The Effect on Your Practice

Chapter FastFACTS

1. **Physicians should examine their practice's financial well-being to cope with current and future challenges.**
2. **Patients are cutting prescription dosages and skipping appointments; those who come in are sicker than ever.**
3. **Physicians are seeing more uninsured patients and decreasing revenues.**
4. **Get comfortable asking patients for payment upfront.**
5. **Use physician assistants and nurses to see more patients.**

The Family Medicine Residency of Idaho, which opened its doors in Boise in 1975, recently responded to plummeting patient volume by doing something it never thought it would: changing to an open-access schedule. The practice now holds 40% to 50% of its schedule open for same-day patient access, and 50% to 60% for chronic care patients. Family physician Ted Epperly, MD, says he and his colleagues "drastically modified" their practice in response to the recession-based drop. Their goal: to stay afloat and to be more accessible to patients by becoming a patient-centered medical home.

After seeing patient volume fall by approximately 33%—from 3,189 to 2,141 patients per month—the practice took action, putting patients on a sliding fee schedule based on their income, writing off "a lot of patient bills," and switching patients to generic drugs and lower-cost pharmacies like Wal-Mart.

"These tough times are putting primary care physicians to the test," says Dr. Epperly, who served until recently as president of

Treat today with NAMENDA

Proven efficacy and tolerability

- Improves function, delays onset of behavioral symptoms, and provides benefits in cognition[1-3]
- Proven safety and tolerability with low risk of gastrointestinal side effects may lead to therapy persistence[4,5]
- Reduces caregiving time, cost, and caregiver distress[3,6,7]
- Effective first-line and in combination with an acetylcholinesterase inhibitor[1,2]

Broad patient access–covered on 98% of Medicare Part D formularies[4]

Namenda® memantine HCl

Extending memory and function

NAMENDA® (memantine HCl) is indicated for the treatment of moderate to severe Alzheimer's disease.

NAMENDA is contraindicated in patients with known hypersensitivity to memantine HCl or any excipients used in the formulation. The most common adverse events reported with NAMENDA vs placebo (≥5% and higher than placebo) were dizziness, confusion, headache, and constipation. In patients with severe renal impairment, the dosage should be reduced.

References: 1. Reisberg B, Doody R, Stöffler A, Schmitt F, Ferris S, Möbius HJ, for the Memantine Study Group. Memantine in moderate-to-severe Alzheimer's disease. *N Engl J Med.* 2003;348:1333-1341. **2.** Tariot PN, Farlow MR, Grossberg GT, Graham SM, McDonald S, Gergel I, for the Memantine Study Group. Memantine treatment in patients with moderate to severe Alzheimer disease already receiving donepezil: a randomized controlled trial. *JAMA.* 2004;291:317-324. **3.** Cummings JL, Schneider E, Tariot PN, Graham SM, for the Memantine MEM-MD-02 Study Group. Behavioral effects of memantine in Alzheimer disease patients receiving donepezil treatment. *Neurology.* 2006;67:57-63. **4.** Data on file. Forest Laboratories, Inc. **5.** NAMENDA® (memantine HCl) Prescribing Information. Forest Pharmaceuticals, Inc., St Louis, Mo. **6.** Wimo A, Winblad B, Stöffler A, Wirth Y, Möbius HJ. Resource utilisation and cost analysis of memantine in patients with moderate to severe Alzheimer's disease. *Pharmacoeconomics.* 2003;21:327-340. **7.** Winblad B, Poritis N. Memantine in severe dementia: results of the ³M-BEST Study (Benefit and efficacy in severely demented patients during treatment with memantine). *Int J Geriatr Psychiatry.* 1999;14:135-146.

Forest Pharmaceuticals, Inc.

For more details, please visit **www.namenda.com**.

Please see brief summary of Prescribing Information on the adjacent page.

62-1014307R R2 03/09

Namenda
memantine HCl

Tablets/Oral Solution
Rx Only

Brief Summary of Prescribing Information.

For complete details, please see full Prescribing Information for Namenda.

INDICATIONS AND USAGE
Namenda (memantine hydrochloride) is indicated for the treatment of moderate to severe dementia of the Alzheimer's type.

CONTRAINDICATIONS
Namenda (memantine hydrochloride) is contraindicated in patients with known hypersensitivity to memantine hydrochloride or to any excipients used in the formulation.

PRECAUTIONS
Information for Patients and Caregivers: Caregivers should be instructed in the recommended administration (twice per day for doses above 5 mg) and dose escalation (minimum interval of one week between dose increases).

Neurological Conditions
Seizures: Namenda has not been systematically evaluated in patients with a seizure disorder. In clinical trials of Namenda, seizures occurred in 0.2% of patients treated with Namenda and 0.5% of patients treated with placebo.

Genitourinary Conditions
Conditions that raise urine pH may decrease the urinary elimination of memantine resulting in increased plasma levels of memantine.

