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DIABETES PRACTICE OPTIONS™

Improving Patient Care Through Increased Practice Efficiency

JULY 2011

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EDITORIAL

France Provides a Good Example of Access to Primary and Preventive Care

By Michael Bihari, MD, contributing editor

I'm writing this editorial while on vacation in Paris. At lunch earlier this week, I spoke with a Canadian couple from Toronto, an anesthesiologist and a dentist. The wife extolled the virtues of the French system. Earlier this year while staying in the French countryside her teenage grandson woke in the middle of the night with a fever and a severe sore throat. She called *SOS Medicin*, a physician house-call service, and within an hour her grandson was visited by a physician. The physician charged 55€ (about \$75) and apologized for writing an expensive prescription that cost 10€.

As a pediatrician and an advocate for healthy nutrition for our youth, I was astounded at the apparent lack of a significant (by current U.S. standards) obesity problem in the French children that we've seen. One afternoon, as my wife and I were sitting on a park bench across from a public school, hundreds of French teens poured out onto the street

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with never a high BMI in sight. We were astounded that neither of us was able to spot an overweight kid.

In our local high school in New England more than 25% of the kids are overweight or obese. According to comparative data from the World Health Organization, the percentage of the French population with a body mass index (BMI) of more than 30 is 16.9%, while for the United States the figure is 34.1%. The French live longer (82 years versus 78 years on average) and spend less than Americans on health care (11% of GDP versus 15.7% of GDP annually).



Michael Bihari, MD

Type 2 diabetes data are also telling, since 8.3% of the U.S. population has been diagnosed with diabetes while for France the number is 4.6%. In the United States the number may actually be higher, because many cases of diabetes are not diagnosed. In France, because of vigorous screening and awareness, most people with diabetes have been identified.

The French love American fast food; McCafes are popping up all over Paris and other French cities. In fact, the branch on the Champs Elysees is the biggest money maker in the world for the franchise. However, the French government has eliminated junk food from schools and spends millions of Euros every year to educate youth and their parents about nutrition and fitness.

C'est la Vie! ■

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DIABETES STRATEGY

Patients' Self-Care May Be Improved by Addressing Competing Demands on Time

Diabetes patients are required to devote considerable effort to self-managing their disease. Activities such as glucose monitoring, attention to dietary choices, physical activity, and implementation of complicated medication regimens require significant time and energy. A study published in the May 2011 issue of *Diabetes Care* quantifies how competing demands for time, including care giving and employment responsibilities, can affect a patient's self-care behaviors and outcomes of care.

"Our research findings suggest that to improve clinical outcomes, physicians must understand the demands on each patient's time and try to help that patient develop strategies to build self-management activities into their daily lives," says William H. Herman, MD, MPH, an endocrinologist and professor in the Department of Internal Medicine at the University of Michigan in Ann Arbor, one of the study's co-authors. The University of Michigan study consisted of an analysis of data from Translating Research Into Action for Diabetes (TRIAD), a multicenter prospective observational study of diabetes care that involves approximately 12,000 diabetes patients enrolled in managed care plans across the United States.

Patient Challenges

Diabetes patients face a number of challenges due to the time-consuming nature of self-care requirements, notes Laura McEwen, PhD, MPH, a senior epidemiologist at the University of Michigan and also a study co-author. "The self-care required of diabetes patients involves many different personal health behaviors, including dietary modification, regular physical activity, foot care, self-testing of blood glucose levels, and medication management and administration," she says. "Therefore, physicians who treat diabetes patients should expect that the time involved for self-care will be a challenge for many of their patients."

Previous research has highlighted that self-care can be quite time-consuming for diabetes patients. For example, a cross-sectional analysis of 1,482 diabetes patients enrolled in three managed care plans published in the July/August 2005 issue of the *Journal of the American Board of Family Practice* found that diabetes patients spend approximately one hour per day on self-care. Furthermore, many diabetes patients did not perform selected elements of self-care. Of the patients examined, 37.9% reported not completing foot care, 37.7% did not exer-

cise, and 54.4% spent no time on food shopping or preparation.

A qualitative study published in the January 2005 issue of the *Journal of Family Practice* that involved interviews with certified diabetes educators reported that experienced patients using oral agents to manage type 2 diabetes require more than two hours per day to perform all recommended self-care activities. Certain groups of patients, such as elderly patients, patients with newly diagnosed disease, and patients with physical limitations, devote even more time to managing their condition, the study found. It also found that diet and exercise requirements were the most time-consuming self-care tasks for diabetes patients.

"We wanted to see if the major competing demands on patients' time—employment and caring for a child or disabled relative—had a measurable impact on patients' ability to complete processes of care, which in turn could affect their clinical outcomes," says McEwen. "Previous studies on competing demands for time and self-care processes in diabetes patients have focused largely on African-American women living in the southern United States, studying how care-giving responsibilities affected the time these women had allotted for self-care. We could not identify any studies that evaluated the impact of competing demands for time on both men and women, the impact of employment on self-care, or the impact of competing demands for time on diabetes disease outcomes. Overall, our study is unique in that it involved a more diverse population in terms of gender, race, geography, education, and socioeconomic status, as well as a broader definition of the activities that constitute competing demands."

Reduced Self-Care

For both men and women, the researchers found that employment responsibilities with or without caregiver responsibilities were associated with lower rates of diabetes self-care

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behaviors, poorer compliance with processes of care, and higher blood glucose levels.

The analysis identified a number of examples of how competing demands for time affect self-care activities. For example, among female diabetes patients, 53% who had both care-giving and employment responsibilities were taking aspirin, compared to 63% of patients without such responsibilities. Similarly, 59% of men with both types of responsibilities had received influenza immunization, compared to 71% of men with neither care-giving nor employment responsibilities. The trends were similar for both genders for nearly all processes of care, although not all results were statistically significant.

