Three-Tiered Advocacy: Using a Longitudinal Curriculum to Teach Pediatric Residents Advocacy on an Individual, Community, and Legislative Level

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ABSTRACT:

BACKGROUND: Pediatricians play a critical role as health advocates. Teaching residents to advocate for their patients on an individual, community, and legislative level is a priority for residency training programs. This study examined the effects of a longitudinal curriculum teaching 3-tiered advocacy on pediatric residents’ attitudes, knowledge, and practice.

METHODS: This was a prospective pre- and postintervention study using an anonymous survey of pediatric residents (N = 78) in an urban academic children’s hospital. The survey assessed advocacy on an individual level through comfort and experience in discussing social determinants of health (SDH), on a community level through comfort and practice referring patients to community resources, and on a legislative level through comfort and practice with legislative advocacy. Descriptive statistics and chi-square tests were used to analyze the data.

RESULTS: Postimplementation, pediatric residents reported the curriculum changed their clinical practice (66%), encouraged them to take a more in-depth social history (46%), and helped them guide patients to more community resources (38%). Comfort in discussing SDH with patients in the ambulatory clinic increased (27% vs 76%; \( P = .001 \)). Reported frequency in inquiring about SDH significantly improved in the following areas: income (39% vs 60%; \( P = .025 \)), education (71% vs 93%; \( P = .008 \)), and legal issues (13% vs 26%; \( P = .012 \)).

CONCLUSIONS: Most of the residents reported that the curriculum changed their clinical practice. Residents reported knowledge and comfort with advocating for their patients on an individual level improved. However, there was no significant difference on the community or legislative level. This curriculum raised awareness and armed residents with practical skills to be health advocates on an individual level. Further research is needed to explore effective means of creating 3-tiered advocates.

KEYWORDS: Advocacy, medical education, social determinants of health, residency, community pediatrics

Background

It is well established that adverse social conditions in childhood contribute to an elevated burden of disease in affected children.¹ Living in poverty puts children at higher risk of low functional health (vision, speech, mobility), failure to thrive in infancy, respiratory infection, nutritional deficiency, asthma, obesity, and poorer cognitive scores.² In 2015, 43% of children in the United States were living in low-income households, making children the largest subgroup of the impoverished population in the United States.³ Pediatricians have the privilege of frequently interacting with children and are therefore in a critical position to advocate for the prevention of poverty-related disorders.

With increasing awareness and research on the effect of poverty on children’s health, the American Academy of Pediatrics (AAP) recommended that pediatricians increase their understanding of health and social risks.⁴ In a statement on poverty and child health, the AAP Council on Community Pediatrics urged pediatricians to improve their understanding of the root causes and distal effects of poverty.⁵ In that same statement, the AAP stated pediatricians could advocate for their patients in many ways, including these 3 levels: (1) on an individual level, pediatricians can begin by screening for risk factors within social determinants of health (SDH) during patient encounters; (2) on a community level, pediatricians can collaborate with community organizations already working to address social needs; and (3) on a legislative level, pediatricians could use their physician voice to reframe poverty as an evidence-based health concern.

In addition to the AAP, the medical education community also identifies advocacy as a priority in pediatric resident education. In 2010, the Lancet Commission on medical education development. The Association of Pediatric Program Directors was not involved in the curriculum development or the research for this study.

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for the 21st century criticized medical education for not responding to societal needs in their curricula, stating, “fragmented, outdated, and static curricula are producing ill-equipped graduates.” Further supporting the need for advocacy training in pediatrics, the American Accreditation Council for Graduate Medical Education mandated in 2013 that all pediatric residency programs’ curricula include elements of community pediatrics and child advocacy.

Despite these recommendations, residency programs often lack the necessary resources to implement effective educational advocacy curricula. Pediatric residents may be limited in their knowledge of social needs and how to address them using community resources. Although residents are interested in learning about and engaging in advocacy and community health, advocacy is one of the most difficult subjects to teach, learn, and evaluate. A recent study reported that although almost 90% of pediatric residency programs surveyed reported requiring residents to learn about community and legislative advocacy and almost 80% required learning about SDH, there was a wide range of how these were taught.