Special Populations
Hepatic Impairment
Namenda undergoes partial hepatic metabolism, with about 48% of administered dose excreted in urine as unchanged drug or as the sum of parent drug and the N-glucuronide conjugate (74%). No dosage adjustment is needed in patients with mild or moderate hepatic impairment. Namenda should be administered with caution to patients with severe hepatic impairment.

Renal Impairment
No dosage adjustment is needed in patients with mild or moderate renal impairment. A dosage reduction is recommended in patients with severe renal impairment (see CLINICAL PHARMACOLOGY and DOSAGE AND ADMINISTRATION in Full Prescribing Information).

Drug-Drug Interactions
N-methyl-D-aspartate (NMDA) antagonists: The combined use of Namenda with other NMDA antagonists (amantadine, ketamine, and dextromethorphan) has not been systematically evaluated and such use should be approached with caution.

Effects of Namenda *on substrates of microsomal enzymes: In vitro* studies conducted with marker substrates of CYP450 enzymes (CYP1A2, -2A6, -2C9, -2D6, -2E1, -3A4) showed minimal inhibition of these enzymes by memantine. In addition, *in vitro* studies indicate that at concentrations exceeding those associated with efficacy, memantine does not induce the cytochrome P450 isoenzymes CYP1A2, CYP2C9, CYP2E1, and CYP3A4/5. No pharmacokinetic interactions with drugs metabolized by these enzymes are expected.

Effects of inhibitors and/or substrates of microsomal enzymes on Namenda: Memantine is predominantly renally eliminated, and drugs that are substrates and/or inhibitors of the CYP450 system are not expected to alter the metabolism of memantine.

Acetylcholinesterase (AChE) inhibitors: Coadministration of Namenda with the AChE inhibitor donepezil HCl did not affect the pharmacokinetics of either compound. In a 24-week controlled clinical study in patients with moderate to severe Alzheimer's disease, the adverse event profile observed with a combination of memantine and donepezil was similar to that of donepezil alone.

Drugs eliminated via renal mechanisms: Because memantine is eliminated in part by tubular secretion, coadministration of drugs that use the same renal cationic system, including hydrochlorothiazide (HCTZ), triamterene (TA), metformin, cimetidine, ranitidine, quinidine, and nicotine, could potentially result in altered plasma levels of both agents. However, coadministration of Namenda and HCTZ/TA did not affect the bioavailability of either memantine or TA, and the bioavailability of HCTZ decreased by 20%. In addition, coadministration of memantine with the antihyperglycemic drug Glucovance® (glyburide and metformin HCl) did not affect the pharmacokinetics of memantine, metformin and glyburide. Furthermore, memantine did not modify the serum glucose lowering effect of Glucovance®.

Drugs that make the urine alkaline: The clearance of memantine was reduced by about 80% under alkaline urine conditions at pH 8. Therefore, alterations of urine pH towards the alkaline condition may lead to an accumulation of the drug with a possible increase in adverse effects. Urine pH is altered by diet, drugs (e.g. carbonic anhydrase inhibitors, sodium bicarbonate) and clinical state of the patient (e.g. renal tubular acidosis or severe infections of the urinary tract). Hence, memantine should be used with caution under these conditions.

Carcinogenesis, Mutagenesis and Impairment of Fertility
There was no evidence of carcinogenicity in a 113-week oral study in mice at doses up to 40 mg/kg/day (10 times the maximum recommended human dose [MRHD] on a mg/m^2 basis). There was also no evidence of carcinogenicity in rats orally dosed at up to 40 mg/kg/day for 71 weeks followed by 20 mg/kg/day (20 and 10 times the MRHD on a mg/m^2 basis, respectively) through 128 weeks.

Memantine produced no evidence of genotoxic potential when evaluated in the *in vitro S. typhimurium* or *E. coli* reverse mutation assay, an *in vitro* chromosomal aberration test in human lymphocytes, an *in vivo* cytogenetics assay for chromosome damage in rats, and the *in vivo* mouse micronucleus assay. The results were equivocal in an *in vitro* gene mutation assay using Chinese hamster V79 cells.

No impairment of fertility or reproductive performance was seen in rats administered up to 18 mg/kg/day (9 times the MRHD on a mg/m^2 basis) orally from 14 days prior to mating through gestation and lactation in females, or for 60 days prior to mating in males.

Pregnancy
Pregnancy Category B: Memantine given orally to pregnant rats and pregnant rabbits during the period of organogenesis was not teratogenic up to the highest doses tested (18 mg/kg/day in rats and 30 mg/kg/day in rabbits, which are 9 and 30 times, respectively, the maximum recommended human dose [MRHD] on a mg/m^2 basis).

