



# DOCTOR'S DIGEST®

Delivering In-depth

Practice Solutions

From the Experts

Jan/Feb 2010

[www.doctorsdigest.net](http://www.doctorsdigest.net)

## How to Error-proof Your Practice

The Bottom Line on Errors

Reducing Medical Errors

Addressing Billing and Staff Issues

How Technology Can Help

What to Do When Errors Occur



**NEW** iPhone/iPod Touch App!  
*PracticeRx* by *Doctor's Digest* and ISMP—  
Free in Medical Category.  
Delivering **REAL-TIME** Medication/Safety  
Alerts and Practice Management Tips.

PERMIT NO. 366  
MECHANISBURG, PA  
PAID  
U.S. POSTAGE  
PRESORTED STD



HELP SUPPORT HIS CV HEALTH  
IN A BIG WAY WITH LIPITOR

## LIPITOR PUTS THE POWER TO HELP CHANGE THE OUTCOME OF CVD IN YOUR HANDS BY REDUCING THE RISK OF MI AND STROKE

LIPITOR is the only potent statin that delivers both proven CV outcomes indications in many of your high-risk patients,\* and mean LDL-C reductions >50%. Additionally, only LIPITOR has >10 CV outcomes trials,<sup>1</sup> 6 of which have impacted lipid treatment guidelines.<sup>2-6</sup> And ask your sales representatives about the new patient support tools available.

### PRESCRIBE LIPITOR FOR THE STRENGTH PROVEN TO REDUCE THE RISK OF CV EVENTS

LIPITOR is indicated as an adjunct to diet to reduce the risk of myocardial infarction (MI), stroke, revascularization procedures, and angina 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 dyslipidemia.

#### Important Safety Information

LIPITOR is contraindicated in patients with active liver disease or unexplained persistent elevations of hepatic 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. Tell patients to promptly report muscle pain, tenderness, or weakness. Predisposing factors include advanced age ( $\geq 65$ ), uncontrolled hypothyroidism, and renal impairment. Patients with a history of renal impairment merit closer monitoring. In cases of myopathy or rhabdomyolysis, therapy should be temporarily withheld or discontinued.

The concomitant use of higher doses of LIPITOR with certain drugs such as cyclosporine and strong CYP3A4 inhibitors (eg, clarithromycin, itraconazole, and HIV protease inhibitors) increases the risk of myopathy/rhabdomyolysis. Lower doses of LIPITOR should be considered. Physicians should carefully

monitor patients for signs or symptoms of myopathy early during therapy and when titrating the dose of either drug.

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

In a post hoc analysis of the SPARCL study in patients without CHD who had a stroke or TIA within the preceding 6 months, a higher incidence of hemorrhagic stroke was seen in the LIPITOR 80-mg group compared with placebo (2.3% vs 1.4%). Some baseline characteristics, including hemorrhagic and lacunar stroke on study entry, were associated with a higher incidence of hemorrhagic stroke in the LIPITOR group.

The most commonly reported adverse reactions with LIPITOR in placebo-controlled trials were: nasopharyngitis, arthralgia, diarrhea, pain in extremity, and urinary tract infection.

References: 1. Data on file, Pfizer Inc, New York, NY. 2. Smith SC Jr, Allen J, Blair SN, et al. AHA/ACC guidelines for secondary prevention for patients with coronary and other atherosclerotic vascular disease: 2006 update: endorsed by the National Heart, Lung, and Blood Institute. *J Am Coll Cardiol*. 2006;47(10):2130-2139. 3. Adams RJ, Albers G, Alberts MJ, et al. Update to the AHA/ASA recommendations for the prevention of stroke in patients with stroke and transient ischemic attack. *Stroke*. 2008;39(5):1647-1652. 4. Grundy SM, Cleeman J, Bailey Marz CN, et al. for the Coordinating Committee of the National Cholesterol Education Program. Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidelines. *Circulation*. 2004;110(2):227-239. 5. American Diabetes Association. Standards of medical care in diabetes—2008. *Diabetes Care*. 2009;32(suppl 1):S13-S61. 6. KDIGO. KDIGO clinical practice guidelines and clinical practice recommendations for diabetes and chronic kidney disease. *Am J Kidney Dis*. 2007;49(2)(suppl 2):S1-S170.

