

History of Community Pediatrics

Alpert JJ. History of community pediatrics. *Pediatrics*. 1999;103:1420–1421

In this brief commentary, Alpert reviews the history of community pediatrics in the United States, from its beginning in the mid-19th century through 1999. Alpert also discusses the Community Access to Child Health (CATCH) program, which has had a significant impact on community pediatrics.

Haggerty RJ. Community pediatrics. *N Engl J Med*. 1968;278:15–21

In this article written in the late 1960s, Haggerty comprehensively discusses the basic cornerstones of community pediatrics, focusing on the inclusion of medical students in the research, philosophy, and care of patients, using a community approach to pediatric care. This is an excellent resource for individuals interested in the foundations and early applications of community pediatrics.

Community-oriented Primary Care

Chamberlin RW. Preventing low birth weight, child abuse, and school failure: the need for comprehensive, community-wide approaches. *Pediatr Rev*. 1992;13:64–71

Chamberlin asserts that the United States must adopt a community-wide approach to identifying and eradicating certain medical and psychological issues to prevent a cycle of individual, family, and societal dysfunction. He establishes a connection between early health and developmental problems and lists a number of individual and community risk factors that could be corrected or improved through targeted intervention programs.

Basing much of his research on Schorr's *Within Our Reach: Breaking the Cycle of Disadvantage*,¹ Chamberlin describes the success of programs that have increased access to comprehensive, community-based services, such as neonatal care programs established in a number of states that have reduced the frequency of low-birth-weight neonates while also reducing the amount of money spent on neonatal intensive care.

Chamberlin believes that primary prevention should focus on preventing medium-risk families from becoming high-risk instead of focusing most

resources on high-risk families. In this article, he states that it is important to have cooperation and support on all government levels, as well as support from the local community. Specifically, Chamberlin identifies defining a geographic area, developing a broad-based coalition, building an accurate database, establishing an overall framework, providing a variety of proven programs, using marketing skills, and forming a local advocacy group as essential components of a successful community-wide program.

Kark SL, Kark E. An alternative strategy in community health care: community-oriented primary health care. *Isr J Med Sci.* 1983;19:707-713

This article examines applications of community health care in both urban and rural communities in Israel. It includes a review of the basic features of community-oriented primary health care systems, which most notably include accessibility of the practices and participation of community members. Community-oriented primary health care focuses on the social, behavioral, psychological, and environmental aspects of health, and the authors assert that programs must actively involve the community members the program is designed to aid. Education of disadvantaged groups and empowerment and ownership of the programs will ensure greater participation and better results.



Lairson DR, Schulmeier G, Begley CE, Aday L, Coyle Y, Slater CH. Managed care and community-oriented care: conflict or complement? *J Health Care Poor Underserved*. 1997;8(1):36–55

Lairson et al look at the history of community-oriented primary care and health maintenance organization (HMO) models, comparing the strengths and weaknesses of each model. Compared criteria include the following: (1) structure of the models, including target populations and cost control methods, (2) process that examines the focus of each model, and (3) an outcome that is measured by equity, effectiveness, and efficiency. Lairson et al discuss the outline of a conceptual model—a hybrid of the community-oriented primary care and HMO models that would merge the strengths of both models—specifically focusing on the role of technology, sources of funding, and the importance of relationships between governmental agencies.

Mullan F. Community-oriented primary care. *N Engl J Med*. 1982;307:1076–1078

In this brief editorial, Mullan asserts that the medical field has not made the most of opportunities provided by the dual community medicine and primary care movements and challenges the United States to adopt a widespread, community-oriented primary care system. Although examples of community-oriented primary care are in place, Mullan argues that adopting a more comprehensive system not only would improve existing programs but also would unify the medical field and improve both public and private practices by creating a cost-efficient database. Mullan argues that change must start with the education of primary care physicians.

Nevin JE, Gohel MM. Community-oriented primary care. *Prim Care*. 1996;23:1–15

After providing a brief history of community-oriented primary care, Nevin and Gohel discuss the key elements needed to establish a successful model. They stress the importance of designating the community to be studied as *predefined*, *practice-defined*, or *problem-defined*, as well as identifying and prioritizing health problems within the community. The article briefly mentions common obstacles facing the community-oriented primary care model, such as working with limited resources, limited expertise for most practitioners, and reimbursement. Case studies are provided to illustrate success in the design and evaluation of a number of interventions.

