Pediatricians Contributing to Poverty Reduction Through Clinical-Community Partnership and Collective Action: A Narrative Review

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Abstract

Poverty affects child health and well-being in short- and long-term ways, directly and indirectly influencing a range of health outcomes through linked social and environmental challenges. Given these links, pediatricians have long advocated for poverty reduction in both clinical settings and society. Pediatricians and others who work in pediatric settings are well-suited to address poverty given frequent touchpoints with children and families and the trust that develops over repeated encounters. Many pediatricians also recognize the need for cross-sector engagement, mobilization, and innovation in building larger collaborative efforts to combat the harmful effects of poverty. A range of methods, like co-design, community organizing, and community-engaged quality improvement, are necessary to achieve measurable progress. Moreover, advancing meaningful representation and inclusion of those from underrepresented racial and ethnic minority groups will augment efforts to address poverty within and equity across communities. Such methods promote and strengthen key clinical-community partnerships poised to address poverty's upstream root causes and its harmful consequences downstream. This article focuses on those clinical-community intersections and cross-sector, multi-disciplinary programs like Medical-Legal Partnerships, Medical-Financial Partnerships, clinic-based food pantries, and embedded behavioral health services. Such programs and partnerships increase access to services difficult for children living in poverty to obtain. Partnerships can also broaden to include community-wide learning networks and asset-building coalitions, poised to accelerate meaningful change. Pediatricians and allied professionals can play an active role; they can convene, catalyze, partner, and mobilize to create solutions designed to mitigate the harmful effects of poverty on child health.

Keywords: clinical-community partnership; poverty; pediatrics; social determinants of health

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What's New

Pediatricians and their partners can help to address poverty by working collaboratively. This narrative review includes strategies to bolster collective action and facilitate progress in the direction of solutions designed to mitigate the ill effects of poverty on child health outcomes..

What This Narrative Review Adds

This narrative review introduces methods pediatricians can use to build and sustain clinical-community approaches that address child poverty. Examples of partnerships and interventions, inside and outside clinical settings, are provided. Finally, challenges to and opportunities for continued progress are outlined.

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POVERTY DISPROPORTIONATELY AFFECTS children, particularly in communities of color. This reflects known connections between poverty and the social determinants of health, including structural racism.[1] The coronavirus disease 2019 (COVID-19) pandemic has magnified the effects of poverty and increased related risks like social isolation, unemployment, food insecurity (FI), and housing instability.[2] Such social and environmental challenges affect child health in short- and long-term ways.

Health and poverty are interrelated. Therefore, the role of medical professionals as advocates for poverty reduction cannot be overemphasized. Advocacy is embedded within the professional legacy of pediatricians. Dr Abraham Jacobi, the "Father of American Pediatrics," voiced a sophisticated understanding of the intersection of pediatrics, civic engagement, and community activism.[3] Dr Jacobi leveraged his platform to share a compelling vision for child health, where pediatricians actively contribute to the mitigation of poverty's ill effects.

Dr Jacobi's influence persists. In the last decade, pediatricians and partnered child health advocates have emphasized the importance of promoting health by addressing poverty.[4] Both the Academic Pediatric Association and the American Academy of Pediatrics have deemed poverty reduction as preventive medicine.[4,5] Embedded within this call is the realization that progress requires collective action and innovation. Currently, the COVID-19 pandemic provides an instructive account of how pediatricians can both lead and partner with multi-sector coalitions to combat complex, multifaceted challenges.

We are positioned to shape initiatives relevant to child health. We can, collectively, highlight the need for cross-sector engagement, mobilization, and innovation to extend from COVID-19 to other long-standing, virulent pathogens like poverty and structural racism. We are part of larger, cohesive efforts to combat societal ills, working in partnership with community organizations and families. These integrated efforts enable a re-envisioning of existing systems, facilitating a results-oriented approach to meeting child and family needs. We see meaningful progress within clinical settings and communities where health and disease occur.[2] Here, we highlight such progress, first introducing methods used to build and sustain clinical-community collaborations to address poverty. We then provide examples of poverty-reducing efforts deployed inside and outside of clinical settings. We close by considering tensions that challenge action, and future steps we might collectively take to accelerate progress.

METHODS TO BUILD AND SUSTAIN POVERTY-RESPONSIVE ACTIONS

In this section, we discuss strategies for building cross-sector partnerships targeting poverty-related needs and health risks, approaches that move upstream to confront poverty's root causes.

