The Pediatrician’s Role in Community Pediatrics

ABSTRACT. This policy statement reaffirms the pediatrician’s role in community pediatrics. It offers pediatricians a definition of community pediatrics and provides a set of specific recommendations that underscore the critical nature of this important dimension of the profession. Pediatrics 2005;115:1092–1094; community, pediatrics, pediatrician, role of, definition of, profession.

ABBREVIATION. AAP, American Academy of Pediatrics.

INTRODUCTION

Today’s children and families live in a period of rapid social change. The economic organization of the health care and other human service systems in the United States is undergoing profound changes. Pediatric training programs are searching for the optimal blend of knowledge, skill, attitudes, and experience to prepare tomorrow’s pediatricians for the new challenges and morbidities that they will face. As clinicians and educators encounter new demands on their expertise and resources, it is important to reaffirm the vital and long-standing role of pediatricians in promoting the physical, mental, and social health and well-being of all children in the communities they serve.

DEFINITION OF COMMUNITY PEDIATRICS

The American Academy of Pediatrics (AAP) offers a definition of community pediatrics to remind all pediatricians, generalists and specialists alike, of the profound importance of the community dimension in pediatric practice. Community pediatrics is all of the following:

- A perspective that enlarges the pediatrician’s focus from one child to all children in the community;
- A recognition that family, educational, social, cultural, spiritual, economic, environmental, and political forces act favorably or unfavorably, but always significantly, on the health and functioning of children;
- A synthesis of clinical practice and public health principles directed toward providing health care to a given child and promoting the health of all children within the context of the family, school, and community; and
- A commitment to use a community’s resources in collaboration with other professionals, agencies, and parents to achieve optimal accessibility, appropriateness, and quality of services for all children and to advocate especially for those who lack access to care because of social, cultural, geographic, or economic conditions or special health care needs; and
- An integral part of the professional role and duty of the pediatrician.

For many pediatricians, efforts to promote the health of children have been directed at attending to the needs of particular children in a practice setting, on an individual basis, and providing them with a medical home. This approach, in combination with pediatricians’ own personal community interests and commitments, has proven to be very successful. Increasingly, however, the major threats to the health of America’s children, the new morbidities, arise from problems that cannot be addressed adequately by the practice model alone. These problems include high infant mortality rates, children with chronic health care needs, obesity, disproportionately high levels of intentional and unintentional injuries, exposure to lead and other environmental hazards, substance abuse, behavioral and developmental consequences of inappropriate care and experience, mental health conditions, poor school readiness, family dysfunction, sexually transmitted diseases, unwanted pregnancies, and lack of access to medical homes. An integral component of a community-pediatrics approach incorporates interdisciplinary practice. As former AAP president Robert Haggerty, MD, FAAP, reminded us in 1995, “we must become partners with others, or we will become increasingly irrelevant to the health of children.”

Communities should impart a sense of health, safety, and well-being and promote a supportive environment for families of all types. Just as children depend on the interaction of families in which they live, the communities that support them affect families. The health and welfare of children depend on the ability of families and the community support system to foster positive emotional and physical development. Recently the AAP’s Task Force on the Family examined the concept of family pediatrics and the discipline that must be practiced within the context of the community.
Pediatricians remain instrumental in efforts to create, organize, and implement changes in communities' efforts that can substantially improve the health of children. As far back as Abraham Jacobi, MD (1830–1919), a leading child advocate of his time and a founder of the discipline of pediatrics, pediatricians recognized that children are best understood, and their needs attended to, within interlinking contexts of biology, family, and community. More recently, Haggerty identified the unique contribution and focus of community pediatrics:

Community pediatrics (has sought) to provide a far more realistic and complete clinical picture by taking responsibility for all children in a community, providing preventive and curative services, and understanding the determinants and consequences of child health and illness, as well as the effectiveness of services provided. Thus, the unique feature of community pediatrics is its concern for all of the population—those who remain well but need preventive services, those who have symptoms but do not receive effective care, and those who do seek medical care either in a physician's office or in a hospital.

With the sweeping changes occurring in medicine and other human services, it is especially important now for pediatricians to reexamine and reaffirm their role as professionals in the community, as community pediatricians, and prepare themselves for it just as diligently as they prepare for traditional clinical roles.

RECOMMENDATIONS

1. Pediatricians should use community data (epidemiologic, demographic, and economic) to increase their understanding of the health and social risks on child outcomes and of the opportunities for successful collaboration with other child advocates.

