5 smart planning moves in a volatile market

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SGJRNA220003 May 2022
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Inflation is the big financial story these days. As I’m writing this note in mid-June, U.S. Federal Reserve officials have made the decision to raise interest rates 0.75%, the biggest rate hike since 1994. That’s in response to the U.S. Bureau of Labor Statistics report that inflation rose 8.6% in May, the largest number since 1981.

Between rising prices and interest rates and the volatility in the stock market, many investors are wondering whether we’re headed for a recession. And for physicians who rely on their investment portfolios for their retirement plans, some anxiety is expected.

Our cover story for July focuses on how physician investors should approach these economic challenges and make sure their portfolio is protected. We interviewed financial advisers who focus on physician clients, and they provided practical advice for physician investors to navigate these troubled economic times, so don’t miss the timely tips. As always with finances, some perspective is in order, says Jeff Pratt, a financial adviser for the Finity Group.

“Regardless of whether it’s inflation or any other factor, investors should remain focused on their long-term goals and be cognizant of not taking on risk they can’t handle,” he says. That’s not all the financial news we have in this issue. We’ve also got:

- Insights from our investment columnist on real estate investment funds, and why they may be a good option right now.
- An investment analysis of the health care market and how investors should approach stock purchases in this arena.

As always, we want to hear from our readers about what they think about our content, and we want to hear your story ideas too. Please email Editorial Director Chris Mazzolini at cmazzolini@mjhlifesciences.com with any thoughts.

Mike Hennessy Jr.
President and CEO
of MJH Life Sciences®
30-DAY MONITORING IS NOT ENOUGH

Cardiac patients with hard-to-diagnose conditions can strain your practice, especially when short-term monitoring is inconclusive. Break free from this cycle.

GET ANSWERS

Suspected atrial fibrillation:
Clinicians are 4.3x more likely to reach a diagnosis with an ICM versus a one-time 30-day monitor.1-4

Syncope:
Clinicians are 3.6x more likely to reach a diagnosis with an ICM versus standard of care.4

Learn more about Reveal LINQ™ ICM indications at Medtronic.com/PatientSelection
References:

Brief Statement
Reveal LINQ™ Insertable Cardiac Monitor

Indications: The Reveal LINQ insertable cardiac monitor (ICM) is an implantable patient-activated and automatically activated monitoring system that records subcutaneous ECG and is indicated in the following cases:

- Patients with clinical syndromes or situations at increased risk of cardiac arrhythmias
- Patients who experience transient symptoms such as dizziness, palpitation, syncope, and chest pain, that may suggest a cardiac arrhythmia

The device has not been tested specifically for pediatric use.

Contraindications: There are no known contraindications for the implant of the Reveal LINQ ICM or for the Reveal LINQ Mobile Manager system. However, the patient’s particular medical condition may dictate whether or not a subcutaneous, chronically implanted device can be tolerated.

Reveal LINQ Insertable Cardiac Monitor

Warnings/Precautions: Patients with the Reveal LINQ ICM should avoid sources of diathermy, high sources of radiation, electrosurgical cautery, external defibrillation, lithotripsy, therapeutic ultrasound, and radiofrequency ablation to avoid electrical reset of the device, and/ or inappropriate sensing as described in the medical procedure and EMI precautions manual. MRI scans should be performed only in a specified MR environment under specified conditions as described in the Reveal LINQ MRI Technical Manual.

Potential Complications: Potential complications of the Reveal LINQ device include, but are not limited to, device rejection phenomena (including local tissue reaction), device migration, infection, and erosion through the skin.

See the device manuals for detailed information regarding the implant procedure, indications, contraindications, warnings, precautions, and potential complications/adverse events. For further information, please call Medtronic at 1-800-328-2518 and/or consult the Medtronic website at medtronic.com.

Caution: Federal law (USA) restricts these devices to sale by or on the order of a physician.
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Low-Valuation REITs for Growth and Income

Many investors are looking for assets that don’t move with stocks and are inflation-proof. Are REITs the answer?

By David S. Gilreath, CFP, and Edward “JR” Humphreys II, CFA, CAIA

After suffering steep drawdowns this year, many investors with stock-heavy portfolios are looking for assets that don’t always move with stocks. And with inflation at a 40-year high and interest rates rising, investors are also seeking assets resistant to the negative impacts of these trends.

An investment type that satisfies these needs is real estate investment trusts (REITs), an alternative to stocks or bonds. Often overlooked by individual investors, these publicly traded companies are landlords that own various types of rental property, including apartment complexes, office buildings, shopping malls, data centers and self-storage facilities.

Investing in REITs is a convenient way to get income from rental properties that can be extremely messy to own directly. Though REITs usually involve more risk than bonds, they provide far higher income. They can be essential components of the retirement portfolios of physicians, especially those at small private practices that lack pensions.

Currently, fundamentals and markets of REITs in various categories signal likely growth over the next two or three years. However, today’s negative economic headlines — inflation, rising interest rates, the effects of Russia’s invasion of Ukraine and recession fears — are causing headwinds, and investors are showing reluctance to buy REITs in some sectors. Thus, the clear potential of these REITs has not yet translated into higher share prices.

Less damage

Characteristically, REITs in general have suffered less damage than stocks in the last year’s tumultuous market. In the trailing 12 months as of May 31, the MSCI US REIT Index has returned about +2%, whereas the S&P 500 has returned approximately 0.4% (dividends included). A key reason for this difference is REITs’ attraction for investors as a hedge against inflation (8.5% annually), as landlords can raise rents to cover rising costs. And historically, REIT prices have moved with stocks’ only about two-thirds of the time, so REITs can somewhat diversify stock-laden portfolios.

Fortifying REITs against rising interest rates is their high credit quality, which stems from ownership of hard assets. Moreover, they usually have low debt levels and, depending on the type of properties they own, fixed-rate debt with longer maturities. As a result, increases in short-term interest rates usually don’t have much impact on these REITs’ cost of capital.

One of the best things about REITs is the income they provide in the form of high, regular dividends, stemming from a special tax status requiring landlords to pay out 90% of their taxable income to shareholders. Many have dividend yields (the percentage of a company’s share price annually paid out to investors) above 4% and some, much higher.

This is generally more than stocks, which rarely have dividend yields above 2% or 3%. Of course, the main goal of owning stocks is to get price appreciation, but investors can get that from REITs, too. Good growth and reliable dividend income represent the best of all possible REIT scenarios.

Time to be greedy

Fear is a strong factor currently holding down some REIT prices. This scenario invokes Warren Buffett’s classic advice for investors to be “fearful when others are greedy and greedy when others are fearful.”

A key metric used to value REITs is the ratio of the price per share to funds from operations (P:FOF). Similar to price-earnings ratios for stocks, this metric represents the price investors must pay to get a given level of earnings.

In late May, the median P:FOF ratio for all REITs was 22.57. Some REIT sectors with good market outlooks remain well below that level. To the extent that these low valuations stem from investor fear, this pricing gap in REIT sectors might signal opportunities for the greedy, in the Buffettesque sense.

Low-valuation sectors

Those REIT sectors include:

Office buildings

In this period of rising interest rates, this category’s specific tendency to rely on floating-rate debt has probably been
a turn-off for professional investors, and share prices are still swooning even as postpandemic demand for office space has started to rise.

Fear that office REITs will suffer if more companies make work-from-home policies permanent is likely suppressing interest in office REITs.

But don’t bet the farm on the longevity of work from home. In markets outside major urban centers such as San Francisco, Chicago and New York, the return to the office is well under way as CEOs stress the value of face time and workers see potential benefits from spending time with the boss up close and personal.

As demand for office space increases, so will landlords’ pricing power over rents. In the meantime, share prices of some office REITs, pushed down by the pandemic, remain bedrock low. For example, in late May, SL Green Realty Corp. (SLG) was trading roughly at 2011 or Great Recession levels. Other examples of this sector include Vornado Realty Trust (VNO) and Alexandria Real Estate Equities (ARE).

Regional shopping malls
With a P:FFO of 10.82, less than half the level for REITs overall, this category remains badly beaten up, despite shoppers’ returning to stores in droves this year, boosting bricks-and-mortar sales.

As it turns out, online sales are also up substantially this year. The rise in both types of shopping indicates great potential for retailers who offer both — a tandem model now common to many large department stores anchoring shopping malls and served by salespeople who help in-store shoppers order online if items aren’t in stock. People can still see and feel merchandise, yet stores don’t have to carry as much inventory.

The dominant name in shopping mall REITs is Simon Property Group (SPG), which probably owns almost every high-quality mall you’ve ever walked into. Despite a recent dividend increase (bringing the yield to nearly 6%) and a strong tenant demand outlook for mall space, Simon’s share price was down about 25% for the year as of late May.

The company owns more than 200 properties in 35 states and also operates overseas. The next largest U.S. competitor is Macerich Co. (MAC), with 45 malls. Macerich’s price is down more than 30% this year.

Suburban shopping centers
Also known as strip centers, these are small clusters of retailers where you drop off your dry cleaning and pick up groceries on your way home from work.

Typically anchored by chain supermarket or drug stores, these centers also have restaurants, ice cream shops, spas and other small retail establishments as tenants.

Their market niche is convenience for people who want to shop near their homes — especially attractive during quarantining but also a perennial advantage.

Examples include Urstadt Biddle Properties (UBA) and Kimco Realty Corp. (KIM).

Health care
Unlike hotel or self-storage REITs, the health care category can’t raise rents abruptly because of long-term leases (though they tend to have automatic escalator clauses linked to inflation).

Consumer demand for skilled nursing facilities is slow to return amid fear lingering from publicity about high mortality rates in nursing home populations early on in the pandemic. At the same time, operators have been forced to pay substantially higher wages to compete for employees. But as fears abate and facilities adjust to higher costs, performance, which is currently good relative to share prices, should improve.

Examples include Omega Healthcare Investors (OHI) and Healthpeak Properties (PEAK).

When selecting REITs that rely on local consumer demand, such as apartments, offices and retail, it’s best to focus on those owning Sunbelt properties. To a large extent, their growth is aligned with population growth, which is currently brisk in the South and Southwest as people move to those regions from crowded population centers in the Northeast and on the West Coast.

In addition, it’s usually better to own REIT shares directly rather than through funds. This way, you won’t end up investing in underperformers included in indexes. And owning directly means you don’t have to share income and appreciation with fund managers.

David S. Gilreath, a certified financial planner, is a 40-year veteran of the financial services industry. He is a partner and chief investment officer of Sheaff Brock Investment Advisors, LLC, a portfolio management firm for individual investors, and Innovative Portfolios, LLC, an institutional money management firm.

Edward “JR” Humphreys II, a chartered financial analyst and chartered alternative investment analyst, is a senior portfolio manager with the firms, specializing in fixed-income and alternative investments. Based in Indianapolis, the firms manage about $1.4 billion in assets nationwide.
What’s next for biotech and health care

By Tarun Chandra, CFA

The stock market has retreated sharply this year and quite relentlessly over the past few months. Biotechs have been in retreat since late last year and the industry group is well into a deep bear market with valuations on the S&P Biotechnology Select Industry Index (XBI) slashed by over 60% from their highs. Investors face an uphill task this year: things have been difficult thus far but there will be selective opportunities to recover lost ground and perhaps record some gains this year.

A deep decline

Biotech valuations have fallen precipitously as the stock market encounters an environment not seen in nearly 50 years — spiraling inflation and an aggressive and determined Federal Reserve (FED). The S&P 500 (SPY) has declined 21% and likely has more to go based on a historical perspective.

The four major corrections or bear markets this century can provide some helpful insights, though the picture remains incomplete due to the uniqueness of the present environment. The 2020 pandemic-related pullback, and the brief recession, are omitted.

Biotechs declined sharply in each of these pullbacks. The 2002-03 period is not as instructive because the Nasdaq Biotechnology Index (IBB) was started right during the middle of the decline and the S&P biotech index did not exist.

