



# NEXUS

Newsletter of the American Academy of HIV Medicine

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## Defining the Critical Knowledge of an HIV Specialist

*The Core Curriculum Is Headed to Your Mailbox*

Over the last nine months the Academy has developed a Core Curriculum of critical knowledge for a healthcare provider to possess in order to be an HIV Specialist. We began from the premise that to define an HIV Specialist was to define what that specialist must understand about the virus, its treatment, and the people who suffer its effects. The curriculum was crafted with a panel of 50 of the nation's leading frontline clinicians, academics, and other experts in the field of HIV medicine. Together, this panel drafted a consensus document outlining the topics, issues, and facts that every HIV Specialist should know. They then specified 250 Educational Objectives critical for a frontline provider to meet to be considered an HIV Specialist. This Core Curriculum is a unique educational tool designed to be used in a wide array of educational efforts by many different organizations.

One of these uses will be aiding HIV Specialists in assessing and expanding their current treatment knowledge. Many of the Educational Objectives are familiar to experienced HIV treaters. For example, most of us have known for years at least six symptoms of seroconversion. So for a practical Study Guide, the Academy has selected the 28 objectives that represent the most

recent advances in HIV treatment, for example, how and when to combine amprenavir and lopinavir-ritonavir, knowledge that has come to us just in the past 12 months.

Using the Educational Objectives, the Academy is also designing a short self-assessment tool that HIV Specialists can use to make sure their knowledge and understanding of treatment methods are as current as possible. The self-assessment tool includes about 60 questions and takes less than an hour to complete – and is weighted to emphasize the 28 most recent Educational Objectives.

A self-directed Study Guide for all 250 Educational Objectives will be available by the end of this year. It will list all of the clinical and factual data needed to meet the objectives, ranging

from the symptoms of seroconversion to how amprenavir and efavirenz should be used together.

The Educational Objectives, Study Guides, and self-assessment tool can become core elements in a variety of

educational programs. They can be valuable to private practices, medical groups, specialty organizations, and larger institutions, which can use them to help keep up with recent changes in HIV knowledge that affect their practices. Residency organizations can use them to develop their HIV treatment curricula. Medical groups can use them internally to certify and recognize members with knowledge of critical issues in HIV medicine. And continuing medical education organizations can use them in their educational programs.

This, in the end, is the mission of the American Academy of HIV Medicine – to promote excellence in HIV/AIDS care, and helping HIV Specialists stay current helps them provide the best possible care to their patients. Anything we can do to promote our

collective body of knowledge is not only our mission but also our duty.

The 250 Educational Objectives will be mailed to all Academy members in a few weeks. ✦





# Defining an HIV Specialist

*20 years ... and again it's time to fight to change the status quo*

I am sure many of you read stories or gave interviews at key milestones during the history of this disease. Yet as I have read the stories and given interviews over the last two months, I keep catching myself in a long pause as I stop and really fathom that number – 20 years. We have lived and worked through one of the greatest health challenges in the history of humankind. We will continue to meet the challenges by treating patients and guiding public policy.

**Repeatedly we have seen treatment paradigms literally reverse course in a period of six months.**

When asked, "What do you think is the next issue in HIV?" without hesitation I answer, "The next issue is already upon us – improving the quality of care!" As this disease has become more treatable, it has brought us to a crossroads that will literally define whether patients thrive or suffer in the face of this disease.

Treatment for HIV disease is one of the fastest-evolving areas in the entire medical field. Repeatedly we have seen treatment paradigms literally reverse course in a period of six months. In this issue we summarize a recent study demonstrating that physicians with more

experience treating HIV give higher quality of care (see Study, p. 4). Other studies continue to document that patients actually survive longer and have a higher quality of life with an experienced HIV physician. Also in this issue we summarize a study on the increasing rate of new HIV infections (see Rates, p. 4). Yet at this crucial time, we continue to see more experienced HIV physicians exiting the field for reasons ranging from patient load, to reimbursement issues, to lack of professional

standing.

So we have a disease with growing patient needs that will require more knowledgeable and more skilled clinicians yet is experiencing decreasing service capacity. How do we begin to turn this situation around and reach our mission of improving the quality of care, especially since quality of care is such a broad area to affect? We begin by doing what we have always done in HIV – we carve out an area we can change, and we take a stand. For frontline HIV treaters that meant forming an independent group, the Academy, with a clear mission to improve the quality of care, which

then started by creating a standard of measure for the HIV Specialist.

