Community-Based Advocacy Training: Applying Asset-Based Community Development in Resident Education

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Abstract

Communities and Physicians Together (CPT) at University of California, Davis Health System provides a novel approach to teaching residents to be effective community advocates. Founded in 1999, CPT is a partnership between a pediatric residency program, five community collaboratives located in diverse neighborhoods, and a grassroots child advocacy organization. Using the principles of Asset-Based Community Development, the program emphasizes establishing partnerships with community members and organizations to improve child health and identifies community assets and building capacity. Community members function as the primary faculty for CPT.

The authors describe the CPT curriculum, which teaches residents to build partnerships with their assigned community. Residents have three, two-week blocks each year for CPT activities and maintain a longitudinal relationship with their community. In the first year, collaborative coordinators from each community orient residents to their community. Residents identify community assets and perform activities designed to provide them with a community member's perspective. In the second and third years, residents partner with community members and organizations to implement a project to improve the health of children in that community. CPT also provides faculty development to community partners including a workshop on medical culture and resident life. A qualitative evaluation demonstrated residents' attitudes of their role as pediatricians in the community changed with CPT.

CPT is unique because it provides a model of service learning that emphasizes identifying and utilizing strengths and building capacity. This approach differs from the traditional medical model, which emphasizes deficits and needs.

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Healthy People 2010[1] emphasizes the importance of social and physical environments in health. For children, the leading threats to health, referred to as "the newer morbidities,"[2] include school problems, mood and anxiety disorders, suicide, homicide and violence, drug and alcohol abuse, and effects of the media on violence, obesity, and sexual behavior.[3] Pediatric professional and academic societies have recognized that, to address these issues, pediatricians must advocate for children in their communities,[4] and they must develop skills necessary to mobilize and collaborate with others in their communities to improve the environment for children.[5]

With this in mind, all pediatric residency programs are required to provide structured educational experiences designed to prepare residents to be effective advocates for the health of children in the community.[6] In this report, we describe a nationally recognized, community-centered approach to child advocacy training in pediatric residency called Communities and Physicians Together (CPT) at the University of California (UC), Davis Health System. CPT is fundamentally different than other community-based training programs previously described[7–9] because it uses an approach called Asset Based Community Development (ABCD).[10] The ABCD approach focuses on building community capacity by recognizing and mobilizing community strengths rather than identifying community needs or deficits.

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Establishing CPT

Asset-based community development

In *Building Communities From the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets,* Kretzmann and McKnight[10] describe five assets found within communities that can be used as resources for community development: (1) individuals' skills, (2) voluntary associations, (3) institutions (businesses, governments, and nonprofit organizations), (4) economic potential, and (5) land and physical assets. ABCD involves applying all of these assets to increase the capacity of communities to act. The CPT program teaches residents to identify and mobilize assets within a community and to collaborate with community members to build the community's capacity to improve health.[11] Using these collaborative methods, the goal is to enhance the social environment influencing the health of children in that community.[12]

The community component of CPT

The CPT program, founded in 1999 by leaders of the pediatric residency program at the UC Davis School of Medicine and community organizers in

Sacramento, California, is based on a shared belief that having physicians engaged in communities would make for healthier communities and better physicians. The pediatric residency program partnered with five community collaboratives already working with poor, minority, or immigrant populations in the Sacramento, California area. The collaboratives are volunteer associations, which include community residents, professionals, businesses, volunteer organizations, and government agencies, who all share the common goal of improving the health of children within their community. The origin of these community collaboratives can be traced to the Community Partnerships for Healthy Children Initiative, begun in 1990 by a regional not-for-profit foundation, the Sierra Health Foundation. Inspired by the "social reconnaissance" model,[13] this initiative provided funding and technical assistance on ABCD to the collaboratives with the goal of enhancing each community's capacity to address the needs of children living in their communities. Although each collaborative has a part-time paid coordinator, the collaboratives are otherwise composed of unpaid volunteers from within the community. Thus, the collaboratives use the gifts and skills of individuals and build social capital within the community, thereby mobilizing community assets. Pediatric residents from our program are assigned to a collaborative, and the partners work together with the members of the collaborative to apply the concepts of ABCD to address the health needs of children in each community.

