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EDITORIAL

Liability Concerns Lead to Defensive Practices 2

STRATEGY

Following Patients at High Risk 3

PRACTICE MANAGEMENT

Consider Re-Engineering Your Office 6

Liability Concerns Lead to Defensive Practices

Recent survey results document that physicians practice defensive medicine in an effort to prevent malpractice suits. Among 824 physicians surveyed in Pennsylvania in 2003, 93% said they sometimes or often practice defensive medicine because of malpractice worries. Practicing defensive medicine may include an extensive workup involving diagnostic testing, prescribing medicine, or performing procedures to minimize chances of patients suing for negligence.

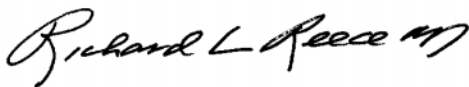
The researchers said they were surprised by the widespread use of the practice. But in fact, such a high percentage should be expected for two reasons. First, physicians want to ensure that they are doing all they can to make a proper diagnosis and treat each patient's condition properly. Therefore, many physicians tend to err on the side of caution on behalf of their patients. And, second, physicians have learned that in the current litigious climate, it is easier to defend against a test that was done than it is to defend against one that was not done.

In 1996, Mark McClelland, MD, PhD, administrator of the Centers for Medicare & Medicaid Services, said malpractice reform could decrease medical expenditures by 5% to 9%. If reform is able to reduce the number of lawsuits, it might also decrease the number of tests done in doctors' offices, the unnecessary antibiotics prescribed for viral illnesses, the number of Caesarean sections performed, or the use of CT scans and MRIs.

But what can be done until significant reform occurs? Neil Baum, MD, a urologist in New Orleans, says warding off malpractice suits is often a matter of being able to spot potentially troublesome patients. Physicians should be wary of patients who have complex problems, who have seen numerous other doctors, and who complain about past treatment, he says. Physicians should make sure these patients understand what you are saying by carefully spelling out potential complications and having them repeat what you have said, he advises. He also says physicians should take meticulous notes and always have patients sign informed consent forms.

The use of electronic medical records in physician offices to appropriately document patient histories and clinical findings may help improve patient-doctor communication. Allen Wenner, MD, an expert in electronic patient records and a family physician in Columbia, S.C., says a patient-generated history could help to eliminate malpractice suits because it would capture the patient's history in their own words.

The practice of defensive medicine represents a convergence of three factors in American medicine: the relentless rise of medical costs, a lack of electronic medical records in physicians' offices, and the lack of effective malpractice reform.



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Following Patients at High Risk

Most gastroenterologists are familiar with colorectal cancer screening guidelines for average risk individuals, but patients with associated conditions that put them at high risk are less common. Individuals at high risk for colorectal cancer include those with familial adenomatous polyposis (FAP), hereditary nonpolyposis colorectal cancer (HNPCC), or a personal history of chronic inflammatory bowel disease (IBD) over a long time. While these individuals represent a relatively small percentage of colorectal cancer cases, they have a much greater risk of developing colorectal cancer. Therefore, gastroenterologists must monitor these patients very closely to ensure optimal outcomes.

Almost 100% of patients with a family history of FAP, a genetic condition affecting one in 10,000 individuals, will develop colorectal cancer. Patients with FAP develop hundreds of polyps; the polyp burden varies among FAP families and even among members of the same family. "In the classic FAP syndrome, patients develop more than 100 pre-cancerous polyps," notes Douglas Rex, MD, professor of medicine at the Indiana University School of Medicine and director of endoscopy at Indiana University Hospital in Indianapolis. Rex is the recent past-president of the American College of Gastroenterology. "Attenuated FAP, caused by mutations in the same gene, is harder to recognize," he adds. "Patients develop fewer polyps—between 20 and 100. Furthermore, attenuated FAP patients usually develop colorectal

cancer about 10-15 years later than classic FAP patients."

The American Cancer Society (ACS) recommends that patients with a family history of FAP receive counseling to consider genetic testing. "It is very important that the patient visit a genetic counselor prior to testing," Rex asserts. "Gene testing is best done in the context of counseling and informed consent, but unfortunately, this frequently does not occur." The ACS recommends early surveillance with endoscopy, but sigmoidoscopy or colonoscopy may be indicated depending on the patient's circumstances.

