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The internship I completed took place at the Pediatric Pulmonary Center (PPC) at UF Health and Shands Hospital. I worked under the supervision of Ms. Ellen Bowser, registered dietician, and had the privilege to shadow a variety of health professionals as they went about their daily tasks. I watched an interdisciplinary team of nutritionists, doctors, nurses, pharmacists, respiratory therapists, social workers and psychologists coordinate their care to provide a full spectrum of services to many patients, specifically at the Cystic Fibrosis (CF) and Sleep Disorder clinics. Outside of the clinics, I participated in the Pediatric Pulmonary Center’s training program and learned of the goals, issues, and challenges faced by the Maternal and Child Health Bureau (MCHB).

 The Maternal and Child Health Bureau is the funding agency behind the PPC’s training program. I learned about this department in depth during a visit from Dr. Russell Kirby, PhD, who came to the UF PPC as a guest lecturer for the training program. He is from the University of South Florida’s School of Public Health, and enlightened our group on the history, goals, and challenges faced by the MCHB. This agency was enacted under Title V of the Social Security Act in 1935. About 85% of its funding comes from state grants, and this year the government allocated around $637 million to the 50 states and US territories. Individual allocations are determined by a formula that considers the number of low-income children in a state compared to the total number in the country (“Title V Maternal”, n.d.). Once they receive the money, states are required to spend 30% on special needs, another 30% on preventative primary care to children, and no more than 10% on administration. The MCHB receives the other15% from SPRANS (Special Projects or Regional and National Significant) grants which goes towards, research, demonstration grants (Kirby, 2015)- t*his* is the money that supports the PPC training program here at UF Health and Shands!

The general goal of MCHB is to promote the interest in improving the health and well-being of all children and their families. They have shifted from condition-focused assessment back when they started in 1935, towards more preventative service, such as the creation of more public awareness programs (Kirby, 2015). Another goal is eliminating health disparities by continuing training programs like the PPC’s that inspire and train a workforce that is culturally competent and reflects the increasingly diverse population. It still remains a challenge for the health industry to provide care totally void of disparities and implicit bias. I witnessed the interaction between race, income level, and social background on implicit bias during my time at UF health, due to the variety of patients see in outpatient clinic. We saw Pediatric patients from Panama, Tallahassee, Jacksonville- places all over the state, both rural and urban. The MCHB has done a lot of work on patient trust by expanding care to larger populations, easing access to the necessary facilities, and improving medical literacy. Not only do patients need to trust the system, but they need to trust the providers, which in turn increases treatment compliance and adherence.

Patient adherence to treatment is a major component of recovery and was the main problem I witnessed during my internship. One reason behind patient reluctance was because of the general inconvenience of the treatment. For example, I saw many patients with cystic fibrosis (CF), an inherited disease that causes the body’s exocrine (sweat) glands to function improperly, leading to a thick, sticky mucus that forms along the body’s epithelial cells (Cunningham, 2003). These epithelial cells are found in the lining of the lungs and other tubes connecting the body’s organs (such as from the pancreas to the stomach), so patients with CF usually have respiratory and digestive problems. If the pancreas cannot send digestive enzymes to the small intestine to break down food for necessary nutrient absorption, that individual has to consume a lot more calories to get enough nutrients to grow. Patients with CF are either pancreatic sufficient or insufficient, the latter leading to enzyme consumption and higher caloric intake. Pancreatic insufficient patients must take enzyme capsules (protease, lipase, amylase- the enzymes that break down proteins, fats, and carbohydrates) with *every* meal, or else their body won’t absorb anything. They must also eat *a lot* more than an average person their age. Working with Ms. Ellen, I was able to hear various cases portraying the struggles of maintaining a high calorie diet. It is especially difficult for infants since they are limited in what they can eat/drink. One mom makes her 18-month old “super” milk which consists of whole milk, carnation instant breakfast powder, powdered milk and heavy cream which totals to about 520 calories! The child also drinks three cans of *Pediasure* (a nutrient-dense formula for children) a day. Even with this abnormally high calorie-diet, the child struggles with weight gain because of his condition. His caloric needs amount to 130-150 calories/kg weight a day verses just a 100 calories/kg for a child without CF.

