Achieving Consensus on Competency in Community Pediatrics

Lynn C. Garfunkel, MD*; Dean E. Sidelinger, MD, MSED‡; Beth Rezet, MD§; Gregory S. Blaschke, MD, MPH||; and Wanessa Risko, MD, DSc¶

ABBR EVIATIONS. ACGME, Accreditation Council for Graduate Medical Education; RRC, Resident Review Committee; APA, Ambulatory Pediatric Association; PAC, Program Advisory Committee; AAP, American Academy of Pediatrics.

During the past few years, changes in medical practice and curricula have heightened the need to establish guidelines for expected competencies in community pediatrics. The shift of the Accreditation Council for Graduate Medical Education (ACGME) toward an outcome-focused process for the training of physicians and the 1996 Pediatric Resident Review Committee (RRC) extended requirements for training in the community have contributed to the expectation that residency programs will define and evaluate the achievement of competency in community pediatrics.

Specifically, the 1996 (as well as the revised 2003) RRC requirements called for structured educational experiences that would prepare residents to advocate on behalf of the health of children within communities. It was recommended that curricula should include but not be limited to community-oriented care with a focus on the health needs of all children within a community, particularly underserved populations; multicultural dimensions of health care; the role of the pediatrician within school and child care settings; the role of the pediatrician in the legislative process; and the role of the pediatrician in disease and injury prevention.1 Additionally, the RRC proposed a variety of settings in which these experiences potentially could take place, including community-based primary care practices, community health resources, community-based organizations, local and state public health departments, voluntary agencies, schools and child care settings, home care services for children with special health care needs, and facilities for incarcerated youth.

A competency can be defined as an ability, a proficiency, or an entire skill set that evolves over time and involves performance of behaviors based on a complex set of knowledge, skills, and attitudes.2 Translating knowledge into patient care; communicating with patients, family members, and other health care professionals; developing care plans; and advocating for the patient within the health care system are all necessary elements for physician competence. Competency-based education, unlike knowledge-based education, is not evaluated easily by traditional testing methods.3–5 Traditional evaluation emphasizes knowledge acquisition and process, whereas competency evaluation attempts to measure behaviors. Competency development for training in psychiatry,6 emergency medicine,7 geriatrics,8 preventive medicine,9 various surgical specialties,5,10 environmental health11 and medical school curriculum12 all have been reported. Carraccio et al13 recently described the development of benchmarks based on the 6 ACGME competencies for pediatrics.

In response to curricular shifts, the Curriculum Committee, a cross-site committee composed of representatives from the 10 training sites of the Anne E. Dyson Community Pediatrics Training Initiative (Table 1), developed a set of competencies to use as a resource for resident training in community pediatrics (see “Competency in Community Pediatrics: Consensus Statement of the Dyson Initiative Curriculum Committee”14 later in this supplement). It is the goal of the committee to disseminate these competencies so that they can serve as an educational tool to pediatric residency-training programs around the country.

BACKGROUND

The Anne E. Dyson Community Pediatrics Training Initiative was established in 1999 and called on pediatric residency programs to produce pediatric professionals with a greater capacity to improve the health of children in their communities. The initiative was developed in response to the problems facing children and families within communities and the need to train pediatric residents and practitioners to address these issues. The objectives of the Dyson Initiative are15:

- To equip pediatric residents with the tools and knowledge that they need to become future professionals committed to improving the health of the children in their communities;
urban communities. The training programs ranged 23 to 125 residents, with settings in urban and non-faculty. The residency programs varied in size from addition to hospital and community-based medical miologists, anthropologists, and family members in educators, nurses, advanced practice nurses, epide-

Faculty included community agency representatives, and selected represented hundreds of faculty members design and implement their proposals. The programs at rigorous review to receive 5 years of support to all pediatric training programs responded to the re-

