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The Independent Pediatrician

The Business of Adolescent Medicine: Supporting and Embracing Transitions

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EDITOR'S NOTE

Adolescent Medicine: A Path to Change

We welcome you to the 4th edition of *The Independent Pediatrician*. We're excited to share with you another inspiring issue filled with stories of independent physicians on the forefront of pediatric care, and how they continue to give their very best to their patients.

After our last issue, when we decided to try a new format, we asked you, our readers for feedback. We were pleased to hear you liked the change. You affirmed that you want stories about "pediatricians just like me," and you told us these stories are meaningful to you, both personally and professionally. Thank you all for your valuable input!

For this issue, we are shining a light on adolescent care, a subspecialty within pediatrics. We were interested in exploring well-known teenage struggles and highlighting the importance of dedicated care to a pediatric population that may be facing more challenges than prior generations. Their use of social media, exposure to greater risk factors, and participation in their community make adolescents a unique group of pediatric patients.

> "They are bonded to me, and I am bonded to them."
>
> – Dr. Eileen Chan

Knowing that the transition from childhood to adulthood is marked by a series of changing needs, pediatricians have both an opportunity and a responsibility to make a difference in a young person's life.

We are certain that the stories that follow will inspire and inform you.

Enjoy!

Feel free to drop us a line with your thoughts or ideas for stories at **mystory@IndependentPediatrician.com**. We also welcome a story directly from you! You can find our issues online, sign up for your free subscription, and share our publication with colleagues, friends and family at **www.IndependentPediatrician.com**.

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The Independent Pediatrician

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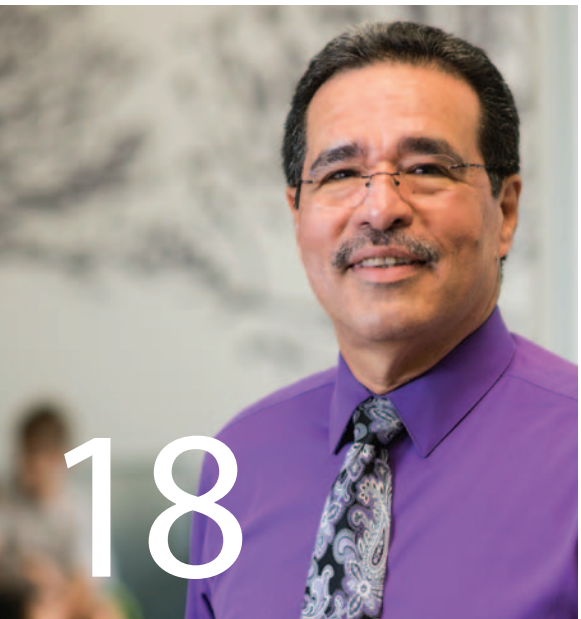
We want to hear from you!

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 find that reading about them will inspire you to spread the word and tell your 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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An Eternal Optimist

BY CHIP HART

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 the AAP, CCHIT, 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.

I've just returned from our annual Users' Conference out on the West coast and find myself reinvigorated. Any gathering with hundreds of pediatricians and those who work for them is going to make me both excited and anxious — so many challenges solved, so many new challenges to face.

This year, the conversations at meals, in classes, and over dinner and drinks circled around two consistent topics: the growth of ACOs and other "narrow networks" (how are these networks legal?!) and a continued focus on how practices might work together to fight these growing impositions.

I was also excited to spend time teaching about employed clinician compensation models and partner compensation modeling. One class was scheduled for an hour but we went almost twice that with questions and commentary. When practices focus on their growth and maturity, rather than "How do I code for XYZ?" or "What laptop should I use with my EHR?" I begin to feel that pediatricians are evolving up the professional evolutionary scale. The coding is still important, of course — look at all the packed ICD-10 training courses — but pediatricians now discuss the macro environment and not only the micro-, day-to-day issues.

Although fear and uncertainly are still woven throughout the discussions, I sense a tremendous interest and willingness to consider working with larger pediatric-led groups. New pediatric groups-without-walls are forming in California, North Carolina, Texas and Florida — everywhere the hospitals and health systems are carving up the business. Where I used to be quite cynical about these merged groups and mega-practices, I now see that a pediatric-led endeavor can be incredibly capable. I am optimistic that these new projects will keep pediatric needs at the forefront and I see my optimism reflected in the faces of many pediatricians who were recently concerned about their long-term viability. We've written about a few of these practices in the past and will be sure to continue to highlight them here.

For a great example of the breadth of support a large pediatric-centric group can provide, take a look at our piece inside featuring Dr. Velez-Domenech. Dr. Velez-Domenech is part of Children's & Women's Physicians of Westchester, LLP, an enormous pediatric-focused group in the northeast. His participation with them allows him to focus specifically on adolescents, perhaps the most poorly served population in all of healthcare. Which leads me to...

Our theme

With this fourth issue, we decided to devote ourselves to a theme to help guide our thoughts. There are so many important topics in the independent pediatric world that we felt as though we do a disservice when we jump around in a disorganized fashion. With this, and each successive issue, we expect to apply a particular lens to the conversation and to help us identify new practices whose stories we will share.

As a result, in this issue, we have looked into the specific world of Adolescent Medicine. As you will see from the conversations, the theme within the theme is quite clear: adolescents have particular clinical and developmental needs which are not well met. Those who work with these kids find that their greatest rewards are not financial, but they are significant nonetheless.

Once we identified adolescent medicine as our focus, we searched for progressive and leading practices, as well as for physicians who identified an important need and are doing something about it. We found many, of course, and chose a handful who represent the diversity of practice styles around the country. From the Pediatric Wellness Group's fascinating new adolescent practice on the Pacific to the Center For Pediatric and Adolescent Medicine's long-established vision on the Atlantic to Dr. James Hendricks' efforts in the center of the country, these are the physicians who give me hope for the future of pediatric medicine. When you read about these practices, I hope you find their enthusiasm as contagious as I do. They are not only practicing good medicine, they are good business people who raise the bar of quality for all of us.

Of course, some pediatricians question my shared optimism. Don't I know that the practice of medicine gets worse every year? Isn't my perspective skewed because I work with too many well-run practices?

PCC Staff and Clients during the annual PCC Users' Conference

Practices with their heads up and ears open to opportunities to improve? Perhaps I don't take into account the "average" practice and I often ignore the constant threats from payers, the government, the lawyers, or, worst of all, other physicians.

The accusations are true, I suppose, but I make no apologies. If I'm going to work for a better world for pediatricians and their patients, am I going to sit in the back of the class and hope the teacher doesn't call on me? Or, am I going to sit up front and work next to the future leaders in pediatrics?