Decline in the context of FED policy

What can be more useful is placing these pullbacks in the context of a FED interest rate policy reflecting the economic environment at the time.

During the first two periods the FED was working to prevent or manage a recession by cutting interest rates. The biotech indexes dropped less than the market did and for good reason. Biotechs are relatively less affected by slower economic growth than the broader market, and the declining interest rate provides support for risk taking, thus allowing the biotech group to reach a bottom more quickly. Biotechs went from highs to lows in four months, compared with the S&P 500's 17 months.

In these situations of low growth and declining interest rates, biotechs typically outperform the S&P 500. This index is a good proxy for broader health care but not as much for biotechs as it is derived from stocks within the S&P 500 index. There were only six biotechs in the S&P 500 at last count.

The 2015-16 decline, like the present one, began in an environment of rising rates or expectations thereof. Rising interest rates tend to be harmful to biotech (and growth stock) valuations as they lead to a lower discount rate applied to future potential earnings and diminish risk taking. In 2015-16, the biotech indexes fell between 40% and 50%, compared with a 15% decline for the S&P 500 and a 27% decline for health care.

In the present pullback, biotechs at the worst point had declined 65% and 41% for the two key indexes. This exceeds the maximum decline in 2015. During the 2015 period, the rise in rates began from the 0% to 0.25% range, just like the present one. However, the FED’s language was supportive and soothing, reiterating central bank patience and a rise in small increments at a measured pace. Biotechs reached their lows in that cycle in seven months. Presently, the S&P biotech index is 15 months into the decline and the Nasdaq Biotechnology Index nine months into it.

Health care has materially outperformed the broader indexes of S&P 500 and Nasdaq in the present pullback. However, one has to be careful when forming broad-based opinions about health care performance from the S&P health care index. It is a market cap weighted index and a top 10 holdings account for 55% of its performance. A few defensive groups within health care, such as pharmaceuticals, drug distributors and insurance, have done significantly better than most other groups and dominate the index performance because of their higher market caps.

A twist that muddies the investing waters

When the federal funds rate rose in 2015 from 0% to 2.5%, it eventually topped out at 2.5%. That is the level most likely to be reached in September after another three increases of a half-point each. Where the 2015 framework diverges from the present situation is that there was no inflation monster
to slay at that time. This time 2.5% will very likely not be a sufficient rate at which the FED can stop.

The twist in the current scenario comes from the likelihood that even slowing economic growth numbers may not bring the inflation headline numbers down fast enough. This is because structural global imbalances are resolving rapidly but may take another year to start approaching normal and even longer to return to the desired 2% inflation target. This means that the FED, for the first time since the 1970s, will be placed in a position of considering tightening in the face of declining economic growth.

That is the risk being reflected in the market valuations. Biotechs in this environment cannot rely on the usual help from the combination of lower economic growth and falling rates, as this time interest rates will continue rising — hence the 60% decline in the equal-weighted S&P biotech index. The Nasdaq Biotechnology Index has declined 41% but masks the deeper industry decline, as it is a market-cap weighted index with the Top 10 companies accounting for over 50% of the performance.

The deep decline in the S&P biotech index can also be attributed to a surge in biotech offerings over 2020 and 2021 when nearly 160 companies became public through initial public offerings and special purpose acquisition companies. As per a McKinsey report, 66% of these had products and platforms in the early stages of preclinical or phase 1 development, a marked uptick in early-stage, higher risk offerings compared with those of prior years. Many of these companies may not be well prepared for the present environment of tightening financial conditions. Lay-offs, closings and mergers and acquisitions are inevitable.

**Investing in biotechs and health care**

For the market to consolidate and rebound with consistency, it requires a step-down by the FED from its present aggressive rate increase strategy.

Such an opportunity could arise if the FED, after its increase in 50 basis points in September, concludes its series of half-point hikes and steps down to increases of 25 basis points thereafter. This will allow the FED to shift from a blunt force approach to a relatively measured, surgical one.

Although a much slimmer possibility, the FED may even decide to pause on further increases to evaluate the progress on inflation over the subsequent months if the financial markets are heavily stressed, inflation numbers are declining meaningfully, and the FED would like to guide the economy to a “softish landing.”

It is often said in the commodities market that a cure for high prices is high prices. If the FED believes so, then it will need to exercise patience later in the second half of the year, after a period of significant tightening, and allow higher prices as well to depress demand and contribute toward lower prices.

Even if only a step-down to 25 basis points materializes, and there is a good possibility for that to occur, it will set up the market for a strong fourth-quarter rally. The FED may begin to telegraph its intentions in late August or early September.

The current miasma of gloom shrouding the biotech group could dissipate rapidly in the late third quarter, and we may witness a rally of over 20% in biotechs during the final months of the year if the FED provides the right signals and tone in September. Of course, if the FED does not offer soothing signals as it gets to the 2.5% level, the biotech rally will be much more muted and selective as the indexes consolidate after a brutal shake-down. Mergers and acquisitions will inevitably grow later in the year as rapidly eroding biotech valuations attract mountains of big pharma cash.

With a 65% drop or about a two-thirds valuation erosion in the S&P biotech index, it would appear we are closer to a bottom than at any other time over the past few months. However, it may not mean a quick reversal but more of a consolidation around these levels and a slow grind higher till the FED relents.

Tarun Chandra, CFA, is an analyst with Graycell Advisors and Prudent Biotech. The original version of this article was published on Seeking Alpha.
INVESTING AGAINST INFLATION

Don’t let rising inflation wreck your portfolio
INVESTING AGAINST INFLATION / PHYSICIAN’S MONEY DIGEST

By Todd Shryock

Inflation is at its highest point in decades, and interest rates are on the rise. For many investors this type of environment is unknown after years of low rates and stable prices, creating multiple questions for physicians tending to their investment portfolios.

Doctors close to retirement may wonder what impact this economic volatility will have on their investments and how it will affect their timeline for hanging up their stethoscopes. Younger physicians are grappling with student loan payments and rising prices for almost everything and may be wondering where to put their money.

These are all valid concerns. “Not only does inflation erode purchasing power, it can have a detrimental impact on an investment portfolio,” says Michael Joyce, C.F.A., C.F.P., president of Agili, a financial planning and investment management firm. “If inflation increases, interest rates will also increase; bond prices will fall when interest rates rise. But there will also be a negative impact on stock and real estate values. As interest rates rise due to inflation, the stock market will be discounting future earnings with a higher discount rate, which means lower values.”

Investors have to be cautious to consider all factors affecting their portfolio. “Sure, an investor might see a return of 7% on their portfolio in a given year. However, what if inflation for the same year was measured by the Consumer Price Index at 9%?” says Jeff Pratt, CRC, a financial advisor with Finity Group, which specializes in financial planning for medical professionals. “On paper that’s a real return loss of 2% since the portfolio growth didn’t keep pace with inflation for the same year.”

If inflation rises to the point where consumers shift from being unhappy about paying more to not buying products, this could have even bigger economic consequences. “Inflation can only outpace wage growth for so long before consumer spending is negatively impacted, and drop-off in consumer spending could in turn lead to an economic slowdown,” says Pratt.

**Clear goals help protect your investments**

Physicians who are close to retirement have reason to be more worried about their investments as inflation rises because they have a shorter timeline to weather an economic storm and recover any losses. They might be tempted to make sudden changes to their portfolio, but experts say this isn’t always the best strategy.

“Regardless of whether it’s inflation or any other factor, investors should remain focused on their long-term goals and be cognizant of not taking on risk—or too much risk at the very least—they can’t handle,” says Pratt.

If, for example, a physician is nearing retirement with a $5 million portfolio and anticipates only needing $100,000 annually to meet their lifestyle needs due to other income sources, this person may not need any adjustment, says Pratt. But if the lifestyle needs require $500,000 a year, that is a faster draw down and will have a much larger impact on the portfolio, possibly requiring some assets to be repositioned. On the other hand, if they have a short life expectancy with no goal of leaving wealth to heirs or charities, this may not matter.

Investment strategies need to match overall goals and not just be knee-jerk reactions to changes in the economy.

“Assuming (a physician) were invested appropriately for retirement, the best move is likely no move at all.”

—W. Ben Utley, CFP, president and primary adviser, Physician Family Financial Advisors.
“Diversification is the key,” says Joyce. “Physicians should include investments in their portfolios that will perform relatively well in a rising inflation environment.”

And if a lot of time was spent planning investments early on, there is one key move to keep in mind. “Assuming they were invested appropriately for retirement, the best move is likely no move at all,” says W. Ben Utley, CFP, president and a primary advisor at Physician Family Financial Advisors, a firm exclusively serving physicians.

If moves are required, Joyce says investors should look at options such as inflation-protected bonds, commodities, short-term bonds (which are less interest rate sensitive), stocks that pay high dividends and real estate that generates a lot of cash flow.

One option is Government Series I Savings Bonds. These can be purchased at Treasurydirect.com, but there’s a limit of $15,000 per calendar year. However, they are exempt from state income tax.

“If an I bond is purchased, the money must be left in the bond for at least a year,” says Pratt. “Also, if cashed out in less than five years, then the previous three months of accrued interest is forfeited. Because of this, Series I bonds are most likely to be considered by folks with cash needs between one and five years out.”

Each inflationary environment is driven by different factors, so there is no one-stop shop to inflation-proof a portfolio, notes Pratt. Lower-duration bonds, which have less exposure to inflation and rising interest rates, might be one option. But within equities, high-quality companies with competitive advantages that give them pricing power in their industries are worth considering.

“The idea here is that these companies will be able to pass along price increases to consumers without significantly affecting demand — or their profit margins,” explains Pratt. “Fixed income typically struggles in an inflationary environment, but as an asset class it can still be an essential risk management tool despite potential headwinds.”

**Will rising interest rates derail retirement plans?**

The COVID-19 pandemic and the economic and mental hardships it caused forced some physicians to consider retiring sooner rather than later. But that was before inflation started eating away at investment earnings and concerns about the future of the economy came fully to bear. If a physician had been looking to retire in the next three years, is that still a good idea with so many unknowns?

“Three years from now, everything will look very different,” says Utley. “I mean, look at where we were three years ago. Nobody could have seen today’s dumpster fire glowing in the distance. I think older physicians should have a very solid plan before they make the decision to hang it up. Going back to work, especially after a failed retirement, is no fun.”

Physicians looking to retire soon should determine whether they are financially independent enough to go from earning their money from their hard work to depending entirely on their financial investments. This should include an analysis that includes a stress test of a major market downturn the day of their retirement, says Joyce.

“The knee-jerk reaction to ‘just do something’ about inflation is probably going to be the wrong move at the wrong time since the market prices of securities already reflect people’s perceptions of inflation, both now and in the future,” Utley points out. “Remember, if you’re trading, there’s a good chance you’re either buying your securities from a professional or selling your securities to a professional. The markets know more than we think they do.”

If there are losses in the portfolio due to inflation, will this have a substantial negative impact on the retirement income distribution strategy? A lot depends on the current portfolio, age of the physician and the life expectancy, says Pratt. An analysis of the goals may reveal changes are needed to the portfolio.

**“Not only does inflation erode purchasing power, it can have a detrimental impact on an investment portfolio. … As interest rates rise due to inflation, the stock market will be discounting future earnings with a higher discount rate, which means lower values.”**

— Michael Joyce, CFA, CFP, president, Agili
“Short-term bonds can be a good place to hide when riskier assets are plummeting,” notes Joyce. “But in a rising inflation environment, bonds can result in poor investment performance. It is good to focus on long-term goals and objectives and maintain a diversified portfolio that can provide for both security of principal in the short term and portfolio growth in the long term. In other words, to be able to sleep at night now but eat better in 10 years.”

