Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.comhttps://evolvemeded.com/cme/RetinaQI2026/systems-in-sync-optimizing-retina-clinic-workflows-for-timely-anti-vegf-care/37712/

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Systems in Sync: Optimizing Retina Clinic Workflows for Timely Anti-VEGF Care, Part of the Focused Sight Initiative: Quality Improvement Interventions in Retinal Disease

Dr. Eichenbaum:
Welcome to Systems in Sync: Optimizing Retina Clinic Workflows for Timely Anti-VEGF Care. Today, we're going to identify and share real-world solutions to streamline patient flow and coordination in retina practices, particularly around the initiation and continuation of anti-VEGF therapy for common retinal disease. I have an incredible panel with me with both clinical and administrative expertise here. Let's go ahead and introduce everyone on the panel.

Deepak, why don't you start?

Dr. Sambhara:
Sure. Thanks for having me, Dave. So my name is Deepak Sambhara. I'm one of the managing partners at the Eye Clinic of Wisconsin, which is a multispecialty ophthalmology and optometry full-service clinic located in north-central Wisconsin. We are active in clinical trials as well as in comprehensive retinal care. With me, I have one of our best technicians as well as a member of our research department. He is a BCVA technician, Damion Pfaff. Damion, you want to give us a little intro?

Mr. Pfaff:
My name is Damion Pfaff. I am a 3-year technician at the Eye Clinic Wisconsin under Dr. Sambhara's tutelage, but also 10 years total experience in the optometry and ophthalmology world.

Dr. Eichenbaum:
Thanks, Deepak and Damion. Pam, I've got you here from our practice, Retina Vitreous Associates of Florida.

Ms. Pautler:
Hi, my name is Pam. I'm the practice administrator. I've been with Retina Vitreous now for about 34 years. Prior experience with Baxter Healthcare in operations management. So I've been in the eye world a long time.

Dr. Eichenbaum:
We're lucky to have you, Pam. Thanks, everyone, for joining me. And lastly, I'm David Eichenbaum. I'm a director of research and one of the practice partners at Retina Vitreous Associates of Florida.

We are a physician-owned, independent, retina-only practice with a strong clinical research component. And that's how I know Deepak, is through doing clinical research and seeing his career flourish in the first couple of years out of training.

So thank you everyone for joining me. Pam, always grateful to have you. Damion, great to meet you. And Deepak, it's good to see your friendly face.

So let's go ahead and get started. First question for you, Deepak. In your practice, in your clinical experience, what factor most commonly delays a new patient who is indicated to have anti-angiogenic therapy and anti-VEGF injection from getting their first anti-

VEGF injection?

Dr. Sambhara:
Thanks, Dave. I think it's a really unique question because of where in the country we're located. We have a really big catchment area. So our mothership is located in Wausau, but we also have satellite outreach clinics that go as far north as Rhinelander, Wisconsin, which is a stone's throw from the Canadian border, more or less. And so we cover a large, large territory. And thus, our referral network is also just as big.

And so oftentimes, one of the biggest delays to care is time to travel and distance for patients. But when we add to that the recent complexities of step therapy and prior authorizations, I think the big bugaboo that a lot of us face, no matter where in the country we're located, is getting authorization even for that very first anti-VEGF injection prior to the patient ever setting foot through our clinic doors.

And so we have a few different strategies that we've tried to employ in our practice to try and mitigate some of that risk to make sure patients get timely therapy. And one of those strategies are obtaining authorization for a diagnosis before the patient ever is seen at our practice. And that's something that can be hit or miss at some times. And I know Damion can do a good job at talking us through how we do it in our practice to identify these patients and make sure we get them plugged in appropriately. So, Damion, I'll actually turn it over to you to help kind of shed some light on how we do things at the Eye Clinic Wisconsin.

Mr. Pfaff:
Yeah, of course. So I know for when we start seeing the referral notes through all of our other optometrists within our large network, like Dr. Sambhara was mentioning, that we review these referral notes and we usually get a pretty good sense of the diagnosis that we need to treat further with our patients.

