MEDICAL COLLEGE OF WISCONSIN
Physicians & Clinics

FOCUS
on The Business of Medicine
JANUARY 1997

Three Executive Committee members elected

The three new members of the Executive Committee elected by the CPG Board in January are :

• **Guillermo Carrera, MD**, Professor of Radiology, joined the faculty in 1977. A specialist in musculoskeletal radiology, Dr. Carrera is Chief of Diagnostic Radiology and Program Director of the residency training program in diagnostic radiology.

• **Dwight Cruikshank, MD**, Patrick J. and Margaret G. McMahon Professor and Chair of Obstetrics and Gynecology, has been with the College since 1991. He is a nationally recognized perinatologist and a leader in high-risk pregnancy research and prenatal fetal diagnosis and therapy.

• **J. Frank Wilson, MD**, Chair and Professor of Radiation Oncology, and Director of the Cancer Center, joined the faculty in 1974. He is an internationally known researcher in radiation oncology and an authority on breast cancer.

Each member will serve a two-year term (1997-98). The Executive Committee meets weekly and provides leadership on CPG policies, resources decisions and strategic direction.

Three members of the Executive Committee completed their terms at the end of 1996. They are: Robert Kliegman, MD, Pediatrics; Guillermo Carrera, MD, Radiology; and Richard Lofgren, MD, Medicine (General

January CPG Board report

The CPG Board met on Jan.14 to hear from candidates for the Executive Committee, discuss a new pathology contract with Horizon community hospitals, receive an update on the discussions with Froedtert and Children's Hospitals, and review a report on the initial actions being taken on the primary care plan.

By vote of the CPG Board members, six candidates were selected for the final ballot of the Executive Committee. Presentations by all six candidates were heard.

Frequency of Board meetings in 1997 was discussed and the Board decided to change the meeting frequency from monthly to quarterly.

Carl Becker, MD, Pathology, and Janice Lato, Clinical Affairs, presented

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INSIDE

Medical College leads the way in use of bone marrow transplant as promising treatment for multiple sclerosis

Medical College Bone Marrow Transplant and Neurology specialists at Froedtert have performed Wisconsin's first and the country's third bone marrow transplant for a Wisconsin woman with severe, progressive multiple sclerosis (MS). As part of a clinical study, the transplant represents a new and promising approach in the treatment of this progressive neurological disease.

The woman, who is in her 30s, was discharged from Froedtert in early December. She had the transplant in November and left the hospital stronger, with better vision. William H. Burns, MD, Director of the Bone Marrow Transplant Program, is encouraged by the progress of their first patient. She will be monitored to see if the transplant succeeded at arresting her disease and whether her body will be able to repair or compensate for any of the neurological damage done by MS.

The Medical College and Northwestern University Medical Center have a joint protocol to look at the feasibility and safety of bone marrow transplants for patients with the severest form of MS.

During this Phase I study, both institutions will enroll 20 patients for whom alternative therapy has been exhausted and who have progressive disease. The bone marrow transplant treatment includes separating the stem cells from the patient's blood and lymphocytes using apheresis and columns. These stem cells mature into the various types of blood cells in the body. Following the apheresis procedure, the patient is given chemotherapy and total body irradiation to kill the immune system attacking the nervous system. The stem cells are then reinfused into the patient with the hope that they will produce a new immune system and not attack the body's myelin sheath. Additionally, it is anticipated that any viruses or other environmental factors initially contributing to the development of the disease may no longer be present and would not influence the new immune system.

The patient will continue under the care of Lorri J. Lobeck, MD.

HCFA issues new rules regarding observation status

HCFA has issued new rules regarding observation status (also known as 23-hour admission) which became effective Nov. 1, 1996. Observation services are defined as "those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition, or determine the need for a possible admission to the hospital as an inpatient." Observation must be specifically ordered by the MD, eg: "Admit to Observation" must appear on the order sheet.

The latest directive indicates that Medicare expects that 24 hours of observation for a patient should be adequate in most cases, and a few cases might require services into a second 24-hour period. Due to evidence of abuse, HCFA is limiting observation services to a maximum of 48 hours. Observation services that exceed 48 hours will be denied by Medicare as not reasonable and necessary. Managed Care organizations define observation more strictly and limit observation services to 24 hours. The observation clock starts ticking as soon as the patient is admitted to an observation bed.

