Commentary

Collaborating with Private Sector Physicians: The Example of Childhood Lead Poisoning Prevention

Thomas L. Schlenker

Collaboration between public and private health sectors to achieve public health goals can be difficult. The experience of childhood lead poisoning prevention programs in two cities where private practitioners dramatically increased blood lead screenings is used as an example of how successful collaborative relationships can be constructed. Seven action steps toward effective collaboration are offered: establish a rationale, document the problem, attend to logistics, clarify reimbursement, make known available support, build demand, and demonstrate leadership.

Key words: *childhood lead poisoning prevention, clinical practice guidelines, collaboration, local health officer, local public health, private medical sector*

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MUCH OF WHAT public health strives to achieve is dependent, at least in part, on the efforts of private physicians practicing in communities. Private physician participation in surveillance systems, childhood immunization efforts, and cancer screening programs represent collaborations that form the basis of some of the most important work of public health. Relative to the subject of this article, Weitzman et al[1] state that "there is perhaps no other child health problem the prevention and treatment of which requires such close collaboration between personal health and public health services as is the case of lead poisoning."[1(p 80)]

Unfortunately, as the Institute of Medicine (IOM) warns, there is a "lack of a natural alliance" between public and private health sectors and traditionally, "many physicians look down on public health, as an organized activity, believing it to be second-rate or meddlesome."[2(p 130)] Starfield calls the public/private relationship an "unstable coexistence."[3(p 1 365)] Moreover, since World War II, functional separation and cultural divergence between the two sectors has increased.[4] Thus, the necessary task of collaboration can be daunting.

For approximately the last decade, the national effort to eliminate childhood lead poisoning, directed

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by the Centers for Disease Control and Prevention (CDC), has been challenged by this "lack of a natural alliance." There often is a great gap between public health practitioners who set policy and provide community nursing and environmental services and practicing physicians who are exhorted to screen children through blood lead testing and provide ongoing medical oversight. To date, despite the public/private composition of the advisory committees that guided the construction of the CDC's 1991 document promoting universal screening of all children 1–6 years old[5] and the 1997 document that recommends more targeted screening,[6] approximately 75 percent of U.S. children remain unscreened.[7]

Low screening rates should not be surprising in that it has been noted that clinical practice guidelines, in general, "have been remarkably unsuccessful in influencing physicians."[8] It is hoped that the *Guide to Community Preventive Services* currently under development by the CDC will be more successful than past guidelines in changing medical practice patterns, but much will depend on its implementation.[9]

Barriers to effective private sector screening and appropriate follow-up care for children with lead poisoning include the belief among childrens' physicians (pediatricians plus family and general physicians who care for children) that lead exposure does not occur in the communities they serve, the fact that most follow-up care is nonmedical, concerns about the validity of testing methods and their feasibility in the office setting, and anxiety over reimbursement. In addition to nationally promulgated clinical practice guidelines, overcoming these barriers requires the initiative of local public health agencies.

Ten years of experience collaborating with the private sectors in two very different metropolitan areas, one with a high prevalence for lead poisoning (Milwaukee, Wisconsin) and one with a low prevalence (Salt Lake City, Utah), shows that local public health can effect change in private medical practice. In both cities, private practitioners dramatically increased blood lead screenings in response to local health department (LHD) efforts. In Milwaukee, over just two years, private sector screenings increased by 600 percent, ultimately reaching 21 percent of the targeted population.[12] In Salt Lake City, during one 12-month period, screenings increased from zero to approximately 150 per month (see Figure 1). Based on this experience, seven action steps toward achieving effective collaboration between the public and private health sectors are presented below.

Seven Action Steps toward Effective Collaboration

1. Establish a rationale

Lead poisoning screening guidelines published by national public health authorities like the CDC and authoritative medical bodies like the American Academy of Pediatrics[13] are necessary but often not sufficient to change significantly the practice of medicine in communities.[14,15] Local public health, informed of the "complexities and tradeoffs" inherent in all screening programs,[16,17] can succeed where national guidance fails if it is able to communicate to local physicians a compelling rationale for screening for lead poisoning among their own patients. Such a rationale should address the seriousness of the disease, its prevalence, the adequacy of screening methods, and the benefits and costs of treatment adjusted for the unique circumstances of each community.

While serving as Deputy Commissioner of Health in Milwaukee, the author, a pediatrician, wrote an article titled "A Rationale for Universal Screening for Childhood Lead Poisoning" that was published in the widely read Wisconsin Medical Journal.[18] The article presented local data interpreted in terms of the guidelines being promulgated by the CDC. By making national policy relevant to local practitioners, it legitimized the issue of universal screening and created a local framework for discussion and debate.

