A SUPPLEMENT TO CONTEMPORARY PEDIATRICS®

RESIDENT '94

JUNE 1994

THE REAL WORLD: Pharmaceutical reps

Recurrent abdominal pain

The 16th Street Community Health Center

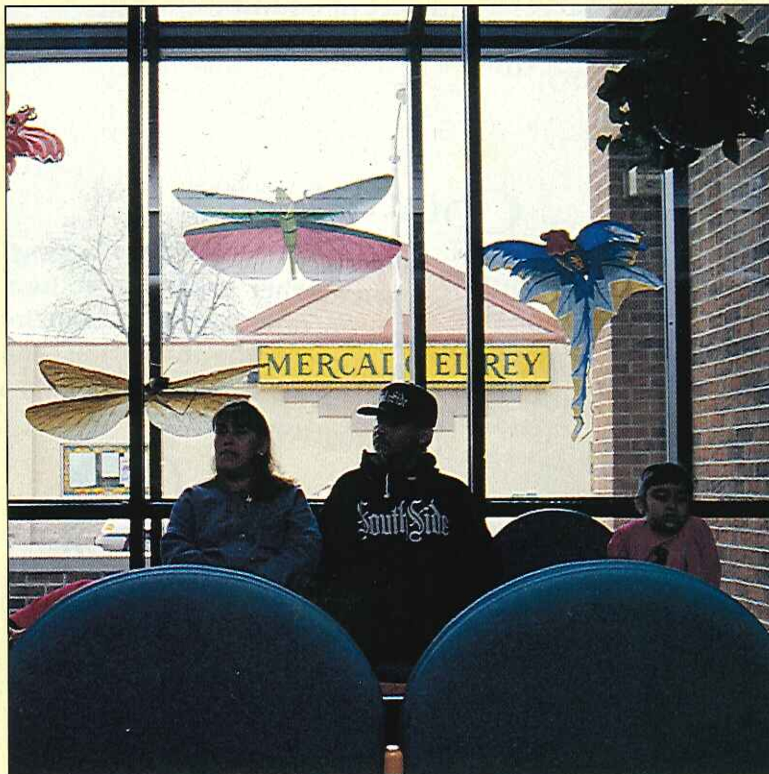
CONTENTS

JUNE 1994/RESIDENT '94
CONTEMPORARY PEDIATRICS

6
THE REAL WORLD
The practitioner and the pharmaceutical rep
GLENN C. SNYDERS, MD
MICHAEL G. BURKE, MD
Keeping up with the latest pharmaceutical innovations is a difficult but vital task. Pharmaceutical reps can be a real help—just so long as you keep in mind where they're coming from.

24
WRITING CONTEST
Just another cold
LYDIA A. SHRIER, MD
In the last issue of *Resident '94*, we promised to publish winning entries in a contest series on "Residency experiences that changed my life." We thought Dr. Shrier's story was a real winner, and we hope seeing it here will encourage more of you to try your hand.

28
Recurrent abdominal pain: Who needs a workup?
J. CARLTON GARTNER, Jr., MD
The pain is real, but organic causes are rare. Elaborate, costly testing "in case" you might be missing an obscure disorder is not sound clinical practice. In 90% of cases, the patient will respond to a careful history and physical and a healthy dose of reassurance.



12
Cover story
The 16th Street Health Center
DAVID WATERS, MD
Have you ever wondered how you could provide top quality primary care to patients who really need your help—and get out from under your debt load at the same time? Let this pediatrician tell you how practicing in a community health center could fill the bill.

DEPARTMENTS

5 EDITORIAL
The importance of anecdotes

27 CLASSIFIED

Picture credits: Cover, 3, 12, 13, 20, Paul Calhoun; 7, Dave Coverly; 28, A. Michael Velthaus.

Copyright © 1994 and published by Medical Economics Publishing Inc. at Montvale, NJ 07645-1742. Contemporary Pediatrics® is a registered trademark of Medical Economics Publishing Inc.