Slight maternal toxicity, decreased pup weights and an increased incidence of non-ossified cervical vertebrae were seen at an oral dose of 18 mg/kg/day in a study in which rats were given oral memantine beginning pre-mating and continuing through the postpartum period. Slight maternal toxicity and decreased pup weights were also seen at this dose in a study in which rats were treated from day 15 of gestation through the post-partum period. The no-effect dose for these effects was 6 mg/kg, which is 3 times the MRHD on a mg/m^2 basis.

There are no adequate and well-controlled studies of memantine in pregnant women. Memantine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers
It is not known whether memantine is excreted in human breast milk. Because many drugs are excreted in human milk, caution should be exercised when memantine is administered to a nursing mother.

Pediatric Use
There are no adequate and well-controlled trials documenting the safety and efficacy of memantine in any illness occurring in children.

ADVERSE REACTIONS
The experience described in this section derives from studies in patients with Alzheimer's disease and vascular dementia.

Adverse Events Leading to Discontinuation: In placebo-controlled trials in which dementia patients received doses of Namenda up to 20 mg/day, the likelihood of discontinuation because of an adverse event was the same in the Namenda group as in the placebo group. No individual adverse event was associated with the discontinuation of treatment in 1% or more of Namenda-treated patients and at a rate greater than placebo.

Adverse Events Reported in Controlled Trials: The reported adverse events in Namenda (memantine hydrochloride) trials reflect experience gained under closely monitored conditions in a highly selected patient population. In actual practice or in other clinical trials, these frequency estimates may not apply, as the conditions of use, reporting behavior and the types of patients treated may differ. Table 1 lists treatment-emergent signs and symptoms that were reported in at least 2% of patients in placebo-controlled dementia trials and for which the rate of occurrence was greater for patients treated with Namenda than for those treated with placebo. No adverse event occurred at a frequency of at least 5% and twice the placebo rate.

Table 1: Adverse Events Reported in Controlled Clinical Trials in at Least 2% of Patients Receiving Namenda and at a Higher Frequency than Placebo-treated Patients.

Body System Adverse Event	Placebo (N = 922) %	Namenda (N = 940) %
Body as a Whole		
Fatigue	1	2
Pain	1	3
Cardiovascular System		
Hypertension	2	4
Central and Peripheral Nervous System		
Dizziness	5	7
Headache	3	6
Gastrointestinal System		
Constipation	3	5
Vomiting	2	3
Musculoskeletal System		
Back pain	2	3
Psychiatric Disorders		
Confusion	5	6
Somnolence	2	3
Hallucination	2	3
Respiratory System		
Coughing	3	4
Dyspnea	1	2

Other adverse events occurring with an incidence of at least 2% in Namenda-treated patients but at a greater or equal rate on placebo were agitation, fall, inflicted injury, urinary incontinence, diarrhea, bronchitis, insomnia, urinary tract infection, influenza-like symptoms, abnormal gait, depression, upper respiratory tract infection, anxiety, peripheral edema, nausea, anorexia, and arthralgia.

The overall profile of adverse events and the incidence rates for individual adverse events in the subpopulation of patients with moderate to severe Alzheimer's disease were not different from the profile and incidence rates described above for the overall dementia population.

Vital Sign Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, diastolic blood pressure, and weight) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. There were no clinically important changes in vital signs in patients treated with Namenda. A comparison of supine and standing vital sign measures for Namenda and placebo in elderly normal subjects indicated that Namenda treatment is not associated with orthostatic changes.

Laboratory Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Namenda treatment.

ECG Changes: Namenda and placebo groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in ECG parameters associated with Namenda treatment.

Other Adverse Events Observed During Clinical Trials

Namenda has been administered to approximately 1350 patients with dementia, of whom more than 1200 received the maximum recommended dose of 20 mg/day. Patients received Namenda treatment for periods of up to 884 days, with 862 patients receiving at least 24 weeks of treatment and 387 patients receiving 48 weeks or more of treatment.

Treatment emergent signs and symptoms that occurred during 8 controlled clinical trials and 4 open-label trials were recorded as adverse events by the clinical investigators using terminology of their own choosing. To provide an overall estimate of the proportion of individuals having similar types of events, the events were grouped into a smaller number of standardized categories using WHO terminology, and event frequencies were calculated across all studies.

All adverse events occurring in at least two patients are included, except for those already listed in Table 1, WHO terms too general to be informative, minor symptoms or events unlikely to be drug-caused, e.g., because they are common in the study population. Events are classified by body system and listed using the following definitions: frequent adverse events - those occurring in at least 1/100 patients; infrequent adverse events- those occurring in 1/100 to 1/1000 patients. These adverse events are not necessarily related to Namenda treatment and in most cases were observed at a similar frequency in placebo-treated patients in the controlled studies.

Body as a Whole: *Frequent:* syncope. *Infrequent:* hypothermia, allergic reaction.

