

# 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 pediatrics 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

## Deflux®

## Stop Febrile UTIs in Their Tracts

For a list of pediatric urologists in your area who use Deflux, visit [www.deflux.com](http://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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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](http://www.atlantichealthpartners.com); and Physicians' Alliance, 866-348-9780, [www.physall.com](http://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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## '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](http://www.talk-aboutrx.org). ■