without protection.

Q6: I've seen another schedule in a magazine that allows the shots to be spread out. It was developed by a pediatrician. Why can't I follow that schedule? My child would still get his immunizations in time for school.

A: There is no scientific basis for such a schedule. No one knows how well it would work to protect your child from diseases. And if many parents in any community decided to follow such a schedule, diseases will be able to spread much more quickly. Also, people who are too sick or too young to receive vaccines are placed at risk when they are around unvaccinated children.

For example, following one alternative schedule would leave children without full polio protection until age 4. Yet it would take only one case of polio to be brought into the U.S. for the disease to take hold again in this country. This schedule also delays the measles vaccine until age 3. We have already seen outbreaks of measles in some parts of the country because children were not immunized. This is a highly infectious disease that can cause serious harm—even death. The reason we recommend vaccines when we do is because young children are more vulnerable to these diseases.

Pediatricians want parents to have reliable, complete, and science-based information, so that they can make the best decision for their child about vaccination.

Q7: Isn't it possible that my child has natural immunity to one or more diseases? If he does, can't he skip the shot?

A: Tests that check for immunity to certain diseases do not work well in young children.

Q8: Isn't it overwhelming to a child's immune system to give so many shots in one visit?

A: Infants and children are exposed to many germs every day just by playing, eating, and breathing. Their immune systems fight those germs, also called antigens, to keep the body healthy. The amount of antigens that children fight every day (2,000-6,000) is much more than the antigens in any combination of vaccines on the current schedule (150 for the whole schedule). So children's immune systems are not overwhelmed by vaccines.

Q9: There are no shots given at 9 months, other than maybe flu vaccine or catch-up vaccines. Why not give some at that visit instead of at 6 months or 12 months?

A: Waiting until 9 months would leave the child unprotected from some diseases, but 9 months is too early for some of the 12-18 month vaccines. For example, it is too early for the live measles, mumps, rubella and varicella vaccines, since some infants might have a bit of protection left from their mother during the pregnancy, and that protection could make the vaccine less effective.

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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5th Annual Advocacy Project: ImmuneWise
Section on Medical Students, Residents, and Fellowship Trainees
2009-2010
CC: 12 month old male with rash
CC: 12 MONTH OLD MALE WITH RASH

You are in the busy emergency department at the community hospital…

What questions do you want to start with?
CC: 12 MONTH OLD MALE WITH RASH

• 12 month old awoke with small spots on his face (right side > left) and fainter spots on his stomach and back

• He went to his pediatrician this morning for evaluation

• The rash worsened/spread this afternoon/evening to include genitals, legs, palms of his hands – more confluent and itchy
CC: 12 MONTH OLD MALE WITH RASH

ROS:

- Decreased PO intake today (UOP x 3)
- Tactile fever
- Rhinorrhea this evening
- No vomiting or diarrhea
- No blisters or vesicles
- No ingestions/medications
CC: 12 MONTH OLD MALE WITH RASH

- General: Happy infant with diffuse rash
- T 36.8  HR 120  RR 30  Pain 0/10
- HEENT: NC/AT, EOMI, no conjunctival injection, no oral lesions or erythema
- Neck: Supple, no LAD
- Chest: Lungs CTA, HRRR
- Abd: Normal bowel sounds, soft, NT, no HSM
CC: 12 month old male with rash
Differential Diagnosis

- Discussion
Management
Erythema Multiforme Minor

• Self-limiting

• Acute onset of acral and symmetrical erythematous papules evolving into target lesions

• Relative absence of constitutional symptoms

• Most commonly caused by infections, especially by HSV and Mycoplasma pneumoniae
MMR Vaccine Reactions

• Pain, redness, swelling at the site

• Fever in 5-15%, with an onset within the 6-12 days following injection

• Non-specific rash in 5%, particularly within the second week following vaccination (more common with MMRV than MMR)
  – One case report from Bernardini et al. Erythema multiforme following live attenuated trivalent measles-mumps-rubella vaccine
  – Finnish studies show EM minor from MMR to be common

• Thrombocytopenia associated with measles component

• Arthritis/Arthralgias associated with rubella component
Vaccine Adverse Events Reporting System (VAERS)

- Cooperative program of the CDC and FDA started in 1990
- Post-marketing safety surveillance program
- Passive reporting system
- Collects information about adverse events that occur after the administration of US licensed vaccines
- Can identify safety signal but cannot determine causation
Vaccine Adverse Events Reporting System (VAERS)

- **Who** reports?
  - Health care professionals, manufacturers, parents, state immunization programs

- **What** to report?
  - Any event after a vaccine concerning to the reporter – fever, rash, seizure, fainting, etc.
  - A reporter does not have to be certain the vaccine caused the event

- **Why** report?
  - To improve vaccine safety and strengthen public trust in the FDA and CDC

- **How** to report?
  - [http://vaers.hhs.gov/](http://vaers.hhs.gov/)
  - 1-800-822-7967
REPORTING ADVERSE REACTIONS

VAERS - The Vaccine Adverse Event Reporting System - Microsoft Internet Explorer

Introduction

Welcome to the Vaccine Adverse Event Reporting System (VAERS) Web site.

The Vaccine Adverse Event Reporting System is a cooperative program for vaccine safety of the Centers for Disease Control and Prevention (CDC) and the Food and Drug Administration (FDA). VAERS is a post-marketing safety surveillance program, collecting information about adverse events (AERS).
Vaccine Adverse Events Reporting System (VAERS)

• National Childhood Vaccine Injury Act **requires** physicians to report two events to VAERS
  1. Any event listed by the manufacturer as a contraindication to subsequent vaccine dosages
  2. Any event listed in the Reportable Events Table that occurs within the specified time period after the vaccination
Exam Questions about Vaccine Reactions
Vaccine Reactions
CME questions from Pediatric Emergency Care

• Which of the following vaccines is most strongly associated with hypotonic-hypo responsiveness episodes?

A. MMR
B. DTaP
C. IPV
D. Pneumococcal conjugate
E. Hib
Vaccine Reactions
CME questions from Pediatric Emergency Care

• Which of the following vaccines is most strongly associated with hypotonic-hypo responsive episodes?

A. MMR
B. DTaP – episodes occur within the first 48 hours; lasts 1 minute to 48 hours
C. IPV
D. Pneumococcal conjugate
E. Hib
Vaccine Reactions
CME questions from Pediatric Emergency Care

Which of the following vaccines has a known association with protracted inconsolable crying?

A. Hep B
B. IPV
C. MMR
D. DTaP
E. Pneumococcal conjugate
Vaccine Reactions

CME questions from Pediatric Emergency Care

- Which of the following vaccines has a known association with protracted inconsolable crying?

A. Hep B
B. IPV
C. MMR
D. DTaP – events lasting > 3 hours and occurring within 48 hours of injection
E. Pneumococcal conjugate
Vaccine Reactions
CME questions from Pediatric Emergency Care

• Which of the following vaccines is most likely to be implicated as causing thrombocytopenia?

A. IPV
B. MMR
C. Hib
D. Pneumococcal conjugate
E. Hep B
Vaccine Reactions
CME questions from Pediatric Emergency Care

• Which of the following vaccines is most likely to be implicated as causing thrombocytopenia?

A. IPV
B. MMR – 1 in 30,000 doses (0.003%), usually 2-3 weeks post vaccine
C. Hib
D. Pneumococcal conjugate
E. Hep B
Vaccine Adverse Reactions Morning Report Brief

The patient: 12 month old male who developed erythema multiforme minor 10 days after receiving his MMRV vaccine.

Adverse Reactions

Rash
- Most commonly associated with MMR, varicella and MMRV
  - Up to 5% of children who get those vaccines develop rash
    - MMR rash may be accompanied by lymphadenopathy
  - Most appear in the second week following vaccination
  - An additional 4% of children will get a varicelliform rash 8-21 days after vaccination

Fever (and Febrile Seizures)
- Low-grade fever within a few days of vaccination is associated with Hep B, influenza, HiB, pneumococcal vaccines
- High fever and febrile seizures are associated with MMR and DTP
  - 5% of children who receive MMR; fever peaks at 7 to 14 days after administration; thought to be caused by the measles component
  - 0.3% of children who receive DTP will have fevers as high as 40.5°C within the first 48 hours following administration

Other Notable Reactions
- Serious neurological events (encephalitis) can (rarely) present within 15 days of receiving MMR (1/2,000,000) or DTP (1/100,000).
- Hypotonic-Hyporesponsive Episodes are associated with DTP vaccines.
  - These are episodes of limpness, reduced responsiveness and pallor occurring within 48 hours of vaccination and lasting up to 48 hours.
  - Incidence 0.3% with whole-cell pertussis and 0.2% with acellular pertussis
- Protracted Inconsolable Crying (lasting >3 hours) is associated with DTP.
  - Occurs in up to 1% of children getting the whole-cell pertussis.
- Arthralgia/Arthritis is most commonly associated with the rubella component of the MMR, and seems directly related to patient age... 25% of young women develop acute arthralgias and 10% develop acute arthritis, especially of the knees and fingers. Both usually present 1-3 weeks after administration.
- Extensive Limb Swelling developing within the first day following immunization can be seen with both pneumococcal conjugate and DTaP (especially after boosters).
- Thrombocytopenia (ITP) occurs 1 case per 40,000 doses of MMR.
  - It presents within 6 weeks of vaccination (usually at 3-4 weeks)

Reporting
- 1986 – National Childhood Vaccine Injury Act passed requiring health professionals and vaccine manufacturers to report specific adverse events following the administration of particular vaccines
Requires physicians to report two things to the VAERS:

- Any event listed by the manufacturer as a contraindication to subsequent vaccine dosages
- Any event listed in the Reportable Events Table (found in the specific vaccine packaging) that occurs within the specified time period after that particular vaccination is received.

- 1990 – CDC and FDA established the Vaccine Adverse Event Reporting System (VAERS)

A passive surveillance system

- Objectives: identify rare adverse reactions not detected during pre-licensure studies, monitor increases in known reactions, identify risk factors or pre-existing conditions that may promote reactions, identify particular lots with unusually high rates or types of events
- Over 123,000 reports to date, most sent in by vaccine manufacturers
- You can report online at http://vaers.hhs.gov/ or by phone (800)822-7967

- It is okay to report any reaction following vaccination, whether or not you can tell that the vaccine caused it

References
Centers for Disease Control website www.cdc.gov
- Iskander JK et al. Vaccine safety post-marketing surveillance: the vaccine adverse event reporting system.
SPEAKING POINTS
THE VAERS REPORTING SYSTEM

The Vaccine Adverse Events Reporting System (VAERS) was designed to encourage the reporting of serious vaccine reactions to the Food and Drug Administration (FDA).

This system gives officials the most complete information possible about vaccine adverse events. While it is not known how many reactions go unreported, research has shown that more serious events are likely to be accounted for.

It is estimated that about 40 percent of VAERS reports come from manufacturers with the rest from health care providers, state health care coordinators, and a small percentage from individuals. Physicians are being provided information to help report any adverse reactions through reporting forms.

The FDA assesses manufacturers’ compliance with reporting regulations through regular inspections of their records.

A number of approaches are being taken to increase the reporting of adverse events:

1. Vaccine Information Statements, which are required by law to be given to parents at the time of vaccination, include the toll-free hotline telephone number to report vaccine reactions (1-800-822-7967).

2. The media can also help by assuring that stories carry accurate information about where the public should submit VAERS reports, for example through health care providers and public health departments.

Many VAERS reports about serious health problems that happen around the time of vaccination can be attributed to other causes not related to vaccines. Children regularly experience conditions such as fevers, and are the only age group to fall victim to sudden infant death syndrome (SIDS), regardless of when they were vaccinated.

When millions of doses of vaccine are administered, rare events can be expected to follow vaccination by coincidence alone. Any common reactions to vaccinations are uncovered during FDA drug trials.

Large linked databases, like those maintained by HMO’s, are now being used to provide information on the proportion of people who experience an adverse event or disease after having received a vaccine with those who experience the same conditions in the absence of vaccination.

The CDC analyzes and publishes surveillance reports to provide VAERS information to the health care community and to others with the proper analysis. Scientists at the CDC can discuss appropriate interpretation of VAERS data with interested parties to avoid misunderstandings.
5th Annual Advocacy Project: IMMUNEWISE
Section on Medical Students, Residents, and Fellowship Trainees 2009-2010

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
VACCINES: A HISTORICAL PERSPECTIVE
Vaccines Timeline

1950s
- 1955: Jonas Salk’s inactivated polio vaccine is licensed

1960s
- Monovalent → then trivalent polio vaccines introduced
- 1964: ACIP holds its first meeting
**Vaccines Timeline**

**1970s**
- 1971: Routine smallpox vaccination ceases
- 1979: Last reported case of natural polio reported in the U.S.

**1980s**
- 1982: Hepatitis B vaccine becomes available
- 1986: National Childhood Vaccine Injury Act → no-fault compensation system
Vaccines Timeline

- 1989-1991: Major measles resurgence, 55,000 cases reported; 2 dose vaccine recommended
- 1990: VAERS established, monitoring safety of vaccines
- 1990: Hib vaccine established
- 1991: Hep B vaccine recommended for all infants
- 1995: 1st vaccination schedule recommended by ACIP, AAFP and AAP is published
- 1995: Varicella and Hep A vaccines licensed
- 1996: Acellular Pertussis vaccine licensed for use in infants
- 1998: 1st Rotavirus vaccine licensed → withdrawn from market in 1999 due to adverse events
- 1999: FDA recommends removing mercury from all vaccines
Vaccines Timeline

- 2003: Measles no longer endemic in the US
- 2003: 1st live attenuated Influenza vaccine approved for use in 5-49 years of age
- 2004: Inactivated Influenza vaccine recommended for children 6-23 mo of age
- 2005: Rubella no longer endemic in US
- 2005: Meningococcal conjugate vaccine licensed
- 2006: HPV and Rotavirus vaccines licensed
IMPACT OF VACCINES IN THE United States
# Impact of Vaccines in the US

<table>
<thead>
<tr>
<th>Disease</th>
<th>Baseline 20th Century Annual Cases</th>
<th>2006 Cases</th>
<th>Percent Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>503,282</td>
<td>55</td>
<td>99.9%</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>175,885</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Mumps</td>
<td>152,209</td>
<td>6,584</td>
<td>95.7%</td>
</tr>
<tr>
<td>Pertussis</td>
<td>147,271</td>
<td>15,632</td>
<td>89.4%</td>
</tr>
<tr>
<td>Smallpox</td>
<td>48,164</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Rubella</td>
<td>47,745</td>
<td>11</td>
<td>99.9%</td>
</tr>
<tr>
<td><em>Haemophilus influenzae</em> type b, invasive</td>
<td>20,000</td>
<td>29</td>
<td>99.9%</td>
</tr>
<tr>
<td>Polio</td>
<td>16,316</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Tetanus</td>
<td>1,314</td>
<td>41</td>
<td>96.9%</td>
</tr>
</tbody>
</table>

Credit: Morbidity and Mortality Weekly Report, Centers for Disease Control and Prevention, 4/2/99, 3/21/08
A LOOK AT GLOBAL VACCINATION
# Global Vaccination Coverage, 2007

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Number of countries in which vaccine is in use</th>
<th>Estimated global coverage (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>171</td>
<td>65%</td>
</tr>
<tr>
<td>Hib</td>
<td>115</td>
<td>26%</td>
</tr>
<tr>
<td>Rubella</td>
<td>126</td>
<td>--</td>
</tr>
<tr>
<td>Mumps</td>
<td>114</td>
<td>--</td>
</tr>
<tr>
<td>Maternal and Neonatal Tetanus (MNT)</td>
<td>92</td>
<td>70%</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>20</td>
<td>--</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>13</td>
<td>--</td>
</tr>
<tr>
<td>HPV</td>
<td>10</td>
<td>--</td>
</tr>
<tr>
<td>Yellow Fever</td>
<td>33 (out of 44 at-risk countries)</td>
<td>--</td>
</tr>
</tbody>
</table>

Measles global annual reported incidence and MCV coverage, 1980-2007

2007 global figures
- 279,006 reported cases
- 197,000 estimated deaths (2007)
- 82% estimated MCV coverage
- 60% of countries reached >=90% MCV coverage
Pertussis global annual reported incidence and DTP3 coverage, 1980-2007

2007 global figures
152,535 reported cases
294,000 estimated deaths (in 2002)
81% estimated DTP3 coverage
Global Vaccination Rates - A Few Examples

Global Immunization 1990-2007,
3rd dose of Hib coverage in infants
global coverage at 26% in 2007

International Mortality Vaccine-preventable Disease

- In 2002, WHO estimated that 1.4 million of the deaths among children < 5 years old were due to diseases that could have been prevented by routine vaccination.
- 14% of total global mortality in children < 5 years of age.
A PERSONAL EXAMPLE
**Impact of Vaccine-preventable Disease**

- Heather Whitestone, named Miss America in 1994
- Became deaf at 18 months of age after contracting Hib meningitis
5th Annual Advocacy Project: ImmuneWise
Section on Medical Students, Residents, and Fellowship Trainees
2009-2010
“What About Mercury?”
Vaccine Components and Manufacturing Process
Vaccine Components

- Live viruses
- Killed viruses
- Purified viral proteins
- Inactivated bacterial toxins
- Bacterial polysaccharides
- Preservatives (eg, thimerosal)
- Adjuvants (eg, aluminum salts)
- Additives to stabilize live, attenuated viruses
- Residual substances from manufacturing process

Offit PA and Jew RK. Addressing parents’ concerns: Do vaccines contain harmful preservatives, adjuvants, additives, or residuals? *Pediatrics.* 2003; 112(6):1394-1401
Preservatives

• Required component of vaccines since 1930s
  – 1916 Typhoid Vaccine contaminated with *Staphylococcus aureus* led to 4 deaths, 68 serious systemic infections and 26 kids with local abscesses
  – Many other reports of bacterial and fungal contamination
• 3 were licensed in US
  – Thimerosal
  – Phenol
  – 2-Phenoxyethanol
Thimerosal

- Removed from all multi-dose vaccines by 2001 by the FDA Modernization Act of 1997
- Previously in DTaP, Hep B, Hib
  - For a total of 187.5 micrograms mercury by 6 months
- Thimerosal contains ethylmercury, which is excreted faster than methylmercury

Exposure limits of methylmercury in micrograms by 6 months of age by % Body Weight

<table>
<thead>
<tr>
<th>Agency</th>
<th>5% Body Weight</th>
<th>50% Body Weight</th>
<th>95% Body Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPA</td>
<td>65</td>
<td>89</td>
<td>106</td>
</tr>
<tr>
<td>ATSDR</td>
<td>194</td>
<td>266</td>
<td>319</td>
</tr>
<tr>
<td>FDA</td>
<td>259</td>
<td>354</td>
<td>425</td>
</tr>
</tbody>
</table>
• Current thimerosal containing vaccines:
  – Influenza
  – Meningococcal
  – Japanese Encephalitis
  – Pneumococcal polysaccharide (Pneumovax)
  – Diphtheria-Tetanus
• Studies published to date have not shown thimerosal exposure to be harmful
  – 2004: UK prospective cohort study of >14,000 infants showed no convincing evidence that thimerosal has deleterious effect on neurological or psychological outcome (Heron and Golding)
  – 2004: UK retrospective cohort study of 110,000 children found that with the exception of tics, there was no evidence that exposure to thimerosal through DTP/DT vaccines causes neurodevelopmental disorders (Andrews et al.)
  – 2007: CDC and Vaccine Data Safety Network published retrospective cohort study on neuropsychological outcomes in 1047 children aged 7-10 years old and found no deleterious effects from early thimerosal exposure (Thompson et al.)

• Vaccine Data Safety Network
  – Large case-control study of autism and thimerosal exposure currently in data collecting phase
Adjuvants

- Enhance the immune response
  - Enhance antigen uptake by antigen presenting cells
  - Activate antigen presenting cells
  - Induce production of cytokines and complement

- Aluminum salts
  - First added to diphtheria and tetanus in the 1930s
  - Benign Adverse Reactions – mostly erythema
  - Aluminum quantities
    - Breast milk – 40 micrograms/liter
    - Formula – 225 micrograms/liter
    - Vaccines – 125 micrograms – 625 micrograms/dose
  - Mouse studies established safety of aluminum in humans to be <62 mg/kg/day
# Adjuvants — Vaccines Containing Aluminum

<table>
<thead>
<tr>
<th>Adjuvant</th>
<th>Vaccine</th>
<th>Trade Name</th>
<th>Company</th>
<th>Quantity (per Dose)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aluminum hydroxide</td>
<td>DTaP</td>
<td>Infanrix</td>
<td>GlaxoSmithKline</td>
<td>≤0.625 mg</td>
</tr>
<tr>
<td></td>
<td>Hepatitis A</td>
<td>Havrix (pediatric)</td>
<td>GlaxoSmithKline</td>
<td>0.25 mg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vaqta (pediatric)</td>
<td>Merck and Co</td>
<td>0.225 mg</td>
</tr>
<tr>
<td></td>
<td>Hepatitis B</td>
<td>Engerix</td>
<td>GlaxoSmithKline</td>
<td>0.25 mg</td>
</tr>
<tr>
<td></td>
<td>Hib</td>
<td>PedVax Hib</td>
<td>Merck and Co</td>
<td>0.225 mg</td>
</tr>
<tr>
<td></td>
<td>Hepatitis A-hepatitis B</td>
<td>Twinrix</td>
<td>GlaxoSmithKline</td>
<td>0.45 mg*</td>
</tr>
<tr>
<td></td>
<td>DTaP-IPV-hepatitis B</td>
<td>Pediarix</td>
<td>GlaxoSmithKline</td>
<td>≤0.85 mg*</td>
</tr>
<tr>
<td>Aluminum phosphate</td>
<td>Pneumococcal conjugate</td>
<td>Prevnar</td>
<td>Wyeth</td>
<td>0.125 mg</td>
</tr>
<tr>
<td></td>
<td>Td (adult)</td>
<td>None</td>
<td>Massachusetts Department of Public Health</td>
<td>0.45 mg</td>
</tr>
<tr>
<td>Aluminum sulfate</td>
<td>DTaP</td>
<td>Daptacel</td>
<td>Aventis Pasteur</td>
<td>0.33 mg</td>
</tr>
<tr>
<td></td>
<td>DTaP</td>
<td>Tripedia</td>
<td>Aventis Pasteur</td>
<td>≤0.17 mg</td>
</tr>
<tr>
<td></td>
<td>Td (adult)</td>
<td>None</td>
<td>Aventis Pasteur</td>
<td>0.28 mg</td>
</tr>
<tr>
<td></td>
<td>Hib-hepatitis B</td>
<td>Comvax</td>
<td>Merck and Co</td>
<td>0.225 mg</td>
</tr>
<tr>
<td></td>
<td>Hepatitis B</td>
<td>Recombivax HB</td>
<td>Merck and Co</td>
<td>0.5 mg</td>
</tr>
</tbody>
</table>

*Contains both aluminum hydroxide and aluminum phosphate.*
**Additives**

- Stabilize vaccines from heat and cold
- Prevent adherence to vials
- Types of additives
  - Sugars (sucrose, lactose)
  - Amino acids (glycine, glutaminic acid)
  - Proteins (gelatin, albumin)
- Known adverse events
  - Immediate type hypersensitivity to gelatin
## Additives — Containing Gelatin

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Trade Name</th>
<th>Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dtap</td>
<td>Tripedia</td>
<td>Aventis Pasteur</td>
</tr>
<tr>
<td>Influenza</td>
<td>Fluzone</td>
<td>Aventis Pasteur</td>
</tr>
<tr>
<td>Measles</td>
<td>Attenuvax</td>
<td>Merck and Co</td>
</tr>
<tr>
<td>Mumps</td>
<td>Mumpsvax</td>
<td>Merck and Co</td>
</tr>
<tr>
<td>Rubella</td>
<td>Meruvax II</td>
<td>Merck and Co</td>
</tr>
<tr>
<td>Measles, rubella</td>
<td>MRVAX II</td>
<td>Merck and Co</td>
</tr>
<tr>
<td>Mumps, rubella</td>
<td>Biavax II</td>
<td>Merck and Co</td>
</tr>
<tr>
<td>MMR</td>
<td>MMR II</td>
<td>Merck and Co</td>
</tr>
<tr>
<td>Varicella</td>
<td>Varivax</td>
<td>Merck and Co</td>
</tr>
<tr>
<td>Rabies</td>
<td>Rabavert</td>
<td>Chiron</td>
</tr>
<tr>
<td>Japanese encephalitis</td>
<td>JE-Vax</td>
<td>Aventis Pasteur</td>
</tr>
</tbody>
</table>
Additives — Albumin & Infectious Risks

- Albumin derived from human serum derived from human blood

- Theoretical risk of infection

- FDA requirement that albumin derived from screened donors

- No viral diseases have ever been associated with the use of human albumin
# Additives — Containing Albumin

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Brand Name</th>
<th>Manufacturer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>Attenuvax</td>
<td>Merck and Co</td>
</tr>
<tr>
<td>Mumps</td>
<td>Mumpsvax</td>
<td>Merck and Co</td>
</tr>
<tr>
<td>Rubella</td>
<td>Meruvax</td>
<td>Merck and Co</td>
</tr>
<tr>
<td>MMR</td>
<td>MMR II</td>
<td>Merck and Co</td>
</tr>
</tbody>
</table>
Additives — Containing bovine derived products

- Gelatin, glycerol, enzymes, serum, amino acids are derived from cows

- Creutzfeld-Jacob Disease
  - Caused by prions
  - No association of CJD to blood products
  - Prions not found in cow hooves (used to make gelatin)
  - Epidemiologic evidence does not support vaccines as a cause for CJD in the UK
MANUFACTURING RESIDUALS - INACTIVATING AGENTS

• Formaldehyde
  – Influenza, Polio, Diphtheria, Tetanus
  – Human blood contains 10x more than any one vaccine
  – Natural intermediate in synthesis of amino acids, purine, and thymidine
  – Animal and human studies do not show increased risk for malignancies after formaldehyde exposure

• Beta-propiolactone
  – Rabies

• Glutaraldehyde
  – Acellular pertussis
MANUFACTURING RESIDUALS-ANTIBIOTICS

- Theoretical risk of immediate-type hypersensitivity to residual antibiotics (used to prevent contamination during manufacturing)

- Antibiotics used: Neomycin, streptomycin, polymyxin B, chlortetracycline, amphotericin
  - Only neomycin is associated with immediate-type hypersensitivity but no cases documented at this time
  - Risk of delayed-type hypersensitivity but not a contraindication
MANUFACTURING RESIDUALS - EGG PROTEINS

- Egg allergies occur in 5% children with atopy

- Vaccines manufactured in chick embryos
  - Influenza – contraindicated if egg allergy, follow strict protocol if asthma and egg allergy
  - Yellow fever
  - Measles and mumps – very small quantity – egg allergy in not a contraindication
REFERENCES

Studies on Thimerosal


Other Readings

AAP Media – Thimerosal Speaking Points
Sears RW. *The Vaccine Book*.
McCarthy, J. *Louder Than Words*. 
Thimerosal Speaking Points

Q. What is thimerosal?
Thimerosal is an organic mercury-based preservative used in vaccines.

Thimerosal has been used as an additive to vaccines since the 1930s because it is very effective in preventing bacterial and fungal contamination, particularly in opened multi-dose containers such as those used to package vaccines.

Thimerosal is also found in other medicines and products including some throat and nasal sprays and contact lens solutions.

Q. Does thimerosal cause autism?

No valid studies show a link between thimerosal in vaccines and autistic spectrum disorder.

The rates of autism have NOT declined since the removal of thimerosal from childhood vaccines.

The CDC examined the incidence of autism in relation to the amount of thimerosal a child receives in vaccines. They found no change in autism rates relative to the amount of thimerosal a child received from vaccines in the first 6 months of life. In other words, a child who received more thimerosal was not more likely to be autistic.

A 2004 report from the Institute of Medicine, entitled “Vaccines and Autism,” concluded that the available evidence rejects a causal relationship between thimerosal-containing vaccines and autism.

The U.S. Court of Federal Claims on Feb. 12, 2009, found the scientific evidence is “overwhelmingly contrary” to the theory that MMR vaccine and the vaccine preservative thimerosal are linked to autism. This decision is in keeping with the numerous medical studies that have been performed worldwide.

Q. Have any studies shown thimerosal in vaccines causes health problems in children?

In rare cases, children have shown hypersensitivity to thimerosal, but no lasting health problems have been documented.

However, the CDC did find an inconclusive (weak) correlation (one that is inadequate to support or refute a causal link) with thimerosal intake and certain neurodevelopmental disorders (such as ADHD, speech and language delays, and tics) but not autism. A number of experts who reviewed that initial study believed the study was flawed, and later studies failed to support the first study’s correlations.

Q. Which vaccines contain thimerosal?

Since 2002 all routinely recommended licensed childhood vaccines that are currently being manufactured for the U.S. market, with the exception of influenza vaccine, have contained no thimerosal or only trace amounts.

Some influenza vaccines distributed in the United States contain thimerosal as a preservative. However, some contain only trace amounts of thimerosal and are considered by the Food and Drug Administration (FDA) to be preservative-free. Manufacturers of preservative-free flu vaccine use thimerosal early in the manufacturing process. The thimerosal is diluted as the
vaccine goes through the steps in processing. By the end of the manufacturing process there is not enough thimerosal left in the vaccine to act as a preservative and the vaccine is labeled “preservative-free.”

For the 2008-09 season, there is one product licensed for 6- to 23-month-old children (the product is thimerosal-free). For children between the ages of 2 and 5 years of age, there are three products available that are thimerosal-free (Sanofi’s Fluzone; MedImmune’s FluMist) or preservative-free (trace thimerosal - Novartis’ Fluvirin). Specific information about these products and other influenza vaccines can be found in the Table: Influenza Vaccine Manufacturers for the 2008-09 Influenza Season. Given the uptake of influenza vaccine among children less than 5 years of age, and the anticipated increase in vaccination coverage for this season, CDC projects that the vaccine supply for this age group will be adequate to meet demand.

**Q. What is the difference between thimerosal-free, thimerosal-reduced and preservative-free vaccine?**

Vaccines may be termed “thimerosal-free” if no thimerosal can be measured... if the level of thimerosal is so low that it can’t be detected.

“Thimerosal-reduced,” or “trace thimerosal,” usually means that thimerosal is not added as a vaccine preservative, but trace amounts (less than 0.5 micrograms per 0.5 ml dose) may remain from use in the manufacturing process.

“Preservative-free” means that no preservative (thimerosal or otherwise) is used in the vaccine - however, traces used during the manufacturing process may be present. (Note: other preservatives like 2-phenoxyethanol have been and are being used as a preservative in place of thimerosal.)

**Q. Why was thimerosal removed from vaccines if there is no danger?**

Even though there’s no evidence that thimerosal in vaccines is dangerous, the Public Health Service and the AAP believed the effort to remove thimerosal from vaccines was the right decision. The removal is a feasible way to reduce an infant’s total exposure to mercury in a world where the number of beneficial childhood vaccines are sure to increase in the future where other environmental sources of mercury are more difficult to eliminate.

**Q. Before it was removed, how much mercury was in vaccines?**

The thimerosal content of vaccines varied from 0 ugm per dose (IPV, MMR, combination HBV /Hib, pneumococcal conjugate and some Hib and DTaP vaccines) to 12.5 ugm per dose of hepatitis B vaccine to 25 ugm per dose of some DTaP and Hib vaccines. Depending on the combination of different manufacturing sources of vaccines given to infants at birth, 2 months 4 months and 6 months, an infant could have received a range of 0 mgms to 62.5 mgms of ethyl mercury during a visit.

No infant would have received more than 187.5 mgms of ethyl mercury via immunizations in the first 12 months, below the World Health Organization’s allowable exposure levels for methyl mercury of 200-230 mgms in the first year of life. Most infants would have received far less.

**Q. What risk does mercury pose to an infant's health?**

Studies of mercury ingested from fish and other sources have shown that in high doses, the
methyl form of mercury can cause brain damage. Mercury can also affect the kidneys and immune system.

Preliminary studies that examined the properties of ethyl mercury and reviewed by the IOM suggested that ethyl mercury may be less toxic than methyl mercury at similar exposure levels. Researchers will be continuing to look at this question.

New research (Pediatrics, February 2008) shows that in infants, the mercury used as a preservative in vaccines is cleared from the body at least 10 times faster than researchers had previously believed, a finding that casts further doubt on the theory that the preservative causes autism.

It is difficult to predict adverse effects of ethyl mercury exposure based on studies of exposure to other forms of mercury. However, studies of ingestion of high doses of methyl mercury, as in the Minamata Bay disaster (in the 1950s) where large amounts of methyl mercury were released into the bay and taken in by fish and then by pregnant women, show that this high dose methyl mercury exposure can have disastrous effects on neurodevelopment. Studies in the Faroe Islands involved much lower exposures to methyl mercury. Results from the Faroe Islands study, described in the 2001 AAP Technical Report, Mercury in the Environment: Implications for Pediatricians, “suggested that exposure in utero to methyl mercury at lower levels is associated with subtle adverse effects on the developing brain. Memory, attention, and language tests were inversely associated with higher methyl mercury exposures in children up to 7 years of age, even after controlling for PCB exposures.” Another similar, well-controlled study in the Seychelles showed that adverse effects on development or IQ were not found at up to 66 months of age, although exposures to methyl mercury were in the same range as the Faroe Islands study. Clearly, more studies are needed.

**Q. Have any adverse reactions to thimerosal in vaccines ever been reported?**

When vaccines containing thimerosal have been administered in the recommended doses, hypersensitivity (hives, shock) to the preservative has been noted on rare occasions. To date, no other harmful effects have been reported.

**Q. Should parents have their children who have received vaccinations with thimerosal tested for mercury?**

No. Screening children for mercury exposure will likely result in more questions than answers. Testing for mercury in hair, nails or blood should not be done in response to concerns regarding thimerosal in vaccines because the results cannot distinguish between exposures from food stuffs (such as fish), vaporized elemental mercury (broken thermometers) or thimerosal. This should not preclude testing for mercury levels in children who are suspected to have had environmental exposures to mercury.

**Q. Who should be concerned about exposure to large amounts of mercury?**

Pregnant women, nursing mothers, and infants should be especially careful about mercury exposure. Some fish contain high levels of organic mercury. Following fish advisories from state health, environmental and conservation officials can reduce exposure to mercury. Pediatricians can also advise parents on avoiding exposure.

**Q. In 1999, you recommended that premature infants should not receive vaccines with thimerosal. What should we do about immunizing premature babies today?**
There is no scientific evidence to indicate that premature infants were at risk from thimerosal. Premature infants posed certain concerns because they were shown in a study (by Stajich) to clear ethyl mercury (from hepatitis B vaccine) much more slowly from their bodies than full term infants. Fetuses and premature infants also appeared to be more sensitive to the neurologic consequences of methyl mercury exposure at lower level exposures than term infants. That is why we recommended deferring the hepatitis B vaccine in small premature babies born to hepatitis B surface antigen negative (-) mothers. Now all hepatitis B vaccines are thimerosal-free, so premature infants can, and should, receive this vaccine on schedule. All other vaccines premature infants receive in the first six months are now available in thimerosal-free form.

Q. In 1999 the AAP recommended that children no longer receive the hepatitis B vaccine that contained thimerosal. But the AAP also said that pediatricians who had that vaccine in stock could use it until they had depleted their inventory. Why would you allow children to continue receiving thimerosal if you knew it was bad for them?

The AAP agreed that pediatricians could use the inventory they had in stock because there was no evidence of side-effects due to the amount of thimerosal in vaccines and there was not enough thimerosal-free vaccine available to replace that inventory. Hepatitis B vaccine contained the least amount of thimerosal of any vaccine using thimerosal as a preservative. The risk of not vaccinating an infant against serious, life threatening, preventable disease far outweighed any theoretical concern about thimerosal.

The most important thing to consider is that children continue to receive their vaccinations. We know for a fact that many children will be harmed by infectious diseases if they are not immunized.

Q. Pediatricians promote vaccination because they get paid every time they give a child a shot. Are pediatricians damaging children so they can turn around and treat those same children?

The number one concern of any pediatrician is simple: it's the health and well being of children. We know that immunizations keep children healthy- that's why we encourage parents to vaccinate their children. Incidentally, many pediatricians give vaccines at no profit—or even a loss—to their business because they think vaccination is so important. Payment rates for vaccines are often inadequate to cover the practice’s costs for vaccine administration.

Q. Why aren’t the dangerous side effects of vaccines always determined well before the AAP recommends routine immunization?

The process of vaccine research and development is long and thorough. A conservative estimate is that it takes 10 to 15 years from the “discovery” of a candidate vaccine to its development and testing.

Following extensive animal testing, initial tests are conducted on small numbers of adult volunteers. These tests are done in order to learn as much as we can about both the immune response to the vaccine, as well as its basic safety.

Following these evaluations, candidate vaccines that continue to show promise are tested in additional volunteers to determine the optimal dose and dosing schedule.
Finally, large-scale tests are conducted, involving a large number (often thousands) of infants and children, to determine how well the vaccine works, and to look for more uncommon adverse events. Only then is all this information presented to the Food and Drug Administration for consideration of licensure.

Rare adverse reactions that occur with very low frequency can appear once the vaccine is given to very large numbers of people. For example, rotavirus vaccine may produce a form of bowel blockage called intussusception once in every 10,000 first doses given to infant ages 2 to 3 months. Measles vaccine may produce a bleeding disorder in one in 35,000 doses given. The previously used oral polio vaccine caused a case of paralytic polio in one out of every 750,000 doses given to an infant under 6 months of age. These rare reactions are only identified after millions of doses of a vaccine are given and cannot be picked up in even the largest vaccine trials before FDA licensure.

Nonetheless, even the rarest reactions like vaccine-related paralysis following the introduction of oral polio vaccine were identified within two years of general use. Nine months after the introduction of rotavirus vaccine, surveillance systems that were in place identified the very low-frequency occurrence of intussusception following administration of that vaccine to some infants. If autism was related to the use of thimerosal in vaccines over the past 70 years, isn’t it reasonable to assume that an association would have been established long before 2008?

Q. What should parents do if they suspect their child has been harmed by a vaccination?

Since every child has a unique medical history, we always need to listen to parents about any concerns they have regarding their child’s health.

If parents are concerned about a possible negative reaction to a vaccine, the Vaccine Adverse Events Reporting System (VAERS) is designed to encourage the reporting of serious vaccine reactions.

Pediatricians use VAERS in the rare instance of an adverse reaction.

Reports to VAERS may be made by anyone, including physicians and parents.

The Vaccine Injury Compensation Program should be contacted if parents believe their child has been harmed and seek compensation.

Q. Immunizations have already been successful at nearly wiping out many diseases, so why should children continue to get vaccinated when these diseases barely exist anymore?

Although the diseases for which there are vaccines have been reduced to record low numbers, the organisms that cause these diseases are still present. Unvaccinated children continue to be at risk. We are only one airplane ride away from many parts of the world where these diseases are still rampant and where immunization is not available. We cannot afford to let down our guard.
Questions and Answers about Vaccine Ingredients

Q. What ingredients are in vaccines?
A. All vaccines contain antigens. Antigens make vaccines work. They prompt the body to create the immune response needed to protect against infection. Antigens come in several forms. The form used in a vaccine is chosen because studies show it is the best way to protect against a particular infection.

Antigen forms include:

- **Weakened live viruses.** They are too weak to cause disease but can still prompt an immune response. Measles, mumps, rubella, rotavirus, chickenpox, and one type of influenza vaccine contain weakened live viruses.

- **Inactivated (or killed) viruses.** These viruses cannot cause even a mild form of the disease, but the body still recognizes the virus and creates an immune response to protect itself. The polio, hepatitis A, influenza and rabies vaccines contain inactivated viruses.

- **Partial viruses.** These are made up of the specific part of the dead virus that will prompt a protective immune response. Some vaccines are made this way including the hepatitis B and HPV vaccine.

- **Partial bacteria.** These vaccines work in two ways. First, the Hib, pneumococcal and meningococcal vaccines are made using part of the sugar coating (or polysaccharide) of the bacteria. The vaccine creates immunity against this sugar coating, providing protection against the bacteria. Second, vaccines against diphtheria, tetanus and pertussis (whooping cough) are made by inactivating the protein in the bacteria that causes harm.

Vaccines also contain other ingredients, which help make them safer and more effective. They include:

- **Preservatives.** They keep the vials from getting contaminated with germs.

- **Adjuvants.** They help the body create a better immune response. These are aluminum salts.

- **Additives.** They help the vaccine stay effective while being stored. Additives include gelatin, albumin, sucrose, lactose, MSG and glycine.

- **Residuals of the vaccine production process.** Some ingredients are needed to make the vaccine. Although these ingredients are removed, tiny (residual) amounts are left in the final product. Depending on how the vaccine is made, it may include tiny amounts of antibiotics (neomycin), egg protein or yeast protein.

Q. Why are these other ingredients in vaccines? Are they safe?
A. Each ingredient has a specific function in a vaccine. These ingredients have been studied and are safe for humans in the amount used in vaccines. This amount is much less than children encounter in their environment, food and water.

- **Aluminum salts.** Aluminum salts help your body create a better immune response to vaccines. Aluminum salts are necessary to make some of the vaccines we use more effective. Without an adjuvant like aluminum, people could need more doses of shots to be protected. Everyone is exposed to aluminum because there is much aluminum in the earth’s crust. It’s present in our food, air and water, including breast
milk and formula. The amount of aluminum in vaccines is similar to that found in 33 ounces of infant formula. Aluminum has been used and studied in vaccines for 75 years and is safe.

- **Formaldehyde.** Formaldehyde is used to detoxify diphtheria and tetanus toxins or to inactivate a virus. The tiny amount which may be left in these vaccines is safe. Vaccines are not the only source of formaldehyde your baby is exposed to. Formaldehyde is also in products like paper towels, mascara and carpeting. Our bodies normally have formaldehyde in the blood stream and at levels higher than in vaccines.

- **Antibiotics.** Antibiotics, such as neomycin, are present in some vaccines to prevent bacterial contamination when the vaccine is made. Trace amounts of antibiotics in vaccines rarely, if ever, cause allergic reactions.

- **Egg protein.** Influenza and yellow fever vaccines are produced in eggs, so egg proteins are present in the final product and can cause allergic reaction. Measles and mumps vaccines are made in chick embryo cells in culture, not in eggs. The much smaller amount of remaining egg proteins found in the MMR (measles, mumps, rubella) vaccine does not usually cause a reaction in egg allergic children.

- **Gelatin.** Some vaccines contain gelatin to protect them against freeze-drying or heat. People with severe allergies to gelatin should avoid getting gelatin-containing vaccines.

**Q. Do vaccines contain antifreeze?**
A: No. Antifreeze is typically made of ethylene glycol, which is unsafe. Polyethylene glycol (a chemical used in antifreeze and personal care products like skin creams and toothpaste) is used in vaccines and is safe. It is used to inactivate the influenza virus in some influenza vaccines. It is also used to purify other vaccines.

