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Legislative Advocacy: Evaluation of a Grand Rounds Intervention for Pediatricians

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Abstract

Objective—To evaluate the impact of a Grand Rounds Action Alert (GRAA) intervention on the behaviors, knowledge, and attitudes of pediatric grand rounds (GR) attendees; and to assess its acceptability.

Methods—A cross-sectional, quasi-experimental study was performed at a freestanding children's hospital. GRAA on child health legislative topics were presented in the first 2 minutes of the pediatric GR session as well as posted outside. Each session included an action item, such as writing/signing letters to elected officials or informational sheets with legislator contact information. Main outcome measures included self-reported behavior, advocacy knowledge, attitudes, and acceptability.

Results—One year after GRAA implementation, GR attendees with high exposure to the intervention were more likely to have written/signed a letter to a legislator compared to those with low/no exposure (60% vs 35%, $P = .016$). Those with high exposure were also more knowledgeable regarding financing of health care for low-income children (20% vs 5%, $P = .027$). Attitudes toward advocacy at baseline were positive: respondents agreed it is important to remain informed about (98%) and advocate for (94%) legislation favorable to children's health. Implementing this program was challenging, but the intervention was accepted favorably: 93% of respondents agreed that GRAA should continue.

Conclusions—GRAA facilitated participation in legislative advocacy behaviors while improving self-perceived knowledge of legislative issues relating to children's health. They were well received in a large tertiary children's hospital.

Keywords

advocacy; education; grand rounds

The threats to child health are deeply intertwined with a family's economic, social, and environmental conditions.¹⁻⁴ Thus, pediatricians increasingly need to engage at the community^{5,6} and policy levels³ to improve child health. Accreditation bodies charged with shaping pediatric⁷ and other medical training⁸ have responded by increasing community and advocacy training requirements.^{9,10}

The public role for physicians is defined "assuming responsibility for addressing health-related matters beyond care of individual patients."¹¹ Despite recent debate whether a public role should be an expectation of all physicians,¹² an overwhelming majority of physicians and pediatricians endorse the centrality of this role.¹¹ Although some research has been done on advocacy training within pediatric residencies, there is little evidence for how to effectively engage practicing pediatricians. Physicians are less civically engaged than their peers of comparable socioeconomic status,¹³ and pediatricians demonstrate less political engagement than anesthesiologists and general surgeons.¹¹ Furthermore decreasing engagement in community health activities has been reported,¹⁴ citing lack of time being a barrier.¹⁵

An untapped opportunity to engage pediatricians in advocacy activities is weekly grand rounds (GR).¹⁶ A series of brief presentations, called Grand Round Action Alerts (GRAAs), were given at the beginning of GR to educate and provide an opportunity for pediatricians to engage in advocacy activities. The project's goal was to implement and assess the effectiveness and acceptability of the GRAA model. Our hypothesis was that exposure to GRAA would increase advocacy behaviors (writing to or calling legislators) and improve self-perceived knowledge of legislative issues of GR attendees.

Methods

Setting

The study was conducted in a large quaternary, freestanding children's hospital between March 2009 and May 2010. The Department of Pediatrics holds weekly GR consisting of an hour long presentation, typically attended by 60 to 90 individuals.

Participants

Attendees at GR include pediatric providers from a wide range of backgrounds: medical students, residents, fellows, retired and active, academic- and community-based physicians, nurse practitioners, physician assistants, pharmacists, physical therapists, support staff, child life specialists, and community members. Inclusion criteria were attendance at pediatric GR. Exclusion criteria included being any type of student (including medical, pharmacy, or physical therapy), given their transient nature in the department and thus their ability to attend GR. GR attendance varied from week to week, resulting in a high degree of variability in exposure to the intervention.

