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Physicians Become Wary of Litigious Patients

Earlier this year, physicians in Texas could visit a Web site (at www.doctorsknowus.com) to search a database listing the names of plaintiffs who had filed medical malpractice lawsuits against doctors, according to published reports. Following an article about the site in *The New York Times*, patients, trial lawyers, and patient advocates objected strongly and the site was shut down. The Texas Medical Association and the AMA feared the site might damage physician-patient relations.

A number of surveys underscore the depth of the medical malpractice problem. A survey of 736 doctors by the Doctors' Co., a physician-owned insurance company in Napa, Calif., shows that more than 72% of doctors view their patients as potential malpractice adversaries. Nearly 40% of surveyed doctors said they had limited services to minimize liability risk. Half of 4,000 medical students in an AMA survey said fear of medical liability was a major factor influencing their choice of specialty. A survey by Merritt, Hawkins & Associates, physician recruiters in Irving, Texas, shows that among doctors aged 50 to 65, more than half plan to quit practice in the next three years. Their greatest source of frustration was malpractice worries.

Neil Baum, MD, a urologist in New Orleans and author of *Take Charge of Your Practice Before Someone Else Does It for You* (Jones & Bartlett Publishers, 1996), advises physicians to be particularly careful when trying to identify the 15% of patients who represent 90% of lawsuits. Make sure the patient understands what you are saying, he counsels. Patients who don't understand a course of treatment or a procedure account for most malpractice litigation. Take meticulous notes, particularly if a patient complains about former physicians, and avoid criticizing another physician. Be careful if a patient requires complex care because malpractice cases often involve complex patient management and difficult communication with family members, either because of multiple physicians working on the case or a confusing care regimen.

Also, make sure that patients have given their informed consent. For physicians in surgical specialties, a lack of informed consent causes many lawsuits, especially for patients with a complication or an unfavorable result. Physicians should make sure that each patient is given sufficient information about all known potential complications so the patient can make an informed decision about a treatment.

However one views the propriety of the Texas Web site, it shows the depth of concern among physicians about medical liability. Tim Norbeck, executive director of the Connecticut Medical Society, says professional liability is by far the issue of most concern to physicians. "And it's not going to go away," he adds.



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Hospital CABG Volume Only Modestly Associated With Higher Care Quality

The link between procedure volume and outcomes seems to have become an accepted tenet of health care quality, especially for such cardiac procedures as coronary artery bypass graft (CABG) surgery and percutaneous transluminal coronary angioplasty (PTCA).

Now, however, a new study shows that hospital CABG volume is only moderately associated with outcomes and therefore may not be an adequate quality indicator. Published in the Jan. 14 issue of JAMA, the study shows that while the association between CABG volume and overall operative mortality was statistically significant overall, the link was weaker when data were adjusted for patient case mix and the association was not observed at all in low-risk patients or in those younger than 65 years old.

Obvious Advantages

The link between CABG volume and outcomes has been the topic of numerous studies over at least two decades. "Using hospital procedure volume as a quality indicator for CABG surgery is appealing for several reasons," says Eric D. Peterson, MD, MPH. "First, procedural volume is a straightforward measure: It is simply a count of the number of procedures performed at an institution in a given time period. Second, it is easy to gather: We can find volume data by drawing from billing or claims data. Finally, the volume-outcome link is easy to understand: The idea that more experience results in better outcomes is intuitively obvious and is a simple number for the public to grasp." Lead author of the study, Peterson is a cardiologist at Duke

University Medical Center in Durham and director of cardiovascular outcomes research and quality at the Duke Clinical Research Institute.

Past research has found a strong link between the number of CABG surgery cases performed at an institution and actual outcomes, but Peterson and his colleagues were

hoping to refine this existing body of research. The researchers used the STS National Cardiac Database, established in 1989 by the Society of Thoracic Surgeons, in Chicago. "These data are more complete than the data used in a number of previous studies," Peterson says. "The STS database includes detailed information on the clinical risk of patients before CABG surgery. In addition, the database allowed us to consider patients of all ages, not just older patients. Finally, we used more sophisticated statistical techniques than had been used previously."

Past research found a strong link between the number of CABG surgery cases performed at an institution and actual outcomes.

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Choosing Providers

Verifying the magnitude of the volume-outcome link is important because patients and cardiologists may be tempted to use that relationship as the basis for choosing an institution for care, Peterson explains. "Patients and cardiologists who are scheduling CABG surgery may have two or more nearby hospital providers from which to choose," he adds. "They may assume that the

hospital with the highest CABG procedure volume will offer the best quality, and choose that hospital based on that assumption." Using data from more than 267,000 CABGs performed at 439 STS hospitals, the researchers calculated CABG surgery mortality rates after accounting for patient case mix.

Mortality was defined as "all cause operative mortality": in-hospital or 30-day mortality, whichever was longer. Major morbidity included any of the following postoperative in-hospital complications: stroke, reoperation for any reason, need for mechanical ventilation for more than 24 hours following surgery, renal failure, or deep sternal wound infection.

The results show that researchers found a statistically significant relationship between procedure volume and outcome, but this relationship was much weaker than the association found in previous studies. Other studies have found as much as a 1.3% absolute difference in unadjusted mortality rates between the lowest and highest volume hospital quartiles, but Peterson's analysis found a 0.7% difference in adjusted mortality rates.

Assessing Risk

"Many previous research efforts have not incorporated risk adjustment when analyzing the link between CABG volume and outcomes,"

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Peterson says. "It is very difficult to accurately adjust for risk when using claims data or billing data. In contrast, the STS database tracks actual clinical information around the time of the procedure, which allowed us to better adjust for disease severity and the comorbid illnesses patients have before surgery. Certainly, these factors affect a patient's likelihood of dying with surgery and need to be accounted for."