Community Pediatrics and Private Practice

American Academy of Pediatrics Medical Home Initiatives for Children with Special Needs Project Advisory Committee. The medical home. *Pediatrics*. 2002;110:184–186

The American Academy of Pediatrics (AAP) believes that primary care physicians should provide medical care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. Physicians should work to develop a partnership with families that is based on mutual responsibility and trust. These are the core characteristics that define the *medical home*. The AAP believes that when all these elements come together, children receive care that is cost-effective and of higher quality than primary care provided in emergency departments or urgent care facilities.

American Academy of Pediatrics Committee on School Health. School health centers and other integrated school health services. *Pediatrics*. 2001;107:198–201

The AAP recommends that a number of core screening, diagnostic, treatment, and health counseling services be provided by every school. Procedures should be in place to address management of medical emergencies, medication delivery, services for children with special health care needs, referral guidelines, and use of screening tools. This policy statement addresses the benefits of providing such services and asserts the importance of integrating health services with the educational sector.

Schools can successfully expand access to health care services for all students when their programs include careful community assessment and endorsement, are integrated with existing school health programs, have a sound plan for financial sustainability, and pay adequate attention to quality assurance, evaluation, promotion, and integration within a medical home. In this manner, school health services can be an effective vehicle for integrating medical care and psychosocial care within an educational environment.

Margolis PA, Lannon CM, Stevens R, et al. Linking clinical and public health approaches to improve access to health care for socially disadvantaged mothers and children. *Arch Pediatr Adolesc Med*. 1996;150:815–821

A feasibility study was conducted in North Carolina to see if it was possible to link clinical and public health approaches to improve care for disadvantaged children. Ninety-three first-time pregnant, Medicaid-eligible women were selected in 2 counties in North Carolina—1 rural and 1 urban. Data were collected at the time the women enrolled in the study, within 1 month of the infant's birth, and

when the infant reached 6 months of age. This study indicates that a link between clinical and public health approaches can be established with positive results, although a number of challenges can impede the progress. Identified problem areas include training time for nurses, coordination efforts with other child health initiatives, physician concerns about working with Medicaid recipients, and changing the structure of office routines. However, researchers concluded that it is possible to implement interventions for home-based, at-risk children.

Nazarian LF. A look at the private practice of the future. *Pediatrics*. 1995;96:812–816

Nazarian notes that although infectious diseases have been on a general decline for US children, there has been a steady increase in psychosocial disorders and a slow decline in the number of autonomous pediatric practices. Nazarian describes the private practice of the future, which will address issues such as learning disabilities, behavior problems, substance abuse, and family dysfunction as readily as private practices of the past treated infections.

Rosenbloom AL. A public/private partnership providing an integrated system of health care for children. *Clin Pediatr*. 1993;32:597–600

This article is a review of the Children's Medical Services Program of Florida, which was created to provide comprehensive and coordinated care for children with chronic illnesses. Rosenbloom discusses the components of the program, which include regionalization, funding strategies, case management, and private-sector involvement.

Rushton FE, Wolff B, Byrne W, Cooper S, Porter R, Burton M. Public-private partnerships: working at the local level to increase the quality and number of medical homes for Medicaid children. *J SC Med Assoc*. 1999;95:14–19

The South Carolina Department of Health and Environmental Control awarded 4 communities grants to create public-private partnerships that address access to health care for at-risk children. Among the issues addressed were fragmentation of care, obstacles to participation in Medicaid, and barriers to performing Early and Periodic Screening Diagnosis and Treatment program visits.

The authors discuss the findings and share recommendations for other health care professionals about ways to promote partnerships among public and private practices.

Sia CC. Abraham Jacobi Award address, April 14, 1992: the medical home: pediatric practice and child advocacy in the 1990s. *Pediatrics*. 1992;90:419–423

Sia discusses his role as a practitioner in adapting an integrated approach to treating children. Specifically, Sia worked with health, education, and human services agencies to design a health care system that addressed the entire child and ensured that more children received the care they need. According to Sia, the role of the pediatrician “must be one of a child advocate or activist.”