**Balance risk versus reward**

Many financial paths can be followed through unknown market conditions and higher interest rates. Mutual funds or individual stocks? Real estate? Bonds? Something else? Experts say what’s most important is understanding the risks and rewards of each option and how they compare to financial goals and the investment timeline.

For example, mutual funds might be seen as a safer choice than individual stocks, but that’s not necessarily always the case.

“Mutual funds can insulate (investors) from single stock risk, but diversified portfolios can also be constructed using individual stocks, bonds, real estate and nontraditional investments whose returns, (which) are somewhat uncorrelated with each other, can also insulate a portfolio from purchasing power risk,” says Joyce.

Pratt points out that a portfolio with multiple mutual funds has its own set of risks to consider. “If one share of an S&P 500 index fund is purchased, the underlying exposure carried is spread across roughly the largest 500 companies in the U.S. economy,” he says. “If you layer in other funds across mid- and small-sized companies as well as overseas (funds), a portfolio can quickly be built with underlying exposure to potentially underlying exposure to potentially

**What to do with those variable rate loans**

ow interest rates enticed a lot of people, including physicians, to take on more debt than they probably should have. A new house, new car, new boat — all sound great with cheap financing and a low interest rate.

But some of those loans may have variable rates, which are increasing as the Federal Reserve continues to raise rates to counter inflation. Each time the rate goes up, so do all those loan payments. Should physicians be looking to refinance variable-rate loans into fixed-rate loans?

“In general, loans on assets that will decline in value, such as boats and cars, should be paid down or paid off,” says Michael Joyce, CFA, CFP, president of Agili. “Homes will generally increase in value and can be leveraged. Always be careful about refinancing costs, which can rapidly eat up any interest rate savings.”

W. Ben Utley, CFP, president and a primary advisor with Physician Family Financial Advisors, says that now is a good time to refinance variable rate loans to fixed rate loans, but one thing needs to be kept in mind. “Having debt is a good thing during inflationary times,” he says. “You borrowed with 2022 dollars and you’ll be repaying with dollars from 2023, 2024 and beyond, and all those future dollars are worth less than they would be if there were no inflation.”

If a loan has a short payback timeline of only a few months, Jeff Pratt, CRC, a financial advisor with Finity Group, says there probably isn’t a need to refinance. Although physicians may also be tempted to try to quickly pay off fixed rate loans with low interest rates, this might not always be the best option. For example, if the loan rate is 2%, taking the extra money that would be used to pay off that loan might be better allocated into the stock market where that money might yield a better overall return.

“Risk tolerance in the stock market can also play a role in determining how best to approach debt repayments as someone who believes they can average an 8% return in the market is likely going to address their debt package differently than someone who believes they can only average a 5% return in the market,” says Pratt.

For those with multiple debts with different interest rates and loan types, Pratt says the most efficient way to pay them down is to rank them by their after-tax interest rates and pay the minimum due on all of them expect for one — the debt with the highest interest rate — and pay extra on this one to accelerate its repayment. Once the highest interest debt is paid off, then apply the amount you were paying on the original highest interest rate debt toward the balance on the next highest rate, and so forth.

“Mathematically, this will minimize the total amount of interest paid over the life of all debts on a balance sheet as we’re considering the opportunity cost of each unique debt carried,” says Pratt.
thousands of different individual companies. Is this better than owning individual stocks? Maybe, maybe not.”

Each investor has to establish their own timeline and risk tolerance level to help them navigate through changing market conditions.

“Regardless of whether it’s inflation or any other factor, investors should remain focused on their long-term goals and be cognizant of not taking on risk they can’t handle.”

— Jeff Pratt, CRC, financial advisor, Finity Group

“For any investor, whether it’s inflation or something else, the broad scope of current economic conditions should be considered in relation to how investment portfolios are allocated,” says Pratt. “As economic conditions change, as well as individual circumstances of investors themselves, portfolios should be reviewed and adjusted as needed to ensure proper alignment of goals and time horizons.”

For example, a physician approaching retirement who is heavily invested in stocks may want to consider reducing risk in their portfolio by increasing bond exposure. A physician who is young and doesn’t plan on retiring for 30-plus years may not need to do the same, says Pratt.

Younger physicians may be wise to simply ignore inflation and focus on making the right financial moves, says Utley.

“Young physicians should be buying a home, whose value tends to rise with inflation, and owning a diversified portfolio that’s tilted heavily toward equities, whose returns tend to outpace inflation. Basically, if young docs are making smart moves with their money, they’re already taking the right steps to weather inflation.”

But it still comes down to risk tolerance. Even though a younger physician has a longer investment timeline and can take a more aggressive investment strategy, that might not be something they are comfortable with,” he says.

If that’s the case, experts say they should take a less aggressive approach that matches their comfort level.

Understand the big picture
The day-to-day market changes and news cycles can affect stock and bond prices. But physicians should not be investing based on what headlines they are reading. For example, the Russia-Ukraine war generates a lot of news, but it has had little actual impact on market performance.

Pratt says Federal Reserve policy will continue to be the primary driver of market returns in the near term, particularly in the fixed-income space. “While bonds are an important risk management role within diversified portfolios, their prices — and performance — are negatively correlated with interest rates, meaning they are likely to see continued volatility as rates rise,” he says. According to the CME FedWatch Tool, market participants are currently pricing in an 86.4% probability of the federal funds rate rising by an additional 2.5% by the end of 2022. “If the Federal Reserve signals a more aggressive approach than currently expected, fixed income markets could come under further pressure; conversely, a dovish shift could lead to a rebound.”

Utley points out that inflation isn’t the biggest risk to a physician’s finances. “The things that clobber docs are entirely within their control,” he says. “The triumvirate of physician destroyers are a nasty divorce, running a small practice into the ground, and failing to save enough for retirement.”

In addition to those things, he says too many doctors are making mistakes with their student loans around public service loan forgiveness. “It’s costing them literally hundreds of thousands of dollars, often the equivalent of five or ten more years of time on the job, in the clinic, working harder than they have to,” says Utley.

Inflation might get most of the headlines, but that doesn’t necessarily mean it should be the guiding factor in all investment decisions.

“As with any investment portfolio related approach, it’s important to consider the whole puzzle and not just one piece of it,” says Pratt. “Some folks may be more impacted in their investment portfolio by inflation while others not so much. Every investor likely has goals, time horizons, risk tolerances and investment preferences unique to them, so take these considerations into account and be sure to maintain proper diversification that matches the investor’s specific time horizons and risk tolerance.” —
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Perspective is everything.
Volatile times require smart financial planning moves

By Anthony Moffa, CFP Contributing Author

With the return of inflation, continuing COVID-19 shocks and geopolitical instability, many investors have girded themselves for volatility. Fortunately, you can help to protect your assets from sudden, unpredictable moves in the markets and the economy. Here are a few ideas.

1 CONVERT TO A ROTH IRA
Many investors have seen significant drops in value for their portfolio recently. If those values rebound, one way to shelter the recovery from income tax is by converting from a traditional individual retirement account (IRA) to a Roth IRA. When a traditional IRA is converted to a Roth IRA, income tax is assessed on the value of the asset on the date of the transfer, which in today’s market can potentially result in a lower taxable transaction. If you are interested in an IRA conversion, note that dollar-cost-averaging can also help protect your assets from volatility, so you might want to make this a cornerstone of your retirement strategy.

2 REFINANCE YOUR DEBT
With inflation increasing and the Federal Reserve already planning future rate hikes, interest rates may be due to follow. If you have been considering a refinance of your mortgage — whether for your home or your medical practice — this might be a good time to lock in a lower rate before they start edging upward. But be mindful of the costs that can accompany it, such as appraisal and application fees, and try to balance your monthly savings against any up-front costs. This can be especially significant if you have plans to sell your home or practice in the next few years, in which case refinancing may not be worth it.

3 MAKE USE OF TAX-LOSS HARVESTING
Tax-loss harvesting allows you to sell securities that have declined in value at a loss but then use those losses to offset current and future capital gains. You can apply up to $3,000 of these losses against your ordinary income and carry forward any unused capital losses to use in future years. If you own stocks that have lost value, it is important to keep an eye on how long you have held them, because short-term capital gains are taxed at your marginal tax rate whereas long-term capital gains are taxed at a 15% (or 20% for higher income earners) tax rate. Be careful to avoid using the short-term, and more valuable, loss against any income taxed at the lower 15% or 20% rate.

4 FUND YOUR HSA
One of the most beneficial tools to prepare you for future medical expenses is a health savings account (HSA), which holds pretax dollars that can be used on qualified medical expenses for yourself, your spouse and/or other family members tax and penalty free. Any funds not used by the end of the year can be rolled to the following year and continue to grow tax free. To be eligible for an HSA, you must be enrolled in a high-deductible health plan with a minimum annual deductible before health care costs are
If you have heirs who are feeling the economic pinch now and could benefit from getting their inheritance early, this could be an excellent time to use a gifting strategy.

Covered. Although The American Journal of Managed Care® reports that physicians typically opt out of high-deductible health plans, HSAs can offer significant benefits through pretax contributions, tax-deferred growth and tax-free withdrawals. You also have a one-time opportunity to convert a portion of your traditional IRA to an HSA, limited to the annual contribution limit. Taking advantage of this strategy changes the funds from tax deferred to tax free, assuming the HSA funds are eventually used for qualified medical expenses.

5 GIVE TO YOUR HEIRS

If you have heirs who are feeling the economic pinch now and could benefit from getting their inheritance early, this could be an excellent time to use a gifting strategy. Individuals have an exemption against gift, estate and generation-skipping taxes of $12.04 million per person ($24.08 million for a married couple). This historically high exclusion is scheduled to decrease to about $6 million on January 1, 2026, when the Tax Cuts and Jobs Act sunsets. This exemption can be used throughout your lifetime via gifts or at death via bequests from your estate. Currently, the annual gift exemption is $16,000 per year per recipient (or $32,000 annually per recipient for a married couple), so only gifts above the $16,000 (or $32,000) annual limit per recipient would reduce your lifetime gift and estate tax exclusion.

Several of these strategies require the guidance of tax and legal professionals and can be complicated to execute, so tread carefully. A certified financial planner can partner with your certified public accountant and/or attorney to help ensure you are on the right track to weather whatever volatility we may see.

Anthony Moffa, CFP, is with The Smith Group at Baird, and has worked exclusively with clients in Private Wealth Management. Anthony works with medical professionals and business owners who want peace of mind when it comes to their portfolios and financial plan, and views both aspects as integral parts for successful wealth management. To discuss your personal or business financial planning goals, please contact Anthony at (704) 571-7395 or amoffa@rwbaird.com. For more information on Baird, visit BairdWealth.com.

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Medical necessity denials
How to avoid them and ensure timely payment

By Lisa A. Eramo, M.A. Contributing Author

Medical necessity denials are a source of frustration for many practices nationwide. “It feels like the game of whack-a-mole,” says Holly Ridge, B.S.N., RN, CPC, CPMA, manager of medical necessity and authorization denials at Duke University Health System in North Carolina. “We have an increase in denials in one service, determine the root cause, improve our processes and [then] appeal — and then something else comes up.”

Ridge, who oversees hospital and professional denials for medical necessity, says payer policies have become more detailed and restrictive. “Payers have also improved their edits to automate denials,” she adds.

Toni Elhoms, CCS, CPC, CPMA, CRC, the CEO of Florida-based Alpha Coding Experts, LLC, agrees. The worst part? “These denials can add up very quickly,” she says. For example, Medicare pays approximately $40 for a test for vitamin D (CPT code 82306). If a practice fails to support medical necessity and receives denials for this test 30 times a month, that’s $1,200 a month or $14,400 a year.

1. Sick visit on the same day as an annual wellness visit (AWV)

**REASON FOR DENIAL:** Lack of clear clinical documentation regarding why the physician had to go above and beyond what is normally addressed during an AWV.

