



**Improving Quality:
Chronic Kidney Disease**

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A Patient's Perspective

[A patient encourages providers to help people with CKD learn to cope]



"I think it is important for a clinic or doctor to designate a 'buddy' for new CKD patients to help them understand what is going on, what will be happening and who can give sound advice."

— Jackie Bland
CKD Patient since 2003



After 25 years with diabetes, Jackie Bland was accustomed to the adjustments the disease has made to her daily routine.

That is until she was diagnosed with chronic kidney disease (CKD) in the fall of 2003.

Now it's pills (morning, noon and night), one shot daily for her diabetes, a 32 ounces of fluid limitation daily and seven hours of dialysis three days a week.

It has taken a while, but she is used to the schedule that dialysis has put on her life. "Well...adjusted to just about everything," she says with a laugh.

"I think I can live with just about everything, but the fluid limitation," she said. "I can not live with only 32 ounces of fluids a day. I love a glass of ice-cold water. That's my third Heaven."

Knowledge is Power

While she has come to terms with having CKD, she has discovered that coping with the disease is difficult.

Not as difficult as getting into a routine that centers on dialysis and medication, but attempting to understand her disease and learn about the complexities that come along with it.

Especially the medical jargon.

"I hardly knew what the kidney was for. What the heck is creatinine?" she said. "I didn't have an idea that kidneys do two functions — they filter and they produce urine. I thought as long as I was making urine, I was fine. It didn't make any sense. I was ignorant myself."

Little did she know that there are simple tests that doctors can perform to

determine a kidney's functioning level and tell-tale signs that patients can look for themselves to determine if there may be a problem.

Such as high blood pressure.

"That's what alerted me that something was wrong," she said, describing how her blood pressure reached 200/140 and sent her to the hospital for treatment. "My feet started to swell. I was tired all the time. I was thirsty all the time. But it was my blood pressure. That's when it started to sink in that something was going on."

She admits never having a formal one-on-one discussion with her doctor once she was diagnosed with CKD. Instead she was "shuffled off" to a nephrologist with the knowledge that her diabetes and high blood pressure were to blame.

"It was a fast, hard transition that I couldn't handle and there was nobody to help me," she said. "I went through a whole new world of stuff I knew nothing about."

In The Mix

Bland had three strikes against her — she has diabetes, has high blood pressure and falls into an ethnic category designated as being a high risk group. She was not aware of anyone in her family that had a history of these conditions.

Her diabetes was induced from medication treating a condition known as Sarcoidosis that involves inflammation that produces tiny lumps of cells in various organs in the body.

Adding to her health problems and the stresses of daily life, Bland said she

was at the end of her rope when she was diagnosed with CKD in 2003.

Within a six-month period, she went from working as an elementary school teacher to forced retirement and ending a job working nights at FedEx, with her father dying and having an adult son share her home.

She attributes the stress of work, retirement and family taking a toll on her blood pressure and triggering CKD.

“You don’t burn the candle at both ends,” she said.

Learning To Cope

After her diagnosis, Bland said she went into a deep depression and spent a lot of time crying. While the events in her life played a big part in her emotional response to the diagnosis, it was the “not knowing what to do” feeling that overwhelmed her.

“If my doctor had taken time to talk to me about CKD and explained what it meant, it would have helped,” she said. “But he didn’t. Everything I know about CKD I learned on my own.”

Most of her knowledge about her conditions comes from Internet resources, primarily a patient message board she uses religiously for support, advice and information. The message board has been a big help — especially once she made the transition to nocturnal dialysis, a treatment that scared her for obvious reasons.

“The first clinic I went to, there were many of the patients there that had amputations,” she said. “They had one

foot or one leg or both legs amputated. And that scared the heck out of me, because I knew I was diabetic and diabetic people lose limbs. So I thought that dialysis meant I was going to have to give up a limb. I couldn’t do that.”

Bland turned to the Internet for answers and discovered her fear was valid, but not necessarily her fate.

“I’ve gotten smart. I’ve gotten everything under control,” she said about her diabetes.

Nighty Night

After spending time researching dialysis options, Bland was given the green-light by her nephrologist to use nocturnal dialysis. Sunday, Tuesday and Thursday nights are usually spent wrapped in a blanket and connected to a dialysis machine for seven hours.

“You can’t miss too many treatments. If you do, then you probably won’t be around here very long,” she said. “Even though I don’t like treatments, I decided I had better go, so I go.”

Treatments are made a little easier, Bland said, thanks to her arteriovenous fistula (AVF). The fistula allows for easier access and isn’t unsightly as a previous access procedure that left her upper arm disfigured.

“My advice to people is to do what you need to do to stay off of these machines. It isn’t any fun to be on these. And there are still a few empty chairs here if they want to join us,” she said with an insightful grin.

