VOL. 3 | WINTER 2015

The Independent Pediatrician

THIS ISSUE:
Remaining Independent in Challenging Times

www.IndependentPediatrician.com

EDITOR'S NOTE

Independence Day

Welcome to the third edition of The Independent Pediatrician. Our revamped look and feel is the result of feedback from readers and contributors alike and we hope you enjoy perusing this volume as much as we enjoyed creating it.

In this issue, we plan to follow the format of our previous work and highlight the breadth and history of independent pediatric practices across the country. We share stories about independent pediatricians and their practices, each at different points in their careers and development. In future issues, we will endeavor to tie the content together thematically — we will see how that works!

No matter the theme, we will continue to highlight and honor the dedication of pediatricians everywhere who have made it their mission to provide the best care possible for their patients and families. As you read through their stories, we hope and expect that you will recognize a familiar tale and are reminded of why your "job" is so wonderful and important (for a note about "jobs," see the editorial inside from Chip Hart).

> "There are so many things pediatricians can do. Be open to what's out there and take the chance."
>
> – Dr. Cecilia Penn

Feel free to drop us a line about your thoughts at **mystory@IndependentPediatrician.com**. If you have a special story to share, or know someone who does, let us know! As always, you can find our issue online and available to share with colleagues, friends and family at **www.IndependentPediatrician.com**.

Enjoy!

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The Independent Pediatrician

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We want to hear from you!

PCC created this publication to start telling the stories of friends we've made in our 30 years of working with independent pediatric practices. We hope you enjoy learning about these successful practices and that reading about them will inspire you to spread the word and tell your own unique story.

If you would like to be on our mailing list, or want your own copy of *The Independent Pediatrician*, please email mystory@IndependentPediatrician.com

The Independent Pediatrician *is brought to you by PCC, which provides tools and services to help pediatricians remain independent and in control of their practices. PCC itself is a fiercely independent business. As a Benefit Corporation, it puts the interests of its clients, community, and employees on an equal footing with those of its shareholders.*

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The death of Independent Pediatric Practices is greatly exaggerated

Chip Hart
Pediatric Practice Consultant

Chip Hart is a nationally recognized expert on pediatric practice management as evidenced by "Confessions of A Pediatric Practice Management Consultant" (chipsblog.com), his many presentations for pediatric organizations around the country, his work with CCHIT, the AAP, CDC, AHRQ, and more. For nearly 25 years, Chip has worked directly with independent pediatric practices around the country in an effort to share their knowledge and improve the quality of care for children.

BY CHIP HART

Have you ever considered the expression "to earn a living?" The concept is distinguished from your "job" or what you do for "work," and I think both terms — "to earn" and "living" — are important.

As pediatricians, you surely understand the "earn" part. You started with good grades in college. You worked hard and got into medical school. There, you faced long competitive hours of study and even more grades. Massive student debt piled up as you raced into residency where, between long periods of sleep deprivation, you then learned how little you really knew. The pathways to independent practice post-residency are myriad, but in on form or another, you've worked countless hours, shouldered enormous financial risk, and your patients, employees, and partners (if you have any) depend on you to perform small miracles every day.

It's a rare pediatrician I meet who hasn't earned every inch of what he or she has achieved.

The second half of that expression is more interesting to me, however. Living. Being a pediatrician isn't your "work." You didn't throw a dart when you were 18 to watch it land on PHYSICIAN and then, worse, PEDIATRICIAN. It called to you. You like to play with the kids. You get special joy from the positive effect you have on their lives.

In fact, you told us why you chose to be a pediatrician in the first issue of *The Independent Pediatrician* — ultimately, you believe that "Pediatricians deliver pediatric care best. Better than hospitals, insurance companies, or health care organizations."

Being a pediatrician is what you do to *live*.

That's one of the reasons why, when I hear pre-retirement pediatricians talk about walking away from their jobs, I always ask, "To do what?" What other role could you play in your life that would be as fulfilling? If there were an obvious choice, you'd have identified it and gone to it a long time ago!

In this issue, we feature a piece about the Nash family of St. Louis, MO, whose calling to pediatrics is so powerful that it spans across generations. They've earned their American Dream.

An accurate data-driven review of the pediatric world for 2014 isn't yet possible at the time of this writing, but much of the evidence looks positive. Thanks in large part to the Medicaid boosts from the ACA, many pediatric offices have seen a significant improvement to their bottom lines, though it has already disappeared into a puff of smoke — a puff of smoke that is gone before it even arrived for many.

Pediatricians are coding more accurately, CPT slowly creeps towards better valuation of your work, and the general business acumen of pediatric practices improves. On the other hand, the administrative burden has definitely worsened over the last year without a lot of relief in sight. The mess created by narrow networks as health systems compete for covered lives is unconscionable. Add the confusion introduced, and not at all resolved, by the ACA-driven insurance pools and many practices effectively employ a full time employee just to help patients answer the simplest question: is today's visit covered or not?! An insurance card may be the most worthless piece of paper in America right now.

On the technology front, I think we are in the nascent phase of an enormous shift in how medicine is delivered in primary care. Your patients *will* become more engaged (finally!) and interactive with you. In the not-too-distant future, you'll be able to talk with your patient in the exam room, on a screen, at your mutual convenience. Or it will happen asyncronously as you exchange messages with each other in your effort to help them manage their chronic conditions. Can you imagine what someone like Dr. Bill Zurhellen, whose story is inside, could develop for his patients?

The secret to making this new pediatric world order work for independent practices is to get the new patient communication paradigm *paid* for. Fortunately, you can count pediatricians like Dr. Sue Kressly among your peers. Her constant battle on behalf of her patients and pediatricians everywhere has delivered real, long-lasting results.

One amazing trend that we've seen at PCC is the increase in new or "start up" practices. In 2014, we've had a higher rate of these practices than any year I can remember. About a third of PCC's new clients last year started from scratch, having left a larger group or

An example of a successful, small independent pediatric practice in Burlington, VT

otherwise gone out on their own. Our review of Dr. Cecilia Penn's office in the Virgin Islands is a classic example. She knew she would be more effective for her patients and more successful if she *did it herself*. And she was clearly right.

