

Impact of an HMO on a University-Based Family Practice Program

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The impact over a 12-month period of a major increase in enrollment of prepaid insurance patients on the clinical, administrative, and educational activities of a university-based family practice residency program is described. Patient services increased by 40 percent, placing a heavy clinical load on faculty and third-year residents. There were significant increases in referral to psychology, psychotherapy, ophthalmology, and otolaryngology specialists. The high demand for services caused logistical difficulties for office and nursing staff. Adaptation to these changes and cost-containment efforts were hampered by institutional relationships. Strategies to manage the impact included hiring additional staff and part-time clinicians, introducing quality assurance and internal control procedures, and repeated orientation to the prepaid plan. Overall, the impact of the plan was of educational value to both residents and faculty.

There is ample evidence of the growing influence and participation of prepaid insurance systems in the American health care system and of the major changes in health policy that may eventually result.¹⁻⁵ Many of these schemes are based on the concept of the gatekeeper or case manager who ensures that efficient, economical, and effective preventive and curative services reach target populations.⁶⁻⁹ Health maintenance organizations (HMOs) are a recent development in North Carolina. In 1983 Blue Cross/Blue Shield and Health America introduced plans, followed by Kaiser-Permanente and Prudential in 1985.

Primary care physicians appear to be well suited to act as case managers for prepaid plans, as they are trained not only in ambulatory and secondary hospital care, epidemiologic concepts, and community issues, but also in practice management techniques. Their clinical tasks cover the management of self-limited disorders and the early symptoms of disease as well as psychosocial problems. They must also deal with the uncertainties of diagnosis, appropriate referral to specialists, and hospital admission and care for their patients.

Primary care residency programs, particularly in family practice, in the past have been based on the idea of training physicians for fee-for-service practice in which there is continued responsibility for the individual patient and his family. The advent of prepaid care and urgent care centers has produced not only a much wider range of practice choices for these physicians but also a variety of attitudinal and behavioral reactions to different methods of delivering care, both positive and negative.¹⁰⁻¹² For many, there has been an abrupt change in the way physicians run their practices and care for their patients. Ideally, residency programs that are training physicians for primary care practice should adapt to these innovations in health care delivery, but because of institutional relationships and slowness in changing educational planning, these programs may have difficulty in adapting proactively to alternative health care systems.¹³

This paper describes certain aspects of the short-term impact of an HMO on a family practice residency in terms of services provided to patients, attitudes, adaptation strategies, and educational implications.

SETTING

The Family Practice Center, the clinical base of the Department of Family Medicine at the University of North Carolina, is located in a tertiary care center (North Car-

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olina Memorial Hospital) in the heart of the university complex. The practice was established in 1973, and from 1977 to 1984 averaged approximately 1,000 patient visits per month. The patient population has been mixed, serving outlying rural areas, small local industries, and many hospital and university personnel. Patient care is provided by 18 resident physicians (six in each year), 10 attending physicians, 1 part-time family nurse practitioner, 3 licensed practical nurses and 1 registered nurse, a small office laboratory with technical staff, and office staff. By 1985 nearly 9,000 patients were enrolled in the Family Practice Center. The residents receive training in a wide range of specialties as well as spend a major part of their time in the third year in the Family Practice Center. A number of rotations are arranged at hospitals in other towns because these opportunities provide a more realistic and effective experience than the tertiary care center can or is willing to offer primary care physicians. Strong efforts have been made over the years to create a system within the Family Practice Center that promotes and models continuity of care and that emphasizes behavioral and practice management skills.