When the researchers compared the relative impact of employment responsibilities versus care-giving responsibilities on processes of care, they found that employment responsibilities had a greater negative impact. Among men, those with employment responsibilities only had lower rates of foot care (53%

versus 58% of men with care-giving responsibilities only), as well as lower rates of self-monitoring of blood glucose in oral medication users (33% versus 38%). Among women, employment responsibilities only were associated with lower rates of glycemic control being assessed (82% versus 86% for women with care-giving responsibilities only), influenza administration (66% versus 72%), and fewer processes of care.

“Physicians have limited time... and a limited ability to influence those aspects of their patients’ lives that affect both motivation and ability to comply with treatment recommendations.”

—William H. Herman, MD, MPH, University of Michigan, Ann Arbor

“The time demands associated with employment outside of the home are likely to be less flexible than care-giving duties, making it more difficult for diabetes patients to accommodate their schedules to their self-care needs,” said Herman. “For example, patients who have employment responsibilities may find it more difficult to schedule doctor

or nutritionist office appointments outside of business hours.”

Poorer Outcomes

The presence of competing demands for time was also associated with poorer intermediate outcomes. For example, male diabetes patients with no competing demands for time had a mean HbA1C level of 7.81, compared to 8.16 in men with care-giving responsibilities only, 7.98 in men with employment responsibilities only, and 8.32 for those with both types of responsibilities. Women with care-giving responsibilities had a higher mean HbA1C (8.17) than women with no competing demands for time, who had a mean HbA1C level of 7.86.

HbA1C was also higher for women with both types of responsibilities compared with women with no competing demands for time, although this difference was not statistically significant.

“Interestingly, competing demands for time had more of an impact on blood glucose levels than on blood pressure or cholesterol control,” says

UNIVERSITY OF MICHIGAN DIABETES SELF-CARE STUDY SURVEYS TRIAD DATA

A study published in the May 2011 issue of *Diabetes Care* that quantifies how competing demands for time can affect a patient’s self-care behaviors and outcomes of care consisted of an analysis of data from Translating Research Into Action for Diabetes (TRIAD). TRIAD is a multicenter prospective observational study of diabetes care that involves approximately 12,000 patients with diabetes enrolled in managed care plans across the United States. It is a ten-year project funded by the Centers for Disease Control and Prevention (CDC) and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).

“The goal of TRIAD is to investigate the impact of health plan, provider group, physician, and patient factors on processes and outcomes of care,” says Laura McEwen, PhD, MPH, a senior epidemiologist at the University of Michigan, a co-author of

the *Diabetes Care* study. McEwen notes that the University of Michigan is one of six TRIAD study sites. “We follow patients over time using self-administered questionnaires and medical record review. For this particular study, we included data from diabetes patients who completed the baseline and 18-month follow-up interviews, which limited our study population to 5,478 respondents.”

Using statistical techniques, the researchers evaluated the association between competing demands for time, seven processes of care (aspirin use, dilated eye examination, foot examination, glycemic control assessment, influenza administration, LDL cholesterol assessment, and proteinuria assessment) and three intermediate diabetes care outcomes (HbA1C level, systolic blood pressure, and LDL cholesterol).

—DJN

McEwen, speculating that these findings reflect the fact that controlling blood glucose is more time-consuming. “Blood pressure and cholesterol can often be adequately controlled with once-daily medications, whereas blood sugar control is more challenging, requiring frequent self-monitoring of blood sugar levels and more frequent medication administration as well as careful attention to diet and physical activity.”

Implications for Physicians

“It is critical for physicians to be aware that patients do have competing demands for their time, requiring them to juggle many responsibilities—including self-care activities—every day,” notes Herman. “Whenever possible, physicians should ask their patients about their competing time demands and how these demands may affect their self-care behaviors.”

“I believe physicians are well aware that competing demands for time can affect patient outcomes,” observes McEwen. “However, they may not be aware of the specific demands each individual patient faces. Physicians can ask patients to identify the particular concerns and pressures in their lives and the scheduling limitations that might constitute obstacles to compliance with self-care recommendations.”

Once these competing demands are identified, physicians can talk to their patients about how to manage the demands of diabetes self-care while still meeting daily responsibilities. “Physicians can also identify medication-related strategies that can help,” says Herman. “For example, physicians may be able to modify drug regimens in ways that will help improve convenience and, therefore, adherence.”

In general, patient-level variables are extremely important with respect to processes and outcomes of care, notes Herman. “Research has shown that younger diabetes patients seem to have more difficulty with compliance than older patients,” he says. “Similarly, poorer and less educated patients seem to have poorer processes and outcomes of care. To improve care quality, physicians must recognize the importance of patient characteristics like income, education, and competing demands for time, and try to tailor care recommendations to suit individual circumstances. In addition, systems of care should be designed so that they can better support the needs of both physicians and patients.”

In a practical sense, physicians’ control over patient-level variables is limited. “Physicians cannot always influence systems of care when working in a managed care environment or when

dealing with health plans,” acknowledges Herman. “Physicians have limited time to see each patient, and a limited ability to influence those aspects of their patients’ lives that affect both motivation and ability to comply with treatment recommendations. Yet their approach to working with an individual patient is something that physicians can control—so physicians can at least acknowledge and discuss the issues their patients face during office visits.”

As an example,” Herman continues, “rather than telling a patient, ‘You must monitor your blood sugar four times a day and administer an insulin injection four times a day,’ the physician can ask if the patient is employed and will face challenges in adhering to that type of regimen. A discussion may reveal that while the patient may not be able to monitor blood glucose at lunchtime during the workdays, more frequent monitoring is possible on the weekends. Then the physician can make adjustments in treatment based on that information. If limitations are presented by the patient’s lifestyle, the physician and patient can discuss and identify reasonable accommodations, making it more likely that the patient will be able to successfully manage his or her condition over time.”■

—Reported and written by Deborah J. Neveleff, in North Potomac, Md.