CLINICAL-COMMUNITY PARTNERSHIP DEVELOPMENT

Clinical settings, like pediatric primary care practices, are frequent touchpoints for children and families. Such settings can be leveraged to deliver resources and interventions from or informed by community partners. Optimal clinical-community partnership development requires alignment and strategic planning to achieve desired outcomes and sustainability. Teams developing partnerships will be stronger if they are assembled with intentional and

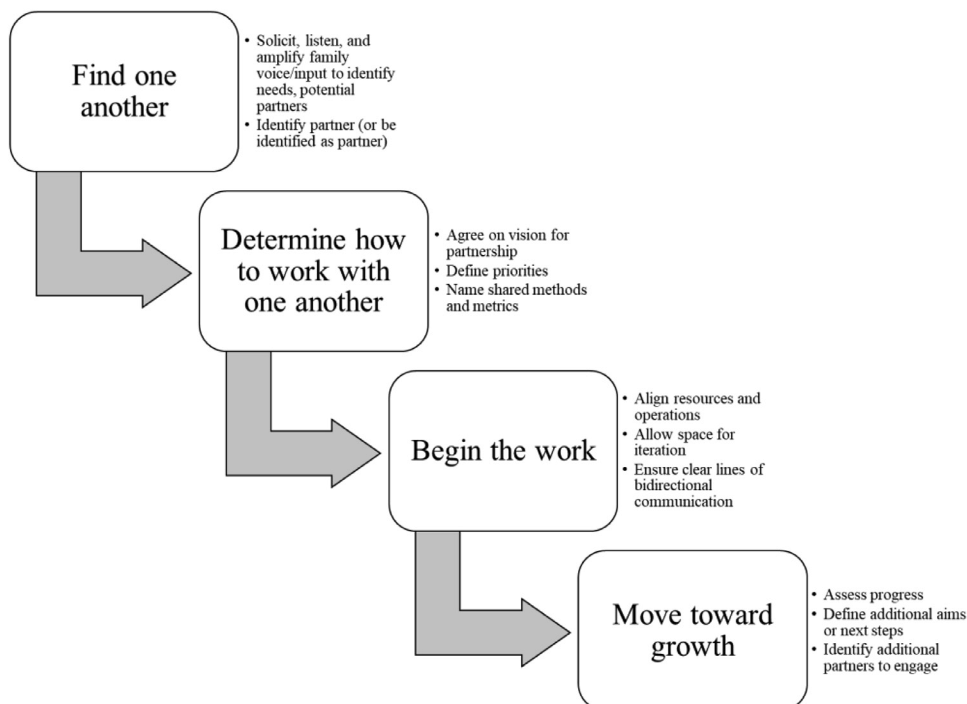

Figure 1. *Proposed steps for clinical-community partnership development and growth. Adapted from Henize et al. (2015).[6]*

meaningful inclusion of diverse voices (eg, that of patients or families). Then, we suggest a stepwise approach to partnership development, understanding that staging may not always be linear (Fig. 1).[6] This approach is grounded in our own collective experiences, distilled to the steps described below.

First, the team must identify a partner or coalition of partners. A horizon scan can objectively determine "who" is doing "what" and "how" across a community. Families, as active team members, must inform the identification of partners based on specific risks or challenges faced. Discussions with families may also highlight partners and organizations that have high on-the-ground value. As teams seek out partners, those embedded within the pediatric setting must be prepared to be sought out themselves.

Once identified, partners must together determine how they will work with one another. When possible, partnerships should align with clinical and community priorities to ensure collaboration enhances each partner's capacity and provides mutual benefit. Optimal collaboration can be achieved with clearly defined mission, vision, short- and long-term goals, priorities, strategies, roles, and measurement strategy. Data sharing can be difficult due to privacy issues; early completion of data sharing agreements can be helpful.

When work begins, continuous and shared iteration ensures resources and operations are well aligned. Clear lines of communication are paramount. Discussions and joint reflection related to progress, funding, programmatic growth, and capacity are important throughout the process.[6]

Methods to Strengthen Partnerships and Accelerate Collective Action

Partnership development can be accelerated and strengthened through consistent use of co-design,[7] community organizing,[8] and community-engaged quality improvement (QI) methods.[9] Each, often in combination, help encourage stakeholder inclusion, transparency, complementarity, and equitable investment of time and resources (Fig. 2). An environment of true, equitable partnership demands an understanding of historical context and power hierarchies that influence the partnership and its work.