Models and Assessment

Bergman DA. Thriving in the 21st century: outcome assessment, practice parameters, and accountability. *Pediatrics*. 1995;96:831–835

In this article, Bergman questions whether quality patient care is possible while still adhering to the financial objectives valued by the health care system. Specifically, pediatricians face the challenge of trying to care for entire communities using limited resources. Quality assessment is especially problematic in pediatrics because the viewpoints of the child, parent, teacher, and health care system must be taken into consideration. In addition, there are a number of problems associated with outcome assessment tools, such as designing and using age-appropriate instruments and factoring in outside considerations. Bergman discusses the application of practice guidelines—analytical formulas that define high-quality care—and the use of output from these formulas and outcome assessment instruments to increase the quality of care offered to pediatric patients.

O’Callahan C. Community pediatrics: not only can it be taught, practicing can be easy. *Pediatrics*. 2000;106:1480–1481

In a brief commentary, O’Callahan states that addressing the new morbidities requires a commitment from the pediatric community; however, he believes that it can be done. One of the primary barriers facing community pediatricians is lack of resources and funding. O’Callahan suggests asking communities to help pay for community pediatrics, citing an Indian Health Service clinic in an urban county that agreed a newly hired pediatrician would focus 60% of his or her time on clinical responsibilities and 40% on preventive health. After weighing the challenges against the benefits, O’Callahan concludes that community pediatrics is no different to practice and, in fact, is difficult to stop practicing because it is so rewarding.

Sia CC, Taba SC, Howard-Jones A. The role of the medical home and interprofessional collaboration. *Hawaii Med J.* 1995;54:549–551

The Healthy and Ready to Learn Center establishes a medical home for children by promoting interprofessional collaborative teams of primary care physicians, nurse practitioners, early childhood educators, and social workers to work with families to identify issues that hinder development. The goals of this program are to identify children who are at high risk for school failure and to provide early support and education to lower this risk. Although many challenges can impede the effectiveness of interprofessional collaboration, such as role definition among team members, differences in philosophy and language, and traditional hierarchical medical models, the move from illness-oriented care to cost-efficient well-care is a major benefit of such collaboration.

The authors also discuss the Health and Education Collaboration training program, designed to give preservice professionals experience working in family-centered clinics with collaborative interprofessional teams. As part of this program, trainees are involved in dialogue with families, diagnose and treat children, assess well-care needs of patients, provide developmental information to parents, and educate parents and children. By working together, health professionals can identify and prevent conditions that negatively affect children's development, as well as increase accessibility to services for families with the most need for medical care.

Zuckerman B, Parker S. Preventive pediatrics—new models of providing needed health services. *Pediatrics.* 1995;95:758–762

This article offers a concise overview of innovative programs used at the Boston City Hospital to combat the growing number of problems affecting children. Zuckerman and Parker discuss hiring early childhood educators and child development specialists to provide education for expectant mothers and monitor early development, as well as hiring a public-interest lawyer to provide legal and preventive services.

In addition, this article details a system of 2-generation health care after a connection between a mother's medical needs and the needs of her child become apparent. Ideally, the 2-generation approach would include women's health specialists who work with mothers and pediatricians who educate and provide family planning services to their patients. Because of the link that exists between the psychological health of parents and their children, the authors assert the importance of monitoring maternal depression and paternal addiction.

Community Pediatrics and the New Morbidity

American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health. The new morbidity revisited: a renewed commitment to the psychosocial aspects of pediatric care. *Pediatrics*. 2001;108(5):1227–1230

In 1993, the AAP adopted the policy statement, “The Pediatrician and the ‘New Morbidity.’”² Since then, social difficulties, behavioral problems, and developmental difficulties have become a main part of the scope of pediatric practice, and recognition of the importance of these areas has increased.