FLEXIBLE PRACTICE STRUCTURE COULD AID DIABETES PATIENTS IN MAINTAINING SELF-CARE

One of the things we have learned from TRIAD [Translating Research Into Action for Diabetes] analyses is that health system organization and structure can have a major impact on processes and outcomes of care for diabetes patients,” says William H. Herman, MD, MPH, a professor in the Department of Internal Medicine at the University of Michigan in Ann Arbor, co-author of a study on the effects of competing time constraints on the self-care regimens of diabetes patients. The study, which was published in the May 2011 issue of *Diabetes Care*, analyzed data from the TRIAD study, in which the University of Michigan is a participant. “Holding early morning, evening and weekend

office hours in order to accommodate patients who work from nine to five can have a meaningful impact on diabetes care quality,” Herman says.

“Physicians could potentially offer more convenient office hours or possibly communicate by phone or e-mail to provide a more expedient mode of communication with their patients who have busy lives,” adds study co-author Laura McEwen, PhD, MPH, a senior epidemiologist at the University of Michigan. “Improving access to care via greater flexibility could potentially improve patient adherence to the recommended self-care behaviors that could, in turn, lead to improved diabetes outcomes.” —DJN

CAPITAL IDEAS

Regularly Review Financial Advisers to Keep Abreast of Changes to Financial Systems

By Christopher Jarvis, MBA, and Jason O'Dell, CWM

The most common mistake seen by financial advisers who work with physicians is in doctors' choice of specialists. The successful delivery of health care is based on patients' need for physicians to refer them within and between specialties and subspecialties when unique challenges arise. But when it comes to the navigation of their own financial health, doctors do not apply the same logic or expect the same level of sophistication from their advisers. As a result, doctors routinely receive and follow advice that is designed for the masses.

If a primary care doctor decided to diagnose and treat all surgical patients, it would be a case of malpractice. Yet this is how doctors are treating their financial planning when they don't regularly review, interview, and replace members of their advisory team as their financial situation and needs change from residency to mature practice to retirement. Even if your financial goals do not change, tax laws and the health care delivery system are changing around you every month. Without a team working with you to help you address those changes, you are bound to become less efficient.

Reviewing Advisers

As a quick test to see if you need to take a look at who is on your team, ask yourself the following questions:

- Does your CPA regularly explain tax law changes and offer suggestions to save you money on taxes?
- Has your attorney explained the 2010 estate tax changes and suggested strategies to transfer millions to your heirs without losing control of those funds during your lifetime?
- Has your estate planner discussed with you multigenerational planning



Christopher Jarvis, MBA (left), has over 15 years of financial consulting experience. **Jason O'Dell, CWM** (right), is a financial consultant, lecturer, and the author of four books for physicians. He is a principal of the financial consulting firm O'Dell Jarvis Mandell LLC (www.ojmggroup.com), of which Jarvis is a member.

that will protect your heirs from spending too much or losing inheritances to lawsuits or divorce?

- Have your tax and investment advisers explained tax diversification as a hedge against future tax rate increases?
- Are you one of the smaller clients of your advisers, and do they specialize in working with doctors on their unique challenges?
- Have your advisers discussed your long-term view of the U.S. economy and explained investment strategies that provide hedges against a devalued dollar, increased inflation and interest rates, commercial real estate collapses, increased tax rates, and increased costs of commodities such as oil?
- Did your insurance expert explain how you could receive up to \$50,000 per month of disability insurance, a partial deduction on your life insurance premiums, federal government subsidies for your long-term care pre-

miums, and the tax benefits of insurance company ownership?

- Do your advisers communicate with one another to discuss your situation, bring in additional experts, and regularly make valuable suggestions to you?

If you answered "no" to any of these questions, you are not taking advantage of existing opportunities and you are settling for inadequate financial health care. Fortunately, there are tools doctors can use to help circumvent such mistakes and avoid the unnecessary costs that come with poor planning.

Life Insurance

Has your financial planner or insurance agent explained to you the two different, equally acceptable, ways to purchase life insurance? Do you understand how "max funding" and "minimum funding" options work and why almost everything in the middle is an overpayment of commission and a

waste of your money? Do you understand how funds in insurance policies may or may not be protected even if you had to file bankruptcy? Are you aware that you could get a partial net tax deduction for your life insurance premiums or buy life insurance with your retirement plan (pre-tax) dollars and leave almost all of the death benefit to your spouse tax-free? Did you know you could buy life insurance, leave the death benefit to your heirs, and still have access to the cash value while you are alive?

If you answered “no” to any of these questions, you either hastily purchased your insurance or the agent hastily sold it to you. Cash value life insurance can be a valuable tool for asset protection, tax management, wealth accumulation, and estate planning. But it must be used properly. Unfortunately, to use it properly, the adviser needs to know a lot about your situation, must take a great deal of time explaining the countless options, and must coordinate the insurance purchase with the other advisers on the team to maximize the benefit you receive. The insurance purchases of most doctors are either poorly designed so cash values are not accumulating as well as they could with a better design, owned improperly so

that funds will be left in the estate, or owned in irrevocable trusts where cash values are not available in the event they are needed.

Take time to get a better understanding of how life insurance may work for you. Don't assume that you did everything right because your agent told you that you did. Most policies that advisers who work with physicians see as part of their comprehensive insurance reviews for new clients are inefficiently structured for the doctors and their families. Not surprisingly, the

Even if your financial goals do not change, tax laws and the health care delivery system are changing around you every month.

policies are almost always structured to generate high commissions and are seldom structured to meet the goals of maximum tax-efficient accumulation or minimum cost of income replacement or estate liquidity, which are the only two acceptable ways to purchase life insurance as part of a well structured, comprehensive financial plan.

Find Appropriate Advisers

In medicine, doctors in each specialty

have a certain set of health concerns they are uniquely trained for and dedicated to address for their patients. What many high-income Americans fail to realize is that their financial, legal and tax concerns are not well managed by generalists. Doctors need to build an advisory team of subspecialists who not only work with high-income, high-liability and high-tax rate clients but who also understand the unique challenges of working within the constraints of a more complicated health care system that includes the Stark laws, the Health Insurance Portability and Accountability Act (HIPAA), insurance fraud risk, reduced Medicare reimbursements, and other factors.