To improve the quality of any industry, product, or procedure, you must first define what you want to provide, set a standard of measurement, and then measure it. In the case of the HIV Specialist, that means first creating a Core Curriculum that defines the critical knowledge an HIV Specialist should know, then developing a tool to measure that competency, which leads to a standard national definition of an HIV Specialist. The Academy began that process by announcing a definition of an HIV Specialist in February (see Definition, p. 3). The Core Curriculum Educational Objectives (see cover story) are being released this month, followed quickly by a short self-assessment tool to measure competency on the 28 most recent educational objectives in the Core Curriculum. This process will culminate this fall when the Academy begins to certify HIV Specialists.

It all sounds so logical, doesn't it? After 20 years of treating this disease, a diverse group of experts come together and reach consensus on a critical level of knowledge and a standard national definition for the purpose of ensuring quality care in a complex disease. It is the course most specialties have followed in becom-

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## Academy Definition of an HIV Specialist

- Current and valid MD, DO, PA, NP, or PharmD license to practice in your state
- Have clinically managed at least 20 HIV patients in the past two years
- Demonstrate continuous professional development by one of three ways:
  - 1) Successfully completing the ID Board certification or maintenance of certification (recertification) examination for the current year (MDs and DOs); or
  - 2) Completing annually at least 30 hours of HIV-related CME Category 1 credits\*; or
  - 3) Completing annually at least 15 hours of HIV-related CME Category 1 credits\* plus passing the HCME (HIV Medicine Competency Exam) – a self-assessment tool, a short web-based/take-home exam weighted to emphasize the 28 most recent Educational Objectives

\*Continuing Education Units for DOs, NPs, PAs, and PharmDs.

ing recognized. Yet after 20 years, unfortunately there is disagreement and indeed opposition to this process. Other established medical professional organizations have already come out against the Academy's stance on measuring quality and certifying specialists.

This is not a surprise – in fact, it is actually predictable. We have seen this many times in HIV, and indeed in a variety of other industries. Any time a group within an industry joins together to create a standard of quality, the existing establishment opposes it. For example, J.D. Powers is now the established institution to measure quality for the auto industry and has now branched out into many other industries. Yet in its first few years, almost every automotive company and even their suppliers fought its representatives, disputed its legitimacy, and even took it to court. For the existing establishment, measuring quality and submitting to that measure were extra steps beyond the status quo. In HIV care, the status quo enables anyone – with any level of experience – to use the label "HIV specialist," and it serves physicians who do not see a large number of patients or do not keep up-to-date. The status quo is not serving all patients well!

In HIV care, we have all fought the establishment for 20 years to bring quality care to our patients. We fought to be able to treat our patients with dignity, to offer them more and better treatments, and to have those treatments

covered by insurers. Now that we have reached the point that HIV can be treated, we are fighting the status quo so that our patients can see a qualified specialist as measured by an established industry standard.

The Academy's staff, board members, and I have received a great deal of feedback on the definition and certification process, even in these early stages. In the case of defining the HIV Specialist, the status quo is being maintained by a variety of well-intended, well-established players. Health plans have traditionally fought defining a specialist and paying them accordingly.

IDSAs HIVMA and IAPAC have both publicly opposed our certification process. Government has been slow to define, certify, or back a definition of an HIV Specialist because those activities are usually done from within the industry. Both national and local AIDS organizations, while supportive of our organization and not opposed to the definition or certification, have not been quick to endorse it either, with no expertise within this area, no resources to research the issues, and pressure from other professional medical organizations.

However, just as in the J.D. Powers example, the momentum has already begun to shift. Health plans have begun to consider a definition, and a few are beginning to work with the Academy or utilize the expertise of our members to aid them in defining quality care within their plans. Government departments and legislative bodies have consulted with us on a definition. And numerous AIDS organizations have begun to support the Academy's definition of an HIV Specialist.

The status quo of no standards and no definition has not and will not improve the quality of care for our patients. The status quo does not help them understand and find quality care, but defining and measuring critical knowledge and certifying specialists will. The Academy will begin to certify HIV Specialists this fall, because the Academy is the only organization ready, willing, and able to change the status quo. ✚

## Is Your Profile Correct?

*www.aahivm.org Referrals Are Rapidly Increasing ...*

**T**he Academy Website is quickly becoming an important source of referrals for our members, for a number of reasons. We have changed how the Website is listed on many of the most popular search engines by expanding our keyword listings. We have also expanded the number of websites that have direct links to us as a resource, for example, The Body.com (at [www.thebody.com](http://www.thebody.com)).