THE HEALTH MAINTENANCE ORGANIZATION

In 1984 the Family Practice Center affiliated with the Blue Cross/Blue Shield independent practice association health plan, known as the Personal Care Plan (PCP). In the plan primary care physicians would receive a specific monthly capitated fee per patient depending on age and sex. For this fee the physician provided comprehensive medical services and coordinated the use of other medical services including referrals and hospital admissions. Access to other health care providers had to be authorized by the primary physician. In 1984-85 the percentage of office visits to the Family Practice Center by prepaid patients was 5 percent, and 8 percent in 1985-86. In 1986 Blue Cross/Blue Shield offered this plan as one of the health insurance options for all the employees of the state of North Carolina (in competition with other health insurance groups). As the Family Practice Center already served a large number of state employees, failure to join the plan might have led to a considerable loss of patients (estimated at 1,500 to 2,000), seriously jeopardizing the viability of the training program in terms of accreditation. Consequently, on July 1, 1986, approximately 3,000 patients, of whom 1,500 were original patients who had simply changed their insurance status, selected the Family Practice Center as their source of primary care under the Personal Care Plan. Thus 1,500 new patients needed health care services, and the Family Practice Center went from having a small number of prepaid members—277 patients in 1984 to 476 in early 1986—to having a total of 3,000 by the summer of 1986.

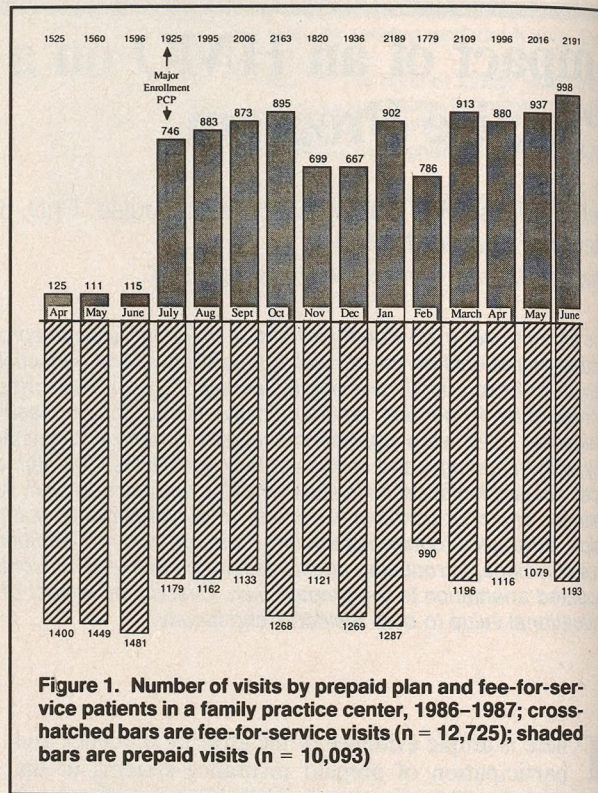


Figure 1. Number of visits by prepaid plan and fee-for-service patients in a family practice center, 1986-1987; cross-hatched bars are fee-for-service visits (n = 12,725); shaded bars are prepaid visits (n = 10,093)

IMPACT

Patient Care Services

Patient visits to the Family Practice Center made by newly enrolled PCP members rose from just under 10 percent of all visits in the three months preceding the major enrollment in July 1986 to 44 percent in the subsequent six-month period (Figure 1). Total encounters increased by 40 percent to approximately 2,100 per month and have remained at that level until the present time. Fee-for-service visits dropped by only 18 percent, although one third of the practice had switched to the PCP. The proportion of routine physical examinations of all PCP visits doubled to 20 percent one month after the enrollment, and dropped to an average of 10 percent at the end of 12 months, while fee-for-service examinations dropped in absolute terms but remained at a stable proportion of all fee-for-service visits (8.5 percent). The proportion of office procedures performed for PCP patients (which were included in the capitation fee for members) showed little change and, contrary to other services, remained 50 percent lower than the number performed for fee-for-service patients.

Ancillary Services

The major ancillary services covered by capitation were x-ray studies, obtained through the adjacent teaching hospital, and laboratory studies, either performed in the Family Practice Center or sent to the hospital for analysis. The number of x-ray studies ordered almost doubled from 65 in both May and June to 120 in July, the month of the major PCP enrollment. Of the July procedures, 46 percent were for PCP patients. The total number of x-ray studies peaked in September (146), giving a rate of one study for every 13 visits, compared with the previous one per 23 visits. The number of monthly x-ray studies gradually dropped to 76 in the seventh month after the enrollment and then stabilized at 110 per month. Charges for these studies by the radiology department rose from an average of \$5,500 per month before the major enrollment to \$10,000 a month. Mammograms and chest films made up close to 40 percent of all studies performed over this period, reflecting the role of screening in primary care. Personal Care Plan patients (now one third of the practice population) accounted for nearly one half of all x-ray studies.