A detailed analysis of patients admitted to observation status at Froedtert during the months of June, July and August 1996 showed that we were in substantial compliance with this new ruling. Of the 458 patients admitted to observation during the three-month period, 92 percent were here 24 hours or less. With one exception, the remaining eight percent were here less than 48 hours.

A matter of serious concern noted during the above analysis is the use of observation status as a matter of routing following ambulatory surgery. In a recent communication, HCFA clearly states that standing orders for observation following outpatient surgery is not an appropriate use of observation status. Patients scheduled for outpatient surgery should be recovered as ambulatory surgery patients and discharged unless complications develop that may warrant observation or an inpatient stay.

Please direct questions to Jean Lambert, RN, Director of Case Management for Froedtert, at 259-2645.

CPG meeting report

continued from front cover

the proposed pathology contract which is under negotiation with the Horizon community hospitals. This three-year contract would provide 10 to 12 pathologists for the four Horizon community hospitals — St. Mary's Milwaukee, St. Mary's Ozaukee, Columbia and Community Memorial. The contract would start July 1, 1997.

Michael Dunn, MD, Dean and Executive Vice President, updated Board members about the strategic planning occurring with Froedtert and Children's Hospitals.

An update on the primary care plan was provided by Richard Lofgren, MD, Associate Dean for Primary Care. Two sites have been identified for satellite locations; one is in West Allis, the other is in Greendale. The primary care initiative is a joint venture of the Medical College and Froedtert.

John Eversman, MD, Senior Associate Dean and CEO of Clinical Practice, provided the December financial report. Charges are up 11.4 percent compared to last year and net collections are up 10.9 percent. More revenue is coming from managed care plans than in prior years. Patient volume remains strong for the CPG.

CPG Briefs

Medical College Physician Services Directory distributed

The Medical College of Wisconsin *1997-98 Directory of Physician Services* has been distributed to more than 8,500 physicians in the group practice's service area, including 3,500 physicians who referred to College physicians this past year. For the convenience of our faculty, directories are also being placed in Medical College clinic exam rooms.

Special thanks is extended to the clinical department administrators who helped in compiling the information.

Plans are underway to put the directory on the internet for the Clinical Practice Group's Home page, which will allow timely access to information for referring physicians.

Clarification- Dermatology:

The phone number for Ellen Loughran in the Department of Dermatology was incorrect in the December issue of *Focus*. The correct number is 454-5308.

Froedtert establishes discharge time

Froedtert continues to have difficulties with patient flow due to the large daily influx of patients and persistent delays in discharge time. Patients are in the ED, PACU, ICUs and waiting rooms for extended periods of time due to the unavailability of bed space. This creates higher cost, reduced patient satisfaction, and inefficiencies in many of the support departments. In addition, patients are often displaced from their primary nursing care units, necessitating greater travel for medical staff and increased number of patient transfers which, in turn, generate unnecessary expense and potential confusion.

Intensive evaluations of discharge times were conducted on 3NW and 4NW during June and December 1996. These evaluations showed that the absence of timely discharge orders is one of the primary reasons for delayed discharges. In June, 80 percent of the 187 discharged patients studied left the hospital after 1100. Reasons for delay were as follows: 45 percent were due to late discharge orders, 20 percent were related to transportation problems, and the remaining 35 percent were due to miscellaneous reasons. In December, a sample of 140 discharges was studied. Eighty-seven percent of the patients in this study left the hospital after 1100. Reasons for delay were as follows: 67 percent were due to late discharge orders, 13 percent were related to transportation problems, and the remaining 20 percent were due to miscellaneous reasons. At it's December meeting, the Medical Executive Committee issued a resolution which states that discharge orders must be written by 0900 so that patients can be discharged before 1100. When this is accomplished, patient flow and placement will be substantially improved. Questions regarding the above may be directed to Jean Lambert, RN, Director of Case Management for Froedtert, 259-2645.