What is behind this potential resurgence of small independent practices? And what about the clear boom in the larger independent group model? I think we're seeing an accelerated version of the pendulum that swung back and forth in the 90s into and out of private practice. Previously, as hospitals and health systems bought up practices, there was a 3-5 year lag before clinicians woke up to their dislike of being "owned" and returned to private practice. Today, I think there are enough doctors with institutional memory and enough stories have been shared with new practices that there are actually pediatricians going independent or forming independent groups before the cycle has even run its course!

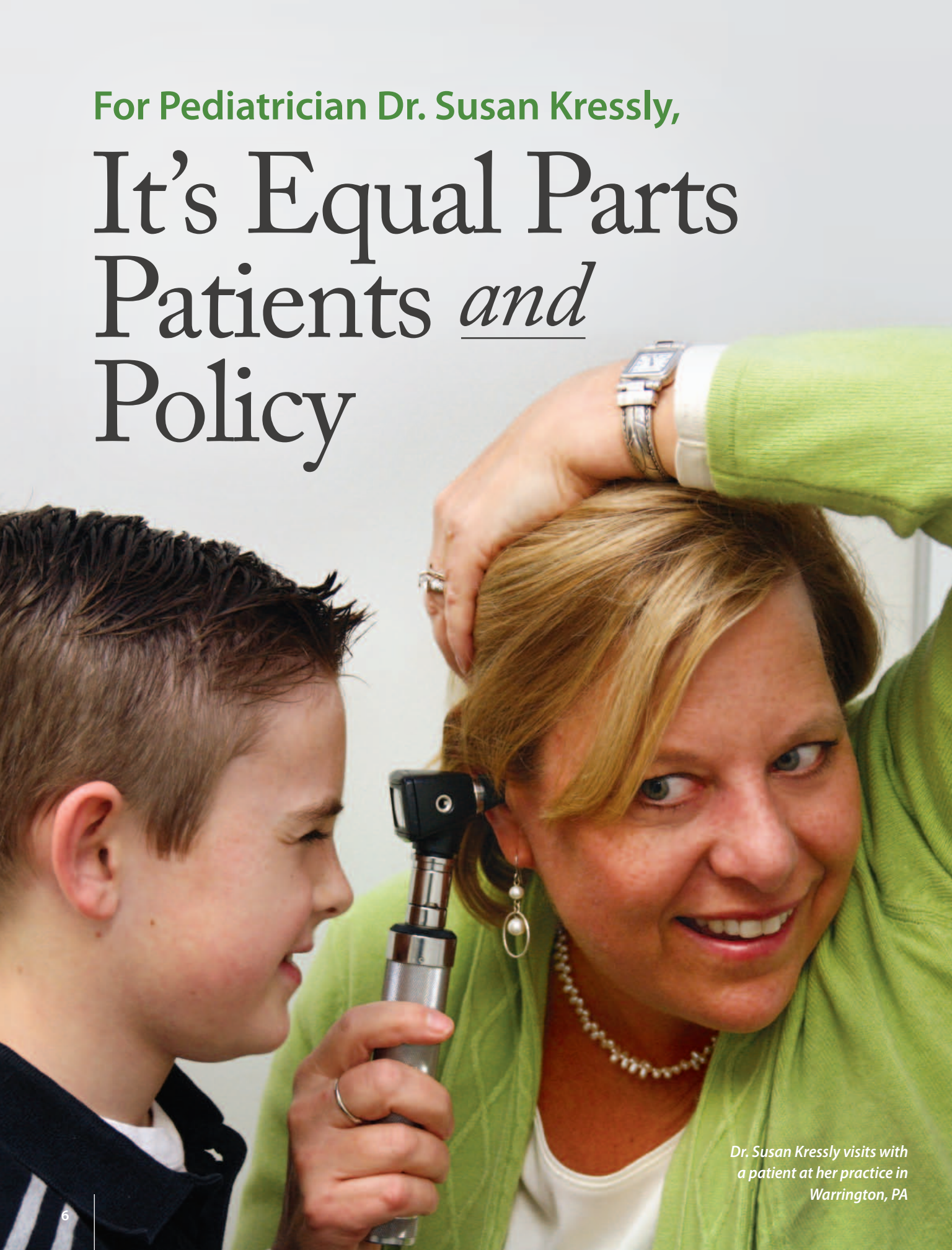
According to the US Small Business Administration, any pediatric practice with less than $11m in annual revenue qualifies as a "small business." *www.sba.gov/content/summary-size-standards-industry-sector*

Non-scientifically, the majority of independent pediatricians reading this magazine are within a standard deviation of that $11m definition. (Fear not, you mega-groups, today's message still counts.) Although the practice of pediatrics is a calling, although you didn't choose your specialty because of the money, and although it may not feel like a "job," at the end of the day it's still your business.

That's really the distinction between you and your peers who have decided to become someone else's employee. Why are you up at night? Because you want to do more. For yourself, your family, and your patients. ■

For Pediatrician Dr. Susan Kressly,

It's Equal Parts Patients *and* Policy



Dr. Susan Kressly visits with a patient at her practice in Warrington, PA

BY JILL FAHY

When you grow up never taking 'no' for an answer, you're liable to either end up in trouble or become very successful — relating to guys like Walt Disney, who didn't listen to people telling him over and over that a cartoon rodent was a bad idea.

Dr. Susan Kressly, a successful pediatrician and health policy advocate, drew her first battle line over bedtime at age 4. But she was not looking to challenge the status quo when she joined her first pediatric practice in 1990.

The newly minted MD was welcomed as the fourth member of a four-doctor group in suburban Philadelphia. She took to the office immediately, appreciating its small town feel and the easy rapport doctors had with their patients.

"It was a well-balanced practice," Dr. Kressly said. "One of the doctors was my age, and the older pediatrician became a mentor who taught me about relating to families and doing what's right for the patient."

But when the practice grew — then acquiesced to the HMO-dominated environment of the 1990s without a plan to make it work — Dr. Kressly decided to blaze her own trail.