With the right team of subspecialists, you can protect your assets from lawsuits, taxes, and divorce while maintaining control of and access to funds and successfully transferring \$10-\$15 million of today's value to future generations. If you aren't confident that these goals are being met by your advisers who have worked together to adjust your plan since the tax law changes in December 2010 or would like a second opinion (review) of what you do have, please seek out the advice of financial advisers who may be able to help you get to a place that you want to be. ■

CONSULT AN ADVISER BEFORE \$10 MILLION ESTATE PLANNING OPPORTUNITY VANISHES

Under the new tax laws, which may or may not last beyond 2012, tools exist for doctors to easily leave \$10-\$15 million tax free to their children and grandchildren. Doctors can do this in a way that allows them to retain control of and access to the funds while alive and leave the funds in a way that protects the recipients from losing their drive to be productive, losing the inheritance to a divorce or lawsuit, or having to do estate planning for their children.

Unfortunately, this strategy requires customized planning, and doctors often get “off the rack” solutions that don't work. Over

90% of American families will never earn more than \$150,000 per year, be in the highest marginal tax bracket, or be worth more than \$2,000,000. Accountants, financial advisers, insurance agents and estate planning attorneys do not spend the majority of their time dealing with people who have the relatively unique challenges doctors do.

Download and read the 2010 tax law change summary and article at www.docworthy.com/2010estatetaxchange. Users will need to create a password. Then contact your estate planning attorney to discuss the options that exist under the new law. —CJ, JO

TECHNOLOGY

Patient Check-In Devices Streamline Front Office Function, Improve Payment Capture

Busy physicians are constantly seeking ways to improve their practices' efficiency and improve patients' experience during office visits. In their efforts to streamline office procedures and reduce staffing levels or decrease staff overtime hours, medical practices in recent years have adopted numerous solutions, including electronic medical record (EMR) systems, patient engagement solutions, practice management software, and a variety of other technologies.

Just as daily administrative burdens can place a significant financial strain on a medical practice by limiting the number of patients who can be seen, the need to collect co-pays and patient balances can result in excessive amounts of accounts receivable when patients unused to being asked to pay at the point of service are unwilling or unable to pay, or, as is more commonly the case, when front desk staff who are not trained to request payment fail to ask for it. Further potential for failing to capture payment is created when office staff check patients' insurance eligibility, often using out-of-date information provided by patients during previous visits. Uncollected patient balances and co-payments are cited by many physicians as a leading source of lost practice revenue.

Verifying Eligibility

A group of devices that address these concerns among providers are referred to as patient check-in systems. Available from a number of manufacturers, with a range of functions and features, check-in systems seek to streamline the patient check-in process. Many systems can aid in verifying patients' insurance eligibility and collecting co-pays and outstanding balances. Some include other advanced



Shari Crooker, RN



Mark O'Leary, MBA

capabilities, such as the ability to collect patients' demographic data and offer targeted messaging related to their health status and conditions.

"The device does real-time eligibility and benefits [E&B] checks with the insurance companies, which we were never able before to do in real time," says Shari Crooker, RN, practice administrator for Gwinnett Center Medical Associates, an internal medicine practice in Lawrenceville, Ga., that has been using the Phreesia check-in system since June of 2009. "By the time the patient gets to the company screens, it has already integrated his or her updated co-payment information. It has already let us know whether the patient is eligible or not, or if there is some missing information that either the patient or someone from our practice had entered erroneously, so we can correct it."

Payment Capture

In addition to E&B checks, the check-in system also asks patients to pay outstanding balances and co-payments at the point of service. A "dumb terminal," the PhreesiaPad has no hard drive or other means of storing any type of

patients' financial or clinical information, and includes a scanner for reading credit and debit cards. Having a device that automatically asks patients for all outstanding charges has dramatically improved Gwinnett's rate of payment capture, Crooker says.

"Before, if the patient didn't have the money, or just didn't bring their card, and the front office was busy, they ignored the co-payment," says Crooker. "The staff would let the patient be seen by the doctor, the patient would sneak out, and we wouldn't get his or her co-pay. We were rarely collecting balances because the front office people didn't know when the patients had a balance and didn't bother to look, or were afraid to ask the patient for the money up front. At the end of the check-in interview, the pad pops up a screen asking the patient to pay their co-pay now. They swipe their credit card on the pad and pay on the spot. I recently looked back at my time of service payments, which are co-pay balances, things people pay in the office. It was significantly increased."

"The Phreesia system does something that people often fail to do: we always ask for payment," says Mark

O’Leary, MBA, the chief marketing officer of New York, N.Y.-based Phreesia, manufacturer of the PhreesiaPad. “If a patient has a financial responsibility, then we ask for that payment.”

“We have started to capture the data for the last 11 months now, and we’re capturing nearly 95% of our outstanding balances,” Crooker says. “We’re capturing 100% of our co-pays. Since September [of 2010], we are capturing \$10,000 more a month by using the PhreesiaPad at the time of service.”

Collecting Data

The PhreesiaPad, which is able to integrate with numerous popular EMR platforms, also collects patients’ clinical and demographic data during the check-in interview. “It’s a rather lengthy interview,” says Crooker. “It takes about 12 minutes for the patient to complete on average, but it gets all the patients’ demographic information. Then, the next time they come back in, it is simply an editing process.

“We actually developed three interviews,” she says. “We have the long interview for new patients, in which they fill out their insurance information, their address, their allergies, what meds they take, and why they are here, as well as a past medical history. In the

“[The system] flags a patient’s record if it notices that their information has changed since their previous interviews.”

— Shari Crooker, RN, Gwinnett Center Medical Associates, Lawrenceville, Ga.

short interviews and the co-pay interviews they don’t go through all that. That information is already there. All the patient needs to do is review it and edit it, if necessary. If their insurance changes, they simply hit that ‘edit’ button; they don’t have to go through the entire interview again.”

