



## Telehealth Tips that Benefit the Provider and Patient

**Kelly Skelly, MD**, Clinical Associate Professor,  
Department of Family Medicine,  
University of Iowa Hospitals and Clinics

**Marcy E. Rosenbaum, PhD**, Professor of Family Medicine,  
University of Iowa Carver College of Medicine

With the onset of an unprecedented pandemic, health care providers are increasingly asked to provide high-quality health care through video and phone calls to treat a variety of medical conditions and illnesses in their pediatric patients, not just those with COVID-19 concerns. Available research confirms that patients are accepting of telehealth visits.<sup>1</sup> Telehealth visits can and do effectively include pediatric patients with their parents.

In this brief article, the focus is on how to make communication during a telehealth visit the most effective using several evidence-based communication strategies.

### Pre-visit preparation

Regarding scheduling telehealth visits, evidence suggests that the best telehealth visits are with a

*(continues on page 2)*

provider known to the patient/family.<sup>2</sup> When possible, consider the age of the pediatric patient to schedule the most effective visit time, to avoid naps or other age-specific behaviors. Before initiating the call, it is helpful to make certain the area is free from background noise, and the provider is relatively comfortable with minimal distractions (real or virtual). For video visits, making sure the provider's face is well lit with no back lighting allows the patient to clearly see the provider.

### Beginning the visit

Smiling and using a pleasant tone of voice when beginning the call conveys to the patient a welcoming attitude from the provider.<sup>3</sup> Opening the visit with an introduction and explanation of the provider's role is helpful. It is important to confirm that the time is correct, the patient has privacy, and the interaction is confidential. During pediatric visits, communicating directly with the child as well as the parent is important. Acknowledging that technology can be an issue is helpful so that the parent or patient knows what to do if they are cut off or things do not work as planned. Encouraging the patient and parent to ask questions if they are unable to hear or see is also helpful. It may be appropriate to overtly state the purpose of the visit and review its expected duration. Similar to in-person patient encounters, taking a minute at the beginning to establish rapport with the patient about a nonmedical topic allows a personal connection to set a caring tone for the visit. Additionally, having an age-appropriate prop, such as a book or stuffed animal during a video visit, can set a kid-friendly atmosphere.

### During the visit

Throughout the visit, it is important to use positive nonverbal communication through a warm tone of voice. Also, looking at the camera rather than the person's face on the screen during a video visit can help put the patient at ease. It is useful for the provider to acknowledge when looking at or typing in the Electronic Health Record (EHR), so patients do not feel the provider is distracted by working on other tasks. In addition, because it is difficult to notice nonverbal expressions of emotion and empathy over the phone or video, it is important that the provider is very explicit in recognizing and responding to emotional cues from the patient when they express concerns, hesitate, or sigh, indicating emotional distress. Responding to these cues with verbal empathy and statements like, "That sounds really difficult," can make the patient feel more heard and supported.<sup>3,4,6,7</sup>

Summarization, and using animated nonverbal acknowledgments (nodding) during a video visit, also demonstrates to the patient the provider is listening.

During the sharing information and patient education part of the visit, there are real opportunities to improve patient outcomes with effective communication. Beginning information sharing by assessing the patient/parent starting point, "What do you know about strep throat?" can identify concerns and knowledge base early, and help save time depending on the patient/parent level of understanding. To aid in patient comprehension, it is important to speak slowly and clearly and avoid jargon where possible. In telehealth visits in particular, it can be helpful to minimize information density by shortening the amount of information into small chunks that the patient can easily take in and understand, followed by pauses to check patient understanding and make room for patient or parent questions.<sup>3,4,6,7</sup>

### Ending the visit

Closure of the visit is most successful if communication is clear with several simple steps. Orienting the patient to the end of the telehealth encounter is important by summarizing what has been discussed or planned. Utilizing teach back to assess the patient's understanding with a question like, "To make certain I made sense, what changes will you make to your medication?" is really effective in identifying misinformation and increasing patient adherence.<sup>3,6,7</sup> At the end of each visit, clarifying next steps regarding follow-up and future communication is the final thing patients really value.