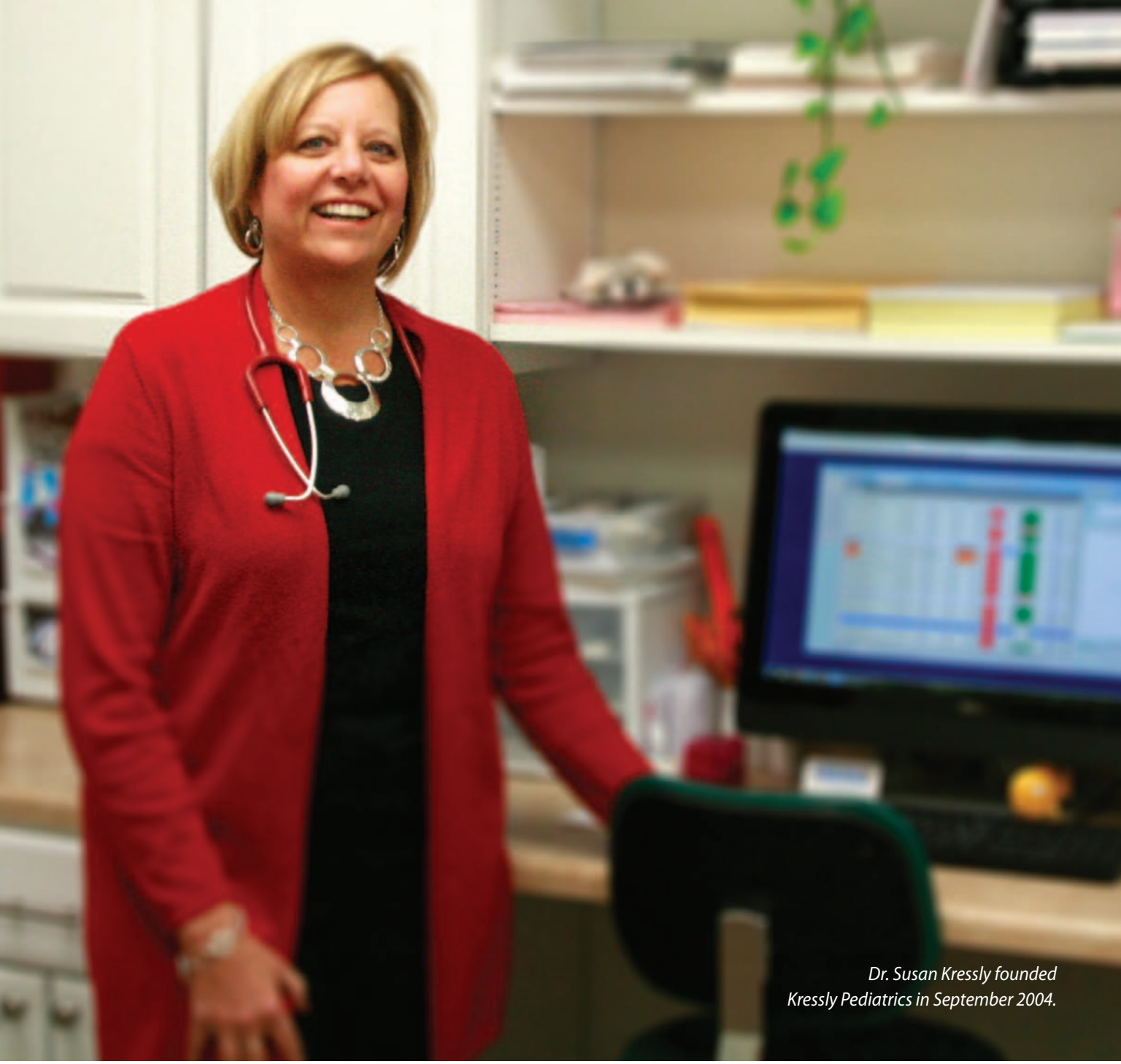
"They sold to a health care system with the philosophy of 'see more patients, make more money,'" Dr. Kressly said. "We were in a capitated market and that doesn't work, but none of the doctors had the stomach to challenge it. They became complacent; I did the opposite."

> Action by a physician to promote those social, economic, educational, and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise.

Dr. Kressly broke with the group and started her own practice in 2004, assuming as little financial risk as possible. She adopted an EHR, hired two nurses to cover clinical and staffing duties, and doubled as the office janitor for the first two years.

The practice was also an early purveyor of social media, providing a web site and patient portal through which patients could find information on their own. This cut down on administrative phone calls, keeping staffing lean and freeing nurses to deal with more critical patient issues.

"I knew I never again wanted to apologize for not giving patients what they need, so I kept it very realistic," Dr. Kressly said.



Dr. Susan Kressly founded Kressly Pediatrics in September 2004.

Generally, pediatricians are driven, not by the desire to get rich quick, but by the impact they have on medical care. For Dr. Kressly, this impact is made not only in the office, but in board rooms and plenary sessions, where advocacy can have a wide-ranging effect on state and national health care.

Dr. Kressly is president of the AAP's Pennsylvania Chapter. She is also a member of the Academy's Section on Administration and Practice Management (SOAPM), Council on Clinical Information Technology, the Quality Improvement Innovation Network, and Pediatric Research in the Office Setting. And since 2010, she has served as Medical Director for a provider of EHR software for pediatric practices.

It is at leadership meetings, said Dr. Kressly, where she uses her "dominant advocacy gene" to advance an issue.

"You've got three kinds of people at these meetings," Dr. Kressly said. "You've got the neutral chair stuffers who absorb and occasionally contribute. You've got a

group of negative people who use meetings as a forum to complain. And you've got the leaders, who motivate the chair stuffer to do more and convince the negatives to strategize a collaborative fix."

Dr. Kressly, in addition to advocating for better patient outcomes, is keen in her support of physician education.

Last fall, at the AAP's National Conference & Exhibit, Dr. Kressly had the ear of residents who attended her presentation on how to thrive in a small practice. She said she was disturbed to learn that the residents felt discouraged from going into private practice by faculty and program directors who view hospital employment as the better alternative.