How To Help A Patient

As a patient who has received treatment from many doctors, Jackie Bland knows a thing or two about what the medical staff can do to help patients make the transition from “normal life” to “a new life.”

Having been self-educated about the disease, here are a few things she suggests providers take into consideration to provide improved care:

- ▶ Providers should understand patients as individuals and how the disease affects them not only physically, but also their entire lifestyle.
- ▶ Providers could designate a “patient buddy” who can talk to other patients about their disease, offer advice and help with the transitions the disease brings in a patient’s life.
- ▶ Providers could become more online savvy by joining online patient discussion groups to offer advice and make resources available to patients.
- ▶ Don’t pass the buck or assume patients understand medical treatments. Providers should slow down and take more than five minutes to discuss treatment. Providers should begin education immediately and direct patients to reliable educational resources.



Save the Vein



Shelby County hospitals are saving lives by saving CKD patients' veins as part of a systems change process.

By the time chronic kidney disease (CKD) patients are assessed for hemodialysis venous access, many already have iatrogenic injury to their veins which impedes the surgical construction of an arteriovenous fistula (AVF).

As an acute care coordinator for Fresenius Medical Care, Sherri Butler has seen the results of such injuries. She knows the irreversible damage the injuries can cause. She also knows they can be prevented.

"Having vein access is very important for dialysis patients," she said. "It is their lifeline for treatment. If their veins are damaged in both arms, it means the difference of being able to have a fistula or not."

Butler decided to "save the vein" by educating staff, gaining buy-in from hospital staff and spreading a concept system-wide.

National Need

AVFs are the focus of national efforts by the Centers for Medicare & Medicaid Services (CMS) and the Fistula First campaign. Medicare funded organizations such as QSource and the End Stage Renal Disease (ESRD) Network 8 are working with providers in Tennessee to improve fistula usage.

AVFs are the preferred hemodialysis access as they provide the best patient outcomes as measured by mortality, hospitalization

rates, infections and requirement for repeated access interventions. AVFs are also less expensive.

The ability to create a more functional fistula is critically dependent on the availability and condition of a patient's central and peripheral veins.

Frequent venipuncture and the indiscriminate use of peripheral intravenous lines, peripherally inserted central catheters (PICCs) or central venous catheters can damage veins, impair venous circulation and jeopardize future fistula construction or function.

Any hemodialysis vascular access is at risk for failure and, therefore, protecting the veins for future fistula creation remains an important part in the dialysis patient's healthcare. Any loss of these veins from iatrogenic injury represents a significant morbidity that should be avoided. To do so requires a method of alerting medical staff to not to use a non-dominant arm for injections or blood pressure.

System Change

While working at the dialysis center at Baptist Memorial Hospital (BMH) in Memphis, Butler noticed a doctor's notation on a chart asking for a wristband to alert others not to use the dialysis patient's arm because of a fistula.

"I thought this was a good idea and took the idea with me to

discuss it with staff,” she said, seeing it as the perfect opportunity to use the concept and get support to spread it systemwide. The idea was discussed during one of the monthly meetings between Fresenius Medical Care (FMC) and BMH.

The concept is not a completely foreign idea. It is actually mentioned in a position paper posted online by the American Society of Diagnostic and Interventional Nephrology (ASDIN). In the paper, the researchers suggest using a wrist identification system, but refer to medical bracelets that contain a patient’s personal health information.

The authors also recommend a hospital-wide collaboration between primary physicians, nephrologists, nurses, interventionists and hospital administrators to work together to develop consensus policies to address the issue of saving a patient’s vein for future use.

In late 2007, FMC and BMH began an effort to identify dialysis patients when undergoing procedures at the hospital by using the wristband concept.

“We were looking for a way to identify access limbs so that blood pressure and needle sticks would not occur on that affected arm. Prior to the arm band, the doctor used to request a note placed in the patient room saying ‘No BP or STICKS to [blank] arm’, but this did not help when the patient travelled to other areas of the hospital for treatment and tests. The arm band is a quick and easy way to identify a patient and it is always with the patient.”

By placing a wristband on the patient, the medical provider knows that the arm is a “restricted extremity” either because a patient has a fistula or their veins are being saved for the possibility of having a fistula.

“Pink is commonly associated with mammography. But it was the color available to us at the time so we used it,” she said. “My hospital liaison at BMH, Sharon Stubblefield, suggested that we use the pink band.”

The wristband concept complemented the hospital’s efforts to reorganize its color coding system for wristband use system-

wide at the same time. This allowed the pink wrist band to be designated for use at all BMH locations on all floors and at each station.

The cost to implement the program was very little, Butler said.