Previous advocacy curricula that focused on just a single level of advocacy—screening for SDH, community-based advocacy, or legislative advocacy—have successfully shown an impact on resident’s knowledge of issues and resources related to advocacy. Other curricula have combined these 3 levels of advocacy, but used short-term interventions to achieve this effect. However, one of the key predictors of lifelong advocacy is continuous learning in a long-term fashion.

To train physicians who learn to advocate for their patients on an individual, community, and legislative level and to provide longitudinal exposure to effectively improve attitudes, we designed and evaluated a pediatric advocacy curriculum. We chose to incorporate the AAP policy statement on poverty and child health into resident education by teaching elements of advocacy on 3 different levels—individual, community, and legislative. This 3-tiered definition of advocacy was adapted from a previous national study to identify an operational definition of pediatric advocacy. The purpose of this study was to test the impact of a longitudinal 3-tiered advocacy curriculum on residents’ attitudes, comfort, and practice regarding SDH.

Methods
This was a prospective pre- and postintervention study of an educational curriculum conducted over a 9-month period during the 2015 academic year. Data collection began 1 month prior to the intervention and concluded 2 months postintervention.

Study settings and subjects
The study was conducted at the Children’s Hospital at Montefiore (CHAM), which had a large categorical pediatric training program comprising 78 residents. The residents trained in the Bronx, New York, an underserved community, where 1 in 3 individuals lives below the poverty level. All pediatric trainees had their primary care clinic in 1 of 3 sites located throughout the Bronx. Prior to 2015, CHAM fulfilled its advocacy requirement through a clinical rotation consisting of 6 weeks during the third year of residency divided between a school-based health center and the Child Advocacy Center where patients are referred for cases of child abuse. In 2015, residents continued this clinical rotation supplemented with the addition of our advocacy curriculum. The study was funded by 2 grants to initiate the programming, the Community Pediatrics Training Initiative Advocacy Training Grant and the Association of Pediatric Program Directors Harvey Aiges MD Memorial Trainee Investigator Award. The curriculum was later sustained without any additional costs.

Development of educational curriculum/intervention
We developed the new advocacy curriculum using Kern et al’s 6 steps of successful curriculum design: (1) problem identification; (2) needs assessment for targeted learners; (3) goals and objectives; (4) educational strategies; (5) implementation; and (6) evaluation and feedback.

Step 1: problem identification. Pediatric residents at CHAM treat children from an underserved population with unmet basic needs that may impact their health. However, we identified that the residency curriculum had limited training on how to address these needs and further advocate for patients. The problem of limited training affects both learners (pediatric residents) and their patients. The authors conducted an extensive literature review to gain an understanding of advocacy curricula among other residency programs. The literature search included identifying previous research on educational curricula, investigating the impact of advocacy and SDH on health outcomes, outlining the current sociodemographic profile of the Bronx community, as well as exploring local and national policies. The problem was further identified with a pilot study completed on a small subset of residents the year prior. This study found that implementation of an advocacy teaching-module enabled residents to screen for and document SDH consistently.

The residents engaging in this pilot were excluded from this study.

Step 2: needs assessment for targeted learners. As part of the pre-intervention survey in this study, the current residents were asked via open-ended questions to comment on what they hoped to gain from the curriculum, identify what barriers they faced in attempting to advocate, and suggest ideas for new curriculum content. The answers were coded and grouped by 2 independent authors of this study.

Step 3: goals and objectives. The goal of the curriculum was to train each pediatric resident to advocate for his or her patients...
on an individual, community, and legislative level. More specifically, the study’s objective was to improve resident attitudes, comfort, and screening and referral practices across the 3 tiers of advocacy.