Patient age and surgical risk were included in case mix adjustment, but their effect on volume was analyzed separately as well. "The volume effect is more pronounced in patients who are at higher risk, as defined either by age or by actual risk factors," Peterson notes. "When we analyzed the volume-outcome link in young patients and in relatively healthy patients, we found no difference between low- and high-volume centers. Among complex patients and older patients, a performance difference was measured across sites."

This finding is reasonable, Peterson believes. "If experience matters, it will make the biggest difference in the most complex cases," he says. "But the important implication of this finding is that the people who are most likely to reference a public reporting system on hospital volume and make an objective decision about where to have their surgery are those who are younger or who are healthier and in a position to choose the location for an elective procedure. Unfortunately, those are the groups for which these volume data make absolutely no difference. The people who are critically ill and need acute surgery or who are older would benefit the most from this information, but they are often not in

a position to choose their hospital."

Interestingly, Peterson's analysis revealed that very low-volume centers sometimes handled cases that were more complex than those at the high-volume centers. "That might sound counterintuitive," Peterson notes, "but low-volume centers may have excess capacity and therefore may be willing to take on tougher cases to fill the schedule."

The finding that patient risk is a crucial qualifier relationship supports results from a study published in the December 2001 *Journal of the American College of Cardiology*, which also suggested that patient risk of undergoing CABG surgery has an effect on the volume-outcome relationship. Specifically, researchers involved in this study found that while moderate-risk and high-risk patients may in fact experience better outcomes when they undergo CABG surgery at a high-volume institution, low-risk patients will have similar outcomes regardless of CABG procedure volume at the institution.

Correcting for Variance

In addition to adjusting for case mix, the researchers involved in the JAMA study also used other sophisticated analytical techniques. One such technique corrected for site variance. "The mortality rates measured at the higher volume centers, because they have a greater number of procedures, will more accurately reflect their performance than the mortality rates measured at the low-volume centers, unless we correct for site variance," explains Peterson. "Low-volume centers can look like they have very high mortality rates because they do fewer cases."

Overall, the analysis implies that CABG surgery volume is not a strong discriminator of hospital quality. "In trying to select a hospital for CABG surgery, patients and cardiologists should not use procedure volume as the sole quality indicator," Peterson says. "The ability of the volume data to identify the better provider in terms of lower mortality rate is actually rather weak. While there is a general relationship between volume and outcomes in general, there is wide variation across sites. Many low-volume centers had outcomes that were better than average, and some high-volume hospitals exhibited mortality rates that were worse than average. Statistically, this scatter in terms of individual institution performance means that if patients and cardiologists use CABG procedure volume as the sole metric in trying to choose an institution, they would be choosing poorly almost as many times as they would be choosing well."

Accordingly, cardiologists do not necessarily need to seek out high-volume hospitals for referrals, especially for patients who are younger and have fewer comorbid conditions, Peterson adds. "Cardiologists are in a much better position than patients to gather information about the outcomes of the centers to which they refer," he says. "In fact, data are available in the majority of institutions. Cardiologists should be aware of how their institutions are performing. If this performance is not ideal, they can work actively with the cardiac surgeons in those centers to help improve outcomes."

Given the results of the JAMA study, cardiologists should look beyond patient volume when choos-

Those who are critically ill and need acute surgery or who are older would benefit most from the research findings.

ing a hospital and when choosing a cardiac surgeon to whom to refer cases, Peterson says, even though his analysis revealed that the volume-outcome link is stronger for surgeons than it is for hospitals. “Cardiologists should look for data about cardiac surgeon performance other than procedure volume,” Peterson asserts. “Although surgeon CABG volume is certainly related to outcomes, volume alone is not the sole metric for quality. While the volume-outcome link is stronger for surgeons than it is for institutions, it is still a relatively crude quality indicator.”

Effect of Heart Centers

Some experts have proposed that, even if volume is not a strong indicator of quality among individual cardiologists, strategies or legislation that limits the number of low-volume providers and concentrates volume in fewer institutions would result in improved outcomes overall, Peterson says. In fact, there has been much discussion among heart specialists regarding the creation of designated heart centers, just as trauma centers have been established in certain markets.

To investigate the effect of heart centers, the researchers analyzed the closure of low-volume centers. “We found that even if we eliminated the lowest volume centers, up to one quarter of all the bypass surgery centers in the United States, the effect on bypass surgery mortality rates in the United States would basically remain unchanged,” Peterson explains, adding that less than 1% of the potential perioperative deaths would be avoided by closing the centers that perform the lowest volume of CABG surgeries. “This is a relatively minor benefit considering that

in many areas the closure of these centers would result in reduced access to care, and in some cases great hardship in terms of distances traveled for surgery.”

Therefore, Peterson explains, “From a policy perspective, it really does not make sense to triage patients based on volume criteria or propose the closure of low-volume centers, because such policies would not impact the overall health of the population.”

In fact, some groups view procedure volume as a surrogate for health care quality. For example, the Leapfrog Group, a large national coalition of private and public purchasers of health insurance in Washington, D.C., has set standards suggesting that employers should refer their employees to institutions that perform at least a certain minimum volume of procedures. The Leapfrog Group has suggested that an institution with a procedure volume of 500 CABG procedures annually will be more likely to have better outcomes. The federal Centers for Medicare & Medicaid Services has considered implementing a similar policy, but has not done so.

Determining Quality

If volume data are not the answer, what is the best way to determine CABG provider quality? “Patients should find out if a hospital collects data and tracks performance on an ongoing basis,” Peterson says. “They should also ask whether the hospital belongs to a national quality improvement registry or participates in a system that allows them to monitor and benchmark their outcomes, such as the STS national database.” In addition, many regional databases

(such as the Northern New England Cardiovascular Disease Study Group, the largest validated regional cardiac surgical database in the country), and state systems (such as those in California, Massachusetts, and Minnesota) track cardiac surgery quality and outcomes. “In part, knowing that the hospital is tracking its performance and working to improve it is very meaningful, because those are the hospitals that tend to have better results,” says Peterson.

