Media advocacy: an introduction

Advocating for Children Together Conference

Oakland, CA
October 5th, 2019

berkeley media studies group

Shaddai Martinez Cuestas, MPH

berkeley media studies group

Disclosures:

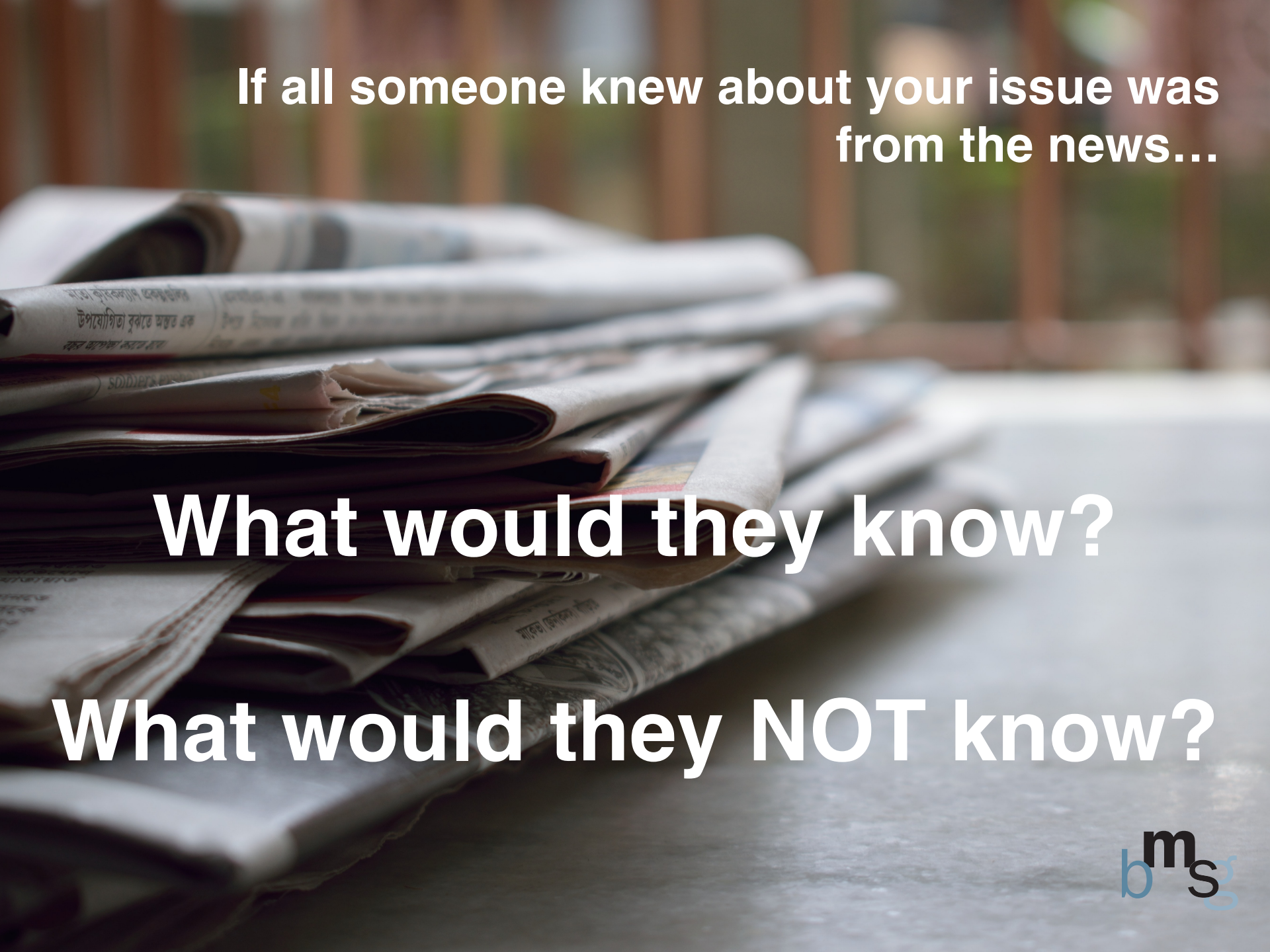
I declare that neither I, nor any immediate member of my family, have a financial arrangement or affiliation with any corporate organization offering financial support or grant monies for this continuing medical education activity. In addition, I do not intend to include information or discuss investigational or off-label use of pharmaceutical products or medical devices.

- Research on news coverage of public health issues
- Media advocacy training and strategic consultation for community groups and public health advocates
- Professional education for journalists

berkeley **media** studies group

Training objectives

- Recognize the news media's role in shaping debates on health and advocating for change;
- Clarify your media strategy to create change at the policy level;
- Develop strategic messages for advocacy.


If all someone knew about your issue was from the news…
What would they know?
What would they NOT know?

Key Functions of the News

Setting the agenda → What we think **about**

Shaping the debate → **How** we think about it

Reaching opinion leaders → What we **do** about it

News media coverage trends

- Most news stories are “episodic” and emphasize individual responsibility.
- Reporters try to “put a face” on an issue to illustrate its impact on a person’s life.
- Most news stories lack discussion of context or policy implications.

What is media advocacy?

Media advocacy is the **strategic** use of mass media to **support** community organizing to **advance** a social or public policy initiative.

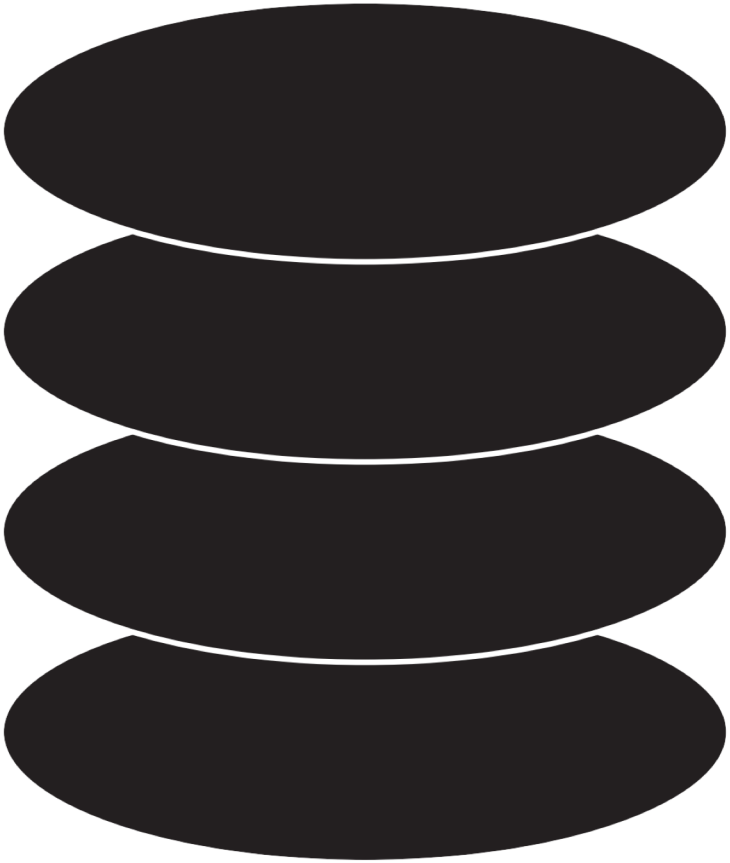
What's the difference?

Social Marketing	Media Advocacy
Individual Focus	Issue Focus
Warns & Informs	Pressures & Mobilizes
Personal Change	Policy Change
Message	Voice
Information Gap	Power Gap

Media is never first

You can’t have a media strategy without an overall strategy.

The Layers of Strategy



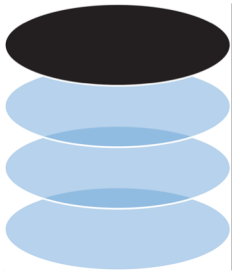
Overall strategy

Media strategy

Message strategy

Access strategy

Overall strategy

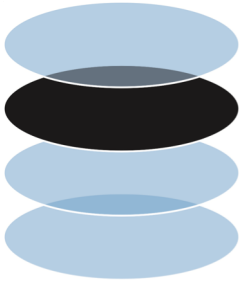


- Define the **problem** you want to address
- Clarify the **policy solution** for which you'll advocate
- Identify the **target** with the power to make the change
- Enlist the **allies** who can help make your case
- Identify what **actions** you'll take to influence the target

Activity: overall strategy

- Think of one policy/solution you are advocating for
- Brainstorm answers to the Overall Strategy worksheet
- Share what was hard, what was easy

Media Strategy



- Identify the best **methods to communicate** with your target
- Decide if engaging with the **media will advance** your goals
- Find the media that will **reach your targets**
- Compile the **media tactics** you will use

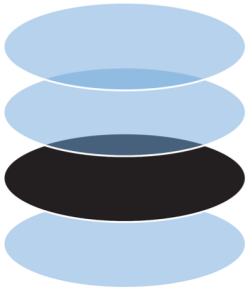
Media tactics

- Letters to the editor
- Editorials and op-eds
- Creating news
- Piggyback on breaking news
- Paid advertisement
- Social media

Message is next

You got media attention, now what?

Message Strategy



Framing: how we characterize the issue

Message: what we say

Messenger: who says it

Target: who we want to hear it


Frames are mental pathways that help people understand the world.

Portrait frames and solutions

Portrait frames

- Kids going hungry
- Kids don't have a place to live
- Kids experience violence

Trigger personal responsibility **solutions**

- Irresponsible lazy parents = Take the kids away; punish the parents
- Not my problem = inaction

Landscape frames and solutions

Landscape frames

- Gaps in understanding of ACES in system of care
- Programs that offer support for families are limited, threatened, etc.

Trigger social responsibility solutions

- Trauma informed systems
- Support programs
- Support initiatives/policies

Reframing diabetes

Portrait

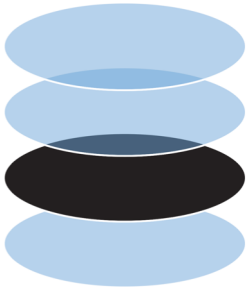
- Bad personal choices and behaviors
- Absent parents and lack of oversight
- Poor role models

Landscape

- Lack of healthy eating and physical activity options
- Target marketing of soda and junk food to kids of color
- Celebrity endorsements of soda and junk food

The need to reframe

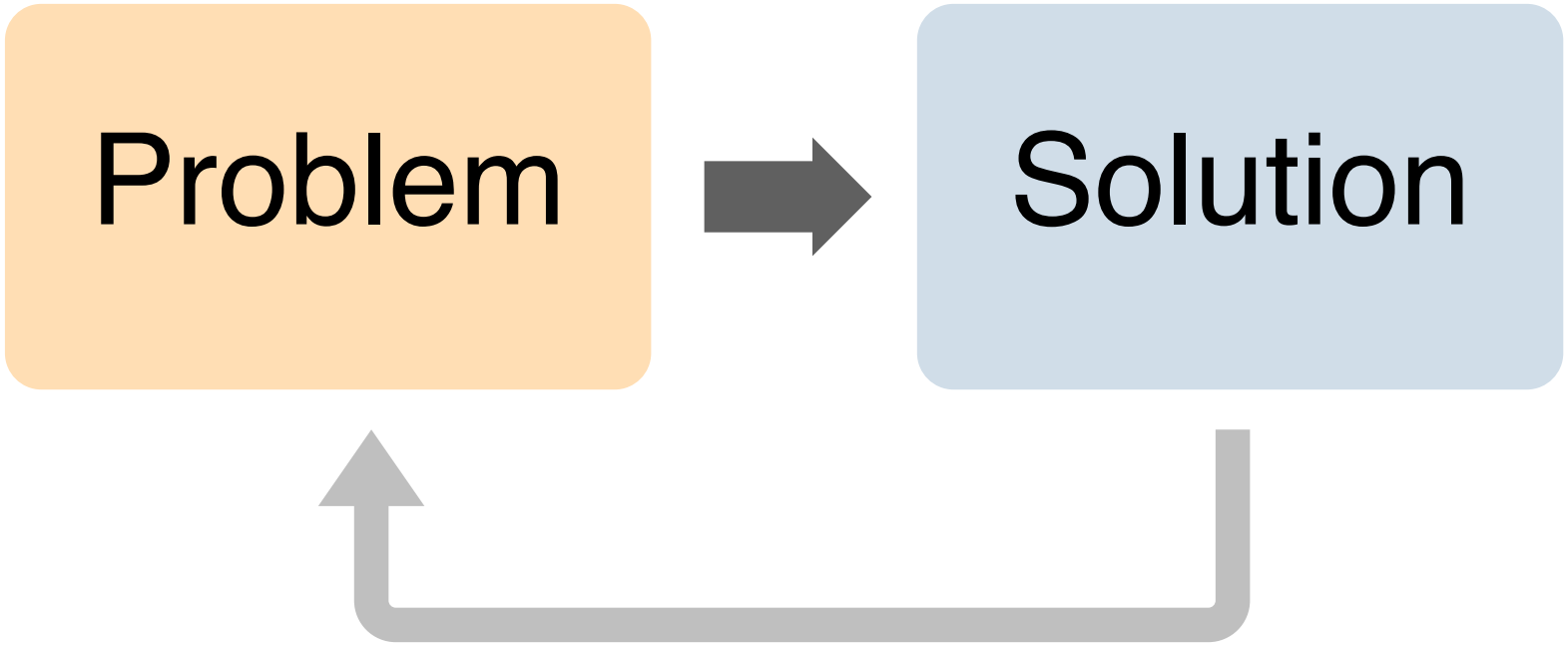
Message development



Components of a message:

- Statement of problem
  What's wrong?
- Value dimension
  Why does it matter?
- Policy solution
  Who should do what by when?