**HOW TO AVOID IT:** “I often tell doctors to write the note as if it were two separate visits — one for the problem and one for the well visit — to make it clear,” says Elhoms. “The provider needs to spell out what makes the sick visit significant and separately identifiable from the well visit.”

Providers also need to report the correct ICD-10-CM code for the visit, says Elhoms. When there are abnormal findings (ie, when the physician addresses a separate problem), report Z00.01 as well as any additional diagnosis codes to represent those findings. Only use ICD-10-CM code Z00.00 to indicate the absence of abnormal findings. Payers may question and deny Z00.00 when billed with an AWV and separate evaluation and management (E/M) service on the same day, she adds. Finally, be sure to append modifier -25 to the E/M code so it passes through clearinghouse edits, she adds. Modifier -25 is for “Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day of the Procedure or Other Service.”

2. In-house labs and diagnostic testing

**REASON FOR DENIAL:** Testing too frequently. For example, a payer might deny a prostate screening when the patient had it done six months ago through a different physician. Or a payer might deny a hemoglobin A1C every four months because its policy states it only covers the test every six months.

**HOW TO AVOID IT:** For annual tests (eg, prostate screenings), patient communication and care coordination are critical, says Elhoms. “Good communication with the patient can help you avoid some of these issues on the back end,” she adds.

For other frequency-related denials, clinical documentation is paramount, says Ridge. “If a patient is diabetic and doesn’t appear to be responding to the original treatment plan even though they’re [adherent], you could appeal this very easily,” she adds. “The clinical circumstances of ongoing hyperglycemia would warrant frequent A1C monitoring.”

**REASON FOR DENIAL:** Incorrect ICD-10-CM diagnosis code. For example, a patient on long-term anticoagulant medication requires checks of their prothrombin time every few days. The payer might deny this test if the physician simply pulls the patient’s entire problem list (e.g., atrial fibrillation, heart disease and presence of coronary stent) onto the lab order. Another common reason for denial is that physicians do not report the correct ICD-10-CM code to justify testing a patient’s vitamin D — especially when
7 tips to combat medical necessity denials

If you want to address medical necessity denials but are uncertain where or how to begin, experts provide these seven tips.

1. **Appoint someone to stay on top of each payer’s medical policies.** For example, this could be a certified coder, biller or outside consultant. “The return on investment is absolutely worth it,” says Ridge.

2. **Trend and monitor your denials.** What are your most frequent denials in terms of volume? What are your high-dollar denials? Knowing this information can help you take a targeted approach, says Ridge.

   It can also help you quickly spot denials that may be due to the payer’s own error, says Ridge. For example, Ridge says Medicare started denying Botox injections due to lack of medical necessity; however, it was referencing a policy that was not applicable. Bringing this to the Medicare Administrative Contractor’s attention can quickly resolve the issue and improve cashflow, she adds.

3. **Appeal denials.** Start with your high-volume, high-dollar denials, says Elhoms. To save time, create standard letter templates for certain types of appeals.

   Also, remember that the quality of your appeal will make or break your case. In the absence of internal expertise, consider working with an external consultant who knows what payers are looking for in terms of appeal language, she adds. Remember to include research studies, CPT Assistant references, the payer’s own medical policy and any other information that can help support your argument, she adds.

4. **Submit corrected claims.** In cases where diagnosis codes are omitted or not specific, consider adding the correct codes and resubmitting the claim, says Elhoms. Be sure to check with your payer regarding how to handle resubmitted claims. Also highlight the part of the note that supports the new or revised codes, she adds.

5. **Build edits in your practice management system.** The goal is to catch potentially problematic claims before they go out the door. “Coders can review these cases to make sure the right diagnosis codes are linked to the lab or test,” says Ridge.

6. **Involve the patient.** Consider asking the patient to sign a form (i.e., the Designation of Authorized Representative form) allowing you to appeal the denial on the patient’s behalf under the Employee Retirement Income Security Act. “It gives you additional appeal opportunities and it’s another chance for a new set of eyes to review it,” says Ridge. Member appeals also have the opportunity for an independent review organization to review the denial, which may increase your chances of overturning it.

7. **Leverage contract negotiations.** If you’re having trouble with a payer, the time to bring up the issues is during contract negotiations, says Elhoms. “Don’t walk away from the discussion without having some type of resolution.” For example, will the payer build a custom edit in its system or provide a direct contact who can easily address these denials without adding administrative burden on your practice?

   If the payer is not willing to work with you, consider walking away, says Elhoms. “Is the payer even worth your time? If you’re spending this much time with medical necessity denials, it may not be worth it,” she adds.

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**3. High-cost medications**

**REASON FOR DENIAL:** Patient does not meet the payer’s medical policy criteria for coverage.

**HOW TO AVOID IT:** Know each payer’s coverage criteria and appeal denials when possible, says Ridge. “Most Medicare Administrative Contractors will consider other indications at their own discretion,” she adds.

   Another tip is to work with pharmaceutical representatives to understand indications and coverage criteria. “Not all, but many, pharmaceutical companies offer patient assistance programs if the physician determines the patient really needs the medication and they have failed multiple other treatments,” says Ridge. One caveat: For patients to qualify for some of these programs, physicians may need to bill the patient’s insurance, receive a denial, appeal that denial and fail to overturn the appeal, she adds.
renuptial agreements, or prenups, have an undeserved reputation as the destroyer of romance. Preunups offer a level of lifelong protection unmatched by any other contract you will enter.

Is a prenuptial agreement worth it? The short answer is yes. The long answer is also yes.

This is true for most people, but especially for physicians. Although doctors are not the most likely to get a divorce (quite the opposite, according to a 2015 article published by Harvard Medical School), the possibility exists, and physicians (no matter their age) have much to protect.

A prenup need not be expensive or overly complicated to potentially save hundreds of thousands (even millions) of dollars while minimizing litigation (and all the nastiness that divorce litigation brings). It can protect generational wealth, help direct what will happen to your estate when you die and preserve assets for your children. It can even ensure clear communication and understanding of how money will be treated during the marriage, removing a typical cause of marital strife. The prenuptial agreement can help maintain marital relationships. Nothing is more romantic than a strong, healthy marriage.

Prenups are not just for millionaires. They are a wise decision for most people. There are countless situations where a prenup is an effective tool for building and maintaining wealth no matter the couple’s financial situation prior to the marriage. Prenups are insurance.

People do not want to be sued, but they carry malpractice insurance. They do not want to get sick, but they have health insurance. There is life insurance, long-term care insurance, disability insurance, and even key man insurance for partners in one’s medical practice, and no one questions that a sound financial plan includes these protections. It would be foolish not to have them. The same is true of a prenup.

Simply stated, a prenuptial agreement is a contract between two people who intend to marry. Should the wedding not take place, the contract is void. If the wedding does happen, then the prenup is a valid contract that directs certain financial paradigms, and it does so algorithmically.

In Massachusetts, for example, a prenup cannot direct matters regarding the couple’s children (custody, child support, college, etc.), but it can address the following issues. (See box above.)

For physicians, a prenup will be useful in protecting income and assets, including a medical practice. Your practice may be (or will become) your most valuable asset. Absent a prenup, closely held and privately owned businesses (even those started before the marriage) are considered marital property, no matter the duration of the marriage. If a divorce occurs, this asset may need to be valued, and then a buyout of the nonpractitioner spouse’s share will take place. This could translate into a physician paying hundreds of thousands to an ex-spouse.

The prenup can declare that certain classes of assets (such as a medical practice) are separate property and therefore no valuation or costly buyout is necessary.

Marriage is a partnership. You would not enter a medical partnership without an agreement, so you would also be wise not to enter the marital partnership without a prenup.

Among other assets protected by prenups are houses (including the marital home), assets acquired before the marriage, retirement assets, family monetary gifts and inheritances.

The list is endless. For a physician, such an agreement can be invaluable.

Carolyn “CiCi” Van Tine is a prominent divorce and family law attorney at Boston law firm Davis Malm. Send your legal questions to medec@mjlifesciences.com.

Alimony, which is the money one party would pay the other for support for a determined period. Without a prenup, this could be as high as one-third of one’s income for life. A prenup can waive alimony (no matter how much someone earns) or limit the amount or the duration of payments.

Division of assets, which involves deciding what will be considered marital property and how much of the marital property each party receives (if any). Assets can be tangible (real estate, bank accounts, retirement and investment assets) or intangible (business licenses, certain trust assets, inheritance expectancies).

Division of debt, which involves deciding who is responsible for debt. This includes any class of debt, including premarital debt (like student loans) and unsecured or credit card debt.
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TECHNOLOGY

Cybersecurity  How medical practices can protect patient data from hackers

By Lisa A. Eramo, M.A. Contributing Author

Picture this: You come into the office and all your electronic patient files are encrypted. When you try to access them, this is what you see: “You can't access information unless you pay a ransom.” If you’re lucky, it might only be a few thousand dollars. Experts say “bad actors” have been known to demand hundreds of thousands of dollars or more. Without a system backup, you could face significant operational disruptions.

“The data that medical practices have is incredibly valuable to the bad guys,” says Errol Weiss, M.S., chief security officer at Health Information Sharing and Analysis Center (H-ISAC), a global, nonprofit, member-driven organization that collaborates with other entities to share vital physical and cyber threat intelligence and best practices.

What’s so valuable about patient records? The information that’s inside — names, dates of birth, addresses, financial information, and more. Hackers can sell it on the dark web (i.e., private computer networks that communicate and conduct business anonymously without divulging identifying information, such as a user’s location), open credit cards and more, says Weiss.

Even small practices are not exempt as targets. “Small medical practices are low-hanging fruit for hackers because they haven’t typically tightened down their cyber environment,” says Emily Jones, practice leader and director of operations at Warren Averett Technology Group. “You’re never going to get a risk of zero, but there are measures you can put in place to protect yourself and your patients.”

1 **Perform a security risk assessment.** Not only is this a Health Insurance Portability and Accountability Act requirement for all covered entities, it can also help practices identify specific areas of vulnerability, says Vanessa Bisceglie, MBA, president and CEO of CareVitality.

2 **Invest in staff training.** Once you know your practice-specific vulnerabilities, provide targeted education. “Your employees need to be your first line of defense,” notes Jones.

   The good news? Between webinars and free eazines, there are plenty of ways to educate staff on a tight budget, says Weiss. It’s the simple strategies that can be most effective, says Linda Renn, vice president at STAT Solutions, Inc.

3 **Perform patch updates.** Cybersecurity threats change quickly, and software can immediately become vulnerable, says Weiss. Patch updates are designed to fix security vulnerabilities and other bugs so hackers can’t hack patient records as easily. Make it a habit to check for systems updates regularly, he adds.

4 **Enable multifactor authentication on all devices.** Multifactor authentication requires users to provide two or more verification factors (e.g., password and answer to a security question). Why is this important? “All password resets go to your email,” says Weiss. “If the bad guys have access to your email, it’s game over for you.”

BUSINESS EMAIL COMPROMISE: WHAT YOU NEED TO KNOW

Business email compromise is one of the most common methods for cyberattacks. Here’s how it works: Hackers go to a medical practice’s website, reverse engineer staff email addresses, and then send countless emails with malicious links to employees, often posing as vendors, colleagues, or even patients. All it takes is one click, and the hacker has entered your network where they’re free to steal patient data or potentially breach your bank account, says Bisceglie.
5. **Create a password policy.** For example, prohibit employees from using the same password for personal and work devices, says Jones. Why? If a hacker gets access to one, they have access to both.

“Hackers move laterally,” she says. “They see where you bank or where you work, for example, and then try using the same credentials.” Requiring employees to change their password every 60 or 90 days is also important. So is using a complex password of 12 characters that includes a combination of symbols, numbers and upper- and lowercase letters.

6. **Use encryption.** Make sure all hardware devices and emails that hold electronic patient health information are encrypted, says Bisceglie.

