ABSTRACT. Objectives. As part of the evaluation of the American Academy of Pediatrics (AAP) Community Access to Child Health (CATCH), to 1) identify, retrospectively, the actual chronology of activities undertaken through CATCH, and 2) review its antecedents within the AAP, and its predecessor program—Healthy Children.

Methods. Key informant telephone interviews with 14 national leaders in CATCH were conducted. Relevant program and administrative files and other documents were reviewed. AAP staff assisted the authors in preparing a detailed chronology of Healthy Children and CATCH activities and events from spring 1988 through summer 1996.

Results and Conclusions. A decade of change in the AAP, under the acronym CATCH began in the late 1980s. The formation of the AAP’s Partnership for Children and the Access to Care for Children Initiative, combined with the decision by the Robert Wood Johnson Foundation to transfer the funding of Healthy Children to the AAP, underpinned the changes. The Foundation’s decision provided the resources and stimulus for the expansion and increased recognition of Community Pediatrics at the national AAP office, culminating in the establishment of the Department of Community Pediatrics in mid-1994. A national program of pediatrician-led, community-based programs and supportive services was launched, other resources were attracted, and a philosophical shift in defining the role of the pediatrician was put forward. A responsibility toward all children within the community was included in the role of the pediatrician, as well as caring for the individual child within a community context. Pediatrics 1999;103:1373–1383; child health, community-based, Community Pediatrics, Healthy Tomorrows, history, medical home, pediatrician, planning funds, social marketing, universal health insurance, visiting professor.

ABBREVIATIONS. AAP, American Academy of Pediatrics; CATCH, Community Access to Child Health; RWJF, Robert Wood Johnson Foundation; AMA, American Medical Association; PNP, pediatric nurse practitioner; REACH, Rural Efforts to Assist Children at Home; COCHS, Committee on Community Health Services; PFC, Partnership for Children; MCHB, Maternal and Child Health Bureau; PI, principal investigator; PAC, Project Advisory Committee; CF, CATCH Planning Funds.

The history of the Community Access to Child Health (CATCH) Program reflects an orientation and set of activities that have waxed and waned in pediatrics over the years. Through caring for children in their communities, pediatricians are cognizant of the community resources, beyond physical health care, required by children to meet their needs—schools, recreation, mental health, child care, protective and other social services—and initiatives and programs in the private, non-profit, and public sectors. Pediatricians not only recognize children’s needs but assist them and their families in accessing community resources. These ideas have particular relevance in the late 1990s; a decade when insurance coverage is absent or inadequate for too many, public programming is fraught with complexities, new morbidities are emerging, definitions and organization of “family” are shifting, and increased numbers of children with special needs (immigrant children, children in minority racial and ethnic groups, children with chronic illness and disability, and other socially and/or medically vulnerable children) have become major concerns. Strategies for addressing these concerns, embodied in Community Pediatrics, is assuming a greater presence nationwide.

We find that the history of the CATCH Program dates back to a set of principles related to a community focus on child health expressed even in the last century as the specialty discipline of pediatrics emerged. In addition, CATCH’s history is intertwined with both the individual expression of these ideas in the social marketing work of Dr Philip Porter and in the development of organizational attention to Community Pediatrics within the American Academy of Pediatrics (AAP, Academy). Both expressions—Porter’s and the AAP organization’s—took shape along parallel tracks during the the 1960s, 1970s, and early portion of the 1980s. In constructing the history of CATCH, we observe a series of events converging beginning midway into the decade of the 1980s that brought together these people and their
means of expressing the ideas embodied in “Community Pediatrics” and nourished a set of activities nationally and within the AAP that ultimately became known as CATCH in 1991 (see CATCH Timeline, Appendix A). Since then, we see expansions and refinements of both social marketing and organizational approaches to fostering the principles of Community Pediatrics as well as an integration of the two. This article traces the paths of these ideas and the individuals who promoted them, and explores their struggles and accomplishments along the way to the present incorporation of Community Pediatrics in the AAP.

The CATCH Program, part of AAP’s Access to Health Care Initiative, is located within the Academy’s Department of Community Pediatrics. Through CATCH, the AAP supports pediatricians’ involvement in community efforts that improve children’s access to health care. The AAP received funding for CATCH from the Robert Wood Johnson Foundation (RWJF) during its initial 7 years. Full funding from AAP and other sources has been in place since 1995. The history of CATCH, recorded here, examines both the program and its antecedents within the AAP, and its predecessor program—Healthy Children.