However, sometimes those challenges arise with prior authorizations, insurance coverages, even like the simple travel mechanisms that I think there are satellites can kind of help out with to reach us. But when we review those diagnoses and start getting the ball rolling, being like, okay, which injections can be utilized to treat these patients as soon as possible, sometimes requires a bit more extra work and we have to actually contact these offices and kind of dig more information regarding, okay, what area of the eye is most affected? Is there any further diagnoses that could help with further treatment, just to help with Dr. Sambhara or any other providers to expedite their treatment as soon as possible.

Dr. Eichenbaum:
So we're in a different geography. Pam, what do you think is the biggest barrier to our patients initiating treatment when they first come into our offices? Just so the audience knows where we're at, we're in coastal Florida. Our practice is over 50 years old. We've expanded from four locations when I joined in 2007 to 7 locations now, covering 3 counties of about 3 million people in the catchment area. There are a lot of retina specialists where we're at. We have about 25 to 30 practicing within those three counties at all times in Tampa Bay. And our offices span probably about an hour and a half total drive time from tip to tip, which translates to about probably 55 or 60 miles from tip to tip. So a smaller geographic area than where you guys are, Damion and Deepak, but a much denser area.

And that poses different problems, right, Pam?

Ms. Pautler:
Yeah. Honestly, we don't try to get authorizations prior to seeing a patient. Once the doctor meets with the patient and educates the patient on what the disease is and what the options are in terms of treatment, if a treatment is needed right away, between the technician and our clinic coordinators who get authorizations, we're pretty savvy about getting authorization same day. It's very rare for us not to be able to treat same day. And if we need to, obviously there's the option of a sample.

Most of our patients live fairly close and because of the location of all our offices geographically, it's usually not difficult for a patient to come back in if necessary, or if they need to make a decision about the financial responsibilities of one drug over another, that type of thing

Dr. Eichenbaum:
It mirrors exactly what I see from the clinical side. We don't delay treatment because of the absence of authorization.

Instead, we lean on bevacizumab, we lean on samples. Many of our patients in our geography have commercial insurance or a Medicare Advantage plan, which mandates a step at it in 100% of the plans that we participate with today. We still fortunately, have patients who have open access with original Medicare and a supplement or self-pay or the rarer open access plan. But we have the ability to do the prior authorization when it's required, usually after the patient is seen. And we don't typically participate in plans that require things like prior authorizations for every single code. Like, if we see a patient and they need treatment, we don't have to get a prior authorization for then an OCT and a prior authorization for an injection. We don't have too many plans like that. And I think, Pam, when we do have plans like that, we already have those prior authorizations to do a complete assessment.

Ms. Pautler:
We do. We get a referral from the primary care doctor if it's necessary for the evaluation, the testing, that type of thing. Once that's received, it's real easy to go to the insurance company, usually electronically, sometimes by fax to get an authorization. I rarely get denied for an authorization for a drug. So if we're following the clinical policies of the particular insurance carrier, we're in good shape.

The one thing that Damion's good at, that our staff's good at, are identifying which ones need to get approval versus which ones give us a little bit more latitude or free reign. One thing that we have employed the last couple of years is kind of a cheat sheet.

So it basically has the 15 most common payers in our region, and we have diagnoses, the common ones, so neovascular AMD, the age 35, 32, whatevers, as well as diabetic macular edema and retinal vein occlusion. We have like a red light, yellow light, green light type Excel spreadsheet. So it makes it easy for a medical assistant or a technician when looking at a patient's policy to refer to that manual, which we try and keep up to date once a year, to know, okay, this patient has X diagnosis, I'm good for Y drug, or no, do not pass go. Make sure that we call or at least talk to our billing department to try and figure out if we need to take any additional measures.

Dr. Eichenbaum:
Let me ask one more question for you, Damion and Deepak. Do you guys deal with capitation in your market? Is that something that you accept in your practice or is that something you exclude? Because we do not participate in capitated plans and I'd love to hear a perspective from you if you do.

Dr. Sambhara:
We typically don't have capitated plans in our region right now. And everything is in flux. I think that based on how we negotiate our contracts, we're actually part of a larger hospital network that negotiates payer contracts on our behalf in addition to many other private practices. So we are in, as far as a payer standpoint goes, part of a larger network. And so the ball goes which way they decide to let it travel, right? So right now we're not in capitated plans, but certainly that can change depending on that network's future goals.

Dr. Eichenbaum:
And you don't want to ever use a dose of an expensive drug that is potentially uncovered. You need to have 100% covered doses and authorized doses to make the buy and build drug business work. So would you agree, Pam, that our best practices include when in doubt, use a sample or use an avastin?

Ms. Pautler:
Yeah, I would say that's the case. And a lot of times, a patient will come in with a new insurance that we had no knowledge of and when that happens, we kind of have to put the brakes on and kind of assess the situation. But it's not uncommon to go back to avastin if necessary, and hope the patient stays stable. And if not, then we move forward after that.

Dr. Eichenbaum:
And the cheat sheet that you guys mentioned is a great idea, but in our experience, in our market, I think the plans change more often than annually. They change quarterly almost, sometimes. How do you guys deal with that type of change in course?

Dr. Sambhara:
It's a great point. I think we have to update it ad hoc. And a lot of times, what we do is we lean on our industry partners. So the territory business manager for certain drug companies from which we're utilizing their medicines, we're able to be in constant communication with them because they almost know our region better than we know it ourselves based on other retina offices, regionally, that have maybe had issues or not had issues.

I know it's shifting gears a little bit, but I think it's appropriate for the conversation.

Damion can tell you about not having the Good Days Foundation funding and how much of a strain that's created for us. And I'm curious to see what strategies you guys employed when you had to go through transitioning patients who previously never had to pay a dime for their branded therapies, who now potentially were on the hook for hundreds of dollars per treatment or having to be faced with the uncomfortable decision of maybe switching to a non-branded agent like bevacizumab. And as a kind of secondary question to that, how are you guys looking at it going forward now in 2026?

Dr. Eichenbaum:
So I'll let Pam address what we did because it's harder for everyone, definitely most hard for our patients who have their access restricted because of budgetary concerns. But I think our practice navigated that well. Pam, can you talk about what we did when we had the Good Days funding essentially evaporate in late 2024?

Ms. Pautler:
Yeah, it was really a matter of just educating the patients. I think a lot of them just kind of took it for granted that they didn't have a co-insurance anymore. And that was going to be available to them, which was unfortunate. So a lot of it was a re-education and explaining to them what their insurance was and what their options were. We actually produced patient handouts in the waiting room, letting them know that they don't have to be on a Medicare managed plan, that there were things called Medicare with a supplement, trying to encourage patients to stay in networks if they're going to switch to a different plan. Really understand during open enrollment what their options were.

A number of patients just said, no problem, I'll pay the co-insurance. The ones that really financially couldn't do it, we did switch to avastin, I believe. And if they stayed stable, wonderful. If not, it really was a decision of the patient to get into a different drug and have to pay for it.

Dr. Eichenbaum:
Yeah. And it also, unfortunately, and you have the same unique option that we do. We have clinical trials available for patients with active exudative macular degeneration or diabetic macular edema that doesn't respond well to bevacizumab. So a lot of those patients who couldn't afford the branded drug did elect to come into a clinical trial.

Dr. Sambhara:
It's a great point. I think the last several years, losing chronic disease funding has happened, but we've always seen a rebound by January. And I think this past January was the first time we didn't actually see that happen. It was always closed for new enrollees at the end of the year, but Jan one, all is right with the world, right? And I remember January this year when we were just like, holy smokes, something's wrong, put the bat signal out. Like, we got to figure out what to do.

And so I think we adopted a very similar strategy. So we came out with patient-centric and patient-facing information we give at the time of check-in.

And I will say that probably many of our patients ended up switching to bevacizumab. And to your point, Dave, it was actually a very big opportunity to get patients more involved in clinical trials, and so I think that was the other kind of the silver lining that could have existed, or that existed, because of Good Day's funding is that we got more people excited about participating in clinical research where the standard of care is typically aflibercept.

I've got a question for you guys. So you guys see a lot of treatment naive patients, as do we. There's oftentimes a little apprehension from patients about the prospects of getting a needle in the eye. And when it comes to follow-up, right, it's one thing we've been talking about, getting patients in the door, trying to make sure we get them treated in a timely fashion. But when the moment comes to stick a needle in somebody's eye and get an injection and then talk about the prospects of this being potentially a chronic procedure that they will have to endure, how do you guys kind of deal with that? Are there things that you guys do to make it a little bit easier?

I know in Florida, probably everybody and their neighbor gets injections, so maybe there's a acquiescence by community. People just feel better because they know others who have the same things done. But are there any things that you guys see with any specific populations of patients or people that might still struggle with the idea of getting serial anti-VEGF therapy.

Dr. Eichencaum:
So you bring up a good question. The question is, how do we get patients to adhere to what's likely a lifelong therapy, if it's neovascular macular degeneration or a long course of therapy, at least if it's diabetic macular edema? Well, I can speak to that clinically, and then Pam and Damion can speak to how it works from the front office all the way through the back office with the technical staff. But clinically, I do two things that I think my patients say are unique. Number one is, I focus on comfortable injections. And I know everyone says that, but we do things a little bit differently. We use lidocaine pledgets, which patients love. They require a little bit of production every day in the morning with 4% lidocaine and gentamicin, and we put them in the inferior fornix of patients who are expected to get injections to make them numb. I don't use a lid speculum. I believe that lid speculums and Betadine get the fornices extremely irritated. And I use a very unique 33-gauge needle for all drugs except for pegcetacoplan, because of its viscosity that comes from a vendor called OcuJect. It's a steri-cap needle with a sheathed tip on a spring, and it's a steeply beveled 33-gauge needle. The only needle I know of that's produced exclusively for intravitreal injections. And I have no financial interest in OcuJect or the needles. I just like them as a product. I have no disclosures regarding that product. And I think that the focus on comfortable injections is important.

And the second thing we do is, in most of our clinics, most of our doctors don't dilate the patients every time. We dilate them periodically. And I think a dilation and a speculum and a couple of proparacaine drops and a big honking 30-guage needle is what most patients get. And I think most patients who get something more patient-centric and comfortable are more likely to come back because it's less unpleasant than other injections they would have had or what they anticipate the injection would be like.

Pam, what do we do outside the clinical considerations or with the patient flow and with the staff to encourage adherence?

Ms. Pautler:
I really feel like our technicians do a really good job with educating the patients and making them feel comfortable and being available to answer questions that they call back in later with a concern. The patients that don't come in or a no-show, we follow up with immediately with a phone call. Usually, a technician speaks to the patient, again, directly, trying to help them understand the importance of the treatment and being timely in the treatment. And a lot of times it may just be a conflict with transportation or they have other medical conditions that are preventing them to come in timely, but rarely is it because they were uncomfortable.

And most often they want to keep that vision stable and they notice a change in their vision, they'll come back.

Dr. Eichenbaum:
And Pam says a very important thing, a profound thing. Our offices do not have automated menus when people call in. People call in any of our seven locations and a human picks up the phone and can transfer the patient to a technician who's another human. We have zero dial 1 for this, dial 2 for that, dial 3 for that. Yeah, it costs more, right? The operations are more expensive than having a call center or an automated call menu, but it works very well from a patient-centric perspective. And the patients love the staff. The patients ask for specific technicians. Every single day I get a patient asking after a certain technician. They're probably like, oh geez, I wish they were more like Damion back in Wisconsin or something like that. But truly, Pam makes a great profound point. The staff is available, the staff is very human, and the staff does a great job making the patients. And I deeply appreciate that about our practice.

Damion, what about your strategies for adherence? What does the staff at ECW do?

Mr. Pfaff:
So much like Pam mentioned, the callback situation, having our fellow technicians – I'm a technician myself, that's my primary role, but I help out where I can otherwise. But yeah, very similar to what Pam said. We try to get back as soon as possible if an appointment was no-showed or if a patient, let's say even can't find a ride because they're relying on other family members to bring them to their appointments. We usually develop strategies then to help them be seen at another satellite potentially, or if there's even a different spot that would be normally reserved on the doctor's schedule for let's say referral, and we have that opening tomorrow and be like, hey, listen, let's just use this for them as soon as possible. Bring them in, so that at least they can still get their treatment in a timely manner.

On top of that, though, too, I'm actually very impressed with the system that we adopted, I would say within the past year. But we actually have an online portal system that our patients can access. And let's say, if they're reviewing their personal chart information and they have further questions from Dr. Sambhara's visit, they can type in these questions directly to our technician line. The technicians pull it up, see their question, and we can respond back either via phone call if the patient requested it, or via back that chat as well, and

try to explain as much as possible any questions, concerns, or things that we need to change to help them with further treatment.

Dr. Eichenbaum:
Damion, does that become part of the medical record seamlessly?

Mr. Pfaff:
I haven't seen any troubles or glitches, I guess you can say, with the system.

Dr. Sambhara:
But I think one of the other things that you hit on, Dave, about just adherence has to do with comfort, right? And so one thing that I've adopted in my practice recently, about 6 months ago, was transitioning away from Betadine to the use of chlorhexidine.

Dr. Eichenbaum:
Chlorhexidine, yeah.

Dr. Sambhara:
And so using 0.05% chlorhexidine has been a game changer in my practice. It's probably cut down callbacks in my own clinic by 40% to 50%. And the rates and safety for endophthalmitis, at least from publishable data sets that have been most recently presented at ASRS and AAO, are just on par with povidone iodine.

Now, what I'll tell you is that financially, it might be a little more expensive to use chlorhexidine, which we get under the brand name Irrisept, and we bottle it ourselves in little droppers that we get off of Amazon. But what I'll tell you is, the money lost on the front end of spending on chlorhexidine is certainly saved on the back end when it comes to callbacks, patient discomfort issues, and also first-time anxiety.

A lot of patients have anxiety about the fear of the unknown when the injection is done. Many times, that's not the worst part in our practice. It's the day of and the day after, that recovery period. And since transitioning to chlorhexidine, that recovery period is significantly less. I've had patients tell me that they now actually plan to do things the day of their injection where it was almost inconceivable prior to using chlorhexidine. And so that just makes me feel better about it.

I think just having a tiered approach as well with people like Damion, who are rock stars in our clinic who are calling patients back, educating them. Yes, that little red spot on the white of your eye is normal, it happens. Don't freak out about it. Or those little bubbles, they're floaters. You're ok. I think having patients talk to people who are just easy to talk to, like Damion, really goes a long way in creating this culture of adherence that brings them back for their subsequent appointments.

Dr. Eichenbaum:
So, Deepak, one of the most significant things I've seen in the last 18 years I've been in practice is the increased sophistication of medical optometry. Most of our referring optometrists use OCT. Almost all of them have wide field color fundus photography. And I'd say that a good deal of our medical retina problems, sometimes even medical retina diagnoses, are first detected by medical optometry. Oftentimes, we get a referral for abnormal macula, please eval, or abnormal OCT, and sometimes it's as specific as branch retinal vein occlusion, please eval.

What have you seen change in your area in the last several years with optometry and how they've worked into the landscape of retinal care?

Dr. Sambhara:

I think it's only been a boon. I think that the modern retina clinic is so reliant on multimodal imaging, which has been ubiquitously adopted by the optometric community, which has only helped to get patients into retina physician chairs sooner and with more prompt and timely treatment.

We are the benefactors of employing eight optometrists are in our own practice. And so we're also a physician-owned group, but we employ optometrists, which is awesome because we can look at the same images, we share the same medical record, and it creates a

level of collegiality that we may not otherwise have.

But that being said, even with our external providers, our external referral sources and optometrists that practice in other parts of North Central and Central Wisconsin, the sophistication of their imaging is such that they can now send over OCTs or wide field photos. They can text me. I have a rule of thumb. If I'm going to practice in your neck of the woods, you're going to have my phone number because if there's something that you are unsure of, I want to be your guy to answer that question. And so it's not uncommon for me to get two or three text messages a day with an OCT or a fundus photo asking what's next or what we should do. And I'm always happy to be curbsided.

