

# The Independent Pediatrician

Volume 2 / Summer 2014

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# The **Independent** Pediatrician

This publication is dedicated to the men and women who have chosen to care for our children. Whether they work in hospitals, academic settings, or private practices, pediatricians have taken the path less traveled.

## THE PAST— **A UNIQUE HISTORY OF SUCCESS**

Pediatricians have an amazing history of reducing and eliminating childhood disease. Children today will never experience smallpox, polio, and, for the most part, meningitis and measles. Pediatricians deliver preventive care and immunizations to millions of children every year while also being on-call 24 hours-a-day to provide acute care. They assist and reassure parents and patients, ensuring that today's children grow up to be tomorrow's future. These accomplishments are a credit to the physicians, scientists, and clinicians who continue to tackle the most vexing health care problems facing children.

## THE PRESENT— **CHANGE AND CHALLENGE**

Today, pediatricians are faced with an array of uncertainty: health care reform, hospital take-overs, private insurance challenges, government mandates, and ever-changing regulations. But those who actually provide the health care services have never wavered from the goal of delivering quality care at an affordable cost.

## THE FUTURE— **THE PEDIATRICIAN IN CONTROL**

We will introduce you to successful independent pediatricians and share their secrets for success. They are entrepreneurs running smart businesses. They are good doctors. Most importantly, when faced with a dilemma, they do what is in the best interests of their patients over and over again. These pediatricians choose the road less traveled, and, as you will see, it has made all the difference.

*The **Independent Pediatrician*** is brought to you by PCC, which provides tools and services pediatricians across America have told us they need to remain independent and in control of their practices. PCC itself is a fiercely independent business. It puts the interests of its clients, community, and employees, on an equal footing with those of its shareholders as a Benefit Corporation.

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 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](mailto:mystory@independentpediatrician.com).

# The **Independent** Pediatrician

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**W**elcome to the second issue of *The Independent Pediatrician*.

Independent Pediatricians are, by their nature, entrepreneurial.

Independent Pediatricians want to remain independent so they can make decisions based solely on what is in the best interest of patients.

This magazine, while focused on independent pediatricians from across the U.S., is dedicated all pediatricians and those who have dedicated their lives to the health of children.

We hope you will share our vision, spread the word, and tell **YOUR** story at: [mystory@independent-pediatrician.com](mailto:mystory@independent-pediatrician.com)

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# The Pediatrician as Ringmaster

by Chip Hart



*Chip Hart coaches and guides pediatricians as they navigate the changing business world of medicine. He combines more than two decades of experience working with busy pediatric practices all over the country with his passion for real world data and good medicine, to deliver practical observations, pragmatic advice, and proactive strategies.*

**I** was at an AAP chapter meeting and got quite a thrill when I overheard someone say, “You sound just like the Independent Pediatrician people.” Another pediatrician asked her, “What’s the Independent Pediatrician?” I got to hear an unedited review. “It’s a magazine about our practices, for pediatricians fighting to stay independent. It’s like they knew my practice.”

Apparently, the first issue of TIP is reaching the intended audience.

Based on the surprising amount of feedback we received — all positive — the first issue of TIP clearly struck a chord. We heard from pediatricians all over the country who were excited, and even relieved, to finally witness a celebration of independent pediatricians. “Can you send me more copies?” Of course we can, just ask.

Many of us had lost perspective on the importance of independent pediatricians as a result of the daily assaults on a lifestyle that, while stronger than ever, remains constantly besieged by forces that envy your freedom, clinical effectiveness, or financial success. Or all three.

We forget that pediatricians might just have the best job in the world. The Independent Pediatrician is here to remind us. Because the fight to remain independent is important — not only for you, but for your patients as well.

**2014** has been interesting so far.

Many practices reported a significant reduction in patient visits in January. We looked into this and published some evidence that the impact of the weather (school and even office closings), combined with an early viral peak, were largely responsible for perceived downturn, but that wasn’t enough to keep some practices from concluding the sky is falling. Yet, here we are in the summer and the smart practices are filling up with well visits. No collapse yet. [You can see the data at <http://bit.ly/1gDqxw7>]

During our research, it became clear to us that practices didn’t suffer equally. Some practices, it appears, have evolved from their seasonal fluctuation to develop ancillary service solutions that not only protect their businesses, but provide better care. We spoke to two of those practices — RBK Pediatrics and Eden Park Pediatric Associates — who agreed to share some of the secrets of their success.

Meanwhile, the pressure to “get big,” yet stay independent, remains the most compelling storyline among pediatricians. In the first issue, we reviewed the success of BCD Health Partners LLP in NJ bringing

3 (now 6!) pediatric practices together. In this issue, we turn to Chicago, where Pediatric Trust has followed a slightly different path, but has helped seven pediatric practices maintain their autonomy.

In April, we watched the ICD-10 can get kicked down the road until late 2015. Regardless of the pros and cons of the delay, it was a reminder of the seemingly endless mandates that get layered between you and your clinical time with patients. I'm not a big believer in the concept of "the good ol' days," but there's a clear yearning for a time when the administrative burden of owning a medical practice was lighter. We spoke to the administrators at Hershey Pediatrics and Pediatric Associates of Fall River to hear how they keep up with the hundreds of regulations they need to follow and what they do to keep the focus on the kids.

We also spoke to Dr. Mary Kiepert and heard about her transition from mother to full time, solo pediatrician. Dr. Karen Foti left the world of employed physician work and jump started her own practice. I think many of you will recognize these stories.



**"We forget that pediatricians might just have the best job in the world."**

*— Chip Hart*



# Survey: Work/Life Balance



**T**o prepare for this issue, we reached out to independent pediatricians to learn how they feel about their workloads. The results are interesting — we’ve included some of the details and quotes inside — and although there are few surprises, the verification of our assumptions is worthwhile.

Subjective experience and, now data, make it clear that the definition of “hard work” is fairly broad among pediatricians. For some, a 30-hour week is more painful than a 60-hour week for others. We did identify patterns, though:

- **Most** respondents answered that a “full time physician” works 4–4.5 days a week.
- A majority of physicians work between 40–60 hours a week, most commonly 45–55 hours.
- **One-** and two-physician practices work more hours than any other group size. About 80% of physician work time is spent seeing patients, on average. And very few pediatricians see patients more than 45 hours/week.
- **Most** pediatricians are on call 3–10 nights a month, though 3–5 nights covers more than a third of you. A surprising number — more than 15% — are on call more than half of the time.
- **In** addition to being on call, 75% of pediatricians work 1 night a week or less.
- **More** than 85% of pediatricians take 2–6 weeks of vacation every year, with

more than 45% taking 4–6 weeks.

