PM's 30th Annual Survey:

Making Every Dollar Count

As patient numbers and net income drop, DPMs surveyed cut some costs while investing in the long term with more spending on equipment, staff and computer technology.

BY STEPHANIE KLOOS DONOGHUE

The recession may be over, but its effects on doctor income are anything but, as revealed by *Podiatry Management*'s 30th annual survey. The 609 respondents saw fewer patients and reported an overall drop in fees, with solo doctors reporting a median net income decrease of 9 percent. Perhaps in an effort to stave off an even bigger drop in their net income, DPMs surveyed reduced expenses slightly and joined more managed care plans. They also grew their diabetic patient base and handled a higher percentage of wound care patients.

Membership in key professional organizations and Board certification continued to have a positive impact on income. DPMs surveyed sent more pairs of true custom orthotics to an outside lab each week—quite a feat, considering the drop in patient numbers. In addition, respondents invested more in new equipment, and a larger percentage incorporated such technology as digital x-rays. They spent more on staff and even boosted staff pension contributions.

This year, we've added some new cross-tabulations to further explore how such factors as age, gender, location and practice type may influence patient mix, managed care participation and percentage of diabetic and wound care patients. We will broaden our data compilation in next year's survey to explore other factors that may have an impact on practice choices, patient makeup and income.

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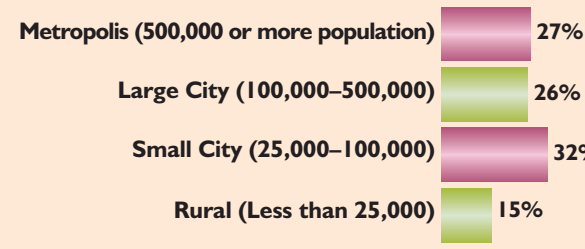
Fotosearch

RESPONDENT CHARACTERISTICS & TRENDS

New York on Top

Thirteen percent of the respondents to this year's survey practiced in New York, followed by California (7.6 percent), Florida (7.4 percent), New Jersey (6.7 percent) and Pennsylvania (5.9 percent). This breakdown was at least in part reflected by statistics from the U.S. Census Bureau (USCB). Its data indicates that the top five states in terms of population in 2011 were California, Texas, New York, Florida and Illinois, with Pennsylvania coming in sixth and New Jersey at eleventh. Top five states with populations of *65 and over*, a key patient demographic, were (in order of highest to lowest) California, Florida, Texas, New York and Pennsylvania.

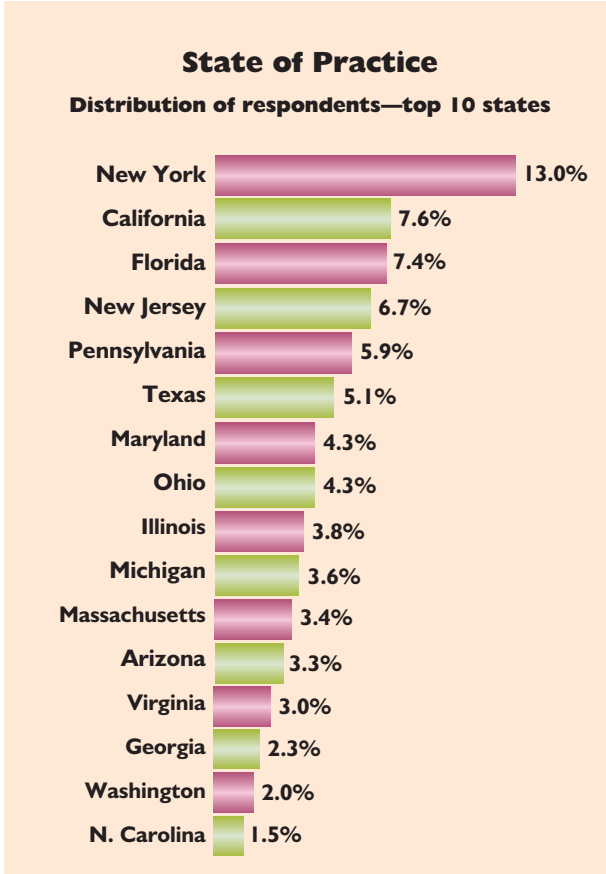
Migration patterns provide useful data for doctors looking to locate, relocate and open satellite offices. USCB data shows that from 2010 to 2011, the South and West experienced population increases while the Northeast and Midwest (formerly called North Central) saw a drop in population. States reporting the largest *percentage change* in population growth during this period were the District of Columbia, Texas, Utah, North Dakota and Colorado. The most common state-to-state moves in 2011 were New York to Florida (59,288 movers), California to Texas (58,992) and California to Arizona (49,635).



Little Change in Practice Location

Of those surveyed, 32 percent practiced in small cities (populations of 25,000 to 100,000), which was down slightly from 35 percent last year. While the percentage of those practicing in a metropolis (populations of 500,000+) remained unchanged at 27 percent, small gains were reported by large cities (populations of 100,000 to 500,000) and rural areas (populations of less than 25,000).

According to USCB statistics, several metropolitan areas experienced a surge in population growth from 2010 to 2011. Top five (in order of population change) were the metropolitan areas of Dallas/Ft. WorthArlington, Texas; Los Angeles/Long Beach/Santa Ana, Calif.; Houston/Sugar Land/Baytown, Texas; New York/New Jersey/Pennsylvania metropolitan areas; and Miami/Ft. Lauderdale/Pompano Beach, Fla.



Larger Percentage of New DPMs

There was a much larger percentage of new DPMs surveyed than in last year's report. This year, the majority (53 percent) of doctors were in practice 20 years or less, compared to 45 percent last year. Those in practice five years or less comprised 27 percent of the latest survey respondent pool, which was up from 14 percent in last year's report. The percentage of DPMs in practice less than a year grew from 5 percent last year to 13 percent.

This overall younger patient base will be shown to have had an impact on several areas in the survey results, including median net income and

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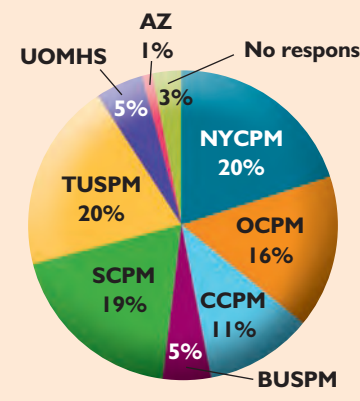

This Little Piggy Had ONMEL™
(itraconazole) 200-mg tablets

Provide the efficacy of itraconazole in a single, once-daily tablet[1]

Indications and Usage

ONMEL is indicated for the treatment of onychomycosis of the toenail due to *Trichophyton rubrum* or *T. mentagrophytes* in non-immunocompromised patients. Prior to initiating treatment, appropriate nail specimens for laboratory testing (KOH preparation, fungal culture, or nail biopsy) should be obtained to confirm the diagnosis of onychomycosis.

Important Safety Information for ONMEL

WARNING: CONGESTIVE HEART FAILURE, CARDIAC EFFECTS, AND DRUG INTERACTIONS

Do not administer ONMEL for the treatment of onychomycosis in patients with evidence of ventricular dysfunction such as congestive heart failure (CHF) or a history of CHF. When itraconazole was administered intravenously to dogs and healthy human volunteers, negative inotropic effects were seen. If signs or symptoms of congestive heart failure occur during administration of ONMEL, discontinue administration.

Drug Interactions: Co-administration of cisapride, pimozide, quinidine, dofetilide, levacetylmethadol (levomethadyl), felodipine, oral midazolam, nisoldipine, triazolam, lovastatin, simvastatin, ergot alkaloids such as dihydroergotamine, ergometrine (ergonovine), ergotamine and methylergometrine (methylergonovine) or methadone with ONMEL is contraindicated. ONMEL, a potent cytochrome P450 3A4 isoenzyme system (CYP3A4) inhibitor, may increase plasma concentrations of drugs metabolized by this pathway. Serious cardiovascular events, including QT prolongation, torsades de pointes, ventricular tachycardia, cardiac arrest, and/or sudden death have occurred in patients using cisapride, pimozide, levacetylmethadol (levomethadyl), methadone or quinidine concomitantly with itraconazole and/or other CYP3A4 inhibitors.

Please see Important Safety Information included in accompanying full Prescribing Information for ONMEL, including BOXED WARNING.

For more information, please visit www.ONMEL.com

MERZ

ONMEL™
Itraconazole, 200 mg tablets

Reference: 1. ONMEL [package insert]. Greensboro, NC: Merz Pharmaceuticals, LLC; 2012.

ONMEL™ (itraconazole)

Initial U.S. Approval: 1992

Brief Summary: For complete details, please see full Prescribing Information.

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CONTRAINDICATIONS

Congestive Heart Failure: Do not administer ONMEL for the treatment of onychomycosis in patients with evidence of ventricular dysfunction such as congestive heart failure (CHF) or a history of CHF.

Drug Interactions: Concomitant administration of ONMEL and certain drugs that are metabolized by the cytochrome P450 3A4 isoenzyme system (CYP3A4) or where gastrointestinal absorption is regulated by P-gp may result in increased plasma concentrations of those drugs, leading to potentially serious and/or life-threatening adverse events.

Co-administration of cisapride, dofetilide, ergot alkaloids such as dihydroergotamine, ergotamine, ergometrine (ergonovine), and methylergometrine (methylergonovine), felodipine, levacetylmethadol (levomethadyl), lovastatin, methadone, oral midazolam, nisoldipine, pimozide, quinidine, simvastatin, and triazolam with ONMEL is contraindicated.

Do not administer ONMEL for the treatment of onychomycosis to pregnant patients or to women contemplating pregnancy.

Anaphylaxis and hypersensitivity have been reported with use of itraconazole. ONMEL is contraindicated for patients who have shown hypersensitivity to itraconazole products.

WARNINGS AND PRECAUTIONS

Congestive Heart Failure, Peripheral Edema, and Pulmonary Edema

Cases of CHF, peripheral edema, and pulmonary edema have been reported with itraconazole administration among patients being treated for onychomycosis and/or systemic fungal infections.

Cardiac Dysrhythmias

Life-threatening cardiac dysrhythmias and/or sudden death have occurred in patients using cisapride, pimozide, levacetylmethadol (levomethadyl), methadone, or quinidine concomitantly with itraconazole and/or other CYP3A4 inhibitors. Concomitant administration of these drugs with ONMEL is contraindicated.

Cardiac Disease

ONMEL should not be administered in patients with evidence of ventricular dysfunction such as congestive heart failure (CHF) or a history of CHF.

Itraconazole has been shown to have a negative inotropic effect. When itraconazole was administered intravenously to anesthetized dogs, a dose-related negative inotropic effect was documented. In a healthy volunteer study of itraconazole injection, transient, asymptomatic decreases in left ventricular ejection fraction were observed using gated SPECT imaging; these resolved before the next infusion, 12 hours later.

For patients with risk factors for congestive heart failure, physicians should carefully review the risks and benefits of ONMEL therapy. These risk factors include cardiac disease such as ischemic and valvular disease; significant pulmonary disease such as chronic obstructive pulmonary disease; and renal failure and other edematous disorders. Such patients should be informed of the signs and symptoms of CHF, should be treated with caution, and should be monitored for signs and symptoms of CHF during treatment. If signs or symptoms of CHF appear during administration of ONMEL, discontinue administration.

Hepatic Effects

Itraconazole has been associated with rare cases of serious hepatotoxicity, including liver failure and death. Some of these cases had neither pre-existing liver disease nor a serious underlying medical condition, and some of these cases developed within the first week of treatment. If clinical signs or symptoms develop that are consistent with hepatotoxicity, treatment should be discontinued immediately and liver function testing performed.

In patients with elevated or abnormal liver enzymes or active liver disease, or who have experienced liver toxicity with other drugs, treatment with itraconazole is not recommended. Liver function monitoring should be done in patients with pre-existing hepatic function abnormalities or those who have experienced liver toxicity with other medications and should be considered in all patients receiving ONMEL.

Calcium Channel Blockers

Calcium channel blockers can have negative inotropic effects which may be additive to those of itraconazole. In addition, itraconazole can inhibit the metabolism of calcium channel blockers. Therefore, caution should be used when co-administering itraconazole and calcium channel blockers due to an increased risk of CHF. Concomitant administration of ONMEL and nisoldipine is contraindicated.

Neuropathy

If neuropathy occurs that may be attributable to ONMEL, the treatment should be discontinued.

Hearing Loss

Transient or permanent hearing loss has been reported in patients receiving treatment with itraconazole. Several of these reports included concurrent administration of quinidine which is contraindicated. The hearing loss usually resolves when treatment is stopped, but can persist in some patients.

ADVERSE REACTIONS

Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, the adverse reaction rate observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice.

Patients in the trial for toenail onychomycosis were treated with a dosing regimen of 200 mg once daily for 12 consecutive weeks.

The most commonly reported adverse reaction leading to discontinuation of ONMEL was increased hepatic enzyme (6 subjects, 1.0%), followed by dizziness (3 subjects, 0.5%). No other adverse reaction leading to discontinuation occurred in more than one subject.

The adverse reactions reported by at least 1% of ONMEL-treated patients (N=582) and placebo (N=191) during 12 weeks of treatment, respectively, were upper respiratory tract infection (6.0%, 7.3%), bacteriuria (1.4%, 1.6%), urinary tract infection (1.0%, 0.5%), hepatic enzymes increased (2.9%, 0.0%), electrocardiogram abnormal (1.4%, 1.6%), hypoacusis (3.3%, 3.1%), headache (2.2%, 1.6%), dizziness (1.2%, 0.0%), abdominal pain or discomfort (1.7%, 2.6%), diarrhea (1.7%, 3.1%), nausea (1.7%, 1.6%), fatigue (1.5%, 2.6%), sinus bradycardia (1.0%, 0.0%), cough (1.2%, 0.0%), pharyngolaryngeal pain (1.0%, 0.5%), and back pain (1.2%, 2.1%).

Post Marketing Experience

The following adverse reactions have been identified during post-approval use of itraconazole (all formulations). Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establishing a causal relationship to drug exposure.

Blood and lymphatic system disorders: Leukopenia, neutropenia, thrombocytopenia

Immune system disorders: Anaphylaxis; anaphylactic, anaphylactoid and allergic reactions; serum sickness; angioneurotic edema

Metabolism and nutritional disorders: Hypertriglyceridemia, hypokalemia

Nervous system disorders: Peripheral neuropathy, paresthesia, hypoesthesia, headache, dizziness

Eye disorders: Visual disturbances, including vision blurred and diplopia

Ear and labyrinth disorders: Transient or permanent hearing loss, tinnitus

Cardiac disorders: Congestive heart failure

Respiratory, thoracic and mediastinal disorders: Pulmonary edema

Gastrointestinal disorders: Abdominal pain, vomiting, dyspepsia, nausea, diarrhea, constipation, dysgeusia

Hepato-biliary disorders: Serious hepatotoxicity (including some cases of fatal acute liver failure), hepatitis, reversible increases in hepatic enzymes

Skin and subcutaneous tissue disorders: Toxic epidermal necrolysis, Stevens-Johnson syndrome, exfoliative dermatitis, leukocytoclastic vasculitis, erythema multiforme, alopecia, photosensitivity, rash, urticaria, pruritus

Musculoskeletal and connective tissue disorders: Myalgia, arthralgia

Renal and urinary disorders: Urinary incontinence, pollakiuria

Reproductive system and breast disorders: Menstrual disorders, erectile dysfunction

General disorders and administration site conditions: Peripheral edema

DRUG INTERACTIONS

Effects of ONMEL on Other Drugs

Itraconazole and its major metabolite, hydroxy-itraconazole, are strong inhibitors of the cytochrome P450 3A4 isoenzyme system (CYP3A4). Therefore, concomitant administration of ONMEL and certain drugs metabolized by the cytochrome CYP3A4 may result in increased plasma concentrations of those drugs due to decreased elimination, leading to potentially serious and/or life-threatening adverse events. Itraconazole is also an inhibitor of P-glycoprotein (P-gp) transporter and may result in increased plasma concentrations of drugs whose gastrointestinal absorption is regulated by P-gp. Whenever possible, plasma concentrations of these drugs should be monitored, and dosage adjustments made after concomitant ONMEL therapy is initiated. When appropriate, clinical monitoring for signs or symptoms of increased or prolonged pharmacologic effects is advised. Upon discontinuation, itraconazole plasma concentrations decline gradually (especially in patients with hepatic cirrhosis or in those receiving CYP3A4 inhibitors). This is particularly important when initiating therapy with drugs whose metabolism is affected by itraconazole.

Effects of Other Drugs on ONMEL

Inducers of CYP3A4 may decrease the plasma concentrations of itraconazole. ONMEL may not be effective in patients concomitantly taking ONMEL and one of these drugs. Therefore, administration of these drugs with ONMEL is not recommended.

Inhibitors of CYP3A4 may increase the plasma concentrations of itraconazole. Patients who must take ONMEL concomitantly with one of these drugs should be monitored closely for signs or symptoms of increased or prolonged pharmacologic effects of ONMEL.

The following are selected drugs that altered or are predicted to alter the plasma concentration of itraconazole or have their plasma concentration altered by ONMEL.[1]

Drug plasma concentration increased by itraconazole

Antiarrhythmics: digoxin, dofetilide, quinidine, disopyramide

Anticonvulsants: carbamazepine

Anti-HIV Agents: indinavir, ritonavir, saquinavir, maraviroc

Antineoplastics: busulfan, docetaxel, vinca alkaloids

Antipsychotics: pimozide

Benzodiazepines: alprazolam, diazepam, midazolam,[2] triazolam

Calcium Channel Blockers: dihydropyridines (including nisoldipine and felodipine), verapamil

Gastrointestinal Motility Agents: cisapride

HMG CoA-Reductase Inhibitors: atorvastatin, cerivastatin, lovastatin, simvastatin

Immunosuppressants: Cyclosporine, tacrolimus, sirolimus

Oral Hypoglycemics: oral hypoglycemics (repaglinide)

Opiate Analgesics: fentanyl, levacetylmethadol (levomethadyl), methadone

Polyene Antifungals: amphotericin B

Other: ergot alkaloids, halofantrine, alfentanil, buspirone, methylprednisolone, budesonide, dexamethasone, fluticasone, warfarin, cilostazol, eletriptan, fexofenadine, loperamide

Decrease plasma concentration of itraconazole

Anticonvulsants: carbamazepine, phenobarbital, phenytoin

Anti-HIV Agents: nevirapine, efavirenz

Antimycobacterials: isoniazid, rifabutin, rifampin

Gastric Acid Suppressors/Neutralizers: antacids, H_2-receptor antagonists, proton pump inhibitors

Increase plasma concentration of itraconazole

Macrolide Antibiotics: clarithromycin, erythromycin

Anti-HIV Agents: indinavir, ritonavir

[1]This list is not all-inclusive.