### References

1. Gardner MR, Jenkins SM, O'Neil DA, Wood DL, Spurrier BR, Pruthi S. Perceptions of video-based appointments from the patient's home: a patient survey. *Telemed J E Health*. 2015;21(4):281-285.
2. McGrail KM, Ahuja MA, Leaver CA. Virtual Visits and Patient-Centered Care: Results of a Patient Survey and Observational Study. *J Med Internet Res*. 2017;19(5):e177-e177.
3. Martinez E, Sattler A, Sherman M, Wootten M. Communication tips for physician phone visits during COVID-19. *Family Practice Management*. [https://www.aafp.org/journals/fpm/blogs/inpractice/entry/telephone\\_visit\\_tips\\_2.html](https://www.aafp.org/journals/fpm/blogs/inpractice/entry/telephone_visit_tips_2.html)
4. Schrage S. Managing a telephone encounter: five tips for effective communication. *Family Practice Management*. [https://www.aafp.org/journals/fpm/blogs/inpractice/entry/telephone\\_visit\\_tips.html](https://www.aafp.org/journals/fpm/blogs/inpractice/entry/telephone_visit_tips.html)
5. Powell RE, Henstenburg JM, Cooper G, Hollander JE, Rising KL. Patient Perceptions of Telehealth Primary Care Video Visits. *Annals of Family Medicine*. 2017;15(3):225-229.
6. Academy of Communication in Healthcare. COVID-19 Quick-Tips To Connect. Accessed April 25, 2020. [https://www.achonline.org/Portals/36/COVID-19%20Resources/Covid-19%20telemedicine%20FINAL4\\_2\\_20.pdf](https://www.achonline.org/Portals/36/COVID-19%20Resources/Covid-19%20telemedicine%20FINAL4_2_20.pdf)
7. Saba GW, Chou CL, Satterfield J, et al. Teaching patient-centered communication skills: a telephone follow-up curriculum for medical students. *Med Educ Online*. 2014;19:22522-22522.

# Factors Contributing to Health Care Disparity

By Emad Abou-Arab, MD,  
Clinical Assistant Professor,  
Department of Family Medicine,  
University of Iowa Hospitals  
and Clinics



In Iowa, as in the rest of the country, COVID-19 continues to disproportionately affect minority communities. Hispanics and Blacks make up close to 10% of the population in Iowa, but 25% percent of COVID-19 cases.<sup>1</sup> Iowa has a small but growing community of immigrants. As of 2018, 6% of Iowa residents are foreign born and about 8% speak a language at home other than English.<sup>2</sup> Five percent of native-born Iowans have at least one immigrant parent. Although the nonwhite population in Iowa is close to 10%, 30% of Medicaid patients in Iowa are nonwhite.<sup>3</sup> Social determinants of health such as sociocultural factors, ethnicity, race, and limited English proficiency (LEP) have an essential role in patient care. Many other factors, including health systems, provider bias, and the patient, may contribute to racial and ethnic disparities in health care.<sup>4</sup> The ability to communicate effectively is increasingly important to provide quality health care to patients from diverse cultural backgrounds.

ASKED is a mnemonic useful for health care providers to consider prior to seeing patients of diverse cultures.<sup>5</sup> The following questions can help providers reflect on their ability to treat patients in the most objective way possible.

<b>A</b>	<b>Awareness</b>	Am I aware of my personal biases and prejudices toward cultural groups different than mine?
<b>S</b>	<b>Skill</b>	Do I have the skill to conduct a cultural assessment in a culturally sensitive manner?
<b>K</b>	<b>Knowledge</b>	Do I have knowledge of the client's worldview and the field of biocultural ecology?
<b>E</b>	<b>Encounters</b>	How many encounters have I had with patients from diverse cultural backgrounds?
<b>D</b>	<b>Desire</b>	Do I really "want to" be culturally competent?

*(continues on next page)*

Health care providers interact with their patients differently, but must be aware of certain principles that can affect their ability to interact with patients in a culturally liberated manner.<sup>6</sup>



**1. Explicit racism:** Overt and often intentional, practiced by individuals who openly embrace racial discrimination and hold prejudice toward racially defined groups.

**2. Implicit racism:** This is not the opposite of explicit racism. It refers to a provider's utilization of unconscious biases when making judgements about people from different racial and ethnic groups, e.g., microaggression.

**3. Cultural ignorance:** A health care provider who has little or no prior exposure to the specific cultural group and may experience fear or a lack of understanding due to their inability to relate to the patient.

**4. Colorblindness:** A health care provider who denies the reality of cultural differences that are important for effective interactions. They have made the decision that they are committed to equality for all and treat all people alike, regardless of cultural background.