Furthermore, the National Quality Forum in Washington, D.C., is developing national quality indicators for cardiac care, notes Peterson, who is a member of the forum’s board of directors. “Through the forum, we are trying to develop a system to determine which care processes are associated with better outcomes,” he says. “Eventually, information regarding these care processes, and the outcomes achieved by individual hospital providers, will be made available to the public.”

The trend toward shifting from relatively crude measures of quality to more refined measures of process and outcome is occurring across cardiology. “Eventually, cardiologists—and not just cardiac surgeons—will be expected to track their care processes and outcomes with regard to the care of patients with heart failure and myocardial infarction as well as the interventional cardiac procedures they perform,” Peterson says. “In the end, this data tracking, and the quality improvements it prompts, will refine how we deliver care across the specialty.”

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

“Cardiologists should be aware of how their institutions are performing,” says Eric Peterson, MD, MPH, of Duke University Medical Center.

Registries Help Improve Quality

Computerized disease registries function as affordable and practical information systems for physicians who want to improve the treatment of patients with chronic diseases, according to a recent report by the First Consulting Group in Long Beach, Calif. A registry is more affordable than an electronic medical records system and enhances patient management, thus improving quality and lowering costs, the researchers say.

"Disease registries are important because as more physicians seek to improve care for patients with chronic diseases, they quickly discover that paper-based systems are inadequate and they need information technology to track their patients and provide follow-up care," says author and researcher Jane Metzger. "Computerized chronic disease registries are an economical way to meet that goal."

The report, *Using Computerized Registries in Chronic Disease Care*, was prepared for the California HealthCare Foundation in Oakland and published in February. In the report, the researchers say chronic conditions—such as diabetes, asthma, and coronary artery disease—are the major causes of illness, disability, and death in the United States.

Chronic Care Burden

The research is important because chronic diseases afflict about 20% of the population and account for more than 75% of health care spending, say CHCF officials. "Inadequate management of patients with chronic diseases increases health care costs and affects patients' health," says

Sophia Chang, MD, director of CHCF's Chronic Disease Care program. "Access to timely, accurate, and well-organized clinical data through disease registries is an important step toward improving care for those with chronic conditions."

Other studies support the foundation's contention that patients with chronic diseases are undertreated. In an article in the June 26 NEJM, "The Quality of Health Care Delivered to Adults in the United States," researchers at the Rand Corp. in Santa Monica, Calif., said that Americans received less than 55% of the care recommended under guidelines from professional associations for the treatment of patients with chronic diseases. "The deficits we have identified in adherence to recommended processes for basic care pose serious threats to the health of the American public," they said. "Strategies to reduce these deficits in care are warranted."

Disease registries can play a vital role in improving that number, according to the Institute of Medicine's report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. The IOM report states that treatment for patients with chronic conditions can be improved through a systematic approach that emphasizes self-management, care planning with a multidisciplinary team, and ongoing assessment and follow-up—all elements of an effective chronic disease registry.

The most recent study of how many physician practices are using stand-alone chronic disease registry programs was done by University of Chicago

researchers. Their results, published in "External Incentives, Information Technology, and Organized Process to Improve Health Care Quality for Patients With Chronic Disease," appeared in the Jan. 22-29, 2003, issue of NEJM. The researchers reported that 40.3% of the 1,040 surveyed physician organizations used a disease registry to track patients with diabetes, 31.2% to track patients with asthma, 34.8% to track patients with congestive heart failure, and 15.7% to track patients with depression.

"Our registry gives us the information we need to contact patients with gaps in care, as well as to examine and rework how we care for patients with chronic diseases," says Joel Diamond, MD, medical director of Deer Lakes Medical Associates, a family practice in Pittsburgh with nine physicians. Since early last year, the medical group has used a disease registry sponsored by one of its payers for patients with several chronic diseases.

Collecting Data

A chronic disease registry is a "computer application used to capture, manage, and provide information on specific conditions to support organized care management of patients with chronic disease," the report says. Registries supplement rather than replace individual patient medical records and help ensure that data are complete and readily available. Registries generate patient lists that have significant advantages over paper-based registries in efficiency and accuracy, the report says.

Registries differ from EMRs in that registries are used to manage only

Physicians who seek to improve care for patients with chronic diseases quickly discover that paper-based systems are inadequate.

selected information relevant to patients with one or more chronic diseases, rather than to manage more comprehensive information about individual patient problems, health history, and care. Registries also are designed to manage up-to-date aggregate lists of chronic disease patients so they can be tracked effectively. Most EMRs are designed primarily to support providers at the point of care and usually do not contain registry software. They generally are not necessarily used to generate lists for physicians managing a population of patients. While some EMRs include registry functions for population management, the CHCF report focused on stand-alone disease registries that are not integrated with an EMR.

Monitoring Care

To illustrate how a stand-alone chronic disease registry would be used for patients with diabetes, the report shows that a diabetes registry can be used to collect information on patient blood tests, eye exams, and other protocols critical to maintaining high-quality individual treatment. Registry software for patients with diabetes also can notify staff at the point of care about whether a patient or a group of patients has received such tests and, if so, inform physicians about test results.

Notification is made through hard-copy reports about an entire population suffering from a particular disease or condition, and these reports can be published daily, weekly, or monthly. Adequate chronic disease registry software programs provide physicians with three types of reports: printed, exception, and aggregate.

- Printed reports are used at the

point of care to provide information on specific conditions and prompt provider teams to conduct appropriate assessments, deliver recommended interventions, and capture information to update patient records.

- Exception reports are used to identify patients who are overdue for care or who are not meeting management goals. Because these reports also include such information as the patient's last visit and test dates, they can be used to develop an appropriate outreach strategy for each patient.
- Aggregate reports provide information about how well individual care teams and the overall provider organization are delivering recommended care to the patient population.