Included in this expansion are several popular government websites that receive several thousand hits each day. As a result of this increased visibility, more patients, caseworkers, and other medical professionals are using the Academy website and its Referral Database to find an HIV Specialist. From interaction with online users, we have learned that the following information is most important to them: insurance plans that are accepted; hours of operation; phone number and address; e-mail address; and description of the practice.

Please log onto the Academy's Website ([www.aahivm.org](http://www.aahivm.org)) and check your profile – is it complete and up-to-date? Does it have all the information patients find important? If you have any questions regarding your profile, you may either update it online or call our membership coordinator at (Toll Free) 866-241-9602. ✚


# Bill AB 937 Passes in the California Assembly

## Bill Requires Risk-Adjusted Reimbursement Rates for HIV Specialists

The Academy is cosponsor of California Bill AB 937, which will require risk-adjusted reimbursement rates for HIV specialists. The bill has passed the California Assembly and is now headed for the Senate and the Governor's desk.

What defines an HIV specialist has become a key part of the debate surrounding the bill, highlighting the importance of the Academy's definition of an HIV Specialist. It will continue to be a difficult uphill battle, with strong opposition from the

health plans. But we are hopeful that our strategy will prevail.

Why is this important to all of our members? Requirements in California, the largest health care market in the country, often serve as templates for legislation in other states. Bill AB 937 establishes a precedent that HIV specialists should be paid appropriately for the services they provide. If health plans are paying risk-adjusted rates in one area of the country, you can argue that they can pay them in your area. 

### HIV in Seven Major U.S. Cities

Both new and overall infection rates among gay men aged 15 to 22 rose from the mid to late 1990s.

Race/Ethnicity	New Infections*		Overall Infections**	
	1994-98	1998-00	1994-98	1998-00
Black	4.0%	14.7%	14.1%	30%
Hispanic	1.8%	3.5%	6.9%	15%
White	2.4%	2.5%	3.3%	7.0%

Cities surveyed: Baltimore, Dallas, Los Angeles, Miami, New York, San Francisco, Seattle.

\*Annual percentage of new HIV infections.

\*\*Overall percentage infected with HIV, regardless of when they became infected.

Source: Centers for Disease Control and Prevention.

### Rates of New HIV Infection Surging in Young Gay Men

In the June 1 special issue of the CDC's *Morbidity and Mortality Weekly Report*, a new study documented a dramatic rise in new infections in young gay men ages 15 to 22, and especially in young gay black men.

#### Key points of the study:

- Approximately one in seven young gay black men (15%) are newly infected each year.
- The rate of new infections for all urban young gay men is as high now as it was at the peak in the mid 1980s.
- About 4.4% of all young gay and bisexual men are newly infected with HIV every year.
- There has also been a rise in other STDs in this same group.

"Now we are seeing these extremely high overall rates and really frightening

rates among blacks – numbers similar to those we saw in the beginning of the epidemic, during some of the peak years," commented Dr. Helene Gayle, director of the CDC's National Center for HIV, STD, and TB Prevention. But she also cautioned that the sample size was small and may not be representative of all gay men. Despite this, when combined with other data it points to a clear trend of increasing new infections.

In another CDC study published in March 2001, almost half of young urban gay men reported having unprotected anal sex during the preceding month.

The CDC strategic plan, released in January 2001 this year, largely targets Americans who are infected but do not know it. "Those who are unaware of their status – and consequently not receiving prevention and care services –

are contributing significantly to the spread of new HIV infections," stated Dr. Gayle. "Our program will encourage all Americans who engage in high-risk behaviors – primarily unprotected sex with a partner whose HIV status is not known to them and IV drug use – to get tested now."

### Study Finds HIV Specialists More Likely to Recommend Appropriate Care

A study published in the June 2001 issue of the *Journal of General Internal Medicine* by Academy member Valerie E. Stone, MD, MPH, and colleagues suggests that generalist physicians and those with little experience in treating HIV need expert advice to deal with the increasingly complex treatment options.

"Based on the data presented here, generalists in several high-HIV-prevalence states may not be prepared to provide state-of-the-art care for those with HIV/AIDS," says Dr. Stone.