Recent surveys conducted by physician and hospital organizations, and national recruiting firms indicate that between one-half and two-thirds of current physician practice opportunities or searches are for employed positions. Also, the number of physicians employed by hospitals grew by 34 percent between 2000 and 2010.

A recent survey conducted by Jackson Healthcare, a staffing firm that also conducts research on physician practice and other industry trends, found that hospital-employed physicians increased from 20 percent to 26 percent between 2012 and 2013.

Dr. Kressly hopes to spotlight the issue at the AAP's next Annual Leadership Forum.

"I can only influence where I've been able to penetrate," says Dr. Kressly. "I've learned that having someone's ear may at least give me the voice."

Meanwhile, Dr. Kressly's practice continues to thrive. Her leadership commitments continue to increase and demand more of her time. And while she admits to pondering her limits now and again, giving up on either role is not an option.

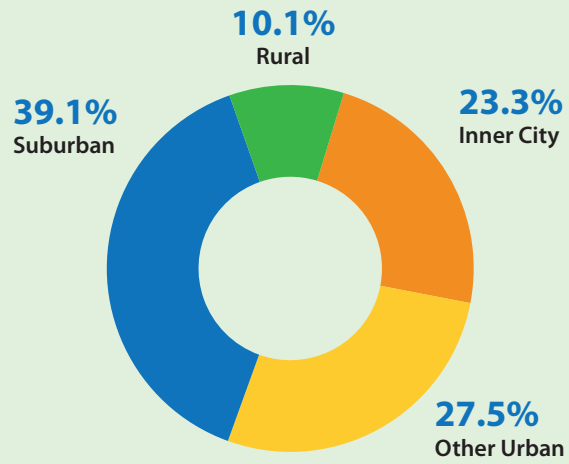
"If I can talk to the governor in Harrisburg and change the way he thinks about a bill he's trying to pass, that's as important to me as when I sit on the floor, building a tower of blocks with a patient, or when I get a call from a teenager who needs advice," said Dr. Kressly. "I get satisfaction from both." ■

*Source: American Academy of Pediatrics, Division of Health Services Research, Periodic Survey of Fellows #82, 83, and 84, 2013

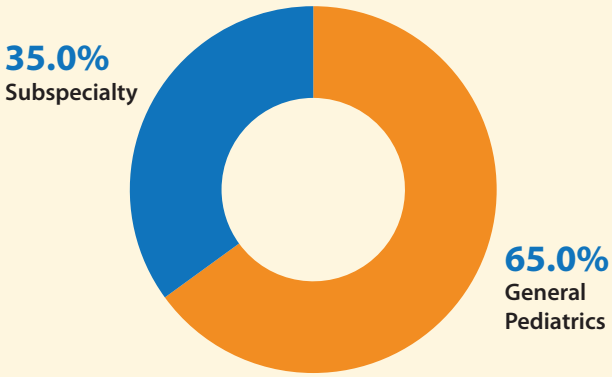
AT A GLANCE:

TODAY'S PEDIATRICIANS

Percent of Pediatricians by Practice Location (Excluding Residents)*



Average Percent of Time in General Pediatrics and Subspecialty (Excluding Residents)*



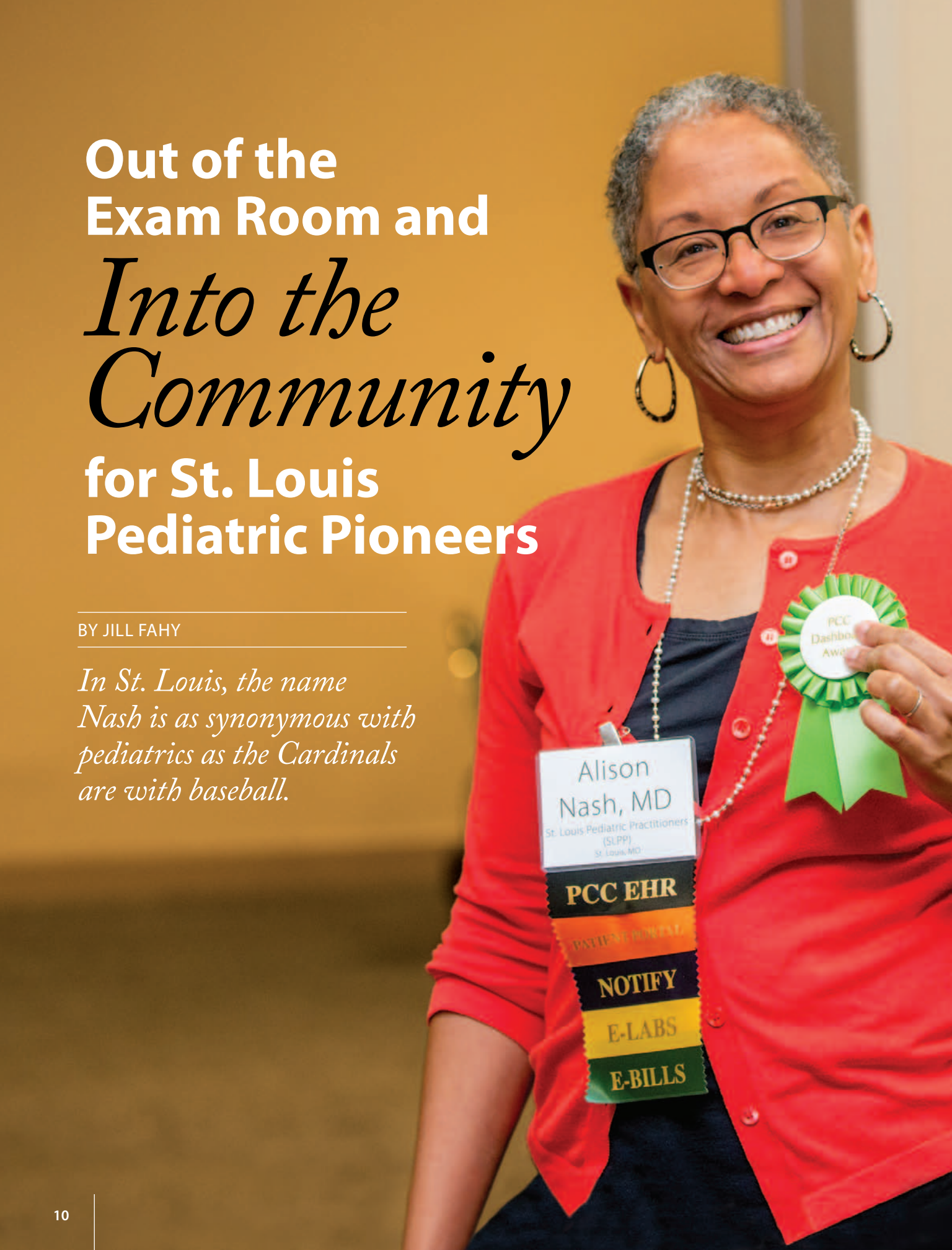
Percent of Pediatricians by Primary Employment Settings (Excluding Residents)*

