An Essential Role for Pediatricians: Becoming Child Poverty Change Agents for a Lifetime

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Poverty has profound and enduring effects on the health and well-being of children, as well as their subsequent adult health and success. It is essential for pediatricians to work to reduce child poverty and to ameliorate its effects on children. Pediatricians have important and needed tools to do this work: authority/power as physicians, understanding of science and evidence-based approaches, and first-hand, real-life knowledge and love of children and families. These tools need to be applied in partnership with community-based organizations/leaders, educators, human service providers, business leaders, philanthropists, and policymakers. Examples of the effects of pediatricians on the issue of child poverty are seen in Ferguson, Missouri; Denver, Colorado; and Rochester, New York. In addition, national models exist such as the American Academy of Pediatrics Community Pediatrics Training Initiative, which engages numerous pediatric faculty to learn and work together to make changes for children and families who live in poverty and to teach these skills to pediatric trainees. Some key themes/lessons for a pediatrician working to make changes in a community are to bear witness to and recognize injustice for children and families; identify an area of passion; review the evidence and gain expertise on the issue; build relationships and partnerships with community leaders and organizations; and advocate for effective solutions.

**Keywords:** advocacy; child poverty; community partners; pediatric education; pediatricians

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The most recent US Census data reveals that child poverty has not recovered from the great recession. Twenty-one percent of children younger than the age of 18 years (15.5 million) live in poverty and this percentage is not improving. Pediatrics see the reality of poverty play out in their offices every day as prescriptions for medications go unfilled, transportation to appointments is limited, utilities get cut off, and children go hungry.

Due in part to the high poverty rates, too many young children are exposed to stressful and unhealthy early life environments. The hardship and stress associated with living in poverty affects children’s health by creating obstacles to establishing a foundation for healthy child development. Exposure to toxic stress and adverse childhood experience puts young children at significant risk for poor health and developmental outcomes. These adversities affect brain development and other organ systems, and thus affect health and well-being for a lifetime.

To promote the well-being of all children, health care delivery must be broadened by incorporating effective community and population health strategies to reduce toxic stress.

In addition, the Affordable Care Act asks pediatricians and other child health professionals to look after populations of children, which, to do well, requires a different kind of training and expertise. This approach to health requires an understanding of the social and environmental factors that contribute to the creation of health disparities and the skills to collaborate with diverse stakeholders to solve child health problems through structural and policy changes.

Pediatricians and pediatric clinicians have also been supported in serving the needs of poor children through the largest pediatric membership organization, the American Academy of Pediatrics (AAP). Numerous Policy Statements issued by the AAP support efforts to work in community and attend to the needs of poor children and families.

In this article, we put forth a model with tools that we believe are critical for becoming change agents for children and families. We define a change agent as a person who is willing to take responsibility or serve as a leader for system change to improve the lives of children and families. We present examples of pediatricians from around the country who have used these tools to transform children’s lives in meaningful ways in their communities. In our work described in this article we have focused on pediatricians and pediatricians in training,
but other child health professionals could use the proposed framework and methodology. We have also highlighted work done through the Community Pediatrics Training Initiative (CPTI) network and recognize this is an example of one successful medical–community partnership that has widespread implementation. Others like the Medical–Legal Partnership also exist and have been described in the literature. We hope to inspire ongoing and future education, training, and advocacy efforts across the country. Reducing child poverty in the United States will take many kinds of leaders: parents, families, community leaders, and us, pediatricians and child health professionals.

**TOOLS FOR CHANGE**

In *Rhetoric*, Aristotle described the 3 categories of persuasion as: ethos: authority/credibility; pathos: emotion/stories; and logos, data/logic. In 2005, at an Institute for Medicine as a Profession Meeting, Jeff Kaczorowski, MD, proposed a model for pediatrician leaders in community-partnered efforts to change the lives of poor children on the basis of these categories. The model describes 3 critical tools for pediatricians to use to transform children’s health, especially children with special health care needs and children living in poverty: Science/Evidence, Love/Community, and Power/Authority (Fig. 1).

**SCIENCE/EVIDENCE**

“The only thing new in the world is the history you do not know.”

—President Harry S. Truman, National Archives

“Do what works, don’t reinvent the wheel, don’t repeat proven mistakes.”