Defining the problem



Example

Problem

Too many liquor stores create neighborhood blight, crime, and loitering, and detract from the quality of life.

Solution

The city should limit the number of liquor stores allowed within a certain radius.

Why does it matter?

Value dimension

- Facts alone do not move people
- Connect first
- Evoke shared values

Example

Evoke shared values

It is not **fair** that certain **families** are subjected to such degraded conditions. Every **family** should have the **opportunity** to raise **children** in a **safe** and **vibrant** neighborhood.

Tobacco example

Tobacco companies are targeting consumers in our state with cheap tobacco products. Sometimes this is done through discount coupons and sometimes through financial incentives provided directly to the stores that sell cigarettes. Kids are especially vulnerable to these tactics since they have less money to spend. Restricting coupons and other promotions would go a long way toward solving this problem and when we can do something to improve the health of the community, we have an obligation to do it.

Problem

Solution

Shared values

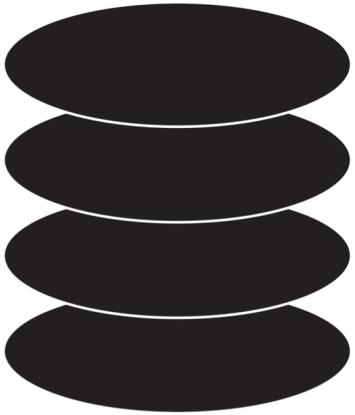
bmsg

Activity

On your Message Development worksheet:

- Write down your **problem** statement
- Write down your **solution** statement under “what should be done”
- Write down your **values** statement
- Put it all together!

Summary




Frames are mental pathways that
help people understand the world.


Institutional
accountability
Personal
responsibility

berkeley media studies group

THANK YOU!

Shaddai Martinez Cuestas, MPH

cuestas@bmsg.org

www.bmsg.org

Twitter: @BMSG

Facebook: Berkeley Media Studies Group

Worksheet: Overall strategy

Before trying to get media attention for the issue you are working on — or determining what your message is going to be — you and your coalition need to have clarity in your overall advocacy goals, as well as the steps you will take to achieve them. Answering the questions in this worksheet will help you identify what information you need to move forward and what immediate steps you need to take. Think of this sheet as your primary guiding tool: Your media strategy and message strategy should derive from your overall strategy, so all your actions are in alignment with your advocacy goals.

What is the issue that you want to see addressed?

What is the specific solution you want to advance to address that problem?

Who has the power to make that change (i.e., your target)?

What is the target's position on your policy goal?

What allies must be mobilized to apply the necessary pressure?

What advocacy actions will you take to reach or influence your target?

Message delivery: tools for spokespersons

Advocating for Children Together Conference

Oakland, CA
October 5th, 2019

berkeley media studies group

Shaddai Martinez Cuestas, MPH

berkeley media studies group

Disclosures:

I declare that neither I, nor any immediate member of my family, have a financial arrangement or affiliation with any corporate organization offering financial support or grant monies for this continuing medical education activity. In addition, I do not intend to include information or discuss investigational or off-label use of pharmaceutical products or medical devices.

- Research on news coverage of public health issues
- Media advocacy training and strategic consultation for community groups and public health advocates
- Professional education for journalists

berkeley **media** studies group

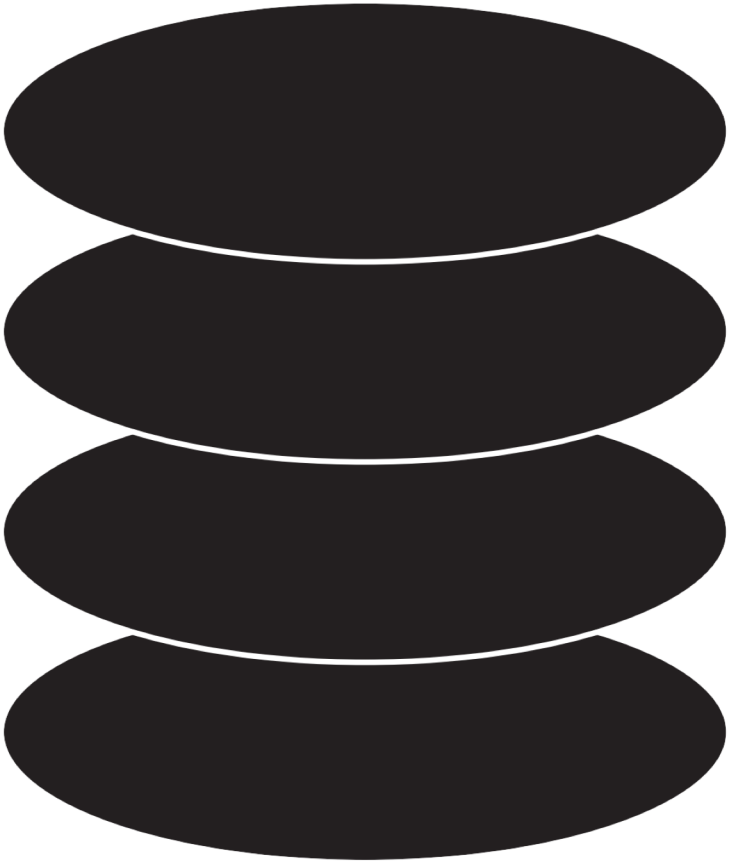
Training objectives

- Prepare for media interviews
- Deliver advocacy messages in high stakes settings
- Respond to difficult questions by staying on message

Message is never first

Before you know what to say,
you need to know what to do

The Layers of Strategy



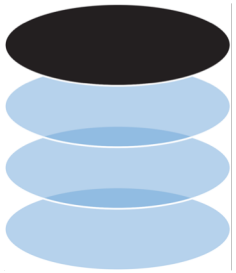
Overall strategy

Media strategy

Message strategy

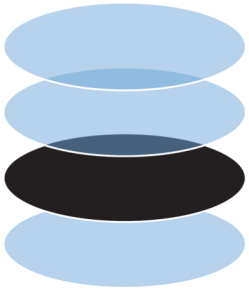
Access strategy

Overall strategy



- Define the **problem** you want to address
- Clarify the **policy solution** for which you'll advocate
- Identify the **target** with the power to make the change
- Enlist the **allies** who can help make your case
- Identify what **actions** you'll take to influence the target

Message Strategy



Framing: how we characterize the issue

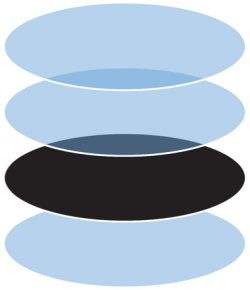
Message: what we say

Messenger: who says it ←YOU!

Target: who we want to hear it

The need to reframe

Message development



Components of a message:

- Statement of problem
  What's wrong?
- Value dimension
  Why does it matter?
- Policy solution
  Who should do what by when?

Tobacco example

Tobacco companies are targeting consumers in our state with cheap tobacco products. Sometimes this is done through discount coupons and sometimes through financial incentives provided directly to the stores that sell cigarettes. Kids are especially vulnerable to these tactics since they have less money to spend. Restricting coupons and other promotions would go a long way toward solving this problem and when we can do something to improve the health of the community, we have an obligation to do it.

Problem

Solution

Shared values

bmsg

Children’s mental health example

"Children whose mental health needs are met will be more likely to graduate, be employed and become productive members of the community. Current mental health services for children are fragmented and inconsistent. We know what it would take to fix that."

Solution

Shared values

Problem

Sexual violence example

To thrive and develop their full potential, children need to be safe and supported. It is hard to think about , but many kids in our state are dealing with sexual assault or abuse. It's easy to feel overwhelmed, but something needs to change. Strong standards in afterschool programing can help prevent abuse or assault!

Shared values

Problem

Solution

Activity: message

On your Message Development worksheet:

- Write down your **problem** statement
- Write down your **solution** statement
- Write down your **values** statement
- Put it all together!

Activity: hard questions

Brainstorm the hard question you often get about the issue you are advocating for:

- Opposition questions
- “Devil’s advocate” questions
- Genuinely curious questions
- Surprising questions

Dealing with hard questions

Within your frame

- *“who is paying for this?”*
- -Prepare answers
- -Have facts ready

Drifting to portrait frame

- *”Isn’t that parents’ responsibility?”*
- -Appeal to values
- -Use pivot phrases

Pivot phrases

“Of course parents have responsibility. But parents need help... *[Go on to your policy solution].*”

“That is indeed a tragic story but fortunately not typical. Let me tell you a more typical story…”*[landscape story]*

“That's not what's important here. Let me tell you what is… *[Go on to your policy solution]*”

Activity: triad interview

Get up and find a partner

Choose a role:

A. Reporter or elected official
B. Advocate
C. Observer

We will tell you when to start and when to stop

Debrief

Switch roles

First question

What was the conference about?

Summary

- Know your goals.
- Resist the urge to say everything.
- Use reasonable, everyday language.
- Stay on your frame, not the opposition's.
- Prepare for hard questions.

berkeley media studies group

THANK YOU!

Shaddai Martinez Cuestas, MPH

cuestas@bmsg.org

www.bmsg.org

Twitter: @BMSG

Facebook: Berkeley Media Studies Group

Worksheet: Message development

Developing a message that succinctly frames your solution(s) is important. Avoid the default "portrait" frame of personal responsibility and activate a "landscape" frame that brings into focus the many factors outside of a person's control that undermine good health and make your solution the logical remedy.

1. You can activate your frame by creating a message that answers the following key questions strategically.

What is the problem?

_____
_____
_____
_____

Why does it matter?

_____
_____
_____
_____

What is the solution and who is responsible for implementing it?

_____
_____
_____
_____

2. Once you have the answer to these questions you can work on polishing your message by synthesizing your answers into a cohesive message:

_____
_____
_____
_____
_____
_____
_____

WHAT IS A RESOLUTION?

- Request that the Academy develop a statement or take action on a particular issue
- Request that the Academy inaugurate a new program or activity or reconsider a current AAP program or activity
- Request that the Academy change its operating procedures or Bylaws

***All resolutions are *advisory* to the Board of Directors and are not binding.**

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

1

WHAT IS THE PURPOSE OF A RESOLUTION?

To provide a formal mechanism whereby the members of the Academy can give input concerning Academy policy and activities.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

2

WHAT IS AN EFFECTIVE RESOLUTION?

- The Resolved(s) portion of the resolution should define as specifically as possible the action to be taken by the Academy
- The resolution should be limited to one page

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

3

WHO CAN SUBMIT A RESOLUTION?

