

Tips to Save Your Pediatric Practice Money Now

BY BETSY BATES

LAS VEGAS — Physician office overhead costs are up 15%; reimbursements and collections are down. To say the least, 2009 hasn't been a boom year for pediatricians.

But don't despair.

There are ways to save money and tilt your balance sheet back in the direction of a healthy bottom line, said Dr. Norman

"Chip" Harbaugh, a primary care pediatrician and practice management specialist from Atlanta.

Here are some cost-saving tips from his talks at a seminar on practical pediatricians sponsored by the American Academy of Pediatrics:

► **Maximize tax-free benefits for you and your partner(s).** Don't forget to deduct payments for malpractice, major medical, disability, life, and liability

insurance. Personal expense account charges are deductible as well, including the cost of attending CME meetings; dues and subscriptions; and up to \$45,000 a year for retirement spending. Younger physicians may also want to self-fund their own buyouts over the long term by purchasing variable adjustable life insurance policies.

► **Stretch your office services with mid-level providers.** Salaries for nurse practi-

tioners and physician assistants can quickly reach the "breakeven" point and begin increasing the profits of the practice once they perform 10-13 checkups a day. Such providers also can coordinate hugely popular "quick visit" clinics, such as a sore-throat/earache walk-in clinic each weekday morning from 8 a.m. to 10 a.m.

► **Reevaluate your ratio of front office to clinical personnel.** A "good" ratio is 1 front office person to 3.5 clinical staff. "Better" is 1:3.4 if your office has a lab and 1:3.2 if your office has no lab. A ratio that's "too low" is 1:2.8 or 1:2.3, said Dr. Harbaugh.

► **Charge patients for simple but time-consuming tasks.** For example, consider charging a fee for filling out forms for camp.

► **Save on supplies.** Become part of a Physician Buying Group (PBG) for office supplies, medical supplies, and lab supplies, and especially, vaccines. Such groups

Any physician or group whose lease is expiring within 2 years should "renegotiate now." Some landlords are offering 3-6 months of free rent in exchange for a renewal of a lease.

have the potential for saving a practice 10%-25% on "big ticket" items and thousands of dollars a year on vaccines. Three PBGs are the National Discount Vaccine Alliance, 785-273-4165, <http://nationaldiscountvaccinealliance.com>; Atlanta Health Partners, 800-741-2044, www.atlantichealthpartners.com; and Physicians' Alliance, 866-348-9780, www.physall.com.

► **Renegotiate your rent.** "Commercial real estate? They're hurting," said Dr. Harbaugh. He suggested that any physician or group whose lease is expiring within 2 years should "renegotiate now." Some landlords are offering 3-6 months of free rent in exchange for a renewal of an office space lease. Another option, especially in light of the dismal commercial real estate market, is to consider buying your own building while prices are low.

► **Stretch the use of your office space.** Could you accommodate another provider and expand your business hours from early morning to late evening, with physicians staggering their hours? Could

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Deflux[®]

Stop Febrile UTIs in Their Tracts

For a list of pediatric urologists in your area who use Deflux, visit www.deflux.com.

Intended Use/Indications

Deflux[®] is indicated for treatment of children with vesicoureteral reflux (VUR) grades II-IV.

Contraindications

Deflux is contraindicated in patients with any of the following conditions:

- Non-functional kidney(s)
- Hutch diverticuli
- Ureterocele
- Active voiding dysfunction
- Ongoing urinary tract infection

Warnings

- Do not inject Deflux intravascularly. Injection of Deflux into blood vessels may cause vascular occlusion.

Precautions

- Deflux should only be administered by qualified physicians experienced in the use of a cystoscope and trained in subureteral injection procedures.
- The risks of infection and bleeding are associated with the cystoscopic procedure used to inject Deflux.
- The usual precautions associated with cystoscopy (e.g. sterile technique, proper dilation, etc.) should be followed.
- The safety and effectiveness of the use of more than 6 ml of Deflux (3 ml at each ureteral orifice) at the same treatment session have not been established.
- The safety and effectiveness of Deflux in the treatment of children under 1 year of age have not been established.