**Q. Do vaccines contain mercury?**
A: Thimerosal, a mercury-based preservative, was removed from most childhood vaccines in 2001. It is still present in some influenza vaccines. Thimerosal is still used in the manufacture of some vaccines to prevent contamination. The thimerosal is removed at the end of the manufacturing process. In some cases, a tiny amount of thimerosal remains. The remaining amount is so small, that it is not possible for it to have any effect. Valid scientific studies have shown there is no link between thimerosal and autism. In fact, autism rates have actually increased since thimerosal was removed from childhood vaccines. The American Academy of Pediatrics (AAP), the American Medical Association (AMA), the CDC, and the Institute of Medicine (IOM) agree that science does not support a link between thimerosal in vaccines and autism. For the IOM report, go to [http://www.iom.edu/CMS/3793/4705/4717.aspx](http://www.iom.edu/CMS/3793/4705/4717.aspx).

**Q. Should vaccines be “greener”?**
A: The amount of each additive used in vaccines is very small. In fact, we are exposed to much higher levels of these chemicals in our everyday lives. In vaccines, these ingredients are used to make the vaccine safer and more effective. Each vaccine is tested many times to make sure it is safe and works. Taking ingredients out might affect the ability of the vaccine to protect a child.

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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5th Annual Advocacy Project: IMMUNEWISE
Section on Medical Students, Residents, and Fellowship Trainees
2009-2010
Case Presentation

• A 24 year old G1P0 woman and her husband arrive for a prenatal visit

• The woman is a day care provider, and lets you know that there was a case of rubella reported at the day care center where she works
  – She was in her first trimester
Case Presentation

• In order to work at the day care center, her immunization record was reviewed
  – She was up-to-date (had two MMRs)

• She also had blood work done following her exposure (because she told her OB about it)
  – She was tested for rubella antibody
  – Her rubella IgG was positive
Case presentation

• The positive rubella IgG indicates immunity!

• The woman still has a lot of questions about rubella, especially about what it could have meant for the baby and what to watch for in the children at the day care center…
Rubella - Epidemiology

- Droplet or Direct Transmission
- Humans are the only source
- Pre-vaccine
  - Epidemic disease in 6-9 year cycles
- Post-vaccine (1969)
  - < 25 cases/year in the U.S. since 2001
  - Vaccine is immunogenic in 98% of recipients
  - Lifeline immunity in 90%
Rubella - Epidemiology

- In the last decade, the rate of congenital rubella is down to less than 10 cases each year

- Occurrence of congenital defects is 85% if the maternal infection is during the 1st trimester --- this drops to 25% by end of 2nd trimester
  - One-half of maternal infections are subclinical
Rubella — Clinical Congenital

• The ‘R’ of TORCH infections
• Clinical findings may include:
  – Ophthalmologic: Cataracts, pigmented retinopathy, microphthalmos, congenital glaucoma
  – Dermatologic: Dermal erythropoiesis (“blueberry muffin rash”)
  – Cardiac: PDA, pulmonary artery stenosis
  – Auditory: Sensorineural hearing impairment  
    • This is the most common manifestation  
  – Neurologic: Mental retardation
• A majority of infants with proven congenital rubella are asymptomatic in the neonatal period
Congenital Rubella
Rubella – Clinical
Children/Adolescents

• Incubation period 14-23 days
  – 25% of patients are asymptomatic but still transmit disease

• Prodrome: Malaise, low-grade fever, eye pain, sore throat, lymphadenopathy (occipital, post-auricular, cervical)

• Exanthum
  – Discrete, pinkish red, fine, maculopapular; rarely puritic
  – Begins on face – spread is cephalocaudal
  – Generalized by 24 hours, usually resolved within 72 hours
Fine, maculopapular rash on face and chest
Rash (close-up)
Rubella – Clinical Children/Adolescents

• Arthralgias/Arthritis
  – Especially Fingers, wrists, and knees
  – More common in adolescents
  – Develops day 2-3 and lasts for up to 10 days

• Encephalitis – rare!

• Thrombocytopenia and purpura – rare!
Rubella Diagnosis

- Rubella-specific IgM antibody usually indicates a recent infection
  - False positives from rheumatoid factor, parvovirus IgM, heterophile antibody

- Virus is best isolated by cell culture of throat or nasal specimens (special test)

- Blood, urine, CSF can be particularly helpful in congenital infections
Rubella - Treatment

• Supportive care

• Isolation with droplet precautions for 7 days after the onset of rash

• Infants with congenital rubella are considered contagious until 1 year of age!
A 3100 gram term male infant is being evaluated in the nursery shortly after birth. Findings on physical examination include a cataract in the left eye and a heart murmur. There is no evidence of intrauterine growth retardation, microcephaly, or hepatosplenomegaly. Of the following, the MOST likely cause of these findings in this infant is

A. Cytomegalovirus
B. Herpes simplex virus
C. Rubella
D. Syphilis
E. Toxoplasmosis
A 3100 gram term male infant is being evaluated in the nursery shortly after birth. Findings on physical examination include a cataract in the left eye and a heart murmur. There is no evidence of intrauterine growth retardation, microcephaly, or hepatosplenomegaly. Of the following, the MOST likely cause of these findings in this infant is

A. Cytomegalovirus
B. Herpes simplex virus
C. Rubella
D. Syphilis
E. Toxoplasmosis
References

• Centers for Disease Control

• Red Book 2009 – paper and online

• www.sciencemuseum.org.uk/broughttolife
5th Annual Advocacy Project: IMMUNEWISE
Section on Medical Students, Residents, and Fellowship Trainees 2009-2010
Case Presentation

- 4 year old female is on the illness clinic schedule
- Her mom reports 2 days of fever and decreased energy level
Case Presentation

• Review of Systems
  – Temp to 102°F
  – Mild headache
  – Eye redness
  – Mild congestion
  – Non-productive cough
  – No GI complaints
  – No rash

• PMHx
  – Healthy
  – Due for 4-5 year old immunizations

• SHx
  – Lives with parents
  – No known sick contacts
  – Recent travel to Disney World (about 10 days ago)
Case Presentation - Exam

- **General**: Cooperative, NAD but appears ill
- **HEENT**: PERRL, bilateral conjunctival erythema and watery eyes, nares patent, MMM without lesions, neck supple, no lymphadenopathy
- **Chest**: CTA bilaterally, no wheeze/rales/rhonchi; HRRR, no murmur/rub/gallop
- **Abd**: Active BS, soft, non-tender, no HSM
- **Skin**: No rash or lesions noted
Case Presentation

- Diagnosed with a viral upper respiratory infection
- Supportive care was discussed with the patient’s mother
Case Presentation

• The 4 year old returns the next day with a new rash...

• Exam is unchanged except for a blotchy, blanching erythematous maculopapular rash on her face and neck
Differential Diagnosis

- Discussion
Management
Measles

Epidemiology

• Humans are the only natural host
• Transmitted by direct contact with droplets
  – may contract from airborne droplets too
• Most common in preschool and early school-aged children with a late winter peak
• Vaccine licensed in 1963
• Vaccine failure rate of 5% in those with only a single dose
Measles vaccine was licensed in 1963. Evidence suggests that measles is no longer endemic in the United States.
**Measles Epidemiology**

Reported Measles Cases
Region of the Americas, 1980 - 1998

- **Catch-up campaigns**
- 86% coverage <1 yr old
- **Follow-up campaigns**

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Measles

Clinical Presentation

- Incubation period of 8-12 days
- Symptoms and signs include:
  - Fever, malaise, cough
  - Conjunctivitis, coryza, +/- photophobia
  - Koplik spots on soft palate (often occur before the rash and are diagnostic)
  - Rash, usually day 2-3 of illness
- Contagious for 1-2 days before onset of symptoms until ~4 days after rash appears
Measles
Clinical Presentation
**Measles Diagnosis**

- Serum sample positive for measles IgM antibody on initial presentation
  - Sensitivity varies - low in first 72 hours of rash
  - If the initial test is negative, consider repeating after the rash is present > 72 hours
- Significant rise in measles IgG in paired acute – convalescent samples
- Measles RNA in blood, throat, nasopharyngeal or urine samples (by PCR)
Measles Complications

- Complications include:
  - Otitis media
  - Croup or bronchopneumonia
  - Diarrhea

- Severe complications:
  - Acute encephalitis in 1/1000 cases
  - Death in 1-3/1000 cases
    - Usually due to respiratory or neuro complications
  - Subacute sclerosing panencephalitis (SSPE)
    - Degenerative CNS disease
Measles Treatment

- Supportive care
- Vitamin A
  - Give if vitamin A deficiency is endemic
  - Give in the U.S under certain conditions
    Consult Red Book
- Ribavirin
  - Not FDA approved, but may help those severely affected and immunocompromised
Measles
Infection Control

- Vaccine given within 72 hrs of exposure may provide protection in susceptible individuals.

- Immune globulin given within 6 days of exposure may prevent or modify measles.
FACT: Vaccines save 33,000 lives each year

For more information
www.VaccinateYourBaby.org
IMMUNIZATIONS AND QUALITY IMPROVEMENT

American Academy of Pediatrics
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Quality Improvement (QI)

A method for analyzing a particular clinical practice, implementing change in that practice and assessing the effects of changes.

QI is prospective and retrospective in its approach

Looks at where something is in the present and aims to help in improving it in the future.
ACGME Program Requirement on Practice Based Learning and Improvement states, “systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement. Residents are expected to participate in a quality improvement project.”
Quality Improvement

• Quality can be defined in multiple ways
  – Consistent value or safety of a product, service, job, benefit, etc

• In reference to immunizations, it could be the “quality” of the actual immunization, its delivery, or the number of patients in a practice immunized
Quality Improvement

The stakeholders in Pediatric QI include:
- Patients and their parents (or families)
- Health care providers
- Office staff
- Parent’s employers
- Payors
Quality Improvement

• Getting started
  – Select a small problem and measure where the practice or service stands
  – Narrow the focus
  – Track and study the focus looking for target areas to improve
QI Project
Immunization Rates

- QI projects focused on improving immunization rates can target
  - Particular vaccine (eg, influenza)
  - Target population (eg, 2-24 month olds)
  - Entire population served
QI Project

Immunization Rates

• An example of how to do QI for immunization rates comes from TIDE – Teaching Immunization Delivery and Evaluation
Designing QI — Step 1

• Assess Immunization Rates (“Plan”)

• Assessment methods:
  – Chart method
  – Active method
  – Consecutive method

• Record the assessment data collected
  • There is a sample to download
This is an example of an Individual Encounter Record, which can be used to record vaccination data for each patient. You can find this form at the following site: www2.edserv.musc.edu/tide/moduleb/ier/ier.pdf
Designing QI – Step 2

- Implement Change ("Do")
  - Describe and analyze key office routines related to immunizations using an office immunization practices questionnaire
    - There is a sample to download
  - Based on findings…
    - Select an intervention likely to improve immunization rates
    - Focus on the “vital few” interventions (or even one) rather than the “useful many”
## Office Immunization Practices Questionnaire

<table>
<thead>
<tr>
<th>Factor</th>
<th>Office Practice</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment and feedback</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are practice immunization rates assessed regularly?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Is feedback of immunization rates given to providers?</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td><strong>Records</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical record is always available, prompts for providers</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Medical record is available</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>Record of immunizations available</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Immunizations systematically checked at all visits?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Immunization prompts for providers at the time of visits?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Patient-held immunization record/card?</td>
<td>[ ]</td>
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</tr>
<tr>
<td><strong>Opportunities</strong></td>
<td></td>
<td></td>
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<tr>
<td>Immunize at all opportunities</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Immunize at both sick and well visits?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Contraindications to immunizations are appropriate and consistent?</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>All immunizations due administered simultaneously</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Are there standing orders for</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
Designing QI – Step 3

- Assess the Effects of Change (“Study”)
  - Assess the immunization rates again (after a set period of time)
  - Continue to improve your effort after noting barriers / set-backs
  - Celebrate successes
  - Continue to re-measure at periodic intervals
Designing QI – Key Points

• It is important that the key players buy into the project – incentives help!
• More detailed information and forms such as the Standardized Encounter Form and the Immunization Practices Questionnaire can be found on Modules A, B, and C of the TIDE (Teaching Immunization Delivery and Evaluation) website
  • [http://www2.edserv.musc.edu/tide/reg/main.las](http://www2.edserv.musc.edu/tide/reg/main.las)
4. Alternative schedules are not supported by scientific evidence.

- Arguments for alternative/selective schedules play on the public’s fears: animal products, prions, thimerisol, aluminum, autism

- Arguments of the pros and cons of vaccines do not distinguish between good and bad studies

- Arguments often based on anecdotal experience rather than scientific studies

References


2. Fisher and Bocchini. Adhering to vaccine schedule is best way to protect children from disease. *AAP News* 2009; 30: 4
The Schedules:

1) “Dr. Bob’s Selective Vaccine Schedule” is for parents who wish to decline or delay vaccines. On this schedule, children may not receive MMR, Varicella, Hep A, Polio, Influenza, Pertussis booster.

2) “Dr. Bob’s Alternative Vaccine Schedule” is based on spacing out the vaccines. With this schedule, flu vaccine is not given until 5 years, Hepatitis B until 2.5 years, and Measles until 3 years. Vaccines are spaced out so children receive at most 2 shots per visit. Under this schedule, you must have vaccines given at the following months: 2, 3, 4, 5, 6, 7, 9, 12, 15, 18, 21, 24 months as well as at 2.5, 3, 3.5, 4, 5 and 6 years of age.

The problems with this approach?

1. The current vaccine schedule is recommended by the CDC, American Academy of Pediatrics, and the American Academy of Family Physicians
   - Dr. Bob states that many MDs do not understand vaccines and their risks
   - The expert committees certainly do understand vaccines. Recommendations are evidence-based
   - Vaccines are much more rigorously tested than most medications prior to licensure

2. Delaying or declining vaccines exposes children to vaccine-preventable diseases
   - Vaccines have contributed to an increase of ~30 years in the human lifespan over last 100 years
   - Vaccine mandates have decreased hospital deaths due to vaccine-preventable diseases
   - States with philosophical exemptions have higher rates of vaccine-preventable diseases, e.g. Pertussis

3. Most alternative schedules require a greater number of office visits
   - More visits = Higher costs to deliver vaccines
   - In addition, more visits equals more waiting room time, which in one study was associated with a higher risk of developing measles
8. **MYTH:** Some vaccines have infectious agents that may hurt my child  

**FACT:** All vaccines that are recommended for your child are tested and overseen by the FDA. They are tested for the presence of any infectious agent, like viruses, bacteria, fungi, and parasites.

9. **MYTH:** Vaccines cause autism  

**FACT:** There are many studies that prove that vaccines do not cause autism. They have studied the genetics of autism, the nervous system of children with autism, the timing of the first symptoms of autism, the relationship between autism and being immunized with the MMR vaccine, and thalidomide and natural rubella infection. All of these studies support the fact the autism occurs during the development of the nervous system early on in pregnancy.

10. **MYTH:** A mercury-containing preservative (Thimerosal) contained in many vaccines harm children  

**FACT:** Thimerosal has been used as a preservative in vaccines to help prevent the growth of bacteria and fungi in the vial containing the vaccine, especially in multi-dose vials. The amount of mercury in thimerosal is below the level that would be needed to hurt your child. Even so, it is now being taken out of vaccines for two reasons. Single dose vials have replaced multi-dose vials of vaccine and there are other preservatives that do not contain mercury that can be used instead. The bottom line: there is no evidence that shows that thimerosal can harm your child and no vaccine currently given in the United States contains it anymore.

For more information:  
www.cdc.gov  
www.aap.org  
www.immunizationinfo.org  
www.ecbt.org
1. MYTH: Vaccines don’t work

FACT: Vaccines have been the single most important public health intervention in the last century. Vaccines are the reason we don’t see smallpox worldwide. Polio is unheard of in the United States and many young physicians have never seen a case of chicken pox. This is because of vaccines.

2. MYTH: Babies are too young for vaccines

FACT: The truth is that babies start building up their immune system shortly after birth. Many of the diseases that babies are exposed to at a few weeks to months of age are those that we vaccinate babies against (e.g. pertussis, diphtheria, haemophilus).

3. MYTH: Vaccines aren’t necessary

FACT: As more and more people get vaccinated against a disease, we see less of the disease. Secondary to this, people forget how bad the disease was in the first place and think that there is no need for vaccination. It is because of these vaccinations that we don’t see the disease we used to see and why we need to keep immunizing. We have to prevent these diseases from coming back.

4. MYTH: Vaccines are unsafe

FACT: Most vaccines are very safe. Nothing is 100% without side effects though. Most of these are not serious and the most common side effects are low-grade fever, redness or pain at the site of injection, and fussiness. The diseases which these vaccinations prevent are more dangerous than the vaccinations themselves.

5. MYTH: There are too many vaccines

FACT: Infants and children are exposed to millions of different viruses and bacteria. Giving multiple shots at one time is much less than they are exposed to on a daily basis.

6. MYTH: It is better to be naturally infected than immunized

FACT: It is true that natural immunity is almost always better at establishing immunity than the vaccination. However, the risk to your child from getting the disease is much greater than the risk posed by the immunizations to prevent the disease.

7. MYTH: Vaccines suppress my child’s immune system

FACT: Infection with the natural disease can suppress your child’s immune system. Immunizations do not work like this. The viruses used to deliver the vaccine are too weak to suppress the immune system.
Reliable Web Resources for Immunization Information
Between your child's physician, your family and friends, and all of the information you find on the internet, how do you decide what information to use to decide on whether you should immunize your child?

Below are a few internet sites that can give you reliable information to help you decide.

1. **American Academy of Pediatrics (AAP):** [www.cispimmunize.org](http://www.cispimmunize.org)
   - At this site, you will find the following features:
     - AAP Immunization Initiatives
     - Section for Families – a question and answer section
     - Section for Clinicians
     - Section that Reviews Vaccine Preventable Diseases Resources
     - Current Recommended Vaccination Schedule
     - Updated information on infections heard that are currently in the news (e.g. – Swine Flu)
     - Information on vaccine safety and efficacy

2. **Centers Disease Center (CDC):** [www.cdc.gov/vaccines/](http://www.cdc.gov/vaccines/)
   - At this site, you will find the following features:
     - Current Recommended Vaccine Schedules
     - Section for Questions
     - Section explaining vaccines and the diseases they prevent
     - Section on Vaccine Side Effects & Safety
     - Section explaining why immunizations exist

3. **National Network for Immunization Information (NNII):** [www.immunizationinfo.org](http://www.immunizationinfo.org)
   - At this site, you will find the following features:
     - Section on the science behind vaccines
     - Section on issues associated with vaccines
     - Section explaining vaccines and the diseases they prevent
     - Section for parents
     - Section for healthcare professionals

4. **Every Child by Two (ECBT):** [www.ecbt.org](http://www.ecbt.org)
   - At this site, you will find the following features:
     - Section for parents
     - Section for advocates
     - Section for healthcare professionals
     - Section for vaccine safety

5. **Children’s Hospital of Philadelphia (CHOP):** [www.chop.edu/consumer/jsp/division/generic.jsp?id=75697](http://www.chop.edu/consumer/jsp/division/generic.jsp?id=75697)
   - At this site, you will find the following features:
     - Section to learn about each vaccine
     - Section in the science behind vaccines
     - Recommended vaccination schedules
     - Section on vaccine safety
     - Section that has informational sheets on each vaccine

6. **Parents of Kids with Infectious Diseases:** [www.pkids.org](http://www.pkids.org)
   - Section that explains infectious diseases
   - Section for families
   - Section on immunizations
   - Section where families can discuss concerns with other parents and professionals
The Problem With Dr Bob's Alternative Vaccine Schedule
Paul A. Offit and Charlotte A. Moser
Pediatrics 2009;123;e164-e169
DOI: 10.1542/peds.2008-2189

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://www.pediatrics.org/cgi/content/full/123/1/e164
The Problem With Dr Bob’s Alternative Vaccine Schedule

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ABSTRACT

In October 2007, Dr Robert Sears, in response to growing parental concerns about the safety of vaccines, published The Vaccine Book: Making the Right Decision for Your Child. Sears’ book is enormously popular, having sold >40,000 copies. At the back of the book, Sears includes “Dr Bob’s Alternative Vaccine Schedule,” a formula by which parents can delay, withhold, separate, or space out vaccines. Pediatricians now confront many parents who insist that their children receive vaccines according to Sears’ schedule, rather than that recommended by the American Academy of Pediatrics, the Centers for Disease Control and Prevention, and the American Academy of Family Physicians. This article examines the reasons for the popularity of Sears’ book, deconstructs the logic and rationale behind its recommendations, and describes how Sears’ misrepresentation of vaccine science misinforms parents trying to make the right decisions for their children.

Many parents are hesitant about vaccinating their children. Vaccine hesitancy can be explained in part by a lack of trust in those who make vaccine recommendations; a suspicion of profit motive driven by pharmaceutical companies; misinformation on the Internet; failure to appreciate the seriousness of vaccine-preventable diseases, given their low rates; and constant stories in the media claiming that vaccines cause a variety of illnesses, ranging from allergies to autism. Most recently, with the addition of several new vaccines to the infant schedule, some parents have become concerned that children receive too many vaccines too early. Given that young infants currently receive 14 different vaccines, requiring as many as 5 shots at a single visit and 26 inoculations by 2 years of age, the concern that children might be overwhelmed by too many vaccines is understandable.

To address parents’ concerns about vaccines, Dr Robert Sears, son of noted pediatrician and author Dr William Sears, wrote The Vaccine Book: Making the Right Decision for Your Child. Sears’ book, published in October 2007 as part of the Sears Parenting Library, has already sold >40,000 copies and has moved into the top 100 on the Amazon.com bestseller list. The popularity of Sears’ book centers in part on 2 schedules, called alternative and selective, that offer parents a way to avoid giving their children several vaccines at one time.

Sears’ book is unique. Unlike typical antivaccine books, he offers a middle ground, allowing parents to act on their fears without completely abandoning vaccines. Unfortunately, Sears sounds many antivaccine messages.

THE MESSAGE

Doctors Do Not Understand Vaccines

In his preface, Sears writes, “Doctors, myself included, learn a lot about diseases in medical school, but we learn very little about vaccines. . . . We don’t review the research ourselves. We never learn what goes into making vaccines or how their safety is studied. . . . So, when patients want a little more information about shots, all we can really say as doctors is that the diseases are bad and the shots are good.” Implicit in Sears’ premise is the idea that doctors do not know much about vaccines and that if parents educate themselves they will know more than their doctors. For some parents, this admission can be quite reassuring, allowing them to negate their doctor’s advice and take control of a worrisome situation.
Although Sears is correct that doctors do not often review all of the studies on vaccine science, safety, and efficacy, he ignores the expert committees that do, specifically the Advisory Committee on Immunization Practices, which advises the Centers for Disease Control and Prevention (CDC), and the Committee on Infectious Diseases, which advises the American Academy of Pediatrics. Collectively, these advisory committees and their parent agencies have the expertise in virology, microbiology, statistics, epidemiology, and pathogenesis necessary to review the studies that inform their recommendations. Their advice to doctors has served us well; during the past century, vaccines have helped to increase the lifespan of individuals in the United States by ~30 years, with an excellent record of safety.

Public Health Agencies and Pharmaceutical Companies Are Not Trustworthy

Sears casts doubt on the reliability and motives of the CDC and pharmaceutical companies. For example, he writes, “Twenty years ago a group of doctors from the CDC, several US medical centers, and two pharmaceutical companies (GlaxoSmithKline and Merck) undertook the task of determining just how common the hep B [hepatitis B] infection was in infants and children. If they found that hep B was very common in kids, it would make sense to begin vaccination of all newborns . . . . The consensus of the researchers was that approximately 30 000 infants and children were being infected with this virus each year.” After taking a closer look at the data, Sears thought that only “about 360 cases [were] reported in kids from birth through age nine each year.” Sears’ implication is clear, that is, to provide a rationale for newborn hepatitis B vaccine, the CDC, in league with pharmaceutical companies, misrepresented the data.

It is not difficult in today’s society to appeal to the notion of corporate or government malfeasance. But Sears’ estimate of the impact of hepatitis B infections is not supported by the facts. Before the hepatitis B vaccine became part of the routine schedule for children, every year ~16 000 children <10 years of age were infected with hepatitis B virus after nonsexual, person-to-person contact.2 Given that reported cases might not include subclinical infections, this estimate is probably low.

Vaccine Mandates Should Be Eliminated

Sears thinks that vaccines should be optional. “Only twenty states allow parents to decline some or all vaccines at public school registration on the basis of personal beliefs,” writes Sears. “Parents who decline vaccination in [some] states can have their children taken away from them.” Sears fails to mention that enforcement of vaccine mandates, which were initiated because of measles outbreaks that swept across the United States in the middle 1970s, has dramatically reduced hospitalizations and deaths resulting from vaccine-preventable diseases3,4 or that states with philosophical exemptions have higher rates of vaccine-preventable diseases (such as pertussis), compared with states without such exemptions.5 His claim that unvaccinated children have been removed from the home is alarming and false, only inflaming an already frightened public.

Vaccine-Preventable Diseases Are Not That Bad

In his chapter on pneumococcal infection, Sears tells the following story. “A six-month-old unvaccinated infant had a pneumococcal ear infection that spread to the skull bones behind the ear. She required surgery and IV [intravenous] antibiotics. Afterward, I asked the parents if they regretted their decision not to vaccinate. They said no. They were both well-educated professionals, had done a lot of reading on this issue, and still felt comfortable with their decision.” Sears implies that vaccine-preventable diseases, although occasionally serious, are not really that bad. Before the conjugate pneumococcal vaccine became part of the routine schedule in 2000, however, pneumococci caused ~17 000 cases of invasive disease every year in children <5 years of age, resulting in 700 cases of meningitis and 200 deaths.6 The parents in Sears’ story were fortunate that their child did not suffer sepsis, severe pneumonia, or fatal or debilitating meningitis.

Hide in the Herd

Perhaps the most disingenuous comment in the book is directed at parents who are afraid of the measles-mumps-rubella (MMR) vaccine. “I also warn [parents] not to share their fears with their neighbors,” writes Sears, “because if too many people avoid the MMR, we’ll likely see the diseases increase significantly.” In other words, hide in the herd, but do not tell the herd you’re hiding; otherwise, outbreaks will ensue. Sears’ advice was prescient. Recent outbreaks of measles in 15 states, caused by an erosion of herd immunity in communities where parents had chosen not to vaccinate their children, were the largest in the United States since 1996.7

Natural Infection Is Better Than Vaccination

Sears describes the value of chickenpox parties. “Some parents . . . may purposely get their child exposed to get the disease over with,” he writes. “If you’ve ever been invited to a ‘chickenpox party,’ you’ll know what I’m referring to. Having the disease in most cases provides lifelong immunity (better immunity than the shot provides), so there is practically no worry about catching the disease as an adult.” Sears’ concern that immunity to chickenpox will fade, only shifting the burden of disease from children to adults, fails to take into account decades of experience with other live viral vaccines. Although measles, mumps, and rubella infections are often more serious in adults, widespread immunization of children has not shifted the burden of disease; rather, it has reduced dramatically or eliminated these infections. Furthermore, although Sears is correct in stating that natural immunity is generally better than vaccine-induced immunity, the high price of natural immunity, that is, occasionally severe and fatal disease, is a risk not worth taking.
Vaccination Has Eliminated Infectious Diseases at the Price of Causing Chronic Diseases

Sears writes, “When I reviewed numerous studies, I did find some that show a possible link between a vaccine and a chronic disease. Examples include the Hib [Haemophilus influenzae type b] vaccine and diabetes, the Hep B vaccine and multiple sclerosis and rheumatoid arthritis, and the MMR vaccine and eczema.” Sears fails to point his readers to the clear body of evidence that has exonerated vaccines as a cause of these disorders (reviewed in ref 8).

Vaccine Safety Testing Is Insufficient

Sears writes, “A new medication goes through many years of trials in a select group of people to make sure it is safe. . . . Vaccines, on the other hand, don’t receive the same type of in-depth short-term testing or long-term safety research.” On the contrary, vaccines are tested in larger numbers of children for longer periods of time than drugs. For example, the human papillomavirus vaccine was tested in 30,000 women,9 the conjugate pneumococcal vaccine in 40,000 children,10 and each of the current rotavirus vaccines in ~70,000 children before licensure.11,12 No medication receives this level of scrutiny. Furthermore, safety mechanisms such as the Vaccine Adverse Event Reporting System (VAERS) and the Vaccine Safety Datalink Project are model systems for detecting rare adverse events after licensure. Drug surveillance would benefit from mimicking these vaccine catchment systems.

Public Health Officials Make Recommendations for the Public and Not for Individuals

Sears writes, “Obviously, the more kids who are vaccinated, the better our country is protected and the less likely it is that any child will die from a disease. Some parents, however, aren’t willing to risk the very rare side effects of vaccines, so they choose to skip the shots. Their children benefit from herd immunity . . . without risking the vaccines themselves. Is this selfish? Perhaps. But as parents you have to decide. . . . Can we fault parents for putting their own child’s health ahead of the other kids’ around him?” Sears’ argument represents a fundamental flaw in logic. For example, Sears states that the polio vaccine, which prevents a disease that has not occurred in the United States since 1979, is given to protect the population and not the individual. “[Polio] doesn’t occur in our country,” he writes, “so the risk is zero for all age groups.” Although it is true that polio has been eliminated from the United States, it has not been eliminated from the world. The disease is still prevalent in India, Africa, Southeast Asia, and the Middle East. Because international travel is common and because only 1 of every 200 people infected with poliovirus exhibits symptoms, it is likely that people who are unknowingly shedding poliovirus come into the United States every year. An unimmunized child would be particularly susceptible if an outbreak occurred. Furthermore, the unimmunized child might later travel to a country where polio is endemic. Therefore, every individual benefits from receiving polio vaccine.

The Problem

Decision-Making

Sears wants parents to use the information he has provided to make their own decisions about whether to vaccinate their children. “I have offered you all the information you need to make this decision,” he writes, “but I have held back from actually telling you what to do. I want you to formulate your own decision without letting my opinion sway you one way or the other.” Unfortunately, Sears, who wants parents to make informed decisions, has written a book that will largely misinform them.

Distinguishing Good Science From Bad Science

At the end of every chapter describing individual vaccines, Sears includes sections titled “Reasons to get the vaccine” and “Reasons some people choose not to get the vaccine.” In the latter sections, Sears often takes the position that, if parents think that a vaccine is problematic, then the vaccine is problematic. He believes that parents’ fears should be indulged by offering alternative schedules, not countered by scientific studies, and he fails to explain that good science is the only way to determine whether a vaccine causes a particular adverse event. Instead, Sears alludes to evidence on both sides of any issue, failing to distinguish studies on the basis of their quality, internal consistency, or reproducibility and failing to distinguish those that are accepted by the scientific community from those that are not.

Risks From Vaccines

In chapters describing individual vaccines, Sears lists side effects found in product inserts and VAERS reports. Weighing the risks and benefits of the conjugate pneumococcal vaccine, he writes, “In the first two years of Prevnar’s use in the United States, about 32 million doses were given, and about 4100 adverse reactions were reported to VAERS. Most reactions were fairly mild, but about 15 percent (around 600) were considered serious. This means that for every 53,000 doses, one serious reaction occurred.” Like many parents who are concerned about vaccines, Sears thinks that reports to VAERS represent an accurate profile of a vaccine’s side effects. However, VAERS is a passive surveillance system and cannot be used to determine the true incidence of adverse events, which can be determined only by using control groups (not provided by VAERS). For this reason, VAERS reports often represent coincidental and not causal associations. Furthermore, the source of VAERS reports can be misleading. For example, many of the recent VAERS reports of autism after receipt of vaccines came not from parents, doctors, nurses, or nurse practitioners but from personal-injury lawyers.13 Finally, pharmaceutical company lawyers often list in product inserts all adverse events that occurred after receipt of vaccines even if those events occurred at rates similar to those found among placebo recipients.

Risks From Vaccine-Preventable Diseases

Sears often counters data on the national incidence of specific infectious diseases with personal experience. For
example, in the section on pneumococcal disease, he writes, “I’ve seen only one serious case of [pneumococcal] infection in my office in my ten years of practice.” Regarding meningococcal disease, he writes, “I saw one case during my medical training, and I haven’t seen it since.” Because Sears works in a private practice and not a hospital, he is unlikely to see serious infectious diseases commonly. His individual experience should be enriched by his knowledge of published studies, however, and not used to negate them. This see-no-evil approach only misinforms his readers.

**Animal Products**

Sears explains that some vaccines are made by using fetal bovine serum, raising the specter of mad cow disease. “All animal and human tissues are carefully screened for all known infectious diseases,” he writes. “Some vaccine critics are still worried, however, that there may be other viruses or infectious agents (called ‘prions’) . . . that are much smaller than viruses and that we don’t yet know how to screen for.” Sears fails to mention that prions propagate in the nervous system and not the bloodstream, that they do not grow in the mammalian cells used to produce attenuated viral vaccines, that they have never been found to contaminate fetal bovine serum, that mad cow disease is not a human health problem in the United States, and that studies found no increased risk of mad cow disease in children who did or did not receive vaccines in the United Kingdom, where mad cow disease was a problem (reviewed in ref 14). Rather, in keeping with his theme that parental fears trump scientific studies, he concludes, “If exposure to animal tissues worries you, you may want to choose the brand that doesn’t use cow extract.”

**Thimerosal**

Sears does not take a clear stand on this issue, writing, “Do I think mercury is harmful? Yes. Do I think the amount in the old vaccines caused harm? I’m not 100% convinced one way or the other.” It is hard to imagine a better conceived, better designed study on the subtle effects of mercury poisoning than that performed by Bill Thompson and colleagues at the CDC and published in 2007. The study carefully identified the quantity of mercury exposure from thimerosal before birth (from RhoGam; Ortho Diagnostics, Raritan, NJ) and after birth (from vaccines) for >1000 children. Researchers then subjected the children to >40 neurologic, psychological, and developmental tests and found no significant differences for those who received greater or lesser quantities of mercury. By choosing not to evaluate the quality of the scientific findings on this issue, Sears again fails to educate his readers.

**Aluminum**

Sears’ main argument for spacing out vaccines is to avoid giving infants too much aluminum at one time, writing, “When a baby gets the first big round of shots at two months, the total dose of aluminum can vary from 295 micrograms . . . to a whopping 1225 micrograms if the highest aluminum brands are used and a hep B vaccine is also given. . . . These doses are repeated at four and six months.” Extrapolating studies of patients undergoing hemodialysis and severely premature infants to healthy newborns, Sears claims that these quantities might be unsafe. However, Sears fails to put aluminum exposure in context. By 6 months of age, infants typically ingest ~6700 µg of aluminum in breast milk, 37 800 µg in infant formula, or 116 600 µg in soy-based formula. Furthermore, Sears fails to describe scientific studies that led the National Vaccine Program Office to conclude that the amount of aluminum contained in vaccines did not warrant changing the vaccine schedule.

**Other Vaccine Ingredients**

Sears claims that the MMR vaccine contains human albumin purified from human blood. “The human and cow blood products used in manufacturing may also concern some parents,” he writes. However, the MMR vaccine contains genetically engineered human serum albumin, a product that is not derived from human blood, as a stabilizer.

**MMR Vaccine and Autism**

Sears writes, “Some doctors and researchers who suspect the MMR vaccine may play a role in autism also feel it is safer to give the three injections separately, spaced out one year apart. I can’t find enough research to determine if this precaution is justified, but in theory it does make sense.” For this reason, Sears recommends that the measles, mumps, and rubella components of MMR be administered separately. Sears fails to mention the many epidemiological studies that showed that the MMR vaccine did not increase the risk for autism or to note that the theory that measles-containing vaccine causes intestinal inflammation has been thoroughly debunked. Worse, Sears takes the discredited notion that measles vaccine causes intestinal disease one step further, recommending that “the MMR vaccine not be given when a child is suffering from diarrhea or has taken antibiotics in the past few weeks. This vaccine may cause more reactions when the intestines aren’t at peak health.”

**THE LOGIC**

**Coincidence Versus Causality**

Sears’ general theories of science and medicine are often poorly reasoned or illogical. Sears writes, “Sometimes infants and children develop medical problems . . . within days or weeks of a vaccination. Although it can be highly suspected that the vaccine was the cause, it can’t be proven. I’m sure the truth of the matter is somewhere in between causality and coincidence.” Epidemiological studies, which are the single best way to determine whether a vaccine is associated with an adverse event, have shown consistently that vaccines cause certain problems, such as measles-containing vaccine causing thrombocytopenia and diphtheria-tetanus toxoids-pertussis vaccine causing seizures. Some studies have failed consistently to find an association, such as
thimerosal in vaccines causing autism. In all of these cases, it can be said that a truth has emerged. There is no middle ground between coincidence and causality; a vaccine either causes a problem or it does not.

Scientific Proofs
Sears has a poor grasp of the scientific method. “Some studies have been published in recent years that have failed to show statistical proof of a relationship between vaccines and autism,” he writes. “However, by the same token, it is also difficult to prove that there is not a connection.” Using the scientific method, investigators form the null hypothesis. Good epidemiological studies are powered to reject or not to reject the null hypothesis. However, the scientific method does not allow investigators to accept the null hypothesis. Said another way, scientists can never prove never. The most that scientists can show is that 2 events are not associated statistically; scientists cannot prove that the events can never be associated statistically. In stating that it is “difficult to prove that there is not a connection,” Sears is suggesting the impossible.

Context
Sears argues that elements such as mercury are neurotoxins and the presence of mercury in thimerosal makes some vaccines (such as multidose preparations of inactivated influenza vaccines) dangerous. However, Sears never discusses the fact that mercury is present on the earth’s surface and that, like aluminum, children ingest mercury in breast milk and infant formula at levels that often exceed those contained in vaccines. Sears also fails to explain that small quantities of heavy metals such as cadmium, beryllium, lead, and thallium, which can be toxic in large quantities, are present in everyone who lives on our planet. By creating the notion of zero tolerance, Sears fails to educate his readers that the dose makes the poison, that it is the amount of a potential toxin and not its mere presence that counts.

Understanding Risk
Sears does not recommend the meningococcal vaccine for teenagers because of the possible risk of Guillain-Barré syndrome. Indeed, the most recent estimates are that the conjugate meningococcal vaccine might cause Guillain-Barré syndrome for ~1 per 1 million recipients. However, the risk of meningococcal disease for a child who is not vaccinated is ~10-fold greater than the possible risk of Guillain-Barré syndrome for a child who is vaccinated. Furthermore, the high rates of death and permanent sequelae caused by meningococci make the choice not to be vaccinated an illogical one. By failing to weigh the relative risks of the disease and vaccine side effects accurately, Sears again misinforms his readers.

THE HARM
For parents who are worried about vaccines, Sears offers 2 alternative schedules. One, titled “Dr Bob’s Selective Vaccine Schedule,” is for parents who want to decline or to delay vaccines. Children whose parents choose this schedule might not be receiving the measles, mumps, rubella, varicella, and hepatitis A vaccines and will not be receiving the polio and influenza vaccines or a booster dose of pertussis vaccine.

The other schedule, titled “Dr Bob’s Alternative Vaccine Schedule,” is written for parents who worry that children are receiving too many vaccines too early. Children whose parents choose this schedule will not be receiving the influenza vaccine until 5 years of age (which is unfortunate, given that tens of thousands of children <4 years of age are hospitalized with complications resulting from influenza every year), will not be receiving the hepatitis B vaccine until 2.5 years of age, will not be receiving measles vaccine until 3 years of age, and, to space out vaccines so that children do not receive >2 shots at 1 visit, will be visiting the doctor for vaccines at 2, 3, 4, 5, 6, 7, 9, 12, 15, 18, 21, and 24 months and 2, 2.5, 3, 3.5, 4, 5, and 6 years of age. Increasing the number of vaccines, the number of office visits, and the ages at which vaccines are administered will likely decrease immunization rates. In addition to the logistic problem of requiring so many office visits, Sears’ recommendation might have another negative consequence: recent outbreaks of measles showed that several children acquired the disease while waiting in their pediatricians’ offices.

At the heart of the problem with Sears’ schedules is the fact that, at the very least, they will increase the time during which children are susceptible to vaccine-preventable diseases. If more parents insist on Sears’ vaccine schedules, then fewer children will be protected, with the inevitable consequence of continued or worsening outbreaks of vaccine-preventable diseases. In an effort to protect children from harm, Sears’ book will likely put more in harm’s way.

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9. Schiller JT, Frazer IH, Lowy DR. Human papillomavirus vac-


# The Problem With Dr Bob's Alternative Vaccine Schedule

Paul A. Offit and Charlotte A. Moser

*Pediatrics* 2009;123:e164-e169

DOI: 10.1542/peds.2008-2189

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The division staff monitor legislation related to pediatrics in the every state and alert chapters to important developments in this area. Information on the experiences of other states and chapters can also be obtained from the division. By means of the State Government Affairs e-mail update, the division keeps chapter leaders, executive directors, and lobbyists in-tune with the latest state advocacy issues and news about state governments. Division staff provides assistance to chapters with their state advocacy efforts to ensure that children have access to quality medical care, public (Medicaid and SCHIP) and private insurance coverage, and physician payment issues. In addition, consultation is available on state government initiatives related to injury prevention, immunization issues, child abuse prevention, substance use/abuse prevention, disaster preparedness, scope of practice, physician workforce, early childhood development, newborn screening, adoption and foster care, parenting issues, health disparities, school health, environmental health, child nutrition, emergency medicine, and many more.

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Medicaid and SCHIP Monitor provides in-depth reporting on the title subjects as well as other state-level child health finance and access to care issues.