COMMUNITY PEDIATRICS: CONCEPTUAL EVOLUTION AND TENSIONS

In the half century after the end of the Civil War, the subject of child health became defined, and pediatrics emerged as a distinct branch of medicine. In 1860, Abraham Jacobi, MD, the founder of American pediatrics, was appointed to the first Special Chair of Diseases of Children at New York Medical College. Pediatrics was officially designated as a specialty the same year when Jacobi founded the American Medical Association’s (AMA) Section on Diseases of Children. Pediatrics in the 1880s was an underrecognized, underserved academic area and, when taught at all, was under the aegis of internal medicine or obstetrics. In 1888, the few physicians who identified themselves as interested and involved in the medical problems of infants and children—perceiving a need for a medical organization independent of the AMA—formed the American Pediatric Society. Jacobi, in the first American Pediatric Society presidential address delineated the field of pediatrics, asserting that the “development and maturation of the whole child was key,” and emphasizing the responsibility of the pediatrician to practice preventive medicine.2 Jacobi also noted that, “Questions of Public Hygiene and Medicine are both professional and social. Thus every physician is by destiny a political being” in the sense in which the ancients defined the term; viz., a citizen of the commonwealth with many rights and great responsibilities.”3 Recently, Robert J. Haggerty commented that, “Abraham Jacobi was an outspoken rebel, a vigorous advocate for better health care of children, but he was a responsible one who worked through professional organizations. . . . The message for us today is that to improve the health of children we need to be responsible and respectable rebels. We need to be rebels to push society to do what is right for children.”4

Children’s issues, tied to the women’s and social reform movements of the Progressive era, came to the forefront during the early days of the 20th Century. Harvard’s Thomas M. Rotch said in 1909, “The large body of women who are connected with the Child Labor Movement has added greatly to the accomplishment of markedly successful results. . . . We physicians, however, whose mission it really is to guide the progress of the various reforms connected with early life and see that they do not go astray, should interest ourselves in curbing exaggerated ideas and in the prevention of unwisely pressing on our legislators unsound views on which to base new laws.”5 These pioneering words presaged the AAP’s philosophy that the primary role of pediatricians is commitment to the welfare of children.

The gradually emerging concept of child health in those years arose from three sources: 1) social action for the welfare of children; 2) more rapid pace of advances in medicine, especially in pediatrics and obstetrics, and in medical education; and 3) development of state and local health departments, providing a governmental framework where pediatric knowledge and social action for children could join to form programs.6 During those years, more than one third of all infants born in cities died before reaching 5 years of age. Most of these deaths were attributed to improper bottle-feeding; overcoming this major contributor to infant mortality became the raison d’etre of pediatrics for the 60 years between 1870 and 1930.

The formation of the AAP grew out of a bitter disagreement within the AMA over the Sheppard-Towner Act. Passed as the Maternity and Infancy Act (Sheppard-Towner Act) of 1921, it established the national policy that the people of the United States, through their federal government, share with the states and localities the responsibility for helping to provide community services that children need for a good start in life. The AMA House of Delegates condemned the Act as “an imported socialist scheme,” leading to outrage among the members of its Section of Disease of Children and, ultimately, the creation of an independent physician organization comprising pediatricians.

Although pediatricians have been involved directly and indirectly in the health of the children in their communities for many years, the Academy has undergone significant philosophical and programmatic changes throughout its 68-year history. At its first meeting in 1930, the Academy defined its purposes (see opening quote).7 The AAP claimed a focus on education, public health, and social issues affecting children. However, not all involved in those early years agreed; some leaders thought it was ill-advised to engage in activities of social interest. They believed that enhanced private cooperation rather

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4 The Robert Wood Johnson Foundation funded an evaluation of CATCH to 1) identify, retrospectively, the achievements of CATCH; and 2) identify the characteristics of successful and unsuccessful elements of the program. The history of CATCH and its antecedents, recorded here, are major components of the evaluation.
than the expansion of public agencies was what was needed to bring about a complete program of child health services. Notwithstanding such discussions, a significant part of the rich history and tradition of the membership of the AAP has long involved reaching out to communities in need, especially in serving children and families.

In the 1960s, during a period of rapid changes in US society, marked by the War on Poverty and its emphasis on community participation, two events occurred that would have a bearing on our story of CATCH. Pediatricians were expressing their concerns about both child health in underserved communities and other flaws in the delivery systems for poor and underserved children, including lack of access, fragmented services, and emergency rooms becoming the primary caretakers of many of these children. Members of the Academy formed an organizational unit to begin to address these concerns. In the Boston environs, a pediatrician began efforts that would lead to school-based clinics.

PHILIP PORTER’S LEADERSHIP IN COMMUNITY PARTNERSHIPS AND SOCIAL MARKETING

The Cambridge Program

The CATCH Program had its origins in Cambridge, Massachusetts, more than 30 years ago. In March 1965, Philip J. Porter, MD, a faculty member at Harvard, became chief of pediatric services at Cambridge Hospital, a municipal hospital that was affiliating with the Harvard School of Medicine. With this appointment, Porter also became Director of Maternal and Child Health for the Cambridge City Health Department. Not liking what he saw in the context of his newly assigned role, Porter assessed child health care needs and resources in Cambridge through extensive interviews with public officials, service clubs, students, and parents. He identified five publicly funded but uncoordinated programs. With dual authority in the hospital and health department, and armed with a recent city ordinance requiring the consolidation of the two, Porter integrated all child health programs in 1967. Over the next 15 years, Porter nurtured and developed a program in Cambridge that replaced traditional school nurses with “clinical nurses,” and eventually with pediatric nurse practitioners (PNPs) as they became available, to create comprehensive school-based clinics and to provide nurse home visiting and coordination of care in public health clinics.