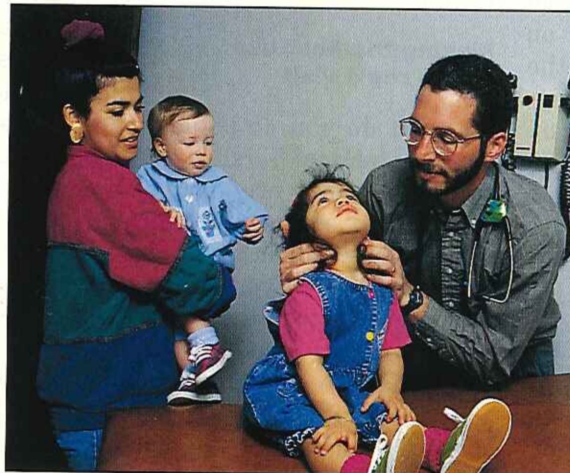
The 16th Street Health Center

By David Waters, MD

Have you ever wondered how you could provide top quality primary care to patients who really need your help—and get out from under your debt load at the same time? Let this pediatrician tell you how practicing in a community health center could fill the bill.

I've been practicing pediatrics at the 16th Street Community Health Center on the near South side of Milwaukee since 1987. I always wanted to practice this kind of medicine, even though— ironically—I got turned down for a scholarship while I was in medical school by the National Health Service Corps (NHSC). The people who ran the NHSC then didn't think a kid who grew up in the suburbs as I did was likely to stay in the kind of work they were trying to encourage, the way they thought someone from the inner-city or a rural area might.

When I was a medical student at the University of Wisconsin in Madison, a group of us who were interested in working with Hispanic patients founded a Spanish medical club and translated medical information into Spanish. Then, when I was a resident in Portland, OR, I got some experience working in several free clinics as a volunteer. In my third year, I took a rotation at the Northeast Health Clinic. It was an interesting model, with a central office staffed by one full-time pediatrician working with medical students and residents, and a bunch of satellite clinics scattered all over the county. The satellites were staffed by pediatric nurse practitioners, who consulted the pediatrician by phone when they needed help. He'd go out to each satellite once a week to see the more difficult and complex patients. I loved it, and after I finished my residency I took over the job for a year. I also worked at a federally funded clinic for migrant workers, in Woodburn, OR.



Dr. David Waters, doing what he always wanted to do—practice pediatrics.

Then one day I came home to Milwaukee, to run in the annual benefit run for the Children's Hospital of Wisconsin. A friend took me out to eat in a Mexican restaurant, and I saw a sign across the street for the 16th Street Community Health Center. I walked in and said, "Who are you and what do you do and do you need a pediatrician?" And they said, "Yes, step right in." They had one pediatrician who was overwhelmed and needed another to help. So I wound up with what I always wanted to do, which was to work with underserved, Spanish-speaking people, in my own home town, about 10 miles from where I grew up. I moved back in July of 1987 and I've been here ever since.

For me, it's the ideal practice setting—an incredibly diverse patient population, the support services my patients need, and freedom to do my work without

THE AUTHOR practices pediatrics at the 16th Street Community Health Center in Milwaukee.

getting bogged down in the details of running a business. All I have to do is what I was trained to do—practice pediatrics. If that sort of a practice option appeals to you, read on.

Dr. Waters' neighborhood

The 16th Street Community Health Center is basically a neighborhood clinic. The area has changed over the last decade, as an influx of Spanish-speaking migrants from Mexico and Hmong refugees from Laos came to live alongside the working class, mostly Polish residents of the area.

Currently, our patient population is about 65% Hispanic, 24% Caucasian, 2% African-American, and about 10% Southeast Asian—mostly Hmong and Laotian—refugees who came here when the US forces pulled out at the end of the Vietnam War, leaving their allies, the Hmong, in danger. Some 6,000 of these Hmong refugees have came to Milwaukee since 1975, and a large number of them are our patients.

About 50% of our patients don't speak any English. Most of our staff speak Spanish, but none of our doctors or nurses speak Hmong or Laotian. We work through clinic translators.

A team approach (at left, Sharon Simi, RN, Lee Vang, nurse-technician, and Nancy Avila, community health worker) provides comprehensive care for a diverse patient population (below).

It's a poor neighborhood, and our patients tend to be even poorer (70% have incomes below the poverty level) than many of their neighbors. It's not the sort of area that can readily support a private practice, and access to primary care services is very limited. The stresses of poverty weigh very heavily on our patients: Poor housing, lead poisoning, crime. Then if, on top of that, the family doesn't understand English and is unfamiliar with the dominant culture, the problems are compounded. So we end up being advocates, especially when we refer patients to other institutions (like the Children's Hospital of Wisconsin, where we refer most of our children) for care. About 38% of our families have no medical insurance and no ability to pay for medical care; about 47% are on Medicaid.