Cardiovascular System: *Frequent:* cardiac failure. *Infrequent:* angina pectoris, bradycardia, myocardial infarction, thrombophlebitis, atrial fibrillation, hypotension, cardiac arrest, postural hypotension, pulmonary embolism, pulmonary edema.

Central and Peripheral Nervous System: *Frequent:* transient ischemic attack, cerebrovascular accident, vertigo, ataxia, hypokinesia. *Infrequent:* paresthesia, convulsions, extrapyramidal disorder, hypertonia, tremor, aphasia, hypoesthesia, abnormal coordination, hemiplegia, hyperkinesia, involuntary muscle contractions, stupor, cerebral hemorrhage, neuralgia, ptosis, neuropathy.

Gastrointestinal System: *Infrequent:* gastroenteritis, diverticulitis, gastrointestinal hemorrhage, melena, esophageal ulceration.

Hemic and Lymphatic Disorders: *Frequent:* anemia. *Infrequent:* leukopenia.

Metabolic and Nutritional Disorders: *Frequent:* increased alkaline phosphatase, decreased weight. *Infrequent:* dehydration, hyponatremia, aggravated diabetes mellitus.

Psychiatric Disorders: *Frequent:* aggressive reaction. *Infrequent:* delusion, personality disorder, emotional lability, nervousness, sleep disorder, libido increased, psychosis, amnesia, apathy, paranoid reaction, thinking abnormal, crying abnormal, appetite increased, paroniria, delirium, depersonalization, neurosis, suicide attempt.

Respiratory System: *Frequent:* pneumonia. *Infrequent:* apnea, asthma, hemoptysis.

Skin and Appendages: *Frequent:* rash. *Infrequent:* skin ulceration, pruritus, cellulitis, eczema, dermatitis, erythematous rash, alopecia, urticaria.

Special Senses: *Frequent:* cataract, conjunctivitis. *Infrequent:* macula lutea degeneration, decreased visual acuity, decreased hearing, tinnitus, blepharitis, blurred vision, corneal opacity, glaucoma, conjunctival hemorrhage, eye pain, retinal hemorrhage, xerophthalmia, diplopia, abnormal lacrimation, myopia, retinal detachment.

Urinary System: *Frequent:* frequent micturition. *Infrequent:* dysuria, hematuria, urinary retention.

Events Reported Subsequent to the Marketing of Namenda, both US and Ex-US

Although no causal relationship to memantine treatment has been found, the following adverse events have been reported to be temporally associated with memantine treatment and are not described elsewhere in labeling: aspiration pneumonia, asthenia, atrioventricular block, bone fracture, carpal tunnel syndrome, cerebral infarction, chest pain, cholelithiasis, claudication, colitis, deep venous thrombosis, depressed level of consciousness (including loss of consciousness and rare reports of coma), dyskinesia, dysphagia, encephalopathy, gastritis, gastroesophageal reflux, grand mal convulsions, intracranial hemorrhage, hepatitis (including increased ALT and AST and hepatic failure), hyperglycemia, hyperlipidemia, hypoglycemia, ileus, increased INR, impotence, lethargy, malaise, myoclonus, neuroleptic malignant syndrome, acute pancreatitis, Parkinsonism, acute renal failure (including increased creatinine and renal insufficiency), prolonged QT interval, restlessness, sepsis, Stevens-Johnson syndrome, suicidal ideation, sudden death, supraventricular tachycardia, tachycardia, tardive dyskinesia, thrombocytopenia, and hallucinations (both visual and auditory).

ANIMAL TOXICOLOGY

Memantine induced neuronal lesions (vacuolation and necrosis) in the multipolar and pyramidal cells in cortical layers III and IV of the posterior cingulate and retrosplenial neocortices in rats, similar to those which are known to occur in rodents administered other NMDA receptor antagonists. Lesions were seen after a single dose of memantine. In a study in which rats were given daily oral doses of memantine for 14 days, the no-effect dose for neuronal necrosis was 6 times the maximum recommended human dose on a mg/m^2 basis. The potential for induction of central neuronal vacuolation and necrosis by NMDA receptor antagonists in humans is unknown.

DRUG ABUSE AND DEPENDENCE

Controlled Substance Class: Memantine HCl is not a controlled substance.

Physical and Psychological Dependence: Memantine HCl is a low to moderate affinity uncompetitive NMDA antagonist that did not produce any evidence of drug-seeking behavior or withdrawal symptoms upon discontinuation in 2,504 patients who participated in clinical trials at therapeutic doses. Post marketing data, outside the U.S., retrospectively collected, has provided no evidence of drug abuse or dependence.

OVERDOSAGE

Signs and symptoms associated with memantine overdosage in clinical trials and from worldwide marketing experience include agitation, confusion, ECG changes, loss of consciousness, psychosis, restlessness, slowed movement, somnolence, stupor, unsteady gait, visual hallucinations, vertigo, vomiting, and weakness. The largest known ingestion of memantine worldwide was 2.0 grams in a patient who took memantine in conjunction with unspecified antidiabetic medications. The patient experienced coma, diplopia, and agitation, but subsequently recovered.