Finding these service arrangements both medically feasible and cost-effective, by 1982 Porter was convinced that 1) what had been accomplished in Cambridge could be replicated; 2) other communities in the United States had undertaken similar successful projects, but were not well known; and 3) other communities could benefit from the experiences of Cambridge and the other still unidentified communities. Porter spent a sabbatical year searching for “other Cambridges”—communities that accomplished good things for children in need through a comprehensive approach. He looked for exemplary health service programs at the community level that could be replicated without additional new resources.

Five programs stood out and, together with the Cambridge program, formed the core of what he named the Healthy Children Program: 1) Rural Efforts to Assist Children at Home (REACH), providing health care management for children with special health needs in a rural setting (Gainesville, Florida); 2) primary care health services coupled with social stimulation for preschool children in a rural setting (Great Barrington, Massachusetts); 3) comprehensive school-based health services for urban adolescents with special emphasis on family planning counseling (St. Paul, Minnesota); 4) maternal and child health services delivered via the public health department using a public–private contract for physician services (Sarasota, Florida); and 5) Conquering the Public Health Bureaucracy: A Lesson from Rural Southeast Georgia (Waycross, Georgia).

After analyzing these programs, Porter described his findings in terms of five principles: 1) a strong and intimate link between well-planned and universally accessible health care and cost; as access increases, cost decreases; 2) a strong and intimate link between universally accessible health care and quality of care; as access increases, quality improves; 3) in most (but not all) communities, both human and financial resources are available for the development of children’s health care services; 4) the PNP is a central and necessary element in successful child health programs; and 5) exemplary health care programs for children are the product of a few strong local leaders in each community.

Social Marketing Through the National Healthy Children Program

Based on the information obtained from these case studies, the Healthy Children program was formally established in 1983, with funding from the RWJF. The goal of the Healthy Children program was to make health care services universally accessible to children who need them, and to do so at reduced cost through imaginative and efficient use of resources—both human and fiscal—already available in the community. Community organizations and community leaders (predominantly not physicians) were targeted for engagement (Healthy Children Fact Sheet, undated). The Foundation appointed an advisory committee (Appendix B) to oversee the program and provided Porter with an intensive course in communications and social marketing.

The means to achieve this purpose was quite simple and direct: provide information (rather than grant funds), with the belief that information about successful programs would stimulate local action in similar directions. Porter described it as, “a social marketing effort aimed at transferring existing information to community leaders and then giving ongoing assistance to them as they develop their own response to a particular demonstrated need.” Porter’s tools were his own experience and skill and the assistance of several consultants, including communications expert Jim Butler, who developed promotional materials and provided marketing expertise.
Butler wrote and published a number of widely disseminated, individual case studies in attractive brochures. In addition, he made a videorecording of model programs that also was used as a marketing tool. A two-part program was established: technical assistance and the communications materials, including a community assessment quiz or “yardstick,” and a case book.

Porter worked out a system with Butler and the RWJF to disseminate information to targeted communities. Porter did not visit the community unless he could be assured that the setting would include a large, diverse group of participants including representatives from the health profession, the mayor’s office and others in politics, the business community, and parents. The leaders (predominantly not physicians) had to have time to network and to develop the social strategy. Physicians, in Porter’s view, were too busy.

Porter used the policy formulation developed by Julius B. Richmond to organize his thinking about the program’s success. Adapting that formulation, Porter believed that leadership almost always demonstrates three steps: 1) generating creative and resourceful ideas (knowledge base) to address an important community need or problem; 2) giving shape and form to those ideas by developing a social strategy that would incorporate the most successful approaches to accomplishing a goal; and 3) marshaling the political will among colleagues and other community leaders to address child health issues. A contribution of Healthy Children and later the CATCH Program was to develop and initiate mechanisms and processes that would assist pediatricians in generating and shaping ideas, implementing social strategies, and capturing political support for their ideas.

In September 1986, a National Healthy Children Workshop was held in Boston to publicize the program to a national audience. At the end of 5 years (1989), 78 communities had received direct assistance from Porter and 43 had organized important new comprehensive services for children. During this period, Porter confirmed the five principles (see “the Cambridge Program,” above). None of the communities establishing programs required more than a handful of people to stimulate the community to action. Physicians frequently blessed the effort; however, the leadership and work, as in the original five communities, came from others in the community.

STRUCTURAL DEVELOPMENT OF A FOCUS ON COMMUNITY PEDIATRICS AT THE ACADEMY

Meanwhile, during these decades of the 1960s, 1970s, and 1980s, events were slowly moving toward an expanded awareness and a growing interest of a number of pediatricians in the health of the child, the health of the family, and the support of its community resources—Community Pediatrics.

Committee on Community Health Services (COCHS) and Community Pediatrics

For at least the past 30 years, the AAP has maintained an organizational focus on the health of children in underserved communities. The traditional focus for community programs in the AAP is COCHS, established as a subcommittee of the Council on Pediatric Practice in 1967. It became a full committee in 1970. Concern for special populations, such as Native Americans and migrants, often was expressed, and specific committees sometimes were formed for these special populations. Stimulation of new community activities frequently arose from COCHS. The ongoing discussions and leadership provided by the COCHS stimulated much of this interest. Significant effort initiated by the AAP in the early 1970s gave rise, under Walter Campbell’s direction, to the Child Health Program. Projects were established in such places as rural Vermont, central Missouri, and the Texas border community of Eagle Pass as collaborative ventures between the local community and the state chapters of the AAP to provide children with accessible quality services where none previously existed. Such organized, community-based pioneer efforts served to expand the Academy’s role in community health services and coincided with the work of the COCHS in supporting community-based health care delivery systems for poor and underserved children.