Computerized registries capable of generating such reports generally require a database to store patient information and software that can sort the information to meet various needs. Registries generally manage a much smaller amount of patient information than EMRs and focus on selected information relevant to patients with one or more chronic diseases.

Design Variety

According to the report, there is no standard design for the chronic disease registries in use today. The various models use different software and have a variety of data sources and sponsorship. Software can be developed locally, purchased from a vendor, or obtained from one of several organizations offering registries for free.

Often, a nurse or other member of the care team will develop a registry

that begins with a spreadsheet. The University of Washington Physicians Network, a nonprofit primary care delivery system in Seattle, developed a registry in this way. UWPN has nine clinics linked by a computerized, networked clinical information system.

In 1998, UWPN developed a diabetes management program in collaboration with the Institute for Healthcare Improvement in Boston. In the process of developing a diabetes registry, several types of systems were constructed using a spreadsheet and a simple database on a PC, such as Microsoft Access. "For beginning programs, it makes sense to start with a spreadsheet," says Jeffrey Hummel, MD, director of research and clinical improvement at UWPN.

The data that are collected depend on what care interventions physicians and other providers want to deliver and what information is needed to track delivery to patients, the CHCF report says. Generally, the data needed will be related to established treatment guidelines.

Software Tools

As the registry is used, Hummel and others say that practices begin to transfer data into larger databases. Many federal agencies or quality improvement organizations offer free registry databases to physicians and other providers. Two examples of public domain registry applications are Chronic Disease Electronic Management Systems (CDEMS) (at www.cdems.com) and the Cardiovascular and Diabetes Electronic Management System (CVDEMS) (at www.apiweb.org/CVDEMS.htm).

Some practices and health systems develop their own registries. These

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“For beginning programs, it makes sense to start with a spreadsheet,” says Jeffrey Hummel, MD, director of research and clinical improvement at UWPN.

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are appealing because the builder retains control over functionality and can ensure that the system meets local needs. The disadvantage is that development and ongoing maintenance require programming and database management that may not be available internally.

A small number of companies sell stand-alone registry software that may be more sophisticated than that developed internally and likely would accommodate future growth readily. A large number of users may be able to enter or view data simultaneously, and the accompanying databases would accommodate multiple conditions and could be used to manage large amounts of data. Disadvantages of vendor-purchased software include the cost, the fact that customization options sometime involve additional cost, and the possibility that the vendor offering the product may cease operations or be acquired. The cost of commercial products can range from \$500 to \$600 per physician per year.

Sponsorship Concerns

Another concern is sponsorship. Health plans and other external sponsors may offer free or nominally priced registry software. Among the organizations that may sponsor a registry are a medical practice or group, a quality improvement organization, a clinic consortium, an independent practice association, a health plan, or a governmental entity.

The software itself and the accompanying database can reside on a PC or on a networked server run by the provider organization, or it can be hosted by a commercial vendor or other external sponsor which would retain the software and database information. If the software

and database reside on a network server, the physicians and other providers may access the registry over the Internet or through a private network. In such a case, where a sponsor hosts the application and database on its server, the physicians may want to ask about the provisions for security and patient privacy as required under the Health Insurance Portability and Accountability Act.

When considering a system sponsored by another organization, physicians may want to know if the registry can be used to manage the care of patients with one disease or multiple conditions and whether data can be entered manually or electronically from such sources as practice management systems, claims management software, laboratory or pharmacy systems, or EMRs.

After considering the various aspects of the design of a registry, physicians also will want to consider the cost of using the software. While the cost of implementing a disease registry may be relatively low, substantial costs may be required for managing and maintaining the system and these costs are difficult to estimate, the report states. The cost of establishing and managing a registry can be substantial and should be considered before committing to using the tool, the report adds.

"A significant amount of labor is required to enter and update patient data, generate patient lists, conduct outreach programs, and generally maintain the registry," the report explains. Usually, existing staff would be asked to establish and manage the registry. "The challenge is to find enough time in the busy environment of a primary care practice to accomplish the necessary work," the report adds. But the results

are often worth the effort.

Improving Results

Physicians who are using chronic disease registries report a labor-intensive process that rewards staff time with positive clinical results. "Just grafting a registry onto the clinic system doesn't work. You have to change how work flows and care is delivered," said Sean Gaskie, MD, director of special programs at the Family Practice Center of Sutter Medical Center in Santa Rosa, Calif.

The center implemented a diabetes registry in 2000. Initially, the 36-physician practice planned to develop its own software, but decided instead to use the CVDEMS program. The registry is maintained on a password-protected network server and is accessible on PCs throughout the center. Gaskie and his colleagues periodically export data from CVDEMS into Microsoft Excel and produce exception reports to distribute to the staff. As a result of using the registry, the center has seen a significant drop in patients' HbA_{1c} levels, from 10.5 to below 7 for a targeted group of patients, Gaskie says.

Physicians who use computerized chronic disease management programs say that the single most important element of a registry may be its ability to provide an overview of a practice's chronic disease population.

"We realized we had to know certain things about certain patients and critical information about them both when they came in for care and when they did not," Gaskie says. "Our inability to do so before implementation of a registry was humbling."

—Reported and written by Martin Sipkoff, in Gettysburg, Pa. More information on practice strategies is available on our Web site (see page 16).

As a result of using a registry, one family practice realized a significant drop in HbA_{1c} levels.

Report Shows New Limits on Care

By Richard L. Reece, MD, editor in chief

Facing pressure to keep costs down while also allowing unrestricted access to care, managed care plans are scrutinizing high-cost and discretionary services more closely, according to a new study by the Center for Studying Health System Change (HSC), in Washington, D.C. They also are shifting more financial and care management responsibilities to consumers, the study shows.