The number of Papanicolaou tests increased from 89 in the month before the major enrollment to 142 in the second month afterward. Fifty-three percent of these were for PCP patients. These tests now are done at an average of 110 per month. None of the above studies were a required standard by the plan, but the marketing literature recommended routine checkups with primary physicians and stimulated the demand.

The pattern of laboratory tests performed in the Family Practice Center also showed a marked change (Table 1). Over a 12-month period the absolute increase was 30 percent. Personal Care Plan visits accounted for 60 percent of the Family Practice Center laboratory tests. These tests, of course, were covered by capitation but performed "in house." In contrast, when tests were ordered through the hospital, fee-for-service patients accounted for 66 percent of the tests and PCP patients, 34 percent. It should be noted that the costs of these hospital tests for PCP patients were billed to the Family Practice Center. It appears that cost-containment activities promoted the use of laboratory tests within the Family Practice Center and reduced the ordering of tests outside the center.

Specialist Referrals

During the three months prior to the start of the PCP, referrals from the Family Practice Center to outside specialists from the hospital and private practice were made at an average of 60 per month, of which 8 percent were PCP related. At that time PCP patients formed 4 percent of the patient population. In the month of the major en-

rollment, referrals increased to 150, and then increased by another 46 percent over the remaining 11 months, a 200 percent increase in total referrals. The proportion of PCP referrals rose from 8 to 70 percent. Referral frequency (number of referrals as a proportion to patient visits) increased from 1:37.5 prior to the major enrollment to 1:11 in the subsequent six months. The relative distribution of referrals to specialists is shown in Table 2. It should be noted that referrals to clinical psychologists and psychiatrists accounted for 12.5 percent of all referrals, and many of these patients required prolonged therapy—a costly item for the case manager (depending on co-payment arrangements).

Referrals to the teaching hospital rose by 45 percent over the 12-month period and dropped by 8 percent to local private specialists. The Family Practice Center thus demonstrated its commitment to the teaching hospital, but at a price: higher specialist fees and considerably less efficient and convenient service for PCP enrollees (which ran counter to their expectations!).

Administrative

These data demonstrate the domino effect of a nearly 40 percent increase in total patient visits (and a 600 percent increase in prepaid enrollment). Planning for this enrollment was hampered by lack of information and training from the Personal Care Plan administration, by clinical space limitations, and by an inability through institutional regulations to acquire extra staffing. The month of July was a period of both orientation for new residents and the enrollment of 1,500 new patients, creating a serious problem. High utilization was noted in terms of referrals and requests for routine health maintenance by plan members during the early enrollment period. Several aspects of the practice were unable to accommodate the overload (Table 3). The reception staff had difficulty responding to telephone calls and inquiries, entering new registrations, and making up new medical charts. Full appointment schedules gave no space for acute care or walk-ins, the waiting area and the laboratory were swamped at times with patients, nursing tasks increased and were often not done, and staff were unable to handle all the authorization procedures. Several staff members resigned. One important issue for some office staff was the rapid change from a personal relationship with patients and physicians (as well as a reasonable work pace) to the more production-oriented approach, which was essential (although not necessarily desirable) to deal with the numbers of patients requesting care. The loss of time to chat with and get to know patients removed an important part of the job satisfaction for some staff members.