The UC Davis School of Medicine's pediatric residency program

The UC Davis pediatric residency program is based at UC Davis Children's Hospital (part of the UC Davis Medical Center) and is the only pediatric residency program in inland northern California. The three-year program usually has 12 residents in each class, and all 36 residents participate in the CPT program.

Financial support for the CPT program

The pediatric residency program and the community partners founded CPT without external funding. Both the community collaboratives and the residency program donate staff time to teach the residents and coordinate the program. In 2002, CPT received a five-year, $1.7 million grant from the Community Pediatric Training Initiative that funded a full-time CPT program manager, residency faculty and collaborative coordinator time, curriculum development, faculty development, and evaluation. After the conclusion of this grant, other grants and institutional funding continue to support the program manager position. Also, CPT partners have worked together to obtain additional resources including grants and AmeriCorps*/VISTA volunteers for the community partners.

Integrating the CPT Program Into the Curriculum

Longitudinal design

CPT is designed in a longitudinal fashion to develop a three-year relationship between residents and the community to which they are assigned. A schematic of the curriculum is provided in Table 1. Collaborative coordinators and CPT staff assign residents to collaboratives based on shared interests and unique resident and community assets. Residents are scheduled for two weeks of protected time each year (six weeks total) to work with their assigned community, although many residents are involved in community activities outside their block rotations. In addition, the collaborative coordinators send the residents community newsletters and announcements. Resident education continues throughout the entire three-year residency with ongoing educational workshops and quarterly meetings between the collaborative leaders and residents. The regular communication and face-to-face meetings enhance the longitudinal relationship between residents and their assigned community. Residents develop a community health project with one-on-one support from CPT staff and from a workbook created specifically for the CPT program.

Faculty development for CPT staff

Collaborative coordinators and other community volunteers serve as the primary faculty in our program. To help them become effective teachers, the CPT curriculum involves a robust faculty development component. The faculty development curriculum includes annual

Table 1

Summary of Communities and Physicians Together Curriculum for Pediatric Residents at University of California, Davis, School of Medicine

Level of training	Goal/objective	Activity
Orientation	Introduction to project	Discussion of project goals and objectives tour of community sites and ongoing projects
First-year resident	Describe the community	Attend community meetings and activities
	Identify community strengths, assets and needs (application of ABCD*)	"Windshield Survey"
	Begin developing idea for project	"A Day in the Life" exercise
	Understand principles of ABCD	ABCD workshops
Second-year resident	Develop project goals and objectives	Collaboration with community members
	Apply ABCD and identify community partners for project	Develop logic model and project evaluation
		ABCD workshops
Third-year resident	Implement project	Project activities with community
		Apply logic model
	Evaluate project	Complete project evaluation Interviews with residents and collaborative coordinators
		Resident self-reflection
		Sharing of project successes at symposium

* ABCD indicates asset-based community development.

workshops, which focus on adult education methods, the principles of ABCD, and methods for designing effective program evaluation. Other workshops also address the challenges of bridging cultural differences between the hierarchical, highly structured medical culture experienced by the pediatric residents and the collaborative, associational nature of communities and volunteer associations. This workshop, taught by pediatric residents, describes the life of a resident and includes a hospital and clinic tour for community members. These workshops are designed to provide community members with a better understanding of the demands placed on residents and also provide community members with insight and education to recognize the skills and social capital they possess to participate in resident education and to improve health in their community. The collaboratives identify the faculty development curriculum topics to help train their own community members. Community members experienced with CPT and teaching residents partner with pediatric faculty and residents to teach the workshops.

In addition to formal training, the collaborative coordinators and CPT staff meet quarterly to share experiences and revise the CPT curriculum. These meetings provide education and support for new collaborative coordinators and are a source of curricular innovations for CPT.

CPT during the first year of residency

Residents' introduction to CPT takes place during intern orientation week. One day of orientation is devoted to the program's goals and objectives, and fundamental principles of ABCD are discussed. The residents also tour several of the communities with the collaborative coordinator and the CPT director. During the tour, residents have an opportunity to interact with the community partners and observe the successes of ongoing projects developed by previous residents.