"If the family is characterized by having hundreds or thousands of polyps, colonoscopy is usually not required; the polyp burden can be characterized using endoscopy or sigmoidoscopy," Rex says. "Also, screening of classic FAP patients is typically done with sigmoidoscopy, but in attenuated FAP, full colonoscopy is warranted to determine the polyp burden because the polyps are fewer and may be located only in the right (proximal) colon."

An individual in whom genetic testing has confirmed the presence of the FAP-causing mutation should undergo a full colonoscopy at puberty or as soon as FAP is diagnosed, whichever comes first, Rex explains. "Subsequently, a gastroenterologist should perform an annual sigmoidoscopy or colonoscopy, depending on the expected polyp burden," he adds.

If the polyp burden is large, colectomy is indicated, Rex continues. Otherwise, it is common to delay

colectomy, especially in teenagers.

If a family has undergone genetic testing, no mutation has been identified, and the individual is polyp-free by age 40, it is likely that person is not affected by FAP. "In this case, I would examine the patient in a few years with sigmoidoscopy, and then, if normal, suggest more infrequent screening according to average-risk guidelines," says Rex. "However, if attenuated FAP is suspected, frequent screening should continue in case the polyp burden has simply not yet appeared."

Screening and Therapy

If genetic testing is inconclusive or has not been done, but FAP is present in the family, the gastroenterologist should assume that all potentially affected relatives will be affected and should receive annual sigmoidoscopy or colonoscopy until they reach an age when they have proven to be no longer at risk, Rex says.

Medical therapy may be prescribed in an attempt to decrease the number or size of the polyps, but its effectiveness varies among patients, Rex notes. "Some patients have a dramatic response, while others will not respond at all," he explains. "But even in cases of dramatic response, a patient must still undergo regular screening, because reduction in the number and size of polyps does not necessarily imply a corresponding reduction in cancer risk." In an attempt to suppress the rectal polyp burden or for whom a total colectomy is delayed, medical therapy is reasonable to consider in patients for whom an abdominal colectomy is performed, he says. "But ultimately,

The American Cancer Society (ACS) recommends that patients with a family history of FAP receive counseling to consider genetic testing.

(Continued on page 4)

(Continued from page 3)

medical therapy is not a substitute for colectomy.”

After polyps are discovered, the timing of colectomy depends on the number and size of polyps and other patient circumstances, such as age, Rex continues. The standard treatment is total colectomy. “But an abdominal or subtotal colectomy, in which the rectum is spared, is appropriate in certain circumstances, since the morbidity of an abdominal colectomy is lower,” Rex says.

FAP patients are at higher risk of developing certain other cancers as well, particularly cancer of the duodenum. “The upper GI tract should be screened for duodenal polyps that can arise around the pancreas,” says Stephen B. Hanauer, MD, professor of medicine and clinical pharmacology director of the section of gastroenterology and nutrition at the University of Chicago Medical Center, and chairman of the Section of Clinical Practice at the American Gastroenterological Association.

The duodenum is examined with upper endoscopy; screening frequency depends on initial findings. “Gastroenterologists typically examine the duodenum with a forward-viewing scope, but if the papilla is not well viewed, then it should be examined with a side-viewing scope also,” Rex explains. “If all is normal, then repeat screening every 2 to 3 years is appropriate. However, patients with many duodenal adenomas require aggressive endoscopic therapy followed by annual surveillance.”

A second complication is the development of desmoid tumors, often located in the abdomen. These

tumors are benign but they can be locally invasive and can cause mechanical problems that can be fatal. Finally, Rex notes that FAP patients are also at increased risk of thyroid cancer, so thorough annual examination of the thyroid is indicated.

Monitoring HNPCC

Like FAP, HNPCC is a genetic condition, but multiple polyps do not form. About 85% to 90% of HNPCC gene carriers develop colon cancer. According to the ACS, gene carriers should receive colonoscopy beginning at age 21 and counseling to consider genetic testing. If the genetic test is positive or if the patient has not had genetic testing, colonoscopy should be repeated every 1 to 2 years until age 40 and then annually thereafter.

While HNPCC can be definitively diagnosed through genetic testing, gastroenterologists must first recognize the condition in a family based on clinical presentation, which is complicated because there is no set of criteria that is sensitive and specific for defining an HNPCC family, Rex notes. “Gastroenterologists tend to use a set of criteria called the modified Amsterdam criteria,” he says. “Families that meet those criteria, and even those that approach those criteria, should be considered for a possible diagnosis of HNPCC.”