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## Insurance Mandates for Immunizations: 2009 State Law

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Note: State laws change on a frequent basis. This tally is excerpted from the 2008 AAP State Legislation Report. For an update on this issue, contact the [AAP Division of State Government Affairs](https://www.aap.org).
## Immunization Challenges: 2009 State Law

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(*MO: philosophical exemption-child care, Headstart. NE: philosophical exemption-child care. VA: parental opt-out to HPV requirement only.)*

Note: State laws change on a frequent basis. This tally is excerpted from the 2008 AAP State Legislation Report. For an update on this issue, contact the [AAP Division of State Government Affairs](http://www.aap.org).
State Government and State Law—Sources for Information

50States.com - General information on states and state capitals

Child Welfare Information Gateway - This database from the US Department of Health and Human Services - Administration for Children and Families allows you to search more than 30 different child welfare statutes in every state and territory

Cornell University Legal Information Institute - Constitutions, statutes, judicial opinions, and regulations for the 50 states, DC, the US territories and affiliation jurisdiction

FindLaw: State Resources - Links to Constitutions, codes, bills, opinions and administrative documents for the 50 states, DC, and the US territories

State Legislatures Web Sites from the National Conference of State Legislatures - Provides links to state legislature Web pages. Be sure to visit and research the Web pages of state legislatures to track bills and see what issues your legislators are focusing on and research various state agencies engaged in activities related to child health and well-being, such as departments of public health, education, insurance, public safety, etc

Associations of State and Local Government Officials

Association of Maternal & Child Health Programs (AMCHP)

The Association of State and Territorial Health Officials (ASTHO)

The Council of State Governments (CSG)

Council of State and Territorial Epidemiologists (CSTE)

Federation of State Medical Boards (FSMB)

National Association of Attorneys General (NAAG)

National Association of County & City Health Officials (NACCHO)

National Association of Chronic Disease Directors (NACDD)

National Association of Insurance Commissioners (NAIC)

National Association of State Alcohol and Drug Abuse Directors (NASADAD)

National Association of State Budget Officers (NASBO)

National Association of State Medicaid Directors (NASMD)

National Association of State Mental Health Program Directors (NASMHPD)

National Association of State & Territorial AIDS Directors (NASTAD)

National Black Caucus of State Legislators (NBCSL)

National Center for State Courts (NCSC)

National Conference of State Legislatures (NCSL)

National Governors Association (NGA)

National Hispanic Caucus of State Legislators (NHCSL)

State Legislative Leaders Foundation (SLLF)

State & Territorial Injury Prevention Directors Association (STIPDA)

The United States Conference of Mayors (USCM)

Women in Government (WIG)

State Government and Health Policy News Sources

Governing.com - A monthly magazine with a daily online companion about governing the states and localities

Health Affairs - A bimonthly, peer-reviewed journal that explores health policy issues of current concern

National Conference of State Legislatures (NCSL) Grasscatcher - Today's state and policy news from NCSL

National Conference of State Legislatures (NCSL) Thicket - A daily blog about the state legislative institutions written by and for "legislative junkies"
PubMed - A service of the US Library of Medicine that includes citations from MEDLINE and other life science journals for biomedical articles back to the 1950s

State Legislatures Magazine - A portal of news for and about state legislatures: the latest innovations, problems, policies, and trends from the 50 state capitols and Washington, DC

Stateline.org - A nonprofit, nonpartisan online news site, funded by the Pew Center on the States, that practices journalism in the public interest by reporting on emerging trends and issues in state policy and politics

StateNet Capitol Journal - A weekly journal of news from the 50 states compiled by StateNet, a computerized legislative and regulatory tracking system

Health Professional Organizations
American Academy of Allergy, Asthma, & Immunology (AAAAI)
American Academy of Child & Adolescent Psychiatry (AACAP)
American Academy of Dermatology (AAD)
American Academy of Family Physicians (AAFP)
American Academy of Neurology (AAN)
American Board of Medical Specialties (ABMS)
The American Board of Pediatrics (ABP)
American College of Emergency Physicians (ACEP)
American College of Physicians (ACP)
American College of Obstetricians and Gynecologists (ACOG)
American College of Surgeons (ACS)
American Medical Association (AMA)
Association of Medical School Pediatric Department Chairs (AMSPDC)
American Osteopathic Association (AOA)
American Public Health Association (APHA)
American Psychiatric Association (APA)
National Hispanic Medical Association (NHMA)
National Medical Association (NMA)

Child and Health Advocacy Organizations
Action for Healthy Kids
All Kids Count
American Diabetes Association (ADA)
American Heart Association (AHA)
American Hospital Association (AHA)
American Lung Association (ALA)
American School Health Association (ASHA)
Bazelon Center for Mental Health Law
Campaign for Tobacco-Free Kids
Center for Adolescent Health Law (CAHL)
Center for Effective Discipline (CED)
Center for Science in the Public Interest (CSPI)
Child Welfare League of America (CWLA)
Children’s Defense Fund (CDF)
Children’s Healthcare is a Legal Duty (CHILD), Inc
The Children’s Partnership (TCP)
Community Voices
Cover the Uninsured
E Health Initiative (eHI)
Every Child By Two (ECBT)
Every Child Matters (ECM)
Families USA
Family Voices
The Future of Children
Governor’s Highway Safety Association (GHSA)
Home Safety Council (HSC)
Immunization Action Coalition (IAC)
Mental Health America (MHA)
National Alliance for Hispanic Health (NAHH)
National Alliance on Mental Illness (NAMI)
National Association of State Boards of Education (NASBE)
National Association of Children’s Hospitals and Related Institutions (NACHRI)
National Association of Community Health Centers (NACHC)
National Association of Counsel for Children (NACC)
National Coalition on Health Care (NCHC)
National Council Against Health Fraud (NCAHF)
National Emergency Management Association (NEMA)
National Health Law Program (NHeLP)
National Immigration Law Center (NILC)
National Partnership for Women & Families (NPWF)
National Rural Health Association (NRHA)
National Safety Council (NSC)
National School Boards Association (NSBA)
National Highway Transportation Safety Administration (NHTSA)
North American Council on Adoptable Children (NACAC)
Safe Kids

State Health Policy Centers
Academy Health - The professional home for health services researchers, policy analysts, and practitioners, and a non-partisan resource for health research and policy
Alliance for Health Reform - A nonpartisan, nonprofit group that believes that all in the United States should have health coverage at a
reasonable cost

American Lung Association's State Legislative Action Tobacco Issues (SLATI) - An extensively researched source of information on tobacco control laws and policy

The Catalyst Center - A national center funded by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA), dedicated to ensuring that all families of Children and Youth with Special Health Care Needs (CYSHCN) have access to adequate public and/or private insurance to pay for the services they need

Center on Budget and Policy Priorities (CBPP) - A policy organization working at the federal and state levels on fiscal policy and public programs that affect low- and moderate-income families and individuals

Center for Health Care Strategies (CHCS) - A nonprofit health policy resource center dedicated to improving the quality and cost effectiveness of health care services for low-income populations and people with chronic illnesses and disabilities

Center for Studying Health System Change (HSC) - A nonpartisan policy research organization that designs and conducts studies focused on the US health care system to inform the thinking and decisions of policy makers in government and private industry

Georgetown University Center for Children and Families (CCF) - An independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families

Guttmacher Institute State Center - The state policy center of the Guttmacher Institute, a research and policy analysis center which advances sexual and reproductive health worldwide through research, policy analysis, and public education

Healthy States - The Council on State Governments - Created through a partnership of the Council of State Governments, the National Black Caucus of State Legislators, and the National Hispanic Caucus of State Legislators, this Web site provides up to date information, reports, and publications about public health issues

Kaiser Commission on Medicaid and the Uninsured - A division of the Kaiser Family Foundation (KFF) that provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured

Maternal and Child Health Policy Research Center (MCHPRC) - A health policy group that provides strategic guidance on financing and service delivery issues affecting children and adolescents, particularly those with special needs and those from low-income families

Mathematica Policy Research - A policy analysis and research firm which focuses on health policy issues

National Academy for State Health Policy (NASHP) - An independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice, NASHP provides a forum for constructive, nonpartisan work across branches and agencies of state government on critical health issues facing states

National Center for Children in Poverty (NCCP) - A public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children

Rockefeller Institute of Government - An institute that conducts studies and special projects to assist government and enhance the capacity of states and localities to meet critical challenges

State Coverage Initiatives (SCI) - A nonprofit that works with states to plan, execute, and maintain health insurance expansions, as well as to improve the availability and affordability of health care coverage

Urban Institute’s Health Policy Center - A policy center that analyzes trends and underlying causes of changes in health insurance coverage, access to care, and use of health care services by the entire US population

Child Health Foundations
Annie E. Casey Foundation
The Commonwealth Fund
David & Lucile Packard Foundation
Henry J. Kaiser Family Foundation (KFF)
Pew Charitable Trusts
Robert Wood Johnson Foundation (RWJF)

Federal Government
Agency for Healthcare Research and Quality (AHRQ)
Centers for Medicare & Medicaid Services (CMS)
Centers for Disease Control and Prevention (CDC)
US Department of Health and Human Services Office of Civil Rights (OCR)
Health Resources and Services Administration (HRSA)
Maternal and Child Health Bureau (MCHB)
National Institutes of Health (NIH)
Substance Abuse and Mental Health Services Administration (SAMHSA)
US Department of Health and Human Services (HHS)
US Department of Health and Human Services Office of Minority Health (OMH)

Insurance, Business, and Quality Organizations
America’s Health Insurance Plans (AHIP)
The Joint Commission
National Business Group on Health (NBGH)
National Committee on Quality Assurance (NCQA)
October 17, 2009
Senator John Doe
511 Dirksen Senate Office Building
Washington, D.C. 20510

October 17, 2009
The Honorable John Doe
(Your state) Senate
(Capitol address)
(Your state capitol), (state) (zip code)

RE: Mandatory HPV (Human papillomavirus) Vaccination for Female Children

Dear Senator Doe,

As a pediatric resident, I am charged with protecting all children in our community from preventable harm. I take this responsibility seriously and am therefore urging you to consider making HPV vaccination mandatory for all adolescent girls entering the sixth grade by supporting (insert bill number here).

According to the Centers for Disease Control, HPV infects 6.2 million Americans every year. It can cause multiple kinds of disease, ranging from genital warts to cervical cancer—the second-leading cause of cancer death in women around the world. In fact, HPV causes 70% of cervical cancer cases. In the United States, the Papanicolaou (“Pap”) test has decreased these numbers secondary to early detection and treatment for cervical cancer. Despite efforts at early detection, there are still 3,700 deaths and 10,000 new cervical cancer diagnoses each year. Vaccination against HPV can therefore save lives and reduce unnecessary suffering.

Vaccines led to the eradication of smallpox and have largely eliminated diseases like polio and diphtheria that once threatened the lives of American children. Now, with the advent of the HPV vaccine, we have an opportunity to prevent HPV infection and a chance to protect future generations of female children against yet another potentially fatal disease. Please help us protect our patients from cervical cancer and pass (insert bill number here) requiring mandatory HPV vaccination for all females prior to entering the sixth grade.

Best regards,

Signature: (your name, MD) ______________
Print Name: (your name, MD) ______________________
Pediatric Resident Physician
(Address)

References used to create this sample letter:


Dear Program Delegate:

The media section contains various resources to aid you in your interactions with the media – there are materials for letter- or editorial-writing, links to public service announcements (PSAs), and general guides for advocacy communication.

A sample letter to the editor is available in this section. This manner of media advocacy is easy and effective; however, each institution has their own policies about using their name when working with the media – so please check with them before signing! To provide reliable sources within your letter, there are two handouts available. The first, titled “Information on Vaccine-Related Studies” provides a short synopsis of various studies that have been done on vaccinations. The second, titled “Information on MMR and Autism” discusses the lack of evidence supporting a link between the MMR vaccine and Autism. Other immunization-specific handouts are available at http://www.aap.org/newsroom.

You may also reference the “Media and Communications Advocacy” document under the “Media Resources” tab for more information on how to write a letter to the editor as well as other media topics. It is an excerpt from a great new resource, the AAP Advocacy guide, which can be found at the following link in its entirety. http://www.aap.org/securemoc/advocacyguide.pdf (you must be signed to your AAP Member Account.)

Finally, there is a document called “AAP Communications Handbook” which is another great resource for public relations. This handbook, in conjunction with the AAP Advocacy guide, will give you the tools to convey your message in the most effective way.

By preparing yourself on the topic of immunizations and how to deal with different types of media, you will be able to take your advocacy projects to the next level. Please remember that by interacting with the media, you represent yourself and your project only. If you are interested in becoming an AAP Spokesperson, please refer to the AAP website at http://www.aap.org/moc/pressroom/pressroom.htm.

Sincerely,
The Advocacy Subcommittee
Section on Medical Students, Residents, and Fellowship Trainees
Childhood Immunization: Our Greatest Health Care Achievement

Thanks to the development and widespread use of modern vaccines, we have entered a new era of child health. Immunizations have reduced vaccine-preventable infectious diseases in this country by up to 99 percent, saving millions of lives.

No longer do parents fear that their children will develop life-threatening paralysis from polio when they are at a swimming pool or movie theater. From 1951 to 1954, four years before the polio vaccine was licensed, 16,316 reported cases of polio were reported each year. Today, the US is polio-free. We have vaccines to thank for that.

No longer do pediatricians worry that a child with a high fever who is attending a child care center has developed Haemophilus influenzae bacterial meningitis which can lead to seizures, deafness, or mental retardation. Prior to the licensure of Hemophilus influenzae type B vaccine in 1985, over 20,000 cases of Hemophilus influenzae serious infections were diagnosed each year. Today, the incidence of this disease in the United States is less than 1 in 100,000 children under age 5.

No longer do pediatricians worry about large epidemics of whooping cough. In the 1920s, before pertussis vaccine was available, over 147,000 cases of whooping cough per year were reported in the United States, compared with 15,600 cases reported in 2006.

The success of vaccines relies on their effectiveness, and the confidence that the public has in their safety. Additionally, the level of protection is fragile and depends on what we refer to as community (or herd) immunity.

Modern childhood vaccines are 90 percent to 95 percent effective. If sufficient numbers of children in a community are immunized, the vaccinated ones protect the unprotected by stopping the chain of transmission in its tracks and drastically lowering the probability that the susceptible child will encounter the bacteria or virus. As long as most children receive their vaccines, we will be able to maintain our current level of disease control. However, should the level of the community protection drop to a point where viruses and bacteria travel unimpeded from person to person, from school to school and from community to community, we will return to a time when deadly epidemics were an accepted part of life.

It is important to balance the public health and safety of our children and community with personal freedom of choice. Immunization has a clear community benefit in addition to its benefit to the individual child. An individual’s “freedom” to ignore a stop sign while driving or to spread disease does not ultimately serve the principle of personal freedom. Failure to immunize one’s own children also increases the potential for harm to other children who, for a variety of reasons, are either not able to be vaccinated because they are too young or too ill, or who were vaccinated, but in whom the vaccine did not provide the expected protection.

Our experience with measles vaccine illustrates this point. In the late 1960s and early
1970s, despite the availability of a safe and effective measles vaccine, we experienced regular epidemics of measles. Without school requirements, we were only able to achieve vaccination rates of 60 percent to 70 percent in most communities, which did not provide sufficient "community immunity" to prevent an outbreak. A recent study published in the Journal of the American Medical Association found that on average, those who chose to exempt from immunizations ran a 35-fold greater risk of contracting measles compared to those who had been immunized. Many states, recognizing the importance of community immunity, passed school immunization requirement legislation.

Vaccines are not perfect. However, the benefits of immunization far outweigh the very small risks. I feel great sympathy for those unfortunate few who may have been harmed as a consequence of immunization. Though we recognize these reactions are rare, virtually every time a pediatrician advises a patient on the benefits to be derived from vaccines in preventing disease and about the risks of these vaccines, it is important to acknowledge the remote chance of an adverse reaction to the vaccine. However, it is important and responsible not to sensationalize unproven reports about adverse effects of vaccines.

Childhood immunization is society's greatest health care achievement. Many improvements and new vaccines are being developed. We do our children and ourselves a disservice when we fail to immunize our children.
Tips for Writing a Letter to the Editor

Choose your Publication
- Each publication has its own standard Letter to the Editor length

Write a Letter
- The topic must be timely – tie in to an event in the community or an awareness campaign
- Present a clear argument and offer solutions in “lay speak”
- Follow the Associated Press Essay Structure
  o Intro – hook the reader
  o Supporting arguments – keep it simple but cite some sources
  o Closing – advocate your position
- Signing it typically includes name, title, address, organization (but most major organizations want to review it if their name is going on it!)

Why is a Letter to the Editor a Good Venue?
- Elected officials (or their staff) read them
MMR Vaccine and Autism Speaking Points

This information is intended to help AAP members prepare for media interviews and for talking with parents. It is not intended for reproduction or distribution. Updated April 2009

Q. Is there a link between measles vaccination and autism?
No, there is no scientifically proven link between measles vaccination and autism.

Autism is a chronic developmental disorder, often first identified in toddlers from age 18 months to 30 months. MMR is administered just before the peak age of onset of autism, leading some parents to assume a causal relationship.

Increasing evidence indicates that some cases of autism are genetic in origin. In those cases, autism occurs at conception. Other causes, such as maternal infection with the rubella virus, occur early in pregnancy.

The U.S. Court of Federal Claims on Feb. 12, 2009, found the scientific evidence is “overwhelmingly contrary” to the theory that MMR vaccine and the vaccine preservative thimerosal are linked to autism. This decision is in keeping with the numerous medical studies that have been performed worldwide.

The Centers for Disease Control and Prevention, the National Institutes of Health and the Food and Drug Administration continue to conduct studies to further ensure the safety of vaccines.

Q. What about Dr. Andrew Wakefield’s research claiming a link between MMR and autism?
Dr. Wakefield’s 1998 Lancet paper is simply a description of 12 children who were referred to his clinic because of diarrhea or abdominal pain. The 12 children also had a history of normal development followed by loss of certain skills. When a history was taken, questions were asked about MMR immunizations that had been administered as many as 9 years earlier and the relationship of these vaccines to onset of loss of skills. From this data, Wakefield proposed an association between immunization and autism. Any association with MMR was based on parental recall about events that occurred many years earlier, instead of objective data. Further, in four of the 12 cases, the behavioral disorders predated the bowel symptoms, which refutes Wakefield’s own theory that bowel dysfunction (caused by MMR) causes autism. There was clearly selection bias as the children already had gastrointestinal symptoms. And there was no control group, a critical omission that casts further doubt on the findings. This was not a scientific paper but rather a description of parental recall from a skewed population of children referred to Wakefield’s clinic.

In 2004, investigative reporter Brian Deer revealed that prior to the Lancet study, Dr. Wakefield had accepted money from a personal-injury lawyer representing families who were suing pharmaceutical companies claiming vaccines caused their children’s autism. Some of those children were included among the 12 in Dr. Wakefield’s study. Soon after, 10 of Dr. Wakefield’s 12 co-authors dissociated themselves from the Lancet study.
Replication of findings is a standard of good science. Dr. Wakefield’s original research showed measles virus in Crohn’s patients. (JMV 1993;39:345.) He shared these specimens with colleagues at Royal Free Hospital, who were then unable to find the measles virus using more sensitive methods (RT-PCR). Many other scientists examined intestinal biopsies of Crohn’s patients and could not find measles virus. Dr. Wakefield’s findings could not be replicated.

A September 2008 Columbia University study attempted to replicate key parts of Wakefield’s original study. Researchers analyzed samples from 38 children with bowel disorders, 25 of whom also had autism. The investigators found only one child in each group had trace amounts of the measles virus in their samples.

Dr. Wakefield’s 2002 paper in the Journal of Molecular Pathology is also critically flawed. It states that 75 of 91 children with autism were found to have measles virus genome in intestinal biopsy tissue as compared with only 5 of 70 control patients. But measles vaccine virus is live and diluted. After the vaccine is given, the virus is likely to be taken up by specific cells and carried throughout the body (including the intestine). To determine if MMR is associated with autism, one must determine if the finding is specific for children with autism. Therefore, all the children studied, whether they have autism or not, must have the same immunization status and the same length of time between receipt of the MMR vaccine and collection of the biopsy specimen. This information was clearly available to the investigators and critical to their hypothesis, but it was not included in the paper. (Paul Offit, M.D., FAAP, April 3, 2002) Even if the measles genome is truly present in the tissue, it is not clear if it is the genome from the vaccine strain and not the genome from natural measles virus.

Q. Why are we seeing a rise in the incidence of autism?
Physicians use a book called the Diagnostic Statistical Manual to help them diagnose cases of autism. In the past decade, the guidelines in that book have become more inclusive. So children who used to be considered "learning delayed" or to have "behavior problems" may now be more correctly diagnosed with mild autism. Higher functioning forms of autism (Asperger’s, PDD-NOS) account for two-thirds of ASDs; 25 years ago, these children would have received a different diagnosis or no label at all.

Parents and medical professionals are simply more aware of the condition and are more likely to pursue a diagnosis and treatment than in years past. As there are more state and federally funded programs available for children with autism, there is an increased incentive to make a diagnosis, so those children will have access to those programs.

Taylor et al (BMJ 2002:324:393-396) found no rise in incidence of autism in children who received MMR as compared to those who did not. The authors also showed that in autistic children (both ASD and classical) the age at which a child received MMR did not affect the age at which the diagnosis of autism was made. They also demonstrated that in the years after the MMR vaccine was introduced in the UK, there was no increase in autism rates in comparison to the years before the vaccine was available.

Q. Why not separate the measles, mumps and rubella vaccines and immunize for each illness individually?
A few people have advocated for the separate administration of the measles, mumps and rubella vaccines, rather than the combination shot, because they believe simultaneous administration might affect a child's immune response.

A panel of experts convened in June, 2000, by the Academy concluded in its report that “separate administration of measles, mumps and rubella vaccines to children provides no benefit over administration of the combination MMR vaccine and would result in delayed or missed immunizations.”

There is no scientific reason for or benefit to separating the vaccines. By separating them, we are putting children (and pregnant women who may be exposed to them) at increased risk by extending the amount of time they go unvaccinated.

Studies have shown that there is an increased risk that children may not receive all the shots they need if their parents have to schedule additional appointments for immunizations.

We would be increasing our children’s discomfort. They would have to receive three shots instead of one to be properly protected.

Individual vaccines for measles, mumps and rubella are not always available.

**BACKGROUND ON MMR**

**Q. What can happen if I don't get my child immunized?**
Without immunizations, your child can catch diseases that may cause high fever, coughing, choking, breathing problems, and even brain injury.

These illnesses may leave your child deaf or blind, cause paralysis, and even death.

Failure to immunize a child not only puts him or her at risk, but it also opens up the possibility of outbreaks in schools, child care centers and other public settings.

**Q. Why should we still vaccinate against measles when cases are so uncommon?**
Measles kills approximately 200,000 people a year, mostly in developing countries. The virus is common throughout the world and is frequently imported into the U.S.

In recent years about 100 cases of measles occur each year in the United States. These cases are caused by people traveling to the U.S. from other countries. In 1998, 1999 and 2000 all U.S. measles cases reported were linked to imported cases.

Before measles immunizations were available, nearly everyone in the U.S. contracted measles. There were approximately 3 to 4 million measles cases each year. An average of 450 measles-associated deaths were reported each year between 1953 and 1963.

From 1989 to 1991 there was a resurgence of measles in the United States, resulting in over 55,000 cases and more than 120 deaths. There were 2 deaths for every 1,000 cases.
A reduction in measles vaccination rates would substantially increase the potential size and morbidity of any outbreak. That means we would see more people die from measles.

**Q. What are the known complications of measles vaccination?**

Measles vaccine is very safe; most people have no reactions.

About 5 percent to 15 percent of vaccine recipients may develop a fever five to 12 days after MMR vaccination. The fever usually lasts one to two days and usually is not associated with other symptoms. About 5 percent of MMR recipients may develop a transient rash one to two weeks after immunization.

Central nervous system disturbances, such as encephalitis, have been reported with a frequency of less than one per 1 million doses of MMR vaccination administered, a frequency many times lower than the incidence of serious central nervous system disorders that follow natural infection at a rate of one per 800.

**Q. Aren't measles, mumps and rubella relatively harmless illnesses?**

**Measles**
- Highly contagious respiratory disease
- Causes rash, high fever, cough, runny nose and red, watery eyes, lasting about a week
- Causes ear infections and pneumonia in 1 out of every 12 children who get it
- Causes encephalitis that can lead to convulsions, deafness or mental retardation in 1 to 2 of every 2,000 people who get it
- In 1989-90, there was a US measles epidemic, resulting in 55,000 cases of measles, 11,000 hospitalizations, and 123 deaths. The majority of these cases were in unimmunized preschool children.
- Of every 1,000 people who get measles, 1 to 2 will die
- Measles vaccine (contained in MMR, MR and measles vaccines) can prevent this disease

**Mumps**
- Causes fever, headache and swelling of one or both cheeks or sides of the jaw
- Four to six persons out of 100 who get mumps will get meningitis
- Inflammation of the testicles occurs in about 4 of every 10 adult males who get mumps, which may lead to sterility
- May result in hearing loss, which is usually permanent

**Rubella**
- Also known as German measles
- Mild disease in children and young adults, causing rash and fever for 2 to 3 days Causes devastating birth defects if contracted by a pregnant woman; there is at least 80% chance of damage to the fetus if a woman is infected early in pregnancy
BACKGROUND ON AUTISM

Q. What is autism?
Autism is a spectrum of chronic developmental disorders. The main characteristics of autism are difficulties in social interaction, communication, and restrictive and repetitive interests and activities. Autism may be noted initially in infancy as impaired attachment, but autism is most often first identified in toddlers, mostly boys, from 18 to 30 months of age. Although there is no cure, autism is treatable. Symptoms associated with autism often improve as children start to acquire language and learn how to communicate their needs.

Q. What causes autism?
The causes of autism are not known for certain. The current theory favored by most experts is that autism is a genetically based disorder. Studies of people with autism have identified abnormalities in brain structures that develop in the first few weeks of gestation (that is, while the fetus is in the womb). Evidence that genetics is an important, but not exclusive, cause of autism includes a 3 to 8 percent risk of recurrence in families with one affected child. Also, when one identical twin has autism, the chances are extremely high that the other twin will also have autism. A working group convened by the National Institutes of Health in 1995 reached a consensus that autism is a genetic condition. An issue unresolved by the group was the role of immune factors in certain forms of autism; it was suggested that studies to clarify the situation are needed.

Q. Is there any evidence linking measles vaccine or MMR and autism?
No. There is no scientific evidence linking measles vaccine or MMR with autism. There is however, a great body of scientific evidence showing that MMR vaccination is not associated with autism.

Q. Has the measles vaccine been successful?
Around 1960 in the U.S., there were over a half-million measles cases and more than 400 deaths associated with this disease. Thanks to immunization efforts, there were only 100 cases of measles in 2000 and no deaths. Despite this and other successes, some parents still refuse to have their children immunized. This not only puts children at risk, it also opens up the possibility of outbreaks in schools, child care centers and other public settings.

Q. What is being done to find the causes of autism and to ensure the safety of the MMR vaccine?
The U.S. Centers for Disease Control and Prevention is conducting other scientific studies to further examine any possible association between autism and the MMR vaccine. The CDC and the AAP continue to recommend two doses of MMR vaccine for all children. The first dose is recommended at 12-15 months of age and the second dose is recommended at 4-6 years of age. Immunizations are one of the most important ways that parents can protect their children against serious infectious diseases.
Vaccine Studies: Examine the Evidence

The safety and efficacy of vaccines are under constant study and scrutiny. Since vaccines are designed to be given routinely during well child care visits, they must be extraordinarily safe. Safety testing begins as soon as a new vaccine is contemplated and continues until it is licensed and indefinitely after licensure. The Committee on Infectious Diseases of the American Academy of Pediatrics works closely with the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention to make recommendations for vaccine use.

Over the past decade, questions have been raised regarding a relationship between autism and vaccines, specifically the measles, mumps, rubella combination vaccine (MMR) and the preservative thimerosal, which while not present in MMR, was present in several vaccines used in the 1990s. In 1999, vaccine manufacturers began to remove thimerosal from their products. Currently thimerosal is present some of the inactivated influenza vaccines. The concerns regarding vaccine safety have received a great deal of attention by parents, doctors, vaccine manufacturers and the media. Dozens of studies have been performed in the United States and elsewhere. The purpose of this document is to list those studies and provide links to the publications to allow parents and all those who administer or recommend vaccines to read the evidence for themselves. The studies provided have been published in peer-reviewed medical journals. This is not an exhaustive list and it will need to be updated frequently since vaccine safety studies are ongoing.

It is not surprising that these studies do not show any link between vaccines and autism. Natural measles virus causes a respiratory infection but can cause infection of the brain and subsequent brain damage; however, autism has not been reported as a complication of wild measles. The measles vaccine is a weakened strain of the wild measles virus. Thimerosal is a mercury-containing preservative which does not stay in the body. Mercury itself can cause brain damage when present in excessive amounts. The amount and type of mercury in vaccines was not enough to cause damage.

Please examine the evidence for yourself.

Studies looking at measles, mumps and rubella (MMR) vaccine

**Lack of Association between Measles Virus Vaccine and Autism with Enteropathy: A Case-Control Study**

Researchers looked for measles virus in the guts of 25 children with both autism and gastrointestinal disorders, and another 13 children with the same gastrointestinal disorders but no autism. The virus was detected in one child from each group.

AUTHOR CONCLUSION: This study provides strong evidence against association of autism with persistent measles virus RNA in the gastrointestinal tract or with measles, mumps and rubella (MMR) vaccine exposure.

**Measles Vaccination and Antibody Response in Autism Spectrum Disorders**
Baird G et al., *Archives of Disease in Childhood* 2008; 93(10):832-7

Case-control study of 98 vaccinated children aged 10-12 years in the UK with autism spectrum disorder (ASD) and two control groups of similar age: 52 children with special educational needs but no ASD and 90 children in the typically developing group. No difference was found between cases and controls for
measles antibody response. There was no dose-response relationship between autism symptoms and antibody concentrations.

AUTHOR CONCLUSION: No association between measles vaccination and ASD was shown.

**MMR-Vaccine and Regression in Autism Spectrum Disorders: Negative Results Presented from Japan**

Study of 904 patients with Autism Spectrum Disorders (ASD). During the period of measles, mumps and rubella vaccine (MMR) usage, no significant difference was found in the incidence of regression between MMR-vaccinated children and non-vaccinated children. Among the proportion and incidence of regression across the three MMR-program-related periods (before, during and after MMR usage), no significant difference was found between those who had received MMR and those who had not. Moreover, the incidence of regression did not change significantly across the three periods.

AUTHOR CONCLUSION: The data do not support an association between MMR and autism.

**No Evidence of Persisting Measles Virus in Peripheral Blood Mononuclear Cells from Children with Autism Spectrum Disorder**
D’Souza Y et al. *Pediatrics* 2006; 118(4):1664-75

Peripheral blood mononuclear cells were isolated from 54 children with Autism Spectrum Disorders (ASD) and 34 developmentally normal children, and up to 4 real-time polymerase chain reaction assays and 2 nested polymerase chain reaction assays were performed. No sample from either ASD or control groups was found to contain nucleic acids from any measles virus gene. In the nested polymerase chain reaction and in-house assays, none of the samples yielded positive results. Furthermore, there was no difference in anti-measles antibody titers between the autism and control groups.

AUTHOR CONCLUSION: There is no evidence of measles virus persistence in the peripheral blood mononuclear cells of children with ASD.

**Immunizations and Autism: A Review of the Literature**

Literature review found very few studies supporting an association between vaccines and autism, with the overwhelming majority showing no causal association between the measles, mumps and rubella (MMR) vaccine and autism. The vaccine preservative thimerosal has alternatively been hypothesized to have a possible causal role in autism. No convincing evidence was found to support an association between the vaccine preservative thimerosal and autism, nor for the use of chelation therapy in autism.

AUTHOR CONCLUSION: With decreasing uptake of immunizations in children and the inevitable occurrence of measles outbreaks, it is important that clinicians be aware of the literature concerning vaccinations and autism so that they may have informed discussions with parents and caregivers.

**Pervasive Developmental Disorders in Montreal and Quebec, Canada: Prevalence and Links with Immunizations**

Study of thimerosal and measles, mumps and rubella (MMR) vaccine uptake in 28,000 Canadian children born between 1987 and 1998, of whom 180 were identified with a pervasive developmental disorder.
AUTHOR CONCLUSION: The data rule out an association between pervasive developmental disorder and either high levels of ethyl mercury exposure comparable with those experienced in the United States in the 1990s or 1- or 2-dose MMR vaccinations.

Is there a ‘regressive phenotype’ of Autism Spectrum Disorder associated with the measles-mumps-rubella vaccine? A CPEA Study

A multi-site study of 351 children with Autism Spectrum Disorders (ASD) and 31 typically developing children used caregiver interviews to describe the children’s early acquisition and loss of social-communication milestones. For the majority of children with ASD who had experienced a regression, pre-loss development was clearly atypical.

AUTHOR CONCLUSION: No evidence that onset of autistic symptoms or of regression was related to measles, mumps and rubella vaccination.

Relationship between MMR Vaccine and Autism

Ten articles that specifically evaluated the possible relationship between the measles, mumps and rubella (MMR) vaccine and autism were identified. Review articles, commentaries, and evaluations of a link between gastrointestinal symptoms in autistic children and MMR immunization were excluded.

AUTHOR CONCLUSION: Based upon the current literature, it appears that there is no relationship between MMR vaccination and the development of autism.

Immunization Safety Review: Vaccines and Autism
Institute of Medicine, The National Academies Press: 2004

The IOM's Committee on Immunization Safety Review was convened in the fall of 2000 to provide an independent review of increasingly prominent vaccine safety concerns. The 15 committee members with expertise in pediatrics, internal medicine, immunology, neurology, infectious diseases, epidemiology, biostatistics, public health, risk perception, decision analysis, nursing, genetics, ethics and health communications analyzed over 200 relevant studies.

AUTHOR CONCLUSION: The committee rejected a causal relationship between the MMR vaccine and autism as well as a causal relationship between thimerosal-containing vaccines and autism.

No effect of MMR withdrawal on the incidence of autism: a total population study

Study examined incidence of Autism Spectrum Disorders (ASD) to age 7 for children born between 1988 and 1996 in Yokohama, Japan. The measles, mumps and rubella (MMR) vaccination rate in Yokohama declined significantly in the birth cohorts of years 1988-92, and no MMR vaccines were administered in 1993 or thereafter. In contrast, cumulative incidence of ASD up to age 7 increased significantly in the birth cohorts of years 1988 through 1996 and most notably rose dramatically beginning with the birth cohort of 1993.

AUTHOR CONCLUSION: MMR vaccination is not likely to be a main cause of ASD, and cannot explain the rise over time in the incidence of ASD. Withdrawal of MMR in countries where it is still being used cannot be expected to lead to a reduction in the incidence of ASD.
**No evidence for links between autism, MMR and measles virus**
Chen W et al, Psychological Medicine 2004 April;34(3):543-53


AUTHOR CONCLUSION: No increased risk of autism was found following exposures to wild measles and vaccinations with monovalent measles, and Urabe or Jeryl-Lynn variants of measles, mumps and rubella (MMR) vaccine.

**Age at First Measles-Mumps-Rubella Vaccination in Children with Autism and School-Matched Control Subjects: A Population-Based Study in Metropolitan Atlanta**

Study compared ages at first measles, mumps and rubella (MMR) vaccination between children with autism and children who did not have autism in the total population and in selected subgroups, including children with regression in development.

AUTHOR CONCLUSION: Similar proportions of case and control children were vaccinated by the recommended age or shortly after (i.e., before 18 months) and before the age by which atypical development is usually recognized in children with autism (i.e., 24 months).

**MMR Vaccination and Pervasive Developmental Disorders: A Case-Control Study**

Matched case-control of 1,295 people born in 1973 or later who had first recorded diagnosis of pervasive developmental disorder while registered with a contributing general practice between 1987 and 2001. Controls (4,469) were matched on age, sex and general practice. 1,010 cases (78.1%) had measles, mumps and rubella (MMR) vaccination recorded before diagnosis, compared with 3,671 controls (82.1%) before the age at which their matched case was diagnosed.

AUTHOR CONCLUSION: Data suggest that MMR vaccination is not associated with an increased risk of pervasive developmental disorders.

**Prevalence of Autism and Parentally Reported Triggers in a North East London Population**
Lingam R et al. Archives of Disease in Childhood. 2003; 88(8):666-70

Study of reported age of onset of Autism Spectrum Disorder (ASD) among 567 children in northeast London born between 1979 and 1998. The age at diagnosis of ASD was estimated to have decreased per five-year period since 1983, by 8.7% for childhood autism and by 11.0% for atypical autism. There was some evidence that measles, mumps and rubella (MMR) vaccine was more likely to be mentioned as a trigger after August 1997 than before.

AUTHOR CONCLUSION: The data suggest that a rise in autism prevalence was likely due to factors such as increased recognition, a greater willingness on the part of educators and families to accept the diagnostic label, and better recording systems. The proportion of parents attributing their child’s autism to MMR appears to have increased since August 1997.

**A Population-Based Study of Measles, Mumps, and Rubella Vaccination and Autism**

Compared relative risk of Autism Spectrum Disorder (ASD) in children vaccinated with measles, mumps and rubella (MMR) vaccine and unvaccinated children born in Denmark between 1991 and 1998. Of the
537,303 children in the cohort, 82% had received the MMR vaccine. Researchers identified 316 children with a diagnosis of autism and 422 with a diagnosis of other ASDs. There was no association between the age at the time of vaccination, the time since vaccination, or the date of vaccination and the development of autism.

AUTHOR CONCLUSION: This study provides strong evidence against the hypothesis that MMR vaccination causes autism.

**Neurologic Disorders after Measles-Mumps-Rubella Vaccination**

1- to 7-year-old children who were vaccinated between November 1982 and June 1986 in Finland.

AUTHOR CONCLUSION: Data do not support an association between measles, mumps and rubella (MMR) vaccination and encephalitis, aseptic meningitis or autism.

**Relation of Childhood Gastrointestinal Disorders to Autism: Nested Case Control Study Using Data from the UK General Practice Research Database**
Black C et al. British Medical Journal. 2002; 325:419-21

Nested case control study of 96 children diagnosed with autism and 449 controls. The estimated odds ratio for a history of gastrointestinal disorders among children with autism compared with children without autism was 1.0 (95% confidence interval 0.5 to 2.2).

AUTHOR CONCLUSION: No evidence was found that children with autism were more likely than children without autism to have had defined gastrointestinal disorders at any time before their diagnosis of autism.

**Measles, Mumps, and Rubella Vaccination and Bowel Problems or Developmental Regression in Children with Autism: Population Study**
Taylor B et al. British Medical Journal. 2002; 324(7334):393-6

Population study of 278 children with core autism and 195 with atypical autism, born between 1979 and 1998. The proportion of children with developmental regression (25% overall) or bowel symptoms (17%) did not change significantly during the 20 years from 1979, a period which included the introduction of measles, mumps and rubella (MMR) vaccination in October 1988.

AUTHOR CONCLUSION: Data provide no support for an MMR associated “new variant” form of autism with developmental regression and bowel problems, and further evidence against involvement of MMR vaccine in the initiation of autism.

**No Evidence for a New Variant of Measles-Mumps-Rubella-Induced Autism**

Study compared 96 children with a pervasive developmental disorder (PDD) born between 1992 and 1995 and who had received the measles, mumps and rubella (MMR) vaccine, to PDD patients who did not receive MMR.

AUTHOR CONCLUSION: No evidence was found to support a distinct syndrome of MMR-induced autism or of “autistic enterocolitis.” These results add to the large-scale epidemiologic studies that all failed to support an association between MMR and autism at population level. These findings do not argue for changes in current immunization programs and recommendations.
Measles-Mumps-Rubella and Other Measles-Containing Vaccines Do Not Increase the Risk for Inflammatory Bowel Disease: A Case-Control Study from the Vaccine Safety Datalink Project

A case control study of 155 persons with inflammatory bowel disease with up to five controls each. Neither past vaccination nor age at vaccination with other MCV was associated with increased risk for Crohn’s disease, ulcerative colitis, or IBD. Risk for Crohn’s disease, ulcerative colitis, or IBD was not elevated in the time immediately following vaccination with either vaccine.

AUTHOR CONCLUSION: Vaccination with MMR or other MCV, or the timing of vaccination early in life, did not increase the risk for IBD.

Time Trends in Autism and in MMR Immunization Coverage in California

Scientists looked for correlation between increases in the rate of autism diagnoses and increases in the rate of measles, mumps and rubella (MMR) vaccination in children born between 1980 and 1994.

AUTHOR CONCLUSION: These data do not suggest an association between MMR immunization among young children and an increase in autism occurrence.

MMR and autism: further evidence against a causal association

Data from an earlier measles, mumps and rubella (MMR) vaccine study (Taylor et al, 2000) were reanalyzed to test a second hypothesis.

AUTHOR CONCLUSION: Results provide further evidence against a causal association between MMR vaccination and autism.

Mumps, Measles, and Rubella Vaccine and the Incidence of Autism Recorded by General Practitioners: A Time Trend Analysis

Study compared prevalence of measles, mumps and rubella (MMR) vaccination among children in the United Kingdom to rising prevalence of autism diagnoses for children.

AUTHOR CONCLUSION: The data provide evidence that no correlation exists between the prevalence of MMR vaccination and the rapid increase in the risk of autism over time.

Further Evidence of the Absence of Measles Virus Genome Sequence in Full Thickness Intestinal Specimens from Patients with Crohn’s Disease

Study of specimens of macroscopically inflamed and normal intestine along with mesenteric lymph nodes from patients with Crohn’s disease. None of the samples examined gave any evidence of the persistence of measles virus in the intestine of Crohn’s disease patients.

AUTHOR CONCLUSION: The study supports previous findings produced by this laboratory and others using highly sensitive measles virus specific PCR diagnostic technology.
Absence of Detectable Measles Virus Genome Sequence in Inflammatory Bowel Disease Tissues and Peripheral Blood Lymphocytes

Study looked for measles virus in 93 colonoscopic biopsies and 31 peripheral blood lymphocyte preparations, examined and obtained from patients with inflammatory bowel disease (IBD) and noninflammatory controls.

AUTHOR CONCLUSION: Measles virus was not detected using this method.

Autism and Measles, Mumps, and Rubella Vaccine: No Epidemiological Evidence for a Causal Association

Researchers looked for a change in trend in incidence or age at diagnosis associated with the introduction of measles, mumps and rubella (MMR) vaccination to the United Kingdom in 1988. The study identified 498 cases of autism (261 of core autism, 166 of atypical autism, and 71 of Asperger syndrome) in children born in the UK since 1979. There was a steady increase in cases by year of birth with no sudden “step-up” or change in the trend line after the introduction of MMR vaccination. There was no difference in age at diagnosis between the cases vaccinated before or after 18 months of age and those never vaccinated. There was no temporal association between onset of autism within 1 or 2 years after vaccination with MMR. Developmental regression was not clustered in the months after vaccination.

AUTHOR CONCLUSION: Data do not support a causal association between MMR vaccine and autism. If such an association occurs, it is so rare that it could not be identified in this large regional sample.

No Evidence for Measles, Mumps, and Rubella Vaccine-Associated Inflammatory Bowel Disease or Autism in a 14-year Prospective Study

Prospective study of 3 million adverse events in temporal relation to MMR vaccine. A form was filled and posted to the data collectors, followed by another form with further information 2-3 weeks later. Researchers traced subjects who developed gastrointestinal symptoms or signs lasting 24 hours or more at any time after MMR vaccination (apart from within the first hour). Researchers also checked hospital and health center records or interviewed the local public-health nurses.

AUTHOR CONCLUSION: Over a decade’s effort to detect all severe adverse events associated with MMR vaccine could find no data supporting the hypothesis that it would cause pervasive developmental disorder or inflammatory bowel disease.

Exposure to Measles in Utero and Crohn’s Disease: Danish Register Study

Investigators identified 472 women aged 15 to 43 years who had been admitted with measles between 1915 and 1966. Thirty-three were pregnant: 11 developed measles during the first trimester, 9 during the second, 6 during the third, and 9 had exanthema less than 14 days after delivery. Of the 26 offspring identified (including one set of twins), four died, one in infancy. The diagnoses of the other three, who died as adults, did not suggest inflammatory bowel disease. Among individuals still alive (median age 51.4 (36-79) years) none were registered as having Crohn’s disease or inflammatory bowel disease.

AUTHOR CONCLUSION: Exposure to measles in utero does not seem to be strongly associated with the development of Crohn’s disease later in life.
U.S. Court of Federal Claims decision in Omnibus Autism Proceeding

On Feb. 12, 2009, the “vaccine court” ruled in three test cases on the theory that MMR vaccine and the vaccine preservative thimerosal are linked to autism. The court found the scientific evidence is overwhelmingly contrary to this theory.