You know the answer already. I want to work with the practices with vision, with ambition, and with high expectations for themselves and others. Where are you going to sit? As W. Somerset Maugham once said, "...if you refuse to accept anything but the best, you very often get it."

As a reader of *The Independent Pediatrician*, you are part of this small army dedicated to serving children in the best way possible. Sit up here in the front row with us. The teacher will call on you next. ■

Treating Adolescents Using

Compassion, Curiosity & Clinical Care


Dr. James Hendricks

BY JILL FAHY

The U.S. has nearly 42 million people aged 10 to 19. In other words, some 20 percent of the nation's population may be walking around with acne or anorexia, obesity or ADHD, new tattoos and belly-button piercings, a penchant for pot or alcohol, or a broken heart that feels like the end of the world.

And yet, concern continues about risky health behaviors, mental health issues, and substance abuse problems among adolescents. Today's youth are getting much less clinical attention than this significant subset of the population deserves.

It was Dr. James Hendricks' interest in these complicated issues that helped him successfully treat the bridge population between childhood and adulthood.

"Looking back, one of my major sub-interests in medical school involved developmental medicine and school-related problems," says Hendricks, a pediatrician from Oklahoma who has since retired from practicing. "I recognized early on that this is an underserved population that needed a lot of other things besides their first well woman exam, or a sports physical, or college exam."

In 1990, an anonymous questionnaire was sent to general pediatricians in suburban New York who saw, on average, 28 patients a day (Marks, Fisher and Lasker, 1990). About 1 in 10 regularly saw patients with a sexuality-related concern, substance abuse problem, or anorexia. But fewer than half provided anticipatory guidance regarding sexuality, and only 14 percent questioned teens about depression.

Respondents perceived low reimbursement, lack of time, and lack of knowledge as obstacles to providing expanded care to adolescents.

And while many of these gaps have been filled with improved anticipatory guidance materials, such as the AAP's Bright Futures guidelines, there are still holes in the fabric. A 2009 report by the Committee on Adolescent Health Care Services and Models of Care for Treatment, Prevention and Healthy Development posited that the nation's current system of health services is ill-suited to providing the right mix of clinical and preventive services to adolescents (www.nap.edu/openbook.php?record_id=12063).

The report also says significant gaps remain in achieving a well-equipped and properly trained workforce ready to meet the health needs of adolescents. And there are those who simply resist further training in adolescent care, viewed by many as time-consuming and low-paying.

Dr. Hendricks is on the opposite end of the spectrum. He considers it gratifying to see a patient he once held in his arms hop onto the exam table and talk about applying for college. Good at putting teenage patients at ease and earning their trust, he was able to open the door to conversations about tender subjects, such as smoking and sex, without offending or embarrassing his patients.

Using practice-based research

A long-time partner at Pediatric and Adolescent Care in Tulsa, Oklahoma, Dr. Hendricks embraced practice-based research as key to administering successful anticipatory guidance and motivational interviewing on topics such as smoking, gun safety and safe teen driving.

"Participating in these clinical studies allowed me to have a perspective bent toward transitions of care," Dr. Hendricks says. "It helped me get a better understanding of the families of my patients, and really just helped me ask better questions."

Dr. Hendricks worked specifically with the AAP's Pediatric Research in Office Settings (PROS) Network, which conducts national, collaborative, practice-based research.

Dr. Richard "Mort" Wasserman, a Professor of Pediatrics at the University of Vermont College of Medicine and director of PROS, has known Dr. Hendricks for many years. He says pediatricians say they have often found different ways of approaching their work as a result of participating in PROS. *(See our conversation with Dr. Wasserman on page 12.)*

"The day-to-day work is intense, demanding, time-consuming, and frustrating at times," Dr. Wasserman says. "This kind of participation can remind pediatricians of what they had in mind when they started practicing and helps them think about different ways to help families and kids."

Dr. Hendricks says he further honed his adolescent training by attending adolescent medicine seminars, and later, by taking advantage of features in the office's practice management system that aided clinicians and staff in booking appointments to best fit the needs of adolescent patients.

"For us, doing adolescent care was very much a part of pediatrics, so in that way, we didn't see it as being a separate part of the practice."

"Using the scheduler, we varied appointment times based on the complaint, whether it was an acute problem-focused issue, or something like an asthma followup," says Dr. Hendricks. "We also varied appointment times based on provider desire and grouped appointments based on gender, so you could book pelvic exams with the provider of choice."

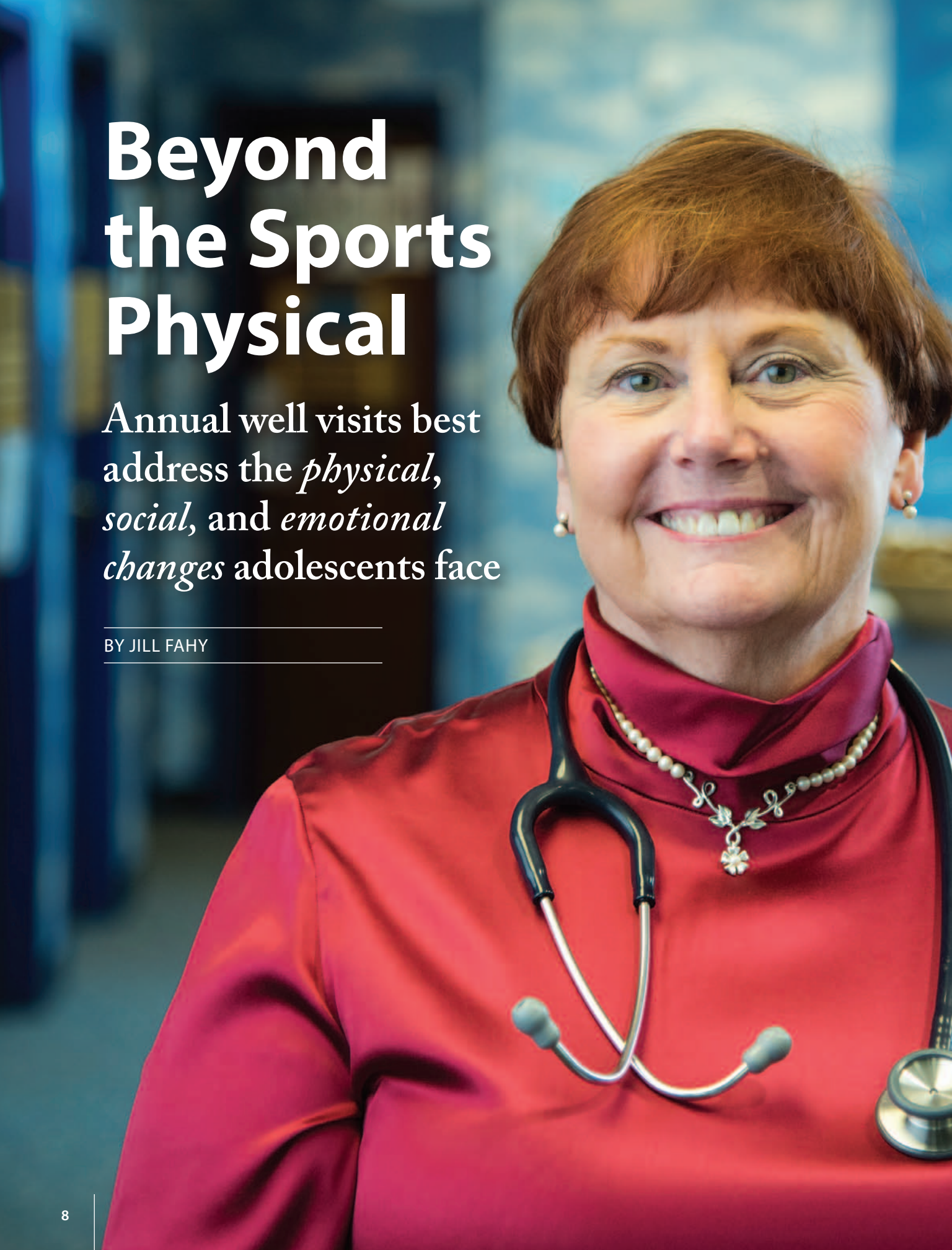
The practice also uses the scheduler to stagger appointments by age group, as the office uses a common waiting room. Another important part of their adolescent clinical attention was using the pediatric recall functionality in their system to contact kids who were overdue for well visits and to avoid missing opportunities to see patients that had not been in for a while.

