"You Get What You Pay For": Resources for Training and Practice in Community Pediatrics Matter

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US children continue to live in communities where failing schools are common, food desserts exacerbate obesity, and violence is endemic, giving rise to the expression that when it comes to health, your zip code dominates your genetic code. The health outcomes of US children and youth are troubling: our infant mortality rate ranks 56th among world countries,[1] homicide is the leading cause of death for African American youth,[2] and, despite a recent decline, our teen birth rate remains the highest in the developed world.[3] Today nearly half of US children live in low-income families and 22% live under the poverty line.[4] Although 4 of 5 physicians acknowledge a need to write prescriptions for their patient's unmet social needs, they simultaneously lament their ability to do so.[5] Addressing these "Millennial Morbidities" in training and in practice remains the context of community pediatrics.[6]

The field of pediatrics is leading in addressing the mismatch between what physicians need to do and currently do. Required training in community health and advocacy[7] to address the root cause of health disparities began in 1999. Reshaping pediatrics to extend beyond the bedside and clinic to incorporate community engagement was prescient, and it was Dr Anne E. Dyson's vision and philanthropy that enabled the evolution. The Anne E. Dyson Community-Based Pediatric Training Initiative invested in 10 pediatric training programs nationwide to develop innovative training models of community engagement.[8,9] Astutely a simultaneous evaluation arm was established to rigorously measure the investment's impact.

Today we learn the answer to the question that the field of community pediatrics has waited 15 years to learn: Does training in community pediatrics change the way a pediatrician practices? The answer is yes. In this issue of *Pediatrics*, Minkovitz et al reveal elevated rates of self-reported participation in community pediatrics by Dyson site graduates compared with age-matched controls (43.6% vs 31.1%, $P < .01$) in "Five Years Later: Community Pediatrics Training Initiative Graduates and Community Involvement." This is particularly important when considered in the context of an ongoing decline in pediatricians' involvement in community engagement between 2004 and 2010.[10]

The Dyson initiative's sustained and significant investment in community pediatric training has "immunized" graduates against the backdrop of waning community involvement nationally, despite the Residency Review Committee requirement for such training in 1999. This brings to mind the adage of "you get what you pay for" on 2 levels.

First, the Dyson Initiative was a significant investment, the likes of which will likely not be replicated. Each Dyson site received $400 000 to $500 000 per year for 5 years, allowing for intensive faculty development, significant technical assistance, and creation of sustained

partnerships between academic pediatric programs and community-based organizations. But the initiative's impact was greater than the programs it funded: it produced a wide range of training models,[11–14] developed leaders in the field, and now has provided definitive evidence of the training's effect. Models working to bring community pediatrics training to scale exist. For example, The California Collaborative has worked with 13 pediatric institutions and residency programs across California over 3 years[15] and the American Academy of Pediatric's Community Pediatrics Training Initiative, successor to the Dyson Initiative, has provided smaller amounts of funding and technical assistance to more than 60 additional pediatric residency programs nationwide in the past 7 years.[16] Despite these efforts, the evidence of an overall decline in community engagement indicates more needs to be done. We now know that investing in community pediatrics training can change how pediatricians practice, but the question remains: who is willing to make the sustained investment required to ensure the pediatrician of the 21st century is working to address growing child health inequality and our most concerning child health outcomes?

The answer lies in health reform and brings us to the second exemplar of "you get what you pay for": when the child health care system begins to reimburse practicing pediatricians for community engaged work, the declining trends of community engagement will likely reverse. The current backdrop of decreasing community engagement between 2004 and 2010 occurred despite continuing high levels of pediatricians reporting child health as their responsibility, instead being ascribed to younger pediatricians having competing priorities (young families and high levels of educational debt) making it difficult to "volunteer." Here exists great promise. The Affordable Care Act incorporates new payment models, including Accountable Care Organizations, where the responsibility shifts from the individual patient level to the health of a defined community. This new paradigm aligns well with community pediatrics. This shift requires bridges be built between academic medical centers, community organizations, and departments of public health: the very nexus where community pediatric expertise exists.[17] In a new system in which effective prevention creates savings, the funds captured could and should support the work of pediatricians engaged in evidence-based community partnerships. It will be important to track pediatricians' community engagement in areas where these models are already in place.[18] This shift will require the leadership of pediatrics, particularly at the level of the states, to go this last mile.

Our time is now. The emerging model of health care delivery, with its focus at the population level, can support community pediatrics and offer the remarkable opportunity to bring to scale the role of pediatricians in practicing to address the social determinants of health and our most concerning child health outcomes. With the significant contribution of Minkovitz et al, we have evidence that training in community pediatrics changes the practice of pediatricians. Thus, now is the time to reimburse pediatricians who do this work. Realization of this transition, moving community pediatrics from a professional aspiration to a defined obligation,[19] will honor the legacy of Anne Dyson in perpetuity.

