

DIABETES PRACTICE OPTIONS™

Improving Patient Care Through Increased Practice Efficiency

DECEMBER 2009

CONTRIBUTING FACULTY



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INNOVATIONS

New Technologies Unveiled To Reduce Costs, Improve Access

By Richard L. Reece, MD, editor-in-chief

Earlier this year, General Electric Co. unveiled a new handheld ultrasound machine, the Vscan. The device resembles a cellular telephone and has been called the “stethoscope of the 21st century.” Portable ultrasound enables primary care and other physicians to diagnose a wide array of serious conditions and guide procedures at the point of care. While office-based ultrasound may not be the newest idea, a handheld device that does what much larger machines have done is a good example of how a new technology may radically change the practice of medicine.

The Cleveland Clinic (www.clevelandclinic.org) hosts an annual Innovations Summit for experts in medicine and technology to review the latest advances and medical devices. Each year, the top ten up-and-coming innovations for the following year are listed on the clinic’s Web site along with a “where are they now” list of past picks. This year’s list holds some promising new innovations.

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Take, for instance, the number two item on the list: a low-volume, low-pressure tracheal tube cuff to reduce ventilator-associated pneumonia. Pneumonia has a high incidence among patients in intensive care who need to be mechanically ventilated, often extending patients' length of stay, and is the most frequent cause of ICU-acquired mortality. The new cuff forms an effective airway seal, eliminating the accumulation of fluid from the throat in the lungs. This pooled fluid is where pneumonia takes root.

Also of note are two new non-vitamin K agonist oral anticoagulants, which have the potential to eliminate the numerous difficulties clinicians find in dealing with warfarin. Both agents have been approved in Europe and Canada. Because they come in



Editor-in-Chief Richard L. Reece, MD

pill form, they could eliminate the need for warfarin injections, enabling patients to administer their own anticoagulants.

For patients with atrial fibrillation, a new device effectively prevents blood from pooling in the left atrial appendage. This pooling can lead to clot formation, increasing the risk of stroke. The small mesh device can be installed through a catheter, and is quickly covered over with natural tissue, which seals the left atrial appendage. This innovation may help minimize the need for warfarin therapy.

These innovations have the potential to provide convenient, less costly care in decentralized settings. They are good news at a time when the issues of health care costs and access to care are on the minds of patients, physicians, and politicians alike. ■

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More information on physician practice strategies is available at www.DiabetesOptions.net



sional practice committee that developed the 2009 *Position Statement on Standards of Care in Diabetes*, which includes a section on older adults.

“Persistent high blood sugar levels can also be associated with alterations in cognition,” Korytkowski adds. “Finally, older adults with diabetes are at risk for complications such as vision changes and impaired sensation due to neuropathy that can affect the ability to

perform activities of daily living.”

While there are no formal screening recommendations for diabetes in older adults, blood glucose testing is warranted in patients who have symptoms or risks associated with diabetes, such as hypertension or other cardiovascular risk factors. “The classic red flags to suggest diabetes include frequent urination, unintentional weight loss, and excessive thirst and hunger,” Durso explains. “In older adults, more subtle red flags include frequent falls, poor wound healing, or the presence of neuropathy, which might be caused by hyperglycemia.” The high incidence of diabetes in older adults means physicians should consider whether undiagnosed diabetes may be causing or exacerbating a patient’s health conditions.

Function Follows Form

Once a physician diagnoses diabetes in an older patient, the question becomes how aggressively to manage the condition. “Overall, treatment recommendations will be highly individualized and

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DIABETES STRATEGY

Assessing Patient Functionality Is Key When Treating Seniors

Age is a risk factor for type 2 diabetes. As pancreatic beta cells become impaired, insulin production decreases with age, while insulin resistance increases as the body loses lean tissue and accumulates body fat. Also, diabetes is associated with or increases the effect of age-related syndromes such as cognitive impairment, depression, pain, urinary incontinence, and injurious falls.

“Diabetes itself can be debilitating if poorly controlled, and furthermore can lead to dangerous macrovascular and microvascular complications,” says Samuel Durso, MD, MBA, AGSF, associate professor of medicine and interim director of the Division of Geriatric Medicine and Gerontology at Johns Hopkins Bayview Medical Center in Baltimore. “Thus, physicians should be alert for the presence of undiagnosed

diabetes in their older populations.” A former member of the American Geriatrics Society (AGS) Panel on Improving Care for Elders with Diabetes, Durso co-wrote the 2003 *AGS Guidelines for Improving the Care of Older Persons with Diabetes Mellitus*.

A Need to Screen

“If diabetes goes untreated, older adults can develop fluid and electrolyte abnormalities, and can become easily dehydrated in part due to an impaired thirst mechanism,” says Mary T. Korytkowski, MD, professor of medicine in the Division of Endocrinology and Metabolism at the University of Pittsburgh Medical Center. Korytkowski served on the American Diabetes Association’s (ADA) profes-

AMONG ADULTS OVER 60, ALMOST 25% HAVE DIABETES

According to estimates from the American Diabetes Association, nearly one-quarter of American adults aged 60 and older have diabetes. In fact, the National Diabetes Information Clearinghouse estimates that seniors account for

more than half of all U.S. diabetes patients. The prevalence of diabetes will certainly grow as the population ages, meaning that diabetes prevention and treatment in older adults will continue to be an important focus for physicians caring for seniors.

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depend on factors including the patient's health status, life expectancy, level of independence, and willingness to comply with treatment regimens," Durso says.

With regard to health status, the senior population is heterogeneous. "Unlike younger adults, seniors can differ widely in functionality," Durso continues. "Some are very ill while others are healthy and active. Therefore, recommendations for diabetes treatment and glycemic targets are highly influenced by the patient's functionality and other circumstances."

An older adult, for example, may have more concerning medical condi-

tions that constitute the major focus of medical care; in contrast, a relatively healthy senior may be willing and able to comply with more detailed nutrition

"Health plans may require us to defend our rationale to accept a moderate glucose control target for an older patient."

