How to Thrive During a Recession

Chapter FastFACTS

1. **Reviewing and evaluating your practice costs can help you stay financially healthy.**
2. **Renegotiating your office lease to include more flexibility can reduce overhead costs.**
3. **Deferring purchases or improving efficiency in your technology systems can save money.**
4. **Options like offering membership plans, accepting credit cards, or providing free care for established patients in need can pay off.**
5. **A written form of your practice's payment policy should be given to each patient at the initial visit.**

If you're seeing more uninsured patients and suffering from falling revenues, you can implement strategies—such as flexible payment arrangements for your patients—that will improve your bottom line.

If you're one of those physicians who just wish the recession would end and everything would return to the way it was before, Mr. La Penna says it's time to face reality. "We won't return to the same days, so consider your options and make changes now to thrive in the recession," he advises.

The first step to getting your practice through economic bad times is to go back to basics and improve your business model, according to Mr. La Penna. "Take what you do well and do it

For the treatment of hypertension

BYSTOLIC.

Significant blood pressure reductions with a low incidence of side effects.[1-3]

Bystolic®
(nebivolol) tablets
www.BYSTOLIC.com

Important Safety Information

Patients being treated with BYSTOLIC should be advised against abrupt discontinuation of therapy. Severe exacerbation of angina and the occurrence of myocardial infarction and ventricular arrhythmias have been reported following the abrupt cessation of therapy with beta blockers. When discontinuation is planned, the dosage should be reduced gradually over a 1- to 2-week period and the patient carefully monitored.

BYSTOLIC is contraindicated in severe bradycardia, heart block greater than first degree, cardiogenic shock, decompensated cardiac failure, sick sinus syndrome (unless a permanent pacemaker is in place), severe hepatic impairment (Child-Pugh >B), and in patients who are hypersensitive to any component of this product.

BYSTOLIC should be used with caution in patients with peripheral vascular disease, thyrotoxicosis, in patients treated concomitantly with beta blockers and calcium channel blockers of the verapamil and diltiazem type (ECG and blood pressure should be monitored), severe renal impairment, and any degree of hepatic impairment or in patients undergoing major surgery. In patients who have compensated congestive heart failure, BYSTOLIC should be administered cautiously. If heart failure worsens, discontinuation of BYSTOLIC should be considered. Caution should also be used in diabetic patients as beta blockers may mask some of the manifestations of hypoglycemia, particularly tachycardia.

Use caution when BYSTOLIC is co-administered with CYP2D6 inhibitors (quinidine, propafenone, fluoxetine, paroxetine, etc). When BYSTOLIC is administered with fluoxetine, significant increases in d-nebivolol may be observed (ie, an 8-fold increase in AUC).

In general, patients with bronchospastic disease should not receive beta blockers.

BYSTOLIC should not be combined with other beta blockers.

The most common adverse events with BYSTOLIC versus placebo (approximately ≥1% and greater than placebo) were headache, fatigue, dizziness, diarrhea, nausea, insomnia, chest pain, bradycardia, dyspnea, rash, and peripheral edema.

Forest Pharmaceuticals, Inc.
Pharmaceuticals • Therapeutics • Healthcare • Ethicare • Managed Care • Specialty Sales

Please see brief summary of Prescribing Information on adjacent page.

References: 1. BYSTOLIC [package insert]. St. Louis, Mo: Forest Pharmaceuticals, Inc.; 2008. **2.** Data on file. Forest Laboratories, Inc. **3.** Saunders E, Smith WB, DeSalvo KB, Sullivan WA. The efficacy and tolerability of nebivolol in hypertensive African American patients. *J Clin Hypertens.* 2007;9:866-875.

 44-1014950 01/09

Bystolic
(nebivolol) tablets
2.5 mg, 5 mg, 10 mg and 20 mg

Rx Only

Brief Summary: For complete details please see full Prescribing Information for BYSTOLIC.

INDICATIONS AND USAGE
BYSTOLIC is indicated for the treatment of hypertension. BYSTOLIC may be used alone or in combination with other antihypertensive agents.

CONTRAINDICATIONS
BYSTOLIC is contraindicated in patients with severe bradycardia, heart block greater than first degree, cardiogenic shock, decompensated cardiac failure, sick sinus syndrome (unless a permanent pacemaker is in place), or severe hepatic impairment (Child-Pugh >B), and in patients who are hypersensitive to any component of this product.

WARNINGS
Abrupt Cessation of Therapy
Patients with coronary artery disease treated with BYSTOLIC should be advised against abrupt discontinuation of therapy. Severe exacerbation of angina and the occurrence of myocardial infarction and ventricular arrhythmias have been reported in patients with coronary artery disease following the abrupt discontinuation of therapy with β-blockers. Myocardial infarction and ventricular arrhythmias may occur with or without preceding exacerbation of the angina pectoris. Even patients without overt coronary artery disease should be cautioned against interruption or abrupt discontinuation of therapy. As with other β-blockers, when discontinuation of BYSTOLIC is planned, patients should be carefully observed and advised to minimize physical activity. BYSTOLIC should be tapered over 1 to 2 weeks when possible. If the angina worsens or acute coronary insufficiency develops, it is recommended that BYSTOLIC be promptly reinstituted, at least temporarily.

