EXAMPLES OF SUCCESSFUL COMMUNITY PEDIATRICS PROGRAMS AND TRAINING

Community-Level Child Health: A Decade of Progress

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ABSTRACT. In the late 1980s, the leadership of the South Carolina Chapter of the American Academy of Pediatrics (AAP) developed a growing awareness that there was a population of children in the state who frequented emergency departments and public health clinics but were not considered patients in any medical professional’s office. Coincidentally, the commissioner of the South Carolina Department of Health and Environmental Control was struggling to expand resources needed to care for these children, who were crowding his facilities in search of primary care. Department of Health and Environmental Control clinic staff increasingly were unable to provide core public health services because of the need to treat illnesses and conduct well-child visits.

Concurrently, with mounting concerns over the inadequacy and/or unavailability of quality health care for all children, the AAP embarked on the Access to Care campaign, a multiyear effort to improve access to care. The South Carolina Chapter of the AAP and Department of Health and Environmental Control subsequently launched an initiative, the Partnerships for Children program, to ensure that South Carolina children who were medically disenfranchised could have a medical home and all other services necessary for health and well-being. Although structured somewhat differently in various communities and practices, each of the >75 partnerships statewide focused on using public health professionals for specific care coordination and support that complemented physician office visits and encounters. These partnerships have gained substantial leverage through the expanding resources of the AAP Access to Care campaign.

In reviewing claims for children <3 years old who were enrolled in Medicaid before the establishment of the Partnerships for Children program, <45% had evidence of a well-child visit. Data in the fourth year of the program indicate that 84% of children in this age group have had at least 1 well-child visit. Other data suggesting improved access to care are equally reassuring.

In this report, I describe the evolution of the Partnerships for Children program, identify key ingredients for its success, and provide examples of effective strategies that bring community resources into pediatric practices to allow for more efficient and productive delivery of primary care. I also indicate the important role of the AAP Community Access to Child Health infrastructure in the maintenance and further development of this initiative. Pediatrics 2005;115:1139–1141; community pediatrics, advocacy, public health, public-private partnerships, Medicaid, access, health care delivery, medical home.

ABBREVIATIONS. AAP, American Academy of Pediatrics; SCAAP, South Carolina Chapter of the American Academy of Pediatrics; DHEC, South Carolina Department of Health and Environmental Control; PRS, preventive and rehabilitative services.

The increasingly important role of community pediatric practice was recognized in 1989 when the American Academy of Pediatrics (AAP) Board of Directors asked a group of pediatricians to address the expanding crisis of access to health care for a growing number of children in the United States.1 The group identified 3 barriers to care: financial difficulties, lack of public awareness of the necessity of appropriate access to services, and the need to support pediatricians who work in their communities to improve the health and well-being of children. The AAP then launched its Access to Care initiative with the following 3 focus areas: to work to obtain universal health insurance coverage for all children, to undertake a public-awareness campaign addressing the growing crisis in access to care, and to increase resources within the AAP to support pediatricians who work in their communities to reduce barriers to care. This last focus area has evolved into an enduring philosophy and organized approach called “community access to child health” that has been a resource for thousands of pediatricians who are looking beyond the charts in their offices to improve the health and well-being of all children in their communities. In fact, the AAP has an entire Department of Community Pediatrics with community-based initiatives and programs to support the interface between community resources and the practice of pediatrics. Community Access to Child Health is 1 of the programs housed in the department.

THE BEGINNING

I was enjoying an active pediatric practice in 1989, serving 1 day each week as attending pediatrician in the county public health clinic, when I noticed a somewhat disturbing trend: large numbers of children were presenting for illness care, follow-up care from emergency department visits, and posthospitalization asthma management. It was unusual for these children to have seen any 1 physician more than once. Their care was fragmented by episodes, and it became obvious that these children were medically disenfranchised. The plight of these children was in
stark contrast to the children seen in my office practice, in which continuity and coordination of care were routine. Similar to many South Carolina Chapter of the AAP (SCAAP) member colleagues from around the state, I came to recognize that there was a population of children who needed and deserved better-quality health care delivery than they were receiving.