**5. Culturally liberated:** A provider who does not fear cultural differences and is aware of his or her attitude toward specific groups. The provider encourages the patient to express feelings about ethnicity and then uses these feelings as a shared experience.

Providers should learn a set of key concepts and skills that enhance the ability to communicate with, diagnose, and treat patients with diverse, sociocultural backgrounds. There are six core, cross-cultural issues, which are discussed below. They are: (1) styles of communication; (2) mistrust and prejudice; (3) autonomy, authority, and family dynamics; (4) the role of the provider and biomedicine; (5) traditions, customs, and spirituality; and (6) sexual and gender issues.<sup>6</sup> In addition, the mnemonic ETHNIC is a framework for culturally competent clinical practice.<sup>7,8</sup> See page 6.

**1. Styles of communication:** How patients communicate matters. Issues related to communication include eye contact, physical contact, and personal space. How patients prefer to hear "bad news." Is the patient stoic or displays symptoms freely?

**2. Mistrust and prejudice:** Many patients mistrust the health care system. Providers must recognize prejudice and its effects and attempt to build trust by reassuring the patient of their intentions. Show respect for the patient's concerns and keep in perspective the patient's best interests.

**3. Autonomy, authority, and family dynamics:** How does the patient make decisions and what is the role of the family? Who makes the decisions, the patient or the family? Often there is an authority figure within the family or community. What role do spiritual leaders play in making important decisions?

**4. The role of the provider and biomedicine:** What are the patient's expectations of the clinician and traditional medicine? Does the patient have differing views on alternative medicine versus biomedicine?

**5. Traditions, customs, and spirituality:** How do traditions and spirituality influence the patient? What are the patient's views and attitudes toward medical procedures, such as drawing blood?

(continues on page 7)



# TELEHEALTH TIP SHEET

Phone and Video Visits (Developed by Drs. Kelly Skelly and Marcy Rosenbaum, University of Iowa Hospitals and Clinics)