Because strategies for the management of overdose are continually evolving, it is advisable to contact a poison control center to determine the latest recommendations for the management of an overdose of any drug.

As in any cases of overdose, general supportive measures should be utilized, and treatment should be symptomatic. Elimination of memantine can be enhanced by acidification of urine.

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the American Academy of Family Physicians (AAFP). "Many patients have trusted personal relationships with their family physicians and the practice's medical team, and it is important at times like this that we all redouble our efforts to ensure that people are cared for in an expedited manner."

Similar scenarios are playing out across the country as the economic downturn has led patients to make choices that are not always in their health's best interest. If patients put off seeing their physician for chronic disease problems like hypertension or diabetes—or do not get basic prevention such as influenza vaccines, mammograms, or colonoscopies—then they are putting their health at risk, living sicker, and dying younger.

It's no surprise that physicians' incomes are being affected just like other businesses. A 2009 Medical Group Management Association (MGMA) survey found that physicians' compensation did not keep pace with the 0.1% inflation rate in 2008. Physicians in primary care reported a 2% increase in their salary, minus a 1.73% adjustment for inflation, for a median of $186,044. (See "Physician Compensation and Production Survey Report," below.)

That makes it critical for physicians to examine and address their practice's own financial well-being, not only to make changes to cope with current economic times, but also to ensure post-recession survival. To do so, they need to better understand

Physician Compensation and Production Survey Report*

Specialty	Median
Family Practice (w/o OB)	$179,672
Geriatrics	179,150
Internal Medicine: General	191,198
Obstetrics/Gynecology: General	285,812
Pediatrics: General	186,641

*Based on 2008 data: physician compensation.

Source: MGMA Physician Compensation and Production Survey: 2009 Report Based on 2008 Data. Copyright 2009. All Rights Reserved. Medical Group Management Association.

what's causing the problems, including declining patient volume, declining revenue, and patients' postponing preventive care at the same time physicians are gaining only minimal increases in reimbursement. As physicians become more financially savvy, they will be better able to make tough decisions to keep their businesses—and their patients—healthy.

Health Insurance Coverage

The tough times are exacerbating an already-difficult environment with rising healthcare costs (see "Signs of the Times in Healthcare: Rising Costs," p. 14). The U.S. Census Bureau reports that approximately 253.4 million people had health insurance coverage in 2007, while 45.7 million people younger than age 64 did not. About 83 million people get health insurance from government programs like Medicare, Medicaid, the State Children's Health Insurance Program, or the Veterans Affairs Administration. The number of uninsured is higher now, according to many experts, because of rising unemployment.

In fact, one-fourth of 2,003 adults polled by the Henry J. Kaiser Family Foundation (KFF) in April 2008 stated that they had had serious problems paying for health insurance and healthcare as a result of the recent economic downturn.

According to the KFF "Focus on Health Reform" report released last July, "One in six [respondents] report that they or someone in their family lost a job; 10% lost their health insurance. A quarter report problems paying medical bills in the past year, and this has impacted their access to healthcare. Over half say that they or another family member have postponed, cut back, or skipped needed healthcare altogether in the past year because of its cost." (The report is available at *http://www.kff.org/healthreform/upload/7951.pdf*.)

To make matters worse, employer-sponsored healthcare is gradually falling by the wayside. Many people now pay higher

Signs of the Times in Healthcare: Rising Costs

It's not just the recession that's causing patients to lose insurance coverage. Economists have found that rising healthcare costs are also to blame, says the Henry J. Kaiser Family Foundation (KFF). Those costs totaled an estimated $2.4 trillion in 2008 and are projected to reach $3.1 trillion in 2012 and $4.3 trillion by 2016, the KFF reported in a 2008 article in *Health Affairs*, "Health Spending Projections Through 2017: The Baby Boom Generation is Coming to Medicare."

Here are other signs of the trend:

- Healthcare expenditures have surpassed the growth in national income. The economic share directly related to healthcare costs increased from 7.2% to 16.6% between 1970 and 2008, according to Health Affairs.
- A February 2009 survey conducted by the Centers for Medicare and Medicaid Services (CMS) found that healthcare spending in the U.S. is expected to have its largest single-year increase in 2009.
- Healthcare spending will account for 20.3% of the U.S. Gross Domestic Product (GDP) by 2018. The 2009 share of GDP will reach 17.6%, a 1% increase over 2008, the largest one-year increase ever seen, according to the CMS report.
- By 2018, healthcare is projected to account for $1 of every $5 of economic activity, according to the California HealthCare Foundation in an April 2009 report, "Health Care Costs 101."

deductibles and higher premiums for their employer-sponsored healthcare insurance, notes KFF in its "Employer Health Benefits 2009 Annual Survey" (see *http://ehbs.kff.org/* for more details). The result, according to KFF, is that more than half of working-age, middle class adults or a family member have skipped, reduced, or postponed necessary healthcare in the last year because of cost.