[2]For information on parenterally administered midazolam, see the Benzodiazepine paragraph below.

Selected drugs that are contraindicated for use with itraconazole[1]

Antipsychotics: pimozide

Antiarrhythmics: dofetilide, quinidine

Benzodiazepines: oral midazolam[2], triazolam

Calcium Channel Blockers: Nisoldipine, felodipine

Ergot Alkaloids: dihydroergotamine, ergotamine, ergometrine (ergonovine), methylergometrine (methylergonovine)

Gastrointestinal Motility Agents: cisapride

HMG CoA-Reductase Inhibitors: lovastatin, simvastatin

Opiate Analgesics: levacetylmethadol (levomethadyl), methadone

[1]This list is not all-inclusive.

[2]For information on parenterally administered midazolam, see the Benzodiazepine paragraph below.

Antiarrhythmics

The Class IA antiarrhythmic, quinidine and

class III antiarrhythmic, dofetilide are known to prolong the QT interval. Co-administration of quinidine or dofetilide with itraconazole may increase plasma concentrations of quinidine or dofetilide, which could result in serious cardiovascular events. Therefore, concomitant administration of ONMEL and quinidine or dofetilide is contraindicated.

The Class IA antiarrhythmic, disopyramide has the potential to increase the QT interval at high plasma concentrations. Caution is advised when ONMEL and disopyramide are administered concomitantly.

Concomitant administration of digoxin and itraconazole has led to increased plasma concentrations of digoxin via inhibition of P-glycoprotein.

Anticonvulsants
Carbamazepine, phenobarbital, and phenytoin are all inducers of CYP3A4. Reduced plasma concentrations of itraconazole were reported when itraconazole was administered concomitantly with phenytoin. Although interactions with carbamazepine and phenobarbital have not been studied, concomitant administration of ONMEL and these drugs would be expected to result in decreased plasma concentrations of itraconazole. In addition, in vivo studies have demonstrated an increase in plasma carbamazepine concentrations in subjects concomitantly receiving ketoconazole. Although there are no data regarding the effect of itraconazole on carbamazepine metabolism, because of the similarities between ketoconazole and itraconazole, concomitant administration of ONMEL and carbamazepine may inhibit the metabolism of carbamazepine.

Anti-HIV Agents
Non-nucleoside Reverse Transcriptase Inhibitors (NNRTI) such as nevirapine and efavirenz are inducers of CYP3A4. Human pharmacokinetic studies have shown that efavirenz, when concomitantly administered with itraconazole, greatly decreased serum concentrations of itraconazole and hydroxyl-itraconazole. Concomitant use of ONMEL and efavirenz is not recommended.

In vivo studies have shown that nevirapine induces the metabolism of ketoconazole, significantly reducing the bioavailability of ketoconazole. Studies involving nevirapine and itraconazole have not been conducted. However, because of the similarities between ketoconazole and itraconazole, concomitant administration of ONMEL and nevirapine is not recommended.

Concomitant administration of ONMEL and protease inhibitors metabolized by CYP3A4, such as indinavir, ritonavir, and saquinavir, may increase plasma concentrations of these protease inhibitors. In addition, concomitant administration of ONMEL and indinavir and ritonavir (but not saquinavir) may increase plasma concentrations of itraconazole. Caution is advised when ONMEL and protease inhibitors must be given concomitantly.

Concomitant administration of ONMEL and maraviroc has been reported to increase plasma concentration of maraviroc. The dose of maraviroc should be decreased to 150 mg twice daily when given in combination with itraconazole.

Antimycobacterials
Drug interaction studies have demonstrated that plasma concentrations of azole antifungal agents and their metabolites, including itraconazole and hydroxyitraconazole, were significantly decreased when these agents were given concomitantly with rifabutin or rifampin. In vivo data suggest that rifabutin is metabolized in part by CYP3A4. ONMEL may inhibit the metabolism of rifabutin. Although no formal study data are available for isoniazid, similar effects should be anticipated. Therefore, the efficacy of ONMEL could be substantially reduced if given concomitantly with one of these agents and co-administration is not recommended.

Antineoplastics
ONMEL may inhibit the metabolism of busulfan, docetaxel, and vinca alkaloids.

Antipsychotics
Pimozide is known to prolong the QT interval and is partially metabolized by CYP3A4. Co-administration of pimozide with itraconazole could result in serious cardiovascular events. Therefore, concomitant administration of ONMEL and pimozide is contraindicated.

Increases in plasma aripiprazole concentrations have been demonstrated in subjects concomitantly receiving ketoconazole, requiring a reduction of the aripiprazole dose. Because of the similarities between ketoconazole and itraconazole, a similar dose reduction for aripiprazole is recommended when patients concomitantly receive itraconazole and aripiprazole.

Benzodiazepines
Concomitant administration of itraconazole and alprazolam, diazepam, oral midazolam, or triazolam could lead to increased plasma concentrations of these benzodiazepines. Increased plasma concentrations could potentiate and prolong hypnotic and sedative effects. Concomitant administration of ONMEL and oral midazolam or triazolam is contraindicated. If midazolam is administered parenterally, special precaution and patient monitoring is required since the sedative effect may be prolonged.

Calcium Channel Blockers
Calcium channel blockers can have a negative inotropic effect which may be additive to those of itraconazole; itraconazole can inhibit the metabolism of calcium channel blockers such as dihydropyridines (e.g., nifedipine, nisoldipine, and felodipine) and verapamil. Therefore, caution should be used when co-administering itraconazole and calcium channel blockers due to an increased risk of CHF.

Concomitant administration of ONMEL and nisoldipine results in clinically significant increases in nisoldipine plasma concentrations, which cannot be managed by dosage reduction, therefore the concomitant administration of ONMEL and nisoldipine is contraindicated. A clinical study showed that felodipine exposure was increased by co-administration of itraconazole, resulting in approximately 6-fold increase in the AUC and 8-fold increase in the C_{max}. The concomitant use of ONMEL and felodipine is contraindicated.

Edema has been reported in patients concomitantly receiving itraconazole and dihydropyridine calcium channel blockers. Appropriate dosage adjustment may be necessary.

Gastric Acid Suppressors/Neutralizers
Reduced plasma concentrations of itraconazole were reported when administered concomitantly with H_2-receptor antagonists. Studies have shown that absorption of itraconazole is impaired when gastric acid production is decreased. ONMEL should be administered with a cola beverage if the patient has achlorhydria or is taking H_2-receptor antagonists or other gastric acid suppressors. It is advised that antacids be administered at least 1 hour before or 2 hours after administration of ONMEL. In a clinical study, when itraconazole capsules were administered with omeprazole (a proton pump inhibitor), the bioavailability of itraconazole was significantly reduced.

Gastrointestinal Motility Agents
Co-administration of itraconazole with cisapride can elevate plasma cisapride concentrations, which could result in serious cardiovascular events. Therefore, concomitant administration of ONMEL with cisapride is contraindicated.

3-Hydroxy-3-Methyl-Glutaryl CoA-Reductase Inhibitors
Human pharmacokinetic data suggest that itraconazole inhibits the metabolism of atorvastatin, cerivastatin, lovastatin, and simvastatin, which may increase the risk of skeletal muscle toxicity, including rhabdomyolysis. Concomitant administration of ONMEL with 3-Hydroxy-3-Methyl-Glutaryl (HMG) CoA-Reductase inhibitors, such as lovastatin and simvastatin, is contraindicated.

Immunosuppressants
Concomitant administration of ONMEL and cyclosporine or tacrolimus has led to increased plasma concentrations of these immunosuppressants. Similarly, concomitant administration of ONMEL and sirolimus could increase plasma concentrations of sirolimus.

Monitoring of blood concentrations of cyclosporine, tacrolimus, or sirolimus are recommended when ONMEL are co-administered with these immunosuppressants and appropriate dosage adjustments should be made.

Macrolide Antibiotics
Erythromycin and clarithromycin are known inhibitors of CYP3A4 and may increase plasma concentrations of itraconazole.

Oral Hypoglycemic Agents
Severe hypoglycemia has been reported in patients concomitantly receiving azole antifungal agents and oral hypoglycemic agents. A human pharmacokinetic study showed that co-administration with itraconazole and a single dose of repaglinide (on the third day of a regimen of 200 mg initial dose, twice-daily 100 mg itraconazole) resulted in a 1.4-fold higher repaglinide AUC. Blood glucose concentrations should be carefully monitored when ONMEL and oral hypoglycemic agents are co-administered.

Polyenes Antifungal Agents
Prior treatment with itraconazole, like other azoles, may reduce or inhibit the activity of polyenes such as amphotericin B. However, the clinical significance of this drug effect has not been clearly defined.

Opiate Analgesics
Levacetylmethadol (levomethadyl) and methadone are known to prolong the QT interval and are metabolized by CYP3A4. Co-administration of methadone or levacetylmethadol with itraconazole could result in serious cardiovascular events. Therefore, concomitant administration of ONMEL and methadone or levacetylmethadol are contraindicated.

Fentanyl plasma concentrations could be increased or prolonged by concomitant use of itraconazole and may cause potentially fatal respiratory depression.

In vitro data suggest that alfentanil is metabolized by CYP3A4. Administration with itraconazole may increase plasma concentrations of alfentanil.

Other
- Elevated concentrations of ergot alkaloids can cause ergotism, i.e., a risk for vasospasm potentially leading to cerebral ischemia and/or ischemia of the extremities. Concomitant administration of ergot alkaloids such as dihydroergotamine, ergometrine (ergonovine), ergotamine and methylergometrine (methylergonovine) with ONMEL is contraindicated.
- Halofantrine has the potential to prolong the QT interval at high plasma concentrations. Caution is advised when ONMEL and halofantrine are administered concomitantly.
- Human pharmacokinetic data suggest that concomitant administration of itraconazole and buspirone results in significant increases in plasma concentrations of buspirone.
- Itraconazole may inhibit the metabolism of certain glucocorticosteroids such as budesonide, dexamethasone, fluticasone and methylprednisolone.
- Itraconazole enhances the anticoagulant effect of coumarin-like drugs, such as warfarin.
- Cilostazol and eletriptan are CYP3A4 metabolized drugs that should be used with caution when co-administered with ONMEL.
- Co-administration of itraconazole with meloxicam decreased peak plasma concentrations and the exposure of meloxicam by 64% and 37%, respectively. Monitor patients for responses to meloxicam when itraconazole is concomitantly administered and dose adjustment should be considered if warranted.
- Co-administration of itraconazole with fexofenadine increased the peak plasma concentration and the total exposure of fexofenadine by approximately 3-fold and augmented its anti-histamine effects.
- Co-administration of itraconazole with loperamide increased peak plasma concentrations of loperamide by 3-fold and the total exposure by 3.9-fold. In addition, itraconazole is an inhibitor of P-glycoprotein and may inhibit the transport of loperamide out of the brain, leading to elevated concentrations of loperamide in the brain. Patients should be monitored for signs and symptoms of loperamide overdose, such as CNS depression, including drowsiness, dizziness and respiratory depression, and a dose or dosing frequency should be adjusted as necessary.

USE IN SPECIFIC POPULATIONS
Pregnancy
Teratogenic effects.
Pregnancy Category C
There are no adequate and well-controlled clinical trials in the pregnant women with itraconazole. However, cases of congenital abnormalities have been reported with itraconazole drug products in post-marketing reports. Therefore, ONMEL should not be administered to pregnant women, women planning pregnancy, or women of child bearing potential unless these onychomycosis patients are using effective contraception measures to prevent pregnancy. Effective contraceptive measures should continue throughout the treatment period and for two months thereafter. ONMEL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Itraconazole produced a significant dose-related increase in maternal toxicity, embryotoxicity, and teratogenicity in rats at dose levels of 40-160 mg/kg/day (2-10 times the maximum recommended human dose [MRHD], based on mg/m^2/day comparisons), and in mice at 80 mg/kg/day (2 times MRHD, based on mg/m^2/day comparisons). Teratogenic changes in rats included major skeletal defects; encephalocele and/or macroglossia developed in mice.

Nursing Mothers
Itraconazole is excreted in human milk; therefore, the expected benefits of ONMEL therapy for the mother should be weighed against the potential risk from exposure of itraconazole to the infant.

Pediatric Use
The safety and effectiveness of ONMEL in pediatric patients have not been established. No pharmacokinetic data on ONMEL are available in children.

Geriatric Use
ONMEL was evaluated in 42 of 593 subjects (7.1%) greater than 65 years of age.

Transient or permanent hearing loss has been reported in elderly patients receiving treatment with itraconazole. Several of these reports included concurrent administration of quinidine which is contraindicated. Itraconazole should be used with care in elderly patients.

Renal Impairment
Limited data are available on the use of oral itraconazole in patients with renal impairment. Caution should be exercised when ONMEL is administered to patients with renal impairment.

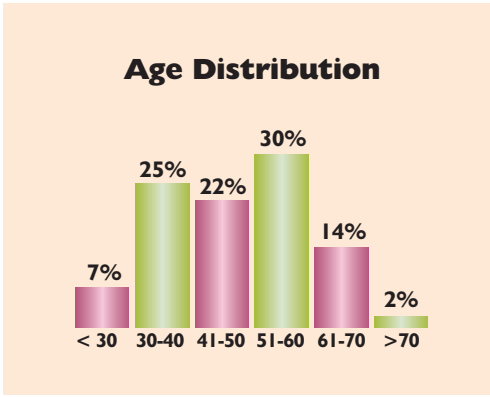
Hepatic Impairment
Limited data are available on the use of oral itraconazole in patients with hepatic impairment. Caution should be exercised when ONMEL is administered to patients with hepatic impairment.

OVERDOSAGE
Itraconazole is not removed by dialysis. In the event of accidental overdosage, supportive measures, including gastric lavage with sodium bicarbonate, should be employed.

Manufactured by:
Sanico N.V.
2300 Turnhout, Belgium

Manufactured for
Merz Pharmaceuticals, LLC
4215 Tudor Lane
Greensboro, NC 27410

SAP item #5011957
Rev date 01/2013



number of patients seen; equipment, educational and pension expenses; and nursing home involvement; among other factors explored in this report.

Solo Stays Steady

Solo practice remained the top practice setting in our latest survey. Solo, self-employed DPMs comprised 34 percent of the respondent pool, which was unchanged from last year. The percentage of solo doctors in professional corporations dropped slightly from 15 percent previously to 13 percent. With the larger percentage of new doctors came the rise in percentage of those employed by another DPM—8 percent this year vs. 5 percent in our last survey.

Several viable solo practice arrangements exist, as described by Jon Hultman, DPM, MBA, in the February 2012 issue. These include a "micro-practice" with heavy use of technology and a small staff; a concierge cash practice, offering superior services; and a narrow niche specialty practice. With the increasing competition from large group practices, doctors may need to explore one of these options to continue to grow their businesses.

Eighteen percent of respondents were in partnership/group practice, which was down slightly from 19 percent previously. The percentage of those in professional corporations with other DPMs dropped more, from 14 percent last year to 10 percent this year.

The trend toward partnership/group practice in medicine continues unabated. We've seen mergers and acquisitions of multidisciplinary practices as well as single-specialty practices incorporating sub-specialists to target specific patient groups (for instance, adding a doctor specializing in podopediatrics). The super-group has emerged as a viable form in certain areas as well. Benefits to partnership/group practice include economies of scale; the ability to combine different specialties at a single location; extended hours, perhaps including very early morning hours and nights/weekends to respond to patient demand; scheduling flexibility to allow for immediate consultations; and greater leverage in negotiating managed care contracts. Doctor teams can also divide up major capital expenses and can provide more collateral for bank loans and financing. Implementation of new technology, such as electronic medical records (EMR), may be done more efficiently in a partnership/group setting as well. The implementation of new revenue streams, such as selling over-the-counter (OTC) items and prescription pharmaceuticals, is often more feasible/effective in larger offices serving greater numbers of patients. External marketing and building a referral base become more effective when multiple doctors spread the word about the practice and its specialties. Perhaps most important is the fact the DPMs in partnership/group practice earn more than solo colleagues (see "Net Income" section).