When HNPCC is suspected, the patient can proceed to genetic testing after being counseled. Alternatively, it is possible to initially screen the proband’s tumor via microsatellite instability testing or immunostaining for gene products before proceeding

with genetic testing.

Patients with HNPCC-associated colon cancer present differently than those with other colon cancers. “Unlike in FAP or in sporadic colon cancers, polyps in patients with HNPCC are more likely to be located in the proximal colon, although they can also arise in the left colon,” Rex explains. Also, tumors tend to progress through the adenoma-to-carcinoma sequence faster than sporadic or FAP-associated tumors, making frequent screening a requirement. Furthermore, metachronous cancerous polyps are more likely to develop, and they are likely to develop in different locations in the colon than the original polyps.

“When screening patients with HNPCC, gastroenterologists should be aware of where the polyps occurred in the family member, because the patient is at greatest risk of developing polyps in that same region,” Hanauer adds.

When advanced polyps or cancer are found, abdominal colectomy is usually indicated. “Usually the rectum is left in place, and patients are screened annually via sigmoidoscopy,” Rex says. “Rather than removing only the segment in which the cancer is found, as is typically done with sporadic cancers, the surgeon should remove the colon all the way down to the rectum.”

Prophylactic colectomy is considered in patients who are known HNPCC gene carriers. “But it is also quite reasonable to undergo annual colonoscopy and pursue colectomy after polyps develop,” Rex says. “The goal is to properly evaluate the patient and inform the patient about the risks and options.”

Prophylactic colectomy is a consideration in other situations as well. “For example, a female HNPCC gene carrier is at a very high risk of developing both colorectal cancer and uterine cancer,” Rex explains. “A woman with HNPCC who is no longer interested in bearing children might elect

“About 85% to 90% of HNPCC gene carriers develop colon cancer and gene carriers should receive colonoscopy beginning at age 21 and counseling to consider genetic testing,” the ACS says.

to undergo a prophylactic abdominal colectomy and a prophylactic hysterectomy at the same time.”

Female HNPCC patients are also at risk for developing ovarian cancer and should consider undergoing CA-125 blood testing or transvaginal ultrasound every six months. Other cancer risks for both men and women include cancers in the small intestine, ureters, and renal pelvis.

Patient Management

IBD, including ulcerative colitis and Crohn's disease, is another condition that increases colorectal cancer risk. But determining the percentage of patients with IBD who develop colon cancer is somewhat controversial.

“Studies using population-based registries suggest that, on average, an ulcerative colitis patient's risk of developing colorectal cancer is not greater than that of the general population,” Rex says. “But other data from referral centers suggests that the risk is dramatically higher.” The risk also depends on how many years the patient has had the disease; how much of their colon is involved; and whether the patient also has a family history of colorectal cancer or suffers from primary sclerosing colangitis (PSC), a liver disorder, he adds.

Under ACS guidelines, in patients with IBD affecting a significant extent of the colon and rectum, cancer risk begins to escalate eight years after the onset of panulcerative colitis or 12 to 15 years after the onset of left-sided colitis. Colonoscopy with biopsies for dysplasia should begin following the onset of symptoms and should be repeated every 1 to 2 years thereafter. Rex adds, however, that PSC patients should begin screening immediately upon diagnosis; similarly, screening might begin earlier in patients with a family history of colorectal cancer.

Hanauer emphasizes that it is important that both polyps and normal-looking tissue of the colon lining be tested. “In most high-risk popula-

Studies show that high-magnification chromoendoscopy performed during colonoscopy can guide gastroenterologists in gathering tissue samples in areas likely to have dysplasia, Rex says.

tions, gastroenterologists are mainly looking for polyps when they perform colonoscopy,” says Hanauer. “However, in patients with inflammatory bowel disease, pre-cancerous lesions can arise in either polypoid tissue or in the flat lining of the colon. Therefore, the colorectal cancer screening and surveillance of those individuals is unique in that gastroenterologists must biopsy normal-appearing mucosa as well as any polyps that are found.