2. Pediatricians should work collaboratively with public health departments and colleagues in related professions to identify and decrease barriers to the health and well-being of children in the communities they serve.

3. Pediatricians should become comfortable with an interdisciplinary collaborative approach and advocacy effort to child health. Pediatricians can play an important role in coordinating and focusing new and existing services to realize maximum benefit for all children.

4. Pediatricians and other members of the community should interact and advocate to improve all settings and organizations in which children spend time (e.g., child care facilities, schools, youth programs). School and community resources should be considered as assets in developing strategies for the problems that children will face now and throughout their lives.

5. Pediatricians should nurture and advocate for neighborhood structures that support healthy families capable of promoting optimal health, safety, and development in their children.

6. Pediatricians should advocate improving the effectiveness and efficiency of health care for all children, striving to ensure that every child in the community has a medical home.

7. Pediatricians should educate themselves concerning the availability of community resources that affect the health and well-being of the children they serve.

8. Pediatricians are encouraged to become involved in the education of residents and medical students in community settings. Pediatricians have the unique opportunity to model roles outside the traditional clinical roles that students and residents encounter. Pediatric academicians should use resources from the AAP and the Ambulatory Pediatric Association to engage the community pediatrician as an educator, both in the care of individual patients in community-based practice and in roles related to promotion of the well-being of all children in the community. Community-based resources outside the bounds of the traditional hospital and outpatient office setting should be used to instruct residents in the effect of the community on child health status and the positive effect of interdependent collaboration of community agencies with health professionals on child health.

9. Medical student, resident, and continuing medical education programs should consider and periodically review basic community pediatric competencies to be included in training and maintenance of certification efforts for pediatricians.

10. AAP chapters and their members should provide leadership for furthering the understanding of community pediatrics and encourage participation in creative, community-based, integrated models such as those supported through the Community Access to Child Health program and the Healthy Tomorrows Partnership for Children.

11. AAP chapters should provide leadership, support, and recognition for pediatricians involved in advocacy efforts at the local, state, and national levels to ensure that children have access to care and to foster integration of these activities as an integral part of the professional role and duty of the pediatrician.

Caring, compassionate, and knowledgeable pediatricians should address the needs of their patients and all children in the context of the community.

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SUGGESTED READINGS


All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.
The Earn-A-Bike Program

As Pediatrics in Review begins a new series focusing on community pediatrics, we are privileged to begin with an introduction by one of the most influential leaders in that area, Dr Robert J. Haggerty, the founding editor of this journal.—LFN

Introduction
The quality of children’s health results from many factors other than the direct medical care they receive in physicians’ offices, important as that is. Critical are the physical, psychological, educational, and recreational environments in which they live. All of these make up a healthy community for children.

The concept of community pediatrics includes dedication to serving all children in a community and to working with other individuals to improve the environment of the communities in which children live as well as to ensure their access to medical care. It is entirely appropriate that Pediatrics in Review begin a section on community pediatrics. This journal has been dedicated, since its inception 27 years ago, to meeting pediatricians’ need for up-to-date reviews designed to help them deliver better health care to children. Our readers serve the children in their offices well, but many do even more in the wider community.

In an article I wrote in Pediatrics in 1999, (1) I observed that there were a number of successful examples of programs that teach the “how to do it” of community pediatrics. Although it is difficult to incorporate this approach into a busy practice, many dedicated pediatricians go the extra mile to serve those not in their practices. They serve in a variety of ways, such as expanding clinical services to children who are not receiving care—for example, by working in community health centers and in agricultural migrant camps—and by securing “CATCH” grants to develop new services for the underserved.

Pediatricians also address the broader issues of improving the environment in which children live by serving on boards of many different community health and social services agencies that seek to change the environment: school boards; local, state, or national planning and advisory committees; and, of course, the many American Academy of Pediatrics (AAP) committees. These pediatricians have been effective advocates for public policy innovations, such as spearheading the passage of seat belt and bicycle helmet laws. Making communities healthy for children requires that pediatricians collaborate with other disciplines and community leaders.

The articles in this series are intended to help practicing pediatricians learn how others have found useful ways to improve children’s health. Almost universally, pediatricians who go this extra mile have found it to be very rewarding.