"For us, adolescent care was very much a part of pediatrics, so in that way, we didn't see it as being a separate part of the practice," Dr. Hendricks says. "We worked hard to develop a relationship with that growing child and the family so we could later meet the needs of adolescents, and give very important health care to an underserved population that didn't fit in." ■

Beyond the Sports Physical

Annual well visits best address the *physical*, *social*, and *emotional changes* adolescents face

BY JILL FAHY



Dr. Julia Pillsbury

While caring for adolescents is implicit in every general pediatrician's day, Dr. Julia Pillsbury chose — in naming her practice — to give this at-risk patient population special attention.

"We made the decision from the get-go to put 'adolescent' in the name so parents know their teenager is part of the practice," said Dr. Pillsbury, managing partner at The Center for Pediatric and Adolescent Medicine in Dover, Delaware. "It's very rewarding to take care of someone from birth to college."

> "It's important for the child to feel they have privacy. We're trying to prepare them for when they're adults..."

Rewarding but not easy, especially when it comes to providing clinical preventive services to a population at risk for some of society's most serious and costly health problems — alcohol and drug use, smoking, unintended pregnancy, accidents, suicide and sexually-transmitted disease. Nationally, some 25 to 30 percent of adolescents are considered to be vulnerable to these behavioral health problems.

And while studies show that adolescents and their parents look to, and trust, clinicians to address these risk-taking behaviors, this population generally underutilizes clinicians more than any other. Also, adolescents are more likely to lack coverage than younger children. Nationally, one in seven adolescents ages 10 to 18 has no form of public or private health insurance. In Delaware, Dr. Pillsbury's home state, 10 percent of youth aged 13-18 were uninsured compared to 6.5 percent of those aged 0-5, according to a 2008 report by the Urban Institute and the Robert Wood Johnson Foundation.

This is a concern for pediatricians because adolescents make up nearly 20 percent of the population.

"Once kids in Delaware get into high school, pediatricians lose a tremendous number of well visits," Dr. Pillsbury said. "It's really down considerably."

Data shows the dropoff for adolescent well visits begins at age 12, as the percentage of patients up to date decreases with each year the patients are active in the practice. Fewer than half of all 16 year olds have had a well visit in the last year.

Well Visit Coverage by Age

Under 15m	85%	11 years	60%
15m-3y	66%	12 years	60%
3 years	68%	13 years	56%
4 years	68%	14 years	54%
5 years	68%	15 years	50%
6 years	57%	16 years	49%
7 years	55%	17 years	45%
8 years	54%	18 years	40%
9 years	54%	19 years	8%
10 years	54%		

SOURCE: National average of PCC clients, July 2015

The active patient mix at The Center for Pediatric and Adolescent Medicine is like most pediatric offices; patients under age 5 are seen most frequently, followed by elementary school-age kids. "Once they hit their teens, it's almost impossible," Dr. Pillsbury said. "Parents say, 'why should I worry about it?' They really aren't aware of the kinds of developmental counseling we do."

The importance of well checks

Pediatricians offer a broad range of preventive services for adolescents, including immunizations, screening for depression, vision problems and scoliosis; and anticipatory guidance on nutrition, exercise, alcohol and drugs, sexual behavior, peers and injury prevention. Many services can be targeted toward specific teenage demographics, including age, gender and income.

Despite their overall aversion to doctor visits, some 73 percent of adolescents in the U.S. see a physician at least once a year, according to the American Academy of Family Physicians (2008).

Bright Futures guidelines recommend a well visit every year for healthy adolescents. Patients who show risk behaviors should be seen more frequently.

Annual checkups are the perfect forum for addressing adolescent health issues. Healthcare professionals say teens are twice as likely to ask about important health topics during these checkups. Well visits allow the clinician to give the patient a thorough physical exam, as well as touch on developmental and emotional issues.

A well visit at Dr. Pillsbury's practice generally takes between 25 and 30 minutes for an adolescent. Privacy becomes a big focus around age 12, when patients and their physicians can speak confidentially, without parents present. Patients age 12 and over may sign a HIPAA authorization form which addresses whether or not health information can be shared with family.

"Some parents hold on like crazy, and getting them out of the room is nearly impossible," said Dr. Pillsbury, "but it's important for the child to feel they have privacy. We're trying to prepare them for when they're adults… for when they'll be legally responsible for medical care."

Although adolescent well visits are time-consuming and often not well paid, Dr. Pillsbury views these comprehensive exams in a clinical setting as the best opportunity to provide preventive health care. "All the developmental counseling and risk prevention we do doesn't happen during the sports physical at an urgent care or school-based health center."