Cardiac Failure
Sympathetic stimulation is a vital component supporting circulatory function in the setting of congestive heart failure, and β-blockade may result in further depression of myocardial contractility and precipitate more severe failure. In patients who have compensated congestive heart failure, BYSTOLIC should be administered cautiously. If heart failure worsens, discontinuation of BYSTOLIC should be considered.

Angina and Acute Myocardial Infarction
BYSTOLIC was not studied in patients with angina pectoris or who had a recent MI.

Bronchospastic Diseases
In general, patients with bronchospastic diseases should not receive β-blockers.

Anesthesia and Major Surgery
If BYSTOLIC is to be continued perioperatively, patients should be closely monitored when anesthetic agents which depress myocardial function, such as ether, cyclopropane, and trichloroethylene, are used. If β-blocking therapy is withdrawn prior to major surgery, the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

The β-blocking effects of BYSTOLIC can be reversed by β-agonists, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Additionally, difficulty in restarting and maintaining the heartbeat has been reported with β-blockers.

Diabetes and Hypoglycemia
β-blockers may mask some of the manifestations of hypoglycemia, particularly tachycardia. Nonselective β-blockers may potentiate insulin-induced hypoglycemia and delay recovery of serum glucose levels. It is not known whether nebivolol has these effects. Patients subject to spontaneous hypoglycemia, or diabetic patients receiving insulin or oral hypoglycemic agents, should be advised about these possibilities and nebivolol should be used with caution.

Thyrotoxicosis
β-blockers may mask clinical signs of hyperthyroidism, such as tachycardia. Abrupt withdrawal of β-blockers may be followed by an exacerbation of the symptoms of hyperthyroidism or may precipitate a thyroid storm.

Peripheral Vascular Disease
β-blockers can precipitate or aggravate symptoms of arterial insufficiency in patients with peripheral vascular disease. Caution should be exercised in these patients.

Non-dihydropyridine Calcium Channel Blockers
Because of significant negative inotropic and chronotropic effects in patients treated with β-blockers and calcium channel blockers of the verapamil and diltiazem type, caution should be used in patients treated concomitantly with these agents and ECG and blood pressure should be monitored.

PRECAUTIONS
Use with CYP2D6 Inhibitors
Nebivolol exposure increases with inhibition of CYP2D6 (see **Drug Interactions**). The dose of BYSTOLIC may need to be reduced.

Impaired Renal Function
BYSTOLIC should be used with caution in patients with severe renal impairment because of decreased renal clearance. BYSTOLIC has not been studied in patients receiving dialysis.

Impaired Hepatic Function
BYSTOLIC should be used with caution in patients with moderate hepatic impairment because of decreased metabolism. Since BYSTOLIC has not been studied in patients with severe hepatic impairment, BYSTOLIC is contraindicated in this population (see **CLINICAL PHARMACOLOGY, Special Populations** and **DOSAGE AND ADMINISTRATION**).

Risk of Anaphylactic Reactions
While taking β-blockers, patients with a history of severe anaphylactic reactions to a variety of allergens may be more reactive to repeated challenge either accidental, diagnostic, or therapeutic. Such patients may be unresponsive to the usual doses of epinephrine used to treat allergic reactions.

In patients with known or suspected pheochromocytoma, an α-blocker should be initiated prior to the use of any β-blocker.

Information for Patients
Patients should be advised to take BYSTOLIC regularly and continuously, as directed. BYSTOLIC can be taken with or without food. If a dose is missed, the patient should take the next scheduled dose only (without doubling it). Patients should not interrupt or discontinue BYSTOLIC without consulting the physician.

Patients should know how they react to this medicine before they operate automobiles, use machinery, or engage in other tasks requiring alertness.

Patients should be advised to consult a physician if any difficulty in breathing occurs, or if they develop signs or symptoms of worsening congestive heart failure such as weight gain or increasing shortness of breath, or excessive bradycardia.

Patients subject to spontaneous hypoglycemia, or diabetic patients receiving insulin or oral hypoglycemic agents, should be cautioned that β-blockers may mask some of the manifestations of hypoglycemia, particularly tachycardia. Nebivolol should be used with caution in these patients.

Drug Interactions
BYSTOLIC should be used with care when myocardial depressants or inhibitors of AV conduction, such as certain calcium antagonists (particularly of the phenylalkylamine [verapamil] and benzothiazepine [diltiazem] classes), or antiarrhythmic agents, such as disopyramide, are used concurrently. Both digitalis glycosides and β-blockers slow atrioventricular conduction and decrease heart rate. Concomitant use can increase the risk of bradycardia.