Studies looking at thimerosal

Continuing increases in autism reported to California's developmental services system: mercury in retrograde

Study analyzed autism client data from the California Department of Developmental Services between 1995 and 2007. Even though thimerosal was absent from scheduled childhood vaccines after 2002, cases of autism continued to climb quarter by quarter.

AUTHOR CONCLUSION: The California DDS data do not show any recent decrease in autism in California despite the exclusion of more than trace levels of thimerosal from nearly all childhood vaccines. The data do not support the hypothesis that exposure to thimerosal during childhood is a primary cause of autism.

Mercury Levels in Newborns and Infants After Receipt of Thimerosal-Containing Vaccines

Study assessed blood mercury levels of 216 healthy children prior to immunization with thimerosal-containing vaccines, and 12 hours to 30 days after. The blood mercury half-life was calculated to be 3.7 days and returned to prevaccination levels by day 30.

AUTHOR CONCLUSION: The blood half-life of intramuscular ethyl mercury from thimerosal in vaccines in infants is substantially shorter than that of oral methyl mercury in adults. Increased mercury levels were detected in stools after vaccination, suggesting that the gastrointestinal tract is involved in ethyl mercury elimination. Because of the differing pharmacokinetics of ethyl and methyl mercury, exposure guidelines based on oral methyl mercury in adults may not be accurate for risk assessments in children who receive thimerosal-containing vaccines.

Early Thimerosal Exposure and Neuropsychological Outcomes at 7 to 10 Years

Study compared early exposure to thimerosal-containing vaccines to 42 neuropsychological outcomes in 1,047 children between the ages of 7 and 10 years. Exposure to mercury from thimerosal was determined from computerized immunization records, medical records, personal immunization records and parent interviews.

AUTHOR CONCLUSION: The study does not support a causal association between early exposure to mercury from thimerosal-containing vaccines and immune globulins and deficits in neuropsychological functioning at the age of 7 to 10 years.

Pervasive Developmental Disorders in Montreal, Quebec, Canada: Prevalence and Links With Immunizations
Quantified thimerosal and measles, mumps rubella (MMR) vaccine uptake in 28,000 Canadian children born between 1987 and 1998, of whom 180 were identified with a pervasive developmental disorder.

AUTHOR CONCLUSION: The data rule out an association between pervasive developmental disorder and either high levels of ethyl mercury exposure comparable with those experienced in the United States in the 1990s or 1- or 2-dose measles-mumps-rubella vaccinations.

Immunization Safety Review: Vaccines and Autism
Institute of Medicine, The National Academies Press: 2004

The IOM's Committee on Immunization Safety Review was convened in the fall of 2000 to provide an independent review of increasingly prominent vaccine safety concerns. The 15 committee members with expertise in pediatrics, internal medicine, immunology, neurology, infectious diseases, epidemiology, biostatistics, public health, risk perception, decision analysis, nursing, genetics, ethics and health communications analyzed over 200 relevant studies.

AUTHOR CONCLUSION: The committee rejected a causal relationship between the MMR vaccine and autism as well as a causal relationship between thimerosal-containing vaccines and autism.

Thimerosal Exposure in Infants and Developmental Disorders: A Retrospective Cohort Study in the United Kingdom Does Not Support a Causal Association

Study analyzed thimerosal exposure and possible development delays in 109,863 children born in the United Kingdom from 1988-97. Exposure was defined according to the number of DTP/DT doses received by 3 and 4 months of age and also the cumulative age-specific DTP/DT exposure by 6 months.

AUTHOR CONCLUSION: With the possible exception of tics, there was no evidence that thimerosal exposure via DTP/DT vaccines causes neurodevelopmental disorders.

Autism and thimerosal-containing vaccines: Lack of consistent evidence for an association

Study compared the prevalence/incidence of autism in California, Sweden and Denmark from the mid-80s to the late 90s with average exposures to thimerosal-containing vaccines. In all three countries, the incidence and prevalence of Autism Spectrum Disorders began to rise in the 1985-1989 period, and the rate of increase accelerated in the early 1990s.

AUTHOR CONCLUSION: The data is not consistent with the hypothesis that increased exposure to thimerosal-containing vaccines is responsible for the apparent increase in the rates of autism in young children being observed worldwide.

Thimerosal and the Occurrence of Autism: Negative Ecological Evidence From Danish Population-Based Data
Madsen et al., Pediatrics; Vol. 112 No. 3, 2003, pp. 604-606

Analyzed data from the Danish Psychiatric Central Research Register recording all psychiatric admissions since 1971, and all outpatient contacts in psychiatric departments in Denmark since 1995. There was no trend toward an increase in the incidence of autism during that period when thimerosal was used in Denmark, up through 1990. From 1991 until 2000 the incidence increased and continued to rise after the removal of thimerosal from vaccines, including increases among children born after the discontinuation of thimerosal.
AUTHOR CONCLUSION: The discontinuation of thimerosal-containing vaccines in Denmark in 1992 was followed by an increase in the incidence of autism. The data do not support a correlation between thimerosal-containing vaccines and the incidence of autism.

**Association Between Thimerosal-Containing Vaccine and Autism**
Hviid et al., *Journal of the American Medical Association*, 2003; 290(13):1763-6

Study of 467,000 children born in Denmark between 1990 and 1996 compared children who were vaccinated with a thimerosal-containing vaccine to children who received a thimerosal-free formulation of the same vaccine. The risk of autism and other autism spectrum disorders did not differ significantly between children vaccinated with thimerosal-containing vaccine and children vaccinated with thimerosal-free vaccine.

AUTHOR CONCLUSION: The results do not support a causal relationship between childhood vaccination with thimerosal-containing vaccines and development of autistic-spectrum disorders.

**Thimerosal Exposure in Infants and Developmental Disorders: A Prospective Cohort Study in the United Kingdom Does Not Support a Causal Association**

The researchers monitored the thimerosal exposure of more than 14,000 children born in the United Kingdom between 1991 and 1992. The age at which doses of thimerosal-containing vaccines were administered was recorded, and measures of mercury exposure by 3, 4 and 6 months of age were calculated and compared with a number of measures of childhood cognitive and behavioral development covering the period from 6 to 91 months of age.

AUTHOR CONCLUSION: No convincing evidence was found that early exposure to thimerosal had any deleterious effect on neurologic or psychological outcome.
Public Service Announcements (PSAs) about Immunization Topics

The best way to access these is through the PKids (Parents of Kids with Infectious Diseases) website at www.pkids.org. There are several places on this website to go to access various PSAs.

1. Scroll over the heading at the top that is titled “Media” and find the text “PSA.” Clicking on this will take you to another page that has several PSAs of varying lengths in both audio and video formats that you can download. The topics covered in these PSAs are pertussis, meningitis, and influenza. The actress, Keri Russell, stars in several of these PSAs.

2. Starting at the main web page www.pkids.org, place your mouse over the heading at the top of the page titled “Immunizations” and find the text “M.O.V.E.” Clicking here will take you to another page that has information about M.O.V.E. On this page, find the link titled “Radio Public Service Announcement” and click on it. This will take you to two radio PSAs on the importance of vaccinating children under the age of two told from the perspective of a parent.
The best way to help people understand why your issue is important is to **tell them a story about the real people affected by it**. Media and communications advocacy allows you to share your story with a broader audience than is possible through person-to-person strategies alone. This chapter explains how you can use media and communications vehicles to tell your story and effect change. In addition to this guide, the American Academy of Pediatrics (AAP) has dedicated staff and resources available to assist you and your chapter with a variety of media and communications activities.

## 1. What is Media and Communications Advocacy?

**Building awareness**

Media and communications advocacy refers to the intentional use of any type of media or communications mechanism to bring about awareness and, eventually, change, on behalf of your issue. This could include newsletter articles, letters to the editor, an Internet blog, or an appearance on the local news. Effective advocacy leverages media and communications vehicles as tools to demonstrate the importance of an issue to a broader audience. It is important to think of media and communications advocacy broadly, and while they are somewhat ambiguous terms, consider the following definitions:

### Media Advocacy

*Media advocacy* refers to using the media—such as newspapers, magazines, medical websites, television and radio, and working with reporters—to reach a broader audience to build awareness on behalf of your issue and, in some instances, gain more attention from decision-makers. When it comes to advocacy, media can be paid or earned. *Paid media*, as the name implies, is media for which you pay. It could include advertising space you buy on the Internet, in newspapers, or on television.

### Earned Media

*Earned media* refers to the media that you create on behalf of an issue you care about. It is not advertising that you pay for, but rather media attention that you earn through your advocacy work. Earned media is a great way to generate attention and energy around your issue by demonstrating why your issue is important and how it affects real children and families in your community or state, or nationwide. Additionally, it is often considered more influential than paid media because it is coming from "real" people. Earned media could consist of letters to the editor, op-eds, television or radio news interviews, and persuading a local newspaper editorial board to run a positive editorial about your issue.
COMMUNICATIONS ADVOCACY

Communications advocacy is a broad term that describes any material and mechanism (other than the media) used to create awareness around your issue, get others involved, or influence decision-makers. Communications advocacy can assist you in proactively framing the importance of your issue and informing others about developments or actions needed around your issue. Communications can be print-based (such as newsletters, articles, flyers, or brochures), Internet-based (such as Web sites, e-mail lists, blogs, social networking sites, or e-mail alerts), or it can take place in person (e.g., through public speaking, setting up a booth at a local event, or making a presentation to a local group or organization).

II. WHY MEDIA AND COMMUNICATIONS ADVOCACY MATTERS

Influencing public opinion

As an advocate, you can use media and communications advocacy to influence public opinion, and therefore public policy, on behalf of the issues that are important to you. Decision-makers pay attention to and are influenced by public opinion, particularly that of their constituents. Media and communications advocacy can bring attention to your issue and keep it in the forefront of the public’s hearts and minds. Media and communications advocacy allows you to share your story with more people, making your issue real and meaningful to an even broader audience. This can directly contribute to change at the community, state, or federal level by increasing awareness of and attention to your issue, getting more people involved, and pressuring decision-makers to act in favor of your issue, because your issue has the public’s attention.

Consider how as a pediatrician your personal perceptions are influenced by the many conversations you have with your patients, colleagues, friends, and family members on a daily basis. The same is true when it comes to influencing the general public’s perception of an issue or problem. Media and communications can spark public conversations and debates, contributing to changing community norms and public perceptions. Additionally, public policy at the state and federal levels is often influenced by what decision-makers hear their constituents talking about in the news, such as the letters to the editor or opinion column of the local paper. Media and communications advocacy allows you as a pediatrician to shape community and public policy discussions on behalf of the issues you care about.

Specifically, media and communications advocacy can help you propel your issue forward by

- Persuading community leaders and elected officials to act on behalf of your issue because they believe the public is paying attention to your issue
- Increasing the likelihood that more people get involved because they are aware of the issue and how they can help change circumstances affecting the children they know and care about
- Establishing credibility on behalf of your issue by demonstrating that your experiences are those of many and the issue deserves the public’s attention
III. THE KEY TO EFFECTIVE MEDIA AND COMMUNICATIONS ADVOCACY: YOUR MESSAGE

**Framing your issue**

As a pediatrician, you know that treatment is only effective when your patients and their families understand and pay attention to your medical advice. The same is true with media and communications. These tools are a great way to build awareness on behalf of your issue but are only effective if people understand and pay attention to your message.

Your message is the core statement of why your issue is important and should be the underpinning of all your media and communications work. An effective message creates consistency in the way your issue is talked about and cuts across the many stories that relate to your issue. Essentially, your message is what follows "because." Consider the following example of a message:

"Medicaid is an indispensable health program because it provides health insurance coverage to more than 26 million low-income children who otherwise wouldn't have access to critical and much needed health care services."

This message makes the case about the importance of Medicaid funding. Your personal experiences and stories of working with children who are uninsured can then help support this message. Consider the following points as a guide to creating an effective message:

**CLEAR**
Your message must be easily understood in words that can be internalized and repeated by others, including other child advocates, the general public, and decision-makers. Use language that you would use to talk to a parent. As a pediatrician, you break down technical jargon for your patients and their families every day. Use the same rule when creating your message.

**CONCISE**
Your message must be to the point. Keep in mind that most people have short attention spans and like their information given in concise formats. Stay focused on your main message and 2 to 3 supporting points that you can easily remember. Every word matters—choose each carefully.

**MEMORABLE**
The most effective messages are captivating and memorable. Consider running your message past a friend or colleague to get their feedback, or work with your chapter for further assistance.

**PERSUASIVE**
The message should convince people that your issue is something they can support. Use personal examples and stories to help paint a picture that people can relate to.

**REPEAT, REPEAT, REPEAT**
All communications should carry your intentional message. The average person needs more than 6 contacts before a message sticks with them.
Having an effective message is the backbone of all communications and media work. How you use your message is also important. Combining your message with personal stories and experiences can help you illustrate the importance of your message by capturing people’s attention, pulling at their heart strings, and putting a human face on your issue. Consider the following ways in which you can connect your message to your story and compel people to pay attention and decision-makers to act:

**MAKE IT PERSONAL**
The personal experiences that you have as a pediatrician are incredibly compelling. While your story in and of itself will not be the central message or core argument, your personal examples can complement your message and illustrate the need for change firsthand.

**KEEP IT LOCAL**
People pay more attention to news and communications that affect them personally, or hit close to home. Look for ways to keep your message local by including a perspective about how your issue affects your neighborhood, community, city, or state.

**CONNECT YOUR MESSAGE TO THE ISSUE YOU ARE SEEKING TO CHANGE**
Help people see that your story is one of many. Be sure your message highlights solutions. Explicitly state the change you are seeking and explain why that change matters to children in your community or state, or nationwide. This will help people understand why they should pay attention to your issue and why change is needed.

**INVITE OTHERS TO GET INVOLVED**
A compelling message will encourage people to act. When delivering your message, include an invitation to get involved and information regarding how others can help bring about change.
HOW DO I CHOOSE BETWEEN WORKING WITH THE MEDIA AND USING OTHER COMMUNICATIONS EFFORTS?

Media allows you to get your message out to the largest audience in the least amount of time, whereas communications tools, such as newsletters and Web sites, allow you to target your message to specific audiences.

When choosing whether to use media or broader communications tools, the most important strategic consideration should be your audience. Consider the audience you would like to reach and how that audience can help you accomplish your goals. For example, if your goal is to get more pediatricians involved in your efforts, it may be best to focus on communications tools that reach other pediatricians, such as a health journal, hospital or clinic Web site, or chapter newsletter. If you want to raise awareness on behalf of your issue with citizens in your local community, it may be smart to use media tools that reach the general public, such as letters to the editor, an appearance on your local news, or a press release.

There may be times in the course of your advocacy efforts where you feel that your audience can best be reached through both media and communications advocacy efforts, or that it is critical to get information out to as many people as possible. When you find this to be the case, don't be afraid to use both strategies. Media and broader communications efforts complement each other and shouldn't be viewed solely as an either/or strategy.

WHAT ARE THE VARIOUS WAYS THAT I CAN WORK WITH THE MEDIA?

There are many tools that you as a pediatrician can use in working with the media to get your message out and quickly capture the attention of decision-makers, community leaders, and the general public. Many of these tools can be used electronically, making them increasingly convenient within your busy schedule. In fact, many reporters prefer to get their information electronically. Just remember to use a catchy subject line and to copy your text into the body of the e-mail. Many reporters do not trust attachments if the e-mail was sent by someone they don't know. The Tools and Support section of this chapter can provide you with additional tips and support for working with the media.

THE PITCH LETTER

A pitch letter is an initial step that you can take to inform the media about your issue. It is a way to introduce your work and get the media interested in your issue. Pitch letters should be personalized and directed to the attention of editors, reporters, or producers.
THE PRESS RELEASE

Press releases can be used to announce a new policy, position, or community initiative undertaken by you or your AAP chapter. Press releases can also be used to comment on a recent event or occurrence in your community or state, such as a children's health day or a measles epidemic.

PRESS EVENTS OR PRESS CONFERENCES

Press events involve inviting the media to cover an actual event that is being held to raise awareness for your issue. Press events provide a great opportunity to show the media what you are doing and offer good visuals that work well with television or where a picture can be included, such as a Web article, magazine, newsletter, or newspaper. A press event could include an immunization clinic that you are part of through your professional setting or community effort, or a rally that you, your AAP chapter, or another organization is holding on behalf of your issue. Press conferences involve inviting the press to attend a short conference in which you share information or new developments with the press. They are generally more formal than a press event. A press release should be included as part of both a press event and press conference to provide greater background to the press, as well as to alert them that the event or conference is taking place.

THE FACT SHEET

A fact sheet can accompany the pitch letter or press release and should be used to back up your personal stories and examples. A fact sheet is generally 1 page long and contains concise statements and statistics on your issue.

LETTERS TO THE EDITOR

Letters to the editor are exactly that: letters written to the editor of a newspaper with the objective of being published on the editorial page. These letters generally respond to specific articles or editorials that have already been published. You can use your letter to the editor to clarify a point, highlight the importance of an issue, or simply react to a recent situation or occurrence that received media coverage.

EDITORIALS

The editorial board of a newspaper often comments on issues that they see as especially important. This is called an editorial. Editorial page coverage can be initiated by meeting with the newspaper's editorial board and selling them on the importance of your issue. An editorial is a great way to bring credibility to your issue because it is the media's way of informing the community on which issues are particularly important.

OP-EDS

Op-eds are submitted by the general public instead of the newspaper editorial board. Often op-eds are submitted by community leaders, or by experts on an issue, such as a pediatrician who is an expert in the area of children's health and well-being. Op-eds are longer than a letter to the editor and are an excellent way to bring awareness to your issue or to express your feelings about the action or inaction of decision-makers on behalf of children's health and well-being.

FEATURE STORIES

Feature stories are largely based on human interest topics and can appear in print and on Web sites, television, or radio news. Feature stories can result from pitch letters, as a result of recent events or occurrences, or through demonstrating to the media that your issue has broad appeal to the general public. Feature stories are an excellent way to help put a human face on your issue.
MAGAZINES

Parenting, child, or baby magazines provide a great medium to get your message out to a captive audience. Magazine coverage could include paid advertising, a guest column or editorial, or a feature story about your issue.

TELEVISION

Television coverage could include interviews with reporters on a specific subject that’s making news, television news coverage from an event or rally taking place around children’s health, or as a guest on talk shows. Television is a quick way to reach a large number of people to inform them about your issue and the work being done to bring about change.

RADIO

Radio, much like television, can be used by pediatricians to provide commentary or public education and awareness on behalf of an issue. This could be done through formal radio interviews or via radio talk/call-in shows.

No matter which media tool you use, concentrate on presenting your message accurately, professionally, and personally. The more sincere and understandable your message is, the more widely it will be accepted and respected.

PEDIATRICIAN ADVOCACY STORY

Every other week the Albuquerque Journal (my state’s largest newspaper) published an article on pet health. I thought that our children deserved at least as much attention as our pets. I wrote to the people that I knew at the Journal and, after some lobbying, I got a gig as a semiweekly columnist. For the past 6 1/2 years I’ve written columns (now up to 175 of them) on child health issues and have received many comments on them.

Lance Chilton, MD, FAAP
Albuquerque, NM

WHAT ARE SOME WAYS THAT I CAN GET MY MESSAGE OUT BY USING BROADER COMMUNICATIONS TOOLS?

In addition to working with the media, you can get your message out to more people by using broader communications tools. These communications tools can be targeted to specific audiences—such as other pediatricians, health care professionals and clinicians, parents, schools, child care centers, and child advocates—as well as to the general public. Broader communications tools could include

NEWSLETTERS AND BULLETINS

Many organizations, including your AAP chapter, community groups, places of employment or worship, and schools, publish regular newsletters or bulletins. Many of these groups regularly invite and encourage content submissions and announcements from their readers. Pediatricians like yourself can use these tools to help build support and awareness for your issue by submitting articles, information, or invitations to get involved.
PUBLIC SPEAKING AND PRESENTATIONS

Public speaking arrangements or presentations provide an opportunity to talk about the importance of your issue and make a personal connection with others at the same time. Public speaking and presentations can be done in schools, at community or civic groups (e.g., Rotary clubs or chambers of commerce), or as part of an annual conference or awards dinner.

INTERNET

The Internet refers to a network that facilitates many different types of electronic communications, including Web sites, e-mail, e-mail lists, blogs, and social networking sites. The Internet provides almost unlimited ways for you to share information, resources, and advocacy opportunities. The Internet can aid you in conducting research, getting more information about your issue, and helping you find and communicate with other people or groups working on your issue. It can also be used as an advocacy tool, such as a Web site or e-mail communication that encourages others to take action on behalf of issues affecting children’s health and well-being.

INFORMATION BOOTHs

An informational or advocacy-related booth is yet another example of a broader communications tool. These booths contain information about your issue and how it affects children and pediatricians, and can provide opportunities for others to get involved. Informational booths can be set up in your professional setting, local school, place of worship, or in the lobby of another organization that cares about children’s health. In addition, you could set up a booth at a community event, such as a back-to-school celebration or town festival.

Regardless of the communications tools you choose, remember that they are only as effective as your message. Make sure your message is concise and prominent in all of your communications and includes a personal story or example that helps make your issue tangible to others.

TELL ME MORE ABOUT HOW THE INTERNET CAN ASSIST ME WITH MY ADVOCACY EFFORTS.

The Internet provides a convenient and opportune way for pediatricians to connect with others, share ideas and interests, carry on public discussions, create “buzz” or attention on an issue, work on projects together, and take collective action on behalf of children’s health and well-being. Consider the following ways that you can use the Internet to help build support for, and advocate on behalf of, your issue:

WEB SITES

Ask your AAP chapter, employer, or another group that you are working with to post information about your issue and how others can get involved through their Web site. A Web site is a great location to host an online petition or to publicly list the names of people in your community or state, or nationwide—including pediatricians—who care about your issue or endorse your efforts.

E-MAIL LISTS

Ask your colleagues, patients’ parents, friends, family members, and other child advocates for their e-mail addresses. Send them regular electronic updates about your issue, and ask them to call, write, or e-mail their decision-makers on behalf of the issue. Consider asking your contacts to forward the e-mail to other people they know. Using e-mail and technology
to spread a message electronically is a great way to reach a lot of people, and is often referred to as viral marketing.

INTERNET FORUMS

Internet forums are an online place where people have discussions over time on a particular topic. Internet forums are also commonly referred to as message boards, Web forums, discussion boards, discussion forums, discussion groups, and bulletin boards. Find a forum that centers around your issue specifically, or children’s health and well-being generally, and use it to post messages, information, and invitations to get involved. The great thing about posting on a forum is that it doesn’t take a lot of time and can be done in between your other professional responsibilities.

BLOGS

A blog is a Web page that functions as a personal journal or diary in which regular entries are made. If you have an interest in technology and a few hours per month to dedicate to your communications advocacy effort, consider authoring a blog as a way to tell your story, provide information and resources, and post contact information or list the Web sites of other groups working on your issue. A pediatrician’s blog can also generate earned media in and of itself, as well as provide a resource for reporters and journalists to go to for more information.

GROUP COMMUNICATIONS TOOLS

Online group communications tools make it possible for you, or others that you are working in coordination with, to help manage the information, communications, and activities of your advocacy efforts. They are also a simple and easy way to keep people informed, sign up new members, and manage projects.

When developing electronic communications, it is especially important to think about what you include and how you write it. Because it is so easily disseminated, it is likely that your messages will be read by a much broader audience than you realize. Avoid including offensive or disrespectful language. Also, your opponents may be reading your posts, so be careful not to reveal strategy that you do not want them to see. At the same time, visit the Web sites and sign up for e-mail lists of those who oppose your issue. You may gain valuable insight into potential areas for common ground or arguments you need to prepare for.

PEDiatrician Advocacy Story

Through the course of taking care of patients in medical school, residency, and a community pediatrics fellowship, I have developed a strong interest in community medicine, child advocacy, and health policy. However, through all these years of training, I still feel at times that I struggle with understanding the policies that affect children’s health. In working with medical students and residents, it seems I am not alone in this feeling. I am a strong fan of the Internet and often go to health care Web sites, but found these hard to navigate in terms of finding basic information on health care policies. My colleagues and I recently decided to take this into our own hands and develop a Web site with the goal of providing pediatricians, and other health care professionals and clinicians, with a basic explanation of policies that affect children’s health and well-being.

Candice Chen, MD
Children’s National Medical Center, Washington, DC
YOU MENTION THE VARIETY OF MEDIA AND COMMUNICATIONS TOOLS AVAILABLE, SUCH AS LETTERS TO THE EDITOR, NEWSLETTERS, AND THE INTERNET. HOW DO I KNOW WHICH OF THESE TOOLS I SHOULD USE?

There are no right or wrong media and communications tools to use. Your message—more so than the tool that you use to get your message out—is what's most important. The tools that you choose should reflect your goals, will likely vary over time, and will depend on the following factors:

TIMING
Consider the immediacy of what you are trying to accomplish and weigh your goals against the timing of the media and communications tools available to you. For example, if you want to use media and communications tools to inspire people to call their decision-maker on behalf of a time-sensitive issue—such as before a vote—use the tools that will allow you to do this quickly, such as the Internet or the daily paper. Avoid your call for action being printed after the fact by paying attention to media and communications deadlines and publication dates. If your goal is less time-sensitive, such as informing other pediatricians about your advocacy work, then consider using printed publications and newsletters to get your message across as well.

AUDIENCE
Think about the people, or audience, that you would like to reach, or that would respond favorably to your issue, and target the media and communications outlets they are likely to use. For example, if you want to reach a broad audience, most of the general public still gets their news from the television. If you are trying to reach parents, try a parenting or baby magazine or publication. To reach a younger audience, consider using the Internet, and to reach decision-makers, seize opportunities to use local newspapers and editorial or opinion pages.

INTEREST AND COMFORT LEVEL
Choose media and communications tools that you feel comfortable using. If you’re camera shy, you may want to stick to using print, such as writing letters to the editors or articles for your local paper, AAP chapter newsletter, or Web site. If you enjoy telling your story in front of others, then consider public speaking or television and radio. If you’re tech-savvy, consider using the Internet, such as Web sites, blogs, or Internet forums, to get your message out.

WHAT DO I NEED TO KEEP IN MIND WHEN WORKING WITH THE MEDIA AND REPORTERS?

The cornerstone of working with the media is having a strong and effective message. Before you begin your work with the media, consider

PRACTICING WHAT YOU ARE GOING TO SAY
Take time to prepare what it is you want to convey, what you want to share to personalize the message, and what you want the audience to do as a result of your message.
PAINTING A PICTURE OF WHY YOUR ISSUE MATTERS
Make your message real and meaningful to others by sharing your personal experiences with the issue. Talk about your story, the faces affected by your issue, and why change is needed.

KEEPING YOUR MESSAGE CONCISE AND INCLUDING INTENTIONAL REPEITION
Keep your message brief, and focus on the most compelling parts of your story. It’s OK, in fact encouraged, to intentionally repeat the most important parts of your message, such as using phrases like, “the important thing to remember is...”

In addition to your message, consider the following suggestions for working with the media:

DECLARE, THEN EXPLAIN
Speak in paragraphs that have a confident statement (sound bites) then add supporting points. For example, “Insuring children is an important investment in America’s future. Children with insurance coverage are more likely to get the health care they need when they need it, and healthy children are better prepared to learn in school and succeed in life.” Make each answer short and strong, don’t hesitate to repeat yourself to make sure they know what your main point is.

MAKE YOUR POINT UP FRONT
This may feel contradictory to how you as a pediatrician and scientist are trained. Many people working in the health- and science-related fields are taught to build evidence before making a conclusion. The exact opposite is true when working with the media. The media will want to hear your main point or headline up front.

ANSWER THE QUESTIONS YOU WANT TO ANSWER
Use questions as bridges to your message. Give answers you want them to hear, not what they want to hear. Think about what you want the quotation to be in the first paragraph of the article.

USE THE FACTS
Children’s health and well-being are compelling issues, and we have the benefit of strong data to support this. Use the facts to support your case, but don’t sacrifice personal stories for statistics.

ASSUME YOU ARE ALWAYS ON THE RECORD
Radio, television hosts, and journalists will sometimes chat with you “off air” first, to talk things through. Plant your message during these conversations. Be aware of what you are saying even before the formal conversation or interview begins.

LOOK FOR OPPORTUNITIES TO BUILD RELATIONSHIPS
If you have a chance, introduce yourself to the health, science, and political reporters covering the news in your area. Establish yourself as a resource by letting them know that you are willing and available for interviews or background information. If you like their coverage on an issue, compliment them on their work, and look for ways to keep in touch with them.
WILL THE MEDIA REALLY CARE WHAT I HAVE TO SAY?

The media cares what you as a pediatrician have to say because they are looking for, and want to cover, stories that are message-based and newsworthy. Having a newsworthy story means that your message is

CLEAR AND COMPPELLING
Your message is easily understood by the general public.

RELEVANT AND CREDIBLE
There is real and pertinent news and information to share.

PERSONAL
The message demonstrates that the issue is real and puts a human face on the people affected.

LOCAL AND APPLICABLE
Your message affects others in your area in a meaningful way.

As a pediatrician, the media will consider you a reliable expert in the area of children’s health and well-being and will be interested in your message. Furthermore, sharing your message with the media not only gives the media their story, but it allows you the opportunity to help bring about change by demonstrating how your issue affects children in your community and state, and nationwide.

DO LETTERS TO THE EDITOR REALLY MAKE A DIFFERENCE?

Yes. Letters to the editor are highly effective in influencing public opinion, demonstrating the importance of your issue, or responding to related events. In addition, elected officials and community leaders pay close attention to letters to the editor because it gives them an insight into what people in their community care about. Furthermore, letters to the editor are great for pediatricians because they can be written in a short amount of time and in between other professional responsibilities. Consider the following steps to writing a letter to the editor:

TAKE TIME TO SKIM NEWSPAPER WEB SITES
Watch for articles or stories related to your issue specifically, or to children’s health and well-being generally.

RESPOND TO TOPICS OF INTEREST
Find ways to connect your issue to other stories in the news. Children’s health and well-being are related to many factors in society. Look for ways to bridge your issue to the larger discussion that’s taking place.
KEEP YOUR LETTER SHORT

Letters to the editor should be brief and to the point. Aim for 250 words or less. Be sure to check with your local paper to find out about their guidelines for submitting letters because many of them have restrictions on length. Most newspapers have Web sites with their letter guidelines posted, along with an e-mail address to send the letter. Paste your letter into the body of the e-mail. Don’t send an attachment. Most reporters and media outlets don’t like e-mail attachments from unknown sources because of computer virus concerns.

MAKE YOUR MESSAGE THE CENTRAL PART OF YOUR LETTER

Be sure your letter incorporates your message in an easily understandable format.

TELL YOUR STORY

Your letter should include a personal story or experience that illustrates why readers should care about the issue, or how the issue affects children, families, or pediatricians in their area.

HOW CAN I GET MY LOCAL PAPER TO WRITE AN EDITORIAL ON BEHALF OF MY ISSUE?

Monitor the editorial page of your newspaper to learn about the issues they have commented on in the past. You may wish to respond to the viewpoints that have been published by writing an opinion editorial to support, oppose, clarify, or enhance the information that was presented in the published editorial.

Editorial page coverage can also be initiated by meeting with the newspaper’s editorial board. Try to include others that support your issue in this meeting, such as members of your chapter, pediatricians or other health care professionals and clinicians that you work with, teachers, parents, and/or child advocates. This will help demonstrate the breadth of support for your issue. Briefly state your case and provide personal stories and examples, as well as documented supporting data and statistics. Last, but not least, make a direct ask of the editorial board to cover your issue and follow up as necessary. Your AAP chapter may be able to help you prepare for and set up your editorial board visit.

Once the editorial board covers your issue, recruit like-minded colleagues, parents, child advocates, friends, and family to submit letters to the editor or op-eds in support of the editorial. This will help create further buzz and energy around your issue. Send a copy of the editorial, along with the letters to the editor, to your community leaders and decision-makers and encourage others to do the same. Remember to thank the editorial board, and celebrate your media and communications efforts!
HOW DO I GET STARTED WITH MY MEDIA AND COMMUNICATIONS ADVOCACY EFFORTS?

There are 4 steps to engaging in media and communications advocacy.

FIND OUT ABOUT THE MEDIA AND COMMUNICATIONS TOOLS AND MECHANISMS AVAILABLE TO YOU

Consider the media and communications tools and resources that are available to you in your area or professional setting. Hospitals and universities generally have public relations staff that may be able to help you identify the media and communications tools available to you, such as community television, print media, and chapter communications. They may also be able to supply you with the necessary details of how to effectively work with the available tools, such as deadlines for submitting letters to the editor, or the contact information for your local health reporters or editorial boards.

LOOK FOR OPPORTUNITIES TO GET YOUR MESSAGE OUT

Watch the news, listen to the radio, monitor your favorite Internet sites, and read the paper. Be aware of the issues that are receiving attention and look for opportunities to use these issues as a way to build awareness for your issue specifically, or for children's health and well-being generally. For example, if violent video games are receiving media attention, use this as an opportunity to talk about positive children's health and well-being initiatives taking place in your community, or about your efforts to educate parents on the importance of monitoring the images their children see.

At other times, you or your chapter may find that you will have to bring your issue to the media's attention proactively instead of waiting for opportunities. Your AAP chapter can help you gain the media's attention by writing and submitting press releases or meeting with an editorial board.

DELIVER YOUR MESSAGE

Prepare and practice your message, then deliver it. This could be through participating in a media interview, writing an article or letter to the editor, making a presentation to a community group, or posting a message on an Internet forum. Whatever media or communications tool you choose, make sure your message illustrates your core argument, demonstrates the importance of your issue, connects your issue with the bigger picture of children's health, and is in a concise format.

WORK FOR MESSAGE REPEITION

Look for additional opportunities within the media, and in broader communications tools, to reinforce your message and keep reminding people why your issue matters. You could do this by submitting additional articles or updates on your issue; sharing new stories; or recruiting a colleague, friend, or another child advocate to submit a follow-up letter or story to the media, or by using a broader communications tool.
This section contains tips and tools to help guide you through using media and communications tools to advance your issue. Within this section, you will find the following tip sheets:

**Tips for Capturing Media Attention**
Suggestions for getting the media interested in covering your issue.

**Media and Communications Bridging Techniques**
Ideas on how to keep your interviews on target.

**Public Speaking 101**
Tips on how to tell your story and share your message in front of groups.

**Using Technology to Make Your Voice Heard**
Ideas and examples on how to bring your issue into cyberspace.

**Tips for Writing “Printable” Letters to the Editor**
Guidance on how to ensure your letter to the editor gets printed.

**Tips for Writing an Effective Press Release**
Guidance on how to write an effective press release on behalf of your issue.

**AAP Media and Communications Resources**
Links, resources, and examples of media and communications tools available from the AAP.
TIPS FOR CAPTURING MEDIA ATTENTION

Getting media attention for your issue specifically, or for children's health and well-being generally, isn't a matter of luck—it's a matter of persistence and creativity. Consider these ideas for giving the media reasons to cover your issue.

THINK ABOUT CHILDREN'S HEALTH IN TERMS OF "NEWS": Generate more interest by leveraging an existing story about children's health or well-being. For example, if an area youth is injured in an accident, write letters to the editor that explain how this child is one of many and why child safety should be a community, state, or national priority.

HAVE PRESS EVENTS RATHER THAN PRESS CONFERENCES: Press conferences involve individual people talking at a podium; press events have many people involved in an activity. A rally, activity, or other event is more compelling than a press conference because it is dynamic.

CREATE EVENTS WITH GOOD VISUALS: If there is color, liveliness, and people involved, the press are more likely to have a photo run in print or online news, thus increasing your chances of good coverage. Build action into your press events.

EXPAND YOUR DEFINITION OF "MEDIA": Post your own blog, post on other blogs or online forums, consider small neighborhood weekly or specialty papers as media outlets, and participate in live call-in radio shows. All of these outlets have active readership and listeners that you can affect with your children's health message.

MAKE IT PERSONAL: The personal experiences of pediatricians are incredibly compelling. They can also illustrate the need for change and can be linked to larger statistics about children's health and well-being generally. Let your personal stories be the centerpiece of your message.

SUGGEST BOLD SOLUTIONS: The media will be likely to cover new ideas and/or innovative solutions to community, state, or national problems.

BE PERSISTENT: Build relationships with reporters who cover issues that can relate to children's health. Start with the health reporters, but don't forget those who cover politics, education, and community news, all of which have a huge impact on children's health and well-being.
MEDIA AND COMMUNICATIONS BRIDGING TECHNIQUES

"Pivoting" is a way of redirecting the flow of an interview. If the direction of the question is heading down a road you would rather not travel, try some of the following phrases to pivot and get back on track.

In my personal experience, what happened was...

That's an interesting question, let me remind you...

What's important to remember is...

What I think your readers would like to know is...

Before we get off that subject/topic, let me add...

That's a good point, but I think your readers/viewers/audience would be interested in knowing that...

Let me give you some background information...

Let's take a closer look at...

That's an important point because...

Now that we've covered that issue, let's move on to...
PUBLIC SPEAKING 101

With a little practice, any pediatrician who is interested and willing can make an effective presentation to a group. Whether you are talking to your colleagues or making a presentation to a local school board, these tips can help you speak with ease and comfort.

USE YOUR FEET: Stand with both feet firmly planted, and move your feet only when it creates emphasis—stepping forward to underline a point, or to heighten the energy, and alternatively, stepping back to indicate a pause.

USE YOUR HANDS: Keep your hands folded or at your sides unless you are using gestures to illustrate your point or to create energy. Know your speaking style well enough to know how much is too much.

CHANNEL YOUR ENERGY: You are the source of the energy in the room. Use your voice, face, and hands to generate that energy. Pacing is like "flaring" gasoline rather than using it as fuel.

MAXIMIZE YOUR NATURAL STYLE: Some very powerful speakers are low-key and soft-spoken; they have learned to use these characteristics to create a reflective or conversational tone. Others are boisterous and use humor. Choose a style that reflects you.

SKIP THE THANK-YOUS, SMALL TALK, AND BANTER at the beginning of your speech; they drain energy and momentum from the room. Start HOT.

YOUR PASSION, STORY, AND VOICE WILL ESTABLISH YOUR CREDIBILITY: Don’t feel compelled to give a verbal resume. You are credible. It will show.

GET THEM TALKING: Build in ways for the audience to interact with you, however small. Try to do this as early in your presentation as possible, as well as a few times along the way. It provides the audience with a more interesting discussion, and you will gain valuable cues about who they are and what they can bring to your issue.

USE SILENCE: Pausing can be powerful when used intentionally. Consider how brief silences can help underscore a point.

KNOW YOUR NOTES: If you prefer to have notes, use a pause point to look at them. Try not to read to your audience, and consider note cards with 3-sentence cues, rather than dense text.

HAVE FUN! If you enjoy it, your audience will too. Be yourself. Breathe.
USING TECHNOLOGY TO MAKE YOUR VOICE HEARD

The Internet has provided an increasingly important space for people to connect with others, share ideas and interests, carry on public discussions, create "buzz" or attention on an issue, work on projects together, and take collective action. If you have access to the technology and the Internet, they can be very useful tools for building awareness and support for your issue specifically, and for children’s health and well-being generally.

Please note: Technology is a rapidly expanding and evolving medium. This tool contains definitions, tips, and a few examples for getting started. Please note that these examples are just a few of the mediums currently available; they do not imply AAP endorsement.

INTERNET FORUMS

DEFINITION: Internet forums are also commonly referred to as message boards, Web forums, discussion boards, discussion forums, discussion groups, and bulletin boards. Forums are an online place where people have discussions over time on a particular topic. Forums are also generally organized by a category or topic, called threads.

HOW TO USE A FORUM TO ADVANCE CHILDREN’S HEALTH: Participating in a forum is a way for you to talk about your specific experience, and about children’s health and well-being in general, in the context of a larger group discussion. You could either start a thread on a forum or chime in on an existing thread. Forums generally focus on a specific interest, such as fishing or parenting; your task is to find a forum that fits your interests, and when children’s health issues intersect with those interests, discuss them in the forum.

TIPS
• Don’t try to fit a square peg into a round hole. Avoid trying to turn a thread about gardening into a thread about children’s health and well-being. Find a genuine way for the issues to connect.

• If you are joining a preexisting message forum, follow the rules. Most of these forums are self-regulated.

• If you are starting a forum, you need to have a plan for driving people to that particular forum. Usually the most effective forums reside on a preexisting Web site.

RESOURCES
Look for the “forums” section of these Web sites for more information.

• http://www.yahoo.com
• http://www.google.com
• http://www.websitetoolbox.com (if you are developing your own forum)

Most social networking sites also have forums. There are also many health-related forums that may have specific threads dedicated to discussing, for example, children’s health and well-being.
**BLOG**

**DEFINITION:** Blog is short for Web log. It is a Web page that functions as a personal journal or diary in which regular entries are made. The term blog can also be used to describe the act of authoring a Web log. Most blogs are textual, although visual, audio, and video blogs are increasingly common. A podcast is an audio blog that can either be played through a computer or downloaded from the Internet to an mp3 player.

**HOW TO USE A BLOG TO ADVANCE CHILDREN’S HEALTH:** You can easily create your own online blog and post entries either related to your issue specifically, or to children’s health and well-being generally. Consider posting about:

- Your experience as a pediatrician
- Patients’ stories that you find inspiring (When using examples from your patients, be sure to use general information, such as “a nine-year-old boy I treated...” Keep patient privacy in mind.)
- Your advocacy efforts and activities
- Events in your community that relate to children’s health and well-being
- Public policy issues or community initiatives that affect children’s health

**TIPS**

- Make it personal. The voice of your blog should be yours. Include things about yourself that bring you and your story to life on the Web.
- If you enjoy working with technology, consider posting photos, audio, visuals, and/or video (if available), in addition to text.
- Consider allowing people who support your issue to post guest blogs and/or submit comments related to your blog.
- Offer links to other Web sites or ways to learn more, get involved, or take action.
- Tell people about it! Invite friends, family members, colleagues, child advocates, and others to view your blog. Send them a link via e-mail so they can just click and read.

**RESOURCES**

- [http://www.blogger.com](http://www.blogger.com) or [http://www.blogspot.com](http://www.blogspot.com). These Web sites allow you to create your own blog on the Web, and it’s free!
- [http://www.typepad.com](http://www.typepad.com). This Web site has a cost associated with it, but allows you to use additional graphics and to integrate advanced and highly interactive tools on your blog.
SOCIAL NETWORKING WEB SITES AND VIRTUAL COMMUNITIES

DEFINITION: Social networking sites connect individuals online in an interactive way. They generally offer a space for blogs, user profiles (a profile that a person creates to tell others about themselves), forums, chat groups (a mechanism for people to discuss a topic online, in real time), and photos. Some sites also offer ways to send private messages from one user to another, raise money, or organize events.

HOW TO USE A SOCIAL NETWORKING SITE TO ADVANCE CHILDREN’S HEALTH: By creating your own profile on a social networking site that best fits your interests, you can participate in online discussions and activities, create a blog, and find other people with similar interests. In this way you can share your story; educate others about your issue specifically, and children’s health and well-being generally; organize meetings or events; and find other people who want to get involved.

