Expanding Health Policy and Advocacy Education for Graduate Trainees

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Abstract

Background Education in health policy and advocacy is recognized as an important component of health professional training. To date, curricula have only been assessed at the medical school level.

Objective We sought to address the gap in these curricula for residents and other health professionals in primary care.

Innovation We created a health policy and advocacy curriculum for the VA Connecticut Healthcare System, Center of Excellence in Primary Care Education, an interprofessional, ambulatory-based, training program that includes internal medicine residents, nurse practitioner fellows, health psychology fellows, and pharmacy residents. The policy module focuses on health care finance and delivery, and the advocacy module emphasizes negotiation skills and opinion-based writing. Trainee attitudes were surveyed before and after the course, and using the Wilcoxon signed rank test, relative change was determined. Knowledge acquisition was evaluated with precourse and postcourse examinations using a paired sample *t* test.

Results From July 2011 through June 2013, 16 trainees completed the course. In the postcourse survey, trainees demonstrated improved comfort with understanding health law and the American health care system (Likert mean increased from 2.1 to 3.0, $P = .01$), as well as with associated advocacy skills (Likert mean increased from 2.0 to 2.9, $P = .04$). Knowledge-based test scores also showed significant improvement (increasing from 55% to 78% correct, $P \leq .001$).

Conclusions Our curriculum integrating core health policy knowledge with advocacy skills represents a novel approach in postgraduate health professional education and resulted in sustained improvement in knowledge and comfort with health policy and advocacy.

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Introduction

With increased attention on US health care reform, health policy, leadership, and advocacy skills are becoming critical components of health professional training. The importance of integrating health policy into graduate medical education has been well recognized by the Accreditation Council for Graduate Medical Education.[1] However, most existing programs have been designed for medical school education,[2,3] and few offer formal training for medical residents and other health professionals.[2–8] We created a novel, longitudinal course for internal medicine residents and other interprofessional trainees during ambulatory rotations at the VA Connecticut Healthcare System and evaluated changes in trainee attitudes and knowledge base.

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TABLE 1 **Sections of Course**

Health policy and delivery	■ Health economics ■ Health finance and law ■ Models of health care delivery ■ Key players in US health care ■ Models of health care reform
Advocacy	■ Physician engagement ■ Organizational power-building ■ Media and advocacy ■ Strategy for health care leaders ■ Public narrative

What was known

Health policy and advocacy curricula for residents and other health professions trainees appear to be lacking.

What is new

A Veterans Affairs–developed, dedicated curriculum for residents and other graduate health professionals working in primary care settings.

Limitations

Single-site study and nonvalidated assessment instruments may limit generalizability.

Bottom line

A Veterans Affairs health policy and advocacy curriculum for residents and other professionals may be useful for adoption or adaptation in other postgraduate training contexts.

Methods

Participants

We designed a health policy, leadership, and advocacy curriculum for the VA Connecticut Healthcare System Center of Excellence in Primary Care Education (CoEPCE). The VA Connecticut Healthcare System CoEPCE aims to transform interprofessional education for internal medicine residents, pharmacy residents, health psychology fellows, and post-Master's nurse practitioners, who are completing a 12-month adult primary care fellowship. Residents and the CoEPCE physician codirector developed the course, which required significant initial time commitment but minimal material costs.

All interprofessional trainees participated in the health policy and advocacy curriculum between July 2011 and June 2013.

Curriculum Design

We divided the curriculum into 2 sections: health policy and delivery and advocacy (TABLE 1). The faculty full-time equivalent was approximately 0.1, and the resident full-time equivalent was approximately 0.3. Both were divided between multiple faculty and trainees. Faculty funding was provided through the CoEPCE grant, as well as through the VA Office of Academic Affiliations. Resident time was supported through standard postgraduate medical education funding mechanisms, and time allocated to the curriculum was a result of the grant.

Section 1: Health Policy and Delivery Six modules, each lasting 1 1/2 hours, comprised didactic, fact-based lectures, followed by case-based discussions to prompt critical thinking. Topics included (1) health care economics, (2) malpractice regulations and the creation of managed health care organizations, (3) stakeholders in the health care system nationally, (4) models of health care delivery, and (5) health care reform. This module culminated in a debate, requiring the use of acquired competencies to explore and develop health care policy arguments relevant to the Affordable Care Act.

Section 2: Advocacy Six modules, lasting 1 to 3 hours each, focused on predetermined key advocacy skills—public speaking, opinion-based writing, and debate strategy—using workshops designed to apply knowledge and skills into practice. Trainees participated in creating opinion editorials and letter-to-editor pieces for publication through a writer's workshop in which participants were asked to compose 1-page opinion pieces.