**Step 4: educational strategies in curricular development.** The educational strategies to achieve our goal included a 6-workshop curriculum over 9 months comprised problem-based learning, didactics, readings, and a panel discussion. Residents were able to use what they learned in these workshops in their continuity clinics, where they were guided by faculty preceptors, and through attending AAP state lobby day. Previous research shows that problem-based learning promotes self-directed learning among pediatric residents.\(^{24}\) We chose this technique in combination with didactics to reinforce the goal of preparing lifelong learners for self-directed learning after residency. The panel discussion comprised subspecialists active in pediatric advocacy, showing residents that regardless of their career trajectory, advocacy was both feasible and an important part of their role as pediatricians. Active learning through hands-on experiences kept learners engaged,\(^{25}\) and generating new concrete experiences both in clinic and at legislative advocacy day allowed for retention of skills acquired.

The curriculum was case-based, using examples of patients seen by the authors in the hospital, emergency room, or clinic, where an SDH-related cause led to poor health outcomes or obstacles in care. Residents were also asked to provide cases throughout the individual workshops where they may have seen an SDH-related cause impact the health of a patient. This case-based strategy was based on the understanding that incorporating health advocacy into case-presentations supports reflection and dialogue, which is pivotal to assessing and valuing health advocacy.\(^{26}\) The cases were all framed by relevant local community data and supported by research that proves the need for addressing these SDH.

**Workshop I: introduction to advocacy.** The curriculum began with a small-group problem-based learning activity. Residents were introduced to the concept of 3-tiered advocacy (on an individual, community, and legislative level) and the IHELLP model, a mnemonic developed by the National Center for Medical-Legal Partnership to assist residents and medical students in gathering a more thorough social history.\(^{27}\) IHELLP stands for Income sources and benefits, Housing, Education, Legal Issues (including immigration), Literacy, and Parenting/Psychosocial. The case used for this workshop was based on a real incident in New York State of an accidental ingestion of liquid nicotine by a toddler.\(^{28}\)

As residents identified social history elements to this case, they were introduced to 3 levels of advocacy they could engage in for this family. On an individual level, they learned about empowering patients to apply for benefits and how to counsel on the use of food pantries for food insecurity. On a community level, the residents learned about community-based organizations that they could refer the family to, such as adult literacy programs and parenting programs for previously incarcerated fathers. On a legislative level, residents brainstormed ideas for writing op-eds and lobbying public officials. For example, they may have lobbied for child-safe packaging or lobbying to ban the marketing of liquid nicotine products to minors.

**Workshop II: introduction to advocacy part II.** This workshop introduced the importance of addressing SDH and reinforced the IHELLP model as a concrete tool to screen for SDH. Residents were given an overview of child poverty in the United States and in our local community, introduced to research supporting the impact of SDH on health outcomes, and taught to recognize the medical and psychosocial effects of poverty on children. Finally, they were taught the IHELLP model as a concrete tool to screen for SDH.

**Workshop III: income and government benefits.** This workshop included defining the federal poverty line, educating residents on various public benefits, and empowering residents to screen for benefit eligibility and food insecurity through validated questionnaires.\(^{29}\)

**Workshop IV: housing and education.** Housing. Residents were trained on public housing, tenant rights, and the health consequences of poor housing conditions. Using this knowledge, they were then taught how to screen for poor housing environments and write effective letters to landlords advocating for their patients. The workshop also connected residents to local community organizations and legal groups advocating for housing rights that they could refer patients to.

Education. To empower residents to advocate further on educational needs of patients and families, residents were first trained on the Individualized Education Program (a written statement of the educational program to meet a child’s individual needs) and special education placement process in our community. Residents were then taught how to screen for unmet educational needs and use their physician voice to communicate with schools and teachers via phone/letter for improved services. The workshop also introduced a local educational advocacy group that runs an education hotline for parents and provides legal support for families with unmet educational needs.

**Workshop V: legal, literacy, and parenting.** In this workshop, residents were taught how to screen for literacy and parental education, the challenges immigrants face in receiving benefits and health care, and how to screen for and address domestic violence and safety concerns.