The difficulty of adequate planning for this major enrollment was compounded by poor communications and

TABLE 1. PREPAID PLAN VS FEE-FOR-SERVICE LABORATORY WORK, FAMILY PRACTICE CENTER, 1986-1987

	Number of Tests Ordered*			Charges(\$)		
	FFS	PCP	Total	FFS	PCP	Total
Teaching hospital (external)						
June	301	2	303	4,662	79	4,741
July ← PCP	204	97	301	3,178	1,774	4,952
August	172	94	266	2,501	1,556	4,057
September	211	94	305	3,406	1,666	5,072
October	271	116	387	4,292	1,966	6,258
November	178	103	281	3,017	1,817	4,834
December	245	143	388	4,073	2,494	6,567
January	204	128	332	3,612	2,399	6,011
February	230	109	339	4,198	1,952	6,150
March	270	124	394	4,639	2,336	6,975
April	283	205	488	4,770	3,547	8,317
May	265	173	438	4,429	3,278	7,707
June	269	208	477	5,021	3,209	8,230
Total	3,103 (66%)	1,596 (34%)	4,699	51,798	28,073	79,871
Family practice (internal)						
June	325	107	432	3,109	838	3,947
July ← PCP	173	207	380	1,586	1,781	3,367
August	198	280	478	1,887	2,237	4,124
September	220	312	532	2,040	2,589	4,629
October	290	416	706	2,900	2,876	5,776
November	229	301	530	2,088	1,856	3,944
December	239	384	623	2,229	2,406	4,635
January	242	376	618	2,164	2,441	4,605
February	219	334	553	2,121	2,094	4,215
March	288	378	666	2,622	2,199	4,821
April	320	429	749	2,915	2,631	5,546
May	278	516	794	2,639	2,888	5,527
June	278	521	799	2,577	2,756	5,333
Total	3,299 (42%)	4,561 (58%)	7,860	30,877	29,592	60,469

* Does not include Papanicolaou smears, microbiology and surgical pathology laboratory work. FFS—fee for service; PCP—Personal Care Plan

TABLE 2. DISTRIBUTION OF MAJOR SPECIALIST REFERRALS, PERSONAL CARE PLAN PATIENTS (n = 2,810)

Specialty	Percent of Referrals
Ophthalmology	11.3
Ear, nose, throat	9.5
Gynecology	9.5
Psychology	7.0
Orthopedics	6.0
General surgery	6.0
Obstetrics	5.6
Psychiatry	5.5
Emergency room	5.1
Dermatology	4.6
Cardiology	4.1
Urology	3.2

public relations by the Personal Care Plan staff. Patient information materials were not distributed early enough, orientation seminars were run by representatives who did

not understand the plan thoroughly, and prospective members often had difficulty getting information from the plan's offices. Prospective members then turned to the practice for information, increasing the telephone workload considerably. The materials developed by the PCP raised a number of expectations among patients including easy referrals, a range of prevention services, early appointments to "get a physical," and immediate care on demand. Consequently, requests for appointments increased considerably in the first three months after enrollment, and plan members complained when their expectations were not being met.

Another problem was the initial high-utilization and referral rates generated by patients with chronic or serious disease who had joined the prepaid plan. Many of these people were seeking authorization to continue the patterns of regular visits to specialists without limitations and thereby challenged from the outset the case manager or gatekeeper role. The main clinical areas at issue for the

TABLE 3. IMPACT OF A PREPAID PLAN: WORKLOAD EFFECTS ON OFFICE STAFF

Category	Problem
Telephone inquiries	Overload on reception staff with diminished responsiveness to patients
New registrations	Overload on daily registration process
Adverse enrollment	Increased contact needed with PCP administrators and specialists
Routine physical appointments	Swamped appointment system. No slots for acute walk-in patients
Referrals	Increased. New complex patient problems: difficulties with authorizations
Medical records	Overload in making up new charts. No more storage for records. Charts often unavailable to physician
Laboratory	Increase in tests. Overload at certain times of the day
Financial counseling	Marked increase. Office too small to respond adequately. Extra person needed
Nursing	Overload. Delay in response to triaging calls. Tasks often not completed
Waiting area	Space inadequate. Sometimes patients have to stand while waiting
Morale	Damaged. Loss of ability to personalize care. Little time to work on new management strategies. Patients not well informed of prepaid system by PCP. Staff resignations

PCP—Personal Care Plan

physicians in the Family Practice Center were the large number of requests for continued psychotherapy, chiropractic therapy, and allergy programs.