TIPS
• Social networking sites are public domains, which means anyone with an Internet connection can read your profile, so don’t post anything you wouldn’t want a lot of people to know (e.g., your phone number, address, etc.). Some people only use their first name, or create a screen name, and do not include their full name in their profile. Posting limited information may minimize your opportunities for meaningful networking, and you should weigh this consideration with your privacy concerns.

• Ask your AAP chapter if you may include a link on your site to your chapter’s Web site. Reporters go to the Web to look for stories and to find out the positions of various groups. This is a great way to control your message and further educate the media on your issue.

• Learn the basic rules of conduct on the site you select and follow them. Most sites have posted rules and some are moderated. View other people’s profiles to get a feel for how people customarily interact.

• Be careful about meeting people in person whom you’ve met online and do not fully know.

RESOURCES
• http://www.myspace.com. MySpace is currently hosting a site called Change.org that enables visitors to join virtual foundations of peers committed to specific politicians or causes and fundraise for them.

• http://www.facebook.com. Facebook features a program called Causes, in which users create online communities to advocate for issues, charities, and political candidates.

• http://www.care2.com. Care 2 provides an opportunity for social networking and participation in advocacy activities online and through volunteer opportunities.

GROUP COMMUNICATIONS TOOLS

DEFINITION: Group communications tools allow you to manage the information and activities of a group. These tools are facilitated by companies such as Yahoo, Google, and many more. Many offer free list management, e-mailing services, calendar tools, and mini-database services. You can create or join a group to discuss a topic, set up an e-mail distribution list and/or send newsletters, and plan group events and volunteer activities. Many group communications tools can also be facilitated through social networking sites, such as MySpace and Facebook. Additionally, explore the opportunities available for online group communications through your alumni association, university group, professional setting, or the AAP.

HOW TO USE GROUP COMMUNICATIONS TOOLS TO ADVANCE CHILDREN'S HEALTH: Online group communications tools make it possible for you (or anyone else that you are working with on your advocacy efforts) to help manage your information, as well as your communications and activities. They also are a simple and easy way to keep people informed, sign up new members, and manage projects.

TIPS
• Consider whether you want to start a group or join a preexisting group based on a topic.
• If you start a group, consider whether you want your group featured in a public directory, such as Yahoo’s, for newcomers to join.

RESOURCES
• http://groups.yahoo.com
• http://groups.google.com
• http://groups.msn.com/Browse?CatId=10
TIPS FOR WRITING “PRINTABLE” LETTERS TO THE EDITOR

An underused resource in advocacy work is the local media. Letters to the editor can be powerful vehicles for influencing or inspiring public debate, making the case for your issue, or responding to related events. In addition, decision-makers often read the opinion pages of their local papers because it gives them an idea of what members of their community are thinking and talking about. The trick is to write a letter that the editors find compelling enough to print. Use these tips to help you craft a letter that is more likely to be printed.

KNOW THE RULES: Do your homework about how to submit a letter and what information you should include to increase the likelihood that it will get printed. Usually this information is printed on the opinion page of the newspaper itself or on the newspaper’s Web site.

CAPITALIZE ON THE HOT STORIES: Find ways to tie stories in the news into your issue. Open your letter with a reference to a recent event, and then quickly build a logical bridge to your issue. Children’s health issues cut across topics such as health insurance, health care delivery, safety, community support, education, faith, and leadership. These and other angles can help illustrate children’s health issues in your community or state, or nationwide.

KEEP IT BRIEF: Letters to the editor should generally be less than 250 words. Edit your letter aggressively.

PAINT A PERSONAL PICTURE: All grassroots strategies rely on personal stories to convey larger issues. Touch both the minds and hearts of the reader by giving both the broader facts about children’s health as well as your personal experience as a pediatrician.

BE CLEAR: This may seem obvious, but a surprising number of letters that don’t get published just plain don’t make sense. Avoid jargon; use common vocabulary; and let a few friends, colleagues, or your AAP chapter review the letter for you before you send it.

USE WORD CUES TO UNDERSCORE YOUR POINT: For instance, preface your major conclusion with, “The important thing is....” If you have research that makes your case, preface the facts with, “Research proves that....”

DON’T OVERLOOK NEIGHBORHOOD WEEKLIES AND SMALLER PAPERS: Often these publications have more room for letters, and community papers have very large readerships.

INCLUDE A CALL TO ACTION OR A SOLUTION: If you are illustrating a need or making a case for a specific action, include a line about what people can do to help.

DON’T BE AFRAID TO TOOT YOUR OWN HORN: If you, your AAP chapter, or another organization you are working with is involved in work that addresses the issue, include that in your letter.

BE PASSIONATE, BUT NOT POISONOUS: There is a difference between “fire in the belly” and righteous indignation. Avoid sarcasm, and if you’re angry, cool off a bit before sending a final version.

CONSIDER THE ONLINE EDITORIAL PAGE: Some papers will accept letters to the editor online, and some even print additional letters in their online publications that don’t make it into the print copies of the paper.

DON’T STOP ONCE YOU GET PRINTED: Use your printed letter to the editor to further educate others. Think about who you could send a copy of your letter to as a way to educate them and let them know what you are seeking to change. Friends, family, health care professionals, child advocates, and the decision-makers themselves are good places to start.
TIPS FOR WRITING AN EFFECTIVE PRESS RELEASE

Getting children’s health issues into the news is a great way to get people talking about your issue. A press release is a simple way to announce new developments in your advocacy efforts and to keep your issue in the public eye. When crafting your press release, work with your AAP chapter and consider these tips.

HAVE LEGITIMATE NEWS: Even though you want the press to cover your issue, be careful not to send out press releases for everything. Ask yourself what makes this important to a reporter.

STARTING OUT: Always begin a press release with your name or your organization’s name, the date, “For Immediate Release” in the upper left-hand corner; and “For More Information” and your contact information in the upper right-hand corner.

FOLLOW THE FORMULA: A press release should consist of a headline, a subhead, a lead paragraph, a quote, the facts, and a closing quote.

KEEP IT SHORT: Try to keep the release as brief as possible—1 page is ideal, 2 pages at the most. If more than 1 page is necessary, write the word “More” centered in the footer of the page.

GET THEIR ATTENTION WITH THE FIRST PARAGRAPH: Editors and reporters are busy, so make your first paragraph something that will catch their attention.

PROOFREAD, THEN PROOFREAD AGAIN: A press release reflects the professionalism of your efforts. Take the time to be accurate, neat, and double-check for typos.

RESPECT DEADLINES: Sending press releases early in the day will increase the likelihood that they’ll be used.

SHOWTIME: Remember that this is your version of the story. Showcase your issue in the best possible light, and make sure the press release is quotable.

FINISHING TOUCH: End your release with “- ### -” centered at the bottom of the page to indicate the final sentence of the press release. This indicates to the press that your release is finished and there is no further information you are sending them at this time.

DISTRIBUTION: If you are sending your press release to reporters electronically, include your press release within the body of the e-mail—don’t use attachments. Remember to include your contact information, and use an attention-grabbing subject line in your e-mail.
AAP MEDIA AND COMMUNICATIONS RESOURCES

The following link provides resources, tips, and examples of media and communications tools available from the AAP:

http://www.aap.org/moc/presroom/presroom.htm: This link will get you to the AAP Media Center. The Media Center is designed to supply you as a pediatrician with speaking points and interview tips that will help you in working with the media. The site includes links to many AAP communications and media resources including the following:

SPEAKER READY ROOM: An archive of AAP speeches and speaking tip sheets.

SAMPLE LETTERS TO THE EDITOR: Samples of letters to the editor submitted by the AAP and pediatricians like you.

PREPARATION FOR MEDIA INTERVIEWS: Frequently asked questions, tip sheets, and speaking points that you can use to prepare for a media interview.

BECOMING AN AAP SPOKESPERSON: The role of an AAP spokesperson along with member communication information.

SAMPLE TALKING POINTS: Examples of talking points for AAP issues.

AAP COMMUNICATIONS HANDBOOK: The handbook provides media lessons, news-gathering information, tips on how to respond when the media calls you, and guidelines for better media interviews.
For more of the new “Advocacy Guide” made available through the AAP, go to

AAP Communications Handbook

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Introduction
In today's news media climate, informed and articulate spokespersons are not only in demand, but effective spokespersons can shape what's covered in the press. In recent years, health issues, in particular, have dominated the media. The public is eager for knowledge about medicine and health. This updated handbook on working with the media was developed by the AAP's Office of Public Relations to help you do better interviews and develop a good relationship with the media and ultimately, your community. This guide also offers tips on generating local media coverage on issues you feel are important. As an AAP representative, you can serve the media by providing accurate information about current issues in the field of pediatrics. You also can bring to the media's attention topics that are important to you and your colleagues. We hope you find this handbook effective and useful.

A Quick Media Lesson
There are numerous news outlets and a variety of newspeople. The most influential media -- The New York Times, The Washington Post, the network news programs, to name a few -- set a national news "agenda." The stories these top media report on filter down to your community media. Regional press aim to cover national news stories with an added local angle. As a pediatrician and AAP spokesperson, you are an expert on children's health issues and are invaluable as a source to the media. Your first task in establishing a good working relationship with the media is to become familiar with the reporters in your area -- know who they are and what type of stories they cover.

Understanding the media is an important first step to a good working relationship. It's in your best interest to establish a relationship with the media as you would a courtship; think of them as friends, not adversaries, and ultimately, you will win their trust.
What is the life of a reporter like? He or she is always looking for new information, constantly under deadline pressure, and may be uninformed about a story him or her has been assigned. Although there are many specialized reporters today who cover specific areas, general reporters can be assigned to a health story and may not understand the complexity of issues in the manner you do. Although you may be skeptical about the media’s ability to report accurately on medical topics, remember that journalists are ultimately the ones who present medical information to the public. The majority of reporters want to get it right -- they don’t want their stories to be erroneous. Reporters think differently than the rest of us. They think in an "inverted pyramid" style. The rest of us think sequentially: we build our case, make our points, and state our conclusion. Reporters state the conclusion first -- it becomes the lead (or lede) of their story and then back it up with the supporting material. The reason for inverted pyramid style is simple. If a story needs to be cut for lack of space or time, by cutting from the bottom, the essential elements still remain. Don't forget that the media are in business. They are not producing information solely to serve the public good. Reporters and their editors are interested in stories that appeal to large numbers of people, have balance, are accurate, dramatic, and above all, timely. Remember -- what is news to you may not be news to them.

**News Gathering**

Journalists operate on the "5 W's and 1 H" theory. Who, What, When, Where, Why and How must be included in every news story. Most important, journalists are curious. There are two categories of news: hard news and soft news.

| Hard News: Breaking news, timely information that captures the public's attention. A medical break-through, for example. |
| Soft News: Feature stories, or human interest pieces, that are not time sensitive. Can be warmer in tone. |

Journalists define "news" as anything from 'what people should know' to 'what we say it is' to 'anything topical and controversial.' Others say news can be anything as long as the reporter is creative enough. Often, what is news is a subject of debate in the newsroom. Ask yourself these important questions before approaching the media:

- Will my story have an impact on people?
- Is there a conflict?
- Is it new? Really new?
- Is it timely?
- Is it localized?
- Is it a hot news topic? Are the media already covering it? If so, what can I add that's different?
- Does my story relate to current legislation?
• Can I give my expert opinion? Am I willing to debate the "other side?"

**Hint for print interviews:** Be specific. Clarify and explain details. Unlike television, print journalists have more space to tell the story; they want depth.

**Print Media** Although there are not as many newspapers as there once were, print journalism still flourishes. In 1989, there were 530 morning newspapers in the country, and 1,125 evening papers. Although there are two types of print media -- newspaper and magazine -- your dealings with them will depend on whether their audience is local or national. National magazines and newspapers, with circulations of several million, such as Parents Magazine or USA Today, blanket every city nationwide. Community newspapers have smaller circulations and reach a targeted local audience. Keep the audience in mind when working with a publication. Often, a magazine feature can take weeks or even months to prepare. The magazine staff may refer back to you to check quotes or add information because they have time to perfect their stories. Newspapers have shorter deadlines -- a newspaper reporter can spend a day or a week on a story. Newspaper reporters often have afternoon deadlines for the next morning's edition. When the story is hard news, reporters will need information or a quote from you immediately. If it's soft news, usually, you have more time to get back to them.

**Broadcast Media** More than 97 percent of all homes have televisions. Over 90 million households owned at least one television set in 1989. The cable television industry has seen expansive growth, and much of its programming is extremely specialized. Although news is generated by thousands of television stations to millions of viewers, television is an intimate medium. With the increase of the number of stations in the future, there will be an increased demand to find articulate experts. There are more than 9,300 radio stations in the U.S. transmitting to over 470 million radios. Radio has the widest range of interview possibilities because of all the media, it has the largest number of daily broadcasts. Television and radio operate differently than print media. In television, news stories are produced with sound, motion and color, in radio, it's sound alone. Both media operate on much shorter timelines and produce shorter stories than print media.

**New Media** The Internet has created a media explosion of new Web sites and a convergence of print, broadcast, and cable mediums on the "Net." This has accelerated the speed of news gathering process to light speed. Reporters previously had days to file a story. Now, the Web has created a voracious appetite for health information among the public - - and all media now must keep up. These new media reporters are developing their own style and trying to carve out a niche among other "press." It's important to remember these Web media are an important outlet for AAP media spokespersons to get their messages out. Keep in mind that today's corporate media mergers may mean that a Web reporter could be representing a major television or print outlet in the future.
Hint for broadcast interviews: Relax! Try to imagine yourself talking only to one person. Crystallize your ideas into a few short hard-hitting points.

**Who's Who**
Titles of media people can be confusing. Here's a quick guide.

**PRINT MEDIA**
*Reporter* -- Usually the best person to contact with a story idea. This person researches and writes news and features for the publication. Larger publications may have medical and health specialty reporters. *Investigative reporter* -- The person who digs for details and often writes "expose" type stories.

*City editor* -- Tracks news on a daily basis, usually in charge of news reporters' assignments. Sometimes called Metro Editor.

*Editor-in-chief* -- Administrative head of publication. Depending upon the size of the publication, this person may write editorials, be involved in day-to-day work or only administrate. Oversees operations with the publisher.

*Feature editor* -- Person in charge of human interest stories, "soft" news. There may be additional specialty editors such as the Political Editor. *Managing editor* -- Oversees the day-to-day operation of the publication. Often makes story assignments. Sometimes called Executive Editor.

*Editorial page editor* -- Person responsible for producing the editorial and op/ed (opinion) pages. Often has several editorial writers on staff. *Photo editor* -- The person who assigns photographers to cover events.

**BROADCAST MEDIA**
*Anchor* -- The central figure who "hosts" the radio or television news.

*News reporter* -- Radio or television reporters who cover news and human interest stories. Larger outlets often have medical or health reporters.

* Assignment editor* -- The person who decides which stories to cover; he assigns camera crews and reporters. In television, the assignment editor works with producers to decide the day's coverage.

*News director* -- The head of the news staff, often a radio term. She makes major story decisions and decides when a story or series will air.

*Producer* -- The person responsible for lining up guests (often for talk shows), topics to be covered and determining time needed for stories. There are usually different producers for different talk shows and some larger TV stations have producers who solely work on medical and health news.

*General manager* -- The administrative head of the station, she oversees operations. This person can be contacted with complaints about the station’s news coverage.

*Public affairs director* -- The person that selects and produces public service announcements (PSA). All PSA materials should be directed to his attention.

*Talk show host/Disc jockey* -- This role varies, but often they can be influential in getting stories on the air. Usually, producers are better to contact with an idea.
Deadlines Deadlines, as stated earlier, are an essential part of any reporter’s life. Remember, deadlines mean different things to different media.

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How To Get Your Foot in the Door
As a spokesperson, you are an advocate for children’s health. The Academy receives about 100 calls a week from various local and national reporters, and often refers these media to you, as a local spokesperson or national expert. Committee/section members and chapter leaders are often sought by the media as authority figures to quote. Your objectives as a spokesperson are:

Provide the media with a professional resource -- yourself. Help reporters whenever your time allows -- in researching stories and providing interviews. They won’t forget you. Once you’ve become a contact, the media will return to you for help with future stories.

Seize the opportunity to work with the media. Watch and read the news and surf the Web. Be aware of the trends the media are covering, and be ready to seize the opportunity for a timely story. Generate media coverage by distributing news releases or background information.

Know your local media. Become familiar with reporters who cover health and establish contacts. You can obtain a list of all media the Academy’s Office of Public Relations sends news releases to by contacting Office staff. Staff also can provide you with a list of smaller circulation media the Academy does not send news releases to. These smaller outlets are often well-read by communities and are in need of information. You can be a vital resource for them.

Provide a vital link between the media and the public, furthering the education of your community on important issues. Publicize the Academy as well.

It’s easier to build a relationship with the media when you can offer help, not ask for it.

Building a presence with the media is a gradual process; don’t become discouraged if your
first few attempts are turned down. One way to begin to develop a relationship and establish your credibility is to write a short note complimenting a reporter on a particular story. Begin to collect reporters’ names in your Rolodex. When a national pediatric issue breaks, you can call or write a note to a reporter you know, and offer background information or yourself as an interview source. Nurture the "courtship" with the media. Another method is to utilize the letters-to-the-editor column, one of the most well-read sections of the newspaper. Respond to an article and begin to get your name out there. After you’ve won the respect of your media contacts, you may be able to influence them by suggesting story ideas or a slant to an issue. The best person to contact with an idea for a story is usually the reporter who will be doing the story -- for example, contact the medical writer, not the city editor. Remember that the reporter doesn’t care about the details of your practice, but the newsworthy issue. If you can put a local "spin" on a national story, you’re a valuable source. Reporters always appreciate tips, so if you see a newsworthy article in one of the medical journals, send the reporter a copy with a note. She may not receive that particular journal and will appreciate the tip. Remember that the AAP’s Office of Public Relations can assist you. Staff can help you develop a news release, write a letter to the editor or a guest editorial. You also can provide AAP news releases to smaller media such as weekly newspapers -- the AAP does not send its releases to these smaller outlets. (Staff can provide you with a list of media we send news releases to in your state.) Don’t overlook any opportunity to get your messages out. Your city may have a cable program devoted to health. Many pediatricians are also sought by local newspapers to write question and answer columns -- you might inquire with an editor. Your chapter might consider pursuing a newspaper supplement on child health or producing public service messages for local radio or TV.

When the Media Call
Simply being an expert doesn’t assure you a successful interview; even the best authorities have been known to go blank under the intimidating television lights. There are several interviewing techniques and tips that can help you do a better job, but first, the 10+1 commandments of media interviews.

**TALK FROM THE VIEWPOINT OF YOUR AUDIENCE.** Knowing your audience is the first step for any effective interview. Every audience has knowledge, education and socioeconomic differences. Your tone and manner should be tailored to the audience of the particular medium you’re communicating with.

**DON’T USE JARGON.** Explain any technical medical terminology. The majority of any layperson audience is most likely a non-medical one; you’ll need to clarify and explain.

**SPEAK IN PERSONAL TERMS.** A human example always helps readers, viewers and listeners relate.

**IF YOU DON’T WANT A STATEMENT QUOTED, DON’T MAKE IT.** There is no such thing as "off the record." Anything you say can be quoted.

**STATE THE MOST IMPORTANT FACTS AT THE BEGINNING.** Remember the inverted pyramid.
DON'T ARGUE WITH THE REPORTER OR LOSE YOUR COOL.

IF A QUESTION CONTAINS OFFENSIVE OR ERRONEOUS LANGUAGE, DON'T REPEAT THE NEGATIVE. If you say it, the statement becomes your quotable words. It's better to answer with a positive, correct statement.

IF A REPORTER ASKS A DIRECT QUESTION, HE IS ENTITLED TO A DIRECT ANSWER, GENERALLY.

IF YOU DON'T KNOW, DON'T SAY "NO COMMENT." These are flag words for reporters; they may believe you're hiding something. Say you don't know, and offer to find out and follow up.

DON'T EXAGGERATE THE FACTS.

TELL THE TRUTH, EVEN IF IT HURTS.

How to do Better Interviews

Before your interview, come up with a few SOCOS -- Single Overriding Communications Objectives -- or main points. Crystallize these into a few short sentences and hammer away at them during the interview. Know the "who, what, when, where, why and how" of your story and be prepared to tell the reporter the most important details first. There are three techniques that can enable you to set the agenda of the interview. These techniques help you stay focused on your SOCOS.

Bridging -- using a transitional phrase to go from a negative question to a positive statement. Use words such as: and, but, however, on the other hand. Hooking -- answering a question by leading to one of your SOCOS by offering statistics, data, lists. Although x has occurred, new data show that y is true.

Flagging -- using phrases that make the reporter stop and listen: the most important thing is, what I want to leave you with is, the key issue here is... These techniques are especially useful with a reporter who has a set agenda for the story -- an idea of what the answers are before she asks you. Use these techniques to turn the tables.

Remember that when you're being quoted as an AAP representative, you should stick to Academy policy. If your personal opinion differs, clarify this with the reporter.

Remember to keep abreast of new research, articles and AAP positions. Stating the AAP position on a particular issue will enhance your credibility during an interview. The Office of Public Relations' news releases can help keep you informed. These news releases are sent directly to about 2,500 media in the U.S. In that sense, the Academy has become a medical information service for hundreds of reporters.

Print Interviews Print journalists have more time to perfect their stories and more space to run the stories. Information is conveyed through words alone. Many times, your interview will be blended with the angle of the story. Remember these tips for print interviews:
• Be concise, clear and to-the-point. Be specific and explain details. Print reporters want depth.

• State the most important facts first, then provide background information. Be careful if the person is a general reporter and unfamiliar with medical stories.

• Don't speak off the top of your head. If you can't remember exact figures, tell the reporter you will get back to him with the information.

• Correct spelling, titles and addresses are essential, as they will be in print. Help the reporter by spelling these as well as any confusing medical term.

• If a photograph, chart or graph is helpful in explaining the story and you have one, offer it to the reporter for reproduction in the publication.

Reporters from larger newspapers are generally well-educated and experienced. Some develop a specialty and write stories only in that area, such as medical reporters. Save the print reporter time by gathering background for him before your interview.

Broadcast Interviews

RADIO
Most stations broadcast news several times a day, and radio reporters are constantly turning over new stories. The nation’s radio stations conduct about 5,000 interviews every day. A quick pre-interview briefing with a radio reporter will help him understand the message. The use of voice is critical because it is your only means of communication in a radio interview.

• Ask if the interview is live or taped. A taped interview is easier to do since it is edited before aired.

• The reporter wants your voice on tape, not hers. Avoid simply answering yes or no to her questions; expand.

• Speak clearly and articulately. The reporter will probably pull out a 10-15 second "sound bite" from your interview. The rest of the information you provide may be summarized in the reporter's capsulization of the story.

• Relax and speak in a conversational tone. Modulate your inflection where appropriate.

• Think before you speak. It is easier to edit out a silence than many "umms" and "aahs". If you become tongue-tied, simply take a breath and start again. Your goof can be edited out.

• Use the interviewer's name once or twice, but don't overdo this. (Do not use this technique in a news conference. Recognizing one reporter by name may prevent competing stations from using your answer.)
• If you've answered the question and the reporter hasn't asked a follow-up, don't feel you have to fill the empty space. Wait for the reporter to continue.

• Remember to crystallize your message into a few, short sentences and repeat them.

• You may be asked to participate in a radio call-in show where listeners phone in with questions. Although this may seem intimidating, it's often quite similar to taking every-day questions from parents.

TELEVISION

Every day in the U.S., about 15,000 people are interviewed for television news. Visual images must accompany every story. The two most common types of interviews are for a newscast and a talk show. For a news interview, 60 seconds of airtime for your quote or "sound bite" is about the standard length of time. The talk show interview is more relaxed and you usually have more time to prepare, as guests are booked in advance. You also have more time to get your SOCOs across. Talk shows tend to focus on the feature or human interest side of the story. Here are tips for both types of interviews:

• Relax. Speak naturally. Try to imagine you're talking to one person. Convey interest, concern and confidence.

• The use of charts, graphs and pictures can often help clarify your points. Offer them to the reporter before the interview if appropriate.

• Use anecdotes when possible. Personal stories play well on television. Make sure anecdotes are interesting and to the point.

• Always look at the interviewer, not the camera. The cameraperson will find you.

• When you've finished answering a question, pause. You don't need to fill air space. The interviewer will continue. If you sense the interviewer did not understand a response, feel free to say: "I'd like to elaborate on something I said earlier."

• Don't be surprised if the reporter's off-camera style is friendly and sympathetic. She may be very different on-camera.

• Television interviewees also need to check their visual appearance before going on-camera. Here are some tips:

• Men should wear a dark suit with a solid color shirt (blue, grey) but not white, as that can reflect the television lights and make you look washed-out. Choose a simply-patterned or solid tie. Socks should be knee-length for any sit down interview. Remove wallets or appointment books from inside jacket pocket. Open jacket button when seated, and make sure your collar and tie are straight.

• Women should avoid busy prints, long or overly-noticeable earrings, and should keep personal accessories simple. Keep makeup simple and clean.

• You can ask for powder to avoid a shine or cover "five-o'clock shadow."

• Avoid light-sensitive glasses that may darken on-camera.

• Gesturing and using your hands when you talk is fine. Lean slightly forward when
you talk. Avoid any nervous gestures such as rocking in your chair, gripping the sides of your chair, playing with pencils, microphone, jewelry.

- The television call-in format is an excellent opportunity to talk directly with the public. All calls are screened beforehand. These can be handled as if talking to a parent, but don't be afraid to tell callers to check with their own pediatrician. The toughest type of television interview is the live satellite, where the interviewer is in one city and you're in another. It's best to practice, not in front of a mirror, beforehand, if you can.

**Overcoming Nervousness** It's natural to be nervous before any interview: The best way to combat nervousness is to know your subject thoroughly and review the points you want to make. Arrive early to get a feel for your surroundings and practice a few relaxation exercises before the interview. Try to spend a few minutes with the reporter before the interview to get a feel for his style and the questions he might ask. During the interview, maintain eye contact with the reporter; this will make you appear less nervous. Smiling, if appropriate, will often help you relax.

Remember, you're "on-camera" whether the camera is running or not. Don't make any comments off-camera that you don't want repeated on the air.

**Handling Hostile Situations** If you are "ambushed" by a reporter, try to obtain as much information as possible from him and offer to return as soon as possible with a response. Try to avoid answering on the spot if you are uninformed. Remember, don't say "no comment." These are flag words that you may be hiding something, even if you aren't. You can have some control. If a reporter nabbed you in a hallway, suggest moving the interview to your office. This is a quieter environment and may help calm the reporter. Never lose your temper or take personal offense at the reporter's question. Don't let him put words in your mouth. Try to make your statements concisely and clearly, and hammer away at them. If questions are flying at you several at a time from a group, try to answer them calmly one at a time. Answer questions directly and try not to appear evasive. Don't allow an interviewer to make a negative statement and get away with it. A courteous rebuttal is perfectly acceptable.

Phrases that respond to hostile questions are: "Let's put that in perspective," or "Let me give you the facts of the situation." You then become the voice of reason against illogical questions.

**Being Mis quoted** If you hear or read your interview and feel you've been misquoted, ask yourself these questions before responding:

- Was the AAP's or your credibility undermined or threatened?
- Could the story erode public confidence in pediatrics?
- Is the story balanced? Does it contain dangerously erroneous information?
Will your planned response have the desired effect? Could it backfire?

If you decide a response is warranted, prepare it quickly while the issue is still fresh. Write a letter to the editor or request airtime for a television editorial reply. You also can write a note to the reporter who interviewed you, stating your case.

Follow-Up It’s a good idea to write a short thank you note to the reporter after the interview to continue the "courtship." Remember the 3 C's of interviews: Communicate key points, Cooperate with the news media, and Control the interview. By thinking of these guidelines and using the tips in this handbook, you're sure to tame even the toughest interviewer.

Glossary (Strange Things Media People Say)

**ACTUALITY**: In TV, an on-the-scene report.

**ANGLE**: The slant or direction a news story takes.

**BEAT**: The area in which a reporter specializes.

**BITE**: Short for "sound bite." A small portion of audio or a videotaped interview which is edited into the reporter’s story. Usually less than 15 seconds. One bite is sometimes edited to another in a way that makes it appear that both phrases were spoken together in sequence.

**BULLDOG EDITION**: The earliest, fast edition of a newspaper, the one with the earliest deadline.

**CAMERA-READY**: Art that can be reproduced exactly as it is in print.

**CUT**: When an editor shortens a story due to space or time limitations.

**DEADLINE**: The time a reporter must have her story finished and ready to print or broadcast.

**FEED**: To transmit audio or video tape via wires. Network TV crews feed their stories to the network daily. Radio reporters can feed stories through phones.

**GRAF**: A shortened word for paragraph.

**HOOK**: The most intriguing point about your story, one which entices a reporter to cover it.

**JUMP**: The advantage you give a reporter by providing him with exclusive. Information, a scoop, thereby giving him the 'amp" on the story.

**LEAD**: Pronounced and sometimes spelled LEDE, the beginning paragraph of a news story; includes most of the information and captures reader’s attention.

**LEAD-IN**: The introduction to a TV news story read by the anchor. Usually less than 15 seconds. This is the headline.

**LEAD TIME**: The period of time a reporter needs to prepare a story.

**NEWS PEG**: A local story pegged to a national or international story with a local angle.

**NEWS RELEASE**: Also called a press release, a document that acquaints reporters and editors with the basic facts of a story.

**OP-ED**: The issue-oriented opinion page opposite the editorial page in a newspaper. Often runs pieces submitted by the public.

**RIP 'N READ**: A news or feature item in radio news that is written in broadcast style short script form. It is intended for disc jockeys to read over the air.

**ROUND-UP**: A story that joins several items in one story. For example, a round-up on different community health programs.
SIDEBAR: A secondary, usually shorter newspaper or magazine story that runs alongside a major story. Can be a profile of a character in the story, for example.

SLICK: Camera-ready artwork prepared for a publication’s use.

SPIN: The angle on the story, a term used frequently by TV reporters.

STOCK FOOTAGE: Film previously shot that is held in a TV station’s video library and may be reused. -30-: The traditional sign ending newspaper copy. Used as shorthand to tell the typesetter "the end."

VNR: Short for video news release. A pre-packaged video story sent to TV stations, similar to a written news release distributed to print media. VNRs are usually used in part, for example, part of the video only. Rarely is the entire VNR used word-for-word.

WIRE: One of the media’s sources for news, wire services such as the Associated Press and Reuters electronically transmit breaking news via wires. Many large cities have a city-wide wire service.
Dear Program Delegate,

Within the Section on Medical Students, Residents, and Fellowship Trainees’ 5th Annual Advocacy Campaign, you will find the AAP Pediatric Residency Advocacy Training Curriculum. This curriculum was created by members of the Community Pediatrics Training Initiative (CPTI) as a tool for advancing advocacy training and involvement at the resident-level.

The curriculum (Advocacy Modules) is under the Advocacy tab of the ImmuneWise CD-ROM. There are five modules to the curriculum:

1. Overview of the Legislative Process
2. Working in Partnerships
3. Working with Decision-Makers
4. Advocacy Communications
5. Voting with Children’s Health and a Pediatric Resident’s Schedule in Mind

Each module has an introductory guide, a ready-made presentation, and a summary of related advocacy opportunities based on the time you have to invest. Presenting each module takes about 45 minutes, making the curriculum ideal for the noon conference setting. It is not expected that you complete this specific curriculum, but we want to make sure you are aware of this excellent resource. The modules are fun, interactive, and can stand alone (without the other modules). For more information on the modules or other advocacy opportunities, please visit the CPTI website: http://www.aap.org/commpeds/CPTI.

We hope that you find these modules helpful as you expand your and your fellow residents’ advocacy skills.

Sincerely,

SOMRFT Advocacy Subcommittee
Introduction to the Trainer Guides

Welcome to the AAP Pediatric Residency Advocacy Training Curriculum. **You are an integral part of the Academy’s efforts to incorporate advocacy into pediatric residency training programs across the country.** We believe your training and instruction will help provide future pediatricians with the skills and confidence necessary to advocate on behalf of their patients and advance children’s health and well-being at the local, state, and federal level. **Thank you for being part of this important initiative.**

The AAP Pediatric Resident Advocacy Trainer Guides were created to help you prepare for and present the advocacy training curriculum in an easy-to-follow and uniform format. The trainer guides provide prompting questions you can use to encourage participation and input, tips for presenting the training content, and suggestions on timing. A trainer guide accompanies each of the five AAP Pediatric Advocacy Training Modules.

**A special note about medical education accreditation:** Each of these modules relates to one or more of the ACGME Competency Domains. We have listed each module below and identified the relevant competencies:

The training modules topics include:

1) **Overview of the Legislative Process**: Systems-Based Practice, Professionalism
2) **Working in Partnerships**: Interpersonal and Communication Skills, Professionalism
3) **Working with Decision-Makers**: Interpersonal and Communications Skills, System-Based Practice, Professionalism
4) **Advocacy Communications**: Interpersonal and Communication Skills
5) **Voting with Children’s Health and a Pediatric Resident’s Schedule in Mind**: Interpersonal and Communication Skills, Systems-Based Practice

The training modules—along with the trainer guide—were designed as stand-alone trainings and do not need to occur sequentially. However, as you are able, we suggest starting with the Overview of the Legislation Process module. This module will help get pediatric residents comfortable with basic skills outlined in subsequent modules. Also, we encourage you to use the Voting module in the time leading up to an election, allowing residents to register to vote in accordance with your state’s voter registration deadlines.

Each module is designed to take about 45 minutes, incorporate “real time” learning, and be fun and interactive. While each guide is unique to the content of the specific training module, they also include intentional repetition of key advocacy themes and follow a similar format. Upon completion of each training module, pediatric residents will receive additional opportunities that relate to the training topic and can be performed as their interest and time allows.

We view you as an important partner in our efforts to provide advocacy training to pediatric residents and value your feedback. Please don't hesitate to contact the Community Pediatrics Training Initiative at [cpti@aap.org](mailto:cpti@aap.org) or 847/434-7397 regarding any questions you may have or if you would like to share your comments and input with us.

Thank you.
Overview/Schedule: This module is designed to take 45 minutes. Options for additional and follow-up activities are included. A general break down of the time is as follows:

- Welcome, Introductions, and Case Study:
  - Welcome and Why We’re Here (5 minutes)
  - Case Study (5 minutes)

- Core Concept (15 minutes)

- Practice (15 minutes)

- Closing, Evaluation, and Opportunities (5 minutes)

Please note that this module is more content heavy than the other modules. This is due to the level of details within the legislative process. These details were included in order to give pediatric residents an overall understanding of the legislative process at the local, state, and national level. As such, you may find it challenging to cover all of the content contained within this trainer guide into a 45 minute time frame. If time becomes a challenge for you, we suggest skipping the practice section (the How a Bill Becomes a Law game). Instead, this game can be given to pediatric residents as a “take away” from the module.

Educational Objectives: This module is designed to give pediatric residents a basic understanding of the legislative process. The intent of the module is:

- To define advocacy; the role it plays in improving children’s health and well-being; and the unique role pediatric residents can play in advocating on behalf of children.

- To provide pediatric residents with a basic understanding of the legislative process and the opportunities throughout the process where they can use their voice to advocate on behalf of issues they care about. Please note that while there are differences from state to state regarding the legislative process and distinctions between the way state legislatures and the US Congress pass legislation, the module is designed to build a general familiarity and understanding of how the legislative process works.

- To increase pediatric residents advocacy-related confidence and comfort level.
To demonstrate that advocacy is doable and can fit within the demands of a pediatric resident's busy schedule.

**Materials and Equipment:** For this module, you will need the following handouts, materials, and equipment:

**Handouts:**
- Copies of the evaluation for each pediatric resident participating in the module.
- Copies of the Opportunities Worksheet. The Opportunities Worksheet contains a list of advocacy activities that relate to the module's topic and can be performed by pediatric residents following the module as their interest and time allows.
- Copies of the advocacy leadership skills inventory.
- Quick Reference Cards that contain instructions for looking up chapter contact information and links to additional resources.

**Equipment:**
- Flip chart or white board
- Markers/Dry erase markers for flip chart/white board
- If using PowerPoint:
  - PowerPoint projector
  - Screen or white wall for viewing PowerPoint
  - Copy of PowerPoint with trainer notes on computer or zip drive.
- If using School House Rock YouTube video in place of PowerPoint:
  - Internet connection with projector
  - School House Rock YouTube link: [http://www.youtube.com/watch?v=mEJL2Uuv-oQ](http://www.youtube.com/watch?v=mEJL2Uuv-oQ). DVD's of the School House Rock video are also available at Amazon.com or barnesandnoble.com.
- Copies of the “How a Bill Becomes a Law” board game, playing pieces, dice, and instruction guide (one game per group of four residents, along with four playing pieces, one dice, and four instruction guides per group).

**Room Set-up and Environment:** You are encouraged to set-up the room in a way that promotes participation and provides a safe learning environment for pediatric residents. Some room set-up tips to consider include:

- Setting up tables in a “u-shaped” formation to encourage sharing.
- Greeting residents as they enter the room.
- Playing upbeat music as residents are coming in to the room.
- Providing refreshments.
The Overview of the Legislative Process: Welcome, Introductions, and Case Study:

**Trainer Note:**
- The Welcome, Introductions, and Case Study section is designed to give you the opportunity to welcome pediatric residents and quickly highlight the topic and skills that will be covered within the module. It also includes a case study or story from an actual pediatric resident that illustrates the role a pediatric resident can play in relation to the module’s advocacy topic. The purpose of the case study is to provide a familiar and comfortable format for introducing the module’s topic in a way that pediatric residents can relate to.

- The Welcome, Introduction, and Case Study section is designed to take about ten minutes total. The Welcome and Why We’re Here sections should take roughly five minutes total with the Case Study section taking another five minutes.

**Welcome**

- Welcome everyone.

- Acknowledge that pediatric residents have a lot going on in their lives right now and thank them in advance for being here today.

- Briefly introduce yourself. Some things to consider sharing include:
  - Your experience with advocacy work.
  - Why you got into your career path.
  - How you’ve personally seen advocacy improve the health and well-being of children and/or the profession of pediatrics.
  - A personal quotation that relates to the training module topic.

- Optional: If time allows, briefly ask each pediatric resident participant to share a story about why they wanted to become a pediatrician. If it is a large group, consider simply asking for a show of hands from those who have participated in advocacy before. If only a few people raise their hands, mention that advocacy simply means speaking out on your patients’ behalf or helping influence a choice or decision. Ask for a show of hands for specific advocacy activities that pediatric residents may have participated in, such as voting, writing a letter of medical necessity for a patient, calling a specialist to get a patient an earlier appointment, e-mailing a decision-maker or elected official, or talking to a friend, family member, or colleague about a children’s health issue that is important to you.

- Mention that there is a lot of wisdom and experience in the room. Encourage pediatric residents to share and participate throughout the training module.
Why We’re Here

Trainer Note:
The Why We’re Here section is meant to be included in each module. The intentional repetition is designed to help underscore the key training principles for the pediatric residency training program—that advocacy is important and doable, that pediatric residents are uniquely positioned to be powerful advocates, and that advocacy is not much different from the work pediatric residents are already doing.

Briefly share why advocacy is an important part of being a pediatrician. Some talking points include:

- Advocacy means speaking out on your patients’ behalf. Advocacy assumes that there is a problem that needs to be changed and it is a way to drive, or affect that change.

- As a pediatric resident, you are already engaged in individual advocacy. Individual advocacy describes the work you are already doing to improve the health and well-being of individual patients. This could include calling the insurance company, school, another provider, or a social service agency on behalf of an individual patient.

- Individual advocacy easily translates to the community, state, and federal level advocacy that we will talk about during today’s module. At its core, each level of advocacy is about speaking out on behalf of children’s health and well-being, whether it is for one child or for systematic solutions that benefit many children.

- Pediatricians can play a powerful role in creating lasting and meaningful change for the patients they serve. We’re here today to continue that tradition—Isaac Abt, MD, the first AAP President, said: "It should be our aim to discover neglected problems and, so far as in our power, to correct evils and introduce reform.”

Case Study

- Focus of today’s module is on the overview of the legislative process.

- Purpose of the module is to help inform you where in the legislative process you can use your voice to speak out on behalf of children’s health and wellbeing and other issues that you care about.

- Share a case study from a pediatric resident that illustrates how other pediatric residents have got involved or used the process to advocate on behalf of an issue that was important to them:
As a pediatric resident, I worked with kids in juvenile detention. Once the youth left the juvenile detention center, many were without ongoing medical treatment because they did not have health insurance. I wanted to work to get them enrolled into public health insurance programs before they were released back into the community. I saw the youth’s lack of health insurance as the first hurdle for getting them connected into medical homes.

I set up a meeting and met with a staff person from my state senator’s office in order to share this concern. I provided her with information regarding the current state of health care for youth in juvenile detention. I discussed why these kids were a group that especially needed access to health care.

My story brought home why this issue was important and why legislative change was needed. It served as the impetus behind SB1469, a piece of legislation introduced by California State Senator Gil Cedillo from Los Angeles. This legislation makes it mandatory for county juvenile halls to enroll eligible youth into public health insurance programs as part of their release protocol. The bill passed both the state senate and assembly and was signed into law by the governor. California’s adolescents in juvenile detention now have a better chance of getting plugged into a medical home upon release because of an idea I had as a resident.

Mana Golzari, M.D.

Following the case study, ask pediatricians their reactions to the case study, including what they liked about it and what surprised them about it.

Note that the case study illustrates that:

- Pediatric residents don’t need to be experts in the process or be intimately involved in policy change every step of the way. Advocacy, after all, consists of a series of steps. It often starts with just one small step. By understanding how and when to use the process—in this case meeting with her state senator’s staff—small increments of time can lead to big change on behalf of children’s health and well-being.

- Change can take time. The bill in the case study didn’t pass overnight—many people who care about children—including pediatricians, psychologists, juvenile court judges, parole officers, social workers, and lawyers—took a few minutes of their time to write, call, or e-mail their legislators in support of this bill. Some even testified publicly at the State Capitol in support of the bill. Each of these individual advocates can share in the success of this new law that further protects children’s health and well-being.
When getting started with advocacy, it is important to define success. Not all good ideas become laws. Even if an issue you care about doesn’t become a law, your advocacy raises attention to the issue and builds dialogue about children’s health and wellbeing.

By raising awareness at the local level, you might get a neighborhood or city to change. This can help children in those communities and can build a case for a statewide or national law.

As a pediatric resident, it’s important for you to remember that when you speak out or advocate on behalf of children’s health and wellbeing, decision-makers will see you as children’s health experts. Pediatric residents are powerful advocates and can effect positive change because they are credible and well-respected in the community, have compelling stories to tell, and have science on their side.

- Ask pediatric residents what issues they see in their work that they’d like to change. Write these issues on a white board or flip chart.
The Overview of the Legislative Process:
Core Concept

**Trainer Note:**
- The Core Concept section of the Overview of the Legislative Process module emphasizes the “how to” or the basic tips and information pediatric residents need to keep in mind in relationship to the module’s topic. The purpose of this section is to emphasize how the skills used in this concept relate to the skills pediatric residents use in their work everyday.