Adverse Events

List of treatment-related adverse events for 39 patients from a randomized study and 170 patients from nonrandomized studies. (Follow-up for studies was 12 months).

| Adverse Event Category | Randomized Study (n=39 DEFLUX patients) | Nonrandomized Studies (n=170 DEFLUX patients) |
|--|---|---|
| UTI(i) | 6 (15.4%) (ii, iii) | 13 (7.6%) (ii, iii) |
| Ureteral dilation (iv) | 1 (2.6%) | 6 (3.5%) |
| Nausea/Vomiting/ Abdominal pain (v) | 0 (0%) | 2 (1.2%) |

- (i) Cases of UTI typically occurred in patients with persistent reflux.
- (ii) Patients in the nonrandomized studies received antibiotic prophylaxis until the 3-month VCUG. After that only those patients whose treatment had failed received further antibiotic prophylaxis. The patients in the randomized study received antibiotic prophylaxis 1 month post-treatment.
- (iii) All UTI cases were successfully treated with antibiotics.
- (iv) No case of ureteral dilation required intervention and most cases resolved spontaneously.
- (v) Both cases of nausea/vomiting/abdominal pain were resolved.

Although vascular occlusion, ureteral obstruction, dysuria, hematuria/bleeding, urgency and urinary frequency have not been observed in any of the clinical studies, they are potential adverse events associated with subureteral injection procedures. Following approval, rare cases of post-operative dilation of the upper urinary tract with or without hydronephrosis leading to temporary placement of a ureteric stent have been reported.

References: 1. American Academy of Pediatrics. Committee on Quality Improvement, Subcommittee on Urinary Tract Infection. Practice parameter. The diagnosis, treatment, and evaluation of the initial urinary tract infection in febrile infants and young children. *Pediatrics*. 1999;103(4):843-852. 2. Elder JS, Shah MB, Batiste LR, Eaddy M. Part 3: endoscopic injection versus antibiotic prophylaxis in the reduction of urinary tract infections in patients with vesicoureteral reflux. In: Hensle TW. Challenges surrounding vesicoureteral reflux: fuel for a paradigm shift in treatment. *Curr Med Res Opin*. 2007;23(suppl 4):S15-S20. 3. Chi A, Gupta A, Snodgrass W. Urinary tract infection following successful dextranomer/hyaluronic acid injection for vesicoureteral reflux. *J Urol*. 2008;179:1966-1969. 4. Elmore JM, Kirsch AJ, Heiss EA, Gilchrist A, Scherz HC. Incidence of urinary tract infections in children after successful ureteral reimplantation versus endoscopic dextranomer/hyaluronic acid implantation. *J Urol*. 2008;179:2364-2368. 5. Cerwinka WH, Scherz HC, Kirsch AJ. Endoscopic treatment of vesicoureteral reflux with dextranomer/hyaluronic acid in children. *Adv Urol*. Published Online: May 14, 2008 (doi:10.1155/2008/513854). 6. DEFLUX[®] [Package Insert]. Edison, NJ: Oceana Therapeutics (US), Inc; 2009. 7. Data on file. Oceana Therapeutics (US), Inc.

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'Teen Influencer' Initiative Online

The National Council on Patient Information and Education is launching the "Maximizing Your Role as a Teen Influencer: What You Can Do to Help Prevent Teen Prescription Drug Abuse" initiative, an online education workshop. For more information and to download the resource, visit www.talk-aboutrx.org. ■

R.I. Using E-Prescribing Data to Track H1N1

BY MARY ELLEN SCHNEIDER

Public health officials in Rhode Island are using electronic pharmacy data to track the use of oseltamivir and other antiviral medications being used to treat patients infected with the 2009 H1N1 influenza virus.

As part of an ongoing partnership with SureScripts, an electronic prescribing network, all 181 pharmacies in Rhode Island now can send and receive electronic prescription information over a secure network. As a result, pharmacies are able to transmit information to the Rhode Island department of health on all antiviral prescriptions written in the state. Even if a physician uses a handwritten prescription, the information is available from the pharmacy's electronic system.