BYSTOLIC should not be combined with other β-blockers. Patients receiving catecholamine-depleting drugs, such as reserpine or guanethidine, should be closely monitored, because the added β-blocking action of BYSTOLIC may produce excessive reduction of sympathetic activity. In patients who are receiving BYSTOLIC and clonidine, BYSTOLIC should be discontinued for several days before the gradual tapering of clonidine.

CYP2D6 Inhibitors: Use caution when BYSTOLIC is co-administered with CYP2D6 inhibitors (quinidine, propafenone, fluoxetine, paroxetine, etc.) (see **CLINICAL PHARMACOLOGY, Drug Interactions**).

Carcinogenesis, Mutagenesis, Impairment of Fertility
In a two-year study of nebivolol in mice, a statistically significant increase in the incidence of testicular Leydig cell hyperplasia and adenomas was observed at 40 mg/kg/day (5 times the maximally recommended human dose of 40 mg on a mg/m^2 basis). Similar findings were not reported in mice administered doses equal to approximately 0.3 or 1.2 times the maximum recommended human dose. No evidence of a tumorigenic effect was observed in a 24-month study in Wistar rats receiving doses of nebivolol 2.5, 10 and 40 mg/kg/day (equivalent to 0.6, 2.4, and 10 times the maximally recommended human dose). Co-administration of dihydrotestosterone reduced blood LH levels and prevented the Leydig cell hyperplasia, consistent with an indirect LH-mediated effect of nebivolol in mice and not thought to be clinically relevant in man.

A randomized, double-blind, placebo- and active-controlled, parallel-group study in healthy male volunteers was conducted to determine the effects of nebivolol on adrenal function, luteinizing hormone, and testosterone levels. This study demonstrated that 6 weeks of daily dosing with 10 mg of nebivolol had no significant effect on ACTH-stimulated mean serum cortisol $AUC_{0\text{-}120\ min}$, serum LH, or serum total testosterone.

Effects on spermatogenesis were seen in male rats and mice at ≥40 mg/kg/day (10 and 5 times the MRHD, respectively). For rats the effects on spermatogenesis were not reversed and may have worsened during a four-week recovery period. The effects of nebivolol on sperm in mice, however, were partially reversible.

Mutagenesis: Nebivolol was not genotoxic when tested in a battery of assays (Ames, *in vitro* mouse lymphoma $TK^{+/-}$, *in vitro* human peripheral lymphocyte chromosome aberration, *in vivo* Drosophila melanogaster sex-linked recessive lethal, and *in vivo* mouse bone marrow micronucleus tests).

Pregnancy: Teratogenic Effects. Pregnancy Category C:
Decreased pup body weights occurred at 1.25 and 2.5 mg/kg in rats, when exposed during the perinatal period (late gestation, parturition and lactation). At 5 mg/kg and higher doses (1.2 times the MRHD), prolonged gestation, dystocia and reduced maternal care were produced with corresponding increases in late fetal deaths and stillbirths and decreased birth weight, live litter size and pup survival. Insufficient numbers of pups survived at 5 mg/kg to evaluate the offspring for reproductive performance.

In studies in which pregnant rats were given nebivolol during organogenesis, reduced fetal body weights were observed at maternally toxic doses of 20 and 40 mg/kg/day (5 and 10 times the MRHD), and small reversible delays in sternal and thoracic ossification associated with the reduced fetal body weights and a small increase in resorption occurred at 40 mg/kg/day (10 times the MRHD). No adverse effects on embryo-fetal viability, sex, weight or morphology were observed in studies in which nebivolol was given to pregnant rabbits at doses as high as 20 mg/kg/day (10 times the MRHD).

Labor and Delivery

Nebivolol caused prolonged gestation and dystocia at doses ≥5 mg/kg in rats (1.2 times the MRHD). These effects were associated with increased fetal deaths and stillborn pups, and decreased birth weight, live litter size and pup survival rate, events that occurred only when nebivolol was given during the perinatal period (late gestation, parturition and lactation).

No studies of nebivolol were conducted in pregnant women. BYSTOLIC should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers

Studies in rats have shown that nebivolol or its metabolites cross the placental barrier and are excreted in breast milk. It is not known whether this drug is excreted in human milk.

Because of the potential for β-blockers to produce serious adverse reactions in nursing infants, especially bradycardia, BYSTOLIC is not recommended during nursing.

Geriatric Use

Of the 2800 patients in the U.S.-sponsored placebo-controlled clinical hypertension studies, 478 patients were 65 years of age or older. No overall differences in efficacy or in the incidence of adverse events were observed between older and younger patients.

Pediatric Use

Safety and effectiveness in pediatric patients have not been established. Pediatric studies in ages newborn to 18 years old have not been conducted because of incomplete characterization of developmental toxicity and possible adverse effects on long-term fertility (see **Carcinogenesis, Mutagenesis, and Impairment of Fertility**).

