How Do US Pediatric Residency Programs Teach and Evaluate Community Pediatrics and Advocacy Training?

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Abstract

Objective: In 2013, the Accreditation Council for Graduate Medical Education updated requirements for training in community pediatrics and advocacy in pediatric residency programs. In light of this update, the aim of this study was to better understand how community pediatrics is being taught and evaluated in pediatric residency programs in the United States.

Methods: Cross-sectional exploratory study using a Web-based survey of pediatric residency program directors in September 2014. Questions focused on teaching and evaluation of 10 community pediatrics competencies.

Results: Of 85 programs (43% response rate), 30% offered a separate training track and/or 6-block individualized curriculum in community pediatrics or advocacy. More than 75% required all residents to learn 7 of 10 competencies queried. Respondents in urban settings were more likely to teach care of special populations ($P = .02$) and public speaking ($P < .01$). Larger programs were more likely to teach ($P = .04$) and evaluate ($P = .02$) community-based research. Experiential learning and classroom-based didactics were the most frequent teaching methodologies. Many programs used multiple teaching methodologies for all competencies. Observation was the most frequent evaluation technique used; portfolio review and written reflection were also commonly reported.

Conclusions: Our findings show a strong emphasis on community pediatrics and advocacy teaching among responding US pediatric residency programs. Although respondents reported a variety of teaching and evaluation methods, there were few statistically significant differences between programs.

Keywords: advocacy; community pediatrics; residency training

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What's New

The 2013 Accreditation Council for Graduate Medical Education Program Requirements included new requirements for community pediatrics and advocacy training. We found that pediatric programs use a variety of strategies and curricular approaches to teaching and evaluating a broad range of community pediatrics and advocacy competencies.

THE AMERICAN ACADEMY of Pediatrics (AAP) defines community pediatrics as the practice of promoting positive social, cultural, and environmental influences on children's health while also addressing the potential negative pressures on child health within a community. It includes a perspective that focuses on children as a part of a community and that recognizes that child health is influenced by family, education, social, cultural, spiritual, economic, environmental, and political forces.[1] Although the basic concepts of community pediatrics date back to the time of Abraham Jacobi and the founding of the discipline of pediatrics,[2] it was not until 1997 that the Accreditation Council for Graduate Medical Education (ACGME) Program Requirements for Residency Education in Pediatrics stipulated that training include "structured educational experiences to prepare trainees for their roles as advocates within the community."[3] This emphasis from the ACGME coincides with the shift in threats to child health to issues such as chronic health care needs, mental health conditions, exposure to environmental hazards, and lack of access to medical homes,[4] as well as an increased understanding of the effect of social determinants of health and toxic stress. More recently, there have been increasing calls from outside the ACGME to include exposure to community pediatrics within residency training with a focus on social determinants of health, population-based approaches to improving health, techniques for identifying and accessing community resources, as well as advocacy skills.[5–11] This is becoming increasingly important because recent research has shown that exposure to

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principles of community pediatrics during residency increases pediatricians' involvement in community engagement after training.[12,13]

Studies as early as 1988 documented some involvement of residents in community settings.[14] More recent surveys done in 2002[3] and 2005[15] showed that most programs required resident involvement with schools (71%), child protection teams (60%), and child care centers (55%). Additionally, more than 80% of programs in these studies reported providing didactic training and practical experiences relating to children with special health needs, the mental health system, and cultural competency.

Although several publications describe individual program curricula for community pediatrics and advocacy,[16–20] to our knowledge no national studies since 2005 have addressed how community pediatrics and advocacy are being taught in pediatric residency programs. This aspect of training is of particular interest because the most recent (2013) ACGME Program Requirements for Graduate Medical Education in Pediatrics mandate that pediatric residency programs have "a minimum of 5 educational units of ambulatory experiences, including ambulatory experiences to include elements of community pediatrics and child advocacy (2 educational units)."[21] In addition, despite the fact that the ACGME has emphasized resident outcomes, very little has been published regarding assessment in community pediatrics and advocacy training, and most previous studies of community pediatrics training and curricula did not include information about evaluation methods.

Therefore, to better understand how training in community health and advocacy during residency has evolved since 2005, especially in light of the new program requirements, we conducted a national survey of pediatric program directors to collect information on how community pediatrics is being taught and evaluated. We hypothesized that most programs would include elements of community pediatrics and advocacy in their training, but that the breadth and depth of opportunities and experiences would vary among programs. We also hypothesized that evaluation would be mostly observational and that other types of evaluation tools would be used infrequently.

METHODS

In this exploratory study we used a cross-sectional survey design. In September 2014, an invitation with a link to complete a Web-based survey was e-mailed by the Association of Pediatric Program Directors (APPD) to all member pediatric residency program directors. Program directors were asked to forward the survey link to the person who could best answer questions about their program's community pediatrics and advocacy education (eg, community health track director, advocacy director, chief resident, community pediatrics rotation director). The survey was available for 6 weeks, and 2 reminder e-mails were sent to all program directors through the APPD during that time period. Each program was directed to submit only 1 response.

The survey solicited data about the residency program, including program size (using ACGME categories), location of primary teaching site (urban vs rural vs suburban; state capital or not), and classification of setting where residents spend most of their time (freestanding children's hospital, university-based hospital, private general hospital, public general hospital, military hospital, or other), but did not ask program name. The survey also asked about the structure of the community pediatrics and advocacy rotation (eg, block vs longitudinal design, existence of separate training track, or integration into a 6-block individualized curriculum) and whether they used any readily available Internet resources for curriculum design such as community health and advocacy teaching modules or published curricula. Finally, questions were asked about methods of teaching and evaluation in 10 competencies central to community pediatrics and advocacy. Eight of the 10 competencies queried were the core competencies of community pediatrics previously defined by national consensus and published by the AAP.[22] On the basis of the content from AAP's Community Pediatrics Self-Assessment,[8] AAP's Periodic Survey of Fellows #77 (unpublished survey questions), and our professional experience, we added 2 additional competencies: sociocultural determinants of health and public speaking on behalf of children (Table 1 contains a full listing of topics). Respondents were asked whether each of these 10 competencies was required for all or some residents or was available as an elective, which methods were used for teaching (classroom-based didactics, online learning, experiential learning, required reading, or other), in which rotation the competencies were covered, and how residents were evaluated (observation, oral or written assessment, objective structured clinical examination, simulation, review of resident portfolio, written reflection, other, or not evaluated).

The survey was created with the assistance of an expert in survey design (R.Y.M.) and an expert in community pediatrics and advocacy (B.D.H.). The initial questions were revised on the basis of feedback from several additional experts in community pediatrics and advocacy. The survey was then piloted by a national group of leaders in community pediatrics and advocacy training for residents. The survey content and format were also reviewed and approved by the APPD Research Task Force. The Children's National Medical Center institutional review board deemed this study exempt.

To determine if our sample was representative, data about program size, location of primary teaching site, and classification of primary teaching hospital were collected from all US pediatric residency programs through a review of all pediatric residency programs listed on the on-line Fellowship and Residency Electronic Interactive Database (FREIDA).[23] Any information not available on FREIDA was obtained by a search of the Web sites of individual residency programs.

Descriptive statistics were calculated. Categorical data were tabulated into contingency tables and compared using chi-square tests. Fisher exact test was used to compare the

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