\*Patients with type 2 diabetes and  $\geq 1$  risk factor, or CHD.

**LIPITOR®** (Atorvastatin Calcium) Tablets  
Brief Summary of Prescribing Information

**CONTRAINDICATIONS:** Active liver disease, which may include unexplained persistent elevations in hepatic transaminase levels. Hypersensitivity to any component of this medication. **Pregnancy**—Women who are pregnant or may become pregnant. LIPITOR may cause fetal harm when administered to a pregnant woman. Serum cholesterol and triglycerides increase during normal pregnancy, and cholesterol or cholesterol derivatives are essential for fetal development. Atherosclerosis is a chronic process and discontinuation of lipid-lowering drugs during pregnancy should have little impact on the outcome of long-term therapy of primary hypercholesterolemia. There are no adequate and well-controlled studies of LIPITOR use during pregnancy; however, in rare reports, congenital anomalies were observed following intrauterine exposure to statins. In rat and rabbit animal reproduction studies, atorvastatin revealed no evidence of teratogenicity. LIPITOR SHOULD BE ADMINISTERED TO WOMEN OF CHILDBEARING AGE ONLY WHEN SUCH PATIENTS ARE HIGHLY UNLIKELY TO CONCEIVE AND HAVE BEEN INFORMED OF THE POTENTIAL HAZARDS. If the patient becomes pregnant while taking this drug, LIPITOR should be discontinued immediately and the patient apprised of the potential hazard to the fetus [see *Use in Specific Populations* in full prescribing information]. **Nursing mothers**—It is not known whether atorvastatin is excreted into human milk; however, a small amount of another drug in this class does pass into breast milk. Because statins have the potential for serious adverse reactions in nursing infants, women who require LIPITOR treatment should not breastfeed their infants [see *Use in Specific Populations* in full prescribing information].

**WARNINGS AND PRECAUTIONS: Skeletal Muscle**—Rare cases of rhabdomyolysis with acute renal failure secondary to myoglobinuria have been reported with LIPITOR and with other drugs in this class. A history of renal impairment may be a risk factor for the development of rhabdomyolysis. Such patients merit closer monitoring for skeletal muscle effects. Atorvastatin, like other statins, occasionally causes myopathy, defined as muscle aches or muscle weakness in conjunction with increases in creatine phosphokinase (CPK) values >10 times ULN. The concomitant use of higher doses of atorvastatin with certain drugs such as cyclosporine and strong CYP3A4 inhibitors (e.g., clarithromycin, itraconazole, and HIV protease inhibitors) increases the risk of myopathy/rhabdomyolysis. Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of CPK. Patients should be advised to report promptly unexplained muscle pain, tenderness, or weakness, particularly if accompanied by malaise or fever. LIPITOR therapy should be discontinued if markedly elevated CPK levels occur or myopathy is diagnosed or suspected. The risk of myopathy during treatment with drugs in this class is increased with concurrent administration of cyclosporine, fibric acid derivatives, erythromycin, clarithromycin, combination of ritonavir plus saquinavir or lopinavir plus ritonavir, niacin, or azole antifungals. Physicians considering combined therapy with LIPITOR and fibric acid derivatives, erythromycin, clarithromycin, a combination of ritonavir plus saquinavir or lopinavir plus ritonavir, immunosuppressive drugs, azole antifungals, or lipid-modifying doses of niacin should carefully weigh the potential benefits and risks and should carefully monitor patients for any signs or symptoms of muscle pain, tenderness, or weakness, particularly during the initial months of therapy and during any periods of upward dosage titration of either drug. Lower starting and maintenance doses of atorvastatin should be considered when taken concomitantly with the aforementioned drugs [see *Drug Interactions* (7)]. Periodic creatine phosphokinase (CPK) determinations may be considered in such situations, but there is no assurance that such monitoring will prevent the occurrence of severe myopathy. Prescribing recommendations for interacting agents are summarized in Table 1 [see also *Dosage and Administration, Drug Interactions, Clinical Pharmacology* in full prescribing information].