One change of note is the percent-

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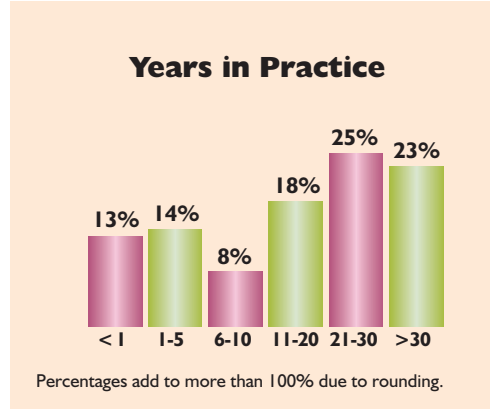
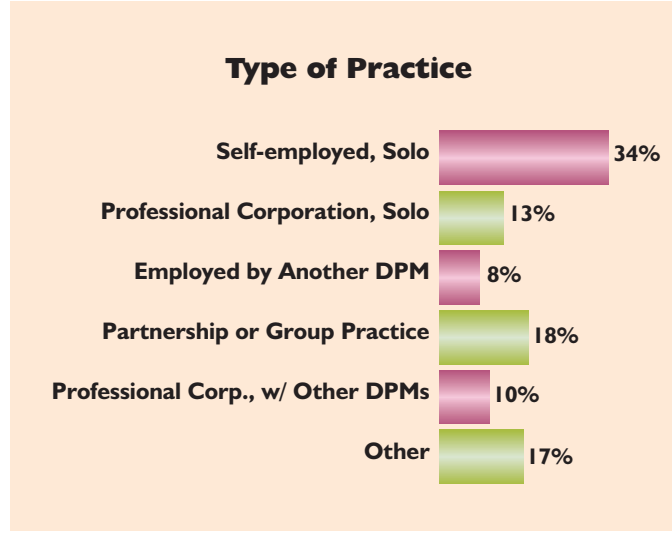
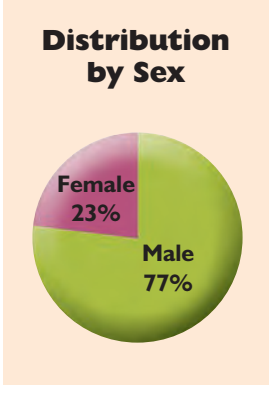
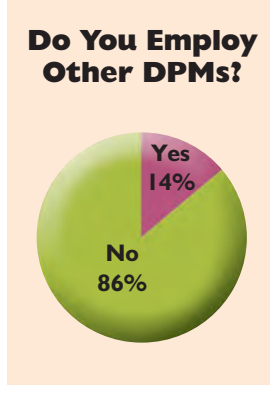
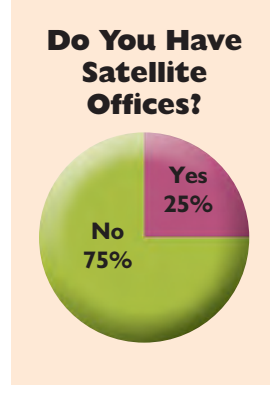










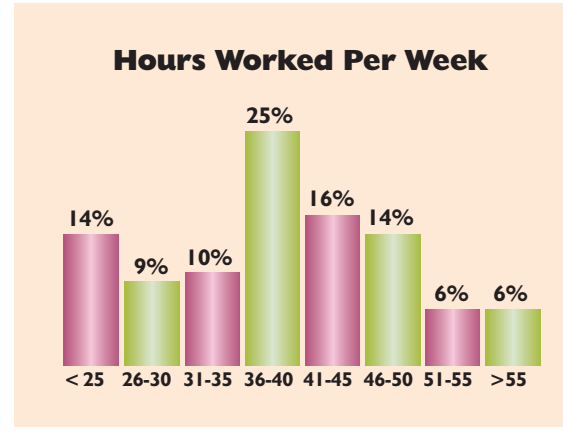
age of doctors who work in settings not listed ("other"), which grew from 13 percent last year to 17 percent this year. This category may include DPMs who work with an MD or group of physicians; those who work in hospitals, nursing homes and/or independent and assisted living facilities; podiatrists in the military; respondents who work in academia; and those who work in a combination of different settings.

Compared to last year's survey, a smaller percentage of respondents employed other DPMs: down from 18 percent to 14 percent. Perhaps this was due to the less experienced respondent pool, who were more likely to be employees than employers.

Satellite Offices Less Popular

Fewer respondents indicated that they had satellite offices: 25 percent this year vs. 35 percent last year. Again, newer doctors generally focus on building their patient base and reputation in a primary office before branching out to other locations. Among respondents who did have satellite offices, about two-thirds (65 percent) had a single satellite, 22 percent had two satellite offices, 6 percent had three satellite offices and 7 percent had four or more satellite offices.

For the first time, we looked at whether doctors in certain regions of the country were more likely than doctors in other regions to have satellite offices. The answer seems to be yes—a slightly higher percentage of Northeast and Southern doctors had satellite offices as compared to the other two regions.



No Change in Gender Ratio

The male/female ratio was identical to that reported for the past three surveys: 77 percent male and 23 percent female. Female enrollment in colleges of podiatric medicine has remained steady for the past three years (2009-2010, 2010-2011 and 2011-2012) at approximately 39 percent, according to the American Association of Colleges of Podiatric Medicine (AACPM). Its female percentage is a much higher percentage than our response, and it will likely stimulate an increase of female respondents in the future. Reviewing the breakdown of 2011-2012 enrollees by year, one sees a slight *rise* in the percentage of female students, with AACPM reporting that females comprise 40 percent of first-year students vs. 36 percent of the fourth-year students. This may further boost female percentages as the younger graduates start to enter the profession.

A slightly higher percentage of Northeast and Southern doctors had satellite offices as compared to the other two regions.

Fewer Patients Seen

There was an 9 percent drop in the average number of patients treated per week: 85.6 patients this year vs. 94.3 patients last year. Undoubtedly, the younger practitioner pool accounted for some of this decrease, as it can take years for a DPM to grow his or her patient base. Also, the unstable state of the economy may have influenced the number of patients seen, perhaps due to general practitioners supplementing their own incomes with foot-related services rather than referring cases to DPMs.

While patient numbers are lower,

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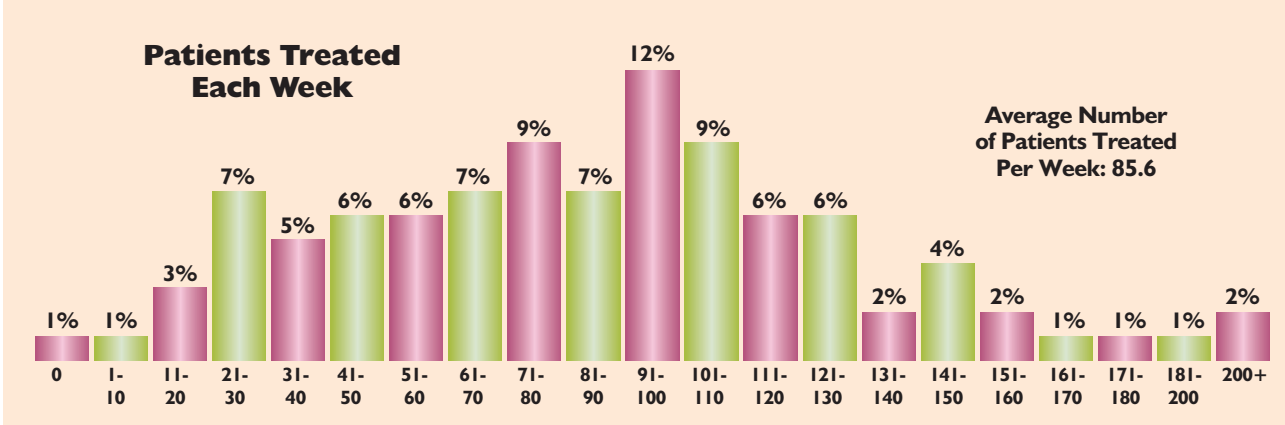
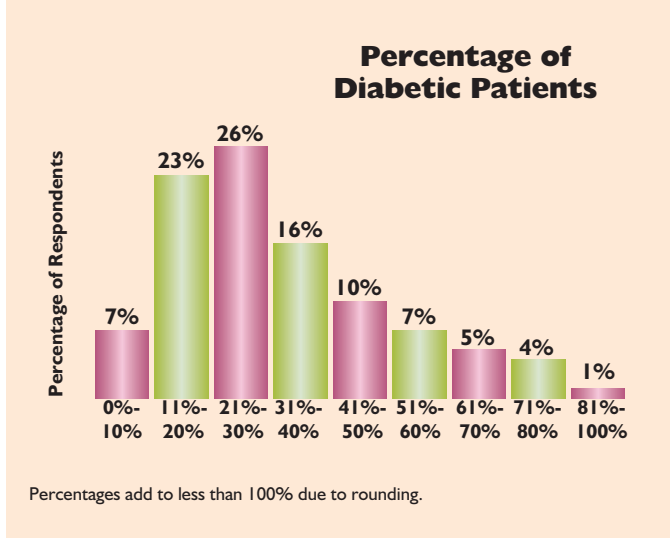


Percentages add to less than 100% due to rounding.

USCB data points to increases in two leading patient groups: diabetics (see "More Diabetic Patients" below) and the elderly. Among the latter, the U.S. population of those 65 and over edged up from 12.7 percent in 2010 to 12.8 percent in 2011. Looking further into the future, the USCB projects that the population age 65 and older will *more than double* between 2012 and 2060, from 43.1 million to 92.0 million. This group will comprise about 20 percent of the population, up from about 14 percent in 2012. What's more, the number of those age 85 and older will *triple* from 5.9 million to 18.2 million, according to USCB estimates.

Another notable change in patient makeup that will likely help doctors plan for practice growth is the changing racial and ethnic mix. For example, the USCB projects that the Hispanic population will double from 53.3 million in 2012 (one in six residents) to 128.8 million in 2060 (one in three residents). Although not as large, the Asian population is expected to double as well. "All in all, minorities, now 37 percent of the U.S. population, are projected to comprise 57 percent of the population in 2060," according to the USCB's report "U.S. Census Bureau Projections Show a Slower Growing, Older, More Diverse Nation a Half Century from Now."



Percentages add to less than 100% due to rounding.

DPMs Worked Fewer Hours

In tandem with the reduced number of patients was a notable decrease in the number of hours worked. For example, the percentage of respondents who worked more than 40 hours per week dropped from 46 percent to 42 percent. In addition, 23 percent of doctors worked 30 hours or less vs. 21 percent of last year's respondents. The younger makeup of the respondent pool also likely was a reason for this drop. What's more, shorter hours may be a reflection of increased delegation among respondents (since much higher salaries were paid; see "Expenses") and/or an indication of greater practice efficiencies such as utilization of EMR and incorporation of automated equipment and processes.

A study among MDs from The Physicians Foundation entitled "A Survey of American Physicians: Practice Patterns and Perspectives" (2012) revealed that the reduction of patients and work hours was not limited to podiatry alone. Its survey of 13,575 MDs found that they were working 5.9 percent fewer hours and were seeing 16.6 percent fewer patients per day than they did in 2008. They also expected to be seeing fewer patients in the next one to three years.

More Diabetic Patients

While patient numbers overall have dropped, doctors surveyed saw a larger percentage of diabetic patients. For example, last year 10 percent of our respondents said that the *majority* of their patients were diabetic compared to 17 percent reporting the same this year. While 12 percent said they saw a minimal percentage of diabetic patients last year (0-10 percent of their patient base was diabetic), only 7 percent of the respondents in our most recent survey reported the same.

For the first time we cross-tabulated the number of diabetic patients by region to determine the influence of geography on this patient base and to compare our findings with national diabetic statistics. According to the latest fig-

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Number of Patients Seen: How Do You Compare?

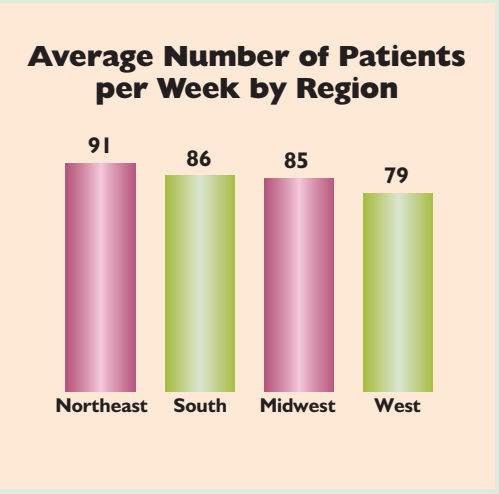
For the first time, we cross-tabulated number of patients seen with several other data items, including number of years in practice, region, size of city/town and gender. Here are some of the findings:

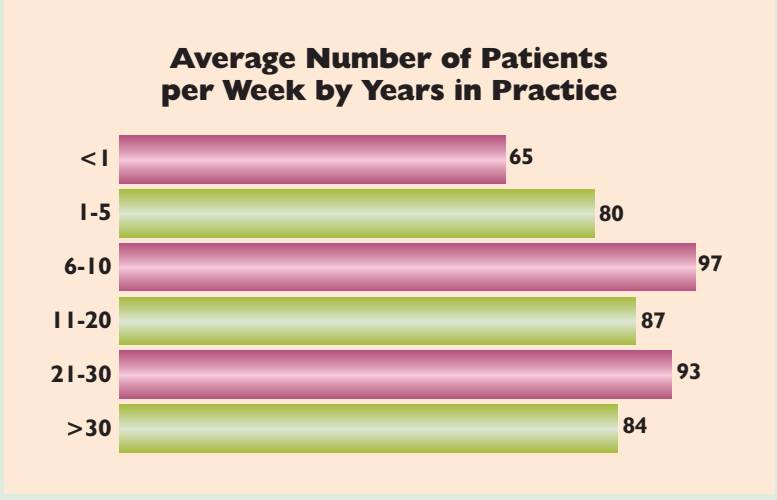
• **Respondents in practice six to 10 years saw the most patients.** On average, they saw 97 patients per week. The group that saw the fewest patients were those in practice less than a year (65 patients) followed by those in practice one to five years (80 patients).

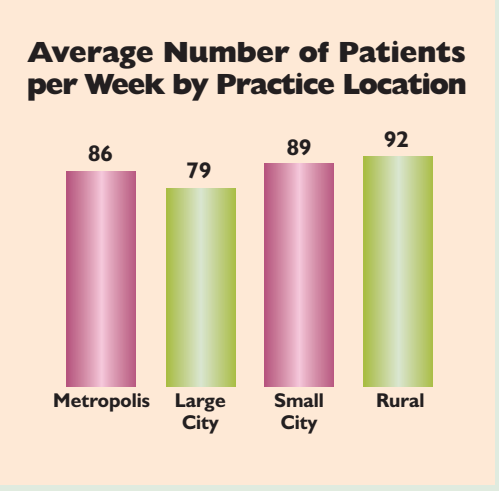
• **Northeastern doctors saw the most patients.** DPMs reporting from there averaged 91 patients per week. Western doctors saw the fewest at 79 patients.

• **Rural doctors saw more patients.** This factor seems to negate the one above, since the Northeast is filled with many urban areas. However, our data showed that doctors in areas with populations of less than 25,000 saw 92 patients per week, the highest of any location. By contrast, large-city doctors (populations of 100,000-500,000) saw just 79 patients, on average, per week. This may well be due to increased competition in urban areas.

• **Men outpaced women in number of patients seen and number of hours worked.** Men saw an average of 89 patients per week, while women saw 76 patients. A related cross-tabulation by gender of hours worked per week uncovered the fact that the male DPMs surveyed worked slightly longer than female colleagues: 39 hours vs. 37 hours per week, respectively. •







ures available from the Center for Disease Control and Prevention (CDC) in its report "National Diabetes Fact Sheet, 2011" (based upon 2010 data), the South from Texas eastward had the highest percentage of adults diagnosed with diabetes. Top states by percentage were Mississippi (11.3 percent), Alabama (11.1 percent), West Virginia (10.7 percent), Louisiana (10.3 percent), Tennessee (10.2 percent) and Kentucky (10.1). In our cross-tabulations, doctors in the South did see a high percentage of diabetic patients—62.4 percent of their patient base—but this was less than DPMs in the Midwest, who reported that 67.2 percent of their patients were diabetic. This points to a potentially untapped need for podiatric care among Southern diabetics.

Besides the increasing prevalence of diabetes alone as a factor in the increased number of these patients, public education campaigns have become increasingly valuable resources to drive diabetics into doctors' offices. For example, the National Diabetes Education Program (NDEP) is a partnership of the National Institutes of Health, the CDC and more than 200 public and private organizations, according to its website (ndep.nih.gov). In NDEP's publication "Redesigning the Health Care Team: Diabetes Prevention and Lifelong Management," podiatrists are part of the collaborative care cited. "Team care" is further discussed in its publication,

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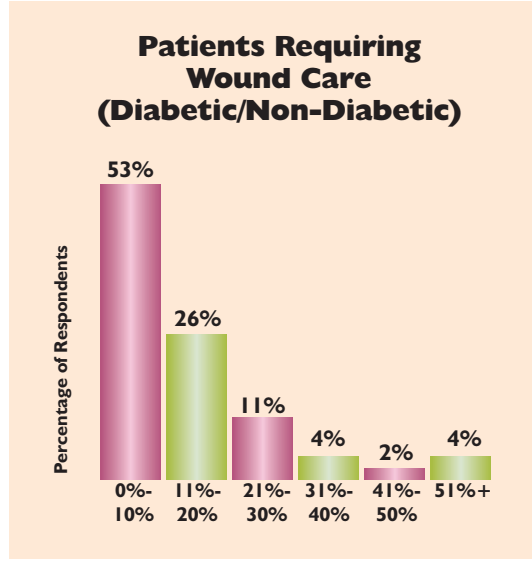
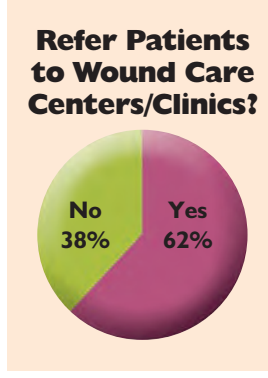
"Working Together to Manage Diabetes: A Guide for Pharmacists, Podiatrists, Optometrists, and Dental Professionals, 2007," also available on the website.

Due to a technical error, the question on participation in the Diabetic Shoe Program was omitted from this year's survey. As previously discussed, footwear and practice management experts applaud the program as mutually beneficial to patients and practitioners: patients pay only 20 percent or less of the cost when they are deemed medically necessary, and practitioners create goodwill and future practice growth potential in other areas. We will reinstate this question in next year's survey questionnaire.



Doctors Saw More Wound Care

Given the reported increase in the diabetic patient population, it's not surprising that there was an overall increase in the percentage of wound care patients as well. *Today's Wound Clinic* estimates that 2 percent of the U.S. population in 2011 suffered from chronic wounds. What's more, the Wound Care Center at Greater Baltimore Medical Center reported that "approximately 6 million Americans will suffer from problem wounds caused by diabetes, circulatory problems and many other conditions, with 1.1 million to 1.8 million new cases each year." It goes on to report that 15 percent of all diabetics will develop problem wounds. In addition, diabetic patients "have a 15-fold increase in the risk of amputation, and approximately 82,000 diabetics will undergo amputation each year."



In our latest survey, 21 percent of those surveyed said that at least one in five of their patients (including diabetic and non-diabetic) required wound care. That's up from 17 percent in last year's survey. Another telling piece of data is that the percentage of DPMs who said that *more than half* of their patients were treated for wound care grew from 1 percent to 4 percent. Although it was a small segment of the database, the four-fold percentage increase highlights the increasing importance of wound care. According to the report "Research and Markets: Wound Care Market—Current Trends, Opportunities & Global Forecasts (2011-2016)," which covers wound care on a global scale, "The wound care market is driven by increase in the aging population, rise in chronic diseases (such as diabetes and hypertension), and technological advancements. The demand for portable and easy-to-use devices is expected to drive the growth of the wound care market in the coming years. At the same time, tissue-engineered products like skin substitutes and biological growth factors are expected to drive the market in the long term." It indicates that the U.S. leads nations globally in demand for these products, which will increase as more cost-effective devices and treatments enter the market. This will likely expand the treatment options for DPMs in the future.