Intervention

GRAA focused on timely child health legislation, consisted of 4 to 5 PowerPoint slides presented in the first 2 minutes of GR by 2 of the authors (LC and RB). A variety of topics were presented (Table 1), with 2 recurring themes: the impact of national health reform proposals on children and the California budget shortfall. GRAA were not considered to be formally a part of GR, but they preceded GR and were not included in the Continuing Medical Education provided at GR. Opportunities to take action included signing letters and being provided with key talking points for calling legislators. A summary of the PowerPoint presentation was placed on a table outside the auditorium near the coffee provided for GR attendees, providing information to latecomers. Resources from the American Academy of Pediatrics and a variety of local and national child health advocacy organizations were utilized in preparing presentations and action items. All topics and presentations were approved by the hospital director of government relations before presentation.

Survey

An anonymous survey was used to assess the behaviors, knowledge, and attitudes of pediatric GR attendees. The survey utilized both dichotomous yes/no and a 5-point Likert scale ("strongly disagree" to "strongly agree"). Space was provided for respondents to provide open-ended feedback on the intervention. The survey was developed in consultation with a research scientist familiar with survey design (MB), piloted with 10 individuals, and then revised for clarity. The baseline survey had a total 35 brief items, while the follow-up contained 29 items and took 4 to 5 minutes to complete. When possible, questions were adapted from existing survey tools.^{17,18} Cronbach's alpha scale assessed the survey's internal reliability within the domains, ranging from .86 (knowledge) to .91 (attitude). This was not done for the behavior domain because Cronbach's alpha scale is not typically used for binary outcomes, precluding measuring aspects of the construct in a comparable way. Instead, a summative scale was created cataloging completed activities.

Surveys were distributed to all attendees of pediatric GR lectures upon arrival to the auditorium. Data were collected before the first GRAA (baseline) and at 1 year. Because attendance at GR varied weekly, surveys were collected for 2 consecutive weeks at each time point with verbal instructions to complete the survey only if one had not completed it the previous week.

Analysis

We dichotomized GRAA attendance into 0 to 1 (low/no exposure) and 2 or more sessions (high exposure) because of the way the data clustered creating a natural breakpoint. Approximately half of the respondents attended between 0 and 1 sessions, while the second half attended 2 or more ($n = 43$, 49%, and $n = 45$, 51%). Because of small cell sizes, calculating a dose response was not possible, but collapsing the small cell sizes allowed us to examine the impact of the intervention. Chi-square analyses by Fisher's exact test were used to compare behavior and knowledge among the baseline and postintervention groups overall as well as between low/no and high attendees. GRAA participants were considered to be those who responded sometimes or always completing the action at GR, such as signing a letter to a legislator. For the knowledge questions, a response of "strongly agree"

(5) was coded as well informed. All analyses were performed by IBM SPSS Statistics software, versions 18 and 19. The institutional review board at Stanford University approved the study.

Results

During the study period, 15 GRAAs were presented and 172 attendees were surveyed (Table 2). Slightly more than half were women (61%), and pediatric specialists were in equal attendance with trainees (29% each), followed by general pediatricians (22%). Half of attendees reported attending GR once or twice per month, while 29% attended weekly. At 1 year after intervention, 51% were classified as “high exposure,” having attended 2 or more GRAAs. Seventy-one percent were GR participants reporting “always” or “sometimes” participating by completing the action item.

The pediatricians with high exposure to the GRAAs (2 or more GRAA sessions) demonstrated increases across all areas of behaviors and knowledge assessed than those with low/no exposure (0 to 1 GRAA sessions). The overall GR attendees experienced no change or declines in knowledge level with increases in behaviors that did not reach statistical significance (Table 3). One year after GRAA administration, those with high exposure were significantly more likely to report they had signed a letter to an elected official in the prior 4 months compared to the providers who had low/no exposure (60% vs 35%, $P = .016$). Those reporting having called legislators increased but did not reach statistical significance (13% vs 7%, $P = .265$). Attendees with high exposure to GRAAs reported a significant increase in being more informed of health care financing for low-income populations (20% vs 5%; $P = .027$), a topic touched on in several of the GRAAs, compared to the low/no exposure group. Although not reaching significance the high versus low/no GRAA attendees “strongly agreed” with being well informed about the legislative process “at the state level” (14% vs 2%) and “at the federal level” (16% vs 7%).