Vigilance Recommended

Rex adds that gastroenterologists should be vigilant regarding strictures in IBD patients, particularly symptomatic strictures, as well as ulcerations in the colon that can look relatively benign but may be cancerous. Typically, four quadrant biopsies are taken every 10 centimeters to yield a total of 30 to 35 biopsy samples from several sections of the colon, he says. “A biopsy showing dysplasia in flat mucosa should be reviewed by an expert pathologist who is familiar with reading dysplasia in IBD,” Rex asserts. “A confirmed reading of high-grade dysplasia or multi-focal low-grade dysplasia signals the need for colectomy. Some gastroenterologists believe that a patient with confirmed unifocal low-grade dysplasia (present in only one biopsy specimen) also requires colectomy, but I personally believe that those patients may reasonably continue in a regular surveillance program.”

Rex adds that studies of ulcerative colitis show that high-magnification chromoendoscopy performed during colonoscopy can guide gastroenterologists in gathering tissue samples in

areas more likely to have dysplasia. This test can generate a higher yield of affected tissue than random biopsies every 10 centimeters, especially in a colon with heavy scarring and “cobblestoning,” he says. “There is a fair chance that this will be the first indication for which chromoendoscopy will emerge as an important practice tool,” he explains.

When polyps are found, the patient with IBD may be continued in surveillance if the polyps are not IBD-related, Rex says. “Polyps that arise simply due to the patient's age—sporadic adenomas or adenoma-like masses (ALMs)—are quite common, and many experts believe that they can be removed and the patient can continue with a surveillance colonoscopy program.” On the other hand, a smaller group of polyps displayed associated lesions or masses (DALMs) arise as a result of the presence of ulcerative colitis. “The presence of a DALM is considered an indication for colectomy,” Rex states, adding that gastroenterologists use a distinct set of criteria for distinguishing ALMs from DALMs. Patients with IBD are at risk of developing other cancers as well, including lymphoma and small bowel cancers.

—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 8). Also, *The American Cancer Society guidelines for screening individuals at high and increased risk of colorectal cancer, including a one-page summary table, was published most recently in the January/February 2001 issue of CA: A Cancer Journal For Clinicians; guidelines are available at <http://caonline.amcancersoc.org>.*

Consider Re-Engineering Your Office

By Neil Baum, MD

It's 9:55 am, and you are 25 minutes late for your first patient. Your nurse tells you the patient must be seen as soon as possible. A referring doctor is on the telephone waiting to discuss a patient he wants to send you. For your first patient, the result of the CT scan you ordered last week is not in the chart. Upon entering the exam room of your next patient, you address the patient as Mr. Jones, and he tells you he is Mr. Smith!

These are probably situations that have happened to each and every physician more frequently than they would like to admit. Yet most of these circumstances can be avoided.

We all know the difference between a well-run office and an office going from one crisis to the next. When the latter occurs, there is less personal satisfaction with the practice of medicine, staff gets burned out, and patient satisfaction deteriorates.

So if you are feeling overwhelmed, overworked, and underappreciated, then you may want to consider re-engineering your practice. Here are some practical ideas that will help you fine-tune your practice without a major overhaul and without increasing your already bulging overhead expenses.

Looking Inward

I suggest that we all do some introspection. Many of us, me included, are in a funk about the significant loss of income from the administration of medications. If we come to

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Take Charge of Your Practice

Practice management expert and author, Michael Gerber writes in his highly recommended book, *The E-Myth Physician: Why Most Medical Practices Don't Work and What to Do About It*, (HarperCollins Publishers, New York, 2003) that physicians need to stop working in our practices and begin working on our practices. "All physicians are being pulled in so many different directions that we tend to spend most of our time being run by our practices rather than being in control of them. Because we are so busy and suffer from time constraints, we often feel that it is impossible to stop and take an objective look at what is happening in our practices. It is then that we need to give our office protocols, processes, and procedures, a check up.

One of the best ways to accomplish this check up is to ask patients what they think of our practice and the services we provide them. I survey every patient on every office visit with a brief questionnaire. This simple 5-question form allows me to get a daily pulse on my practice. The patients simply check "yes" or "no" on the form and a nurse or office manager addresses all positive and negative comments every day.

Here are the questions:

- Was it easy for you to get an appointment in this office?
- Is your general impression of this office favorable?
- Was the office staff friendly and concerned?
- Did the doctor adequately answer your questions?
- Would you recommend this office to someone else?

I also leave space for and ask if the patient wants to add any other additional comments.

In addition, I ask each patient upon entering the office what three questions he or she would like answered during the visit. A nurse gives the patient a form with space to provide three separate problems to address and the form says, "What three questions would you like answered today."

Invariably, I find out about problems that I can address that I might not have learned about otherwise.