Almost 10% of respondents take 7 or more weeks of vacation every year.

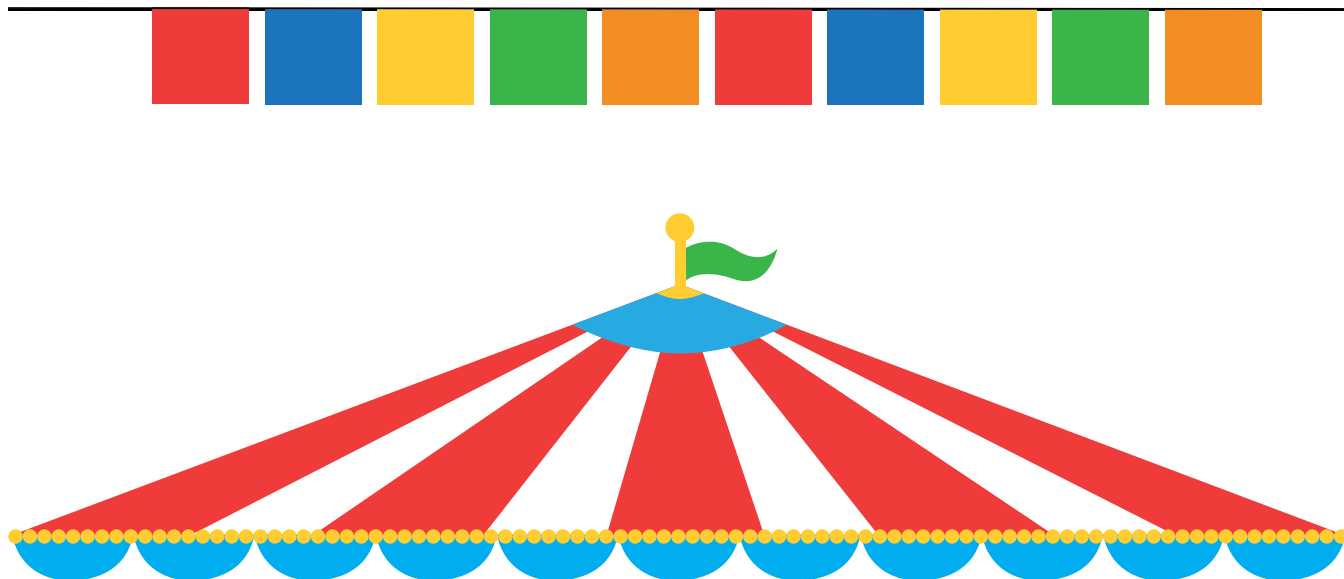
- **70%** of the pediatricians work for practices that allow flexibility for appointments or family emergencies.

In this issue we will review more details, particularly which factors lead to the highest and lowest rates of feeling “overworked.”

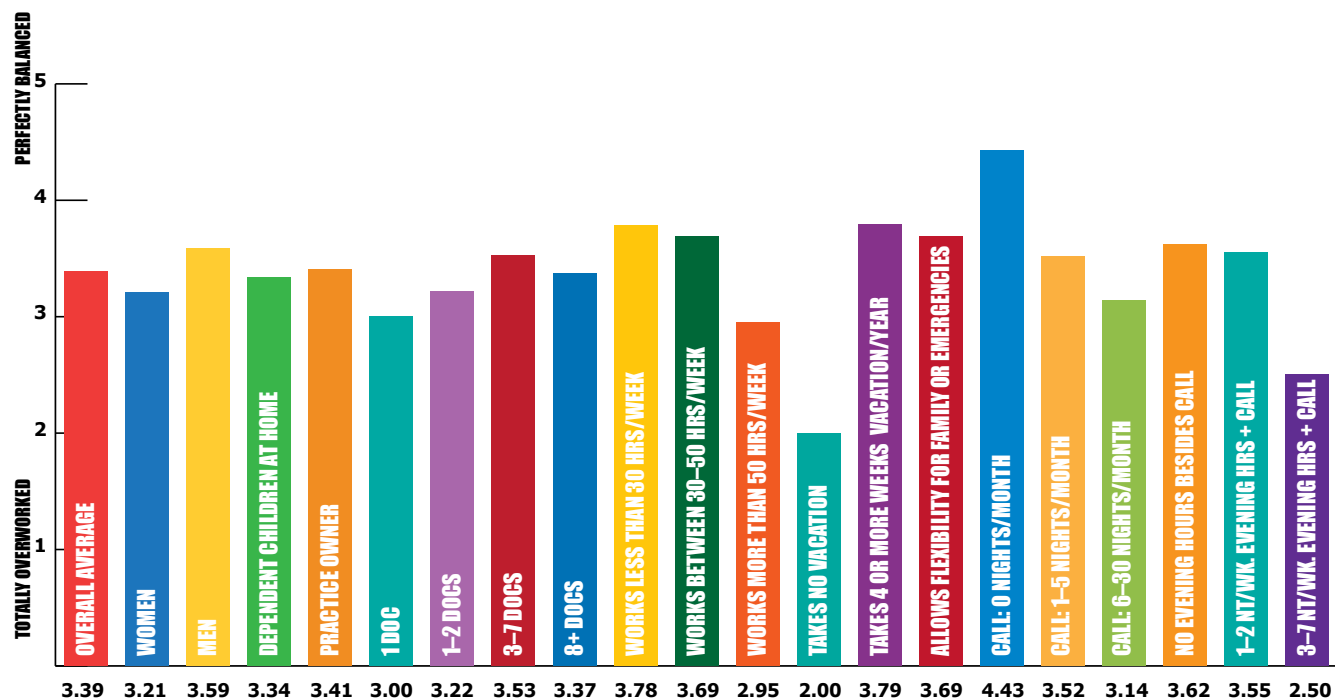
Owning a small business is hard work; we’ve heard it many times. If it were easy, everyone could and would do it, as the cliché goes. You’re not alone with your workload, however. According to the US census<sup>1</sup>, almost 30% of full time small business owners who have employees work more than 60 hours a week. For many of us, that doesn’t always leave enough time for family, hobbies, or even needed time off.

But the reward is significant. Self-determination. Knowing that you improved the lives of many children. Doing things your way. For me, the most rewarding response to our first issue of TIP was Dr. Patricia Edwards’s “My Story.” I hope you can take a moment to share your story, too at [mystory@independentpediatrician.com](mailto:mystory@independentpediatrician.com). ■

<sup>1</sup> Statistics for Owners of Respondent Firms by Owner’s Average Number of Hours Per Week Spent Managing or Working in the Business, 2007.