- Chapters
- Committees
- Councils
- Sections
- Districts
- Fellows of the Academy with or without group endorsement

IMPORTANT: RESOLUTIONS ARE DUE NOVEMBER 1st

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

4

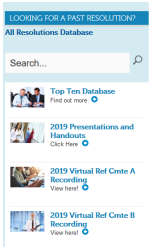
ALF Web page

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

5

CHECK OUT THE RESOLUTION DATABASE

- The database is a quick reference for looking up past resolutions
- The database allows members who are thinking about developing a new resolution to review past resolutions on the same subject and what the Academy is doing about it



American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

6

The Body of a Resolution

"Whereas" clauses:

- Should define problem, relevance of the problem and possible solutions
- Not voted on and must be limited to 3 or 4 statements in order to assure the focus remains on the resolved portion of the resolution

"Resolved" clauses:

- Each resolution must contain a "Resolved" which stands alone and request action by the Academy
- A resolution may not have more that 2 "Resolved" clauses

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

7

The Body of a Resolution

Fiscal Note:

- Are generally supplied by staff, during the request for background information, but whenever possible, the authors are encouraged to supply fiscal notes upon resolution submission

Author/Contact Person:

- Fellow(s) of the Academy
- Resident and candidate fellows who author a resolution must also obtain support of an AAP Fellow to co-author the resolution

Email:

- Email address where the author/contact person can be reached

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

8

A Late Resolution

- A resolution provided <u>after</u> November 1st and before the opening session of the Forum, will be considered a <u>Late Resolution</u>
- All Late Resolutions must be accompanied by a statement from the author(s) setting forth:

A. The reason(s) the Late Resolution was not submitted by the deadline date;
B. The reason(s) that the Late Resolution cannot wait until the next Annual Leadership Forum and be submitted on time; and
C. If expenditure of funds is anticipated in the implementation of any Late Resolution, a fiscal note is required

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

9

By Late December

- Chapter staff assigns final numbers to the resolutions and groups them by similar subject matter

  Advocacy, Health Care Finance, Practice, Education, or AAP Governance and Operations

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

10

Chapter Forum Management Committee (CFMC)

- All ten districts of the AAP have a CFMC representative
- The CFMC can assist with the resolution writing process
- CFMC representatives can help guide the development of resolutions at district meetings
- CFMC members track resolutions before and after the Annual Leadership Forum (ALF), and maintain contact with resolution authors, providing updates on Academy responses

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

11

Virtual Reference Committee Hearings

- New for 2019
- Three different evenings in February
- Allowed more time at ALF for enhanced discussion and plenary sessions

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

12

Virtual Reference Committees

- Hearings were open to all ALF attendees, authors, and guests from chapter, committees, councils, and sections
- 549 total participants
- 53 resolution authors participated
- 116 non-ALF attendees participants

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

13

2020 Virtual Reference Committees

- Reference Committee A – Saturday, February 8, 11:00 am CT
- Reference Committee B – Thursday, February 13, 7:00 pm CT
- Reference Committee C – Wednesday, February 19, 7:00 pm CT
- More Participants
- More Technology

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

14

How are resolutions handled at the Forum?

- Review and Vote on Calendars (Consent, Unsponsored)
- Voting
- Selecting the Top Ten Resolutions
- Discussion of Top Ten Resolutions at District Breakfasts

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

15

Fate of a Resolution

- Adopted
- Adopted as Amended
- Defeated
- Postponed
- Tabled
- Referred

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

16

Adopted Resolution

- AAP Executive Staff assigns for response
- Resolutions are sent to staff for response
- Responses to Resolutions are due **late summer/early fall**
- Disposition document is shared monthly with the CFMC beginning in August, September, and October
- Final disposition of the resolution is sent to authors in November

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

17

What is a response?

- Only adopted resolutions require responses
- Action plan or how the intent will be implemented
- A "response" to a resolution is different than "background Information"
- A response form is provided for use

*Responses Resolutions are due: **Late Summer/Early Fall**

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

18

WHAT IS A RESPONSE?

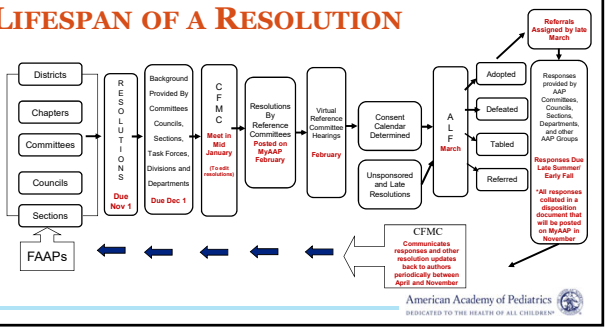
Responses should include the following:

- AAP group concurs that the resolution's intent is one that the Academy should pursue
- If the group agrees with the intent, but cannot pursue the specific activities this year due to budgetary constraints or other Board approved directives that must be completed during the fiscal year, note as part of the response
- If, given the group's expertise in this area, it does not agree that the Academy should pursue the issue, state the rationale for that decision

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

19

LIFESPAN OF A RESOLUTION



American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

20

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

GUIDELINES FOR SUBMITTING RESOLUTIONS

Purpose of Resolutions

Resolutions afford AAP members the opportunity to provide input regarding AAP efforts to address important child health issues. All resolutions are advisory to the Board of Directors.

Resolutions should relate to the Academy's mission

The mission of the American Academy of Pediatrics is to attain the optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. To accomplish this mission, the Academy supports the professional needs of its members. As such, resolutions should address the Academy's mission, core values, or strategic plan, and the proposed action of a given resolution should be desirable, doable, feasible, and ethical. Some useful types of resolutions include:

1) A request that the Academy take action on a particular issue not already addressed in policy statements, clinical reports, technical reports, the strategic plan, or any other AAP endorsed publications or advocacy initiative.
2) A request that the Academy inaugurate a new program or activity.

If a resolution is submitted and the resolve is already being addressed by the Academy, there is existing board policy, or it is out of scope of AAP activities, the ALF Executive Committee (ALF EC), Chapter Forum Management Committee, (CFMC) and the AAP's Senior Leadership Team (SLT) reserve the right to not accept the resolution. The author will be notified of the appropriate body within the AAP that is addressing the issue or provided an explanation as why the resolve is beyond the AAP's scope of activity.

Drafting an Effective Resolution

Research is the first step to determine whether the Academy is already addressing the resolution's topic. Data to support the need for the resolution above and beyond what the AAP is already doing is necessary. The resolve should clearly define the action to be taken by the Academy. The resolution should be limited to one page.

Types of Ineffective Resolutions:

1. Resolutions on already existing AAP policy that only reinforces what the policy recommends. Search Academy policies here.
2. Resolutions on upcoming AAP policy that will address the issue the resolution is recommending. View the Academy's Statement in Progress List here.
3. Resolutions that request the Academy take a position for which there is existing policy or advocate for a position on which there are existing advocacy efforts. View the Academy's advocacy initiatives related to federal and state advocacy here.
4. Resolutions requesting the creation or promotion of existing educational materials or resources. View the Academy's professional education resources here.
5. Resolutions to develop caregiver resources or educational materials that already exist. Search the Academy's caregiver resources here.
6. **Note for committees, councils, and sections** - A committee or council should not write a resolution about drafting a policy statement if they are the group responsible for drafting that policy. Neither should a council or section submit a resolution about developing an educational program if that entity is responsible for developing that program. In short, it is important to consider whether the work that would ensue from an adopted resolution from a committee, council, or section would in fact be undertaken by that group. If that is the case, and the work is

clearly within the purview of that group, a resolution before the Annual Leadership Forum is not needed.

7. Resolutions that are out of scope of the Academy's mission. The ALF EC, CFMC, and the SLT reserve the right to exclude resolutions beyond the scope and purview of the AAP. If the request is to undertake activities that are beyond the competencies or capacity of the AAP; if the resolve is already being addressed by the Academy, or if there is existing board policy, the resolution will not be accepted.

Who can submit resolutions?

Resolutions may originate from:

1) Individual members of the AAP (voting fellows)
2) Chapters
3) Committees
4) Councils
5) Sections
6) Districts

Sponsorship of Resolutions

Resolutions must be sponsored by chapters, committees, councils, sections, or districts. Sponsorship implies agreement on the resolution content. Please note, provisional sections cannot sponsor resolutions. Multiple sponsorships are not necessary. For questions regarding sponsorship of resolutions, please contact your District's CFMC member, who can be found here.

Conflicts of Interest

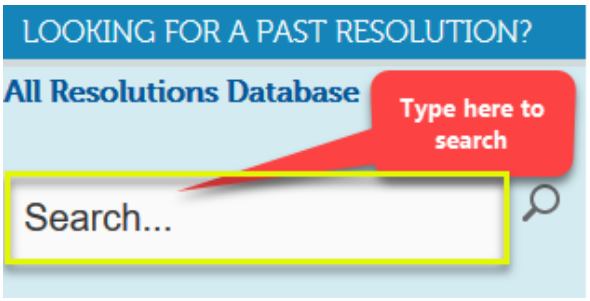
To be transparent and avoid potential or perceived conflicts of interest, an AAP Fellow who has a financial interest in a resolution he or she submits is asked to disclose this conflict of interest upon submission of the resolution. In addition, anyone with a conflict of interest will be asked to disclose it prior to speaking to a resolution in both reference committee hearings and during the general voting sessions of the ALF.

The use of industry names in resolutions

To further its mission, the AAP does seek financial partnerships provided that these relationships are in agreement with AAP core values. When making a reference to industry in a resolution, generic names should be used (ie, soft drink, pharmaceutical, etc). References to company names in resolutions will be changed by the CFMC to the generic form. However, company names in reference to industry may be included in the background information of a resolution by the author.

Review the resolution database

The purpose of the resolution database is twofold; 1) The database is a quick reference for looking up past resolutions; and 2) The database allows members who are thinking about developing a new resolution to review past resolutions on the same subject and learn about AAP activities on the topic. In many cases an author may find that their issue is already being addressed.



Instructions:

- Go to the ALF Main page, here.
- Log in with your MyAAP credentials.
- To the right of the page, under "Looking for a Past Resolution", click in the search box to search for any resolution.
- Type a keyword, date, author name, or title to search for a resolution.

All resolutions dating from 1995 to the present will appear in your search. This will help you determine whether or not a resolution is still needed.

Top ten resolution database

To review past top ten resolution responses, click here (add link). Top ten resolutions dating from 1999 to the present will be included in your search.

What happens after a resolution is submitted?

The resolution is sent to the central AAP office where it is typed in proper format and given the next available number. The resolution will be thoroughly reviewed by the CFMC, the SLT, and the Manager, Chapter Programs. If accepted, the resolution is then referred to the staff liaison of the committee, council, sections, or area most likely to have background information. Once background information is received, it is included with the resolution.

By January of each year resolutions are assigned final numbers so that they can be grouped by similar subject matter. After reviewing the background information supplied by the staff liaison, the CFMC, and the SLT have the authority to withdraw any resolution if the background information reveals that the resolve portion is already being addressed by the Academy, there is existing board policy that addresses the resolution, or it is out of scope of the Academy. If the CFMC has any questions regarding a particular resolution, they will contact the author for clarification or changes. Accepted resolutions will then be placed on the MyAAP section of the AAP Web site within 30 days of the ALF to provide members the opportunity to view the resolutions prior to the ALF.

Resolution authors are discouraged from lobbying for a particular resolution prior to the ALF on group Listservs or on AAP websites. AAP staff is not permitted to provide any resolution author or individual with Listerv or group email information for the purposes of resolution lobbying. Lobbying for the top ten is prohibited during ALF voting.

Resolution format

RESOLUTION # -	a number will be supplied by AAP central office staff
TITLE -	should reflect the action for which the resolution calls and be concise
SPONSORED BY -	the sponsor of the resolution must be identified. Resolutions must be sponsored by chapters, committees, councils, sections, or districts.
DATE -	Date submitted.
DISPOSITION -	Reflects vote.
WHEREAS -	These statements should be written clearly to define the problem and state that a solution is possible. Please remember that the whereases are not voted on and should be limited to three or four statements in order to assure that the focus remains on the resolved portion of the resolution.
RESOLVED -	Each resolution must contain a resolved which stands alone and requests action by the Academy. The resolution may not have more than 2 RESOLVES. The resolution also may not include bullet points within the resolves. For clarity, authors are encouraged to be as succinct as possible.
FISCAL NOTE -	Fiscal notes are generally supplied by staff, but whenever possible, the authors are encouraged to supply fiscal notes upon resolution submission.
REFER TO -	Resolutions should be referred to the Annual Leadership Forum.