AAP’s Partnership for Children (PFC)

Through a planning process begun in 1986, the AAP’s PFC was conceived. Planning, organizing, and recruiting for the Partnership occurred during 1986–1987, with the first meeting held in late 1987. The Partnership was formed to support national programs and activities enhancing children’s well-being and ensuring their healthy futures through advocacy, education, public outreach, and community action. In 1988, national leaders with an interest in the health of children were asked to join the Board of Trustees of the AAP’s PFC to provide oversight, direction, and leadership. Functioning as advocates and spokespersons on pertinent issues, the trustees committed to helping the Academy develop priorities and to draw on their own professional and volunteer experiences to provide the Academy’s leadership with advice, counsel, and new resources for support.

In partial support of this effort, individual members of the Academy were asked to contribute financially and to share their best ideas for the new national Partnership, whose purpose was to give children greater access to health care and to reduce the country’s high rate of infant mortality. This venture was called the Academy’s Friends of Children Fund Annual Campaign.

The Academy’s Access to Care Initiative

Concurrent with the early formation of the Partnership, a 3-year initiative designed to achieve universal access to quality health care for all the nation’s children and pregnant women was formulated by the AAP through a strategic planning process. The Access to Care Initiative was a three-pronged approach with the goals of 1) universal health insurance cov-

3 Beginning in 1994, all members’ contributions were dedicated to the CATCH Program (officially renamed in 1991) for 3 years.
verage for children and pregnant women; 2) public awareness; and 3) community programs. The Initiative was presented to the PFC as a focus area (American Academy of Pediatrics. Access to Care Initiative, Building for a Healthy Future. Undated).14

Universal health insurance coverage for children and pregnant women, the AAP’s federal legislative proposal introduced in Congress by Representative Matsui (D-CA) and others, was the only comprehensive bipartisan legislation on the Floor during the health reform discussions of 1993–1994. However, recognizing that lack of financial access was not the only barrier to care, the Academy pursued the other two components of the Initiative. The educational component included efforts to apprise its members, policy leaders, and the public about the issue of inadequate access to health care. A public affairs firm was hired to pursue these objectives. The most encouraging outcome was Child Health Month, which is recognized each October. The AAP also sought ways to work more effectively at state and community levels, using the resources of its state chapter structure and its 36,000 member pediatricians. Thus, the third component of the Access to Care Initiative involved establishing community-based programs. Healthy Children and Healthy Tomorrows were to become the two models (Schiff DW. President’s letters to the AAP chapter presidents and membership. AAP files).

CONVERGENCE AND TRANSITION

In 1988, the 5-year funding from RWJF for Phil Porter’s Healthy Children Program was coming to an end, and the Foundation was searching for a way to broaden and institutionalize it. A Foundation publication noted, “Healthy Children has had the benefit of remarkable leadership by one man. . . [The] Foundation is planning to see if Healthy Children now can be institutionalized that is, if program activities can be placed in other institutional settings, if such activities can generate long-term funding, and if other people can be found to assume the role of ‘child health missionary’. ”9 The next stage of Healthy Children was about to unfold.

Harvard’s Julius B. Richmond, MD, served as chair of the RWJF’s Advisory Committee to Healthy Children (Appendix B) from 1984 to 1988. A leader in the AAP, Richmond was aware of the Academy’s Access to Care Initiative as it developed. He suggested to the RWJF leadership that a marriage between the Healthy Children program and the AAP’s Access to Care Initiative might enhance both activities. RWJF’s Ruby Hearn, acknowledging that the Academy was a potential “other institutional setting,” agreed; she was interested in the Academy having a major role in supporting the Healthy Children program.

In 1988, the Academy was awarded a 2-year grant by RWJF to educate and involve pediatricians in community-based activities, using the Healthy Children program concept as a model. At the same time in a separate action, Porter at Harvard University was awarded a 2-year grant from RWJF to consult with the AAP on the Healthy Children program. The Partnership, its trustees, and the Friends of Children Fund were critical to the development of Healthy Children/CATCH. The Partners contributed funds and urged others to do so to augment programs and to underwrite some administrative costs. Partners also funded or intervened in their localities to obtain funds for local community-based programs (Minutes of AAP/MCH meeting; 1989 [2/17/89]).

During late summer and fall 1988, the AAP developed and submitted the Academy’s initial grant proposal to RWJF, which included a key role for Phil Porter. Beginning in October 1988, presentations on the community-based portion of the Access to Care initiative were provided at AAP district meetings around the country. Porter presented the philosophy of the Healthy Children program and described the program at these meetings to motivate, inform, and educate the AAP membership.