The system enables individual physicians to customize their interview to capture different sorts of patient data. Each practice can decide how these data will be stored. The system is designed to automatically interface with numerous EMR systems.

Gwinnett uses an EMR from eClinicalWorks. “Phreesia originally built me an interface that used to print out the patients’ interviews, which we had to scan in and add to the electronic documents,” says Crooker. “Then they built me a PDF interface. I have one person doing intakes for a couple of minutes a day. She finds the patient’s name, and goes into the EMR; the form is there, so we no longer have to scan. Phreesia has also built me an interface for the balances on the co-pays. I hit two buttons, I hit a comma separated values [CSV] file, and it calculates from the EMR into Phreesia for a quick check-in.

“Phreesia flags a patient’s record if it notices that their information has changed since their previous interviews,” Crooker continues. “There’s a little red star. My front office knows to look for these little red stars and make sure we have the patient’s data entered correctly.”

Based on the demographic and clinical information patients enter during their interviews, Phreesia can be programmed to offer targeted messaging.

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MULTIPLE CHECK-IN SYSTEMS OFFER VARYING FUNCTIONS

Medical practices seeking to streamline the patient check-in process, improve their rates of payment capture for patient balances and co-payments, and speed up eligibility and billing (E&B) functions in recent years have increasingly turned to electronic patient check-in systems. While internal medicine practice Gwinnett Center Medical Associates of Lawrenceville, Ga., along with over 10,000 other physicians in the United States, has found the PhreesiaPad from New York, N.Y.-based Phreesia a useful addition to its front office, a number of other companies produce products designed to fulfill similar functions. These other check-in devices feature a range of overlapping functions, with varying degrees of clinical utility and patient engagement, to suit the needs of various types of medical practices. Three prominent check-in devices are described below.

eClinicalWorks: Practice management software available from electronic medical record (EMR) manufacturer eClinicalWorks has

the capability to perform E&B checks, enable patients to schedule appointments, collect demographic data, perform reporting, and manage medical billing. According to the company’s Web site (www.eclinicalworks.com), the system does not yet have the capability to process payments.

NCR MediKiosk and eClipboard: Patients can pay co-pays, schedule appointments, and receive directions to important clinical locations with the MediKiosk and eClipboard (www.ncr.com). The system does not collect clinical or demographic data. The eClipboard is a wireless tablet version of the MediKiosk.

PatientPoint Patient Kiosks: These patient-facing kiosks offer patient check-in capabilities including the gathering of demographic data, performing E&B checks, and collecting patient payments. PatientPoint (www.patientpoint.com) also offers an online portal that is accessible through a computer or a mobile device.

—RD

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The messaging is specific to the patient's complaint or health status, and is intended to help the patient manage his or her health.

"It works more on their medical complaint," says Crooker. "If a patient comes in for diabetes, at the end of the interview, he might see sponsored messages for diabetic medications or cholesterol-lowering medications, since those two conditions typically go hand in hand. The patients can choose to look at that information or they can skip it."

Maximizing Collections

The PhreesiaPad is a 128-bit, encrypted wireless device. "It's a HIPAA [Health Insurance Portability and Accountability Act] compliant check-in process," says O'Leary. "It's also PCI Data Security Standards compliant, which is a payment industry standard. It's very secure.

"With Phreesia, you don't have capital expenditure, and you've got something that can affect your receivables right away," O'Leary continues. "It's really different from the capital outlay and the implementation process associated with an EMR."

"They sent me four pads to begin with, but we're up to 10 pads now," says

Crooker. "It's pretty self-explanatory to use. We've had to teach some of our front office people about entering credit card data, like if somebody's card is demagnetized." Beyond this basic training, there was no education required for the staff at Gwinnett to get up to speed with the devices.

The setup process was quick and easy, Crooker says, and it did not disrupt the practice's operation. "The Phreesia representative was only here for a little while," she says. "Probably 30 minutes or less. And the company has excellent customer service. If we send

Check-in systems seek to streamline the patient check-in process.... Some include other advanced capabilities, such as the ability to collect patients' demographic data and offer targeted messaging related to their health status and conditions.

them an e-mail requesting that something be removed from one of our interviews, it's gone in five minutes. If we have a printer problem, they have it fixed within minutes."

Phreesia is inexpensive to run, she says. She cites a single flat rate to use

the system, based on the number of pads the practice uses, along with a flat \$1 per \$25 charged on payments collected through the pads. When the numbers are added up, this fee works out to significantly less than the cumulative charges incurred when using a bank's card machine, according to Crooker. "I know to a lot of people the flat rate sounds like a lot, because with a bank or another processing center it's more like 1.75% or 2%," she says. "But you also have third-party fees and transaction fees." Gwinnett accumulated fees of more than \$27,000 in a nine-

month period with its old credit card processing company, Crooker says, compared with under \$9,000 for a similar period with Phreesia; she also reports that funds were more quickly deposited into Gwinnett's bank account with Phreesia. In addition to the improved payment capture,

Crooker also reports that the convenience afforded by the check-in system has enabled Gwinnett to reduce its front office staffing by two full-time positions, lowering the practice's operating expenses. ■

—Reported and written by Editor Rev DiCerto.

PATIENT CHECK-IN DEVICES REPLACE THE CLIPBOARD

Physician practices seeking to streamline their front office function and improve patients' experience may wish to consider adopting an electronic patient check-in system. Such systems can be used to eliminate repetitive paperwork, request and collect outstanding patient balances and co-payments that practice staff may not always collect, perform eligibility and billing tests, and even, in some cases, collect patients' clinical and demographic data or schedule appointments, depending on the system used. The added convenience of these systems is popular with patients as well as practice managers, and in some cases has been sufficient to enable busy

practices to decrease their level of front-office staffing, lowering operating costs.