The *new morbidity* represents a shift in the understanding of what impacts the health of children and families. Because pediatricians witness complex psychosocial family issues and care for the patients impacted by them, understanding and addressing these issues will make pediatricians more effective in serving children and families. The cooperation of pediatric residency directors, educators, practicing pediatricians, and developmental and behavioral pediatricians is required to train residents and experienced pediatricians, and the authors address specific strategies and areas of focus for accomplishing this.



Haggerty RJ. Child health 2000: new pediatrics in the changing environment of children's needs in the 21st century. *Pediatrics*. 1995;96:804–812

Surveys suggest that 25% of children have a psychosocial problem, 15% to 20% have psychosomatic problems, and 9% to 15% have a chronic medical problem. Haggerty discusses changes necessary to allow pediatricians to serve the children of the 21st century. Among the most notable changes are a deeper appreciation of diversity and multicultural issues, an increased knowledge of foreign diseases as international travel becomes more common, a child-centered approach to care, and a focus on education for parents and children. Haggerty asserts that pediatricians must be trained to deal with traditional problems as well as the range of problems identified as *the new morbidity*. Many medical and psychological conditions may contribute to a child's well-being, and a pediatrician must be equipped to address them all.

Haggerty RJ. Community pediatrics: past and present. *Pediatr Ann*. 1994;23:657–663

A study published in a 1961 issue of *New England Journal of Medicine* found that 25% of adults sought medical care for an illness each month. Another study found that only 8% of children's illnesses were seen by physicians, while more than 60% of illnesses were addressed exclusively by mothers.

Haggerty uses these statistics to frame his argument about the importance of community pediatrics in combating both traditional pediatric problems and the increasing number of health problems known as *the new morbidity*. In addition, Haggerty details the development of a Rochester-based community pediatric program over a 30-year span and looks ahead to the future of integrated community pediatric programs across the United States.

Horwitz SM, Leaf PJ, Leventhal JM, Forsyth B, Speechley KN. Identification and management of psychosocial and developmental problems in community-based, primary care pediatric practices. *Pediatrics*. 1992;89:480–485

To refocus attention on the problems associated with those of the new morbidity, Horwitz et al conducted a longitudinal study of children 4 to 8 years old in the New Haven, CT, area. Clinicians identified at least 1 psychosocial or developmental problem in approximately 27% of the 515 children studied, which is a much higher number than previously reported. The study also found that 31% of children with problems did not receive intervention, 40% received intervention directly from their primary clinician, and 16% were referred to specialists or specialized services.

Results indicate that use of a primary care classification increases the probability that primary clinicians will be cognizant of, and active in, the intervention of

children with psychosocial or developmental problems. Use of this classification also increases the number of referrals to community resources and specialists.

Wilson-Brewer R, Spivak H. Violence prevention in schools and other community settings: the pediatrician as initiator, educator, collaborator, and advocate. *Pediatrics*. 1994;94:623–630

Violence among youth is considered one of the new morbidities and one of the greatest problems facing US youth today. Wilson-Brewer and Spivak believe that pediatricians can have a key role in preventing violence in community settings. The authors identify and discuss a variety of strategies being applied to the problem of youth violence, including educational, environmental/technological, and recreational approaches.

To maximize efficiency, a combination of strategies and levels of intervention must be used. Wilson-Brewer and Spivak identify a number of roles the pediatrician can have in decreasing incidences of youth violence, including serving as initiator, educator, collaborator, and advocate. Because pediatricians have a great deal of credibility with respect to issues related to children and youth, they should use this reputation to educate parents, administrators, and community leaders.

Special Issues in Community Pediatrics

American Academy of Pediatrics Committee on Community Health Services. Health needs of homeless children and families. *Pediatrics*. 1996;98:789–791

It is estimated that families with children represent 43% of the homeless population in the United States and comprise the fastest growing subgroup. An estimated 100,000 to 300,000 adolescents currently live on the streets without the supervision or support of family members or guardians. A number of medical problems commonly are seen in homeless children, including respiratory tract infections, tooth decay, anemia, and trauma-related injuries. A homeless child is 2 to 3 times more likely to have developmental problems than children from poor families who are not homeless. Finally, rates of pregnancy, drug and alcohol abuse, mental illness, and inadequate nutrition are much higher among this population of children.