Concurrently, Irving B. Harris, a Chicago businessman and philanthropist with a strong interest in preventive child health and an original member of the Board of Trustees for AAP’s PFC, facilitated negotiations among the key players. Harris met with officials of the federal maternal and child health program and persuaded them to invest in the community-based programs component of the AAP’s Access to Care initiative. After considerable discussion with Harris and AAP officials concerning structure and operation, the Maternal and Child Health Bureau (MCHB) committed $5 million over the next 5 years toward the AAP-MCHB partnership. The initiative, called Healthy Tomorrows, invited local health care professionals and community leaders to join together to devise comprehensive, community-based solutions to community-defined problems. Nonfederal funds were not required the first year; however, applicants were expected to identify sources of nonfederal matching funds for subsequent years.

Program planning for the community-based programs of the AAP Healthy Children and Healthy Tomorrows was completed during winter 1988–1989. The Community Programs of the Access to Care initiative were now in place with two models.

Healthy Children began at the Academy on January 1, 1989, and was administered through AAP’s Office of the Executive Director, because it was AAP’s custom to have the executive director or the associate executive director lead such efforts. Associate Executive Director Joseph M. Sanders, Jr, MD, was named the principal investigator (PI). The Academy’s grant had a consultant budget line item, which included Porter and Butler. The Healthy Children program methodology and materials were to continue to be developed and published by Porter, with an increased emphasis on training and using pediatricians as community leaders, catalysts, and technical assistants. The transformation was beginning. Sherry Zachariah became the AAP Healthy Children Project Manager in February 1989. In July of that same year, when the Division of Community Health Services was created within Department of Child Health Care Finance and Organization, the Healthy Children program was transferred to this new division, with Zachariah as division director. Sanders
remained as PI in the Office of the Executive Director. The department had responsibility for the COCHS and the Council on Pediatric Practice, so it seemed a natural home for the Healthy Children program.

Over the next 6 months, foundation-building work was undertaken, including presentation of the Healthy Children concepts through print and video materials as well as through appearances at AAP meetings. The RWJF Advisory Committee, established in 1983, continued its oversight of Porter’s grant and now added oversight of the RWJF-funded AAP grant. At a special meeting in August 1989, AAP’s Advisory Committee to the Board on Pediatric Practice approved the membership and its directives of the AAP Project Advisory Committee (PAC), which held its first meeting in November (Appendix B). The functions of the two committees did not overlap to any degree. The RWJF Advisory Committee, with a broader representation, had a more global view and advised the Foundation. With responsibility for both Healthy Children and Healthy Tomorrows, the PAC functioned in a more detailed manner, had a membership of pediatricians only, and reported to the AAP.

In year 1, the groundwork for a national AAP Healthy Children conference was also set. In a series of communications to the AAP Fellows, the Healthy Children program built awareness and encouraged participation at the chapter level. Chapter coordinators were recruited, and by the time of the June 1990 meeting, 49 of 59 chapters had appointed coordinators. The national conference convened in Chicago, IL, with approximately 100 Healthy Children program coordinators attending. The new Academy brochure One Pediatrician Can Make A Difference for America’s Children was distributed at the AAP Healthy Children conference, and a position description for the Healthy Children chapter coordinator was reviewed and amended by participants.

During AAP’s first 2 years of involvement with Healthy Children, the leadership had been transformed from the personal and pediatric model of Porter at Harvard to a staff-operated model at the Academy. Although Porter continued as a consultant during this period, he gradually withdrew from an active role; Sanders was the titular leader as the PI, but the actual management was provided by Zachariah, the project manager. The shift at the community level was from community leadership generally, to pediatric leadership specifically. Also during this period, both components of the Access to Care Initiative—Healthy Tomorrows and Healthy Children—matured under the influence of the Academy and the MCHB. Both initiatives invited local health care professionals, including pediatricians, and community leaders to join together to devise comprehensive, community-based solutions to community-defined problems.

The RWJF, however, continued to be interested in pediatric leadership, and this is reflected in the Phase II (1991–1993) grant budget, which included two new positions, program director (pediatrician) and program assistant. The program manager’s time was reduced from 75% to 50%.

HEALTHY CHILDREN BECOMES CATCH

On February 1, 1991, the Academy received notification from the RWJF that Phase II was funded for 1991–1993. During Phase II, it was clear that the continued Academy effort would evolve into a program with its own identity. To this end, the Academy contributed an increasing part of the budget. At the end of the RWJF funding, the Academy assumed full financial responsibility for the program in its general operating budget. Thus, AAP’s PFC and the Friends of Children Fund became actively involved in the funding and oversight of the program during this period.

Public information efforts continued. The first issue of the Healthy Children Reporter was published in March 1991. In spring of that year, Community, the AAP Special Report profiling the Healthy Children program, was sent to the AAP membership. A CATCH fact sheet was developed in November, and the first issue of the CATCH Express was published in December 1991.

F. Edwards Rushton, MD, was recruited as project director for the Healthy Children program. Before working as a private practice pediatrician in Maine, Rushton directed the Sarasota, FL, project, which Porter had identified and included in his early Healthy Children brochure. He also had worked in state government in Florida and at the federal National Institute of Mental Health. Rushton came to the Academy in August 1991, with a goal to start 20 new projects in the first 2 years of the grant.