### WORK/LIFE BALANCE SCALE FOR PRACTICING PEDIATRICIANS, 2014



In a spring 2014 survey of over 150 pediatricians nationwide, we asked for a measure of “Work/Life Balance” where 1 is “Totally Overworked” and 9 is “Totally Underworked.” 5 is “Perfectly Balanced.” No respondent gave an answer higher than 6. Here, we break down variables which affected the results most profoundly.

## Work/Life Balance

*“Primary Care When You Want It,  
Urgent Care When You Need It.”*

*— RBK Pediatrics*

*George Rogu, MD, partner, RBK Pediatrics*

A photograph of a man with grey hair and glasses, wearing a white dress shirt and a patterned tie, standing in a hallway. The hallway has yellow walls, framed pictures, and a wooden door in the background.

**Give the People  
What They *Want***

*by Jill Fahy*

*RBK Pediatrics  
Location: South Shore,  
Long Island, N.Y.  
Offices: 2  
Practitioners: 11  
After Hours: Staffed by 2 practitioners*



**W**hen retail health clinics recently started popping up on Long Island like 1950s tract housing, RBK Pediatrics launched its own answer to the need for after-hours care.

For RBK Pediatrics, adding urgent care was a practical solution for families who can't wait to see their regular pediatricians.

In 2011, Eden Park Pediatric Associates added a lactation center, knowing Millennial Generation moms need flexibility, efficiency, and convenience. In 2012, a practice poll determined 33 percent of new moms chose Eden Park for its lactation services.

"Prior to us providing in-office lactation support, the common age for moms to stop breastfeeding was six months," said Lynn Cramer, Eden Park's Chief Administrative Officer. "By providing breastfeeding support along the continuum of the first year, moms are breastfeeding much longer."

Positive results like these can build a strong case for adding services to a pediatric practice. Ancillary services have also become increasingly important for doctors who want to stay independent. Primary care practices can earn as much as 15 percent or more from expanding their preventive care models.

Currently, 19 percent of U.S. pediatricians offer ancillary services, according to Medscape's 2014 Physician Compensation Report. These services can include dietary and nutritional guidance, management of minor mental health issues, and programs for coordinating care, as well as services for lactation and urgent care.

## DOES IT SERVE A NEED?

While adding services can be a boon to practices, not every service is going to be a good fit. Doing your homework can mean all the difference. Successful services are those your patients want, and those that pay for themselves.

Cramer views the lactation center and Eden Park's other services as logical additions to the medical home. "We manage all our diabetic patients on insulin pumps. We manage all minor mental health issues. We manage all our asthma and allergy kids, and we manage obesity and lactation," Cramer says. "We try not to send our patients elsewhere for pediatric care unless it requires a subspecialty."

Only 29 percent of U.S. primary care physicians offer after-hours care, in spite of a marked increase in the number of urgent care centers in recent years, according to PCC data.

"Unfortunately, most doctors still have that 9 to 5, 'when it's a good time for me' mentality. This is no longer a viable model," RBK's Dr. George Rogu says. "Kids get sick at unexpected times, when these offices are closed. Yes, an ear infection can probably wait until tomorrow, but for the first-time mom or busy mom, it is an emergency."

Opening an urgent care can be a major project, but RBK did it with little overhead. The practice picked one of its existing locations to double as the urgent care. Parking and visibility there is better, and there are more children per household near that location. Two clinicians and a front desk staffer were hired to cover after-hours, from 6 to 10 p.m. The center operates on the slogan "Primary Care When You Want It, Urgent Care When You Need It."



Lynn Cramer, RN,  
Eden Park Pediatric Associates

"Having a successful, independent practice depends on constantly observing what the medical community is doing."

Eden Park Pediatric Associates  
Location: Southeastern PA  
Offices: 3  
Practitioners: 7  
Active Patients: 4,426

Clinically, the urgent care is already a success, says Dr. Rogu. “Families love knowing somebody from the organization will be there to see their kids. And they know if they see a doctor they don’t know, the electronic record has all the child’s basic information. Nobody goes to the ER anymore.”

RBK’s senior partners are also happier. “I cannot remember the last time my beeper rang,” Dr. Rogu said. “The lifestyle of our doctors is much better.”

Financially, it’s a break-even proposition, although revenue is expected to increase as patients outside the practice

are now welcome. “We haven’t seen enough volume to make it a home run, but as I’ve learned over the years, if you do the right thing medically, the finances will follow.”

## IS YOUR PRACTICE READY?

Just because a service seems to be a good fit for your patient demographic doesn’t necessarily make it a good fit for your practice. When researching a service, look at your organization. Do you have the time, the space, and

the equipment? Are your partners on board? Will adding a service disrupt your current workflow?

Eden Park’s Cramer suggests no service works unless clinicians and staff are 100 percent committed to the effort. “If you want to maintain these services, somebody has to be the driving force behind them,” says Cramer. “You need someone who is innovative and effective, and someone who is passionate about that particular subject.”

Since 2007, Cramer has championed the implementation of Eden Park’s special programs. She recently laid the



*Clinicians at RBK Pediatrics. From left to right: George Rogu, MD, Jasilin Mathew, MD, Gina Cartwright, CPNP, and Yekaterina Ryzova, MD.*

groundwork for a VIP (Very Important Parents) service, in which children with chronic illnesses have quick, dependable access to their clinicians.

## ADAPT OR SURVIVE

Unfortunately, not all practices employ people like Lynn, who are always looking for new ways to increase clinical excellence and revenue. Physicians often miss out on opportunities because they are too cautious.

“You have to be open to new things,” agrees Dr. Rogu. “If you continue with business as usual, you’ll find yourself turning into a dinosaur very quickly.”

“Having a successful, independent practice depends on constantly observing what the medical community is doing,” Cramer says. “Everything changes, and if you don’t adapt, you slow down, revenue slows. Our patients expect us to be the first to do what’s happening out there.” ■



*“I cannot remember the last time my beeper rang,” Dr. Rogu said.  
“The lifestyle of our doctors is much better.”*





*Susanne Madden, MBA,  
COO, National  
Breastfeeding Center*

## Q&A with **Susanne Madden**, COO of the National Breastfeeding Center:

# Adding Breastfeeding Support Services to Your Practice

**W**ith the implementation of the Affordable Care Act came the mandate to cover breastfeeding support (and equipment) under preventive care services. This means breastfeeding support is now a covered service and there is no cost-sharing by the patient. This offers a rare opportunity for pediatricians to expand their services, improve their bottom lines and deliver care highly valued by parents.