**Table 1. Drug Interactions Associated with Increased Risk of Myopathy/Rhabdomyolysis**

Interacting Agents	Prescribing Recommendations
Cyclosporine	Do not exceed 10 mg atorvastatin daily
Clarithromycin, itraconazole, HIV protease inhibitors (ritonavir plus saquinavir or lopinavir plus ritonavir)	Caution when exceeding doses > 20 mg atorvastatin daily. The lowest dose necessary should be used.

LIPITOR therapy should be temporarily withheld or discontinued in any patient with an acute, serious condition suggestive of a myopathy or having a risk factor predisposing to the development of renal failure secondary to rhabdomyolysis (e.g., severe acute infection, hypotension, major surgery, trauma, severe metabolic, endocrine and electrolyte disorders, and uncontrolled seizures).

**Liver Dysfunction**—Statins, like some other lipid-lowering therapies, have been associated with biochemical abnormalities of liver function. Persistent elevations (>3 times the upper limit of normal [ULN] occurring on 2 or more occasions) in serum transaminases occurred in 0.7% of patients who received LIPITOR in clinical trials. The incidence of these abnormalities was 0.2%, 0.2%, 0.6%, and 2.3% for 10, 20, 40, and 80 mg, respectively. One patient in clinical trials developed jaundice. Increases in liver function tests (LFT) in other patients were not associated with jaundice or other clinical signs or symptoms. Upon dose reduction, drug interruption, or discontinuation, transaminase levels returned to or near pretreatment levels without sequelae. Eighteen of 30 patients with persistent LFT elevations continued treatment with a reduced dose of LIPITOR. It is recommended that liver function tests be performed prior to and at 12 weeks following both the initiation of therapy and any elevation of dose, and periodically (e.g., semiannually) thereafter. Liver enzyme changes generally occur in the first 3 months of treatment with LIPITOR. Patients who develop increased transaminase levels should be monitored until the abnormalities resolve. Should an increase in ALT or AST of >3 times ULN persist, reduction of dose or withdrawal of LIPITOR is recommended. LIPITOR should be used with caution in patients who consume substantial quantities of alcohol and/or have a history of liver disease. Active liver disease or unexplained persistent transaminase elevations are contraindications to the use of LIPITOR [see *Contraindications* in full prescribing information]. **Endocrine Function**—Statins interfere with cholesterol synthesis and theoretically might blunt adrenal and/or gonadal steroid production. Clinical studies have shown that LIPITOR does not reduce basal plasma cortisol concentration or impair adrenal reserve. The effects of statins on male fertility have not been studied in adequate numbers of patients. The effects, if any, on the pituitary-gonadal axis in premenopausal women are unknown. Caution should be exercised if a statin is administered concomitantly with drugs that may decrease the levels or activity of endogenous steroid hormones, such as ketoconazole, spiro lactone, and cimetidine. **CNS Toxicity**—Brain hemorrhage was seen in a female dog treated for 3 months at 120 mg/kg/day. Brain hemorrhage and optic nerve vacuolation were seen in another female dog that was sacrificed in moribund condition after 11 weeks of escalating doses up to 280 mg/kg/day. The 120 mg/kg/day dose resulted in a systemic exposure approximately 16 times the human plasma area-under-the-curve (AUC, 0-24 hours) based on the maximum human dose of 80 mg/day. A single tonic convulsion was seen in each of 2 male dogs (one treated at 10 mg/kg/day and one at 120 mg/kg/day) in a 2-year study. No CNS lesions have been observed in mice after chronic treatment for up to 2 years at doses up to 400 mg/kg/day or in rats at doses up to 100 mg/kg/day. These doses were 6 to 11 times (mouse) and 8 to 16 times (rat) the human AUC (0-24) based on the maximum recommended human dose of 80 mg/day. CNS vascular lesions, characterized by perivascular hemorrhages, edema, and mononuclear cell infiltration of perivascular spaces, have been observed in dogs treated with other members of this class. A chemically similar drug in this class produced optic nerve degeneration (Wallerian degeneration of retinogeniculate fibers) in clinically normal dogs in a dose-dependent fashion at a dose that produced plasma drug levels about 30 times higher than the mean drug level in humans taking the highest recommended dose. **Use in Patients with Recent Stroke or TIA**—In a post-hoc analysis of the Stroke Prevention by Aggressive Reduction in Cholesterol Levels (SPARCL) study where LIPITOR 80 mg vs. placebo was administered in 4731 subjects without CHD who had a stroke or TIA within the preceding 6 months, a higher incidence of hemorrhagic stroke was seen in the LIPITOR 80 mg group compared to placebo (55, 2.3% atorvastatin vs. 33, 1.4% placebo; HR: 1.68, 95% CI: 1.03, 2.59, p=0.0168). The incidence of fatal hemorrhagic stroke was similar across treatment groups (17 vs. 18 for the atorvastatin and placebo groups, respectively). The incidence of nonfatal hemorrhagic stroke was significantly higher in the atorvastatin group (38, 1.6%) as compared to the placebo group (16, 0.7%). Some baseline characteristics, including hemorrhagic and lacunar stroke on study entry, were associated with a higher incidence of hemorrhagic stroke in the atorvastatin group [see *Adverse Reactions* in full prescribing information].