7. **Configure your firewall correctly.** A firewall is a device (either physical or virtual) that acts as a barrier to permit or deny access to your practice’s network. When configuring the firewall, you’ll need to think about internal and external access, says Jones. For example, what vendors (e.g., transcription companies, coding outsource companies, or telehealth vendors) will you permit to access your network? What websites will you permit staff to visit?

8. **Separate your guest Wi-Fi and medical practice networks.** “If you don’t do this, someone who knows what they’re doing can get into the practice’s network and access medical records in a matter of minutes,” says Jones.

9. **Ensure role-based access to electronic health records.** “Many times, vendors give broad access when the system is set up, and it’s up to a practice to really cut the access down and give staff the minimal access they need to do their role,” says Bisceglie. In the event of a breach, role-based access may help restrict the information to which hackers have access.

10. **Back up your system.** “If you don’t back up your systems and check those backups, a ransomware attack can be devastating,” says Weiss.

Make sure backups are off-site and, if possible, on a separate electric grid, Renn says.

11. **Consider cyber liability insurance.** However, know what type of coverage you’re getting, advises Bisceglie, adding that practices should ask about coverage specifics, deductibles and required prerequisites for coverage.

12. **Retain a cyber liability attorney.** This should be the first person you call if you suspect your practice has been hit with a cyber-attack because they can advise you on what to do next, says Renn. “If you don’t follow the right steps, the insurance company could null and void your coverage.”

Don’t just assume you can pay ransomware, says Renn. Engaging in a financial transaction with a sanctioned country, for example, could mean major civil and criminal penalties. “Contact your legal team because sanctions risks can be complex,” she says. “Your cyber liability attorney will be able to guide you in this area.”

13. **Consider managed cybersecurity services.** Small medical practices may not be able to afford an IT staff member to focus on cybersecurity. That’s why having someone else do it may be the best option, says Weiss. A managed cybersecurity services provider will properly secure the medical practice’s network and provide ongoing cybersecurity monitoring services. Weiss says to consider these questions when vetting providers:

- What does the provider do when it detects malicious activity?
- Can the provider detect when a breach has occurred? Can they detect when data has been lost?
- Does the provider give recommendations on enhancing security? Are they available 24/7?

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**Creating an annual operating budget for cybersecurity**

Not sure how much to budget for a cybersecurity risk mitigation strategy? Bisceglie says to consider the following five must-have line items and their approximate costs:

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Fixing the primary care system after the COVID-19 pandemic

A strategic blueprint for fixing primary care

By Timothy Hoff, Ph.D.

Nothing in the U.S. health care system will be or should be the same after a two-year global pandemic. Our primary care system has recovered in some ways from the sudden financial shock and the loss of patients, but a closer look suggests it is still the same underperforming, under-funded, and under-cared-for prepandemic system. That needs to change over the next five years. Here is a blueprint detailing how.

**GOAL 1 Transform the Way Health Care Treats the Primary Care Workforce**

We knew that doctors, nurses and pretty much all other primary care workers were overworked and burned out prior to the pandemic. The pandemic made it worse. Things like burnout and job dissatisfaction do not get better on their own. Health care employers will have to radically alter how they view and treat their workforce. In business, successful companies apply a concept called “talent management,” which involves a sustained and holistic approach to recruiting, motivating and retaining workers. It forces organizations to become desirable places to work. It also involves employers seeing their employees as individuals with unique needs, wants and situations. To achieve this goal, primary care employers must move beyond compensation as the chief human resource focus for physicians, nurse practitioners, physician assistants and nurses, and work on meeting the full range of their workplace needs. Employers must redesign health care jobs and work settings with this in mind.

**GOAL 2 Allow Patient Choice to Drive the Primary Care Marketplace More, Not Less**

Patient choice was never really taken seriously in primary care before the pandemic. But it must be taken seriously now. For example, the inconveniences that still exist in trying to schedule, get to and follow up on primary care provider visits are unacceptable. Patients want choices for when and how they access their primary care. They want low-cost options, virtual and in-person options, easy access and convenience, and real-time communication. Primary care providers and their offices need to embrace digital health tools and a new mindset that regards patients as their customers. Virtual primary care delivery, which has fallen off dramatically since the height of the pandemic, should become more mainstream than it is now, especially for certain diagnoses and for patients with already established relationships with primary care providers. Electronic patient care portals must be more interactive, operate in real time, and be designed with input from the user, the patient, on how they wish to use them. Most patient portals remain asynchronous, lack interoperability, and are limited in their functionality from the consumer side.

Patients should have 24/7 access to their primary care provider’s office, not just nine-to-five access. That’s a mindset change as much as anything else, and primary care doctors know it. Yes, payment will need to account for some of this extra access and time by providers (see below), but payment cannot be used anymore as an excuse. Physician-centric primary care as we know it will continue to decline unless patients have more choice in how they wish it to be organized and delivered to them. Primary care physicians will continue to lose relevance with their customers if they do not deliver on the choice imperative.
GOAL 3: Stop Big Delivery Systems From Making Primary Care a “Loss Leader”
Big delivery systems that continue to spread weedlike throughout the U.S. treat primary care as something beneath them—a loss leader important mainly for stopping patient “leakage” to outside specialists and other delivery systems with whom they compete. These systems, most with hospitals and powerful specialty groups at their core, must be forced to take primary care delivery more seriously in letting their primary care providers, and not their specialists, manage more of the chronic disease and preventive needs of their patients. They need to make their brand of primary care less transactional and corporate-like, and more relational and human. They need to be incentivized or forced to focus on keeping their patients healthier. In a best-case scenario, there should be more free-standing primary care offices that are not so closely aligned economically with these large hospital-based systems. This falls on individual primary care doctors to make happen and on government and venture capital to help seed fund it. Collaboration with tech companies that can provide digital health tools for these stand-alone practices at reduced cost is also a good idea.

GOAL 4: Give Payment Control to the Primary Care Provider and Patient
We have been saying for decades how we need to invest more in primary care and keeping people healthy. But it really has not happened. Call it value-based reimbursement, bundled payment, global capitation, whatever—the words no longer matter. They are the toothless, feel-good vocabulary of an army of policy makers and industry executives who have been unable to see the follies of an approach to fixing primary care payment that depends on providers creating reams of documentation; moving through authoritarian quality checklists for every type of visit and patient; reading and reacting to a mass of analytics about how they should take care of their patients; and being chastised constantly for falling short per some half-evidence-based clinical guideline.

That’s not a good payment system. That’s a Pavlovian one that turns primary care providers into dissatisfied and burned-out lab rats. Move to payment systems that return on-the-ground decision-making and control to the individual provider, payment systems that reflect trust in how they do their jobs. Give providers the freedom to interact with patients how they see fit, and in the process get rid of much of the inane documentation requirements that add no value for either patient or provider. Not everyone needs a detailed checklist to help assure they receive appropriate care. Hold primary care providers accountable but in more global ways that do not require them to justify their decisions for every patient. Push risk onto them but also give them the appropriate amount of funds up front to manage this risk at a population level; don’t dole out the dollars in piecemeal fashion.

GOAL 5: Amass an Army of Primary Care Providers at Different Skill Levels
We know there won’t be enough primary care physicians to meet the needs of our system moving forward. But we also face shortages of nurses and medical assistants, both of whom increasingly shoulder more administrative and basic care duties in primary care. Medical schools alone cannot be relied upon to turn out more primary care physicians. They have no incentive to do so.

More initiatives of the kind that Kaiser Permanente has developed, in which they invest in developing primary care physicians, should be encouraged. There needs to be much more loan forgiveness for those wishing to pursue primary care careers. Establishing a plethora of health training programs in community colleges for medical assistants, who now do most of the primary care prep work, makes sense, and reaching into high schools to attract select individuals to such careers can be part of that initiative. Make the employers who need these types of positions invest in the training programs in return for having graduates work locally in their organizations for a period of time.

These are just the big picture strategies, and there is much more to do. But until the overarching blueprint gets articulated and adopted, the tactical details will remain devalued.

Timothy Hoff, Ph.D., is a professor of management, healthcare systems, and health policy at Northeastern University in Boston, Massachusetts, and author of the new book, “Searching for the Family Doctor: Primary Care on the Brink” (Johns Hopkins University Press).
The physician shortage

Why concierge medicine may be the solution, not the problem

By Terry Bauer Contributing Author

As the pandemic slowly morphs into an endemic, its impact on primary care physicians continues to tug at the seams of an already fraying health care system. Now rising to the top of America’s health care challenges is the looming physician shortage, predicted with increasing urgency every year since the early 2000s. The Association of American Medical Colleges now estimates a shortage of between 37,800 and 124,000 physicians by 2034, accelerated by a perfect storm of pandemic closures, physician retirements, an aging population and escalating demand for care. Simultaneously, the surging popularity and predicted 10% annual growth of concierge medicine practices, characterized by intentionally small patient panels, appears to be intensifying the issue.

However, appearances can be deceiving and the opposite may prove to be true: concierge medicine is not fueling the physician shortage but may represent one of the most viable potential solutions. By presenting a sustainable model that eliminates much of the burnout pummeling the spirits of our country’s health care providers, concierge medicine is extending the active practice years of experienced physicians, keeping the doors of primary care practices open and inspiring new generations to enter the field.

The dialogue on how to fix a broken health care system, which began well before the pandemic, has shifted to increased recognition of the value offered by concierge medicine. For example, Erin E. Sullivan, Ph.D., research and curriculum director at Harvard Medical School Center for Primary Care, told Scientific American: “(Before the) pandemic, I would have said, ‘We don’t have enough physicians choosing to practice primary care.’ And if those physicians who do choose primary care elect to practice in models such as concierge, then you could see how that would exacerbate a shortage. On the other hand, if these models prove to be more attractive or sustainable ways for physicians to practice primary care, then can we increase the number of physicians electing to practice primary care? And can we learn from these models to build something better and accessible for all patients?”

And when asked about the effect of concierge and direct primary care models on the physician shortage, Reid B. Blackwelder, M.D., past president of the American Academy of Family Physicians, told Medscape: “All these models are ways of investing in primary care. With the pandemic, we’ve made some changes in how we interact with our patients that I think were exactly what we needed.”

“Listen to your patient, he is telling you the diagnosis.” The observation made in the 1890s by internal medicine pioneer William Osler, M.D., CM, holds true for today’s physicians, who have accurately diagnosed the major cause of our system’s ills: volume-based care with little regard for the individual practitioner trapped on the hamster wheel. Doximity reports that over 75% of physicians said they were overworked, and 55% of physicians surveyed by Medscape said they would take a salary reduction to achieve a better work-life balance.

Failing to care for the caregivers in a traditional
fee-for-service practice model or in a large health care system group is quickening the exodus of dedicated physicians. The Advisory Board sounded the alarm earlier this year, writing: “There has never been a moment when we think doctors are more likely to quit. And even if they don’t quit, we question the quality of care that’s being delivered, given that burnout leads to worse patient outcomes and increased medical errors.”

In contrast, concierge medicine physicians are remaining in practice longer than initially planned, buoyed by intense professional satisfaction and the ability to balance work and life needs. Physician search expert Craig Fowler notes in his work on succession planning that doctors in a concierge practice consider retirement at a significantly older age than those in a traditional model. “They’re able to enjoy a good quality of work life and retire on their own timetable,” he says.

**Not the retiring type**
At Specialdocs we are privileged to work with many experienced physicians who remain more committed than ever to staying in active clinical practice. Here are some highlights:

**DR. J.W., RIVERSIDE, CT:**
“I’m now starting my 41st year as a physician and I’ve never loved being a doctor more.”

“Before transitioning with Specialdocs in 2018, I was ready to retire early. My spirit was completely broken by a medical system focused on superficial care and high patient volume. As a concierge physician, I am making a real difference in my patients’ lives, with time to take a thorough history at each visit or cut through the bureaucracy and arrange an urgent consult with a specialist.”