AUTHOR/CONTACT PERSON - Fellow(s) who drafted the resolution and can be contacted for clarification. Resident and candidate fellows who author resolutions must obtain the support of an AAP full fellow to co-author the resolution. District Chairpersons and District Vice Chairpersons are not eligible to be authors of resolutions.

EMAIL - Email address where the author/contact person can be reached.

BACKGROUND INFORMATION - The author of the resolution may supply background material, if necessary. This information will be sent to the CFMC and the SLT to review.

Deadlines

1) Regular Resolutions

To be considered as regular business of the ALF and to be included in the ALF agenda book, resolutions must be received by the central office **no later than November 1st, 2019**. Resolutions which require AAP bylaws changes should be submitted at least 90 days prior to the ALF. Resolutions requiring a bylaws change will be noted in the background information.

2) Late Resolutions (LR#)

Resolutions presented after November 1st and before the opening session of the Forum, will be considered **Late Resolutions**. All Late Resolutions must be accompanied by a statement from the author(s) setting forth the following:

- The reason (s) the Late Resolution was not submitted by the deadline date;
- The reason(s) that the Late Resolution cannot wait until the next ALF.
- If expenditure of funds is anticipated in the implementation of any Late Resolution, a fiscal note is required.

Resolutions should be emailed to **Jonathan Faletti, Manager, Chapter Programs, at jfaletti@aap.org,** with a cc to the author's district CFMC representative. To see who your CFMC representative is visit My AAP here.

What happens to a resolution once it is adopted at the ALF?

The SLT and the AAP Board of Directors reviews all adopted resolutions and refers them to the appropriate committee(s)/ council(s)/ section(s)/ business unit(s) for response. A letter is sent to the staff liaison to have the resolution addressed by their group in a timely fashion.

The staff liaison then forwards the response to the Manager, Chapter Programs. The response is added to the resolution. A disposition document which includes the status of all resolutions is posted on the ALF Web site and will be included in the following year's ALF agenda book.

All committee/council/section/and business unit responses are tracked by the CFMC. The CFMC representatives receive responses to his/her district's adopted resolutions, follows-up with resolution authors on an individual basis, and reports on them at their respective district meetings and at the National Conference and Exhibition.

Fiscal Notes

Resolutions are written to define a problem and suggest a possible course of action or solution. Often times the solution has a fiscal impact on the Academy. In such a case, the resolution should always include a fiscal note. Below is a listing of some of the more common fiscal notes. The Academy strongly suggests that authors of resolutions refer to this reference guide in order to better understand the implications their resolution might have on the Academy. Fiscal notes are also a very important factor in determining whether a resolution should be adopted or defeated.

Examples	Approximate Cost
Creation of a Task Force for in-person meetings	**$20,000 - $30.000**
Committee Meeting (10 members, 1 staff)	**$7,000**
Conference Call ($.16 a minute, 11 people, 2 hours) Reserved line, toll free service	**$211**
AAP Bylaw Referendum (if the referendum is in conjunction with the AAP elections **AAP Bylaw Referendum done on its own**	**$1,200** **$35,000**
Oral History (per person)	**$4,000**
PediaLink Course **Flat rate, courses included Maintenance of Certification (MOC) Part 2 Credits**	**$5,000- $60,000**
EQIPP Course **(Flat rate, courses can include Continuing Medical Education (CME), MOC Part 2, and MOC Part 4 Credits**	**$150,000-$200,000**
Public Relations: **Issue a news release to print and broadcast media nationwide** **Distribute camera-ready feature to local newspapers across the country** **Hold a news conference featuring AAP spokesperson** **Produce and distribute a video news release (pre-packaged for broadcast)**	 **$1,000** **$4,000** **$6,500** **$20,000 - $25,000**

Date last reviewed: 5/14/19

Resolution # 2020 Annual Leadership Forum

TITLE:

SPONSORED BY:

DATE:

DISPOSITION:

Whereas,

Whereas,

Whereas,

RESOLVED,

FISCAL NOTE:

REFER TO: 2020 Annual Leadership Forum

LEAD AUTHOR:

Email and chapter:

BACKGROUND INFORMATION:

CRAFTING AN OP-ED
ADVOCATING FOR CHILDREN TOGETHER CONFERENCE

Michael Bakal, M.Ed, MPH

OAKLAND, CA

OCTOBER 5, 2019

1

TODAY'S GOALS

- Identify situations when op-eds can support your advocacy
- Understand and apply 10 key concepts of op-ed writing
- Develop an opening hook for your op-ed
- Think like a newspaper editor, and craft a pitch email that highlights the newsworthiness of your op-ed

2

DISCLOSURE

- "I declare that neither I, nor any immediate member of my family, have a financial arrangement or affiliation with any corporate organization offering financial support or grant monies for this continuing medical education activity. In addition, I do not intend to include information or discuss investigational or off-label use of pharmaceutical products or medical devices".

3

WHY ENGAGE WITH THE MASS MEDIA?

Agenda setting function of news

WHAT issues we think about

Framing function of the news

HOW we think about issues

bmsg.org

4

OP-EDS ARE ONE OF FOUR GENERAL MEDIA STRATEGIES

- Create news
- Paid advertising
- Social media and digital strategies
- Editorial strategies

Dorfman and Bakal, 2019

5

ADVANTAGES OF OP-EDS

- You have complete control over the message
- Reaches a wide audience
- Establishes your credibility
- Free (!)

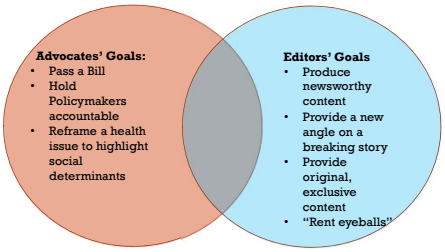
6

YOUR GOALS ARE NOT IDENTICAL TO THOSE OF A NEWSPAPER EDITOR…

BUT THEY OVERLAP

7

YOUR GOALS ARE NOT IDENTICAL TO THOSE OF A NEWSPAPER EDITOR…BUT THEY OVERLAP



8

ADVOCATES' GOALS & CONSIDERATIONS

Possible Goals

- Pass a bill
- Hold Policymakers accountable
- Reframe a health issue to highlight social determinants

Considerations (from top to bottom!)

- What is my policy goal?
- Who is the decision maker with the power to create that change?
- What outlet will my target find most influential?
- What message will work?

Bmsg.org

9

TIPS FOR OP-ED WRITERS…


Opinion

BRET STEPHENS

Tips for Aspiring Op-Ed Writers

By Bret Stephens

Aug. 25, 2017

As a summertime service for readers of the editorial pages who may wish someday to write for them, here's a list of things I've learned over the years as an editor, op-ed writer and columnist.

- "Get to the point: Why does your topic **matter**? Why should it matter ***today***? And **why should the reader care** what you, of all people, have to say about it?"
- "Opinion editors are often keen on writers who can provide **standing-with-surprise. . .**"

10

EDITORS' GOALS & CONSIDERATIONS

Possible Goals

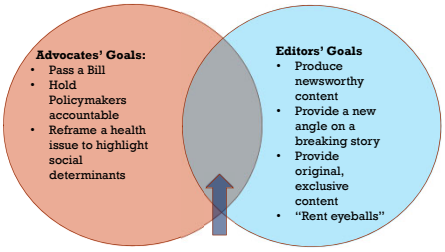
- Produce newsworthy content
- Provide a new angle on breaking story
- Provide original, exclusive content
- "Rent eyeballs"

Considerations

- Is this story newsworthy **today?**
- Will it get approved by my editor?
- Will my audience care?
- Is the author a credible voice on the subject?
- Is this a new, or surprising story angle?

11

YOUR GOALS ARE NOT IDENTICAL TO THOSE OF A NEWSPAPER EDITOR…BUT THEY OVERLAP



Successful Op-Ed!

12

SFCHRONICLE.COM

Open Forum: Save San Francisco's board-and-care homes - and then fix them

GENESIS OF AN OP-ED

13

GENESIS OF AN OP-ED

The Authors

Alex Barnard

Neil Gong

Their Goal

- To highlight pitfalls of current system of housing for homeless people with mental health and other disabilities
- To identify promising policies to fund and improve quality of housing for those with mental health challenges
- First targeted outlet: LA Times
- Second Targeted outlet: SF Chronicle

14

4 VERSIONS…

- Version 1: Initial LA Times submission
- Version 2: Revised op-ed in response to breaking local news from San Francisco
- Version 3: Revised version, incorporating Michael's feedback
- Version 4: Final published version

15

WHAT MAKES A STORY NEWSWORTHY?

- "Piggy-backing" on recent breaking news
- Offering a new take on a controversial issue
- Being a credible voice on that issue
- Offering "local angle" on a broad, national issue?
- Giving your story a "holiday peg"
- Linking your story to an important anniversary
- Highlighting the release of a new study

Dorfman and Bakal, 2019

16

"PIGGY-BACKING" EXAMPLE...

TRUTHOUT.ORG
Guatemala Is Not a "Safe Third Country." Decades of US Policy Made It That Way.

"On July 26, President Trump and Guatemalan President Jimmy Morales officially announced their safe third-country agreement."

17

HOLIDAY PEG EXAMPLE...

VIEWPOINTS

U.S. should acknowledge its role in driving Guatemalans to flee their country

"As millions of Americans gathered on Christmas Eve to celebrate love and family, the lifeless body of Jakelin Caal Maquín, 7, who died in the custody of the U.S. Customs and Border Patrol, was returned to her family home in Guatemala. Then on Christmas Day, the Border Patrol announced another Guatemalan child, 8-year-old Felipe Gómez Alonso, had died in the agency's custody."

18

NEW TAKE ON A CONTROVERSIAL ISSUE

MERCURYNEWS.COM
Opinion: Separating children from parents harms their development

- "When traumatic events are prolonged or repeated they become toxic. The physiologic stress response (fight or flight response) goes into hyper-drive: children panic, scream, and look for the reassurance of a parent. If the stable parent relationship is missing, the hormonal stress response persists and changes brain structure with long-term negative consequences: growth delays, sleep disturbances, tantrums, attachment difficulty, learning disabilities and problem behaviors… The American Academy of Pediatrics (AAP) represents more than 66,000 pediatricians in the United States and has repeatedly opposed the detention of children."

19

ACTIVITY # 1

1) Read the **first 2 paragraphs** of version 1 and Version 2 of Alex and Neil's OP-ED. Identify the news hook for each. (Share out)
2) Read **version 2** in its entirety. What general recommendations would you give Alex and Neil? (Put aside till later)

20

10 KEY CONCEPTS OF OP-ED WRITING

A. Convince the Editor
B. Master the op-ed "voice"
C. Keep your goal in mind

21

A. CONVINCING THE EDITOR…

22

CONCEPT 1: MAKE IT NEWSWORTHY

- "Piggy-backing" on recent breaking news
- Offering a new perspective on a controversial issue
- Being a credible voice on that issue
- Offering "local angle" on a broad, national issue?
- Giving your story a "holiday peg"
- Linking your story to an important anniversary
- Highlighting the release of a new study

http://www.bmsg.org/wp-content/uploads/2015/10/bmsg_newsworthy_elements.pdf

23

CONCEPT 2: GET TO THE POINT

- **Give your piece a strong opening**
  - **Tell a Dramatic Anecdote:** "As I entered the exam room, the screaming began. 14-month old Antonio (not his real name) began to shake and cling to his mother. He had just arrived from El Salvador after a traumatic border crossing."
  - **Piggy-back on the news:** "On July 26, President Trump and Guatemalan President Jimmy Morales officially announced their safe third-country agreement."
- **State your thesis immediately after the lede**
- **Remember space is limited:** (650-750 words)

24

CONCEPT 3: KNOW YOUR AUDIENCE

- **Identify your target.** Which outlet is most likely to to matter to them?
- **What is the outlet's purview?** Local? State? National?
- **Join the conversation.**
  - Track coverage of your issue
  - What's been covered? What's missing?
  - Pick up the conversation where it left off
- **Write to a general audience.**

25

CONCEPT 4: BE OPINIONATED

"The purpose of an op-ed is to offer an opinion. It is not a news analysis or a weighing up of alternative views. It requires a clear thesis, backed by rigorously marshaled evidence, in the service of a persuasive argument."

26

CONCEPT 5: ESTABLISH CREDIBILITY

"Authority matters. Readers will look to authors who have standing, either because they have expertise in their field or unique experience of a subject."

- "As I entered the exam room…"
- "As sociologists who study outpatient psychiatric teams in the Bay Area and Los Angeles, we have seen firsthand the risks of delegating these public-safety-net functions to poorly regulated private industry."

27

B. THE OP-ED "VOICE"

28

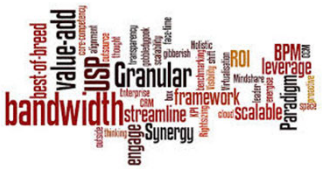
CONCEPT 6: MAKE IT PUNCHY

1. Never use a metaphor, simile or other figure of speech which you are used to seeing in print.
2. Never use a long word where a short one will do.
3. If it is possible to cut a word out, always cut it out.
4. Never use the passive where you can use the active.
5. Never use a foreign phrase, a scientific word or jargon word if you can think of an everyday English equivalent.

Orwell, G. *Politics and the English Language*, 1946.

29

CONCEPT 7: AVOID JARGON



30

THE JARGON GAME!! *(Try to make each of these phrases jargon free…)*

- Early intervention is critical to stop childhood diabetes
- Policymakers must restrict access to firearms
- We need to move upstream
- Youth of color are a disproportionately affected group

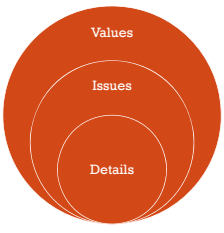
https://www.cdc.gov/other/pdf/EverydayWordsForPublicHealthCommunication.pdf

31

C. KEEP YOUR GOAL IN MIND

32

CONCEPT 8: HIGHLIGHT VALUES



"We don't ask for a "deadline extension" when it comes to a child's health because the stakes for Antonio and countless other children are just too high." (Jaime Peterson op-ed, July 2018)

http://cubegroup.com.au/why-equality-and-fairness-matters/

33

CONCEPT 9: FRAME THE PROBLEM

- Portrait

- Landscape

34

CONCEPT 10: PROVIDE A SOLUTION & CALL TO ACTION

- **Think in terms of accountability: Who** needs to do **what** by **when?**
- Ex. "Given the U.S.'s responsibility for creating these conditions, it is incumbent on the United States to help address them. As a starting point, the U.S. must fulfill its moral obligation to provide for the basic needs of refugees, rather than attempting to outsource this responsibility to Guatemala."

https://truthout.org/articles/guatemala-is-not-a-safe-third-country-decades-of-us-policy-made-it-that-way/

35

ACTIVITY #2

Now, review the recommendations you wrote for version 2 of Alex and Neil's op-ed.

Skim version 2 again. What further revisions would you suggest, based on the 10 key concepts?

36

MICHAEL'S FEEDBACK ON V. 2...

- Very publishable and timely (credible voices offering a new perspective on a newsworthy topic…it's a slam dunk)
- Establish your credibility and purpose of the piece earlier.
- Don't "bury your lede." Make your main point earlier, and more directly.
- Break up the wonkiness by highlighting values
- Don't overload your readers with a panoply of solutions. Consider focusing more narrowly on one or two LOCAL solutions rather than the panoply of options, local and federal. Given that this is the Chron., the local policies will probably be of greater interest than federal.
- In general, try to assume little to no prior knowledge and avoid jargon, like de-institutionalization.

37

ACTIVITY #3

Now read Version 4 of the Alex and Neil's OP-Ed.

What changes did notice?

(If time allows, it's interesting to compare version 3, the submitted version, and version 4, the published version, to see the kind of revisions made by a newspaper editor!)

38

ILLUSTRATIVE EXAMPLES...

39

CUTTING JARGON…

- **Version 3:** ~~The second~~ tragedy of the system is that private operators can "~~cream,~~" taking only the "easy" residents. People linger in locked settings or are discharged onto the street because many facilities refuse those with complex medical needs, criminal ~~justice histories~~, or ~~co-occurring~~ substance abuse.

- **Version 4:** Another tragedy of the system is that private operators can take only those residents seen as less difficult. People linger in locked settings or are discharged onto the streets because many facilities refuse those with complex medical needs, criminal records, or substance abuse problems.

40

GETTING TO THE POINT…

- **Version 2:** ~~The imminent closure of another two "Board and Care" homes seems to have forced the city's hand.~~ On Monday Mayor Breed announced a new plan to stabilize a handful of privately run adult residential facilities and prevent yet more people with psychiatric disabilities from homelessness. ~~It took a protest at SF General and shaming from Chronicle editorials,~~ but these stopgap measures are crucial ~~and welcome either way.~~

  Now we must confront a fact that the sympathetic media coverage of mom-and-pop operators has downplayed: many of these facilities are awful human warehouses.

- **Version 4:** Mayor London Breed and three supervisors last week announced a plan to stabilize privately run adult residential facilities, known as board-and-care homes, to prevent yet more people with psychiatric disabilities from becoming homeless. While these stopgap measures are crucial, it is important for the mayor and the Board of Supervisors to recognize that such facilities are not always the humane mom-and-pop residences portrayed in recent media coverage.

41

PITCHING YOUR OP-ED

42

BEFORE THE PITCH

- Track the news
- If possible, have a rough draft or outline of your op-ed ready.
- Consider newsworthiness.
- Remember that timing is everything.

43

THE PITCH…

- Be persistent (may have to pitch to more than once!)
- Honor exclusivity requirements
  - Cannot pitch the same story to multiple outlets at the same time.
  - Time-sensitive? Give it 24 hours
  - Not time sensitive? Give it a week
- Make a strong case for the newsworthiness of your piece
- Make the case for why the topic is of interest to the outlet's readership
- Explain why you're the right person to speak on the issue
- Follow guidelines carefully (each outlet is different)
- Carefully follow the word limit

http://www.bmsg.org/blog/getting-your-op-ed-published-lessons-from-a-media-advocate/

44

AFTER THE PITCH

- Be available and respond quickly to the editor!
- Work collaboratively with editor (understand they have the final word)
- Re-use the news

http://www.bmsg.org/blog/getting-your-op-ed-published-lessons-from-a-media-advocate/

45

ACTIVITY #4

Select a topic you would be interested in writing an op-ed about (or that you have drafted)

Using the pitch template, draft a pitch email to an editor.

46

REFERENCES

- Dorfman, L; Bakal, M. (2019). Using Media Advocacy to Influence Policy. In *Community Health Education Methods: a Practical Guide.* 4th ed. Sudbury, Mass.: Jones and Bartlett Publishers
- www.Bmsg.org
- http://www.bmsg.org/blog/getting-your-op-ed-published-lessons-from-a-media-advocate/
- https://www.theopedproject.org/oped-basics#ledesnewshooks

47

THANK YOU!

Michaelbakal@berkeley.edu

48

Op-Ed Pitch Template

Dear Truthout Editors:

I am sending for your consideration an op-ed about the the recent "safe third country" deal between the U.S and Guatemala. I'm writing from Guatemala where I have been attending the court hearings of indigenous rights defenders who have suffered criminalization. I have worked in Guatemala since 2007, including as a Fulbright Scholar in 2014. I have previously published an op-ed on Guatemala in the Sacramento Bee.

The angle I offer on the topic is a new one, because I tie in findings from a new global witness report which showing that Guatemala is the most dangerous country in the world per capita for indigenous land defenders. I describe the direct role U.S. policy has played in creating these conditions, and I argue that that the U.S. has a moral responsibility to address root causes of the migration crisis because of its historical role in creating them. This is an exclusive for truthout. I think is appropriate for your readership and consistent with your editorial goals because the angle of U.S. culpability in causing the migration crisis has been almost completely absent from mainstream coverage of the "safe third" agreement.

Text of the op-ed is below [note: make sure to include in the body of the email and also as attachment], and I would eagerly welcome the opportunity to revise the op-ed with per recommendations from editors.

Many thanks for your consideration,

Michael Bakal, M.Ed, MPH.
510-838-9345
michaelbakal@berkeley.edu; michaelbakal@gmail.com
Graduate School of Education
University of California Berkeley

Op-Ed Pitch Template

Dear Editors:

I am sending for your consideration an op-ed about …

I currently work as a … and I am particularly concerned about this issue because [highlight what's been missing from news coverage]…

[If relevant] I have previously published a related article/s/report on this issue here [link] and [here]

The angle I offer on the topic is a new one, because…

I think this topic will be of great interest to your readership because…

This is an exclusive for [insert outlet name]

The text of the op-ed is below [note: make sure to include in the body of the email and also as attachment], and I would eagerly welcome the opportunity work with your editorial team to revise the piece as necessary.

Many thanks for your consideration,

Name
Phone [make sure it is a number you will have access to!]
Email
Affiliations

Worksheet: Genesis of an Op-Ed

Version #: 1
Submitted to: LA Times
Date: 7/15/19
Word Count: 904
Title: California Never Really Deinstitutionalized Its Psychiatric Patients—Until Now

When California closed its mental hospitals in the 1970s many people with serious psychiatric disabilities shamefully wound up in another institution—prisons and jails. Others went to "Board and Care" homes, smaller for-profit institutions that provided rent, food, and minimal supervision in exchange for residents' meager disability checks. One sociologist at the time described the system as "privatized malign neglect" that re-created the back-wards of the state hospitals in the community. Such facilities at least ensured survival for people a step away from homelessness or incarceration.

Now, even these community-based-institutions are closing. According to an April 2019 forum in Sacramento, the state lost 10,867 beds in these facilities in the past five years, adding to the homelessness crisis throughout the state. Gentrification, rising labor costs, and stricter regulations have made it harder to turn a profit. In markets like Los Angeles and San Francisco, where one Board and Care operator simply closed his business and sold his property for $2 million, owners have much more lucrative options than housing poor people diagnosed with severe mental illness. That's the problem with for-profit provision of safety net services—they disappear when there's no profit to be made.

It is tempting to say, "good riddance" to neglectful and sometimes inhumane institutions. One regulator described a home that padlocked psychotic people in a shed, and another where the floor was crawling with cockroaches. We've visited homes where only 30% of those living in the facility were receiving any kind of therapy. Residents report few activities or opportunities for living fuller lives. Some disability rights advocates argue that Board and Care homes should be shuttered and replaced with permanent supportive housing—independent apartments with support staff and services for community integration.

Yet through years of research with outpatient psychiatric teams in Los Angeles and the Bay Area, we've also seen why Board and Care homes can be, as one policy brief put it, a "precious and affordable housing resource." For poor people ready for release from the hospital, this is one of the few options that offers a modicum of on-site attention. As counties mercifully reduce their incarcerated populations, the Board and Cares again serve as a rare bed in the community. While many people thrive in permanent supportive housing, others may need a place to return with greater assistance in daily living. We've seen people inadequately supported in apartments evicted and endangered, and given the struggle to develop housing stock to keep pace with demand, Board and Care homes remain a crucial residential option. Closures would leave people with complex needs—precisely those who might be especially difficult to re-house—homeless.

Worksheet: Genesis of an Op-Ed

In the immediate future, the state needs stopgap measures to save existing facilities. Board and Care operators serving people with severe mental illness are typically paid only about $35 a day through social security. If they house people with developmental disabilities, they can earn up to $110, paid directly by the state. There's no good justification for the difference, and some state legislators have already developed plans to lessen the disparity. Housing funds like propositions C in San Francisco and HHH in Los Angeles can also play a role, if counties broaden their mandate. Recently reported surpluses from the CA Mental Health Services Act could serve as another possible funding source.

Upping reimbursement for operators is a start, but in the long-run, we must ask whether it makes sense to leave public safety net functions to for-profit private industry. Board and Cares are rarely profitable unless operators cut back on service, move multiple people into small rooms, or otherwise compromise quality of life. A publicly run alternative, where government has an obligation to meet housing needs, may be our bulwark against shutdown and profit-driven skimping. Tulare County, for instance, has begun just such an experiment running its own adult residences.

More ambitious still would be to reimagine the role of adult homes in a redesigned mental health care system. Keeping people from homelessness while condemning them to a poor quality of life is not enough. Residents deserve access to rehabilitative services, vocational and educational support, and recreation. Operators, providers and residents might engage local communities to fight nimby-ism and stigma. Residents could become involved in shared decision making, as seen in mental health clubhouse models and various forms of peer support.

Psychiatric disabilities are often recurring, and while some people may experience significant recoveries, others will experience relapses that make access to supervised facilities important. For them, redesigned Board and Cares with active therapeutic supports could be actual homes that provide a crucial step in the continuum of care alongside permanent supportive housing.

To be sure, re-envisioning the Board and Care system appears idealistic in a moment when counties are simply trying to stem homelessness. Their potential destruction without replacement housing would be disastrous, and must be addressed immediately. We've identified some possible options for an alternative funding model, including a fully publicly run version. Yet rescuing the Board and Care system only to reproduce the status quo is not acceptable.

We can simultaneously save facilities and create more ambitious reforms. Rather than replicating the worst of deinstitutionalization—abandoning people to the streets, jail, or flophouses— the crisis surrounding Board and Care closure can be an opportunity to deliver on its promise. This means creating robust pathways to independent housing as well as ensuring that group facilities truly function as homes, rather than institutions in the community.

Worksheet: Genesis of an Op-Ed

Version #: 2
Date: 9/13 (*Version sent to Michael at 10:59 am)*
Word Count: 902
Title: Save the Board and Cares…and then Remake Them

The imminent closure of another two "Board and Care" homes seems to have forced the city's hand. On Monday Mayor Breed announced a new plan to stabilize a handful of privately run adult residential facilities and prevent yet more people with psychiatric disabilities from homelessness. It took a protest at SF General and shaming from Chronicle editorials, but these stopgap measures are crucial and welcome either way.

Now we must confront a fact that the sympathetic media coverage of mom-and-pop operators has downplayed: many of these facilities are awful human warehouses. This crisis requires not only that we rethink financing and the delegation of public safety net functions to private industry, but also what it is an adult care home is supposed to do.

A little background: many know that when California closed its mental hospitals in the 1970s, people with serious psychiatric disabilities often found themselves in other institutions, namely jails and prisons. Less known is that even more people went to Board and Care homes, smaller for-profit institutions that provided rent, food, and minimal supervision in exchange for residents' meager disability checks. One sociologist at the time described the system as "privatized malign neglect" that re-created the back-wards of the state hospitals in the community.

Now, even these community-based-institutions are closing. According to an April 2019 forum in Sacramento, the state lost 10,867 beds in these facilities in the past five years, adding to the homelessness crisis throughout the state. For poor people ready for release from the hospital, this is one of the few options that offer a modicum of on-site attention. As counties mercifully reduce their incarcerated populations, the Board and Cares again serve as a rare bed in the community. Given the struggle to develop housing stock to keep pace with demand, Board and Care homes remain a crucial residential option alongside permanent supportive housing.

Yet the fact that such facilities serve a necessary function is not a recommendation for saving them *as they are*. As two sociologists who study outpatient psychiatric care in Los Angeles and the Bay Area, we've visited facilities where only 30% of the residents were receiving any type of therapy, and many complained of long days with no activities beyond cigarettes and television. We've spoken with regulators about a home that padlocked psychotic people in a shed, and another where the floor was crawling with cockroaches. If California doesn't reform its Board and Cares, it could face lawsuits like those in New York that will force them to be shuttered.

That there is little "care" to go along with the "board" is not the fault of unscrupulous operators: its simple economics. Homes serving people with severe mental illness are typically paid only about $35 a day through social security, meaning that they can only increase their profits by eliminating day programming and moving multiple people into small rooms. The city's plan to raise its subsidy from $22 to $35 is a start, but this problem requires more than local funding. Similar facilities that house people with developmental disabilities can earn up to $110, paid directly by the state, and some legislators have already developed plans to lessen the disparity.

Worksheet: Genesis of an Op-Ed

Housing funds like propositions C in San Francisco or surpluses from the Mental Health Services Act could also play a role, but only if counties treat Board and Cares as one step in a system where permanent independent housing and recovery are the goals. New funding should be coupled with the expectation that facilities provide rehabilitative services, vocational and educational support, and recreation. Residents could become involved in shared decision-making, as seen in mental health clubhouse models and various forms of peer support. This combination allows facilities like Psynergy, in Morgan Hill, to graduate 80% of their residents in months, not years. This model of an active and rehabilitative rather than warehousing Board and Care can actually save the state money and free up spots without the expense of buying new properties or facing down community opposition to new facilities.

The other great tragedy of the current system is that private operators are able to "cream," taking only the "easy" residents. As we've learned in interviews around the state, people linger in locked settings or are discharged onto the street because many facilities aren't interested in people with complex medical needs, criminal justice histories, or co-occurring substance abuse disorders. Conservatees—people on long-term legal guardianship—can be particularly undesirable to private operators, because they come with the prying eyes of the county and the judge.

A publicly operated segment of facilities could be obligated to house such people. We are encouraged that Mayor Breed's plan proposes the city directly purchasing some homes, an approach already being tried out in counties like Tulare. Unfortunately, we're headed in the other direction with plans to turn SF General's residential beds into a crisis respite center. Because it is so important to have facilities committed to serving the most vulnerable people with the most costly care, it is essential that the city act immediately to stop the closure of these beds.

Rather than replicating the worst of deinstitutionalization—abandoning people to the streets, jail, or flophouses— the crisis surrounding Board and Care closures can be an opportunity to deliver on its promise. This means creating robust pathways to independent housing as well as ensuring that group facilities truly function as homes, rather than institutions in the community.

Worksheet: Genesis of an Op-Ed

Version #: 3 (version submitted to SF Chronicle)
Date: 9/14 (submitted 9:19am)
Word Count: 797
Title: Save the Board and Cares…and then Remake Them

On Monday Mayor Breed announced a new plan to stabilize a handful of privately run adult residential facilities, known as "Board and Care" homes, to prevent yet more people with psychiatric disabilities from becoming homeless. While these stopgap measures are crucial, it is important for the Mayor and Supervisors to recognize that such facilities are not always the humane, mom-and-pop residences portrayed in recent media coverage. Often, Board and Cares are for-profit human warehouses that one scholar bitterly described as "privatized malign neglect."

As sociologists who study outpatient psychiatric teams in the Bay Area and Los Angeles, we have seen firsthand the risks of delegating these public-safety-net functions to poorly regulated private industry. If the City is serious about addressing mental health and homelessness, now is the time to start a conversation not only about saving one or two facilities, but also about how we can create a comprehensive system that is policy smart, financially sustainable, and committed to human dignity.

After California closed its state mental hospitals in the 1970s, Board and Cares emerged to provide housing in exchange for residents' meager disability checks. In today's California, however, they are no longer lucrative, and many are at risk of closure due to rising labor costs, nimbyism, and gentrification. According to an April 2019 forum in Sacramento, the state lost 10,867 Board and Care beds in the past five years, adding to the homelessness crisis throughout the state.
We've seen hospitals refuse to release patients without Board and Care bed availability, or on the flip side, simply release them to the streets. As counties finally reduce their incarcerated populations, the Board and Cares again serve as a rare bed in the community. And given the struggle to develop housing stock, Board and Care homes remain a crucial residential option alongside permanent supportive housing.

Yet the fact that such facilities serve a necessary function is not a recommendation for saving them as they are. We've visited facilities where only 30% of the residents were receiving any type of therapy, with few opportunities for fuller lives. We've spoken with regulators about a home that padlocked psychotic people in a shed, and another where the floor was crawling with cockroaches. If California doesn't reform its Board and Cares, it could face lawsuits like those in New York and North Carolina, potentially disrupting the entire system.

The first tragedy of the Board and Care model is that there is rarely "care" to

speak of. This isn't necessarily the fault of operators: it's simple economics. Homes serving people with severe mental illness are typically paid only about $35 a day through social security plus small local subsidies, meaning that they can only increase their profits by eliminating day programming and moving multiple people into small rooms.

The second tragedy of the system is that private operators can "cream," taking only the "easy" residents. People linger in locked settings or are discharged onto the street because many facilities refuse those with complex medical needs, criminal justice histories, or co-occurring substance abuse. Conservatees—people on long-term legal guardianship because they've been deemed unable to care for themselves—can be particularly undesirable to private operators, because they come with the prying eyes of the county and a judge.

Making "care" a reality requires both funding and a new mentality. The city's plan to raise its subsidy from $22 to $35 is a start, but we can look also to proposition C or recently reported surpluses from the state Mental Health Services Act. Funding should be coupled with the expectation that there will be access to vocational and educational support, recreation, and a belief in residents' capabilities. Residents could become involved in shared decision-making, as seen in mental health clubhouse models and various forms of peer support.

To address "creaming" we must develop a publicly operated segment of facilities that would be obligated to house "difficult" people. We are encouraged that Mayor Breed's plan proposes directly purchasing some homes, following the lead of counties like Tulare. Unfortunately, we appear to be headed in the other direction with plans to turn SF General's residential beds into a crisis respite center. It is essential that we save those beds and expand the public operation of facilities to create a true safety net.

To be sure, re-envisioning the Board and Care system as a truly public-safety-net appears idealistic in a moment when counties are simply trying to stem homelessness. But saving people from the streets or jail only to put them in flophouses replicates the worst failures of de-institutionalization. Mayor Breed's plan is a welcome start, but the challenge now is to offer our disabled neighbors group homes that truly function as homes, and can prepare them to live in homes of their own in the community.

Worksheet: Genesis of an Op-Ed

Version #: 4
Date: Appeared in the SF Chronicle on Sept. 17
Word Count: 754

OPINION // OPEN FORUM

Open Forum: Save San Francisco's board-and-care homes — and then fix them

By Neil Gong and Alex Barnard Sep. 17, 2019 Updated: Sep. 17, 2019 8:50 a.m.
Comments

Steven Lax looks out a window at a residential care facility in San Francisco.
Photo: Yalonda M. James / The Chronicle

Mayor London Breed and three supervisors last week announced a plan to stabilize privately run adult residential facilities, known as board-and-care homes, to prevent yet more people with psychiatric disabilities from becoming homeless. While these stopgap measures are crucial, it is important for the mayor and the Board of Supervisors to recognize that such facilities are not always the humane mom-and-pop residences portrayed in recent media coverage.

Often, board-and-cares are for-profit human warehouses guilty of what one scholar bitterly described as "privatized malign neglect."

As sociologists who study outpatient psychiatric teams in the Bay Area and Los Angeles, we have seen firsthand the risks of delegating these public-safety-net functions to poorly regulated private industry. If San Francisco is serious about addressing mental health and homelessness, now is the time to consider not just saving a few facilities but also creating a comprehensive system that is smart, financially sustainable and committed to human dignity.

After California closed its state mental hospitals in the 1970s, board-and-cares emerged to provide housing in exchange for residents' meager disability checks. Today, however,

they are no longer lucrative, and many are at risk of closing due to rising labor costs, NIMBY-ism and gentrification. According to information provided at an April forum on the subject in Sacramento, the state lost 10,867 board-and-care beds over the past five years, exacerbating the homelessness crisis.

We've seen the lack of board-and-care beds lead hospitals to refuse to release patients or to simply put them on the streets. As counties at long last reduce their incarcerated populations, they are creating more demand for such facilities. And the state's struggle to develop housing stock makes them a crucial residential option alongside permanent supportive housing.

But saying such facilities serve a necessary function is not the same as recommending that they be saved as they are. We've visited facilities where only 30% of residents were receiving any type of therapy, with few opportunities for fuller lives. We've spoken with regulators about a home that padlocked psychotic people in a shed and another where the floor was crawling with cockroaches. If California doesn't reform its board-and-cares, it could face lawsuits that disrupt the entire system.

One tragedy of the board-and-care model is that there is rarely "care" to speak of. This is partly a matter of simple economics. Homes serving people with severe mental illness are typically paid only about $35 a day per patient through Social Security along with small local subsidies, meaning they can increase their profits only by eliminating programming and packing more people into smaller rooms.

Another tragedy of the system is that private operators can take only those residents seen as less difficult. People linger in locked settings or are discharged onto the streets because many facilities refuse those with complex medical needs, criminal records, or substance abuse problems. Conservatees — people subject to long-term legal guardianship because they've been deemed unable to care for themselves — can be particularly undesirable to private operators because they come with the prying eyes of county officials and judges.

Making care a reality requires both funding and a new mentality. The city's plan to raise its subsidy from $22 to $35 a night is a start, but money from last year's Proposition C and recently reported surpluses from the state Mental Health Services Act could also help. Funding should come with the expectation that homes offer recreation, facilitate access to vocational and educational programs, and support residents' capabilities. Residents can participate in shared decision-making, for example, as seen in peer support and mental health clubhouse models.

The problem of selectivity can be addressed by a publicly operated subset of facilities obligated to house people perceived as particularly difficult. We are encouraged that the mayor's plan proposes directly purchasing some homes, following the lead of counties like Tulare. Unfortunately, the move to turn San Francisco General Hospital's residential beds into a crisis respite center appears to be going in the opposite direction. It is essential that we save those beds and expand the public operation of facilities to create a true safety net.

Worksheet: Genesis of an Op-Ed

To be sure, re-envisioning the board-and-care system in this way seems idealistic at a time when counties are struggling just to stem homelessness. But saving people from the streets or jail only to put them in flophouses replicates the worst failures of deinstitutionalization.

Breed's plan is a welcome start. The challenge now is to offer our disabled neighbors group homes that truly function as homes and can prepare them to live in homes of their own.

Neil Gong is an assistant professor of sociology at the University of Michigan. Alex Barnard is an assistant professor of sociology at New York University.

Opinion

Opinion: Separating children from parents harms their development

When a child is separated from a parent, the resiliency of the young brain erodes

Share this:

- Click to share on Facebook (Opens in new window)
- Click to share on Twitter (Opens in new window)
- Click to email this to a friend (Opens in new window)
- Click to print (Opens in new window)
-

Liana Chavarin, of Berkeley, carries her son Oliver, 9, during a recent protest outside ICE headquarters in San Francisco. (Ray Chavez/Bay Area News Group)

By Dr. Jaime Peterson |

PUBLISHED: July 10, 2018 at 6:45 am | UPDATED: July 10, 2018 at 6:47 am

As I entered the exam room, the screaming began. 14-month old Antonio (not his real name) began to shake and cling to his mother. He had just arrived from El Salvador after a traumatic border crossing. It took 15 minutes before I could approach him for a cursory physical exam. I never took him from her arms.

During the critical first years of life children need safe, stable and nurturing relationship for early brain development. If a child experiences an adverse event the young brain can recover and is remarkably resilient in large part due to the social-emotional buffering provided by a strong, loving parent relationship. But when you fracture that relationship

by separating a parent and their child, the resiliency of the young brain erodes and if prolonged, permanently changes the brain architecture.

I remember the first day I dropped off my 14-month old daughter at daycare. Despite the bright room full of toys she was terrified. She cried the entire day. At pick-up I could still hear her frantic wail: "Mammaaaa!!!" Unlike Antonio, once safe in my arms, she quickly calmed. Each day she cried less and played more. Our strong, consistent relationship helped her "cope." She knew I would always come back.

What if I had not returned? What if Antonio had been "ripped from his mother's breast while feeding him" to be housed in a "tender aged" detention facility? We know what happens.

When traumatic events are prolonged or repeated they become toxic. The physiologic stress response (fight or flight response) goes into hyper-drive: children panic, scream, and look for the reassurance of a parent. If the stable parent relationship is missing, the hormonal stress response persists and changes brain structure with long-term negative consequences: growth delays, sleep disturbances, tantrums, attachment difficulty, learning disabilities and problem behaviors. What's worse is the collective impact of each adverse childhood event may extend into adulthood with higher rates of substance use, anxiety, depression, diabetes, obesity and heart disease.

Antonio wasn't separated, but he was detained with his mother. Soon after he developed breath-holding spells. When frightened, he stopped breathing, turned blue and passed out. He was never separated. For months he cried at night, even in his mother's arms. His language development stopped. Any detention, even with a parent, is harmful.

The American Academy of Pediatrics (AAP) represents more than 66,000 pediatricians in the United States and has repeatedly opposed the detention of children. While the executive order signed by the president ends family separation and the recent court injunction mandates reunification, children remain separated and families now face indefinite detention.

Children are not silent when they are in distress. Listen to their cries and their pleas for "Papi." They are asking for safety, for familiarity, for comfort. With a parent they can heal. Antonio is slowly learning to cope, re-wire his stress response and adapt to a new life full of opportunity. Now in clinic, I get "high-fives" and hugs. The power of a loving, parent is remarkable.

Yet, I still can't sleep at night knowing we could have prevented much of Antonio's trauma. The pediatric and public health fields are rooted in upstream prevention: If you know lead is in the water, remove the water source. If we know separating and detaining children harms their development, stop the practice and find an alternative. Not July 11, not after the mid-terms, immediately. We don't ask for a "deadline extension" when it comes to a child's health because the stakes for Antonio and countless other children are just too high.

Dr. Jaime Peterson is a pediatrician at Lucile Packard Children's Hospital.

Dr. Jaime Peterson

Op-Ed Reference Links:

http://www.bmsg.org/blog/getting-your-op-ed-published-lessons-from-a-media-advocate/
https://www.nytimes.com/2017/08/25/opinion/tips-for-aspiring-op-ed-writers.html
https://truthout.org/articles/guatemala-is-not-a-safe-third-country-decades-of-us-policy-made-it-that-way/
https://www.sacbee.com/opinion/op-ed/article223645355.html?fbclid=IwAR1WnEejxSf4DtzY0QV7Hnobi_VPJV-PgXhj0dkCqRjnYdDBSurF6LrQ7vs

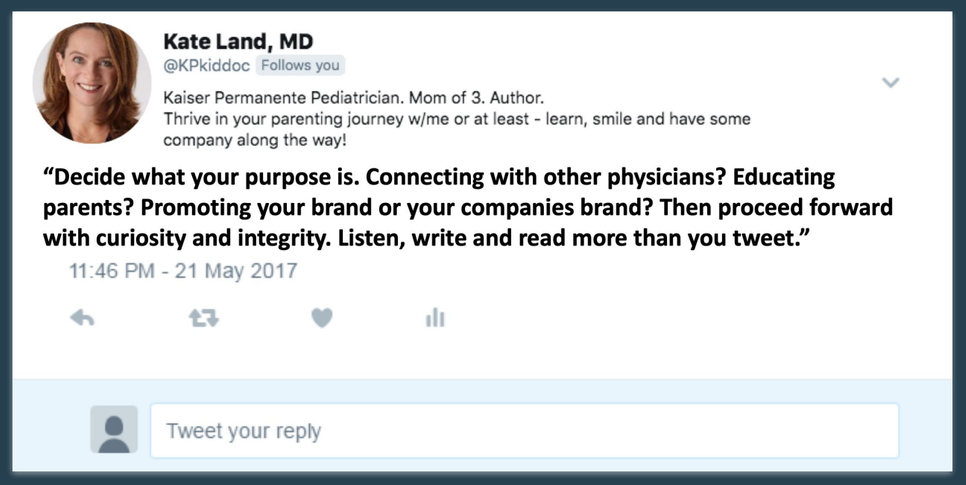
GET SOCIAL

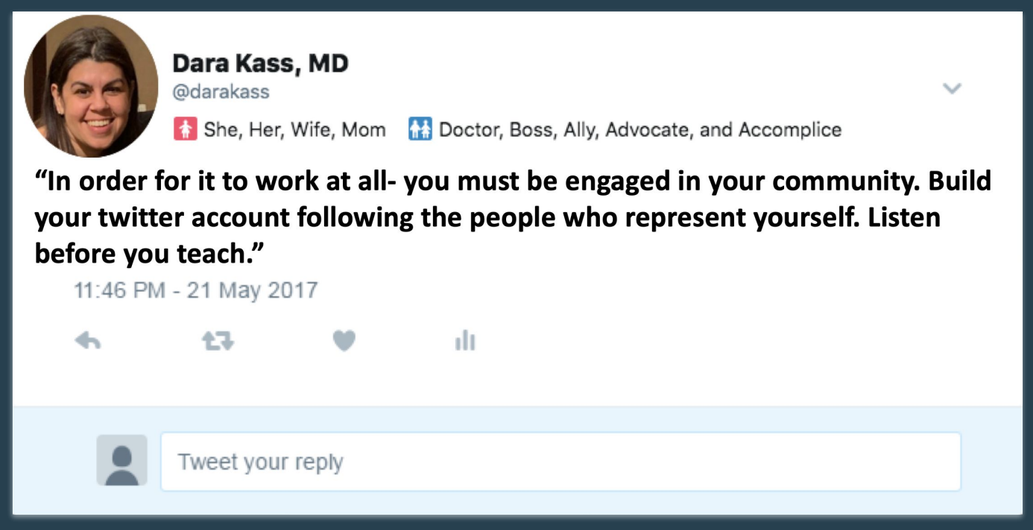
MEDIA SAVVY

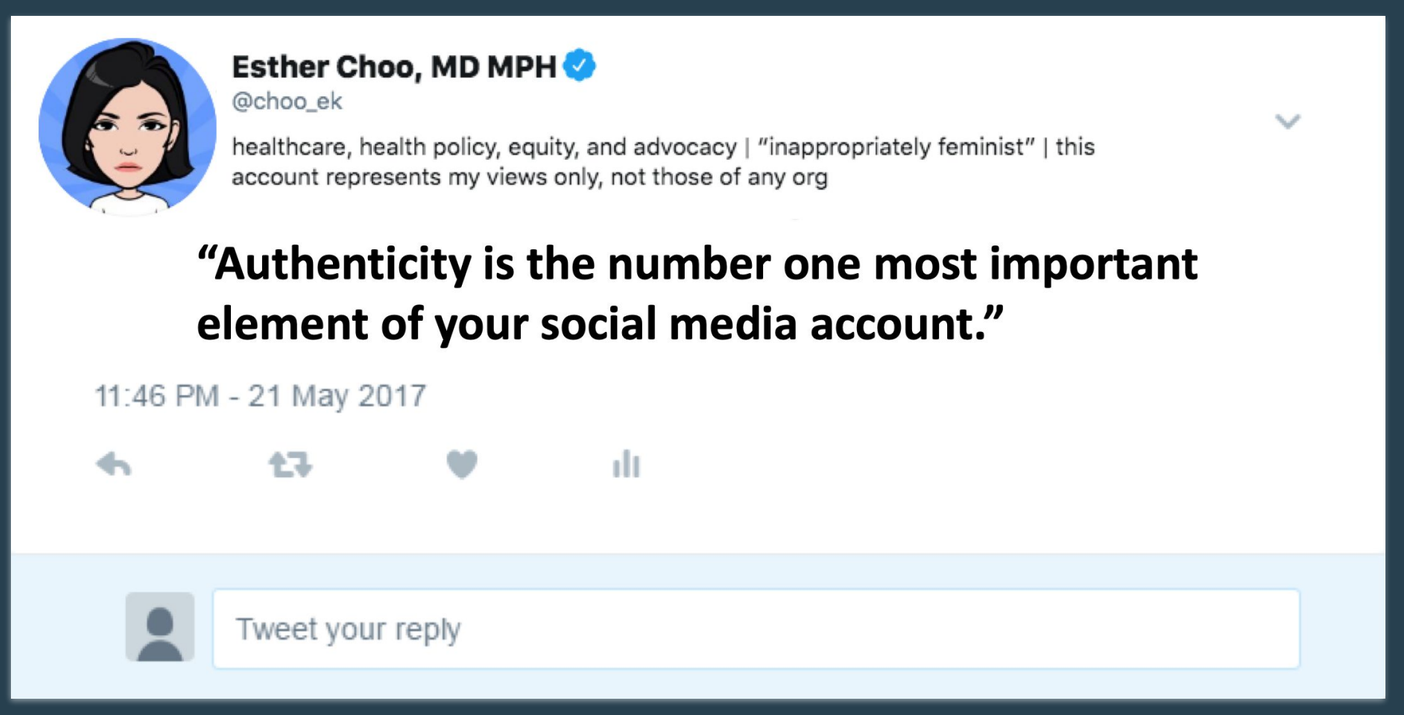
NEW TO TWITTER?