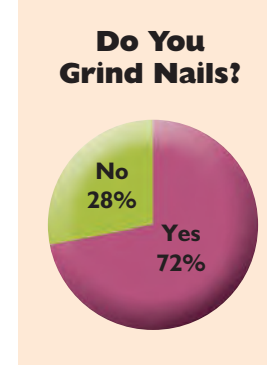
A slightly higher percentage of DPMs referred patients to wound care centers/clinics: 62 percent this year vs. 60 percent last year. This correlates directly with the increase in wound care patients as previously mentioned. The latest data available from *Today's Wound Care* indicates that there are approximately 800 such centers in the U.S.

Organizations geared toward this specialty include the Academy of Physicians in Wound Healing, the American Podiatric Wound Care Association, the American Academy of Wound Management and the American Board of Multiple Specialties in Podiatry.

Given the reported increase in the diabetic patient population, it's not surprising that there was an overall increase in the percentage of wound care patients as well.

New This Year: Data on Nail Grinding and Use of Whirlpools

For the first time, we added questions on two services: nail grinding and whirlpool use before routine footcare. Seventy-two percent of respondents said that they grind nails. Some who don't grind nails cite air quality issues and respiratory problems (see sidebar "The Physical Impact of Podiatry on the DPM"), while others feel it is a valuable service and an essential step in the nail



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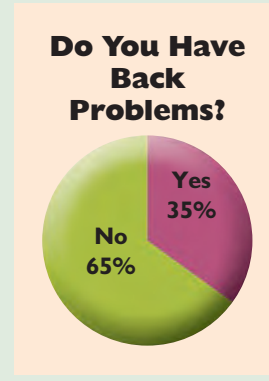
debridement protocol.

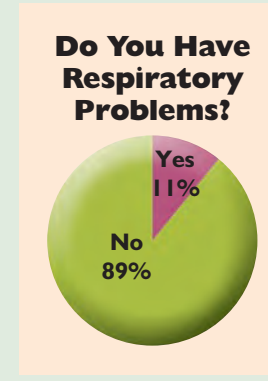
Whirlpool users comprised 13 percent of the responses in our latest survey. Doctors who use hydrotherapy cite the rehabilitative aspects of its use. Perhaps offices were too small (with so many new DPMs) in our latest survey to offer this service or there were not enough patients to support its purchase and use.

We will follow both of these factors and cover them in greater depth in future surveys.

The Physical Impact of Podiatry on the DPM

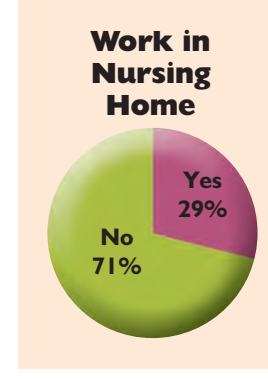
For the first time in our most recent survey, we explored two physical issues that face some podiatrists: back issues and respiratory problems. Thirty-five percent of those surveyed reported having back problems, while 11 percent said they had respiratory problems. We assume that these figures are lower than they would have been with an older respondent pool. However, we will use these figures as a baseline for comparison in future surveys. •





More Practice in Nursing Homes

The percentage of podiatrists practicing in nursing homes grew from 23 percent last year to 29 percent this year. A number of factors were likely in play here:



• **The need for new practitioners to supplement new-practice income with off-site care—** Many of the younger doctors surveyed may have used nursing homes to provide income as well as to establish referral and patient/family relationships.

• **The increase in number of skilled nursing facilities—**The number of skilled nursing facilities rose slightly to 15,702 in 2011 (our survey year), according to the CDC, after several years of falling numbers. States with the highest number of nursing homes were California, Texas, Ohio, Illinois and Pennsylvania. Given that

Continued on page 116

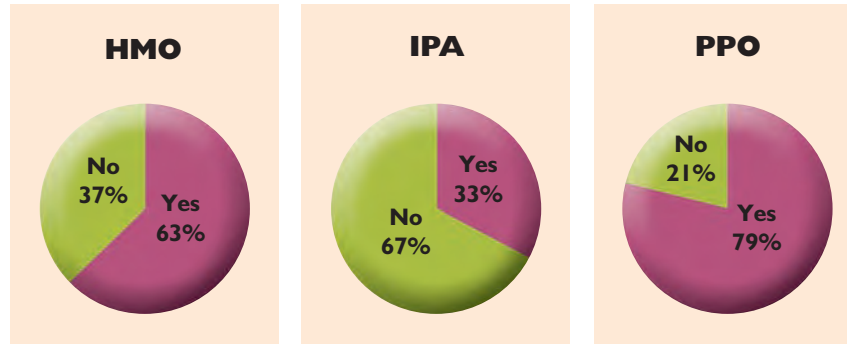
some of these states were on our top-five list indicating where respondents practice, we anticipate even great participation in nursing home care in coming years. We also predict that Florida (currently sixth) will move into one of the top slots, given the migration and population data provided by the USCB.

• **The aging population**—With larger numbers of elderly and longer lifespans come the likelihood of more people needing nursing home care.

• **The increasing diabetic landscape**—With diabetes more prevalent, the impact on nursing-home-age residents is inevitable. According to the CDC/National Center for Health Statistics' "National Survey of Residential Care Facilities, 2010," 17 percent of residential care residents in the U.S. in 2010 were diabetic, and diabetes was listed as one of the top-10 most common chronic conditions among nursing home residents.

We anticipate even greater need for podiatric care in nursing homes, spurred on by preventive measures being discussed at the national level. For instance, the "2012 Nursing Home Action Plan" from the Centers for Medicare and Medicaid Services (CMS) promotes a collaborative approach to reduce hospital admissions and readmissions and to curtail avoidable heath care expenditures.

MANAGED CARE GROUP PARTICIPATION



With early physician intervention playing a key role in this endeavor, we see demand for podiatric services will be inevitable, especially given the high percentage of diabetic patients residing in these facilities.

Alternative Housing Continued to Expand

The senior living market has exploded in recent years, providing independent, assisted-living and hybrid residential alternatives to the aging population. Senior-focused apartment complexes continue to spring up in senior-heavy populations, while a number of closed hospitals have been converted into assisted living facilities to handle the increased demand.

Perhaps the proliferation of alternative housing arrangements is one reason why nursing home enrollment has not kept pace with the rise in the aging population. According to a recent study in *Health Services Research* entitled "Assisted Living Expansion and the Market for Nursing Home Care," researchers found by reviewing data over a 14-year span that "a 10 percent increase in assisted living capacity led to a 1.4 percent decline in private-pay nursing home occupancy." What's more, they concluded that "assisted living serves as a potential substitute for nursing home care for some healthier individuals with greater financial resources, suggesting implications for policy makers, providers, and consumers."

More Doctors in HMOs, PPOs

In direct contrast to last year's report, the percentage of doctors who were on physician panels for health maintenance organizations (HMOs) and preferred provider organizations (PPOs) rose: HMO participation grew from 57 percent to 63 percent, and PPO participation edged up slightly from 78 percent 79 percent of respondents. Also in contrast to last year's report, the percentage of providers for independent practice associations (IPAs) dropped from 39 percent to 33 percent.

Overall, doctors surveyed reported a greater share of income from managed care organization (MCO) plans: 28 percent this year vs. 23 percent in the previous report. Three out of 10 patients were in managed care plans. The average number of programs that participating doctors

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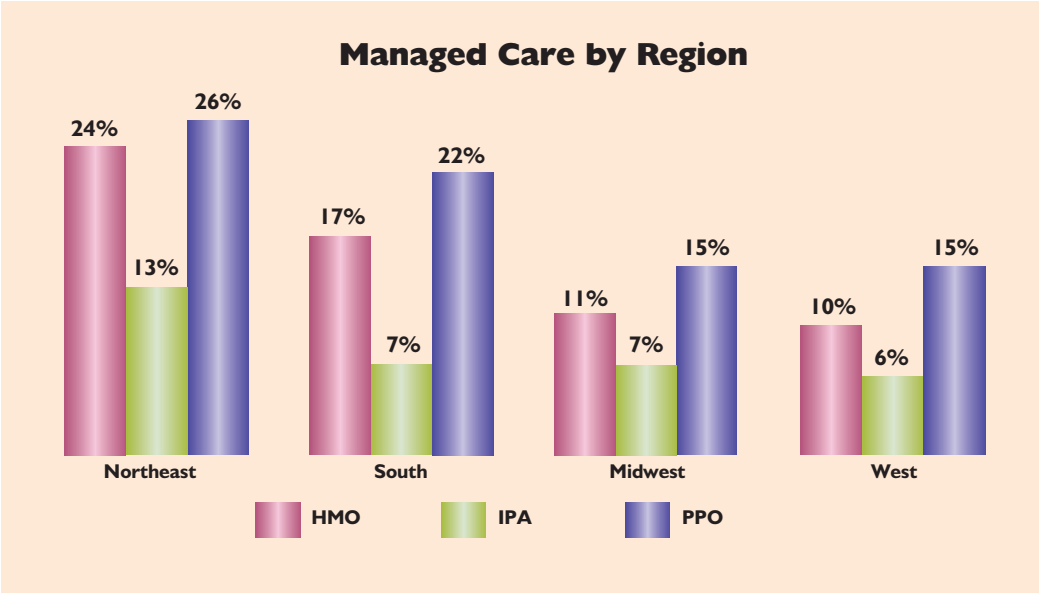
Who Earns More from Managed Care?

We cross-tabulated the percent of income from managed care organizations (MCOs) and number of years in practice to determine whether experience played a role in DPM involvement in managed care. The answer seemed to be yes, with a peak in mid-career. New doctors (those in practice less than a year) derived 26 percent of their income from MCO plans, the lowest percentage of all age categories. By contrast, podiatrists in practice for 11-20 years derived the most income from these plans: 32.7 percent. However, this percentage dropped off slightly to 27.8 percent after the 20th year in practice. •



joined was 5.4, up from 3.2 in last year's report. Interestingly, 28 percent of those surveyed said they participated in *eight or more* managed care programs.

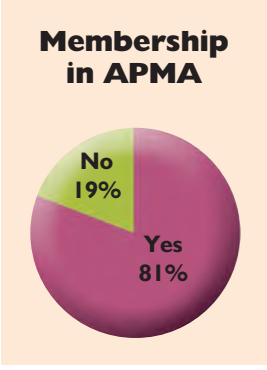
Undoubtedly, the improved employment numbers during 2011 vs. 2010 prompted many doctors to join or rejoin the most popular MCO panels in their area. According to the U.S. Dept. of Labor's Bureau of Labor Statistics (BLS), unemployment dropped from 9.6 percent in 2010 to 8.9 percent in 2011. The downward trend continues into 2012, so perhaps MCO participation will remain strong in our next report.

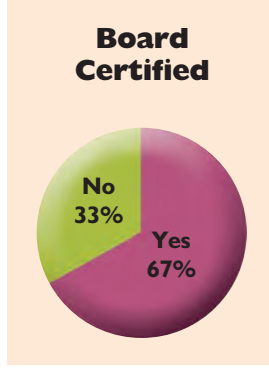
We also see more doctors banding together in IPAs; that form may show an upswing in our future surveys as well.

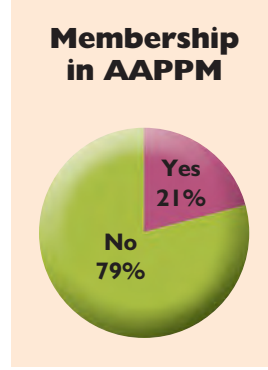
For the first time, we sought to determine whether the region in which a respondent practiced played a role in MCO participation. According to cross-tabulation results, that seems to be the case: A higher percentage of Northeast doctors were on MCO panels, including all three types (HMO, PPO and IPA), compared to other regions. By contrast, the lowest percentage of MCO involvement (across all three types) was in the West.

Also, the accompanying sidebar "Who Earns More from Managed Care?" indicates the impact of years in practice on rate of MCO participation.

Twenty-eight percent of those surveyed said they participated in eight or more managed care programs.







Trends in Health Insurance

Ever since President Obama signed the Patient Protection and Affordable Care Act (ACA) into law in 2010, 43 provisions went into effect through the end of 2011, according to an analysis by the Henry J. Kaiser Family Foundation (KFF), with more than two dozen others scheduled to be implemented through 2018. The impact on costs, patient access to health care and reimbursements are already being felt.

KFF further reports that annual premiums for employer-sponsored family health coverage jumped 9 percent from 2010 to $15,073 in 2011 with employers paying an average of 62.3 percent toward those annual premiums.

According to the USCB, 16.3 percent of the U.S. population did not have health insurance in 2011. Under the ACA, by 2014 nearly all Americans will need to obtain health insurance or pay a penalty. Options include health care coverage through employers, a health insurance exchange and through Medicaid. There will likely be more emphasis placed on consumers, rather than employers. With the ACA's authorization of Accountable Care Organizations in 2012, we expect to see more multidisciplinary patient care as the Federal government looks to lower health care costs under Medicare.

APMA Membership Down Slightly

The percentage of those who

Continued on page 120

were members of the American Podiatric Medical Association (APMA) dropped 4 percentage points to 81 percent in our most recent survey. Some new practitioners simply may have not joined yet—especially considering that 13 percent had been in practice less than a year. Besides key benefits such as Federal and state advocacy, the APMA offers a "Find a Podiatrist" section on its website, consumer information, professional conferences and access to members-only features.

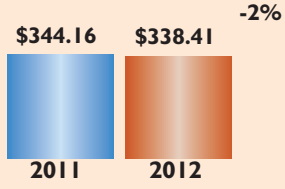
APMA members earned a median net income of $129,750 compared to $100,750 for non-APMA members.

APMA members earned more than non-member colleagues as well. In our latest survey, members earned a median net income of $129,750 compared to $100,750 for non-APMA members.

Continued on page 122

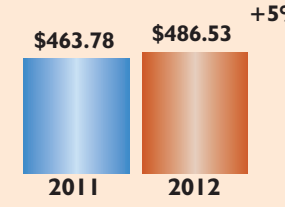
FEES

Matrixectomy, Partial Permanent (11750)

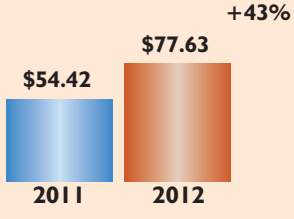


Matrixectomy, Total Permanent (11750)

Orthoses *(Including Casting, Fabrication and Dispensing)* (L3000x2)

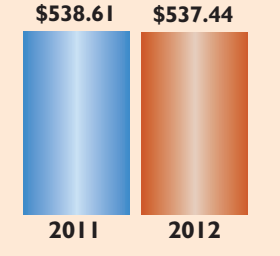


Strapping (29540)



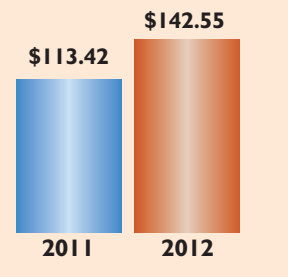
X-Rays *(1 Plate) 2 Views* (73620)

MPJ Capsulotomy/ Tenorrhaphy (28270)



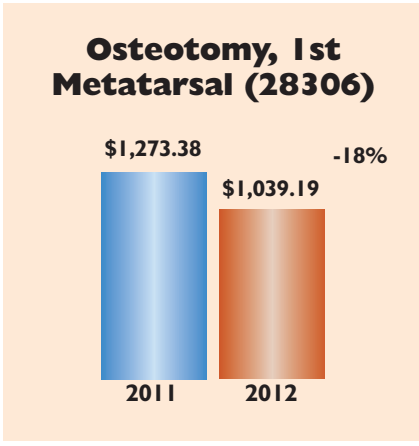
Injection, Small Joint/Bursa (20600)

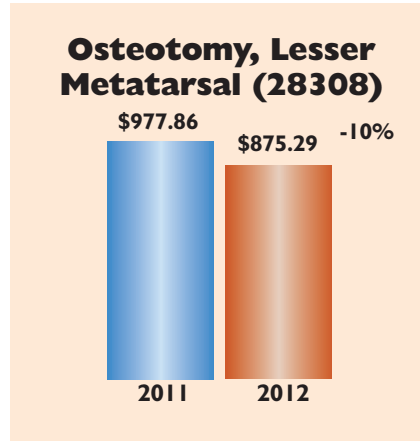
Initial Exam (99203)

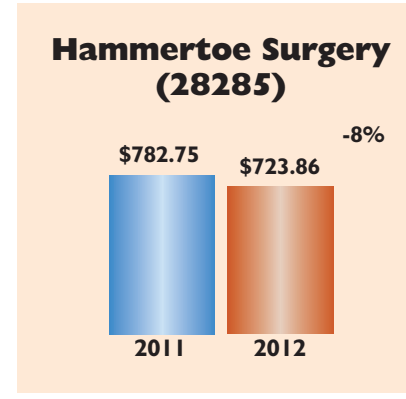


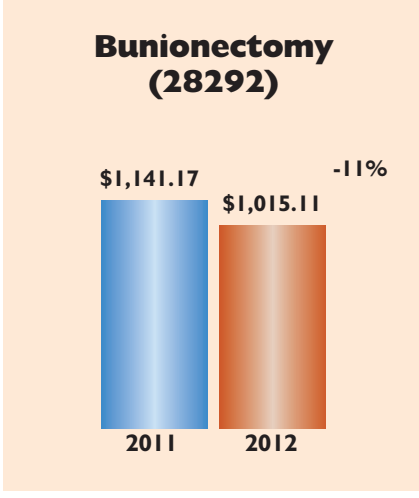
Subsequent Visit (99212)

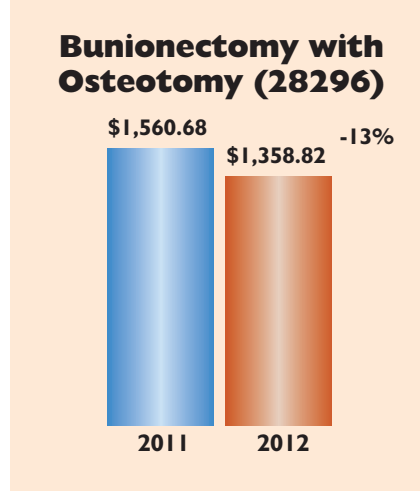
FEES

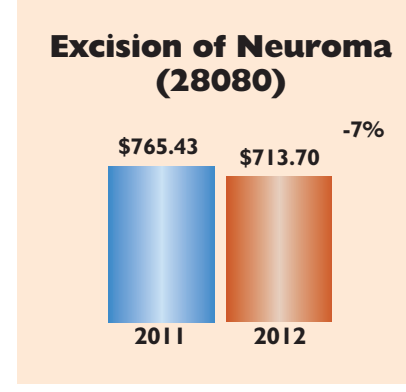












Fewer Are Board Certified

About two-thirds (67 percent) of our most recent respondents were Board Certified. That was down from 76 percent in our last report. This is not surprising given the fact that the recent survey group was less experienced overall, and may not yet have pursued Board certification or were in the midst of attaining it.