According to the study results, physicians with less HIV experience, regardless of specialty, were less likely to choose recommended therapies and recommend treatments consistent with guidelines from the Department of Health and Human Services.

"It should be emphasized that the generalists with moderate to high HIV experience in this study had high levels of knowledge and prescribing practices that were in line with current stan-

dards," commented Dr. Stone. "These results suggest physicians are able to gauge their own HIV competency and determine when there is a need for consultation," she added.

The study emphasizes the importance of HIV experience and concludes that primary care physicians should consult with an HIV specialist when caring for HIV/AIDS patients if they feel they need treatment advice.

## The Academy Presents at Historic Meeting

On June 14, the Academy took part in a historic meeting in California, sponsored by the California Department of Managed Care. The five largest health plans, the five largest AIDS organizations, and many others met to discuss important issues in HIV/AIDS. The Academy presented its initiatives and definition of an HIV Specialist.

As a result of past and pending legislation in California, the issue of defining an HIV specialist dominated the open and frank discussion. Many of the health plans and AIDS organizations wanted a standard statewide definition of an HIV specialist explained and after discussion showed support for the Academy's initiatives in this area.

The meeting was an important step in continuing to build consensus around the Academy's definition and certification process. ✚

## Local Academy Updates

### Arizona Chapter

In response to survey results from our members, we have incorporated CME classes, case presentations, and nationally recognized speakers into our chapter meetings. We are beginning to raise the standard of HIV care with our local health care providers. We are considering developing an educational component for AIDS Walk Arizona. AIDS service organizations, the Academy, and Ryan White Title I are developing a community medical forum for consumers. Mark Kezios has been appointed as the Administrative Director of the chapter.

### California Chapter

The Chapter has been very active in supporting and lobbying for AB 937 (see story, p. 4). This advocacy has definitely increased understanding of the quality of care and HIV Specialists issues amongst our legislators. The Chapter also recently elected a new board of directors: Stephen Becker, Eric Daar, Jason Flamm, Michael Fratkin, W. David Hardy, Mark Holodny, Marshall Kubota, Larry Lyle, Donald Northfelt, Jorge Rodriguez, John Stansell. The board will meet at ICAAC.

### Florida Chapter

Recently the Florida Academy of HIV Medicine sponsored a table at the AIDS Education Training Center (AETC) State HIV Conference in Orlando. We had a lot of activity at our table, and prospective members took all of our literature for review. We are also currently enrolling 30 Correctional Physicians into AAHIVM/FAHIVM with the help of Dr. David Thomas and Dr. Gene McCarty. We now have over 100 members in the state of Florida and are on an active membership drive. Due to our increasing membership, we will soon be holding elections in Florida to add three more board members, making a total of seven. In addition to increasing our membership, we are also organizing an approach to the Florida Medical Society regarding their support of the Academy. In addition, we are working with Positive Healthcare and the AIDS Healthcare Foundation to help organize educational programs throughout the state. ✚

## Academy Question and Answer

### Q: When should I renew my membership in the Academy?

**A:** All current members will receive a membership renewal letter in September or October. Once you renew this year, your membership will be valid until December 2002.

### Q: Will defining an HIV Specialist reduce the number of physicians providing HIV treatment in rural areas?

**A:** During the development of the Academy's definition of an HIV Specialist, rural physicians have told us that they are accustomed to practicing general medicine and comanaging specific cases of a variety of specialties with a specialist in a neighboring city. This is a common situation for HIV treatment because, by all of the definitions of HIV specialists commonly used today, a rural physician does not see enough patients to qualify as a specialist.

The Academy's definition and certification of HIV

Specialists will assist rural physicians by identifying experienced HIV physicians in their geographical area. With the Referral Database available on our website ([www.aahivm.org](http://www.aahivm.org)), a rural physician can quickly locate an HIV Specialist to comanage specific cases.

### Q: Once the Academy has a certification process, will you have to be a member of the Academy to certify? Will you have to certify to be a member of the Academy?

**A:** You will not have to become a member of the Academy to be certified as an HIV Specialist, nor will you have to earn certification to become a member – these are two separate subjects that will not be linked.

Membership is open to anyone who is interested in assisting the Academy in reaching its mission of promoting excellence in HIV/AIDS care. Certification is available to anyone who wishes to qualify as an HIV Specialist.

