



Operation Homefront: Meeting Clerkship Competencies with Home Visits to Families of Children With Special Needs

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ABSTRACT

OBJECTIVE: We assessed how third-year medical students' written reflections on home visit experiences with families of children with special needs demonstrate evidence of exposure to 9 selected competencies for pediatric clerkships designated by the Council on Medical Student Education in Pediatrics.

METHODS: We reviewed written reflections from 152 third-year medical students. For each competency (2 related to communication were combined), we tabulated the number of reflections in which a given competency was demonstrated. Within each competency, themes are described and presented with exemplary quotes to provide a more robust picture of students' exposure and experience.

RESULTS: Of 152 reflections, 100% demonstrated at least 1 of the 8 expected competencies. Each reflection exhibited an average of 3 (3.1) competencies (range: 1–7). The competencies most frequently mentioned were demonstration of respect for patient, parent, and family attitudes, behaviors, and lifestyles (90%) and demonstration of positive attitude toward education (76%). Less frequently mentioned competencies included demonstration of behaviors and attitudes that promote

patients' and families' best interests (41%), demonstration of effective verbal and nonverbal communication skills (a combination of 2 communication-related competencies) (33%), and description of barriers that prevent children from accessing health care (37%). The following competencies were least often mentioned: description of a pediatrician's role and responsibility in advocating for patients' needs (10%), description of the important role of patient education (8%), or description of the types of problems that benefit from a community approach (17%).

CONCLUSIONS: Our analysis demonstrates that community-based home visits can provide medical students with opportunities to meet required pediatric clerkship competencies.

KEYWORDS: children with special needs; clerkship competencies; community-based experience; home visit; written reflection

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WHAT'S NEW

Medical trainees' knowledge of and attitudes toward children with special health care needs can be enhanced by engaging patients and families as educational partners through a home visit. Written reflection on the encounter can provide evidence of required educational competencies.

ENGAGING PATIENTS AND families as educational partners can teach medical trainees about patient-centered care, provider-patient communication, professionalism, and advocacy.^{1,2} Studies of home visit programs among pediatric, internal medicine, and family medicine residents have identified a variety of outcomes, including improved understanding of social and environmental determinants of health³ and family structure

and dynamics^{1,4}; appreciation for patients' living environments, barriers to care, and community-based resources⁵; and improved self-efficacy in caring for children with special health care needs.⁶ Home visits can also promote empathy⁷ and transform trainees' perceptions of the provider-patient relationship.^{1,8} Most studies of home visits, however, have involved residents who are accompanied by the patient's treating physician.

Reflective writing can promote the professional development of medical students.⁹ Analysis of student reflections can also provide insight regarding whether educational objectives are being met. Previous analyses of medical students' written reflections have focused on experiences with death and dying,^{10–12} patient spirituality,¹³ and medical professionalism.^{14,15} We identified only one study of medical students' written reflections on pediatric experiences.¹⁶

Another study examined reflective writings in relation to learning (geriatric) competencies.¹⁷

At Loyola University Chicago Stritch School of Medicine, Operation Homefront (OH) engages pediatric patients with special health care needs and their families as educational partners. This program is unique in that it combines parent-directed home visits with reflective writing within the context of a third-year pediatrics clerkship. In this study, our primary aim was to assess how students' written reflections on OH provide evidence of 9 selected competencies for pediatric clerkships as designated by the Council on Medical Student Education in Pediatrics (COMSEP) (<https://www.comsep.org/educationalresources/curobjectives.cfm>).

METHODS

OH PROGRAM LOGISTICS

Third-year medical students participate in OH during the pediatric clerkship. OH was started 15 years ago when a parent contacted the medical school expressing the desire to expose students to families with complex medical needs. OH aims to promote physician sensitivity to the challenges of caring and accessing services for a child with special health needs. Families who receive services from Easter Seals are recruited through a parent program leader. Each year, approximately 20 families participate. They receive a brief, informal orientation. Each group of 3 to 4 students visits the same family twice during the 6-week pediatric clerkship; each visit lasts approximately 2 to 3 hours. The family chooses the activities. Ideally, the first visit occurs in the family's home, and the second visit is a family outing or a visit to a doctor or therapist. Most families are visited by multiple student groups throughout the year. An introductory session prepares students for the visit with background information about the family and a list of questions to facilitate discussion. At the end of their clerkship, after completing both visits, students submit a 1- to 2-page written reflection.