- This section includes two options for presenting the core concept:
  - A brief PowerPoint accompanied by guided group brainstorms and prompting questions that you can use to present the skills and encourage pediatric residents to share their experiences and input.
  - An alternate activity that includes a different medium for presenting the core concept. For this module, the alternative activity is the School House Rocks video, “How a Bill Becomes a Law.” The module contains a link to the video, information on where to purchase the video, as well as guided questions that follow the video.

The two options are designed to help you build flexibility into the pediatric residency advocacy training program curriculum. It allows you to pick and choose which teaching medium to use based on your time, resources, and the current needs and make-up of the pediatric resident participants.

- The Core Concept section is designed to take about 15 minutes.

**Option #1: PowerPoint and Guided Questions**

- Point out that many of the issues just shared, and that the group would like to see changed, can be addressed through legislative change.

- Note that the PowerPoint you are about to walk through focuses on how to understand and use the legislative process in order to create change for children’s health and wellbeing.

- Show PowerPoint. As you are presenting the PowerPoint, pay special attention to the notes section. The PowerPoint notes section includes key points and prompting questions to include in your presentation.

- Following the PowerPoint, ask the pediatric residents if they have questions. Spend a few minutes answering their questions.
Briefly mention that pediatric residents—acting as individual citizens—can contact decision-makers on behalf of any issue; however, they need to be careful that unless they have been given explicit permission, they should never speak on behalf of the AAP, their hospital, or their training program. When in doubt, please check with your place of employment or the AAP.

Option #2: Video: School House Rock “I’m Just a Bill”

Trainer Note:
- The School House Rock cartoon was chosen because it provides a fun and non-intimidating way to learn about the process. While the cartoon was originally created for children, we believe that pediatric residents will also enjoy the light and entertaining format.

- We suggest prefacing the video with a note that it focuses on the Congressional/federal process. State processes are similar, but have some unique nuances, including procedures, deadlines, powers, etc. Let pediatric residents know that information on their specific state’s process can be found by following the links provided through the AAP Advocacy Guide. (Pediatric residents will receive a card at the end of module with links to the AAP Advocacy Guide.)

- Point out that many of the issues just shared, and that the group would like to see changed, can be addressed through legislative change.

- Note that the video that they are about to watch focuses on how to understand and use the legislative process in order to create change for children’s health and wellbeing.

- Emphasize that the video, School House Rock “I’m Just a Bill”, is a cartoon designed to teach children about the legislative process. Explain that you are using a cartoon because it’s not important for pediatric residents to be an expert on the legislative process.

- Refer back to the case study to illustrate that the pediatric resident we heard about was not an expert on the legislative process, but rather, had a basic understanding of the decision-making process and where he/she could weigh-in to influence these decisions by telling their story.

- A basic familiarity is all you need to know about how decisions are made and when. This information can help inform you on how to best influence public policies that affect children’s health and wellbeing.

- Play video.
• After video, summarize the following points that pediatric residents should keep in mind in regards to the legislative process:

  ➢ Important to remember you don’t have to be a legislative expert to effect change.

  ➢ Decision-makers who are voting on a bill do not necessarily have health or medical backgrounds and need to hear from people who do – including pediatric residents.

• Ask the group: When are the opportune times in the legislative process to weigh-in on public policies affecting children’s health and wellbeing? (Look for coming up with the idea to have a bill, during committee hearings, before key votes, before the bill goes to the executive branch).

• Ask the group: Who should you talk to in order to help an idea become a bill, or to help a bill become a law? (Look for their own decision-makers—local, state, and federal, as well as key committee members, executive branches of government, and decision-makers in charge of setting budgets).

• Briefly mention that pediatric residents—aacting as individual citizens—can contact decision-makers on behalf of any issue; however, they need to be careful that unless they have been given explicit permission, they should never speak on behalf of the AAP, their hospital, or their training program. When in doubt, please check with your place of employment or the AAP.

• As time allows, ask the pediatric residents if they have questions. Spend a few minutes answering their questions.
The Overview of the Legislative Process: Practice

**Trainer Note:**
- The Practice section of the Overview of the Legislative Process module allows pediatric residents to practice what they have just learned and increase their comfort level with the advocacy topic in a safe, fun, interactive, and open environment.

- The practice section is designed to take about 15 minutes.

How a Bill Becomes a Law Board Game

**Trainer Note:**
Ten minutes will not likely provide enough time for residents to finish the game, but will provide a good introduction to the process. Let pediatric residents know that they may not finish the game but are encouraged to take the game, as well as the handout, with them for future reference. Consider encouraging pediatric residents to leave the game in their lounge so their colleagues can play it as well.

- Tell the pediatric residents that now that they have learned about the basics of the legislative process, they are going to have a chance to practice their new found knowledge by playing the “How a Bill Becomes a Law” board game from Families USA.

- Divide the group into teams of four people each. Give each team a “How a Bill Becomes a Law” board game, dice, and playing pieces, and take-home instruction guide.

- Ask each pediatric resident to select a game piece. Let pediatric residents know that they will be taking turns within their team to shake the dice. Once they shake the dice, they should move their game piece according to the roll. Ask them to pay special attention to places along the way where they could weigh-in on public policies that relate to children’s health and wellbeing. Let them know that they will not likely have enough time to finish the game, but playing the game will help build a greater familiarity with the legislative process and where and when they can influence the process.

- Alternatively, to demonstrate that one can become involved at any step in the process, before handing out the game, ask each resident to select a number between one and fifty. After handing out the game, ask them to place their playing piece on the square corresponding with the number they have selected.
• Tell the group that they can take the longer instruction sheet with them to reference after today. Encourage them to begin playing the game immediately and let them know it is not necessary for them to read it before they begin the game.

• After the groups have had about ten minutes to play the game, ask them to come back as a large group.

• As time permits, ask pediatric residents for their feedback on the game. Some examples of questions to ask could include:
  ➢ What did they like or dislike about playing the game?
  ➢ What made you feel hopeful about it?
  ➢ Did where you started the game change how you felt about it?
  ➢ Where were some key places that you identified you could influence health public policy?
  ➢ Who are the people who can affect whether a bill becomes a law? (Participants will likely mention elected officials, key committee members, and members of the executive branch. Remind pediatric residents that they can also affect the process by contacting decision-makers and sharing their experience and perspectives as a pediatric resident.)
  ➢ What did they learn from the game?
The Overview of the Legislative Process: Closing, Evaluation, and Opportunities

**Trainer Note:**
- The purpose of the closing, evaluation, and opportunities section is to provide closure on the module’s topic, identify action steps that pediatric residents can do next as a result of attending this training module, and gives pediatric residents a chance to evaluate the session.

- The closing and evaluation section is designed to take about five minutes.

**Closing**

- Thank pediatric residents for participating in the training module.

- Emphasize that advocacy doesn’t have to be hard or take a lot of their time. It’s really about using their voice to speak on their patients’ behalf.

- Don’t get frustrated if you don’t see immediate results. Change takes time. Know that your actions make a difference, celebrate the small steps, and stay persistent.

- Remind them that they don’t have to be experts on the legislative process. In fact, they already know everything they need to know about the decision-making process in order to influence public policies that affect children’s health and wellbeing.

- Let pediatric residents know their voice is needed in the legislative process. Pediatric residents can provide decision-makers with information and expertise in the area of children’s health and wellbeing, and also help decision-makers understand the affects of public policy by putting a human face on children’s health issues.

**Evaluation**

- Invite any final questions or observations from the group.

- Optional: If time allows, go around the room and ask each pediatric resident to share one thing that they learned today about how they can influence the legislative process or one thing they will do to influence the legislative process on behalf of a children’s health issue in the future.

- Pass out an evaluation form to each pediatric resident and ask them to fill it out and turn it in.
Opportunities

- While pediatric residents are completing their evaluations, hand out the Opportunities Worksheet that contains a list of activities that residents can do over the next month to deepen their understanding of the skills highlighted in today’s module.

- Tell pediatric residents that these opportunities were designed with their busy schedule in mind and many of them can be done in as little as five minutes.

- Consider offering an incentive or prize to residents who complete opportunities listed on the sheet. One idea is to ask residents to e-mail the opportunities they completed to you and allow a couple minutes at the beginning of the next module to recognize residents’ efforts and give them a round of applause.

- Also, hand out Quick Reference Cards with links to accompanying information and materials related to this module. Encourage pediatric residents to put this card in their pocket or wallet and access the link when they have time.

- Thank pediatric residents one last time for their time and participation at today’s module.
AAP Pediatric Residency Advocacy Training

Overview of the Legislative Process
Introduction

• You don’t need to be an expert on the legislative process, but a general familiarity can help you feel more confident and comfortable as you get started.

• Know where to go to get more information if you need it:
  – AAP Advocacy Guide
  – AAP chapter
  – AAP Division of State Government Affairs
  – AAP Department of Federal Affairs
  – AAP Community Pediatrics Training Initiative
The Legislative Process and Children’s Health Policy

• Local, state, and federal governments have processes for enacting and changing the public policies and laws that affect children’s health.

• Public policy refers to a rule, guideline, or framework and can be defined broadly. Essentially, public policy is what government, together with advocates, chooses to do or not to do. This can happen at the local, state, or federal level.

• These policies, bills, and regulations are enacted at the local, city, county, state or federal level.
Basics of Government

• Each decision-making body, whether it is local, state, or federal, has three independent components:

  – The legislative branch makes the laws. An example of the legislative branch at the local level could be a city council. An example of the legislative branch at the state and federal level includes the Senate and the House of Representatives.

  – The executive branch carries out the laws and also has the power to set budgets. The executive branch includes Mayors, Governors, and the President, as well as their cabinet members.

  – The judicial branch interprets the law. The judicial branch includes courts at all levels of government.
Overview of Local Lawmaking

- Local municipalities—including cities and counties—make laws and set budgets that affect children’s health and well-being.
  - Local counties set budgets for county hospitals and public health programs.
  - School boards can determine policies on vending machines.
  - Cities and towns can also set budgets and pass local ordinances related to child health issues, such as bike helmet safety and smoke-free areas.

- The law-making process will vary from one municipality to the next, but one thing is usually consistent—many locally elected officials have more time to respond to their constituents.
Overview of State Lawmaking

• State legislatures have become increasingly active players in the day-to-day governing of the country. In fact, state legislatures on average pass eighty state bills for every one federal bill that Congress enacts.

• State legislatures are responsible for raising enormous amounts of money through state tax revenue and coming up with new solutions to managing complex public problems.

• State legislatures create laws affecting children on issues such as the state’s Medicaid program, child abuse prevention, and safety laws.
State Lawmaking

• Each state operates under a different law-making process, however many commonalities exist among states.

• Forty-nine states have bicameral, or two-chamber legislatures. The “upper” chamber is commonly known as the senate and the “lower” chamber is known as the House of Representatives or the assembly. The exception is Nebraska, which is unicameral, or one house.

• Legislative sessions vary from state to state and year to year.

• The governor is the chief executive of a state and is responsible for the administration of the government.
Overview of Federal Lawmaking

- The federal government is responsible for passing federal legislation and appropriating funds for federal and many state programs.

- The United States Congress has two chambers—the Senate and the House of Representatives.

- Each chamber has its own leadership, its own committee structure, and its own set of rules. Senators serve six-year terms and Representatives serve two-year terms.

- Each state has two senators representing the entire state. The number of representatives for each state depends upon the state’s population. This number may change every ten years when a census is taken.
Federal Lawmaking

• Each Congress has two sessions, each lasting one year. A new Congress always begins in January of odd-numbered years. National elections occur in November of the second session of a Congress.

• The executive branch consists of the president and the various departments of the federal government.

• Each department is headed by a secretary who is a member of the president’s cabinet. A cabinet secretary not only serves as the chief administrative officer for that department, but also as an advisor to the president on policies relating to his or her department.
How A Bill Becomes a Law

• Whether you are working at the local, state, or federal level, each decision-making body has a process they go through to take an idea and turn it into a law or public policy.

• The process will differ somewhat from state to state and by municipality to municipality.

• Regardless of the exact process used in your city, county, or state, the important thing to watch for is where you can influence the process by sharing your perspective, story, and experience.

• The following slide illustrates how a bill becomes a law at the federal level.
Step 1: Someone says, “This ought to be a law…”

Step 2: Bill introduction

Step 3: Committee consideration:
Public participation encouraged!

Step 4: Committee mark-up and vote

Step 5: Floor consideration: Another good time to contact your decision-makers.

Step 6: Second Chamber (Repeat steps 1-5)

Step 7: Conference committee:
Conference committee members are good decision-makers to contact – whether they represent you or not.

Step 8: Final vote: This is another opportune time to contact your decision-maker.

Step 9: Presidential action:
Don’t forget to contact the executive branch in support of the bill.

Step 10: If signed… BILL BECOMES LAW!
Making a Difference

• You don’t have to be a legislative expert to effect change.

• Decision-makers do not necessarily have health or medical backgrounds and need to hear from people who do.

• Opportune times to weigh-in:
  – During committee hearings.
  – Before key votes.
  – During the budget process—when budget is being created by executive branch and when being adopted by legislative branch.

• Decision-makers that need to hear from you include:
  – Your own decision-maker(s).
  – Committee members and conference committee members.
  – Members of the Executive branch.
Additional Resources and Information

- AAP Advocacy Guide (www.aap.org/moc/advocacyguide)
- AAP Chapters (www.aap.org/member/chapters/chapters.htm)
- AAP Division of State Government Affairs (www.aap.org/moc/stgovaffairs)
- AAP Department of Federal Affairs (www.aap.grassroots.com)
- AAP Community Pediatrics Training Initiative (www.aap.org/commpeds/CPTI)
Overview of the Legislative Process Opportunities

The following opportunities were designed to give you a chance to incorporate skills from today's module into your professional practice. Many of these opportunities can be done in as little as 5 minutes. You are encouraged to choose opportunities that relate to your personal interests and that fit within your schedule.

Opportunities in as Little as 5 Minutes:

☐ Look up your state legislature's Web site and set it as a favorite on your computer.
☐ Look up the Congressional Web site and set it as a favorite on your computer. Links for the above sites can be found in the AAP Advocacy Guide and on the AAP Member Center.
☐ Look up your decision-maker(s) phone number and e-mail address and program it into your cell phone and/or PDA.
☐ Watch for AAP Federal Advocacy Action Network (FAAN) alerts by e-mail to learn about when your voice is needed to weigh-in on federal bills affecting children's health and the profession of pediatrics. Keep your eyes open to issues that you see affecting your patients.
☐ Check with your AAP chapter to see if they have a state advocacy e-mail alert and sign-up to receive updates.
☐ Keep your eyes open to issues affecting your patients.
☐ Leave a copy of the "How a Bill becomes a Law" board game in the lounge or general meeting place at your place of residency. Encourage your colleagues to play the game as their time allows.
☐ E-mail or call your local, state, or federal decision-maker about an issue you care about.
☐ Visit the Web site: http://www.vote-smart.org to learn about how your congresspeople stand on issues you care about.

Opportunities in Less than 30 Minutes:

☐ Find a state or federal legislative issue that is important to you and find one way that you can weigh-in to influence the process.
☐ Contact your local AAP Chapter to find out about the state and federal issues they are working on and where these bills are in the legislative process.
☐ Complete the attached advocacy leadership skills inventory to identify your personal strengths and find an advocacy activity that relates to your interests.

Opportunities in about an Hour:

☐ Tour your state capitol building or city hall to learn more about how your decision-makers work and the decision-making process.
☐ Attend a local city council, county commissioner, or state legislative hearing, or congressional townhall meeting in your area on an issue that you care about.
Advocacy Leadership Inventory

Leadership comes in many forms, some of which are easy to overlook or take for granted. As a Pediatric Resident, it is important to recognize the ways you are viewed as a leader to decision-makers and the general public, along with the many advocacy-skills you use when working with others on a daily basis. The following list can serve as a starting point for taking a comprehensive inventory of the talents and leadership potential you possess.

- Courage – the willingness to stand up for what you believe
- Persistence and determination – the ability to work hard even when things are difficult
- Passion – the ability to commit yourself wholeheartedly to what you believe
- Fearlessness – the willingness to take risks
- Community building skills – the ability to bring people together and make them feel good
- Social skills – the ability to work with many different people
- Verbal skills – the ability to communicate or persuade others either individually or in a group
- Writing skills – ability to communicate a message through writing
- Communication or Motivation skills – the ability to articulate a vision and mobilize others toward a common goal
- Analytical skills – the ability to figure out what needs to be done and how to do it
- Conflict resolution skills – the ability to help people resolve or understand differences
- Research and information gathering skills – the ability to find and use information
- Sense of humor and the ability to “roll with the punches”
- Moral commitment – a desire to change what is unfair or unjust
- Precision – ability to work with numbers and “know where things are at”
- Follow-through with details – the ability to do the little things that make the big things possible
- Accountability – willingness to hold yourself and others responsible to the task
- Inspiration – the ability to help others believe in themselves and their capacity for change
- Knowledge of political or social systems
- Access to resources – ability to find money, space, people, talent or community connections
Now that you have identified your personal strengths and leadership skills, write down 1 to 3 ways that you will use these skills to advocate on behalf of children’s health and well-being:

1.)

2.)

3.)
Instructions for How a Bill Becomes a Law Board Game

- One can become involved at any step in the legislative process. Select a game piece and number between 1 and 50.

- Place your playing piece on the square corresponding with the number you have selected.

- Take turns shaking the dice within your team. Once you shake the dice, move your game piece according to the roll. Pay special attention to places along the way where you could weigh-in on public policies that relate to children’s health and wellbeing.

- You will not likely have enough time to finish the game, but playing the game will help build a greater familiarity with the legislative process and where and when they can influence the process.

* This board game is adapted from Families USA and is available at [http://www.familiesusa.org/](http://www.familiesusa.org/)
How a Bill Becomes a Law Playing Pieces
How a Bill Becomes a Law Playing Pieces
Take Home Tips to Accompany the How a Bill Becomes a Law Board Game
(Optional)

Being an effective advocate on legislative issues also means understanding how Congress works.

We have reprinted a cartoon that depicts the legislative process as a board game. When we first looked at it, we thought it was poking fun at the process. Actually, it's a very accurate guide. It takes you step-by-step through the rules under which Congress operates. We hope it will be useful to you in understanding how a bill becomes a law.

A piece of legislation may go through all of the 53 steps shown in the cartoon (and some that aren't shown) before it becomes law. But most bills introduced in Congress do not become law. As a matter of fact, most bills don't even receive serious consideration. Getting a bill introduced is only the first step in what can be a long journey through the legislative process.

Using The Legislative Process
For advocates, there are a few steps on the Board Game to pay particular attention to:

- When bills are introduced and need cosponsors.
- When bills are being considered in committee.
- When bills come to the floor of the House and Senate for voting.

At each of these points, advocates can make effective contacts with their elected representatives.

Introducing A Bill
Ideas for bills come from many sources: constituents (such as pediatric residents), the President, lobbyists, or congressional staff. Any Senator or Representative may introduce a bill. After a bill has been written or "drafted," the member introduces it by formally presenting it to the House or Senate clerk when Congress is in session. In the House, the bill is placed in the "hopper" at the desk of the Clerk; the sponsor of the bill may or may not make a special statement about the bill when it is introduced. In the Senate, the bill may be presented to the Clerk, or the Senator may make a formal statement from the Senate floor to introduce it.

Once a bill is introduced, it is given a number: H.R. _________ (for the House of Representatives) if introduced in the House and S. _________ (for the Senate) if introduced in the Senate. Bill numbers start with H.R. 1 and S. 1 at the beginning
of each new Congress and continue in numerical order until the Congress ends two years later.

While a bill is the form used for most legislation, the House and the Senate can also originate resolutions. These are used for special purposes like budget resolutions or constitutional amendments. They are also numbered: for example, S. Con. Res. _________ (for Senate Concurrent Resolution) and H. J. Res. _________ (for House of Representatives Joint Resolution).

**Cosponsoring A Bill**

When a Senator or Representative introduces a bill, a "Dear Colleague" letter may be sent to other members. The letter explains the bill, what it would do, and why it is important, and asks other members to cosponsor it. An effort to gain cosponsors by calling attention to a bill can help build pressure to move it through the legislative process. A bill has a much better chance of passage if it is introduced by the chair or members of the committee to which it will be referred.

**Referring A Bill To Committee**

Rules of the House and Senate provide general guidelines for which committee will consider which bill. For example, a bill to change Medicare hospital reimbursement would be referred to the Finance Committee in the Senate and the Ways and Means Committee in the House. Sometimes two committees will have responsibility (or jurisdiction) over subjects in the same bill. In that case, bills may be referred to both committees ("jointly referred").

Committees are the heart and soul of the legislative process. That's where the legislative work gets done. The House and Senate each have their own system of committees, and each committee has its own subcommittees, procedural rules, and committee chair. The committee chairs play a critical role in determining the fate of legislation. They control both the schedule (calendar) of when and if bills will be considered and the staffing of the committee.

Usually, work on a bill begins in a subcommittee. The subcommittee chair calls hearings to learn more about the effects of the proposed legislation and also to find out who supports and opposes the bill. A record of the hearing is published (available to the public through the Government Printing Office). After hearings, the subcommittee will start "marking up" or rewriting the bill. If the subcommittee votes its approval, the "marked up" bill is sent to the full committee for its consideration. The full committee must then approve the bill, usually after marking it up again.

If a favorable vote is taken, the bill is "reported out" of committee. A written report, which explains the origins, purposes, content, and effect of the legislation accompanies the bill. The committee report also must include information from
the Congressional Budget Office on the bill’s estimated cost and its impact on the federal budget.

The reported bill can now be considered by the full House or Senate. If the full committee does not approve the bill, it is usually dead for the rest of that Congress. Most bills die in committee. Even if hearings are held, the committee may fail to act. Once the two-year congressional term ends, all bills that have not become law must be reintroduced to be considered again.

**Voting On A Bill**

Now, we've reached Step #11 on the gameboard: placing the bill on the House or Senate calendar. Bills that make it this far are not guaranteed passage, but they did make it through the critical first phase.

The House and Senate have different rules about how bills are presented to their respective members for debate and voting. But in each case, a schedule is set up for consideration of the bill. The schedule allows for debate and, in some instances, the opportunity to offer amendments. In the House, the Rules Committee sets up the schedule. Those steps are outlined in Steps #12-15 in the cartoon. In the Senate, the leadership (headed by the Majority Leader) sets the schedule.

When a bill is passed by one house of Congress, it is then sent to the other. Usually, it will be referred to committee in the second house. More hearings may be held, and a favorable committee report issued, or the committee may decide to take no action at all. In some cases, the committee process on a given legislative issue occurs simultaneously in the House and the Senate. A bill may pass one house while a similar companion bill is moving forward in the other house at about the same time. A bill can also be placed directly on the calendar in the other house without being referred to any committee, where it will be promptly considered by the whole Senate or House.
Conference Committee
Even after both chambers approve a bill, the legislative process has not ended. If there are any differences between the House and Senate bills (and there usually are), a conference committee is set up to iron out the differences. The conference committee consists of members of both houses (called "conferees"), who are almost always members of the committees that sent the bill to the floor. On important bills like the budget or health care reform, representatives of the House and Senate leadership are likely to be included. Conferees are supposed to deal only with differences between the House and Senate bills; they are not supposed to delete provisions that are identical in both bills or to add new provisions that don't relate to the differences between the bills. Increasingly, however, they step over these boundaries to develop a compromise that resembles neither of the original bills.
When the conference committee reaches an agreement reconciling the differences between the two bills, a conference report and a final version of the bill are presented to both houses for a final vote. Only after the House and Senate both approve the compromise is the bill sent to the President.

Signing A Bill Into Law
Once the President has received a bill passed by Congress, he may sign it into law or veto it within 10 days. He may also allow the bill to become law without a presidential signature by failing to act within 10 days (if Congress is in session). If he vetoes it, he returns it, along with a statement of his objections, to the house that originated the bill.

If a bill is vetoed by the President while Congress is in session, the members of the house that originated the legislation can vote to override the veto. If two-thirds of the members vote to override the veto, the bill then goes to the other house, where a two-thirds vote by the second house will turn the bill into law without the President's signature. If either house fails to override by a two-thirds majority, the veto stands.

* These resources taken from Families USA. They are available online at:
  □  http://www.familiesusa.org/resources/tools-for-advocates/tips/how-a-bill.html
  □  http://www.familiesusa.org/resources/tools-for-advocates/tips/board-game.html
Training Evaluation: Module #1: The Overview of the Legislative Process
AAP Pediatric Residency Advocacy Training Program

Question
• What part of the training was most valuable to you?

Content: Please rate the following aspects of your training experience according to the following scale:

1. I learned specific advocacy strategies that I will use in my advocacy efforts. _____
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

2. The training included new ideas that inspired me to action. _____
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

3. The materials will be useful to me after I leave the training. _____
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

4. The content included things I was hoping to gain in the training. _____
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree
Overview/Schedule: This module is designed to take 45 minutes. Options for additional and follow-up activities are included. A general break down of the time is as follows:

- Welcome, Introductions, and Case Study:
  - Welcome and Why We’re Here (5 minutes)
  - Case Study (5 minutes)

- Core Concept (15 minutes)

- Practice (15 minutes)

- Closing, Evaluation, and Opportunities (5 minutes)

Educational Objectives: This module is about working in partnerships. For the purpose of this training module, partnerships are defined as working with individuals, as well as groups, alliances, or coalitions to accomplish an advocacy goal. This module will help pediatric residents understand the benefits of working in partnerships and how to identify other people, organizations, or institutions that are working on similar issues. The intent of the module is:

- To help pediatric residents identify common allies and unlikely partners.

- To explore the potential roles pediatric residents can play within these partnerships and how partnerships can help them achieve their advocacy goals.

- To increase pediatric residents advocacy-related confidence and comfort level in working in partnerships.

- To demonstrate that working in partnerships to accomplish an advocacy goal is doable and can fit within the demands of a pediatric resident’s busy schedule.
**Materials and Equipment:** For this module, you will need the following handouts, materials, and equipment:

**Handouts:**
- Copies of the evaluation for each pediatric resident participating in the module.
- Copies of the Opportunities Worksheet. The Opportunities Worksheet contains a list of advocacy activities that relate to the module's topic and can be performed by pediatric residents following the module as their interest and time allows.
- Copies of the Bull’s Eye worksheet.
- Quick Reference Cards that contain instructions for looking up chapter contact information and links to additional resources.

**Equipment:**
- Flip chart or white board
- Markers/Dry erase markers for flip chart/white board
- If using PowerPoint:
  - PowerPoint projector
  - Screen or white wall for viewing PowerPoint
  - Copy of PowerPoint with trainer notes on computer or zip drive.
  - Consider inviting a representative or staff from the AAP chapter to help present this module in order to help reinforce the resources and benefits of working in partnership.
- Tower Building exercise requires four pieces of poster board, five paper plates, six drinking straws, a pair of scissors, and a roll of masking tape per group

**Room Set-up and Environment:** You are encouraged to use the room set-up to promote participation and provide a safe learning environment for pediatric residents. Consider:
- Setting up tables in a “u-shaped” formation to encourage sharing.
- Greeting residents as they enter the room and providing refreshments.
- Playing upbeat music as residents are coming in to the room.
Trainer Note:

- The Welcome, Introductions, and Case Study section is designed to give you the opportunity to welcome pediatric residents and quickly highlight the topic and skills that will be covered within the module. It also includes a “case study” or story from an actual pediatric resident that illustrates the role a pediatric resident can play in relation to the module’s advocacy topic. The purpose of the case study is to provide a familiar and comfortable format for introducing the module’s topic in a way that pediatric residents can relate to.

- The Welcome, Introductions, and Case Study section is designed to take about ten minutes total. The Welcome and Why We’re Here sections should take roughly five minutes total and the Case Study section taking another five minutes.

Welcome

- Welcome everyone.

- Acknowledge that pediatric residents have a lot going on in their lives right now and thank them in advance for being here today.

- Briefly introduce yourself. Some things to consider sharing include:
  - Your experience with advocacy work.
  - Why you got into your career path.
  - How you’ve personally seen advocacy improve the health and wellbeing of children and/or the profession of pediatrics.
  - A personal quotation that relates to the training module topic.

- Mention that there is a lot of wisdom and experience in the room. Encourage pediatric residents to share and participate throughout the training module.
**Why We’re Here**

**Trainer Note:**
The Why We’re Here section is meant to be included in each module. The intentional repetition is designed to help underscore the key training principles for the pediatric residency training program—that advocacy is important and doable, that pediatric residents are uniquely positioned to be powerful advocates, and that advocacy is not much different from the work pediatric residents are already doing.

Briefly share why advocacy is an important part of being a pediatrician. Some talking points include:

- Advocacy means speaking out on your patients’ behalf. Advocacy assumes that there is a problem that needs to be changed and it is a way to drive, or effect that change. At its core, advocacy is about speaking out on behalf of children’s health and well-being, whether it is for one child or for systematic solutions that benefit many children.

- Pediatric residents work with others everyday. The same skills you use when working with patients, hospital administrators, or insurance companies can be applied when working in advocacy partnerships. Through working together we can accomplish more than we can alone.

- Pediatricians can play a powerful role in creating lasting and meaningful change for the patients they serve. We’re here today to continue that tradition—Isaac Abt, MD, the first AAP President, said: "It should be our aim to discover neglected problems and, so far as in our power, to correct evils and introduce reform."

**Case Study**

- Focus of today’s module is on working in partnerships.

- Purpose of today’s module is to help understand how working in partnerships can advance the children’s health issues that you care about, explore the potential roles you can play within these partnerships, and identify common allies and unlikely partners to work with.

- Share a case study that illustrates how other pediatric residents have worked in partnership to advance a children’s health issue that they cared about.
During my second year of residency, smoke-free workplace legislation was emerging as an important issue in Philadelphia and I grew very interested in supporting this effort. With some prior experience in grassroots policy work and enjoyment from writing letters, I started to engage in this process. I obviously knew the public health benefits of reducing exposure to secondhand smoke, but an encounter with a patient in the emergency department really solidified my resolve: a 12-year-old girl with asthma developed a severe flare-up because she was exposed to smoke in a restaurant. This story, among others, became a powerful tool in advancing this work.

I began by writing letters-to-the-editor in support of the legislation in the local newspapers as well as to the mayor and council members. I was connected to the lead organizer for the local Breathe Free Coalition office and we began to collaborate. In particular, we worked on ways to engage physicians to speak out in support of smoke-free workplace legislation.

My professional network was a starting place and I talked to co-residents and attendings at the hospital where I was in training. Together, we wrote letters and contacted elected officials supporting the legislation. Working with the Breathe Free Coalition and other advocacy groups in the city, we wrote and distributed letters to be signed at grand rounds held in several hospitals across the city. I also sought out the specific support of doctors working on asthma and other pulmonary issues, as well as the leadership of hospitals and insurance companies.

In the process, I learned that working with partners is critically important to success. When it comes to a health-related topic, the credibility that physicians bring is often more meaningful than we realize -- and that it really does not take huge amounts of time to have your voice heard. It didn't happen overnight, but ultimately the voices of many people in our city were heard and comprehensive smoke-free legislation was passed and signed by the mayor. All of us now benefit from cleaner air -- including young patients like the girl I met in the ED years ago.

Evan Fieldston, M.D.

- Following the case study, ask pediatric residents for their reactions, including what they liked about it and what surprised them about it.
- If time allows, ask if anyone has a story of their own that they would like to share about how they worked in a partnership to accomplish something that they cared about.
- Note that the case study (and the stories shared by pediatric residents if applicable) illustrates that:
  - One pediatric resident can make a difference, but that by working in partnership, we can leverage other people’s or group’s strengths and become even more influential.
■ Working with the coalition made it easier to write and distribute sign-on letters throughout the city.

■ Other people and groups don’t differentiate between pediatricians and pediatric residents. Pediatric residents are powerful advocates and can affect positive change because they are credible and well-respected in the community, have powerful stories to tell, and have science on their side. Many groups are happy and excited to have pediatric residents involved in their efforts.

■ Advocacy can fit into the busy schedule and competing demands of pediatric residents. Getting others involved can be as simple as having a conversation with your colleagues. Many advocacy activities—such as those highlighted in the case study—can be completed within five to thirty minutes.

■ Ask pediatric residents what issues they see in their work that they’d like to change. Write these issues on a white board or flip chart. (Some examples could include mental health care, smoking laws, low-income housing, and nutritious lunches in the schools).
Working in Partnerships:  
Core Concept

**Trainer Note:**

- The Core Concept section of the Working in Partnerships module emphasizes the “how to” or the basic tips and information pediatric residents need to keep in mind in relationship to the module’s topic. The purpose of this section is to emphasize how the skills used in this concept relate to the skills pediatric residents use in their work everyday.

- This section includes two options for presenting the core concept:
  
  - A brief PowerPoint accompanied by guided group brainstorms and prompting questions that you can use to present the skills and encourage pediatric residents to share their experiences and input.
  
  - An alternate activity that includes a different medium for presenting the core concept.

The two options are designed to help you build flexibility into the pediatric residency advocacy training program curriculum. It allows you to pick and choose which teaching medium to use based on your time, resources, and the current needs and make-up of the pediatric resident participants.

Consider inviting a representative or staff from the AAP chapter to help present this module in order to help reinforce the resources and benefits of working in partnership.

- The Core Concept section is designed to take about 15 minutes.

**Option #1: PowerPoint and Guided Questions**

- Point out that the issues that were just shared affect many different people and groups and that many people—in addition to pediatric residents—care about these issues.

- Some of the people or groups who support these issues are common allies to pediatric residents or “usual suspects.”

- Choose one of the examples that were shared. Ask the group to identify the usual suspects who would likely care about this issue. Common examples include children’s advocacy organizations, children, parents, teachers, school administrators, environmental groups, other health care professionals, and social workers.
• Note that issues affect various groups differently and that sometimes an issue will also attract the support of unlikely partners. Refer back to the example and ask the group to identify unlikely partners for this issue. Some examples could include the law enforcement community, people concerned with economic development, or people within the business community.

• Note that the PowerPoint you are about to walk through focuses on how to reach out to both likely and unlikely partners.

• Show PowerPoint. As you are presenting the PowerPoint, pay special attention to the notes section. The PowerPoint notes section includes key points and prompting questions to include in your presentation.

• Following the PowerPoint, ask the pediatric residents if they have questions. Spend a few minutes answering their questions.

• Mention that the AAP chapter is an excellent place to find out about existing partnerships around children’s health and well-being. Encourage pediatric residents to contact their AAP chapter to find out about partnership efforts and resources around issues they care about.

Option #2: Book: “Swimmy” by Leo Lionni

Trainer Note:
The book “Swimmy” (Knopf Children’s Paperbacks by Leo Lionni (author) is a children’s book. It was included as an option for this module because it provides a fun and unintimidating way to talk about partnerships and helps connect advocacy to the pediatric resident’s focus on children.

• Point out that the issues that were just shared affect many different people and groups and that many people—in addition to pediatric residents—care about these issues.

• Some of the people or groups who support these issues are common allies to pediatric residents or “usual suspects.”

• Choose one of the examples that were shared. Ask the group to identify the usual suspects who would likely care about this issue. Common examples include children’s advocacy organizations, children, parents, teachers, school administrators, environmental groups, other health care professionals, and social workers.

• Note that issues affect various groups differently and that sometimes an issue will also attract the support of unlikely partners. Refer back to the example and ask the
• Note that the book you are about to read demonstrates the power that working in partnerships—whether it is common allies or unlikely partners—can bring to your cause or issue.

• Read the book aloud to the pediatric residents. Alternatively, you could ask one of the pediatric residents to volunteer to read it or pass the book around the room and let each pediatric resident read a page.

• Once the book is finished, ask pediatric residents the following questions:
  
  - What issue did Swimmy care about? (Note that we each have self interests that compel us to get involved in an issue we care about. Mention that what drives one person to get involved may be different from what motivates another. Finding out other’s self-interests is an important first step to building partnerships.)

  - What did Swimmy do to help advance his issue? (Mention that Swimmy was both pro-active as well as reactive at first. State that this is common—we might not have all the resources or answers we need at first and may need some time to think about what to do and who can help us.)

  - Did the other fish want to help Swimmy at first? What obstacles did they express were keeping them from helping right away? (Look for fear, hopelessness, and uneasiness. Mention that these are real obstacles that keep many people from getting involved.)

  - How did Swimmy eventually get the other fish to help him? (Look for responses such as: He asked them, he appealed to their self-interest, he acknowledged their fears and hesitations yet gave them reason to be hopeful and provided them help to getting started. Mention that pediatric residents can use these same skills as they approach other individuals and groups to get involved in an issue they care about. Also mention that another helpful tool is taking a few minutes to jot down what you will say when you approach potential partners— including what’s happening with your issue, what’s at risk, what can happen with their support, and what specifically they can do to help. This can be as simple as a handwritten note or a typed one pager.)

  - Ask who Swimmy’s opposition was (big tuna fish). Mention that when working on issues as important as children’s health and well-being it can be hard to imagine why others wouldn’t support your issue, much less oppose it. However, your issue will almost always be competing with other groups over resources and funding or reflect a different point of view. Building strength in numbers
Mention that the other little fish that Swimmy approached were interested in the issue because they shared a similar story or concern as Swimmy did—that makes these fish common allies or usual suspects. Ask pediatric residents to use their imagination to come up with some unlikely partners for Swimmy. Remind residents that there are no right or wrong answers—you never know who is on your side unless you ask them. Also mention that using their imagination or thinking outside the box is a good tool to use when identify potential partners for advocacy efforts.

- Summarize the discussion by noting that we all have different strengths and resources at our disposal, and just like Swimmy, we can use them to get more people or groups involved and build power in numbers.

- As time allows, ask the pediatric residents if they have questions or would like to share additional reactions to Swimmy’s story. Alternatively, you could also ask the group if they have additional examples of how one person or group accomplished something significant by working with others and getting more people involved.

- Mention that the AAP chapter is an excellent place to find out about existing partnerships around children’s health and well-being. Encourage pediatric residents to contact their AAP chapter to find out about partnership efforts and resources around issues they care about.

**Trainer Note:**
- *If your training budget allows, consider giving a copy of Swimmy to each pediatric resident to take with them.* (The book Swimmy is available at bookstores and online for around $6.99)
Working in Partnerships: Practice

Trainer Note:
- The Practice section of the Working in Partnerships module allows pediatric residents to practice what they have just learned and increase their comfort level with the advocacy topic in a safe, fun, interactive, and open environment.

- For the Working in Partnerships module, the practice centers on a tower building exercise and is designed to take about 15 minutes. A general breakdown of the timing for the tower building exercise is as follows:
  - Set-up: Dividing groups and explaining instructions (two minutes)
  - Tower building (8 minutes total)
    - One minute of silent planning.
    - Seven minutes to build tower.
  - Debrief (five minutes)

Tower Building Exercise

- Start by dividing the group of pediatric residents into small teams of four to five residents each.

- Explain that each team will get the following resources: four pieces of poster board, five paper plates, six drinking straws, a pair of scissors, and a roll of masking tape.

- Let groups know that their assignment is to build a tower out of the materials that is at least four feet tall, is self-supporting, and can withstand a light breeze.

- Tell groups that they will have eight minutes to build their tower, however during this time they are not allowed to verbally communicate with one another. Also, tell the groups that they can not begin building the tower until a full minute has passed. While they can not begin to build the tower during the first minute, they can use the minute to examine their materials and create a plan.

- Ask the groups if they have any quick questions before they get started. Once questions are answered, begin the eight minutes tower construction time. Keep track of the time and let pediatric residents know when their one minute is up and they can begin building the tower. Remind them that they can not verbally communicate with each other throughout the duration of tower building exercise.

- After the eight minutes is up, quickly test each group’s tower to make sure it is at least four feet tall, is free standing, and can withhold a light breeze.
Tower Exercise Debrief:

- Ask the groups to briefly share what happened within their group. Probe for things such as the different roles members of the group played, how they managed to communicate with each other, and how they integrated their different teammates ideas into the tower.

- Ask the groups why they think you made them wait one minute before starting to build the tower. Let them know the minute was intended for planning purposes and to examine the resources they had to work with. Ask the groups what they did in that minute. Also, ask them how that minute affected the way they built their tower or worked with one another.

- Ask the group what was hard about working in teams to build the tower. (Look for responses such as communication was challenging because we couldn’t talk, different group members had different ideas or visions about what the tower should look like or how to go about building it, and limited resources and time to build the tower.)

- Point out that these same things are true when working in partnerships – we may have limited time to spend in meetings and planning sessions, may not be able to communicate personally with each other and will need to do it over e-mail or phone, and different people may have different goals or different things that are driving them to get involved.

- Ask the group what made working in teams to build the tower successful? (Look for responses just as it was fun and had more energy than building it alone, there were different skill sets, talents, and view points to draw from, we were able to get more done with other people helping us.)

- Again, point out that these same strengths are true when working in partnerships. Mention that although working in partnerships can at times be frustrating, it is worth it in the end because the more people means more influence on behalf of the issues we care about.

- As time allows, ask pediatric residents what they will take with them from this exercise as they begin to work with different individuals and groups on their advocacy efforts.
Trainer Note:
- The purpose of the closing, evaluation, and opportunities section is to provide closure on the module’s topic, identify action steps that pediatric residents can do next as a result of attending this training module, and gives pediatric residents a chance to evaluate the session.

- The closing and evaluation section is designed to take about five minutes.

Closing
- Thank pediatric residents for participating in the training module.

- Emphasize that advocacy doesn’t have to be hard or take a lot of their time. It’s really about using their voice to speak on their patients’ behalf.

- Don’t get frustrated if you don’t see immediate results. Change takes time. Know that your actions make a difference, celebrate the small steps, and stay persistent.

- Remind them that by working with others, they can often times accomplish more and build more influence on behalf of the issues that are important to them.

- Let pediatric residents know their voice is needed when working with others. Pediatric residents can provide information and expertise in the area of children’s health and well-being, and also help put a human face on children’s health issues. Remind the residents that people outside of the hospital walls do not differentiate between pediatric residents and pediatricians and that many groups will be happy to have a pediatric resident involved.

Evaluation
- Invite any final questions or observations from the group.

- Optional: If time allows, go around the room and ask each pediatric resident to share one thing that they learned today about how they can build partnerships on behalf of the issues they care about or one thing they will do to build partnerships on behalf children’s health issue in the future.

- Pass out an evaluation form to each pediatric resident and ask them to fill it out and turn it in.
Opportunities

- While pediatric residents are completing their evaluations, hand out the Opportunities Worksheet that contains a list of activities that residents can do over the next month to deepen their understanding of the skills highlighted in today’s module.

- Tell pediatric residents that these opportunities were designed with their busy schedule in mind and many of them can be in as little as five minutes.

- Consider offering an incentive or prize to residents who complete opportunities listed on the sheet. One idea is to ask residents to e-mail the opportunities they completed to you and allow a couple minutes at the beginning of the next module to recognize residents’ efforts and give them a round of applause.

- Also, hand out Quick Reference Cards with links to accompanying information and materials related to this module. Encourage pediatric residents to put this card in their pocket or wallet and access the link when they have time.