26.0%	Pediatric Group of 3-10 Peds
18.6%	Medical School
14.1%	Hospital/Clinic
12.4%	Multi-specialty Group
12.0%	Solo / 2-Physician Practice
5.9%	Pediatric Group >10 Peds
5.7%	Other
3.3%	Community Health Center
2.1%	HMO

Out of the Exam Room and *Into the Community* for St. Louis Pediatric Pioneers

BY JILL FAHY

In St. Louis, the name Nash is as synonymous with pediatrics as the Cardinals are with baseball.



Between them, Drs. Helen, Homer, and Alison Nash have seen tens of thousands of patients, spanning four generations in metropolitan St. Louis. From gritty downtown to the foursquare and bungalow-lined neighborhood of Kingsway East and West, chances are you'll meet someone who opened up and said 'ahh' for a Nash.

Today, there are two fewer Nashes practicing in the city. Helen Nash, revered as the first African American physician at St. Louis Children's Hospital, died in 2012 at age 91. And Helen's brother Homer, who helped pioneer the hiring of nurse practitioners, retired three years ago.

> "Now that I'm in a management role, I have to plan and think ahead, and work hard to keep families connected to resources..."
>
> – Dr. Alison Nash

Now, it is Homer's daughter Alison, 59, who continues the family tradition as successor to her father's practice. She is not new to the family business — having practiced by her father's side for the last 25 years — or to the practice mission of providing excellent care for families in the community. She was tagging along on house calls before age 10.

But there are new challenges. The needs of families have changed and are more complex. Also, a mutable economy and health care system require her to adapt and reinvent — as her father and aunt once did, Dr. Nash says.

"Now that I'm also in a management role, I have to plan and think ahead, and work hard to keep families connect to resources," says Dr. Nash.

Dr. Nash was born in 1955, the same year her father opened his first medical practice above a drug store in North St. Louis. Back then, an office visit was $3; a visit to the Nash home (about a 10-minute drive from the practice) was free, and welcome.

"This was back when doctors made house calls," Dr. Nash said. "I remember sitting at the kitchen table in patients' homes, and I remember we would also have families at our house. Dinner conversation involved a lot of medical talk back then."

It wasn't until late in high school, after a summer spent working for her father, that Dr. Nash considered a career in pediatrics.

"Back in the day, my dad was up all night returning phone calls, but he was never irritated by questions," Dr. Nash said. "He always kept a positive attitude, and that was the takeaway for me. You could work that hard and still be happy."

Today, Dr. Nash practices in the North St. Louis office building her father moved to in 1965. Homer Nash and other African American physician specialists bought the property, making it a one-stop shop for the surrounding community. Most of the group have since passed away or retired, leaving Dr. Nash as one of the few independent physicians left in the area.

"Young physicians coming out of residency now tend to be going into big groups and hospital-owned

situations, so independent physician practices are few and far between," Dr. Nash said. "I am fortunate that my location is good for our patients, and I think we're doing a pretty good job taking care of them."

Dr. Nash and two pediatric nurse practitioners see about 50 patients a day; the numbers have grown with the business, but the patient demographic in urban St. Louis has not changed significantly in recent years. There are middle class families where one or both parents work, families living in shelters, families living with their extended families, single parent families where the parent works full time, and every iteration in between.

For the practice, reality has always dictated its whole family, whole community approach to treating and preventing illness in children. What's changed are the types of stressors children and their parents face today, and how Dr. Nash and her colleagues address them.

"So many more social and environmental factors come into play now — issues of cyber bullying, drugs, kids getting involved in sex at an earlier age," Dr. Nash said. "Many families are in need of and would benefit from medical or community services they don't have easy access to or they are not aware of. We find ways to help families connect to resources and stay in touch."

Getting out of the exam room and into the community has been an effective way for Dr. Nash to stay connected with her patients. She recently was named medical director for St. Louis Children's Hospital's Healthy Kids Express, a health program that uses a van to deliver clinical expertise and dental outreach activities to schools and day care centers.

Serving patients with limited resources has also driven the practice to look for innovative ways to save money and boost efficiency. Employing pediatric nurse practitioners was not yet commonplace in 1978, when Dr. Homer Nash brought his first PNP into the office. Unlike many primary care doctors, he saw hiring nurse practitioners not as a turf battle, but as an effective way to scale his practice cost-effectively.

His prescience has since been reinforced by research. According to the 2003 study, *Who is Caring for the Underserved? A Comparison of Primary Care Physicians and Nonphysician Clinicians in California and Washington,* nurse practitioners and physician assistants can provide a substantial proportion of primary care and that they tend to be more willing to practice in underserved areas.

"Having a different point of view and being open-minded has always been very important to my father," said Dr. Nash.

The elder Dr. Nash was also dedicated to keeping a lean staff. Some employees, like his first nurse practitioner, were former patients he helped put through nursing school.

Independent practices, like St. Louis Pediatric Practitioners, continue to defy the odds, as many young and female physicians are fleeing solo practice in favor of group practice.

The practice has also survived as a viable family business in uncertain times. In 2011, the year Dr. Homer Nash passed the reigns to his daughter, only 30 percent of family businesses survived into the second generation, even though nearly 70 percent wanted to keep the business in the family, according to the Conway Center for Family Business.