"Basically, we replace the clipboard," says Mark O'Leary, MBA, the chief marketing officer of New York, N.Y.-based Phreesia, manufacturer of the PhreesiaPad, a popular new patient check-in device. "We've all had that experience where you check into a doctor's office and you're handed the clipboard with all the paper forms. We also, in real time, verify patients' eligibility and insurance benefits. Perhaps most significantly, we also ask patients to pay their co-pay amount and any outstanding balances." —RD

COMMUNICATION

How Social Media Will Affect Medical Practices and the Health Care System

By Tim Morton, design director, Product Development Technologies



Since 2002, Tim Morton has been involved with multiple design projects for Product Development Technologies (PDT), ranging from facilitating fast innovation workshops to guiding in-depth research and development programs. He has previously held roles within research, design, marketing and sales as both client and consultant. Prior to PDT, Tim operated as an independent consultant for four years in the U.K., providing creative guidance and design direction to multiple industries.

Most companies and even a growing number of medical practices recognize that social media have become established as a viable business tool. Many effective medical practices and a large number of businesses are using sites like Facebook, Twitter and LinkedIn to connect to their customers, recruit followers and promote their services in real time. However, medical practices have yet to realize the opportunity to

“connect the dots” and utilize social media in a safe and meaningful way. Whoever achieves this goal first has the opportunity to revolutionize and forever change the medical industry.

Reaching Patients and Peers

Social media sites for the medical industry range from broad, open platforms to niche, narrowly concentrated forums. Facebook, Twitter and YouTube have become broad platforms for individuals and corporations alike to broadcast experiences and opinions large and small. Web sites such as CancerDoc (<http://cancerdoc.blogspot.com>), HealthLine (www.healthline.com), and RevolutionHealth (www.revolutionhealth.com) are more narrowly targeted venues for rapidly communicating and connecting to users who are sharing similar experiences. They offer medical professionals the opportunity to communicate information and share ideas with patients and medical industry peers. Expert Q&A sites such as WebMD (www.webmd.com) and AskDrWiki (<http://askdrwiki.com>) have become popular with patients, who can use them to find credible information to answer their health care-related questions. Physician networks like Sermo (www.sermo.com) and Ozmosis (<http://ozmosis.org>) serve as “virtual water coolers” where physicians can collaborate in real time. Sermo, the largest online physician community with over 115,000 members, serves as an exclusive forum to share medical insights and expertise.

But no matter what portal is being used by a patient or a health care provider, the single most beneficial aspect of social media is the collaboration enabled by the openness of vast

numbers. Most users of social media are trying to broadcast a message, educate, inform, or simply share. The portals themselves, empowered by the strength of their large numbers of members, are positioning themselves as the source of true, real-time data and insights. Many health care facilities use social media to crowdsource, basically asking for input from users to help them to develop or improve products and services quickly and efficiently. Others are enabling real-time learning by running podcasts of surgeries that medical students can “attend” remotely online.

In 2010 specifically, there was a significant jump in the number of medical companies utilizing social media tools, taking after early success stories like that of the Mayo Clinic. Mayo has gained over 25,000 Facebook fans just in the past year (they now have over 33,000). The Mayo Clinic’s “wall” is filled with patients’ thanks, interviews, advice, industry news and nearly 150 videos. Its presence in this space has strengthened the Clinic’s name as a thought leader in medical care and innovation.

Leveraging Data

While a presence on social media sites such as Facebook and HealthLine is important to medical practices and health care companies trying to build relationships and brands, these building blocks could be the source for much more revolutionary advancements. Over time the intimate knowledge of a contributor, a regional demographic or an international group of sufferers of a common condition or ailment could be used as proactive triggers for action. Imagine a device that collects signs of a patient’s general well-being, then com-

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bines these data with his or her Facebook postings on location, time, diet, and feeling while aggregating information from other users and facilities. When linked to the patient's medical facility and medication status, his or her pharmacy, his or her caregiver or gym, such a device could generate guidance and suggestions, which would then be sent back the patient daily. If a hazardous situation is suspected by the device's auto analysis of the data, this device could directly alert the patient's doctor to provide personal, quick advice and instructions. The potential to use social media and connected, aware devices to enhance patients' well-being and preventative care is huge, as are the possibilities for predicting and tracking patterns in health globally.

Social media offers unique opportunities for scalable interaction and collaboration. This interaction is a source of huge potential opportunity for manufacturers of medical and lifestyle devices. By developing products that become part of the users' daily lives (think how important your smart phone is to you now), manufacturers will have the ability to build a loyal customer base

that is not only using their device, but is also interacting with them and providing unparalleled insight into their habits in real time, helping fuel future understanding and developments in health care. The potential of such devices and such social media for collecting population-based health data has only just begun to be tapped. In the future, the data collected and the health care benefits derived from them are likely to increase at a rapid and increasing pace.

Despite all the progress over the past year, there remain challenges for med-

Medical practices have yet to realize the opportunity to “connect the dots” and utilize social media in a safe and meaningful way.

ical practices and medical device manufacturing companies when they begin to dive into social media. The field is still a very new horizon for the health care industry. It faces numerous hurdles posed by the traditions of both the health care industry and the insurance industry. Medical practices and manufacturing companies that are

agile and able to pivot in response to the times and the data they gather using social media will likely be more successful than their less tech-savvy competition in the future. It is not difficult to imagine Google as the Centers for Disease Control's leading information source in the future, aggregating and reporting data culled from clusters of users searching for key disease symptoms through an app portal or tweeting about their chronic illnesses. Used as tools that can serve as triggers for health care activity, social media can serve to take the temperature of societal health, allowing the health care community to observe as health-related patterns, such as the effects of pollution in specified areas of the country or the effects of population density and socioeconomic variations around the world, unfold.