A two-week advocacy block introduces and integrates first-year residents into the community. Residents begin this process by identifying the strengths and assets in the community and developing an understanding of the community's priorities. Residents work closely with the collaborative coordinator and attend community meetings, events, and programs. They identify community assets through several structured activities. Using a tool called the "Windshield Survey," residents and the collaborative coordinator tour their community and make structured observations, noting characteristics such as housing, transportation, parks and recreation, government, schools, businesses, services, and people. Residents record and reflect on their observations to better understand life in the community.

Residents also participate in an activity designed by the community collaboratives, called "A Day in the Life." In this activity, residents are given scenarios of members of the community with specific needs (e.g., a parent with a sick child, someone looking to acquire job skills and employment). The resident takes on the role of this individual in the community. He or she is provided with a brief community resource guide and bus pass and then has to figure out how to utilize community resources to meet the needs of the individual he or she is role playing. After the exercise, residents debrief with the collaborative coordinator in which they reflect on the assets they found in the community, resources that were lacking, and what it was like to be in the role of this community member.

Having immersed themselves within the communities, first-year residents end their advocacy block experience by compiling an asset map of the community and of themselves. An asset map is an integrated list of ABCD assets. After reflecting on their experience, residents complete the first-year rotation by working with the collaborative coordinator and CPT staff to identify a project focus, which the resident pursues in the second- and third-year rotation. The goal is to develop a project focus that addresses child health in the community and is a priority for both the resident *and* the community.

CPT during the second and third years of residency

At the beginning of the second-year rotation, the resident meets with the collaborative coordinator and CPT staff to further develop the project idea and identify potential community partners for the project. To clearly describe the project, residents use the logic model, adapted from the *Logic Model Development Guide*[14] by the W.K. Kellogg Foundation, as a planning aid. The logic model serves as a visual schematic of how the resident and community accomplish the goals and objectives of the project and requires the resident to identify the assets needed and how they would be employed when the resident meets with community partners. It also defines objectives for evaluation and illustrates how the project is intended to impact the community. Figure 1 shows an example of a logic model for a resident project.

For the two-week block during their second year, residents immerse themselves in aspects of the community that relate to their project and apply assets they identified the year before. They work closely with the collaborative coordinator and other community members to design and evaluate the project. Residents can develop their own individual project or work jointly with other residents on a project. Some projects have spanned several years and resident classes, with one or two residents in each class developing and implementing a phase of the project. By the end of the second year, the goal is to begin implementation of the project.

The third-year experience, which residents often choose to extend beyond the designated two-week block, involves implementation and evaluation of resident projects. The two years of relationship building and integration into the community, which occurs during the first and second years of residency, are designed to ease the resident's transition from project planning to hands-on implementation.

Resident community projects

Resident projects are as varied and unique as the residents and collaboratives in the communities.[15] One Russian-speaking resident partnered with a primarily Russian and Ukrainian immigrant community to develop a monthly Russian radio talk show named *Zdorovie Deti* (Healthy Children), which aired on a community radio station. To identify community priorities, this particular resident began by conducting focus groups with parents to determine health topics of concern such as vaccinations, pool safety, and good child care. Importantly, the resident learned from the Russian immigrant families that