### **“BUT I KNOW NOTHING ABOUT PROVIDING LACTATION SERVICES!”**

Good point, but lucky for you there are thousands of very well-qualified lactation consultants, many of whom are available to work with you to provide in-house lactation consultations. There are a couple of ways this can work. You could hire a lactation consultant and pay her by the hour for pre-scheduled visits. Or, you can contract with a lactation consultant as an independent entity. With an employee arrangement, you would establish the initial visit with the mom (usually at the newborn visit) and bill the consultant's services as 'incident-to' that visit. In the latter case, you might refer your patients to the independent contractor and rent space and services to her. She would charge patients directly for her services, or if she is a licensed provider, she may bill insurance companies directly for those services.

### **“ARE YOU SUGGESTING THE PRACTICE BILL FOR SERVICES FOR THE MOM?”**

I am. At the newborn visit, you examine the baby and bill for that well child visit. You also counsel the mom by educating her about breastfeeding and determining if there are any issues related to nursing. If there are, you would create a new chart for the mom, and the lactation counseling services provided to her are a separate service and a covered benefit under that mom. If you are concerned about providing services to adults, check with your malpractice carrier. In most cases carriers have no problem with you providing this level of care for infants' mothers as it is not procedural in nature and carries very little 'risk.' In terms of getting paid for those services, insurers routinely pay a variety of provider types for breastfeeding services and do not restrict pediatricians from doing so.



## **“I HAVE A NURSE PRACTITIONER WITH LACTATION TRAINING. CAN SHE PERFORM THOSE SERVICES?”**

Of course, and no doubt that provider would love to put her skills to good use. Instead of incident-to billing being required, the NP, as a licensed provider, may already be credentialed and contracted with insurers and would simply bill for lactation services the same way as any other evaluation and management service.

## **“OKAY, BUT WHAT CODES SHOULD WE USE?”**

This really depends on who is providing the service and what services are rendered. Typically the initial visit with the mom could be billed using a consultation code (99241-99245), if performed in conjunction with a physician and if the mom was referred by another physician, such as her OB-GYN. If the visit is not referred, but the physician is the one establishing the problem, the visit could be based on time (99202/12-05/15) or billed as preventive counseling (99401-04). If the service was performed by a non-licensed provider, then use preventive counseling codes 99401-04 or 96150-55. The 99401-4 codes are the most widely recognized by payers.

## **“SOUNDS GOOD. SO WHAT’S THE DOWNSIDE?”**

There really isn’t one. Helping moms breastfeed more effectively is a win for everyone, and being able to receive those services from a trusted pediatric office is a great community builder for your practice. Attention needs to be paid to finding the right lactation consultant for the job, but once you successfully incorporate breastfeeding services into your practice you will find it a welcome addition for your patients and your bottom line.

**ABOUT THE AUTHOR:** Susanne Madden is COO of the National Breastfeeding Center, a consulting firm centered on delivering comprehensive breastfeeding solutions to employers, hospitals and healthcare providers. She can be reached at [Susanne.madden@nbfcenter.com](mailto:Susanne.madden@nbfcenter.com).

### **RESOURCES:**

Breastfeeding — So Easy Even a Doctor Can Support It, Todd Wolynn, MD, MMM, IBCLC  
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3192361/>

How to have a Breastfeeding Friendly Practice

<http://www2.aap.org/breastfeeding/files/pdf/AAP%20HaveFriendlyPractice.pdf>

Pediatrician’s Guide to Getting Paid for Lactation Services

<http://www2.aap.org/breastfeeding/files/pdf/coding.pdf>

National Breastfeeding Center

[www.nbfcenter.com](http://www.nbfcenter.com)

Urgent Care Association of America

[http://www.ucaoa.org/acc\\_about.php](http://www.ucaoa.org/acc_about.php)



# TAMING the LION

by Jill Fahy



Jayme Spangler, Hershey  
Pediatric Center, Hershey, PA

**L**ast September, Hershey Pediatric Center of Hershey, PA, launched an effort to become a Level 3 Patient-Centered Medical Home. In January, with the ink barely dried on its completed PCMH application, the independent practice in Pennsylvania turned its attention to acquiring a nearby solo practice.

To make matters worse, one of Hershey Peds' three providers recently quit to become a stay-at-home mom. Ask Hershey Peds' biller, Jayme Spangler, what she thinks of the latest delay in ICD-10.

"Thank goodness that has been put on hold a little longer," Spangler says with an audible sigh of relief.

She is among the handful of staff and clinicians at small practices everywhere who, along with the day-to-day, keep their offices up-to-date and compliant with the demands of a fickle health care industry.

## BURIED IN BUREAUCRACY

Practices face a deluge of government-sponsored requirements. There are updated rules for the Health Insurance Portability and Accountability Act (HIPAA) and Stage 2 of the Meaningful Use incentive program. Add to this the looming October 2015 deadline for ICD-10 coding implementation, which will require more documentation, staff re-training, changes to work flow and revised forms. Physicians now spend at least 22 percent of their time on non-clinical paperwork, according to the Physicians Foundation 2012 Biennial Physician Survey. The increased bureaucracy is, in part, to blame for a general loss in morale among physicians, the survey indicates.

"It's amazing how solo practitioners can even make it," says Judy Rapoza, practice administrator at Pediatric Associates of Fall River, MA. "Getting organized, getting a practice manage-

**"Getting organized, getting a practice management and EHR system that works and having enough staff is key."**

— Judy Rapoza, Practice Administrator  
*Pediatric Associates of Fall River*

ment and EHR system that works and having enough staff is key,” Rapoza says.

Since 1997, the federal government has issued 100 new or revised federal health care regulations, and this does not include state and local regulations. The Affordable Care Act has, so far, added 109 distinct regulations. The time and effort to comply with these rules and regulations will “equal an estimated 190 million hours of paper-work per year imposed on business and the health care industry,” according to a recent study conducted by The Heritage Foundation.

## IT'S A JOB FOR STAFF

While streamlining is a necessity, especially for solo pediatricians and small practices, Rapoza says cutting corners on staff can further burden physicians who fear mounting regulatory paper-work is cutting into their time with patients.

“Doctors should be able to spend time with their patients,” Rapoza says. “Sometimes you have to hire.” Rapoza, who oversees daily operations at the seven-doctor practice, says a well-chosen staff should shoulder the majority of burden. This means keeping up-to-date on government regulations, practice policies and coding changes.

## KEEPING AN EAR TO THE GROUND AND EYE ON THE CODES

Twenty years ago, there were no internal policies at Pediatric Associates of Fall River. The practice left itself open to missed opportunities and audits. Today, under Rapoza’s leadership, practice expectations and documentation are in writing. Changes are discussed at team meetings and reviewed by the practice’s employment lawyer.

Successful practices are also good at staying current with industry news. Keeping an ear out for changes in coding or HIPAA regulations can help maximize revenue, or even prevent future fines. It allows you to shape practice strategy, make better decisions, and spot threats and opportunities early on.