Dr. Pillsbury with an adolescent patient

School-Based Health Centers can effectively provide preventive health care to children, particularly those who are underserved or uninsured. Nationally, there are more than 1,900 SBHCs located in schools, according to an analysis in the Guttmacher Policy Review (2015).

> "Health care has changed. That's the critical thing."

Where these services often fall short, however, is in a lack of funding or in the availability of sexual and reproductive health services, according to the Guttmacher study. Fewer than four in 10 SBHCs dispense contraceptives on-site, partly because of restrictive state and local laws.

In Delaware, where Dr. Pillsbury practices, there are nearly 30 School-Based Health Centers in local high schools, so she and other pediatricians who value the adolescent well visit have their work cut out for them. The Center for Pediatric and Adolescent Medicine uses its practice management system to recall adolescents in need of well visits. And patients and their parents who are in for a sick visit are automatically reminded of upcoming well visits.

Despite the obstacles, Dr. Pillsbury remains optimistic that adolescents can receive the preventive services they need. The Affordable Care Act guarantees certain patient rights and protections for adolescents, including free STI prevention counseling and screening for adolescents at higher risk; vision screenings for all children; depression screenings; and behavioral assessments.

"When I was young, people only went to the doctor when they were really sick," said Dr. Pillsbury. "Health care has changed. That's the critical thing." ■

AT A GLANCE:

TODAY'S ADOLESCENTS

The 5 C's of Positive Youth Development

COMPETENCE

Definition: Perception that one has abilities and skills

How to foster it: Provide training and practice in specific skills, either academic or hands-on

CONFIDENCE

Definition: Internal sense of self efficacy and positive self-worth

How to foster it: Provide opportunities for young people to experience success when trying something new

CONNECTION

Definition: Positive bonds with people and institutions

How to foster it: Build relationships between youth and peers, teachers and parents

CHARACTER

Definition: A sense of right and wrong (morality), integrity, and respect for standards of correct behavior

How to foster it: Provide opportunities to practice increasing self-control and development of spirituality

CARING

Definition: A sense of sympathy and empathy for others

How to foster it: Care for young people

Core supports & opportunities of youth problem prevention

SOURCE: Clea McNeely, MA, DrPH Jayne Blanchard, Johns Hopkins University, *The Ten Years Explained: A Guide to Healthy Adolescent Development, Forum for Youth Investment*

Dr. R. "Mort" Wasserman

AT YOUR FINGERTIPS:

A chance to advance pediatric research with your practice's EHR data

BY DR. R. "MORT" WASSERMAN

In the hectic world of 21st century pediatrics, how can a busy independent pediatrician find the time to participate in research and help advance the pediatric knowledge base while also meeting the demands of practice? What if researchers could use their EHR data?

Have you heard of Pediatric Research in Office Settings, PROS, the practice-based research network of the AAP?

(www2.aap.org/pros/) PROS was founded in the 1980s as a collaboration with independent pediatric practitioners and the AAP and pediatric researchers. Now in its 30th year, PROS has allowed independent pediatricians to help generate new knowledge while engaged in the day-to-day work of pediatric practice. Findings from PROS research have made and continue to make a major impact in pediatrics. For example, in the adolescent medicine world, a PROS study provided the first evidence that girls were maturing earlier than stated in textbooks[1] and led to the revision of guidelines for referral for precocious puberty.[2] The guidelines to be released in the coming year on the management of febrile infants will be significantly informed by data from a major PROS study,[3] and the results of a recently published PROS randomized controlled trial[4] have shown that motivational interviewing done in pediatric practice can help ameliorate pediatric obesity.

PROS projects typically have involved pediatricians providing study-specific data apart from the medical record, but in the 21st century, the electronic health record (EHR) data that pediatricians and their staffs enter in the day-to-day care of patients provide a significant resource for both epidemiological and comparative effectiveness research. Large health systems with informatics resources can provide such EHR data in bulk, but what about data representing the many children seen in the large number of independent practices that continue to thrive? In 2011, PROS created an electronic subnetwork — ePROS (www2.aap.org/pros/epros/) — to make sure that the many patients seen in independent practices could be included in this research opportunity.

In ePROS, after a data use agreement between the AAP and a participating practice has been signed, a HIPAA limited dataset, deidentified in such a way as to be usable for research without need of written consent,[5] is extracted from the practice's EHR. The original ePROS model required involvement of a data extraction vendor to pull and standardize the EHR data, but PROS has now changed its model for ePROS. One variation has been implemented for a practice that had the ability to extract and deidentify its own EHR data and has made it available for analysis. Allied Physicians Group (formerly Allied Pediatrics of New York) has joined ePROS under this arrangement. Most independent practices do not, however, have the informatics capacity to extract, standardize, and deidentify their EHR data. So ePROS is moving to what is likely to be a more widely available model involving interested EHR vendors.

Two EHR vendors, Physician's Computer Company (PCC) and Office Practicum (OP), recently have agreed in principle to work with the AAP to help recruit ePROS practices from among their clients and, after interested practices have signed data use agreements with the AAP, periodically extract HIPAA-limited datasets from these practices for use in research. This is an exciting

development for ePROS in that it will make available EHR data from a large group of independent practices whose patients might otherwise be missing from important research, and which can be added to an even larger AAP EHR data collaboration[6] in order to get the most accurate picture of U.S. pediatric health care.

How would ePROS practices benefit?

Practices benefit from ePROS participation by:

- Learning how their patients compare with the patients of other practices (e.g., prevalence of common conditions such as obesity and ADHD)
- Learning how the care their practice delivers (e.g., medications prescribed) compares with the care delivered by other practices
- Receiving recognition from the AAP for participation in ePROS
- Knowing that their practice is contributing to a national effort to improve pediatric care for all children by generating new knowledge.

In addition, potential ePROS benefits of the future could include Maintenance of Certification Part IV credit for projects designed to be implemented through ePROS and satisfaction of the Meaningful Use Stage 3 requirement for public health and clinical data registry reporting.

Although the benefits of ePROS participation will initially be limited to practices that use the OP or PCC EHR systems, the AAP is certainly open to working with other EHR vendors interested in ePROS.