BEFORE THE VISIT: PREPARATION	
<b>Scheduling</b>	<ul style="list-style-type: none"> <li>For scheduling, if possible, it is best with a provider known to the patient.</li> </ul>
<b>Documentation</b>	<ul style="list-style-type: none"> <li><b>Start the clinic note</b>, or add to the template started by nursing staff who made initial contact, with the key interim history. <b>Create a mental agenda</b>, if not written outline, in your History of Present Illness (HPI) prior to calling.</li> </ul>
<b>Self-preparation</b>	<ul style="list-style-type: none"> <li><b>Take a breath</b> to ready yourself for the call.</li> <li>Make sure you are <b>comfortably seated</b> before you call the patient. Consider having a kid-friendly toy/book/prop to use during the call.</li> <li>Check that the <b>background in your video</b> is not distracting.</li> <li>If possible be <b>away from noisy areas</b> – such as others talking or on camera.</li> </ul>
KEY COMMUNICATION TIPS FOR PHONE AND VIDEO VISITS	
<b>Maintain full attention</b>	<ul style="list-style-type: none"> <li>Remove all distractions and <b>avoid multitasking</b> (checking emails, etc.) as patients can pick up on this.</li> </ul>
<b>Convey attention and interest</b>	<ul style="list-style-type: none"> <li>Use <b>warm tone of voice</b> throughout.</li> <li>Use <b>verbal listening acknowledgments</b>, such as uh-huh, okay, etc. For video, use explicit nonverbal listening, such as <b>eye contact</b> and nodding.</li> <li><b>Summarize</b> periodically.</li> </ul>
<b>Pacing and language</b>	<ul style="list-style-type: none"> <li><b>Speak slowly</b> and clearly.</li> <li><b>Avoid jargon</b> unless necessary.</li> <li><b>Pause</b> after asking questions.</li> <li><b>Pause</b> for patient questions and elaborations more frequently.</li> </ul>
<b>Explicit empathy</b>	<ul style="list-style-type: none"> <li>Listen/watch carefully for <b>patient and parent emotional cues</b>, including pauses or hesitation.</li> <li>Increase <b>explicit, empathic statements</b>, especially on the phone since the patient/parent won't see nonverbal empathy, i.e., <i>"Gosh, this sounds really tough."</i></li> </ul>
BEGINNING THE CALL	
<b>Introductions</b>	<p><b>Identify patient.</b> <i>"I just need to confirm your full name and birthdate,"</i> and (reintroduce yourself.) Check that this is a <b>good time for the patient and/or parent to talk.</b></p> <ul style="list-style-type: none"> <li>Make certain that they are in a safe place and conversation can be <b>confidential.</b></li> <li>Warm greeting: <b>Smile</b> (will come through in tone of voice) and indicate you are happy to talk.</li> </ul>
<b>Initial check in</b>	<ul style="list-style-type: none"> <li>Check that patient/parent <b>can hear/see you.</b></li> <li>Indicate <b>how you will reconnect</b> with patient/parent if disconnected.</li> <li>Rapport building: Especially during COVID-19, ask <b>how the family is coping?</b> Connect on a personal level.</li> </ul>
<b>Orientation</b>	<ul style="list-style-type: none"> <li>Describe your understanding of the <b>visit purpose</b> (from MyChart, etc.). If relevant, describe visit duration.</li> </ul>
GATHERING INFORMATION	
<b>Agenda setting</b>	<ul style="list-style-type: none"> <li><b>Elicit list of problems/concerns</b> patient and parent want to talk about up front. Add what you want to talk about and <b>negotiate</b> what can and cannot be covered in this visit.</li> </ul>
<b>Asking questions</b>	<ul style="list-style-type: none"> <li><b>Speak slowly</b>, clearly, and pause after asking questions, avoiding jargon.</li> <li>Listen attentively.</li> <li>Clarify what patient and parent says using clarifying questions, repetition, and summary.</li> </ul>
<b>Signposting</b>	<ul style="list-style-type: none"> <li>Explicitly identify when <b>moving from one topic to another.</b></li> <li>Tell patient and parent <b>when you are looking at or writing in their chart.</b></li> </ul>
SHARING INFORMATION: PATIENT EDUCATION	
<b>Structure the conversations</b>	<ul style="list-style-type: none"> <li><b>Signpost the number and types of issues</b> you will be talking about for easier tracking. <i>"I want to talk about three things: your test results, your medications, and where we go from here."</i></li> <li><b>Summarize frequently.</b></li> </ul>
<b>Minimize information density</b>	<ul style="list-style-type: none"> <li><b>Speak slowly</b> and clearly.</li> <li>Shorten your educational spiels. Break up your explanations into <b>short chunks.</b> Repeat them if necessary.</li> </ul>
<b>Elicit patient input frequently</b>	<ul style="list-style-type: none"> <li><b>Assess patient/parent knowledge</b> before a new topic. <i>"What do you know about diabetes?"</i></li> <li>Periodically <b>check patient and parent understanding</b> and concerns about information.</li> <li>Check for <b>patient and parent questions frequently.</b> <i>"What questions do you have so far?"</i></li> </ul>
CLOSING THE VISIT	
<b>Orientation</b>	<ul style="list-style-type: none"> <li>Orient the patient/parent to the end of the encounter, <i>"We have just a few minutes left and I want to summarize and plan next steps."</i></li> </ul>
<b>Review</b>	<ul style="list-style-type: none"> <li>Be clear about the plan. Review what you discussed during the call</li> <li>Establish what will happen after you hang up (follow-up, next steps, etc.).</li> <li>Identify whom to contact with additional concerns and elicit any additional questions.</li> </ul>
<b>Teach back</b>	<ul style="list-style-type: none"> <li>Have patient and/or parent summarize specific, important things such as next steps, management options, etc.</li> </ul>



## ETHNIC: A mnemonic framework for culturally competent clinical practice

<b>E</b>	<b>Explanation</b>	<ul style="list-style-type: none"> <li>• What do you think may be the reason you have these symptoms?</li> <li>• What do friends, family, others say about these symptoms?</li> <li>• Do you know anyone else who has had or who has this kind of problem?</li> <li>• Have you heard about/read/seen it on TV/radio/newspaper? (If the patient cannot offer explanation, ask what most concerns them about their problem.)</li> </ul>
<b>T</b>	<b>Treatment</b>	<ul style="list-style-type: none"> <li>• What kinds of medicines, home remedies, or other treatments have you tried for this illness?</li> <li>• Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy?</li> <li>• What kind of treatment are you seeking from me?</li> </ul>
<b>H</b>	<b>Healers</b>	<ul style="list-style-type: none"> <li>• Have you sought any advice from alternative/folk healers, friends, or other people (nondoctors) for help with your problem? Tell me about it.</li> </ul>
<b>N</b>	<b>Negotiate</b>	<ul style="list-style-type: none"> <li>• Negotiate options that will be mutually acceptable to you and your patient and that do not contradict, but rather incorporate your patient's beliefs.</li> <li>• Ask what are the most important results your patient hopes to achieve from this intervention.</li> </ul>
<b>I</b>	<b>Intervention</b>	<ul style="list-style-type: none"> <li>• Determine an intervention with your patient. May include incorporation of alternative treatments, spirituality, and healers, as well as other cultural practices (e.g., foods eaten or avoided in general, and also when sick).</li> </ul>
<b>C</b>	<b>Collaboration</b>	<ul style="list-style-type: none"> <li>• Collaborate with the patient, family members, other health care team members, healers, and community resources.</li> </ul>