Commercial support of CME

As an accredited sponsor of continuing medical education, the Medical College is responsible for the quality and scientific integrity of CME activities. Such activities must appear to be objective, free of commercial bias, and based on scientific methods. Sometimes it makes sense to partner with commercial entities to defray the expenses associated with delivering CME. Partnerships with drug companies, equipment manufacturers, and other commercial supporters, when done correctly, can contribute significantly to the quality of CME programs. The following guidelines apply:

• A commercial supporter may be asked to help with the preparation of conference-related educational materials, but these materials shall not, by their content or format, advance the specific proprietary interests of the commercial supporter. Educational materials include slides, syllabi, reference materials, etc.

• Information that will assist the College in planning and producing an educational activity from any outside source, whether commercial or not, is allowed. However, acceptance of advice or services concerning speakers, invitees or other educational matters, including content, cannot be among the conditions of providing support by commercial organizations. Funds should be received as "unrestricted educational grants."

• The College may authorize commercial supporters to disseminate information about CME opportunities to the medical community, but MCW controls the content of such marketing and must be designated as the accredited sponsor on any promotional piece thus distributed.

• Commercial supporters may be recognized for their contributions in many ways. Most often a CME activity brochure will include a list of supporters or exhibitors. Remember, outside entities are NOT sponsors—the College is the ONLY sponsor. Verbal announcements at meetings and appropriate signage indicating grant support of the activity are also common means to acknowledge commercial partners. No product names may be mentioned or printed.

• No commercial promotional materials or sales literature should be displayed or distributed immediately before, during, or immediately after an educational activity designated for CME credit. While representatives of the commercial entity may attend a CME activity, no sales activities should occur in the room where the activity takes place.

• Payment of reasonable honoraria and reimbursement of out-of-pocket expenses for faculty is customary and proper.

• Commercially supported social events at CME activities should not compete with, nor take precedence over, the educational events.

CPG administrative group supports practice

The CPG administrative group is comprised of clinical department administrators and directors in clinical practice service, including the executive director, ambulatory care, billing and collections, finance, managed care and marketing. Additionally, the chief executive officer of the CPG attends and other administrative officers of the College and affiliates participate on an ad hoc basis.

The group's primary role is to address administrative issues affecting the CPG, including those influencing the financial well-being of the Clinical Practice Plan, service issues relating to the provision of care, relationships with our affiliate institutions, new managed care contracts and marketing opportunities. Current examples of activities the group is involved with include workgroups addressing charge capture and charge processing issues and analysis of the overhead costs of the practice plan.

The group meets the second and fourth Thursdays of every month and is chaired by a clinical department administrator on a rotating basis. The agenda includes a monthly report from each of the directors of clinical practice services and usually two or three specific issues of concern which affect the majority of the group. Practice plan or other non-medical issues relating to patient care which readers feel should be brought to the attention of the CPG Administrative Group may be addressed to the current chair, William Aldershof, MS 756, Department of Pediatrics, 3082 MFRC; aldersho@post.its.mcw.edu; fax 266-8549; or phone 456-4101.

HCFA clarifies teaching physician requirements

Health Care Financing Administration (HCFA) officials, in response to numerous requests, have adopted a number of clarifications to the documentation rules for Teaching Physicians. These clarifications were discussed during a teleconference, co-sponsored by the Association of American Medical Colleges and the Medical Group Management Association, December 13. A video tape of this conference was sent to each Department Administrator. Faculty are encouraged to take the opportunity to view the tape. The major questions clarified by HCFA are as follows.

1. Medical student documentation: Only a Medical Student's documentation for the review of systems (ROS) and past family and social history (PFSH), may be referred to and utilized by the Teaching Physician (TP) in writing his/her note. As a Medical Student is not a licensed physician and since Medicare does not pay for the services of Medical Students, the student's documentation relative to the History of Present Illness (HPI), Physical Exam, and Medical Decision Making (diagnosis and care plan) is not relevant. The TP must perform and document the HPI, exam and decision making in order to bill. TPs are urged to review CPT documentation requirements. The use of a Medical Student as a scribe is discouraged and would have to be justified by highly unusual circumstances. Please contact Teresa Young at 456-5003 to set up an appointment for a teaching session or review of these rules.