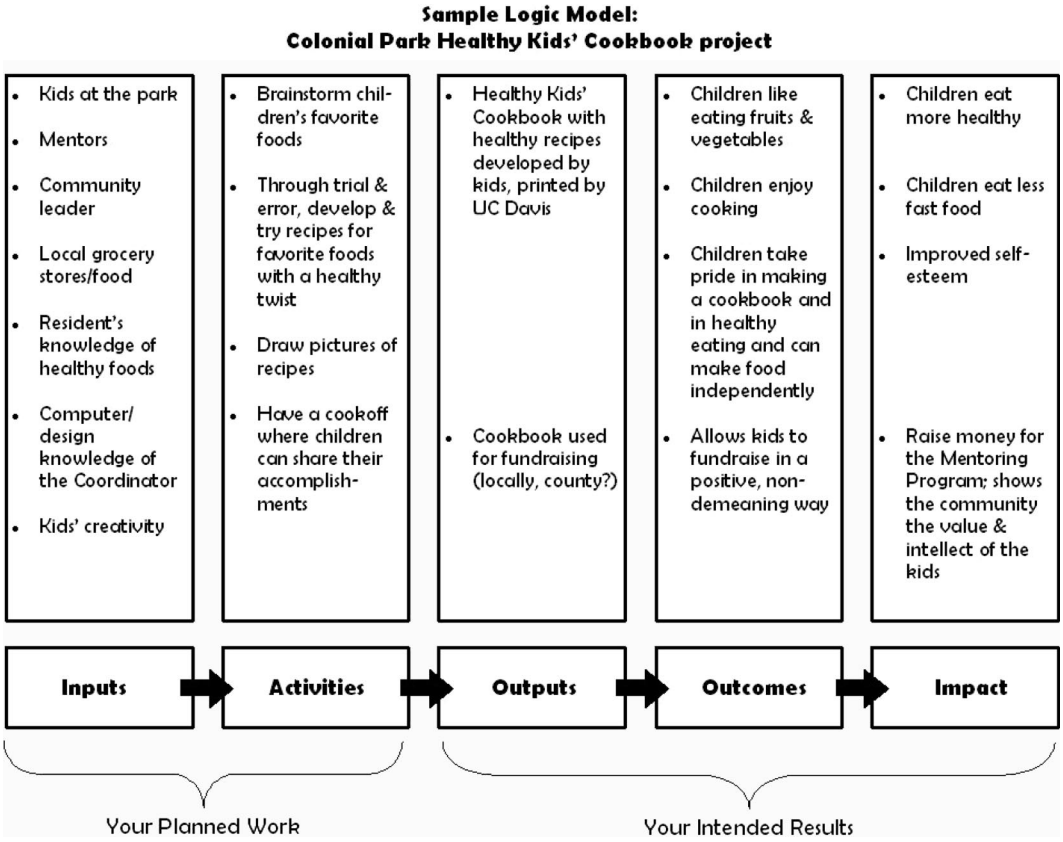

Figure 1 Residents create a logic model to develop their community project and describe its impact. This logic model was developed by a resident creating a cookbook of recipes for children in an after-school program.

the biggest element lacking in the health care of their children was developing trust with their physicians here in the United States, who practice Western medicine. On the basis of this observation, the resident tailored her talk show to dispel myths about Western medicine and build trust through open communications with herself, a U.S. trained physician.

Another resident built on her experiences visiting an after-school program at a park during her first-year rotation. She noted that many children had to provide snacks and dinner for themselves and that the food they chose was often prepackaged, high-calorie, high-fat foods. This prompted the resident to engage the children and a local grocer in developing healthy recipes that children could make independently and then compiling them together in a cookbook illustrated by the children who played in the park. The resident wrote a reflection paper as part of the CPT program discussing the effect of the project on the community and on herself. She noted, "The children took pride in developing the recipes and making them for their friends and families." The resident formed close relationships with many of the older children in the park. She had a clearer understanding of what daily life was like for many of her patients, of the influences affecting children, and of the overall problem of childhood obesity.

After completion of the projects, residents write brief reflections on their overall experience. They are asked to describe what they learned about child advocacy and what, specifically, they learned from their project. Residents also have the opportunity to share their projects and personal reflections at an annual CPT Symposium, a year-end event showcasing many of the third-year resident projects and their communities. The event, attended by residents, community members, university faculty, and regional and national child advocates, serves as a celebration of all who have been involved in CPT.

Evaluation and Assessment

To assess the influence of CPT on residents and the partner communities, we conducted semistructured interviews with residents, collaborative coordinators, and community members from 2002 to 2008. Residents were interviewed individually three times during their residency: at intern orientation, after their first-year CPT rotation, and within a few months of residency graduation. The emphasis on ABCD has changed the way residents perceive child advocacy and their role as a pediatrician from a paternalistic notion of fixing problems for needy clients to one that focuses on forming partnerships with community members interested in improving the health of children.[16] Residents learn about the value of community associations and how these associations, coupled with community networks and other critical resources, can serve as a source of innovation and change that can alter the social environment of the community and the health of children. CPT community partners value teaching the residents and having them as assets in their communities.