## Marc Johnson, MD: A Profile

*Founding member of the New York chapter of Minority Providers of HIV Care*

**M**arc Johnson, MD, is assistant professor of medicine at Mount Sinai School of Medicine, physician in charge at the New York Hospital Medical Center of Queens, and head of primary care at the AIDS Center of Queens County. As a founding member of the New York chapter of Minority Providers of HIV Care, Dr. Johnson sees his organization bringing two important things to its members and their clients: support and respect.

"One of our biggest strengths," he tells *The NEXUS*, "is our ability to educate communities of color in a culturally appropriate manner. We're sensitive to the beliefs and cultures of the community, and we offer respect for the members of that community."

"We're also a support group for providers to talk about issues," Dr. Johnson emphasizes. "The group is meant to be a support mechanism to share some of the frustrations and some of the tribulations. It helps each of us realize we're not the only ones suffering these problems as we try to provide care to a complex group of individuals."

Toward that end, he notes, "we've been very supportive of the American Academy of HIV Medicine. Several of our members are also members of the Academy, and we plan to have further discussions about how we can support each other's endeavors. We want to have members from the communities of color represented at all levels of the Academy, from the board to the state chapters."

The Academy, he adds, "legitimizes us as a specialty. One of the problems with HIV medicine is that it's been thought of as something that general practitioners do. We never had our own specialty. But I think that one of the ben-



Marc Johnson, MD

efits of the Academy is it defines what HIV Specialists are and what our roles are. And that gives us credibility in terms of being a unique and vital branch of medicine."

Johnson emphasizes, "The Academy gives us a voice at the various legislative bodies around the nation. And that

gives us the ability to advocate for our patients and help shape legislation and policy as it relates to funding and, ultimately, to help shape legislation that affects HIV care."

The New York chapter of Minority Providers of HIV Care started about two years ago when Sharon Rascoe, a community relations manager with Agouron Pharmaceuticals, Inc., gathered half a dozen or so HIV specialists at a meeting in San Diego. "We came back to New York and formed the group," Johnson recalls. "Since then, we've met almost every month. There are now about 200 members, including MDs, RNs, PAs, NPs, social workers, substance abuse counselors, and the whole spectrum of care providers for the HIV-infected and -affected individual."

The group meets to talk about issues as they relate to HIV care. For example, a recent topic at one of its 40-minute educational forums was AIDS and the central nervous system. Each meeting also features an open-mike session and a session on the legislative and policy aspects of HIV care and funding.

The group has set its sites even higher, Johnson says. Last year, for example, the chapter cosponsored – with the New York Hospital Medical Center of Queens and New York State's HIV Clinical Education Initiative – a conference on the legacy of the Tuskegee experiment on communities of color and their views of the medical establishment. In this experiment, sharecroppers with syphilis were intentionally denied treatment so that the natural history of the disease could be followed. "Because of that study," Johnson points out, "people of color have a lot of mistrust of the medical community and of medical research. We felt we should address its impact on how our community sees us as providers – and how that's translated to HIV care." The all-day meeting attracted about 200 attendees, and the staff, lecturers, and presenters were all people of color.

This focus on communities of color supporting themselves is critical, Dr.

Johnson stresses. "We know that the demographic of the epidemic right now is in communities of color," he says. "We're trying to respond by having people of color do dedicated programs, particularly at health fairs, educational forums, and such events in those communities, and to provide education to their own patients

and to the significant others of their patients around issues of HIV treatment – new drugs, clinical trials, things like that." He adds: "We know our own

**"One of our biggest strengths is our ability to educate communities of color in a culturally appropriate manner. We're sensitive to the beliefs and cultures of the community, and we offer respect for the members of that community."**

communities. We try to deal with some of our biases."

One arena the group enters – with appropriate respect – is integrating clients' faith with the organization's clinical mission. "It's very difficult in certain communities to get the church to help in educating the community," he says. "There are churches that haven't rallied around this issue as we would expect them to. They're not penalizing people, but we don't get the support in terms of

outreach, education, and prevention messages that we'd like."

But, he stresses, "there are religious leaders who are very progressive who will allow educational forums in the church." He continues, "My patients generally have religious access. In the sense that this is one of the things they need for their care, I suggest they seek support from the denomination of their faith and try to get the support they feel is necessary. But by no means do we try to be pastors or

preachers or imams or rabbis."

