KOHLER
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Putting the pieces together

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Welcome to our newest edition of Kohler HealthCare Consulting's "Pieces for Success". *We hope you find this periodic newsletter to be informative and of assistance. If you know others who may find this information useful, please feel free to share our newsletter with them or with their permission, forward their email address to us for inclusion in our distribution list.*

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TIDBITS, ANNOUNCEMENTS AND EDUCATIONAL/SPEAKING ENGAGEMENTS

Free Kohler Connection Webinars [check our website frequently for any changes]. Contact Noel Asen (nasen@kohlerhc.com) for webinar information. Existing webinars are also available and we can hold one just for your organization! See our website for listings. Again, if interested, please contact us at 410-461-5116.

- **KHC White Papers -** (1) Telemedicine; (2) Proposed E/M Changes for 2019; (3) Hierarchical Codes - Contact Jessica Felder at jfelder@kohlerhc.com or 410-461-5116 to request a copy.

- KHC's Jessica Felder, MHA, CPCS, Consultant has now graduated and received her MHA from the University of Maryland University College in December. She has also received her NAMSS Certification. Congratulations on her hard work and achievements!

- ***RESCHEDULED* - *Wednesday, January 16, 2019 from 12:00 noon to 12:30 p.m. Eastern Time.*** Join us with Daria Malan for *a* **FREE Kohler Connection Webinar** *on* ***"Trends in ASC Surveys - Perspectives from a Mock Surveyor's Point of View".*** We are seeing a trend in increased reviews of ASCs. Here is an opportunity to learn about what is included in the surveys and how to focus the internal efforts to survive them well.
- ***January 16, 2019 at 1:30 p.m.*** *- Charge Master Updates webinar presented by Khalida Burton and Julie Leonard to AAHAM.*
- ***January 25, 2019 from 8 a.m. – 4:30 p.m.*** *- HSCRC Workshop hosted by MD HFMA.*

- **Do You Have Patients from the EU? So, You're All Set Up for GDPR.**

The regulations were effective May 25, 2018 for countries outside the EU. If you have a patient from the EU, (even if via telemedicine), or have joint ventures with EU companies (or universities), you may be subject to this regulation and must comply. It's important to do a risk assessment and let in place indemnity in the contracts.

Interestingly, its approach regarding failure to comply does not have to be proven by a GDPR (General Data Protection Regulation) regulator, rather the hospital must prove it complied to avoid the penalties, and not pay the complainant's legal fees, which is part of GDPR. It is not a HIPAA ala EU-version. There are many requirements. For example, Notice and Consents, which are called "transparency provisions". Do you have them ready and trained staff to use them? Both the Compliance Office and IT Officers need to be aware and set up the provisions. Some provisions cover topics that are familiar to us, for example: right of access, and patient's rights. Others are very different: right to object to automated decision making, and the

right to be forgotten. Yes, the patient has the right to be totally deleted from your system. This is counter to the record retentions laws of the USA. You will need to seek legal opinion on whether storing that record in a firewalled location will suffice. And, it's not just medical records – it could cover billing records, electronic files, data supplied to other providers and vendors. Very complicated and complex.

- **EMTALA and the Homeless.** Many hospital have the homeless on their hospital grounds – the sidewalks in the city, or in the grassy areas around the building. In addition, locations considered to be "provider-based" (or called "regulated" in Maryland), are also consider part of the hospital and probably have the same EMTALA requirements (42 CFR § 413.65(a)(2)). Security and other non-clinical personnel (including contracted staff such as parking lot/valet or housekeeping staff, for example) must be aware that if the homeless person asks for an examination, it creates an "EMTALA moment". The Medical Screening Examination (MSE) must be performed even if the individual is well known as a "frequent" visitor to the ED. That means that everyone needs to know the perimeter location for the EMTALA requirement – and when in doubt, err on the side of providing the requested examination in the ED by knowing the steps to take. Documenting the discharge, given the multiple chronic medical conditions of the homeless is challenging and must be done well. Further, the EMTALA log should maintained with all relevant information. Multiple visits to the ED in a short period of time is common.