Despite all the difficulties outlined above, the staff and physicians adjusted remarkably well, partly because of a number of compensatory organizational strategies (Table 4), some of which had been planned previous to the enrollment, which included hiring extra management and clinical staff, adding more patient care hours, and developing procedures to supervise referrals and high-cost ancillary services. Additionally, after the first six months the Family Practice Center closed all new patient enrollment for three months to allow major staffing and record room changes to occur in a less pressured environment.

Education

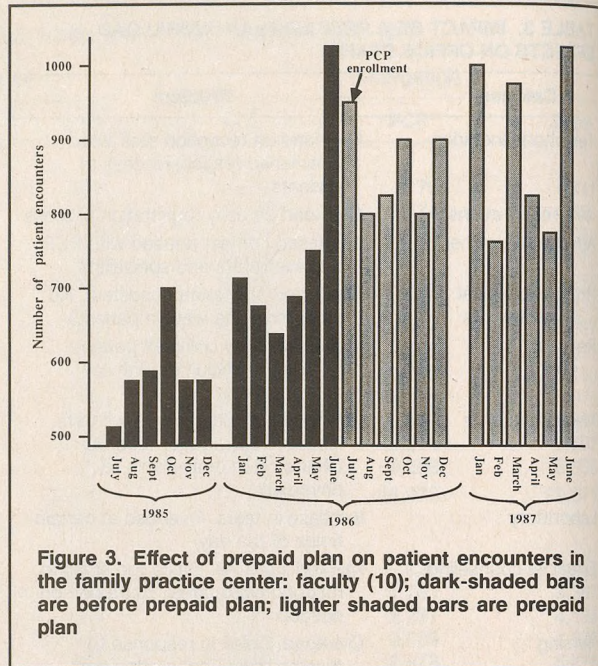
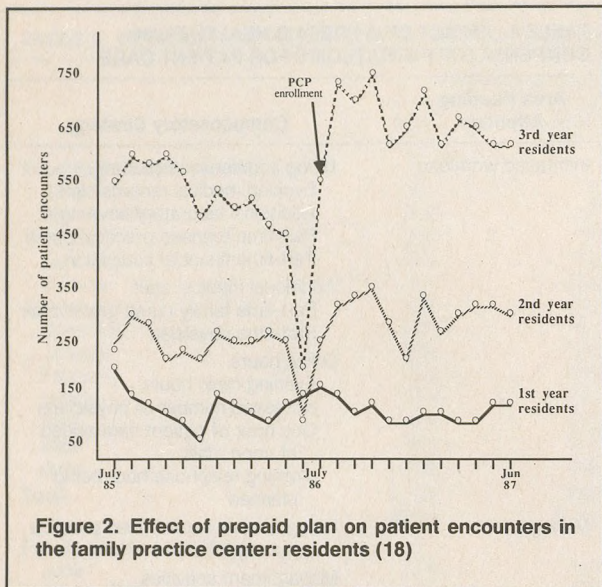
For the residents, the main impact of the increased enrollment occurred in the outpatient setting of the Family

TABLE 4. IMPACT OF A PREPAID HEALTH PLAN: COMPENSATORY STRATEGIES FOR PATIENT CARE

Area Needing Attention	Compensatory Strategy
Increased workload	Hiring additional office staff Evening medical records clerk Additional laboratory coverage Part-time licensed practical nurse Part-time financial counselor Additional medical staff Part-time family nurse practitioner Part-time physician
Management	Office hours Evening clinic hours Increased number of physicians One hour of patient care added at noon, daily Morning telephone hour being planned Hiring a more experienced practice manager Management activities Weekly supervisors meeting Weekly long-term planning meeting Biweekly management committee Cap on enrollment to allow systems to be developed Financial counselor participates in management supervision
Communications with patients	Setting up mechanism for handling patient complaints Patient education Patient newsletter started Patient information packet developed
Cost containment/gatekeeping	Signed approval by another physician for referrals (laboratory and x-ray studies not reviewed) Continued orientation to HMO mechanisms Reduction in external ancillary and laboratory requests Increased FPC internal management procedures
Specialist/institutional relations	Development of primary care hospital interest group Negotiations to reduce specialist fees

HMO—health maintenance organization; PCP—Personal Care Plan; FPC—Family Practice Center