Committee members urge every pediatrician not only to become aware of homelessness as a societal problem but also to work as advocates for the well-being of homeless children. The committee asserts that pediatricians should educate local agencies on the pervasiveness of homeless families and children, lobby for and

help create national guidelines that address specific health concerns for people living in temporary residences, and seek a variety of sources to contribute money to community-based organizations that work with homeless populations.

Butz AM, Malveaux FJ, Eggleston P, et al. Use of community health workers with inner-city children who have asthma. *Clin Pediatr*. 1994;33:135–141

African American and impoverished children show persistently high prevalence rates for childhood asthma. Communication between health care professionals and children with asthma cannot occur when children lack access to medical care. This excellent study focuses on the effects of recruiting and training community health workers to deal with inner-city, African American children with asthma.

The authors discovered that use of well-trained community health workers was effective in both obtaining medical information and providing basic asthma education to families in the study. The overall results were encouraging and indicated that well-trained community health workers can open lines of communication among inner-city families and primary health care physicians and effectively educate families on asthma-related issues.

Chamberlin RW. “It takes a whole village”: working with community coalitions to promote positive parenting and strengthen families. *Pediatrics*. 1996;98:803–807

Chamberlin supports making preventive health services available to all families and children within a community, arguing that a focus on high-risk children does not alter the underlying conditions that cause children to be high risk in the first place. By providing prevention for all children, pediatricians can prevent low- and medium-risk children from reaching high-risk status.

Chamberlin presents a number of models that have been used to successfully implement community-wide prevention programs, such as the Stanford Heart Disease Prevention Program, the World Health Organization Healthy Cities Initiative, and a family support system developed and commonly used in European countries. Chamberlin notes that communities must develop a number of preventive programs that work in tandem to be successful. Among those preventive programs necessary for maximum effect are comprehensive health care, neighborhood family resource centers, and high-quality affordable child care and early childhood education programs.

Colvard K. Spanking and triage. *Pediatrics*. 1996;98:807–808

In response to Chamberlin’s “It takes a whole village’: Working With Community Coalitions to Promote Positive Parenting and Strengthen Families,” Colvard

disagrees that preventive health services should be provided for all members of the community instead of targeting high-risk children, owing to limited public funds and social services. Colvard states that although only 5% to 8% of children have problems with aggression, 80% of boys growing up in poverty-stricken neighborhoods will be arrested for a violent crime before they reach the age of 18 years. Overall, violence has decreased in the United States except in indigent populations. Reasons include poor education, more exposure to violence in the home and in the streets, and fewer opportunities to learn social competence. For these reasons, Colvard believes that community-based services must continue to target the cross-section that is most likely to fall prey to the range of problems that comprise *the new morbidity*.

Dworkin PH. Ready to learn: a mandate for pediatrics. *J Dev Behav Pediatr.* 1993;14:192–196

Early detection of children at risk for school failure is important because of the potential for early intervention to avert secondary emotional problems such as low self-confidence and poor self-esteem. A 1991 survey of more than 7,000 kindergarten teachers found that 35% of US children were not prepared to learn when they started kindergarten. In addition, more than half the teachers surveyed reported having students with health, nutritional, and/or family problems that hindered school performance.

One solution is to have primary pediatric professionals participate in the early detection of children who are not prepared to begin the process of academic learning. Such efforts of pediatricians must be accompanied by a broad-based societal effort to reinforce the importance of school readiness. The problem lies in identifying the children who are at high risk. Fortunately, pediatricians have a number of tools for gauging school readiness, such as developmental surveillance and anticipatory guidance. Dworkin notes that the key to identifying students at risk of school failure ultimately lies in the exchange of information among parents, health care professionals, and education personnel.

Kaplan LC. Community-based disability services in the USA: a paediatric perspective. *Lancet.* 1999;354:761–762

In 1999, Kaplan asserted that at least 10% of American children had a chronic illness or disability. In Kaplan's estimation, the family must have a prominent role in the identification and treatment of children with illness or disabilities. The author specifically discusses the role the family should have with health care professionals, social service organizations, and funding agencies.