—Samuel Durso, MD, Johns Hopkins Bayview Medical Center

and exercise regimens to manage high blood sugar.

"More aggressive management of diabetes may be reasonable in a very robust person, but may not be justified in a patient who suffers from multiple

serious conditions," Durso explains.

Korytkowski agrees, adding, "The glycemic goals as recommended by the ADA suggest modification in the context of other medical conditions, which can limit efforts to achieve tight control."

"In frail, complex patients, physicians may be comfortable with moderate blood sugar control, setting the HbA1C target at 8% instead of 7% or below," Durso adds.

"Geriatricians who treat frail older adults very rarely recommend tight control, because it doesn't seem sensible for this population. However, internists and family doctors who treat younger seniors may find that some of these patients may be

COMPLEXITIES ACCOMPANY MEDICATION PRESCRIPTIONS FOR SENIORS

Medical therapy can be complicated for older patients, who typically take numerous medications for multiple conditions and whose physiology can affect drug absorption and response.

"Many elderly individuals are on multiple medications for conditions other than diabetes, which necessitates careful pharmacologic management due to age related changes in drug metabolism," says Mary T. Korytkowski, MD, professor of medicine in the Division of Endocrinology and Metabolism at the University of Pittsburgh Medical Center. Guidelines recommend that medication therapy should be initiated at the lowest dose and then gradually titrated upward until glycemic targets are achieved.

Cognitive impairment is another important consideration in recommending therapy. "Physicians should formally assess patients for cognitive impairment, which is not always immediately apparent in informal conversations with patients," suggests Samuel Durso, MD, MBA, AGSF, associate professor of medicine and interim director of the Division of Geriatric Medicine and Gerontology at Johns Hopkins Bayview Medical Center in Baltimore. "Physicians can easily miss the fact that a patient's memory is poor or that his or her decision-making is impaired." The AGS guidelines recommend that physicians screen patients initially and periodically for cognitive impairment.

Patients with some degree of cognitive impairment should not be prescribed excessively complicated medication regimens. "The physician must balance the risks and benefits of medical therapy for each patient," Durso adds. "For example, I may forego

aggressive medical therapy if I am more worried about a patient getting low blood sugar, fainting, and breaking a hip than I am about tight blood sugar control."

Insulin accounts for a significant portion of medication-related emergency room visits. "Insulin itself is a relatively dangerous drug," Durso explains. "It can be used safely, but physicians must be careful to select patients for insulin therapy based upon their cognitive ability and visual and motor skills."

Insulin therapy is indicated in many older patients with diabetes, says Korytkowski.

"Although safe use of insulin requires patient education, many older adults are perfectly capable of taking insulin, even more complex basal bolus insulin regimens," Korytkowski notes. "In seniors with failing eyesight who find it difficult to draw up an accurate dose of insulin with a syringe, use of a pen device can help ensure administration of an accurate dose."

For patients with diabetes, it is important to treat hypertension and high cholesterol, conditions that are prevalent in this population, Korytkowski says. "Taking a low-dose aspirin for cardio protection is often recommended in this population," she adds. "We might also recommend vitamin D and vitamin B12 supplementation in cases of deficiency, since absorption of these vitamins decreases as people age."

The safety of oral medications can vary depending on patient circumstances. "Contraindications to therapy tend to be patient-specific," Durso explains.

—DJN

more appropriate candidates for tight blood sugar control.”

Even in patients who are not trying to achieve tight control, managing diabetes is critical to avoiding acute complications such as dehydration and poor wound healing. Some issues related to diabetes management hold true regardless of patient age. “When the diagnosis of type 2 diabetes is made early, it can be easier to achieve and maintain a desirable level of glycemic control,” Korytkowski says. “Management is more challenging when blood sugar levels are significantly elevated at the time of diagnosis. Diabetes management is often easier in people who are physically active and who are willing and able to eat a healthy diet.” But managing diabetes in older adults can be challenging.

Diet and Exercise

Like most experts, Durso recommends healthy eating and physical activity, even for frail elders. But nutritional issues, such as access to healthy foods and the ability to chew, can complicate dietary recommendations. “As people age, they can develop dental problems that can make it difficult to chew high-fiber foods, or they may simply be entrenched in their preferences for foods with a higher fat or sugar content,” he notes.

Exercise also might be difficult for some older patients. “Older people are at a higher risk for falls, may have problems with their knees and lower extremities, and may have reduced muscle strength and balance problems,” Durso continues. “Furthermore, because of a lack of a social network or living circumstances, older people may not be able to exercise easily.”

Risk of Falls

Other medical problems may limit the ability of a person with diabetes to exercise. For these patients, a physician can help design a modified exercise regimen. “Patients with peripheral neuropathy, which causes absent or

reduced sensation in the feet, can be instructed to wear well-fitting diabetic shoes that prevent the development of pressure in areas at risk of ulceration,” says Korytkowski. “For patients who have difficulty walking due to diabetic neuropathy or other conditions, a stationary bike or arm exercises might be good options.”

Physicians may be concerned about glucose control benchmarks set forth by health plans or health systems, Durso comments. “Luckily, the general recommendation that older people require a more relaxed regimen than younger, healthier individuals is gaining recognition,” he says. “However, health plans may require us to defend our rationale to accept a moderate glucose control target for an older patient. Physicians should carefully document their conversations with patients about the relative merits of tight control, the reasons why moderate control is recommended, and justify that reasoning based on the patient’s comorbid conditions and health status.”

Advice for Physicians

Particularly complex patients may require special care. “Physicians might consider referring a patient to a subspecialist in certain circumstances, such as when hospitalization is required,” Durso says. “Diabetes teams in hospitals led by an endocrinologist and nurse practitioners with diabetes expertise can offer optimal management of patients who have poor control.”