Practice Center. Obstetric care and admissions to the family practice inpatient service increased only moderately—certainly not by the 40 percent experienced in the ambulatory visits. As much as possible, during the initial days of the enrollment period, first-year residents were protected from overload in the Family Practice Center



both by restricting appointments and by assigning PCP patients only to third-year residents and faculty. All physicians were required to see these patients if necessary, however. No specific guidelines were given to treat the PCP patients in any way different from fee-for-service patients. In Figure 2 the increase in patient visits per month for residents is compared with the previous year; the brunt was taken by third-year residents, who saw an extra two patients per half-day care session (four half-days per week), while second-year residents saw an extra 1.5 patients (two half-days per week) and first-year residents saw an occasional extra patient (one half-day per week). The decline in resident patient visits in June 1986 was the result of routine transition in the residency program. At this time faculty carried an increased patient care workload.

Increased patient visits provided residents with the opportunity to learn efficiency and patient-flow management in collaboration with office staff. The gatekeeper role increased contact and helped to build relationships with consultants, particularly those giving adequate feedback to the primary physician. Faculty also increased their clinical workload by 50 percent (Figure 3) through more concentrated scheduling of patients within given half-day care sessions rather than an absolute increase in the number of sessions. Extra clinical and precepting sessions were provided for the Family Practice Center, however, by hiring a part-time physician and a half-time family nurse practitioner. How much the increase in clinical work affected faculty teaching, administrative, and research activities is difficult to assess.

The boost in patient volume also increased the number of telephone calls to third-year residents (who frequently

covered the care of the junior resident's patients) and greatly increased after-hours work such as coverage of the inpatient service, outpatient calls and emergency room care, medical coverage of a nursing home, and obstetric care. The extensive administrative work generated by the prepaid practice was a particularly frustrating additional burden.

Although residents came to understand the realities of functioning within a prepaid practice, the lack of a personal financial stake in the enterprise and the lack of a per visit charge may, in fact, have encouraged physicians to order diagnostic tests or to recall patients for follow-up. Resident training for prepaid care can be accomplished by establishing and continuing review of referrals, using faculty and laboratory staff to question workups, feeding back utilization data, and auditing clinical care.

Other effects of the increased patient volume were a reduction in teaching interactions with attending physicians in the Family Practice Center and less time to read and study during the daytime (replaced by administration and chart dictations). Residents were sometimes uncomfortable in taking a more directive role with consultants, especially in requesting cost-effective strategies; in turn, many consultants in the teaching institution were unhappy with the whole philosophy of the PCP. Despite the apparent switch of the mission of the Family Practice Center from education to providing care and coping with stresses of prepaid medicine, the main objective remained the training of primary care residents in cost-effective,

comprehensive, and careful medical care without too much emphasis on the solvency of the outpatient training site. This balancing act was difficult both philosophically and financially.

DISCUSSION

The data reported in this paper show the major effects of a large enrollment of prepaid patients on an academic primary care setting in which there was limited ability to expand space or staff. Beneficial effects included increasing clinical ambulatory experiences for residents and faculty, exposing them to the concept of a health maintenance organization, and attracting an increased and guaranteed income.

Many of the strategies implemented to counter these effects were aimed at managing an increased patient care workload and therefore were not specific to PCP patients. The suddenness and volume of the enrollment created a problem that is extremely unlikely to occur in the case of practice growth created by fee-for-service demand. The prepaid plan resulted in major commitments of time by the medical director and the practice manager, an increase in planning and meeting time for supervisors, and the development of a management committee representing those parts of the department with a stake in the Family Practice Center. Strategies for controlling high-cost procedures and referrals as well as quality assurance programs were stimulated by the PCP enrollment and were beneficial to the educational and clinical work in the center. For residents in this program, the PCP not only created an important and expanded clinical experience but also offered exposure to a different style of medical practice.

Adverse effects of excessive workload and lack of time for in-service training and discussion were also experienced by office and nursing staff, with concomitant damage to morale and resignations in which experienced and perhaps irreplaceable personnel were lost. One fact was evident: the gatekeeper role of the primary care physician had permitted the Personal Care Plan to shift a considerable administrative load into the primary care physician's office. This increased administrative burden should be taken into account in calculating and contracting for capitation payments in the future.