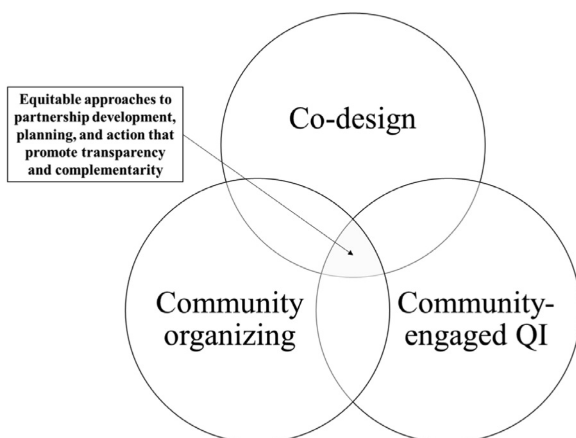

Figure 2. *Accelerating equitable approaches to clinical-community partnership using collaborative methods. QI indicates quality improvement.*

Co-design is defined as the "collaborative generation of knowledge by academics working alongside stakeholders from other sectors."[7] The term "academics" here could be applied more generally, illustrative of those working in pediatric clinical settings. This generation of knowledge involves developing a deep understanding of the priorities of partner organizations, families and community members, and developing solutions, together, that leverage and enhance strengths.

Community organizing, a form of leadership that identifies, recruits, develops, and enables people to achieve community-prioritized goals, can complement co-design.[8] The who and what of organizing will depend upon shared objectives and a commitment to accountability (to patients, families, and communities). By organizing, stakeholders build a shared understanding of how and why they must work together to achieve collectively desired outcomes.

Community-engaged QI begins with the important question of "what are we trying to accomplish?" Answers then help define shared aims and theory for action. Ideally, theory is co-designed, built on published insights and lived experience. Teams pursue small-scale tests of change built atop that theory. Measurement, over time, enables near real-time assessments of whether tests, and interventions, are achieving the stated aim. The team determines, quickly, whether to adopt, adapt, or abandon change strategies while iteratively moving forward, continuously learning.[9]

Pediatrics and Strategies to Address Poverty: Examples

In this section, we describe several example interventions that have been successfully integrated into pediatric clinical care, extending the reach of pediatricians and pediatric offices into the community. Such strategies enable provision of the right care (and service) in the right place at the right time. These strategies are complemented by additional examples that reach further, outside the context of a clinical encounter or setting.

Clinical Approaches to Poverty Reduction

Access-Expanding Programs

Health care may not be accessible to children and families living in poverty. For example, there is a shortage of pediatric behavioral health specialists; as such, many go without needed treatments or services.[10] Integrated partnerships between behavioral health specialists and those in pediatric primary care settings increase access to behavioral health services for at-risk children.[11] Although such partnerships do not solve or specifically address poverty, they demonstrate how clinical teams can overcome

poverty-related barriers to provide better care. Indeed, integrated behavioral health is an example of how a "medical home" can be multisectoral. The pediatric medical home model promotes alignment between the clinical setting and relevant agencies or supports.[12] This and the more expansive "medical neighborhood" model promote a multidisciplinary approach to care provision, expanding access and connections that foster more equitable health outcomes.[13,14] Such connections often extend to those outside medicine's traditional purview.

MEDICAL-LEGAL PARTNERSHIPS

Many poverty-related challenges are rooted in unmet legal needs. The Medical-Legal Partnership (MLP) model leverages complementary expertise to address poverty-related social, economic, and environmental barriers that perpetuate inequities.[15,16] In >400 MLPs across the United States, legal advocates work closely with clinicians to co-design social risk screening, educate health care professionals about legal remedies, and intervene to address health-harming legal issues (eg, poverty-related housing, public benefits, utilities, and educational needs).[17–19] MLPs effectively mitigate such downstream poverty-related challenges and are powerful allies in driving upstream changes to promote both health equity and health justice.[15] In addition to the positive effects at the bedside, the tight connection MLPs bring enables broader, system-level pattern recognition and advocacy in pursuit of poverty reduction.[18]

Advocates from Cincinnati's Child Health-Law Partnership (Child HeLP) assist ~800 children, and their families, referred from pediatric primary care annually. Advocates represent families in cases ranging from evictions to insufficient individualized educational plans. They also help identify patterns affecting more than just a referred child or family. In Cincinnati, advocates have identified and responded to "outbreaks" of substandard housing and pushed for systemic changes to how public benefits are initiated for newborns.[18] Legal partners can help us, as their clinical partners, develop into stronger advocates by enhancing awareness and understanding of legislation affecting child poverty.