—Andrew Aligne, MD, MPH, *Leadership in Community Health: A Manual for Pediatricians and Other Health Care Professionals*, University of Rochester 2004

Pediatricians can generate and evaluate evidence through research and critical examination of the literature. Pediatric practitioners can ascertain what practices and programs have made a difference in varying contexts and communities. This unique skill set allows pediatric clinicians to engage in strategies and programs that work, promote policies and practices to try in new communities, and discover new possibilities to make a difference in children’s lives. At the same time and equally importantly, we can use this framework to avoid repeating what does not work. This tool, Science/Evidence, tends to be the most familiar to pediatricians in the clinical and research arena, yet might not be fully deployed in the community setting. Science and discovery changes what we know and how to determine what works to encourage healthy growth, development, and well-being of children in the communities where they live.

**LOVE/COMMUNITY**

“Pediatricians are the ultimate witnesses to failed social policy.”

—Paul Wise, MD, MPH

“We must become partners with others or we will become increasingly irrelevant to the health of children.”

—Robert J Haggerty, MD

This tool is where emotions and stories enter change agent practice. A Merriam-Webster dictionary definition describes love as warm attachment, enthusiasm, devotion. Pediatricians bring love to their work with children, and they see many children living in poverty and desperate social circumstances that others might not witness. In addition, in our experience, effective work involving pediatrics in the community usually stems from a pediatrician’s passion for an issue that is shared with a devoted, skilled community-based organization and community leaders.

These community partnerships are an absolutely critical tool for change agents, because no one person or one agency can accomplish all of the improvements that children and families need to be healthy. As experts in their communities, community agencies can offer pediatricians insight on community know-how and context, as well as deep relationships to those who live in and understand poverty. Honoring and partnering with this expertise makes pediatricians more effective in their work, and it is our experience that with mutual respect and benefit, these relationships drive effective system change that is long-lasting and meaningful for children.
Power/Authority

“What is needed is a realization that power without love is reckless and abusive, and love without power is sentimental and anemic.”

—Martin Luther King, Jr

“In the long run, child health is about advocacy.”

—C. Everett Koop, MD

We define power as the ability to act, the ability to make a difference. Pediatricians are trusted voices. As leaders in the public arena of child poverty, pediatricians must shoulder the responsibility with community partners and families to act on their love for children and the science they understand to make a difference for kids. On many days and in many communities, it takes courage, persistence, and risk-taking to give a public voice to the system change needed for children and families. To respond to social determinants of health like poverty, child health requires advocacy. As experts on child health, pediatricians need to engage their authority and power to advocate for and create lasting systemic change.

Integration and Application of the Tools

Together these 3 tools are powerful and well within the domain of skills that pediatricians use daily. We use the science to know the best treatment for our patients, and often partner with community agencies to deliver services children need, like Head Start and early intervention. We speak out and advocate for our patients to get their needs met with insurance companies or schools. Now we are asking pediatricians to use these same tools to bring system change in the public arena for poor children.

Pediatricians by no means have an exclusive role in using these tools. Researchers, psychologists, and policy experts, among others, help us to understand what is evidence-based and effective to alleviate poverty and health inequities due to social determinants of health. Community leaders and front-line service providers provide a deep understanding of the real needs of children and families and the challenges faced to meet them. Business leaders and philanthropic funders leverage power and authority on behalf of their communities. However, pediatricians are relatively unique in that they can use each of these tools and partner with these other key entities. We will next describe several examples of pediatrician/community-partnered efforts around the United States.

Ferguson, Missouri

On August 9, 2014 in Ferguson, Missouri, an unarmed Michael Brown was shot to death by police officer Darren Wilson. Ferguson and St Louis became a war zone with protestors and police battling each other in the streets. Katie Plax, MD, at Washington University in St Louis is the medical director of a free youth center that provides health and social services, The Supporting Positive Opportunities with Teens, and the Division Director of Adolescent Medicine. The center was teeming with hurt, angry, sad and confused youth, many of whom had experiences with police that were challenging and many of whom lived in the communities where the tear gas and violence erupted.

On November 18, 2014 in response to the unrest, Missouri Governor Jay Nixon appointed the Ferguson Commission—16 community, business, and faith leaders—to address the underlying causes that led to the unrest in response to Michael Brown’s death. The charge also specified that the Commission make policy recommendations with a report to the community by September 2015. The Commission engaged in a public dialogue with community-based organizations, institutions, experts, and the public all weighing in and welcomed to 60 public meetings. Strong public feedback led to the establishment of 4 workgroups, one of which was Child Well-Being and Education Equity. Dr Plax had longstanding relationships in the community from past advocacy work and was invited to participate in this work group’s efforts. A well-known community partner, the Executive Director of Big Brothers/Big Sisters of Southeast Missouri, led work group meetings. For Dr Plax, the invitation to participate was transformative. The depth and breadth of trauma, emotions, and stories of injustice was powerful. With community partners and a deep love and commitment to the youth she serves, Dr Plax was able to listen and advocate for things she knew from the literature and science worked for kids—universal prekindergarten, school-based health centers, trauma-informed schools, improved access to the Supplemental Nutritional Assistance Program and improved access and organization of summer feeding programs. In addition, she was able to learn from and partner with others to better understand the lives of children/youth and to appreciate the challenges in the public education system. The Child Well-Being work group put forward 37 recommendations to the Commission. Seven of these recommendations became final priorities and included school-based health centers, trauma-informed schools, universal prekindergarten, and ending childhood and family hunger, among others. As a pediatrician, Dr Plax was able to use the tools to advocate for kids, grounded in science and evidence for what works, to listen and collaborate with incredibly committed community partners, and to weigh in and speak out for change and equity.

