To improve children’s health outcomes and to save health care dollars, the American Academy of Pediatrics (AAP), Institute of Medicine, and others have called for health care delivery transformation.1,2 They recommend community child health activities and advocacy that address morbidities such as asthma, environmental toxicity, mental health concerns, obesity, substance abuse, and violence. The Residency Review Committee of the Accreditation Council for Graduate Medical Education has required community health and advocacy educational components.3 The AAP and others are sponsoring residency programming and faculty development, learning collaboratives, and issue-based community health and advocacy opportunities.

With all this emphasis on community child health, the findings in the article “Pediatrician’s Involvement in Community Child Health from 2004 to 2010”4 appear counterintuitive. Using AAP periodic surveys, Minkovitz et al have been monitoring pediatricians’ involvement in community child health. In 1989, 56.6% of pediatricians reported community health engagement, rising to 59.4% in 1993 and then falling to 45.1% in 2004,5 and 39.9% in 2010.4

However, this trending is only 1 part of the story. Seventy-seven percent of the surveyed pediatricians feel very or moderately responsible for child health. Those pediatricians who received formal training in community health and advocacy are significantly more likely to practice it. Furthermore, the percent of pediatricians who have a moderate/high level of specific community health skills has increased since 2004.4

The big issue is not whether pediatricians have the motivation. Nor is the question whether educational tools are available to boost community health and advocacy know-how. The big issue is whether the pediatric field has a strategy to integrate our child health activities into the changing health care system.

In the late 1990s, pediatrician and philanthropist Anne Dyson challenged pediatricians to “think outside the box” in tackling the millennial morbidities. As a continuity clinic preceptor, she worried that the least prepared doctors were expected to care for the most complex problems. She could not understand how a new intern was supposed to alleviate the social, economic, and health burdens of a 15-year-old mother living in a domestic violence shelter.

For Dyson, the answer was an integrated program of service and training.4 Just as residents learn to care for cardiac patients by following the role model of the cardiac attending physicians, she saw the need for a pediatric faculty truly engaged in the practice of community child health and advocacy. Once teachers were “walking the walk,” their students could follow.

Dyson also asked, “Why do older pediatricians conduct more child health advocacy than younger doctors?” Minkovitz et al suggest that systems challenges constrain young doctors more than well-established...
practitioners. These challenges include fee for service, high throughput care, lack of integration of services (particularly physical and mental health services), poor articulation of pediatrics and public health care, high debt load on young physicians, and inadequate support for underrepresented minority physicians. The failing economy and increased fiscal pressures on physicians has intensified these problems since the early 1990s.

The goal of the Annie Dyson Community Pediatrics Training Initiative was to embed community health and advocacy into the fabric of what it means to be a pediatrician, not added-on volunteerism. This meant integrating community health activities into the health care system, with adequate time and reimbursement.

Minkovitz et al suggest that the transformation under the Affordable Care Act (ACA) is a possible breakthrough to allow this to happen. Preventive services, the medical home, wellness, breastfeeding, and home visiting are all expanded, and many of the new activities include substantial funding. The challenge ahead for pediatrics is to create an explicit social strategy to engage in ACA-promoted community health initiatives. For starters, training programs at the residency level should develop sustained community health programming and service. ACA offers funding support for academic health centers to become involved in training in “new competences,” community health and community health worker training, public health epidemiology, home visiting for early childhood development, among other initiatives. Young physicians should participate actively in the expanded National Health Service Corps, which offers substantial loan forgiveness. Future continuing medical education in community child health should offer detailed information on how practitioners can engage in wellness programs and learning collaboratives. This opportunity to expand community child health has been long in coming, the product of serious debate, conflict, and negotiation. There is a real chance that the next periodic survey will not only show a strong knowledge base and a high level of commitment but also an increased level of involvement by pediatricians in the attack on socially determined causes of child ill health and in the promotion of child, growth, development, and wellness.

REFERENCES

7. CCH. CCH’s Law, Explanation and Analysis of the Patient Protection and Affordable Care Act. 2 vols. Riverwoods, IL: Wolters Kluwer/CCH; 2010
Transforming Child Health Care
Judith S. Palfrey

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