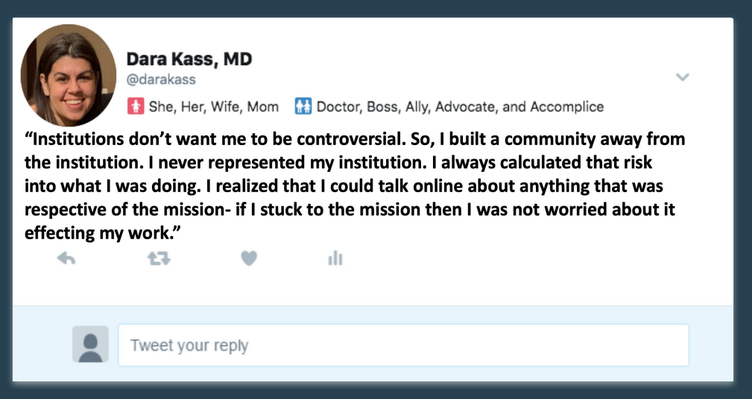
WANT TO STEP YOUR GAME UP?

ASK OUR EXPERTS ANYTHING.









#PEDSACT #TWEETIATRICIAN #DOITFORTHEKIDS #MEDTWITTER

UPCOMING CME CONFERENCES

Visit https://aapca1.org/events/

Organized by
California Chapter 1
American Academy of Pediatrics

Hosted & Sponsored by
Valley Children's HEALTHCARE

Pediatric Mental Health Day

Continuing Medical Education Conference

Saturday, November 9, 2019

8:30 a.m. – 3:30 p.m.

Valley Children's Hospital
9300 Valley Children's Place
Madera, CA 93636
Conference Room: G150A/B

5.5 CME Credits Offered AMA Category 1 credit

4th Annual Pediatric Puzzles

An Interactive Case-Based Conference

Brought to you by AAP California Chapter 1

Saturday, December 7, 2019

Mission Bay Conference Center, UCSF
1675 Owens St, San Francisco, CA 94158

DISCLOSURES

Disclosure of Commercial Support for AAP CME Activities

The AAP gratefully acknowledges financial support for this activity from UCSF Benioff Children's Hospital, Department of Community Health and Engagement at UCSF Benioff Children's Hospital Oakland, California Wellness Foundation, Stanford Children's Health/Lucile Packard Children's Hospital and Kaiser Permanente Oakland, Graduate Medical Education Pediatrics Residency Program.

Disclosure of Financial Relationships and Resolution of Conflicts of Interest for AAP CME Activities

The AAP CME/CPD program develops, maintains, and improves the competence, skills, and professional performance of pediatricians and pediatric healthcare professionals by providing quality, relevant, accessible, and effective educational experiences that address gaps in professional practice. The AAP CME/CPD program strives to meet the educational needs of pediatricians and pediatric healthcare professionals and support their lifelong learning with a goal of improving care for children and families. *(AAP CME/CPD Program Mission Statement, May 2015)*

The AAP recognizes that there are a variety of financial relationships between individuals and commercial interests that require review to identify possible conflicts of interest in a CME activity. The "AAP Policy on Disclosure of Financial Relationships and Resolution of Conflicts of Interest for AAP CME Activities" is designed to ensure quality, objective, balanced, and scientifically rigorous AAP CME activities by identifying and resolving all potential conflicts of interest prior to the confirmation of service of those in a position to influence and/or control CME content. The AAP has taken steps to resolve any potential conflicts of interest.

All AAP CME activities will strictly adhere to the *Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support: Standards to Ensure the Independence of CME Activities.* In accordance with these Standards, the following decisions will be made free of the control of a commercial interest: identification of CME needs, determination of educational objectives, selection and presentation of content, selection of all persons and organizations that will be in a position to control the content, selection of educational methods, and evaluation of the CME activity.

The purpose of this policy is to ensure all potential conflicts of interest are identified and mechanisms to resolve them prior to the CME activity are implemented in ways that are consistent with the public good. The AAP is committed to providing learners with commercially unbiased CME activities.

DISCLOSURE OF FINANCIAL RELATIONSHIPS

All individuals in a position to influence and/or control the content of AAP CME activities are required to disclose to the AAP and subsequently to learners that the individual either has no relevant financial relationships or any financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in CME activities. Listed below are the disclosures provided by individuals in a position to influence and/or control CME activity content.

** A commercial interest is defined as any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.*

Name	**Role**	**Relevant Financial Relationship** (Please indicate Yes or No)	**Name of Commercial Interest(s)*** Please list name(s) of entity AND Nature of Relevant Financial Relationship(s) (Please list: Research Grant, Speaker's Bureau, Stock/Bonds excluding mutual funds, Consultant, Other - identify)	**Disclosure of Off-Label (Unapproved)/Investigational Uses of Products** AAP CME faculty are required to disclose to the AAP and to learners when they plan to discuss or demonstrate pharmaceuticals and/or medical devices that are not approved by the FDA and/or medical or surgical procedures that involve an unapproved or "off-label" use of an approved device or pharmaceutical. **(Do intend to discuss or Do not intend to discuss)**
Lisa Patel, MD	Planner	NO	NONE	Do not intend to discuss
Anna Kaplan, MD	Planner	NO	NONE	Do not intend to discuss
Simran Behniwal, MD	Planner	NO	NONE	Do intend to discuss
William Burrough, MD	Planner	NO	NONE	Do not intend to discuss
Allison Coleman, MD	Planner	NO	NONE	Do not intend to discuss
Stephanie Fong Gomez, MD	Planner	NO	NONE	Do not intend to discuss
Juan Raul Gutierrez, MD	Planner	NO	NONE	Do not intend to discuss
Betsy Hayes, MD	Planner	NO	NONE	Do not intend to discuss
Zarah Iqbal, MD	Planner	NO	NONE	Do not intend to discuss
Hannah Keppler, MD	Planner	NO	NONE	Do not intend to discuss
Zarin Noor, MD	Planner	NO	NONE	Do not intend to discuss
Heyman Oo, MD	Planner	NO	NONE	Do not intend to discuss
Hannah Perrin, MD	Planner	NO	NONE	Do not intend to discuss
Nora Pfaff, MD	Planner	NO	NONE	Do not intend to discuss
Lena Rothstein, DO	Planner	NO	NONE	Do not intend to discuss
Vania J.Singleterry, MD	Planner	NO	NONE	Do not intend to discuss
Nia Stallworth, MD	Planner	NO	NONE	Do not intend to discuss
Sohil R. Sud, MD	Planner	NO	NONE	Do not intend to discuss
Vivien Sun, MD	Planner	NO	NONE	Do not intend to discuss
Sara Szkola, MD	Planner	NO	NONE	Do not intend to discuss
Isra Uz-Zaman, MS	Staff/ COI reviewer & Resolver	NO	NONE	Do not intend to discuss
Lisa Chamberlain, MD	Faculty	NO	NONE	Do not intend to discuss
Anda Kuo, MD	Faculty	YES	Cricket health and Tai Diagnostics: Advisory Board and Stocks/bonds	Do not intend to discuss
Paula Whiteman, MD	Faculty	NO	NONE	Do not intend to discuss
Patricia Salber, MD	Faculty	NO	NONE	Do not intend to discuss
Shaddai Martinez Cuestas	Faculty	NO	NONE	Do not intend to discuss
Kris Calvin	Faculty	NO	NONE	Do not intend to discuss
Tim Valder rama	Faculty	NO	NONE	Do not intend to discuss

Sanjay Ranchod	Faculty	YES	Consultant for Merck, Vizient, Clorox	Do not intend to discuss
Rhea Boyd, MD	Faculty	NO	NONE	Do not intend to discuss
Aaron Nayfack, MD	Faculty	NO	NONE	Do not intend to discuss
Thomas Newman, MD	Faculty	NO	NONE	Do not intend to discuss
Tomas J. Aragon, MD	Faculty	NO	NONE	Do not intend to discuss
Dayna Long, MD	Faculty	NO	NONE	Do not intend to discuss
Mark Del Monte, JD	Faculty	NO	NONE	Do not intend to discuss
Celeste Allen	Planner	NO	NONE	Do not intend to discuss
Kamaal Jones	Planner	NO	NONE	Do not intend to discuss
Michael Bakal	Faculty	NO	NONE	Do not intend to discuss
Smita Patel	Faculty	NO	NONE	Do not intend to discuss
Louis Freedberg	Faculty	NO	NONE	Do not intend to discuss
Ted Lempert	Faculty	NO	NONE	Do not intend to discuss
Wilma Chan	Faculty	NO	NONE	Do not intend to discuss
Cameron Donald	Planner	NO	NONE	Do intend to discuss

Product-Specific Advertising / Links to Product Websites
No product-specific advertising of any type appears in this activity. No links to product websites appear in this activity.

List of Principal Faculty and Credentials
Mark Del Monte, JD
Dayna Long, MD
Tomas J Aragon, MD, MPH, DrPH
Rhea Boyd, MD
Aaron Nayfack, MD
Thomas Newman, MD, MPH
Wilma Chan
Ted Lempert, JD
Sanjay Ranchod
Tim Valderamma
Kris Calvin
Shaddai Martinez Cuestas
Patricia Salber, MD
Paula Whiteman, MD
Anda Kuo, MD
Lisa Chamberlain, MD
Michael Bakal
Louis Freedberg
Smita Patel

Method of Participation, Minimum Performance Level, and Credit Claiming
Participants will participate in the live presentations and workshops. Upon completion of the activities, participants will complete an online evaluation based on the content of the presentations. Participants must successfully complete the post activity evaluation in order to receive CME credit for this activity. Upon submission of the evaluation and verification, participants will be emailed their CME certificate. Alternatively, participants will be able to log onto PediaLink to claim their CME credit or receive a CME certificate via e-mail.

To record your *AMA PRA Category 1 Credit(s)™* in the AAP transcript system, physicians need to directly access the transcript system on *Pedia*Link® at www.pedialink.org, within one year of the activity, which took place on October 5, 2019 AAP members and *Pedia*Link® subscribers may access their transcripts free of charge; non-members may choose to access their transcripts for a fee. The subscription fees are posted at www.pedialink.org. AAP Members, *Pedia*Link® subscribers or non-members who want the AAP to record

their credit for them must return this form and a check for $25.00 payable to the AAP. Your credits will be recorded and a transcript sent to you. AAP Members and *Pedia*Link® subscribers, please make sure to include your AAP ID number.

Name of Medium or Combination of Media Used
Live presentations with slides for presentation via a computer and internet connection

List of hardware/software requirements
N/A

Need more help?
If you need further assistance, please call Executive Director Monday-Friday at 916.274.4173 between 8:00 am and 5:00 pm PST or email us at info@aapca1.org.

Provider Contact Information
If you have questions about this course or encounter technical problems, please contact iuzzaman@aap.net

Privacy and Confidentiality Statement
At the American Academy of Pediatrics (AAP), we take the issue of privacy very seriously. We do not sell, distribute, barter, or transfer personally identifiable information obtained from a user to a third party without your consent. Any information collected on the Web site is only used for the purpose stated.
The AAP list is only for important communications, and your e-mail address will not be sold or provided to third parties. You will not receive advertising or promotional materials on this list.

The AAP may use "cookie" technology to obtain non-personal information from its online visitors. We do not extract personal information in this process nor do we provide this information to third parties. We also do not contact you based on the information in your cookie file.

The AAP has taken steps to make all information received from our online visitors as secure as possible against unauthorized access and use. All information is protected by our security measures, which are periodically reviewed.