Several months after Rushton arrived, the name of the Healthy Children program was changed to secure AAP ownership. Suggestions were solicited from chapter facilitators and the PAC; the AAP Executive Committee chose Community Access to Child Health (CATCH) as the official name of the program.

Rushton received permission from the RWJF to shift strategies from convening national annual meetings to holding more frequent district and chapter meetings, thus focusing efforts closer to the community level. Rushton devised district meetings where each chapter facilitator for CATCH would bring a community pediatrician with whom the facilitator worked. Rushton held district meetings during his first year, solicited interest from the participants, and claimed 50 to 60 new CATCH projects. At chapter meetings, he developed a “recognition by peers theme” that provided camaraderie with others doing the same thing in adjacent communities or across the nation. Because of his contacts around the country, networking became an important component. Rushton stated, “Anything a pediatrician does sitting with others in the community to assess and meet a need (and lots of pediatricians do that) could be called a CATCH project.” Rushton’s professional experience had taught him that to make programs like CATCH work, “one has to talk face-to-face to explain the idea.”

A program emphasis on rural health was also
Rushton’s idea. He called together 20 to 30 pediatricians from northern New England to meet near Bangor, Maine. From this meeting, the Northern New England Rural Pediatric Alliance was created, emphasizing and supporting rural pediatrics in that area. When the AAP Kentucy chapter president was unable to find a facilitator for CATCH, Rushton brought together 20 to 30 Kentucky pediatricians to discuss CATCH and to find a facilitator. The meeting was successful, and two pediatricians agreed to serve as co-facilitators.

Contrary to Porter, Rushton believed that physicians are not too busy to become involved in community work because they benefit directly from such activity through reductions in emergency department calls, after-hour calls, and schedule overload. He believed that pediatricians are particularly well-suited to initiate leadership in the community.

In March 1992, the first CATCH brochure, featuring Robert Earnest, MD, of North Carolina, was sent to all AAP members. An article on Earnest’s public–private partnership appeared in AAP News the same month. In addition to the feature on Earnest, AAP News highlighted Florida’s Child Health Assistance Program, the Northern New England Rural Pediatricians Alliance in 1992, and inner-city community-based programs in Chicago and Cleveland, OH, in 1993. CATCH articles appeared in American Medical News in late 1992. Information also was disseminated routinely through the CATCH Reporter (originally called the Healthy Children Reporter)—published quarterly through April 1993—and the monthly CATCH Express newsletter. The AAP distributed a report in September 1992 stating that since Rushton’s arrival in August 1991, 115 programs had contacted chapter facilitators for CATCH, with 40 of those programs being “started, impacted on, or improved by CATCH staff or facilitators.”

A special presentation on CATCH, “Community Pediatrics: How to Practice Better Pediatrics for Children,” was delivered at the AAP Annual Meeting in October 1992. CATCH awards for contributions to Community Pediatrics (an idea conceived by Rushton) were presented to Jeffrey Golhagen, MD; Francisco Ramos-Isern, MD; and William J. Reed, MD; in 1992; Colin Scher, MD; Edward Gergesha, MD; Marsha Raulerson, MD; and Thomas Whitney, MD; in 1993.

At the time that Rushton became project director for CATCH, the Academy’s PFC was searching for an activity to fulfill its role in “furthering the goals and objectives of the AAP.” At the PFC meeting in October 1992, Rushton made a detailed presentation on CATCH. As a result, the PFC agreed to establish a CATCH Advisory Group to discuss how the Partnership could help support the program, primarily through a development effort. The PFC–CATCH Advisory Group met several times and delineated an effort to enhance the scope, reach, and impact of CATCH; the CATCH Advisory Group effort was folded into the general activities of PFC in 1994.

PFC deliberations clarified the need to improve communication about the impact and potential of CATCH, educate Academy members about the program’s benefits, and fund expansion of the program’s scope of activities. The results of the PFC’s focus include the Visiting Professorship Program; the CATCH videorecording Making A Difference for America’s Children, designed to market the program to the AAP membership; and in 1996 the Len Rome Sabbatical Fellowship funded by the PFC with $150 000.

The CATCH Visiting Professorship Program was established in 1994, at approximately the same time as the fellowship electives. The idea was conceived by Anne Dyson, MD, of the Dyson Foundation, and Joel Alpert, MD, chair of the PAC. The program originally was funded by the Dyson Foundation. Each participating school receives up to $4500 to host a professional expert in Community Pediatrics to facilitate a 3-day program of interacting with students, faculty, community leaders, CATCH facilitators, and Academy leadership. Goals include 1) exposing students and residents to Community Pediatrics; and 2) enhancing Community Pediatrics within an academic setting and incorporating it into the core of pediatric training.