Jayme Spangler, the biller at Hershey Pediatrics, attends pediatric webinars hosted by her practice’s EHR vendor, reads the AAP’s monthly Pediatric Coding Newsletter and subscribes to coding resource magazine *BC Advantage*.

This same brand of alertness at Pediatric Associates of Fall River has prevented billing errors that might otherwise have left money on the table. In a recent case, Billing Supervisor



*Hershey Pediatric Center  
Location: Central Pennsylvania  
Offices: 1  
Practitioners: 4  
Level 3 Patient-Centered  
Medical Home*

*Pediatric Associates of Fall River*  
*Location: Southern MA*  
*Offices: 3*  
*Practitioners: 8*

Charlotte Carlson, who was on top of a coding change in well child checks, successfully reversed an insurance company's denial of clinical quality measure money for those visits.

"It used to be that one-third of these denials were wrong and we were able to prove it," Rapoza said. "Now it's much better and a lot of this is because we're able to educate the insurance companies."

Keeping on top of change requires efficient, flexible staff who are willing

to work as a team. It also calls for clinicians who can trust their staff to apply new information in a way that works best for the practice.

Training is also paramount in an age of new and changing regulation, particularly as it applies to the transition to ICD-10. Practice owners should plan for the additional hours and costs required for staff training. ■



*Judy Rapoza, Practice Administrator of Pediatric Associates of Fall River, MA (seated) works with Billing Supervisor Charlotte Carlson.*

# How Pediatricians feel about: Work/Life Balance



## WHAT ADVICE DO YOU HAVE FOR NEW PHYSICIANS STARTING THEIR OWN PRACTICES?

Setting reasonable expectations creates acceptance of what life and the profession brings. Plan and discuss with the significant other/others in your life. Have a good team of people for personal and professional counsel to map out your path.

If you are going to have a part in running the practice, make sure you have protected time for it and that there is compensation.

Get excellent staff, train them well and delegate a lot.

Recruit as much help as you possibly can and if possible speak to other pediatricians already in practice.

Learn from other physician's mistakes, there is no need to re-create the entire wheel. I have found the AAP SOAPM list serve to be extremely helpful.

Being in private practice can give MORE flexibility. I had thought being an employee of a hospital would provide better coverage, but it doesn't work that way. If that is all you are concerned with, work for someone else. If you want to control both, work for yourself.

I have exchanged a lower personal income in order to be Mom, wife, and me.





Chip Hart  
Pediatric Practice Consultant

# Consultant's Corner: E&M Coding

One of the most common requests Chip Hart gets as a pediatric practice management consultant is to examine a physician's "coding curve." Sometimes, it's an effort to encourage a higher level of coding from someone afraid of an audit. Other times it's to corral a dangerous partner whose notes and codes have little relationship to each other.

Ultimately, the question comes down to, "What 'should' my E&M distribution be?" The proper answer to that question is simple: your E&M distribution should reflect what is in your notes. Nothing more, nothing less. Pediatricians often lose sight of this concept, afraid that there is some magic audit line they need to stay behind. But it's simply not true: if you complete your chart notes properly, you should have nothing to fear. Proper charting is vital to this process, there is no excuse.

The issue has been made more complicated by the move towards requiring the Medical Decision Making component of an E&M calculation a requirement — no more 99214 otitis rechecks, thanks to EHRs.

Generally speaking, pediatricians are remarkably conservative with their coding. More than 10 years ago, I estimated that the average pediatrician leaves \$15–\$20K on the table every year from over-conservative E&M coding. Things have improved

significantly for our clients since I looked at this data, as you'll see here.

That brings us back, then, to what "should" a pediatric E&M distribution be? That is, if we assume that the chart is proper, what is the clinical distribution of pediatric visits? Let's look at our history and sources.

Originally, as we all know, the E&M concept assumes a "normal" distribution of codes. For those who haven't revisited their economics textbooks in a while, a "normal" distribution in this instance implies an even, bilateral distribution — historically, the 99213 was the peak with the 99211/99215 and 99212/99214 paired off evenly.

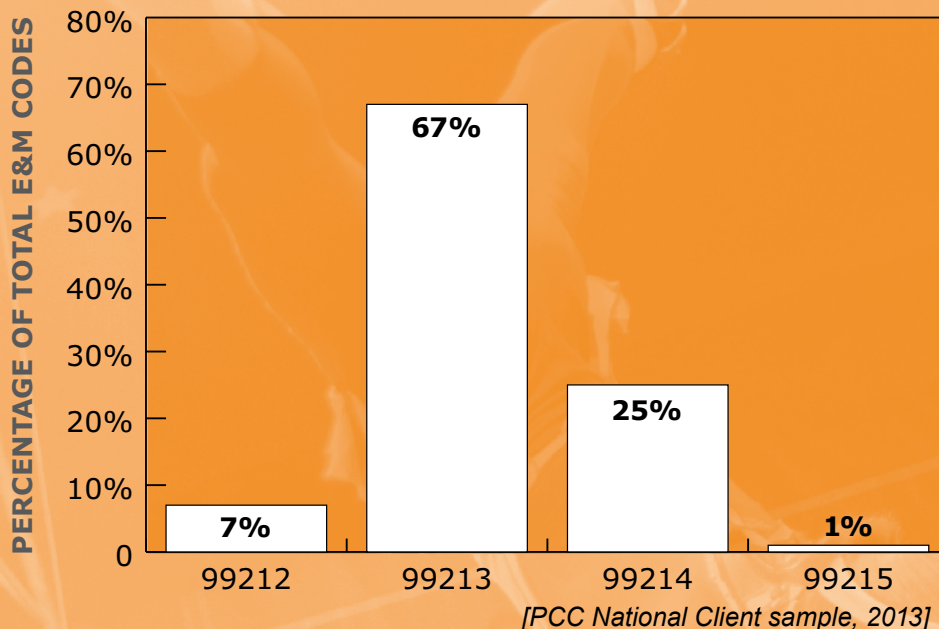
One problem with this viewpoint is that physicians are not supposed to perform 99211s. Those are, generally, "nurse visits." Thus, we should reapply the normal distribution to the 99212 through 99215 and you see that the 99213 and 99214 are now even and the 99212 and 99215 are even. The financial impact of this change is profound.

Still, no one will come out and say, "You should probably have 50% 99213s." Corner a pediatric coder or consultant and we all have different thresholds for what we think is appropriate. But it would still be nice to know what other people are doing.