**ADVERSE REACTIONS:** The following serious adverse reactions are discussed in greater detail in other sections of the label: Rhabdomyolysis and myopathy [see *Warnings and Precautions* in full prescribing information], liver enzyme abnormalities [see *Warnings and Precautions* in full prescribing information]. **Clinical Trial Adverse Experiences**—Because clinical trials are conducted under widely varying conditions, the adverse reaction rates observed in the clinical studies of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice. In the LIPITOR placebo-controlled clinical trial database of 16,066 patients (8755 LIPITOR vs. 7311 placebo; age range 10-83 years, 39% women, 91% Caucasians, 3% Blacks, 2% Asians, 4% other) with a median treatment duration of 53 weeks, 9.7% of patients on LIPITOR and 9.5% of the patients on placebo discontinued due to adverse reactions regardless of causality. The five most common adverse reactions in patients treated with LIPITOR that led to treatment discontinuation and occurred at a rate greater than placebo were: myalgia (0.7%), diarrhea (0.5%), nausea (0.4%), alanine aminotransferase increase (0.4%), and hepatic enzyme increase (0.4%). The most commonly reported adverse reactions (incidence ≥ 2% and greater than placebo) regardless of causality, in patients treated with LIPITOR in placebo controlled trials (n=8755) were: nasopharyngitis (6.3%), arthralgia (6.3%), diarrhea (6.3%), pain in extremity (6.0%), and urinary tract infection (5.7%). Table 2 summarizes the frequency of clinical adverse reactions, regardless of causality, reported in ≥ 2% and at a rate greater than placebo in patients treated with LIPITOR (n=8755), from seventeen placebo-controlled trials.

**Table 2. Clinical adverse reactions occurring in ≥ 2% of patients treated with any dose of LIPITOR and at an incidence greater than placebo regardless of causality (% of patients)**

Adverse Reaction*	Any dose N=8755	10 mg N=3908	20 mg N=188	40 mg N=604	80 mg N=4055	Placebo N=7311
Nasopharyngitis	8.3	12.9	5.3	7.0	4.2	8.2
Arthralgia	6.9	8.9	11.7	10.6	4.3	6.5
Diarrhea	6.8	7.3	6.4	14.1	5.2	6.3
Pain in extremity	6.0	8.5	3.7	9.3	3.1	5.9
Urinary tract infection	5.7	6.9	6.4	8.0	4.1	5.6
Dyspepsia	4.7	5.9	3.2	6.0	3.3	4.3
Nausea	4.0	3.7	3.7	7.1	3.8	3.5
Musculoskeletal pain	3.8	5.2	3.2	5.1	2.3	3.6
Muscle Spasms	3.6	4.6	4.8	5.1	2.4	3.0
Myalgia	3.5	3.6	5.9	8.4	2.7	3.1
Insomnia	3.0	2.8	1.1	5.3	2.8	2.9
Pharyngolaryngeal pain	2.3	3.9	1.6	2.8	0.7	2.1

\*Adverse Reaction ≥ 2% in any dose greater than placebo.