quest for proposals. Ten sites, representing 12 pedi-

TABLE 1. Current Members and Program Sites of the Curriculum Committee

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<thead>
<tr>
<th>Committee Member</th>
<th>Program Site</th>
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<tbody>
<tr>
<td>Beth Rezet, MD*</td>
<td>Children’s Hospital of Philadelphia</td>
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<tr>
<td>Dodi Meyer, MD</td>
<td>Columbia University†</td>
</tr>
<tr>
<td>Eva Desrosiers, MD</td>
<td>Harlem Hospital Center†</td>
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<tr>
<td>Mary Ciccarelli, MD</td>
<td>Indiana University</td>
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<tr>
<td>Virginia Cleppe, AM, ACsw</td>
<td>Medical College of Wisconsin</td>
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<td>Earmestine Willis, MD, MPH</td>
<td>Medical College of Wisconsin</td>
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<tr>
<td>Gregory S. Blaschke, MD, MPH*</td>
<td>Naval Medical Center San Diego‡</td>
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<tr>
<td>Dianne Littlefield, MPH</td>
<td>University of California Davis</td>
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<tr>
<td>Dean E. Sidlinger, MD, MSeD</td>
<td>University of California San Diego‡</td>
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<tr>
<td>Carole Ewart, MS, EdD</td>
<td>University of Florida Jacksonville</td>
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<tr>
<td>Anthony P. S. Guerrero, MD</td>
<td>University of Hawaii</td>
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<tr>
<td>Louise Iwaisaki, MD</td>
<td>University of Miami</td>
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<tr>
<td>Arturo Brito, MD</td>
<td>University of Rochester</td>
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<tr>
<td>Lynn C. Garfunkel, MD</td>
<td>Dyson Initiative National Program Office</td>
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<td>Grace Chi, ScM</td>
<td>Dyson Initiative Program Advisory Committee</td>
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<tr>
<td>Steve Shelov, MD, MS*</td>
<td>Dyson Initiative Technical Advisory Team</td>
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<td>Wanessa Risko, MD, DSc</td>
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* Cochairs of the Curriculum Committee.  † Residency programs partner for community pediatrics training.  ‡ Residency programs partner for community pediatrics training.

- To engage pediatric residents in the communities in which they work;
- Using resources of the local community, to provide didactic and experiential opportunities in advocacy and the assessment of community goals, strengths, and needs so that residents learn to practice as medical home providers;
- To develop meaningful partnerships between academic departments of pediatrics (and their medical centers), community-based organizations, community pediatricians, and families in their regions; and
- To enhance pediatric training through interdiscipli

TABLE 2. Disciplines and Roles of Current and Past Committee Members

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<tr>
<th>Disciplines</th>
<th>Roles</th>
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<tr>
<td>Medicine</td>
<td>Continuity-clinic directors/faculty</td>
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<tr>
<td>Research</td>
<td>Pediatric residency program directors</td>
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<tr>
<td>Social work</td>
<td>Medical student clerkship educators</td>
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<tr>
<td>Education</td>
<td>Community pediatrics rotation faculty</td>
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<tr>
<td>Law</td>
<td>Curriculum designers and evaluators</td>
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<td>Public health</td>
<td>Department chairs</td>
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<td></td>
<td>General pediatrics faculty/clinicians</td>
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<td></td>
<td>Combined internal medicine-pediatrics faculty/clinicians</td>
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<td></td>
<td>Behavior-developmental pediatricians Community members</td>
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Nearly three fourths of medical schools and half of all pediatric training programs responded to the request for proposals. Ten sites, representing 12 pediatric residency-training programs, were selected after rigorous review to receive 5 years of support to design and implement their proposals. The programs selected represented hundreds of faculty members and 620 residents distributed across the country. Faculty included community agency representatives, social workers, lawyers, public health professionals, educators, nurses, advanced practice nurses, epidemiologists, anthropologists, and family members in addition to hospital and community-based medical faculty. The residency programs varied in size from 23 to 125 residents, with settings in urban and non-urban communities. The training programs ranged from those with an emphasis on primary care to those with emphasis in subspecialty areas.

METHODS

The cross-site Curriculum Committee is composed of individuals from multiple disciplines including medicine, social work, law, public health, and education. The committee includes residency directors, continuity clinic directors, researchers, teachers, and practicing pediatricians (Table 2). In addition to reviewing the competency-based training literature, the committee reviewed the Pediatric RRC guidelines, 1996 Ambulatory Pediatric Association (APA) educational guidelines for residency training in general pediatrics, and the Future of Pediatric Education II recommendations for training in community pediatrics. In February 2002, representatives from the committee met to discuss community-pediatrics competencies. During this initial session, all possible topic areas that could be included in these competencies were recorded. Using principles of the nominal group technique, content was provided by individuals, reviewed by the group, grouped into larger themes, checked for duplication, and distributed to all sites for review and addition of any omitted topics. A complete list was compiled, distributed for additional review, and discussed at subsequent meetings. The competencies in community pediatrics were formatted into 8 broad competency statements, each outlining a specific content area and the professional performance expectations for general pediatricians in that particular area. The competency statements were followed by a list of more specific objectives that represented tangible suggestions to define and evaluate the competency.