**Workshop VI: legislative advocacy.** We hosted a faculty panel of pediatric subspecialists involved in legislative advocacy. This panel helped illustrate that advocacy is an important and feasible part of every pediatricians’ practice regardless of what field they enter.

**AAP Lobby Day.** The curriculum culminated in resident attendance at the New York State AAP Lobby Day in Albany, NY. The residents learned about current federal and state-level health policies that impact the lives of their patients. They also learned about the legislative process and met with state...
representatives to advocate for issues relevant to our patient population.

*Step 5: curricular implementation.* The curriculum was created and led by a faculty–resident pair with guest speakers at select sessions, and was approved for implementation by the pediatric program directors. With support of the chief residents, the workshops were incorporated into the existing educational framework of the residency program—using the noon conference time slots residents were expected to attend. This made for an easy transition, without any scheduling accommodations, and allowed us to capture pediatric residents and anyone on a pediatric rotation (medical students and visiting residents). Attendance to the AAP State Lobby Day was encouraged for all residents on outpatient electives with support of the program directors.

Prior to rolling out the curriculum, faculty champions were chosen from each of the 3 resident clinic sites to help facilitate faculty training and encourage preceptorship conducive to screening and addressing SDH. In addition to workshop sessions, a clinic lecture was given at each clinic site introducing IHELLP to all residents and faculty to address residents who may have missed the introductory workshop. In addition, flyers were hung in the precepting rooms as visual reminders for residents to document and address SDH. Shortcuts were created in the electronic medical record that would populate an outline of IHELLP to remind residents what to screen for, and after-visit summary shortcuts populated with community resources residents could refer patients to. These were created in conjunction with social workers at each of the clinic sites.

*Step 6: evaluation and feedback.* We developed a self-completion, anonymous survey (See Appendix 1) based on literature review to evaluate residents’ attitudes, perceived competency, and advocacy practices before and after the longitudinal 9-month advocacy curriculum. We used fixed-choice multiple choice, multiple-answer multiple choice, and rating-scale type questions. The survey used a 5-point Likert-type scale to inquire about residents’ attitudes, comfort, and screening practices for SDH in the clinic setting and in the emergency room. The survey was developed de novo for this study on an Internet survey platform (http://www.surveymonkey.com) and distributed via email containing a link to the survey.

Experts on the pediatric subcommittee of the Institutional Review Board reviewed the survey for content validity, and it was piloted with outgoing residents prior to this study. The survey was amended according to their feedback. Feedback from the preintervention survey was used to inform the advocacy curriculum workshops. The same survey was administered to residents pre- and postimplementation of the curriculum.

**Statistical analysis**

Descriptive statistics were used to describe the level of residency training of the study population and distribution of each variable. Chi-square test was used to compare the pre- and postintervention results of the group as a whole.

**Results**

A total of 78 residents (the entire residency program) were invited to participate in this study. Sixty-nine residents (69/78, 88%), 28 interns (PGY1, 28/29, 97%) and 41 senior residents (PGY2/3, 41/49, 84%), completed the preintervention survey. Fifty-five residents (55/78, 70%), 24 interns (24/29, 83%) and 31 senior residents (31/49, 63%) completed the postintervention survey. Over the 9-month intervention period, 70% (17/24) of interns and 23% (7/31) of senior residents reported attending 2 or more workshops.

**Preintervention assessment**

Prior to implementation, residents were asked what the single most important thing they hoped to gain from the curriculum. Common themes that arose included gaining knowledge of local community resources (What resources are available to patients so that I can refer them), general knowledge of advocacy issues (What level of involvement I can have, [and] how to be involved; I didn’t know I could do these things [in residency]), and practical skills for advocacy (Who to contact and what the important issues are).

**Postintervention assessment**

**Attitudes.** Pediatric residents reported positive feelings toward advocacy with no significant difference before (85%) or after (86%) curricular implementation. Postimplementation, residents’ perception of how well trained they felt to discuss SDH with patients in the ambulatory clinic increased (48% vs 67%; P=.02).