Other adverse reactions reported in placebo-controlled studies include: *Body as a whole*: malaise, pyrexia; *Digestive system*: abdominal discomfort, eructation, flatulence, hepatitis, cholestasis; *Musculoskeletal system*: musculoskeletal pain, muscle fatigue, neck pain, joint swelling; *Metabolic and nutritional system*: transaminases increase, liver function test abnormal, blood alkaline phosphatase increase, creatine phosphokinase increase, hyperglycemia; *Nervous system*: nightmare; *Respiratory system*: epistaxis; *Skin and appendages*: urticaria; *Special senses*: vision blurred, tinnitus; *Urogenital system*: white blood cells urine positive.

**Anglo-Scandinavian Cardiac Outcomes Trial (ASCOT)**—In ASCOT [see *Clinical Studies* in full prescribing information] involving 10,305 participants (age range 40–80 years, 19% women; 94.6% Caucasians, 2.6% Africans, 1.5% South Asians, 1.3% mixed/other) treated with LIPITOR 10 mg daily (n=5168) or placebo (n=5137), the safety and tolerability profile of the group treated with LIPITOR was comparable to that of the group treated with placebo during a median of 3.3 years of follow-up.

**Collaborative Atorvastatin Diabetes Study (CARDS)**—In CARDS [see *Clinical Studies* in full prescribing information] involving 2838 subjects (age range 39–77 years, 32% women; 94.3% Caucasians, 2.4% South Asians, 2.3% Afro-Caribbean, 1.0% other) with type 2 diabetes treated with LIPITOR 10 mg daily (n=1428) or placebo (n=1410), there was no difference in the overall frequency of adverse reactions or serious adverse reactions between the treatment groups during a median follow-up of 3.9 years. No cases of rhabdomyolysis were reported.

**Treating to New Targets Study (TNT)**—In TNT [see *Clinical Studies* in full prescribing information] involving 10,001 subjects (age range 29–78 years, 19% women; 94.1% Caucasians, 2.3% Blacks, 1.0% Asians, 2.0% other) with clinically evident CHD treated with LIPITOR 10 mg daily (n=5006) or LIPITOR 80 mg daily (n=4995), there were no serious adverse reactions and discontinuations due to adverse reactions in the high-dose atorvastatin group (92, 1.8%; 497, 9.5%, respectively) as compared to the low-dose group (69, 1.4%; 404, 8.1%, respectively) during a median follow-up of 4.9 years. Persistent transaminase elevations (≥ 3 x ULN twice within 4–10 days) occurred in 62 (1.3%) individuals with atorvastatin 80 mg and in nine (0.2%) individuals with atorvastatin 10 mg. Elevations of CK (≥ 10 x ULN) were low overall, but were higher in the high-dose atorvastatin treatment group (13, 0.3%) compared to the low-dose atorvastatin group (6, 0.1%).

**Incremental Decrease in Endpoints through Aggressive Lipid Lowering Study (IDEAL)**—In IDEAL [see *Clinical Studies* in full prescribing information] involving 8888 subjects (age range 26–80 years, 19% women; 99.3% Caucasians, 0.4% Asians, 0.3% Blacks, 0.04% other) treated with LIPITOR 80 mg/day (n=4439) or simvastatin 20–40 mg daily (n=4449), there was no difference in the overall frequency of adverse reactions or serious adverse reactions between the treatment groups during a median follow-up of 4.8 years.

**Stroke Prevention by Aggressive Reduction in Cholesterol Levels (SPARCL)**—In SPARCL involving 4731 subjects (age range 21–92 years, 40% women; 93.3% Caucasians, 3.0% Blacks, 0.6% Asians, 3.1% other) without clinically evident CHD but with a stroke or transient ischemic attack (TIA) within the previous 6 months treated with LIPITOR 80 mg (n=2365) or placebo (n=2366) for a median follow-up of 4.9 years, there was a higher incidence of persistent hepatic transaminase elevations (≥ 3 x ULN twice within 4–10 days) in the atorvastatin group (0.9%) compared to placebo (0.1%). Elevations of CK (≥ 10 x ULN) were rare, but were higher in the atorvastatin group (0.1%) compared to placebo (0.0%). Diabetes was reported as an adverse reaction in 144 subjects (6.1%) in the atorvastatin group and 89 subjects (3.8%) in the placebo group [see *Warnings and Precautions* in full prescribing information].