**DR. W.K., CHICAGO:**
“The term ‘burnout’ is no longer part of my vocabulary.”

“In the mid-2000s I felt I was just a few years away from retirement. The pace was such that I feared making mistakes I would regret. Changing to the Specialdocs model eliminated the day-to-day stress so well it’s added years to my practice. I’m in no hurry to retire now and am truly grateful that I was able to continue to care for my patients throughout the pandemic.”

**DR. E.B., WANTAGH, NY:**
“I undoubtedly would have left medicine earlier had it not been for my change to concierge medicine.”

“I was burnt out, and at 68, I felt my choices were limited to early retirement or joining a local large hospital group. Partnering with Specialdocs to launch a concierge medicine practice offered a much better alternative and I now plan to keep caring for patients as long as possible.”

**Keeping the doors open**
Among the pandemic’s many heartbreaking statistics is this one: In 2020 and 2021, more than 24,000 independent practices were reported permanently or temporarily closed. New data from the Physicians Advocacy Institute shows almost three-fourths of U.S. doctors now work for hospitals, health systems or corporate entities, an almost 20% jump since 2019.

We have long understood that the traditional fee-for-service payment model is not sustainable. Since 2001, Medicare physician payment has fallen 20%, adjusted for inflation, whereas the cost of running a medical practice has increased 39%. Becoming employed by a hospital system doesn’t provide a neatly packaged solution either, as most hospital-employed physicians earn 20% less than independent practitioners, according to Medscape.

Although a sense of normalcy is returning, for primary care physicians in traditional fee-for-service practices the situation remains bleak. According to the Primary Care Collaborative, nearly half of physicians say primary care is crumbling, over 40% describe themselves as mentally and financially fragile, one-third report they are currently denied and/or seriously overdue payments from insurers and health plans and only 21% find the fee-for-service form of payment sufficient. Most troubling, one in five physicians surveyed by the American Medical Association said they would likely leave their current practice within two years. This is an incalculable loss that will be felt for many years to come.

However, for concierge medicine physicians, although the pandemic was demanding, their professional survivability was never in question. A stunning 0% of concierge medical practices were closed during the pandemic, and they continue to thrive in 2022 based on a solid foundation of membership fee revenues. Freed from financial worries and overloaded patient panels, concierge physicians not only keep their doors open but their minds and hearts as well. As Dr. B.B. shares, in 2021 his long-time multidisciplinary cardiology practice in the Boston area was about to be shuttered because of the pandemic. “Making the change to concierge medicine with Specialdocs saved our entire organization with an approach that has enormously benefited patients and restored our joy in practicing medicine.”

Terry Bauer is CEO of Specialdocs, a concierge medicine pioneer that has transformed physicians’ professional lives since 2002.
Refresher: How to determine new vs. established patients

**Q:** We are implementing a policy to define new and established patients. Can you please refresh our understanding of how to determine this?

**A:** New patient codes carry higher relative value units and for that reason are consistently under the watchful eye of payers, who are quick to deny unsubstantiated claims.

**Who is a new patient?** According to the Current Procedural Terminology codebook, a “new” patient is “one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.”

The Centers for Medicare & Medicaid Services further defines a new patient in Medicare Claims Processing Manual, Chapter 12 (30.6.7) as follows: “An interpretation of a diagnostic test, reading an x-ray or EKG (electrocardiogram) etc., in the absence of an E/M (evaluation and management) service or other face-to-face service with the patient does not affect the designation of a new patient.”

What do each of these key components mean? Let’s break it down.

**PROFESSIONAL SERVICE:** If the provider has never seen the patient face to face, a new patient code should be billed.

**THREE-YEAR RULE:** The general rule in determining whether a patient is “new” is that a previous, face-to-face service must have occurred at least three years prior to the date of the current service.

**DIFFERENT SPECIALTY/SUB-SPECIALTY WITHIN THE SAME GROUP:** This area causes the most confusion. For Medicare patients, you can use the National Provider Identifier registry to see what specialty the physician’s taxonomy is registered under. For other payers, this usually is determined by the way the provider was credentialed.

**New to whom?** If a doctor changes practices and takes his patients with him, the provider may want to bill the patient as new based on the new tax ID. This is incorrect. The tax ID does not matter. The provider has already seen these patients and established a history. He cannot bill a new patient code just because he’s billing in a different group.

If a doctor of medicine (M.D.) or doctor of osteopathic medicine sends a patient to a midlevel provider, such as a nurse practitioner (NP) or physician assistant (PA), and the visit does not fall under “incident-to,” then the NP or PA should calculate new vs. established patient based on the specialty in which they are working. If the M.D. is a family practice provider and the NP sees hematology patients, for example, the specialty is different and a new patient code can be billed. But if the NP is also considered family practice, it would not be appropriate to bill a new patient code.

If one provider is covering for another, the covering provider must bill the same code category that the regular provider would have billed, even if they are a different specialty. For example, a patient’s regular physician is on vacation, so she sees the internal medicine provider who is covering for the family practice doctor. The internist must bill an established patient code because that is what the family practice doctor would have billed.

**Renee Dowling** is a compliance auditor at Sansum Clinic, LLC, in Santa Barbara, California. Send your coding and documentation questions to medec@mjhlifesciences.com.
Welcome to this special CardioView presentation. Atrial fibrillation (AF) represents one of the most common, yet overlooked, forms of cardiovascular disease. With the number of AF-attributed deaths increasing in recent years, optimizing management of the condition stands to have a significant impact on a patient and societal level. In this edition of CardioView, two experts provide an overview of AF and take a deep dive into the current state of its management, including risk factors, patient presentation, the role of implantable cardiac monitors (ICMs) and best strategies based on actionable data.

The guests for this special presentation of CardioView are:

**Deepak L. Bhatt, M.D., M.P.H.,**
Executive Director of Interventional Cardiovascular Programs, Brigham and Women’s Hospital, Boston, Massachusetts

**Solomon Sager, M.D.,**
Director of the Electrophysiology Division and Managing Director of the Chicago Cardiology Institute, Chicago, Illinois

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**Risk Factors for AF**

**Deepak Bhatt, M.D., M.P.H.:** AF is the most common arrhythmia in the United States and worldwide, with a prevalence that is growing. Why is the prevalence growing? Because of a number of trends.

First is the aging of the population. In the U.S. and globally there are many older people and prevalence increases markedly in both men and women as people get older. When patients enter their 70s, 80s and 90s, the incidence of AF is much higher than at younger ages. So this is a real issue in terms of a growing burden of AF.

Beyond the aging population, several other factors appear to be contributing to AF. It wasn’t fully appreciated until relatively recently that obesity contributes to AF and it appears that weight loss can decrease AF burden.

Obesity is a risk factor for cardiovascular disease, whether it’s ischemic heart disease or heart failure. That’s well known, but it turns out that it is also a risk factor for developing AF. In people who have AF, obesity can also increase disease burden. Even in patients who have had an AF ablation, it appears that weight loss decreases the risk of recurrence.
Regardless of the stage of AF — at risk for it, has it, has had an ablation for it — it appears that weight loss decreases risks of recurrent AF, de novo AF, and AF after procedure. For patients who are overweight, particularly (those who are obese, if they’re asking what can they do to decrease AF risk, weight loss is definitely on that list.

Another risk factor that’s relatively new is alcohol intake. A number of studies now point to the fact that even a single drink a day increases the risk of AF. This is true of people who have AF and it also appears to be true of people who are just at risk for AF but don’t have it yet.

In terms of things patients can do to decrease AF risk, they can cut down or eliminate alcohol intake. That’s not always a popular answer, but that’s what the data show. We know that binge drinking can precipitate the occurrence of AF; that’s been known by physicians for years. There’s no question that acute alcohol intake, especially large amounts, can trigger AF, but what’s novel and true is that more modest chronic intake can do it as well. Studies show that even a single drink can increase the risk of developing AF.

Interestingly, we’ve thought coffee or caffeine intake is a trigger for AF, but the trials are more ambiguous about whether that’s true. I’ve certainly met patients who are convinced that AF has been triggered by caffeine intake, but that’s not been as clearly established by rigorous clinical trial data.

It can get tricky because if someone is drinking a lot of caffeine, it might mean they’re also staying up all night, under a lot of stress and not eating right. So there are other bad things going on that could also serve as triggers for AF.

It gets tricky figuring out what an actual trigger for AF is. I’m not saying that an individual patient’s caffeine, stress and lack of sleep might not be part of it. I’m sure it is, but in terms of very rigorous data, we can say with certainty that alcohol is a trigger for AF.

Challenges in AF Treatment

Bhatt: Although AF is very common, there are a lot of challenges to it as well. There’s been a lot of controversy through the years.

For example, is rate control sufficient or do we also need to control the rhythm to restore normal sinus rhythm? Intuitively, it makes a lot of sense to restore normal sinus rhythm, but older trials suggested no benefit to a rhythm control strategy versus rate control alone.

Obviously, you need to control the (person’s) rate if (it) is very quick. You want to get their heart rate down with beta-blockers, calcium channel blockers or those sorts of medicines, but should you also restore a normal sinus rhythm? Then should that be done with anti-arrhythmic medications, like amiodarone and dronedarone, or should that be done with procedures? Or should it be done with medicines, and if people fail medicines, then procedures?

The general feeling is that if people are healthy, not having heart failure and (are) asymptomatic, rate control is probably sufficient, but if they’re very symptomatic with their AF it’s important to see if the rate is controlled with exercise. Even if it is controlled at rest, it may not be well controlled with exercise, especially in younger more active people.

Assuming that the rate is well controlled, if they’re still symptomatic, that is a reason to do more with drugs, procedures or potentially with both. In part it depends on underlying comorbidities, patient preference and so forth. Obviously, AF ablation is an invasive procedure. There can be complications, but the procedure has (become) safer, especially in experienced hands.

In patients with heart failure as well, there appears to be a benefit of ablation. Even some meta-analyses suggest there might be lower mortality in patients, especially patients with heart failure with reduced ejection fraction who have AF, (if they) undergo ablation. It’s a bit controversial, but there are meta-analyses that support that.

In a young person, what about them? There are a lot of challenges. On the one hand, they’re probably going to tolerate things pretty well if they have rate control without rhythm control. On the other hand, the longer people are in AF, the harder it is to get out of it. So we’re in a theoretical appeal to try to restore normal sinus rhythm early before the left atrium remodels, dilates, and becomes fibrotic.

There’s some work looking at things like MRI (magnetic resonance imaging) to see if left atrial
fibrosis can help guide exactly what our therapy should be.

There are a lot of challenges in knowing exactly what to do with AF in different patients. Randomized clinical trials and guidelines are useful in that decision-making, and ongoing research such as the imaging research might end up being really useful in terms of tailoring therapy to different types of patients with AF.

**Leveraging ICMs for AF Diagnosis**

**Solomon Sager, M.D.:** We use ICMs quite frequently in patients who have undergone full workups and still don’t have a diagnosis but (have) symptoms such as syncope, palpitations or dizziness.

There’s two different ways that we can reach the diagnosis. First, the patients have a button that they can push, which will have the ICM store data from a certain period of time from before and after ... they clicked that button. The amount of time before and afterward is proprietary to each company’s device.

The second way is that the devices are automatically set to look for low and/or high heart rates based on algorithms in each device, even if a patient doesn’t have the clicker by their side to click when they have symptoms. If something abnormal happened, the device will automatically store that data and then will communicate it via the programmer at the patient’s bedside to the cloud. Most practices and hospitals are checking that data on a daily basis to allow for ongoing communication within 24 hours of symptom onset.