"Mindful of the managed care backlash, plans are increasing scrutiny of high-cost services, especially services that pose a high risk of inappropriate use, such as imaging," says HSC President Paul B. Ginsburg, PhD. "Faced with employers seeking relief from double-digit premium increases and consumer demand for broad choice, health plans are under pressure to identify new ways to slow escalating premium trends while tempering consumer discontent." A group of employers also is developing new ways to control costs by empowering consumers.

Changing Tactics

The HSC study is based on visits by researchers in 2002 and 2003 to 12 nationally representative communities: Boston; Cleveland; Greenville, S.C.; Indianapolis; Lansing, Mich.; Little Rock, Ark.; Miami; northern New Jersey; Orange County, Calif.; Phoenix; Seattle; and Syracuse, N.Y. A report on the study, *Managed Care Redux: Health Plans Shift Responsibilities to Consumers*, was done by Debra A. Draper, an HSC consulting researcher from Mathematica Policy Research

Inc., and Gary Claxton, an HSC consulting researcher from the Kaiser Family Foundation.

During visits to the communities in 2000 and 2001, HSC researchers found that health plans in the 12 communities were reporting no major changes in the use of services as a result of the relaxation of utilization management controls. The plans had eased up on the restrictions on utilization in response to complaints by patients, physicians, and consumer advocates.

By 2002 and 2003, however, many plans had changed their assessment, the HSC study says. As looser utilization management was becoming more widespread, many plans reintroduced administrative controls on care. In the 12 communities, health plans expressed little interest in returning to blanket preauthorization requirements. Instead, they began focusing on services that are considered to be high-cost or at high risk for inappropriate use, the researchers found. These services included outpatient and plastic surgery, diagnostic imaging, chiropractic care, and physical therapy. Likewise, plans were increasing patient cost-sharing requirements for services that tend to be more discretionary and prone to overuse.

Entering Limbo

The report shows that the U.S. health care system is entering an awkward period between the end of tight restrictions on utilization that characterized traditional managed

care and the rise of consumer-driven health care. The most restrictive forms of managed care were the least costly, but they failed because consumers and physicians revolted against severe limits on choice.

Conversely, consumer-driven care promises to remove restrictions and favor choice, but this more relaxed approach also may fail because consumers and physicians are likely to revolt against cost shifting that falls most heavily on patients who have chronic conditions. In other words, consumers want low costs and wide choice, but the health care system has so far been unable to deliver both.

Consumer Empowerment

There are two make-or-break factors in the move to a consumer-driven health care system. The first is a political factor that could stop any movement that allows health care consumers more choice. Many observers believe health care should be a paternalistic system in which a central organization, such as the federal government, covers all consumers and protects all patients. These observers are convinced that consumers will never have sufficient information to make rational choices in a marketplace in which for-profit companies are seeking to provide a return to investors rather than providing care for patients. In such a market, it is best to have an organization designed to protect consumers against all exigencies, these observers say.

Conversely, those who believe

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Health plans are pressured to identify new ways to slow escalating premium trends while tempering consumer discontent, says Paul Ginsburg of the Center for Studying Health System Change.

Findings Focus on Costs

Among several steps health plans are taking to control costs are developing disease management and intensive case management programs for the small percentage of members who use a disproportionate share of resources, according to *Managed Care Redux: Health Plans Shift Responsibilities to Consumers*, a report by the Center for Studying Health System Change.

The report shows that health plans also are developing new products that provide consumers with significant control over how they access and use health care and that plans are encouraging more consumer involvement in weighing the costs and benefits of those decisions. New products include consumer-driven plans tied to health spending accounts, tiered provider networks that require higher patient cost sharing, and customized plan designs that permit employees to choose different cost-sharing and benefit options after their employer has chosen a core set of benefits. The most expensive tiers offer the greatest choice and the least costly tiers have more limited choice.

Health plans also recognize that increased patient responsibility for financial and care decisions requires more and better information for consumers, the report says. As a result, many health plans are increasing their consumer education efforts.

Plans across the 12 communities in the study are designing and enhancing their Web sites to provide enrollees with more information about claims and available benefits and, in some instances, providing more general information about costs, quality, and treatment options, according to the report.

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consumer-driven care can work say that health care is simply a marketplace and that if smart and pragmatic consumers are given the right information, they will make the right choices and choose the greatest value at the right price. The supporters of consumer-driven care have the second factor in their favor: health savings accounts (HSAs), which are available to most Americans under the new Medicare Prescription Drug Improvement and Modernization Act of 2003.

Among those who favor HSAs is Martin Feldstein, a Harvard economist. Feldstein says that HSAs may be the most important piece in the 2003 legislation and have the potential to transform health care financing, bringing costs under control and making health care reflect what patients and physicians want. He

believes patients and physicians are capable of deciding what is best and the market will provide competition that will keep costs under control while also helping to ensure that providers deliver quality care.

While critics may complain about managed care, health plans nevertheless are developing consumer-driven programs. All major health plans have or will soon offer consumer-driven products, and a number of stand-alone consumer-driven plans have been selling services for several years. So far, in the study of 12 representative markets, results are uncertain. The health plans are taking tentative steps to modify existing managed care products, to instruct consumers to navigate the market, and to cut costs by focusing on high-risk diseases; they are also trying to deter-

mine how much responsibility for cost consumers will accept. If consumer-driven care fails, advocates of universal coverage believe the government should step in.

Employers Take Steps

As health plans take steps to develop new forms of care, so too are employers. In March, a group of large employers joined with two health plans in an effort to foster consumer-driven care, according to a statement by Mercer Human Resource Consulting in New York. The employers want to change the current approach to buying health care benefits into one that focuses on the quality and efficiency of health care providers in what they call care focused purchasing (CFP). The employers believe that their current plan designs and cost-sharing strategies focus on the short term and fail to solve the underlying causes of significant annual increases in costs and troubling issues about inconsistent quality, varied outcomes, and unacceptable error rates in the care employees and their families receive, the statement says.