"For the most part, people over 65 are doing okay, because they have healthcare insurance and Medicare Part D," says Joseph Stubbs, MD, an internist in Albany, Ga., and president of the American College of Physicians (ACP). Suffering more are younger people who have been laid off or have had benefits cut by their employers and are now trying to pay for medical expenses out of pocket. As a result, they are waiting longer to

see a doctor, aren't taking their medications as directed, and are trying to treat an illness or injury at home.

An AAFP survey of its 8,000 members last spring found patients are worried about healthcare costs: Almost 90% of the respondents stated that their "patients have expressed concerns recently over their ability to pay for their healthcare needs" and are making adjustments to cope. More specifically, the survey found the following:

- 73% said more patients are cutting their prescription dosages.
- 60% said they are noticing more health problems caused by patients' skipping preventive care.
- 58% reported more canceled appointments.
- 66% indicated that they were taking specific actions to help their patients manage healthcare needs, such as discounting fees, providing free screenings, and increasing charity care.
- 54% said that they had seen fewer patients since January 2008, when the recession began.

According to an MGMA survey, "declining reimbursement" rated highest on the list of issues that physicians identified as hindrances to the delivery of patient care, followed by "demands on physician time." See "Impacts of Economic Recession on Physician Practices," p. 16.

The survey revealed that family physicians are seeing fewer patients and are experiencing more cancellations. And many of those patients who are coming in are sicker than ever: 60% of

Impacts of Economic Recession on Physician Practices

Poll results: physicians' expectations of probable effects of the recession on their practices.

	Zero probability	Low probability	Moderate probability
Decrease in revenue	0.5% (9)	5.3% (98)	25.6% (471)
Inability to meet payroll	23.7% (434)	49.4% (906)	14.8% (272)
Difficulty in obtaining loans for capital purchases	12.2% (224)	39.6% (730)	20.3% (374)
Increase in accounts receivable	1.1% (20)	10.3% (189)	33.0% (606)
Increase in uninsured patients	0.5% (10)	4.7% (87)	20.3% (374)
Increase in patient no-shows	0.4% (8)	15.5% (285)	33.1% (608)
Reduction in wellness, preventive, and other elective visits	1.4% (26)	8.7% (161)	22.3% (411)

*Source: Medical Practice Today: What You Have to Say, MGMA Connexion™. Reprinted with permission from the Medical Group Management Association, 104 Inverness Terrace East, Englewood, Colo. 80112. 877.ASK.MGMA.*www.mgma.com. *Copyright 2009.*

respondents said they are noticing more health problems in their patients because of the recession, according to Dr. Epperly. "The nation is sicker as a whole because of the recession," he says.

Patients are sicker because they are putting off preventive care, are not picking up their medical prescriptions, or are altering dosages by cutting pills in half or skipping a dose. In a February 2009 report, KFF says it found that 53% of Americans are reducing their healthcare due to costs. (See "Consequences of Healthcare Costs," p. 18.)

For example, after a 45-year-old man with type II diabetes lost his job last year, he could no longer afford his oral medication and stopped taking it. As a result, his diabetes went out of control. He subsequently had a heart attack and died. Then there was the 37-year-old man trying to cut financial corners who quit taking his antipsychotic medication for bipolar disorder. As his disease quickly spun out of control, he was fired from his job. Ultimately, his family left him; and he lost his house after he defaulted on his mortgage.

Had either of these patients told their physicians they lost their

Considerable probability	This has already happened	No opinion or not applicable to my practice's situation	Rating average	Response count
35.2% (648)	32.9% (606)	0.5% (9)	3.95	1,841
5.9% (109)	2.6% (48)	3.6% (66)	2.11	1,835
10.7% (197)	4.0% (74)	13.2% (244)	2.48	1,843
35.9% (659)	19.1% (351)	0.7% (13)	3.62	1,838
38.8% (715)	34.2% (631)	1.4% (26)	4.03	1,843
22.9% (422)	23.6% (434)	4.5% (82)	3.56	1,839
27.8% (512)	19.9% (366)	19.9% (366)	3.70	1,842
			Other?	24
			Answered question	1,849
			Skipped question	234

job or medical insurance, something could have been done to prevent their downward spiral, Dr. Epperly says.

In particular, patients with diabetes have been delaying or going without medical care. As a result, more patients are ending up in emergency rooms with out-of-control blood sugar levels. In addition, patients are choosing insulin injections over oral medications, since the injections are cheaper. Sales have dropped for expensive brand-name test strips, diabetes pills, and blood glucose monitors, according to industry sales figures. Sales of the generic metformin are up 7% since June 2008, most likely because a typical monthly prescription costs only four dollars per month out of pocket. Brand-name versions of metformin, which can cost ten times as much, are down nearly 9% in the same timeframe.