In the outpatient setting, one often underused resource is the diabetes educator. “Medicare will cover visits with diabetes educators who can provide consults related to nutrition, weight loss, exercise, and medication management,” Durso notes. “I may refer patients who can benefit from ongoing interventions that will help them absorb the lessons regarding self-care.” ■

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

More information on physician practice strategies is available at www.DiabetesOptions.net

FUNCTIONALITY DETERMINES LEVEL OF GLYCEMIC CONTROL

The American Geriatrics Society (AGS) diabetes guidelines and the American Diabetes Association’s (ADA) 2009 Position Statement on Standards of Care in Diabetes emphasize that patient functionality is a major consideration in diabetes management. The documents also suggest that moderate blood sugar control may be a reasonable option for patients who are frail or have multiple chronic illnesses.

Strong evidence suggests that tight control will lead to significant long-term benefit in older adults, says Samuel Durso, MD, MBA, AGSF, interim director of the Division of Geriatric Medicine and Gerontology at Johns Hopkins Bayview Medical Center in Baltimore.

The AGS diabetes guidelines were published in the 2003 supplement to the *Journal of the American Geriatrics Society*. The ADA Position Statement was published in the January 2009 supplement to *Diabetes Care*. Here are the links:

- www.americangeriatrics.org/products/positionpapers/JAGSfinal05.pdf
- http://care.diabetesjournals.org/content/32/Supplement_1/S13.full

Q & A

Secure Online Visits Help Family Practitioner Increase Patient Access and Boost Revenue

Q *Electronic consultations are becoming popular. How do webVisits work?*

A A patient logs in to the RelayHealth Web site, selects his or her ailment from a menu of non-emergent clinical symptoms and answers a series of online questions related to that specific condition. Sometimes I'll have additional questions and will send the patient a message. Depending on the response, I can make a diagnosis following one round of messaging about 90% of the time. I can order or renew a prescription electronically, forward a lab slip to the lab, arrange an in-office X-ray, or instruct the patient to check back within a week if the condition has not improved. Patients understand that the webVisit service is not a real time interaction and that our typical turnaround time is one business day. At the initiation of every webVisit, patients see a pop-up message explaining that this is not for urgent issues. It's also part of the terms of understanding that the patient agrees to when he or she requests connectivity with RelayHealth.

Q *So is the RelayHealth webVisit system only for routine care?*

A Yes. webVisits are designed for routine care as in addressing an acute problem that is not emergent and this can include managing a chronic problem, too. Patients log on whenever it's convenient for them. I log on whenever it's convenient for me, including early morning or very late hours or weekends.

Q *Is there more to the RelayHealth system than secure messaging and webVisits?*

A The eScript electronic prescribing component is in use by community pharmacists who contact local physician offices online, including mine, to request or fulfill medication refills or



Lisa Rankin, MD, has been a solo family practitioner in Port St. Lucie, Fla., since 2004. Her practice (<http://lisarankinmd.com/>) includes two nurse practitioners and a mental health therapist. Rankin also cares for many pediatric patients and performs skin biopsies, massage, ultrasound, and some gynecology. In addition to traditional office-based care, she conducts e-visits with her established patients using the RelayHealth webVisit consultation system. Rankin discussed the RelayHealth system with Richard L. Reece, MD, editor-in-chief.

renewals on behalf of their customers. Using RelayHealth, staff members can view a list of prescriptions from nearby pharmacies waiting for my authorization to be refilled. We explain to patients that they can either schedule an in-office appointment to discuss ordering a new prescription or refill, or submit a request via RelayHealth, which is faster and more convenient than the more conventional method.

Q *Does RelayHealth save time because there is less phone tag between staff and patients?*

A Yes. Nonurgent conditions or requests that patients normally phone in now go directly to me via the RelayHealth service. With webVisits, you're in control of the amount of time you spend on the interaction.

Q *Have you been able to increase the number of patients seen by your practice?*

A A family practitioner typically sees 2,500 to 3,000 patients annually. We average 11,000 registered patients. But we rarely schedule more than 20 patients per provider per day. Though we see fewer patients than the typical provider, these are patients who

really need to be seen in person, and many have multiple chronic problems.

Q *Have you ever conducted a webVisit consultation with a patient whom you later wished you had seen in the office?*

A No. If I believe the person needs to be seen (for example, a patient suffering from an acute serious condition), we'll schedule an in-person appointment. I have yet to experience a negative webVisit encounter. Some acute problems such as bladder infections can be addressed over the computer.

Q *What does a webVisit cost? How do you get reimbursed?*

A I charge \$30 for a webVisit. We receive reimbursement from the patient's participating insurance plan. The RelayHealth system checks the patient's insurance eligibility during the webVisit, sends a claim to the health plan for reimbursement, collects the co-payment, and sends it to me. If the patient's insurer does not consider the webVisit a covered benefit, RelayHealth then will collect the fee equivalent to a co-payment amount via credit card.

Q *Which insurers are participating in this system?*

A Blue Cross, Aetna, and CIGNA HealthCare are covering my practice's webVisit consultations. If a patient's insurance covers it, then the patient doesn't pay anything. If insurance doesn't cover it, the charge is \$30, which is very similar to the \$25 co-pay a patient would pay for a live visit. The advantages of webVisits are time savings, affordability, increased productivity, and convenience. For example, there is no need for the patient to take time off from work and drive to the office, or pull a child out of school.

Q To you, is \$30 an equitable fee to charge patients for a webVisit?

A It seems reasonable. I rarely experience a patient refusing a webVisit because of the \$5 cost difference of being seen in the office. Though the webVisit formalized questionnaire is detailed and thorough, most patients complete it online in a short time.

Q What about patients who are unemployed or uninsured?

A We aggressively promote online communications to our economically disadvantaged patients who are uninsured or who have high deductibles. We've created an online program called the Virtual Medical Office (VMO) exclusively for these patients who must be established in order to receive the discounted online medical care services. An office visit is more expensive for uninsured patients versus a webVisit. In the past six months as more patients have lost their

insurance, we've seen the number of patients using webVisits increase. They can also log in for information about chronic illnesses. The VMO provides an easier way for me to provide affordable and consistent care to a larger number of people who otherwise would forego seeing me.