I also look at it from the standpoint that the OD is also kind of the front line, right, when it comes to patient care and follow-up, because many times I'm meeting a patient in the context of a very busy clinic, and at most, they might have 5 or 10 minutes with me, even a brand new referral patient. And it sometimes can be very disconcerting to know that I'm having to stick a needle in an eye or do some sort of invasive procedure. And I really rely on the partnership with our internal and external optometry partners to try and help create a level of compliance because those are relationships that they have built and nurtured over years through annual eye exams or semi-annual exams. So that level of trust is something that I can never get to off the bat on an initial referral, but it's something I aspire to get, and that's trust that I gain over time. But it's not without having good collaboration with our optometrist partners.

What about you guys? What are you guys doing in Tampa?

Dr. Eichenbaum:
Yeah, we always ensure that the optometrist has a front and center role in the patient's care. As a retina-only practice, we're kind of a safe space for our optometric community, I think, because they know they're going to get the patients back in their chair for refraction, for cataract checks, for dry eye management, if they manage glaucoma, for managing glaucoma. The optometrists, I think, preferentially seek out our services for posterior segment problems because they know that we don't have a dispensary, we have no interest in a dispensary, so we foster these strong referral relationships and we ensure that optometry continues to have a significant role in the patient's care for all the things that we're not doing in the scope of retina and the things that we don't want to do, regarding comprehensive eye care, as retina specialists.

Pam, what have you seen in the last 30+ years in Tampa Bay for the role of optometry and retinal care?

Ms. Pautler:
We definitely have developed a relationship, and it's not just that with our physician, but with the offices and our front desk. I mean, they know our front desk by first name. They have a relationship with our front desk when they're scheduling appointments. They obviously get the clinical notes back from our physicians, so the optometrists feel like they're aware of what's going on, that they were successful in diagnosing or sending a patient over to be treated, which is huge.

Dr. Eichenbaum, you need to touch on the CME work that you do with the outcomes of the local community.

Dr. Eichenbaum:
That's right. We do a lot of CME. We do our own practice-sponsored CME annually, which is a kind of a large event in two of our three counties. We have a big event in a large restaurant. And of course, all of this is something we provide as a community service. And then, at least once a quarter, often more, we do satellite CMEs, often in conjunction with education about our clinical trial program.

So, Pam, thank you for reminding me to bring that up. But we do provide a, I would say, essentially a complete posterior segment curriculum, which has COPE credit for optometry. And that's something that we take a lot of pride in, and we think certainly builds our referral relationships.

Damion, how about you? What do you see with your ECW relationship with optometry in Wisconsin?

Dr. Sambhara:
And before Damion answers, I'll preface, because I feel like you have a very unique perspective, Damion, because you came from a optometric referral practice to our practice, so you've been on both sides of the coin. So I'm actually curious to hear what your experience has been like prior to and then joining ECOW and kind of seeing what that relationship looks like now.

Mr. Pfaff:
Yeah, certainly. So I do remember when I was working in the optometry field more, there was moments where we could experience firsthand, I guess, seeing how the Eye Clinic Wisconsin operated. What each department, mainly retina, how the starting position of seeing one of our optometrists.

We would send them over to Eye Clinic Wisconsin to see one of the medical doctors for a certain treatment. And then, depending on what needed to happen, maybe they would either come back to the optometry clinic and then we would have all the information from Eye Clinic Wisconsin stating, okay, this is what we're treating them for, this is the next steps for their care, but continue to see them, especially if let's say, the patient's place of residence was in closer proximity to the optometry clinic. Okay, we can still continue to make sure everything was going normally with OCT.

I think we even did fundus photography very commonly, as well. And if anything arised where they need to go back to the Eye Clinic Wisconsin for emergency treatment, a certain surgery, or anything like that, there was a good relationship even at that time in my earlier years, that we could rely on the Eye Clinic Wisconsin at that time.