Levin SJ, Like RC, Gottlieb JE. ETHNIC: A framework for culturally competent clinical practice. In Appendix: Useful clinical interviewing mnemonics. *Patient Care*. 2000;34(9):188-189.

## EMBARC's COVID-19 Crisis Response Hotlines

Hours: Monday to Friday, 9 a.m. to 5 p.m.  
Please leave a message if the line is busy, or after 5 p.m.

Burmese: 515-207-9442

Karenni: 515-216-0712

Spanish: 515-344-3936

Chin dialects: 515-216-0974

Kirundi: 515-207-9614

Swahili: 515-216-0611

French: 515-216-0654

Kunama: 515-216-0745

Tigrinya: 515-207-0127

Karen: 515-216-0143

Lingala: 515-216-4329

Weekly News in the above languages at:

<https://sites.google.com/embarciowa.org/embarc-crisis-response/home>

## COVID-19 Language Resources

For links to the following web sites, view the EPSDT newsletter online at: [iowaepsdt.org/other-resources/epsdt-newsletter](http://iowaepsdt.org/other-resources/epsdt-newsletter)

- [American Sign Language Videos-CDC](#)
- [Centers for Disease Control and Prevention - Resources for Limited English Proficient Populations](#)
- [Congolesse Health Partnership Videos](#)
- [COVID-19 in Iowa](#)
- [Crescent Community Health Center - Marshallese Language](#)
- [EMBARC \(Ethnic Minorities of Burma and Advocacy and Resource Center\)](#)
- [Hawaii Office of Language Access](#)

- [Iowa Department of Human Rights – Language Access](#)
- [Iowa Department of Public Health](#)
- [Iowa Spanish Helpline \(515-344-3936\)](#)
- [Refugee Alliance of Central Iowa and partners Multilingual Hotline \(877-558-2609\)](#)
- [Test Iowa – Free COVID-19 Testing \(Spanish available\)](#)
- [Switchboard](#) – technical assistance site for refugee health and translated health materials.

Are there culturally specific therapies that the patient prefers or practices, such as diet?

**6. Sexual and gender issues:** Regarding the physical exam, does the patient prefer a male or female provider? Office staff should check with the patient when scheduling the appointment. Clinicians should use preferred pronouns for patients who are transgender. They must also consider the issue of shame or embarrassment when discussing sexual issues. Understand the differences in sexual behavior, orientation, and identity.

Another important aspect of cross-cultural communication is the proper use of interpreters when seeing patients with LEP. When a patient has LEP and the provider doesn't speak the same language, the provider must use a competent health care interpreter. Interpreters need to be used when any part of the patient's care is funded by a federal program (e.g., Medicaid). Most importantly, interpreters must be used when the quality of care will be affected if there is any misunderstanding. Research has shown that untrained interpreters or family and friends result in about 50% of miscommunication and is a significant source of medical errors. The clinician is ultimately responsible for effective communication.

**Tips for successful interpretations:<sup>7</sup>**

- Do not depend on relatives, friends, or children to interpret.
- Ensure the interpreter is appropriate for the encounter.
- Always address the patient, not the interpreter.
- Focus on the patient during interpretation. Observe their body language and cues.
- Speak in a normal voice, clearly, and not too fast.
- Avoid medical jargon and technical terms.
- Keep statements short, one question at a time, allowing for interpretation.
- Be prepared to repeat statements or questions.
- Have the interpreter ask the patient to repeat important instructions or details.
- Instruct the interpreter not to add or omit information, especially not to offer advice.