In a post-hoc analysis, LIPITOR 80 mg reduced the incidence of ischemic stroke (218/2365, 9.2% vs. 274/2366, 11.6%) and increased the incidence of hemorrhagic stroke (55/2365, 2.3% vs. 33/2366, 1.4%) compared to placebo. The incidence of fatal hemorrhagic stroke was similar between groups (17 LIPITOR vs. 18 placebo). The incidence of non-fatal hemorrhagic strokes was significantly greater in the atorvastatin group (38 non-fatal hemorrhagic strokes) as compared to the placebo group (16 non-fatal hemorrhagic strokes). Subjects who entered the study with a hemorrhagic stroke appeared to be at increased risk for hemorrhagic stroke [7 (16%) LIPITOR vs. 2 (4%) placebo].

There were no significant differences between the treatment groups for all-cause mortality: 216 (9.1%) in the LIPITOR 80 mg/day group vs. 211 (8.9%) in the placebo group. The proportions of subjects who experienced cardiovascular death were numerically smaller in the LIPITOR 80 mg group (3.3%) than in the placebo group (4.1%). The proportions of subjects who experienced noncardiovascular death were numerically larger in the LIPITOR 80 mg group (5.0%) than in the placebo group (4.0%).

**Postmarketing Experience**—The following adverse reactions have been identified during postapproval use of LIPITOR. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Adverse reactions associated with LIPITOR therapy reported since market introduction, that are not listed above, regardless of causality assessment, include the following: anaphylaxis, angioneurotic edema, bullous rashes (including erythema multiforme, Stevens-Johnson syndrome, and toxic epidermal necrolysis), rhabdomyolysis, fatigue, tendon rupture, hepatic failure, dizziness, memory impairment, depression, and peripheral neuropathy.

**Pediatric Patients (ages 10–17 years)**—In a 26-week controlled study in boys and postmenarcheal girls (n=140, 31% female; 92% Caucasians, 1.6% Blacks, 1.6% Asians, 4.8% other), the safety and tolerability profile of LIPITOR 10 to 20 mg daily was generally similar to that of placebo [see *Clinical Studies* in full prescribing information and *Use in Special Populations*, *Pediatric Use* in full prescribing information].

**OVERDOSAGE**: There is no specific treatment for LIPITOR overdose. In the event of an overdose, the patient should be treated symptomatically, and supportive measures instituted as required. Due to extensive drug binding to plasma proteins, hemodialysis is not expected to significantly enhance LIPITOR clearance.

Please see full prescribing information for additional information about LIPITOR.

Rx only

Distributed by:



**Parke-Davis**

Division of Pfizer Inc, NY, NY 10017

Manufactured by:  
**Pfizer Ireland Pharmaceuticals**  
Dublin, Ireland  
Rev. 7 August 2009

# DOCTOR'S DIGEST

How to Error-proof Your Practice

By Elizabeth Gardner

## ABOUT THE AUTHOR

**E**lizabeth Gardner is a Chicago-based freelance writer specializing in healthcare, science, and technology. She began her journalism career at *Modern Healthcare*, covering information technology and quality measurement. She has also contributed to *Inside Healthcare Computing*, *HealthLeaders*, *Health-IT World*, *Bio-IT World*, *Popular Science*, *New Scientist*, and *Internet World*.

### ADVISORY BOARD

Judy Aburmishan, MBA, CPA, CHBC, CMPA, Partner-in-Charge of Health Care Industry Services, FGMK, Bannockburn, Ill.

Yul D. Ejnes, MD, FACP, Coastal Medical, Inc., Cranston, R.I., Member, American College of Physicians Board of Regents, Philadelphia.

Erica S. Friedman, MD, Associate Dean for Undergraduate Medical Education, Mount Sinai School of Medicine, New York City.

John Hickner, MD, Chair, Family Medicine Department, Cleveland Clinic, Cleveland.

Russell H. Jenkins, MD, Medical Director, Institute for Safe Medication Practices, Horsham, Pa.

EDITOR Paula S. Katz

SENIOR EDITOR Frank Murphy, Ph.D.