Q What do you say to your peers who question whether it is good medical practice to see patients online when you can't "lay hands" on them?

A I try to educate my colleagues that online consultations are most useful for patients who have an ongoing, established relationship with their physicians, who enjoy the convenience of online care for problems that are non-acute, and who have recognizable symptoms or known concerns that they want to discuss with their physicians. Certainly, patients with acute conditions or those with vague or unusual symptoms are best seen by a care provider in person.

Not every patient needs to be seen in the office. Here's an example: When certain patients visit my office, a nurse will take their vitals and we'll talk about why their cholesterol levels are high, for example. This same discussion can be conducted via a HIPAA-compliant secure online communication service. A live appointment is more important for a 6-month-old child so I can conduct an examination. In this way, webVisits allocate resources more appropriately.

I can treat many patients with non-

urgent medical issues through webVisits. I also have 20 patients on my daily schedule, which is pretty full; but, because I have this secure Internet communication option, I can actually spend more time with the patients who need to be seen in the office.

Q Is there an advantage for you in allowing patients to submit the completed questionnaire online?

A Yes, absolutely. If I happen to be responding to webVisits while I'm logged onto my server, it's very easy to open up my patients' electronic charts and look at their records. Their archived medical history gives me additional information for the webVisit.

Also, I have remote-access software on all my laptops at home. I can access RelayHealth and pull patients' electronic medical record (EMR) files if needed. If I'm going to be in the car with my husband driving somewhere on a weekend, for example, I can respond to one or two patient webVisits.

Q Do you access the online connectivity system during the evenings and weekends?

A I usually check RelayHealth throughout the day. One morning a week I'll skip my exercise routine to sign off on labs and other similar tasks. I do not mind the online work because it cuts down on hours in the office.

Q Some doctors might hesitate to use online connectivity because

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ONLINE MEDICAL VISITS GAIN GROUND

Web-based services such as webVisits that offer interactive, secure question-and-answer systems can help a physician diagnose a patient's complaint without the need for an in-person examination. Among the companies offering these services are RelayHealth in Atlanta, Ga., Virtual Office Visits from Medfusion of Raleigh, N.C., and MDLiveCare, a company in Boca Raton, Fla., with more than 100,000 members who pay \$35 per online visit to consult with primary-care providers, specialists, and therapists in a network.

American Well Corp. of Boston offers physicians the opportu-

nity to host real-time telemedicine encounters with patients anywhere the physician is licensed to practice, using telephone, Webcams, e-mail, and instant referral tools.

These online systems can help physicians increase practice revenue and expand access to insured and uninsured patients alike.

More information is available online at:

www.americanwell.com

www.mdlivecare.com

www.medfusion.com

www.relayhealth.com

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they think it requires more effort or they might be concerned about security issues such as the Health Insurance Portability and Accountability Act (HIPAA). Are these valid concerns?

A They really aren't. For me, the HIPAA issues are not even a question. Offices leave messages on telephones every day. Any person can pick up your phone and listen to your messages which, unlike online consultations, are not secure and not auditable, nor are they HIPAA compliant. In addition, e-mail communication between a patient and a physician uses free-form text and is less secure. RelayHealth's online service including its webVisit is HIPAA-compliant. webVisit consultations also have the advantage of being archived and cannot be deleted or altered.

Some doctors may consider an online system to be extra work. But doctors must experience online connectivity first hand to recognize its ease of use and efficiency benefits. Doctors actually can be more efficient and generate extra revenue using this system.

Tasks that doctors typically perform as phone triage can now be converted into webVisits. It's actually better medicine than simply calling in prescriptions for every patient.

Q Have you found any shortcomings with this system?

A webVisits have some limitations. I can't use it to examine a patient's ears closely, for example. And, until

“A family practitioner typically sees 2,500 to 3,000 patients annually. We average 11,000 registered patients. But we rarely schedule more than 20 patients per provider per day.”

—Lisa Rankin, MD

recently, we had no way to identify a rash properly.

RelayHealth has since added the capability of uploading photographs, which is great. Now patients can send pictures of their rashes. In fact, the majority of routine patient problems can be addressed online.

Q This system sounds like something you would never give up.

A Along with the EMR, communicating securely online with patients has simplified my work life. If I didn't have both an EMR and the ability to do webVisits, it would pretty much be impossible for me to run my practice as efficiently. Online connectivity enables me to practice medicine and have a life outside of the office with my husband and three children.

We also have had some really nice patient experiences that otherwise would be impossible without webVisits. For instance, one patient family visited Japan, where one of their small children became ill. Because they were able to reach me via webVisits, I was

able to help them immediately. That's extraordinary, and it's reassuring for my patients to know they can reach their family doctor through this secure online service any time from anywhere in the world. ■

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HEALTH PLANS ARE USING RELAYHEALTH'S WEBVISITS

Currently, 11 health plans, including MVP Health Care, CIGNA HealthCare, Aetna, Health Net of California, and several of the nation's largest Blue Cross/Blue Shield plans including three affiliates of WellPoint, Inc., offer members secure online webVisit consultations as part of their health plan benefits. webVisit is a service of RelayHealth of Atlanta.

The webVisit system creates a permanent, auditable record that meets criteria established by the American Medical Association for a CPT code 0074T that enables reimbursement by participating payers. The health plans establish reimbursement rates for their participating physicians and co-pay amounts for eligible members. webVisit reimbursement rates vary by health plan and typically range from \$25 to \$35. Patient co-pays range up to \$10.

Using the webVisit, physicians can generate incremental

revenue and some health plans provide reimbursement for these "visits." During a webVisit, RelayHealth verifies insurance eligibility and collects any patient fees or co-pays via credit card.

