Integrating Home-Visits into Developmental Disabilities Clinical Service Learning Program
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Innovation

Introduction: As the medical profession transitions to a patient-centered care model, it becomes increasingly important for medical students to be exposed to patient interactions and caring for patients of all-manners. The Arie home-visit program offers students the opportunity to assess their attitudes and perceptions of people with developmental disabilities and interact on a personal level with assigned families. Medical students gain insight into the home life, medical needs, and personal concerns of their family, which translates into greater empathy and understanding of the specific needs of these families.

Description of practice innovation: Core methodologies involved with running the program are:
1. Student assessment utilizing the Medical Students’ Perceptions of Disability and Definitions and Criteria Associated with Disabilities Assessments (MSPD)
2. Family surveys using the Jefferson Scale of Physician Empathy (JSPE) adapted for health profession students (JSE-HPS version), Jefferson Scale of Patient’s Perceptions of Physician Empathy (JS3PE), and a general physician trust scale (GPTS). Student pairs complete two home-visits (each scheduled for two hours) approximately 30-60 days apart, with a phone call in between. During the home-visit, one of the family members complete the JSE-HPS independently and students verbally ask questions from the JS3PE and GPTS with the family.
3. Communication logistics utilized GoogleDrive as the primary mode of communication with students participating in the program. A main page was created including family demographics, student’s zip code for family matching purposes and family matches. Another sheet was continuously updated by students with dates for scheduled visits, completed phone calls and event attendance information.

Evaluation: Program participation led to significant increases in medical students’ confidence in communicating with disabled patients as well as increases in elements of “compassionate care” (p<0.05), a major component of empathy. Family trust in physicians did not significantly change over the program (p>0.05), probably because initial measures of trust (4.66±0.75) and perceived empathy (3.82±1.20) were very high or because of a lack of understanding the objectives of the program and a common language.

Discussion: A positive change made to the program this year was implementing home-visits rather than having interviews at the medical school. This increased program participation among families and introduced students to the challenges of raising a child with a developmental disability.

Areas for improvement include creating a website detailing the purpose of the program and possibly as a way to recruit families for the study. This website should include resources provided to families. A handbook is being created to ease the transition to new leadership. The handbook should include a mission statement describing the purpose and goals of the program; a timeline for completing the various tasks like family matches and home-visits; and an explanation of the assessment methods. By utilizing a handbook to ease the transition from year to year, program coordinators can focus on innovation and successful outcomes, reducing the learning curve. This problem is unique to medical school programs, as schedules differ greatly between the first through fourth year, which is why it is important to include first year coordinators.