For additional information about ePROS, contact R. "Mort" Wasserman (rwasserm@uvm.edu) or Alex Fiks (fiks@email.chop.edu). ■

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AT A GLANCE:

TODAY'S ADOLESCENTS

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THE NUMBER OF PEDIATRIC STUDIES COMPLETED **SINCE 2007**

SOURCE: *www.orphan-drugs.org/2013/12/13/rare-disease-pediatrics-facts-day-premier-research-infographic*

"**EHR and other electronic health data may be particularly important in moving forward research on pediatric medicine, a field where clinicians and families have typically depended on findings from adult clinical trials.**

A number of pediatric primary care practice-based research networks have developed that are beginning to explore the use of electronic health data for research. For example, Pediatric Research in Office Settings (PROS) is the American Academy of Pediatrics' practice-based research network and has begun an EHR-based sub-network called ePROS.

This sub-network was funded through the American Recovery and Reinvestment Act of 2009 and is being built to develop and test the infrastructure needed to conduct pediatric research using EHR systems. It includes providers from diverse practice settings across different states and using a variety of vendors, with plans to expand the sub-network substantially within the next one to two years."

SOURCE: *The Feasibility of Using Electronic Health Records (EHRs) and Other Electronic Health Data for Research on Small Populations*, September 2013, Urban Institute

Dr. Niki Saxena

Aging Out of Pediatric Care is All Relative at Pediatric Wellness Group

A Northern California Practice Expands its Adolescent Services

BY JILL FAHY

Not long ago, the physicians at Pediatric Wellness Group (PWG) noticed a tip in the balance of its patient mix. Many of their newborns and diaper-clad tots were morphing into teens with a range of behavior-related health issues and young adults on the verge of leaving home.

College-age patients clamored to stay with the practice, fearing the pokings and proddings of a new clinician. There were patients with chronic illnesses who were aging out, facing an uncertain future with new specialists. And pediatricians found themselves just plain busier, treating patients who were neither big children nor little adults, but somewhere in between.

So, in turning its attention to this growing adolescent population, the San Francisco Bay area practice pondered how to best serve a group of patients whose physical, behavioral and emotional needs are its most diverse and challenging.

Their solution? Create a separate clinic — one that treats adolescents as a distinct patient population, yet maintains PWG's core medical home model emphasis on preventive health and education. Located down the hall from its pediatric offices in Redwood City, the planned Young Generation Wellness Group is scheduled to open in summer 2016.

"As a Patient-Centered Medical Home, our ultimate goal is to get better patient engagement among our adolescent population and give them tools to manage their own health," says Dr. Niki Saxena, who manages PWG with partner Dr. Eileen Chan. "To achieve this, we think it's helpful to physically separate out the adolescent piece. This reinforces the fact that there are different issues you're dealing with, and sets up a different experience for the adolescent."

PWG's growing adolescent population is representative of pediatric practices across the country that are seeing a similar patient mix. Adolescents ages 12 through 21 make up a third of the patient population in practices, according to a 2009 study by The National Alliance To Advance Adolescent Health.

Yet the field of adolescent medicine remains something of an anomaly among pediatric specialties. The job is demanding, time-consuming and often poorly paid — making it difficult for practices to invest in the array of services needed to improve health outcomes and prevent chronic conditions from continuing into adulthood.

The right location

Drs. Saxena and Chan's practice, as well as others in cities near major teaching hospitals, are more immune to the economic barriers of opening an adolescent clinic. PWG is located at the mid-point of the San Francisco Peninsula, an area in the center of a booming high-tech industry.

"When we opened in 2011, we knew there was additional space if we wanted to expand, so that made it easy," Dr. Saxena says. "Our community is going through a tremendous amount of growth that includes a huge influx of people and an expanding workforce."

Recruiting physicians for PWG's adolescent center is also comparatively easy, with its proximity to Stanford Children's Center and UCSF (University of California at San Francisco). But the partners at PWG — a Level 3 recognized Patient-Centered Medical Home — are choosy, interested in only those candidates whose values match theirs.

"Sometimes it's less about titles and more about fit," says Dr. Saxena.

Finding funding for a stand-alone practice was a different story. With a booming economy comes the high cost of doing business. Pay scales are higher and rent is exorbitant.

> "Our ultimate goal is to get better patient engagement among our adolescent population and give them tools to manage their own health."

"Start-up cost is two- to three-times what anyone else would have, and most people can buy a building outright for what we pay in rent," says Dr. Saxena. "It was hard work finding the type of funding that would work out for our practice. It was necessary for us to get creative and think outside the box."

Dr. Saxena says practices should consider several sources — other doctors, banks, hospitals and lending institutions — when looking to expand their services and facilities.

"It's worth having conversations and potentially partnering with multiple folks," Dr. Saxena says. "Get your business program together and do your homework."

Homework for PWG involved hiring a consultant with experience in start-up practices. The partners chose The Verden Group, a health care consulting firm based in Nyack, NY.

"In creating a business plan," said Susanne Madden, Verden's founder and CEO, "stakeholders looked at adolescent-focused services that are already available in the area. They found many existing services target teens and young adults who are already in trouble, leaving a gap for PWG to provide guidance and services that can prevent and educate against crisis situations."

"The goal is to take the existing medical home model with PWG, replicate it, then apply it in treating a different population," Madden says. "It will exist as

a standalone practice which will be highly specialized and will make a very strong brand."

PWG's adolescent practice will serve patients ages 16 to 26. Many will be existing patients who have technically aged out of PWG; others may be young adults from other pediatric practices who have also aged out and are looking for specialized care for their stage of life. Still other patients may be teenagers who feel out of place in a pediatric setting. The day-to-day practice will be staffed by a family practitioner, an internist and a mental health worker.

"In our experience, there is a growing chunk of kids who don't want to leave because they love the personalized care," Dr. Saxena says. "Also, it's great to offer the kids who age out an option we've vetted, as opposed to an office that may or may not share the same medical home model."

Dr. Saxena's partner, pediatrician Eileen Chan, M.D., says some 50 percent of her patients are now in their mid- to latter teens or are young adults. And the majority of her oldest patients don't want to leave the practice, she says.

"They're bonded to me and I'm bonded to them," says Dr. Chan. "They don't care if their doctor is a female or a male. They just want to have a relationship with a person they've trusted for a long time."

Adds Dr. Chan, "It's incredible to be able to have that gift with somebody who is comfortable telling you 'I took this drug,' or 'I had unprotected sex,' and then to whom I can say, 'that wasn't a good idea. Why would you do that?'"

Like most pediatric office common spaces, the waiting room at PWG is a lesson in bright primary colors. Kid-sized chairs are tucked under a kid-sized table. Patients waiting for their turn in the exam room can flip through picture books, or play with a toy in which red, yellow and blue marbles are pushed or pulled along a looping strand of wire.

PWG's adolescent waiting room will be decidedly different — smaller and more intimate, as teenagers often feel more vulnerable in large, open spaces, said Dr. Saxena.