- **Aetna Data Used in Study Shows Significant Changes in Care Venue for Low Acuity Needs**. As reported in JAMA Intern Med, 9/4/2018, the patient's selection of urgent care settings instead of the Emergency Department (ED) has moved significantly from 2008 to 2015 – with split of visits per 1,000 plan members to urgent care at mid-40s in 2008 and about 90 for ED. This compares to 2015 with urgent care at 102, and ED at about 55. The other interesting note in the study is the claim of telemedicine. In 2008, telemedicine was about 2%, and in 2015, closer to 10%.

- **Health Services Cost Review Commission (HSCRC) Appendix D.** Be sure to reference both the Word and Excel versions when researching an appropriate relative value unit for a service. The acronym "IRC" in the RVU field of the excel version means this particular CPT should be reported as 1 RVU in the IRC rate center. If there is ever notice a discrepancy between the word and excel versions, please notify Bill Hoff at the Health Services Cost Review Commission.

- **Although a Change May be Coming-TRICARE Does Not Cover Services Provided by PTAs and OTAs**. On December 20, 2018, TRICARE proposed regs in the Federal Register to extend coverage to physical therapy assistants (PTAs) and occupational therapy assistants (OTAs). Yes, their services are currently not covered. Further, TRICARE has utilized different definitions of supervision, requiring the physical therapists to be in the same room for direct supervision – whereas Medicare requirements are for the same suite. OTAs and PTAs are subject to direct supervision in private practice, and general supervision in all other settings. Of course, the PT or OT must be authorized by TRICARE to provide services to be covered.

- **Opiod Crisis Statistics.** *P*er *Health Data Management's* November 2018 issue, "The American Medical Association's Opiod Task Force 2018 Progress Report notes that the number of opiod prescriptions decreased by more than 55 million – a 22.2 percent decrease nationally – between 2013 and 2017, with a 9 percent decrease – more than 19 million fewer prescriptions—between 2016 and 2017. In fact, all 50 states have seen a decrease in opiod prescriptions over the past five years, reports the AMA."

- **Are You Struggling with the New Medicare Regulations for Outpatient Referred Laboratory Testing?** If so, you are not alone. CMS confirmed they are allowing providers an extension until July 1st, 2019. For more information on this regulation and the extension, visit: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Clinical-Lab-DOS-Policy.html. If you would like assistance with implementation of this regulation, we have laboratory, billing, and reimbursement team members that can help.

- **Drug Waste – To Bill or Not To Bill?** Even with many vial sizes to choose from, some drug waste for patients is always unavoidable. Waste can often be billed if the waste is clearly documented and billed properly. We are finding, however, that more and more hospitals are "playing it safe" and only billing for the portion of the vial that has been administered to avoid any future headaches (denials, other complaints, etc.). In addition, pharmacy billing is already so complex, that the additional programming and/or manual steps that would be necessary to bill for the waste properly can sometimes make it a losing proposition compared to its associated reimbursement. KHC has team members dedicated to pharmacy charging issues and we often assist our clients with streamlining pharmacy charge capture.

- **Procedure-to-Procedure Edits Have Been Postponed for Maryland Hospitals Until July 1, 2019.** Maryland hospitals should have received correspondence from the Maryland Hospital Association and Health Services

Cost Review Commission regarding these edits. Some of the PTP scenarios are fairly straightforward, others can be more challenging to understand and address. If you need help calculating the impact and/or addressing these edits, let us know.

- ***Please follow KHC on Linked In*: https://www.linkedin.com/company/kohler-healthcare-consulting-inc**

- **HCPro Books Authored by KHC Staff:**

  Long Term Care From A to Z, Written by KHC Staff— published in December 2016. The book is now available for sale thru: https://hcmarketplace.com/long-term-care-billing. See website for more details.

  Hospital Billing From A to Z, written by KHC staff is a reference guide that covers Medicare requirements with ease of use for those involved in hospital billing. The book is available thru: http://hcmarketplace.com/hospital-billing-from-a-to-z?code=EB313813&utm_source=HCPro&utm_medium=email&utm_campaign=HBFAZ

  Physician Practice Billing From A to Z is a comprehensive, user-friendly guide to billing requirements, with particular emphasis on Medicare. This resource will help physician practice billers understand the relevant regulations, code sets, compliance issues, and a myriad of other factors that affect the billing process. To learn more about the book or to order go to HCPro: http://hcmarketplace.com/physician-practice-billing-from-a-to-z?code=PPI&utm_source=edit&utm_medium=enl&utm_campaign=ENL_PPI_063015