STUDY DESIGN

Between July 2015 and May 2016, 152 students completed the OH home visit during their clerkship and electronically submitted a reflection. The Loyola University Chicago Health Sciences Division Institutional Review Board determined the study to be exempt. Prior to the research, reflections were de-identified (student name removed; family names replaced with pseudonyms) by an author (EEA) with no involvement in the clerkship.

To assess our primary aim, 3 authors who are pediatric medical educators—2 clerkship directors (BB and NKQ) and a former clerkship director and current pediatrics department chair (JS)—reviewed the full set of competencies and selected those (primarily attitudinal) that reasonably could be addressed by the OH experience and evidenced in reflective writing. Table 1 outlines the 9 specific competencies selected, as well as the COMSEP competency categories under which they fall and the COMSEP competency description (universal, core to

pediatrics, or master; skills-based or knowledge-based). Two competencies related to communication were combined, and 1-word labels were created to aid in the coding process. Competency categories, subcategories, and descriptions did not factor into our analysis but did inform our selection of competencies.

When reviewing and coding these reflections, we took a systematic, structured conventional content approach.¹⁸ This approach focused on informational content to answer 2 practical questions: what did students learn from the OH experience and how did these lessons align with COMSEP competencies? First, all 6 authors reviewed the same initial set of 20 reflections, reading to assess if the reflection discussed the selected COMSEP competencies. Through this process, we refined competency definitions and finalized a codebook.¹⁹ Then, in 3 rounds, each of the 3 pediatrician authors was paired with each of the 3 medical educators, forming 9 unique pairs that reviewed 16 to 17 reflections each. (Each author reviewed approximately 50 reflections in total.) Coders determined if a competency was present and noted representative quotes. Because of overlap in the COMSEP competencies, a particular quote could be coded as more than one competency. During each round, coding pairs met to discuss individual differences and reach consensus. For each of the selected COMSEP competencies, we tabulated the number of reflections that demonstrated a given competency. Themes within each competency and exemplary quotes were identified in the creation of a final report to provide a more robust picture of students' exposure and experience.

RESULTS

Of 152 reflections, 100% exhibited evidence of at least 1 of the 8 expected competencies. Each reflection exhibited an average of 3 (3.1) competencies, ranging from 1 to 7. Over 30% discussed 4 or more competencies.

The most common competencies mentioned were demonstration of respect for patient, parent, and family attitudes, behaviors, and lifestyles (90%) and demonstration of positive attitude and regard for education (76%). Less frequently mentioned competencies included demonstration of behaviors and attitudes that promote the best interests of patients and families (41%); demonstration of effective verbal and nonverbal communication skills that convey respect, integrity, flexibility, sensitivity, and compassion (a combination of 2 communication-related competencies) (33%); and description of barriers that prevent children from accessing health care (37%). Mention of the following competencies was fairly rare: description of the types of problems that benefit more from a community approach rather than an individual approach (17%), description of a pediatrician's role and responsibility in advocating for the needs of patients (10%), or description of the important role of patient education in the treatment of chronic illness (8%).