Dr. Stubbs says he and his staff try to introduce patients to as many generic medications as possible, sign them up for free medication programs offered through drug companies, and encourage patients to come in and keep on top of their chronic illnesses. Nonetheless, he sees at least one patient every day who

Consequences of Healthcare Costs

A February 2009 Kaiser report says that 53% of Americans are reducing their healthcare due to costs, and another 23% are skipping medical tests and treatments. To get a better idea of the kinds of care people are skipping, the 27% of Americans who said their household had "put off or postponed getting healthcare [they] needed" were asked what types of care they had foregone. Here are the results:

Type of care postponed (multiple responses accepted)	
A visit to the doctor for a temporary illness such as a cold or stomach flu	19%
Preventive care, such as a yearly physical exam	19%
Chronic care visit, major or minor surgery	16%
A visit to the doctor to check on an ongoing health problem, such as diabetes or asthma	10%

Source: "Consequences of Healthcare Costs, Kaiser Health Tracking Poll," The Henry J. Kaiser Family Foundation, February, 2009. This information was reprinted with permission from the Henry J. Kaiser Family Foundation. http://www.kff.org/kaiserpolls/upload/7866.pdf.

has cut back on medications; and every week he sees a "totally avoidable complication," most commonly in patients with diabetes. One recent example was a woman who had been laid off and could not afford health insurance or her blood sugar medication. She finally came in to see him with dark toes and a draining ulcer on the bottom of her foot. He had to admit her to the hospital for expensive wound care that she could not afford, but the care was necessary in order to save her foot and her life.

Pressure on Primary Care Physicians

The result of this economic pressure on patients is that primary care physicians—more so than specialists—are having to cope with patients who are financially strained, according to Dr. Stubbs. "Primary care physicians are the ones from whom people are trying to get free or reduced care or free prescriptions. It's a real strain on us to continually provide a social safety net for those people with chronic illnesses. We patch all the holes in that safety net for them," he says. "For example, I recently referred a patient to a gastroenterologist, who put her on an

expensive medication. When she called him back to ask for a lower-cost prescription, he told her to contact her primary care physician for help obtaining a more affordable medication."

Given the economic environment and trends in how patients are coping, it's not surprising that physicians' bottom line has taken a direct hit. You're not alone if you're feeling it: According to a February 2009 survey conducted by the MGMA, nearly 70% of the 1,732 survey respondents indicated that their practice had suffered decreased revenue or expected their practice revenue to drop. This is the first time the question of decreased revenue has been addressed in a survey by MGMA, due to the economic recession. Approximately 75% reported an increase in the number of uninsured patients at their practice. Fifty-nine percent said they had frozen staff hiring, and two-thirds said they had cut their practice's operating budget.

The recession has affected physicians in other ways, says Michael La Penna, practice management consultant, The La Penna Group, Inc., Grand Rapids, Mich.:

Tight capital: Access to capital is tighter than it used to be even for physicians. Banks are analyzing business plans more closely before approving loans and need to see how medical practices plan to make money with the help of a loan. They may look at the practice's accounts receivable and at the age of the accounts. "Banks understand that physicians can default on loans just like anyone else. Doctors are learning that they have to do more business planning," Mr. La Penna explains.

Pay-for-performance glitch: Some physicians who have been paid by insurance companies for meeting performance goals are now being penalized because many of their patients can no longer afford to see them. The pay-for-performance issue looms

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large, according to Mr. La Penna, because patients who are essential to the performance bonuses actually need to use the doctor's services in order to register on the insurance company's radar screen.

"The commonplace process," Mr. La Penna explains, "is to have the well population, or at least the population that is not critically sick and seeing the doctor for an immediate complaint, be involved in testing and diagnostics; however, this requires a

"Medical costs should be part of a discussion about possible diagnostic tests and treatments with patients, and they may consider a less expensive alternative test or treatment plan, along with generic medications, that may be more affordable."

Kevin Pho, MD

co-pay; and even patients who are working might be reluctant to see a physician because of this cost. This is even more of an issue when the patient is a victim of chronic illness. If he or she does not get in as often to have, say, a blood pressure check, the doctor is then disqualified for any management fees or bonuses."

Making Change Happen

Perhaps the most basic way to confront falling revenue is to do something practices have never been comfortable doing: asking for payment upfront. That's a big change from the traditional "don't worry about it, my insurance will cover it" method, says Kenneth T. Hertz, principal, MGMA Healthcare Consulting Group, Louisville, Ky. He says he's seeing more practices being aggressive about collecting money at the point of service.