According to the American Academy of Pediatrics, a welcoming, teen-friendly environment may include adolescent-specific posters, or pamphlets on substance use and mental and sexual health.

Also, brochures on sensitive topics should be available in the examination rooms, and displaying information about the practice's confidentiality policy and waiting times is key.

Dr. Saxena advises those looking to start an adolescent practice to do their homework.

"Do your market research, and don't be afraid to think outside the box." ■

Dr. Saxena examining an adolescent patient

Key Terms and Definitions: **Healthy Adolescent Development**

Adolescence

Usually defined as the second decade of life, adolescence is the period of transition from childhood to adulthood. Researchers now note that bodily and brain changes associated with adolescence may begin as early as age 8 and extend until age 24.

Health Risk Behaviors

These are behaviors that make one more likely to experience a negative health result. For example, unprotected sexual intercourse is a health risk behavior that makes one more susceptible to sexually transmitted infections and unplanned pregnancy. Health risk behaviors are commonly referred to as risky health behaviors.

Positive Youth Development

Positive youth development is a framework for developing strategies and programs to promote healthy development. It emphasizes fostering positive developmental outcomes by providing young people the experiences and opportunities to develop core developmental assets. The list of core developmental assets typically includes what are known as the 5 C's: competence, connection, character, confidence, and caring. *(See page 11 for more about the 5 C's.)*

Protective Factors

These are characteristics or behaviors that increase the likelihood of experiencing a positive result (e.g., the presence of a caring adult is a protective factor for school success). Protective factors directly promote healthy development and also reduce the negative impact of risk factors. Protective factors exist wherever one finds young people — in school, at home, and in the community — and include things such as a long-term relationship with a caring adult, opportunities to build skills and become good at something, and belonging to a group of friends who value academic achievement. Protective factors can also be internal to a person, such as having a sunny temperament.

Puberty

The World Health Organization defines puberty as "the period in life when a child experiences physical, hormonal, sexual, and social changes and becomes capable of reproduction." It is associated with rapid growth and the appearance of secondary sexual characteristics. Puberty typically starts for girls between ages 8 and 13, and for boys between ages 9 and 14, and may continue until age 19 or older.

Risk Factors

These are characteristics or behaviors that increase the likelihood of experiencing a negative result. For example, smoking is a risk factor for developing heart disease, and harsh parenting a risk factor for depression. Like protective factors, risk factors can be innate (e.g., having a genetic vulnerability to a disease), environmental (e.g., being exposed to lead or living in a dangerous neighborhood), or learned behaviors (e.g., not wearing seatbelts).

SOURCE: Clea McNeely, MA, DrPH Jayne Blanchard, Johns Hopkins University, *The Teen Years Explained: A Guide to Healthy Adolescent Development*

Need for Adolescent Specialists Grows as Pediatric Subspecialty Evolves

BY JILL FAHY

Dr. Gilberto Velez-Domenech

For Dr. Gilberto Velez-Domenech, it was all about newborn care until his third year of medical school, when he made a 180 degree turn — trading in height, weight, and head circumference for reproductive health, eating disorders, and acne.

An adolescent specialist for the past 40 years, Dr. Velez-Domenech says his attraction to the subspecialty that treats kids roughly ages 10 to 24 was piqued by those who ran the adolescent clinic during his internship.

"The doctors there had different interests, such as dermatology or mental health, but a common thread bound them," recalls Dr. Velez-Domenech, who practices at Children's & Women's Physicians of Westchester, in Valhalla, NY. These physicians, including his mentor, Dr. Andrea Marks, really cared for teenagers.

"The way she treated teens, and the way teens responded to her was very impressive," says Dr. Velez-Domenech. "Dr. Marks had a tremendous respect for her patients, and this was in the middle 1970s, when there was not as much consciousness about the legal rights of children."

Through the 1950s, only parents had the legal right to make most decisions, according to the American Medical Association Journal of Ethics. It was not until the late 1960s and early 1970s that minors gained certain constitutional rights, including the right to privacy concerning contraception and abortion.

"I think adolescent medicine doctors have always been sensitive to privacy issues because of the things they're dealing with — development of the reproductive system, physiological changes, emotional and social changes," Dr. Velez-Domenech said. "To us, the new privacy laws only reinforced what we've been practicing all along."

Dr. Velez-Domenech graduated from the University of Puerto Rico School of Medicine, completed his residency in Social Pediatrics at Montefiore Medical Center, and did his fellowship in Adolescent Medicine at The Mount Sinai Hospital. He began practicing in 1979.

Like many adolescent specialists, Dr. Velez-Domenech has subspecialties. He focuses on behavior adjustment, substance abuse disorders, obesity management, and reproductive endocrinology.

Adolescents and young adults deserve a doctor of their own, with whom they feel comfortable privately discussing delicate health issues, says Dr. Velez-Domenech.

"For me, it's not just about taking care of physical issues," he says. "It is about taking care of the whole range — emotional and developmental issues, emerging sexuality, independence and emancipation — that got me interested in the field."

Making inroads

The evolution since the 1970s of privacy rights and scientific advances in clinical, psychological and behavioral issues has changed the way clinicians treat and manage their adolescent patients.

Significant progress has been made in the management of mental illness and chronic medical illness, as well as in the field of gynecology, and in the development of birth control methods, according to a 2003 report on the history of adolescent medicine in Pediatric Research.

The prevalence of adolescent-related problems in recent decades has also allowed adolescent medicine specialists to take the lead — incorporating advances in pediatrics, gynecology and psychiatry to better treat the age group they know best, the report said.

"We now see more patients with a combination of physical and emotional issues that lead to physical illness," said Dr. Velez-Domenech. "For example, we see more patients with reproductive and endocrine disorders as a result of obesity."

An increasing adolescent population in need of specialized treatment, as well as advances in treating adolescent-related problems have provided much needed exposure to the field. The press has also put a spotlight on adolescent-related health, giving more recognition to the specific problems and issues adolescents face.

"Twenty years ago, pediatricians didn't know adolescent medicine existed," says Dr. Velez-Domenech.

"Today, they refer their patients to us."

More work to be done

Adolescent medicine was finally recognized as a board certified specialty in 1991, but it is far from being the cool kid on the block. The specialty draws a niche group of doctors whose clinical skill must be complemented with the kind of listening skills and patience that can crack the surly exterior of a teenager.

What's more, adolescent medicine as a specialty requires an extra three years of training — both a cost in time and money that is rarely offset in payment. Insurance companies have yet to validate through payment the level of intervention a patient demands. "It's still not a field that is very popular," Dr. Velez-Domenech said.