The baseline survey revealed that an overwhelming majority of respondents agreed/strongly agreed it is important to remain informed about (98%) and advocate for (94%) legislation favorable to children’s health, with no significant difference between specialists and generalists. Barriers to participating in child advocacy were lack of time (57%), having other priorities (36%), being unaware when issues arise (34%), and being unskilled in advocacy (30%).

GR attendees were asked “I would like GRAA presentation to continue”; 65% strongly agreed, 28% agreed, and 7% indicated “not sure.” No respondents indicated they would like the presentations to be stopped.

Discussion

A brief presentation covering timely child health legislative topics increased pediatrician participation in advocacy through communication with legislators via letters and increased knowledge about the financing of health care for low-income populations. The baseline attendees’ responses were consistent with the literature indicating that legislative advocacy is important,¹¹ while knowledge of the legislative process, time, and advocacy skills were

limited.¹⁹ Attending GRAAs was associated with an increase in letter writing in an audience who already reported very positive baseline attitudes toward advocacy. The intervention was well received in the setting of GR at a children's hospital.

Although GRAA sessions showed high attendee receptivity, there were challenges. Acceptance from hospital leadership was essential and required many months to obtain. GR is a unique, unifying aspect of the institution's culture, which encompasses 3 hospitals, community physicians, fellows, residents, and medical students. It was not, nor should it be, easily altered. The following GRAA protocol was agreed on: presentations being less than 2 minutes, beginning at exactly start time (8:00 AM), and a commitment to evaluate the impact and to allow for feedback assessing acceptability. We quickly assessed a logistical challenge: the attendance at exactly 8:00 AM was low, with attendees continuing to arrive until approximately 8:10 AM; thus, a proportion of the audience did not hear the GRAA. To reach the entire audience, slides were printed and posted outside the auditorium, accompanying the action items, allowing attendees to learn of the GRAA if they missed the presentation.

Learning advocacy skills is a required part of pediatric residency training,^{7,20} and many studies have demonstrated the utility of such training.^{21,22} One less described but critical aspect of such training is the importance of faculty role modeling for young physicians.^{23,24} The GRAA model assisted the faculty to engage in child advocacy in the presence of trainees and thereby has potential for changing the learning environment, affecting the informal curriculum of residents and medical students.

In our experience, successful implementation of monthly GRAAs required partnership with hospital leadership, particularly in government relations. Although large medical groups and children's hospitals have staff in government relations, their interaction with physicians is often limited. This is a missed opportunity as physicians have a unique voice to bring to policy discussions and government relations professionals have thorough knowledge of health policy, both content and process. Furthermore, laws governing nonprofit 501(c)3 entities are complex, and the government relations staff is critical in assisting us to understand permissible activities, for example we do not endorse or oppose any candidate for public office.

These data are not without limitations. First, the study location is typical for the care of medically complex children, where many pediatric specialists practice, and may differ from community-based hospitals. Second, we were unable to link pre and post surveys as a result of the inconsistent attendance of GR attendees, and thus we could not track individuals over time. Placing GRAA in a real-world setting is required to demonstrate a new model to promote pediatrician advocacy, but this setting comes with inherent limitations. GR is a dynamic environment where some arrive late, some leave early, and others are called out to attend to urgent patient issues. This undermined attempts to assess attendance or calculate a survey response rate. Finally, we did not assess sustainability beyond 1 year.

Conclusions

Pediatricians bring a unique voice to policy decisions regarding the nation's greatest resource, children. GRAAs increased self-reported advocacy behavior and knowledge, and were well received in a large tertiary children's hospital. Facilitating the uncompensated role of advocate for busy pediatric providers is a challenging but surmountable task.

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What's New

A Grand Rounds Action Alert (GRAA) intervention covering timely child health legislative topics increased physician participation through communication with legislators, increased knowledge about the financing of health care for low-income populations, and was well received at a children's hospital.

Table 1**Grand Rounds Action Alert Topics**

Introduction to Grand Rounds Action Alerts**State**

- California special election—discussed ballot measure that threatened funding for First 5 programs (a system of education, health services, child care, and other programs for children up to 5 years of age) and mental health services.
- Multiple sessions highlighting the impact of impending California budget cuts with decreased funding for CHIP on access to care and child health.
- Implications of proposed cuts to the state poison control program.
- Potential impact of proposed changes in eligibility to the Early Start program.
- Support for maintaining California's Title 5 Program, California Children's Services.
- Proposed state legislation to ensure access to drinking water in public schools.
- Proposed legislation to insure adequate vaccine reimbursement in California.

Federal

- Reviewed key features of the recently enacted CHIPRA.
 - National health reform—multiple sessions discussed the potential impact on children's health and how to contact one's representative to encourage attention to these issues.
 - Federal legislation—discussion of preservation of Antibiotics for Medical Treatment Act, and information presented on a federal bill proposing to limit the nonmedical use of antibiotics.
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CHIP = child health insurance program; CHIPRA = children's health insurance program reauthorization act of 2009.

Table 2

Characteristics of 172 Subjects*

Characteristic	Total	Baseline	Follow-up After 1 Year of GRAA
No. of subjects	172	84	88
Female gender	61% (102)	63% (51)	59% (51)
Type of practice			
Pediatric subspecialty	29% (51)	25% (21)	34% (30)
General pediatrics	22% (39)	24% (20)	22% (19)
Trainee (resident/fellow)	29% (51)	35% (29)	25% (22)
Other [†]	18% (31)	17% (14)	18% (17)
Years since completion of MD, mean (SD)	19.5 (16.5)	19 (17.9)	20 (15.5)
Attendance frequency at grand rounds			
Weekly	29% (48)	36% (29)	22% (19)
1–2 times per month	50% (86)	45% (36)	55% (48)
Less than once per month	21% (35)	19% (15)	23% (20)
Attendance at GRAAs			
Attended 0–1	NA	NA	49% (43)
Attended 2 or more			51% (45)
Completion of GRAA action item			
Never	NA	NA	28% (23)
Sometimes			43% (35)
Always			28% (23)

GRAA = Grand Rounds Action Alert; NA = not applicable.

* Percentages may not sum to 100 as a result of rounding or missing responses. Subtotals may not add up to the column total as a result of missing responses. Data are presented as % (n) unless otherwise indicated.

[†] Self-described as nurse practitioner, physician assistant, retired physician, pharmacist, social worker, visiting scholar, researcher, support staff, child life specialist, community members, and patient parents.

Advocacy Knowledge and Behaviors*

Topic	Grand Rounds Attendees Overall		1 Year After Presentations, Low/No Versus High Attendees	
	Baseline (n = 84)	1 Year After Intervention (n = 88)	Low/No Attendance (n = 43)	High Attendance (n = 45)
		<i>P</i> [†]		<i>P</i> [†]
Knowledge				
I am well informed about financing of health care for low-income children (ie, MediCal)	14%	13%	5%	20%
I am well informed about the legislative process at the state level	10%	8%	2%	14%
I am well informed about the legislative process at federal level	11%	11%	7%	16%
Behavior				
Within the past 4 mo I have written/signed letter to a legislator on a child health issue	37%	48%	35%	60%
Within the past 4 mo I have called a legislator on a child health issue	3%	10%	7%	13%

* Students and 1 incomplete survey were excluded from this analysis. Knowledge was assessed on a 5-point Likert scale, with 5 (strongly agree) coded as well informed.

[†] Chi-square analysis used Fisher's exact test.