Below we discuss each competency, beginning with those most frequently present in student reflections. Key

Table 1. Selected Council on Medical Student Education in Pediatrics Curriculum Competencies

Competency	Competency Category	Competency Subcategory	Competency Description*
Demonstrate <u>communication</u> skills with patients and families that convey respect, integrity, flexibility, sensitivity, and compassion. [†]	Professional conduct and attitudes	Humanism and professionalism in patient and family encounters	Universal Skills-based
Demonstrate effective verbal and nonverbal <u>communication</u> skills with children and their parents or families that include establishment of rapport taking into account the patient's age and development stage. [†]	Specific skills	Patient communication skills	Core pediatric Skills-based
Demonstrate <u>respect</u> for patient, parent, and family attitudes, behaviors, and lifestyles, paying particular attention to cultural, ethnic, and socioeconomic influences to include actively seeking to elicit and incorporate the patient's, parent's, and family's attitudes into the health care plan.	Professional conduct and attitudes	Humanism and professionalism in patient and family encounters	Universal Skills-based
Demonstrate behaviors and attitudes that promote the <u>best interest</u> of patients and families, including showing flexibility to meet the needs of the patient and family.	Professional conduct and attitudes	Humanism and professionalism in patient and family encounters	Universal Skills-based
Demonstrate a positive <u>attitude</u> and regard for education by demonstrating intellectual curiosity; initiative; honesty; responsibility; dedication to being prepared; maturity in soliciting, accepting, and acting on feedback; flexibility when differences of opinion arise; and reliability (including completing all assignments with honesty).	Professional conduct and attitudes	Professionalism in the learner role	Universal Skills-based
Describe a pediatrician's role and responsibility in <u>advocating</u> for the needs of patients (individual and populations) within society.	Professional conduct and attitudes	Professionalism and society	Mastery Knowledge-based
Describe the important role of <u>patient education</u> in treatment of acute and chronic illness and prevention of disease.	Specific skills	Patient communication skills	Mastery Skills-based
Describe <u>barriers</u> that prevent children from gaining access to health care, including financial, cultural, and geographic barriers.	Child advocacy	Not applicable	Core pediatric Knowledge-based
Describe the types of problems that benefit more from a <u>community</u> approach rather than an individual approach.	Child advocacy	Not applicable	Mastery Knowledge-based

**Universal* refers to a skill, attitude, or behavior not specific to pediatrics that is essential to all aspects of clinical medicine. *Core pediatric* refers to a skill, attitude, or behavior specific to pediatrics and expected of students by the end of the clerkship experience. *Mastery* refers to a skill, attitude, or behavior specific to pediatrics that is expected of students with advanced training in pediatrics, not necessarily during the clerkship experience.

[†]These 2 competencies related to communication were combined in the analysis. The underlined words in each competency were used by the research team to identify each competency during the coding process.

themes and exemplary quotes provide insight into the meaning of the competencies as experienced by the students.

DEMONSTRATE RESPECT FOR PATIENT, PARENT, AND FAMILY ATTITUDES, BEHAVIORS, AND LIFESTYLES

Student comments that demonstrated respect for patient, parent, and family attitudes, behaviors, and lifestyles were most common, appearing in 136 (90%) reflections. Themes representing how students experienced this competency include demonstration of respect for parental sacrifice, family dynamics, and parental knowledge and compassion regarding families' challenges.

Many student comments related to respect recognized the difficulties and sacrifice involved in parenting a child

with special needs. Some personalized the experience, wondering if they would be up to the task:

I continue to reflect on whether or not I would be able to cope and manage my life with the same strength and endurance if placed in a similar situation. (Student 1 [S1])

Many students expressed awe, conjuring super hero images such as “*live-action Wonder Woman.*” (S2) However, other students had a more realistic view of parental sacrifice:

My biggest realization was that parents of disabled children are not necessarily people who have bigger hearts or are “built” to deal with the struggles that

they do. . . . I think all families with disabled children build the strength that they need. (S3)

Students recognized the joys of parenting a child with special needs “*in spite of all the effort and sacrifice that goes into*” it. (S4)

Students also commented on the effect that a child with special needs can have on family dynamics. Some observations highlighted the positive:

[T]hough this family does go through a lot, they find ways to be strong and stay united and are not willing to let medical problems threaten their unity and cohesiveness as a family. (S5)

Others were more nuanced:

[Lisa’s mother] told us how heartbroken she was when she realized how much time and attention she had sacrificed [prioritizing her over her two younger girls]. This is a family so full of love . . . that I was shocked to hear her admit this and humbled that she shared these sentiments with us. (S6)