RelayHealth says this "virtual house call" is a convenient, secure, and efficient way for patients to exchange information with their physicians, improving care and satisfaction, and making health care more accessible. The webVisit system enables online consultations between patients and their providers for nonurgent requests and communications. Using a Web browser, the patient completes an online evaluation of nonurgent symptoms and follows a step-by-step clinically structured interview, which captures detailed information. The physician can access the patient's condition and respond online, by phone, or, if necessary, request an in-office visit.

—RLR

PRACTICE MANAGEMENT

Survey Reveals Lack of Familiarity With EHR Adoption Incentives



Most physicians do not understand how they could benefit from the stimulus funds available to them if they implement electronic health record (EHR) systems as prescribed in the American Recovery and Reinvestment Act (ARRA) of 2009, according to a recent survey.

The purpose of the online survey conducted by health information technology (HIT) company Ingenix (www.ingenix.com) was to gauge attitudes toward EHR technologies and to understand how federal stimulus incentives might affect purchase decisions, Ingenix said. Ingenix reported that 1,001 physician practice administrators and physicians responded to the survey.

Raising Concerns

The number one concern among physicians considering adopting EHR systems was the cost of these systems, Ingenix said. Even though the cost of these systems was a concern, "More than half (58%) of respondents have little or no familiarity with ARRA," the company said. Some 42% of respondents had some familiarity with the provisions of the act.

The ARRA encourages practices to implement EHR systems through financial incentives—and possible penalties for those who fail to adopt an EHR by 2014. Clearly, there is a need for education about the benefits of the act to physicians, Ingenix said.

The majority of physicians, 82%, responded that they would be more likely to adopt EHR systems if they knew they would be reimbursed; 34% responded that they would be "much more likely." Another majority, 77%, said that penalties that would be incurred starting in 2014 for practices that have not adopted EHR systems would be "likely to motivate them to implement the technology."

In response to the survey results, Ingenix has developed an EHR and ARRA education program. The program features a series of webinars designed to improve physicians' understanding of ARRA incentives for the adoption of EHR systems and the requirements for eligibility. In addition,

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INSURER SETTLEMENT GETS PRELIMINARY APPROVAL

The United States District Court for the Southern District of New York granted preliminary approval of a previously disclosed \$350 million settlement that would resolve a class-action lawsuit against UnitedHealth Group, according to an announcement by the AMA on Dec. 4. U.S. District Court Judge Lawrence McKenna approved the preliminary settlement in a case brought by the AMA and other plaintiffs against Ingenix (www.ingenix.com), a subsidiary of UnitedHealth Group (www.unitedhealthgroup.com).

The action brought by the AMA, Missouri State Medical Association, and the Medical Society of the State of New York, along with several other plaintiffs, alleged that UnitedHealth Group colluded with others to underpay physicians for out-of-network medical services, the AMA said. Filed in March 2000, the suit sought relief for physicians who were harmed by what the AMA said was

the insurers' long-term use of the Ingenix database. The AMA said the database was flawed. A year-long investigation in 2008 by New York Attorney General Andrew Cuomo's office confirmed that the Ingenix database is intentionally rigged to allow insurers to short-change reimbursements, the AMA said.

"The court's approval is an important step in finalizing a settlement that recognizes UnitedHealth's flawed payment scheme resulted in significant damages to physicians who provided out-of-network care to patients enrolled with UnitedHealth," said AMA Immediate Past President Nancy H. Nielsen, MD. "Years of litigation and tireless advocacy from the AMA and organized medicine have exposed the industry-wide insurer scheme and paved the way for a more equitable way to set payments for out-of-network care."

The next step in the case will come when the court schedules a final approval hearing.

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the Ingenix Web site includes an EHR and stimulus education center (www.ingenix.com/ehr), which provides information on reviewing the potential costs and savings physicians could expect from installing EHR systems.

Resources Available

In addition to the information available from Ingenix, a number of other organizations offer information to help educate physicians on the details of ARRA and EHR systems. One such organization is the eHealth Initiative (www.ehealthinitiative.org), an organization dedicated to improving the quality, safety, and efficiency of health care by fostering the adoption and improvement of HIT. The initiative's 2010 conference, "Delivering on the Promise of eHealth," will be held in Washington, D.C., in January, and will focus on how ehealth is being implemented across the country and how physicians are moving toward meaningful use of HIT.

The Medical Group Management Association includes an "Economic Stimulus & Recovery" link in the

DISRUPTIVE BEHAVIOR COMMONPLACE, SURVEY FINDS

Behavior problems between doctors and nurses were reported by more than 97% of the nurses and doctors who participated in a survey by the American College of Physician Executives (ACPE). The survey found that the most common complaints were degrading comments, yelling, cursing, inappropriate joking and refusing to work with one another, the ACPE said.

Survey respondents said "treachery and backstabbing" were common among doctors and nurses as members of each profession tried to undermine each other, often in front of patients, the ACPE said. The organization sent the survey by e-mail to 13,000 nurse and physician executives. The ACPE received responses from 1,428 nurses (67.2% of the total number of respondents) and 696 doctors (32.8% of respondents). The survey was done between July 9 and Aug. 10. The survey results were reported in November.

Other complaints included refusing to speak to each other, spreading malicious rumors, trying to get someone unjustly disciplined or fired, throwing objects, and sexual harassment, the ACPE said.

Practice Solutions section on the home page of its Web site (www.mgma.com). This link leads directly to a page designed to educate physicians on the ARRA incentives and how they affect group practices. The page includes a downloadable webinar on the stimulus package, a section titled "What the Economic Stimulus Package Means to

You," and a number of other links and resources designed to help physicians and physician groups to understand the ARRA and other issues involving health care reform.

In addition, the [Recovery.gov](http://www.recovery.gov) (www.recovery.gov) Web site provides broad information on the ARRA legislation, its goals, and target dates. ■

CMS SEEKS TO ENCOURAGE E-PRESCRIBING

The federal Centers for Medicare & Medicaid Services (CMS) has recently revised its policies regarding coding for e-prescribing, according to the Codapedia Web site (www.codapedia.com). Starting January 1, it will be necessary only to show that e-prescribing has been performed on 25 claims per eligible professional per year, the site said. By using e-prescribing for at least 25 claims in a year, each provider will become eligible for CMS incentives, the site reported. CMS is adjusting its rules to encourage physicians to begin submitting all of their prescriptions to pharmacies electronically.