**AF’s Comorbidity Burden**

**Bhatt:** The predominant risk we worry about is stroke. (In other words) systemic embolism, primarily left atrial appendage thrombus going to the brain causing stroke, but it can go elsewhere as well. For example, it can have emboli to the coronary arteries, causing a myocardial infarction. It’s an unusual cause of myocardial infarction, but 1% to 3% of myocardial infarctions and acute coronary syndromes are due to emboli from the left atrial appendage from AF.

Other places that systemic emboli can lodge in are the kidneys and the feet, causing acute peripheral limb ischemia or kidney failure. Those are much less common than stroke, but systemic embolism is also on the list of bad things that AF can cause. But by far, numbers 1, 2 and 3 are thromboembolic stroke.

Other complications include heart failure, and AF can contribute to heart failure. It can prompt episodes of heart failure, including in patients with heart failure with preserved ejection fraction but also in those with reduced ejection fraction. Sometimes it can be the sole cause for heart failure, not just worsening heart failure that otherwiseexists, but promoting or causing that heart failure. In particular, if the rate of AF is very high, that can cause a tachycardia-induced cardiomyopathy, and controlling the rate might be sufficient to reverse that if the AF is detected early enough.

In any work-up for heart failure, you always want to see if AF is a cause and screen for things like thyroid disease, which can lead to heart failure and atrial arrhythmias. So it’s important to remember that. In terms of negative outcomes in AF, stroke is at the top of the list, but you always want to (remember) that it can cause or promote heart failure.

Among the arrhythmias, AF creates the greatest burden. It’s a burden in terms of the patient’s morbidity and mortality, in terms of stroke and heart failure risk. Beyond the patients, it’s also a burden to the health care system. It’s a major cause of health care costs. AF is a growing burden for reasons I cited previously, in terms of an aging population and other risk factors that are increasing the prevalence of AF.

This is AF that we’re detecting clinically because it’s jumping up and getting our attention. It doesn’t even capture AF that’s silent. That’s a big issue because for a nontrivial proportion of strokes, often the first presentation of AF is with a stroke, sometimes a very disabling stroke. Strokes

“I can tell you from my own practice that for AF management, the earlier you get an ICM in the more likely you are and the sooner you are to get data that is actionable for patient care.”
in the context of AF can be quite disabling.

There's the burden of AF-induced stroke, the disability it causes to patients and downstream health care costs. Sometimes the strokes can be fatal, not just disabling. A lot of burden is placed on patients who have AF, including the ones who have silent AF but then go on to have complications such as stroke, which is an enormous burden on the health care system.

Advantages of Early ICM Uptake

Sager: What we talk about a lot is the timing of when we want to implant ICMs. This is an ongoing topic of conversation.

In the current health care paradigm, there's an ongoing dialogue between doctors and insurance companies about what needs to be done before we can recommend an ICM for patients. Depending on the insurance plan, there are different policies and different guidelines for all the diagnoses.

There's a lot of great data that would suggest that the earlier you get an ICM into patients, the better it is for them. It can avoid many unnecessary health care costs including unnecessary monitoring and procedures that may be preempted by just getting to the ICM right away.

Moreover, the longer the period of time that you ... monitor ... patients' beat-by-beat analysis, the more likely you are to find a diagnosis and potentially discover data that can lead to improved clinical care. There are multiple ongoing studies determining when the optimal timing is for using ICMs.

I can tell you from my own practice that for AF management, the earlier you get an ICM in the more likely you are and the sooner you are to get data that is actionable for patient care.

ICM Benefits in Clinical Decision-Making

Sager: AF is the new paradigm for ICMs. We used to use them only for syncope or for cryptogenic stroke or for undiagnosed symptoms. However, as the usage of ICMs and the technology has improved, we've started to use it much more for the management of AF.

The data that we collect over a period of time can help us determine what the best course of treatment is for our patients and to individualize the care for each patient. (An ICM is) a powerful tool and patients have to do minimal activity in order to generate the data. The monitor for the device just sits by their bed and overnight the communicator by the bed sends the data to a web-based portal from which we the doctors and our technicians can gather information every morning to help us guide clinical decision-making.

When we're managing patients with heart rhythm disorders, the more data we can collect, the better it is for patient care. ICMs allow us to collect data on a beat-by-beat basis for up to three to four years. They are inserted very easily under the skin. It takes about 60 to 120 seconds and can be done in the office. The data that we collect can guide a variety of different clinical decision-making scenarios.

It helps us guide medical management for patients with AF. It helps guide what kind of ablations we may want to perform based on whether the AF is paroxysmal, persistent or even permanent. It helps us decide whether or not patients have enough AF that would warrant anticoagulation and it helps guide decisions regarding anti-arrhythmic therapy. Sometimes patients have palpitations and we're not sure if they have AF, and the ICM can help us to diagnose AF in those patients.
AIDING UKRAINE

By Jeffrey Bendix, Senior Editor

Taras Mahlay, MD, is an internist with University Hospitals in the Cleveland, Ohio, area. Mahlay’s parents emigrated to the United States from Ukraine in the 1940s to escape the Soviet Union, but Mahlay has always stayed involved in the Ukrainian community. Now the physician is helping the war-torn nation by helping to collect and send needed medical supplies. The interview below has been edited for length and clarity.

Medical World News®: How did you get involved with collecting medical supplies and sending them to Ukraine?
Mahlay: I’ve always been involved in the Ukrainian community. And since Ukraine became an independent country in the 1990s, I started traveling over there. And actually, I met my wife there, who is also a physician. I’ve always been helping with supplies, and even lecturing in Ukraine. Basically, I’ve been getting them more prepared for the Western world as opposed to the old Soviet state.

Medical World News®: What sorts of supplies have you been sending?
Mahlay: At first, we just would ask for any supplies. We’re getting a lot of PPE (personal protective equipment), gowns, gloves, masks, and sanitizing items. We had tremendous gifts from various hospitals and from people to the point that we were really stocking up on those things. Now I’m in contact with Ukraine, both with my colleagues there and with the Department of Health. Technology is pretty instantaneous, so I’m getting texts, Facebook messages, (and calls or texts through) Viber and WhatsApp with the needs of the different hospitals. And the biggest thing that they really need is wound care.

You do see some of the things that are happening on TV and on the internet. But there’s a lot more injuries than the 1 bomb or missile that hits an apartment complex. So there’s many injured (people) and the hospitals are overfilled. Right now we’re mostly sending gauze wraps and orthopedic supplies, because there’s been a lot of broken bones, and IVs.

Medical World News®: How do you get the word out to get the supplies?
Mahlay: After the invasion happened, the next day I was on the phone, calling different vendors and hospitals. In my community after 30 years, you develop a lot of relationships. It’s been overwhelming how much everybody’s been helping.

Medical World News®: And you already had the supply chains established for getting them materials over there, it seems?
Mahlay: Well, yes. But before, there was no rush; we would collect things, ... gather enough pallets until we had enough for a shipment that would ... show up in 4 to 6 weeks. Well now they need it yesterday. The other problem is (that regarding) all the major cities in Ukraine, we can’t ship (to them) because of the war. So our chain is now flying it into Warsaw. And then from Warsaw, we have truckers that are coming from Ukraine across the border, picking up (the supplies and) driving them across the border. It’s basically volunteers driving the trucks. I don’t know all the details now because it changes daily, depending on what’s getting bombed, what’s not getting bombed, and where you can go and what bridges are out.

So our supply chain has changed significantly from what (we’ve been) doing over the last several years. And whenever we send a shipment, it becomes a lot more difficult. But we do have some people on the ground and we try to monitor that the shipments are getting to the hospitals.

Medical World News®: What do your patients, colleagues, and people you encounter here say when they hear what you’re doing?
Mahlay: Everybody’s encouraging. My office manager has kind of blocked off time on my schedule. In between patients I’m calling vendors, doing the logistics, and people are calling me. My partner said, “Whatever you need, take the time off, do whatever.” My patients started asking me questions (about) where to donate and how to donate.

Medical World News®: How long do you think you’ll keep doing this?
Mahlay: My plan is to do as much as I can.
Learning Objectives
Upon successful completion of this activity, you should be better prepared to:
• Describe the clinical burden of anemia in patients with chronic kidney disease (CKD)
• Discuss the pathophysiology of anemia in CKD, including therapeutic targets

Acknowledgment of Commercial Support
This activity is supported by an educational grant from GlaxoSmithKline.

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To learn more about this topic, including information on guideline recommendations for the diagnosis and treatment of anemia in CKD, go to www.gotoper.com/acp22-art
The prevalence of anemia in patients with chronic kidney disease (CKD) is double that of the general population.1 Even during the earliest stage of CKD, 8% of patients have anemia, compared with 6% of people without CKD. As CKD progresses, the prevalence of anemia increases to more than half of patients with stage 5 CKD. However, anemia in CKD is underdiagnosed and undertreated, particularly in primary care settings.2,3 Here are three things you should know about causes and effects of anemia in CKD.

1. Anemia in CKD can negatively impact patients.

Anemia in CKD is associated with poorer renal outcomes and an increased risk of cardiovascular (CV) events, including myocardial infarction, stroke, left ventricular hypertrophy, heart failure and mortality.4,5 In a study of non–dialysis-dependent patients with CKD, patients with anemia had a higher number of CV comorbidities than those without anemia, and these CV comorbidities were associated with a reduction in quality-of-life (QOL) measures and work productivity.6 The risk of CV events is higher in patients at any stage of CKD versus unaffected individuals; however, the risk markedly increases in patients with stage 4 to 5 CKD, with CV events being a major cause of death in these patients.4

Symptoms related to decreased tissue perfusion, which may include fatigue, shortness of breath, headaches and reduced mental acuity, can also adversely impact patients’ QOL.8 A recent international survey of physicians and their patients with CKD (both non-dialysis-dependent and dialysis-dependent) found that lower hemoglobin (Hb) levels correlated with worse patient-reported health-related QOL outcomes and diminished work productivity that were independent of CKD stage and other comorbidities.7

2. Many factors can lead to the development of anemia in CKD.

The decreased production of erythropoietin (EPO) is the primary driver of anemia in CKD, but other factors may include inflammation, absolute and functional iron deficiencies, a shortened red blood cell life span, bleeding abnormalities and malnutrition.9 Anemia in CKD can be a form of anemia of chronic disease (also called anemia of inflammation) that is associated with increased levels of interleukins and pro-inflammatory cytokines.9 Up to half of patients with end-stage renal disease exhibit serologic evidence of an active inflammatory state with increased levels of C-reactive protein and pro-inflammatory cytokines.10 Absolute iron deficiencies may be related to blood loss or malnutrition, and inflammation-related upregulation of hepcidin — an important regulator of iron homeostasis — can result in functional iron deficiencies.11 Hepcidin causes the iron transport protein ferroportin to be internalized into enterocytes, hepatocytes and macrophages and then degraded.12 A lack of ferroportin prevents iron absorption in the intestine and traps iron in the liver and macrophages, decreasing the amount of iron that is in circulation and available for erythropoiesis despite adequate iron storage levels.11

Due to the lack of EPO production in anemia in CKD, erythropoiesis-stimulating agents (ESAs) have traditionally been used to raise Hb levels.6 Although effective at reducing transfusion requirements, ESAs are associated with CV risks at higher Hb targets, and optimal target levels have not been established. Iron replacement is also often needed to treat iron deficiency, avoid transfusion and maximize response to ESAs.13 However, oral iron may cause adverse gastrointestinal effects, and elevated levels of hepcidin may limit absorption of oral iron.14 Intravenous iron may be inconvenient, especially for non–dialysis-dependent patients, and it may cause hypersensitivity reactions.

Determining any contributing factors to anemia in CKD is essential to guide treatment.
Recent insights into the pathophysiology of anemia in CKD may lead to new treatment options.

