



COMMUNITY-RELATED ISSUES EDUCATION

Evaluating a Community-based Multiprofessional Course in Community Health

DANIEL S. BLUMENTHAL, MD, MPH, ALMA JONES, MD, MPH & MERYL McNEAL, PhD

Department of Community Health and Preventive Medicine, Morehouse School of Medicine, Atlanta, Georgia, USA

ABSTRACT Purpose: *To evaluate student response to a community health course taught using a small-group, interdisciplinary, service-learning approach.*

Method: *Student evaluations for the course were reviewed for a 3-year period (1994–1997).*

Results: *Student evaluations of the course improved over the 3-year period. A total of 60–76% of the students indicated that they preferred the small-group experiential approach to lectures. Examination of evaluation scores for individual small groups showed that some small groups gave the course very high ratings, while others found the experience inadequate.*

Conclusion: *A course in community health is best taught in the community rather than the classroom. A small-group approach may result in a course with considerable variation among groups as a result of variations in community receptivity, faculty skills, and perhaps other factors.*

KEYWORDS *Medical education, service-learning, course evaluation, population health, community-based education, community-oriented primary care.*

Introduction

Health professions education is shifting in venue from the classroom and hospital to the community. As newer course models emerge, it will be important to evaluate them. In 1991, we inaugurated a multiprofessional

Address for correspondence: Daniel S. Blumenthal, MD, MPH, Department of Community Health and Preventive Medicine, Morehouse School of Medicine, 720 Westview Drive SW, Atlanta, GA 30310, USA. Tel: +1-404-752-1624. Fax: +1-404-752-1160. E-mail: danielb@msm.edu

community-based course in community health. In this report, we present the student evaluation of the new course over the period 1994–1997.

The course is a collaborative effort of Morehouse School of Medicine (MSM), Georgia State University (GSU) School of Nursing, and Clark–Atlanta University (CAU) School of Social Work, all located in Atlanta, Georgia, USA. MSM is a predominantly black private institution whose mission is to train primary care physicians for careers in medically underserved communities. CAU is also a predominantly black private institution, while GSU is a large public university.

The course meets for 3 hours on one morning each week throughout the academic year. The class of about 70 students consists of approximately 45% medical students, 45% senior nursing students, and 10% social work students.

The learning objectives state that at the end of the course, students should be able to:

1. discuss and use community needs assessment approaches;
2. discuss the epidemiology of one or more important health conditions affecting the assigned community;
3. discuss barriers to access to health care in the assigned community;
4. recommend public policy measures to improve the health of the community;
5. develop and implement an interdisciplinary intervention to address a community health issue; and
6. collaborate to develop a cohesive small group and to develop a greater understanding of the roles of the various disciplines included in the health care team.

Students are assigned to groups of 8–10, representing each of the participating disciplines, and each group is assigned to a community organization, a community agency, or simply a community. Two faculty members and a community liaison from the community organization or agency supervise each group. Of the 14–18 faculty supervising small groups each year, approximately one-third are physicians with master of public health degrees or other advanced training in public health; a slightly smaller number are nurses from the GSU faculty; and the remainder are drawn from a variety of disciplines, including behavioral science, health education, social work, epidemiology, and health policy.

During the first semester, students conduct a health needs assessment using techniques such as surveys, focus groups, key informant interviews, and secondary data analyses. At the end of the semester, a mock legislative hearing is conducted at the state capitol before a panel of state legislators and other policy makers. One or more representatives of each student group is allowed 10 minutes to offer testimony on the health problems identified in the assigned community, after which the legislators query the student witnesses.

In the second semester, each group of students implements a health promotion intervention that responds to one or more of the problems identified in the needs assessment. Both the assessment and the intervention are guided by the *precede-proceed* model of Green and Kreuter (1991).