Benefits of Board certification include access to more MCO panels (some of which require it); a public relations and practice-building value as patients compare doctors via online profiles; and an ability to specialize and market themselves as specialists. Board-certified DPMs earned more, too: $137,000 compared to $95,750 for those who were not Board certified in our latest survey.

Board-certified DPMs earned more, too: $137,000 compared to $95,750 for those who were not Board certified in our latest survey.

More AAPPM Members

Twenty-one percent of respondents were members of the American Academy of Podiatric Practice Management (AAPPM), up slightly from 20 percent in our previous survey. AAPPM online resources include sample contracts, forms, manuals, patient materials as well as information on compliance and an "Ask the Experts" feature. These are all benefits that our larger group of new doctors may have found useful. In fact, the AAPPM has

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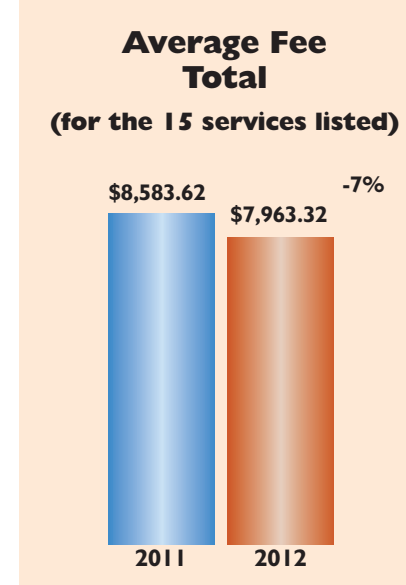
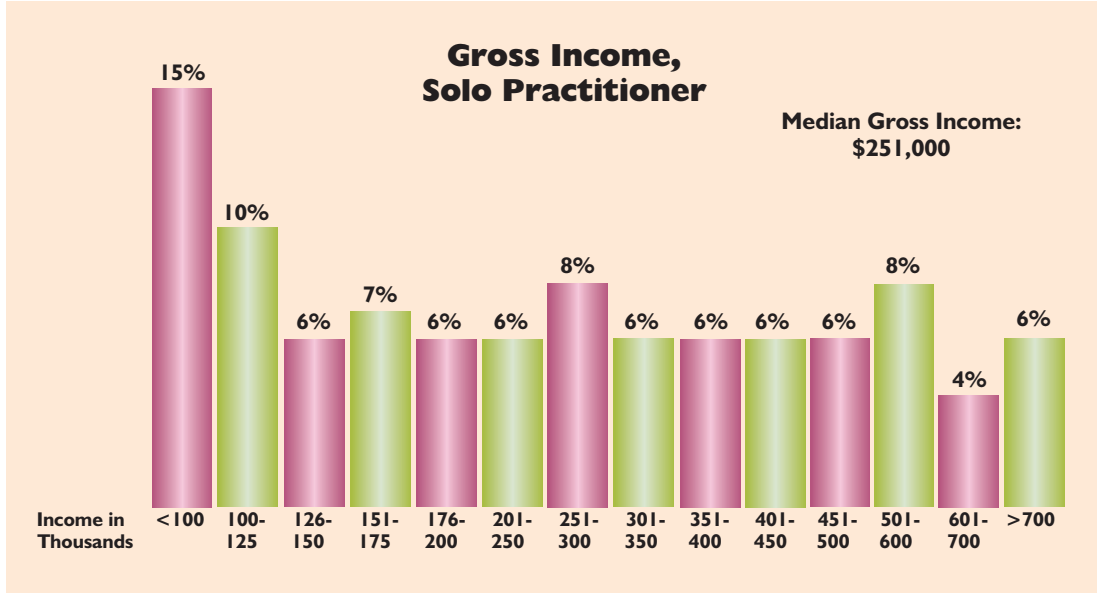


a "Young Practitioners" web page with resources geared toward new DPMs' specific needs. It also offers conferences and workshops for both doctors and staff.

As we saw with membership in APWCA and the APMA, there seems to be a monetary advantage to joining the AAPPM. Its members reported a median net income of $139,500 compared to $115,750 for non-members.



Degree Change Still Favored

A degree change to MD or DO was favored by 65 percent of respondents, down slightly from 67 percent in our previous survey. Some recent graduates may not have fully explored the opportunities and limitations associated with this issue. Some are opposed to a change, arguing that podiatrists do not need a degree change to achieve parity, while others argue that podiatry school applications would increase if a degree change occurred.

The small increases in some fees did not keep up with the reductions in others.

FEES, MEDICARE & AUDITS

Fees dropped an average of 7 percent, for a total of $7,963.32 for all types listed (see charts). Interestingly, several less expensive exams and procedures actually increased compared to our last report, but were weighted down by fee cuts for a number of more expensive procedures. For example, the initial exam fee rose 26 percent to $142.55, and subsequent visit fees jumped from $65.63 to $94.43. By contrast, the average fee for osteotomy (28306) dropped 18 percent or $234.19 from the previous report. Dollar for dollar, the small increases in some fees did not keep up with the reductions in others.

As Barry Block, DPM, JD, editor of this magazine, mentioned in this month's editorial, the APMA "must find a way to permanently do away with the onerous sustained growth rate (SGR) formula, or the future of all medical practitioners will remain in peril." This provides another incentive to support the APMA through membership and active involvement. Until the fee issue is resolved to doctors' satisfaction, we don't anticipate that fees will rise anytime soon.

Note that the fees listed were those charged but were not necessarily what the respondents were paid by Medicare and MCOs. Those amounts are often less than fees charged and can vary regionally and from plan to plan.

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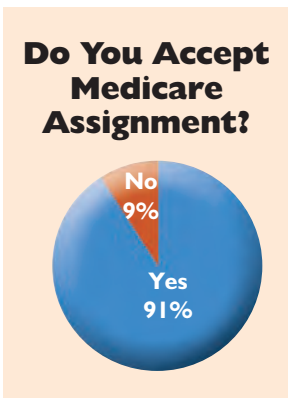
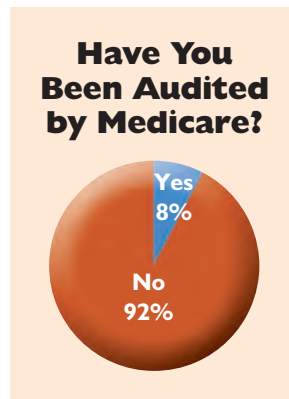
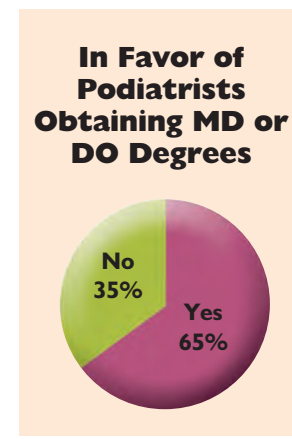
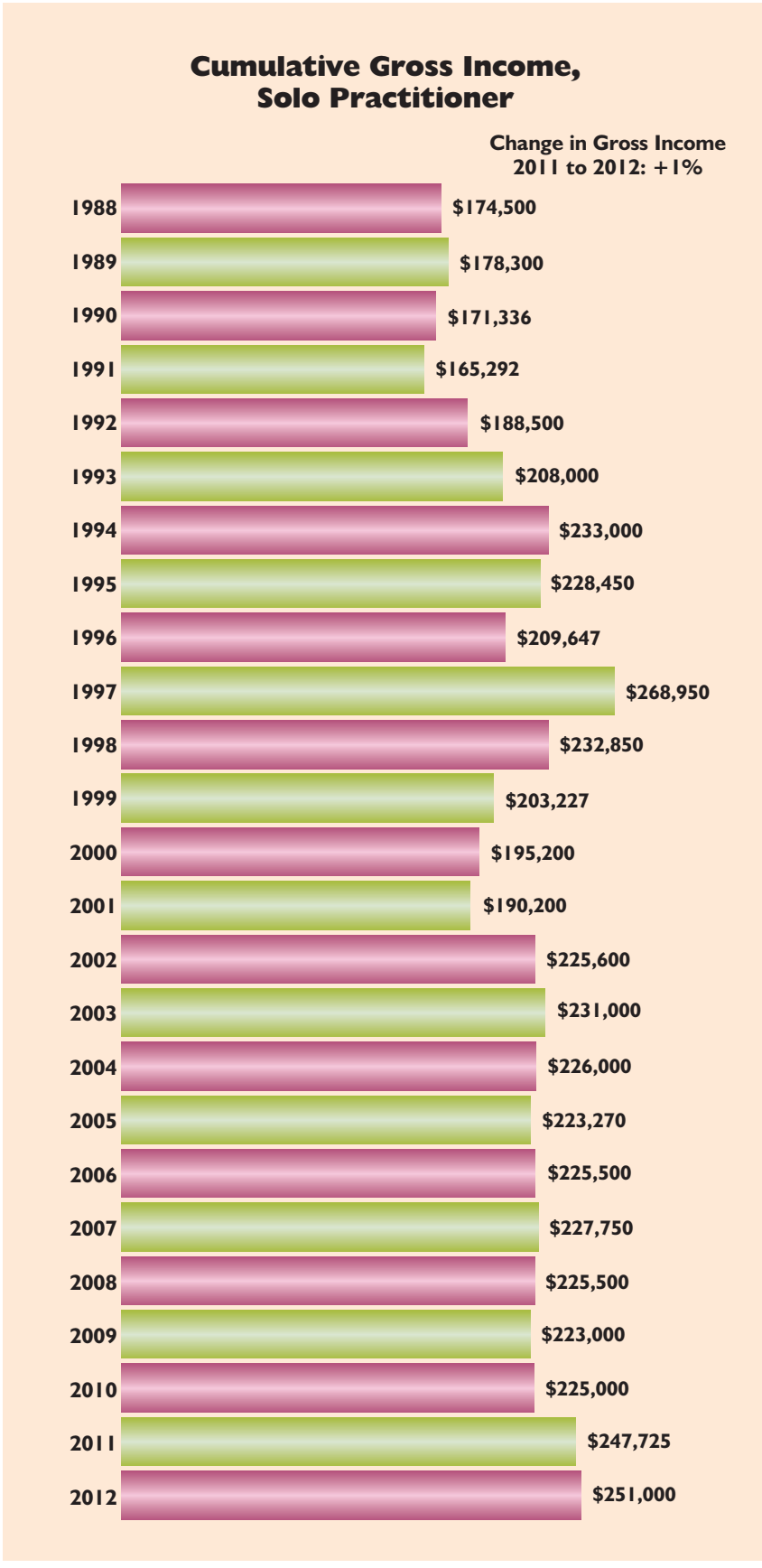








Medicare and Audit

Ninety-one percent of those surveyed accepted Medicare assignment, which was down slightly from 93 percent last year. The CMS reports that Medicare enrollment (in hospital insurance and/or supplementary medical insurance plans) grew by 5.4 percent from 2010 to 2011 compared to 2.4 percent growth from 2009 to 2010. We will continue to watch aging population numbers and their impact on Medicare, as well as the changing requirements that may come about at the Federal level over time.

When asked whether respondents had been audited by Medicare, 8 percent answered affirmatively. That's up from only 3 percent in the last report. The increase is not surprising given the CMS institution of its Recovery Audit Program, which in its 2011 mission statement noted that its purpose was to "reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments." As the Federal government looks to cut spending and increase revenue, we anticipate continued aggressive actions being taken to recover erroneous payments and issue penalties.

When asked how much audited doctors were ordered to pay back, the vast majority (83 percent) owed $1,000 or less and the other 17 percent were required to pay back between $1,001 and $10,000. These amounts generally were smaller than last year's report, in which 50 percent of those surveyed were ordered to pay back between $1,001 and as much as $100,000.

GROSS INCOME

Doctors in solo practice reported a median gross income of $251,000, up 1 percent from last year's report. The percentage of doctors with a top-line

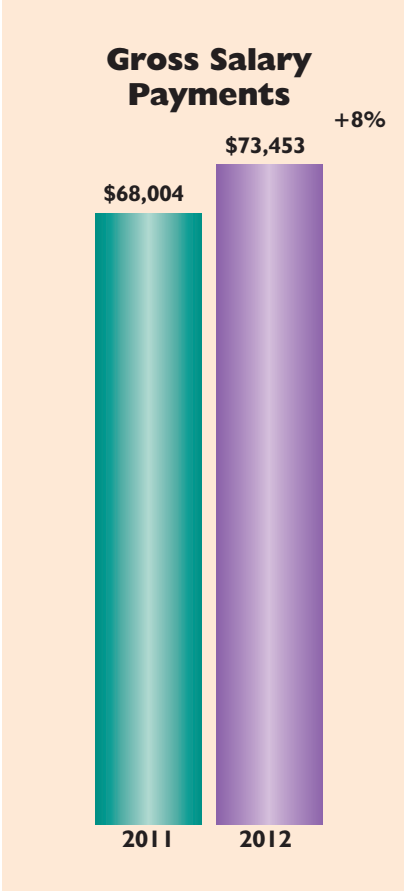
Continued on page 128

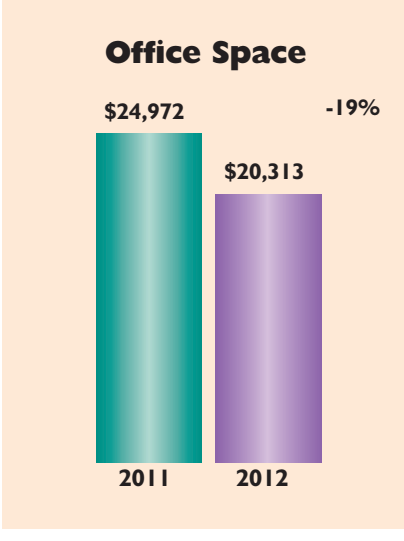
income of less than $100,000 grew slightly from 13 percent last year to 15 percent in our most recent report. While 12 percent of solo doctors reported a gross income of more than $600,000 last year, only 10 percent of respondents reported the same this year.

Regionally, we tallied median gross income for both solo and partnership/group combined. The highest reported figures were in the West, at $193,750, and the South, at $189,250. The median gross income was $177,250 in the East and $157,750 in the Midwest.

One emerging method to improve cash flow and reduce accounts receivable is the use of health care credit options as an alternative to cash and major credit cards. This option provides another way for patients to pay for non-covered services and may result in better acceptance of doctors' treatment recommendations. As a result, this option may improve top-line income for some practices.

YOUR OVERHEAD EXPENSES





The highest reported figures were in the West, at $193,750, and the South, at $189,250.

EXPENSES & TRENDS

Despite the larger number of new practices, DPMs kept costs at bay, reporting a decrease in overall expenses of 1 percent. Since there were larger drops in net income, this expenses figure indicates that doctors invested in areas that they felt would benefit their practices in the long term. Here's how their dollars were spent.

• ***Gross Salary Payments***—Gross salary payments rose an average of 8 percent to $73,453. While the 3.2 percent inflation rate in 2011 was double the rate of 2010, it was still far below the average salary increase reported here. Many factors may have contributed to this higher pay. First, we reported a mere 1.2 percent increase in our previous survey, so perhaps some doctors felt the need to boost salaries to make up for that. The job market, which was still depressed in some areas, did bounce back slightly in 2011 as previously mentioned. This may have reduced the number of qualified applicants and required DPMs to compete for candidates with higher salaries and benefits, including pension plan contributions (see "Pension Contributions" below). Since a larger percentage of doctors were new to practice, they may have opted to hire more highly trained employees rather than take time from practice building to train lower-level assistants.

• ***Office Space***—The cost for office space fell 19 percent compared to last year's survey, for an average annual expenditure of $20,313. Trends in the mortgage rates and rents proved beneficial for respondents, who experienced a buyer's/renter's market during that period. Thirty-year mortgage rates fell to the 4 percent range, while the glut of available office space (much of it because the ailing economy caused so many business closures) provided leverage for lease negotiations. Although the office rental market was not as soft as it was during the height of the recession, renters could still negotiate such perks as free rent, office amenities, tenant improvements and a cap on common area maintenance fees.

In New York, for example—where the highest percentage of respondents practice—average rents were still far below 2008 figures.

• ***Fixed Equipment Expenses***—Doctors surveyed for our latest report spent considerably more on equipment than last year's respondents: $4,605, an increase of 27 percent. New practitioners likely invested

Continued on page 130

heavily in this category as they equipped their practices. Others, who may have put off purchases in previous years, may have taken advantage of Section 179's full deduction benefit (up to $500,000 for qualified purchases). Doctors may have invested in new portable and full console laser systems (whether for pain management, nail fungus or cosmetic treatments), Extracorporeal Shock Wave Therapy equipment, Extracorporeal Pulse Activation Technology, computerized gait analysis, hydrotherapy equipment, pressure assessment and vascular diagnostic equipment, etc. They may have also upgraded some of their equipment. For example, today's chairs built for podiatry patients come with high-tech, patient-friendly and ergonomically designed features.

We asked respondents about their incorporation of digital x-ray technology. Forty-five percent of those surveyed said they use this technology in their practices, up from 41 percent in our previous survey. What's more, another 34 percent of respondents who do not currently have digital x-ray equipment said they planned to incorporate this technology into their practices within the next two years.

We also asked about the use of foot measurement technology for prescribing orthotics and found it was used by 22 percent of respondents. Another 6 percent who did not have the technology when surveyed said they were considering purchasing the technology within the next 12 months.