As of January 1, there will also be only one code to use for e-prescribing, G8553. Use of the G8553 code indicates to CMS that the provider is using a qualified e-prescribing system, said Betsy Nicoletti, a consultant in Springfield, Vt.

Physicians using a qualified e-prescribing system are eligible for a 2% bonus in Medicare reimbursement this year (2009) and next. In 2011 and 2012, this bonus drops to 1%, and it drops to 0.5% in 2013. In addition, physicians and practices that fail to adopt a qualified e-prescribing system will begin to incur penal-

ties starting in 2012. In the first year, the penalty is 1% of Medicare allowance, the site said. This penalty increases to 1.5% in 2013 and to 2% in 2014.

CMS is following suit with current policies designed to encourage medical practices to adopt electronic systems. According to the report, in order to qualify, an e-prescribing system must be able to generate a complete list of medications currently prescribed; inform users of less expensive alternatives such as generic agents; electronically submit prescriptions; print prescriptions; cross-reference prescriptions for safety and interactions; and inform users of patients' eligibility for medications, formulary or tiered formulary medications, and authorization that may be required by health plans.

The report stresses that the switch to e-prescribing is being strongly encouraged. While physicians using such systems will initially receive bonus payments, not switching to e-prescribing will eventually incur penalties, which will cut into practices' revenues. Further information can be found on the CMS Web site (www.cms.hhs.gov).

COMMENTARY

The Medical Home Model Relies on Significant Assumptions

By Richard L. Reece, MD, editor-in-chief

As Congress considers ways to reform the health care system, a question that needs to be answered is how to save primary care. A number of health care organizations believe the answer to this question lies in creating patient-centered medical homes (PCMHs).

Paul Grundy, MD, director of health care transformation at IBM, is an advocate of PCMHs, in which primary care physicians (PCPs) would be paid by Medicare and Medicaid to coordinate the care of patients with chronic diseases and to direct patients to specialists. Critics of PCMHs say they would reintroduce the managed care gatekeeper concept, which was tried and failed in the late 1980s and early 1990s. Grundy counters this argument by saying that IBM, an international corporation, pays much less for its employees' health care and receives better results in those countries that have wide access to PCPs who use electronic health record (EHR) systems.



Since the early 1990s, much has changed, Grundy asserts. In particular, more advanced health information technology systems have been developed that allow physicians to communicate with patients and other providers and that afford access to a wide variety of patient data that help these physicians to be more efficient at the point of care.

Sound Reasoning

The American Academy of Pediatrics introduced the medical home concept in 1967, and lately this idea has been gaining momentum as one that could

Continued on page 12

FEDS REALIGN MEDICAL HOME PROJECTS

In October, the Federal Centers for Medicare & Medicaid Services (CMS) said efforts to reform health care could affect its Medicare Medical Home Demonstration Project, which is currently underway. House Bill 3200 contains a provision to repeal this demonstration project and replace it with an independent practitioner-based medical home pilot and to launch a second medical home pilot project to evaluate community-based medical home models, CMS said.

Instead of continuing to pursue the first demonstration project, CMS is moving forward with an administration-initiated demonstration program in which Medicare would partner with multi-payer medical home pilot projects to improve the delivery of care. This demonstration project would be called the Multi-Payer Advanced Primary Care Practice Demonstration, and would begin next year, CMS said.

—RLR

Continued from page 11

help control costs and improve care, particularly for those patients with chronic conditions. Care for patients with chronic illness, such as diabetes, asthma, and cardiovascular disease, is costly and sometimes highly inefficient. There are many reasons the cost of care for these patients is high. One is the shortage of PCPs, and another is the current specialty physician-driven health care system in the United States. These two factors mean the care of these patients often is uncoordinated.

Dissatisfied with the current system of care for those with chronic conditions, patients and PCPs believe it's time for a change. Why not, then, create a new approach in which PCPs form a medical home, and with the help of a newly hired care coordinator and a team of providers operate under the guidance of a physician who offers continuous, comprehensive, coordinated care?

Such a system is appealing simply because it is logical. Costs associated with health care are out of control. Countless studies show that primary

care-based systems are politically popular, less costly, satisfying for patients, and achieve better care quality and better patient outcomes than the current specialist-based system.

Gaining Momentum

Among the goals of health reform advocates are increasing the number of PCPs, encouraging preventive medicine, subsidizing the widespread adoption of EHRs, and fostering chronic care management. These goals are identical to the basic definition of a medical home. The federal Centers for

Legislatures in 20 states have proposed or started medical home projects.

Medicare & Medicaid Services is testing the effectiveness of medical homes in a project that was scheduled to be completed next year. Federal officials planned to determine the feasibility of medical homes, and particularly whether the model saves money on hospitalizations. But those plans may

change given the efforts by Congress to reform health care (see sidebar, page 11).

At the same time, the American Academy of Family Practice (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA) have formed the Patient-Centered Primary Care Consortium and issued a set of joint principles. Seeing the benefits of PCMHs, legislatures in 20 states have proposed or started medical home demonstration projects. Academic institutions, such as Johns Hopkins University and the University of Rochester, are building and testing medical home models.

The National Committee for Quality Assurance (NCQA) has developed a program to certify PCMHs. The program includes comments from ACP, AAFP, AAP, and AOA in NCQA's efforts to revise its program to assess whether physician practices are functioning as medical homes. NCQA's assessment of physician practices that are forming PCMHs

ADVICE FOR PHYSICIANS INTERESTED IN MEDICAL HOMES

For physicians seeking advice on how to switch from a traditional medical practice to the medical home concept, the American Association of Family Physicians recently published an article on the subject. "Ten Steps to a Patient-Centered Medical Home," by Anton J. Kuzel, MD, MHPE, will be published in *Family Practice Management* and is available online ahead of print (at www.aafp.org).