ADVERSE REACTIONS

The data described below reflect worldwide clinical trial exposure to BYSTOLIC in 6545 patients, including 5038 patients treated for hypertension and the remaining 1507 subjects treated for other cardiovascular diseases. Doses ranged from 0.5 mg to 40 mg. Patients received BYSTOLIC for up to 24 months, with over 1900 patients treated for at least 6 months, and approximately 1300 patients for more than one year. In placebo-controlled clinical trials comparing BYSTOLIC with placebo, discontinuation of therapy due to adverse events was reported in 2.8% of patients treated with nebivolol and 2.2% of patients given placebo. The most common adverse events that led to discontinuation of BYSTOLIC were headache (0.4%), nausea (0.2%) and bradycardia (0.2%).

Adverse Reactions in Controlled Trials

Table 1 lists treatment-emergent signs and symptoms that were reported in three 12-week, placebo-controlled monotherapy trials involving 1597 hypertensive patients treated with either 5 mg, 10 mg or 20-40 mg of BYSTOLIC and 205 patients given placebo and for which the rate of occurrence was at least 1% of patients treated with nebivolol and greater than the rate for those treated with placebo in at least one dose group.

Table 1. Treatment-Emergent Adverse Events with an Incidence (over 6 weeks) ≥1% in BYSTOLIC-Treated Patients and at a Higher Frequency than Placebo-Treated Patients

	Placebo (n = 205) (%)	Nebivolol 5 mg (n = 459) (%)	Nebivolol 10 mg (n = 461) (%)	Nebivolol 20-40 mg (n = 677) (%)
Headache	6	9	6	7
Fatigue	1	2	2	5
Dizziness	2	2	3	4
Diarrhea	2	2	2	3
Nausea	0	1	3	2
Insomnia	0	1	1	1
Chest pain	0	0	1	1
Bradycardia	0	0	0	1
Dyspnea	0	0	1	1
Rash	0	0	1	1
Peripheral edema	0	1	1	1

Other Adverse Events Observed During Worldwide Clinical Trials

Listed below are other reported adverse events with an incidence of at least 1% in the more than 5300 patients treated with BYSTOLIC in controlled or open-label trials, whether or not attributed to treatment, except for those already appearing in **Table 1**, terms too general to be informative, minor symptoms, or events unlikely to be attributable to drug because they are common in the population. These adverse events were in most cases observed at a similar frequency in placebo-treated patients in the controlled studies.

Body as a Whole: asthenia.

Gastrointestinal System Disorders: abdominal pain

Metabolic and Nutritional Disorders: hypercholesterolemia and hyperuricemia

Nervous System Disorders: paraesthesia

Laboratory

In controlled monotherapy trials, BYSTOLIC was associated with an increase in BUN, uric acid, triglycerides and a decrease in HDL cholesterol and platelet count.

Events Identified from Spontaneous Reports of BYSTOLIC Received Worldwide

The following adverse events have been identified from spontaneous reports of BYSTOLIC received worldwide and have not been listed elsewhere. These adverse events have been chosen for inclusion due to a combination of seriousness, frequency of reporting or potential causal connection to BYSTOLIC. Events common in the population have generally been omitted. Because these events were reported voluntarily from a population of uncertain size, it is not possible to estimate their frequency or establish a causal relationship to BYSTOLIC exposure: abnormal hepatic function (including increased AST, ALT and bilirubin), acute pulmonary edema, acute renal failure, atrioventricular block (both second- and third-degree), bronchospasm, erectile dysfunction, hypersensitivity (including urticaria, allergic vasculitis and rare reports of angioedema), myocardial infarction, pruritus, psoriasis, Raynaud's phenomenon, peripheral ischemia/claudication, somnolence, syncope, thrombocytopenia, various rashes and skin disorders, vertigo, and vomiting.

OVERDOSAGE

In clinical trials and worldwide postmarketing experience there were reports of BYSTOLIC overdose. The most common signs and symptoms associated with BYSTOLIC overdosage are bradycardia and hypotension. Other important adverse events reported with BYSTOLIC overdose include cardiac failure, dizziness, hypoglycemia, fatigue and vomiting. Other adverse events associated with β-blocker overdose include bronchospasm and heart block.

The largest known ingestion of BYSTOLIC worldwide involved a patient who ingested up to 500 mg of BYSTOLIC along with several 100 mg tablets of acetylsalicylic acid in a suicide attempt. The patient experienced hyperhidrosis, pallor, depressed level of consciousness, hypokinesia, hypotension, sinus bradycardia, hypoglycemia, hypokalemia, respiratory failure and vomiting. The patient recovered.

Due to extensive drug binding to plasma proteins, hemodialysis is not expected to enhance nebivolol clearance.