Unfortunately, many practices do not have the front-end tools and processes in place to adjust to the economic trends and make sure they are getting properly compensated for their services, says Jeff Drake, executive vice president, Passport Health Communications, Inc. "Those who don't get their revenue cycle man-

agement in order are losing money now and ultimately jeopardizing their long-term viability," he says.

When Kevin Pho, MD, an internist in Nashua, N.H., well-known for his blog (*www.kevinMD.com*), saw that trend, he decided to try something new with his patients. Having noticed that preventive and elective care among his patients was slipping away, he discussed cheaper medication options with his patients, like switching from brand-name to generic medications or finding alternatives at Wal-Mart, which carries a variety of $4 generic medications.

"Many physicians are revenue dependent on patient visits and run their practices like a small business," Dr. Pho says. "Medical costs should be part of a discussion about possible diagnostic tests and treatments with patients, and they may consider a less expensive alternative test or treatment plan, along with generic medications, that may be more affordable." Even so, the end result may be less that optimal. "Sometimes there was nothing I could do," Dr. Pho says. "Patients unable to pay for preventive care would eventually return to me later on, with their condition worse, and require more extensive, and expensive, treatment."

Physicians have already made some changes, according to two physician surveys. In a June 2009 American Academy of Pediatrics (AAP) survey on the effects of the recession on pediatric practices, more than 60% of respondents stated that their practice had made changes to staffing in the last year because of the recession. Many (30%) had suspended raises. Other practices had reduced full-time equivalents (FTE) of staff (28.6%) and physicians (4.3%) or had implemented a hiring freeze (20%). Nearly a quarter indicated that they had reevaluated benefit packages for their employees as a way to reduce costs. Only 2.9% had actually implemented pay cuts. Other activities included giving only cost-of-living increases, eliminating or

Practices Make Changes to Cope With Recession

Some practices have already made changes in response to the recession. According to the 2009 MGMA physician practice survey, 35.2% of respondents have postponed capital expenditures while 33.6% have cut their operating budget. Here are other survey highlights:

- 33.9% have implemented a staff hiring freeze
- 24.2% have frozen staff salaries
- 32.7% have already improved billing, collections, and/or denial management processes
- 18.1% have stopped taking new Medicaid patients
- 4.6% have stopped taking new Medicare patients
- 13.4% have renegotiated or eliminated low-paying commercial payer contracts

reducing overtime, and eliminating bonuses. (For more details on the survey results, see *http://practice.aap.org/content.aspx?aid=2871*.) For highlights of an MGMA survey, see "Practices Make Changes to Cope With Recession," above.

More Coping Strategies

Until proposed changes currently being debated in Congress are voted on and implemented, both physicians and patients will have to cope as best they can. Dr. Epperly urges physicians to ask their patients about job and insurance changes and to let them know that community resources can help them obtain free or reduced-cost prescriptions. Such resources can also supply specific information about resources that can help them make it through a tough economic situation.

He further advises physicians to use physician assistants and nurse practitioners in order to see more patients. Doctors need to focus more than ever on prevention with the patients they see, reminding them to decrease alcohol consumption, stop smoking, increase exercise, and continue taking medication for chronic conditions.

CSC, a global provider of IT-enabled business solutions and services, surveyed health plan executives in November 2008

about how they expected the recession to affect medical providers. In its 2008 report, "Insuring the Future: Health Plans Respond to the Financial Crisis," 73% of those surveyed stated that they expected doctors to have cash flow problems because of the recession, 54% were concerned about the impact on the stability of health plan networks, and 31% were afraid it would affect the quality of healthcare service and care. CSC reports that executives from healthcare plans with Medicaid programs were those most concerned about cash flow and provider solvency. These respondents commented that their providers were demanding faster payments and rate increases in order to remain in networks for Medicaid subscribers.

At the same time, respondents expected Medicaid plans to grow because of deepening unemployment and the economic downturn, but expressed concern about the availability and expansion of state and federal funding. They also anticipated growth in consumer-directed health insurance plans, PPOs/EPOs, and HMOs, despite the downtown in both individual and group markets. (See *http://assets1.csc.com/health_services/downloads/CSC_Insuring_the_Future_Health_Plans_Respond_to_the_Financial_Crisis.pdf*.)

Physicians employed by hospitals may be at even further risk, Mr. La Penna says. While many hospital-employed physicians will likely feel the effects of the recession as they renegotiate their contracts, others may feel more immediate scrutiny. He says some of his hospital clients are now evaluating whether they can keep all employed medical staff. The hospitals are looking at each practice site and each practitioner to evaluate their contribution to the hospital's bottom-line revenue.

"Are the physicians a cash drain, or do they find and refer enough patients and tests and procedures to justify keeping [them] in place?" Mr. La Penna asks. "When hospitals have to invest to maintain the practices and sponsor the physician and provider salaries, they have to be able to show that the doctor is part of an overall process that is financially feasible."