"My dad was always a visionary, always looking ahead, and always open to helping others in whatever way he could be of the most help," Dr. Nash said. "These decisions are part of the reason we're still independent." ■

Daughter's Business Acumen Helps Mother's Pediatric Practice Thrive

As a kid in the 1980s, Carole Dula didn't need a tour of the family business to see its impact on the North St. Louis neighborhood of her youth.

The local pediatric practice Dula's grandfather, Homer Nash, founded in 1956 was, by then, seeing hundreds of children whose parents and grandparents had also once been patients of "Dr. Homer."

"Growing up, we always had to be on good behavior. Wherever we went, people knew my mom or granddad," said Dula, whose mother, Dr. Alison Nash, now owns the practice. "Now that I'm older, I understand why people were always so quick and happy to say 'hi, how are you?'"

Today, at 29, Dula views the family business not only from a family perspective, but from that of an employee. She was hired in 2011 as the practice's scheduler, then transitioned to office manager 2013.

Dula, who holds a master's degree in Business Administration, has helped increase overall revenue by staying on top of policy changes and improving coding.

"I started working for the practice to pay for school, but it's within the past six months that I'm really seeing my MBA coming into play," said Dula. "I'm looking into the insurance companies — who's paying, who's not, when are they paying, and are they a good fit for our practice."

Dula has helped the practice recoup significant revenue previously lost to inadequate coding. Clinicians and billers, she said, are now reminded to include vaccine administration codes, as well as modifiers to well visits that include other services.

"Efficiency has increased, and the concern about not getting paid for insurances is gone," Dula said. "But it's not just about the financial health of the practice; we're also in the business of taking care of patients. I now understand the impact this practice has on this demographic."

"The practice, which treats mostly Medicaid patients, is now seeing fourth generation families. The level of care — through five decades and two owners — has remained the same," Dula said. She attributes the practice's staying power, in part, to financial prudence and a family-like atmosphere among employees, some of whom have worked there more than 30 years. Word-of-mouth, Dula notes, has driven the practice's entire patient base.

Family businesses show higher profitability in the long run, according to Family Firm Institute, Inc. (FFI), a membership association for leaders in family enterprise. The FFI notes that these businesses are less likely to raise debt, and less likely to lay people off despite a bad economy.

Dula said she will eventually leave the practice to expand her horizons, and has her mother's blessing.

"Mom said to me, 'I don't want you to feel like you're locked into the practice. If you go, I'll be fine,'" Dula said. "What more could you ask from a parent?" ■

Beyond the Nuts and Bolts:

One Doctor's Vision for the Perfect Pediatric EHR

BY JILL FAHY

Is necessity the mother of invention and innovation, or does intellectual curiosity drive these advancements?

For Dr. William Zurhellen, a pediatrician of nearly 40 years, it was a little of both.

In September 1981, Dr. Zurhellen was the managing partner of a thriving, three-doctor pediatric practice near New York City when he discovered his biggest payer owed him thousands of dollars.

"Our local health care plan had just started its own managed care program, and by September, I was going broke," Dr. Zurhellen said. "When I finally tracked down our payments, I saw that the carrier hadn't paid a penny since March."

Mailing bills and tracking payments had already become a burden for the growing practice. The office used ubiquitous ledger cards (adequate, back then) for posting payments. At the time, most claims were still submitted by patients, so practices knew every charge and every balance on the ledger card was due from the patient.

But with the new medical plan, patients sometimes only owed a portion of the total charge, and the carrier was responsible for the balance. Trying to determine from a ledger card who owed what had become even more time-consuming, not to mention a recipe for error.

The practice eventually recovered its payments of nearly $20,000, but Dr. Zurhellen said he regarded the snafu as a pivotal moment.

"That's when I started thinking about writing my own practice management system," said Dr. Zurhellen.

If necessity became the "why," Dr. Zurhellen's intellectual curiosity fed the "how" in his project to develop a computer-driven financial tool for making billing more efficient and fool-proof.

The self-professed computer hobbyist further broadened his scope in 1987, launching the first iteration of a home-grown pediatric EHR. Within 10 years, the system could trace clinical information in much the same way it traced billing — enabling the practice to track patients, follow health reminders, and sort and select patients based on pre-set criteria.

Word of his EHR spread among the pediatric community, though Dr. Zurhellen said it was never his intention to aggressively market the system. By the mid-1990s, 16 other practices from around the country were using the EHR. Those with the system were all computer hobbyists, like Dr. Zurhellen, who liked the idea of using technology for more than tracking financials.

> "Preventive care is looking forward, not just looking at today."
>
> — Dr. Zurhellen

EHR use on the practice level in the 1990s was cutting edge. Its application then was mainly limited to academic medical centers. It would be another decade before the American Recovery and Reinvestment Act (ARRA) drove use of the EHR on a grand scale.

Despite his own success with EHR technology, Dr. Zurhellen is adamant that no current EHR system is equipped to meaningfully track and quantify clinical outcomes for patient care.

"If you look at the EHR in terms of Meaningful Use, you're asking it to collect data on whether you did something or not. It doesn't tell you whether the patient is better or not," Dr. Zurhellen says. "It's not in real time. By the time you write a report, it's based on old data."

An expert with the Certification Commission for Health Information Technology (CCHIT), Dr. Zurhellen took his argument to the White House in 2012, filing a national petition to move EHR strategy away from a pay-for-performance based model to improving outcome and costs.

The petition noted that current systems "are not designed properly to assess clinical outcome and perform true quality improvement, nor does a national health information network yet exist." The petition also argued that "the two issues are the major roadblocks to the deployment of electronic health record technology in primary-care practice." The petition did not succeed.

Dr. Zurhellen is no longer working to advance his own system but continues to rally for EHR improvement. Of the original 17 doctors who used the home-grown EHR, only its creator and one other pediatrician continue to practice. And Dr. Zurhellen, who recently joined a large physician group as part of an exit strategy for retirement, must now use the group's EHR of choice.

The trade off, he says, was worth it.