Members of the Curriculum Committee, Dyson Initiative principal investigators, expert faculty at each site, and members of the initiative Program Advisory Committee (PAC) reviewed the competency statements and objectives. Input from these groups was discussed during a series of 7 committee conference calls, and the competencies were revised based on the consensus of the group. Each of the competencies was then assigned to ≈1 of the appropriate ACGME core competency areas. To enhance broader generalizability of the competencies, each content area was assigned to a reviewer whose program was not yet fully developed in that particular content area. The competencies also were shared with Pediatric RRC and APA project team members and section editors working to revise the APA educational guidelines for residency training in general pediatrics. Broad sharing of the competencies allowed reviewers with varied expertise to provide feedback. A final draft was assessed for consistent language, distributed to all committee members for review, and approved by the Curriculum Committee members at a September 2003 meeting.
In May 2004, this draft of the competencies was posted on the Dyson Initiative Web site after announcement at the Pediatric Academic Societies annual meeting. Input was solicited from members of committees and special-interest groups having an interest in the topic areas. After the Pediatric Academic Societies meeting, requests to review the competencies were specifically solicited by postings on electronic mailing lists with the following groups: APA, American Academy of Pediatrics (AAP), Association of Pediatric Program Directors (APPD) and Council on Medical Student Education in Pediatrics (COMSEP), as well as the Advocacy special-interest group and Curriculum Committee of the APA. Each person viewing the site was surveyed (by e-mail) within 2 days of site accession and 2 weeks before the closure of the comment period; 166 people, from organizations in 39 states, Puerto Rico, and Canada (based on geographic-specific domain names), accessed the competencies through the Web site from May 1, 2004, through July 15, 2004, with 30 providing input. Responses were reviewed, and relevant comments and suggestions incorporated into the final draft of the community competencies based on consensus among members of the Curriculum Committee (see Table 3).

RESULTS

Eight domains thought to be integral to the practice of community pediatrics are defined. Each domain is introduced by a competency statement followed by learning objectives related to ≥1 of the 6 ACGME competency areas (see “Competency in lowed by learning objectives related to each objective, ranging from familiarity to mastery, is not established in this article.

1. Delivery of culturally effective care: Pediatricians must demonstrate interpersonal and communication skills that result in effective information exchange with children and families from all cultural backgrounds and diverse communities.

2. Child advocacy: Pediatricians should advocate for the well-being of patients, families, and communities. They must develop advocacy skills to address relevant individual, community, and population health issues. Understanding the legislative process (local, state, and federal) is required to address community and child health issues.

3. Medical home: Pediatricians must be able to identify and/or provide a medical home for all children and families under their care. As defined by the AAP, a medical home consists of well-trained physicians, known to the family and patients, who provide accessible, continuous, comprehensive, family-centered, and well-coordinated medical care.

4. Special populations: Pediatricians must be able to identify youth at risk for poor health outcomes and those with special health care needs. Pediatricians, in concert with other child health professionals, must collaboratively develop and implement management plans that are realistic, family centered, community referenced, nonrestrictive, and effective. They must have a working knowledge of specific psychosocial issues, legal protections/implications, policies, and services provided at the local, state, and federal levels.

5. The pediatrician as a consultant, partner, and collaborative leader: Pediatricians must be able to act as a child health consultant in their community. Using collaborative skills, they must be able to work with multidisciplinary teams, community members, and representatives from schools, child care facilities, and legislative bodies.

6. Educational and child care settings: Pediatricians must be able to interact with the staff of schools and child care settings to improve the health and educational environment for children.

7. Community and public health: Pediatricians must be able to understand and potentially modify the health determinants affecting patients and families in the community they serve. To effect change in health outcomes, pediatricians must be able to identify and mobilize community assets and resources toward preventing illness, injury, and related morbidity and mortality.

8. Research and scholarship: Pediatricians should be capable of pursuing inquiries that advance the health of children, families, and communities.