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the office and are grumpy or distracted, we pass this attitude along to our staff who in turn pass it on to our patients. Let us not forget that we set the tone. Attitudes are contagious. We want to be sure that ours are worth catching!

Many doctors are resistant to making changes and adjustments in the processes or procedures that we have

used for so many years. Remember you can't continue to repeat past performances and hope to achieve new results. Re-engineering your practice means taking a leap of faith. You have to rid yourself of that hurried, rushed, distracted behavior that results in loss of enjoyment and burnout that so many of us are experiencing.

Physicians interested in taking re-

engineering to the next level, should consider the practice management workshops offered by medical specialty associations and state societies. A few years ago, I attended a seminar that focused on accurate coding and reimbursement, overhead reduction,

and practice efficiency. From this one seminar, I found dozens of ideas for improving my practice. Also, these seminars are an opportunity to share ideas with other physicians.

By being proactive and making an effort to control your practice instead

of being a slave to the practice, you can have a practice that is enjoyable, emotionally rewarding, profitable, and a practice that makes you proud.

—More information on physician practice strategies is available on our Web site (see page 8).

Steps to Take to Improve Scheduling

Scheduling problems can have a tsunami effect on your practice, or at least on the tone of your day. Physicians should establish protocols for staff to follow when scheduling patients. For example, look at your procedures for scheduling new patients. Are these new patients given the same 15-minute time slots that are allotted to an established patient? We all know that a new patient requires more time than most established patients. A re-engineered practice will designate certain times such as first appointment of the day when the doctor is fresh and hopefully less distracted or right after lunch.

One way to improve scheduling and to make sure that you maintain a good attitude is to be prepared for each day. Doing so usually means arriving early. Many physicians believe they can't get to the office any earlier. If that is the case, then your schedule needs to change. You may have to start earlier in the morning, or schedule patients later. If you are late coming from the hospital, you may convey an attitude of being overworked or rushed. If you start late, you can be sure you will never be able to play catch up even if you work through your lunch hour (also, not a very healthy example to set for staff and patients).

I suggest physicians build a cushion of 15 to 20 minutes before the start of each day to review charts or EMRs for patients you will see that morning. Leave notes for staff to be certain all reports are on the record or the chart, that equipment you will need for office procedures is ready when the patient arrives, and that special needs of certain patients, such as a wheel chair, are in place. Such simple planning will make your staff more efficient and will improve your processes of care, ultimately leading to increased patient satisfaction and better outcomes.

Making it easier for patients to schedule medical appointments and reducing waits in physicians' offices are the driving principles behind an approach to office practice called open access or advanced access, according to the Institute for Healthcare Improvement, in Cambridge, Mass. IHI (at www.ihl.org) has more information about innovative approaches to scheduling that are helping to improve care and patient satisfaction.

Through IHI, the five-physician Western Colorado Physicians Group in Grand Junction learned about open-access scheduling, sometimes called advanced access. Developed by Mark Murray, MD, and Catherine Tantau, RN, practice consultants in Sacramento, Calif., open access is designed to smooth out each day's schedule, give patients better and more timely access, and reduce the rate of no-shows. Gregg Omura, MD, a family physician in the group, was attracted to the idea of increasing efficiency and meeting patients' needs in a more timely manner. So, he decided to try open access with his patients.

Open access uses advanced queuing theory to reengineer the standard appointment scheduling system, leaving the majority of the slots on a given day open for patients who call that day. "Demand is relatively consistent, and the day fills like a glass, from the morning up, not piecemeal," says Omura. It's a rare day that doesn't fill, he says, but when that happens, he's glad to have the empty slots at the end of the day when he is tired, not at the beginning or scattered throughout. And for patients, the benefit is obvious. "Every patient can get in within an hour or so of when he or she calls," he adds.

Developing open access involves some short-term pain for long-term gain, namely working down the current backlog of patients. This is generally done by temporarily adding extra slots and working longer hours, or adding more staff.

Among the benefits of open-access scheduling are that both telephone access and staff availability improve because the need to triage patients over the phone, or "tease out information" as Omura puts it, is eliminated, as well as the sometimes lengthy negotiations involved in making appointments. Patients' use of urgent or emergency care settings also decreases.

Omura's foray into open access proved so successful that other physicians in the office use open-access scheduling today and one continues to use a standard approach to scheduling. Omura often sees his partners' overflow patients, since his schedule is more open than theirs.

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