Kuzel acknowledges the medical home concept relies to a great extent on new payment models and means of evaluation. "Given that," he writes, "they strike some physicians as overly complex and onerous in the context of the already stressed, poorly organized and poorly staffed" primary care field. He suggests an alternative approach to the formation of a medical home, in a series of steps, that does not rely on a new payment model.

"Start with steps that increase practice revenue," Kuzel writes. "Then you'll be better able to afford the steps that just make practice better and more satisfying."

The ten steps referred to in the title are:

1. Improving documentation and coding
2. Hiring more nurses or assistants
3. Implementing advanced access scheduling
4. Increasing the number of patients seen daily
5. Expanding office hours, which is optional
6. Implementing an EHR
7. Providing population-based care
8. Implementing a patient portal
9. Linking electronically with local health systems
10. Improving the management of high-cost patients.

Kuzel also includes a section on "Essentials for the journey," which sums up the transformation process, and provides a list of suggested further reading.

"If [physicians] are able to achieve the first two steps of the progression, I believe they will recapture the joy of practice, and, with it, the ability to be fully present again to their patients, staff, colleagues, and families," Kuzel writes.

—RLR

is built on the joint principles developed by the primary care specialty societies and emphasizes the use of systematic, patient-centered, coordinated care management processes, NCQA says.

NCQA defines the PCMH as a health care setting that facilitates partnerships between individual patients and their personal physicians, and, when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange, and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Such health plans as Aetna and UnitedHealth Group are seeking to serve as intermediaries in the process of forming medical homes. The insurers want to be involved in deciding which doctors qualify for being medical home participants and how much they will be paid.

Challenging Assumptions

Many experts assume that coordinated, comprehensive, continuous care of patients with chronic disease will improve the delivery of care. But it may be useful to examine some of the assumptions about the value of medical homes.

The first assumption is that there are enough PCPs to staff medical homes sufficiently. The truth is that there is a desperate shortage of PCPs. Currently, many medical students and residents shun primary care. But there is no way to know how many PCPs would be willing to go through the paperwork and effort to qualify or to build the infrastructure needed for medical homes. Fundamental elements of the medical home model include significant use of an EHR and the hiring of a coordinator. Physicians also may be unwilling to be audited to comply with performance measurement markers.

The second assumption is that payment for care in medical homes would

help create and sustain medical homes and attract PCPs. Physicians would be paid at more lucrative rates that would include fee-for-service payment, a capitation fee for managing a panel of patients, and bonuses for responding quickly to patients' requests via e-mail or phone or allowing same-day visits. But to date, no study has quantified how much money would be required to attract enough PCPs to work in PCMHs, or whether financial factors alone will attract enough medical students to consider primary care.

Assessing the Shift

It is also assumed that PCPs would be comfortable managing the medical affairs of each member of their patient panels, entering the required data into an EHR, and then reporting the outcomes. But weary of paperwork and third-party hassles, many doctors may choose not to participate in medical homes because they would rather work in less demanding settings, such as cash-only or locum tenens practices.

The proponents of the medical home model assume that patients would welcome such a change. But in his popular blog, Kevin Pho, MD (www.kevinmd.com), speculates that many patients who have one condition that does not need "management" might be annoyed by being required to join a medical home. Also, 20% of Americans move each year, and may not be looking to form a permanent relationship with a personal physician or a medical home. Finally, most patients who use emergency rooms do so because the ER is available, not because the patients are uninsured, underinsured, or lack a PCP.

It is also widely assumed that the medical home is a politically neutral concept that few will resist. But in fact it is not. Nurse practitioners, physician assistants, and other medical specialists will lobby to set up their own medical homes because they will see an advantage in trying to fill the gap created by the shortage of PCPs. But more signifi-

CAN EHRs SUPPORT MEDICAL HOMES?

A significant assumption being made about the medical home concept is that every physician working in a medical home will have an electronic health record (EHR). EHRs in medical homes are intended to enable physicians to have robust medical information on each patient at the point of care.

This assumption requires that one make a giant leap of faith, since only about 15% of physicians currently use EHRs and few patients use online personal health records (PHRs). It may be possible to overcome this barrier through federal subsidies to physicians. But currently, the spread of EHRs is insufficient to provide the support needed for the medical home model as planners envision it. —RLR

cantly, the model could receive a considerable amount of resistance from specialists. They will reason that if PCPs are rewarded with increased revenue through medical homes, specialists stand to lose revenue.

To be sure, the medical home concept is logical. It is intended to correct the current costly, fragmented, specialist-dominated system by allowing patients with chronic disease to receive more coordinated and comprehensive care at less cost and get better results. Medical homes could potentially transform the health care system, but if they do, these assumptions will need to be addressed. Perhaps the best way to do that is to review the results of the current demonstration projects and revise the model as needed. ■

More information on physician practice strategies is available at www.DiabetesOptions.net

CAPITAL IDEAS

Here's How Group Practices Can Avoid New Financial Threats

By Carole C. Foos, CPA, and Jason M. O'Dell, CWM

At one time, the practice of medicine was an attractive career option. But working in medical groups has become much more challenging over the past 20 years and is no longer as attractive as it once was. Unfortunately, the financial hurdles of operating a successful medical practice could become much more difficult. An approaching confluence of events could have a significant financial effect on most physicians, unless they take steps now to protect themselves.

Cutbacks in Medicare reimbursement will reduce the income of most doctors. Even physicians who don't treat Medicare patients are not immune to this cut. If a practice's private insurance contracts offer the practice some percentage (say 120%) of Medicare rates, a cut in Medicare reimbursement will lower that practice's insurance reimbursements. In addition, the health reform being considered in Congress could further reduce physicians' income. On top of these two events, federal officials are considering a significant tax increase for high wage earners.