ACA, CDC, CMS, OIG, MEDICARE and MEDICAID UPDATES

INCIDENT – TO: KNOW THE RULES AND HAVE ALL NPPS CREDENTIALED WITH PAYERS IF POSSIBLE - Charlotte Kohler

The option of billing for the work of your NPPs – non-physician providers – under the billing numbers of the physicians will increase Medicare payment by 15%. Some other payers may also follow a similar payment process. But the ability to bill as if the physician performed the service comes with obligations: the physician must see the patient first and establish a care plan. The physician must meet the supervision rules. If you don't – it's very easy for investigators to figure it out. A violation – a very easy way to have a false claim. So, do the right thing: credential all your NPPs if the payer allows. In cases where the payer does not credential NPPs, the "options" are based on information from the payer – bill under the physician numbers or not bill at all. Be sure you know what the payer covers. Both the government and other payers are looking at the 15% "gift" as an undue cost that is driving up health care expenditures. The Medicare Payment Advisory Commission (MedPAC) was established to provide information based on research directly to Congress. MedPAC advised Congress 3 months ago that incident-to has the potential to create out of compliance situations and also create higher costs. Check that incident-to is being handled correctly and get all NPPs credentialed. Follow up training for all staff to know the rules is really key. PS – how does Medicare find problems: there are 2 major ways – the volumes of a particular physician seems too high to be performed personally, and perhaps the more prominent way – by a relator, otherwise known as one of the NPPs or billers who know the rules aren't being followed.

HEALTHCARE REFORM NEWS – Jessica Felder

While newly elected members of government are taking office, big changes are already in motion with regards to the healthcare in the United States.

- On January 4, 2019, a coalition of 17 Democratic states filed to appeal the decision that the Affordable Care Act is unconstitutional.
- Janet Mills, the newly installed governor of Maine, called on state health officials to move ahead with implementing ACA expansion in Maine.
- Two lawmakers in Colorado look to establish the country's first state-run, public health insurance plan.
  - Rep. Dylan Roberts' bill will create the infrastructure to create the program and gain approval from the federal government.

- Sen. Kerry Donovan's bill creates a pilot program that will provide an additional option to counties with limited insurance choices.

We are officially on day eight of the new year and these are just a few of the things being implemented and worked on. Looks like the government is on track to make an impact on healthcare as we know it in 2019.

For more information on any of the details shared above, check out https://www.healthmarkets.com/resources/health-insurance/trumpcare-news-updates/.

WHY DID CMS HOST SO MANY PECOS SEMINARS DURING 4TH QUARTER 2018? - Khalida S. Burton

If you are like many people, you are probably asking yourself, "Why did CMS host so many PECOS seminars during the 4th quarter 2018?" Is there something brewing with CMS? This article will not answer the specific question of "why" but will provide general information on PECOS to shed light on the importance of updating your PECOS information annually with CMS.

What is PECOS?

PECOS stands for Provider Enrollment, Chain, and Ownership System. PECOS is an electronic portal that allows institutional providers (hospitals, skilled nursing facilities, home health agencies, etc.) physicians, non-physician practitioners (NPPs), other Part B suppliers and providers to enroll, reenroll, add/delete providers, add/delete locations, or revalidate enrollment in the Medicare program. PECOS can also be used to change information, reassign benefits or to voluntarily withdraw or terminate participation in the Medicare program.

Purpose of PECOS?

The purpose of PECOS is to provide an electronic means for individuals or institutions providing services to Medicare beneficiaries to enroll in the Medicare program. There is no need to submit paper applications for Medicare enrollment. Even if you submit your application on a paper form, a record is still created in PECOS. Becoming a Medicare provider means individuals are able to bill and get paid for services provided. Individual providers and NPPs must have a National Provider Identifier (NPI) to enroll in PECOS. NPI enrollment can be done online, via paper or using a third-party organization to complete the application. For more information on NPI, please see the 'How to Apply' link below.

When to Update PECOS?

CMS requires you to update your enrollment information within 30 calendars days for any 'reportable events'. Reportable events include changes in practice location, ownership, general supervision, banking arrangements, and final adverse actions. All other changes to the must be reported within 90 days. Failure to report these changes can result in issues with claims processing, claims payment, and your eligible to participate in the Medicare program.