2. Generic attestations and signature stamps: Use of generic attestations by the TP are not acceptable. Attestations must be patient specific. Signature stamps and electronic signatures are acceptable as long as presence of the TP during key portion of the service is stated somewhere in the body of the note. Proxy stamps by covering physicians in radiology are acceptable as long as this is solely a billing issue.

3. Resident documentation of evaluation/management services: For an initial care visit, the TP does not need to repeat the ROS or PFSH if documented by the resident. The TP should refer back to the resident's note and confirm the key findings. HCFA re-emphasized that only the key element(s) of the HPI, exam, and medical decision-making need to be documented by the TP for the initial care visit. In contrast, only two of the three key elements need to be confirmed ---in brief---for subsequent hospital or follow-up outpatient visits.

HCFA expects that the documentation for a level 4 or 5 visit service should not require more than a few minutes to complete by the TP. The use of physician "scribes"(eg. residents, nurses taking dictation) is discouraged.

4. Electronic Medical Record Systems: Transition to electronic medical record systems should pose no problem and are acceptable to HCFA as long as electronic macros are not used in place of patient specific documentation and the record is secure.

5. Modifiers: Modifier GC must be used to bill for any service involving a resident regardless of the TP's presence during the entire service or just the key portion. Modifier GE must be used for services performed under the outpatient clinic exception rule. A grace period until March 31 has been approved. The lack of a modifier on any claim will not deny payment of that claim. No modifier means that the TP performed the service personally without a resident. If later audit shows a resident's service was involved in establishing a billable service, the physician and College could be fined.

6. Addendums: Addendums to the documentation are acceptable, if added for legitimate medical reasons. Retrospective documentation, ie. after a claim is filed, performed primarily to assure compliance with documentation requirements, is discouraged.

7. Minor Procedures: The definition of a minor procedure now is time based. A minor procedure that requires a physician to be present for the entire procedure is defined as "any procedure that takes less than three five minutes to perform." Thus, the TP will no longer need to be present for the entire minor procedure, only the key portion, if the minor procedure takes more than five minutes to complete. The TP must still identify and document the critical portion of the procedure, as well as their presence and immediate availability. The change provides substantial relief to teaching physicians, in particular, emergency medicine physicians.

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Teaching physician requirements

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8. Overlapping and concurrent major surgical procedures: HCFA has distinguished between overlapping and concurrent procedures. Overlapping refers to when the key portions of two surgical procedures are performed at the same time or at least partially overlap. This does not mean that the TP can not schedule two procedures to begin at the same time or "concurrently." However, the key portions of the two concurrent procedures must not overlap.

In the case of two concurrent procedures, a second surgeon needs to be on hand to satisfy the "immediately available" requirement for the first procedure if the teaching surgeon has begun the key portion of a second concurrent procedure. Further, when performing two concurrent procedures, a teaching surgeon may not bounce back between the two procedures to complete multiple key portions in either procedure, unless an unanticipated key portion is required in one of the procedures being performed concurrently. In this case, a second teaching physician must be "immediately available."

9. Post-op visit services included in the global fee period: The physical presence of the teaching surgeon is not required for inpatient post-op visit services included in the global period during the same inpatient stay as the surgery. However, physical presence is required for the out-patient post-op visit services that the TP believes are "key" follow-up visits during the global post-op period. Teaching surgeons should bill the surgery with the appropriate modifier (54) indicating "procedure only" if they are not involved with post-op visit services performed on the outpatient basis that are included in the global fee period.

10. Interventional radiology and high-risk procedures: For interventional radiology and high risk procedures, the TP's physical presence during the key portion is required in accordance with "Supervision and Interpretation" code descriptors. The resident may document on behalf of the TP, as in single surgical cases when the TP is present for the entire procedure. For multiple interventional procedures, the TP must document presence for the entire radiology portion and key portion of the associated surgical procedure. Hyperbaric Oxygen requires presence for the entire service.

11. Independent experience for residents: Graded, independent experience for residents in accordance with Residency Review Committee (RRC) requirements, is not being restricted by the rules. However, it does mean that the TP will want to forgo billing to allow a resident total independence in delivering a service when appropriate during the training period.