At a press conference, Dr. David Gifford, director of the Rhode Island Department of Health, said prescriptions for antiviral medications provide a good proxy measure for infection with H1N1

virus and are a complement to other surveillance systems such as school absenteeism and emergency department visits.

Real-time electronic data on antiviral prescriptions also allow health officials to match supply and demand, he said.

For example, if prescriptions are about to outpace the supply, the health department can anticipate shortages in the antiviral supply and release more medication.

If there are reports of a large volume of H1N1 illness in a community, but not a lot of prescribing of antiviral medication, that could indicate the need for more physician education, Dr. Gifford said. Conversely, if the pharmacy data show a large amount of antiviral prescribing in areas where there is not a lot of H1N1 activity, it could indicate inappropriate prescribing of oseltamivir (Tamiflu) for seasonal influenza, he said.

The statewide initiative is believed to be the first in the nation and allows pharmacies to send data that have been stripped of personal patient information to the health department on a weekly basis.

The prescription data include the patient's age and zip code as well as the prescribing physician's name, allowing health officials to track the progress of the outbreak by communities. ■

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you sublease space during off-hours to a lactation consultant; physical, occupational, or speech therapist; or registered dietitian who could provide nutrition counseling and diabetes education?

► **Target missed appointments.** Automated dialing systems can be set to make reminder calls and reduce expensive no-shows, if this is a problem in your practice.

► **Cede out-of-office care.** Dr. Harbaugh admitted that this idea could "run me out of town," but he suggested that practices tally up the cost of delivery/newborn hospital visits, pediatric hospital rounds, and courtesy emergency department visits. The office, he said, "is where we provide the most service. It's our cost center." Some practices may want to poll families to see whether they would be willing to trade a visit to the hospital to see their newborn for an expanded level of office care, including early morning and evening walk-in visits.

► **Consider participating in clinical trials.** "It's a lot of work," but adding research to a pediatric practice can be rewarding and intellectually invigorating, as well as profitable, infusing up to \$100,000 a year into a practice's bottom line. The concept works only as long as a dedicated physician wants to take on the role of principal investigator and at least one office staff member can devote the bulk of his or her time to coordinating the trial(s). ■

Disclosures: Dr. Harbaugh disclosed that he is on the national advisory boards, is on the speakers bureaus, and/or serves as a consultant for several pharmaceutical companies. He recently served as CEO and chairman of the board for Kids First Pediatric Alliance, a metropolitan Atlanta IPA.

When RSV* activity erupts...

More children may be visiting the hospital or your office for help^{1,2}

RSV is responsible for up to 125,000 infant hospitalizations in the US annually³

- From 1997 to 2000, RSV bronchiolitis was the leading cause of hospitalizations for infants <12 months of age¹

A threat in all outpatient settings

- 22% of infants <1 year of age infected with RSV will develop bronchiolitis⁴
- 28% of children <2 years of age infected with RSV will develop bronchiolitis⁴
- In the US in 2000, the estimated RSV-related outpatient visits in children <5 years of age were²:
 - 236,000 hospital outpatient department visits
 - 402,000 emergency room visits
 - 1.7 million office visits

Potentially serious long-term consequences

- RSV-related lower respiratory tract illnesses (LRTIs) in infancy may be associated with an increased risk of asthma in the first decade of life⁵⁻⁷

| Age | Asthma RR† (95% CI)† |
|----------|---------------------------------|
| 3 years | 21.8 (2.90-163.57) ⁵ |
| 7 years | 9.23 (2.79-30.55) ⁶ |
| 13 years | 6.8 (2.7-17.3) ⁷ |

Based on a prospective cohort of 47 (93 control) Scandinavian children <1 year of age in 1989 hospitalized with RSV and followed for 13 years.

Help avert potentially serious consequences for your patients

For additional information, visit www.rsvinsiders.com



*RSV = respiratory syncytial virus.
†RR = relative risk.
†CI = confidence interval.

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