Many student reflections also addressed the importance of physician respect for parental knowledge and perspective:

There is no question that a parent who has been watching a child for their whole life has a far more extensive and detailed understanding of the child’s health and level of function than any physician could probably ever have. (S7)

Student reflections mentioned the need for physicians to demonstrate compassion regarding the everyday challenges facing families of children with special needs:

Living a life in the shoes of a parent that has to WORK for her kid’s health gave me new perspective into what some of my patients have to do to come see me and what it takes to follow through with some of the recommendations we give them. (S8)

DEMONSTRATE A POSITIVE ATTITUDE AND REGARD FOR EDUCATION

Reflections of 116 (76%) students demonstrated a positive attitude and regard for opportunities to learn. Themes that represent how students demonstrated this competency include recognition of the value of the OH experience, gratitude to the family, appreciation for a fuller picture of the patient as more than a diagnosis, and a shift in power between the patient and provider. Many comments such as this one simply acknowledged that the OH experience was valuable:

Getting a first-hand look into the day-to-day life of someone with their own special needs for extra care

and coming to learn the things their family deals with on a regular basis not only internally but with the outside community is an invaluable experience. (S9)

Other students expressed gratitude for the experience. As one student stated:

There is so much to learn, so many assignments and so little time, we often forget the reasons most of us signed up for this profession in the first place: the patients. I am grateful for an “assignment” like OH where we are forced to look up from our books and pay attention to a patient’s life. (S10)

Many students appreciated the experience because it brought textbook learning to life:

Brian’s condition wasn’t something I could read about in a book or learn about in a class. (S11)

Beyond that, some recognized something quite unique in the experience:

Through OH the paradigm through which I’ve seen medicine was flipped. Generally patients are taken out of the comfort of their home and placed in a scary, unknown hospital or clinic and forced to wait hours to see a physician. With OH I was forced to take time out of my busy schedule, pause, and be present with a patient in the place they feel most comfortable. (S12)

A few students affirmed (or reaffirmed) an interest in caring for patients with special needs. The few negative comments about the OH experience questioned the value of simply “hanging out,” observed that difficult topics were avoided, or expressed concern that the home visits seemed “overwhelming” and possibly intrusive.

DEMONSTRATE BEHAVIORS AND ATTITUDES THAT PROMOTE PATIENTS’ AND FAMILIES’ BEST INTERESTS

Reflections of 62 (41%) students demonstrated behaviors and attitudes that promote patients’ and families’ best interests. Students described patient-centered care as that which treats the whole person and the whole family, focuses on care instead of cure, and is tailored; they also pledged to show compassion rather than frustration toward perceived noncompliance.

Many students discussed the importance of treating the person not the diagnosis and seeing “*the story behind each patient.*” (S13) As another student noted:

Going forward, I will make an effort not to give my patient advice or instructions without thinking about what unique struggles they are facing. I won’t walk into a room and presume that just because I understand the pathophysiology of a diagnosis that I understand its influence on relationships and quality-of-life. (S14)

Promoting best interests also included acknowledging the needs of all family members:

[O]ne [lesson] I will take with me that I certainly may have . . . one day became guilty of had it not been for this experience, was Brenda's advice that it often infuriates her when people in public or at doctor's appointment treat Brian extremely well but fail to acknowledge Bobby—to not forget that the siblings are just as special and deserving of equal acknowledgment. (S9)

Some students discussed best interests as focusing on the goals of care as opposed to “cure”:

I think as physicians we often try to find a cure for disease, but this experience was a reminder that the little things can be huge for patients and their families. (S15)

Best interests also involved tailoring treatment:

[The family] went to see at least three different doctors about the problem and were told by all of them that it was nothing. Finally, a holistic doctor suggested a treatment that worked. . . . One of the things I learned during this encounter was that no matter what medical school or residency will teach me, if something is working for the parents and kids, it must actually work and should not be dismissed. (S16)

Finally, under the theme of best interests, many students discussed the importance of demonstrating compassion regarding noncompliance:

I think it's also very important for [doctors] to be respectful of the family deciding what interventions they will follow through with and which ones they won't. In situations this complicated, families already have so many things to do and at some point another therapy to stay on top of may cause more stress than is worth the questionable results it may have. (S17)

DESCRIBE FINANCIAL, CULTURAL, GEOGRAPHIC, AND OTHER BARRIERS THAT PREVENT CHILDREN FROM ACCESSING HEALTH CARE

Barriers that prevent children from accessing health care were described by 56 (37%) students, primarily in terms of cost, coordination, time, travel, and educational needs. Many students mentioned discussions with parents about the costs of health care; for example:

I was troubled by how many legal and/or insurance hoops [parents must] navigate in order to get essential medical supplies. (S18)

Financial barriers also include the costs of medical equipment or structural changes to the home:

Laura's wheelchair is customized to her body and costs more than \$10,000. Per the state's law, the insurance companies only cover a new wheelchair every 5 years.

However, there is no addendum to the policy for children, who may require new wheelchairs more frequently due to growth. (S19)

In addition to costs, the issue of care coordination and the sheer amount of time spent accessing health care was also raised:

What I hadn't considered, though, was the burden of having to travel (and be on time!) nearly every single day and how much time out of every week is consumed doing it. Owen has doctor's appointments, physical therapy appointments, recreational therapy appointments, and a few other commitments at least 5 days a week. (S20)

Some students also discussed how families had traveled great distances to see specialists.

DEMONSTRATE EFFECTIVE VERBAL AND NONVERBAL COMMUNICATION SKILLS THAT CONVEY RESPECT, INTEGRITY, FLEXIBILITY, SENSITIVITY, AND COMPASSION

The importance of effective and respectful verbal and nonverbal communication was discussed by 50 (33%) students. Student reflections particularly emphasized the importance of listening to parents' initial concerns:

[A] physician's role is to navigate through the anxieties, affirmative answers to every question asked and potential exaggeration of issues. Because as was the case with Cathy, sometimes you still have to look for zebras when you hear hoof beats. (S21)

For some students, the OH experience provided an opportunity to learn about ways to communicate with nonverbal patients. The importance of involving children with chronic conditions in their own care as early as possible was also noted by several students:

[R]emember to always treat patients who have any sort of disability with respect and to try and direct interview questions as much as possible to them, not their parents. . . . These patients will grow up and will need a voice of their own to express their issues and how they're handling their disease. (S22)

DESCRIBE THE TYPES OF PROBLEMS THAT BENEFIT FROM A COMMUNITY APPROACH

The types of problems that benefit more from a community approach rather than an individual approach were described by 26 (17%) students. Students discussed that care can be provided in the home and that state and local programs play an important role in supporting families' ability to provide quality care at home. Some students mentioned the support provided by local parent networks as “something that is probably almost necessary for these families.” (S23) Some students discussed the role of community-based allied health care:

[W]e accompanied her to both an occupational therapy as well as physical therapy session at Easter Seals. . . . Though I have always had great respect for the work therapists do, this experience opened my eyes to the type of work they do for children, and how imperative their role is. (S24)

A few students discussed the need for community resources for adolescents who are out of school.

DESCRIBE A PEDIATRICIAN'S ROLE AND RESPONSIBILITY IN ADVOCATING FOR THE NEEDS OF PATIENTS

Only a very small number (15; 10%) of students described pediatricians' advocacy responsibilities. A few students simply recognized the physician's role as advocate:

We [physicians] need to make more of an effort to advocate for children to receive the help they need to live a happy and fulfilling life. (S25)

Others committed to advocacy on both the individual and community level:

As I become a physician, I want to keep Jenny and her family in my thoughts and work to provide the support and resources that are necessary in caring for individuals with chronic, debilitating medical conditions. (S26)

Students also discussed the need for tools and training regarding how to advocate for patients and to help them obtain necessary resources.