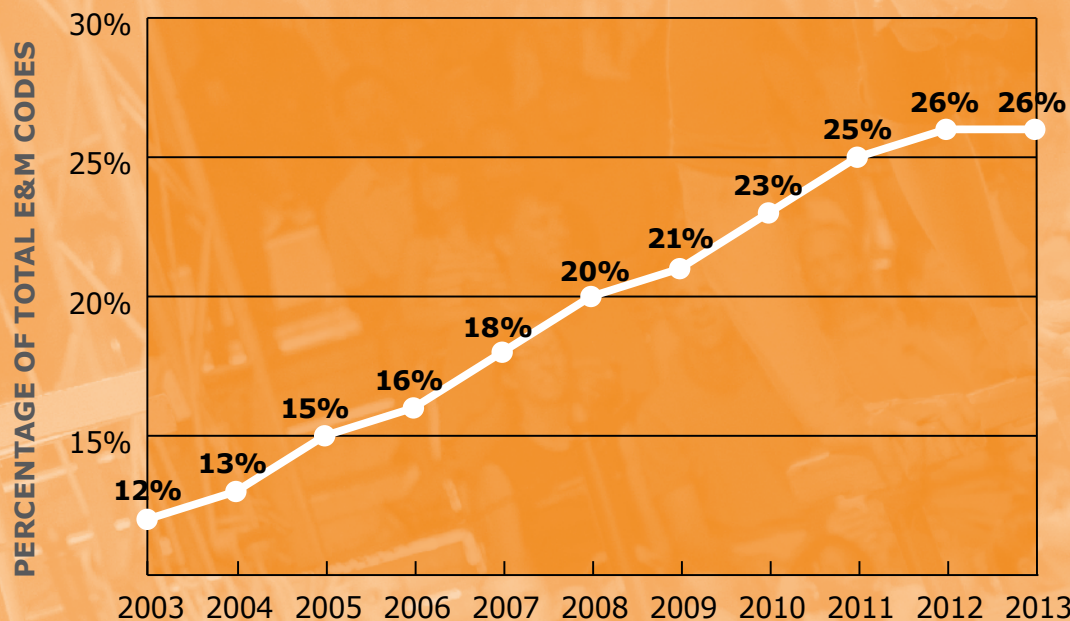
Here is that data.



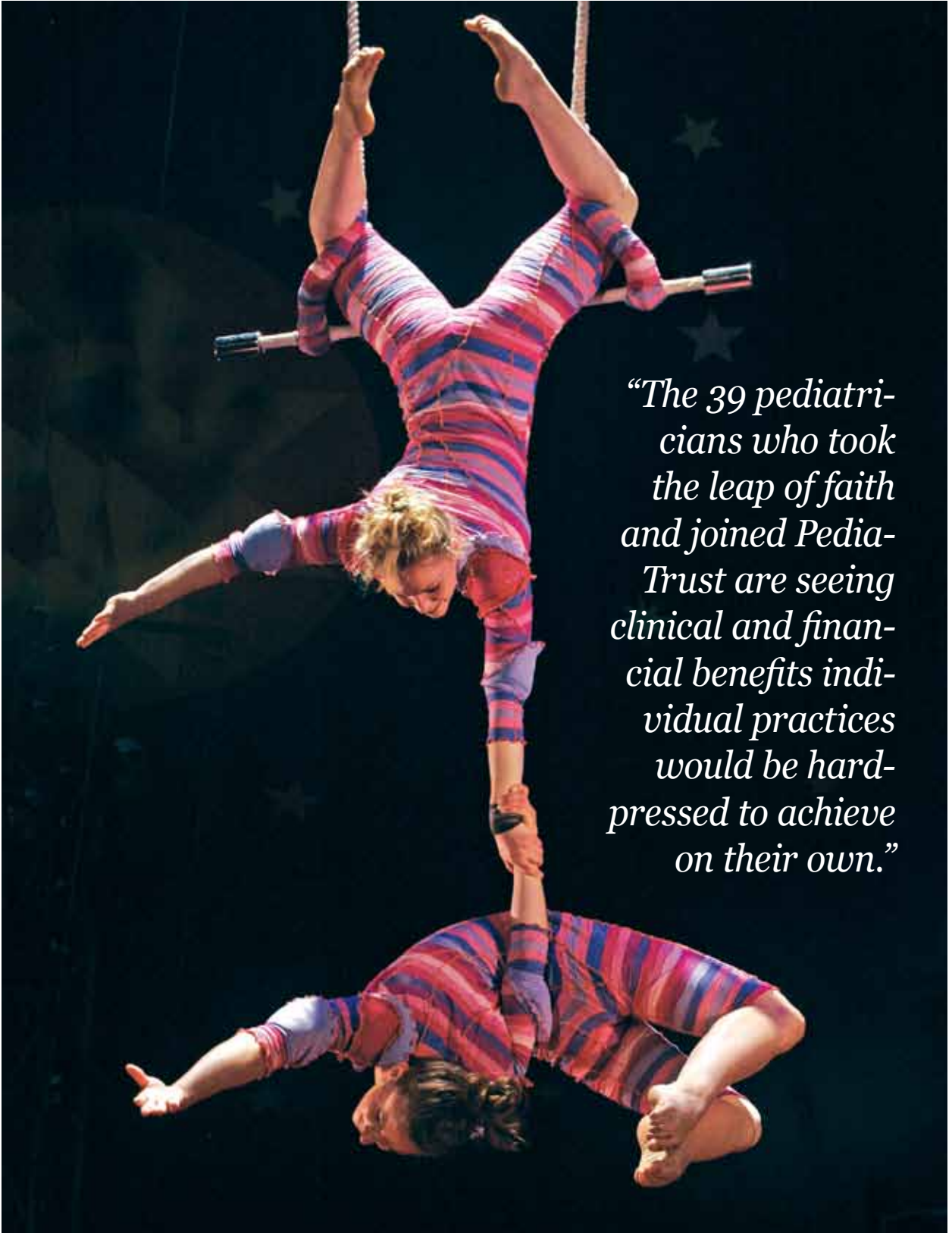
We examined millions of pediatric E&M codes from PCC clients in 2013 and the distribution was quite curious:



Far from a normal distribution! This represents a considerable improvement, however, as the proportion of 99214s and 99215s has effectively doubled in the last ten years:



It doesn't take much math to see how this better coding makes a difference of tens of thousands of dollars for every pediatrician! When is the last time you renewed your E&M distribution?



*“The 39 pediatricians who took the leap of faith and joined Pedia-Trust are seeing clinical and financial benefits individual practices would be hard-pressed to achieve on their own.”*

# Leap of Faith

by Jill Fahy

**I**n 2011, unsettled by the loss of independent practices to hospital consolidation, some 20 Chicago-area pediatric practices worked with an Independent Physician Association to investigate becoming a “group without walls.”