Denver, Colorado

As a pediatrician, Steve Federico, MD found it disheartening to encounter families whose children were ill or in need of preventive care but went without medical services simply because of their inability to pay. One Colorado study shows that children without insurance have greater unmet health care needs, poor patterns of utilization, greater difficulty obtaining medications, and are more likely to lack a medical home. Fortunately, previous studies show that when enrolled in Medicaid or the Children’s Health Insurance Program, children and families exhibit improved access to care and more appropriate patterns of utilization.
In 2006, a group of advocates including Dr Federico worked with state policy makers in Colorado to address the issues of enrollment. The group was called All Kids Covered 2010 and included community advocates, physicians, public health officials, policy experts, and legislators. Dr Federico’s role as a pediatrician was to offer examples from his practice that highlighted the problems resulting from the lack of consistent health coverage. All Kids Covered 2010 used these real-life examples in printed materials as well as legislative testimony. This provided context for policy makers to better understand how these barriers were affecting children and families on a daily basis consistent with the tools of Love/Community and Power/Authority.

The coalition set as its goal to have all children in Colorado covered with some form of health coverage by the year 2010. At that time there were 1.2 million children in the state and approximately 180,000 were uninsured. The estimate was that 120,000 of them were likely eligible for public coverage but were not enrolled because of administrative complexities in the enrollment process, policy barriers, a lack of knowledge, or cultural and language barriers.

The group worked to successfully eliminate many of the administrative and legislative barriers to enrollment over the next 10 years. The net result was cutting the rate of uninsured among children by 50%. Many of the changes required legislative action including such things as eliminating asset testing and adjusting qualifying income levels to coincide with the state’s cost of living. Additional changes included easing the number and frequency of documentation that families had to produce during enrollment. This change allowed delivery systems (especially safety net providers) to enhance their efforts to assist families with enrollment at the site of care. One example of this was where Dr Federico served as the Medical Director, the Denver Health School-Based Health Center (SBHC) program. After this change, the Denver SBHC programs enhanced enrollment and outreach efforts with school officials, parents, and students to identify uninsured families through the school lunch enrollment forms.

Enrolling uninsured children has an enormous effect for their health and for the institutions that care for them—ensuring better access to care and more appropriate utilization among needy children, while relieving safety net providers of some preventable and unreimbursed emergent care and providing reimbursement for previously uncovered populations. Dr Federico used the tools: love of children and his commitment to partnership with others in the coalition, especially schools and SBHCs, power to speak out for change in the public arena, and science to insure more children in their communities, a proven strategy to improve child health and well-being.

**ROCHESTER, NEW YORK**

The Rochester-Monroe County Anti-Poverty Initiative (RMAPI), the local poverty reduction effort in Rochester, New York, began with a request from local political and philanthropic leaders to New York State Governor Andrew Cuomo to improve the health of children in poverty by expanding and integrating evidence-based home visitation and parent support programs, including the medical home. Research, information, and support for this request—the tool of science and knowledge—were provided by the local child advocacy organization, the Children’s Agenda, and pediatrician Jeff Kaczorowski, MD.

The Governor and his team realized, however, that this effort alone would not be enough to significantly improve the persistent problem of child and family poverty in Rochester. Rochester’s child poverty rate is 52%, the highest among comparable-sized US cities. With leadership from the Governor’s office, Assembly Majority Leader Joe Morelle, Mayor Lovely Warren, County Executive Maggie Brooks, Director Leonard Brock, EdD, and Chief Executive Officer Fran Weisberg at the United Way of Greater Rochester, RMAPI was established in 2015 as an unprecedented community-wide effort to reduce poverty in the Rochester region by 50% over the next 15 years. This initiative involves the efforts and input of nearly 1000 people, including more than 200 volunteers on committees and workgroups, more than 800 community members who attended town hall meetings, roundtable discussions, or participated in surveys, and importantly, the active involvement of people this initiative is intended to benefit—individuals affected by poverty. RMAPI workgroups were formed in midyear 2015 to focus on 8 key drivers of poverty: health and nutrition, education, housing, jobs, the justice system, safe neighborhoods, childcare, and transportation. Pediatricians and community leaders, parents, and families shared their real experience of poverty—a key tool in the model for change.