- Thank pediatric residents one last time for their time and participation at today’s module.
AAP Pediatric Residency Advocacy Training

Working in Partnerships
Introduction

• Sometimes it’s easy to assume that just because we’re on the “right” side of an issue—such as children’s health—we will win.

• Unfortunately, being right in and of itself will not yield victory.

• Working in partnerships will help multiply the power of your advocacy efforts and build strength in numbers.

• Working in partnerships includes getting other individuals, organizations, alliances, and coalitions involved to accomplish your advocacy goal.
Building Strength in Numbers

• As a pediatrician, you are both a credible and natural advocate for children and your profession.

• However, even with compelling issues, a powerful story and ongoing advocacy, there is a greater chance of winning when you build strength in numbers.

• There are two ways to build strength in numbers:

  1.) Getting more people involved.
  2.) Getting more organizations involved.
Why Get More People Involved

• Generates hope and excitement for your issue. The more others see they are not alone, the more they will be willing to advocate and believe that a broader solution is possible.

• More people bring a broader set of skills, knowledge, and contacts.

• More people means increased pressure on decision-makers to act.

• Opposition to our issues frequently emerges. Strength in numbers is one of the best ways to counter it.
A Note on Opposition

• When working on issues as important as children’s health, it can be hard to imagine why others wouldn’t support your issue, much less oppose it.

• However, your issue will almost always be competing with other issues for resources or may reflect a different view of the best way to address the issue. Understanding the differences may help you find common ground.

• Building strength in numbers helps demonstrate to decision-makers that children’s health and well-being are a priority and support for your issue is larger and more powerful than any potential opposition’s interests.
How to Get More People Involved

• Recognize that some people may be hesitant to get involved because they are unfamiliar with advocacy.

• Start with people you already know who care about children.

• Ask people—a natural and acceptable thing to do:
  ▪ Connect your issue to other’s self-interests.
  ▪ Convey why your issue is important and why their help is needed.
  ▪ Have a concrete request and be clear about the time commitment.
Why Get More Organizations Involved

- Demonstrates that the issue has visible and wide-ranging support.
- Decision-makers more likely to respond to broader-based support.
- Organizations bring more resources (people, skills, connections).
How to Get Organizations Involved

• Choose organizations with common interests.

• Understand the organization’s processes.

• Balance resources against the challenges.

• Don’t forget about untraditional allies.
Making a Difference

• Getting more individuals and groups involved helps us win on the issues that are important to us.

• Working in partnerships helps us increase the number of people and groups working in improve children’s health and wellbeing and builds strength in numbers.

• When working with others—whether it is an individual or a group—try to understand their motivations and interests.

• Remember that partnerships can include the usual suspects as well as unlikely partners. The only way to know if someone will support your issue is by asking.
Additional Resources and Information

- AAP Advocacy Guide (www.aap.org/moc/advocacyguide)
- AAP Chapters (www.aap.org/member/chapters/chapters.htm)
- AAP Division of State Government Affairs (www.aap.org/moc/stgovaffairs)
- AAP Department of Federal Affairs (www.aap.grassroots.com)
- AAP Community Pediatrics Training Initiative (www.aap.org/commpeds/CPTI)
Working in Partnerships Opportunities

The following opportunities were designed to give you a chance to incorporate skills from today’s module into your professional practice. Many of these opportunities can be done in as little as 5 minutes. You are encouraged to choose opportunities that relate to your personal interests and that fit within your schedule.

Opportunities in as Little as 5 Minutes:

☐ Contact and join your AAP chapter.
☐ Add your AAP chapter’s Web site as a favorite on your computer.
☐ Watch for AAP Federal Advocacy Action Network (FAAN) alerts by e-mail to learn about when your voice – along with pediatrician and pediatric residents from across the country – is needed to weigh-in on federal bills affecting children’s health and the profession of pediatrics.
☐ Check with your AAP chapter to see if they have a state advocacy e-mail alert and sign-up to receive updates.
☐ Keep your eyes open for other people and groups in your area who would likely care about issues affecting your patients. Add these names and contacts to your PDA.
☐ Place the book “Swimmy” in the waiting area or treatment room of your place of residency. Use it as an opportunity to talk to parents about the importance of getting involved in groups or organizations that advocate on behalf of children’s health and well being.

Opportunities in Less than 30 Minutes:

☐ Complete the attached “bull’s eye” worksheet to help identify who might care about your issue, who might be potential unlikely partners, and who may oppose your issue and why.
☐ Do a “google search” to find advocacy organizations or community groups working on the issue you care about. Sign-up to receive updates and alerts from them or call them to see how you could get involved. Add their Web site as a favorite on your computer.
☐ Visit the AAP Member Center and read the latest State Government Affairs Issue Brief.

Opportunities in about an Hour:

☐ Set up a table outside of grand rounds with information about an issue that you care about. Ask your colleagues to support your issue by signing on to a letter of support on behalf of your issue.
☐ Attend a meeting of your AAP chapter legislative committee.
Bull’s Eye Worksheet

This simple worksheet can help you prioritize who you can easily approach to get involved in advocating on behalf of your issue specifically or children’s health and well-being generally:

- **Step One:** Think of the 3-5 individuals and groups with whom you have a direct connection and already know would be supportive of your issue. Write those down in the first ring of the Bull’s-eye. These people are your “base.” These are the first people to ask to get involved.

- **Step Two:** Think of “the next layer out” of individuals and groups in your universe — people with whom you have a direct connection, who might be interested in your issue, but are more distant than your base either because their connection is weaker or because the issue is less relevant to them. Write 3-5 groups that fall into this category in the second ring of the Bull’s-eye. These people are those you can ask to get involved once you have secured your “base.”

- **Step Three:** Think of individuals and groups you would like to see involved, but don’t necessarily have a direct connection with. These groups could include unlikely partners. Write these groups in the third and final ring of the Bull’s-eye.
Training Evaluation: Module #2: Working in Partnerships  
AAP Pediatric Residency Advocacy Training Program

Question
• What part of the training was most valuable to you?

Content: Please rate the following aspects of your training experience according to the following scale:

1. I learned specific advocacy strategies that I will use in my advocacy efforts. ___
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

2. The training included new ideas that inspired me to action. ___
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

3. The materials will be useful to me after I leave the training. ___
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

4. The content included things I was hoping to gain in the training. _____
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree
Overview/Schedule: This module is designed to take 45 minutes. Options for additional and follow-up activities are included. A general break down of the time is as follows:

- Welcome, Introductions, and Case Study:
  - Welcome and Why We’re Here (5 minutes)
  - Case Study (5 minutes)
- Core Concept (15 minutes)
- Practice (15 minutes)
- Closing, Evaluation, and Opportunities (5 minutes)

Educational Objectives: This module will emphasize the key points pediatric residents should keep in mind when working with or communicating to decision-makers. The intent of the module is:

- To define advocacy; the role it plays in improving children’s health and well-being; and the unique role pediatric residents and pediatricians can play in advocating on behalf of children.
- To provide tips and tools for communicating with decision-makers, including how to use their personal stories to educate and persuade decision-makers.
- To increase pediatric residents’ advocacy-related confidence and comfort level in working with decision-makers.
- To demonstrate that advocacy is doable and can fit within the demands of a pediatric resident’s busy schedule.
Materials and Equipment: For this module, you will need the following handouts, materials, and equipment:

Handouts:
- Copies of the Legislative Interview Simulation worksheets for each pediatric resident.
- Copies of the evaluation.
- Copies of the Opportunities Worksheet. The Opportunities Worksheet contains a list of advocacy activities that relate to the module’s topic and can be performed by pediatric residents following the module as their interest and time allows.
- Quick Reference Cards that contain instructions for looking up chapter contact information and links to additional resources.

Equipment:
- Flip chart or white board
- Markers/Dry erase markers for flip chart/white board
- If using PowerPoint:
  - PowerPoint projector
  - Screen or white wall for viewing PowerPoint
  - Copy of PowerPoint with trainer notes on computer or zip drive.

(Optional) Legislative Expert Presentation:
- If using advocacy/legislative expert presentation in place of PowerPoint:
  - Invite a supportive decision-maker or lobbyist from the residency program or AAP chapter who can participate in the module, share tips and tools that get his/her attention on issues, and can help pediatric residents understand that decision-makers want to hear from pediatric residents.
  - Prior to the module, the advocacy/legislative expert should be briefed by you in terms of what to expect from the class, background on the pediatric residents, the time allotted for their presentation, and what you are looking for in the presentation, including:
    - What type of contact and communication captures decision-makers attention.
    - Examples of contact and communication that was highly persuasive or influential.
    - Tips to keep in mind when contacting their decision-maker.
    - How a pediatric resident’s story can build support from a decision-maker and complement direct lobbying tactics.
Room Set-up and Environment: You are encouraged to use the room set-up to promote participation and provide a safe learning environment for pediatric residents. Consider:

- Setting up tables in a “u-shaped” formation to encourage sharing.
- Greeting residents as they enter the room.
- Playing upbeat music as residents are coming in to the room.
- Providing refreshments.
Working with Decision-Makers: 
Welcome, Introductions, and Case Study

Trainer Note:
- The Welcome, Introductions, and Case Study section is designed to give you the opportunity to welcome pediatric residents and quickly highlight the topic and skills that will covered within the module. It also includes a “case study” or story from an actual pediatric resident that illustrates the role a pediatric resident can play in relation to the module’s advocacy topic. The purpose of the case study is to provide a familiar and comfortable format for introducing the module’s topic in a way that pediatric residents can relate to.

- The Welcome, Introduction, and Case Study section is designed to take about ten minutes total. The Welcome and Why We’re Here sections should take roughly five minutes and the Case Study section taking another five minutes.

Welcome

- Welcome everyone.

- Acknowledge that pediatric residents have a lot going on in their lives right now and thank them in advance for being here today.

- Briefly introduce yourself. Some things to consider sharing include:
  - Your experience with advocacy work.
  - Why you got into your career path.
  - How you’ve personally seen advocacy improve the health and wellbeing of children and/or the profession of pediatrics.
  - A personal quotation that relates to the training module topic.

- Mention that there is a lot of wisdom and experience in the room. Encourage pediatric residents and others in attendance to share and participate throughout the training module.
Why We’re Here

Trainer Note:
The Why We’re Here section is meant to be included in each module. The intentional repetition is designed to help underscore the key training principles for the pediatric residency training program — that advocacy is important and doable, that pediatric residents are uniquely positioned to be powerful advocates, and that advocacy is not much different from the work pediatric residents are already doing.

Briefly share why advocacy is an important part of being a pediatrician. Some talking points include:

- Advocacy means speaking out on your patients’ behalf. Advocacy assumes that there is a problem that needs to be changed and it is a way to drive, or effect that change.

- As a pediatric resident, you are already engaged in individual advocacy. Individual advocacy describes the work you are already doing to improve the health and well-being of individual patients. This could include calling the insurance company, school, another provider, or a social service agency on behalf of an individual patient.

- Individual advocacy easily translates to the community, state, and federal level advocacy that we will talk about during today’s module. At its core, each level of advocacy is about speaking out on behalf of children’s health and well-being, whether it is for one child or for systematic solutions that benefit many children.

- Pediatricians can play a powerful role in creating lasting and meaningful change for the patients they serve. We’re here today to continue that tradition—Isaac Abt, MD, the first AAP President, said: "It should be our aim to discover neglected problems and, so far as in our power, to correct evils and introduce reform."

Case Study

- Focus of today’s module is on working with decision-makers.

- Tell pediatric residents that for the purpose of this training, decision-makers are defined as the people who have decision-making authority over the children’s health issues most important to you.

- Ask pediatric residents for examples of decision-makers. Write the responses on the flip chart or white board. Mention that decision-makers could include appointed or elected government officials (mayors, legislators, or state or federal department heads), as well as non-elected leaders of influential groups or organizations (business
- The purpose of today’s module is to help you feel more comfortable and confident in communicating with decision-makers and provide you with tips and tools on how to use your personal story to educate and persuade them.

- Share a case study that illustrates how another pediatric resident shared their personal experience and expertise with a decision-maker in order to advance a children’s health issue they cared about:

I am a third year pediatric resident and this year I, along with a few of my fellow residents, met with members of our state legislature on how proposed budget cuts to Medicaid would affect our patients. We chose this topic because most of our patients rely on some government program for their health care, and we were very passionate about helping them.

I didn’t have any prior experience with lobbying, and I didn’t know exactly what to expect. Along with my fellow residents, I received a couple of training sessions about how to lobby through our pediatric residency training program, researched the topic, and collected some patient stories. We also prepared a packet of information and scheduled legislative visits with both Democrats and Republicans working on our issue.

The experience itself was fantastic. The amazing realization I think we all had was that these powerful and important lawmakers actually work for us. Anyone can schedule a visit with them and your presence really can influence how policy is made.

All in all it was a great experience, and I think it helped us understand better how to wield our power as pediatricians to effect policy change as advocates for children.

Rebecca Dudovitz, M.D.

- Following the case study, ask pediatricians their reactions to the case study, including what they liked about it and what surprised them about it.

- If time allows, ask if anyone has a story of their own that they would like to share about a time when they worked with or communicated with a decision-maker or if they know someone else who did. Probe on what motivated them to reach out to the decision-maker and the result of the communication.
• Note that the case study illustrates that:

  ➢ Being a decision-maker does not automatically make someone an expert in children’s health. Decision-makers need to hear from peoples—including pediatric residents—in order to learn about how the decisions they make affect children’s health.

  ➢ By telling your story and sharing the experiences you see as a pediatric resident through your work, you can help decision-makers put a human face on the issue.

  ➢ Decision-makers don’t differentiate between pediatricians and pediatric residents. They look to pediatric residents as credible and well-respected children’s health experts. You are a powerful and influential advocate to decision-makers because you have compelling stories to tell and have science on your side.

  ➢ Advocacy can fit into the busy schedule and competing demands of pediatric residents. If you don’t have the time to meet with a decision-maker personally, you can still influence them by sending them an e-mail, calling them, or writing a letter on behalf of an issue you care about. Many advocacy activities, including communicating with your decision-maker—can be completed within five to thirty minutes.

• Briefly mention that pediatric residents—acting as individual citizens—can contact decision-makers on behalf of any issue; however, they need to be careful that unless they have been given explicit permission, they should never speak on behalf of the AAP, their hospital, or their training program. When in doubt, please check with your place of employment or the AAP.
Working with Decision-Makers:
Core Concept

**Trainer Note:**
- The Core Concept section of the Working with Decision-Makers module emphasizes the “how to” or the basic tips and information pediatric residents need to keep in mind in relationship to the module’s topic. The purpose of this section is to emphasize how the skills used in this concept relate to the skills pediatric residents use in their work everyday.

- This section includes two options for presenting the core concept:
  - A brief PowerPoint accompanied by guided group brainstorm and prompting questions that you can use to present the skills and encourage pediatric residents to share their experiences and input.
  - An alternate activity that includes a different medium for presenting the core concept.

The two options are designed to help you build flexibility into the pediatric residency advocacy training program curriculum. It allows you to pick and choose which teaching medium to use based on your time, resources, and the current needs and make-up of the pediatric resident participants.

- The Core Concept section is designed to take about 15 minutes.

**Option #1: PowerPoint and Guided Questions**

- Ask the group why they chose to become pediatricians. After a few pediatric residents have shared their stories, note that many of the reasons you heard stem from wanting to make a difference in the lives of children.

- Mention that sometimes this difference means providing information to parents on how to keep their children healthy and at other times, it means providing critical and life-saving treatment. The children that you have made a difference to have names and faces. They are part of the collective story of what drives you to provide the best care possible every day.

- Mention that the same stories that drive you to provide the best care to your patients are also what drive many pediatricians to get involved in advocacy efforts. For example:
  - Pediatricians don’t want to see another child with a brain injury because there are inadequate child helmet laws or enforcement in their community.
Pediatricians don’t want to see another child miss their immunizations or preventive care because of lack of affordable health insurance.

Pediatricians don’t want to limit the number of patients they see because of inadequate payment and burdensome regulations.

Your patients’ stories and your direct experience providing care put a human face on the broader advocacy issues that need to be changed in order to protect children’s health and well-being.

These stories also give pediatricians power and influence to drive change. Your story can make the issue real to decision-makers in a way that fact sheets and statistics alone do not. This personal touch can capture the attention of decision-makers and help propel your issues and concerns forward.

Note that the PowerPoint you are about to walk through focuses on how to use your story in order to communicate effectively with decision-makers.

Show PowerPoint. As you are presenting the PowerPoint, pay special attention to the notes section. The PowerPoint notes section includes key points and prompting questions to include in your presentation.

Following the PowerPoint, ask the pediatric residents if they have questions. As time allows, spend a few minutes answering their questions.

Close by encouraging pediatric residents to make an initial contact with their decision-makers. The purpose of this initial contact should be to introduce and identify themselves as a pediatrician and a resource on children’s health and well-being. Emphasize that a short introductory call begins to build a relationship and this relationship will help them down the line when they are making a request of their decision-makers.

Also, encourage pediatric residents to use their chapter as a resource when contacting their decision-makers. AAP chapters can provide pediatric residents with key messages and speaking points, helping reinforce strength in numbers by creating a consistent message. AAP chapters can also provide key background information on where their decision-maker stands on an issue and may be able prepare residents for their contact.
Option #2: Legislative Expert Presentation

- Ask the group why they chose to become pediatricians. After a few pediatric residents have shared their stories, note that many of the reasons you heard stem from wanting to make a difference in the lives of children.

- Mention that sometimes this difference means providing information to parents on how to keep their children healthy and at other times, it means providing critical and life-saving treatment. The children that you have made a difference to have names and faces. They are part of the collective story of what drives you to provide the best care possible every day.

- Mention that the same stories that drive you to provide the best care to your patients are also what drive many pediatricians to get involved in advocacy efforts. For example:
  - Pediatricians don’t want to see another child with a brain injury because there are inadequate child helmet laws or enforcement in their community.
  - Pediatricians don’t want to see another child miss their immunizations or preventive care because of lack of affordable health insurance.
  - Pediatricians don’t want to limit the number of patients they see because of inadequate payment and burdensome regulations.

- Your patients’ stories and your direct experience providing care put a human face on the broader advocacy issues that need to be changed in order to protect children’s health and well-being.

- These stories also give pediatricians power and influence to drive change. Your story can make the issue real to decision-makers in a way that fact sheets and statistics alone do not. This personal touch can capture the attention of decision-makers and help propel your issues and concerns forward.

- Mention that today a legislative expert is going to spend some time talking about what they view as the most effective ways to capture decision-makers attention and why pediatric residents’ stories are needed to help educate and persuade decision-makers.

- Briefly introduce the legislative expert.

- Give the legislative expert the floor. Encourage them to share a few examples of personal stories that persuaded or influenced decision-makers and tips to keep in mind when contacting their own decision-makers and common mistakes to avoid.
• After the legislative expert has shared a few examples and tips and tools, ask pediatric residents if they have questions for the legislative expert.

• As time permits, allow for questions and answers.

• Following the presentation, reiterate the following important points to keep in mind:
  
  ➢ Effective advocacy—or getting decision-makers to support your issue—is about letting decision-makers know what you think about the issues you care about.
  
  ➢ Through personal and ongoing contact, not only can you gain their attention, but you can ultimately build a relationship with your decision-maker that will make them more likely to support children’s health and well-being in the future.
  
  ➢ Regardless of whether you are reaching out to your elected official through an e-mail, letter, phone call, or meeting, keep in mind the following:
    
    • State you are a constituent and a pediatrician.
    
    • Make your contact personal.
    
    • Tell your story.
    
    • Include a concrete or direct “ask” in your communication.
    
    • Make regular contact.
    
    • Thank legislators for actions that are in line with the things you care about.

• Mention that their AAP chapter, along with the AAP Division of State Government Affairs and AAP Department of Federal Affairs, can help pediatric residents find out information about their decision-makers and how to contact them. Visit the State Government Affairs and Federal Affairs sites on the AAP Member Center at: http://www.aap.org/moc. Contact information is available there or by calling the national AAP office.

• Close by encouraging pediatric residents to make an initial contact with their decision-makers. The purpose of this initial contact should be to introduce themselves and offer to be a resource on children’s health and well-being. Emphasize that a short introductory call begins to build a relationship and this relationship will help them down the line when they are making a request of their decision-makers.
Working with Decision-Makers: Practice

Trainer Note:
- The Practice section of the Working with Decision-Makers module allows pediatric residents to practice what they have just learned and increase their comfort level with the advocacy topic in a safe, fun, interactive, and open environment.
- The practice section is designed to take about 15 minutes.

Legislative Interview Profiles Exercise

- Divide pediatric residents into five groups. Assign each group a legislative interview simulation.
- Explain that each group will have ten minutes to work through their assigned legislative interview scenario. Ask each group to identify the top one to three tips they found most useful from their legislative interview scenario.
- Ask the groups if they have any questions before they begin.
- Keep track of time and give groups both a five minute and two minute warning.
- After the ten minutes has passed, ask each group to quickly share back to the larger group their legislative interview scenario and one to three helpful tips for working with decision-makers that fit this scenario.
- If time permits, ask pediatric residents if they have additional questions about working with decision-makers.
- Alternatively, this exercise could be done through role play with the advocacy/legislative expert and/or other faculty playing the role of the legislator. In order for the role play to be successful, it is important to find people who are comfortable and confident playing this role.
Working with Decision-Makers: Closing, Evaluation, and Opportunities

**Trainer Note:**
- The purpose of the closing, evaluation, and opportunities section is to provide closure on the module’s topic, identify action steps that pediatric residents can do next as a result of attending this training module, and gives pediatric residents a chance to evaluate the session.

- The closing and evaluation section is designed to take about five minutes.

**Closing**

- Thank pediatric residents for participating in the training module.

- Emphasize that advocacy doesn’t have to be hard or take a lot of their time. Communicating with your decision-makers uses the same communication skills you are already using in your professional setting.

- Don’t get frustrated if you don’t see immediate results. Change takes time. Know that your actions make a difference, celebrate the small steps, and stay persistent.

- Remind them that they can be effective advocates for children’s health by telling their story to, and communicating with, their decision-makers. Pediatric residents can provide decision-makers with information and expertise in the area of children’s health and well-being, and also help put a human face on children’s health issues. Remind the residents that people outside of the hospital walls—including decision-makers—do not differentiate between pediatric residents and pediatricians.

**Evaluation**

- Invite any final questions or observations from the group.

- Optional: If time allows, go around the room and ask each pediatric resident to share one thing that they learned today about how they can share their story with decision-makers or one thing they will do to persuade their decision-maker on behalf of children’s health issues.

- Pass out an evaluation form to each pediatric resident and ask them to fill it out and turn it in.
Opportunities

- While pediatric residents are completing their evaluations, hand out the Opportunities Worksheet that contains a list of activities that residents can do over the next month to deepen their understanding of the skills highlighted in today’s module.

- Tell pediatric residents that these opportunities were designed with their busy schedule in mind and many of them can be done in as little as five minutes.

- Consider offering an incentive or prize to residents who complete opportunities listed on the sheet. One idea is to ask residents to e-mail the opportunities they completed to you and allow a couple minutes at the beginning of the next module to recognize residents’ efforts and give them a round of applause.

- Also, hand out Quick Reference Cards with links to accompanying information and materials related to this module. Encourage pediatric residents to put this card in their pocket or wallet and access the link when they have time.

- Thank pediatric residents one last time for their time and participation at today’s module.
AAP Pediatric Residency Advocacy Training

Working with Decision-Makers
Introduction

• There are many problems that affect the lives of your patients and your ability to provide care and treatment. These individual problems are often part of a broader issue.

• Many of the broader issues that children and pediatricians face can be resolved through changing community norms or systemic policy change.

• For every issue you care about, there is a decision-maker who can affect or influence the outcome.
Motivating Decision-Makers to Act

- Effective advocacy involves identifying and persuading these decision-makers to act on behalf of your issue.

- It is important to understand what motivates decision-makers:
  
  - Elected or appointed officials: Influenced by what their constituents think and value.
  
  - Community leaders: Are usually not elected, but their position and scope of influence depends on them being viewed as credible, well-liked, or fair. They are influenced by public opinion, but in a less direct way than an elected official.
Influencing Decision-Makers

• Decision-makers are influenced by personal contact and communications.

• There are many different ways to influence a decision-maker to act on behalf of a children’s health issue.

• When choosing how you want to contact your decision-maker, keep in mind that the more personal you can make your communication, the better.
The Contact Pyramid

- When choosing how you will contact your decision-maker consider:
  - The degree to which the activity is personal
  - The number of people you have to engage in the activity.
What is important to keep in mind when calling a decision-maker?
When Calling Decision-Makers

• **Plan:** Before you make the call, plan what you are going to say. Your phone call will be very brief, so keep your message simple and to the point.

• **Message:** Be sure to tell your story, why you care about children’s health, and why you need their support. Think about the key point and how your story underscores your point of view.

• **Call:** Make the call. No matter who the decision-maker is, remember to tell them that you are a pediatric resident and a resident of their legislative district and/or community.

• **Staff or Message:** If you are calling decision-maker, you may not be able to reach them directly. Be prepared to talk to staff or to leave a message instead.
What is important to keep in mind when writing a decision-maker?
When Writing to Decision-Makers

• **State that you are a pediatrician and a constituent or reside in their community:** This matters because leaders are most interested in the opinions of people who live in their area.

• **Personalize your letter:** Research shows that handwritten letters have the most impact on decision-makers. If you are basing your letter on a form letter, rewrite it and consider using your personal stationary. This also gives you the chance to include your story, which is what will have the most impact.

• **Local, local, local:** Make a strong connection between children’s health and what you and the decision-maker see in your home community.

• **Show restraint:** Keep your letter brief—one to one-and-half pages at most.
What to Include in a Advocacy Letter

• Dear Senator/Representative __________.

• **Opening Paragraph:**
  – States the subject of the letter.
  – Gives the bill number or name, if available.
  – Identifies the writer and their connection to children’s health.

• **Body of Letter:**
  – Explains the issue simply and factually.
  – Gives a local example of potential effects.
  – Clearly states support for or opposition to the bill.
  – Is polite and non-threatening.
  – Thanks the elected official for their attention to the issue.
  – Offers to provide more information on request.
  – Asks for a reply.
What is important to keep in mind when e-mailing a decision-maker?
When E-mailing Decision-Makers

- In the subject line of the message, state that you are a pediatric resident and member of their community: This strategy will increase the likelihood that your message is read. (For example—Subject: Message from a constituent and pediatric resident.)

- If the e-mail is mass-produced, modify it: It doesn’t take much time to insert your personal story and perspective, and it makes a big difference in making your e-mail credible rather than “canned.”

- Follow up: Because e-mail is a more casual and often a mass-produced mode of communication, be sure that you are using other methods to persuade decision-makers. Follow your e-mail with a phone call, handwritten letter or visit.
What is important to keep in mind when meeting with a decision-maker?
Meeting with your elected official gives you the chance to interact with him or her in a way that is not possible through a letter or e-mail.

- **Before the meeting:** Plan out what you are going to share, including why you care about the issue and how it affects other people they represent. Be sure to include a direct ask.

- **During the meeting:** Allow time for dialogue and invite questions.

- **After the meeting:** Thank the decision-maker for their time and let them know how they can reach you should they have questions. Send a thank you note, e-mail, or fax.
Additional Tips to Keep in Mind

• You don’t need to be an expert in all of the technicalities of the issue that you are advocating for.

• You only need to be an expert in your story—how the problem affects your patients and/or your profession and how the solution can bring about meaningful and direct change.

• Communicating with a decision-maker is not much different from the communication you use every day.

• Follow-up and repeated contact makes a difference. Send your decision-maker supporting information or work with your chapter to get them what they need.
In Summary

• Effective advocacy—or getting decision-makers to support your issue—is about letting decision-makers know what you think about the issues you care about.

• Through personal and ongoing contact, not only can you gain their attention, but you can ultimately build a relationship with your decision-maker that will make them more likely to support children’s health and well-being in the future.
Making a Difference

• Regardless of whether you are reaching out to your elected official through an e-mail, letter, phone call, or meeting, keep in mind the following:
  – State you are a constituent.
  – Make your contact personal.
  – Tell your story.
  – Include a concrete or “direct” ask in your communication.
  – Thank them. Follow up and make repeated contact.
Additional Resources and Information

- AAP Advocacy Guide ([www.aap.org/moc/advocacyguide](http://www.aap.org/moc/advocacyguide))
- AAP Chapters ([www.aap.org/member/chapters/chapters.htm](http://www.aap.org/member/chapters/chapters.htm))
- AAP Division of State Government Affairs ([www.aap.org/moc/stgovaffairs](http://www.aap.org/moc/stgovaffairs))
- AAP Department of Federal Affairs ([www.aap.grassroots.com](http://www.aap.grassroots.com))
- AAP Community Pediatrics Training Initiative ([www.aap.org/commpeds/CPTI](http://www.aap.org/commpeds/CPTI))
Working with Decision-Makers Opportunities

The following opportunities were designed to give you a chance to incorporate skills from today’s module into your professional practice. Many of these opportunities can be done in as little as 5 minutes. You are encouraged to choose opportunities that relate to your personal interests and that fit within your schedule.

Opportunities in as Little as 5 Minutes:

☐ Call your decision-maker and introduce yourself. Let them know you are available as a children’s health resource.
☐ Contact your AAP chapter to find out where your decision-maker stands on a children’s health issue that is important to you.
☐ Watch for the AAP Federal Advocacy Action Network (FAAN) alerts by e-mail to learn about when your voice is needed to contact decision-makers on federal bills affecting children’s health and the profession of pediatrics.
☐ Check with your AAP chapter to see if they have a state advocacy e-mail alert and sign-up to receive updates.
☐ E-mail your decision-maker on behalf of an issue that you care about.
☐ Recruit a like-minded friend, family member, or colleague to call or e-mail a decision-maker on behalf of an issue you care about.

Opportunities in Less than 30 Minutes:

☐ Write a letter to your decision-maker on behalf of an issue you care about.
☐ Find a story from your work or from your patients lives that you could share with a decision-maker.
☐ Discuss with your faculty mentor ways in which to present the story to your decision-maker.

Opportunities in About an Hour:

☐ Meet with your decision-maker on behalf of an issue that is important to you. Consider inviting your faculty mentor or others from your program to join you.

Opportunities in Less than a Day:

☐ Attend your AAP chapters “Day at the Capitol” event.
☐ Invite a decision-maker to tour your place of work or attend grand rounds.
Module #3: Working with Decision-Makers
Legislative Visit Handouts

Legislative Visit Scenario #1: “Don’t Call Us, We’ll Call You”
The decision-maker (and/or staff) listens carefully and asks few or no questions. When you ask about his/her position, you are told he/she will think about your comments. You are thanked politely for your time. This is a totally noncommittal meeting.

What do you do?
First, you should realize this is probably the single most common type of legislative meeting. Nor is it a bad one. You have established who you are, whom you represent, what the issue is, and what your position is. For some meetings, this is as much as you can expect or hope to accomplish.

But you can do more.
- First, respect the fact that the decision-maker has not made a decision; don’t try to press him/her for a commitment he/she is not ready to make.
- Do ask questions to find out what forces might influence the decision. For example, are there other active constituent groups in the district that could influence – either positively or negatively – the passage of the legislation.
- Build your case – cite the impact on the pediatric population in your community or district. Cite other supporting groups.
- Discern the level of grassroots pressure. For example, you might find out whether mail has been received and, if so, is it for or against your position. Also, try to discover if he/she has been contacted by other groups.
- Always ask whether you can provide additional information. The single most persuasive document you can provide is a one-page fact sheet outlining how this bill will directly affect your state or district. Other useful information could include a list of cosponsors, especially in the decision-maker’s party. (Your local AAP chapter may be able to provide you with this information).
- Always leave your name, address, and phone number (if you don’t have a business card, write this on the fact sheet you leave) and the phone number for the local AAP chapter office.
- Talk about another issue – briefly. Don’t waste time. This is a good time to discover his/her interests and other information which could provide the personal touch that adds to the relationship. You might be surprised to learn how much you have in common.

As with any important meeting, follow-up is crucial. This is particularly true for the undecided. Write a thank you letter, including any information requested at the meeting. For the undecided, it is also helpful to get others to write and/or phone the decision-maker to urge him/her to support your position.
Legislative Visit Scenario #2: “I’m New” or “I Don’t Know Anything about Children’s Health.”

Although this might happen when you meet with your decision-maker, it is more likely to happen with staff. Many staff – particularly those in the personal offices (with whom you will meet most often) – are young and may know little about children’s health issues. In fact, unless your decision-maker sits on a key health committee, don’t expect the staff to know much about the issue. Decision-makers, as well as their staff cannot be experts on all issues.

Alternately, there are also times when it’s to your advantage to meet with staff. Some staff specialize in children’s health and may have more time to spend on the issue. The congressperson also listens to their staff and looks to them for information. If you can begin to build a relationship with staff, then you can likely get them to gain the congressperson’s attention.

But contrary to what you think, this is not bad news!

This is the best time to begin to develop your position as a valuable resource to decision-makers and their staff – the expert on child health issues. Best of all, you are an expert from back home rather than an “insider.” You are the constituent on whom they can rely for accurate information, even when it is very technical. You become an asset; you can make them look good; you can make his/her job easier.

- Start with the basics. State who you are, what type of pediatrics you practice, where your office or hospital is. Tell them who and what the Academy is.
- Give simple information on the issue or issues. Material pertinent to your state or district is particularly valuable.
- Don’t use medical jargon. Assess level of comprehension. Don’t talk down.
- Let them ask questions. In fact, encourage them do so. And treat all questions seriously.
- In addition to the follow-up outlined previously, do what you can to develop the relationship. Letters, phone calls, and visits are all tools to use.
- Remember, new staff becomes experienced staff. Personal staff can and do move to committee assignments. If you encourage an interest in health, he/she could become a good friend in future years.
Legislative Visit Scenario #3: “I Agree” or “Preaching to the Choir”
After you introduce the issue, you are told that the decision-maker agrees with your position.

Great! Now what?
Instead of ending the conversation right then and there, you can use this opportunity to establish your position and to gather information.

- First, don’t waste time, but do ensure that there is a commitment at this time.
- Ask if the decision-maker is a cosponsor (if there is a bill) or would he/she be willing to sponsor, cosponsor, or introduce the bill (if there isn’t one already).
- Ask if more information would be helpful, particularly relative to how this issue affects your community, state, district, or how many children would be affected. If more information is needed, try to get a specific idea of what would be helpful without overloading them. (Your AAP chapter may be able to provide you with the additional information you’re looking for.)
- Ask if they know other decision-makers who should be approached.
- Ask what they are hearing in support and opposition to the issue.
- Ask about other organizations that support/oppose the decision-maker’s position.
- Ask if you or the Academy can help solidify support or identify the opposition.

Follow-up to this meeting may not be as difficult as with scenario two, but you will need to keep lines of communication open, so that you can be useful as the expert resource.

Legislative Visit #3A: “I Agree, But….”
This is a variation of the #3, but with a twist. You may hear many excuse at the end of “I agree, but…..”, including, “there is no money, so how can we…?”

Don’t let this throw you!
You may not have all the answers; the Academy may not have all the answers. But, find out what the objections are and how the decision-maker can be satisfied. If you cannot supply the answers at the meeting, ensure them you will find out more information and get back to them soon.
Legislative Visit Scenario #4: “That is Not My Position” or “I Disagree” (Politely)

After opening the discussion and presenting your issue, the decision-maker or staff tells you politely he/she disagrees with your position.

The conversation does not necessarily end here.

First, this happens rarely. Decision-makers do not like to directly disagree with constituents. Try the following tactics:

- Find out why there is disagreement. Time can be wasted by trying to argue against misconceptions. If you find out that he/she has misconceptions, you can respond to them, presenting facts about the needs of the children in your community, state, or district, and how the legislation will affect them.
- Attempt to discern whether the problem is the issue of politics, for example, competing interests from a key constituency or pressure from the decision maker’s colleagues or party leaders. Lack of understanding about the issue can be handled with facts. Politics are a different story. A clue that this is the case is that it does not appear that there is an understandable reason (from your perspective) why the decision-maker takes a particular stand.
- Listen carefully. Don’t dismiss criticisms and opposition automatically. There may be a solid basis for his/her opposition. You may need to gather more information and facts to present at a different time. You could win points just because you listened seriously to his/her comments. Time also gives you the opportunity to judge the depth of the opposition.
- Don’t try to negotiate during the initial meetings. Time should be taken to carefully consider his/her position and yours and whether his/her concerns can be addressed.

After the meeting, analyze how what you learned can be used or diffused. Draw upon expertise of others in your chapter and the Academy staff.

An extra postscript is needed here: Don’t debate issues involving ideology, morals, or religious issue (i.e. bioethics, AIDS). If it appears a position has been taken due to ideological or religious grounds, just file that knowledge away. There are other, better, venues for a debate.
Legislative Visit Scenario #5: “I Disagree with Everything You Say, And…”
The adversarial visit is the one you are really worried about, but it almost never happens – honestly!

Decision-makers and their staff may disagree with you, but they will not attack you or your position. In fact, they do not like to disagree with you at all. Remember, you are a constituent.

But, just to round out this exercise, say you do walk into a visit and discover you are in hostile territory. The other person essentially takes charge of the meeting and disputes everything you have tried to say.

What do you do?
- Keep calm. If you are meeting with staff, try to determine whether this is a personal opinion or the position of the decision-maker. If it is the opinion of the staff, a meeting with the decision-maker might be the next step.
- End the meeting as soon as possible.
- You will need to be in contact with the decision-maker again, but you may need reinforcements. Reinforcements may be information, other members of your chapter, the AAP, or finding the right contact that can talk to him/her.
Training Evaluation: Module #3: Working with Decision-Makers
AAP Pediatric Residency Advocacy Training Program

Question:
- What part of the training was most valuable to you?

Content: Please rate the following aspects of your training experience according to the following scale:

1. I learned specific advocacy strategies that I will use in my advocacy efforts.  
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

2. The training included new ideas that inspired me to action.  
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

3. The materials will be useful to me after I leave the training.  
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

4. The content included things I was hoping to gain in the training.  
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree
Overview/Schedule: This module is designed to take 45 minutes. Options for additional and follow-up activities are included. A general break down of the time is as follows:

- Welcome, Introductions, and Case Study:
  - Welcome and Why We’re Here (5 minutes)
  - Case Study (5 minutes)

- Core Concept (15 minutes)

- Practice (15 minutes)

- Closing, Evaluation, and Opportunities (5 minutes)

Educational Objective: This module will explore how pediatric residents can craft their message and use broader mediums for communicating their message in order to advocate on behalf of children’s health. The intent of the module is:

- To define advocacy communication; the role it plays in bringing attention to children’s health and wellbeing; and how pediatric residents are uniquely positioned to use advocacy communications on behalf of children.

- To provide pediatric residents with the tips and tools for crafting their advocacy message.

- To increase pediatric resident’s confidence and comfort level in using advocacy communication strategies, such as giving a speech, making a presentation, writing a letter to the editor, or using a newsletter or Web site to get their advocacy message out and build support for children’s health.

- To demonstrate that advocacy is doable and can fit within the demands of a pediatric resident’s busy schedule.
**Materials and Equipment:** For this module, you will need the following handouts, materials, and equipment:

**Handouts:**
- Copies of the evaluation for each pediatric resident participating in the module.
- Copies of the Opportunities Worksheet. The Opportunities Worksheet contains a list of advocacy activities that relate to the module’s topic and can be performed by pediatric residents following the module as their interest and time allows.
- Quick Reference Cards that contain instructions for looking up chapter contact information and links to additional resources.

**Equipment:**
- Flip chart or white board
- Markers/Dry erase markers for flip chart/white board
- If using PowerPoint:
  - PowerPoint projector
  - Screen or white wall for viewing PowerPoint
  - Copy of PowerPoint with trainer notes on computer or zip drive.
- If using AAP press articles or position papers in place of PowerPoint:
  - Copies of recent AAP press articles and position papers.
  - One-pagers on a recent and timely children’s health issue. Every congressional session the AAP Department of Federal Affairs creates fact sheets/position papers on the top child health issues. These can be found at: [http://www.aap.org/advocacy](http://www.aap.org/advocacy), select child health issues.
  - If resources permit, a video camera for recording the PSA (Public Service Announcements).

**Room Set-up and Environment:** You are encouraged to use the room set-up to promote participation and provide a safe learning environment for pediatric residents. Consider:
- Setting up tables in a “u-shaped” formation to encourage sharing.
- Greeting residents as they enter the room.
- Playing upbeat music as residents are coming in to the room.
- Providing refreshments.
Advocacy Communications: Welcome, Introductions, and Case Study

Trainer Note:
• The Welcome, Introductions, and Case Study section is designed to give you the opportunity to welcome pediatric residents and quickly highlight the topic and skills that will be covered within the module. It also includes a “case study” or story from an actual pediatric resident that illustrates the role a pediatric resident can play in relation to the module’s advocacy topic. The purpose of the case study is to provide a familiar and comfortable format for introducing the module’s topic in a way that pediatric residents can relate to.

• The Welcome, Introduction, and Case Study section is designed to take about ten minutes total. The Welcome and Why We’re Here sections should take roughly five minutes and the Case Study section taking another five minutes.

Welcome

• Welcome everyone.

• Acknowledge that pediatric residents have a lot going on in their lives right now and thank them in advance for being here today.

• Briefly introduce yourself. Some things to consider sharing include:
  ➢ Your experience with advocacy work.
  ➢ Why you got into your career path.
  ➢ How you’ve personally seen advocacy improve the health and wellbeing of children and/or the profession of pediatrics.
  ➢ A personal quotation that relates to the training module topic.

• Mention that there is a lot of wisdom and experience in the room. Encourage pediatric residents to share and participate throughout the training module.

Why We’re Here

Trainer Note:
The Why We’re Here section is meant to be included in each module. The intentional repetition is designed to help underscore the key training principles for the pediatric residency training program—that advocacy is important and doable, that pediatric residents are uniquely positioned to be powerful advocates, and that advocacy is not much different from the work pediatric residents are already doing.
Briefly share why advocacy is an important part of being a pediatrician. Some talking points include:

- Advocacy means speaking out on your patients’ behalf. Advocacy assumes that there is a problem that needs to be changed and it is a way to drive, or effect that change.

- As a pediatric resident, you are already engaged in individual advocacy. Individual advocacy describes the work you are already doing to improve the health and well-being of individual patients. This could include calling the insurance company, school, another provider, or a social service agency on behalf of an individual patient.

- Individual advocacy easily translates to the community, state, and federal level advocacy that we will talk about during today’s module. At its core, each level of advocacy is about speaking out on behalf of children’s health and well-being, whether it is for one child or for systematic solutions that benefit many children.

- Pediatricians can play a powerful role in creating lasting and meaningful change for the patients they serve. We’re here today to continue that tradition—Isaac Abt, MD, the first AAP President, said: “It should be our aim to discover neglected problems and, so far as in our power, to correct evils and introduce reform.”

**Case Study**

- Focus of today’s module is on advocacy communications.

- Share that for the purpose of today’s training, advocacy communications refers to the intentional use of any type of media or communication mechanism to bring about awareness and, eventually, change, on behalf of your issue.