DISCUSSION

Twelve pediatric residency programs at 10 sites encompassing 7% of pediatric residents in training...
nationwide participated in the process of defining the knowledge, attitudes, and skills necessary for competency in community pediatrics. The programs of the Anne E. Dyson Community Pediatrics Training Initiative have been well funded to design, reflect on, and evaluate their training curricula. Defining the competencies was a matter of deliberation, opinion, reflection, thoughtfulness, patience, and consensus building through multiple iterations over nearly 2 years among some 15 members and included dialogue with outside experts in pediatric education, faculty who teach these skills, the Dyson Initiative PAC, APA educational specialists, and the Pediatric RRC.

Community pediatrics, defined in the 1980s and 1990s by Osborn and co-workers,20,21 DeWitt and Starr,22 Roberts23 and Palfrey,24 among others, focused on teaching primary care pediatrics outside the hospital setting. The concept of community pediatrics included in the most recent Pediatric RRC guidelines encompasses a much broader definition of “community.” In a discussion of community pediatrics, Haggerty wrote that “health is the result of more than medical care; …[p]artnerships with public health and other professions that serve children, cultural sensitivity, and advocacy for broader services are required to achieve optimal health for all.”25 The AAP Committee on Community Health Services in 1999 (and in the revised policy statement “The Pediatrician’s Role in Community Pediatrics”26) defined community pediatrics as the focus on all children, not a single child, with recognition that many factors (cultural, economic, educational, environmental, family, political, social, and spiritual) significantly affect the functioning of children. The committee described the importance of understanding the interplay between public health and clinical practice and the need to understand and use community resources as an integral part of pediatric practice. All pediatricians, no matter where or in what general or subspecialty area they practice, need to be equipped with an understanding of the community and the skills necessary to work in the community to support the health of all children.

The objectives within the 8 domains are recommendations to direct residency training for preparation of pediatricians to better care for children in our communities. Special attention is given to children and families affected by special needs, poverty, inadequate education, poor access to health care, cultural differences, or resource restriction that may affect health outcomes. Better skills and education in community pediatrics will prepare pediatric residents not only to care for these children and families during training and in the future but potentially to improve the health and well-being of future generations. To understand the effect community influences have on children, pediatric residents must be exposed to, educated in, and expected to participate in advocacy and public policy, delivery of culturally effective care, and public health, as well as consultation and collaboration with other child- and family-responsive organizations.

A goal in any training program is to provide a foundation on which future career development is built. Ideally, pediatricians work to improve the health of all children, and this aim will be furthered by graduates caring for children who are from diverse cultures, have special needs, are from varied socioeconomic backgrounds, are in substitute care, or are otherwise in need of adult advocacy. The competencies presented in this article are intended to act as a guideline and resource to assist pediatric residency programs in structuring their educational objectives and training experiences in community pediatrics.

The 8 competency areas, encompassing 113 specific objectives, may seem overly ambitious, considering the paucity of community training in some residency programs and the likely increase in subspecialty training in the upcoming revised RRC requirements. However, flexibility is built into the competencies, because it is anticipated that residency programs will set their own expected level of performance for each objective, ranging from familiarity to mastery, which allows tailoring of the curriculum to the unique circumstances of each program. The achievement of these competencies is not limited to community-pediatrics rotations. Some of these learning outcomes are being achieved already in existing training experiences.

We submit these competencies as an answer to that challenge and with the hope that they will serve as an important resource for the training of future generations of community-focused pediatricians.

ACKNOWLEDGMENTS

The inspiration of Anne E. Dyson and the continued support of the Dyson Foundation were integral to the completion of this work.

We thank the children, families, resident members, faculty, and principal investigators at the 10 sites involved in the Anne E. Dyson Community Pediatrics Training Initiative. We are indebted to the leadership of Judith Palfrey and the many members of the Program Advisory Committee, as well as Tom Tonning of the Department of Community Pediatrics at the American Academy of Pediatrics. We also thank the members of the Dyson Initiative Curriculum Committee for time and effort at coming to consensus on competency in community pediatrics; the project team and editorial members of the Ambulatory Pediatric Association Macy project for revising the educational guidelines for residency training in general pediatrics (in particular, Patricia Beach, Diane Kittredge, Miriam Bar-On, John Frohna, Angelo Giardino, and Mary Ottolini); and Paula Duncan from the American Academy of Pediatrics Bright Futures Steering Committee for providing input into the competency statement. Finally, we appreciate input from the Accreditation Council for Graduate Medical Education Pediatric Resident Review Committee.

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