Check-in area of Children's and Women's Physicians of Westchester, LLP in NY

> "For me, it's not just about taking care of physical issues."

"We deal with a lot of stuff that is very private to the patient and the parents. Who wants to advertise that he or she is depressed?"

Only 189 certificates in adolescent medicine were issued from 2004 to 2013. During the same period, 2,835 were issued in geriatric medicine.

In 2014, the American Academy of Pediatrics and 10 fellow medical organizations wrote a letter asking that $5 million be infused into the federal Pediatric Subspecialty Loan Repayment Program as an incentive for medical students to pursue pediatric subspecialties.

"Shortages threaten to become more severe as fewer medical students choose careers in pediatric mental health care and pediatric subspecialties," the letter said. "At the same time, the mean age of pediatric sub-specialists exceeds 50 years."

The dearth of pediatric specialists is also compounded by the growing number of children in the U.S. In 2011, there were 73.9 million children, 1.5 million more than in 2000. This number is expected to grow to 101.6 million by 2050, increasing demand for pediatric and adolescent health care.

Shortages of these specialists means many young patients must wait to get an appointment. Others may not get the treatment they need.

"Adolescent medicine is not progressing as much as other fields — you put in the same amount of time training to become a board certified adolescent doctor as you would training to become a pediatric cardiologist, but I'm not a pessimist. It's getting better," says Dr. Velez-Domenech.

"I have patients who are doctors now. That's the reward," he adds. "You can't pay the mortgage with that, but it keeps me going." ■

Dr. Helm taking photos in Europe

Our *Proust* Questionnaire

PEDIATRICIAN

Mark Helm, MD, FAAP

PRACTICE

Childhood Health Associates

LOCATION

Salem, OR

A Proust Questionnaire is a survey aimed at understanding one's personality. In 1890, while still in his teens, the French literary lion Marcel Proust answered a questionnaire given to him by a friend. His enthusiastic responses gave rise to the popularity of this form of interview, which eventually adopted his name.

We have created a similar questionnaire for independent pediatricians, designed to reveal the respondent's sensibilities and pediatric aspirations.

Why did you become a pediatrician?

Atonement. Prior to going to medical school, I spent almost 10 years working in the pharmaceutical industry. I realized that I was going to spend the rest of my career learning about medicines and studying how physicians decide to treat specific diseases. I decided that I could continue to devote myself to helping huge, highly profitable multinational corporations become richer, or I could do something that might actually help real people. I guess I wasn't a match for Pharma.

I say that I didn't "pick" pediatrics, it picked me. In my third year clinicals, I insisted on doing pediatrics first, trying to avoid too many GI bugs and snotty noses… My first ward patient was a child abuse case involving a 3 month old. Needless to say, this was humbling.

My then fiancé (now my wife, Jade Helm; sommelier, writer and educator) knew I would do pediatrics before I did. She noticed that I always talked about the kids I had seen that day, even through Family Medicine, OB, and Surgery.

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

You have to be clever. I've always liked puzzles and problem solving. Since I was a teen, I've been interested in optimizing processes and systems. In private pediatric practice, there is always some issue that needs a solution. There is the opportunity to find problems and tweak systems to meet the unique needs and personality of a practice.

Which living person do you most admire?

I think when asked this, most folks tend to think of people they don't know. I've got lists of those. Sometimes people name their parents, if they are lucky (I am, and mine are great). But honestly, there are more than a few foster or

adoptive parents I've known who aren't rich or famous, but they devote themselves to the kids in their care in ways that I honestly do not think I could. I'm in awe of them, and if I weren't a pediatrician, I would have no awareness of them.

What are your favorite qualities in a patient?

Being 5 years old.

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

I listen. I vaccinate. I try to choose the safest and most likely effective course of treatment available based on current understanding. I try to stay current, but remain skeptical about the hype. I wash my hands (a lot). Possibly the most important thing I do is sit down in the room with families.

What is your ideal state of mind?

Curious.

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

Remaining profitable. That's a focus on both generating revenue and managing overhead. I do not believe in being shy about charging for the services and expertise we offer. It is impossible to overestimate the value of a healthy child, or even the knowledge that a child is as healthy as they can be. "No margin, no mission," is a good start, but that margin needs to be higher than the return we could get from another type of business activity.

Do you prefer to do sick visits or well visits?

Well visits are vastly preferred. It is so much more important to keep kids in the naturally good health that most are born with. So much of modern life is seemingly designed to sabotage reaching adulthood in good health, with good habits and an understanding of your self and your body.

How do you address urgent/after hours care?

Our group has a bunch of providers and offers great availability for our patients. Five days a week we are open from 8 AM to 8 PM, with regular Saturday morning hours, and availability for urgent needs Sunday mid-day. When we are not there, there is a nurse advice line for patients to call.

At the moment, we are not feeling threatened by competition.

What's your policy on vaccination?

I love them. I'm pro-vaccine and think that the human immune system is amazing. I'm also pro-vaccine in part because I'm anti-antibiotic. I think vaccines are at least

(Continued, next page)

AT A GLANCE:

TODAY'S ADOLESCENTS

2015 Minors' Consent Law Highlights

Contraceptive Services: 26 states and the District of Columbia allow all minors (12 and older) to consent to contraceptive services. 20 states allow only certain categories of minors to consent to contraceptive services. 4 states have no relevant policy or case law.

STI Services: All states and the District of Columbia allow all minors to consent to STI services. 18 of these states allow, but do not require, a physician to inform a minor's parents that he or she is seeking or receiving STI services when the doctor deems it in the minor's best interests.

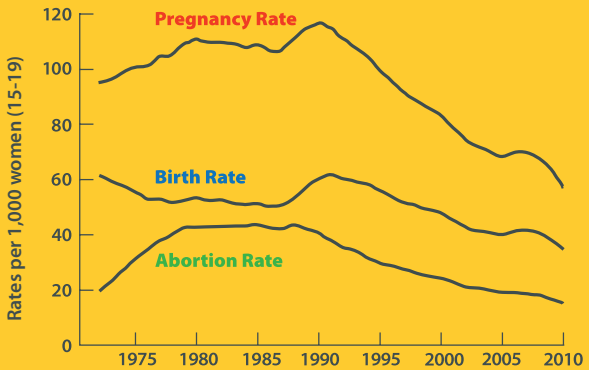
Prenatal Care: 2 states and the District of Columbia explicitly allow all minors to consent to prenatal care. Another state allows a minor to consent to prenatal care during the 1st trimester; requires parental consent for most care during the 2nd and 3rd trimesters. 13 of these states allow, but do not require, a physician to inform parents that their minor daughter is seeking or receiving prenatal care when the doctor deems it in the minor's best interests. 4 additional states allow a minor who can be considered "mature" to consent. 13 states have no relevant policy or case law.