The ability of cells throughout the body to sense tissue oxygenation via the hypoxia-inducible factor (HIF) pathway has created a greater understanding of the pathophysiology of anemia in CKD, with potential for new therapeutic targets. As shown below, HIF-alpha and HIF-beta proteins, along with HIF-specific prolyl hydroxylase (HIF-PH) enzymes, are key elements of this pathway.6

HIF-PH enzymes require oxygen as a co-substrate and therefore act as oxygen sensors in cells. HIF-alpha is continuously produced, but, when oxygen levels are adequate, it is quickly hydroxylated by HIF-PH enzymes.15 Once hydroxylated, HIF-alpha undergoes ubiquitination and proteasome degradation.8 Conversely, HIF-beta is constitutively produced but is not sensitive to hypoxic degradation. Under hypoxic conditions, HIF-PH enzymes do not hydroxylate HIF-alpha. Subsequently, HIF-alpha accumulates and travels to the nucleus, where it dimerizes with HIF-beta.9 This heterodimer activates hypoxia response element genes, which result in increased EPO and red blood cell production and decreased hepcidin levels.16 Other target genes encoding enzymes and transporters involved in iron metabolism, angiogenesis and mitochondrial genesis are also activated.

HIF-PH inhibitors are emerging oral agents for anemia in CKD that block HIF-PH enzymes from hydroxylating HIF-alpha at normal oxygen levels.16 HIF-alpha can then proliferate, translocate to the nucleus, dimerize with HIF-beta and activate the hypoxia response element target genes. Through this mechanism, these agents can stimulate the production of endogenous EPO and potentially modulate hepcidin levels and iron homeostasis.6 HIF-PH inhibitors are in various stages of clinical development and have been studied in both non-dialysis-dependent and dialysis-dependent patients to raise Hb levels.17-22 Major adverse CV events have been the primary safety signal in trials.

The HIF pathway under normoxic (left) and hypoxic (right) conditions.

KEY REFERENCES
1. Which of the following is a true statement regarding anemia in patients with chronic kidney disease (CKD)?
   A. Anemia rarely occurs before patients reach stage 3 CKD.
   B. Anemia generally only affects quality of life in patients once their CKD is serious enough to be managed by a nephrologist.
   C. Anemia is associated with cardiovascular (CV) risk in patients with CKD even if they are not dialysis dependent.
   D. Raising hemoglobin to high targets in these patients lowers their risk of CV complications.

2. All of these factors commonly play a role in the pathophysiology of CKD anemia EXCEPT which of the following?
   A. Inflammation
   B. Increased erythropoietin (EPO) due to EPO resistance
   C. Reduced life span of erythrocytes
   D. Iron deficiency

To learn more about this topic, including information on guideline recommendations for the diagnosis and treatment of anemia in CKD, go to www.gotoper.com/acp22-act
Jorge Plutzky, MD
Director, The Vascular Disease Prevention Program
Director, Preventive Cardiology
Brigham and Women’s Hospital
Associate Professor
Harvard Medical School
Boston, MA

This activity was written by PER® editorial staff based on an online activity developed with Dr Plutzky.

Faculty, Staff and Planners’ Disclosures
In accordance with ACCME Guidelines, PER® has identified and resolved all COI for faculty, staff and planners prior to the start of this activity by using a multistep process.

Disclosures (Dr Plutzky): Grant/Research Support: Boehringer Ingelheim; Consultant: Amgen, Edios Esperion, Novo Nordisk, Sanofi.

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Release Date: July 1, 2022
Expiration Date: July 1, 2023

Learning Objectives
Upon successful completion of this activity, you should be better prepared to:

• Identify which patients are most likely to benefit from PCSK9 inhibition for the treatment of hypercholesterolemia
• Evaluate efficacy and safety data regarding PCSK9 inhibitor therapy for cardiovascular risk reduction in patients not achieving lipid treatment goals
• Discuss current evidence regarding access barriers for the use of PCSK9 inhibitors

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CONTINUING MEDICAL EDUCATION

Things You Should Know About Reducing Cardiovascular Risk With PCSK9 Inhibitor Therapy
Despite significant progress, better risk assessment and therapeutic management are needed to lower morbidity and mortality related to cardiovascular disease (CVD). Statin therapy is an effective option for many patients, but not everyone responds well to statins or can tolerate them. Demonstrated efficacy and increasing availability of inhibitors of proprotein convertase subtilisin/kexin type 9 (PCSK9) serine protease make these therapies a good option for lipid management in select patients. Here are 3 things you should know about lowering CV risk with PCSK9 inhibitors.

1. For effective lipid management in high-risk patients, more than statin therapy may be required.

A priority clinical goal is to address factors that contribute to risk for atherosclerotic CVD (ASCVD). The 10-year risk for ASCVD among persons aged 40 to 79 years based on the American College of Cardiology (ACC) risk calculator is stratified into low (less than 5%), borderline (5%-7.4%), intermediate (7.5%-19.9%) and high (greater than or equal to 20%). However, a calculation is not necessary in high-risk patients with familial hypercholesterolemia, a low-density lipoprotein cholesterol (LDL-C) level above 190 mg/dL, diabetes with an LDL-C level above 70 mg/dL or ASCVD. Current guidelines from the American Heart Association and the ACC recommend intensive statin therapy for patients with severe/nonresponsive hypercholesterolemia and diabetes with multiple ASCVD risk factors, as well as statin therapy for those with moderate calculated risk. Some patients who retain an LDL-C level above 70 mg/dL may require supplemental nonstatin therapy.

Additionally, patients may be statin intolerant, which is determined by assessing cognition, risk of diabetes, liver safety and statin-associated muscle symptoms (SAMS). SAMS can vary from myalgia and flu-like symptoms to myositis and, even more seriously, myonecrosis with myoglobinuria or acute renal failure. Statin discontinuation can increase the risk of ASCVD events; however, electronic health record data indicate that up to 50% of patients discontinue statins 6 to 12 months after the first prescription. Each patient must be treated with empathy and patience to identify the best therapeutic option.

2. PCSK9 inhibitor therapy significantly lowers LDL-C levels in patients at high risk for secondary CV events.

PCSK9 serine protease is a key regulator of cholesterol metabolism. Inhibitors of PCSK9 are now Food and Drug Administration approved for secondary prevention of CV events in adults with established ASCVD. Alirocumab and evolocumab are fully humanized monoclonal antibodies against PCSK9, and inclisiran is a small interfering RNA designed to inhibit translation of PCSK9 messenger RNA.

The FOURIER trial established efficacy of evolocumab in patients with CV disease (NCT01764633). Participants (N = 27,564) received either evolocumab or placebo, and evolocumab lowered LDL-C levels by 59% from a median of 92 mg/dL to 30 mg/dL (P < .001) without significant adverse events. A 15% relative risk reduction for the primary composite end point of CV death, myocardial infarction, stroke, coronary revascularization or hospitalization for unstable angina was observed. Patients with more severe disease tended to achieve even greater improvements following treatment with evolocumab. Clinical benefit was higher in patients with diabetes versus those without diabetes, with CV hazard ratio outcomes measured at 0.83 and 0.87, respectively. Relative risk reduction among patients with polyvascular disease (21%) was also greater.

Statin Discontinuation Is Prevalent.

25% to 50% of patients discontinue statins 6 to 12 months after their first Rx.
relative to those with single vessel disease (7%).

The ODYSSEY trial investigated the efficacy of biweekly alirocumab in patients (N = 18,924) meeting at least one lipid entry criterion (NCT01663402). Patients in the treatment group achieved an absolute LDL-C level reduction of 50 mg/dL, representing a 53% lowering of the LDL-C level than observed in the placebo group. This absolute benefit was greatest for patients with an initial LDL-C level above 100 mg/dL. In a comparison of patients with and without diabetes, an LDL-C level below 70 mg/dL was achieved by 68.3% and 65.8% of participants, respectively. Furthermore, patients with polyvascular disease experienced large absolute reductions in the risk of serious CV events following treatment with alirocumab.

The ORION-10 (NCT03399370) (N = 1561) and ORION-11 (NCT03400800) (N = 1617) phase 3 trials demonstrated the efficacy of inclisiran relative to placebo in participants who had elevated LDL-C levels despite receiving statin therapy at the maximally tolerated dose. In both trials, LDL-C levels were reduced by approximately 50% in the treatment groups. The occurrence of prespecified exploratory CV end points was lower in the treatment group versus the placebo group in both trials (ORION-10, 7.4% vs 10.2%, respectively; ORION-11, 7.5% vs 10.3%).

Helping appropriate patients gain access to PCSK9 inhibitor therapy is critical.

PCSK9 inhibitors have demonstrated clinical benefit, yet their underuse is substantial. A significant barrier to implementation of these therapeutics has been accessibility, with payer denial affecting 80% to 90% of on-label prescriptions for alirocumab and evolocumab. Additionally, cost sharing (out-of-pocket cost) has been a contributor to PCSK9 inhibitor underuse. Coupled with these challenges, resistance among clinicians to adopt new management options has also limited use of PCSK9 inhibitors. There is a call to action for health care providers to take steps that will enhance access to these agents for appropriate patients. For example, ensuring that adequate prior authorization documentation is provided will help to alleviate high payer rejection rates.

To reduce access barriers, the National Lipid Association has generated a checklist to aid in the PCSK9 inhibitor approval process. This list includes the presence of ASCVD, familial hypercholesterolemia (if appropriate criteria are met), recent lipid panel results, use of an adjunctive nonstatin lipid-lowering therapy and statement that the patient has not met their LDL-C reduction goals despite maximally tolerated statin therapy. Data indicate that statin use and indication documentation are among the most important factors in gaining payer approval for PCSK9 inhibitor therapy.

“Access to PCSK9 inhibitors has substantially increased over a relatively short period of time. As medication costs have come down and our ability to provide documentation has increased, we’ve seen that access and affordability have gone up.”

Jorge Plutzky, MD

KEY REFERENCES


For a full list of references go to www.gotoper.com/cr22pcsk9-art
CME POST-TEST QUESTIONS

1. Which of the following patients would benefit the most from further reduction of their low-density lipoprotein cholesterol (LDL-C) level?
   A. A 45-year-old man with hypertension, treated hypothyroidism and LDL-C level of 50 mg/dL
   B. A 55-year-old man who experienced a cardiovascular accident six months ago and who has hypertension and an LDL-C level of 75 mg/dL
   C. A 62-year-old man with nonischemic cardiomyopathy (ejection fraction, 37%) and an LDL-C level of 125 mg/dL

2. In the FOURIER study, the addition of evolocumab to a statin resulted in what degree of relative risk reduction for the primary composite end point of cardiovascular death, myocardial infarction, stroke, coronary revascularization or hospitalization for unstable angina?
   A. 5%
   B. 15%
   C. 25%
   D. 35%

3. In the ODYSSEY trial, patients treated with alirocumab achieved an absolute LDL-C level reduction of which of the following?
   A. 20 mg/dL
   B. 50 mg/dL
   C. 75 mg/dL

4. In the ORION-10 and ORION-11 trials conducted in patients with atherosclerotic CV disease (ASCVD) or an ASCVD risk equivalent who had elevated LDL-C levels despite receiving statin therapy at the maximum tolerated dose, approximately what percentage reduction in LDL-C level was observed with inclisiran administered subcutaneously every six months?
   A. 10%
   B. 30%
   C. 50%
   D. 70%

5. Which of the following is true regarding barriers to PCSK9 inhibitor therapy?
   A. Payers have provided unrestricted access to PCSK9 inhibitors.
   B. Cost sharing (out-of-pocket cost) has not been a contributor to PCSK9 inhibitor underuse.
   C. Failure to escalate guideline-recommended lipid-lowering therapies, including PCSK9 inhibitors, is a source of suboptimal LDL-C management.
   D. Documentation of clinical indication, statin therapy and current laboratory data are unlikely to help facilitate PCSK9 approval.

To learn more about this topic, including information on efficacy and safety of PCSK9 inhibitors and their safe and effective use, go to www.gotoper.com/cr22pcsk9-act
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