Then nowadays, now being part of the Eye Clinic of Wisconsin directly, I know Dr. Sambhara is a very good teacher with a lot of our optometrists. Probably not to the same degree as your program that you guys have down in Tampa, but I know for a fact that we have little meetings with , I know for a while in 2024, Dr. Sambhara would discuss upcoming research programs to a number of our optometrists in the area, future care for injections and other facets that could be utilized by our optometrists to better care for the patients across the state.

Dr. Eichenbaum:
Well, thank you everyone for your comments on optometry. We value our optometric partners. And as I say in our CE meetings, we wouldn't be where we are without the trust of our primary eye care community, so we're grateful for all of the partnership we have. And I'm sure the folks at ECOW are as well.

So this has been a great conversation, guys. What I'd like to do, we have a lot of folks in our audience who are new to practice or going into practice or thinking of opening their own practices, which I applaud. I'm always proud of our new doctors joining groups, or our entrepreneurial doctors opening their own shops. What is one pearl that each of you would give a doctor who's inexperienced in using branded anti-angiogenic drugs and believe that a patient would benefit from any branded drug for the best clinical outcome? For managing that drug, initiating the drug, and keeping a patient adherent. One thing that you think is most important.

I'll start since I'm generating the question. I think the most important thing, if I was hanging a shingle or joining a practice and wanted to make my partners happy, is don't use doses that will not get paid for. When in doubt, use a sample. That's the one pearl that I would give any new doctor. When in doubt, sample it or use an avastin and get to the branded drug next time, or back to the branded drug next time.

Pam, what pearl would you give a doctor coming out who knows nothing about managing or getting reimbursement for branded drugs?

Ms. Pautler:
Yeah. I mean, have a system where you're tracking every line item, every drug you're getting. Make sure you're getting full reimbursement on those drugs and fight for every dollar. I mean, it's not uncommon to wait up to near 9 months sometimes to get a secondary insurance company to pay and you fight for it. You send medical records, you do whatever it takes, but you have to track every drug. Because if you don't, you lose money. You can't afford to lose money. And it's very frustrating.

Initially, we used an Excel spreadsheet and we've moved on to a higher-level inventory management system. But even a simple Excel spreadsheet is sufficient. And having someone really monitoring that on a monthly basis, a weekly basis, making sure everything's getting paid, that's huge.

Dr. Eichenbaum:
Excellent. Thank you. Thank you for doing that for us for all these years, Pam. It's been a pleasure.

Damion?

Mr. Pfaff:
I guess the best piece of advice I would give, honestly, is just not only just educating your patient on what you're doing to help the treatment, but also kind of your staff as well, your technicians, your medical assistants, your scribes. Let's say if a patient has a question mid-exam, before you've seen one of our doctors too, that way they know that they don't get struck down by any sort of stammering or uncertainty. Because if there's uncertainty within the clinic, then there'll be uncertainty with the patient. So having a good knowledge base across the entire staff, including the providers, I think is vital just to ensure that everyone is on the same page and everyone's doing what they can.

Dr. Eichenbaum:
Thank you, Damion.

Deepak, close this out. Give us the best pearl.

Dr. Sambhara:
Yeah, I think you guys all said great things. The one thing I'll add is, do a benefits investigation if you're unsure. I think that covers your butt at some level with most of these branded agents. So if in doubt, do the BI, submit it, and at least the industry partners that we have that make these medicines, as long as you have documentation of that, will cover you if something goes awry.

I think it's so incredibly difficult to hang up your own shingle right now because of how convoluted some of these rules have become, and so staying on top of payer policies is just as important as knowing what medicine is most beneficial for a patient.

Dr. Eichenbaum:
Well, thank you, everyone. This has been a fantastic conversation. It's all the time we have for now, and I want to thank everyone for listening in. Thank you, Deepak, for coming on. Pam, I appreciate you joining me later in the evening on this festive week. And Damion, thanks for standing in. This has been an educational panel.

I personally always learn by hearing these conversations, and I hope our audience has as well. I look forward to working with all of you in the near future. And Pam, that means tomorrow for us.

Good night.

Dr. Sambhara:
Hey, thanks for having us.z

Ms. Pautler:
Goodnight.