**Comfort.** Comfort in discussing SDH with patients in the ambulatory clinic increased (26% vs 76%; P=.001). For pediatric interns, comfort in advocating for patients improved on both an individual level (29% vs 58%; P=.04) and a community level (71% vs 96%; P=.016). There was no significant change for senior residents postimplementation in comfort advocating for patients on an individual or community level, and no significant change for any group of residents on a legislative level (see Table 1).

**Practice.** Residents’ self-reporting of their own SDH screening practice significantly changed between the pre- and postimplementation survey. The frequency with which they reported inquiring about the following SDH significantly improved: income (39% vs 60%; P=.025), education (71% vs 93%; P=.008), and legal issues (13% vs 26%; P=.012) (see Figure 1). Reported engagement in legislative practice did not improve (email 38% vs 33%; P=.3; phone 16% vs 17%; P=.94; in person 16% vs 26%, P=.17; social media 26% vs 12.5%, P=.02).
Postimplementation, lack of time was reported as the biggest barrier to engaging in advocacy in ambulatory clinic (61%). This was also reported as the biggest barrier to legislative advocacy (44%).

Postimplementation, pediatric residents reported that the curriculum changed their clinical practice (66%), that they take more in-depth social history (46%), and that they guide patients to more community resources (38%).

When asked how the curriculum affected them as pediatricians, residents cited gaining skills. Some comments included, I guide patients to more resources and feel more confident educating parents/patients and I feel better versed in social history. Residents also cited gaining knowledge in individual advocacy. Some comments mentioned, I have realized that there ARE resources and calling on their (the patients’) behalf actually goes a long way.

**Discussion**

This longitudinal curriculum in 3-tiered advocacy improved resident perceived comfort and practice. Although self-reported attitude did not change, it was consistently high before and after curricular implementation. There was a significant increase in screening for SDH, and most residents felt the curriculum changed their clinical practice for the better.

The 3 SDH-related areas that showed significant improvement were income, education, and legal issues. We hypothesize that these factors may have improved most as these workshops both taught new concepts that trainees had not learned before and provided concrete tools to address them. Comfort and practice in legislative advocacy did not improve, and this may be correlated to amount of time dedicated toward legislative advocacy vs individual and community advocacy during the curriculum.

Few studies have evaluated a longitudinal curriculum that addresses the 3 levels of advocacy. The curriculum is unique in the use of case-based interactive workshops that teach concrete tools to advocate on an individual level, building partnerships with community-based organizations, and a hands-on experience in legislative advocacy. One challenge to teaching public health-oriented curricula that is reported is that medical trainees enter with a sense of social purpose, yet are not interested in learning social sciences. The proposed solution included demonstrating clinical relevance, which is at the core of this curriculum.11,30

Limitations of this study include those inherent to survey assessments of self-reported attitudes, comfort, and practice. These include recall bias and the subjective nature of questions asking for self-evaluation. In addition, other factors might explain the improved measures, such as accruing knowledge and comfort over time with patient interactions. However, significant improvement in practice occurred across training years. Correlation of the results obtained from this study with chart review of clinic patients for screening and referral practices would have allowed for more objective measures; however, our electronic medical record did not allow us to capture this data at the time. These results cannot be generalized because this study involved a single training program located in an urban underserved community.

Further follow-up assessments would be necessary to determine the longitudinal impact of this curriculum on our pediatric residents’ clinical practice and engagement in advocacy. However, research shows that exposure to social injustice and education about SDH are the core factors that lead physicians to be lifelong health advocates.18 This curriculum included both education about SDH and exposure to social injustice through background knowledge at each workshop and through screening for SDH in the practical application with patient encounters. In addition, residents were exposed to a panel of attending physicians in various subspecialties currently working on advocacy, allowing for discussion of how to justify time in advocacy during work to a future employer. This further supports trainees on how to build a lifelong career trajectory in advocacy.31