From the center's recent experiences, recommendations for implementing the prepaid element of a residency-based practice should include a prolonged planning phase led by a committed medical director, a limited enrollment of no more than 20 percent of the total practice to prevent overwhelming the practice and to facilitate the transition phase, an early development of an office triage system to prevent overload of patient demand, a field test of infor-

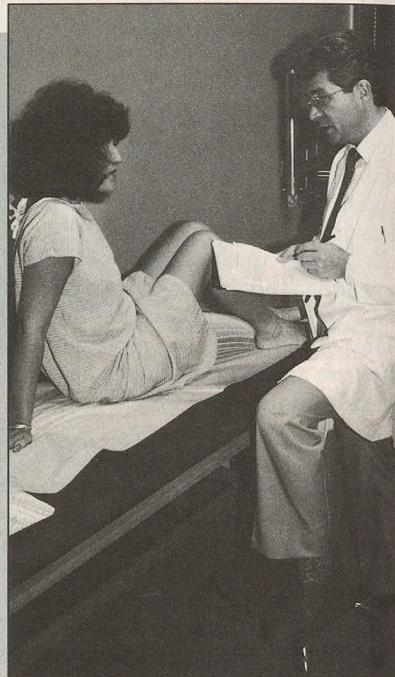
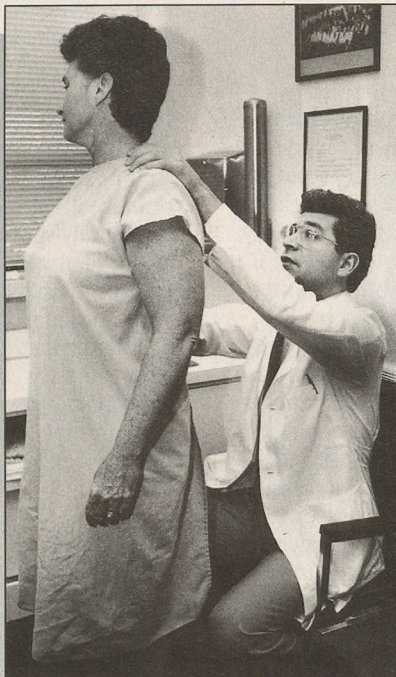
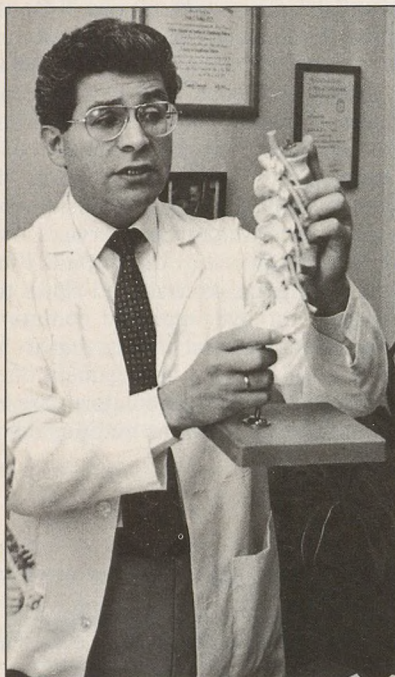
mation systems that track utilization, and a preenrollment increase in office and nursing staff.

The relationship between a primary care residency program having a significant number of prepaid patients and its affiliated hospital can be a difficult one.¹³ On the one hand, the primary care practice must seek cost-containment methods to survive financially and must be allowed to develop strategies to cope with the workload. Ideally, these strategies involve looking for the lowest cost ancillary services and specialist consultants as well as controlling hospital admissions.¹⁴ On the other hand, the practice must support the affiliated hospital by using what are usually more expensive consultants and services. Two major factors need to be recognized by the hospital. First, prepaid managed care promotes referrals and closer ties with specialist colleagues through improved communication and creates significant financial benefits that accrue from primary care units; second, this arrangement offers an opportunity for a special type of ambulatory care education that cannot often be found in the traditional hospital setting.¹⁵

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