A feasibility study yielded positive results. Each practice was financially sound and supported by a large patient volume. And the physician-leaders involved shared similar values – all were willing to investigate new ways of doing business and each wanted to remain independent.

In the end, though, only seven of the nearly two dozen practices decided to merge as PediaTrust, LLC. Why? The answer, suggests PediaTrust’s chairwoman Dr. Susan Sirota, hints at the level of commitment required for forming a successful independent pediatric group.

“You can cover all the steps and see that everything can look good on paper, but still say, ‘Why do this? I’m doing just fine now as an independent physician. Who knows what will happen?’” Dr. Sirota says. “That final decision requires a leap of faith.”

## GETTING BIGGER TO STAY SMALL

Incorporated in October 2012, PediaTrust integrates the operations, as well as the patient care philosophies and treatment models, of its seven member practices. Billing is central-

ized, the practices are clinically integrated through shared EHR systems, and overall group decisions are made by a board of directors. However, day-to-day decisions on workflow and finances are made at the practice level.

The 39 pediatricians who took the leap of faith and joined PediaTrust are seeing clinical and financial benefits that individual practices would be hard-pressed to achieve on their own, says Dr. Sirota. The LLC uses its shared investment in staff and equipment to offer lactation services that were eliminated by area hospitals. This service, which includes breastfeeding classes for expecting mothers, operates out of three centrally-located PediaTrust practices in suburban Chicago.

PediaTrust also offers 365-day-a-year after-hours care, now available to patients outside the seven practice group. The service is a higher quality, less expensive alternative for patients who would otherwise have to visit a retail-based clinic or the local emergency room.

The after-hours clinic has also been a financial success. “Our business model suggested it might take up to three years to make a profit, but we knew it was worth it,” Dr. Sirota says. “We opened July 1, 2013, and have already begun profiting.”

The merger has also yielded at least one unexpected financial benefit. PediaTrust’s central billing operation,

comprised of the most talented staff from each of the seven practices, has since become its own company, having taken on two clients in the past year.

“Where else is it possible to bring in revenue without seeing patients?” Dr. Sirota says. While merging practices may seem counterintuitive to some independent-minded physicians, the group-without-walls model, if well-executed, can take independence to the next level, says Dr. Sirota.

“We like to say ‘we got bigger to stay small,’ to maintain our independence,” Dr. Sirota says. ■



Susan Sirota, MD  
PediaTrust, LLC

*PediaTrust, LLC*  
*Location: North Shore, Chicago, IL*  
*Number of locations: 12 medical,*  
*1 billing*  
*Physicians: 33*



# A Balancing Act

*by Jill Fahy*



*Dr. Mary Kiepert conducting a well child check. Dr. Kiepert sees about 100 patients a week at her practice in downtown Las Vegas, NV.*

**In** a 2011 New York Times

Op-Ed, a female doctor argued that physicians who cut their hours to fulfill a life/work balance are shorting the patients who need them.

Tell that to Dr. Mary Kiepert. She is a mother of two, who, after cutting her hours in half, still sees about 100 patients a week. What's more, carving out more time for her family, she says, has made her a better doctor for her patients — many of whom seek out women physicians with children who are part time.

“I want a happy work environment that includes satisfied employees and happy patients. Then I want to go home and be with my family,” she said. “Having all this is what I love about being independent.” A solo practitioner since 2004, Dr. Kiepert operates out of an office building in urban Las Vegas, where pediatricians are historically in shorter supply. She serves a younger demographic — 20-something moms who live in apartments, take public transportation and are appreciative of the laid-back culture and flexible scheduling at Tendercare Pediatrics.

“When I first started practicing I was really young and didn't have kids,” Dr. Kiepert said. “Since becoming a mom, I have a better perspective on what it's like to drive one kid across town to school, another to day care, and juggle work and appointments.”

## AN UPWARD TREND

Women currently represent more than 50 percent of all practicing pediatricians, a significant upward trend since 1975, when only 23 percent of pediatricians were women, according to current AAP demographic data.

Dr. Kiepert graduated from medical school in 2000, amid the gender boom, having decided long before to practice pediatrics. Kids, she says, don't come with all the medical baggage grownups often shoulder, and even the children with chronic issues are more likely than their adult counterparts to do what it takes to get better.

As for her decision to be a solo pediatrician, that also came easily, but only after she was burned as an employed physician.

“I was just out of residency and still naïve,” she says, lending context to her first job as a physician at a single doctor practice. It turns out some inappropriate billing was conducted there under her name. “That was a bad time, but it became a great learning experience,” she adds. “I knew I never wanted to trust anyone else but myself again.”



*Tendercare Pediatrics  
Location: Las Vegas, Nevada  
Solo Pediatrician, part time  
Visits Per Week: 100*



*“Work and life is a balance, and once you start sacrificing your own life for your work, you’re in trouble.”*

*— Dr. Mary Kiepert*



*Dr. Karen Foti, a solo practice pediatrician in New Orleans, LA.*

## STARTING FROM SCRATCH

Dr. Karen Foti, a pediatrician in New Orleans, recently launched her solo career after a decade working for private practices and Louisiana’s regional children’s hospital. A single mom, Dr. Foti was between jobs in 2012 when she decided to become her own boss. Her position as an on-call physician at a hospital nursery had just been eliminated, and while this type of work paid well, the hours could be hectic. She, like Dr. Kiepert, opened in a location that is underserved.

“I began to detect that new opportunities were out there,” Dr. Foti says. “The area where I am planning on setting up has 1,200 deliveries per year, so I’m trying to fulfill a need in the community while simultaneously forging my own path.”

New to the world of self-employment, Dr. Foti spent the summer and fall of 2012 hunting for direction and advice on how to start a practice. She joined the AAP’s Section on Administration and Practice Management (SOAPM), received guidance from Susanne Mad- den, a practice management consul-

tant, and spent an entire day interviewing practice management and EHR vendors at the AAP’s National Conference and Exhibit.

Dr. Kiepert chose a similar path, looking to the AAP and SOAPM members for help starting from scratch.

Both doctors have implemented EHR and practice management systems at their offices. Dr. Kiepert, who recently switched vendors, looks to her new system to help keep better tabs on patients who are overdue for immunizations and physicals. Dr. Foti, who is new to a solo career, needs a system that helps, not hinders, the transition.

“There aren’t a lot of people out there jumping off the cliff to start their own businesses as a single doctors,” Dr. Foti says. “It’s kind of like learning to drive a car without taking it on the road, so I see that having a good system behind me is going to be helpful for me.”

## INDEPENDENCE EQUALS CHOICE

While their reasons for going solo are different, Drs. Foti and Kiepert both recognized the opportunities this type of practice holds for business and lifestyle independence.