Since they lack the information needed to make informed choices about which hospitals and physicians to include in their networks, the employers are hoping to use their leverage to establish a more open and rational health care market that resembles markets for other goods and services, according to the Mercer statement. A health care market in which performance measures and price are available to users will increase cost awareness, improve quality, and raise the confidence of consumers making health care decisions, they add.

The CFP initiative involves 28 large employers that pay for health care coverage for about 2 million employees and their dependents. The employer group is currently working with Humana, in Lexington, Ky., and

CFP Initiative Participants

The care focused purchasing initiative announced in March by Mercer Human Resource Consulting consists of 28 employers and two health plans. Humana and Empire BlueCross BlueShield. To date, 18 employers have agreed to be identified publicly:

- Adecco
- Analog Devices Inc.
- Assurant (formerly Fortis Inc.)
- BellSouth Corporation
- Capital One Financial Corporation
- Corning Incorporated
- Edward Jones
- Hannaford Brothers Company
- J. C. Penney Company Inc.
- Lowe's Companies Inc.
- Marsh & McLennan Companies Inc.
- Morgan Stanley
- The Pepsi Bottling Group Inc.
- Sears, Roebuck and Co.
- Sprint Corporation
- Texas Instruments Incorporated
- VNU Inc.
- Xerox Corporation

Empire BlueCross BlueShield, in New York, to develop a list of activities for the next 12 months as part of a three- to five-year plan. In the next 12 months, they plan to use existing data sources to develop standardized performance measures of quality and efficiency for hospitals and physicians. The employers also want to unlock the hidden value of databases that employers, insurers, and the government maintain by combining them to produce detailed information needed to measure quality and efficiency among hospitals and physicians without compromising patient privacy, they say.

What's more, the employers believe they should share with employees performance information in provider scorecards on physicians and hospitals to help consumers make more informed decisions. They also want to contribute to efforts to create a market demand for open and accessible information about hospital and physician performance.

"We think the current approach to purchasing employer health care benefits is not effective in delivering quality care consistently at an affordable price," says Sharon C. Leight, benefits director at J. C. Penney Co.,

a member of the group. "Increasing costs that don't result in improved quality and more consistent outcomes impacts our business success and the compensation available for our employees."

Under the current health care system, employers and employees do not have the information they need to make informed decisions about the best providers, adds E. J. Holland, Jr., vice president of compensation, benefits, labor, and employee relations at Sprint Corp., another company involved in the initiative. "Employers have to join together to encourage the market to change," he says.

The employers believe that by using common quality and efficiency measures to evaluate hospitals and physicians, they will accelerate the development of a new health care market in which they will be able to educate employees about how to seek information about quality and efficiency and how to make consumer-based purchasing decisions. Having such measures also will allow them to adopt plan designs that provide the financial incentives to consumers to make smart choices about treatment options and providers, the employers say. They also plan to pool their pur-

chasing power and direct it toward best-in-class health plans, physicians, and other providers.

Clinical performance measures from such sources as the National Quality Forum, the National Committee for Quality Assurance, and the Joint Commission on Accreditation of Healthcare Organizations will be integrated into the employers' initiative, says Arnold Milstein, MD, who has been advising the employers in this effort.

Reforming the Market

It is significant that the employers are working with health plans to develop a new approach to purchasing care. "We support efforts to develop standardized provider performance measures," says Michael A. Stocker, president and CEO of Empire BlueCross BlueShield. "This initiative is consistent with Empire's vision to use available information to support our customers' needs."

David Rahill, a Mercer consultant who is acting as project leader, says, "The participation of a number of health plans is an early sign of the leadership of this group and the interest of many parties to solve the health care dilemma of rising cost and inconsistent quality. This group of employers is committed to thinking about health care differently and using their combined market presence to create positive change."

From all indications, health plans and employers are moving toward a market-driven solution to some of the thorny problems that plague the current health care system. In addition, the federal government has made HSAs available to a great number of Americans. Now those who believe the free enterprise can work in health care have to hope that these steps are sufficient to fend off the inevitable calls for universal, government-provided care.

—More information on physician practice strategies is on our Web site (see page 16).

OIG Warns Boutique Practices on Fees

Physicians could be fined or excluded from Medicare if they treat and charge Medicare patients additional fees for “boutique” care, says the Office of Inspector General of the federal Department of Health and Human Services.

Acting Principal Deputy Inspector General Dara Corrigan said in an OIG Alert in March that physicians participating in Medicare face potential liabilities for billing Medicare patients for services already covered by Medicare. A physician violated his agreement with Medicare when he presented to his patients—including those who participate in Medicare—a “Personal Health Care Medical Care Contract” asking them to pay an annual fee of \$600, the OIG says. Physicians have used such retainer agreements in so-called boutique or concierge practices.

While the physician characterized the services to be provided under the contract as “not covered” by Medicare, the OIG alleged that at least some of these contracted services were already covered and reimbursable by Medicare. Among other services offered under this contract were the “coordination of care with other providers,” “a comprehensive assessment and plan for optimum health,” and “extra time” spent on patient care, the OIG says in its alert.

Seeking a Settlement

OIG alleged that each contract presented to this physician’s Medicare patients constituted a request for payment for already covered services, other than the coinsurance and deductible, and was therefore a viola-

tion of the physician’s Medicare agreement. The physician agreed to pay a settlement to OIG and to stop offering such contracts to Medicare patients, the alert says.

“If participating physicians decide they want to charge patients additional fees, they should be mindful that they are subject to civil penalties if they request any payment for already covered services from Medicare patients other than the applicable deductible and coinsurance,” Corrigan said.