In early 1990, I received a call from Michael D. Jarrett, commissioner of the South Carolina Department of Health and Environmental Control (DHEC), inviting me to his office to discuss a growing concern that his public health clinics were becoming the providers of last resort for >80,000 South Carolina children. I assembled a small group of SCAAP leaders to accompany me. Most of them were already aware that there were similar problems in their local areas. The session concluded with a commitment to study the extent of the problem in all 13 of the state’s health districts and explore solutions unique to each geographic area, where feasible. Pediatricians, other primary care professionals, hospital administrators, local public health professionals, and other community constituents gathered in each of the districts to pattern solutions that made optimal use of community-specific strengths and resources. Jim Burroughs, a volunteer child advocate and retired executive, and I facilitated the activities of all 13 groups as they moved toward solving this access-to-care dilemma. The seemingly endless breakfast meetings all over the state were exhausting but very stimulating. What emerged was a common overarching message that physicians in each community needed a better interface with public health and other community resources to care for this newly identified population of children. Although the specific operational arrangements varied by locale, the core ingredient of each partnership was the public health professional(s) providing clinical health, public health, and care coordination services within the environment of physician office practices. The overall organizational structure of South Carolina’s public health system, 13 districts representing 46 counties with oversight from a central state office, allowed for planning, implementation, and expansion of these programs around the state. Today there are >75 partnerships of public health professionals working alongside practicing primary care physicians to provide medical homes for thousands of children whose care otherwise would be fragmented.

**SUCCESSES**

Early data indicate that these partnerships indeed are making a difference. The Office of Research and Statistics of the South Carolina State Budget and Control Board reviewed all Medicaid claims for children from birth to 3 years of age. Less than 45% of this age group had evidence of a well-child visit in the year before the establishment of the SCAAP-DHEC Partnerships for Children program. Data in the fourth year of the program indicate that 84% of children in this age group had at least 1 well-child visit in the past year (Fig 1). Children cared for in partnership practices also used the emergency department significantly less than children whose care was provided in nonpartnership practices.

There have been other positive developments directly or indirectly related to the Partnerships for Children program. One of the most important advances has been the establishment of a mechanism for Medicaid and managed care organizations to fund preventive and rehabilitative services (PRS). Collectively, PRS activities promote and support the use of primary care services by assisting in compliance with medical appointments, encouraging use of a medical home, and overcoming barriers to using primary care services. These activities also encourage healthy lifestyles and behaviors by teaching life-related coping skills, counseling about risk reduction, and assisting with behavior changes to benefit health outcomes. Recognizing and providing resources for this critical clinical-support element ensure the effectiveness and sustainability of the relationship between physicians and public health professionals. Also, because the medical home concept of delivering care has become the standard of care and best-practice model, Partnerships for Children practices in South Carolina have the platform to continue to improve care delivery in this environment.

**EXAMPLES**

The following brief descriptions of 3 types of clinical support activities in representative South Carolina Partnerships for Children practices should allow for better understanding of some of the operational specifics involved.

In a community with only 1 pediatric practice, there was a need for more nursing support and interaction than the physician’s office could accommodate. An arrangement was developed for a public health nurse, working with a mutually established protocol, to be located in the practice at a specified time each week to develop a relationship with families in need of additional services. Hospital and follow-up home visits are established for new mothers; assistance with keeping well-child appointments is offered, and a full range of care coordination services including transportation, health education, and after-hours telephone advice are made available.
nurse concentrates on closely following families of children from birth to 1 year of age to instill parenting and child care skills that can be carried forward into the toddler stage and school-aged era. No-show rates for scheduled well-child visits have declined from 50% to <10% in this practice.

Another common model demonstrated in Partnerships for Children practices involves the stationing of a PRS liaison within a primary care practice or assignment to (but not necessarily stationing within) an individual practice. The liaison works to decrease fragmentation of services and links patients and families to other community resources as appropriate. Patient and family member education is a key component of this model. Classes that relate to a patient, a family, or a group of patients or families often are conducted in the physician’s practice.

A third partnership model relies heavily on a PRS liaison working with individual patients and families to reinforce clinical care and support in areas that directly or indirectly affect the ability to reap the maximum benefit from clinical care. In these models the liaison helps to ensure that patients do not present late for acute care and encourages them to call their physicians early when symptoms arise. They assist the individual and family members with understanding and adhering to the plan of care. There is ongoing monitoring for risk-taking behaviors and appropriate education and counseling if such behaviors are found. Finally, the liaison tries to facilitate a stable living environment, a healthy family-support network, and adequate finances.

CONCLUSIONS

As the Partnerships for Children program in South Carolina continues to mature, it is well positioned to encompass the criteria that characterize a medical home as defined by the AAP. A recent development has been the willingness of some payers to consider funding care coordination activities that take place in the physician’s office and the community. Care coordination is defined as the process of linking patients and families to community services and resources with the goal of maximizing the effectiveness and efficiency of health care delivery. In practice, this activity often involves the development and implementation of a specific care plan for children with special health care needs. Recent reports have identified limited time and lack of medical staff in offices as significant barriers to providing care coordination services. Human resources (public health professional staff) and financial resources (through payment for PRS and care coordination) are available to Partnerships for Children practices and can effectively reduce or eliminate these barriers. In addition, the resources of public health and unique community assets are embedded in these practices so that they can continue delivering quality care to children that is evidence-based and recognized as best practice. It has indeed been an amazing decade for me, the SCAAP, the AAP, the DHEC, and, most importantly, the children and families we serve.

REFERENCES

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