If device manufacturers and the medical community find a way to harness and leverage the power of people's desire to connect and share their health-related data, they could achieve groundbreaking contributions to health care and the connected world as a whole in the coming years. ■

FUTURE MEDICAL DEVICES MAY ENCOURAGE HEALTHFUL BEHAVIOR WHILE COLLECTING HEALTH DATA

As medical practices and manufacturers of medical devices become more accustomed to using social media such as Facebook, HealthLine, and AskDrWiki, they are increasingly capitalizing on social media's ability to gather patients' health-related data. At the same time, patients are growing increasingly accustomed to sharing such data. Ultimately, these data might be put to use on a large scale, as patients and other social media users provide growing amounts of information about their health states and their daily activities.

One example of a company that has been quick to the punch when it comes to bringing more innovative approaches to applying data gathered through social media to improving patients' well-being is Nike. The Nike+ Running Monitor is an application

that meshes telehealth devices with social media. The device monitors and posts information about users' running habits and experiences on Facebook. All of this tracking and communication of patients' fitness and wellness data also serves as a great promoter of the manufacturer, since Nike's product is advertised every time the user uses it to post a status update. The health care system gains data on the patient's behavior, which could ultimately be used in the patient's primary care physician's practice when advising the patient. In the end, both the experience of posting the exercise information and the feedback provided by the patient's physician serve to encourage the patient in his or her healthful behavior.

—TM

HEALTH CARE REFORM

Proposed CMS Rules Seek to Lower Care Costs Through Increased Transparency

The Centers for Medicare & Medicaid Services (CMS) in June proposed rules that will enable consumers and employers to select higher-quality, lower-cost physicians, hospitals and other health care providers in their area. The new rules will allow organizations that meet certain qualifications access to patient-protected Medicare data to produce public reports on physicians, hospitals and other health care providers. These reports will combine private sector claims data with Medicare claims data to identify

which hospitals and doctors provide the highest quality, most cost-effective care. This initiative is made possible by the Affordable Care Act, in an effort to improve care and lower costs.

For many years employers, consumers, providers, and quality measurement organizations have been frustrated with the limited and piecemeal availability of health care claims data. This has led many health plans to create provider performance reports based solely on the health plan's own claims, which often represent only a small proportion of a provider's overall practice.

Increasing Transparency

The proposed rules seek to change the quality measurement landscape in a way that increases transparency for all stakeholders. "Qualified entities" that have the capacity to process the data accurately and safely would be required to combine the Medicare claims provided by CMS with private sector claims data, to produce quality reports that are more representative of how providers and suppliers are performing. The reports will help employers and consumers better understand the relative

performance of providers in their area. These rules include strict privacy and security requirements for entities handling Medicare claims data.

This new program would provide for the following activities:

- CMS would provide standardized extracts of Medicare claims data from Parts A, B, and D to qualified entities. The data can only be used to evaluate provider and supplier performance

This initiative is made possible by the Affordable Care Act.

and to generate public reports detailing the results.

- The data provided to the qualified entity will cover one or more specified geographic areas.
- The qualified entity would pay a fee that covers CMS's cost of making the data available.
- Qualified entities would need to have claims data from other sources.
- Publicly reporting the results calculated by the qualified entity is important for transparency in health care and consumer empowerment. To prevent mistakes, qualified entities must share the reports confidentially with providers and suppliers prior to their public release.
- Publicly released reports would contain aggregated information only.
- During the application process, qualified entities would need to demonstrate their ability to govern the access, use, and security of Medicare claims data. Qualified entities would be subject to strict security and privacy processes.
- CMS would continually monitor qualified entities. Entities that do not follow these procedures risk sanc-

tions, including termination from the program.

Comments are welcome on this set of proposed rules.

Protecting Patients

These proposed rules are the next step in CMS's effort to improve health care quality and ensure consumers have access to the best available information, using new tools provided by the

Affordable Care Act. The Hospital Value-Based Purchasing initiative will reward hospitals for the quality of care they provide to patients covered by Medicare

and help reduce health care costs. This initiative will be based on quality measures that hospitals have been reporting to the Hospital Inpatient Quality Reporting Program since 2004, which is posted on the Hospital Compare Web site (www.healthcare.gov/comare/index/html).

The Partnership for Patients is bringing together hospitals, doctors, nurses, pharmacists, employers, unions, and state and federal government committed to keeping patients from getting injured or sicker in the health care system and improving transitions between care settings. CMS will invest up to \$1 billion to help drive these changes. In addition, proposed rules allowing Medicare to pay new accountable care organizations to improve coordination of patient care are also expected to result in better care and lower costs. This proposed rule will complement the current effort to improve quality, lower costs, and improve health by providing consumers and employers a more accurate picture of provider and supplier performance.

The proposed rules can be viewed at <http://tinyurl.com/9qjrg>. ■

PRACTICE MANAGEMENT NEWS

AHRQ Report Finds Disparities in Care Between States

States are seeing improvements in health care quality, but disparities for their minority and low-income residents persist, according to the *2010 State Snapshots*, a report released June 1 by the Rockville, Md.-based Agency for Healthcare Research and Quality (AHRQ).

New Hampshire, Minnesota, Maine, Massachusetts and Rhode Island showed the greatest overall performance improvement in 2010. The five states with the smallest overall performance improvement were Kentucky,

Louisiana, New Mexico, Oklahoma and Texas. Among minority and low-income Americans, the level of health care quality and access to services remained unfavorable. The size of disparities related to race and income varied widely across the states.

The report shows whether a state has improved or worsened on specific health care quality measures. For each state and the District of Columbia, this tool features an individual performance summary of more than 100 measures, such as preventing pressure sores, screening for diabetes-related

foot problems and giving recommended care to pneumonia patients. It compares each state to others in its region and the nation.

The report is based on data from the 2010 *National Healthcare Quality Report* and *National Healthcare Disparities Report*, which are mandated by Congress and produced annually by AHRQ. Data are drawn from more than 30 sources, including government surveys, health care facilities and health care organizations. The report can be accessed at <http://statesnapshots.ahrq.gov>.