Klein JD, Allan MJ, Elster AB, et al. Improving adolescent preventive care in community health centers. *Pediatrics*. 2001;107:318–327

Although statistics indicate that preventive care is cost-effective, approximately 75% of adolescents do not receive counseling or screening during routine visits to health care professionals. This article is based on a study of care provided by community and migrant health centers before and after Guidelines for Adolescent Preventive Services (GAPS) were applied to 5 clinics. The study indicated a significant increase in the number of adolescents who reported basic screening and counseling during routine visits to their community and migrant health centers, and evaluations indicated that clinicians documented more information about preventive services.

The goal of the authors was to demonstrate that improvements to adolescent preventive care were possible by applying GAPS. Although this study focused on clinics that were equipped to make the changes necessary for the GAPS program, researchers also found increases in the use of preventive medicine services by adolescents at the target sites.

Landis SE, Janes CL. The Claxton Elementary School health program: merging perceptions and behaviors to identify problems. *J Sch Health*. 1995;65:250–254

Results from a case study conducted at Claxton Elementary School in Asheville, NC, are presented in this article. Working together, teachers, administrators, parents, and local physicians identified nutrition and self-concept as the 2 greatest health risks facing their third-, fourth-, and fifth-grade students. Landis and Janes highlight the entire process, from assessing the potential market through focus groups and surveys to interpreting the results and instituting a community-oriented primary care program to better meet the needs of the students. In addition, 7 recommendations for designing and implementing a successful community-oriented primary care project for elementary students are shared, ranging from ensuring parent and teacher involvement to soliciting feedback and evaluation.

Mayster V, Waitzkin H, Hubbell A, Rucker L. Local advocacy for the medically indigent: strategies and accomplishments in one county. *JAMA*. 1990;262:262–268

The Orange County Task Force on Indigent Health Care convened in 1985 to address issues of barriers to access for disadvantaged medically indigent populations in Orange County, CA. The task force included University of California-Irvine faculty physicians, residents, students, health professionals and administrators, county employees, and individuals from local civic organizations.

The task force discovered a low use of preventive services for indigent families, particularly with regard to services provided for these children. This research helped raise local awareness about the cause being investigated, as well as identified specific areas most likely to result in positive change. Overall, the task force determined that a combination of research, political strategies, and legal strategies could increase medical advocacy.

Quigley P, Ebrahim G.J. Women and community health workers promoting community health and development. *J Trop Pediatr.* 1994;40:66–71

Community health and development pertains to the evolution of organizations that aid the poor to increase awareness of available resources and empower communities to find solutions to their problems. The authors of this study discuss 2 methods of gathering data—*rapid epidemiological assessment*, in which health status, impact, and behavior are measured through surveys and questionnaires, and *participatory rural appraisal*, in which participants analyze the problems facing their communities and generate solutions. By combining a technical approach with one that promotes awareness and participation, communities can improve their response to health initiatives and have a positive affect on health status.

This article shows how community health workers can be important influences in the health development process and outlines strategies that help facilitate their contribution. The general ideas conveyed in this article could be applied to any community health setting in which the goal is to educate and improve the conditions of the community.

Redlener I. Overcoming barriers to health care access for medically underserved children. *J Ambul Care Manage.* 1993;16:21–28

In 1991, the federal government recognized 2,000 health personnel shortage areas that were a direct result of the lack of reasonable access to primary health care professionals. This was especially true in a number of child populations that experience specific barriers because of social, economic, or geographic conditions. The care provided for underserved US children is episodic and focuses on acute medical problems as opposed to preventive or screening interventions, anticipatory guidance, and chronic problems. Homeless children are a particularly high-risk population.

The New York Children's Health Project was started in 1987 to address the rising number of homeless children not receiving adequate medical care. A primary goal of the project was to provide a medical home for underserved pediatric populations. The success of this project readily demonstrates that it is possible to provide a medical home for children in a variety of situations in which access to traditional providers is limited.

However, the author asserts that it would be more cost-efficient and effective to extend services at existing health centers and ambulatory facilities.