MEDICAL-FINANCIAL PARTNERSHIPS

Medical-financial partnerships (MFPs) play a similar role, augmenting clinical care and reducing poverty by, in essence, prescribing cash. Services range from free tax preparation, and facilitation of tax credit receipt (eg, Earned Income Tax Credit [EITC]), to financial coaching.[20] Since 2016, Boston Medical Center's StreetCred MFP has returned >$8.5 million in tax refunds to 3900 families.[21] New York Health and Hospitals found a similar model to be cost-effective from the perspective of dollars returned to families relative to the cost to the health system.[22] Though data on long-term outcomes are not yet available, early evidence suggests patients value such services in clinical settings.[23]

CLINIC-BASED FOOD PANTRIES

FI is the "inability to provide enough food for every person to live an active, healthy life."[24] It is commonly encountered in pediatric settings[25,26] and associated with anemia, obesity, more frequent acute illness, and developmental delays.[27,28] To address FI, some pediatric settings have implemented in-clinic food pantries, co-designed with community partners. These embedded pantries allow staff and clinicians to provide an emergency food supply to families who endorse FI during their child's visit. They also provide a means through which further conversations about FI and hunger can emerge.

One Cincinnati-based pediatric primary care center with an embedded food pantry provided emergency food supply to >500 families in its first year. Food proved to be a valuable connector; families receiving food were often linked to additional in-clinic and community-based resources (eg, MLP) and expressed increased trust in and connectivity with primary care.[29]

SYSTEMIC APPROACHES TO POVERTY REDUCTION

Many pediatricians participate in programs like those outlined above; many more engage daily in patient-level advocacy. Additionally, pediatricians are increasingly advocating for children at societal levels, working to ensure systems benefit all children. Foreshadowed by Dr Jacobi's call for pediatricians to move beyond the "individual bedside,"[3] Dr Kimberly Schrier was the first pediatrician elected to the US House of Representatives in 2018. She, along with many others in pediatrics, is an outspoken advocate for the physical, social, and emotional well-being of children and families living in poverty. But no individual or organization can address poverty alone; meaningful partnerships across disciplines and sectors are necessary to transform systems for, and with, children, families, and communities.

SYSTEM TRANSFORMATION VIA COLLECTIVE ACTION

System transformation requires concerted, aligned efforts. Learning networks accelerate such efforts. In Cincinnati, the All Children Thrive Learning Network (ACT) pursues system transformation using co-design and community-engaged QI.[30] ACT is grounded in shared principles and methods driven by common aims. Specifically, ACT seeks to help make Cincinnati's children the healthiest in the nation through strong community partnerships. Health care partners lead certain efforts and support others, acting as convener and catalyst across systems, institutions, and organizations. The collective goal is to achieve structural change by empowering and enabling one another.[30] Needs are identified and strategies developed to build capabilities and accelerate change concepts.[31]

Learning networks—more so than their individual parts—direct collective action. For example, when a parent group connected with ACT heard that legislation to expand the poverty-reducing Supplemental Nutrition Assistance Program was under consideration, the group

Figure 3. *Picture of the postcard co-designed with parents of children advocating for expansion of the Supplemental Nutrition Assistance Program.*

quickly mobilized to bring their voice to the cause. A team of clinical and public benefits experts supported the parent group as they drafted a message for their elected representatives. The content was co-designed, placed into a template that included space for community members to write their name, address, and personalized messages. The parent-led team strategized how to collect signatures, and parent leaders obtained and sent >500 signed postcards (Fig. 3).

Consider Children's HealthWatch, an additional example of an asset-building coalition focused on poverty-reducing policies that worked synergistically with MFPs to pursue meaningful policy change. This nonpartisan network of pediatricians, public health researchers, and policy experts facilitated the convening of a Healthy Families EITC Coalition in Massachusetts when families highlighted challenges they faced within the tax system. The Coalition saw an opening for expansion of critical tax credits of great relevance to families. Subsequently, members pushed for transformative system change, successfully advocating for the establishment of a state refundable EITC. They convinced the state legislature to increase the value of this credit, a policy change that put more money in the pockets of those in need. The change was built upon an asset-building coalition, one that was effective given strong cross-sector leadership, a common goal, and channels for communication with policymakers.[32]

There are more examples where pediatricians are joining collectives to amplify the voices of children and families, particularly those living in poverty. Multiple national efforts now promote civic engagement, including the Federation of Pediatric Organizations' Counting Every Child initiative, Vot-ER, and Med Out the Vote. The latter examples leverage trust patients have with medical providers and use time in clinical settings to empower families to register to vote or request mail-in ballots. Such efforts are consistent with evidence that voting and health have consistent positive, bidirectional relationships and that health care-based initiatives to increase voter engagement can successfully increase turnout.[33] Increased civic engagement and equitable representation could be powerful antidotes to poverty, structural racism, and other harmful health-related social challenges.