In addition, CPT attracts students interested in community engagement to the UC Davis pediatric residency

program. Although we have not performed a formal survey of our residency graduates, several graduates of the CPT program who remain in Sacramento continue to work with their community collaboratives from residency, and other graduates who left the area have replicated their resident projects in the communities where they practice. Based on community and resident feedback, the CPT program continues to change and grow.

Challenges and Barriers

There were several important challenges that we faced in developing our program that were reflected in interviews we conducted of residents and community members. Although community members value the opportunity to teach and work with residents, they expect residents to become involved in and contribute to their assigned community. However, the clinical time demands of residency are often a significant barrier to resident participation in the community activities. These findings are in agreement with a survey of site administrators of community rotations at two different pediatric training programs.[17] We addressed this problem by scheduling protected time for community activities and regular meetings between residents and collaborative coordinators. We found that to achieve program goals, the CPT blocks must be treated the same as any other component of the residency curriculum by both the residency program and the residents—no more important and no less.

We also found that bridging the organizational cultural differences between the hierarchical, highly structured medical environment to which the residents are accustomed and the consensus-building, associational nature of the community collaboratives is a major challenge. Our evaluation showed that pediatric residents often became impatient with the less structured, consensus-based decision-making process of community associations. We addressed this problem through faculty development described previously and by openly discussing differences at regular meetings between pediatric residents and community collaborative members. In addition, we also bridged this cultural difference when administering CPT through hiring a program manager from the community and engaging a grassroots community advocacy organization to mediate differences between the residency program and the community collaboratives.

We were fortunate to have well-established community collaboratives in our region with expertise in ABCD to partner with when we began CPT in 1999. Other residency programs may believe that they do not have such resources; however, numerous organizations and foundations have used ABCD principles in their communities with relatively little expertise.[18] The best example is the Community Access To Child Health program of the American Academy of Pediatrics, which teaches pediatricians throughout the country to use ABCD to effectively partner with community groups to improve child health.[19] The reality is that even the most disadvantaged neighborhoods are rich with associations representing social networks with which residency programs could develop partnerships.[20] Even in our own program, in the years since we founded CPT, we have brought on additional community partners without previous ABCD training.

Our program has a noticeable positive influence on resident attitudes toward community-centered advocacy. We do not know whether the observed attitudinal changes will increase participation of these residents in community activities once they graduate from our program. However, significant attitudinal changes are an important step toward behavior change.[21]

Dr. Robert J. Haggerty[22] stated that pediatricians "must partner with others, or we will become increasingly irrelevant to the health of children." CPT teaches residents to remain relevant to their patients' health by building strong partnerships with community associations using ABCD to address the health needs of children. Establishing a child advocacy training program based on ABCD principles is feasible. More experience and research is needed to determine whether these changes in attitudes lead to changes in behavior and whether this change is retained later in a resident's career. Finally, research is needed to understand whether physicians using ABCD to establish partnerships with communities can change the social environment to improve the health of children.

Conclusion

In this article, we describe a community advocacy training program that was initially implemented in the UC Davis pediatric residency program, which emphasizes building partnerships and capacity in communities. CPT is the first to teach and apply through service learning the principles of ABCD to the education of physicians. Through a three-year relationship with a community, residents learn to build partnerships and capacities that can sustain efforts to improve health after they have left. In addition, residents learn how their own assets as physicians and as people can support and catalyze change.[23] In 2007, the CPT program expanded to include the UC Davis School of Medicine's family medicine residents and, in 2008, internal medicine residents. Five additional collaborations in Sacramento's underserved communities have joined CPT to accommodate the expansion of the program. Lessons learned from CPT will inform efforts to identify the essential skills physicians need to be effective advocates for improving the health of people in communities.

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