CMS requires providers to revalidate enrollment every 3 years for DMEPOS and every 5 years for all other providers and suppliers. Notifications are generally sent by your Medicare Administrative Contractor (MAC) 2-3 months prior to your revalidation due date. You can also use the Medicare Revalidation Lookup Tool to find out when your revalidation is due. It is advised to send your revalidation prior to your due date.

As mentioned previously, PECOS training has been provided during the last few months of 2018. Please visit your MAC to register for online training.

For more information

CMS Medicare Provider – Supplier Enrollment https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html
CMS National Provider Identifier 'How to Apply' https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/apply.html
CMS National Provider Identifier (NPI) Registry https://npiregistry.cms.hhs.gov/
CMS Medicare Revalidation Tool https://data.cms.gov/revalidation

CODING CORNER

CDMs - WHEN ARE "DUPLICATES" OKAY? – Lauren Rose

In a perfect world, every CPT[1] and/or HCPCS[2] code would only appear once in a charge description master (CDM) because as soon as a CDM becomes too cumbersome, there is the risk of having multiple prices for the same service. Keep in mind, however, that some duplication is unavoidable and in certain situations, different prices for the same CPT/HCPCS are even appropriate.

When should there be multiple lines for the same CPT/HCPCS?

- Unlisted Codes – When a specific code does not yet exist for a service, it is typically recommended that separate charge codes be set up for each underlying situation with an unlisted code. This not only ensures that the specific price is appropriate for the situation at hand; but will also help Patient Financial Services if the service is provided to an outpatient and the payer requests a description. This helps to maintain history of the service, especially if the service has its own code developed in the future.

- Required Tiering - If a regulatory agency or payer has specifically requested that the service be tiered, duplication is required. For instance, in the state of Maryland, the Health Services Cost Review Commission has certain services that are tiered based on the amount of time spent with a patient to perform the service. (This is not the same as a code that includes a time increment within the description of the code; in those instances, claim units are used to report the total amount of time spent with the patient.)

- Different Departments - If the same service is being performed by two completely different clinical departments (typically in different clinical locations with differing underlying cost structures) - and there are appropriate reasons for these "service overlaps", a different price may be permitted. Monitor these scenarios closely - - if at the end of the day, the service is exactly the same, questions could arise when the resulting bills are very different.

When should there not be multiple lines for the same CPT/HCPCS?

It is recommended that other systems/methods be used to apply modifiers vs. hard coding modifiers in the CDM. A CDM should not be used to track services by patient type, by physician, etc. Custom reports can be written to capture this type of data.

In all cases, always keep tight controls over adding unnecessary duplicates and having different prices for the same CPT/HCPCS.

SUTURE REMOVAL UNDER ANESTHESIA – Simbo Famure

There are two codes that can be used for the removal of sutures and both include the use of anesthesia. They are **15850** - Removal of sutures under anesthesia [other than local] same surgeon and **15851** – Removal of sutures under anesthesia [other than local] other surgeon.

The above procedures are normally performed like a surgery and are commonly performed on children or adults that are nervous and need to be kept still for the procedure.

In most cases, suture removal is bundled in the initial procedure that occurred-for example, a laceration closure or a surgical procedure. The surgeon or physician that initially placed the sutures removes them at the stipulated time. In other cases, patients have injuries where they are treated in emergency rooms and when they receive sutures, they are advised to go for follow-up appointments with their primary care physicians. In this case, their primary care physicians can bill E/M codes (99201-99205 for new patients OR 99211-99215 for established patients). For proper billing, the physician should properly document the history regarding the reason why the patient had the sutures and an examination involving the appearance of the suture site and any other present issues affecting the patient. This will determine the appropriate level of the code to be billed. However, if the patient just comes for the removal of

[1] Current Procedural Terminology
[2] Healthcare Common Procedural Coding System

the sutures by a provider that did not perform the procedure that involved the placement of the sutures and no history, exam or medical decision was performed, the E/M code 99211 [Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional] can be coded.

A MATTER OF TIME - DOCUMENT CORRECTLY – Julie Leonard

Providers may document, code, and bill based on the "time" criteria for certain Evaluation and Management (E/M) services. Office visits for both new and established patients (99201-99215) may be reported based on the time spent in face-to-face "counseling or coordination of care". Hospital services (Inpatient 99221-99223, 99231-99233), Observation (99218-99220) and Inpatient or Observation, same date of service, (99234-99236) as well as discharge services all have a time criteria but it includes the "unit/floor" time a provider spends in "counseling or coordination" of care. Emergency Departments (99281-99285) do not have a time component for coding due to the nature of the work flow, and the provider could be involved with the care of more than a single patient at any given time. This article will focus on place of service office (11); see the CPT guidelines for any additional information regarding all E/M services.