- Explain that the best way to help people understand why your issue is important is to tell them a story about the real people affected by it. Advocacy communications allows you to share your story with a broader audience than is possible through person-to-person strategies alone.

- The purpose of today’s module is to demonstrate how you can use media and communication vehicles to tell your story and effect change.

- Share a case study that illustrates how another pediatric resident used an advocacy communications tool in order to advance a children’s health issue they cared about:
As a second year resident, I participated in a round table discussion with the associate editor of the LA Times to learn more about media advocacy. The associate editor gave us tips for telling an effective story and told us about how the media can be a powerful tool for helping us effect change on behalf of our patients.

The round table discussion inspired me to write an op-ed article about an issue I cared about. I had been collecting survey data from other residents about their views on health disparities. I was learning that many residents don’t get formal training on how to advocate for our patients with service providers or connect our patients with vital community resources that can begin to address health disparities.

The LA Times decided to publish my op-ed article. The published article helped generate discussions at my place of residency and the county hospital about creating a training program that would better help residents and physicians advocate for their patients and link them with other resources as it relates to health disparities.

Not only did the op-ed piece help effect change around health disparities training, but a clinic I was interested in working at contacted me after reading my op-ed article and offered me a job.

Dr. Rishi Manchanda, M.D.

- Following the case study, ask pediatricians their reactions to the case study, including what they liked about it and what surprised them about it.

- If time permits, ask if anyone has a story of their own that they would like to share about how they used a media or communications tool to bring about awareness on behalf of an issue they cared about or know someone who did. Probe on what motivated them to use media and communications as a vehicle to create awareness and what was the result of the communication.

- Note that the case study illustrates that:
  
  - Communications and media allowed the pediatric resident to get their message out to more people than they could have done through word of mouth alone.
  
  - The media can be a powerful and compelling tool to creating change on behalf of issues pediatric residents care about.
The media, decision-makers, and the general public—all potential targets of advocacy communications—don’t differentiate between pediatricians and pediatric residents. They look to pediatric residents as credible and well-respected children’s health experts. Media, decision-makers, and the general public all care about what you have to say because you have both powerful stories to tell and science on your side.

Advocacy communications can fit into the busy schedule and competing demands of pediatric residents. Many advocacy communication activities, including writing an op-ed article or a letter to the editor, can be done in under an hour.

Briefly mention that pediatric residents should not represent themselves to the media as spokespeople of the AAP, their AAP chapter, or their hospital without prior approval from the AAP communications office, their AAP chapter leadership, or their hospital public relationships office. However they can represent themselves as individual pediatricians representing their own issues or opinions. When in doubt, please check with your place of employment or the AAP chapter.
Advocacy Communications: Core Concept

Trainer Note:
- The Core Concept section of the Advocacy Communications module emphasizes the “how to” or the basic tips and information pediatric residents need to keep in mind in relationship to the module’s topic. The purpose of this section is to emphasize how the skills used in this concept relate to the skills pediatric residents use in their work everyday.

- This section includes two options for presenting the core concept:
  - A brief PowerPoint accompanied by guided group brainstorms and prompting questions that you can use to present the skills and encourage pediatric residents to share their experiences and input.
  - An alternative activity that includes a different medium for presenting the core concept.

The two options are designed to help you build flexibility into the pediatric residency advocacy training program curriculum. It allows you to pick and choose which teaching medium to use based on your time, resources, and the current needs and make-up of the pediatric resident participants.

- The Core Concept section is designed to take about 15 minutes.

Option #1: PowerPoint and Guided Questions

- State again that media and communications advocacy refers to the intentional use of any type of media or communication mechanism to bring about awareness and, eventually, change, on behalf of your issue.

- Ask pediatric residents for examples of media or communication tools. (Examples could include newsletter or newspaper articles, letters to the editor, an internet blog, or an appearance on the local news, Web sites, social networking sites, e.g. YouTube, or commercials).

- Write the examples on a flip chart or white board. State that these are all great examples of media and communication tools that can be used by pediatric residents to build support and awareness for the issues you care about.

- Note that the PowerPoint you are about to walk through focuses on how to use these tools to get your message out.
• Show PowerPoint. As you are presenting the PowerPoint, pay special attention to the notes section. The PowerPoint notes section includes key points and prompting questions to include in your presentation.

• Following the PowerPoint, ask the pediatric residents if they have questions. As time allows, spend a few minutes answering their questions.

• Mention that AAP has dedicated staff and resources available to assist pediatric residents and their chapter with a variety of media and communication activities and has sample messages and templates available. Share link to AAP Member Media Center: http://www.aap.org/moc/pressroom/pressroom.htm and contact information for the AAP Department of Communication (commun@aap.org).

Option #2: AAP Press Articles or Position Papers

• State again that media and communications advocacy refers to the intentional use of any type of media or communication mechanism to bring about awareness and, eventually, change, on behalf of your issue.

• Ask pediatric residents for examples of media or communication tools. (Examples could include newsletter or newspaper articles, letters to the editor, an internet blog, or an appearance on the local news, Web sites, social networking sites, e.g. YouTube, or commercials).

• Write the examples on a flip chart or white board. State that these are all great examples of media and communication tools that can be used by pediatric residents to build support and awareness for the issues you care about.

• Emphasize that no matter what media and communication tools pediatric residents choose to use, it is important to keep in mind two important things:
  - Your message.
  - How you deliver your message.

• State that your message is the core statement of why your issue is important and should be the underpinning of all your media and communications work. Write this definition on the flip chart/white board.

• Emphasize that effective messages: Write these points on the flip chart/white board as well.
  - Create consistency in the way your issue is talked about and cuts across the many stories that relate to your issue.
- Easily understood and can be internalized and repeated by others.
- Convince people that your issue is something they can support.

- Divide pediatric residents into small groups of four to five people each. Give each group a copy of AAP position paper. Go to http://www.aap.org/org/advocacy.html and select Child Health Issues under Federal Advocacy.

- Let the groups know that they will have ten minutes to:
  - #1: Identify the message.
  - #2: Identify what makes the message memorable.
  - #3: Identify what makes the message persuasive.
  - #4: Identify how the press article or position paper was able to repeat the message.
  - #5: Find the human story within the article.

- Circulate around the room while the pediatric residents are working in small groups. Make yourself available to answer their questions.

- If time permits, ask a representative from each group to briefly report back to the larger group by sharing the main message from their press article or position paper.

- Thank each group for their work and if time permits, answer remaining questions.

- Mention that AAP has dedicated staff and resources available to assist pediatric residents and their chapter with a variety of media and communication activities and has sample messages and templates available. Share link to AAP Member Media Center http://www.aap.org/moc/pressroom.htm and contact information for the AAP Department of Communication (commun@aap.org). There you will find links to:
  - In the Media Spotlight
  - Sample Editorials
  - Speaker Ready Room
  - Award News Release Templates
  - Sample Letters to Editor
  - Questions & Answers
  - Speaking Points
  - AAP Spokesperson
  - AAP Fact Sheet
  - PR Handbook
  - Television Dress Guidelines
  - Contact Info
Advocacy Communications:  
Practice

Trainer Note:
• The Practice section of the Advocacy Communications module allows pediatric residents to practice what they have just learned and increase their comfort level with the advocacy topic in a safe, fun, interactive, and open environment.

• The practice section is designed to take about 15 minutes.

Developing PSA’s (Public Service Announcements)

• Divide pediatric residents into four to five small groups.

• Assign each group a relevant and timely children’s health issue. Give each group a briefing sheet that contains background information and statistics on the health issue.

• Let groups know that their job is to create a one minute PSA on the children’s health issue.

• Their PSA should have a clear and concise message, be memorable and persuasive, and include intentional repetition. Pediatric residents should also look for opportunities within their PSA to include a personal story and let others know how they can get involved.

• Groups will have ten minutes to create their PSA and then will perform their PSA in front of the larger group.

• If time permits, invite feedback from pediatric residents about what elements from each PSA were the strongest and what they would do differently next time.

Trainer Note:
• Consider videotaping the PSAs and posting them on hospital Web site, sharing them with the AAP or AAP chapter, or posting on YouTube. Encourage pediatric residents to go to these sites to see their PSAs and forward the link to their friends, family members, or colleagues.
Advocacy Communications:  
Closing, Evaluation, and Opportunities

Trainer Note:
- The purpose of the closing, evaluation, and opportunities section is to provide closure on the module’s topic, identify action steps that pediatric residents can do next as a result of attending this training module, and gives pediatric residents a chance to evaluate the session.

- The closing and evaluation section is designed to take about five minutes.

Closing
- Thank pediatric residents for participating in the training module.
- Emphasize that advocacy doesn’t have to be hard or take a lot of their time, in fact, crafting a message is much like the communication skills you are already using with your patients and their families.
- Don’t get frustrated if you don’t see immediate results. Change takes time. Know that your actions make a difference, celebrate the small steps, and stay persistent.
- Remind them that one way they can be effective advocates for children’s health is by using media and communication mechanisms to get their message out to a broader audience. As pediatric residents, they are viewed as respected and credible members of the community and their message will be viewed as credible as well. Remind the pediatric residents that people outside of the hospital walls—including decision-makers, the media, and the general public—do not differentiate between pediatric residents and pediatricians.

Evaluation
- Invite any final questions or observations from the group.
- Optional: If time allows, go around the room and ask each pediatric resident to share one thing that they learned today about how they can craft their message or one thing they will do to get their message out to a broader audience on behalf of children’s health and wellbeing.
- Pass out an evaluation form to each pediatric resident and ask them to fill it out and turn it in.
Opportunities

- While pediatric residents are completing their evaluations, hand out the Opportunities Worksheet that contains a list of activities that residents can do over the next month to deepen their understanding of the skills highlighted in today’s module.

- Tell pediatric residents that these opportunities were designed with their busy schedule in mind and many of them can be done in as little as five minutes.

- Consider offering an incentive or prize to residents who complete opportunities listed on the sheet. One idea is to ask residents to e-mail the opportunities they completed to you and allow a couple minutes at the beginning of the next module to recognize residents’ efforts and give them a round of applause.

- Also, hand out Quick Reference Cards with links to accompanying information and materials related to this module. Encourage pediatric residents to put this card in their pocket or wallet and access the link when they have time.

- Thank pediatric residents one last time for their time and participation at today’s module.
AAP Pediatric Residency Advocacy Training

Advocacy Communications
Media Advocacy and Communication Defined

- *Intentional* use of any type of media or communication mechanism to bring about awareness and change on behalf of your issue.

- **Media advocacy**: Using media (newspapers, magazines, television, radio, and internet) to reach broader audience in order to build awareness on behalf of your issue and gain more attention from decision-makers.

- **Communications advocacy**: Broad term that describes any material and mechanism (other than the media) used to create awareness around your issue, get others involved, or influence decision-makers. Examples could include making a guest presentation to a group or organization or hosting an informational table at a public event.
Why Media Advocacy and Communications

• Persuades decision-makers to act because they believe public is paying attention.

• Increases likelihood that more people will get involved because they are aware of issue and how they can help change circumstances affecting the children they know and care about.

• Establishes credibility on behalf of your issue by demonstrating how that issue affects many people and deserves the public’s attention.
Media Advocacy and Communications Pointers

Two important things to keep in mind when using media and communications to advance your issue:

1. Your message.

2. How you deliver your message.
Your Message

- Your message is the core statement of why your issue is important and should be the underpinning of all your media and communications work.

- Effective messages:
  - Create consistency in the way your issue is talked about and cuts across the many stories that relate to your issue.
  - Easily understood and can be internalized and repeated by others.
  - Convince people that your issue is something they can support.
Crafting Your Message

• Essentially, your message is what follows “because”. Consider the following example of a message:

  “Medicaid is an indispensable health program because it provides health insurance coverage to over 26 million low-income children who otherwise wouldn’t have access to critical and much needed health care services.”

• This message makes the case about the importance of Medicaid funding. Your personal experiences and stories of working with children who are uninsured can then help support this message.
Creating an Effective Message

• Consider the following points as a guide to creating an effective message:
  – Clear.
  – Concise.
  – Memorable and relatable.
  – Persuasive.
  – Repeat, Repeat, Repeat.
How to Deliver Your Message

• Combine your message with personal stories to illustrate the importance of your message and put a human face on issue.

• Connect your message to what is happening locally.

• Highlight solutions and inform others of how they can help bring about a solution.
Making a Difference

• Remember to consider 1.) your message, and 2.) how you deliver your message when using media and communications to advance your issue.

• Effective messages:
  – Create consistency in the way your issue is talked about and cuts across the many stories that relate to your issue.
  – Are easily understood and can be internalized and repeated by others.
  – Convince people that your issue is something they can support.
Additional Resources and Information

- AAP Advocacy Guide (www.aap.org/moc/advocacyguide)
- AAP Member Media Center (www.aap.org/moc/pressroom/pressroom.htm) Where you’ll find:
  - In the Media Spotlight | Sample Editorials | Speaker Ready Room
  - Award News Release Templates | Sample Letters to Editor
  - Questions & Answers | Speaking Points | AAP Spokesperson
  - AAP Fact Sheet | PR Handbook | Television Dress Guidelines | Contact Info
- AAP Chapters (www.aap.org/member/chapters/chapters.htm)
- AAP Division of State Government Affairs (www.aap.org/moc/stgovaffairs)
- AAP Department of Federal Affairs (www.aap.grassroots.com)
- AAP Community Pediatrics Training Initiative (www.aap.org/commpeds/CPTI)
Advocacy Communications Opportunities

The following opportunities were designed to give you a chance to incorporate skills from today’s module into your professional practice. Many of these opportunities can be done in as little as 5 minutes. You are encouraged to choose opportunities that relate to your personal interests and that fit within your schedule.

Opportunities in as Little as 5 Minutes:

☐ Identify a story from your work or from a patient that you can use to illustrate why your issue is important.
☐ Find your local newspaper Web site and set it as your home page on your computer. Scan the newspaper periodically for articles about children’s health.
☐ Look for opportunities within your work to talk about the issues that are important to you and share your message with your patients’ families, colleagues, friends and family members.
☐ Watch the news, listen to the radio, or read the paper. Ask yourself, “how does this affect children’s health?” after each news report.

Opportunities in Less than 30 Minutes:

☐ Visit the AAP Member Media Center online at http://www.aap.org/moc/pressroom/pressroom.htm and read past letters-to-the-editors, talking points, and op-eds.
☐ Write a letter-to-the-editor on behalf of an issue you care about.
☐ Keep an advocacy journal that reflects the issues you see in your work and how you can talk about them with others.
☐ Create an “elevator speech” (i.e. a 30 second speech) about an issue that is important to you that you can share with your colleagues while sharing the elevator with them at work.
☐ Post a response on behalf of an issue you care about on your newspaper's comments page, blog, or Web site.
☐ Create a social networking page for yourself or join a social networking group that shares your interest in children's health and well-being.

Opportunities in about an Hour:

☐ Set up a table outside of grand rounds or at a community event or health fair and talk about your issue. Distribute flyers and encourage people to sign-up to get involved or pledge their support.
☐ Contact your AAP chapter to learn about media activities that they are part of. Ask if you can assist, perhaps by writing an op ed on behalf of the chapter, writing a press release, or meeting with an editorial board.
☐ Give a presentation on behalf of an issue that is important to you to a local civic group or school.
☐ Write a letter to the editor and distribute at grand rounds so that your colleagues can sign on and voice support for your issue.

Opportunities in a Day:

☐ Contact the AAP Department of Communications at commun@aap.org. Ask them if you can receive training to become an AAP spokesperson at a national AAP meeting.
Training Evaluation: Module #4: Advocacy Communications
AAP Pediatric Residency Advocacy Training Program

Question:
- What part of the training was most valuable to you?

Content: Please rate the following aspects of your training experience according to the following scale:

1. I learned specific advocacy strategies that I will use in my advocacy efforts.    ___
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

2. The training included new ideas that inspired me to action.    ___
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

3. The materials will be useful to me after I leave the training.    ___
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

4. The content included things I was hoping to gain in the training.    ___
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree
Overview/Schedule: This module is designed to take 45 minutes. Options for additional and follow-up activities are included. A general break down of the time is as follows:

- Welcome, Introductions, and Case Study:
  - Welcome and Why We’re Here (5 minutes)
  - Case Study (5 minutes)
- Core Concept (15 minutes)
- Practice (15 minutes)
- Closing, Evaluation, and Opportunities (5 minutes)

Educational Objectives: This module will emphasize the important role that voting and nonpartisan civic engagement has on children’s health issues at the local, state, and national level. The module also explores the voting process and how pediatric residents can find an opportunity to vote—and encourage others to vote—within the confines of their demanding schedule. The intent of the module is:

- To explore the multiple types of elections that take place and how children’s health issues are tied to each of these elections.
- To provide pediatric residents with the tips and tools for exercising their right to vote, even amongst their busy and demanding schedules.
- To demonstrate that advocacy—including voting—is doable and can fit within the demands of a pediatric resident’s busy schedule.

Materials and Equipment: For this module, you will need the following handouts, materials, and equipment:

Handouts:
- Copies of the evaluation for each pediatric resident participating in the module.
Copies of the Opportunities Worksheet. The Opportunities Worksheet contains a list of advocacy activities that relate to the module’s topic and can be performed by pediatric residents following the module as their interest and time allows.

Quick Reference Cards that contain instructions for looking up chapter contact information and links to additional resources.

Copies of the Political Campaign Activities and Lobbying Guidelines of 501(c)(3) and 501(c)(6) Organizations hand out.

**Equipment:**
- Flip chart or white board
- Markers/Dry erase markers for flip chart/white board
- If using PowerPoint:
  - PowerPoint projector
  - Screen or white wall for viewing PowerPoint
  - Copy of PowerPoint with trainer notes on computer or zip drive.

**(Optional) Presenter:**
- If using AAP chapter representative or children’s advocacy guest speaker presentation in place of PowerPoint:
  - Invite a representative from the AAP chapter or children’s advocacy organization (staff or elections chair) who can participate in the module, help pediatric residents understand the role that elections at all levels of government affect children’s health issues, and share examples of how the AAP and other pediatricians have used voting and elections to advance children’s health and well-being.
  - Prior to the module, the AAP representative or children’s advocacy organization representative should be briefed by you in terms of what to expect from the class, background on the pediatric residents, the time allotted for their presentation, and what you are looking for in the presentation, including:
    - Examples of different types of elections and how they play a role in children’s health and well-being.
    - Tips and tools on how to use voting and elections in a nonpartisan capacity to advance children’s health issues.
    - Ways that pediatric residents can fit voting and other nonpartisan election activities into their busy and demanding schedules.
• The rules to keep in mind when participating in voting and election activities.

➢ Non-partisan election buttons/car magnets for the winning team (or all pediatric residents). Check with your hospital or AAP chapter to see if child health buttons/magnets are available.

**Room Set-up and Environment:** You are encouraged to use the room set-up to promote participation and provide a safe leaning environment for pediatric residents. Consider:

- Setting up tables in a “u-shaped” formation to encourage sharing.
- Greeting residents as they enter the room.
- Playing upbeat music as residents are coming in to the room.
- Providing refreshments.
Voting with Children’s Health and a Pediatric Resident’s Schedule in Mind: Welcome, Introductions, and Case Study

Trainer Note:

- The Welcome, Introductions, and Case Study section is designed to give you the opportunity to welcome pediatric residents and quickly highlight the topic and skills that will be covered within the module. It also includes a “case study” or story from an actual pediatric resident that illustrates the role a pediatric resident can play in relation to the module’s advocacy topic. The purpose of the case study is to provide a familiar and comfortable format for introducing the module’s topic in a way that pediatric residents can relate to.

- The Welcome, Introduction, and Case Study section is designed to take about ten minutes total. The Welcome and Why We’re Here sections should take roughly five minutes and the Case Study section taking another five minutes.

Welcome

- Welcome everyone.

- Acknowledge that pediatric residents have a lot going on in their lives right now and thank them in advance for being here today.

- Introduce yourself. Some things to consider sharing include:
  - Your experience with advocacy work.
  - Why you got into your career path.
  - How you’ve personally seen advocacy improve the health and well-being of children and/or the profession of pediatrics.
  - A personal quotation that relates to the training module topic.

- Mention that there is a lot of wisdom and experience in the room. Encourage pediatric residents to share and participate throughout the training module.

Why We’re Here

Trainer Note:
The Why We’re Here section is meant to be included in each module. The intentional repetition is designed to help underscore the key training principles for the pediatric residency training program—that advocacy is important and doable, that pediatric residents are uniquely positioned to be powerful advocates, and that advocacy is not much different from the work pediatric residents are already doing.
Briefly share why advocacy is an important part of being a pediatrician. Some talking points include:

- Advocacy means speaking out on your patients’ behalf. Advocacy assumes that there is a problem that needs to be changed and it is a way to drive, or effect that change.

- As a pediatric resident, you are already engaged in individual advocacy. Individual advocacy describes the work you are already doing to improve the health and well-being of individual patients. This could include calling the insurance company, school, another provider, or a social service agency on behalf of an individual patient.

- Individual advocacy easily translates to the community, state, and federal level advocacy that we will talk about during today’s module. At its core, each level of advocacy is about speaking out on behalf of children’s health and well-being, whether it is for one child or for systematic solutions that benefit many children.

- Pediatricians can play a powerful role in creating lasting and meaningful change for the patients they serve. We’re here today to continue that tradition—Isaac Abt, MD, the first AAP President, said: “It should be our aim to discover neglected problems and, so far as in our power, to correct evils and introduce reform.”

Case Study

- The purpose of today’s module is to explore the ways that pediatric residents can participate in the voting process in a nonpartisan manner in order to elevate children’s health and well-being in the minds of candidates and elected officials and also how they can fit voting into their busy schedules.

- State that today’s module will focus solely on nonpartisan voting activities. Nonpartisan—for the purpose of this module—is defined as engaging people to vote in a manner that is completely free and devoid of any connection whatsoever with any political party or specific candidate. The focus is on urging people to vote with a particular issue in mind—such as children’s health—not a particular candidate.

- Share a case study that illustrates how another pediatric resident used voting to advance a children’s health issue they cared about:
As a pediatrician and a patient advocate, I see many parents who will sacrifice anything to be by their child's side in their time of need. Before the 2006 elections, a mother of a child in the Immunocompromised Unit for cancer care was one of those parents. She was determined to be with her child, but still wanted to vote in the crucial election. Unfortunately, voting laws in the state of Ohio only allowed absentee ballots to be obtained by hospitalized patients, while parents of hospitalized children were not eligible to vote via absentee ballot.

Identifying a need, we worked with our hospital Government Relations Office to draft legislation that was included in Ohio’s biennial budget bill (HB 119), which allows parents the ability to partake in the political process without ever leaving their child’s side by obtaining an emergency absentee ballot if their child is hospitalized on Election Day. This legislation especially benefits parents of children with chronic diseases, who have already given so much for the care of their child. Today, our office works with head nurses of every facility in our health care system to ensure that patients and parents of hospitalized children can exercise their right to vote without ever sacrificing time spent with their child.

Lolita McDavid, MD, FAAP

- Following the case study, ask pediatricians their reactions to the case study, including what they liked about it and what surprised them about it.
- Ask if anyone has a story of their own that they would like to share about how they used voting and elections as a way to advance an issue they cared about. Probe on what motivated them to use voting and elections as a vehicle to create change and what was the result of the action.
- Note that the case study illustrates that:
  - Explain that many of the priorities and much of the voting behavior of elected officials is shaped by their desire to be reelected.
  - Voting is a way to capture decision-makers attention and let them know that pediatric residents (as well as others who care about children) are paying attention and voting with children’s health in mind.
  - Voting and other types of nonpartisan election activities allow pediatric residents (as well as others who care about children) to advance the children’s health issues that are important to them.
  - Voting can fit into the busy schedule and competing demands of pediatric residents.
• Briefly mention that pediatric residents can engage in almost any political campaign or
election activity as a public citizen (including donating money or volunteering on a
campaign or on behalf of a candidate), but political and election activity on behalf of the
AAP, your AAP chapter, or your place of residency has some restrictions. For example,
endorsing a candidate is prohibited for 501(c) (3) organizations.

• Certain political and election activities are restricted or prohibited due to your chapter
or organization’s tax status and it is crucial to be aware of the activities that you as a
pediatric resident, and that you as part of your chapter, place of residency, or nonprofit
organization, can legally participate in. That is why this module is focused on
nonpartisan activities.

• Mention that the AAP Division of State Government Affairs, the AAP Department of
Federal Affairs, and the hospital government affairs staff can provide you with more
information about permissible nonpartisan political campaign and election activities.
To access the AAP’s permissible non-partisan activities, please visit:  (insert link
here).

• In addition, the Division of State Government Affairs and Department of Federal
Affairs develops an Election Resource for chapters. This resource can be found on
the respective area’s Web pages on the AAP Member Center.
Voting with Children’s Health and a Pediatric Resident’s Schedule in Mind:
Core Concept

**Trainer Note:**
- The Core Concept section of the Voting with Children’s Health and the Demands of a Pediatric Resident’s Schedule in Mind module emphasizes the “how to” or the basic tips and information pediatric residents need to keep in mind in relationship to the module’s topic. The purpose of this section is to emphasize how the skills used in this concept relate to the skills pediatric residents use in their work everyday.

- This section includes two options for presenting the core concept:
  - A brief PowerPoint accompanied by guided group brainstorms and prompting questions that you can use to present the skills and encourage pediatric residents to share their experiences and input.
  - An alternative activity that includes a different medium for presenting the core concept.

The two options are designed to help you build flexibility into the pediatric residency advocacy training program curriculum. It allows you to pick and choose which teaching medium to use based on your time, resources, and the current needs and make-up of the pediatric resident participants.

- The Core Concept section is designed to take about 15 minutes.

**Option #1: PowerPoint and Guided Questions**

- Ask pediatric residents what children’s health issues they are most passionate about or what issues they see commonly in their work.

- Write the examples on a flip chart or white board. State that elected officials at all levels of government can set policy that improves children's health and well-being and many of the examples listed have a direct correlation to voting at the local, state, or national level.

- Walk through one or two examples to illustrate the connection between a children’s health issue and local, state, and federal elections. A few examples or ideas of what this could look like include:
Public health issues:

- Childhood obesity issues can be related to voting because school board members (elected locally) vote on vending machine policies; city council or park board members (again, elected locally) vote on land use that affects open spaces and safe parks; state legislators vote on funding for after-school recreation programs; and at the federal level, the U.S. Department of Agriculture (USDA) develops and approves the food pyramid and federal legislators consider funding for child nutrition programs.

- Asthma issues can be related to voting at the local level (local smoking ordinances or restrictions on pollution from local companies); state level (state-wide second hand smoke legislation), and federal level (funding for asthma research and treatment).

Access to care issues: examples of how this issue is related to voting at local level could include programs for coordinated school health services or home nursing visits for newborns/first time mom/young moms; state level could include state legislative mandates requiring insurance plans to provide certain benefits; national level could include S-CHIP funding and emergency medical services funding and regionalization for children.

Community/family support services: examples of how this issue is related to voting at the local level could include early intervention programs; early childhood education funding at the state level; and national children’s study funding and federal regulations on pharmaceutical testing for children at the national level.

Note that the PowerPoint you are about to walk through focuses on how pediatric residents (and others who care about children) can use elections at all levels of government to effect change on behalf of the children’s health issues they care about.

Show PowerPoint. As you are presenting the PowerPoint, pay special attention to the notes section. The PowerPoint notes section includes key points and prompting questions to include in your presentation.

Following the PowerPoint, ask the pediatric residents if they have questions. As time allows, spend a few minutes answering their questions.

Mention that the AAP Division of State Government Affairs, the AAP Department of Federal Affairs, and their hospital government affairs staff are available to provide help and assistance on what pediatric residents can do to advance children’s health through nonpartisan voting and election activities.
Option #2: Guest Speaker from AAP Chapter or Children’s Advocacy Organization

- Ask pediatric residents what children’s health issues they are most passionate about or what issues they see commonly in their work.

- Write the examples on a flip chart or white board. State that elected officials at all levels of government can pass policy that improves children’s health and well-being and many of the examples listed have a direct correlation to voting at the local, state, or national level.

- Walk through one or two examples to illustrate the connection between a children’s health issue and local, state, and federal elections. A few examples or ideas of what this could look like include:

  - **Public health issues:**
    - Childhood obesity issues can be related to voting because school board members (elected locally) vote on vending machine policies; city council or park board members (again, elected locally) vote on land use that affects open spaces and safe parks; state legislators vote on funding for after-school recreation programs; at the federal level, the U.S. Department of Agriculture (USDA) develops and approves the food pyramid and federal legislators consider funding for child nutrition programs.
    - Asthma issues can be related to voting at local level (local smoking ordinances or restrictions on pollution from local companies); state level (state-wide second hand smoke legislation), and federal level (funding for asthma research and treatment).

  - **Access to care issues:** examples of how this issue is related to voting at local level could include programs for coordinated school health services or home nursing visits for newborns/first time mom/young moms; state level could include state health insurance coverage; national level could include S-CHIP funding and emergency medical services funding and regionalization for children.

  - **Community/family support services:** examples of how this issue is related to voting at the local level could include early intervention programs; early childhood education funding at the state level; and national children’s study funding and federal regulations on pharmaceutical testing for children at the national level.

- Note that the guest speaker they are about to hear from will focus on how pediatric residents (and others who care about children) can use elections at all levels of government to affect change on behalf of the children’s health issues they care about.
• Briefly introduce the AAP chapter representative or children’s advocacy organization representative, including how long they’ve been active or collaborated with the AAP.

• Give the guest speaker the floor. Encourage them to share:
  
  - Examples of how their chapter or organization has gotten involved in nonpartisan voting and election activities at various levels of government and how this has made a difference on behalf of children’s health and well-being.
  
  - Tips on how pediatric residents can fit voting into their busy schedules (absentee ballots, early voting, vote by mail, whatever is applicable), why voting is important, and where they can find credible and nonpartisan information about where candidates stand on children’s health issues.

• After the AAP chapter or children’s advocacy organization representative has shared a few examples and tips and tools, ask pediatric residents if they have questions for the AAP chapter representative. As time permits, allow for questions and answers.

• Following the presentation, reiterate the following important points to keep in mind:
  
  - Elections take place at every level of government and all elections can help advance children’s health issues.
  
  - Elections—especially those at the local level—are often overlooked and provide crucial opportunities for pediatric residents to advocate on behalf of children and children’s health issues.
  
  - Pediatric residents have the power to vote, as well as engage others who care about children’s health and well-being, to get involved in nonpartisan election activities on behalf of the issues that are important to them.
  
  - Don’t forget about the rules!
Voting with Children’s Health and a Pediatric Resident’s Schedule in Mind:
Practice

**Trainer Note:**
- The Practice section of the Voting with Children’s Health and the Demands of a Pediatric Resident’s Schedule in Mind module allows pediatric residents to practice what they have just learned and increase their comfort level with the advocacy topic in a safe, fun, interactive, and open environment.

- The practice section is designed to take about 15 minutes.

**Fitting Voting into the Pediatric Resident’s Schedule**

- Divide the pediatric residents into seven small groups (one group for each of the following pediatric residency rotations).

- Tell the groups that they will be working in small teams to identify the ways they can fit voting in with the demands of a pediatric residents rotations.

- Assign each group one of the following pediatric residency rotations:
  - Pediatric Intensive Care Unit (PICU)
  - Neonatal Intensive Care Unit (NICU)
  - Emergency Department (ED)
  - Primary Care
  - Development and Behavioral Pediatrics
  - Adolescent Medicine
  - Inpatient units or inpatient services (such as Cardiology, Gastroenterology, Endocrinology, Hematology/Oncology, Infectious Disease, Nephrology, or Rheumatology)

- The teams will have only five minutes to identify three realistic, yet creative ways that they can manage to find the time to vote while serving on their assigned rotation.

- Tell teams that after their five minutes is up, they will be asked to share their ideas back to the larger group.

- Add that since this is the voting module, they will each have an opportunity to vote for the team that came up with the best ideas.
• Ask if there are any questions before they begin. Once questions are answered, begin the five minutes. Let group know when they have two minutes and one minute left as a team.

• Once the five minutes is up, ask a representative from each team to share their assigned rotation, along with their ideas with the larger group.

• Once each team has had an opportunity to share their ideas, ask the group to vote via a show of hands for the group that they think came up with the best ideas.

• Give AAP or children’s hospital non-partisan election buttons/bumper magnets to the winning team. Alternatively, you can give them to everyone, regardless of their team.

• Thank the teams for their participation, energy, and great ideas.

• Encourage them to remember these ideas and try them out next Election Day.
Voting with Children’s Health and a Pediatric Resident’s Schedule in Mind: Closing, Evaluation, and Opportunities

**Trainer Note:**
- The purpose of the closing, evaluation, and opportunities section is to provide closure on the module’s topic, identify action steps that pediatric residents can do next as a result of attending this training module, and gives pediatric residents a chance to evaluate the session.

- The closing and evaluation section is designed to take about five minutes.

**Closing**

- Thank pediatric residents for participating in the training module.

- Emphasize that voting and nonpartisan election activities don’t have to be hard or take a lot of their time. Hand out the Political Campaign Activities and Lobbying Guidelines of 501(c)(3) and 501(c)(6) Organizations for them to use as a reference.

- Don’t get frustrated if you don’t see immediate results. Change takes time. Know that your actions make a difference, celebrate the small steps, and stay persistent.

- Remind them that they can be effective advocates through voting at every level of government and that voting gives pediatric residents (and others who care about children) another opportunity to advocate on behalf of children’s health.

- Encourage each pediatric resident to register to vote and to vote in the upcoming election. Let pediatric residents know the date(s) for upcoming elections in their area, as well as the date they must register to vote by and/or apply for an absentee ballot. Write these dates on the flipchart/whiteboard.

  *(Trainer Note: This information can be found by contacting your AAP chapter, your hospital government affairs office, the local League of Women Voters, or your local election board. Additional voting related resources are available through: [www.vote411.org](http://www.vote411.org))*

- Hand out voter registration cards to all pediatric residents. Remind them that they will need to re-register if they changed addresses or had a name change since the last time they voted. Encourage them to register to vote in the state they are currently living in.

  *(Trainer Note: Voter registration cards are available by contacting your local election board or the Secretary of State’s office. Additional voting related resources are available through: [www.rockthevote.org](http://www.rockthevote.org)/ or [www.vote411.org](http://www.vote411.org))*
Evaluation

• Invite any final questions or observations from the group. If time permits, consider going around the room and ask each pediatric resident to share one thing that they learned today about how voting and elections affects children’s health or one thing they will do to assure they have the opportunity to vote on Election Day.

• Pass out an evaluation form to each pediatric resident and ask them to fill it out and turn it in.

Opportunities

• While pediatric residents are completing their evaluations, hand out the Opportunities Worksheet that contains a list of activities that residents can do over the next month to deepen their understanding of the skills highlighted in today’s module.

• Tell pediatric residents that these opportunities were designed with their busy schedule in mind and many of them can be done in as little as five minutes.

• Consider offering an incentive or prize to residents who complete opportunities listed on the sheet. One idea is to ask residents to e-mail the opportunities they completed to you and allow a couple minutes at the beginning of the next module to recognize residents’ efforts and give them a round of applause.

• Also, hand out Quick Reference Cards with links to accompanying information and materials related to this module. Encourage pediatric residents to put this card in their pocket or wallet and access the link when they have time.

• Thank pediatric residents one last time for their time and participation at today’s module.

Trainer Note: Make a note to follow-up with pediatric residents by e-mail two weeks after this module to remind them to register to vote. Also include the dates of upcoming elections in the area, as well as deadlines to request an absentee ballot or register to vote.
AAP Pediatric Residency Advocacy Training

Voting with Children’s Health and a Pediatric Resident’s Schedule in Mind
Introduction

• Elections take place at every level of government and all elections can help advance children’s health issues.

• Elections—especially those at the local level—are often overlooked and provide crucial opportunities for pediatric residents to advocate on behalf of children and children’s health issues.
Keeping the Rules in Mind

- You can engage in almost any political campaign or election activity as a public citizen, but political and election activity on behalf of the AAP, AAP chapter, or your place of residency has some restrictions.

- Certain political and election activities are restricted or prohibited due to your AAP chapter or organization’s tax status.

- If you are acting as a public citizen, don’t use your AAP, hospital/clinic, or academic title, as that can imply endorsement of those organizations.

- The AAP Division of State Government Affairs and the Department of Federal Affairs can provide more information about permissible nonpartisan political campaign and election activities.
Why Elections Matter

• Provide opportunity to demonstrate to decision-makers that pediatric residents and others are voting with children’s health in mind.

• Electing people who are willing to make children’s health a priority results in better public policies and initiatives for children’s health at all levels of government.

• Offers another way to educate elected officials, candidates and voters about children’s health.

• Pediatric residents can establish themselves as a constituency that deserves the attention of those running for office.
Types of Elections

• There are many different types of elections that take place, some example include:
  – School board.
  – Park board.
  – City council or mayor.
  – County government.
  – Judicial elections.
  – Ballot initiatives.
  – State government (state legislators and state executive branch).
  – Federal government (federal legislators and federal executive branch).
How to Use Nonpartisan Election Work to Advance Your Issue

1.) Voter registration.

2.) Voter education.

3.) Voter mobilization, aka Get-Out-The-Vote (GOTV).

4.) Town Hall or Candidate forums.
Voter Registration

• Involves registering new or lapsed voters so that they can legally vote on Election Day.

• Helps assure that people who care about children’s health issues are able to demonstrate their care and concern at the polls.

• Voter registration laws are different in every state, so please consult your secretary of state’s office or state or local election commission for specifics about registering voters in your area.

• A helpful resource for voter registration is: www.vote411.org
Voter Education

• Involves providing voters with the tools they need to learn about candidate’s positions on issues that matter to them, such as children’s health or pediatric practice issues.

• Great way to raise public awareness about your issue and assure that children’s health concerns are included in the public debates that occur during the political campaign and election process.
Voter Mobilization (Get Out the Vote)

- Help ensure that voters get to the polls on Election Day so they can cast their ballots on behalf of children’s health and well-being.
Town Hall or Candidate Forums

- Invite candidates to address community about children’s health and well-being related issues.

- A great opportunity to educate candidates on issues you care about and demonstrate how many other people share your interests.

- Can also bring media coverage to your issue.

- Forums can be big or small, but do require planning.
Tips for Planning Town Hall or Candidate Forums

• Partner with other organizations. This will allow you to draw upon additional resources and divide the work load.

• Important to follow IRS guidelines.

• Talk to your hospital’s government affairs or public relations office—they may be able to help set up these forums.

• AAP has resources and planning guide, with templates and sample agenda. (http://aap.grassroots.com/resources.dyn/TownHallGuide.pdf)

• An alternative might be to invite academic experts or representatives from children advocacy groups to present information about the candidates’ positions at Grand Rounds or at a noon conference or morning report.
Elected officials have the power to make decisions on children’s health issues at all levels of government.

Pediatric residents have the power to vote, as well as engage others who care about children’s health and well-being, to get involved in nonpartisan election activities on behalf of the issues that are important to them.

Don’t forget about the rules!
Additional Resources and Information

- AAP Advocacy Guide (www.aap.org/moc/advocacyguide)
- AAP Chapters (www.aap.org/member/chapters/chapters.htm)
- AAP Division of State Government Affairs (www.aap.org/moc/stgovaffairs)
- AAP Department of Federal Affairs (www.aap.grassroots.com)
- AAP Community Pediatrics Training Initiative (www.aap.org/commpeds/CPTI)
Opportunities in as Little as 5 Minutes:

☐ Look up voter registration information for your state of residence and fill out an on-line voter registration form or apply for absentee voting. (www.vote411.org)
☐ Find out when local elections are taking place by visiting the Secretary of State Web site or the election page of your local municipality’s Web site. Mark the date on your calendar and be sure to vote.
☐ Look for issues that you see in your work and ask yourself how these issue relate to voting at the local, state, and federal level.
☐ Look for opportunities within your work to talk to others – including patients’ family members, colleagues, and friends about the importance of voting with children’s health in mind.

Opportunities in Less than 30 Minutes:

☐ Set-up a table outside of grand rounds and encourage everyone attending to register to vote. If permissible, distribute candidate report cards from a local children’s advocacy organization.
☐ Log on to a non-partisan children’s health Web site to find out how the candidates rank on the children’s health issues that are important to you. Add these sites as a favorite on your computer.
☐ Ask your patient’s families what barriers they experience to voting and help them identify a solution, such as linking them with a community resources that can provide transportation or child care.
☐ Contact the AAP to get non-partisan election buttons, stickers, or magnets related to child health. Wear and display while at work and in your community. Distribute the buttons, stickers, and magnets to your friends, family members, colleagues, and patient’s families to wear or display as well.
☐ Sign-up to receive campaign information from candidates in your area. Monitor their position on children’s health issues.
☐ Contact your candidates. Tell them what issues are important to you and provide them with links of where they can find more information on your issue.
☐ VOTE! Either in person or by absentee ballot.

Opportunities in about an Hour:

☐ Contact your AAP chapter to find out if they are hosting a candidate forum – or know of another organization who is. Attend the forum to learn where your candidates stand on the children’s health issues important to you.
Training Evaluation: Module #5: Voting with Children’s Health in Mind
AAP Pediatric Residency Advocacy Training Program

Question:
• What part of the training was most valuable to you?

Content: Please rate the following aspects of your training experience according to the following scale:

1. I learned specific advocacy strategies that I will use in my advocacy efforts.  ____
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

2. The training included new ideas that inspired me to action.  ____
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

3. The materials will be useful to me after I leave the training.  ____
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree

4. The content included things I was hoping to gain in the training.  ____
   4—Strongly agree
   3—Agree
   2—Disagree
   1—Strongly disagree
Quick Reference Card

Additional advocacy resources and material can be located by accessing the following link:

- [www.aap.org/moc/advocacyguide](http://www.aap.org/moc/advocacyguide)

My AAP Member Number/Log in is:

(Please call 866-843-2271 or 866-THE-AAPI or visit [www.aap.org/moc](http://www.aap.org/moc) and click on the link to “Look up my AAP ID number”)

Contact Information for my local AAP Chapter: (information available at [www.aap.org/member/chapters/chapters.htm](http://www.aap.org/member/chapters/chapters.htm))

Phone: ______________________  E-mail address: ______________________

Web site: ____________________________________________________________
Acknowledgements

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Other Key References/Resources:
Leo Lionni, Swimmy. Random House Inc. 1963
Families USA. How a Bill Becomes a Law Board Game. (www.familiesusa.org)
Rock the Vote. (www.rockthevote.org)
Public Citizens for Children and Youth (www.pccy.org)
League of Women Voters (www.vote411.org)

The guide was supported through funding from the Dyson Foundation.
ImmuneWise Project Outcome Report

Project Leader(s): ________________________________
________________________________________________________________________

Program Name:
________________________________________________________________________

District: I II III IV V VI VII VIII IX X

Program Delegate:
________________________________________________________________________

Faculty Support:
________________________________________________________________________

Project Start Date: ______________

Project Completion Date: ______________

Project Description:
________________________________________________________________________

Did you complete the Pre-test? Y or N

Did you complete the Post-test? Y or N

Thank You!
SOMSRFT Advocacy Subcommittee