The ethnic and linguistic diversity of the population is one of the joys of working here. When you take care of people from different cultures, you're constantly learning. You take what you learned in medical school, which you're used to applying to people who are Westernized, and you have to apply that knowledge to patients who are culturally diverse. You have to read the patients, pay attention to how they interact with you, anticipate whether they're willing or able to follow your directions. In addition, in order to provide good care, it helps to lis-

What is a community health center?

According to the US Public Health Service, the federal agency that funds them, the purpose of community health centers is to provide "comprehensive, high quality, case-managed, and family-based primary health-care services in rural and urban medically underserved areas." Community health centers are targeted at high risk populations whose multiple health and social problems require carefully designed and coordinated comprehensive care. Most of the families they serve are poor and minority.

The program had its beginnings in the Johnson era "War on Poverty," a time when grass roots community organizing flourished and the notion that service programs should be "community based and community responsive" was an article of faith. To ensure that quality, the legislation under which the program operates mandates that all CHCs are run by community boards whose racial and ethnic makeup mirrors the community. At least 51% of the board members must be patients. No clinic may deny services because of inability to pay. Sliding fee scales start with no charge for families below the poverty level, and rise from there.

CHCs must provide, either on site or through contracts with other entities, a full range of primary care health services: preventive and well-child care, family planning, perinatal services, emergency services, transportation where appropriate, preventive dentistry, pharmaceutical services, case management, outreach, counseling, and referral for specialist care when indicated. Currently, the program has 700 community corporations that operate about 1,400 clinic sites: community health centers (the largest number), centers for migrant workers, and—the most recent additions to the program—centers to serve the homeless.

These clinics figure prominently in the Clinton Administration's plans for expanding access to primary care, because they represent an infrastructure that is already in place, in areas where no other system of care exists. What's more, the centers have a 30-year track record of cost-effective performance as well as extensive experience in overcoming cultural and geographic barriers to care. Studies cited by the Administration to support requests for increased funding show that CHC patients have lower hospital admission rates, shorter hospital lengths of stay, lower total annual Medicaid costs, and lower rates of low-birth-weight babies than similar patients who don't use CHCs.

Says Dave Cavanaugh of the National Association of Community Health Centers, "We can provide an average of three outpatient visits a year for a family at a total cost of $200. That's not cut-rate care, either; it has all the bells and whistles. That's why we're liked on Capitol Hill. It's a combination of being anchored in the community, saving a lot of money, and targeting the underinsured population."

If Cavanaugh is reading Congress's attitude correctly, the Administration should not have much difficulty pushing through a significantly expanded budgetary request (up by $100 million) for community health centers in fiscal 1995. Projected funding requests for the five-year period from 1995 to 2000 increase the program's budget by $4.5 billion. For pediatric residents looking for a spot to start a career in primary care, it all adds up to good news. For more detailed information on how CHCs operate and where you can find them, call the National Association of Community Health Centers at 1-202-659-8008.

ten to the patients about their concerns and to learn about their culture.

Hmong parents who traditionally sought healing only for symptoms of illness may not see the point of routine well-baby care, and many feel that their babies are too small and weak to tolerate all the vaccines you want to give. So you may have to bargain. Many Hmong believe that removing blood drains the body of warmth and disrupts essential harmony; getting a blood sample from a Hmong patient may require a delicate negotiation, carried on via an interpreter who may relay the upshot of a prolonged colloquy with a one-word answer: No. You learn to back off, to hope they'll come back another time when they've learned to trust you.

A diverse patient population brings with them diverse, global pathologies—parasitic diseases, hemoglobinopathies—that you may never have seen before. You send the stool for O and P and the lab identifies something you've never heard of, and you have to go look it up. So the stuff you learned in med school and residency gets expanded in an international perspective. Never a week goes by that something doesn't roll in the door that's new and different and often somewhat bizarre.

In pediatrics, you can only look at so many ears and give so many immunizations before it becomes mundane. You need a twist on it, a language, or a culture, something

that jazzes it up and keeps it interesting. And this job has that.

The 16th Street Health Center

The health center is a private, nonprofit, free-standing entity—not part of any governmental or academic institution, although it has ties to both. It was founded in the late 60s, by neighborhood activists who saw a need to gather information about the health needs of the community and find ways of getting access to care for the people here. To begin with, it was funded by the Office of Economic Opportunity out of community development money. The OEO funds paid the rent on the storefront of the building. They had one physician who volunteered some time, a few residents who ran an STD clinic one night a week, and a nurse practitioner who worked with protocols and did triage.