Physicians participating in Medicare can charge Medicare beneficiaries extra for items and services that are not covered by Medicare, the OIG Alert points out. And participating providers may charge beneficiaries for any Medicare deductibles and coinsurance without violating the terms of their assignment agreements, according to the OIG. But when participating providers request any other payment for covered services from Medicare patients, they are liable for substantial penalties and exclusion from Medicare and other federal health care programs, according to the alert.

Donald K. Bruce, MD, who is developing a network of physicians to be paid based on a retainer fee arrangement, says the OIG is correct to remind physicians that charging for covered benefits is a violation of Medicare rules and that retainer medical models vary considerably in the scope of services offered. Bruce is the CEO of MD Information Services (at www.md-is.com), a medical software development company in Pacific Grove, Calif.

Need for Change

The development of retainer-fee models and boutique practices shows that there is widespread discontent among patients and physicians regarding various aspects of the quality and efficiency of the current delivery system, Bruce explains.

“Clearly, the federal government, with its emphasis on allowing the free market to deliver in the marketplace, does not want to be in the business of constraining entrepreneurs who seek to serve the needs of consumers with innovative solutions and better service,” Bruce says. “The ever-increasing complexity of medicine in the hands of well-intended and hard-working clinicians using disorganized paper charts, indecipherable notations, and personal memory on side effects is a prescription for disaster. The market can solve these issues.”

This year, MDiS is launching a retainer model service based on delivering the information systems needed for physicians in internal medicine to practice evidenced-based outpatient medical care. By giving the physicians the electronic medical record and supportive software they need, MDiS hopes to reduce errors and increase convenience to patients.

The AMA says distinguishing what is covered and is not covered under the Medicare program is difficult. Therefore, when physicians sign contracts with patients, they should separate special and “reimbursable” services, the AMA advises.

—Reported and written by editor Joseph Burns. More information on physician practice strategies is on our Web site (see page 16).

Physicians who charge patients additional fees could face civil penalties for requesting payment from Medicare beneficiaries.

'Retainer' Model Plan Needs IT, Evidence-Based Support, Says Physician



Donald K. Bruce, MD, is CEO of MD Information Services (at www.md-is.com), a medical software development company in Pacific Grove, Calif. An

internist, Bruce opened an urgent care center outside Boston that evolved into a primary care network of nine clinical locations and a 33-member internal medicine group practice. After the network was sold to the Partners Community Healthcare Network in Boston, Bruce served as an executive director of the network. In 1998, he moved to California and started MD Information Services. In this interview, he discusses retainer-model plans with Editor in chief Richard L. Reece, MD.

Q: What was your goal in starting MD Information Services?

A: As the leader of a large primary care and urgent care practice, it was disconcerting to me that many of the finest physicians in the clinic were, from a purely economic perspective, failing in the practice. As a result of managed care and other reimbursement pressures, these excellent physicians had to face pay cuts and other negative feedback about their performance. Some of the best physicians in the practice had long waiting lists and fiercely loyal patients and yet they could not succeed financially. The disconnect between clinical excellence and business "failure" resonated with me. I

wanted to build a different model of primary care in which excellent clinicians are the ones who are rewarded.

Q: What do you believe is needed in a new model of patient care?

A: One system that seems to work is "retainer medicine," a term coined by the AMA. Under this model, physicians are paid a retainer just as other professionals are paid and they provide services and add value to the service model by offering noncovered benefits to the consumer. Although this form of practice is not yet very widespread, the retainer fee is attractive because it allows medical practices to redefine the value proposition between physicians and patients.

Physicians should be able to deliver to most patients the kind of service they deserve in the context of the information technology infrastructure that makes their care more effective, more efficient, and more convenient. Health care providers must move beyond the idea that the only solutions we can create are those that third-party insurers and the government think are valuable.

Patients can identify value when they see it, and the old-fashioned notion of delivering value for dollars is still valid. It's the consumer—not the large insurers or government programs—who needs to make that choice based on his or her own value and price decisions. A retainer model in which patients pay a set fee of, say,

\$25 or more per patient per month is based much more on a traditional market-based system than one in which a third party pays for most of the care and the consumer pays only a fraction of the cost.

Q: Once physicians are collecting a fee from patients, what else do they need to succeed?

A: Any new model of care must be information technology focused and use an evidence-based medical practice approach that allows physicians to increase their revenue and reduce their patient load while at the same time developing a patient-focused practice. In other words, physicians need information systems, clinical software, and support to make a new model successful. We also believe physicians will need advertising and training because the retainer model is a much different approach than traditional medicine.

Therefore, to be successful, the health care system needs to solve two issues. The first issue is the severe shortage of superior service to patients due to a lack of adequate time with physicians, a lack of adequate feedback, and a lack of thorough communication. The second issue is the physician's need to secure an income that will enable him or her to practice profitably. It is possible to deliver high-quality, evidenced-based medical care in an outpatient clinical environment while allowing both the patient and the

(Continued on page 14)

"Health care providers must move beyond the idea that the only solutions we can create are those that third-party insurers and the government think are valuable."

(Continued from page 13)

physician the time needed to conduct their affairs in a civilized and thoughtful fashion.

To solve these two core problems, physicians need an efficient information system and they need a reimbursement model that pays them adequately and quickly without the need for a lot of paperwork. First, let's address the information system issues. One of the most cost-effective information systems is a Web-based interface to an electronic medical record. Such an interface allows the patient and the physician to have a comprehensive messaging and management console that they can use to manage the relationship and facilitate care. It is not meant to replace the personal relationship, but rather to enhance it. For example, a patient could log on to a secure and personal Web server to review his or her personal information, care plan, reminders, health calendar, and test results. Additionally, the patient could authorize family members to conduct business on his or her behalf and allow children who live remotely to participate in the care of a parent.