In January 1994, the first CATCH Fellow, Dawn Haut, MD, came to the Academy and visited with pediatricians in Cleveland and Washington, DC. Fellowship electives were conceived as providing an educational experience for viewing CATCH and Community Pediatrics as a practice option. This program, funded by the Friends of Children Fund, existed for 1 1/2 years; five fellows participated. Board members, however, were concerned about the labor intensiveness of the program. They felt that the costs were too high in relation to the outcome and that learning objectives were not clearly defined. Planning funds were another of Rushton’s ideas, based on his experience in private practice in Maine, where he had raised $9000 through local businesses to begin a community effort. In January 1993, Wyeth-Ayerst Laboratories pledged $250 000 to support the CATCH Planning Funds (CPF) program and to provide chapter meeting support. CPFs emerged from the recognition that many pediatricians and communities have ideas for improving the health care of children in their local areas but do not have the time, expertise, or money to plan and implement the projects. The original intent of the planning funds was to support two planning grants (up to $10 000 each) in each district.

To emphasize the AAP’s growing focus on Community Pediatrics and to clear up organizational confusion, the Office of Community Pediatrics was created in July 1993, with Rushton as director, and the CATCH Program was transferred to this office. One year later, the office was elevated to department level, giving new recognition within the AAP structure for Community Pediatrics. Also located within this new department was the Division of Community Health Services (which had been transferred from the Department of Child Health Care Finance and Organization). Rushton served as director of the new Department of Community Pediatrics, and CATCH continued under his direction. AAP Board oversight of the CATCH Program began as a direct result of
the new departmental status for Community Pediatrics. Thomas F. Tonniges (Director, Department of Community Pediatrics) views this a “key moment... when the organizational structure grew to department level.”

Rushton announced his resignation in October 1994, but remained for nearly a year while his successor was recruited. During Rushton’s tenure, CATCH had expanded markedly in scope and content. The structures at the state and community levels were overhauled, and the program (with a name change) was elevated in status within the AAP. New components were tried experimentally and added, including an emphasis on rural health, recognition awards, planning grants, fellowship electives, and visiting professors. On September 29, 1995, Rushton received the 1995 Primary Care Achievement Award from the Pew Charitable Trust, capping his career.

COMMUNITY PEDIATRICS: EXPANSION, INTEGRATION, CONSOLIDATION AND COLLABORATION

In June 1995, Thomas F. Tonniges, MD, became director of the Department of Community Pediatrics. A pediatrician in private practice in rural Nebraska for 18 years, Tonniges had served on the local school board and gained considerable experience within his community. At the time he was selected for the position, he was a member of the AAP board.

Tonniges’ responsibilities involve leadership for the community-based components of the Access to Care initiative, which includes the CATCH Program, the Healthy Tomorrows program, and the Child Care program. Also under Tonniges’ leadership in the Department of Community Pediatrics is the Medical Home Project for Children with Special Needs, brought to the Academy as an extension of CATCH under Rushton’s tenure at the request of Cal Sia, MD (a private-practice pediatrician involved in many community activities in Hawaii), and Merle McPherson, MD (Director of the Division of Children with Special Health Needs, Maternal and Child Health Bureau). The Department of Community Pediatrics now guides all AAP Community Pediatrics activities, including the development of a new definition of Community Pediatrics.15

Tonniges submitted the final grant report for CATCH to the RWJF in August 1995. CATCH was now an integral part of the Academy and dependent on the general operating budget and the Friends of Children Fund.

A number of activities have been initiated since Tonniges’ arrival, including two studies with ongoing data analysis:

- A survey (CATCH Registry Questionnaire) of pediatricians on the CATCH newsletter mailing list was conducted to gain information about their community-based activities (1995–1996).
- A retrospective survey of CPF projects (funded and nonfunded) from 1993 to 1995 was conducted to evaluate the impact and functioning of the CPF program (1996).

- Dyson Foundation funding for a position for an evaluation specialist for the CATCH Program was secured (early 1996).
- The Division of CATCH was created within the Department of Community Pediatrics. CATCH Program activities were transferred to this new division, and Crystal Milazzo was recruited from within AAP to serve as director (mid-1996).

During his initial 15 months, Tonniges continued to broaden the impact of CATCH and the Department of Community Pediatrics. He promoted integrating the Medical Home Program as a CATCH component, and met twice with the Resident Section of the AAP to discuss developing a collaborative CATCH project. To promote collaboration with CATCH nationally, Tonniges has made “CATCH presentations” at several universities and participated in committees and conferences of more than 12 prominent national organizations and initiatives. He also has reached out to major private philanthropies to discuss potential opportunities for collaboration with the CATCH Program. Tonniges provides CATCH updates regularly for the PFC. As Tonniges states, “We want to create an environment where [the CATCH] type of activity is part of the culture of what we all do in pediatrics. We want to develop themes of where we in the AAP relate to the individual member and others serving kids and how... we can embrace this as all one.”

At a November 1995 joint meeting of the PAC and the COCHS, it was decided that COCHS would assume the oversight of the CATCH and the Healthy Tomorrows programs and the PAC would be disbanded. Two members of the PAC, Arthur Lavin, MD, and Paul Melinkovich, MD, joined the COCHS to ensure continuity (Appendix C). The RWJF Advisory Committee had not met for several years, and the National Advisory Committee (for Healthy Tomorrows) had not met in more than a year.

The oversight activities were now institutionalized in one of the AAP’s standing committees. This decision to place the monitoring responsibility for CATCH and Healthy Tomorrows with the COCHS brought this Academy venture almost full circle to the 1970s in terms of gaining the support of management and membership for the increasing number of projects serving children and families throughout the country.