Adoption: 28 states and the District of Columbia allow all minor parents to choose to place their child for adoption. In addition, 5 states require the involvement of a parent and 5 states require the involvement of legal counsel. The remaining 12 states have no relevant policy or case law.

Medical Care for a Child: 30 states and the District of Columbia allow all minor parents to consent to medical care for their child. The remaining 20 states have no relevant explicit policy or case law.

Abortion: 2 states and the District of Columbia explicitly allow all minors to consent to abortion services. 21 states require that at least one parent consent to a minor's abortion, while 13 states require prior notification of at least one parent. 5 states require both notification of and consent from a parent prior to a minor's abortion. 6 additional states have parental involvement laws that are temporarily or permanently enjoined. 5 states have no relevant policy or case law.

U.S. teen pregnancy, birth and abortion rates have reached historic lows



SOURCE: ©2014 Guttmacher Institute; *State Policies in Brief as of July 1, 2015.*

Our *Proust* Questionnaire

100,000 times safer than antibiotics. More than half the time an antibiotic is used it won't do anything helpful for the patient, but there is a significant risk of side effects — even potentially fatal ones.

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

I try to treat everyone, "challenging" or not, the same way. I am a bad judge of what goes on in interpersonal communications. It is a bit "Asperger-y," but I really don't pick up on non-verbal communication cues. I often tell people that I don't have an ego, though I know that is not true — because my mother and my wife tell me so. I do try not to take anything personally.

I think it is important to communicate clearly what are the expectations in the doctor-patient family relationship. I let families know that I'm concerned about doing the right thing for their child. If there is a problem, I want to understand it and help — it just may be that I perceive a different problem than they perceive. My desire to help does not mean that I will prescribe treatments, order tests or make referrals just because they want that. Often it would be easier and faster to do that, but I wouldn't feel that I had done the right thing.

The most frustrating families are the ones who schedule appointments and then don't show up. I suppose I have a bit of a reputation for firing these families. If they don't come, not only can I not help them, but they have prevented us from seeing someone else who wanted to come in. Invariably the "no-show" family will reschedule later, whether or not they show up then.

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

Because this is my second career, my scope is shorter than many. I trained after the current vaccines (excepting HPV) were in wide use. The shift I've most painfully perceived is the evolution of general pediatrics as a mental/behavioral health specialty. Our training programs are not geared toward the issues we face in the clinic. ■

Want to take our questionnaire?
We'd love to hear from you! Contact us at:
mystory@independentpediatrician.com

ADOLESCENT HEALTH
ONLINE RESOURCES

www2.aap.org/sections/adolescenthealth
The AAP's Section on Adolescent Health (SOAH) is a site designed to help pediatricians and related clinicians provide excellent healthcare to teenagers.

hhs.gov/ash/oah
The Office of Adolescent Health (OAH), established by the US Department of Health and Human Services in 2010, addresses adolescent health topics including substance abuse, nutrition, and healthy relationships.

AdolescentHealth.org
The Society of Adolescent Health and Medicine (SAHM) provides clinical and advocacy resources for adolescent health and publishes the *Journal of Adolescent Health*.

aacap.org
The American Academy of Child and Adolescent Psychiatry has resources and tools about adolescent mental health for parents and clinicians.

TeensLivingWithCancer.org
This online support community and information center gives teens dealing with cancer support around issues including body image, school issues, and treatment.

anad.org
The National Association of Anorexia Nervosa and Associated Disorders (ANAD) has information about treatment, a helpline, and other resources related to the treatment of eating disorders.

HealthyTeenNetwork.org
The Healthy Teen Network's mission is to support and advocate for teens around issues of sexual health and reproductive rights.

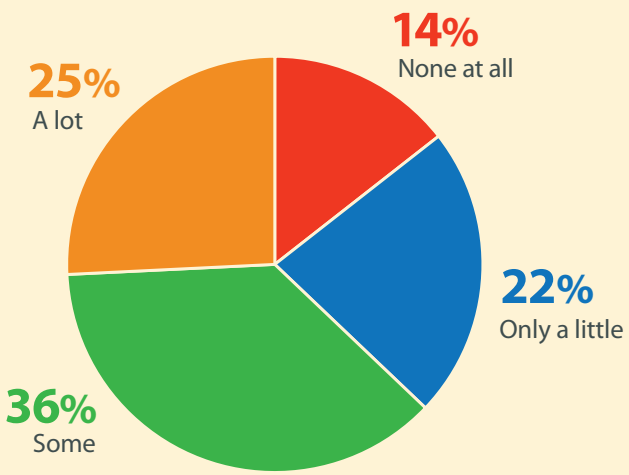
StopBullying.gov
Information about bullying, including its definition and details about cyber-bullying, are the focus of this site.

AT A GLANCE:

HEALTH RESOURCES

Among all media, the Internet is the primary source of health information for teens, far surpassing books, TV, radio, newspapers, or magazines. Eighty-four percent of teens have gotten health information online. A quarter (25 percent) say they have gotten "a lot" of health information online, compared to 10 percent from books, 9 percent from TV news, 4 percent from radio, 3 percent from newspapers, and 3 percent from magazines. Parents can rest assured that they remain by far the leading source of health information for teens, followed by health classes at school and medical providers. But the Internet is the fourth-largest source of health information for teens, far outpacing all other media, and almost on par with doctors and nurses as a health information source.

Amount of health information teens among 13- to 18-years old get from the Internet



SOURCE: *Teens, Health, and Technology*
A National Survey, June 2015
Center on Media and Human Development
School of Communication, Northwestern University

Health information sources for teens

Among all 13- to 18-year-olds, percent who say they get "a lot" of health information from:

Parents	55%
Health classes in school	32%
Doctors/nurses	29%
Internet	25%
Books	10%
TV news	9%
Radio	4%
Newspaper articles	3%
Magazine articles	3%

Top health topics researched by teens online

Among all 13- to 18-year-olds, percent who have used the Internet to research:

Fitness and exercise	42%
Diet and nutrition	36%
Stress or anxiety	19%
STDs	18%
Puberty	18%
Depression or other mental health issues	16%
Sleep	16%
Drug or alcohol abuse	12%
Hygiene	12%
Colds/flu	12%

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