Coming Tax Changes

There has been some discussion about reducing the value of itemized deductions to 28%. If this reduction becomes law, physicians could pay federal income taxes at rates as high as 39.6%, but only be able to write off their itemized deductions at a rate of 28%. This change represents almost a 30% reduction in the value of a physician's deductions. For physicians paying large mortgages, or who have significant health expenses or other itemized deductions, this change could cost them \$5,000 to \$50,000 annually, and this increased tax cost does not include



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any changes to income tax rates.

In addition, most states are facing financial difficulties and many are considering a variety of direct and indirect tax increases, especially for those who are in higher income tax brackets. Some physicians live in states that already have high state income tax rates. And even states that claim not to have a state income tax have hidden taxes such as fees that other states do not impose. Many counties are delaying adjustments in property tax assessments to reflect the downward turn in the real estate market. For example, the home of one high income professional we know was assessed at 50% more than what he paid for it less than three years ago, and his appeal to revalue the home for tax purposes was denied.

Reconsidering Old Plans

In addition to declining reimbursements and rising taxes, there is another concern for physicians in medical

groups. Most group practices of more than three physicians suffer from what may be called lowest-common denominator (LCD) planning. LCD planning occurs when unanimous votes are required to implement asset protection, tax-reduction strategies, or qualified or non-qualified techniques. Generally independent, intelligent, and busy physicians often have too many opinions and distractions to agree unanimously on anything other than the simplest—and often the least beneficial—financial strategies.

This factor alone can be a source of continual frustration for physicians in many practices. The physicians who want to implement more advanced and beneficial planning ideas are usually the same ones who are doing most of the work and generating most of the revenue for the practice. They are usually caught in the middle between younger and older partners. Their younger partners are often busy paying off student loans or paying for a big

new house. Therefore, they aren't likely to be able to afford to fund retirement plans that may reduce taxes because they need every dollar they earn. Conversely, older doctors are likely to have what they need and are reluctant to tinker with any strategy that has worked well for years. This is the "if it ain't broke, don't fix it" mentality. But what many older physicians fail to realize is that in the new medical environment, many strategies that were fine in the past need to be revised or replaced. Old ways cannot continue to be standard operating procedure.

Fortunately, a few concepts can be implemented to help practices avoid LCD planning and address the significant new financial threats. These techniques work for physicians in a variety of practice environments, including solo practitioners, mid-size practices, and large groups.

Hybrid Benefit Plans

Practices currently in an LCD planning mode should consider using a hybrid benefit plan in addition to traditional qualified (401(k), profit-sharing, money purchase, or defined benefit) plans. The main attraction of a hybrid benefit plan created under new pension rules is that each physician can choose the amount he or she wants to contribute into the plan formula. Contributions can range from \$150 to \$100,000 annually.

This simple plan can be implemented for a one-entity medical group with one, two, or even dozens of doctors. Other benefits of this type of plan include:

- Contributions can qualify for current tax deductions.
- The plan acts as an ideal "tax hedge" technique against future income and capital gains tax increases.
- Balances can grow in an asset-protected environment.
- Employee participation requires minimal funding.
- There are no early withdrawal penalties.

Increased Flexibility

In the typical medical group, there is one legal entity, such as a corporation, legal liability corporation, or professional association (PA). Physicians are either owners of the entity, and informally refer to themselves as partners, or are non-owner employees. In all such cases, the physicians have no ability to separate themselves from the central legal entity of the practice. If the central entity does not adopt a corporate planning strategy, no individual doctor has any flexibility to adopt beneficial corporate planning strategies for his or her own benefit.

The one-entity structure promotes LCD planning gridlock. A hybrid benefit plan is one way a practice with a single entity structure can use against this gridlock. But another common way to solve this problem is to alter the practice's legal structure in a way that allows individual physicians to plan their own benefits, without disrupting day-to-day operations or requiring new insurance contracts or Medicare provider numbers.

Each doctor can own a share of the

practice through his or her own professional corporation (PC) or PA. Under this corporate structure, the group receives income from patients, insurers, and Medicare and then pays its bills and overhead. After the bills are paid, the practice then pays its physicians as independent contractors, who would get income listed on Form 1099 rather than W2 income. Physicians who want to implement planning strategies beyond LCD planning may do so through their own individual PCs without affecting their partners' planning or operations. The benefits of this strategy can be implemented at each doctor's level, leaving the central entity and its operations unchanged. Some of the largest medical practices in the United States are using this strategy effectively.

By employing these strategies, physicians can protect themselves from potential losses of revenue, increased taxes, and stagnating benefits. These are the most direct ways in which physicians in today's changing health care environment can protect their earnings and their retirement funds. ■

—More information on physician practice strategies is available at www.DiabetesOptions.net.

Contact the Authors

Readers interested in more information on investment and tax strategies can receive a free book, newsletter, and invitations to webinars by visiting the O'Dell Jarvis Mandell LLC Web site (www.ojmggroup.com) or by calling 877-656-4362.

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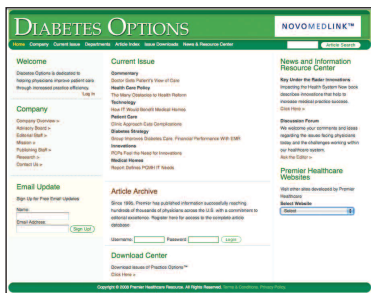
The most common hurdle for medical practices that may want to implement advanced financial planning is gridlock, which occurs when some members of a practice want changes while others are content to do nothing. Such disagreements are common, meaning many physicians do nothing. Those doctors who have successfully overcome this gridlock generally have done so with the help of outside experts.

Experts in the fields of tax, benefits planning, and corporate

law can help the members of physician groups to see all the advantages and disadvantages of different strategies in an unbiased manner. Also, these advisers often can explain a new corporate structure so that a practice's local attorneys or CPAs will agree to the changes and participate in the planning. For these reasons, all physicians should consider bringing in an expert to speak to their groups to initiate productive discussions.

—CCF and JO

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