REFERENCES

1. Central Intelligence Agency. The World Factbook. Country comparison: infant mortality rate. Available at: https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html. Accessed April 10, 2014
2. The Centers for Disease Control and Prevention. Issues, evidence and public health implications of protective factors for youth violence perpetration. Available at: www.cdc.gov/violenceprevention/pub/YV_ProtectiveFactors.html. Accessed April 10, 2014
3. The Centers for Disease Control and Prevention. Prepregnancy contraceptive use among teens with unintended pregnancies resulting in live births — Pregnancy Risk Assessment Monitoring System (PRAMS), 2004–2008. Available at: www.cdc.gov/mmwr/preview/mmwrhtml/mm6102a1.htm?s_cid=mm6102a1_w. Accessed April 10, 2014
4. National Center for Children in Poverty. Child poverty. Available at: www.nccp.org/topics/childpoverty.html. Accessed April 10, 2014
5. Robert Wood Johnson Foundation. Health care's blind side: unmet social needs leading to worse health. Available at: www.rwjf.org/files/research/RWJFPhysiciansSurveyExecutiveSummary.pdf. 2011. Accessed May 13, 2014
6. Palfrey JS, Tonniges TF, Green M, Richmond J. Introduction: Addressing the millennial morbidity—the context of community pediatrics. *Pediatrics*. 2005;115(suppl 4):1121–1123
7. Residency Review Committee for Pediatrics. ACGME Program Requirements for Graduate Medical Education in Pediatrics. Available at: www.acgme.org/acgmeweb/tabid/143/ProgramandInstitutionalAccreditation/MedicalSpecialties/Pediatrics.aspx. Accessed May 13, 2014
8. Nader PR, Kaczorowski J, Benioff S, Tonniges T, Schwarz D, Palfrey J; Dyson Community Pediatrics Network. Education for community pediatrics. *Clin Pediatr (Phila)*. 2004;43(6):505–521
9. Palfrey JS, Hametz P, Grason H, McCaskill QE, Scott G, Chi GW. Educating the next generation of pediatricians in urban health care: the Anne E. Dyson Community Pediatrics Training Initiative. *Acad Med*. 2004;79(12):1184–1191
10. Minkovitz CS, Grason H, Solomon BS, Kuo AA, O'Connor KG. Pediatricians' involvement

in community child health from 2004 to 2010. *Pediatrics*. 2013;132(6):997–1005

11. Pan RJ, Littlefield D, Valladolid SG, Tapping PJ, West DC. Building healthier communities for children and families: applying asset-based community development to community pediatrics. *Pediatrics*. 2005;115 (suppl 4):1185–1187
12. Kaczorowski J, Aligne CA, Halterman JS, Allan MJ, Aten MJ, Shipley LJ. A block rotation in community health and child advocacy: improved competency of pediatric residency graduates. *Ambul Pediatr*. 2004;4 (4):283–288
13. Willis E, Frazier T, Samuels RC, Bragg D, Marcdante K. Pediatric residents address critical child health issues in the community. *Prog Community Health Partnersh*. 2007;1(3):273–280
14. Sidelinger DE, Meyer D, Blaschke GS, et al. Communities as teachers: learning to deliver culturally effective care in pediatrics. *Pediatrics*. 2005;115(suppl 4):1160–1164
15. Chamberlain LJ, Wu S, Lewis G, et al; California Community Pediatrics and Legislative Advocacy Training Collaborative. A multi-institutional medical educational collaborative: advocacy training in California pediatric residency programs. *Acad Med*. 2013;88(3):314–321
16. Community Pediatrics Training Initiative. Current grantees. Available at: http://www2.aap.org/commpeds/cpti/grantees.htm. Accessed April 10, 2014
17. Keller DM, Chamberlain LJ. Children and the Patient Protection and Affordable Care Act: Opportunities and Challenges in an Evolving System. *Acad Pediatr*. 2014;14(3): 225–233
18. The Centers for Medicare and Medicaid Innovation (CMMI) Health Care Innovation Award. Available at: www.partnersforkids.org/hcia/. Accessed May 13, 2014
19. Gruen RL, Pearson SD, Brennan TA. Physician-citizens—public roles and professional obligations. *JAMA*. 2004;291(1):94–98

HAWAIIAN WEAR: *I lived in Hawaii for several years. While some men wore jackets and ties to business meetings, most wore Hawaiian wear, particularly shirts known as Aloha shirts. I liked the Aloha shirts and over the years purchased many. I have shirts with bright or muted colors, floral prints, beach scenes, and abstract ocean themed designs. Since moving to Vermont, I have not had much occasion to wear any of them. I sporadically try to institute Aloha Friday in the courses I teach, but the response from the students has been modest to say the least. However, as reported in* The Wall Street Journal *(Fashion: April 4, 2014), the Aloha shirt has suddenly become quite fashionable. While the shirts can still be found in tourist (and other) shops in Hawaii, they can be also be found in department stores and upscale clothing boutiques across the country.*

The shirts were originally designed as souvenirs for tourists to the Hawaiian Islands in the 1930s. After World War II, their popularity soared. The 1940s and 1950s are considered the high point of Aloha shirt design and wear. However, the principle material (rayon) and loud floral patterns used in the shirts soon fell out of favor and remained so until the late 1960s when Hawaiians began to wear Aloha shirts on casual Fridays. The custom soon spread to other parts of the country, most famously California. The shirts were more often associated with beach parties until recently, when fashion designers picked up on a trend and began introducing new designs or modifying classic motifs from the 1950s. There is even now a brisk market for vintage shirts with some costing thousands of dollars. While I doubt that any of my shirts tucked deep in my closet are worth much at all, I did enjoy wearing them and may have to dust them off. Who knows, when I wear my shirts, maybe someone will think I am a trendsetter at the crest of a fashion wave in that tropical paradise where I live — Vermont.

Noted by WVR, MD

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