Well, one member does. "We have a pastor as a member," Johnson notes. Indeed, Dr. Johnson is perhaps proudest of the fact that the organization "is made up of various providers, so we can provide the whole continuum of HIV services. We've even set up a speaker's bureau, so when people want us to speak, we can provide targeted information from a spectrum of HIV professionals." ✝

## Academy Reimbursement Committee

# Monograph and Hotline Moving Forward

*An Update From Committee Chair Jon D. Kaiser, MD*

**T**he Academy's Reimbursement Committee is very excited about the progress we are making toward providing Academy members with information and services to help ensure fair reimbursement. Below we describe several of our projects that soon will be released. We welcome, as always, your comments, suggestions, and assistance.

### Quarterly Reimbursement Monographs

As a follow-up to the Reimbursement Committee's first publication, *The Physician's Guide to HIV Reimbursement* (2001), we will soon initiate a quarterly series of educational monographs devoted to the billing and coding regulatory issues unique to our specialty. These monographs will identify and discuss the appropriate documentation and highest allowable billing codes.

In addition, we are seeking contributions from Academy members of unique and challenging office visits to include in the series to highlight particularly interesting issues. If you can assist us in this endeavor, please e-mail a brief case history and description of your office visit to [reimbursement@aahivm.org](mailto:reimbursement@aahivm.org). We would also appreciate any suggestions of specific types of visits that you would like included in these monographs.

After searching far and wide, we have recently enlisted the services of a consulting firm to assist us in researching and developing these educational monographs. We are confident their depth of experience in assisting physician specialty organizations with reimbursement and educational efforts will greatly benefit Academy members.

### Reimbursement Support Lines

Another service we offer beginning in September to assist our membership in resolving reimbursement issues is a toll-free hotline, 877-REIM HOT or 877-734-6468, for Academy members to obtain answers to their billing and reimbursement questions. A response will be available within 72 hours. Our reimbursement specialists will service these support lines and provide detailed research needed to answer questions about federal, state, and HMO/PPO reimbursement and billing guidelines.

### HIV-Specific CPT Reimbursement Codes

HIV Specialists currently play a unique and evolving role in medicine. We provide our patients with high-level specialty services such as antiviral medication management, interpretation of specialized viral resistance tests, counseling services in nutrition and behavior modification, and management of complex medication side effects, as well as providing patients with primary care.

As time marches forward, these services will become increasingly more complex and time-consuming. Insurers are getting a bargain by paying us the same rate for providing both primary care and specialty services to their subscribers. One could ask for Medicare and other third-party payers to explain why, as specialists, HIV treatment providers are paid no more, and sometimes less, than the average general internist.

The Reimbursement Committee has begun discussing the process for identifying and implementing HIV-specific CPT codes and RBRVS reimbursement that appropriately reimburse HIV specialists for their time and expertise. ✝

... we will soon initiate a quarterly series of educational monographs devoted to the billing and coding regulatory issues unique to our specialty.



# THE NEXUS

Newsletter of the American Academy of HIV Medicine

## Do you want to renew your membership?

Go to [www.aahivm.org](http://www.aahivm.org) and

- 1) Download an application.
- 2) Renew online.

or

- 3) Call Toll-Free 866-241-9602 to have an application either faxed or mailed to you.

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You are cordially invited to attend:

## AAHIVM's 1st National Update Meeting Sunday, September 23, 2001

### During the 41st Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC)

Sheraton Chicago Hotel & Towers  
301 E. North Water Street  
Michigan Room B  
Chicago, IL 60611

6:00 p.m. – 7:00 p.m.

#### AAHIVM Marches Forward

A review of this year's important initiatives including the introduction of the Core Curriculum, state legislation, initiatives in various states and an explanation of our certification process. Presentation will include an outline of future initiatives and an input session.

7:00 p.m. – 8:00 p.m.

#### Optimizing Reimbursement & Practice Management Efficiency

As managed care becomes a greater percentage of the revenue stream of a medical practice, it is technically more difficult to efficiently manage today's practices due to increased demands on the physicians and their staffs. Improve the operational efficiency of your practice by participating in this important workshop with hands-on, tactical approaches to front office operations, practice management, clinic operations and maximizing reimbursement.

- There is no cost to attend
- Light buffet will be served

RSVP by calling Toll-Free 866-241-9601

We would like thank the following sustaining charter members for supporting the Academy:

