

Five-Year Follow-up of Community Pediatrics Training Initiative

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KEY WORDS

community health services, pediatrics/manpower, child advocacy/education

ABBREVIATIONS

AAP—American Academy of Pediatrics

CPTI—Community Pediatrics Training Initiative

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WHAT'S KNOWN ON THIS SUBJECT: Compared with their peers, pediatric residents who report exposure to community settings anticipate greater future community involvement at the end of training. The impact of community pediatrics training on actual future community involvement is not known.



WHAT THIS STUDY ADDS: Pediatricians exposed to enhanced community pediatrics training during residency report greater participation in community activities and greater related skills than their peers nationally.

abstract



OBJECTIVE: To compare community involvement of pediatricians exposed to enhanced residency training as part of the Dyson Community Pediatrics Training Initiative (CPTI) with involvement reported by a national sample of pediatricians.

METHODS: A cross-sectional analyses compared 2008–2010 mailed surveys of CPTI graduates 5 years after residency graduation with comparably aged respondents in a 2010 mailed national American Academy of Pediatrics survey of US pediatricians (CPTI: $n = 234$, response = 56.0%; national sample: $n = 243$; response = 59.9%). Respondents reported demographic characteristics, practice characteristics (setting, time spent in general pediatrics), involvement in community child health activities in past 12 months, use of ≥ 1 strategies to influence community child health (eg, educate legislators), and being moderately/very versus not at all/minimally skilled in 6 such activities (eg, identify community needs). χ^2 statistics assessed differences between groups; logistic regression modeled the independent association of CPTI with community involvement adjusting for personal and practice characteristics and perspectives regarding involvement.

RESULTS: Compared with the national sample, more CPTI graduates reported involvement in community pediatrics (43.6% vs 31.1%, $P < .01$) and being moderately/very skilled in 4 of 6 community activities ($P < .05$). Comparable percentages used ≥ 1 strategies (52.2% vs 47.3%, $P > .05$). Differences in involvement remained in adjusted analyses with greater involvement by CPTI graduates (adjusted odds ratio 2.4, 95% confidence interval 1.5–3.7).

CONCLUSIONS: Five years after residency, compared with their peers, more CPTI graduates report having skills and greater community pediatrics involvement. Enhanced residency training in community pediatrics may lead to a more engaged pediatrician workforce. *Pediatrics* 2014;134:83–90

Recognition of the critical roles of environmental, social, and political factors in shaping the health and well-being of children has heightened the need for pediatricians to “merge their traditional clinical skills with public health, population-based approaches to practice and advocacy.”¹ Such an approach requires fostering community partnerships among pediatricians, public health, school districts, child welfare agencies, and other community organizations and is essential to promoting health in the context of families, schools, and communities.¹ To equip pediatricians with the requisite skills for assuming these responsibilities, many residency programs have developed curricula focused on community pediatrics.^{2–6} Curricular components have included community-based block rotations, resident projects, and integration of community pediatrics within other educational rotations; among the features that support these structured experiences have been community networking and sustained partnerships, skill-building activities, and exposure to community health outside of hospitals and private practice settings.⁷ These training efforts also are consistent with the current requirements of the Accreditation Council on Graduate Medical Education. As of 2013, the pediatric Residency Review Committee requires a minimum of 2 ambulatory educational units that include elements of community pediatrics and child advocacy.⁸

The influence of residency training on subsequent involvement in community pediatrics is not well understood. Nader, in 2003, reported that residency training in school health was associated with increased involvement in school settings once physicians were established in practice⁹; however, the relevance of those findings to contemporary practice is not known because 71% of study participants completed

residency before 1989. In a 2010 national survey of pediatricians, respondents who reported previous community pediatrics training also reported increased community involvement, broadly defined across an array of settings and activities; however, in this study, training could have occurred before, during, or after residency.¹⁰ Long-standing efforts such as the American Academy of Pediatrics’ (AAP) Community Access to Child Health initiative and the AAP and the Maternal and Child Health Bureau’s Healthy Tomorrows program have supported the engagement of established clinicians in community child health activities.^{11,12} However, given the need to balance competing educational objectives and Accreditation Council on Graduate Medical Education requirements during residency, it is important to understand the effect of enhanced training in residency.

Emerging findings from the national evaluation of the Dyson Community Pediatrics Training Initiative (CPTI) suggest that residency training may influence subsequent engagement in community activities. Goldshore et al (2014) observed that exposures to community settings during residency are associated with expectations for future involvement as reported at the end of residency.¹³ Solomon et al (2012) reported that among pediatricians who trained at programs funded by the Dyson CPTI, those who trained at programs emphasizing population level advocacy reported greater use of strategies to promote community child health one year after completing residency.¹⁴ However, no comparison data were included in the CPTI graduate findings reported to date nor have findings beyond 1 year postresidency been available previously.

The objective of this study is to compare community involvement of pediatricians exposed to enhanced residency

training as part of the Dyson CPTI 5 years after completing residency with involvement reported by a national sample of pediatricians.

METHODS

Sample

The data used in this study are from the evaluation of the Dyson CPTI and a 2010 Periodic Survey conducted by the AAP. Eligible CPTI participants comprised graduates who completed residency training at 1 of 10 CPTI-funded programs in the years 2003 to 2005 and had a valid mailing address 5 years after completing residency. Six CPTI sites were funded for 5 years beginning in 2000, and an additional 4 sites were funded for 5 years beginning in 2002. Sites included Columbia University in partnership with Harlem Hospital Center; Children’s Hospital of Philadelphia; Children’s Hospital of Wisconsin/Medical College of Wisconsin; University of California, San Diego in partnership with San Diego Naval Medical Center; University of Hawaii; University of Rochester; University of California, Davis; University of Florida, Jacksonville; Indiana University; and the University of Miami. Six participants of those initially enrolled in the evaluation withdrew, for a total of 416 eligible.

Eligible national comparison participants were pediatricians ≤ 39 years who completed the AAP Periodic Survey 77 in 2010 and who were not Specialty Fellows (certified by a board other than pediatrics). The AAP conducts Periodic Surveys of its members on topics of importance to pediatricians 3 or 4 times per year. Each survey uses a unique random sample of members of the AAP. Periodic Survey number 77 included questions on involvement with community child health.^{10,15} The final sample of AAP members was 243.

Data

Three data sources informed these analyses: a demographic survey completed by all CPTI residents at the start of training (or when they transferred into a CPTI residency program), a survey of CPTI graduates completed 5 years after residency training, and a national survey of pediatricians conducted by the AAP. The resident demographic survey included gender, race/ethnicity, and date of birth; the Periodic Survey included gender, race/ethnicity, and year of birth. The mailed survey of CPTI graduates was fielded 5 years after completing residency training (fall of subsequent year). Both the 10-page CPTI survey and the 8-page AAP Periodic Survey assessed practice characteristics (setting: urban inner city, urban not inner city, suburban, or rural; % time spent in general pediatrics; part-time vs full-time employment; primary practice setting; whether they were practicing in same community as residency/fellowship; patient insurance; and English proficiency of patients) and personal characteristics (whether they had children).

Respondents to the CPTI and AAP surveys reported on the degree to which they viewed themselves as responsible for improving the health of children (other than those in their practice) in their home or practice community (4-point Likert scale, “not at all” to “very”) and whether they had contact with a person who provides guidance and advice about community pediatrics. Both surveys included a question asking whether they had participated in a professional capacity in any community-based activities in the past 12 months. These surveys also included a question about the use of 7 strategies to influence child health in their home or practice community: serving on community boards; participating on child health committees; working with a coalition; educating legislators; communicating with the media; addressing

parent, teacher, or other community groups; and working with the local AAP chapter.

Respondents indicated whether they had used 6 skills in the past year and their skill level (4-point Likert scale, “not at all” to “very”) for each; skills included locating and accessing resources for individual children, identifying community needs, using population-level data to understand the determinants and consequences of children’s health and illness, working as a member of an interdisciplinary team to promote children’s health in the community, speaking publicly on behalf of children’s health, and using computers/Internet to find information about child health policy and related activities.

For the CPTI survey, up to 5 mailings (work or home address) were sent, and a \$2 incentive was included in the initial mailing. The 2010 Periodic Survey was sent to 1622 active AAP members, and a \$2 incentive was included with the first mailing; the original and 6 follow-up mailings to nonrespondents were conducted from June through November 2010. Nine hundred sixty-eight completed questionnaires were received (response rate, 59.9%) among which 243 respondents were ≤ 39 years of age.

Survey content for both surveys was informed by literature reviews, related AAP Periodic Surveys, an annual survey of CPTI residents, and input from the DINE Advisory Committee for the CPTI survey. For the Periodic Survey, additional input was provided from a national advisory group with expertise in community pediatrics, the AAP Community Pediatrics Action Group, and members of the Council on Community Pediatrics.

Human subjects approval was obtained from the Committee on Human Research at Johns Hopkins Bloomberg School of Public Health.

Analyses

Analysis on both surveys included postresidency pediatricians. The final sample included 234 pediatricians in the CPTI survey (56.0% response) and 243 pediatricians in the Periodic Survey 77 (59.9% response). Group assignments were retained regardless of the extent of exposure to community pediatrics training. We used χ^2 analysis and Wilcoxon Mann-Whitney tests to compare responses between surveys regarding personal and practice characteristics, community involvement, and use of strategies to influence community child health. Logistic regression assessed the independent contributions of personal and practice characteristics and residency exposure to CPTI with participation using factors associated with participation in the literature or statistically different ($P < .10$) between the CPTI and Periodic Survey respondents. We also used χ^2 analysis to compare use and level of skills in community health activities between CPTI and Periodic Survey participants and logistic regression to assess the independent contributions of the variables noted earlier to level of skills. Analyses were conducted using Stata statistical software, version 11 (College Station, TX).

RESULTS

Of the 234 CPTI respondents, 75 completed residency in 2003, 62 in 2004, and 97 in 2005. The number of participants per residency program varied from 3 to 71, with 207 participants training at programs that began receiving CPTI funds starting in 2000 and 27 participants training at programs that began receiving funds in 2002.

To assess potential response bias, respondents and nonrespondents were compared with regard to available variables in each data set. In the Periodic Survey, no significant differences were found between respondents and

nonrespondents for the subset ≤ 39 years with regard to region of the country (Northeast 21.0%, Midwest 21.8%, South 37.6%, West 19.6%) or gender (73.4% female), whereas the median age of respondents was 1 year younger (35.0 vs 36.0, $P = .01$).

In the CPTI survey, respondents and nonrespondents were comparable with regard to median age (35.4 years) and the percentages who were underrepresented in medicine (9.4%), foreign medical graduates (11.4%), and had medical school loans (79.9%). More CPTI respondents relative to nonrespondents had contact with a person who provides guidance during medical school (75.7% vs 63.2%, $P = .004$), and a larger percentage of CPTI respondents were female (66.5 vs 62.9%, $P = .03$).

Personal and practice characteristics were compared among respondents in both surveys (Table 1). A greater percentage of CPTI participants had children (77.8% vs 67.9%, $P = .015$), and a smaller percentage reported moderate or substantial responsibility for improving the health of children in their communities (71.4% vs 81.8%, $P = .008$). The samples were comparable with regard to gender, racial/ethnic underrepresentation in medicine, marital status, and having contact with a person who provides guidance and advice about community child health activities ($P > .05$). Types of practices, practice settings, and percent time spent in general pediatrics also were similar as were patient characteristics with regard to insurance and English proficiency.

More CPTI than Periodic Survey respondents reported participating in activities to promote child health in the past 12 months (43.6% vs 31.1%, $P = .005$) and comparable percentages reported use of ≥ 1 strategies to influence community child health (52.2% vs 47.3%, $P = .29$, Table 2). The most commonly reported

strategies were addressing parent, teacher, or other community groups (27.1%) followed by participating on a child health committee or project (13.6%) and meeting with legislators (13.0%). We conducted a sensitivity analysis of group differences using alternate cutoffs for the number of strategies and found comparable percentages using ≥ 3 (12.6%) and ≥ 4 strategies (6.9%) and a larger percentage of CPTI respondents using ≥ 2 strategies (28.6% vs 20.6%, $P = .041$). In unadjusted analyses, being moderate/substantially responsible for community child health, spending $\geq 50\%$ time in general pediatrics, and participating in CPTI were associated with participation in community activities in the past year (Table 3). In adjusted analyses, being moderate/substantially responsible for community child health (odds ratio 2.57; 95% confidence interval 1.89–3.51) and participating in CPTI (odds ratio 2.37; 95% odds ratio 1.50–3.74) remained associated.

In both surveys, the most commonly used community child health skills were locating and accessing resources, and using computers and the Internet to find information about child health policy and related activities (Table 4). CPTI and Periodic Survey participants reported comparable use of community child health skills except a larger percentage of Periodic Survey respondents reported using computers/Internet to find information about child health policy and related activities (77.4% vs 68.7%, $P = .037$; Table 4). CPTI participants reported greater skill level in 4 of 6 activities (locate and access community resources for individual children, identify community needs, use population data to understand determinants and consequences of children's health and illness, and use computers and Internet to find information about child health policy and related activities;

each $P < .05$). The finding of greater skill level among CPTI participants was observed for 4 activities (not speaking publically or use computers) in multivariate models (Supplemental Table 5).

DISCUSSION

Our study indicates that 5 years after residency, more CPTI graduates relative to their peers, report greater skills in engaging with their communities and involvement in community child health activities. To our knowledge, this is the first study to assess whether enhanced community pediatrics training during residency influences community involvement several years after residency completion. Because most pediatricians are not fully established in their careers 5 years after graduation, our finding suggests that physicians may apply heightened skills and contribute to population health efforts earlier in their careers. This finding has particular relevance because the Affordable Care Act requires community prevention roles for providers and practices. As articulated in the Joint Principles for Accountable Care Organizations, a key principle of Accountable Care Organizations is "a commitment to improving the health of the population served through programs and services that address needs identified by the community."¹⁶

The finding of increased participation of CPTI graduates relative to their peers in community child health activities is notable given changes taking place in all pediatrics residency programs during this initiative and the AAP's renewed commitment to community pediatrics¹ and allocation of training resources to a broad array of programs (eg, CPTI toolkit, legislative advocacy training, visiting professorships). Moreover, many pediatric residency programs, in addition to those funded through CPTI, have established innovative curricula focused on promoting community child health.^{3,4} The

differences in participation, although modest, are also intriguing because the CPTI intervention did not directly address additional recognized barriers to community involvement such as employers' focus on clinical productivity and demographic shifts in the workforce with more pediatricians working part time and balancing work and other responsibilities.^{10,17}

Greater involvement by CPTI graduates was noted despite the Periodic Survey respondents reporting a greater sense of responsibility for community child health, a characteristic previously shown to be associated with community involvement.¹⁰ Whether social desirability differentially influenced reports regarding the extent of responsibility is unknown; perhaps the frame of reference for displaying responsibility was higher among CPTI graduates who trained at programs with heightened visibility of faculty and peers engaged in community pediatrics. Although comparable percentages of CPTI and Periodic Survey respondents reported using ≥ 1 strategies to influence child health and using 5 of 6 skills, higher self-perceived skill levels among CPTI graduates may have contributed to greater involvement. It is possible that enhanced skills (eg, identifying community needs) contributed to increased efficiency, personal fulfillment, or positive reinforcement by community partners with whom pediatricians collaborated. The smaller percentage of CPTI graduates who reported using the Internet to find information about child health policy may reflect access to other sources of information or decreased perceived need to locate such information because of previous interactions and familiarity with community organizations.

Our finding of heightened involvement by CPTI graduates relative to their peers is not likely explained by the matching of

TABLE 1 Personal and Practice Characteristics, *n* (%)

Characteristics	Dyson CPTI (<i>n</i> = 234)	AAP Periodic Survey (<i>n</i> = 243)	<i>P</i>
Personal characteristics			
Gender, female	158 (66.7)	181 (74.5)	.06
Underrepresented in medicine ^a	26 (11.2)	18 (7.5)	.18
Age, median y (SD)	35.5 (3.0)	35.0 (2.8)	.001
Married	207 (50.2)	205 (49.8)	.12
Has children	182 (77.8)	165 (67.9)	.02
Responsibility for child health			.008
High (moderate/substantial)	165 (71.4)	198 (81.8)	
Low (not at all/a little)	66 (28.6)	44 (18.2)	
Contact with person who provides guidance and advice about community child health			.50
Yes	103 (44.4)	30 (40.0)	
No	129 (55.6)	45 (60.0)	
Practice characteristics			
Type of practice			.10
Solo practice	5 (3.9)	13 (5.4)	
Group practice	77 (39.1)	102 (42.2)	
HMO/nongovernmental hospital/clinic	40 (19.7)	50 (20.7)	
Medical school or parent university	60 (23.0)	45 (18.6)	
Nonprofit community health center	5 (3.1)	9 (3.7)	
City/county/state/federal hospital or clinic	14 (5.5)	11 (4.6)	
Other	15 (5.9)	12 (5.0)	
Practice setting			.14
Rural	9 (4.2)	19 (8.0)	
Suburban	77 (35.6)	94 (39.3)	
Urban, not inner city	59 (27.3)	66 (27.6)	
Urban, inner city	71 (32.9)	60 (25.1)	
Same community as residency/fellowship			.88
Yes	82 (38.1)	87 (38.8)	
No	133 (61.9)	137 (61.2)	
>50% in general pediatrics			.06
Yes	128 (59.3)	163 (67.6)	
No	88 (40.7)	78 (32.4)	
Employment status			.07
Part time	52 (22.4)	72 (29.9)	
Full time	180 (77.6)	169 (70.1)	
Insurance (median %)			
Private	49	50	.71
Public/TRICARE	50	50	.71
Uninsured	2	3.5	.64
Limited English proficiency (median %)	10	10	.89

HMO, health maintenance organization.

^a Includes black/African American, Native Hawaiian/other Pacific Islander, American Indian/Alaska Native, and Hispanic/Latino.

individuals with underlying community interests into programs with a greater orientation toward community pediatrics. First, the CPTI-funded programs varied with regard to the extensiveness of preexisting community pediatrics curricula, partnerships with community agencies, orientation toward population-level and individual-level advocacy,¹⁴ and the degrees to which generalist and specialist pediatrician faculty engaged in community pediatrics and

encouraged similar involvement among residents.¹⁸ Second, more than one-third of the CPTI sample in this study matched at residency programs before knowing that CPTI was being implemented given the short turnaround between notice of award and program startup; residents' varying previous expectations for program emphasis on community pediatrics was confirmed in key informant interviews conducted at each site. Third, expectations for involvement

TABLE 2 Involvement in the Past 12 Months and Use of Strategies to Influence Child Health, *n* (%)

	Dyson CPTI (<i>n</i> = 234)	AAP Periodic Survey (<i>n</i> = 243)	<i>P</i>
Participation in activities to promote child health in community in past 12 mo			.005
Yes	102 (43.6)	75 (31.1)	
No	132 (56.4)	166 (68.9)	
Use of ≥1 strategies to influence child health ^a			.29
Yes	117 (52.2)	115 (47.3)	
No	107 (47.8)	128 (52.7)	

^a Includes serving on community boards; participating on child health committees; working with a coalition; educating legislators; communicating with the media; addressing parent, teacher, or other community groups; and working with the local AAP chapter.

in community settings decline over the course of residency and are influenced by exposures during residency.¹³

There are several possible explanations for the comparability in self-reported use of skills and the dissimilarity with regard to skill level between the 2 groups. First, clinicians' attempting to use skills may confront similar barriers (eg, unfavorable practice environment, personal demands outside of work) regardless of previous training, making use of skills comparable. Second, there may be comparability in reported use of skills if those responding to the Periodic Survey are highly invested in community pediatrics (hence choosing to complete a survey on the topic); this could make their use of skills approximate that reported by those with formal training in residency. Third, with regard to reported skill-level differences, those exposed to formal training may have a different perception of skills and may realize that their skill level is higher

than that of peers without training. Alternatively, those exposed to formal training at residency programs receiving 5 years of extramural funding may have provided socially desirable responses, thereby inflating their reported skills.

Several limitations are noted. First, selection bias may have increased the participation of those interested in community pediatrics. However, we do not suspect differential bias in the 2 groups because both surveys focused exclusively on community pediatrics. Overall participation in the surveys is consistent with that of past national surveys of pediatricians, for which respondent bias has not been observed.¹⁹ Second, social desirability may have increased reporting of involvement in community pediatrics and in self-reported skill levels. However, we again have no reason to suspect differential reporting, and in both surveys, less than half of respondents

reported involvement in the past 12 months. It is possible that those who trained at CPTI-funded programs felt obligated to report recent community involvement given previous training and visibility of community pediatrics during residency; however, the passage of time since residency, administration of surveys by an independent evaluation team, and sharing of results only in aggregate with participating programs make this less likely. Third, the full array of community child health strategies and skills were not included; however, we queried participants on those that have previously been commonly reported,^{20,21} and items were comparable in the 2 surveys. Finally, we lack information about the extent and type of community pediatrics training experienced by Periodic Survey respondents; we do know that among Periodic Survey respondents ≤39 years, 51.9% reported receipt of community pediatrics training during residency. In contrast, 96% of CPTI participants report some involvement in ≥1 community settings during residency (data available on request). Although we are unable to definitively attribute heightened involvement of CPTI graduates during residency to enhanced exposures during residency, their higher reported skill levels is consistent with receipt of enhanced training.

CONCLUSIONS

Enhanced participation of Dyson CPTI residents in community child health activities 5 years after residency training reinforces the notion that structured, formal training and experiential learning influence the skills and practices of pediatricians. It is likely that for pediatric residents, exposure to community settings and mentoring in community child health activities during training have an impact on involvement posttraining. The approach of

TABLE 3 Characteristics Associated With Participation in Community Activities 5 Years After Residency

	Bivariate OR (95% CI)	Multivariate OR (95% CI)
Personal characteristics at end of residency		
Gender, female	1.15 (0.76–1.73)	1.14 (0.71–1.83)
Underrepresented in medicine ^a	1.30 (0.69–2.44)	0.83 (0.40–1.73)
Has children	1.00 (0.66–1.52)	0.91 (0.56–1.48)
Age	1.02 (0.96–1.10)	1.03 (0.95–1.11)
Extent of responsibility for child health	2.20 (1.68–2.87)	2.57 (1.89–3.51)
Practice characteristics		
Setting (rural/not rural)	1.51 (0.70–3.26)	1.10 (0.45–2.65)
General pediatrics ≥50%	1.53 (1.02–2.29)	1.44 (0.90–2.29)
Residency exposure		
Dyson CPTI participant	1.71 (1.17–2.49)	2.37 (1.50–3.74)

CI, confidence interval; OR, odds ratio.

^a Includes black/African American, Native Hawaiian/other Pacific Islander, American Indian/Alaska Native, and Hispanic/Latino.

TABLE 4 Use and Level of Skills Related to Community Child Health, *n* (%)

	Dyson CPTI (<i>n</i> = 234)	AAP Periodic Survey (<i>n</i> = 243)	<i>P</i>
Use of skill in community health activities			
Locate and access community resources for individual children			.76
Yes	165 (74.0)	173 (75.2)	
No	58 (26.0)	57 (24.8)	
Identify community needs			.23
Yes	64 (28.8)	78 (34.1)	
No	158 (71.2)	151 (65.9)	
Use population data to understand determinants and consequences of children's health and illness			.62
Yes	63 (28.3)	60 (26.2)	
No	160 (71.7)	169 (73.8)	
Speak publically on behalf of children's health			.12
Yes	51 (22.7)	38 (16.9)	
No	174 (77.3)	187 (83.1)	
Work as a member of an interdisciplinary team/participate in team building to promote children's health in the community			.28
Yes	69 (30.8)	60 (26.2)	
No	155 (69.2)	169 (73.8)	
Use computers/Internet to find information about child health policy and related activities			.04
Yes	156 (68.7)	178 (77.4)	
No	71 (31.3)	52 (22.6)	
High (moderately/very) vs low (not at all/minimal) skill in community health activities			
Locate and access community resources for individual children			.02
Yes	137 (71.4)	119 (60.1)	
No	55 (28.6)	79 (39.9)	
Identify community needs			.02
Yes	59 (41.6)	45 (29.0)	
No	83 (58.4)	110 (71.0)	
Use population data to understand determinants and consequences of children's health and illness			.01
Yes	61 (41.8)	41 (28.1)	
No	85 (58.2)	105 (71.9)	
Speak publically on behalf of children's health			.08
Yes	80 (55.2)	60 (44.8)	
No	65 (44.8)	74 (55.2)	
Work as a member of an interdisciplinary team/participate in team building to promote children's health in the community			.55
Yes	154 (81.9)	159 (79.5)	
No	34 (18.1)	41 (20.5)	
Use computers/Internet to find information about child health policy and related activities			.001
Yes	98 (62.8)	61 (43.3)	
No	58 (37.2)	80 (56.7)	

engaging residents, offering structured, coordinated community experiences with clearly articulated goals and objectives, and the building of strong community partnerships likely contribute to enhanced skills and career activities in community child health.⁷ Longitudinal analyses are ongoing to examine the independent role of training over time in influencing career trajectories of CPTI participants.

Community-based leadership by pediatricians is becoming increasingly

important, particularly with implementation of the ACA. The ACA will promote innovations and redesign of the health care system; however, adult-centered redesigns may inadvertently threaten existing community-based systems of care for children. Pediatricians trained in community engagement and leadership are uniquely poised to take on these challenges and advocate for the special requirements of children and their families.

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