Community Access to Child Health and State Policy

ABBREVIATIONS. AAP, American Academy of Pediatrics; CATCH, Community Access to Child Health; SCDHEC, South Carolina Department of Health and Environmental Control.

This remarkable treatise by Dr. Vince Hutchins and associates recounts the laying of each brick (milestone) in the foundation of child health advocacy for the new millennium. Indeed, the advocacy of the 21st century calls for direct pediatrician involvement and leadership in community initiatives to improve children’s access to health care to ensure that every child has a medical home and all other services needed to promote optimal health and wellbeing. The American Academy of Pediatrics (AAP) has wisely assimilated, organized, and resourced the infrastructure necessary to support individual members in their practice of community pediatrics. The AAP’s partners, collaborators, and sponsors in this effort (The Maternal and Child Health Bureau, The Robert Wood Johnson Foundation, The Dyson Foundation, The Partnership for Children, Wyeth Lederle Vaccines) have provided resources, guidance, and support for each fundamental step. The engineers of the evolution of Community Access to Child Health, or CATCH, (Drs. Porter, Rushton, and Walter Campbell) have masterfully directed each evolving process. The blueprint for the entire “House of Community Pediatrics” lies within the recently established AAP Department of Community Pediatrics. The continued building of this structure should enhance support greatly for individual pediatricians as they work to improve access to health care for all children. The accompanying Evaluation of the CATCH Program by Minkovitz, Grason, Aliza, Hutchins, Rojas-Smith, and Gayer provides the information for appropriate modifications necessary to continue improving the program.

I have been privileged to observe and participate in this impressive initiative for almost a decade. In 1990, I was chosen as the South Carolina Chapter of the AAP Healthy Children program coordinator and attended the June 1990 national conference in Chicago. I was given the AAP brochure “One Pediatrician Can Make a Difference for America’s Children” and a job description as chapter coordinator. In July of the same year, I was called to meet with the Commissioner of the South Carolina Department of Health and Environmental Control (SCDHEC), our state’s public health agency. He had developed an increasing concern that his public health clinics in many counties were becoming the providers of last resort for an ever-increasing number of children in South Carolina. Simultaneously, the South Carolina Chapter of the AAP leadership was being encouraged by the AAP to promote pediatrician led community-based initiatives to improve access to care for children. Our chapter subsequently pursued a public–private partnership with SCDHEC to improve access to care for children in South Carolina who were receiving primary care in local health departments. Task forces of local pediatricians (and in some cases family physicians) and local public health professionals were organized in all 13 of the state’s health districts. The goal was to look at ways to share and integrate the resources of public health and private practicing physicians to create medical homes for these disenfranchised children. Today, there are 76 partnerships in South Carolina involving public health professionals working alongside primary care physicians in private practice, caring for these children. The youngsters are afforded a medical home and all the needed public health services necessary to ensure their health and wellbeing. I remembered Dr. Porter’s advice that public health would make a strong and willing partner. In this state, SCDHEC has been the lead agent for this progress and deserves the lion’s share of the credit for the successes.

If South Carolina pediatricians and public health officials were faced with the same dilemma in 1999, the full array of resources of the AAP CATCH Program in the Department of Community Pediatrics would be available to assist them. Planning funds could support the district task force meetings, the CATCH database could identify similar successful models for benchmarking, technical support could assist with integration strategies, and the chapter/district facilitator would be available for coordination and consultation. The state’s academic medical centers could apply for a CATCH visiting professorship to promote awareness of these and other community-based access-to-care improvement strategies. In 1990, the AAP could only offer general encouragement to the South Carolina initiative.

The AAP now has extensive networking in place to link that “one local pediatrician who can make a difference” to chapter/district resources to Department of Community Pediatrics staff and to funding sources that will help ensure the success of any given initiative. The district CATCH facilitator group has developed vision and mission statements for CATCH and offered a clear and precise definition of a CATCH program. These documents, when fully

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approved by AAP leadership, should serve to better define CATCH and reduce some of the frustrations and tensions identified in the evaluation. District and chapter facilitators will continue to work on the perceptions of vagueness and unfamiliarity that exist with their roles. The Department can readily identify CATCH consultants in each district using the developing database and continuing contacts. The anticipated successes of the next decade of CATCH should validate further the appropriateness of the decisions of Dr Richmond, Ruby Hearn, and others to move the Healthy Children program concept to the AAP where it could become “pediatrician led.” This history, current status, and evaluation of the CATCH Program serve as the stimuli for additional improvements and accomplishments.

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