*Dr. Kiepert reads to one of her patients.*

Until her first child arrived, Dr. Kiepert ran a traditional, somewhat hectic full time practice. The 9 to 5 work day often bled into dinner hour. Wednesdays were for playing catch-up — paying bills, working on protocols and paperwork.

Having kids led to a change in priorities. Her career, while still important, was no longer at the top of the list. “I want to be there for them,” Dr. Kiepert says of son, Soren, 5, daughter Alaina, who is 4, and her husband, an emergency room physician who works full time. “Work and life is a balance, and once you start sacrificing your own life for your work, you’re in trouble.”

Dr. Kiepert says her patient base

has mostly held steady in spite of the decrease in hours, and all this in an era when more than 26 percent of physicians have closed their practices to Medicaid patients. She employs a nurse practitioner who sees about 35 patients a day. Word-of-mouth, referrals and a 10-year reputation keeps Tendercare competitive, she adds.

“I feel proud of the fact that I’ve been able to be successful, and we’ve seen a change in the payer mix, which was at 100 percent Medicaid and is now about 70 percent.”

For 33 percent of pediatricians, gratitude and relationship with patients, not money, is the most important

reward of the job, according to the 2014 Medscape Physician Compensation Report. Dr. Kiepert falls solidly into this category. “I don’t need a million dollars to work comfortably, I just like to work.” ■

# More from Pediatricians about: Work/Life Balance

## HOW DID YOUR PERCEPTION OF THE WORKLOAD AFFECT YOUR DECISION TO BECOME A PEDIATRICIAN?

“I chose pediatrics because I like working with kids and parents — it’s like a cross between a Dr. and a teacher....”

“I just wanted to help make a difference in children’s lives where I could. I know that sounds like a candidate-to-medical-school answer but it really was (and is) true!”

“I knew that medicine in general was going to be hard work and demanding. Yes, there are other specialties that are more lucrative and require fewer hours. However, I love caring for kids and that is why I became a Pediatrician, not because it would provide a better work/life balance.”

“I was born to be a pediatrician. It’s a part of who I am.”

## WHAT ARE THE BIGGEST CHALLENGES YOU FACE WHEN MANAGING WORK/LIFE BALANCE?

“Realizing the work is never completely finished, everything can’t always be perfect, and that others can do the things I do just as well.”

“Feeling like a good parent and a good pediatrician is REALLY hard to do.”

“In order to be more involved in my community and take on leadership roles in the hospital and other organizations, your personal life can suffer.”

“Sure, be your own person. Do solo practice and find out the real joy of medicine.”

“I love my job. Working with kids is amazing, hilarious, interesting and fun. Ultimately, I bring that enthusiasm and happiness home to my family.”



## WHY AND HOW HAS YOUR WORK/LIFE BALANCE CHANGED?

“I used to be a pediatric intensivist/academic physician (writing papers, etc.). I loved it, but it was sapping my energy and my time and my ability to raise my kids. I am now a general pediatrician in private practice. I have much lighter hours.”

“I opened my own practice.”

“I work 80 hours a week for myself so I don’t have to work 40 hours for somebody else.”

“I still work the same total hours per week as I used to, but I do more work I enjoy (less grunt work/paperwork), and I am able to work more at the hours/times of my choosing, rather than work invading at random/inconvenient times.”

“Getting more providers has allowed us to take fewer calls and more vacation.”

## WHAT HAVE YOU LEARNED?

“You must plan time off and take it. Be flexible and willing to delegate tasks. Realize you are not usually the only person that can do a particular job or task.”

“No one cares more about you and your time, than you do, so act like it. The work will expand to fill the time you set for it.”

“There are no universal secrets — everyone walks the tightrope...it’s just thicker for some than for others.”

“Take a lot of vacation. When you are off, you are off.”

“No secret. Just decide how much of me I want to give to my patients, and then I have to respect the limit I set.”

“Get out of a group. Work for yourself! It provides more flexibility.”

“Be able to delegate tasks. Build up the practices of all the new associates.”





# My Story



“We do live by our state motto ‘Live Free or Die’ and are very happy with our private practice.”

**T**wenty-eight years ago I joined a two pediatrician group in Concord, NH. They were two male pediatricians looking for a female pediatrician and anticipated more business due to the creation of Health Source, a new independent HMO that they had helped fund and start up with other physicians in New Hampshire.

I was fresh out of residency and fell in love with their tiny office located in an old two story building in downtown Concord. Their practice appealed to me as it was two docs and one secretary and they did all the patient care themselves without nurses or other staff. I was also impressed by how few calls they received after hours while at dinner on my interview. Other interviews had been interrupted by multiple phone calls that often seemed for very minor illnesses. My soon-to-be partners told me that their patients knew when to call them as they spent time explaining what was an emergency and what could wait 'til the next day's office hours. They also related that they had a 2 hour call-in block every day where patients knew they could call and ask the docs questions. I was sold!

My years since then have been very busy. As the first woman in the practice, I brought in some GYN skills for the teenage girls and some newer ways

of dealing with common childhood illnesses such as asthma. As the years went by we did gain another male partner and a nursing assistant as well as another secretary.

About a decade ago we moved to an office on the hospital campus to make life more convenient. For most of my years of practice we also admitted to and rounded in the local hospital every day. We cared for routine dehydration, asthma and infectious disease in our inpatients as well as stabilizing critically ill children and infants until they could be transported to a tertiary medical center. Despite all the work our practice remained homey and a place where the patients felt they knew and trusted all the physicians and the APRN we added along the way.

Today we only do social rounds at the hospital as we have a full staff of pediatric hospitalists. The other group in town doesn't even go in to the hospital to see patients even on a social basis now. We are much larger but still only have two nurses and one nursing assistant. We have 10 front office staff now but that is well below most practices our size. We have grown to six doctors (two are 3/4 time) and two APRN's but still maintain a level of care where all the providers are aware of our more complicated patients. We remain

fiercely independent and negotiate all our own fees with insurers as well as do our own billing in house. Our schedules can be flexible when we need them to and we are all happy with our income and benefits. We do not have an EMR as of yet and plan to stay with paper charts as long as possible.

We do live by our state motto “Live Free or Die” and are very happy with our private practice. I do believe we are the only private pediatric practice of our size remaining in New Hampshire.

So that's my story! ■

— Patricia Edwards, M.D.



Patricia Edwards, MD,  
Concord Pediatrics

Concord Pediatrics  
Location: Merrimack  
Valley, New Hampshire  
Physicians: 6

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*No one has a right to expect to succeed in life unless he understands his business, and nobody can understand his business thoroughly unless he learns it by personal application and experience.*

*— P. T. Barnum*



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