CODING EDITOR Patricia A. Hubbard, CPC

CREATIVE DIRECTOR Gary DeFazio

PRODUCTION DIRECTOR Jane Pickering

PUBLISHER Jeannette Brandofino

MARKETING DIRECTOR Linda Zani Thomas

MARKETING MANAGER Lisa Shevrin

INTELLECTUAL PROPERTY COUNSEL Janet G. Ricciuti, Esq.

The content of *How to Error-proof Your Practice*, including such material as text, graphics, images, and other material contained in *Doctor's Digest*, is for informational purposes only. The content is not intended to be a substitute for professional advice. Always seek the advice of professionals with any question you may have. Reliance is at your own risk.

The content of *How to Error-proof Your Practice* is protected by copyright under both United States and foreign laws and under United States trademark laws. Title to the content remains with Brandofino Communications, Inc. Any use of the content not expressly authorized by Brandofino Communications, Inc., is a breach of copyright and trademark law. All rights not expressly granted are reserved to Brandofino Communications, Inc.

*Doctor's Digest* (ISSN 1554-6195), January/February 2010, Volume 6, Number 1. Published bimonthly by Brandofino Communications, Inc., 12 Spruce Park, Syosset, NY 11791. For general subscription information and paid subscriptions, e-mail: [doctorsdigest@verizon.net](mailto:doctorsdigest@verizon.net). *Doctor's Digest* is available on a paid subscription basis at the following annual rate: \$54 (foreign, \$108). Single-copy price: \$12. To order, send check or money order payment to *Doctor's Digest*, 12 Spruce Park, Syosset, NY 11791, Attn: Circulation Department (be sure to indicate title of issue, shipping address, and phone number). Visit our Website at [www.doctorsdigest.net](http://www.doctorsdigest.net). For Advertising Sales and Editorial call 516-364-2575 or e-mail [doctorsdigest@verizon.net](mailto:doctorsdigest@verizon.net). Postage paid at Mechanicsburg, PA 17055.

Copyright ©2010 and published by Brandofino Communications, Inc. All rights reserved. No part of this publication may be reproduced or transmitted in any form or by any means electronic or mechanical, including photocopy, recording, or any information-retrieval system, without permission in writing from the publisher.

*Doctor's Digest*™ and the split-diagonal, two-toned publication cover are trademarks of Brandofino Communications, Inc.

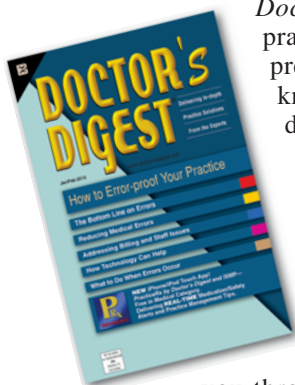
BRANDOFINO COMMUNICATIONS ■ INC.



# Dear Doctor:

In these days of more patients, more paperwork, and more technology, are your efforts to error-proof your practice working? Take a fresh look at what experts tell

*Doctor's Digest* are the keys to tightening up your practice, from developing systems and a culture that prevent mistakes from happening in the first place to knowing what to say to patients if something amiss does occur.



In this issue of *Doctor's Digest* author Elizabeth Gardner takes you beyond checklists to understanding the administrative problems that lead to medical errors and what you can do to stop them today. She tells you how to stem the loss of thousands of dollars due to billing oversights or lack of planning and why trimming your office staff isn't necessarily the answer. She walks

you through low-tech as well as high-tech options, and shows you how different practices are putting them to work.

When it comes to error-proofing your practice, I know that preventing medication errors is critical. I'm proud to announce our partnership with the Institute for Safe Medication Practices (ISMP). Via print, mobile phone, and in our Web-based offerings, *Doctor's Digest* and ISMP will be bringing you the latest practice management and patient safety tips from the experts, REAL-TIME breaking news about Medication and Hazard Alerts of national importance, and secure access to ISMP's medical error reporting form. You may also register for a free e-subscription to *Doctor's Digest-Money Matters*, our quarterly e-newsletter guide to personal finance.

If you are an iPhone user, please download our new FREE **Practice Rx by Doctor's Digest** app in the Medical category in the App store. If you have a Blackberry, Droid, or other mobile phone, you can also sign up for this free service. Simply text DIGEST to 87415 or visit [www.doctorsdigest.net](http://www.doctorsdigest.net) from your cellphone.