NCQA GRANTS PCMH RECOGNITION TO 14 FEDERAL FACILITIES

Fourteen federally qualified health centers are the first federal sites to earn National Committee for Quality Assurance (NCQA) Recognition under the Health Resources and Service Administration (HRSA) Patient-Centered Medical/Health Home Initiative. By meeting NCQA requirements as patient-centered medical homes (PCMH), these centers have brought a proven model of high quality primary care to facilities serving some of America's neediest residents. Three Northwest Health Services sites in Missouri and 11 Hudson Headwaters Health Network sites in New York earned PCMH Recognition.

The HRSA Patient-Centered Medical/Health Home initiative pays the costs of federally qualified health centers, community health centers and military treatment facilities to become NCQA

medical homes. However, Hudson Headwaters Health Network also received support from the New York State Department of Health and from seven other private insurers through a state-sponsored multi-payer medical home initiative.

PCMHs emphasize care coordination and communication. Research shows that PCMHs can lead to higher quality and lower costs, and improve patients' and providers' reported experiences of care. More than 2,024 practices and 8,300 clinicians in the private sector have earned PCMH Recognition. Federal facilities seeking PCMH Recognition must meet the same standards as private sector facilities. To comply with federal contracting rules, application and review procedures are different.

REPORT SUGGESTS CHANGES TO PRIMARY CARE SYSTEM, INCLUDING MENTAL ILLNESS DIAGNOSIS

A report released in May from The Carter Center in Atlanta, Ga. (www.cartercenter.org), and the Philadelphia, Pa.-based American College of Physicians (ACP; www.acponline.org), "Five Prescriptions for Ensuring the Future of Primary Care," argues that an overhaul of the primary care education system, including adopting more rigorous training in mental illness diagnosis and treatment, is necessary to fully implement reform of the U.S. health care system.

Common themes from the report include changing curriculums

and teaching to provide more training in team-oriented settings and to integrate behavioral health care diagnosis and treatment into the primary care setting; leveraging existing funding mechanisms and creating new incentives to facilitate greater adoption of primary care careers among young health professionals; and stimulating a broader research agenda to inform primary care practice and health training of the future.

The entire report can be accessed at <http://tinyurl.com/6z2cmcp>.

IOM Report: Use New Data Sources, Methods to Ensure Accuracy of Geographic Adjustments to Medicare Payments

Geographic adjustments to Medicare payments are intended to accurately and equitably cover regional variations in wages, rents, and other costs incurred by hospitals and individual health care practitioners, but almost 40% of hospitals have been granted exceptions to how their adjustments are calculated, finds a new report from the Institute of Medicine (IOM). The rate of exceptions strongly suggests that the mechanisms underlying the adjustments are inadequate, noted the committee that wrote the report.

The rationale for fine-tuning Medicare payments based on geographic variations in expenses beyond providers' control is sound and should be continued, the committee concluded. However, several fundamental changes to the data sources and methods the program uses to calculate the adjustments are needed to increase the accuracy of the payments.

Medicare payments to hospitals and

health professionals working in private practice topped \$500 billion in 2010, according to Congressional Budget Office estimates. Federal law requires geographic adjustments to be budget neutral; any increase in the amount paid to one hospital or practitioner must be offset by a decrease to others.

Salaries and benefits make up one of the largest costs of providing care. The Medicare program should use health sector data from the Bureau of Labor Statistics (BLS) to develop its indexes for calculating wage adjustments for hospitals and private practice health professionals, the report says. BLS data are a more accurate, independent, and appropriate source than the hospital cost reports, physician surveys, census data, and other information currently used, the committee said. Congress will have to revise a section of the Social Security Act to enable this change.

The full report can be viewed at <http://tinyurl.com/5uffzwe>.

AMGA SUGGESTS CHANGES TO ACO PROPOSED RULE

The Alexandria, Va.-based American Medical Group Association (AMGA; www.amga.org) on June 6 released comments on proposed regulations for Medicare's accountable care organizations (ACO) program. While AMGA supports the ACO concept, it offered suggestions by which to strengthen it.

The changes suggested included allowing ACO participants to elect retrospective or prospective patient attribution; lowering the minimum savings rate to 1%; allowing a participation track with only shared savings risk assumption; dropping "opt-out" provisions for patient data sharing; increasing the shared savings rate and the maximum payout cap; using risk adjustment in a dynamic fashion; simplification of the application process; moderation of the reinsurance provisions; and dropping the number of quality measures required and phasing them in over time.

The full document containing AMGA's comments can be viewed at <http://tinyurl.com/5utthvk>.

AMA CALLS ON CMS TO REVISE ACO PROPOSAL

The American Medical Association (AMA; www.ama-assn.org) on June 3 submitted comments to the Centers for Medicare and Medicaid Services (CMS) on their proposed rule regarding Medicare accountable care organizations (ACOs). The AMA expressed support for developing and testing ACOs as one of various payment and care delivery innovations, but urged CMS to make changes to the proposed rule to allow all interested physicians to participate.

The AMA offered constructive changes to the proposed payment and risk structure of ACOs to encourage participation by physicians in all practice sizes, including providing a payment option that does not require shared loss and allowing groups to

receive a percentage of all savings achieved.

The AMA urged CMS to revise the requirements placed on ACOs, including reducing the mandatory percentage of primary care physicians who must be using electronic health records by the second year. The AMA also recommended changes to quality measures and reporting requirements, including allowing ACOs to report on a lower number of quality measures most relevant to their patient population and ensuring that the data used to calculate quality measures are updated and transparent.

The AMA submitted comments in late May to the Federal Trade Commission and Department of Justice regarding their proposed policy on ACOs.

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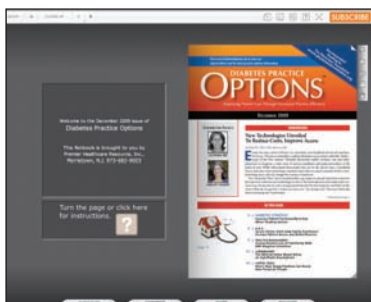


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