2. Document the problem

In many cases, local public health must document the prevalence and distribution of childhood lead poisoning before it can reasonably expect local physicians to screen for the disease. Current blood lead levels from an appropriately selected sample of children in the community are best.[19] However, fairly accurate estimates also can be derived from U.S. Census data and municipal tax information.[20] Such data can be used to project the actual numbers of children at risk by age, socioeconomic status, neighborhood, and even physician practice catchment area. The problem, thus documented, should be presented to

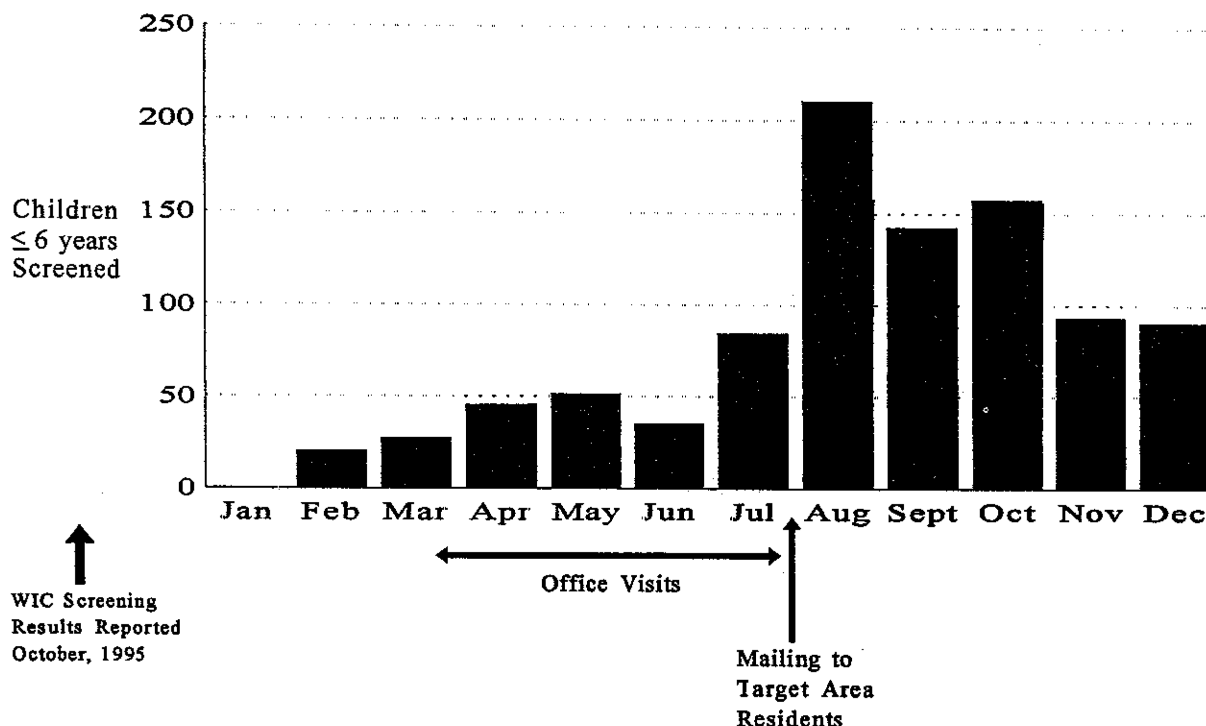

Figure 1. Screening for childhood lead poisoning, Salt Lake County, 1996.

physicians in brief, graphic, and easy-to-read written materials, discussed at grand rounds and other medical meetings, published in appropriate professional journals, actively marketed to the local media, and distributed as directly as possible to the families most at risk. Then, the community challenge of childhood lead poisoning should be revisited with new data in high profile at least once a year. Also, feedback to individual physicians documenting numbers of children screened in their own practices, proportions with elevated lead levels, and case follow-up details may be particularly effective.

In both Milwaukee and Salt Lake City, new data were viewed as an opportunity to present them at media conferences, which usually were held at the homes of lead poisoned children whose parents were eager to help spread the message. In all cases, prior to presenting new data to the media, local physicians were informed of the same by personally addressed letters that also contained clinically oriented information and reminded them of support available through the health department. When a Wisconsin child died of lead poisoning in 1990, the health department made sure that all local childrens' physicians received a copy of the subsequent *Morbidity and Mortality Weekly Review* (MMWR) article.[21] When a lead-poisoned child from Milwaukee appeared on the cover of *Newsweek* magazine in 1991, the health department again sent copies to local physicians.[22] In Salt Lake City, MMWR was chosen as a forum to present the rationale for targeted screening but it was released only after local physicians had previewed the data through a quarterly newsletter produced by the health department and after 10,000 target area families had received a graphic, easy-to-read circular explaining the risks to their children.[19] Thus, for both Milwaukee and Salt Lake City, promotion of the appropriate approach to screening (universal for the former and targeted for the latter) was grounded in local data and analysis.

3. Attend to logistics

In addition to merely providing documentation of the feasibility and effectiveness of office-based blood

lead screening,[23,24] local public health officials should visit physicians' offices and invest the necessary time to train their staffs in phlebotomy techniques, interacting with laboratories, and reporting results. As a preliminary step, the commercial and public health laboratories available for the processing of venous and capillary blood samples need to be surveyed to establish prices, billing procedures, supplies used, transportation of specimens, turnaround time, and other logistical information that is likely to be important to physicians' practices. Although initially labor intensive, such professional outreach creates productive and long-lasting collaborative relationships.

In Milwaukee, the author and/or the lead program nurse (a full-time position donated by Children's Hospital of Wisconsin) visited, over several months, all local pediatricians and some family physicians in their offices. The same was accomplished in Salt Lake City, with the addition of a health educator to the team. Following the visits, health department staff remained in telephone contact with the physicians' offices to troubleshoot the new systems that had been set up.

4. Clarify reimbursement

The plethora of medical insurance systems and the large number of individuals uninsured or underinsured has made reimbursement a nightmare for many U.S. physicians. Managed care and Medicaid arrangements are particularly troublesome. A recent survey reported that only 15 states acknowledged Medicaid reimbursement to private physicians for lead screening.[1] However, in the author's experience, when pushed, Medicaid and managed care programs will acknowledge that they cover lead screening and will work with the local health officer to make their systems accessible to practitioners. Necessary procedures to follow and who to contact if appropriate payment is not received are key elements. Second, because many commercial policies do not cover outpatient care including blood lead testing, it is important to confirm with physicians that screening will be an out-of-pocket expense for many patients while reassuring them that laboratory blood lead processing prices have become very competitive in recent years and are now generally less than $10 per sample. Third, for patients who cannot afford even a small charge, health departments should create funds through grant dollars or local philanthropy that cover screening for those who have no means to pay. In Milwaukee, the Bradly Foundation and in Salt Lake City, three local mining companies, contributed significant amounts to childhood lead poisoning prevention allowing the creation of such funds. Finally, the local health officer should offer to personally intervene with insurance carriers if physicians feel they have been denied appropriate reimbursement. Such an offer eases physicians' minds, creates substantial goodwill, and results in surprisingly few requests to the health officer.

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5. Make known available support

Children's physicians can be expected to provide excellent medical care for patients seen in the office. However, as a general rule, they do not do outreach to patients who do not present themselves for care, do not make house calls, know little about identifying and remediating environmental lead poisoning hazards, and are ill equipped to help children with psychosocial issues in the home. Ironically, they may be unaware that LHDs are willing and able to do all of the above. In the spirit of support for private physicians, which was demonstrated by the New York City Health Department during its diphtheria eradication campaign at the turn of this century[25] and the more recent Monroe County influenza vaccination campaign,[4] local public health should continue to provide to private sector patients services that their physicians do not provide and should take special care to ensure that physicians are aware of the support that is available.

Over the years, the Milwaukee and Salt Lake City health departments have developed user-friendly written materials that are brief and to the point, containing practical information including names and telephone numbers of support staff. These, combined with in-person office visits and a commitment

to respond promptly to all inquiries, helped physicians remember the support services that were available to them and their patients

6. Build demand

Well-educated physicians who understand the need for lead poisoning screening, its local prevalence and distribution, how to implement in-office screening and get appropriately reimbursed, and who are confident of competent support from their LHDs will be inclined further to participate in screening if the clients they serve demand it. In fact, without such demand, the enthusiasm of even the most committed physicians may wane. Parents of children at risk for lead poisoning can be educated and motivated to seek blood lead screening from their physicians if local public health is diligent and skillful in marketing meaningful messages to them. Parents can be accessed through schools, child care centers, children's service organizations, mass media coverage of childhood lead poisoning as "news," by direct mailings, and door-to-door visits in targeted neighborhoods.

Demand increased significantly following the 10,000-piece mailing to targeted neighborhoods in Salt Lake City. In Milwaukee, home visits by community outreach workers were especially effective.[20]

7. Demonstrate leadership

Meaningful public/private collaboration in childhood lead poisoning prevention does require that local public health institutions have the competence, credibility, and audacity to assume leadership positions. IOM puts it very directly, "to achieve public health objectives, public health will need to serve as leader and catalyst of private efforts as well as performing those health functions that only government can perform."[2] It can be expected that some members of the private medical community will be skeptical, even hostile, to public health leadership. Thus, the final step requires that local public health officials have the courage to lead.

Collaborating with private-sector physicians can be difficult, time consuming, and even threatening to some in public health. Nonetheless, it often is necessary and can be very productive. Childhood lead poisoning prevention, using blood lead screenings as a measure of effectiveness, is an example of how effective collaboration can be constructed on a local level.

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