12. Outpatient clinic exception supervision: The rule states that the TP may supervise up to four residents at any one time under the outpatient exception. Medical students may accompany the residents for instruction and observation of ~~the resident's~~ their care. In contrast, if mid-level providers are part of the care team, the TP may revert back to a one-on-one physical presence standard if it is necessary to personally supervise mid-level providers, eg. physician assistant (PA) and nurse practitioner (NP), while supervising residents. Remember, in outpatient hospital settings, the PA and NP may bill for their services independently at the reduced fee schedule rate.

13. Critical care services: In critical care units, the TP must be present for the entire time when using a time-based code. However, the revised minor procedure definition may make performing and billing easier for concurrent procedures on critical care unit patients.

14. Anesthesia services: In anesthesia, induction and emergence are key portions of the service. The resident or other staff may document in the anesthesia report on behalf of the TP indicating the TP's presence during the key portions of each case. If the anesthesiologist supervises CRNAs in addition to one resident, then the special rules for medical direction provided by anesthesiologists will apply (rather than the teaching physician rules) to those mid-level providers.

15. Endoscopy: No change to the current rule. HCFA believes that the physician work relative values for endoscopy reflect the complexity of effort to a degree that scope insertion, diagnostic viewing and scope withdrawal are all key elements.

If clarification is needed about the documentation rules, contact Quin Buechner at 456-4544.

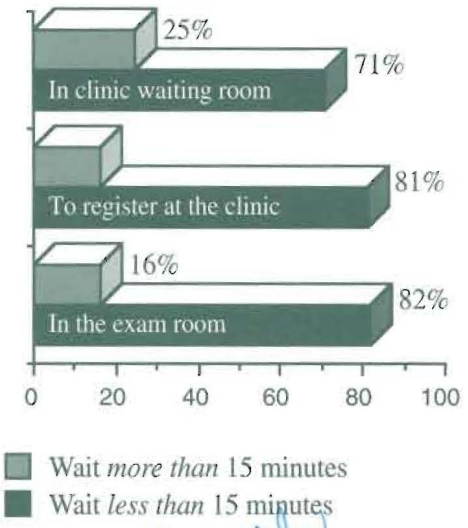
New patients rate clinic services

In an effort to receive immediate patient satisfaction feedback from our new patients, the Marketing Office administers a phone survey among a random sample of new clinic patients within a few days of their clinic visit. The telephone survey is administered in the evening and begins by asking the patient how they are doing. If the patient expresses a concern about their medical status or condition, Susan Conover, the Medical College Clinics Patient Advocate, is notified and she follows through to ensure that the patient's concern is addressed. Of the 300 patients who were surveyed during the first and second quarters of FY 1996/97, a total of 15 patients (5 percent) expressed a medical concern. Nearly all related to a concern about not having received test results. Following are the ratings provided:

New patients appear to be very satisfied with their visit, rating their overall satisfaction with the clinic as 80 percent very satisfied, 16 percent somewhat satisfied, and 3 percent not satisfied. In addition, 78 percent of new patients reported that they would be very likely to recommend Medical College Clinics to others (16 percent were somewhat likely, 2 percent not very likely, but 3 percent were not at all likely).

In terms of specific waiting issues, a quarter of new patients reported waiting more than 15 minutes in the clinic waiting room.

Reported clinic waiting times for our new patients are as follows:



Twenty-three percent of the new patients surveyed offered suggestions to improve service. The top three suggestions were: improve excessive waits in lobby and exam rooms (34 %), change registration (16%), and improve paperwork processing (10%).

A written survey is mailed to a random sample of our established patients each month as well. A summary of how our established patients rate our clinics will be provided in a future issue of *Focus*.

If you have a question about these results or any of the satisfaction surveys administered on behalf of the Clinical Practice Group, please call Marketing at 456-7171.