On the business side, seasoned doctors may have upgraded the high-tech appearance of their practices to include iPads (for such uses as iPad optimized EHR and patient use in the waiting room); large, flat-screen televisions; and patient-accessible desktop and laptop computers. Staff computers and printers continue to drop in price while offering more features.

• ***Computer Service/Maintenance and the Internet***—The $2,274 average cost for computer-related services (such as software installation and training, website maintenance and Internet service) was up 12 percent from our previous survey. For new doctors, this may have included system set-up fees and initial staff training. Both new and seasoned DPMs may have incorporated EMR in advance of Federal deadlines for imple-

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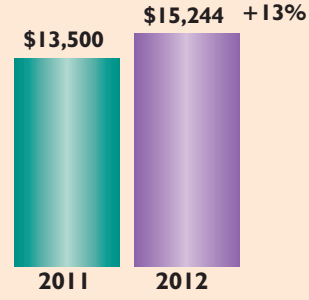
YOUR OVERHEAD EXPENSES

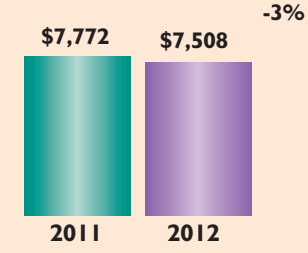
Fixed Equipment Expenses

Bio/Pathology Laboratory Expenses

Student Loan Repayment

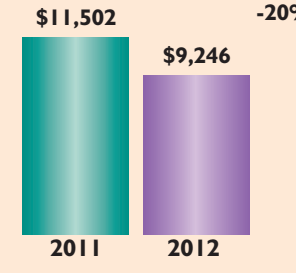


Laboratory Expenses (Orthotic)



Pension Contribution for Staff

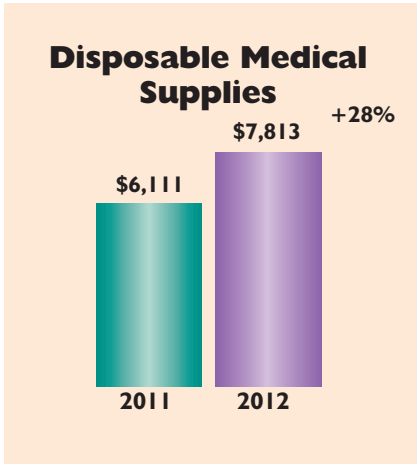
Pension Contribution for Self

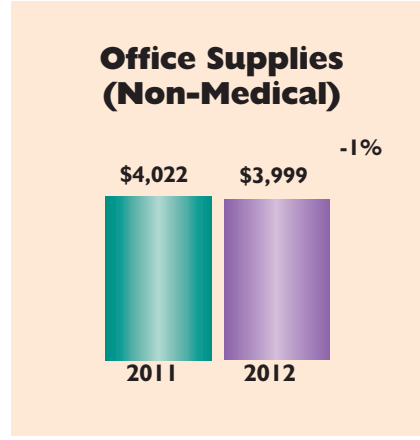


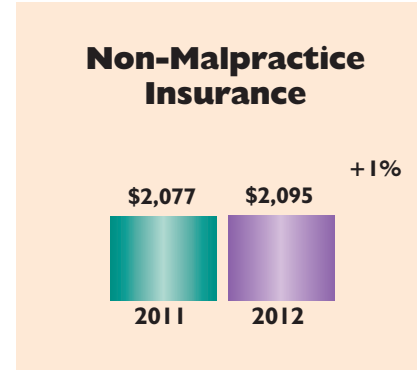
Utilities

Educational Expenses

YOUR OVERHEAD EXPENSES







mentation in order to take advantage of financial incentives.

Despite the increased competition for Internet customers by cable and telephone companies, rates for Internet service continued to climb during the survey period. Some practices may have added "boost" services to increase Internet speeds and reduce buffering. Others may have switched providers to ones that offered free Wi-Fi so the office could offer this to patients as a courtesy.

• ***Utilities***—Total utility costs dropped significantly from our last report, falling 38 percent to an average of $3,955. Given that the respondents were, overall, less experienced and saw fewer patients, it's conceivable that this drop was due, at least in part, to smaller offices with lower utility costs. Here are three areas that might have made an impact on this cost.

Energy: The end of 2011 (our survey period) started one of the warmest winters in U.S. history. Undoubtedly, all small business owners benefitted from lower oil, gas and electric bills. Continued competition from alternative energy suppliers made this line item even more affordable. According to the National Oceanic and Atmospheric Administration, the 2012 average temperature was the highest on record. Thus we anticipate that energy costs will remain low in next year's report.

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Water: In contrast to lower energy bills, the cost for water service continues to climb. According to Circle of Blue (COB), which provides data collection on water and other resources, the average cost of water in 30 major U.S. cities jumped 9.4 percent from 2010 to 2011.

In some areas of the country where older water infrastructures exist, we anticipate an increase in cost for maintenance and repair, which will be borne by residential and commercial customers. For example, COB reports that Chicago customers' rate for the survey period jumped nearly 25 percent to raise funds to replace 900 miles of its water distribution network. Other factors stimulating increases nationwide include post-9/11 security requirements of water sources; rising employee costs, such as for pensions and health insurance; and the rising costs for water treatment supplies. A report by CNN Money indicates that some water bills will double or triple over the next 25 years.

In contrast to lower energy bills, the cost for water service continues to climb.

Telephones: Competition among telephone carriers continues to escalate. Service bundles—such as those that combine as landline telephone, cellular, Internet and television services—have moved into the commercial arena after realizing success in the consumer market. Doctors may be finding that just by bypassing the lat-

Continued on page 136

What Brand of Athletic Footwear Do You Prescribe/ Recommend the Most?

	2012
New Balance	58%
Asics	17%
Brooks	8%
Nike	5%
Aetrex	3%
Saucony	2%
Others	7%

est model of phone—for example, choosing an iPhone 4 over an iPhone 4S or iPhone 5—they can realize equipment cost savings.

• ***Educational Expenses***—Doctors surveyed spent slightly less (4 percent) than last year on educational expenses, for an average of $1,967. Fresh out of podiatry school and focused on practice startup or new employment situations, recent graduates may not have viewed continuing education as a priority. Time and money for offsite conferences may have been limited. Perhaps a big priority for new practice owners was practice management-related education, which was limited in podiatry school but would help doctors jump-start new practices. These conferences help them deal with such issues as staffing, contracts, patient relations and reimbursement paperwork. For seasoned doctors, this training can bring practices to a higher level of efficiency and income.

Continuing medical education covering new technologies, treatment options and co-management of patients in multidisciplinary settings benefits both new and seasoned doctors.

Continuing medical education covering new technologies, treatment options and co-management of patients in multidisciplinary settings benefits both new and seasoned doctors. Conference venues and clinical seminars provide the added benefit of face-to-face doctor interaction.

Lower-cost supplements to both practice management and clinical education include webinars, podcasts, YouTube videos and courses such as PM's continuing medical education section in each issue of this magazine. PM News on podiatrym.com allows doctors to pose questions to 14,000+ users and get immediate feedback on difficult cases and management situations. As a hint of what's to come, a mobile version of PRESENT CME lectures, eZines and eTalk was introduced in 2012 for use on doctors' mobile devices. Expect further enhancements as mobile computing becomes faster and devices broaden their features.

• ***Professional Dues***—Surveyed DPMs reported an average expenditure of $1,821, down 11 percent from our previous average. Doctors new in practice may have been too busy with startup to invest time and money in professional organizations. Others may have been more selective in choosing memberships this year, given that their available income was reduced.

Investment in professional organizations proved to pay off in terms of net income for members of the APMA and AAPPM as previously discussed. These associations and others offer such benefits as continuing education, collaborative conferences, representation at the Federal level and peer and professional counseling/advice.

• ***Professional Liability***—Malpractice insurance for surveyed practitioners dropped 15 percent to an average of $7,697 compared to our last survey. According to "Medical Malpractice Insurance Rates Flat Due to Market Forces" on businessinsurance.com, new malpractice underwriters have entered the marketplace, providing a more competitive environment for rates. Tort reform has also kept rates low, with the average claims payment for a medical malpractice at $334,559, according to KFF.

A report from the National Institutes of Health entitled "Health Care Reform and Medical Malpractice Claims" explored the possible impact of Federal legislation on rates in the future. "With the enactment of the Patient Protection and Affordable Care Act of 2010....it is especially appropriate to consider what effect, if any, the new law will have on the rate of medical malpractice claims," according to the report, with researchers arguing that if the rate of claims remains the same but the number of patients increases, "the total number of malpractice claims will increase."

Continued on page 138

• *Non-Malpractice Insurance*—The cost for such insurance policies as liability, fire, theft and workers' compensation rose 1 percent to $2,095. While the plethora of natural disasters in 2010 (including numerous floods, tornadoes and wildfires) may have caused a dramatic rate hike, these were likely tempered by the increasingly competitive insurance landscape. What's more, a larger percentage of respondents were new practitioners who, as previously mentioned, likely had smaller offices with less square footage and equipment to insure and fewer employer-associated policies.

The fees for 2011 did not yet reflect the numerous natural disasters of 2011 and 2012. It's likely that premiums will rise in the future to pay for such widespread disasters as Hurricane Irene in 2011 and Hurricane Sandy in 2012.

• *Legal and Accounting Fees*—The cost for lawyer and accountant services dropped 3 percent to an average of $2,817. While new practitioners grappled with the legal and tax issues of starting a practice, they also needed to handle such paperwork as supplier contracts, leases and managed care agreements.

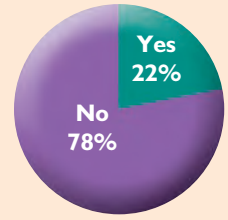
The fees charged by legal firms for the year rose 3 percent in 2011, according to Thomson Reuters' "Peer Monitor Index." But it noted that increased rate negotiation and client pressure for reduced fees, which had already been felt since the height of the recession, kept fees low and would curtail increases in legal fees into the immediate future.

We expect accounting fees will rise due to the increasing complexity of new tax codes and provisions as well as ongoing changes in filing requirements. While some smaller practices may benefit from the services of a growing number of tax preparation franchises (one of the fastest-growing franchise categories in the U.S.), many may still opt to select private individuals or small firms familiar with the ins and outs of medical practices.

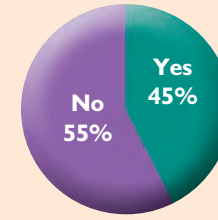
• *Pension Contributions*—Pension contributions to the doctors themselves dropped 20 percent compared to last year. Now contributing an average of $9,246, DPMs surveyed likely reduced contributions due to lower overall income. Younger practitioners may have put off contributing

Continued on page 141

Do You Use Foot Measurement Technology for Prescribing Orthotics?



Do You Incorporate Digital X-ray Technology into Your Practice?

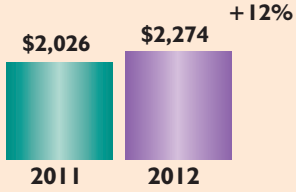


It's likely that insurance premiums will rise in the future to pay for such widespread disasters as Hurricane Irene in 2011 and Hurricane Sandy in 2012.

YOUR OVERHEAD EXPENSES

Advertising

Computer Service Maintenance & Internet



Type of Advertising

	2011	2012
Yellow Pages	61%	50%
Internet	57%	46%
Newspapers	26%	21%
Mailings	12%	9%
Radio	7%	5%
TV Cable	5%	2%
TV Network	3%	1%
Other	12%	22%
Do Not Advertise	31%	14%

Products for Sale

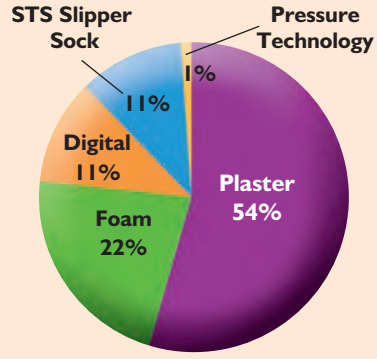
to retirement as they struggled to build new practices.

Pension contributions to staff, by contrast, remained relatively stable, up 1 percent to $2,377. Combined with substantially higher average salaries, these contributions indicate that surveyed doctors viewed staff as a vital link to practice success.

• ***Student Loan Repayment***—Respondents who had loan repayments (zeros were not factored in) reported average payments totalling $15,244, an increase of 13 percent over our previous report. We expected higher costs here due to the larger percentage of recent grads surveyed. In addition, college and professional degree program tuitions rose faster than the inflation rate, and at an even greater rate at public institutions than private ones, according to data from The College Board. As the Federal government looks to reduce costs, we will watch the subsidized interest rates of student loans, with any increase having a huge impact on payments for the long term.

• ***Bio/Pathology Lab Expenses and Disposable Medical Supplies***—DPMs spent 29 percent less than last year on bio/pathology lab expenses, for an average expenditure of $464. The fact that there were fewer patients undoubtedly had an impact on this figure. They also spent $7,813 on disposable medical supplies, an increase of 28 percent. This latter figure reflects new practices spending to build initial supply inventories. In addition, we reported a large drop in this expense last year as part of respondents' cost-cutting efforts. Practitioners surveyed may have reinstated their spending patterns in our report.

What Is Your Preferred Method of Foot Measurement for Prescribing Orthotics?



Percentages add to less than 100% due to rounding.

• ***Orthotics and Ankle-Foot Orthoses (AFOs)***—Podiatrists surveyed spent $7,508 on orthotics and AFOs, down 3 percent from our last survey. Doctors sent an average of 5.5 pairs of true custom orthotics to an outside lab each week, which was up from 4.9 pairs last year. They also dispensed an average of 6 pairs of prefab orthotics weekly, which dropped from 9.8 pairs in the previous survey.

Doctors sent an average of 5.5 pairs of true custom orthotics to an outside lab each week, which was up from 4.9 pairs last year.

With the increased number of diabetic and wound care patients, more doctors may have been using custom orthotics to reduce pressure and shear in order to prevent foot ulceration. It may also reflect respondents' success in overcoming patients' financial objections to custom orthotics, if any—perhaps also their increased success in selling multiple pairs—and training staff on their benefits to improve patient education.

When asked for their preferred method of foot measurement for prescribing orthotics, plaster remained on top at 54 percent, an increase of six percentage points from our previous survey. Second most popular was foam at 22 percent followed by digital (optical or laser) and STS Slipper Sock tied at 11 percent of respondents. Pressure technology was used by only 1 percent.

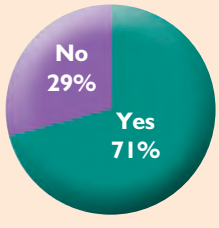
Doctors surveyed reported the average number of prescriptions per month of AFOs for all types. Gauntlet AFOs were prescribed at an average of 3.4 per month (up from 2.7), followed by functional-hinged AFOs (Richie type) at 2.1 percent (no change), solid AFOs at 1.7 (down from 2.2) and Dorsiflex Assist AFOs at 1.7 (up from 1.6).

The preferred method respondents used when performing off-loading procedures was a post-op shoe/boot/walker, which was used by 79 percent of respondents (down from 81 percent last year). Twelve percent modified existing footwear (up from 8 percent), and 10 percent used TCC (down from 11 percent).

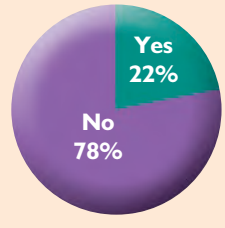
We again asked respondents what brand of athletic footwear they prescribed/recommended the most. New Balance remained on top, recommended by 58 percent of respondents (down from 62 percent last year). Next was Asics at 17 percent (up from 10 percent), Brooks at 8 percent (no change), Nike at 5 percent (down

Continued on page 142

Do You Dispense OTC Products from Your Office?



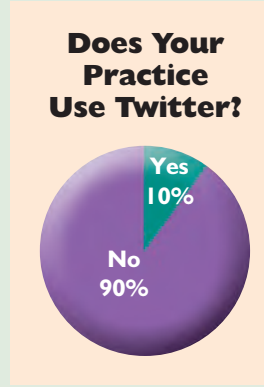
Do You Dispense Rx Products from Your Office?

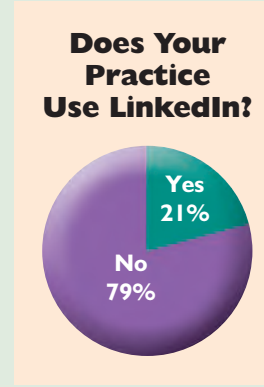


Trends Point to Increased Use of Facebook, LinkedIn

As part of their advertising and marketing strategy, a larger percentage of doctors than our previous survey used Facebook, up five percentage points to 32 percent of respondents. The percentage of DPMs who used LinkedIn grew as well, from 14 percent in our last survey to 21 percent in our most recent one. Twitter use remained steady at 10 percent of respondents. All of these social media vehicles are relatively quick and easy to set up without the use of professional assistance, so we expect their numbers to grow.

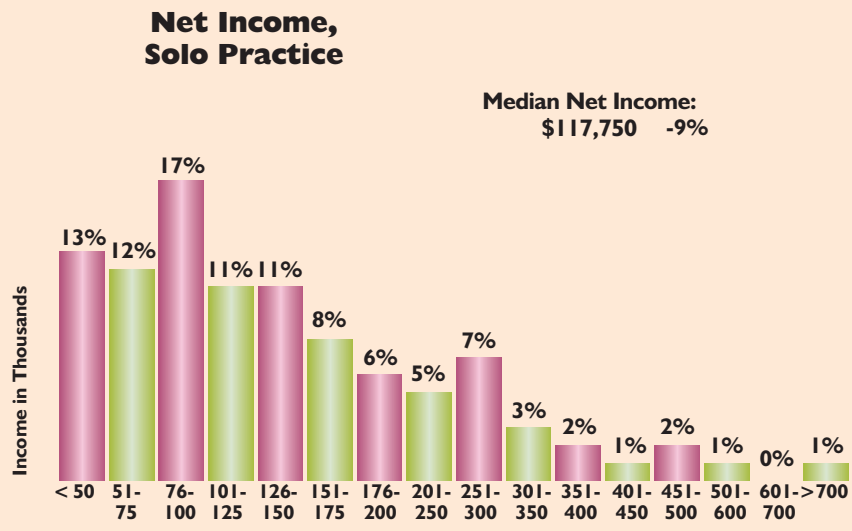
The percentage of practices with a website dropped slightly from 70 percent last year to 68 percent in our latest report. Undoubtedly, this number will increase as the large percentage of new doctors (those in practice less than a year) launch their websites for the first time. •





from 8 percent), Aetrex at 3 percent (up from 2 percent) and Saucony at 2 percent (no change). Seven percent of respondents said they recommended brands not listed here.