If overdose occurs, BYSTOLIC should be stopped and general supportive and specific symptomatic treatment should be provided. Based on expected pharmacologic actions and recommendations for other β-blockers, the following general measures should be considered when clinically warranted:

Bradycardia: Administer IV atropine. If the response is inadequate, isoproterenol or another agent with positive chronotropic properties may be given cautiously. Under some circumstances, transthoracic or transvenous pacemaker placement may be necessary.

Hypotension: Administer IV fluids and vasopressors. Intravenous glucagon may be useful.

Heart Block (second or third degree): Patients should be carefully monitored and treated with isoproterenol infusion. Under some circumstances, transthoracic or transvenous pacemaker placement may be necessary.

Congestive Heart Failure: Initiate therapy with digitalis glycoside and diuretics. In certain cases, consideration should be given to the use of inotropic and vasodilating agents.

Bronchospasm: Administer bronchodilator therapy such as a short-acting inhaled β_2-agonist and/or aminophylline.

Hypoglycemia: Administer IV glucose. Repeated doses of IV glucose or possibly glucagon may be required.

In the event of intoxication where there are symptoms of shock, treatment must be continued for a sufficiently long period consistent with the 12-19 hour effective half-life of BYSTOLIC. Supportive measures should continue until clinical stability is achieved.

Call the National Poison Control Center (800-222-1222) for the most current information on β-blocker overdose treatment.

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Rev. 8/08

better. Don't jump into a new business plan," he says. Instead, focus on low-tech, base-level services, which continue to do well during a recession. Then, he says, you can consider other, more drastic action. (See "How to Survive—and Thrive—During the Recession," below.)

Key strategies include maximizing your staff by, for example, cross-training to reduce overhead; re-evaluating your equipment needs; and communicating clearly to your patients about costs. This chapter will explore these and other ways to weather the present economic climate and to position your practice for post-recession success.

Examine Your Practice Costs

Are you billing properly? Not all practices are, says the MGMA's Mr. Hertz. He recommends that all practices review and evaluate their practice costs, such as unusually high phone charges in a practice with multiple locations. Some practices may choose to hire an external auditor to ensure that coding and billing are being performed efficiently.

"Be realistic about costs and potential utilization," Mr. Hertz says. "Maybe you can expand practice hours to open access for patients, or open satellite locations, or utilize mid-level

How to Survive—and Thrive—During the Recession

To cope with declining patient visits, increasing numbers of uninsured patients, and other effects of the recession, Michael La Penna, a practice management consultant with The La Penna Group, Inc., Grand Rapids, Mich., suggests physician practices do the following:

- Re-examine their accounts receivable [A/R] and billing systems.
- Accept every form of payment, including credit cards.
- Pre-qualify patients first.
- Partner with other initiatives, such as retail medicine.
- Collaborate with other practices, perhaps alternating to provide weekend and evening hours for patients.
- If necessary, consolidate with other practices that have similar patient bases.

providers." Any changes you make should be based on your practice's own business strategy. That strategy should answer questions such as these: Where are we going? What are our specific business goals? How can we effectively leverage technology? How can we best use our resources?

Seek ways to improve production, suggests consultant Judy Capko, Capko & Company, Thousand Oaks, Calif., author of *Secrets of the Best-run Practices*. For example, reduce the lost production caused by missed appointments and improve staff efficiency to reduce overtime expenditure, she says. Your practice may also need to tighten pay structures by freezing wages or reducing hours, according to Ms. Capko. One option to consider is staggering staff hours to maximize what you're already paying in overhead.

Review Your Lease

You may be able to reduce overhead costs by renegotiating your office lease to include more flexibility if your practice changes. Jeremy D. Behar, president and CEO, Cirrus Consulting Group, Toronto, which works with healthcare providers on innovative solutions involving real estate, says a more flexible lease might include the following:

- A death and disability clause, which would enable you to terminate your lease in case of a catastrophe
- Properly worded assignment and subletting provisions. These give physicians the flexibility to bring other healthcare providers into their practice without first having to seek the landlord's permission
- Properly negotiated "options to extend." These help you keep costs down by preventing your landlord from significantly increasing your rent at renewal time. They also help protect tenant improvements and fixture investment by maintaining security for your practice well into the future, and help prevent the huge costs of a surprise move that may occur in a short time and on short notice

Mr. Behar suggests that practices consider relocating to a retail plaza to take advantage of good rental deals or work with their landlord to reduce rents. "The trend of physicians' working with their real estate to increase cash flow and reduce costs is ballooning," Mr. Behar says. "Medical tenants are now as coveted as big brand stores once were in retail centers, and doctors should not overlook this opportunity to change their practices for the better."

"Identify poor payers early on and deal with the problem. Do not wait until the situation reaches a crisis point and puts your doctor-patient relationship at risk."