In the late 70s, the clinic got some Bureau of Maternal and Child Health block grant money and a WIC program. In 1981, they hired their first full time physician, a family practitioner paying back on a NHSC scholarship obligation. They began a grass roots campaign to buy the building, got some city funding for renovation, and some United Way money. Finally, in 1984, the clinic received federal funding as part of the community health service program, with four full-time physicians, professional social workers, and programs for parenting education and nutrition.

Today, we've got a staff of 100. The medical staff includes three

Continued on page 20

The National Health Service Corps wants you!

On a recent swing through the South, President Clinton assured townspeople in tiny Troy, NC, that his health plan had a way to attract primary care givers to their rural area: A "dramatic increase" in funding for the National Health Service Corps to "pay people's way through medical school, let them come out here and practice for a couple of years, and pay their debts." Specifically, President Clinton has asked for an additional $50 million for the Corps, which will bring the total request for fiscal 1995 to $176 million. Proposed funding increases from 1995 through 2000 add up to $950 million.

As the component of the US Public Health Service that recruits health-care professionals for communities that lack adequate access to primary care, the NHSC is a key element in the Administration plans for reform. Sharply cut back in the 1980s, the Corps was reauthorized by Congress in 1990 to run for ten years. "Some people think we don't exist any more," says Dr. Donald Weaver, the Director of the Corps, "but we're alive and well and we think we'll have an important role to play in meeting the needs of the underserved, going where others choose not to go. We appreciate any help we can get in getting that word out to people."

The Corps provides two kinds of assistance: medical school scholarships and loan repayment. Scholarship recipients get money for tuition, fees, books, and a monthly stipend, and are obligated to serve one year in a federally designated shortage area for each year of support. The minimum obligation is two years. The loan repayment program is for physicians who have completed residency and are willing to provide primary care services in a "priority health-professional shortage area" for a minimum of two years. A pediatrician who finds a job at a qualified site can receive up to $50,000 for loan repayment for a two-year commitment, up to $85,000 for three years, and up to $120,000 for four years. Several options for advance payments to reduce interest costs on outstanding loans are available. The program also provides a tax assistance payment (39% of the loan repayment amount) with each quarterly or lump sum payment, to compensate for the increased tax liability.

Each year the NHSC develops a clinician recruitment list of vacancies at sites for which NHSC loan repayment is available. The length of the list varies from year to year, depending on the availability of funds and the number of applicants, but as Dr. Weaver says, "There are always more spots than applicants." In the current recruiting cycle, 278 slots are open for pediatricians. They exist in every state and in the Virgin Islands, in big cities (New York, New Haven, Philadelphia) and small towns (Belle Glade, FL; Johns Island, SC; Port Arthur, TX). To find out where the vacancies are, call the Corps at 1-800-221-9393; they will refer you to a state agency that has the listings for the part of the country you're interested in.

pediatricians and two med/pedes, four FPs, a certified nurse midwife, an ob-gyn nurse practitioner, and a family nurse practitioner. (We have ob-gyns as consultants, but in recent years we haven't been able to keep them on the full-time staff; we can't offer the kind of money they can make elsewhere.) We have excellent nursing, medical assistant, and community health worker staff. Some of the community healthworkers also serve as Hmong translators. Then we have an executive director and an administrative staff, social workers, translators, and nutritionists. We own the whole building, have a roster of 6,000 to 8,000 active patients, and do about 30,000 patient visits a year.

The annual budget is about $2.5 million by now. About half that amount comes from the federal government, part of the urban health initiative of the Public Health Service, and most of the federal money goes for physicians' salaries. The rest comes from a variety of sources: grants (we have a grants manager who spends all her time looking for grants, writing them, and reporting on them); state money; St. Mary's Hospital.

We worry about what would happen if the federal dollars dry up—as we're always being told they will. We get some money now from patients who have insurance, and health reform is supposed to make insurance coverage more widely available—except for illegal immigrants, and we have quite a few of those.

Just show up and practice medicine

What I like best about this job is that all I have to do is show up and practice medicine. I don't have to spend time on billing or insurance forms or paperwork; the administrators deal with that. I don't have to worry about how much money I'm netting; I get paid a salary every two weeks, and I know in advance how much it's going to be. And I don't have to worry about whether the patients can pay; we never turn anyone away.