DISCUSSION

As pediatricians, we often see ourselves in images of inpatient units and bustling clinics. These images remain essential to our professional identities. However, a longstanding commitment to child advocacy has afforded pediatricians and our partners with the opportunity, and responsibility, to reimagine and extend that identity beyond the clinical encounter or setting. Roles increasingly do, and should, span the clinical-community continuum, providing a foundation atop which cross-sector linkages can promote child health and reduce child poverty.

Pediatricians have long held influential societal roles, advocating for policies that promote early childhood development and safety. Advocacy has also long focused on poverty reduction given its undeniable influence on children. Indeed, most of child health is determined not by health care but by where children live, work, grow, and play.[34] As such, we suggest that addressing poverty and mitigating its downstream consequences for children fits squarely within "our lane." Jacobi's famed 1904 advice remains relevant today, pushing us to move beyond the "individual bedside in the hospital" toward "councils of the republic."[3] It is no surprise that pediatricians have embraced this advice and led the way in discovery and advocacy. Pediatricians' recent comments on how racism adversely affects child health illustrate how our profession can be instrumental in identifying and addressing core societal ills.[35,36]

Though pediatricians have long advocated to address societal ills, we must acknowledge and address ills present within our own profession. We know that a diverse workforce contributes positively toward institutional and professional excellence; a lack of representation has wide-reaching negative effects.[37] Yet, physicians from specific racial or ethnic groups remain underrepresented in medicine. Our advocacy, in service to our patients and to poverty reduction, must also address meaningful representation in pediatrics and medicine. Indeed, we must

ameliorate the underrepresentation of Black, Native American, and Latinx individuals.[38] We must complement this push with advocacy to close gaps in medical education regarding the impact of racism, bias, and poverty on health. Such topics must be taught consistently and effectively. The opaque nature of career pathways focused on advocacy must also be addressed to prepare and support the next generation of pediatrician-advocates.[39,40]

While fighting societal ills and reforming our own profession, we cannot and should not work alone. We are experts in child health and disease, not necessarily experts in poverty or structural racism. By the nature of our professional mission and the trust we develop with patients, families, and marginalized communities, we can help to ensure that the "lane" moving toward child health and well-being broadens to make room for all willing partners with shared goals. We must convene and catalyze, partner and mobilize, to overcome current and future challenges.

Clinical-community partnerships are vital to mitigate challenges to our advocacy efforts. First, pediatricians and pediatric practice settings are busy. With limited time, we may struggle to deliver necessary preventive care, diagnose acute illness, and manage chronic disease while also identifying and addressing poverty-related challenges. This may prompt those of us who work in this field to revert to treating the symptom but not the disease. Partners can help us more effectively address poverty-related challenges, allowing us to work more efficiently. Second, the episodic nature of medicine and the misalignment of traditional reimbursement models create barriers to addressing poverty. We must continue to push for aligned incentives that encourage efforts poised to achieve value. Third, when we do act, if we go at it alone, we risk working in parallel instead of working across sectors in true partnership. Working in siloes undermines substantive, sustained progress; the sum created through collaboration is undoubtedly greater than that of the parts. Fourth, when we decide to step beyond the single patient encounter, we may wrestle with how to best advocate. We must always stand up for what we believe, recognizing that at times we should speak or act as a private citizen and not a representative of a larger institution. Nevertheless, we must never abdicate our responsibility to advocate within our institution or across our profession.

Conclusion

We, as pediatricians and advocates, can mitigate the perils of poverty by screening for social risks and addressing social needs at the bedside. We can also move progressively upstream, partnering in a multi-sector, integrated system. We can revisit our role not just within the medical system but within society as child health advocates, pushing for "economic policies and systems, development agendas, social norms and policies, and political systems"[34] that reduce instead of amplify poverty. Pediatrics can be a force for good, developing, augmenting, and promoting strategies to reduce child poverty, a disease long overdue for a cure.

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