"Finding a young pediatrician who wants to go into a small practice is more difficult these days," says Zurhellen, now 68. "I didn't want to work for two more years, then just leave and risk leaving 3,000 families to go find someplace else."

As it turns out, the decision has helped secure Dr. Zurhellen's future as well. His physician group is free of any hospital affiliation, and fewer administrative duties means more clinical time.

"The group negotiates better contracts than I ever could on my own, and I'm now earning what a pediatrician should be earning," he says.

Meanwhile, Dr. Zurhellen continues to proselytize for a pediatric EHR that improves patient outcomes.

"Preventive care is looking forward, not just looking at today," Dr. Zurhellen said. "My vision for the EHR is one that makes patient outcomes better and gives practicing pediatricians an effective and user-friendly electronic tool to be able to do that in real time." ■

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Practice:	Union Pediatrics
Practice Web Site:	unionpeds.com

Solo, But Not Alone

BY ROBIN WARNER, MD

Eight and a half years ago, I decided to leave a primary care medical group to open my own practice.

Once I determined the general area for my new practice, I faced the challenges of finding and designing office space, negotiating insurance contracts, hiring staff, choosing an EHR, and picking out furnishings and equipment.

Being a solo practitioner is very rewarding. No longer do I have to wonder about what partners think or do. No longer do partners have to agree with me regarding major purchases, HR issues, etc. No more corporate "visits" and mandates. After hours, I know my patients and they know me. No more, "But Dr. So-and-So always calls this in for us..." My practice, my rules. Four years ago, it also meant when I was fed up with my EHR, I was able to make the decision to switch to a new one, without having to consult with anyone or get their "blessing". This consistency has benefited both me and my patients.

At the same time, being a solo practitioner is very challenging. I am on call all the time. As a result, I've learned to effectively educate my families on how to utilize my practice's website and mobile app to find answers to common questions they may have after hours. Parents appreciate that I am always available, and thus try to call only if they are really worried. I do encourage them to call me if they feel their child can't wait until the next day to be seen. I am fortunate to only live ten minutes from my office, and often will meet families after hours. I am also lucky to have a large pediatric group see my patients for me when I take vacation. I do, however, continue to take my own after-hours calls when I'm on vacation. I know my patients, the covering group does not.

One challenge I no longer have to face, as a solo practitioner, is being alone. I have a nationwide "extended" family who is also only a phone call, text, or email away. We share best practices from a business standpoint. We bounce ideas off of each other. We share office decorating ideas. If I have an incredibly challenging day, for whatever reason, I know where to turn. And since we have the same EHR, we share ideas on how we make the system work best in our office.

Who is this "extended" family?

A few years ago, I attended our EHR vendor's annual Users' Conference, seated at dinner with a number of other pediatricians. Not only do we have a common EHR, but we all belong to the AAP's SOAPM section and we all have relatively small practices. We'd been in contact via email over the years, but we had never met in person, since we come from very different parts of the country. We spent hours discussing our successes and failures as small business owners, and we shared our "recipes" for good outcomes. That dinner made me realize that I didn't need to operate inside a silo of my own making, I can reach out to other pediatricians with the same benefits and challenges and get their guidance and support. I stay in constant touch with my extended independent pediatric family and it has made all the difference.

> "I can reach out to other pediatricians with the same benefits and challenges and get their guidance and support."

Change is hard. Change can be expensive, challenging, and exhausting. But for me, the changes I have made have been a breath of fresh air. Being my own boss has allowed me freedoms I didn't have working for a large group. And, with my second EHR, I have both improved functionality, and a new "family" to go along with it. It has made me realize that I may be a solo pediatrician, but I am not alone. ■

RESOURCES

Setting up a pediatric practice
goo.gl/4gJv9N

Pediatric billing and coding information
goo.gl/l65sZn
goo.gl/CmJscs
goo.gl/4yV4VG

Pediatric practice consultant selection
goo.gl/OqhvXW

Pediatric peer network
goo.gl/1oe6Sv

Treating patients with a

‘Community-Side Manner’

Dr. Cecilian Penn at her practice, Partners 4 Kids, in the U.S. Virgin Islands

BY JILL FAHY

As a resident, Dr. Cecilia Penn's knowledge of her patients ran much deeper than what she saw at the end of a tongue depressor or heard through a stethoscope.

In those days, Dr. Penn lived and trained in New York City's Washington Heights neighborhood as part of Columbia University's Community Pediatrics program. Home to one of the greatest concentrations of Dominicans throughout the five boroughs, "The Heights," as it is known to the locals, is rich in Latino languages, religion, food, and cultural festivals. Domino games are played on the sidewalks, bachata music blares, and street vendors hawk sweet bean soup and fried empanadas stuffed with meat and cheese.

But the densely developed neighborhood at the northern tip of Manhattan is also one of the poorest and most in need of family-oriented services and education programs, according to current City of New York statistics. Twenty-three percent of residents live in poverty. Some 47 percent of children in the district are listed as overweight or obese, and there are more children at risk for lead poisoning in Washington Heights and neighboring Inwood than in any other neighborhood in New York City.

"Clinical care speaks to only a part of what makes up a patient," said Dr. Penn, who followed up her residency with a master's degree in public health. "You also have to look at where they are coming from and what influences their health. Does their financial situation affect the way they eat? Do they live in substandard housing? Working with one patient at a time has one benefit, but understanding primary care on the community level can affect the multitudes."

Today, Dr. Penn continues to focus on population health management in her own practice on St. Thomas — a hilly, 31-square-mile island in the U.S. Virgin Islands that is home to a diverse ethnic population. Dr. Penn opened Partners 4 Kids a year and a half ago, after leaving a group family practice in which she was the only pediatrician.

Pediatricians are scarce in the U.S. Virgin Islands, according to Dr. Penn. Currently, there are about 25,000 resident children and five pediatricians, three of whom are retiring soon. Partners 4 Kids currently treats 1,777 of those children.

Dr. Cecilia Penn says she designed her practice space to be "all about kids," by incorporating bright colors into a warm, safe, welcoming atmosphere.