The place is run like a private practice, not an outpatient clinic or an emergency room. One of us is on call 24 hours a day. We're attendings at the hospital, and admit patients and take care of them in the hospital when that's necessary. The patients are our patients, and we're their doctors. We're as available to patients as any private pediatrician is.

At the same time, we're in a position to do much more for our patients because we can call on all kinds of on-site help. For instance, if a teen or the mother of one of my patients gets pregnant, I refer her to the perinatal team—two perinatal nurses and two outreach workers. From the time pregnancy is diagnosed to six weeks postpartum, the team will make sure she comes in for regular ob appointments and any referred care. They will help her sign up for Medicaid if she's eligible, and enroll in the WIC program. The team does home visits, before and after delivery. I think their intervention does a great deal to minimize low birth weight and other poor outcomes in a population at high risk.

The team makes my job easier, too. Say I see a baby in the hospital who's a little under weight, and I want to make sure that baby's doing OK at home. I can get an outreach worker to check that out, to go to the baby's home, get a weight, see how the feeding's going, assess the home situation. I can refer new parents to our parenting classes; we have a full-time nurse educator on the staff.

We have substance abuse programs, STD testing (including HIV) and treatment, and family planning services. We have a case manager for HIV patients, and a pediatric case manager to coordinate care for complex cases. We are part of the Milwaukee County Child Abuse Prevention Program, which contacts all first-time parents in the county. Two of the program's social workers have offices here, and I can send them out to visit a family if I'm worried

1st time Parenting?

about conditions at home. It's all here, on site.

To me, these services aren't fluff; they're the most vital thing that goes on here. Often, I can't do anything medically for the kind of thing that families come to the clinic for—like curing a toddler's cold. But once the family is here, I can call on all these resources to help them with the issues in their lives that *really* make a difference: nutritional assistance from WIC; housing assistance; social workers to help them navigate the bureaucracy of entitlement programs that are so complex you and I would have difficulty dealing with them.

There's a team approach in a community health center, and the physician isn't always the most important member of the team. Actually, so much of what we deal with are social rather than medical problems, that I think social workers are the most vital staff we have. We currently have two and are thinking of adding a third. The particular mix of services we offer reflects the makeup of our board of directors, which is made up of actively involved people who live in the community and use the clinic's services. (See page 14 for more background on federally funded community and migrant health centers.)

Can you afford it?

The lure of this kind of practice is considerable, especially for someone who is just out of training. You get to do a lot of good work—hard work, but interesting—and get paid to take care of patients, not to run a practice. The question is, can you afford it?

In terms of salary and benefits package, I think the answer is Yes—especially for pediatricians, who tend to have high levels of social commitment and also realize their salaries will be relatively lower, compared to some other specialties. Generally speaking, the package you will be offered is a lot more than you're earning as a resident and somewhat less than you could get in private practice. That's probably true at entry level, and certainly true in the long range.

For many residents, however, the question isn't only a matter of spendable income, but of income sufficient to pay off student loans. That's where a community health center job may have something very valuable to offer: the possibility of federal reimbursement to pay off your educational loans as a member of the NHSC. About 80% of community health centers, including this one, are approved sites for this loan reimbursement program. (For more information on how loan reimbursement works, see the box on page 17.)

Wave of the future

At one time, the idea of making a medical career as a salaried physician caring for poor people in a clinic had a limited appeal. Clinic medicine sounded bureaucratic and second rate, and the financial grass was a lot greener in the world of private practice. It seems to me that those assumptions are changing radically, however. By now, community health centers have a 30-year track record as models of how to provide nonbureaucratic, responsive, top-quality care for poor people. And in a reformed health-care universe, the financial differential between salaried and private practice medicine is bound to diminish.

Somewhat to my surprise, many of the pediatric residents training here at the Children's Hospital of Wisconsin/Medical College of Wisconsin seem to agree. This is a high-powered tertiary care program, and in my experience in the past the residents tended to see the specialists as role models and to pursue specialty training. But last year something changed. Half the graduating residency class went into primary care, and half of them went into inner-city primary care. At the 16th Street Health Center, we hired both chief residents, an amazing coup for us. They came to us saying they didn't want to go to work in the suburbs, that they wanted to take care of people who don't have other available care.

So we said, Welcome. □

This article is part of an ongoing series on career paths after residency. If you have an idea for an article in this series, please write to:

Judith Asch-Goodkin
Executive Editor, Resident '94
Contemporary Pediatrics
Five Paragon Drive
Montvale, NJ 07645
or call 1-201-358-7234.