Susan Shepard, MSN, RN, CPHRM
The Doctors Company

Evaluate Your Technology

Your practice can save money and become more efficient by evaluating your technology systems and determining whether you can defer additional purchases or improve efficiency in these three areas:

Practice management: It's perhaps most important for your practice to evaluate your systems that manage scheduling, billing, collections, and financial, says Sue Hertlein, manager, The Coker Group, Atlanta, Ga.

Small practices that buy their applications from second-tier vendors who don't offer top brands may not get a state-of-the-art system, she says. What you save in the purchase price can cost you with additional labor to manually handle certain tasks and/or lack of reports or other features. "In some instances, practices continue to use a legacy system that was installed years ago. Those applications can actually cost the practice money due to their lack of features," Ms. Hertlein says. "Because the practice management system is the backbone of all practices … it is crucial for financial success to utilize a sophisticated system."

Electronic medical records (EMRs): Even though it can be a hassle and costly to implement, an EMR system offers many advantages to practices. A good system will be capable of the following:

- Flags patients for follow-ups and certain tests based upon gender, age, and diagnosis
- Flags allergies and drug-to-drug reactions
- Manages patient calls electronically
- Provides an online option to view lab results
- Calculates and recommends appropriate evaluation and management coding
- Includes electronic prescription transmission to pharmacies

Appointment reminder system: Ms. Hertlein recommends that practices use an automated appointment reminder system, which interfaces with a practice management system to call patients electronically. This system can free staff to perform other tasks, reduce no-shows, and even provide lab results, she says.

Establish a Payment Policy

Your practice should have a payment policy that is applied consistently and supplied in written form to each patient at the initial visit. When you can, remind a patient that he or she received a copy of your policy at the time of the first visit. "Identify poor payers early on and deal with the problem. Do not wait until the situation reaches a crisis point and puts your doctor-patient relationship at risk," says Susan Shepard, MSN, RN, CPHRM, director of patient safety education for The Doctors Company, a physician-owned and -operated provider of medical malpractice insurance, based in Napa, Calif.

Encourage patients who are struggling to pay to call your office to set up an action plan. "Talking to your patient first and investigating why the bill isn't being paid can be more fruitful

than using alternative financing options, including bill collection," she says.

Verify Patient Insurance

To avoid claim denials and to increase revenue, collect all important patient information such as the patient's identity and insurance coverage as early as possible, ideally at the point of scheduling, Mr. Drake says. For walk-ins, that should be done at the point of service. "Emergency situations aside, no patient should be treated until his or her information is validated," he says. Office staff should confirm the patient's name, date of birth, Social Security Number, and address. "[That eliminates] the possibility of fraud and identity theft, which usually spikes in a recession," he says. It also ensures the office will be able to reach the patient for any follow–up and billing.

Insurance verification is important because eligibility and benefits data protect payer reimbursement; reduce denials and bad debt write-offs; and reveal co-pay, co-insurance, and deductible amounts that should be collected up front, Mr. Drake explains. Collecting those upfront amounts can be difficult for some practices that are used to billing patients 30 days or more after a visit. "But current insurance plans incorporate patient deductibles of $1,000 to $5,000; and research has shown that once a patient walks out the door, the odds of collecting are 50% at best," he says. If the patient can't pay the entire amount, he recommends setting up a payment plan using an automated recurring deduction or some minimum deposit amount.

Why Accept Credit Cards?

One way to do a better job collecting money is to accept credit cards, Mr. Hertz says. Yet many physicians don't because they don't want to pay the transaction fee rates, which are typically 3% to 4% per transaction. According to an SK&A Information Services survey of more than 202,000 physician offices nationwide, 33% of physician practices did not accept credit cards as of April 2009, an increase from 28% in 2008. Those figures seem to vary by specialty based on reliance on patient self-pay and patient age. (See "Who Accepts Credit Cards?," opposite.)

Physicians who balk should consider the alternative to paying

Who Accepts Credit Cards?

Percentage of practices that accept credit cards	
Otolaryngology	83%
Dermatology	81%
OB/Gyn	78%
Family Medicine	72%
Pediatrics	70%
Cardiology	68%
Internal Medicine	53%
Geriatrics	32%

Source: SK&A Information Services, "Physician Office Credit-Card Acceptance Survey," April, 2009.

credit service charges: collecting nothing. Moreover, accepting credit cards can improve the practice's cash flow with more timely payments and can reduce overhead and billing-related expenses such as chasing down small co-pay amounts, issuing paper statements, and dealing with bounced checks. Credit cards give patients the financial flexibility to receive the healthcare they need, when they need it—regardless of their cash situation.

Some commercial credit companies hold the physician responsible if the patient defaults on a payment. Before using a commercial credit company, read the contract carefully to make sure you won't be liable for a patient's outstanding balance, Ms. Shepard advises. "You should also be aware of your state's consumer protection laws regarding lending and disclosure, and make sure that your patients understand the terms and conditions of the financing. Your bank, local medical society, or professional society can help you locate a commercial credit company," she says. For more information about offering credit cards and lines of credit to patients, see "Tips for Offering Credit to Your Patients," p. 50.