Student learning is assessed through an evaluation of performance at the mock hearing, first- and second-semester group papers, year-end presentations to faculty and students, class participation, and examinations, including a multiple choice examination. For the first two items (performance at the mock hearing and group papers) assessment is done on a group basis—that is, all students in the group receive the same grade. Students receive individual grades on the year-end presentations, class participation, and the examinations.

Evaluation Methods

At the conclusion of each semester, students are required to complete an anonymous evaluation form on which several aspects of the course are rated on a 4-point Likert scale. We analyzed the responses of the class as a whole for the period 1994–1995 through 1996–1997 and also performed analyses at the small-group level. Because the evaluation was not developed as a research project, the form varied somewhat each year. This required us to identify retrospectively a number of similar items across the different forms in order to develop an aggregate evaluation. We therefore limited the evaluation to three summary items: (1) Did the course meet its objectives? (2) Did the course hold the students' interest? (3) Did the students prefer the small-group experiential approach to the lecture method? In addition, student evaluations of individual faculty effectiveness were reviewed. Ranges and means were calculated for the Likert scale responses.

Results

Over the six one-semester evaluation periods, a mean 63.2% (range 53–72%) of students felt that the course met its objectives at a “good” or “excellent” level (3–4 on a 4-point Likert scale), and a mean 58.8% (range 38–70%) found that the course held their interest at a good or excellent level. There was a general upward trend in the course evaluations, with 70% of students in the 1997 spring semester indicating that the course met its objectives and 72% indicating that the course held their interest at a good or excellent level. A mean 69.3% (range 60–76%) of students indicated that they preferred the small-group experiential approach to the lecture method.

There was a wide range of responses to these questions by the small student groups. Among those groups viewing the course most favorably, 88–100% of

students stated that the course met its objectives and was interesting at the good to excellent level; 87–100% of students in these groups preferred the small-group approach to lectures. However, in small groups viewing the course unfavorably, fewer than 50% of students gave good to excellent evaluations to any of the questions, and in some instances, none of the students provided positive responses. In virtually every case in which the small group rated the course unfavorably, the faculty supervising the group were also rated unfavorably. Of the eight faculty who taught in all 3 years, three received positive evaluations every year; four improved their initial student evaluations; and evaluations for one deteriorated.

Overall student performance was generally superior on group projects (papers and presentations before the mock legislative committee) to that on individual examinations. It was not possible to measure *increases* in knowledge or skills, since no pre-test was administered, but it is safe to say that at the start of the course very few students were familiar with most of the concepts (such as the *precede–proceed* model) addressed in the examinations.

Discussion

This study is limited by the fact that it was conducted retrospectively from evaluations that were done for the purpose of making course improvements from year to year, not as a prospective research project. Nonetheless, several points emerge.

First, the learning objectives for a community-based course will necessarily differ from those for a classroom course. The classroom is a more appropriate venue for teaching lists of facts; the community is more appropriate for teaching explicit skills, such as data gathering and health promotion. In order to implement a community-based course, strong partnerships with community agencies and organizations are important.

Second, while an educational program taught in an experiential fashion has the potential of being more exciting than a series of lectures, some students may prefer lectures. In our study, about 30% stated that they preferred lectures.

Third, small-group exercises in the community may result in very different experiences for different groups of students. In some of our small groups, all or nearly all of the students gave the course a positive review, while in others the reverse was the case. This variability may be tied to a variety of factors, including dissimilarities in communities and differences in the faculty supervising the small groups. With respect to the latter, leading a small group of students in the community certainly requires different skills and knowledge on the part of faculty than does the delivery of lectures. The evaluations by the students of the faculty who taught in our course tended to steadily improve.

Conclusion

Teaching community health in the community rather than in the classroom is intuitively appropriate. Moving from the classroom to the community, however, introduces a new set of educational issues. Communities do not necessarily welcome students. The development of a strong community–academic partnership is essential. Moreover, few faculty have been trained to teach in the community environment or are comfortable in this setting. For institutions undertaking this mode of instruction, therefore, faculty development would appear to be a pressing need.

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