Another case involved a patient skipping on some of their enzymes which they need to take in order to absorb nutrients from food. Sometimes the enzymes can cause blockages in the colon, leading to discomfort and abnormal stool formation (Cunningham, 2003). Because of these side-effects and other factors, the patient showed reluctance to treatment adherence. Another issue relating to the health industry that involves this particular case study concerns parental behavior and influence. Instead of encouraging the child to take their enzymes, the parents just gave her *Ensure Clear*, a nutritional drink that doesn’t require enzymes. Instead of working on the problematic behavior, the parents avoided the issue and resorted to a seemingly easier, yet temporary solution. Here is where a psychologist would step in, to actively intervene with family therapy to address the issue of noncompliance with medical treatment as a possible form of “acting out” (Good, 1999). Another example of parental influences on child health was at Sleep Clinic where I saw a family whose child suffered from sleep apnea (recurrent cessations in breathing during sleep) and daytime sleepiness. We found out from the mother that the child stays up as late as he wants (sometimes until 4 AM) with unregulated access to technological stimulants- cell phone, T.V, Ipad, etc. The child then doesn’t wake up until 5 or 6 PM later that day. He was diagnosed with circadian-rhythm disorder, which is basically when one’s biological clock is out of circuit with the general population. When addressing the family about the treatment plan, the doctor was careful to acknowledge the role and responsibility of parental oversight. This situation highlights both the importance of parent management skills as well as the conscientiousness of the physician in situations with socio-cultural implications.

One lesson I learned concerns the importance of professionals keeping an open and dynamic perspective on treatment. Just because two CF patients both have the same genetic mutation and similar symptoms, does not mean they automatically receive the same treatment plan. For one patient, routine airway clearance proves sufficient. They may live in very rural area that prevents them from visiting a pharmacy for routine medication pick-up, so the doctor may issue them a Flutter, a pipe-like device that functions during exhalation to create vibrations of the airway walls to loosen secretions and maintain a resistance that keeps the airway open to allow air to move secretions to be coughed out (Paly, n.d.). The other patient, let’s say a UF student with convenient access to the student clinic, may benefit more from an inhaled bronchodilator such as albuterol, a medicine which works directly on the airways to open them. In summary, doctors need to consider environmental factors when determining if a certain treatment is convenient for the individual.

As mentioned before, health professionals need to keep socio-cultural implications in mind. They would never tell a single dad of five children (and let’s say one is obese and suffers from sleep apnea), who works all day and comes home in just enough time to throw together some Hamburger Helper and Mac-N-Cheese, that he needs to provide healthier food options for his family- that maybe he could buy some quinoa, fresh vegetables, and skim milk instead of all the processed “junk” he currently purchases. In this situation, it would be better to praise the father for the effort he has put in, and make *slight* suggestions towards healthier eating. Health professionals should be very aware of their patient’s socio-cultural background, praise current behavior when appropriate, and suggest treatment plans that are feasible for families to follow.

Situations like these made me understand the significance of social work. Social workers are obligated to help clients overcome barriers that interfere with their “well-being” or attainment of “basic human needs” (Boyle, 2009). These barriers include physical, policy and procedural, emotional, social, cultural and informational ones. The above case with the working father exhibits overcoming social barriers, just as the previous example with the rural family having access to a pharmacy is more of a physical one. The lack of adequate transportation permitting clients access to available services is a major stumbling block for families, especially those that travel across the state for UF Health and Shand’s specific services. Social workers help address this issue by encouraging agencies to locate services on public transportation routes, offering transportation vouchers or other financial assistance in getting to the agency, or at the very least anticipating transportation barriers and potential impact on clients.

As you can see, the healthcare system is very dynamic and involves the cooperation and coordination of various healthcare professionals. From the connections made by the social worker, to the physician’s recommended treatment, to the Family Partners evaluation on care satisfaction, every step of the healthcare ladder is imperative to the overall functioning and efficiency of the system. I am positive that I want to work within the health industry, providing coordinated and optimal care to those in need. I especially want to work within a healthcare system like UF Health, which uses a Patient Centered Medical Home (PCMH) model of care in which the approach to primary care delivery focuses on patient-centeredness, quality, safety, efficiency, and teamwork. It really felt like a family on the Pediatric Pulmonary floor as I sat through team meetings, guest lectures, and chart reviews. Everyone collaborates by sharing notes, recalling episodes, reviewing and discussing treatments, etc.

This experience met above and beyond my expectations! It has even influenced my career interests. I entered this program solely as a nutrition student wanting to become a Registered Dietician, but after observing various healthcare professionals and seeing all the moving parts of the medical system, I have decided that I want to a pursue a career as a Physician Assistant. I am still fascinated with the topics and challenges relating to nutrition, but now I want to integrate my knowledge of nutrition into a career with a broader outlook on medicine. Overall, it was a very successful internship. I would recommend this department to anyone interested in pursuing a health career. It was a wonderful experience that incorporated multiple viewpoints and working professionals- every one of those 60 hours was worth the bike ride down and up that huge hill to the hospital!

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