Most providers and coders understand that to code/bill based on time, the provider must indicate that more than 50% of the total face-to-face time with the patient was spent in "counseling or coordination of care". What tends to get lost are the details of the visit. Simply stating "more than 50% of the 45 minutes with Mr. Jones was spent in counseling" is not sufficient. The provider must indicate what was discussed with Mr. Jones, "Mr. Jones is newly diagnosed with XXXXX and is here to discuss treatment options (list the options) as well as possible side effects (list the side effects) and outcomes (list the possible outcomes). Spent 35 minutes of 60 minutes in discussion or counseling with Mr. Jones". This tells the payer the length of the visit, the amount of counseling/coordination of care and what was discussed with the patient.

The level of services is determined by the entire amount of face-to-face time. In the example above, the visit is based on the 60 minutes; if Mr. Jones is an established patient of the provider the CPT code is 99215, if Mr. Jones is a new patient the CPT code is 99205.

Three steps to avoid denial or recoupment for coding/billing services based on time:

1. Document total time spent face-to-face with the patient
2. Specify how much time was spent counseling or coordinating care with the patient
3. Summarize specific details of the conversation with the patient and why

Be specific and do not use blanket, vague statements when documenting/coding/billing based on face-to-face time with the patient and you should be able to avoid denials and or recoupments from the payers.

OTHER ARTICLES OF INTEREST

THE RIGHT BALANCE OF SKILLS – Christopher Fallon

Casey Stengel is in the Baseball Hall of Fame for his days as a ballplayer and his years as a successful manager in the Major Leagues. He managed the New York Yankees from 1949 to 1960 and the New York Mets from 1962 to 1965. During his time managing the Yankees, they won 10 America League Pennants and 7 World Series. The same cannot be said about his record with the early 1960's lowly Mets.

Stengel was famous for his funny one liners and baseball insights. One of his more famous lines was: "I don't like them fellas who drive in two runs and let in three". There is more wisdom here than what you might think. What he was saying is that ball players, like us all, need to have the right balance of skills to be successful. A ball player that can hit well but is a poor fielder does not really help the team if his fielding is that bad.

Similarly, a healthcare worker that is technically qualified but has very poor communications skills or a worker that works long, dedicated hours but cannot collaborate with fellow employees may be a net minus for the organization.

For the individual, the annual performance evaluation can be an opportunity to review their job description and address serious and fundamental skill or talent voids in an honest self-assessment.

From a larger perspective, departments and organizations should consider preparing an inventory of critical skill requirements for the workforce at large. On a smaller scale, individual departments can prepare an overall talent / skills inventory and consider future needs in that department. Voids can be identified, and an action plan developed

with the steps needed to address skill set vacuums. In fact, such a talent skill set assessment is a fundamental responsibility of management.

Recognizing this need, Casey Stengel once said, “Managing is getting paid for home runs someone else hits”.

ANATOMY OF A MEDICATION ERROR – Daria Malan

The FDA defines a medication error as any preventable event that may cause or lead to inappropriate medication use or patient harm. A medication error is an error (of commission or omission) at any step along the pathway that begins when a clinician prescribes a medication and ends when the patient consumes the medication.

Nearly one-third of adults in the U.S. take 5 or more medications. Medication errors can be lethal, with over 7,000 patients estimated to have died each year from preventable mistakes, despite automated systems. Medicare will not pay hospitals when they make certain errors, nor can the patient be billed for costs associated with errors. This includes medication errors.

Analysis of serious medication errors invariably reveals underlying system flaws, such as human error and an impaired safety culture that allows prescribing or administration errors to reach the patient and cause serious harm.

