Small Practice Survival Guide

Top Challenge: Reimbursement
Insurance and Financial Planning
Making Tech Dollars Count
The Right Staff
Expense Management

Go Green! Doctor's Digest Free E-Subscription and Newsletter Now Available! See page 45.
LIPITOR 80 mg* provided significant reductions in the rate of CV events over and above LIPITOR 10 mg

41% risk reduction† in hospitalization for CHF in patients with CHD and prior CHF (P=0.008)

In a prespecified end point of TNT (N=10,001; P=0.01), LIPITOR 80 mg provided an overall 26% reduction in the risk of hospitalization for CHF. The data cited above were based on a pooled meta-analysis of patients with prior CHF (P=0.01).†

Based on this significant reduction, LIPITOR is the only statin indicated to reduce the risk of hospitalization for CHF.

Now that’s proof you will love—proof you won’t find with Crestor® or Vytorin®.

First choice for second chances.

LIPITOR® atorvastatin calcium tablets

LIPITOR is indicated to reduce the risk of myocardial infarction (MI), revascularization procedures, angina, and stroke in adult patients with multiple risk factors but without clinically evident coronary heart disease (CHD); to reduce the risk of MI and stroke in patients with type 2 diabetes and without clinically evident CHD, but with multiple risk factors; to reduce the risk of nonfatal MI, fatal and nonfatal stroke, revascularization procedures, hospitalization for congestive heart failure, and angina in adult patients with clinically evident CHD.

LIPITOR, as an adjunct to diet, is also indicated to reduce elevated total-C, LDL-C, apo B, and TG levels; and to increase HDL-C in patients with primary hypercholesterolemia (heterozygous familial and nonfamilial) and mixed dyslipidemias.

LIPITOR is contraindicated in patients with active liver disease or unexplained persistent elevations of serum transaminases. In women who are or may become pregnant or who are nursing; in patients with hypersensitivity to any component of this medication.

Rare cases of rhabdomyolysis have been reported with LIPITOR and other statins. With any statin, tell patients to promptly report muscle pain, tenderness, or weakness. Discontinue drug if myopathy is suspected, if creatine phosphokinase (CPK) levels rise markedly, or if the patient has risk factors for rhabdomyolysis.

Due to increased risk of myopathy seen with LIPITOR and other statins, physicians should carefully consider combined therapy with fibric acid derivatives, ezetimibe, immunosuppressive drugs, azole antifungals, or niacin and carefully monitor patients for signs or symptoms of myopathy early during therapy and when titrating dose of either drug.

It is recommended that liver function tests be performed prior to and after 12 weeks following both the initiation of therapy and any elevation of dose, and periodically thereafter. If ALT or AST values >3 x ULN persist, dose reduction or withdrawal is recommended.

In a post hoc analysis of the SPARCL study in 4731 patients without CHD who had a stroke or TIA within the preceding 5 years, a higher incidence of hemorrhagic stroke was seen in the LIPITOR 80-mg group compared with placebo. Patients with hemorrhagic stroke on study entry appeared to be at increased risk of hemorrhagic stroke.

In clinical trials, the most common adverse events were constipation, flatulence, dyspepsia, and abdominal pain.

In TNT, LIPITOR 80 mg provided a 22% reduction vs LIPITOR 10 mg in risk of the primary end point: major CV events (P<0.001). TNT (N=10,001) assessed the efficacy and safety of lowering LDL-C <100 mg/dL in CHD patients with LDL-C >120 mg/dL who were randomized to receive either LIPITOR 80 mg or LIPITOR 10 mg.2

CHF = congestive heart failure.

LIPITOR 80 mg is not a starting dose.

¶Relative risk reduction.

Crestor (rosuvastatin calcium) is a registered trademark of the Astellas group of companies. Vytorin (ezetimibe/simvastatin) is a registered trademark of Merck Sharp & Dohme Canada ULC.


Please see brief summary of prescribing information on adjacent page.
<table>
<thead>
<tr>
<th>ADVERSE EVENTS</th>
<th>Placebo</th>
<th>Atevorstatin 10 mg</th>
<th>Atevorstatin 20 mg</th>
<th>Atevorstatin 40 mg</th>
<th>Atevorstatin 60 mg</th>
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<tr>
<td>Place</td>
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<td>N = 863</td>
<td>N = 26</td>
<td>N = 73</td>
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**BODEY AS A WHOLE**

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<tr>
<th>Event</th>
<th>Placebo</th>
<th>Atevorstatin 10 mg</th>
<th>Atevorstatin 20 mg</th>
<th>Atevorstatin 40 mg</th>
<th>Atevorstatin 60 mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injection</td>
<td>10.0</td>
<td>10.3</td>
<td>2.4</td>
<td>2.6</td>
<td>1.1</td>
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<tr>
<td>Headache</td>
<td>6.0</td>
<td>5.5</td>
<td>4.7</td>
<td>1.7</td>
<td>5.5</td>
</tr>
<tr>
<td>Accidental Injury</td>
<td>3.7</td>
<td>4.0</td>
<td>2.2</td>
<td>1.2</td>
<td>3.2</td>
</tr>
<tr>
<td>Ru Syndrome</td>
<td>1.0</td>
<td>2.2</td>
<td>0.0</td>
<td>0.0</td>
<td>2.2</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>0.5</td>
<td>1.0</td>
<td>0.0</td>
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<tr>
<td>Back Pain</td>
<td>3.0</td>
<td>2.8</td>
<td>0.0</td>
<td>3.8</td>
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<tr>
<td>Allergic Reaction</td>
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<td>2.0</td>
<td>0.0</td>
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<tr>
<td>Asthma</td>
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<td>0.0</td>
<td>3.0</td>
<td>0.0</td>
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**DIGESTIVE SYSTEM**

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<tr>
<th>Event</th>
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<th>Atevorstatin 10 mg</th>
<th>Atevorstatin 20 mg</th>
<th>Atevorstatin 40 mg</th>
<th>Atevorstatin 60 mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constipation</td>
<td>1.8</td>
<td>2.1</td>
<td>0.0</td>
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<tr>
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<td>5.3</td>
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<tr>
<td>Flatulence</td>
<td>4.1</td>
<td>2.3</td>
<td>2.8</td>
<td>1.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>5.6</td>
<td>2.1</td>
<td>0.0</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>2.6</td>
<td>2.8</td>
<td>0.0</td>
<td>2.5</td>
<td>6.4</td>
</tr>
<tr>
<td>Pharyngitis</td>
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<td>2.5</td>
<td>0.0</td>
<td>2.5</td>
<td>3.1</td>
</tr>
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</table>

**SKIN AND APPENDAGES**

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<th>Event</th>
<th>Placebo</th>
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<th>Atevorstatin 20 mg</th>
<th>Atevorstatin 40 mg</th>
<th>Atevorstatin 60 mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin Irritants</td>
<td>0.7</td>
<td>0.0</td>
<td>2.8</td>
<td>3.8</td>
<td>1.1</td>
</tr>
</tbody>
</table>

**MUSCULOSKELETAL SYSTEM**

<table>
<thead>
<tr>
<th>Event</th>
<th>Placebo</th>
<th>Atevorstatin 10 mg</th>
<th>Atevorstatin 20 mg</th>
<th>Atevorstatin 40 mg</th>
<th>Atevorstatin 60 mg</th>
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</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>1.5</td>
<td>2.0</td>
<td>0.0</td>
<td>5.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Myalgia</td>
<td>1.1</td>
<td>2.2</td>
<td>5.6</td>
<td>1.2</td>
<td>0.0</td>
</tr>
</tbody>
</table>

**Angle-Scandinavian Cardiac Outcomes Trial (ASCOT)*** — In ASCOT (see CLINICAL PHARMACODYNAMIC, Clinical Studies in full prescribing information) involving 10,320 patients treated with LIPTOR 10 mg daily (n=5,160) or placebo (n=5,160), the safety and tolerability profile of the group treated with LIPTOR was comparable to that of the placebo group treated with a median of 2.3 years of follow-up.

**Collaborative Atevorstatin Diabetes Study (CARDIS)** — In CARDIS (see CLINICAL PHARMACODYNAMIC, Clinical Studies in full prescribing information) involving 2538 subjects with type 2 diabetes treated with LIPTOR 10 mg (n=1265) or placebo (n=1273), there was no difference in the overall frequency of adverse events of serious adverse events between the treatment groups during a median follow-up of 3.9 years. No cases of rhabdomyolysis were reported.

**Treated to New Targets Study (TNT)*** — In TNT (see CLINICAL PHARMACODYNAMIC, Clinical Studies in full prescribing information) involving 10,001 subjects with a clinically evident CHD treated with LIPTOR 10 mg daily (n=5006) or LIPTOR 80 mg daily (n=4995), there were more adverse events and discontinuations due to adverse events in the high-dose atorvastatin group (19.3%, 497, 9.9, respectively) as compared to the low-dose group (8.1, 4.4, 0.7, respectively). In a median follow-up of 4.9 years, Persistent transaminase elevations (≥ 3 x UNL twice within 4-10 days) occurred in 12 (1.3%) individuals with atorvastatin 80 mg and in nine (0.9%) individuals with atorvastatin 10 mg. Elevations of CK (≥ 10 x UNL) were low overall, but were higher in the high-dose atorvastatin treatment group (13.0, 3.5% compared to the low-dose atorvastatin group 6.1%.

**International Decrease in Endpoints Through Aggressive Lipid Lowering (IDEAL)** — In IDEAL (see CLINICAL PHARMACODYNAMIC, Clinical Studies in full prescribing information) involving 8,888 subjects treated with LIPTOR 80 mg daily (n=4439) or simvastatin 20-40 mg daily (n=4449), there was no difference in the overall frequency of adverse events or serious adverse events between the treatment groups during a median follow-up of 4.8 years.

The following adverse events were reported, regardless of causality assessment: in patients treated with atorvastatin in clinical trials. The events in italics occurred in ≤2% of patients and the events in plain type occurred in <2% of patients.

**Body as a Whole: Chest pain, fever, cough, upper respiratory infection, malaise, dyspepsia.**

**Digestive System: Nausea, abdominal pain, diarrhea, constipation, vomiting, pyrosis.**

**Musculoskeletal System: Arthritis, myalgia, back pain.**

Please see full prescribing information for additional information about LIPTOR.
DOCTOR'S DIGEST

Small Practice Survival Guide

By Laura Gater
Laura Gater’s medical and business articles have been published in various publications, including *Strategic Healthcare Marketing*, *24x7*, and *The American Journal of Managed Care*, as well as medical and business websites. She is based in Columbia City, Ind.
So, Jeannette, what’s new?”

Those who know me well know there is always something new with me! This month, there have been three major developments with *Doctor’s Digest*:

- **Our new podcast series on** [www.doctorsdigest.net](http://www.doctorsdigest.net) **gives you the facts fast on your favorite practice management topics. Check out our five-minute podcasts by going to [www.doctorsdigest.net](http://www.doctorsdigest.net) and clicking on “Podcasts.”**

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What’s driving physicians out of smaller practices? Reimbursement patterns are a major factor, especially for primary care physicians. Financial incentives like pay-for-performance and other data-driven trends favor large practices with more resources to dedicate to information technology and other data collection tools. But there are ways smaller practices can survive and even thrive in this environment.

To ensure an optimal income stream, small practices should take advantage of three useful tools for reimbursement rate analysis: revenue cycle analysis, coding and compliance review, and periodic audits either by internal staff or by an outside consultant.

Claim denials slow down cash flow and, without proper follow-up, can result in lost revenue. By actively managing claim denials and fixing the problems that can lead to non-payment, practices can increase reimbursement and speed up payment.

Physicians, especially those in small practice, often try to do everything themselves. This can be their downfall; keeping up with the clinical aspects of medical practice takes enough time without adding the additional responsibilities of staying current with financial and insurance matters. In these areas, physicians should find qualified and trustworthy advisors to guide them.

Healthcare is a relatively stable industry, in that the healthcare industry is largely immune from the business cycle; but physicians need to keep up with current literature and read healthcare business magazines to see what’s happening throughout the industry.

Transition planning, or planning for a change in practice ownership, is like retirement planning in that it can also begin at the time a physician takes ownership of the business. Two considerations are how much money you will need in retirement, and how you will amass that amount of money by the time you retire.
Making Tech Dollars Count

Although initial costs for technology may be high for a small practice, technology can improve productivity and/or reduce expenses for a small or solo practice in the long run. The key is to zero in on the right hardware and software to fit the particular practice.

- **Technology can help practices manage documents more efficiently, freeing staff to work on more important matters—like patient care. That, in turn, can boost patient satisfaction.**
- **Practice management software can not only help reduce the burden on administrative staff, it can also ensure maximum production and timely, accurate reimbursement for services.**

The Right Staff

Healthcare is growing so rapidly that the supply of labor is challenged to keep up with the need for talented nurses, medical assistants, and other key medical office personnel. Knowing how to hire and retain qualified staff members is key for the long-term success of your practice.

- **Patients may have higher expectations for personal attention when they enter a more intimate setting, like a small medical office. They expect staff to know their names, help them understand insurance, and take an interest in their health and well-being.**
- **Role confusion among registered nurses, licensed practical nurses, and medical assistants can cause conflict among staff members. The best way to manage this is to give clear expectations about what part of each role will be covered during the assignment.**

Expense Management

Identifying ways to cut costs can be relatively easy, but the true test is prioritizing these cut costs in order to optimize the use of capital and maintain the practice’s focus. The number-one method of managing costs is to stay involved in the business of running a practice.

- **Practices without a budget are more vulnerable to a variety of problems, such as embezzlement, over- or under-staffing, inappropriate purchasing and inadequate savings for improvements.**
- **Physicians should also look at how their expenses compare with other similar practices—a process called “benchmarking.” Benchmarking is comparing specific indicators of the practice’s performance with an established number for similar practices.**

For More Information

To learn more about the topics in this issue, consult our list of articles, Websites, and other resources.