Clinic Services rated by new patients

	Excellent	Good	Fair	Poor
Doctor's concern for their condition	62 %	31 %	4 %	2 %
Medical staff (RNs, CAs, etc.)	59 %	36 %	1 %	1 %
Amount of time spent with patient	49 %	42 %	4 %	3 %
Non-medical office staff	53 %	41 %	4 %	1 %
Registration process*	39 %	45 %	5 %	5 %
Appointment scheduling**	39 %	45 %	8 %	3 %
Ease in finding doctor's office	41 %	49 %	5 %	0 %
Ease in finding clinic	40 %	41 %	13 %	3 %

* If "fair or poor," primary reason:
- long waits in line (26%)
- multiple registration during same visit (23%)

** If "fair or poor," primary reason:
- long wait for appointment (lead times) (32%)
- inconvenient hours (15%)

DEPARTMENT PROFILES • DEPARTMENT PROFILES • DEPARTMENT PROFILES

Clinical department and division profiles will be published in Focus during the next year as a resource for CPG physicians.

■ Division of Hematology/Oncology

◆ *15 physicians provide adult care.*

◆ *Call 257-5809 to refer a patient.*

◆◆◆

Clinical services:

- Comprehensive management of hematologic and oncologic diseases (both malignant and non-malignant)
- Bone marrow transplantation: autologous and allogeneic
- Multidisciplinary clinics including brain tumor, breast and prostate.
- Clinical trials: both pharmaceutical and ECOG
- Palliative care program

Faculty by clinic and hospital location:

Froedtert East Clinics, Froedtert Memorial Lutheran Hospital
Tom Anderson, MD
William Burns, MD
Christopher R. Chitambar, MD
Hugh L. Davis, MD
William R Drobyski, MD
Mary M. Horowitz, MD
Janet Robbins Hosenpud, MD
Mark Juckett, MD
Anthony V. Pisciotta, MD
Paul S. Ritch, MD
Philip Rowlings, MD
Federico Sanchez, MD
David Vesole, MD
David E. Weissman, MD.

VAMC
Hugh L. Davis, MD
Joseph A. Libnoch, MD

Community Memorial Hospital-Menomonee Falls
Federico Sanchez, MD

■ Department of Neurosurgery

◆ *9 physicians provide adult and pediatric care.*

◆ *Call 454-5400 to refer a patient.*

◆◆◆

Clinical services:

- Brain tumor surgery
- Cerebrovascular disease
- Epilepsy surgery
- Pediatric neurosurgical services
- Pituitary surgery
- Spinal Cord Injury Center
- Spinal disorders
- Stereotaxis and neuroaugmentive

Faculty by hospital and clinic location:

Froedtert West Clinics, Froedtert Memorial Lutheran Hospital
Jamie L. Baisden, MD
Joseph F. Cusick, MD
James P. Hollowell, MD
Sanford J. Larson, MD, PhD
Dennis J. Maiman, MD, PhD
Glenn A. Meyer, MD
Wade M. Mueller, MD
Kenneth W. Reichert, MD
Patrick R. Walsh, MD, PhD

SpineCare Clinic at Froedtert West
Diane W. Braza, MD
(secondary appointment)

VAMC and Clinic
Jamie L. Baisden, MD
James P. Hollowell, MD
Dennis J. Maiman, MD, PhD,
Patrick R. Walsh, MD, PhD

Children's Hospital of Wisconsin Children's Hospital Clinic
Glenn A. Meyer, MD
Kenneth W. Reichert, MD

Managed Care Morsels: Bed Daze

One of the more publicized effects of managed care has been a decrease in utilization of inpatient facilities. There has been a recognition that many services previously provided in the hospital can be delivered for less cost and with more patient satisfaction in the outpatient setting. This is particularly true where well-organized outpatient delivery systems are in place. There has been a resulting decrease in hospital admissions as well as length-of stay. The statistic used to describe hospital utilization is usually "bed days per thousand covered lives." In some areas of the country, such as the West Coast, "bed days" have plummeted to spectacularly low numbers when compared to Wisconsin data. There is currently an ongoing debate about what the optimum utilization rate really is — witness the recent controversy about "drive-through deliveries."