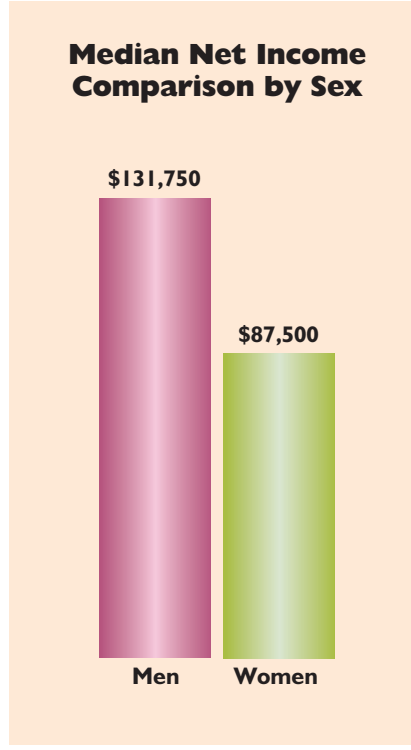
• ***Office Supplies (Non-Medical)***—The cost of office supplies remained nearly steady, down 1 percent to $3,999 from last year. Given the larger percentage of newly minted DPMs, we would have anticipated a bump up in this cost as doctors supplied new offices. Instead, DPMs have benefitted from aggressive competition among office supply vendors, big-box retailers and warehouse stores. Doctors and staff were bombarded by low-price guarantees as well as daily or weekly email promotions and rebate programs. Jumps in office expenses by new doctors may have been tempered by more seasoned doctors going paperless and relying on electronic means for basic patient communication. E-tailers like Amazon and eBay have more aggressively entered the office supply market, providing another force for depressed pricing.

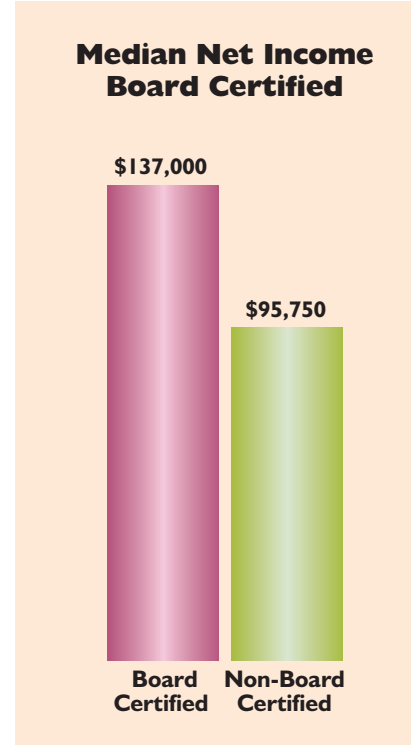


• ***Products for Sale***—Respondents spent 13 percent less on products for sale (i.e.,

Continued on page 144

for in-office dispensing) than our previous report, for an average expenditure of $2,584. While this may be a correction from last year's dramatic increase (up a reported 36 percent), other factors may have come into play. For instance, new DPMs may have not had the opportunity to incorporate these items yet. Since our respondent pool spent considerably less on office space this year, perhaps some doctors did not think they had the space for these items. However, the benefits of in-office dispensing have been widely discussed for improving patient compliance and boosting income. Revenue can come from prescription medications as well as over-the-counter (OTC) items such as insoles, comfort shoes, palliative supplies, post-surgical/injury-care items and diabetic socks. In addition, providing diabetic shoes and inserts under the Diabetic Shoe Bill is a win-win opportunity for both doctors and patients. Companies providing these products can provide space-saving kiosks and counter displays that can be used in even small offices.



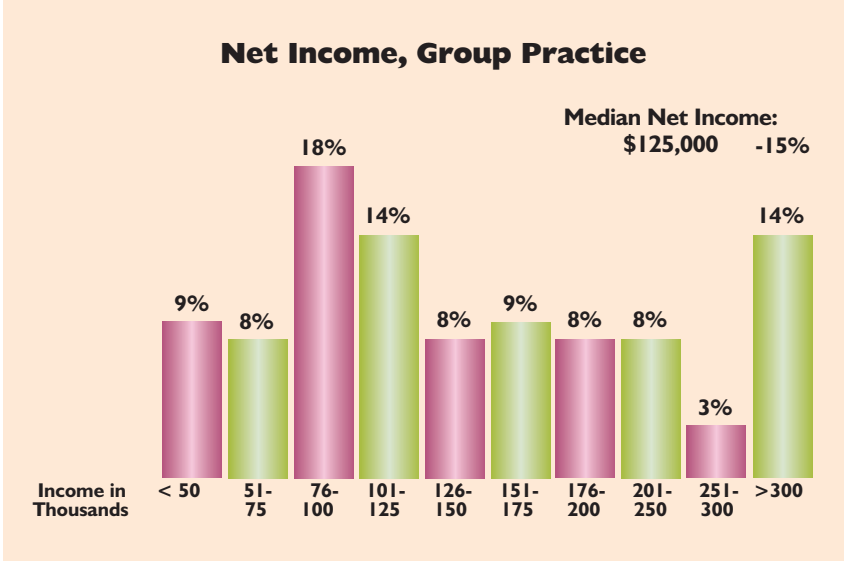


Some companies provide online dispensing systems that help ensure that patients receive the items the DPM has recommended or prescribed.

The percentage of DPMs who said they dispense OTC products from their offices also dropped from 77 percent in our previous survey to 71 percent this year. Of those who did not dispense OTC products, 6 percent said they planned to do so within the next 12 months. With the recent negative turn in net income figures, we will watch to see whether more doctors add product sales for supplementing income.

Another option is using a using a virtual inventory to provide items to patients. Some companies provide online dispensing systems that help ensure that patients receive the items the DPM has recommended or prescribed.

When we asked respondents what percentage of their 2011 income was derived from the sale of products from their offices, 84 percent reported that they earned less than 10 percent of their income from this source. We will watch this figure in future surveys.



• ***Advertising***—The percentage of those who advertised remained fairly steady compared to other changes in expenses categories, down 1 percent to an average of $3,791. It's interesting to note that there was a dramatic increase in the

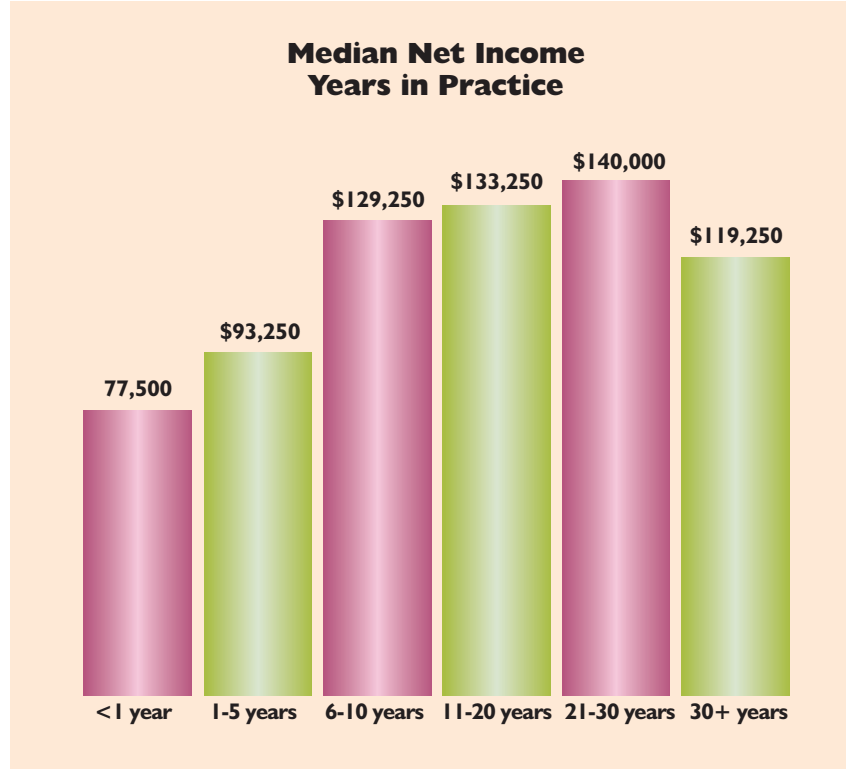
Continued on page 146

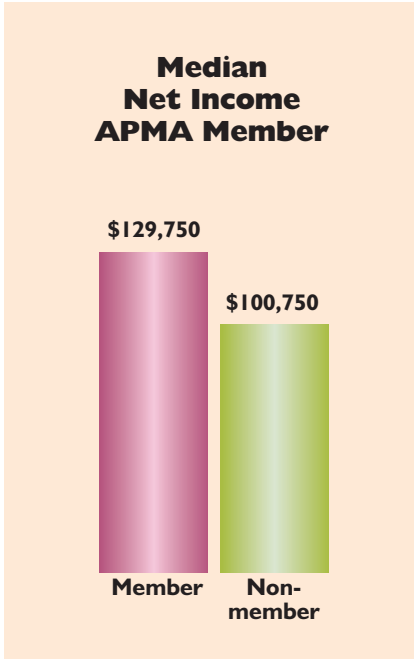
percentage of DPMs who did advertise during our survey year compared to the percentage of those who advertised in the year before: 86 percent said they advertised vs. 69 percent in our previous report.

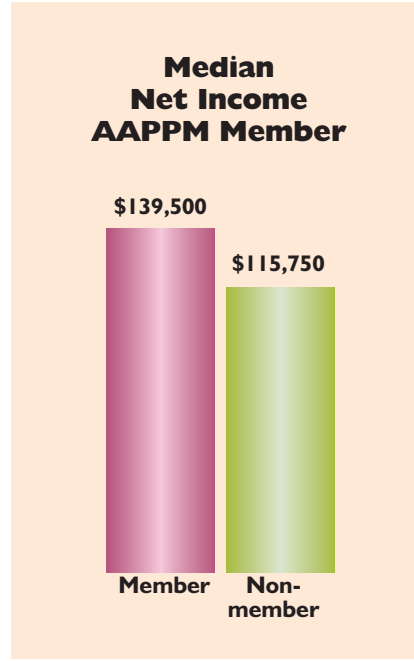
Yellow Pages—Use of *Yellow Pages* as an advertising medium dropped from 61 percent last year to 50 percent in our latest survey. While it remained the most-used medium, this is a large one-year drop, perhaps due to the younger demographic of this year's respondent pool. Many new DPMs may have seen little value in the high expense and fragmented reach of *Yellow Pages* directories today, and determined that online alternatives would provide better results. Doctors who have used this medium for years may have started to gauge the return on their investment, finding that other media was more cost effective for securing patients.

It should be noted that some doctors who answered affirmatively may have included both print and online versions. We will separate the two in our next survey.

Internet—The use of Internet advertising (including website creation and maintenance, banner ads and search engine optimization) remained the number two advertising choice among respondents, with 46 percent using this medium. Although this is a drop from 57 percent in our previous report, it is likely that the jump in percentage of new practitioners may have come into play here, considering the time and expense involved to plan and execute an Internet marketing strategy.







Many doctors have broadened their use of websites beyond a placeholder for basic practice information to include appointment scheduling, the ability to download paperwork before appointments, patient education sections and exit interview questionnaires. Doctors may have invested in online giveaways to increase website traffic. As technology advances and other strategies emerge, we're likely to see interactive web use further enhance the patient experience and give them more reason to visit practice websites and, ultimately, become patients.

Social media sites such as Facebook, LinkedIn and Twitter continued to play an expanded role in patient communication. See the sidebar "Trends Point to Increased Use of Facebook, LinkedIn" for further discussion.

Use of mobile technology rose dramatically during our survey period. New devices—such as the iPhone 4 and iPhone 4S as well as the iPad and various tablets—triggered a major focus by advertisers on reaching the mobile user. In fact,

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according to eMarketer, mobile advertising jumped 88.5 percent to $1.45 billion from 2010 to 2011. It projects ad spending to continue to climb to over $20 billion by 2016. Thus if a DPM's Internet marketing strategy does not already include a mobile component, it will likely need to include one in the near future to maximize patient reach. One of the first we're seeing used on a wide basis is text message appointment reminders. Stay tuned for more.

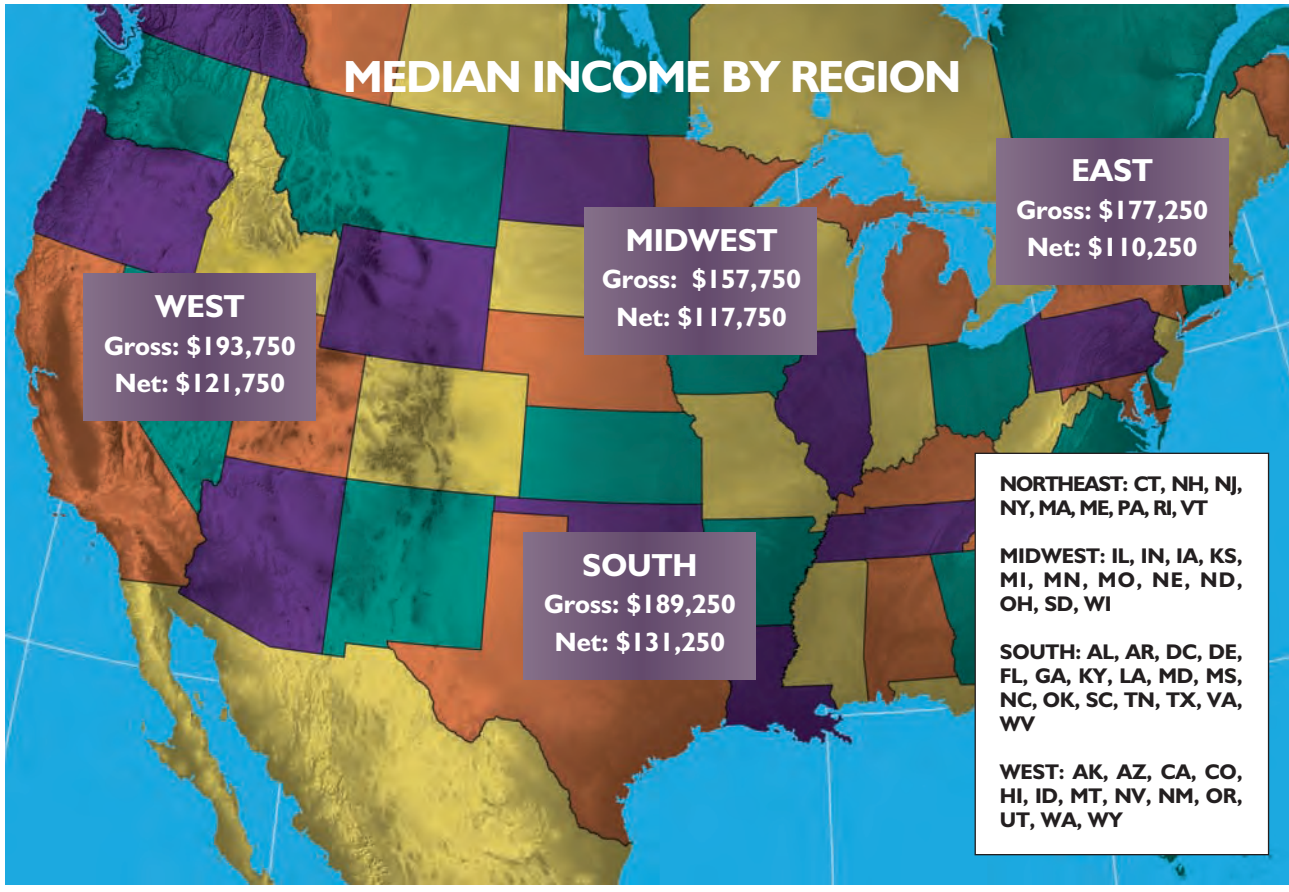
Newspapers—Use of newspapers as an advertising medium fell from 26 percent in our previous survey to 21 percent in our most current one. A Pew Research report "The State of the News Media 2012" noted newspaper print circulation continued to decline in 2011. "When circulation and advertising revenue are combined, the newspaper industry has shrunk 43 percent since 2000," according to the report. Hand-held devices were more often used to access newspapers, with suburban and urban residents more likely to read their newspapers on hand-held devices than rural residents.

Smaller newspapers and those with less frequent circulation, such as weeklies, have found their niche in the market and remained strong. "Rather than filling their pages with material that is readily available on the Internet, smaller newspapers focus on the politics, business, sports, crime and community affairs occurring in narrowly defined geographic areas—a county, a town or, in some cases, even a few neighborhood blocks," according to an Associated Press report featured in Media Biz on nbcnews.com. In Pew Research's report "Trends in News Consumption: 1991-2012," daily newspaper readership continued to drop, while weekly newspaper readership has stabilized. Applicability to the DPM practice includes advertising in weeklies' health-section supplements and doctor-written advertorials (advertising that looks like newspaper stories) featuring doctors as the area experts.

Smaller newspapers and those with less frequent circulation, such as weeklies, have found their niche in the market and remained strong.

Mailings—Only 9 percent of those surveyed used mailings, down from 12 percent in the previous year. While new and inexpensive quick-print companies may have provided doctors with professional-looking newsletters, postcards and

Continued on page 150



the like, some practitioners may have avoided this medium due to escalating postage costs and the substitution of Internet advertising. Email marketing alternatives may have replaced these mailings in some practices, using companies such as Constant Contact for e-newsletters and HTML email for a more engaging reach to current and prospective patients.

Radio—Radio usage for advertising dropped to 5 percent of those who advertise, down from 7 percent in our previous survey. This may be the result of cost-cutting as well as the result of competition from Internet vehicles. In areas where high unemployment lingered, doctors may have determined that the reduction in coveted drive-time audience made radio less desirable.

