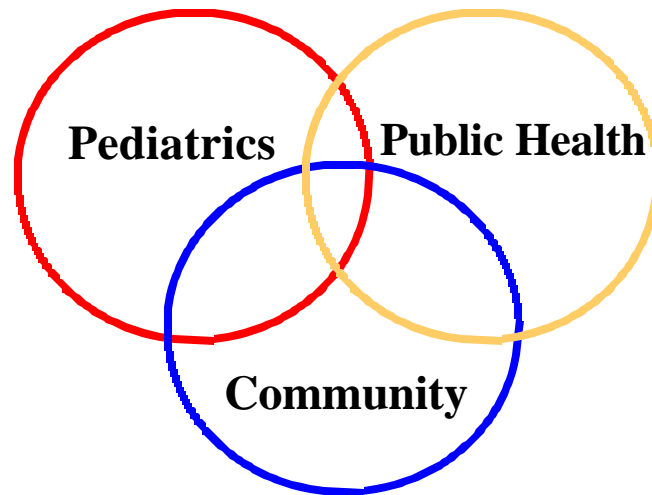


Department of Pediatrics

University of Florida-Jacksonville



Anne E. Dyson
Community Pediatrics Initiative
Evaluation Report, Year 1

August 19, 2003

Submitted by:
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Executive Summary
Year 1 Annual Dyson Evaluation Report
August 19, 2003

Introduction

This executive summary provides a brief description of the evaluation activities during the first year and findings for the first year of the project. The proposed five year evaluation plan was designed to incorporate three levels of analysis reflected in the University of Florida/Jacksonville Dyson Initiative goals: *a) the Institutional level* related to establishing a Residency program, *b) the Individual level* concentrating on the knowledge, attitudes, skills and practices to be acquired by the residents; and *c) the Community level* emphasizing the integration of the Program with the community. The evaluation approach was both formative and summative, with an emphasis on ethnographic methods in the early formative stages and the more quantitative related summative methods evolving as the outcomes emerged.

The proposed evaluation plan was intended to correspond to the three levels of change that were anticipated:

A. First year Status Report of Institutional Analysis:

Curriculum analysis.

Considerable work was required before the proposed curriculum analysis could begin. Curriculum analysis was challenged by the need to come to consensus on the desired outcomes of the curriculum. Considerable effort was devoted to developing consensus among major stakeholders concerning the competencies that would be the primary outcomes produced by the curriculum. The process involved the identification of the roles or responsibilities that a graduating pediatrician should be prepared to assume upon graduation, followed by the development of competencies that would be required to successfully assume those roles or responsibilities. Although it is anticipated that competencies will continue to be revised to meet changing expectations, significant progress was made in establishing competencies using input from a broad range of stakeholders including community members and the competencies emerging from National Dyson coordinated efforts. This provides a sound foundation for future assessment of the curriculum. Analysis by Dyson staff has been part of the continuing development process. Now that competencies have been established, it would be appropriate to engage in baseline data collection concerning the extent that the competencies are integrated within the curriculum, using faculty and resident perceptions as the primary data for triangulation of assessments by Curriculum planners. It is recommended that the Evaluators be used to develop an assessment process.

Assessment of organizational culture.

The interviews, observations and archival data provide a substantial body of baseline ethnographic data for the project.

Assessment of essential components.

Data on student and faculty recruitment have been and continue to be maintained as part of the residency and academic department record keeping. Data is also collected and maintained related to professional development as part of the University and Hospital human resource record

maintenance. Data for years prior to implementation of Dyson and during the first year of the Dyson initiative in Jacksonville comprise a substantial body of baseline data. The process for accessing and analyzing this data by the Evaluators will need to be clarified during the second year.

B. First year status report of Resident Analysis

Assessment of Resident Competencies.

Assessment of resident competencies related to Dyson initiated changes to the curriculum has not begun.

Recommendation: Development of performance measure and assessment tools should proceed with haste during the second year. Development of assessment processes will help to clarify what should minimally be required of all residents versus requirements for residents who select a community/public health pediatrics rotation. Once assessment processes are defined, faculty and and/or community mentors will be able to assess resident acquisition of the competencies. These assessment processes will need to be implemented before the Dyson initiative's impact on competencies can be evaluated.

C. First year status report of Community Analysis.

Assessment of Community Involvement.

Observation of meetings, archival records and to a lesser extent, interviews, provide documentation of extensive involvement of community. Community stakeholder input and expectations were solicited and obtained for a number of critical elements of the Jacksonville Dyson initiative. The following are some of the most prominent examples of community involvement and stakeholder input.

Roles and Competencies:

The Community Advisory Committee provided input during an advisory Committee meeting to identify the roles and responsibilities that a pediatrician should be able to assume upon completion of a Residency Program. These roles and responsibilities were then used to establish the domains/roles upon which the competencies were developed and organized.

Learning Scenario Development:

Community members were invited and actively participated in the development of learning scenarios that would expose residents to the broad social ecology that influences the health of children. These scenarios incorporate a broad range of health related problems that had their origins, solutions or mitigating influences in physical, social, legal and economic elements of the community.

Modification to Clinic with Resident Led Initiative:

The modification of a pediatric clinic to include legal aid referrals evolved extensively from community collaboration efforts through the City's Legal Aid Office. A Resident utilized the opportunity presented by the Legal Aid office guided by Dyson faculty and staff, but the services were actually volunteered through the Legal Aid Office. The contact was facilitated through membership of the Legal Aid Office representative on the Community Advisory Board and the Dyson Faculty.

Findings

A) First Year Evaluation Findings Related to Goals & Objectives

Goal 1. The Residency:

Objective 1.1. *Establish Residency in Pediatrics and Community Health*

Finding: Emerging as a major challenge

Objective 1.2. *Establish Community Partnerships*

Finding: Considerable Success

Objective 1.3. *Interdisciplinary Curriculum*

Finding: Considerable Success

Objective 1.4. *Faculty Development*

Finding: Emerging as a major challenge

Objective 1.5. *COPC & Community Involvement*

Finding: Considerable Success, particularly toward end of year with development of CAI process

Objective 1.6. *Improve Match Results*

Finding: Too early to assess, and will need clarification of what improved Match results means.

Objective 1.7. *Enhanced ecological competence*

Finding: Considerable progress but substantial work is needed related to clarifying measuring expectations and measuring success

Objective 1.8. *Learning Experiences*

Finding: Substantial Progress

Objective 1.9. *Continual Improvement, Replication & Sustainability.*

Finding: Considerable Success related to using feedback to enhance the program

Objective 1.10. *Shift to a "1:n" population perspective.*

Finding: Some success, but resident resistance also obvious

Goal 2. The Residents competencies

Objectives 1 through 6, not assessed as competencies have just been identified and processes have not been developed to assess acquisition of competencies.

Goal 3. The Community:

Objective 3.1. *Engage Community as Partner*

Finding: Substantial Success

Objective 3.2. *Evidenced Based Community Involvement*

Finding: Area of substantial conflict, substantial success, and continued challenge

Objective 3.3. *Children being served will have Medical Home*

Finding: Some success, may need clarification

Objective 3.4. *Community Partners will develop knowledge and skill*

Finding: This objective may need to be reconceptualized within the context of how the Jacksonville Dyson Initiative is evolving.

Objective 3.5. *Paradigm shift from physician as expert to include physician as collaborative partner in community decision-making.*

Finding: Challenge but obvious progress

Objective 3.6. *By Year 5, To provide the community and residents with the perspective, knowledge and skills to assess and lead endeavors to meet the health needs of children.*

Finding: specifics of this capacity will probably need to be further refined and clarified for this to be a meaningful objective.

Objective 3.7. *link practicing pediatricians to communities as practitioners of Community Pediatrics with the capacity to sustain these linkages and community endeavors.*

Finding: Limited data to document this outcome

B) Resident Interview Analysis: Issues and Opportunities

(1) Major Themes emerging from Residents as Stakeholder

- Definition of WHAT needs to be learned to become a “Competent Pediatrician,” including emphasis on “Passing Boards.”
- Characteristics of learning processes within a good residency program.
- Diversity of Perception of “main goals” of the Dyson Initiative
- Resident expectations related to Dyson Initiative have been varied and evolving.
- Diverse ways of understanding and articulating the concept of cultural competence.
- Beliefs (positive & negative) about how the Dyson Initiative has changed or will change their residency experience.
- **Diverse and changing levels of understanding or beliefs about sociocultural issues, ecological issues and the etiology of health problems that persist in some communities.** There seems to be an evolution from a “black and white” view of the world to accepting “shades of gray.”

(2) Opportunities and Challenges

Several important issues emerged from the analysis of the interviews that may need additional attention.

- The residents can be and have been turned on to **the ecological issues that surround population based community health.** However, it was clear from these interviews that the depth and breadth of resident intellectual beliefs and attitudes about community (understanding the importance of community and involvement in communities) is varied when they enter and as they progress through the residency. Recommendation: use the ecological model for understanding the lives of people who live in communities, (Brownson

2003) as an organizing construct to develop informal introductory discussions as the new academic year begins (IOM, 2003).