Dr Kaczorowski and Janice Harbin, DDS, Chief Executive Officer of the Anthony Jordan Community Health Center, cochaired the Health and Nutrition Workgroup, which had 25 members, including pediatricians, family practice and internal medicine physicians, community leaders, child health professionals, and individuals affected by poverty. The workgroup developed 4 Key Recommendations for reducing child and family poverty and ameliorating its effects. These included expanding access to healthy foods, improving government policies and procedures at the department of social/human services, community health campuses, and preventing and addressing trauma across generations. Again, a pediatrician and a dentist used their power in the public arena to bring forward the evidence to make a difference for children in their community.

Ultimately, Early Childhood Development and Support was selected as one of 3 initial priorities for RMAPI in part on the basis of the work of the Health and Nutrition Workgroup and its focus on preventing and addressing trauma across generations, in particular. This initial Early Childhood Development and Support recommendation includes ensuring high-quality, affordable, accessible, and flexible childcare that parents need to engage in community, economic mobility, and wellness-related activities, and in-home parent training/home visitation proven to give new parents the skills to succeed as their children’s first teachers.
The implementation strategy for this effort now needs to be developed with specific actions and policy recommendations. However, it is critical to note that RMAPI has decided to move forward with evidence-based approaches, engagement of the community, and with authority and power of government leaders, funders, community leaders, and pediatricians to help families break the cycle of generational poverty and guarantee Rochester’s children’s future.

This approach is generating important initial results. In conjunction with RMAPI and Mayor Warren, the Rochester City School District has recently obtained new New York State funding to expand Pre-K to include all 4-year-olds in the City of Rochester as well as 1000 3-year-olds. Rochester has measured outcomes and quality for its Pre-K programs for 2 decades and has among the highest-quality programs in the United States. In addition, as part of Governor Cuomo’s Upstate Revitalization Initiative process, Rochester has just learned that RMAPI will receive $100 million over the next 5 years to focus on its initial priorities.

These examples highlight key steps for pediatricians as change agents (Table 1). But how do pediatricians learn these skills, and is there a systematic way to teach them?

**The CPTI**

In addition to change being led by pediatricians, over the past 15 years there has also been a strong movement to develop pediatric faculty and educate residents to use these tools to engage community partners in system change. This effort is currently being led by a team at the AAP through the CPTI, including Jeff Kaczorowski, MD; Ben Hoffman, MD; Lisa Chamberlain, MD, MPH; Jeanine Donnelly, MPH; and Katie Plax, MD. This national CPTI work has been supported by several important funders, including the Josiah Macy Jr Foundation, MetLife Foundation, the Doris Duke Charitable Foundation, Missouri Foundation for Health, and the AAP itself.

Using the national infrastructure of pediatric residency programs, CPTI provides grants, educational tools, and

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<th>Table 1. Key Steps on the Path for Pediatricians as Change Agents</th>
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<td>Witness/recognize an injustice to children and families</td>
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<td>Identify an area of passion/enthusiasm</td>
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<td>Review the evidence and gain expertise on the issue</td>
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<td>Build relationships with community and be an engaged partner</td>
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<td>Advocate for what is known according to the evidence and where the identified area of passion lies</td>
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**Figure 2.** Community Pediatrics Training Initiative (CPTI) residency program engagement 2005 to 2015. Ninety residency programs, 158 grants.
mentoring for pediatric faculty and residents to strengthen their community health and advocacy work. Training pediatricians in community health and advocacy prepares future generations of pediatricians to practice medicine with a population health approach and to engage in community-based child health activities throughout their careers. Since 2005, CPTI has formally worked with 90 pediatric institutions and hundreds of faculty, directly affecting training of thousands of pediatric residents (Fig. 2).

Outcomes for CPTI have been extensively evaluated for over a decade by the Women’s and Children’s Health Policy Center at the Johns Hopkins School of Public Health. Numerous publications, issue briefs, and an overview and timeline are available at their Web site (http://www.jhsphs.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/projects/DINE/dine.html).

In addition, a special edition supplement to the journal Pediatrics published in 2005 offers 13 articles and a dozen commentaries by pediatric leaders on methods and examples for pediatricians to be involved in child health issues in their communities in training and in practice (http://pediatrics.aappublications.org/content/115/Supplement_3.toc). Numerous resources, including goals and objectives, sample curricula and activities, advocacy training modules and a guide, evaluation tools, and a toolkit and videos on planning and undertaking community projects, are available at the CPTI Web site (https://www2.aap.org/commpeds/cpti).

On the basis of these outcomes, tools and resources, and on lessons learned over the past decade, CPTI works with pediatricians, departments of pediatrics, and residents to effect Key Drivers of Success (Table 2) to establish their personal and institutional commitment and ability to act

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<th>Table 2. Key Drivers of Success for Community Health and Advocacy Education in Pediatrics</th>
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<td><strong>Key Drivers</strong></td>
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<tr>
<td>1. Identify and strengthen faculty champions who serve as change agents for children</td>
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<td>2. Build an effective team to lead the work, including residents</td>
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<td>3. Develop and sustain authentic community partnerships</td>
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<td>4. Strengthen institutional and departmental leadership support for the program</td>
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<td>5. Enhance the curriculum and educational activities to increase resident competencies</td>
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<td>6. Build capacity and resources to sustain the program</td>
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CPTI indicates Community Pediatrics Training Initiative.

Table 3. American Academy of Pediatrics CPTI Current Efforts

- Programs that address critical community health topics: Grant programs that provide opportunities for residents to engage with families in the community are an invaluable component of training. For example, CPTI is currently supporting collaborations with community partners to effect systems changes to prevent or mitigate the effects of poverty and toxic stress on children.
- Faculty leadership development activities: Providing support and coaching to faculty will prepare them to train residents on how to bridge pediatrics with community health and advocacy. CPTI provides opportunities to be mentored by pediatrician experts through Visiting Professorships and grant programs.
- Regional collaboration: Bringing together community health faculty from multiple programs accelerates advocacy on behalf of children. Identifying collaborative community health projects has the potential to affect a greater number of families, especially those living in poverty. CPTI has supported collaboration in New York, New Jersey, Ohio, and Missouri, among other states.

CPTI indicates Community Pediatrics Training Initiative.
as change agents on behalf of our vulnerable children, including children living in poverty. CPTI does not “pre-
scribe” a curriculum but rather works with faculty and res-
idents to achieve these 6 Key Drivers through coaching and peer-mentoring. It offers support for pediatricians doing this challenging work and helps them to build colleagues and institutional support too. As an example, for the Key Driver of “Develop and sustain authentic community part-
nerships,” CPTI teaches pediatricians how to identify local resources, engage colleagues who have existing partner relationships and share similar passion, conduct effective meetings, and establish partnership goals. Resources in the CPTI portfolio provide ready reference for this work and efforts are encouraged by the guidance of coaches and peers with experience.

On the basis of the well established model of the Califor-
nia Collaborative in Community Pediatrics and Legislative Advocacy, the CPTI has most recently adopted a strategy of facilitating networking and collaboration across pediatric residency programs to build a national infrastructure for pediatricians to address the social determinants of child health. Such state or regional collaboratives have 2 main goals: 1) to strengthen faculty development and resident community health education, and 2) to improve outcomes for children. The Missouri Foundation for Health is supporting 3 pediatric programs in the state through the Missouri Collaborative for Advocacy and Resident Education. Through regular engagement, faculty leaders share their community projects, curriculum resources, and ideas with each other. These activities enhance professional expertise in community health for faculty, strengthen training to better prepare future pediatricians, and build a network of leaders empowered to improve health outcomes for families in their communities (Table 3).

The long-lasting effects of poverty on children and families, and the mission of pediatrics calls us to engage more pediatricians to use these tools and change children’s lives in partnership with communities and families. We hope these examples provide ideas and models for what is possible, and that by describing CPTI and regional collaboratives, pediatricians recognize that supports are available to help them succeed. We also hope academic pediatrics continues to recognize that these efforts are consistent with education, training, research, and patient care core missions of Departments of Pediatrics throughout the country and that more pediatric faculty and residency training programs take up the charge in meaningful and sustainable ways in their communities. Today kids and families deserve better lives—free of poverty, and filled with opportunity for health and well-being. We in pediatrics have a unique role to play in that vision—one that is exciting, fun, and meaningful work for a lifetime.

ACKNOWLEDGMENTS

We thank the leaders and volunteers of the RMAPI for their continued efforts and engagement of pediatricians and child health leaders. Special thanks to the CPTI team and all of those incredible pediatric training programs and community-based organizations who were courageous enough to make system change for kids.

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