The final assignment at the end of the academic year consisted of the collaborative development of a "white paper" synthesizing the knowledge and perspectives of participating health professional trainees into a statement of principles regarding the need to improve interprofessional education. This activity included anonymous, opinion-based writing followed by a roundtable discussion and negotiation to discuss areas of divergence and to create common ground.

Evaluation

We evaluated our curriculum with precourse and postcourse attitude surveys and precourse and postcourse knowledge-based examinations. As further evidence of impact, we kept track of the publications created from the curricular modules. The surveys were based on previous studies and were expanded to account for our unique curriculum components.[4,5] The knowledge-based surveys consisted of 10 questions.

Approval from the VA Institutional Review Board was obtained for evaluation of educational outcomes of this project.

Analysis

We conducted a Wilcoxon signed rank test to compare precourse and postcourse attitude change along a Likert

TABLE 2 **Attitudes of Trainees Regarding Health Policy Education**

Item Description	Pretest Mean[a] (N = 12)	Posttest Mean[a] (N = 16)	*P* Value
I feel comfortable in my ability to identify and build consensus around shared public values	3.25	3.9	.06
I feel comfortable in my ability to lead group exploration and action in the task of effecting change	2.9	3.6	.07
I feel comfortable in my ability to facilitate group reflection and synthesis to build group knowledge and foster public value creation	2.9	3.5	.09
I feel comfortable identifying and explaining interactions between public- and private-sector actors, payers, and providers in American health care delivery	2.2	3.0	.08
I feel comfortable identifying and explaining current concepts in health law and their role in American health care delivery	2.1	3.0	.01
I feel comfortable identifying and explaining historical trends in American health care reform efforts and their role in American health care delivery	2.2	3.1	.07
I feel comfortable in my ability to navigate, interact with, and influence local, state, and federal governmental actors to effect cultural, structural, and/or policy change	2.0	2.9	.04
I feel comfortable in my ability to navigate, interact with, and influence media organizations to effect cultural, structural, and/or policy change	1.8	2.8	.006
I feel comfortable in my ability to navigate, interact with, and influence private-sector actors to effect cultural, structural, and/or policy change	1.9	2.8	.03
I feel comfortable in my ability to develop organizational and political strategy to successfully effect change	2.3	2.9	.07

[a] 1, strong disagreement; 5, strong agreement.

scale continuum. Precourse and postcourse change in overall knowledge scores was assessed using a paired sample *t* test. Trainees were asked the same 10 content-driven questions before their first session and at the end of the academic year. The threshold for statistical significance was set at $P \leq .05$. Analyses were conducted using Stata version 10.0 (StataCorp LP).

Results

Trainee Characteristics

During the course of 2 years, participants included internal medicine residents (n = 8), nurse practitioner fellows (n = 6), and clinical pharmacy residents (n = 2). Twelve trainees (75%) returned the survey and knowledge-based tests precourse, and 16 (100%) returned surveys and tests postcourse.

Attitude Questions

Attitudes toward learning health policy and perceived comfort with certain topics significantly improved in the postcurriculum survey (TABLE 2). Trainees' comfort levels with laws affecting health care and the American health care system also improved ($P = .01$). Finally, trainee confidence increased regarding navigating local, state, and national health care systems to advocate for patients ($P = .04$) and leading an interprofessional team ($P = .01$).

Knowledge Questions

At the end of the academic year, trainees had improved individual examination scores for key content areas. The difference between before and after, knowledge-based questions improved significantly, from 55% to 78% correct ($P \leq .001$).

Products Generated From Trainees

To date, trainees have published opinion editorials and letter-to-editor pieces in the *Washington Post*,[9] *Yale Daily News*,[10] *Connecticut Post*,[11] and *Academic Medicine*.[12]

Discussion

Our curriculum integrating core health policy knowledge and advocacy skills represents a novel approach in postgraduate health professional education, and the evaluation during the first 2 years of the program indicates trainees feel significantly more comfortable in their understanding of health policy after participating in

the course. In addition, trainees demonstrated comfort with advocacy by the collaborative development of the white paper and the publication of opinion-based articles.[9–12]

Currently, health policy curricula that have been studied are designed for medical students and have found improved learner comfort with health policy topics.[2,3] Our graduate cohort of residents and other health profession trainees indicated increased comfort in navigating the health care system and strengthened advocacy skills. We also found that trainees demonstrated a significant retention of core health policy concepts and facts.

Our study has several limitations. First, the survey and knowledge-based test used have no validity evidence. They were based on previously reported tools and were adapted for our unique curriculum. Second, we did not have a control group, which would allow for a comparison with the intervention of the curriculum because we included all CoEPCE participants.

Conclusion

We successfully implemented a curriculum integrating core health policy knowledge with advocacy skills in a busy academic setting. Our approach could be considered a model for health policy and advocacy education in other programs in a primary care setting.

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