Multiple factors contribute to racial/ethnic disparities in health care, including barriers to effective clinician-patient interactions (e.g., language and different cultural



beliefs), system barriers (lack of interpreter services or ethnically diverse clinicians), and clinician biases. Effective and patient-centered cross-cultural communication is a means of improving quality, achieving equity, and eliminating the significant racial/ethnic disparities in health care that persist today.

Note: CultureVision™ is a user-friendly database that gives health care professionals access to culturally competent patient care. Visit: <https://www.crculturevision.com/>

**References**

1. The COVID Racial Data Tracker. Retrieved from <https://covidtracking.com/race>
2. <https://www.americanimmigrationcouncil.org/research/immigrants-in-iowa>
3. Distribution of elderly and non-elderly with Medicaid by Race/Ethnicity. Retrieved [here](#).
4. Green AR, Carney DR, Pallin DJ, et al. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *J Gen Intern Med* 2007; 22:1231.
5. Campinha-Bacote J. The process of cultural competence in the delivery of health care services: A culturally competent model of care. *Journal of Transcultural Nursing*. 2003;13(3), 181-184.
6. Bell P, Evans J. (1981). *Counseling the Black client: Alcohol use and abuse in Black America*. Minneapolis, MN: Hazelsen Foundation.
7. U.S. Department of Health and Human Services, Health Resources and Services Administration. *Transforming the Face of Health Professions Through Cultural and Linguistic Competence Education: The Role of the HRSA Centers of Excellence*.
8. Levin SJ, Like RC, Gottlieb JE. ETHNIC: A Framework for Culturally Competent Clinical Practice. In Appendix: Useful Clinical Interviewing Mnemonics. *Patient Care*. 2000;34(9): 188-189.



University of Iowa Stead Family Children's Hospital  
 Center for Disabilities and Development  
 University Center for Excellence in Developmental Disabilities  
 100 Hawkins Drive  
 Iowa City, IA 52242-1011

## What's in this issue

Telehealth Tips that Benefit the Provider and Patient ..... 1-2

Factors Contributing to Health Care Disparity ..... 3-4, 7

**Inserts:**

Telehealth Tip Sheet ..... 5

Resources ..... 6

If you have questions about **billing** related to EPSDT Care for Kids services, please call Provider Services: **1- 800-338-7909**. If you have questions about **clinical issues** and EPSDT Care for Kids services, please call **1- 800-383-3826**. Please note: Due to budget restraints, the *EPSDT Care for Kids Newsletter* is sent to offices and organizations, rather than to individuals. **The newsletter is also available online at [www.iowaepsdt.org](http://www.iowaepsdt.org).** Readers are welcome to photocopy or download material from the newsletter to share with others. If you wish to reproduce material from the newsletter in another publication, whether print or electronic, please obtain permission prior to publication by contacting the editor. Please include the following acknowledgment with reprinted material:  
 Reprinted by permission of the Iowa *EPSDT Care for Kids Newsletter*.

The *EPSDT Care for Kids Newsletter* is published three times a year, in print and online, as a joint effort of the Iowa Department of Human Services, the Iowa Department of Public Health, and the Center for Disabilities and Development, which is nationally designated as Iowa's University Center for Excellence in Developmental Disabilities. The goal of this newsletter is to inform Iowa health care professionals about the EPSDT Care for Kids program, to encourage them to make use of this important resource, and to provide them with information about a wide range of developments in the field of health care.

**NEWSLETTER STAFF**

<b>Executive Editor</b>	<b>Editorial Board</b>
Temitope Awelewa, MD	Elizabeth Cramer, MD
<b>Production Editor</b>	Bridget Konz, RN
Lesly Huffman	Analisa Pearson, MSN, RN
<b>Graphics Editor</b>	Anna Ruggle
Leigh Bradford	Shruti Tewar, MD, MPH, FAAP

Please send correspondence concerning **content** to:

**Temitope Awelewa, MD**  
 UI Stead Family Children's Hospital  
 Department of Pediatrics  
 200 Hawkins Drive – BT 1300-2  
 Iowa City, IA 52242  
[temitope-awelewa@uiowa.edu](mailto:temitope-awelewa@uiowa.edu)

Please send **change of address** information to:

**Meredith Field**  
 University of Iowa Stead Family Children's Hospital  
 Center for Disabilities and Development  
 100 Hawkins Drive, Iowa City, IA 52242-1011  
[meredith-field@uiowa.edu](mailto:meredith-field@uiowa.edu)