I look forward to another exciting year and remain dedicated to helping you bridge the gap between the practice of medicine and the business of medicine.

As always, I look forward to hearing from you. Contact me at [jbrandofino@doctorsdigest.net](mailto:jbrandofino@doctorsdigest.net) or by fax to 516-364-2575.

Jeannette Brandofino  
Publisher

e-mail: [jbrandofino@doctorsdigest.net](mailto:jbrandofino@doctorsdigest.net)



## Best Practices Just Got Better With *PracticeRx by Doctor's Digest*



Instantly and Securely Report Medication Safety Errors and Receive **REAL-TIME Instant Medical/Hazard Alerts** from ISMP with our **FREE Medical iPhone/iPod Touch App**



Preventing errors and reporting medication safety events are the cornerstones of the National Patient Safety Goals. In addition to biweekly Practice Management Tips from *Doctor's Digest*, the *PracticeRx by Doctor's Digest* App provides instant error reporting tools from the Institute for Safe Medication Practices (ISMP).

The *PracticeRx by Doctor's Digest* App provides four practice management tools:

- *Doctor's Digest* and ISMP Practice Management Tips, with links to FREE ISMP medication safety material and information on practice-management topics at [www.doctorsdigest.net](http://www.doctorsdigest.net). Tips are available in text, audio and video format.
- ISMP – MedSafety Alerts — Audio Alert accompaniment of urgent drug alerts in real time.
- MERP - Medication Errors Reporting Program – report errors via one-touch direct dial to ISMP, leave a voice-recording, or complete a HIPAA-compliant form.
- Free e-subscription – Opt-in for *Doctor's Digest - Money Matters* containing Personal Financial Tips for physicians from leading experts

### Here is what your colleagues have to say about *PracticeRx by Doctor's Digest*

**Great App! ★★★★★** By Vinny\_V

*Very great functionality and I love the interface. I have seen similar properties in some other apps but at a steep price. Great job with this one!*

**Brilliant! ★★★★★** By FamPracDoc

*Very valuable tool. Love the tips and the instant medication alerts from ISMP. Thanks for looking out for us.*

To download this FREE App, go to the Medical Category of the Apple® iTunes Store and search for PracticeRx, or go to: <http://itunes.apple.com/us/app/practicerx-by-doctors-digest/id345767265?mt=8>

Not an iPhone user? Click on "Doctor's Digest Practice Tips" on the left side of our homepage at [www.doctorsdigest.net](http://www.doctorsdigest.net), or text DIGEST to 87415 from your mobile phone. To access ISMP's Medical ErrorReporting Form online, please go to [www.ismp.org](http://www.ismp.org).

# How to Error-proof Your Practice

**A**lthough it's tempting to look at errors individually, experts say that's not the way to develop an error-proof practice. Instead, they advise physicians to take a step back to first review office processes, which will help reveal how and when errors are happening; only then can you consider options for fixing those problems.

In this issue of *Doctor's Digest* we explain how to look at your office systems and why you should do it. We discuss tools that can help you reduce medical errors. We show you how to regain the thousands of dollars you may be losing because of administrative blunders, from lost charges to misused petty cash. Next we give you the latest on technology (e.g., electronic health records [EHRs] and digital cameras) that can give you a boost in preventing errors. Then we take you behind the scenes to learn how several practices are putting these technologies to work—and the lessons learned. Finally, we address the sensitive issue of what to do when errors do occur, including strategies for minimizing your malpractice exposure while maximizing your responsiveness to your patients.

## The Bottom Line on Errors

8

*Learn how developing good systems can improve communication and create an error-proof office culture.*

## Reducing Medical Errors

24

*Find out how you can get at the “administrative dysfunction” and other causes of medical error in your practice.*

## Addressing Billing and Staff Issues

38

*Capture the thousands of dollars you may be losing due to billing and other problems by following these tips.*

## How Technology Can Help

48

*Observe how other practices are using EHRs right now to reduce errors and save money.*

## What to Do When Errors Occur

62

*Learn how to handle this tough situation, from the issue of “finger pointing” to finding the right words to set things right again.*

## For More Information

73