TENSIONS AND PROGRESS

A decade of change in the AAP, under the acronym CATCH, began in the late 1980s. These changes began to occur with the confluence of three streams of activity: 1) the formation of the AAP PFC and the subsequent development of the Access to Care for Children Initiative with its community focus; 2) the joint development of the Healthy Tomorrows program by the AAP and the federal MCH program; and 3) the decision by the RWJF to transfer the funding of the Healthy Children program to a professional organization, the AAP. It was this latter decision, especially, that provided the resources and
stimulus for the expansion and increased recognition of Community Pediatrics at the national AAP office.

Leadership was recruited for the Healthy Children/CATCH Program, a national program of pediatrician-led, community-based programs and supportive services was launched, and organizational changes within the AAP were initiated. The RWJF funding facilitated garnering other resources, including Wyeth-Lederle Vaccines and Pediatrics funds to support CATCH planning grants and Dyson Foundation funds to support the CATCH Visiting Professorship program. Since the discontinuation of RWJF funding in 1995, these other funds have continued and remain important supports of the program as the AAP has assumed full funding responsibility.

CATCH expanded to include a network of CATCH facilitators, technical assistance to communities, data acquisition and evaluation, community service awards, visiting professorships, and ties to other community-related programs. CATCH also has become an organizational unit within the Department of Community Pediatrics.

The RWJF-funded CATCH Program, arriving at the Academy at an opportune time, became a catalyst for expanding Community Pediatrics and providing increased recognition for the field at the national level. From all indications, the CATCH Program can be declared a success for meeting these objectives.

As these changes were occurring, CATCH attracted new pediatricians to Academy membership. Pediatricians active in community activities who previously felt the Academy didn’t address them or their interests now sensed a welcoming by the AAP. Some pediatricians who have been involved in Community Pediatrics for many years, however, feel that the recognition of a redefined pediatrician is more a perspective of the national Academy office than a reality. These pediatricians think that Community Pediatrics has existed for many years, with only minimal recognition from and support by the national AAP office. The recent development of a Department of Community Pediatrics is seen by these community pediatricians as both laudatory and long overdue. Through development of CATCH, the Academy provides recognition to those pediatricians working in the community to improve child health. In the words of one CATCHer, “It gives us professional affirmation”.

These tensions were apparent in the early days of the Healthy Children/CATCH Program. As Porter identified and publicized “models” of community programs, some of those promoted felt their efforts were being subsumed by Healthy Children without appropriate attribution. In a similar vein, as the program moved into the Academy as Healthy Children/CATCH, the “ownership” issue continued to be a source of tension for some pediatricians. The definition of what is a CATCH project in a specific community often is unclear, and frequently depends on who is defining.

CATCH grew out of Healthy Children and drew some of its community ideas from Healthy Children, but it is not a continuation of Healthy Children. There is no simple definition of CATCH. Both confusion and controversy have existed over the definition of CATCH and the definition has changed over time through the philosophy and activities of its leaders. CATCH is a philosophy, a process, and a program, and is an evolving set of concepts based on program goals. The goals, too, have been additive and evolving. Today CATCH is a series of pediatrician-led community projects, some initiated with planning grants, some not. The development of CATCH has been an iterative process. Older, or “pre-CATCH,” projects helped to define CATCH. So did their leaders. The movement toward common ground by community pediatricians and more traditional pediatricians continues to progress.

The core values of 1) improving child health, 2) increasing access to health care, and 3) promoting advocacy at the community level have been present since the inception of the Healthy Children/CATCH Program more than a decade ago. These values reflect statements, noted above, made by early leaders in pediatrics: “the whole child” (Jacobi); “guide the progress of [reforms] . . . and see that they do not go astray” (Rotch); “every physician [is] a citizen . . . with many rights and great responsibilities” (Jacobi). What has changed in the last decade, however, has been the philosophical shift toward defining the role of the pediatrician as including a responsibility toward all children within the community, looking at the care of an individual child within a community context and, accordingly, a focus on advancing the field of “Community Pediatrics”.

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APPENDIX B. Advisory Committees for Projects

Robert Wood Johnson Foundation Advisory Committee to Healthy Children
Julius B. Richmond, MD, Chair, Division of Health Policy, Research and Education, Harvard University
Richard Narkewicz, MD, Former President, AAP, Burlington, VT
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Frank Karel, III, Vice President, Communications, The Rockefeller Foundation
Ruby Hearn, PhD, Vice-President, Robert Wood Johnson Foundation
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Fernando A. Guerra, MD, Director, City Health Department, San Antonio, TX
Arthur Lavin, MD, Cleveland, OH
Paul Melinkovich, MD, Denver, CO
Hays Mitchell, MD, McDonald, TN
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H. Burt Richardson, Jr, Winthrop, ME
George G. Sterne, MD, New Orleans, LA
G. Neal Wiggins, DeLand, FL

* Assigned to the Committee on Community Health Services when the PAC dissolved, November 1995.

APPENDIX C. AAP Committee

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Jennie McLaurin, MD, MPH
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