Acquiring the knowledge, skills, and practice to effectively advocate for patients and families is a lifelong journey that cannot be achieved by 1 curriculum. However, given the constraints

### Table 1. Pediatric Resident’s Attitudes and Comforts with Advocacy.

|                          | POSITIVE ATTITUDE | PRE               | POST              | P-VALUE |
|--------------------------|-------------------|-------------------|-------------------|---------|
|                          | POSITIVE ATTITUDE | PRE               | POST              | P-VALUE |
| Intern                    | 27/28 (96.4%)     | 21/24 (87.5%)     | NS                |         |
| Senior                    | 28/37 (75.7%)     | 26/31 (83.9%)     | NS                |         |
| Total                     | 55/65 (84.6%)     | 47/55 (85.5%)     | NS                |         |
| Feel well trained         |                   |                   |                   |         |
| Intern                    | 19/28 (67.9%)     | 18/24 (75.0%)     | NS                |         |
| Senior                    | 12/36 (33.3%)     | 19/31 (61.2%)     | .04               |         |
| Total                     | 31/64 (48.4%)     | 37/55 (67.3%)     | .02               |         |
| Comfort in discussing SDH in clinic |                 |                   |                   |         |
| Intern                    | 8/28 (28.6%)      | 21/24 (87.5%)     | .001              |         |
| Senior                    | 9/36 (25.0%)      | 21/31 (67.7%)     | <.001             |         |
| Total                     | 17/64 (26.2%)     | 42/55 (76.4%)     | <.001             |         |
| Comfort in advocating on individual level |                 |                   |                   |         |
| Intern                    | 8/28 (28.6%)      | 14/24 (58.3%)     | .042              |         |
| Senior                    | 23/36 (63.9%)     | 22/31 (70.9%)     | NS                |         |
| Total                     | 58/65 (89.2%)     | 52/55 (94.5%)     | NS                |         |
| Comfort in advocating on community level |                 |                   |                   |         |
| Intern                    | 20/28 (71.4%)     | 23/24 (95.8%)     | .016              |         |
| Senior                    | 34/36 (94.4%)     | 29/31 (93.5%)     | NS                |         |
| Total                     | 58/65 (89.2%)     | 52/55 (94.5%)     | NS                |         |

Abbreviations: NS, not significant; SDH, social determinants of health.
of the demanding pediatric resident schedule, this curriculum proved a successful intervention in laying down the groundwork for creating effective advocates. In addition, the curriculum was built in a sustainable manner, allowing it to continue after the study was complete. In the future, we hope to scale up this curriculum to include faculty across the children’s hospital including subspecialists and inpatient providers.

Conclusions
This study highlights the value of a longitudinal curriculum at 1 institution for pediatric residents that addresses 3-tiered advocacy using clinically relevant research and practical tools for residents to be effective patient advocates. We demonstrate that despite the limited time and lack of comfort residents report, given the appropriate knowledge and tools, they can become successful advocates who incorporate this work into their clinical practice. Future study to determine the feasibility at other training programs, establish validity of the novel survey tools used, and understand the long-term impact will lead to better understanding of the generalizability and impact of this curriculum.

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Author Contributions
YL conceptualized and designed the initial study, collected the data, interpreted data analysis, drafted the article, and approved the final version to be published. SB interpreted the data analysis, contributed to critical revisions of the article, and approved the final version to be published. MP designed the initial study, analyzed the data, drafted the article, and approved the final version to be published.

Availability of Data and Materials
The data sets used and/or analyzed during this study are available from the corresponding author on reasonable request.

Ethics Approval and Consent
The Institutional Review Board at Albert Einstein College of Medicine approved it as an exempt study, and the need for informed consent was waived.

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Appendix 1

Advocacy training survey

This brief survey is designed to assess your experience with advocacy prior to the workshop. It will take approximately 5 minutes to complete.

Many pediatric residents have little formal training or experience in advocacy, whereas others have extensive experience. The following statements are designed to give us information about your level of experience and comfort advocating for your patients on an individual, community, and state/federal level. We will use this information as a baseline measure so that we can determine the effectiveness of our workshop.