DESCRIBE THE IMPORTANT ROLE OF PATIENT EDUCATION IN TREATMENT OF CHRONIC ILLNESS

The important role of patient education in the treatment of children with chronic illness was described by only 12 (8%) students. Among these students there was recognition of the key role that parents play in their children's care. The need for parents to become experts in their child's disease and to take responsibility for certain care functions was also acknowledged. There was little discussion of how the physician can educate parents and patients to assume these responsibilities. In general, comments expressed admiration for parental knowledge, overlapping with the theme of respect:

She amazed me by how much she knew about Wendy's condition, especially on a molecular level. Wanda had devoted her time, ever since learning of Wendy's [disease], to becoming an expert in the subject so she could take care of her daughter. (S27)

Some students also discussed the importance of educating the child directly and not leaving it all up to the parents:

Due to her unique nutritional requirements she needs to take multiple supplements daily and has been managing her own medications, which she is

very good at. This was an interesting example of empowering children to be active participants in their own care and how this can help them understand why they need to follow certain lifestyle modifications, which can be challenging, especially in social situations at school. (S28)

DISCUSSION

Our analysis demonstrates that a community-based, parent-directed experience can fulfill required educational competencies. In written reflections, third-year pediatric clerkship students' comments related to, on average, 3 of the clerkship competencies selected as being relevant to the OH experience and reasonably demonstrable through written reflection. Most students expressed respect for patients, parents, and families and a positive view, even gratitude, for the learning opportunity. Students were able to observe not only the challenges parents face in caring for a child with special needs but also the rewards, seeing a fuller view of patient health and well-being. Observing challenges to accessing care, the significant amount of care that happens outside the clinic, and parental knowledge led students to reflect on the key role of parents as partners in health care and to pledge to maintain compassion for their future patients. Few students said something negative about the experience; however, the negative comments can inform future program planning purposes, particularly with respect to the preparation of families for home visits.

Our study adds to the small yet compelling body of empirical studies that demonstrate the value of including patients and families as educational partners, providing opportunities for medical students to visit patients in their homes, and prompting students to reflect, in writing, on what they are learning. Most other studies of home visits have involved residents and not medical students and have included medical examination of and/or provision of treatment to the patient. OH differs in that the learning experience is parent directed and intended to introduce the students to the patient experience outside the clinical relationship; however, our findings suggest similar benefits in terms of trainee knowledge and attitudes.

Like other studies, we found that our home visit program informed students' understanding of patient-centered care^{1,2} and emphasized the care of the whole person (and family), not the disease. A large proportion of students in our study demonstrated through their reflective writing the importance of incorporating patient and family needs into the health care plan and showing flexibility in order to promote patients' best interests. We also found that OH increased empathy for patients.⁷ Many students mentioned a change in attitude regarding "noncompliance." Students learned to appreciate the role of family dynamics.^{1,4} Students also gained insight into the patient-provider relationship.^{1,8} However, competencies related to communication, advocacy, community-based resources, and

barriers to accessing care were mentioned by only a small number of students.

Our study had several limitations. First, although we selected those COMSEP competencies considered most likely to be achieved through the OH experience, it may be that OH impacted student attitudes on competencies or other outcomes that we did not assess. Another limitation was the amount of overlap between some of the competencies (for example, respect and best interests). However, our carefully refined definitions, multistep coding process, and consensus conferences increased the accuracy of our identification of competencies. Finally, while we have demonstrated students' awareness of issues related to selected competencies, because the selected competencies focus on knowledge and attitudes, and not skills, we are not able to know if or how this awareness will translate into their future practice of medicine.

CONCLUSION

Our research suggests that home visit programs involving parents as educational partners can be valuable supplements to student clinical experience. The value of such programs may be enhanced by including a reflective writing component. Our students responded to an open prompt; future research is needed to determine whether prompting parents and students to discuss and reflect upon issues related to competencies can enhance learning. Discussions regarding physician advocacy, patient education, and how to identify and access community-based resources may require specific prompting, as these issues did not surface as frequently in student reflective writing as did issues related to respect for families, best interest, communication, and barriers to accessing health care.

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