According to media and market research firm Arbitron, 73 percent of people age 12 and over heard at least one network radio commercial in December 2011. While that was down slightly from December 2010's 74 percent, it still represented 189 million listeners. SiriusXM satellite radio remained strong in 2011, with Pandora Radio becoming a bigger competitor. Internet-enabled radio may cut into network and satellite listenerships and reduce radio's advertising reach in the future. That's a trend we will watch, especially as new Internet-friendly car consoles are introduced, or become part of standard equipment, with options that compete for drive-time audiences.

Doctors may have determined that the reduction in coveted drive-time audience made radio less desirable.

Television—The percentage of those using both network and cable television for advertising dropped among those who said they advertised. Only 1 percent advertised on network TV (down from 3 percent last year), and 2 percent advertised on cable (down from 5 percent). Since television was one of the most expensive advertising media, we're not surprised in the drop here. Mobile devices provided strong competition for this medium (see Internet above).

Continued on page 152

Rather than competing with the Internet, some cable stations broadened their reach by combining the two media. One population targeted was Hispanics, with Fox's launch of foxnewslatino.com in 2010 and CNN's companion website cnnespanol.com, which started in 2011.

Other—Twenty-two percent of those who advertised used other types not listed here. These may have included promotional objects (pens, notepads, etc.), sponsorship of sports teams, church bulletins, coupons, counter card displays and other methods.

• ***Computer Service/Maintenance and the Internet***—This relatively new category was a substantial expense in the DPM's practice, as indicated by survey results. Respondents spent an average of $2,274 for computer service/maintenance and the Internet, up 12 percent from our previous report. Many doctors establishing practices in 2011 incurred high computer software and consultancy fees as they set up their networks for the first time and trained staff to run practice software. They also likely set up their websites, which could have been high-ticket items for those who chose a robust approach with varied content. Some doctors, in fact, may have re-evaluated their longstanding websites and added new pages or features at an added cost. For those doctors just starting with EMR in 2011, the start-up costs may have been reflected here. In addition, remote servers and cloud backup systems and service fees may also have contributed to this expense.

• ***Cleaning and Maintenance***—The cost for cleaning and maintenance dropped significantly since last year, down 43 percent for an average of $1,261. Besides the presumably smaller offices of our respondent pool, other factors that may have influenced this drop include the proliferation of new cleaning services (including many fast-growing franchises) and the desire by practice owners to cut non-critical costs in their effort to trim expenses.

• ***Other***—Doctors surveyed spent an average of $1,340 on other practice costs not listed above. These may have included business use of automobiles, satellite/cable television fees, business travel/meals, signage, billing services, waiting room amenities (magazine subscriptions, coffee, children's items, etc.), human resource outsourcing, consultants, postage/shipping, security system fees and bank fees. As any of these becomes a substantial cost, we will itemize and discuss it in detail.

Continued on page 154

PRESCRIBING & DISPENSING

Antiseptics/Topical Antibiotics

	2012	2011	2010
Neosporin	16%	19%	26%
Bactroban	11%	11%	16%
Bacitracin	9%	9%	10%
Silvadene	6%	16%	15%
Amerigel	6%	3%	9%
Gentamicin	4%	5%	9%
Triple Antibiotic	3%	2%	8%
Betadine	3%	5%	—
Mupirocin	3%	3%	4%
Povidone-Iodine	2%	—	—
Polysporin	1%	5%	5%
Iodosorb	1%	—	—
Others	13%	8%	—
Prescriptions per week	4.9	6.8	7.8
Prescribed (RX)	86%	Dispensed (D)	14%

Graft Products (for Wounds)

	2012	2011	2010
Dermagraft	17%	28%	26%
Apligraf	15%	21%	21%
Oasis	4%	6%	4%
Graft Jacket	3%	9%	4%
Integra	2%	2%	3%
Acell	2%	—	—
Others	12%	5%	—
Prescriptions per week	2.1	2.3	1.9

Topical Pain Relievers

	2012	2011	2010
Biofreeze	19%	24%	40%
Voltaren	14%	—	—
Voltaren Gel	11%	22%	20%
Lidocaine	5%	5%	5%
Lidoderm	5%	5%	10%
Capsaicin	3%	2%	7%
Emla Cream	3%	—	—
Flector Patch	2%	6%	7%
Diclofenac	1%	—	—
Solaraze Gel	1%	—	—
Viscous Xylocaine	1%	—	—
Ben Gay	1%	—	—
Others	4%	6%	9%
Prescriptions per week	4.1	3.5	3.0
Prescribed (RX)	78%	Dispensed (D)	22%

NET INCOME

The median net income for solo DPMs surveyed was $117,750, a 9 percent drop from last year. Most notable was the fact that the percentage of respondents earning less than $50,000 grew from 9 percent last year to 13 percent this year.

Group DPMs fared better in terms of dollars, but their income dropped even more than their solo colleagues.

PRESCRIBING & DISPENSING

Antibiotics (Oral)

	2012	2011	2010
Keflex	42%	71%	62%
Augmentin	13%	19%	21%
Cephalexin	12%	10%	18%
Bactrim	8%	7%	9%
Duricef	3%	3%	7%
Cipro	3%	4%	3%
Doxycycline	2%	—	—
Omnicef	2%	3%	4%
Amoxicillin	2%	—	—
Ceftin	1%	—	—
Cleocin	1%	—	—
Clindamycin	1%	—	—
Dicloxacillin	1%	—	—
Levaquin	1%	—	—
Others	5%	9%	5%
Prescriptions per week	4.2	5.6	4.7
Prescribed (RX)	97%	Dispensed (D)	3%

Antifungal (Topical) (Skin)

	2012	2011	2010
Naftin	30%	48%	60%
Spectazole	17%	15%	22%
Lamisil	14%	15%	14%
Lotrimin	9%	—	—
Loprox	5%	13%	11%
Nizoral	5%	—	—
Formula 3	5%	4%	6%
Lotrisone	4%	4%	4%
Ertaczo	4%	10%	14%
Oxistat	2%	4%	10%
Others	12%	5%	—
Prescriptions per week	6.3	5.2	5.7
Prescribed (RX)	92%	Dispensed (D)	8%

Topical Dressings for Matrixectomies

	2012	2011	2010
Amerigel	28%	51%	59%
Silvadene	5%	16%	8%
Neosporin	5%	4%	10%
Betadine	3%	—	—
Gauze	3%	—	—
Bacitracin	3%	4%	5%
Band-Aid	2%	—	—
Cortisporin Otic	2%	7%	8%
Gentamicin	2%	4%	5%
Triple Antibiotic	2%	2%	3%
ADAPTIC	2%	—	—
Polymem	1%	—	—
Bactroban	1%	—	—
Dermagraft	1%	—	—
Others	13%	8%	7%
Prescriptions per week	5.8	3.7	3.9
Prescribed (RX)	59%	Dispensed (D)	41%

Wound/Ulcer (Topical, Non-Graft)

	2012	2011	2010
Amerigel	13%	28%	35%
Silvadene	9%	14%	11%
Santyl	8%	—	—
Iodosorb	4%	7%	5%
Prisma	3%	—	—
Aquacel	3%	3%	5%
Bactroban	3%	4%	3%
Medihoney	2%	—	—
Gentamicin	2%	—	—
Hydrogel	2%	—	—
Regranex	2%	—	—
Saline	2%	—	—
Silvasorb	2%	—	—
Neosporin	1%	2%	3%
Betadine	1%	—	—
Oasis	1%	—	—
Panafil	1%	—	—
Polymem	1%	—	—
Triple Antibiotic	1%	2%	—
Others	21%	12%	9%
Prescriptions per week	4.9	3.8	3.9
Prescribed (RX)	78%	Dispensed (D)	22%

They reported a median net income of $125,000, a drop of 15 percent compared to our previous survey.

DPMs employed by another podiatrist or a group reported an average salary increase of 10 percent to $100,315. For new doctors struggling with high loan repayments, this was good news. With a reported range of $12,000-$240,000 in salary, it's likely that some of the employed respondents worked in podiatry on a part-time basis.

Average Salary of DPM Employed by Another DPM or Group:
$100,315

Median Salary:
$100,000

Range:
$12,000 – $240,000

Analysis of data by years in practice indicates that respondents' net income (combining all practice settings) peaked at 21-30 years in practice, with a median net income of $140,000. Doctors in practice less than one year earned the least ($77,500), while those in practice one-to-five years reported a median net of $93,250. After 30 years in practice, median net income dropped off to $119,250, perhaps due to some older doctors working fewer hours as they approached retirement.

Female podiatrists earned substantially less than male colleagues, and the gender gap remained wide with our latest respondent pool. While male DPMs' income dropped 3 percent to a median net of $131,750, women podiatrists saw a 12 percent decrease and a median net of $87,500. Thus women earned just 66.4 cents for every dollar a male colleague earned in our latest survey. That was considerably less than the national average of 82.2 cents in 2011 as reported by the BLS.

Professional organization membership and Board certification had a positive impact on the bottom line as well, as previously mentioned.

Regionally, there were big differences in median net income (for all practice types). Doctors in the South had the highest median net income at $131,250. That was actually up from $130,600 last year—the only region to show an increase. DPMs in the West earned the second most at $121,750, down from $134,200 last year. The Midwest dropped from $125,000 to $117,750, and the East dropped from $127,800 to a median net of $110,250.

PRESCRIBING, DISPENSING & TRENDS

Respondents indicated which pharmaceuticals, by brand name, they prescribed and dispensed most in several categories (see charts), including the average number of Rxs they prescribed and dispensed each week. Dispensing figures for wart medications, nail treatments, drying agents/odor absorbents

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and emollients/moisturizers were broken down to determine the products "most prescribed" and those "most dispensed in-office."

Twenty-two percent of those surveyed said they dispensed Rx products from their offices, which was down slightly from 24 percent in our last report. Of those who did not dispense Rx products, 3 percent said they planned on dispensing them in the next 12 months.

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PRESCRIBING & DISPENSING

Analgesics (Oral)

	2012	2011	2010
Vicodin	22%	44%	54%
Tylenol	14%	8%	14%
Percocet	13%	14%	18%
Lortabs	5%	14%	19%
Ibuprofen	5%	—	—
Norco	4%	6%	—
Tylenol #3	4%	10%	9%
Ultram	2%	8%	—
Advil	2%	—	—
Hydrocodone	2%	4%	4%
Aleve	2%	—	—
Motrin	2%	3%	—
Vicoprofen	2%	—	—
Others	7%	6%	5%
Prescriptions per week	4.9	4.9	5.2
Prescribed (RX)	98%		
Dispensed (D)	2%		

Anti Inflammatories (Oral)

	2012	2011	2010
Naprosyn/Naproxen	21%	30%	45%
Ibuprofen	16%	16%	25%
Motrin	11%	15%	16%
Mobic	9%	12%	10%
Celebrex	5%	15%	13%
Advil	5%	9%	4%
Voltaren	5%	7%	21%
Aleve	3%	3%	6%
Feldene	3%	—	—
Meloxicam	2%	—	—
Relafen	2%	—	—
Diclofenac	2%	—	—
Anaprox	1%	—	—
Daypro	1%	7%	3%
Others	9%	9%	8%
Prescriptions per week	8.1	8.7	9.2
Prescribed (RX)	95%		
Dispensed (D)	5%		

Enzymatic Debriding Agents

	2012	2011	2010
Santyl	42%	47%	47%
Accuzyme	2%	2%	8%
Panafil	2%	2%	6%
Amerigel	1%	—	—
Elase	1%	—	—
Papain	1%	—	—
Kerasal	1%	—	—
Medihoney	1%	—	—
Others	8%	5%	7%
Prescriptions per week	2.6	2.7	2.6

Steroids (Topical)

	2012	2011	2010
Topicort	12%	21%	27%
Triamcinalone	12%	11%	16%
Hydrocortisone	9%	9%	18%
Lidex	8%	12%	12%
Temovate	6%	2%	7%
Betamethasone	5%	10%	10%
Lotrisone	5%	6%	5%
Kenalog	3%	2%	3%
Diprolene	3%	5%	3%
Aristocort	1%	—	—
Efudex	1%	—	—
Medrol	1%	—	—
Others	2%	7%	6%
Prescriptions per week	2.8	1.9	2.0
Prescribed (RX) 98%		Dispensed (D) 2%	

Antifungal (Oral)

	2012	2011	2010
Lamisil	79%	92%	86%
Gris-PEG	2%	3%	5%
Diflucan	2%	—	—
Others	2%	2%	2%
Prescriptions per week	4.1	3.4	3.5
Prescribed (RX) 97%		Dispensed (D) 3%	

Benefits to in-office dispensing of pharmaceuticals include greater patient compliance, convenience and, of course, added income. According to a survey by pharmatimes.com, 33 percent of patients who receive a prescription from their GP do not fill it. Reasons cited include disagreeing with the diagnosis, finding the same treatment OTC for less money, embarrassment and concern about side effects. Some reported they had lost the prescription after leaving the doctor's office. All of these problems could be countered by in-office patient education and providing patients with needed medications before they leave the office.

According to figures provided by Nielsen, spending on direct-to-consumer advertising of pharmaceuticals dropped 23

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PRESCRIBING & DISPENSING

Wart Medications

	2012	2011	2010	RX	Disp.
Salicylic Acid/ Sal Acid Plaster	16%	16%	17%	90%	10%
Aldara	7%	9%	14%	100%	0%
Mediplast	7%	2%	5%	74%	26%
Compound W	5%	—	—	92%	8%
Cantharone	5%	15%	11%	50%	50%
Duofilm	4%	10%	9%	90%	10%
Lazerformalyde	3%	5%	12%	88%	12%
Efudex	3%	1%	5%	86%	14%
Formadon	2%	—	—	20%	80%
Verucide	2%	—	—	0%	100%
Canthacur	1%	14%	11%	33%	67%
Cantharidin	1%	4%	—	33%	67%
Virasal	1%	—	—	100%	0%
Wartpeel	1%	—	—	100%	0%
Durasal	1%	—	—	50%	50%
Plantarstat	1%	2%	5%	0%	100%
Others	19%	3%	6%		
Prescriptions per week	3.3	3.9	4.3		

Prescribed (RX) 80%
Dispensed (D) 20%

Most Prescribed:
1. Salicylic Acid/Sal Acid Plaster
2. Aldara
3. Mediplast

Most Dispensed In-office:
1. Cantharone
2. Verucide
3. Formadon

Antifungal (Topical) and Keratin Debris Exfoliants (Nail)

	2012	2011	2010	RX	Disp.
Formula 3	24%	38%	42%	19%	81%
Urea 40%	9%	—	—	88%	12%
Kerasal	4%	—	—	100%	0%
Penlac	4%	5%	8%	90%	10%
Carmol	2%	5%	—	100%	0%
Clotrimazole	2%	—	—	100%	0%
Tineacide	2%	12%	10%	0%	100%
Clarus	2%	—	—	40%	60%
Lamisil	2%	—	—	100%	0%
AmLactin	2%	—	—	100%	0%
Naftin	2%	2%	3%	100%	0%
Nonyx	2%	—	—	25%	75%
Gordochom	1%	4%	4%	33%	67%
Mycocide	1%	3%	3%	0%	100%
RevitaDerm	1%	—	—	0%	100%
Others	17%	3%	10%		
Prescriptions per week	5.8	6.0	6.4		

Prescribed (RX) 64%
Dispensed (D) 36%

Most Prescribed:
1. Urea 40%
2. Formula 3
3. Kerasal

Most Dispensed In-office:
1. Formula 3
2. Tineacide
3. Clarus

percent in 2011, down to $2.4 billion. We've seen some movement away from TV and toward the Internet and social media outlets. Since the latter are less expensive, the amount of exposure of brand-name products to patients likely did not drop as dramatically as the 23-percent figure seemed to indicate.

We will look for stricter enforcement of the Medicare Anti-kickback Statute and the Physician Payment Sunshine Provision of the ACA, as the relationships between doctors and pharmaceutical companies come under scrutiny. Any apparent effects on practice income will be covered in future reports. PM

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Data was compiled and tabulated by Thomas Lewis of Hartsdale, NY. Lewis is a market research professional specializing in media research for the magazine and newspaper publishing industries. His extensive survey research experience includes senior positions at GfK MRI, the leading print media audience research organization servicing all major publishers and media buying agencies.

PRESCRIBING & DISPENSING

Drying Agents (for Odor)

	2012	2011	2010	RX	Disp.
Drysol	27%	34%	50%	97%	3%
Formadon	6%	7%	7%	12%	88%
Lazerformalyde	6%	6%	13%	94%	6%
Certain Dry	6%	12%	14%	100%	0%
Zeasorb	2%	2%	3%	100%	0%
Bromi Lotion	1%	4%	3%	0%	100%
Tineacide Shoe Spray	1%	10%	11%	0%	100%
Onox	1%	1%	1%	0%	100%
Betadine	1%	—	—	100%	0%
On Your Toes	1%	—	—	0%	100%
Others	20%	5%	9%		
Prescriptions per week	2.3	3.8	3.7		

Prescribed (RX) 83%
Dispensed (D) 17%

Most Prescribed:
1. Drysol
2. Certain Dry
3. Lazerformalyde

Most Dispensed In-office:
1. Formadon
2. Bromi Lotion
3. Drysol

Emollients/Moisturizers

	2012	2011	2010	RX	Disp.
AmLactin	17%	20%	24%	89%	11%
Urea 40%	8%	5%	3%	76%	24%
Lac-Hydrin	8%	10%	12%	100%	0%
Eucerin	6%	12%	10%	81%	19%
Foot Miracle	5%	5%	4%	25%	75%
Carmol 40	4%	3%	7%	100%	0%
RevitaDerm	3%	11%	12%	13%	88%
Amerigel	3%	6%	—	0%	100%
Lactinol Lotion	2%	2%	5%	67%	33%
Gormel	2%	5%	8%	20%	80%
Kerasal	1%	3%	4%	100%	0%
Aquaphor	1%	—	—	67%	33%
Cerave	1%	—	—	67%	33%
Flexitol Heel Baum	1%	—	—	33%	67%
Kera-42	1%	—	—	33%	67%
Others	26%	8%	11%		
Prescriptions per week	6.5	6.0	6.6		

Prescribed (RX) 70%
Dispensed (D) 30%

Most Prescribed
1. AmLactin
2. Lac-Hydrin
3. Urea 40%

Most Dispensed In-Office
1. Foot Miracle
2. Amerigel
3. RevitaDerm