Robert J. Haggerty, MD

From the Editor of the Series
This new quarterly feature is a partnership between Pediatrics in Review and the AAP’s Community Pediatrics Training Initiative (CPTI). CPTI was founded by Anne E. Dyson, MD, and is generously supported by the Dyson Foundation. (2) The goal of CPTI is to catalyze the broad dissemination of community health and child advocacy within pediatrics. This series reports on residents’
projects that typify the elements of successful community action (3) and are summarized in the project pentad: 1) following your passions, 2) finding the right partners, 3) using evidence-based practice, 4) planning ahead, and 5) leveraging your expertise as a pediatrician. The Earn-A-Bike program includes all of these elements.

Not every physician achieves this level of success with a project. Nevertheless, everyone can do a little bit to improve child health at the community level. Even spending just 1 hour a month away from the office can be helpful. In that amount of time, a pediatrician can serve on the board of a local nonprofit organization, help with an AAP advocacy campaign, or write a letter to the editor of a newspaper.

The stories in this series are designed to inspire and provide practical tips for pediatricians on what works best to combat the many social and environmental threats to the health of our children. Your feedback, including submissions for future articles, is welcome.

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Earn-A-Bike: The Virtuous Cycle of Community Pediatrics in Action
Reducing childhood obesity is a national health priority. (4) As the childhood population becomes increasingly overweight and less active, more type 2 diabetes occurs in children, and other serious medical problems follow. (5)(6) The Children’s Hospital of Los Angeles (CHLA) is located in the inner city, where obesity is rampant. Opportunities for healthy activity are lacking because, among other things, physical education has been cut in schools and parks and recreational centers in which children can play are few.

Marisa K. Bell, a pediatric resident at CHLA, and Somerset Waters of the Los Angeles Bicycle Kitchen created a program that provides adolescents opportunities for increased physical activity. Participants meet twice a week for 8 weeks to learn the skills to build, maintain, and safely ride a bicycle. The bicycle that they build is theirs to keep.

Earn-A-Bike has been an overwhelming success with participants and parents. Alumni have the skills to fix and maintain their own bicycles, know the rules of the road, and use their bicycles for transportation as well as for recreation. An unanticipated positive effect of the program is that it served as a platform for Dr Bell to share her medical expertise in injury prevention and healthy nutrition. Also, alumni have been returning to the Bicycle Kitchen as youth mentors and junior mechanics to help others.

Dr Mary-Ann Limbos, a general pediatrics attending physician at CHLA, mentored Dr Bell throughout the project. Together, they designed an evaluation tool for the program to examine body mass index and activity level. In 2005, Dr Bell was awarded the Krieger Foundation Resident Advocacy Award to develop her project, which also was supported by Community Partners (an incubator of emerging projects and groups). The Earn-A-Bike program has received press coverage from the Los Angeles Times and Bicycling magazine.

The lesson of the Earn-A-Bike program is simple, according to Dr Bell: “Children need ACCESS to activity and to feel that they are a part of something such as a team or a community. We also learned that the participants did not like us doing anything for them; they preferred for us to teach them how to do it themselves.”

Marisa K. Bell, MD
Pediatric Resident
Mary-Ann Limbos, MD
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This project is a model of how partnering with existing organizations multiplies the return on the time invested by the physician. It also illustrates an important point about the evidence-based approach to behavior change. Reducing social and environmental barriers that impede desired health habits is generally more effective than simply providing information. (7)(8) Virtuous cycles indeed!

For more information about Earn-A-Bike, go to www.bicyclekitchen.com

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Taking a Collective Breath to Help Children Who Have Asthma

Childhood asthma is a global epidemic that, in the United States, disproportionately affects the urban poor. (1) Residents Kate Leonard and Maria Mosquera, from Lucile Packard Children’s Hospital at Stanford University, joined forces with their resident colleagues to help create a program to decrease asthma morbidity in East Palo Alto, California, a disadvantaged neighborhood where asthma hospitalization rates are three times higher than in the rest of their county. Their primary partner was the school district, which identified asthma as its top health concern. The residents from two consecutive cohorts agreed to work on this issue under the guidance of general pediatrician Lisa Chamberlain. From a literature review of successful community interventions to reduce asthma, they determined that broad coalitions worked best. (2) Accordingly, they reached beyond the school to partner with the local asthma coalition, the health department, health-care practitioners, pharmacists, community-based organizations, medical students, and undergraduates.

The residents’ project, Health Disparities: Residents and Schools Partnering to Optimize Asthma Care, enjoyed several successes. They identified 495 underserved children who had asthma, conducted asthma education classes with 126 parents and 190 teachers, and made 21 home visits to reduce asthma triggers. They obtained a grant that enabled the school district to hire an asthma case manager who continues to work with the school nurse. They have evidence of improved physician adherence to asthma guidelines and of more children now having asthma plans and inhalers. They are comparing clinical outcomes such as asthma-related emergency department visits, hospitalizations, and school absences, before and after the intervention. An unanticipated positive result of the program is that Drs Leonard and Mosquera and their colleagues recently were asked to chair the asthma coalition for the upcoming year.

Success was made possible by passing the project from one resident to the next. They accommodated time limitations of practicing clinicians with asthma management tools such as easy reference cards that contain guidelines and medications covered by insurance, rubber stamps for writing prescriptions, asthma management plans, and a streamlined school medication authorization form. The residents say that the real key was not just partnering with other physicians, but learning how to be effective members of a broad community-based coalition. For example, they state that mutual respect is important; physicians are not authentic partners if they see themselves as saviors or view others as lacking ability or skills. The residents add that physicians need to capitalize on the strengths and offerings of others as well as make changes on a systems level that do not require continued intervention, resulting in a broader impact than if changes had
been focused at the level of the individual.

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Section Editor’s Note: “First, take a deep breath.” In the hospital, clinicians learn to run “stat” to treat status asthmaticus, but in the community, work moves at a different pace. It is remarkable how much these residents accomplished in 2 years. This was not the result of rushing into action, but of a deliberate process that began with forming relationships, identifying an evidence-based intervention, and building consensus among a wide variety of community partners.

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Drs Legano and Adam did not disclose any financial relationships relevant to this In Brief.

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The discovery of late Stone Age beer jug established that intentionally fermented beverages existed at least as early as the Neolithic period (circa 10,000 BC). Alcohols are hydrocarbons that have a hydroxyl (-OH) group attached. Ethanol is the alcohol found in alcoholic beverages. The most common toxic alcohols encountered clinically
Reducing childhood obesity is a national health priority. (1)(2) After seeing the film Mad Hot Ballroom in 2005, Dr Evan Fieldston, then a resident at The Children's Hospital of Philadelphia, thought that a ballroom dance program in the schools could increase physical activity for disadvantaged children and provide an opening for health education. A team of nine third-year residents led the effort. Each resident made developing the program his or her advocacy-month project so they could implement it longitudinally. Each Thursday, a ballroom dance instructor and one or two residents visited Francis Scott Key public school for about 1 hour. Residents taught a variety of health topics, ranging from asthma to nutrition. The dance instructor, Shana Vitoff, provided weekly lessons at no charge. “Ballroom Dance for L.I.F.E.”—Living Intelligently with Food & Exercise—was piloted with one third-grade class and the enthusiastic support of the teacher, physical education instructor, and principal (Figure).

The students were eager to participate in each dance lesson and reported practicing at home with their parents and teaching others how to perform the foxtrot and cha-cha. When interviewed for television and radio, students stated that the program was a good way to exercise and that it helped them concentrate in class the rest of the day. The health lessons also have been well received, with resident-produced handouts and posters now adorning the classroom walls. For the residents, the

Figure. Students wait to perform in a recital of the Ballroom Dance for L.I.F.E. program.
program has been meaningful because they see the schools and
neighborhoods in which their patients learn and live. Visiting the school
each week has built a connection between the physicians and the
students. Constructing health lessons challenged the residents to keep a
topic brief but informative. The result has been a better understanding
of how to provide anticipatory guidance in the office or hospital.

The success of this program has led to other local schools wanting to
replicate it. Using funds from an American Academy of Pediatrics
CATCH Grant and from a dance party fundraiser, a new cohort of
residents has expanded the program to two schools in Philadelphia. Addi-
tionally, community members and teachers have sought ways to support
the program. In the future, the residents intend to gather data to evalu-
ate the clinical impact on measures such as fitness and body weight. Dr.
Fieldston, who has continued to work on the project as a chief resi-
dent, states: “The experience has been very positive for all, but there is
still a great deal of work to be done.”

Evan Fieldston, MD
Pediatric Residency Program
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Section Headline: Creating Ballroom Dance for L.I.F.E. was
very worthwhile, but it was not a waltz. Although it generally is more
effective for physicians to engage in community pediatrics by collaborat-
ing with existing agencies, sometimes it is necessary to start a pro-
gram from step one. (3) In that case, it is wise to find eager partners and
practice on a small scale, as these residents did. (4) If the first simple
steps are successful, one can advance to more complex activities and seek
support, such as from CATCH, to keep from falling.

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The Children's Advocacy Project of Philadelphia (Cap4Kids) was developed in 2004 to help busy practitioners learn more about social service agencies, advocacy programs, and laws in their geographic area.

The project was started by pediatric residents Raj Raman and, subsequently, Payal Maniar at St. Christopher's Hospital for Children, with attending oversight by Dan Taylor, director of the residency advocacy program. They realized that most physicians were not aware of the myriad social service agencies in their area and, therefore, compiled a comprehensive, verified, up-to-date list of relevant organizations in Philadelphia. This process was extremely time-consuming, but it uncovered many programs and individuals who are committed to improving the lives of children.

The project was funded initially by a grant from the St. Christopher's Foundation for Children and received technical assistance from the Drexel University College of Media Arts and Design to design a web site (www.cap4kids.org) to disseminate the content that had been compiled. In addition to connecting practitioners with service agencies, Cap4Kids provided up-to-date parent handouts and an advocacy teaching tool for residents and students.

After testing the website, the residents introduced it to as many practitioners as possible. To date, they have personally presented this project to all of the medical staff and residents at St. Christopher’s Hospital for Children, Children’s Hospital of Philadelphia, Jefferson University Medical Center, Einstein Hospital, and duPont Children’s Hospital. They also have presented this project to the City of Philadelphia’s Director of Maternal and Family Services, all WIC employees, and the Wireless Philadelphia. Also, with the support of the Pennsylvania Chapter of The American Academy of Pediatrics, they e-mailed announcements to all pediatricians in Pennsylvania.

The initial success of this project can be measured in several ways. Almost 1,000 health professionals, educators, parents, and concerned citizens signed up for the Cap4Kids listserve. The website has had more than 1,000,000 hits—about 2,000 a day. Cap4Kids has been featured in national medical journals as well as in the local newspapers, radio, and television. The following communities have replicated Cap4Kids: the State of Hawaii (Kapi’olani Medical Center), New York City (Mount Sinai), St. Louis (Children’s Hospital of St. Louis), Pittsburgh (Children’s Hospital of Pittsburgh), Central Susquehanna Valley (Geisinger Medical Center), and Baltimore (Johns Hopkins University).

Comments from users of Cap4Kids show how valuable this resource has been for practitioners in Philadelphia:

"A wonderful site! Has truly helped my patients tremendously. Has made me a much more effective and complete pediatrician."

“This is a wonderful resource for..."
WHERE DO YOU GO FOR HELP?

IF YOU OR YOUR FAMILY IS HAVING PROBLEMS WITH...

Finding someone to help?
Money or housing?
School?
Food?
Health?

YOU ARE NOT ALONE.
THERE ARE COMMUNITY RESOURCES THAT CAN HELP!

Go to www.cap4kids.org/philadelphia

CHILDREN'S ADVOCACY PROJECT OF PHILADELPHIA

St Christopher's Foundation for Children

...people who don't easily have access to a social worker to help them find the community resources they need for themselves or their clients."

Daniel R. Taylor, DO
Assistant Professor

Drexel University College of Medicine
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These residents helped children across the country because they lowered barriers separating pediatricians from community agencies. Building and publicizing Cap4Kids.org was much more effective than simply exhorting doctors to use community resources. Their success illustrates the general finding from public health research that one of the best ways to change behaviors is to make the desired behavior as pleasant, productive, and pervasive as possible. (1)

Readers are urged to visit www.cap4Kids.org to explore the types of resources to which the site directs the interested visitor.

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A Smoking Ban in the Heart of Tobacco Country

Pediatricians provide care daily for children who are harmed by secondhand smoke, whether it is a child who has asthma in the pediatric intensive care unit or a toddler who has otitis media. This situation is particularly frustrating because passive smoking is an entirely preventable cause of many childhood illnesses. (1) Beginning in January 2007, the resident advocacy group at Vanderbilt Children's Hospital, led by Drs Warren, Bryant, and Agan, participated in a legislative campaign to ban smoking in public places in Tennessee.

The residents worked with numerous faculty members to review the scientific literature on public smoking bans and to develop a sample letter and a list of talking points based on their findings. Their points emphasized the negative consequences of secondhand smoke in terms of illness and medical costs, the positive impact of smoking bans in other localities, and the overall lack of negative economic consequences from smoking bans (Table). In late February 2007, the residents incorporated the issue into their program's inaugural Advocacy Week, in which several state government officials participated. During this week, members of the resident group presented a lecture on the impact of secondhand smoke on children and began circulating their advocacy toolkit.

The University's legislative liaison, as well as members from the local American Academy of Pediatrics (AAP) chapter and the Children's Hospital Alliance of Tennessee (CHAT), were very helpful in providing guidance in legislative advocacy for children. (2) In early March, residents and their advocacy partners began contacting state legislators by fax, e-mail, phone, letter, and office visits. One of the largest challenges with this initiative was overcoming resistance (among the public and legislators) to smoking regulation in a state where tobacco farming traditionally has been a linchpin of the rural economy. A secondhand smoke ban in Tennessee was not a sure thing. Numerous child advocacy groups in Tennessee (including Campaign for a Healthy & Responsible Tennessee, American Cancer Society, American Lung Association, American Heart Association) also worked on campaigns to promote passage of the bill. The culmination of these efforts was passage of a statewide smoking ban on May 31 that went into effect on October 1, 2007.

Mary Nell Bryan, President of CHAT, commented, "Physicians had a positive impact in helping to pass the ground-breaking smoke-free law Tennessee passed this year. Doctors pack a double whammy: you are constituents of decision-makers and are experts whose opinions are highly regarded on health-care matters. You absolutely can make a difference, so please continue to do so, working with organizations who see advocacy as part of their mission." Speaking for the residents involved in this successful battle for children's health, Dr Warren stated, "We learned that even in the face of powerful, wealthy lobbying against a cause, grass roots advocacy can be effective. If we had the chance to do the project all over again, I think we would partner with even more child advocacy organizations to broaden our message." (Michael Dale Warren, MD, TaTaniisha Bryant, MD, Melissa Agan, MD, Vanderbilt Pediatrics Resident Advocacy Group, Vanderbilt Children's Hospital, Nashville, Tenn)
Table. Clean Air Is Vital For Children’s Health

Children who have never smoked a cigarette die from cigarette smoke. Children who have never smoked a cigarette become very sick from cigarette smoke. It is imperative, for the health of all children, that Tennessee limit children’s exposure to tobacco smoke by banning smoking in all public places.

Children are frequently exposed to environmental tobacco smoke
- One-third to one-half of children are exposed to tobacco smoke on a regular basis. These estimates are based on parent self-report; when urine cotinine levels (a nicotine metabolite) are measured, the truth is that even more children are exposed.
- Children who live in poverty or in households with low education levels are more likely to be exposed to environmental tobacco smoke.
- Children often have little control over their indoor environments and so, unlike adults, may not be able to move away from tobacco smoke.

Environmental tobacco exposure is dangerous to children
- Tobacco smoke is a toxic gas, made up of over 4,000 chemicals. Many of these chemicals, such as formaldehyde and hydrogen cyanide, are known to cause cancer.
- Exposure to tobacco smoke is a known risk factor for Sudden Infant Death Syndrome (SIDS). Tobacco smoke kills children who have never even smoked.
- Tobacco smoke exposure is a risk factor for new cases of asthma, even in children who have never had symptoms of asthma.

Treating the health consequences of environmental tobacco smoke is expensive
- Hundreds of millions of dollars are spent yearly on smoking-related respiratory illnesses in children.
- Asthma is the most common chronic respiratory disease of childhood. Exposure to tobacco smoke results in up to 1,000,000 asthma flares each year. These flares often result in emergency department visits, hospitalizations, and medication prescriptions.
- Exposure to tobacco smoke results in nearly 800,000 doctor visits per year for otitis media (ear infection). In addition to the costs associated with the office visit, there are costs for prescription medications as well as missed work time for parents.

Bans on smoking in public places are effective ways to reduce children’s environmental tobacco smoke exposure
- Urinary cotinine levels in children are reduced when smoking bans are in place.
- Public smoking bans result in reduced inflammation and improvement in lung function tests in asthmatics.
- Hospitality workers, frequently exposed to tobacco smoke, have less exposure to tobacco smoke and have less irritant symptoms when public smoking bans have been initiated.

Public smoking bans are not detrimental to the local economy and have widespread voter support
- In Arkansas and Kentucky, public smoking bans did not affect key business indicators, including employment rate, workers’ earnings, and business openings and closings for bars and hotels.
- Public support for smoke-free cafes and bars has increased dramatically in areas with smoking bans.
- 70% of Tennessee voters said they would favor a law banning smoking in public places. 84% feel that exposure to second-hand smoke is a moderate or serious health hazard. 83% said that they feel that state government has a responsibility to protect public health.

Section Editor’s Note. Where there’s cigarette smoke, there’s the fire of advocacy in the hearts of pediatricians. It took more than passion, however, for these residents to light a flame under their state legislature. First, they based their position on solid epidemiologic science, and then they partnered with their local AAP and other experts in legislative advocacy to communicate their message effectively, leveraging their credibility as physicians to further the cause. Unfortunately, as smoking expands globally, the dark power of Big Tobacco has not been extinguished. The torch of child advocacy must be passed on to others all around the world. (C. Andrew Aignec, MD, MPH, Section Editor, Co-Director of the Pediatric Links to the Community Program, University of Rochester School of Medicine and Dentistry, Rochester, NY)

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The Earn-A-Bike Program

As Pediatrics in Review begins a new series focusing on community pediatrics, we are privileged to begin with an introduction by one of the most influential leaders in that area, Dr Robert J. Haggerty, the founding editor of this journal.—LFN

Introduction
The quality of children's health results from many factors other than the direct medical care they receive in physicians' offices, important as that is. Critical are the physical, psychosocial, educational, and recreational environments in which they live. All of these make up a healthy community for children.

The concept of community pediatrics includes dedication to serving all children in a community and to working with other individuals to improve the environment of the communities in which children live as well as to ensure their access to medical care. It is entirely appropriate that Pediatrics in Review begin a section on community pediatrics. This journal has been dedicated, since its inception 27 years ago, to meeting pediatricians' need for up-to-date reviews designed to help them deliver better health care to children. Our readers serve the children in their offices well, but many do even more in the wider community. In an article I wrote in Pediatrics in 1999, (1) I observed that there were a number of successful examples of programs that teach the "how to do it" of community pediatrics. Although it is difficult to incorporate this approach into a busy practice, many dedicated pediatricians go the extra mile to serve those not in their practices. They serve in a variety of ways, such as expanding clinical services to children who are not receiving care—for example, by working in community health centers and in agricultural migrant camps—and by securing "CATCH" grants to develop new services for the underserved.

Pediatricians also address the broader issues of improving the environment in which children live by serving on boards of many different community health and social services agencies that seek to change the environment: school boards, local, state, or national planning and advisory committees; and, of course, the many American Academy of Pediatrics (AAP) committees. These pediatricians have been effective advocates for public policy innovations, such as spearheading the passage of seat belt and bicycle helmet laws. Making communities healthy for children requires that pediatricians collaborate with other disciplines and community leaders.

The articles in this series are intended to help practicing pediatricians learn how others have found useful ways to improve children's health. Almost universally, pediatricians who go this extra mile have found it to be very rewarding.

Robert J. Haggerty, MD

From the Editor of the Series
This new quarterly feature is a partnership between Pediatrics in Review and the AAPs' Community Pediatrics Training Initiative (CPTI). CPTI was founded by Anne E. Dyson, MD, and is generously supported by the Dyson Foundation. (2) The goal of CPTI is to catalyze the broad dissemination of community health and child advocacy within pediatrics. This series reports on residents'
projects that typify the elements of successful community action (3) and are summarized in the project pen-
tad: 1) following your passions, 2) finding the right partners, 3) using evidence-based practice, 4) planning ahead, and 5) leveraging your expertise as a pediatrician. The Earn-
A-Bike program includes all of these elements.

Not every physician achieves this level of success with a project. Nevertheless, everyone can do a little bit to improve child health at the community level. Even spending just 1 hour a month away from the office can be helpful. In that amount of time, a pediatrician can serve on the board of a local nonprofit organization, help with an AAP advocacy campaign, or write a letter to the editor of a newspaper.

The stories in this series are designed to inspire and provide practical tips for pediatricians on what works best to combat the many social and environmental threats to the health of our children. Your feedback, including submissions for future articles, is welcome.

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Earn-A-Bike: The Virtuous Cycle of Community Pediatrics in Action

Reducing childhood obesity is a national health priority. (4) As the childhood population becomes increasingly overweight and less active, more type 2 diabetes occurs in children, and other serious medical problems follow. (5)(6) The Children's Hospital of Los Angeles (CHLA) is located in the inner city, where obesity is rampant. Opportunities for healthy activity are lacking because, among other things, physical education has been cut in schools and parks and recreational centers in which children can play are few.

Marisa K. Bell, a pediatric resident at CHLA, and Somerset Waters of the Los Angeles Bicycle Kitchen created a program that provides adolescents opportunities for increased physical activity. Participants meet twice a week for 8 weeks to learn the skills to build, maintain, and safely ride a bicycle. The bicycle that they build is theirs to keep.

Earn-A-Bike has been an overwhelming success with participants and parents. Alumni have the skills to fix and maintain their own bicycles, know the rules of the road, and use their bicycles for transportation as well as for recreation. An unanticipated positive effect of the program is that it served as a platform for Dr Bell to share her medical expertise in injury prevention and healthy nutrition. Also, alumni have been returning to the Bicycle Kitchen as youth mentors and junior mechanics to help others.

Dr Mary-Ann Limbos, a general pediatrics attending physician at CHLA, mentored Dr Bell throughout the project. Together, they designed an evaluation tool for the program to examine body mass index and activity level. In 2005, Dr Bell was awarded the Krieger Foundation Resident Advocacy Award to develop her project, which also was supported by Community Partners (an incubator of emerging projects and groups). The Earn-A-Bike program has received press coverage from the Los Angeles Times and Bicycling magazine.

The lesson of the Earn-A-Bike program is simple, according to Dr Bell: “Children need ACCESS to activity and to feel that they are a part of something such as a team or a community. We also learned that the participants did not like us doing anything for them; they preferred for us to teach them how to do it themselves.”

Marisa K. Bell, MD
Pediatric Resident

Mary-Ann Limbos, MD
Attending Physician
Children's Hospital of Los Angeles
Los Angeles, Calif

This project is a model of how partnering with existing organizations multiplies the return on the time invested by the physician. It also illustrates an important point about the evidence-based approach to behavior change. Reducing social and environmental barriers that impede desired health habits is generally more effective than simply providing information. (7)(8) Virtuous cycles indeed!

For more information about Earn-A-Bike, go to www.bicyclekitchen.com

References:
2. AAP Department of Community Pediatrics Training Initiative Web site: www.aap.org/commped/cpi


10 TIPS FOR CHILD ADVOCATES

1. Choose your issue. Personal experiences, community issues, and data on system wide disparities are all sources of potential advocacy issues. Decide what it is you'd like to change.

2. Identify solutions. Prepare a list of possible ways to successfully resolve your issue.

3. Identify supporters. Chances are good that you're not the only person or group advocating for an issue. Talk to parents and parent groups. Use the Internet to find other people or organizations that are working on related issues and seek their assistance. Equally important is choosing a legislator or other government official who will sponsor and be a champion for your issue.

4. Develop a strategy. Will you advocate for change on the local, state, or federal level? Which of the three branches of government-executive, legislative, or judicial, is best positioned to help you achieve your desired outcome? Who will oppose your efforts and what can you do to neutralize the opposition?

5. Frame your message. Work with someone who has experience in public or media relations to help develop and disseminate a clear, concise, and consistent message to help advance your issue.

6. Educate. Attend community, state, and national organization meetings. Offer to be a speaker at a civic group or philanthropic organization, or professional society event. Meet with lawmakers and other government officials. Write letters to your newspaper.

7. Mobilize supporters. Democracy is not a spectator sport! Establish and activate e-mail alert systems and telephone trees to ensure that supporters make their lawmakers aware of the need and support for your initiative.

8. Testify. Offer to tell your story at a public hearing. The personal experiences of constituents are very powerful in convincing government officials to make changes.

9. Don't give up. Often times, it takes more than one attempt to enact a new law or implement changes in public policy. Take Thomas Jefferson's advice, "Eternal vigilance is the price of freedom."

10. VOTE! Pay attention to what candidates are proposing for children...and make your decisions accordingly. Remember, these are the people who will be making decisions about your issue. Take a child with you when you vote to teach them about this important civic duty!
Locate Community Activities:

http://www.cityofgainesville.org/

http://www.co.alachua.fl.us/

http://www.gainesville.com/

www.connectforkids.org

www.helpyourcommunity.org

http://www.unitedwayncfl.org/

http://podarco.skippypodar.net/4aaaa/index.html

Data to support causes/research:

https://per?data.hrsa.gov/mchb/mchreports/Search/search.asp

http://www.cdc.gov/nchs/about/major/slaits/nsch.htm

http://www.floridahealthstat.com/

http://datawarehouse.hrsa.gov/

Sites to learn about legislation:

www.congress.org

http://thomas.loc.gov/

http://www.govtrack.us/