Rosenberg AE. Conducting an inventory of informal community-based resources for children with physical disabilities: enhancing access and creating professional linkages. *Phys Occup Ther Pediatr.* 2000;20:59–79

As the medical system shifts toward managed care, children with physical disabilities have less exposure to long-term physical therapies. One solution to help combat this perceived lack of attention is to rely on established community resources while involving physical or occupational therapists and other health care professionals. The potential of these programs, if successfully implemented, can include enhanced self-esteem and increased strength, endurance, and flexibility.

This article reports the results of a study conducted in Monroe County, NY, that focused on community-based programs offering sports, recreation/leisure, and arts for children with physical disabilities. The survey found that although participation in programs designed with community-based resources is low, there is interest in and potential with the programs. The author provides valuable information for individuals considering implementation of similar programs in their communities and suggests a number of solutions for moving toward a resource-based model that would allow families to seek reimbursement for consultation or direct services from a variety of community resources. This differs from a traditional service-based model in which reimbursement is allowed only for service personnel and strictly defined clinical services.



Schuster MA, Wood DL, Duan N, Mazel RM, Sherbourne CD, Halfon N. Utilization of well-child care service for African-American infants in a low-income community: results of a randomized, controlled case management/home visitation intervention. *Pediatrics*. 1998;101:999–1005

Children living in poverty are less likely to receive general and well-child care because of barriers that exist in poor communities. One solution is to involve case managers in improving access to services available to low-income families. Schuster et al developed a case management intervention program that was less aggressive than the existing models to increase work with the children's mothers, which they believed would lead to greater use of well-child care services and to increased immunization rates.

Although the intervention had little impact on the use of well-child care visits, a 13% increase in immunization rates for intervention group infants at the end of 12 months was noted. Only 1% of the 13% increase was attributed to the shift in well-child care visits, however, indicating that case managers were more successful at providing education about the necessity of immunizations than increasing the number of visits. Schuster et al concluded that the moderate-intensity visitation program was not effective enough to justify the money spent on the project.

Siegel RM, Hill TD, Henderson VA, Ernst HM, Boat BW. Screening for domestic violence in the community pediatric setting. *Pediatrics*. 1999;104:874–877

Children raised in families that engage in domestic violence often experience negative effects, such as behavior disorders, developmental delays, and depression. Siegel et al screened select women who were at the clinic for well-child visits and not accompanied by their partners. Of these women, 31% revealed instances of domestic violence at some point in their lives, with 17% reporting instances within the past 2 years. Five total incidents of child abuse were reported.

More than half the reported incidents had occurred in the past 2 years, but only 1 case of domestic violence had been reported by this clinic in the 4 years before the study. Although a small sample of women were surveyed, this study did not find a significant correlation between women with private insurance and women receiving Medicaid, suggesting that screening for domestic abuse must be universal if it is to be effective. Several studies have shown that practitioners are reluctant to screen because of a lack of time, knowledge, and experience; however, results indicate that women will disclose domestic violence in a community pediatric setting. It is the authors' recommendation that all pediatricians begin screening for domestic violence.

Valentiner-Branth P, Steinsland H, Santos G, et al. Community-based controlled trial of dietary management of children with persistent diarrhea: sustained beneficial effect on ponderal and linear growth. *Am J Clin Nutr*. 2001;73:968–974

Uncontrolled hospital-based studies in developing countries have reported promising results of dietary rehabilitation of children with persistent diarrhea. This study cites the success of a community-based pediatric dietary program in Guinea-Bissau, West Africa. Children in the treatment group received home-based meals prepared with local food and micronutrient supplements, and their growth was compared with the growth of children in the control group who did not receive meals nor nutrient supplements.

Researchers concluded that although there was no evidence of diarrheal morbidity, children in the treatment group experienced greater ponderal and linear growth after exposure to the meals and nutrients. Although most of the article focuses on the problem of persistent diarrhea, it is a good case study of the theories of community-based methods successfully being applied to target communities.

¹ Schorr L B. *Within Our Reach: Breaking the Cycle of Disadvantage*. New York, NY: Anchor Press, Doubleday; 1988

² American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health. The pediatrician and the “new morbidity.” *Pediatrics*. 1993;92(5):731–733