Communicating Costs to Your Patients

It's easy to find out how much a self-pay office visit or follow-

Tips for Offering Credit to Your Patients

If you're considering offering credit cards and/or lines of credit to your patients, here are pointers from Susan Shepard, MSN, RN, CPHRM, director of patient safety education for The Doctors Company, Napa, Calif.:

- Be sure to respond to any letter related to charges that are in question. A credit card company will notify you in writing about an inquiry into a charge that is being challenged. If you don't clarify the dispute, the charge will be disallowed. Make sure your office staff recognize these letters and bring them to your attention.
- Consider placing a limit on allowable credit card charges. The limit can be a percentage of the total treatment charge or a dollar limit, e.g., $3,500, $5,000, or no more than 50% of the procedure cost.
- Put payment plans in writing and have patients sign them.
- Get a reference for credit applications. This can help locate the patient if the account needs to be sent to a collection agency.
- Put a time limit on any adjustments or revisions to the original procedure, such as 60 or 90 days (otherwise a patient could come in months or years later and request a revision that was discussed when the procedure was first done).
- Identify poor payers early on, and deal with any potential payment problem before it reaches a crisis point and puts your doctor-patient relationship at risk.
- Select a reputable collection agency. There are very specific state laws dealing with fair debt collection. A physician who selects a collection agency that violates state laws could face liability for negligent selection.

up costs at Fort Myers Family Medicine in Florida. Just check the practice's Website and you'll find a link on the home page to visit prices. Costs for lab tests, such as a glucose blood test for $10, a thyroid assay for $36, or a Pap smear for $62, are also clearly listed (*www.fortmyersfamilymedicine.com*).

H. Lee Adkins, DO, posted the prices when he began to see the effects of the volatile economy on his practice over two years. He had just moved into his new office and noticed that many patients were not coming in for follow-up visits because they had lost their jobs and healthcare benefits. Last year, he

found his self-pay patient base had grown from about 7% to 30%, another clue that his patients were losing their insurance. That's when he decided to do some research.

His results allowed him to first determine that the cost of his services were appropriate for the market. Then he decided to remove any mystery about costs by plainly listing his fees for those who were paying out of pocket. "Now we refer [patients who call the office] to our Website to get an idea of costs before they come in," Dr. Adkins says. "[Patients] know when they go into an emergency room that it will cost them between $800 and $1,200. If they walk into my office, it will cost them between $85 and $135, with a follow-up visit cost of $65 to $110, depending on complexity."

The result has been that the percentage of the practice's self-pay patients increased from 5% to10% before he started posting the prices to 20% to 30% afterwards. A small but significant portion of the self-pay group consists of established patients whose insurance benefits have been dropped by their small business employers. "New patients say that they came in [to the office] based on a friend's referral, or saw news articles or the Internet," Dr. Adkins says.

Creative Cost Solutions for Patients

Self-pay patients who still struggle to pay Dr. Adkins's fees but still want to benefit from preventive care have another option: joining the practice's membership program. The practice launched its "Self-pay Solution Membership" program in March 2009. Self-pay patients pay $75 per month for one year or $200 quarterly to receive up to 15 office visits per year with a $10 co-pay per visit. The practice started the plan to encourage patients to keep current on preventative services such as immunizations, medication reviews, and cancer screenings. Patients who participate are advised to obtain a hospitalization insurance policy, which is more affordable than a full-coverage policy.

Dr. Adkins says he was able to reduce prices 30% to 35% for non-insured patients by charging only for services they actually utilized and by eliminating the paperwork and reimbursement costs associated with billing Medicare, HMO, and private insurers. "A reduction of 35% for the average primary care visit puts

the service at a price point that the average person can easily afford out of pocket," he says. He says his experience shows not only how much bureaucracy adds to healthcare costs, but also how price transparency can contain costs.

Dr. Adkins also offers his established patients the cost-saving option of a "virtual" office visit. Patients log onto his Website

"Try to stay on schedule, call patients by name, thank them for coming in, tell them that you would welcome the opportunity to treat their friends, and mean it."

Bill Bristow, partner
DoctorsManagement

and complete a "symptom" form—an answer-prompted algorithm of questions, the sequence and content of which are dependent on the patient's previous answer. Dr. Adkins reviews the form; e-mails additional questions if necessary; makes sure he's responding to simple, self-limited conditions; then makes a treatment plan. All the information is encrypted and secure and is communicated to the patient via a HIPAA-compliant online connection. Dr. Adkins is currently revising some of the algorithms with the program vendor to more precisely define the patient's "history of present illness" and to include "sentinel questions" to rule out more complex medical conditions.

He requires the virtual visit to turn into an in-person one under these conditions:

- Patient response to treatment is poor.
- Complexity of the patient's medical condition warrants an office visit.
- Patient's expectations exceed the physician's comfort level.