Historically, academic medical centers have had hospital utilization practices that "scared away" managed care organizations and the patients they control. Can academic medical centers change this situation? The answer is apparently "yes." An increasingly common feature of managed care contracts is to set "risk bands" or "targets" for desired utilization rates. The Medical College of Wisconsin - Family Health Plan contract calls for a neurosurgery "bed days" target of 8.5 days per thousand for adults for the year 1996. As of October 1996, the Medical College had beat this target by averaging 7.9 bed days per thousand. The bed-days example shows how managed care organizations and academic medical centers *can* work together to accomplish mutually agreed-upon goals.

Comprehensive diabetes management program developed

The Medical College Diabetes Management Program at Froedtert represents a comprehensive approach to diabetes management, with the overall goal being twofold: the promotion of health and quality of life in people with diabetes by improving the management of diabetes and reducing acute chronic complications of diabetes and related diseases; and to reduce direct and indirect costs for treatment of diabetes and the related diseases by a comprehensive management plan.

Management components include:

- intensive, on-going patient education;
- structured clinic visits for initiation and follow-up of therapy according to clinical pathways
- pre-planned measures for early detection and treatment of diabetes and complications
- regular team meetings to discuss and revise individual care plans, if necessary
- availability of diabetologist and Diabetes Care Center professionals for consultation and direct team contact for patients in acute situations.

The program is comprised of a multidisciplinary approach to patient care that coordinates resources across the entire delivery continuum, concentrating on the entire life-cycle of diabetes and promoting improvement through the optimal use of health care team resources which include: primary care physicians; diabetologists; diabetes nurse educators; diabetes care managers; dietitian educators; homecare nurses; social workers; and pharmacists.

The program was developed by an expert team consisting of Gabriele Sonnenberg, MD, Medicine (Endocrinology); Rick D. Gillis, MD, Medicine (General Internal); Fredric J. Romm, MD, MPH; Arthur J. Hartz, MD, PhD, Family & Community Medicine; Judy Evenson, RN, Utilization Management, and Jennifer Robertson, RN, CCM, in collaboration with experts from the Wisconsin Affiliate of the American Diabetes Association and Diabetes Control Program, State Division of Health.

The program is located at Froedtert Hospital in the Medical College Primary Care Clinics (General Internal Medicine and Family Medicine), the Diabetes Care Center, and clinics for the various medical specialties.

The Diabetes Management program receives patients in various ways, but ultimately relies on the primary care physician and diabetologist, in concert with the care manager, to enroll eligible candidates. To refer a patient to this program, call the Diabetes Care Center at Froedtert at 454-5124.

Telemedicine plan under development

A telemedicine workgroup was appointed in late 1996 to evaluate the current state of telemedicine technology and determine market opportunities and clinical service applicability for the Medical College. Telemedicine allows for live and interactive use of electronic information and communication technology to provide and support health care when distance separates participants. The workgroup is assessing the business issues related to implementing a telemedicine program and will make recommendations about the organizational structure and development of a program to the CPG Clinical Information Committee and CPG Executive Committee.

Members include: Janice Lato, Chair, Clinical Affairs; Steven Smart, MD, Medicine (Cardiovascular); Michael O'Donnell, Continuing Medical Education; Stephen Hargarten, MD, Emergency Medicine; Gary Barnas, MD, Medicine (General Internal); Bill Lachenauer, Information Systems; Steve Krogull, Instructional Programs; Thomas Wigton, MD, Obstetrics/Gynecology; Edward Southern, MD, Orthopaedic Surgery; Richard Komorowski, MD; and Bruce Dunn, MD, Pathology; Carl Weigle, MD, Pediatrics; Carl Chan, MD, Psychiatry and Behavioral Health; Dennis Foley, MD, Don Stone, and Charles Wilson, PhD, Radiology; Mark Gottlieb, PhD, Family and Community Medicine; and Jim Olson, Froedtert Information Systems.

For more information about the initiative, contact Janice Lato, Administrator for Clinical Affairs, at 456-8025.

Focus is published by the Medical College of Wisconsin Physicians & Clinics for the physicians of its Clinical Practice Group (CPG).

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Jonathan Towne, MD, Surgery (Vascular)
J. Frank Wilson, MD, Radiation Oncology
***ex-officio**

~~Submit articles to:~~
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