- Some residents expressed a lack of clarity as to how the Dyson Initiative can help graduates who do not practice in Jacksonville? How will participation in Dyson help graduates who only want to do hospital work? These are lingering questions that surfaced in interviews.
- In some cases there is a “them” concept of Dyson vs. an “I” concept of residents. For example, several residents described what Dyson was trying to accomplish by saying that “they want us” to do something. This is important because it shows that ownership is tenuous. Much progress was made on this issue throughout the year, but it is important to note that this was still the most common type of statement.
- The concept of **ethics** was not mentioned by even one resident in an interview. Though ethics was on an agenda for a core competency meeting earlier in the year, a review of the most recent set of proposed competencies did not show a major focus on ethics. With the ever-increasing call for more competency development in and emphasis on ethics in medical and public health training (IOM Report, 2003), it would be helpful to articulate specific competencies in this area.
- The fear of/need to **pass the “boards”** was a prevalent theme in this analysis. It is clear that passing the “boards,” and everything that is perceived to go along with that, is a barrier to changing the culture and coming to consensus about where the project should go. It is also a factor in facilitating ownership of a changed type of residency. This concept needs to be understood in ways that can contribute to the growth and change of the residents and the residency.
- There was an incredible amount of fatigue displayed behaviorally during the interviews. In many instances residents were not able to remember questions. They had to have the questions repeated multiple times because they said they were too tired to remember. Many expressed their fatigue and lack of sleep several times.

C) Emergent Themes, Issues and Challenges

- A major challenge facing the Jacksonville initiative and perhaps all of the Dyson initiatives is the culture conflict between the values and practices inherent in community health versus the values and practices inherent in a modern teaching hospital, the home of most medical residencies;
- Need to come to consensus about what Dyson is;
- There are a number of challenges, specific to learning and methods of learning.

Strengths and Weaknesses of the Implementation Process

1. Most effective aspects of implementation.

The first year of the Dyson Initiative at the University of Florida, Jacksonville was primarily a year of exploration and discovery concerning the proposed Dyson Initiative rather than a year of implementing a defined program where fidelity to implementation would be assessed.

Consequently, the proposed evaluation process focused more on formative evaluation as well as developing a rich description of the emergence of the changing residency within the context of the community, rather than summative evaluation. The strengths and weaknesses conveyed at this point should be viewed within the perspective that the proposed program was intended to go through major transition during the first few years. Considerable program development was to

occur during the early years. Within this context, the strengths and weaknesses of implementation efforts are perceived to be:

a.) Program development: The program has gone through considerable change based on feedback from a number of sources, particularly the residents. The program has also adjusted to changes in staff and, conversely, staffing changes were made to meet the evolving needs of the program. For example, the epidemiology position that was originally conceptualized to assist with resident research has been reconfigured to a community mentor position to assist resident involvement with community. In-depth evaluation first year evaluation has the potential to provide formative direction as the project emerges, supporting culture change and opportunities for scholarly publication.

b) Resident Involvement in local Dyson development: Early in the first year, Resident involvement was minimal. Following the first Dyson Symposium and some initial feedback about resident resistance and apathy, resident involvement has increased substantially. One resident, who has become increasingly committed and involved, has been instrumental in facilitating broader resident involvement.

c) Involvement of Community (walking the talk): As described in the earlier sections, the community was involved extensively during the first year, particularly in developing specific curriculum components.

d) Evolution of Community Advocacy Initiative (CAIs): The CAIs emerged from a blending of the original concept of projects and villages, building on concepts of community involvement. This offers promise to be a major asset of the Jacksonville Dyson Initiative. Residents are engaged and discovering passion for community through this effort.

e) Development of community owned competencies: Competencies, which are closely linked to many national Dyson identified competencies, were developed from community and faculty input. This should offer strong potential for ownership by major local stakeholders.

2. Least effective aspects of implementation.

a) Shared Vision across stakeholders: Having a simple, clearly communicated vision for what the Dyson Initiative is or is designed to achieve remains an elusive challenge.

b) Faculty commitment: Faculty commitment and role modeling of Dyson values has been recognized as a problem. Efforts are underway to more effectively engage faculty.

c) Faculty Development: Faculty Development related to Community Competencies is recognized as a challenge. Some efforts such as Learning Rx and developing a Faculty Manual were initiated. However, getting the faculty to embrace a changing residency and to develop the skills and attitudes to support such change remains a major challenge.

d) Assessment of Community Competencies: Establishing assessment process for resident acquisition of competencies or what has been learned is likely to be a major challenge for the second year. It is not clear that the program is ready to tackle the challenge.

e) Efforts to assess the culture and work toward culture change have been difficult to jump-start. Balancing resident ownership of the initiative with vision for the project will continue to challenge these efforts.

SUMMARY:

The first year evaluation was primarily ethnographic in nature, documenting a number of successes and highlighting eminent challenges. Its purpose was primarily formative, intended to provide timely feedback for continued program development.

Anne E Dyson Community Pediatrics Initiative
Department of Pediatrics, University of Florida-Jacksonville
Evaluation Report, Year 1
August 19, 2003

I. Introduction

The following report provides a summary of the proposed evaluation, a description of the evaluation activities during the first year and findings for the first year of the project. The proposed evaluation is described first in the report. The evaluation activities are then described in relation to the proposed evaluation. Findings are then presented, followed by challenges recommendations and evaluation opportunities.

The proposed five year evaluation plan was designed to incorporate three levels of analysis reflected in the University of Florida/Jacksonville Dyson Initiative goals: *a) the Institutional* level related to establishing a Residency program, *b) the Individual* level concentrating on the knowledge, attitudes, skills and practices to be acquired by the residents; and *c) the Community* level emphasizing the integration of the Program with the community. The evaluation approach was both formative and summative, with an emphasis on ethnographic methods in the early formative stages and the more quantitative related summative methods evolving as the outcomes emerged. The following types of methods were proposed to assess processes and outcomes at each level:

- Quantitative evaluations of resident performance will be assessed by KAS analyses, measures of competencies, performance in standardized testing and tracking of professional activities.
- Quantitative evaluation of Program development and implementation using specific process measures will utilize CQI methods with data used for Program improvement.

- Qualitative evaluation by the community, residents and faculty of the Program's function and impact on the community and residents, will use CQI methods for Program improvement.
- Quantitative epi-analyses of the impact on community health outcomes.

A. Institutional Level of Analysis. Learning experiences and curricula were to be assessed for their relationship to the competencies designed as educational outcomes. Changes in the organizational and structural culture of the residency program necessary to support the curriculum and the acquisition of competencies were also to be assessed.

Proposed approach to curriculum analysis. Data collection for curriculum analyses was to be obtained from instructors/mentors and students. A matrix was to be employed to assess the relationship of the competencies to the curriculum components. This assessment will be repeated regularly to provide an on-going formative evaluation of the curriculum to facilitate ongoing improvements.

Proposed approach to assessing the organizational culture. Assessment of the support of the organizational culture for the proposed Pediatric and community health learning experiences were to be attained through ethnographic data collection and analyses. Observations, interviews and documents were to be used for data collection related to the Program's culture, and analysis processes were to include computer-assisted qualitative software.

Proposed approach to assessing essential components. Other Program characteristics were identified which are essential for its viability. Quantitative data was to be collected on an annual basis for the following Program elements: ability to recruit high quality residents including

minorities, the ability to recruit and maintain highly qualified interdisciplinary faculty, impact of personal and professional development support for residents, and professional development.

B. Individual Level of Analysis. Residents will be assessed for the competencies they acquire through the Program. Assessments will include direct performance observation and demonstration of skills in various settings, such as field experiences and clinical rotations. Data collection will use self-assessment and observation/assessment by faculty instructors and community mentors. Assessment of competencies will include the demonstration of scholarship through presentations and/or the development of a publishable paper on their community initiatives.

C. Community Level of Analysis. This analysis will use mixed method evaluation approaches with emphasis on the principles of Stakeholder Evaluation (Guba & Lincoln, Fourth Generation Evaluation, 1989). Quantitative and qualitative data will be collected and guided by continuous assessment of community partner and other stakeholder expectations. Stakeholder Evaluation is a dynamic evaluation process that continually adjusts to the expectations of stakeholders.

D. Summative Evaluation: The preceding formative evaluation will facilitate continuous quality improvement. Annually, these formative evaluation results will also be analyzed to provide a summative evaluation. The annual summative evaluation will include a comprehensive evaluation of the progress of the Initiative that will be presented to the Advisory Committee. At the completion of the 5 years, questions related to the objectives of the Initiative will be answered. To what extent was the Residency able to:

- establish the UFJ Residency as a *Residency Program in Pediatrics and Community Health*,
- develop and implement an interdisciplinary curriculum in biomedical, biopsychosocial and community health that is sustainable and replicable in other U.S. training programs,
- enhance existing and establish new partnerships with public and private sector organizations and community residents/leaders to develop, invest and participate in this Program,
- recruit excellent residents, including minority candidates, committed to the health of children,
- train residents *in* the community using the didactic curricula, community-based and oriented clinical experiences and strategies of Community-Oriented Primary Care,
- provide residents with the knowledge, attitudes and skills necessary to respond to the evolving health issues of children, including child advocacy, health disparities and social determinants,
- ensure personal and professional development of residents during their residency and prepare them to sustain their development and enthusiasm throughout their careers,
- implement a professional development program to prepare professional faculty and community participants to sustain and advance the curriculum and Program,

- continually evaluate and improve the training program, implement strategies for sustainability and work with other communities to replicate relevant Program elements, and
- provide a medical home and partner with families to improve the health status and well being of children in the community?

II. Approach to Evaluation / Evaluator

A. Initial Approach:

The initial approach to evaluation was to employ a University of Florida, Department of Pediatrics Evaluation Research Faculty member who would be employed for approximately 50% FTE to work as the primary Evaluator for the Dyson Project. That approach functioned for approximately 2 months. The initial evaluation efforts focused on base line data collection involving interviews with the first year residents, observation of meetings, document review, and interviews with key stakeholders. An IRB application was submitted for review and approval within the first month of the project. A list of suggested areas of evaluation focus was provided in early July, and an early progress report was provided in August, a few months after the project started. This report provides some initial feedback and provides an overview of the evaluation approach with emphasis on the formative evaluation focus (See Appendix A)

B. Revised Evaluator Approach:

Due to a number of exigent unforeseen circumstances, the initial approach did not remain as a viable option. After it became apparent that the half time faculty position was not desirable for the immediate future, the Institute for Health, Policy and Evaluation Research was contracted for evaluation services with the Director, serving as the Evaluation Principal Investigator. The Evaluation budget was then shifted to pay for the Evaluation PI, an evaluation consultant analyst, a research assistant to collect data and support staff to transcribe and enter data.

Evaluation issues emanating from the Dyson Symposium and recent local Dyson experience were raised in November and again in January (Appendix A & B). An enhanced evaluation protocol (Appendix C) was submitted in January to the Principal Investigators, detailing the data

collection procedures, with a staffing plan. That plan focusing on continued ethnographic data collection was approved. The January meetings between the Evaluators and the Pis Evaluation also resulted in two major understanding for evaluation:

- 1) the evaluator would meet with the Pis on weekly basis
- 2) the evaluator would facilitate a process for assessment and integration of the residency culture with a culture envisioned by the Jacksonville Dyson Initiative.

It was also clear during these meetings, that the Pis of the Jacksonville Dyson Initiative were adopting an approach to encourage Resident ownership, but integration of evaluation with Residency Ownership was left to be resolved.

The use of research assistants to observe meetings was attempted early in 2003 (the second half of the first year). The lack of constructive formative feedback during the meetings was relayed as a concern by the Dyson Co Pis. The Evaluation Principal Investigator began attending many meetings for both observational purposes as well as the opportunity to provide on going formative feedback during meetings.

III. Data Collection & Analysis (first year)

The proposed data collection for the Jacksonville Dyson Project can be summarized at three levels: A) institution, B) resident and C) community. The status of baseline data collection for each of those levels follows a summary of the proposed assessment.

A. Institutional:

Three types of analysis were proposed at the institutional level: Curriculum analysis, organizational culture and essential components. Following is the description of the proposed assessment followed by a baseline data status report:

1) Proposed Curriculum analysis. Data collection for curriculum analyses will be obtained from instructors/mentors and students. A matrix will be employed to assess the relationship of the competencies to the curriculum components. This assessment will be repeated regularly to provide an on-going formative evaluation of the curriculum to facilitate ongoing improvements.

First year Status Report: *Proposed Curriculum analysis.*

An analysis of the relationship of the curriculum to specified competencies using input from faculty and residents is the focus of this proposed analysis. The Curriculum Coordinator has constructed matrices to analyze the relationship of the competencies to the curriculum. These analyses have been presented during a retreat and continue to be refined and disseminated (8/15/03). Assessment by faculty and residents has not begun.

Considerable work was required before the proposed curriculum analysis could begin. Curriculum analysis was challenged by the need to come to consensus on the desired outcomes of the curriculum. Considerable effort was devoted to developing consensus among major stakeholders concerning the competencies that would be the primary outcomes produced by the curriculum. The process involved the identification of the roles or responsibilities that a graduating pediatrician should be prepared to assume upon graduation, followed by the

development of competencies that would be required to successfully assume those roles or responsibilities. Although it is anticipated that competencies will continue to be revised to meet changing expectations, significant progress was made in establishing competencies using input from a broad range of stakeholders including community members and the competencies emerging from National Dyson coordinated efforts. This provides a sound foundation for future assessment of the curriculum. Analysis by Dyson staff has been part of the continuing development process. Now that competencies have been established, it would be appropriate to engage in baseline data collection concerning the extent that the competencies are integrated within the curriculum, using faculty and resident perceptions as the primary data for triangulation of assessments by Curriculum planners. It is recommended that the Evaluators be used to develop an assessment process.

2) *Proposed assessment of organizational culture.* Assessment of the support of the organizational culture for the proposed Pediatric and community health learning experiences will be attained through ethnographic data collection and analyses. Observations and interviews will be used for data collection related to the Program's culture, and analysis will use computer-assisted qualitative software such as NVIVO.

First year Status Report: *Proposed assessment of organizational culture.*

A primary focus of first year evaluation efforts was on ethnographic data collection related to the organizational culture of the residency program. Ethnographic data collection and analysis involved three primary methods: in-depth interviews, direct observation, and review of archival data. In-depth Interviews were conducted with all but two of the first year residents and key leaders during the first few months of the project. Most residents were interviewed, including second interviews with first year residents, during the later part of the first year. Interviews

during the later part of the year were audio recorded. Faculty interviews were commenced toward the end of the first year and early in the second year.

Initially almost all meetings related to Dyson were observed. After a few months observations were reduced but the evaluation PI or evaluation assistants observed most staff meetings and some other meetings such as advisory committee meetings, sub committee meetings, faculty meetings, and various ad hoc meetings.

Considerable archival documents have been accumulated. Minutes or notes are recorded for most if not all meetings. Other documents concerning curriculum, policies, guidelines and schedules are also available for archival review. These documents are important to supplement other sources of data and for analytic triangulation, particularly since they are observed and recorded by different parties than the evaluators.

The interviews, observations and archival data provide a substantial body of baseline ethnographic data for the project.

3) Proposed assessment of essential components. Other Program characteristics can be identified which are essential for its viability. Quantitative data is collected on an annual basis for the following Program elements: ability to recruit high quality students including minorities, the ability to recruit and maintain highly qualified interdisciplinary faculty, impact of personal and professional development support for students, and professional development.

Data on student and faculty recruitment have been and continue to be maintained as part of the residency and academic department record keeping. Data is also collected and maintained related to professional development as part of the University and Hospital human resource record

maintenance. Data for years prior to implementation of Dyson and during the first year of the Dyson initiative in Jacksonville comprise a substantial body of baseline data. The process for accessing and analyzing this data by the Evaluators will need to be clarified during the second year.

B. Resident

The primary focus of the proposed evaluation at the resident level was assessment of the competencies the Residents acquire through the Program. Proposed assessments included direct performance observation and demonstration of skills in various settings, such as field experiences and clinical rotations. Data collection was proposed to include self-assessment and observation/assessment by faculty instructors and community mentors. Demonstration of scholarship through presentations and/or the development of a publishable paper on their community initiatives was also proposed as a tool to assess acquisition of competencies.

First year status report: *Assessment of Resident Competencies.*

Assessment of resident competencies related to Dyson initiated changes to the curriculum has not begun. The competencies were developed too late in the year to have the competencies integrated into the curriculum or to begin the assessment processes during the first year. The means for assessing performance of Residents related to the competencies have yet to be identified. Assessment of competencies represents a potential challenge because of the desire to avoid making Dyson a “punitive” process. On the other hand, avoiding resident accountability for demonstrating required competencies could undermine the initiative’s status as a serious requirement for becoming a pediatrician.

Recommendation: Development of performance measure and assessment tools should proceed with haste during the second year. Development of assessment processes will help to clarify what should minimally be required of all residents versus requirements for residents who select a community/public health pediatrics rotation. Once assessment processes are defined, faculty and and/or community mentors will be able to assess resident acquisition of the competencies. These assessment processes will need to be implemented before the Dyson initiative's impact on competencies can be evaluated.

C. Community.

A mixed method evaluation approached was proposed with an emphasis on the principles of Stakeholder Evaluation (Guba & Lincoln, Fourth Generation Evaluation, 1989). Quantitative and qualitative data were to be collected and guided by continuous assessment of community partner and other stakeholder expectations. Stakeholder Evaluation is a dynamic evaluation process that continually adjusts to the expectations of stakeholders.

First year status report: *Assessment of Community Involvement.*

Observation of meetings, archival records and to a lesser extent, interviews, provide documentation of extensive involvement of community. Community stakeholder input and expectations were solicited and obtained for a number of critical elements of the Jacksonville Dyson initiative. The following are some of the most prominent examples of community involvement and stakeholder input.

Roles and Competencies:

The Community Advisory Committee provided input during an advisory Committee meeting to identify the roles and responsibilities that a pediatrician should be able to assume upon

completion or a Residency Program. These roles and responsibilities were then used to establish the domains/roles upon which the competencies were developed and organized.

Learning Scenario Development:

Community members were invited and actively participated in the development of learning scenarios that would expose residents to the broad social ecology that influences the health of children. These scenarios incorporate a broad range of health related problems that had their origins, solutions or mitigating influences in physical, social, legal and economic elements of the community.

Modification to Clinic with Resident Lead Initiative:

The modification of a pediatric clinic to include legal aid referrals evolved extensively from community collaboration efforts through the City's Legal Aid Office. A Resident utilized the opportunity presented by the Legal Aid office guided by Dyson faculty and staff, but the services were actually volunteered through the Legal Aid Office. The contact was facilitated through membership of the Legal Aid Office representative on the Community Advisory Board and the Dyson Faculty.

D. Other potential sources of data:

Changes in evaluation are facilitated by two major catalysts: changing leadership roles and interaction of evaluators among the Dyson sites. Residents are assuming greater leadership involvement and consequently evaluation should be sensitive to expectations of these stakeholders. Changes in staff, with some having strong influence on program direction, also implies need for evaluation sensitivity to changing expectations.

National Dyson is facilitating cross-site evaluation interaction, providing opportunities for sharing evaluation concepts and tools. This not only facilitates individual Dyson sites learning from one another, but also facilitates synergy in the development of Evaluation concepts and tools. A variety of tools are available for evaluation, some more valid and sensitive to specific outcomes than others. It is recommended that evaluation efforts continue to focus on key stakeholder expectations and not simply use what ever tools are available.

IV. Findings

A) First Year Evaluation Findings Related to Goals & Objectives

Goal 1. The Residency: *To establish and continually improve an academic, interdisciplinary community-based and oriented residency in Pediatrics and Community Health.*

Objective 1.1. *By Year 1, To establish the UFJ training program in Pediatrics as the Residency Program in Pediatrics and Community Health.*

(Revised 9/5/02) By the end of year 2, to establish the UFJ Training program in Pediatrics as the Residency Program in Pediatrics and Community Health, as measured by a formal name change, by meeting with senior management and gaining approval from the Dean of Pediatrics.)

1st year Finding Obj 1.1: This objective, although amended to take an additional year to accomplish the objective, is likely to require more extensive time than two years because it may require support of much of the Pediatric Department Leadership and perhaps broad faculty support. What “Community Health” means and what impact the change will mean will probably need to be addressed more clearly. Faculty resistance to changes in residency expectations appear to be exacerbated by ACGME changes that are reducing resident obligations to traditional clinical requirements. This social/political environment appears to make changes in the residency program, requiring resident commitment to less clinically oriented community health, more difficult to attain.

Objective 1.2. *By Year 1, To enhance and/or establish partnerships with families, public and private sector organizations, institutions, community residents, leaders, agencies and organizations to develop, invest and participate in this Program.*

(Revised 9/5/02) By the end of year 1, to enhance and/or establish partnerships with families, public and private sector organizations, institutions, community residents, leaders, agencies and organizations to develop, invest and participate in this Program as measured by, establishing an Advisory Board, with 75% participation at least 3 meetings per year;

1st year Finding Obj 1.2:

The primary outcome of this Objective (involving a wide spectrum of community in the development and involvement in the Pediatric Residency program) appears to be achieved,

although the specified measure of performance may not indicate success. The indicator of 75% participation in Advisory Meetings was an amendment to the original objective. While quantifiable and easily measured, it may not be a very sensitive indicator of community participation and ownership. Attendance by advisory committee member at the Spring retreat was relatively poor compared to earlier meetings. Ethnographic observation of community involvement and in-depth interviews with stakeholders may be a much more sensitive indicator. In addition to the advisory committee meetings, it may be important to make sure community is involved in community relevant tasks such as the scenario development described in the section on data collection and analysis. Involvement of patients/families is an even greater challenge, and it has yet to evolve as a priority.

Objective 1.3. *By Year 1, to fully develop and implement interdisciplinary curricula in biomedical, biopsychosocial, community and urban health and community-oriented primary care that are sustainable and replicable in other U.S. training programs.*

(Revised 9/5/02) *By the end of year 1, to fully develop and implement interdisciplinary curricula in biomedical, biopsychosocial, community and urban health and community-oriented primary care as measured by X number of interdisciplinary faculty assisting in the development of a published curriculum to implement at least 1 Dyson conference per week for residents.*

And, By the end of year 5, to have developed a replicable community pediatrics model as measured by the identification of project elements that could be used in other pediatric residency programs and ultimately making curriculum materials available via websites. (See also Objective 1.9)

And, By the end of year 5, to fully develop a validated formal curriculum with measures TBD

1st year Finding Obj. 1.3: This objective was met during the first year. Essentially, the interdisciplinary curriculum was planned and implemented and has been revised for implementation in the second year. Substantial progress was also made in refining the “project elements” that could be adopted by other residency programs. The whole “project” concept went through extensive evolution, involving Dyson staff Co-PI leadership, National Dyson Consultant input, Resident feedback and local Dyson staff and consultant assistance during implementation efforts. The “Community Advocacy Initiative (CAI)” process evolved during this first year

through an intensive trial and error effort. The emergent model is planned for implementation based on extensive interaction of residents and integration into key components (institutionalization) of the residency program. The institutionalization of this model within the residency program during the second year of the Dyson initiative, sets the stage for formative evaluation and refinement of the process during the next four years of implementation, and will provide exceptional potential for a replicable model. Evaluation processes need continue to develop to ensure documentation of the process for replication.

Objective 1.4. *By Year 1, To implement a professional development program to prepare faculty and community participants to sustain and advance the curricula.*
(Revised 9/5/02) *By the end of year 1, to implement a faculty development program to prepare faculty to sustain and advance the curricula as measured by the creation of a faculty development plan and the implementation of X faculty development sessions with at least 50% faculty participation.*

And, By the end of year 5, faculty should demonstrate a change in knowledge, attitudes and skills (practice) as measured by participation in advocacy projects, faculty mentorship, faculty development sessions and changes in faculty attitude and knowledge of community pediatrics.

1st year Finding Obj. 1.4: Faculty Development related to Dyson Goals and Objectives has emerged as a major challenge. Little progress has been made on this objective, and alternative approaches to enhance the role of faculty as key leaders and mentors continue to be explored. More subtle efforts have been tried such as providing faculty with “Rx for Learning,” one page guidelines, to help guide faculty promote the lessons from Dyson conferences. There is little evidence that most faculty are involved or committed to a Dyson vision. A major culture change may be necessary to be able to achieve this objective.

Objective 1.5. *By Year 2, To train residents in the community using the didactic curricula, community-based clinical experiences and COPC initiatives.*
(Revised 9/5/02) *By the end of year 2, to train residents in the community using the didactic curricula, community-based clinical experiences and COPC initiatives, as measured by 100% second year resident participation in community experiences (health advocacy projects and pairing with community mentor) and ongoing participation by all residents in their continuity clinics.*

1st year Finding Obj. 1.5: Substantial progress was made in the first year in laying foundations for this Objective to be achieved in the second year as planned. CAIs are being planned in collaboration with the residents. A “community mentor” has been added to the Dyson staff to facilitate a community-residency bridge and this effort appears to be very effective in that most residents are scheduled for community involvement during the second year of the Dyson initiative.

***Objective 1.6.** By Year 2, To recruit excellent candidates committed to improving the health of children into this Dyson Residency Program, including minority candidates.
(Revised 9/5/02) By the end of year 2, to progressively improve the match results recruiting residents from a wide geographical area as measured by the number of applicants, the number of interviews, the geographic distribution of residents and match results.*

1st year Finding Obj. 1.6: This objective is projected for the end of year 2. It is too early to assess. It will depend largely on the visibility that the Jacksonville Pediatric residency is able to obtain related to the Dyson initiative. Marketing strategies may be required to achieve this visibility, and enhanced marketing that increases visibility of the Dyson Initiative is in the process of being developed.

***Objective 1.7.** By Year 3, To provide residents with the knowledge, attitudes and skills necessary to respond to child health issues throughout their career, including an understanding of disparities, social and behavioral determinants of child health and child advocacy.
(Revised 9/5/02) By the end of year 3, residents should demonstrate an understanding of disparities, social and behavioral determinants of child health and child advocacy with measures TBD.*

1st year Finding Obj. 1.7: Considerable progress toward this objective was made in the first year. Several challenges remain including, 1) development of performance measures and means of assessment for the competencies, and 2) identification of required competencies and levels of performance for all residents versus those specializing in community health.

Objective 1.8. *By Year 3, To develop and implement specific learning experiences such as didactic seminars, mentoring, and longitudinal rotations requiring the application of social and behavioral research epistemology, design and methods.*

(Revised 9/5/02) *By the end of year 3, residents should apply social and behavioral research epistemology, design and methodological skills as measured by an increase of % TBD in scholarly publications, completed research projects, TBD presentations at Grand Rounds and participation/recognition at the Dyson Day Event.*

1st year Finding Obj. 1.8: Substantial progress was made in the first year related to this objective. Generic competencies have been identified and learning experiences in the form of conferences were developed and presented during the first year. Substantial progress was also made in the recent development of CAI experiences where students could further develop and apply social and behavioral skills. Recent emphasis has primarily been on experiential learning and less on developing research skills and sound evidenced based approaches to community and public health.

Objective 1.9. *By Year 5, To continually improve the training Program, ensure sustainability and work with other communities to replicate relevant Program elements.*

1st year Finding Obj. 1.9: Extensive commitment to continual improvement using input and feedback from a variety of stakeholders was evident during the first year. Participation with national Dyson sponsored events (PACE, Annual symposium, etc.) was evident during the first year. Efforts to collaborate with other Dyson sites were apparent (i.e. Miami). Foundations appear to have been laid to accomplish this objective by the fifth year.

Objective 1.10. *By Year 5, To expand the perspective of the Residency from a "1:1" client focus to a "1:n" population perspective.*

1st year Finding Obj. 1.10: This appears to be a major challenge. Learning experiences were provided during the first year but there appears to be considerable resistance within the residents to make this population based perspective a high priority. Much of the effort was perceived as being “preachy.” Changing what the residency culture values may need to be addressed before

reasonable progress on this objective can be expected. Findings from resident interviews may provide important insight into the challenges and solutions.

Goal 2. The Residents: *To empower and provide pediatricians with lifelong cultural competence, attitudes, knowledge and skills necessary to serve, advocate and improve the health of all children and families in the communities and environments in which they live.*

The following 6 objectives from the proposal identified many of the competencies that a physician should have upon completion of a community health enhanced residency in pediatrics.

Objective 2.1. *By Year 1, To ensure residents have the cultural competence and understanding of the anthropology and sociology of children and families necessary to work in and with diverse communities, and serve and improve the health and well being of all children.*

Objective 2.2. *By Year 2, To provide residents with the knowledge and skills to practice population-based medicine in the context of Community Oriented Primary Care, including the knowledge and skills to collaborate with public and private sector community resources.*

Objective 2.3. *By Year 2, To ensure residents have the knowledge, attitude and skills to integrate the practice of Community Pediatrics with the practice of Pediatric Medicine.*

Objective 2.4. *By Year 3, To ensure residents are prepared as excellent practitioners in Pediatric Medicine, are able to sustain this excellence and are prepared to practice evidence based Pediatrics and integrate clinical research into their practices of Pediatrics.*

Objective 2.5. *By Year 3, To ensure the personal and professional development of residents and prepare them to sustain their ongoing professional development and enthusiasm for the care and well being of children throughout their careers.*

Objective 2.6. *By Year 3, To demonstrate the application of social and behavioral research epistemology, design and methods to community problem solving and to demonstrate the application of scientific methods and findings associated with community organization, development and empowerment.*

1st year Finding Goal 2 Obj. 1-6: Much of the knowledge, attitudes and skill reflected in these objectives are reflected in much greater detail in the competencies that were identified during the first year of the Dyson Initiative. Consequently, these objectives should be redefined to reflect the newly adopted competencies. Time frames for these competency-based objectives appear to be linked to the year of residency training rather than the year of the Dyson Initiative, although the time frames could also be interpreted the other way. Assessment of the desired knowledge, attitudes and skills are not likely to begin until Objective 1.7 is achieved. It does not appear that

assessment of the competencies will be able to start until the third year of the Dyson initiative, due to the extensive work that is still required to: develop assessment processes, determine what competencies will be tested at each level, and decide what competencies are required of all residents versus those who complete specialty training in community health. However, since extensive work has already been accomplished in implementing the curriculum, assessment of all three levels may be able to be implemented in the third year of the Dyson initiative. Additional insight concerning this issue can be found in the section under Resident Interview Analysis.

Goal 3. The Community: *To engage the community, including practicing pediatricians, as partners and expand their capacity for sustainable health and community and development.*

Objective 3.1. *By Program Year 1, To engage the community as partners and involve them in resident training and endeavors related to health and community development.*

1st year Finding Obj. 3.1: Substantial elements of the community, including prominent practicing pediatricians, have become involved in the Dyson Initiative. The preceding section III, C provides examples. It is not clear how the community is perceiving their involvement. However, since there is some lack of consensus on what Dyson is about within the residents and the faculty, it is also likely that there may be some ambiguity for the community members.

Objective 3.2. *By Year 2, To provide opportunities to utilize or apply the scientific literature associated with community organization, development, and empowerment in engaging with communities.*

1st year Finding Obj. 3.2: This objective may have different interpretations. Providing a practice opportunity where literature might or might not be used is different than facilitating the use and application of the scientific literature for some form of community practice. These differences were at the heart of a struggle over how to proceed with the resident “projects.” National Dyson consultants appeared to emphasize residents getting involved quickly based on

passion and interest. The need for experiential learning to engender resident interest and passion appeared obvious. Scholarship and research related to community involvement appeared to be anathema to resident involvement. Residents also appeared to resist the scholarship and research emphasis.

Local Co-PIs have struggled with the pressure from national, but have maintained the need for sound science based involvement. Residents coming into communities as “experts” to conduct projects for communities related to issues for which they were not well prepared showed up early in some of the projects. The problem of using practices unsupported by evidence or even evidence contraindicated strategies also loomed as a problem. The basic concept of residents working with community instead of doing to community also conceptualized the challenge.

Considerable exploratory (trial and error) efforts involving different approaches led to the Community Advocacy Initiative (CAI) program. CAIs are designed to get residents involved with communities before they decide what project or research they might do. It is anticipated that residents will first learn from the community and then recognize community sensitive ways in which their skill, abilities and passions can be an asset to the community. It is hoped some of these efforts will evolve into scholarly endeavors, contributing to the evidence base of pediatric medicine and community health through participant research, action research, case studies, and other research approaches that can be participant/practice centered. CAI activities will be guided by a Dyson staff person, who was specifically hired for their community involvement practice background. This background, a respect for the public health/community health evidence, and a social/behavioral science base of community organization and community change is expected to facilitate both the passion and the desired experiential learning engendering interest. It is

anticipated that it will provide the evidence/science base for greater involvement should residents choose to take leadership roles.

Objective 3.3. *By Program Year 3, To ensure children in communities served by residents have a medical home and to improve their health status and well being.*

1st year Finding Obj. 3.3: Some elements of a medical home have been introduced to the residency program as a direct result of the Dyson initiative. The previously mentioned location of legal services in the clinic as a “resident project” is probably the best example. However, it is not likely that this objective is attainable within three years. This objective is a very lofty expectation, given the comprehensive and extensive nature of the “Medical Home” concept. Similarly, documenting population based changes in health status as a result of the Dyson project is unlikely to occur in a few years. This objective may need to be revised to reflect more realistic change related to medical homes and health status.

Objective 3.4. *By Year 5, To ensure community partners have the knowledge and skills to independently sustain community development initiatives related to the health of children, including the capacity to define priorities, generate resources, engage professional partners and implement, manage and evaluate community-based development initiatives.*

1st year Finding Obj. 3.4: This objective appears to indicate that the Dyson Initiative will lead to enhanced community capacity by increasing community partner knowledge and skills. It is not clear how Dyson activities will result in these improvements. The community partners should learn more about residency training and how it might benefit the community, but it is not clear how they will enhance other skills from the Dyson initiative. This objective may need to be reconceptualized within the context of how the Jacksonville Dyson Initiative is evolving.

Objective 3.5. *By Year 5, To shift the paradigm from physician as expert to include physician as collaborative partner in community decision-making.*

1st year Finding Obj. 3.5: This outcome is a challenge but progress was obvious during the first year. This shift in paradigm was at the heart of the challenge of having residents simply pick a community project and go out and serve the community as an “expert” that was some how of value to the community. This “expert” phenomenon was illustrated when a resident selected a community intervention to implement where the community already had far more experience and expertise than the resident had. Refinement of the “Project” based only on resident interest and passion to a more guided, evidenced based “CAI” process is expected to complement this Objective.

Objective 3.6. *By Year 5, To provide the community and residents with the perspective, knowledge and skills to assess and lead endeavors to meet the health needs of children.*

1st year Finding Obj. 3.6: Enhancing community capacity to meet the health needs of children may be a realistic impact of the Dyson initiative. The specifics of that capacity will probably need to be further refined and clarified for this to be a meaningful objective.

Objective 3.7. *By Year 5, to link practicing pediatricians to communities as practitioners of Community Pediatrics with the capacity to sustain these linkages and community endeavors.*

1st year Finding Obj. 3.7: Data on the linkage of practicing pediatricians to communities as practitioners of community Pediatrics are not being collected and the ethnographic evidence has not revealed progress related to this objective.

B) Resident Interview Analysis: Issues and Opportunities

Highlighting the voice of the Resident as Stakeholder

Introduction to this section: These main themes were developed through a continuing ethnographic analysis of nine in-depth interviews conducted with the new group of PL1 residents during the summer of 2002 and twenty in-depth interviews of residents (PL1 – PL3) conducted during the spring of 2003. Though formative feedback grounded in these emerging themes has been provided throughout the first year (primarily through verbal input from the evaluator), this document provides a summative look at the themes that emerged from analysis of all of the first year interviews. Lists of types of responses are provided to reduce complexity. Unless otherwise noted, these lists are prioritized according to the frequency that the aspect of the theme was articulated.

The value of having these insights is that the stakeholders (Principal Investigators, project staff, residency faculty, community advisors, community partners, patient populations, partners and residents) will have better insight into how to mold the future of the residency and the initiative. In conveying these themes it should not be assumed that the ideas are all valid, it is just what the residents believe. Understanding what people are thinking can help inform the best approach to enhancing knowledge, attitudes and/skills.

Theme: Definition of WHAT you need to learn to become a “Competent Pediatrician.”

The questions were general and not specific to Dyson or the UFJ Pediatric Residency. In their answers the interviewees were clearly describing knowledge much more than attitude or skill.

Types of responses in numbers 1-4 were the most common. Types of responses in numbers 5 and 6 were mentioned by 1/3 or more residents and 7-10 were given by less than 1/3.

1. “You need enough knowledge in your head to pass the boards.” (Clearly the number one priority.) You need to know the “fundamentals of pediatrics” – this should be “ingrained in all lectures” and discussed everyday. It was unclear if people would converge on their definition of what the “fundamentals of pediatrics” actually are.
2. Knowing basic disease processes – both for normal and abnormal problems. Knowing the “ologies” – pathology, physiology, pharmacology.
3. Knowing how to clinically diagnose using medical tests and by looking at the patient. Being able to develop a plan for care that is medically sound. Knowing when you need to involve someone else.
4. Communication skills: Skills to talk to, relate with and work with parents. “Bedside skills” and good rapport with parents. Discussing difficult news with parents. Knowing crisis intervention. The emphasis was on communicating with parents and not children.
5. Knowing your population. Know how to deal with them socially and culturally. Know how the culture impacts the patient. Being able to pick up the subtle messages from parents that can help you diagnose a problem or know how these messages might be contributing to problems.
6. Professionalism: Leadership skills, presentation skills, resume writing and business skills to know the business of medicine.
7. Knowing what your responsibility is. Being dedicated to what you are doing.
8. Have a well-balanced combination of hands on and academic experience.
9. Understanding normal growth and development. Knowing how to provide guidance for immunizations and basic care.
10. A good grasp of mental illnesses and ADD.

Theme: Beliefs about HOW you should learn to be a Pediatrician within a good residency program. The questions were general and not specific to Dyson or the UFJ Pediatric Residency Program. Numbers 1-3 describe the most common types of responses.

1. You should have faculty members who are dedicated to and interested in teaching. They are available, have a primary focus on teaching, relate their expectations to Residents and are accessible. They should be good mentors and appreciate the resident lifestyle. They should display teamwork, cooperation and flexibility. They should teach in a “non-condescending” way.
2. Faculty should use teaching methods or approaches such as: Case conferences where there are clinical examples, teaching rounds. Sometimes they should hold your hand and sometimes you need independence. They should also use repetition – people do not learn something the first time. Fewer lectures. More opportunities to learn from patients AND discussing their management. More feedback from the teaching faculty. Residents should do more teaching of other residents. Faculty members should also remind people of what is due and give more direction on requirements.
3. Faculty should use hands on approaches – need for more supervision in the clinics and on the floors with opportunities to really discuss the patient afterwards. More teaching-oriented experiences with patients.
4. Have faculty with different backgrounds/specialties providing learning experiences across the spectrum.

5. Faculty should be up on recent literature. One interviewee, whose sentiments were echoed by others, said you need faculty who are “willing to change their views based on the new consensus. A lot of times there are attendings who were trained in a certain way and that is the way they practice and times have changed.” Through opportunities for establishing relationships in and out of the hospital.
6. Tie learning to social opportunities.
7. Learning what the real job is going to be like - to run an office, hiring employees, etc.
8. It should provide more than just learning about resources in the community.
9. Have a well-rounded experience where you become more than a phys-pediatrician medically speaking, but also socially speaking.
10. Institution should have a lot of research capability and faculty who believe in and support research. This was mentioned by only 2 residents and only in the follow up interviews.

Theme: Perceived “main goals” of the Dyson Initiative as described from within the first year of the initiative. There is great diversity in this theme and there are various levels of ability displayed in efforts to construct an answer. Several quotes are provided to adequately convey the voice of the residents. It is also important to note that the interviewees were describing their concept of the main goals of Dyson, not the perceived value they placed on the Dyson activities. The descriptors of this theme are not prioritized. However numbers 1,2 and 3 were heavily weighted in the follow up interviews but did not appear in the preliminary interviews.

1. It is “advocating competent community involvement.” It helps make residents more culturally competent to let them know “what is out there in their community and give them an opportunity to be involved and this goes more to the child advocacy, more treating the patient as a whole socially rather than just medically.” Cultural competence, which is embedded in this quote, was highlighted as a goal by several interviewees.
2. Advocacy, which is also mentioned in the above quote, was also highlighted as a goal. One resident noted that Dyson is designed to “teach them and give them a better understanding of how to be an advocate in that community.”
3. Understanding that there should be a large emphasis on developing resident leadership and professionalism. One resident said, “if in your job someone told you that you have to do something but you don’t see what’s in it for you, you don’t have any interest in that. So, I think what this year has been about is the residents trying to help the faculty develop a system in which the residents can buy into the program and understand that not only does it benefit you in an educational or intellectual way but it benefits you in a practical way. You learn these skills that are important because physicians are community leaders. I mean, they are speakers, they are people who have to convey themselves in an articulate way and there’s not a whole lot of emphasis or hasn’t been a lot of emphasis in residency programs nationally before now. Again, you can be the greatest doctor in the world, but if you can’t communicate what you know, how good are you?”
4. Learning through a particular population. Putting something into practice that benefits that population. One interviewee’s comments help to demonstrate how some concepts have been formed about Dyson, but their thoughts are not necessarily connected to a cogent whole. “They are there for us, for anybody who has a particular interest . . . to

guide us on what resources are out there to be able to do that. What the Dyson funds are about is based on the public health system. To teach what resources are available and if there aren't any to connect to in some way, to fund us in some way and be able to fund certain populations in the community to be able to get access to health care or legal services.”

5. It is perceived to be about needs assessment. One interviewee noted Dyson facilitates ability “to assess the needs in the community that are being unmet and for us to find ways to meet those needs.”
6. It is perceived to expand the traditional residency experience by “expanding the scope of general pediatric residency training to include more community based topics like just being exposed to culturally a more broad spectrum of concepts and beliefs and needs.” Another resident noted, “make primary care providers more aware of not only the health care needs of the patient population but also a lot of the social aspects that play into how well or how poorly your patient does. I really support the Dyson in that aspect.”
7. Several residents noted that it encourages residents to think about research, though many reported that they have not been involved in research.
8. Several residents perceived Dyson to be doing a project or “coming up with an idea that you think that the community can benefit from and kind of try and take action with it.”
9. It helps the pediatrician move into the community. “The goal is to extend the pediatric deeper into the community so we can really help the children, not just when they are sick, but just as a whole. Bring up the level of everything, education, health care and other things. Yeah, it is a very big deal. It's nice that somebody is trying.”

10. When asked about what the main goals of the Dyson Initiative are one resident, whose answer demonstrated the beliefs about Dyson, said, “Um, that is such a good question. If that had been clear to us ten months ago, it would have made a heck of a difference. We had no clue ten months ago. Now I have a vague clue. It is very vague. Evolving. Hard to define. To bring together community resources and pediatricians? To address community problems as pediatricians. Not traditionally part of pediatrics.”

Theme: Resident expectations created by Dyson Initiative have been varied and evolving.

The descriptions of this theme are presented in subthemes.

1. **To become community oriented.** When asked what expectations have been created by Dyson, one resident noted that it is to help them “maybe be a bit more community oriented, just kind of have a bigger picture in our mind rather than the one in front of us.” Another noted that Dyson will “enhance the expectation that residents will be more comprehensively competent in community pediatrics. And, to hopefully build on that to where there is some life-long interest or career interest in what is going on with our patients outside the office.”
2. **To expand thinking.** One interviewee noted, “They’re trying to get us to think outside the box. They try to broaden our horizons and see our patients not only as a physical and physiological beings.” In some cases they named the individual faculty who were trying to do this and did not attribute it solely to Dyson.

3. **Dyson could make us miss something.** Residents have expectations about what they should be learning in the residency experience. Sometimes they are unclear if there is not something else they should be learning instead of going to Dyson conferences, etc., because, “after all it is not the type of thing that is going to prepare you for board exams that people worry about.” However, the same resident noted that for “me it has been more of an enhancing experience than a distracting one, although I did not understand that much in the beginning. They have definitely changed over time. In the beginning I really didn’t see the relevance, the need or what we were trying to get out of it.”

Theme: Diverse ways of understanding and articulating of the concept of cultural competence. The definitions of cultural competence were diverse.

- a. Many residents noted great depth of understanding of the concept. For example, one resident noted, “When a person is culturally competent she is more aware of other culture’s needs and environments and may be less judgmental about what the culture does to try to help members.”
- b. However some definitions of the concept were more restricted. One resident defined cultural competence by stating the following, “To me I think it would mean, are the physicians understanding of the cultures that they’re treating? If they are talking about the patients, I would think that what it means is, is the culture competent enough to understand what the physicians are saying?”
Another resident noted that cultural competence influences delivery of health care because, “It opens your eyes . . . depending on the culture of the family (you can

know) how they are going to adhere to the treatment that you are recommending and what other stuff they are going to be adding to the treatment.”

Theme: Beliefs about how the Dyson Initiative has changed or will change their residency experience. This theme had two extremes noted by the following:

1. **Many residents reported a positive change.** As an example, one resident noted, “Well, for me it’s actually changed mine. I think, quite a bit, um, certainly I’ve gone from being somebody who, you know, saw myself as being a general pediatrician and taking care of my patients as well as I could to, you know, feeling like, you know, there is a large community out there that I can influence or help.” This resident stated that it has been inspirational. Another resident noted, “My first day in the clinic that the legal aid was there I was already referring patients, it felt really good having this new resource for patients. It’s also been inspiring because you see all these people doing these great things and I’m like wow, I can do that during my residency? Because she is doing it all within the time frame. I don’t know how she is making it with that many hours in the day, but if she can do it, I would think that I could if I could just get my act together a little bit better.”
2. **A few residents were less convinced that the change would be positive.** As an example, one resident noted, “It will change a lot for those who are interested in doing community work. Because I believe some of us do not believe in doing community work in the residency. For those of us it is not going to change.” In a summary statement one resident noted, “They’ve had a lot of growing pains. It is hard. It is hard for every body.

Everybody hates change. Everybody hates extra work. I think Dyson is still an untapped resource and I don't think it has found a place in our program yet. The feeling is for Dyson to get more something has to get less." This interviewee noted a problem with a student project and reported that "it just sort of left a unfavorable taste in the resident's mouths as they feel they are being forced to do something that they didn't volunteer for, you know, these are all hard choices and I do not know the answers to them."

Theme: Diverse and changing levels of understanding or beliefs about sociocultural issues, ecological issues and the etiology of health problems that persist in some communities.

There seems to be an evolution from a "black and white" view of the world to accepting "shades of gray."

1. **Many residents, especially those in years 2 or 3 of residency, reported a strong familiarity with these issues.** One noted, "When I deal with a patient I take into account that as an individual they have their own experiences and background, cultures, and definitely approach each patient as an individual and not based on their disease. I also take into account other factors like culture, income and background. It is very important."

Another noted that before the Dyson Initiative his/her experience with the interactive effects of socio-cultural issues was limited. But it has changed. "Since coming here I understand the population much better. The glaring distinction is that before the Dyson Initiative came along that interaction was (observed) in a very artificial setting. I mean most people act differently in the hospital."

2. **Some residents were in the early stages of comprehension.** One resident, whose ideas were reflected by others, noted that Dyson had impacted and changed his/her beliefs by saying, “I guess I was not too familiar until this Dyson Initiative started. I guess we just had different conferences and I guess workshops about different determinants of health. It made me more familiar.” This same resident went on to note, “In the beginning I was sort of one short sighted and felt like people were creating their own problems or even if it wasn’t their fault that they were in a particular position. I think I am a little more open to the fact that there are influences that are outside of their control that may be directing them or influencing them that they aren’t maybe even conscious of.” A few residents who come from out of the US perceived they were still learning about this country yet were somewhat more cognizant of these issues from within the context of their own countries of origin.
3. **A few residents conveyed a very early awakening of understanding.** One resident’s comment highlights the limits of some resident’s understanding prior to entry into the residency. This resident noted that, “I guess I never realized that parents do not do exactly what we told them to do. I thought we told them and they’d do it. So that’s changed. And I’m not saying all parents, just some. Cause they’ll call me from the pharmacy three days later about a prescription which isn’t filled and it’s been three days.” This same resident went on to say, “I think I have more understanding of that fact that there’s people out there who don’t have much money and need a lot of resources and, you know, I just assumed that they can pay for everything.”
4. **There were examples of statements that indicate a different perspective, one that is less sensitive to ecological issues.** For example, one resident said, “I definitely believe that certain things are genetic. You can’t get away from that. But one of the reasons I didn’t do

adult medicine is because I firmly believe that a lot of things that people do fall upon themselves like the lung cancer and obesity and diabetes. There are just so many things, especially when it comes to smoking and I firmly believe that there are a lot of health problems we could be rid of if people were more responsible. . . Unless people are taught to think differently then it's gonna forever be a problem and you are just going to bang yourself on the head.”

There are several important issues that emerged from the analysis of the interviews that may need additional attention. These are listed below along with some suggestions that could help facilitate the effectiveness of the intervention as it moves into year two:

1. The residents can be and have been turned on to **the ecological issues that surround population based community health**. However, it was clear from these interviews that the depth and breadth of resident intellectual beliefs and attitudes about community (understanding the importance of community and involvement in communities) is varied when they enter and as they progress through the residency. Their understanding of the relationship of public health and health care may have been perceived by the Dyson Team to be more extensive than it actually was when the residents entered. The residents' prior training in and involvement with public policy issues appears to have been more limited than expected. Though many of the residents reported experiences in the community (both in interviews and on their charts) it is clear that the bigger picture was frequently absent and was perhaps perceived (by some) to be unimportant for a pediatrician to learn. This awareness should influence how the introductory work with the new PL1 group is

conceptualized. As one possible suggestion, it could be helpful to use the ecological model (for understanding the lives of people who live in communities, Brownson 2003) as an organizing construct to develop informal introductory discussions as the new academic year begins. It might be helpful to have ongoing discussions with new (and older) residents, in a social setting, regarding their beliefs about how realities (across the ecological spectrum) impact the health of the patients (and communities) they will serve. This process might also help the Team get a better understanding of the values and beliefs the residents bring to the residency. (Listening to these discussions could also be helpful to the evaluators.) Rather than immediately dealing with these concepts in a learning environment situation, which carries with it heavy baggage of grading and evaluation (something they really react to strongly and have a vested interest in), you might consider these alternative approaches. The residents were asking for learning to be blended with social activities, so this might be a good way to start. (One important note, very early interviews with the new PL1 for year 2 of the project indicate a greater sensitivity to these issues than was found in the entering PL1 for year 1.)

2. Some residents expressed a lack of clarity as to how the Dyson Initiative can help graduates who do not practice in Jacksonville? How will participation in Dyson help graduates who only want to do hospital work? These are lingering questions that surfaced in interviews.
3. In some cases there is a “them” concept of Dyson vs. an “I” concept of residents. For example, several residents described what Dyson was trying to accomplish by saying that “they want us” to do something. This is important because it shows that ownership is tenuous. Much progress was made on this issue throughout the year, but it is important to note that this was still the most common type of statement.

4. The concept of **ethics** was not mentioned by even one resident in an interview. Though ethics was on an agenda for a core competency meeting earlier in the year, upon review of the most recent set of proposed competencies, it was determined that ethics was not a major focus. With the ever-increasing call for more competency development in and emphasis on ethics in medical and public health training (IOM Report, 2003), it would be helpful to articulate specific competencies in this area.
5. The fear of/need to **pass the “boards”** was a prevalent theme in this analysis. It is clear that passing the “boards,” and everything that is perceived to go along with that, is a barrier to changing the culture and coming to consensus about where the project should go. It is also a factor in facilitating ownership of a changed type of residency. This concept needs to be understood in ways that can contribute to the growth and change of the residents and the residency.
6. There was an incredible amount of fatigue displayed behaviorally during the interviews. In many instances residents were not able to remember questions. They had to have the questions repeated multiple times because they said they were too tired to remember. Many expressed their fatigue and lack of sleep several times.

C) Emergent Themes, Issues and Challenges

1. A major challenge facing the Jacksonville initiative and perhaps all of the Dyson initiatives is the culture conflict between the values and practices inherent in community health versus the values and practices inherent in a modern teaching hospital, the home of most medical residencies. The predominantly acute nature of the medical problems and the high technology-dependent approaches to diagnosis and treatment found in the modern teaching

hospital creates a very different context than the longer term, ecological, non-technology-based context of community health problem solving. The need for change in medical education to reflect more population and community approaches to health is well established in major reports by the Pew Health Professions Committee and the Institute of Medicine. The apparent focus of the Pediatric Boards on the more acute care, higher-technology grounded problems and solutions reflects institutional barriers to these changes. This basic culture conflict is exacerbated by the high state of change of major institutional forces impinging on the Residency Programs, such as ACGME, FOPE, Residency accreditation concerns, UFL College of Medicine, SHANDS Hospital and the Department of Health.

This culture conflict, exacerbated by other forces of change and pressure on the residency program, has resulted in some resident and medical community insensitivity and even hostility to the Dyson initiative at the local level. The force for change is sometimes seen as undermining what pediatric medicine is really all about. In a time when growing pressure is being exerted to shift the emphasis of the residency program from patient care to medical education, changes in values and practice posed by increased emphasis on community are going to be met with even greater resistance. Greater restrictions on resident work hours and residents being away from patient care for non-clinical reasons have implications for income generation and faculty workloads. Both administrators and faculty have reasons to resist the proposed changes and Dyson runs the risk of being the scapegoat for other changes that are forced on residency programs. Dyson community pediatric initiatives are based on the premise that change is needed in pediatric residencies, but the forces of resistances to changing the residency culture are formidable. Vision, leadership, opportunity and commitment are clearly needed and visible with

the Jacksonville Dyson Initiative. However, a very well planned effort to reduce the culture conflict at many levels may be required to support the effort.

2. It is important to **come to consensus about what Dyson is** so that everyone can have ownership of the desired “product” of the pediatric residency – what should a residency graduate look like? It is equally as important to come to consensus about and ownership of a shared definition of how the residency as an institution should change (the goal being that all stakeholders of the residency come to consensus). This is a central issue. Closely aligned to this (and part of this process) is the need to work toward shared values and a **shared understanding of the cultural supports and barriers** that will impact the processes of coming to consensus and facilitating this ownership across all stakeholders.

3. There are a number of challenges, specific to learning and methods of learning, that complicate turning responsibility for development of the Initiative over to the residents.

The challenge is partially grounded in the way that some residents define what they need to know and how to learn it (their epistemology). From the types of statements made by some of the residents it is clear that their concept of learning and teaching is primarily based on a very linear, one problem-one solution approach. This is the way many may have been taught to learn (given that they have come from a very hard science/medical model orientation). Yet many clearly seem to desire a broader model of learning – they have been turned on by the experiences of the last year. Those who have felt this desire are starting to feel the passion for a more holistic/interactive type of learning experience. Cultivating this desire while giving them perceived control of the learning environment will be the real challenge. The goal is to appear to

give up control of the planning of the curriculum, etc. while still helping residents come to appreciate (more than they currently do) that the patient care issues they will deal with are complicated (interactions across the ecological spectrum), that they are not linear, that they are always changing and can not be “solved” in the traditional ways. They need to continually have their growing awareness cultivated, especially in ways that create epiphanies – “ah ha” realizations that these complicated situations NEVER lend themselves to simple, stable solutions (such as writing a prescription or telling a parent to buy a product). From the interviews it is clear that not all residents have embraced this holistic view of the world, consequently, it is difficult to support putting the design of the curriculum and the experiential learning opportunities completely in their hands. On the other hand, ownership is critical for the success of the initiative. So, finding the balance is crucial. It is especially difficult if other stakeholders, such as faculty, are not on board with this challenge. The move toward scenarios and other types of inductive, self-directed learning methods has been pivotal and has done much to complement this balance. The important message here is that change has only begun, so vigilance will be very important. And, as new people enter, the challenge is renewed. Learning opportunities will be less clear and will be of short duration. But, if the opportunities are taken, the learning that emerges will be powerful – as the residents will believe they created it themselves.

V. Strengths and Weaknesses of the Implementation Process

1. Most effective aspects of implementation.

The first year of the Dyson Initiative at the University of Florida, Jacksonville was primarily a year of exploration and discovery concerning the proposed Dyson Initiative rather than a year of implementing a defined program where fidelity to implementation would be assessed.

Consequently, the proposed evaluation process focused more on formative evaluation as well as developing a rich description of the emergence of the changing residency within the context of the community, rather than summative evaluation. The strengths and weaknesses conveyed at this point should be viewed within the perspective that the proposed program was intended to go through major transition during the first few years. Considerable program development was to occur during the early years. Within this context, the strengths and weaknesses of implementation efforts are perceived to be:

a.) Program development: The program has gone through considerable change based on feedback from a number of sources, particularly the residents. The program has also adjusted to changes in staff and, conversely, staffing changes were made to meet the evolving needs of the program. For example, the epidemiology position that was originally conceptualized to assist with resident research has been reconfigured to a community mentor position to assist resident involvement with community. In-depth evaluation first year evaluation has the potential to provide formative direction as the project emerges, supporting culture change and opportunities for scholarly publication.

b) Resident Involvement in local Dyson development: Early in the first year, Resident involvement was minimal. Following the first Dyson Symposium and some initial feedback about resident resistance and apathy, resident involvement has increased substantially. One

resident, who has become increasingly committed and involved, has been instrumental in facilitating broader resident involvement.

c) Involvement of Community (walking the talk): As described in the earlier sections, the community was involved extensively during the first year, particularly in developing specific curriculum components.

d) Evolution of Community Advocacy Initiative (CAIs): The CAIs emerged from a blending of the original concept of projects and villages, building on concepts of community involvement. This offers promise to be a major asset of the Jacksonville Dyson Initiative. Residents are engaged and discovering passion for community through this effort.

e) Development of community owned competencies: Competencies, which are closely linked to many national Dyson identified competencies, were developed from community and faculty input. This should offer strong potential for ownership by major local stakeholders.

2. Least effective aspects of implementation.

a) Shared Vision across stakeholders: Having a simple, clearly communicated vision for what the Dyson Initiative is or is designed to achieve remains an elusive challenge.

b) Faculty commitment: Faculty commitment and role modeling of Dyson values has been recognized as a problem. Efforts are underway to more effectively engage faculty. c) Faculty Development: Faculty Development related to Community Competencies is recognized as a challenge. Some efforts such as Learning Rx and developing a Faculty Manual were initiated. However, getting the faculty to embrace a changing residency and to develop the skills and attitudes to support such change remains a major challenge.

d) Assessment of Community Competencies: Establishing assessment process for resident acquisition of competencies or what has been learned is likely to be a major challenge for the second year. It is not clear that the program is ready to tackle the challenge.

e) Efforts to assess the culture and work toward culture change have been difficult to jump-start. Balancing resident ownership of the initiative with vision for the project will continue to challenge these efforts.

VI. Evaluation Opportunities:

1. To develop assessment processes and tools for assessing resident competency development from knowledge, attitude and skill levels.

Embedded in the evolving, expanding list of domains and competencies are required skills, attitudes and knowledge areas that make up each competency. For the project to legitimately claim success it must document that these skills, attitudes and knowledge areas have been acquired. First these must be delineated. But, it will not be enough to document only knowledge increases. Changes in attitudes and, most importantly, skills, must be agreed upon as necessary for all residents (or a particular type of residents). Following this, assessment can be developed and conducted.

2. To clarify the evolving evaluation needs of the growing body of stakeholders in the project.

As the ownership of the initiative grows, changes and expands, and the emphasis on sustainability grows, the evaluation will be challenged to meet the needs of these changes. For example, as the residents become more involved in the day to day planning, how can (or should) the evaluation provide them with the formative feedback that will be most helpful to them as they provide leadership for the evolving project?

3. To support a better understanding of the issue of “passing the boards” and provide input that can help change the culture of the residency.

The “boards” are a major concern but they are also somewhat of a mystery, an important symbol of the culture. They (personified by the culture?) loom way in the future, but are a source of confusion/stress/control because they will be so important. This symbol seems to be a barrier to change. The residents do not know enough about this to really judge what could be important so

they rely on a cultivated definition and glean what might be important. They receive many confusing facts about the “boards.” Faculty have been observed saying that only 1-3% of the questions on the boards related to the “community issues.” Is this accurate now? Will it be accurate later? Because of this and because the “boards” keep coming up as a barrier to Dyson and, consequently, make them a good topic for a focus group study to find out the range of beliefs and attitudes held about the “boards.” The following questions could form the basis of this focus groups study:

- What do residents believe they need to have learned to pass the boards?
- Who do residents believe holds this knowledge (it seems they believe this is a set of facts as opposed to skills) and how will they get it?
- How/when does this set of beliefs about the boards get so strongly enculturated into their belief systems? Do they have it when they leave medical school – does it evolve at a residency experience? Is it part of the “rite of passage” that is “residency?”
- Is taking and passing the “boards” perceived to be the most important thing that will happen to them throughout the residency? What do they perceive to be the barriers to their ability to pass the boards?
- What might they miss if they concentrate on this one outcome?
- What would it take to build more of a perceived overlap in values – that it is important to work toward passing the boards AND simultaneously valuing an emphasis on community to enhance their ability to be competent pediatricians?

If possible (obviously a very difficult thing to do), conduct a similar focus group study with willing faculty as subjects using many of the same questions modified from above, preferably after the resident groups are conducted. It is clear from the analysis of the interviews that

"passing the boards" is also a very important indicator of the quality of the residency (from a faculty and accreditation perspective) - as it getting residents to take the boards. Clearly, this helps form the culture as perceived by the faculty so understanding this could be of great benefit for planning change.