The reimbursement issue can be resolved through a retainer-based financing model. Patients can pay a modest annual subscription fee, and the price may range from \$25 to \$60 per patient per month. In addition, physicians can be financially rewarded for superior customer service and clinical quality. The physicians receive the majority of the subscription fee for participating in the information management system, and they could get significantly more when the consumer satisfaction and other scores exceed certain thresholds.

In addition to the information sys-

tems and the streamlined reimbursement, new models of health care delivery also must guarantee patients same-day access to care and at least a half-hour appointment if necessary. By doing so, new models of care will be able to attract patients who are tired of waiting for appointments in traditional systems that are not friendly toward consumers.

Q: *So you believe that it is important to have a consumer-focused approach to care?*

A: Yes. Most innovations are driven by consumer demand. In the absence of consumer-driven initiatives, change can be glacial and often not very appropriate.

Q: *Many experts believe that evidence-based guidelines and clinical reminders need to be embedded in the systems physicians use. Do you agree?*

A: Yes. The current elements of evidence-based medicine that some systems are delivering to physicians include reminders to clinicians about taking specific history and a physical exam as well as indications and contraindications of therapeutic approaches. Physicians should be able to turn on or turn off these reminders depending on their preferences.

In addition, information systems must include a comprehensive set of database triggers that allow physicians to automate messaging, such as reminders for Pap smears, cholesterol testing, liver function testing, and warfarin sodium blood tests. All of these processes are traditionally handled by telephone or by mail or sometimes, unfortunately, not at all. These reminders should be automated so that physicians can count on the fact that the patient will receive appropriate testing on a regular basis.

Q: *A recent report from the Rand Corp. indicates that patients received appropriate care only about 55% of the time.*

A: That's a disturbing statistic, and it is a manifestation of the complexity of the typical 11-minute patient-physician encounter during which so many issues need to be managed—economic issues, health plan issues, complex emotional issues as well as the physical issues the patient is facing. As a result of constraints on visit time, preventive care processes are being jeopardized, and in fact are being squeezed out.

High-quality care depends on mandating that physicians adopt information technology and other process tools so that appropriate care can be automatically offered to each patient. Given the trends and complexities of care, which will not get any simpler, I believe that trying to manage patients in the absence of an information technology infrastructure will be tantamount to malpractice in the next decade.

Q: *One criticism of electronic medical record systems is that they address mostly back-office issues but are not clinically relevant. Is clinical relevance growing among EMRs?*

A: Definitely. EMR vendors have been trying to make a financial case for their products by addressing back-office inefficiency. Most of them have done a pretty good job. Now, the next agenda involves bringing clinical reminders and guidelines into the process at the point of care.

For EMRs to be one of the primary solutions for providing quality care, the business design surrounding information technology must be in place.

“High-quality care depends on mandating that physicians adopt information technology and other process tools so that appropriate care can be automatically offered to each patient.”

“A small cadre of physicians is ready today to make substantial changes in how they practice. The level of emotional stress is high enough that they are willing to step forward and take a chance.”

If physicians are driven to treat 30 to 35 patients a day because the economics of the practice environment require volume for financial viability, it will be difficult for them to use an EMR fully. They can certainly use a “bare bones” system, but to leverage that tool with maximum benefit to patient care, physicians need adequate time and resources to dedicate themselves to that process. So, an EMR is a central component, but not the only component, to that solution.

Q: *Are doctors ready to implement information technology more fully within their practices?*

A: The idea that physicians are techno-phobic is very much overstated. About 95% of physicians access the Internet for personal use. So they understand how to use a computer and how to use a browser. But it doesn't make sense for them to use their computer when the only thing they are paid for is running from room to room 10 hours a day. They do not see the validity of an information technology solution because it slows them down. We need to find an economic model that brings physicians to the desktop for one of their fundamental functions, which is coordination and management of patient care.

Q: *Do you believe that models such as the one you describe will bring stability to the primary care profession?*

A: In the absence of other solutions, new models of care are

going to give us a pathway to change. If nothing changes, the number of primary care physicians in many regions of the country will either decline or become nonexistent over the next decade. The exodus of primary care physicians due to the erosion of their quality of life and income has become significant, particularly here in California. Patients will suffer if they can go only to specialists or clinic services for the kind of compassion and understanding that primary care physicians attempt to deliver.

Surveys suggest that many primary care physicians over age 50 are considering a change of profession or early retirement as options over the following three or four years. They also show that some physicians would not recommend their profession to their own children. Those statistics highlight the level of disenchantment and professional dissatisfaction that is present in many markets. This dissatisfaction is probably fairly prominent in many other urban communities, where primary care is suffering as the cost of living escalates. It also exists in rural areas where older physicians are retiring, new physicians are not opening practices, and existing physicians are simply overwhelmed.

Q: *Does it concern you that older patients have fewer choices as physicians leave the Medicare program?*

A: Absolutely. New models of care must be suitable to those

who are over age 50 because older people face chronic conditions of a complex nature. Physicians need to spend an incredible amount of time with these patients to understand the issues, deal with families, and prescribe medications safely and appropriately. Family practitioners who require high patient volumes for financial success drop Medicare patients because those patients take an enormous amount of time, attention, and focus. The predominant reimbursement scheme prompts a volume agenda in most practices. But, in general, the elderly have the most expendable cash and have the most vested interest in finding a physician to spend the time and attention they need to live a more fruitful life.

Q: *How much time do you think it will take to implement such a new model broadly across many states?*

A: A small cadre of physicians is ready today to make substantial changes in how they practice. The level of emotional stress is high enough that they are willing to step forward and take a chance. Physicians are ready to make changes in the way they provide care and in the way they are paid, and patients are looking for new forms of care as well. I believe we will see dramatic changes over the next 12 to 36 months.

—Edited by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

“New models of care are going to give us a pathway to change. If nothing changes, the number of PCPs in many regions of the country will decline.”

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