1. In thinking about your skills in all aspects of pediatric advocacy, where would you place yourself along the path from beginner to expert?
   a. Beginner
   b. Advanced beginner
   c. Competent
   d. Proficient
   e. Expert

2. How comfortable are you with advocating for your patients on an individual level (ie, writing letters to landlords)
   a. Not at all
   b. Slightly
   c. Somewhat
   d. Very
   e. Extremely

3. How comfortable are you with advocating for your patients on a community level (ie, referring families to WIC or food stamp office, referring patient to a local Head Start, etc)
   a. Not at all
   b. Slightly
   c. Somewhat
   d. Very
   e. Extremely

4. How comfortable are you with advocating for your patients on a state/federal level (ie, writing or calling elected officials, lobbying during an advocacy day, etc)
   a. Not at all
   b. Slightly
   c. Somewhat
   d. Very
   e. Extremely

5. Have you ever lobbied for a cause at an elected official’s office by
   a. Email: Yes No
   b. Phone: Yes No
   c. In person: Yes No
   d. Mail: Yes No
   e. Social Media: Yes No

6. If you answered No to question 5, why not?
   a. I don’t think it is important
   b. I don’t know how
   c. I don’t have the time
   d. I don’t know what to lobby for

7. Have you ever written an op-ed advocating for a cause?
   Yes No

8. What is the single most important thing you hope to gain from these advocacy workshops?

_____________________________________________
_____________________________________________
_____________________________________________
_____________________________________________
The following questions pertain to your experience in the EMERGENCY ROOM setting:

9. When you have a patient in the emergency room, do you ever discuss the following issues:
   a. Housing:
      Never Sometimes Often Always
   b. Income (including benefits like WIC, food stamps, etc):
      Never Sometimes Often Always
   c. Child care/school education:
      Never Sometimes Often Always
   d. Domestic violence:
      Never Sometimes Often Always
   e. Legal problems:
      Never Sometimes Often Always

10. What are some reasons you don't discuss these issues in the emergency room (choose all that apply):
    a. Don't feel trained or knowledgeable enough to discuss them
    b. Don't have time to discuss them
    c. Don't think it is my job to discuss them
    d. Don't feel comfortable discussing these issues
    e. Patients are not comfortable discussing these issues
    f. Lack of support in addressing these issues
    g. Other:

The following questions pertain to your experience in the PRIMARY CARE CLINIC setting:

12. When you have a patient in clinic, do you ever discuss the following issues:
    a. Housing:
       Never Sometimes Often Always
    b. Income (including benefits such as WIC, food stamps, etc):
       Never Sometimes Often Always
    c. Education:
       Never Sometimes Often Always
    d. Domestic Violence:
       Never Sometimes Often Always
    e. Legal problems:
       Never Sometimes Often Always

13. What are some reasons you don't discuss these issues in clinic? (choose all that apply)
    a. Don't feel trained or knowledgeable enough to talk about them
    b. Don't have time to discuss
    c. Don't think it is my job to discuss
    d. Don't feel comfortable discussing these issues
    e. Patients are not comfortable discussing these issues
    f. Lack of support in addressing these issues
    g. Other:

14. When these issues come up (housing, income, education, domestic violence, etc) in clinic, how do you guide parents/patients:
    a. I refer them to social work
    b. I google resources
    c. I turn to a resource list
    d. Other:

15. Please rate your feelings about pediatric advocacy on a scale from −3 to +3 where −3 is the most negative possible and +3 is the most positive possible:

   −3  −2  −1  0  1  2  3

16. How has this advocacy curriculum changed your clinical practice? (choose all that apply)
    a. I take a more in-depth social history
    b. I guide patients to more community resources
    c. I advocate for policies that affect my patients
    d. This has NOT changed my clinical practice
    e. Other (please specify)

17. How has this curriculum affected you as a pediatrician?

18. What can we do to improve the advocacy curriculum?