The pathway connecting a clinician's decision to prescribe a medication and the patient receiving the medication consists of several steps, that are often complicated and riddled with risky gaps. Here are some causal factors or med errors during the process:

- *Ordering:* illegibility, prescriber e-system errors, such as selection error from drop down list, weight/age of patient not considered, renewal errors, poor communication between providers, look-alike/sound-alike meds, use of abbreviations/acronyms (vs. full drug name), lack of medication reconciliation, decimal point errors.
- *Transcribing:* inadequate information flow, transcription errors of component(s) of med order, pharmacy prescription mis-reads, inaccurate barcoding, storage, packaging or labeling problems, technical system failures.
- *Dispensing:* lack of pharmacy checks for check drug-to-drug interactions, allergies and other patient alerts, preparation errors, issuance of expired drugs, insufficient patient education.
- *Administration:* non-compliance to the “Five Rights” (right patient, right drug, right dose, right route, right time), lack of double checks of critical meds or order read-back, nurse interruption/loss of concentration, workarounds, staffing issues, inadequate critical thinking re: patient risk or current condition, lack of training, exhaustion/burn-out, lack of available infusion pumps.

No matter what the setting, when is the last time your facility initiated a review of medication processes or a root cause analysis of medication error risk or event? KHC can help. ***For more information, contact Daria Malan at dmalan@kohlerhc.com or 410-598-1221.***

Resources:

https://www.fda.gov/Drugs/DrugSafety/MedicationErrors/default.htm
https://psnet.ahrq.gov/primers/primer/23/Medication-Errors-and-Adverse-Drug-Events
https://journals.lww.com/nursing/Fulltext/2018/09000/Preventing_medication_errors_in_the_information.15.aspx

GOOD NEWS ON CANCER DEATH RATES, BUT… - Charlotte Kohler

According to a report from the American Cancer Society (ACS) published online January 7 in *CA: A Cancer Journal for Clinicians*, the overall cancer death rate in the U.S. dropped by 27% over the past 25 years. However, the rates vary significantly by socioeconomic status. Despite 2.6 million fewer cancer deaths between 1991 and 2016, mortality rates are, for example, twice as high for cervical cancer in poorer U.S. counties than in more affluent areas. Rates are also 40% higher for male lung and liver cancers and 35% higher for male colorectal cancer, as outlined by the ACS researchers, led by Rebecca Siegel, who stated "Although the racial gap in cancer mortality is slowly narrowing, socioeconomic inequalities are widening, with the most notable gaps for the most preventable cancers."

Siegel's team found that steady reductions in smoking and advances in early detection and treatment have contributed to the decrease in cancer mortality over the past two decades. These developments are also reflected in lower mortality rates for lung, breast, prostate, and colorectal cancers:

- The lung cancer mortality rate declined by 48% from 1990 to 2016 among men and by 23% from 2002 to 2016 among women.
- The female breast cancer mortality rate dropped by 40% from 1989 to 2016.
- The prostate cancer mortality rate decreased 51% from 1993 to 2016.
- The colorectal cancer mortality rate dropped by 53% from 1970 to 2016.

These researchers noted that the death rates for some cancers increased between 2012 and 2016. For example, the liver cancer death rate increased by 1.2% per year in men and 2.6% per year in women, the pancreatic cancer death rate (in men only) increased by 0.3% per year, and endometrial cancers increased by 2.1% per year. For 2019, the authors estimate that 1.8 million new cancer cases and 606,880 cancer deaths will occur in the U.S.

Significantly, the researchers noted that despite an overall decrease in cancer deaths and a diminished racial gap in cancer mortality, socioeconomic inequalities are growing. In fact, a recent study estimated that 34% of cancer deaths in Americans 25 to 74 years old could be avoided by eliminating socioeconomic disparities. For example, the prevalence of behaviors that increase cancer incidence and mortality are vastly higher among residents of the poorest counties, including double the prevalence of smoking and obesity compared to residents of the wealthiest counties," the researchers wrote. "Poverty is also associated with lower cancer screening prevalence, later stage diagnosis, and a lower likelihood of optimal treatment."

The recommendation is to reduce the disparities – to highlight the need for more efforts to focus effort in areas in which improvements are needed. The researchers noted that "some states are home to both the poorest and the most affluent counties, suggesting an opportunity for improvement in the distribution of services. Numerous states have reduced inequalities through various strategies that removed barriers to prevention, early detection, and treatment.

ADDITIONAL INFORMATION

Thank you for your interest in Kohler HealthCare Consulting, Inc. If you wish more information about KHC and the services we offer, ***please visit our website*** http://www.kohlerhealthcare.com ***or call 410.461.5116.*** *If you prefer not to receive future issues of our publication, please hit 'reply' and let us know and we will immediately remove you from our distribution. Thank you.*