Nearly 80 percent of Dr. Penn's former patients transferred to her new practice, which offers pediatric services in audiology, physical therapy, speech therapy, and psychology for families who might otherwise have to leave the island for specialist care.

"Clinical care speaks to only a part of what makes up a patient."

The practice is conveniently located in a shopping mall, across from the local hospital and close to a number of daycare centers, schools, and a cruise ship dock.

Dr. Penn said her practice has filled a need in the community.

"In making that decision to start over, it wasn't so much the need to go out on my own as it was having a vision for my professional practice and attaining it," Dr. Penn said.

While Dr. Penn is back to concentrating on one patient at a time as a clinician, she also works at her local hospital as its Performance Improvement physician, helping to build evidence-based measures of clinical quality.

Her advice to residents and young physicians as they ponder a career in pediatrics?

"As physicians, we can be very one-track minded, thinking we have to follow one specific trajectory everyone else has followed," Dr. Penn said. "You can chart your path. Clinical care isn't everything, so don't pigeon-hole yourself. There are so many things pediatricians can do. Be open to what's out there and take the chance." ■

Our *Proust* Questionnaire

Christoph Diasio, MD, FAAP

Practice

Sandhills Pediatrics (NC)
sandhillspeds.com

Number of clinicians in your practice

19

Practicing pediatric medicine since

1998

Dr. Christoph Diasio, pictured here during a recent pediatric conference in Vermont, is a managing partner at Sandhills Pediatrics in North Carolina.

Some 40 years before he became a French literary lion, a teenage Marcel Proust filled out a questionnaire for a friend who was compiling an album aimed at revealing the personalities of those who answered the survey.

Decades later, after Proust's original answers were discovered, television hosts Bernard Pivot and, later, James Lipton submitted their guests to adapted versions of the questionnaire. In 1993, Vanity Fair breathed new life into the questionnaire for its own monthly issue, having since tapped the likes of Bette Midler, Joan Didion, Pele, and Norman Mailer as subjects for the revealing personality quiz.

Now, the Independent Pediatrician will take a shot at it.

We have created a similar questionnaire for independent pediatricians — one designed to divulge the takers' sensibilities and aspirations as pediatricians.

CHRISTOPH DIASIO, MD, FAAP

Reason for becoming a pediatrician?
The opportunity to have long-term relationships with families and to help children reach their best possible development.

Your favorite virtue?
Humor

Your favorite qualities in a pediatrician?
Wisdom, honesty, integrity, humor, patience

Your favorite qualities in a patient?
Trust

What do you appreciate the most in your friends?
Humor

What are your favorite hobby/ies?
Travel, cooking

Your idea of happiness is...
Celebrations with families and friends

With which historical figure would you enjoy sharing a meal?
Abraham Lincoln

Which living person do you most admire?
Stephen Hawking

If you could live anywhere, where would it be?
Paris

The natural talent you'd like to be gifted with is:
Musical ability

What is your ideal state of mind?
Calm

If you could change one thing about yourself, what would it be?
To need less sleep

(Continued, next page)

Our *Proust* Questionnaire

CHRISTOPH DIASIO, MD, FAAP

Now onto questions about practicing pediatric medicine:

If you could change one thing about practicing pediatrics, what would it be?

Reduce interference from government and payers in the practice of pediatrics, less hassles getting paid and payment commensurate with our value to society since we take care of the future of the country

What do you consider to be your greatest achievement?

Growing the practice from 8 to 19 clinicians in 13 years and integrating mental health

Do you prefer to do sick visits or well visits?

Both!

What is the most important work you do as a pediatrician?

Prevention of vaccine-preventable diseases

What do you believe is the most important business aspect for an independent pediatric office?

Using data to manage care

What do you like most about being an independent pediatric practice?

Control over our practice!

How do you address urgent/after hours care?

Open 7 days a week in Southern Pines with extended night hours and Early Bird walk-in clinic

What's your policy on vaccination?

We discuss vaccine hesitancy, but vaccination is required.
IF we are given a fair hearing, the case to vaccinate is compelling!

How do you manage the most challenging parents/families/caregivers?

Hopefully with patience and empathy!

How do you connect with your patients/families when they're not in your office?

Email, Facebook

What is the biggest change in pediatrics you have seen in your career?

Prevnar vaccine and reduction in pneumoccocal illness

What does your practice do best?

Immunization

Online Vaccine Resources

immunize.org
The website for health professionals from the Immunization Action Coalition.

vaccineinformation.org
The website for the public and health professionals from the IAC.

izcoalitions.org
Online database of local, state, regional, national, and international immunization coalitions.

cdc.gov/vaccines
The CDC's comprehensive immunization site.

www2.aap.org/immunization
The AAP's comprehensive immunization site.

healthychildren.org/English/safety-prevention/immunizations/Pages/default.aspx
The AAP's immunization site for parents.

immunizationinfo.com
A science-based information source from Immunizations for Public Health (I4PH).

pediatrics.about.com/od/immunizations
Family friendly articles and videos from about.com's pediatric experts.

vaccinateyourbaby.org
A vaccine awareness campaign launched by Every Child By Two.

ecbt.org
Every Child By Two is a nonprofit organization committed to reducing the burden of vaccine-preventable diseases in children.

vec.chop.edu/service/vaccine-education-center
Vaccine resources for parents and clinicians from The Children's Hospital of Philadelphia.

skepticalraptor.com/vaccine.html
Search engine dedicated to linking to peer-reviewed, science-based websites and blogs.

www.vaccine.org
The Allied Vaccine Group, dedicated to presenting valid scientific information about vaccines.

411pediatrics.com/healthy-kids/immunizations
411 Pediatric's immunization policies and guidance.

AARP Vaccine Coding Resources:

www2.aap.org/immunization/pediatricians/pdf/faqiacodes.pdf
FAQs for the Pediatric Immunization Administration Codes

goo.gl/msJ7u8
Vaccine Coding

goo.gl/pPiRcL
Commonly Administered Pediatric Vaccines Coding Table

goo.gl/msJ7u8
Vaccines Coding Table

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Adolescent Medicine: Supporting and Embracing Transitions