If you'd like to put a similar program in place, Dr. Adkins suggests first figuring out your actual expenses and income. It's not hard to do, he says, noting that 85% of the costs are fixed, such as overhead expenses. Other line items are included in lists provided by the MGMA for members only at *www.mgma.com*.

Focus on Patient Satisfaction

Patient satisfaction in both the nonclinical and clinical part of the office visit is key to making any of these strategies work. A recent McKinsey & Company survey found that 41% of a consumer's choice in a provider is based on the nonclinical experience, notes Mark Williard, senior vice president, product management, The Beryl Companies (*www.beryl.net*), a Bedford, Tex.-based healthcare call center that works with over 450 hospitals/health systems and their physicians.

One change that can have a dramatic impact on patient satisfaction is to reduce patients' wait time. However, in times of financial constraint this is often an area that takes a direct hit as staff members are pulled in many directions. One step is to make sure the practice has adequate resources to run its practice at full capacity. Next, consider outsourcing back-office functions. If staff are overwhelmed during regular office hours, outsourcing patient scheduling and post-discharge calls can free up your nursing staff to spend more time with each patient. That can increase patient satisfaction, which is shown to increase the likelihood of referrals to drive new revenue. It can also save on overtime pay.

Mr. Williard also suggests that your practice be proactive about managing your schedules. "Fill schedules to capacity," he says. Your staff should follow up with reminder calls to reduce no-show rates, Mr. Williard suggests. Having unfilled slots can have a significant financial impact even for small- to mid-sized practices; those practices that see between 90 and 150 patients each day can increase revenues by hundreds of thousands of dollars by reducing unfilled schedule slots, he says.

Bill Bristow, partner, DoctorsManagement, Knoxville, Tenn., advises physicians whose practices are hurting now to make the office experience as pleasant as possible for patients and to add a personal touch. "Try to stay on schedule, call patients by name, thank them for coming in, tell them that you would welcome the opportunity to treat their friends, and mean it," he says.

Is Free Medical Care an Option?

Arvind K. Goyal, MD, MPH, a solo family physician in South Barrington, Ill., says he provides free medical care to his patients

in their time of need, not only because he feels it is the right thing to do, but because it creates good will community wide. While he has offered free care since the mid-1980s, he finds it is necessary now more than ever.

"I ask my receptionist to alert me if she knows that a patient has lost his job. We provide free care for patients until they get their job back," he says. "It is a reasonable way to help those who are out of a job and are established patients in your practice." He also asks drug reps for samples, especially for patients with chronic illnesses, and tries to find help for patients through local clinics and hospitals.

Instead of finding that patients take advantage of his offer, he says he sees just the opposite: Primarily because of pride, some patients are reluctant to take advantage of the offer. He words his offers of free medical care very cautiously so that patients will

"In the long term, [helping those in financial need] stirs a lot of good will and loyalty. People don't forget these things."

Arvind K. Goyal, MD, MPH

not feel belittled. "This situation can happen to any one of us," Dr. Goyal says, noting that he was inspired by those who helped him throughout his medical career. "Tell your patient … we have to help each other. Say, 'You have lost your job, so this is my way of helping you. And if I cannot practice medicine tomorrow, you can help me.'" Then, he says, be sure not to treat them differently because they can't pay. He says those he has helped are quick to let his office know when they are back to work and can begin once again to pay for their healthcare.

Dr. Goyal acknowledges that it's not possible for everyone to offer free medical care to their unemployed patients. Practices may be on a tight budget already; and busy practices in large cities don't always know which patients are unemployed or what

company has just laid off workers, some of whom are likely to be your patients. Still, he says this policy can pay off.

"In the long term, [helping those in financial need] stirs a lot of good will and loyalty." he says. "People don't forget these things."

Increase Marketing

Marketing can attract patients to your practice even in bad economic times. People who still have insurance can usually choose which physician they want to see, have new health concerns, or need to find a new physician if theirs retires or is unavailable. "For the insured patient, the issue is usually one of availability and participation in their insurance plan. In those instances, the practice needs to let the public know that they participate in certain plans and that they will be able to see the patient in a reasonable time—the same day if possible," Mr. Bristow says.

Those using the Consolidated Omnibus Budget Reconciliation Act (COBRA) for their coverage are likely to see physicians while they still have insurance, he notes. For those patients, a marketing plan that promotes "see us now while you still have insurance" may prompt its audience to take quick action upon reading the message.

Most primary care offices could fill their schedules if they "harvest the charts"—that is, encourage regular checkups—Mr. Bristow says. "While it is certainly good medicine, it is also good business," he says.

In addition, your practice can market itself by offering cancer screenings and after-hours sports clinics; and by promoting new techniques it can offer to your established as well as potential patients. For more on how to market your practice, see *Doctor's Digest's* July/August 2009 issue, "Marketing for the Primary Care Physician," *http://www.doctorsdigest.net/issue/ 0504.php*.