“We already had the wristbands in-house and buying more cost pennies,” she said. “So it was cheap.”

Staff on all floors and each department were educated on the addition of the wristband use. Butler used the hospital’s in-house newsletter *The Daily Dose* to inform staff as well as mentioning it during meetings.

Posters were placed on the nursing units and in the dialysis treatment area. Both staff and patients were made aware of the effort.

“The wristbands not only help with the identification and education of high risk CKD patients, but also empower patients in protecting their veins,” she said. “When the patient is aware, the provider is kept aware.”

Spreading Change

BMH changed its armband colors to comply with a citywide initiative between all hospitals to use the same color code for arm bands.

The idea is spreading, according to Butler, as hospitals throughout Shelby County are starting to use the wristband to identify dialysis patients.

Saint Francis Hospital has seen success with the wristband effort and Methodist Hospital is following suit, she said.

“This is an incredible step for everyone involved,” she said. “This means when a patient goes from one hospital to another, they will receive the same type of identification wristband as they would at another. It’s all a part of the continuum of care.”

QSource is working with Butler to develop a statewide intervention based on the “Save The Vein” concept. Posters and other materials will be available in 2009 on QSource’s Web site (www.qsource.org).

For a copy of the ASDIN Position Paper, log on to www.asdin.org.

Save The Vein Tips

- ▶ Avoid needle sticks of any kind (including blood draws) in a non-dominant arm. This is the arm that will most likely be used for a fistula or graft. If the patient is right-handed, the left arm is the non-dominant arm.
- ▶ For a catheter or emergency care, avoid using the sub-clavian artery and/or vein.
- ▶ For a fistula or graft, do not have the blood pressure cuff placed on that arm. Use the other arm whenever possible.



Healthcare staff are made aware to “Save The Vein” of patients wearing this pink wrist band.

>> Measure Focus: ACE/ARB

ACE/ARBs prove to be effective preventive step for CKD

More than 65 million Americans have hypertension, and it is the leading attributable risk factor for death throughout the world. It is also one of the contributing factors to developing chronic kidney disease (CKD).

Hypertension is a cause and complication of CKD that increases the risk of adverse outcomes, including loss of kidney function, kidney failure, early development and accelerated progression of cardiovascular disease (CVD) and premature death.

Along with diet and exercise, physicians usually prescribe an antihypertensive therapy of either an ACE inhibitor (angiotensin converting enzyme inhibitors) or ARB (angiotensin receptor blockers) to treat the disease and deter damage that kidneys may sustain from hypertension.

ACE/ARB

These two kinds of drugs are particularly good for the treatment of people with high blood pressure and kidney disease. An ACE inhibitor decreases the body's ability to make angiotensin, a substance that increases blood pressure (BP). An ARB stops the angiotensin from working so that it can't increase the BP.

These medicines work because they are good at lowering blood pressure and are better than other BP medicines in slowing the loss of kidney function.

They also protect against heart attacks and strokes and are the medicines that should be used first for the treatment of heart failure.

Therefore, these two types of medicines are the best medicines for the treatment of most people with high BP and CKD.

The goals for this therapy in CKD are to lower BP, slow the progression of kidney disease and reduce the risk of CVD.

All antihypertensive agents can be used to lower BP in CKD. Most patients need multi-drug regimens to achieve therapeutic goals, and patients with specific causes of CKD and CVD will benefit from specific classes of agents.

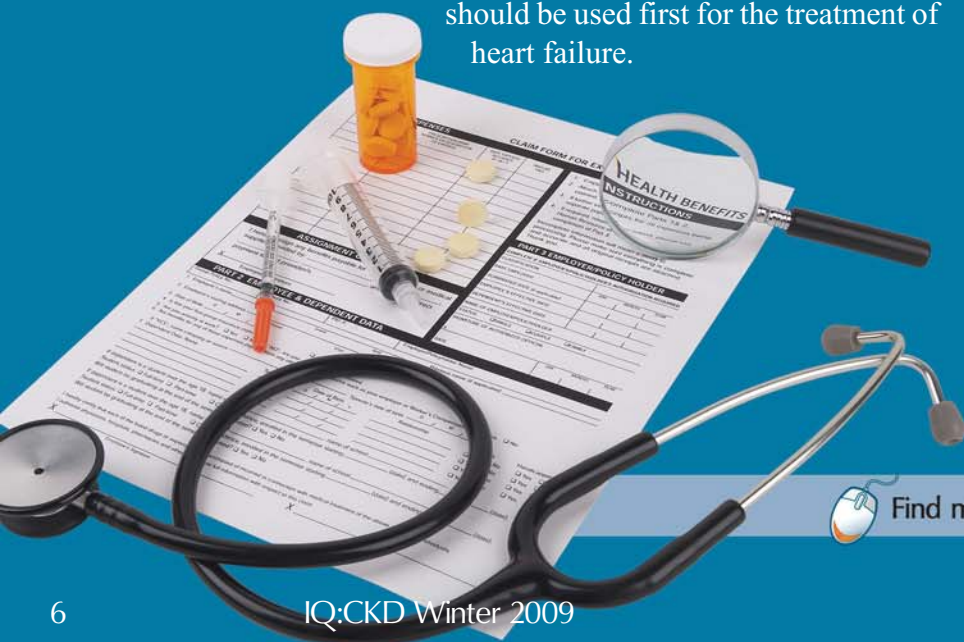
Comprehensive evaluation of CKD patients should include:

- ▶ Measurement of blood pressure
- ▶ Type of diabetes (diagnosis), glomerular filtration rate (GFR) and proteinuria
- ▶ Presence of clinical CVD and CVD risk factors
- ▶ Barriers to self-management
- ▶ Complications of pharmacological therapy
- ▶ Clinical action plan based on stage of CKD

Pearls for Practice

According to a study in the *Annals of Internal Medicine* (January 2008), ACE inhibitors and ARBs are equivalent in efficacy for the treatment of essential hypertension and are similar in efficacy for the treatment of proteinuria of chronic renal disease, with the combination being more effective than monotherapy with either drug.

An article about this study can be found on QSource's Web site (www.qsource.org) by clicking on "Clinical Topics" and selecting ACE/ARB.



Find more information online at: www.qsource.org

March is National Kidney Month

Patients and healthcare providers across the nation are being encouraged to test for symptoms that can lead to chronic kidney disease (CKD) as March is designated as National Kidney Month. The nationwide acknowledgement was created to raise awareness about the importance of the kidneys and support education and understanding of CKD detection programs.

The month coincides with World Kidney Day (WKD) on March 13 and observed by more than 100 countries on six continents. WKD is a global health awareness campaign focusing on kidney care.

►► Free KEEP Screening

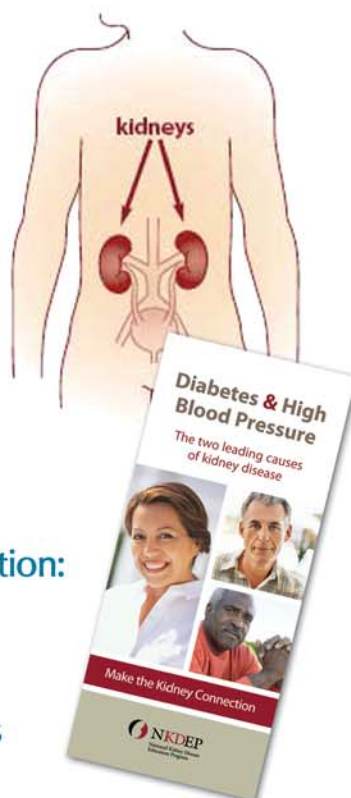
The National Kidney Foundation's (NKF) Kidney Early Evaluation Program (KEEP®) is available for those at risk - anyone 18 years and older with high blood pressure, diabetes or a family history of kidney disease.

It is designed to raise awareness about kidney disease among high risk individuals and provide free testing and educational information, so that kidney disease and its complications can be prevented or delayed.

KEEP provides three simple tests that determine kidney function. Participants receive a comprehensive health risk appraisal, blood pressure screening, blood and urine testing. In addition, participants have the opportunity to discuss health and review results with onsite clinicians.

►► CKD is Treatable

There is now strong scientific evidence that early detection, altering lifestyle factors and aggressively controlling blood pressure, cannot only slow or halt the progression of CKD to end-stage renal disease (ESRD), but can also significantly reduce the incidence of cardiovascular disease that leads to premature death in the majority of patients.



 Online resources for more information:

www.nkdep.nih.gov/resources

This brochure is available online free-of-charge for use with patients



Activities in Tennessee

QSource and partnering organizations are planning special activities and launching patient awareness campaigns during March and April.

Here are a few you should be aware of happening near you:

► **Kidney Day On The Hill**

The NKF of Middle Tennessee is increasing state legislators' awareness of the statewide CKD epidemic by visiting the State Capitol. More details will be made available on the NKF of Middle Tennessee's Web site (www.nkfmdtn.org).

► **Davidson County KEEP Screenings**

Two screenings will be conducted. Details are available at www.nkfmdtn.org.

► **Shelby County KEEP Screenings**

To make early detection of CKD as easy as possible, the NKF of West Tennessee is offering free screenings in March.

► **2009 NKF Spring Symposium**

This one-day clinical meeting focusing on timely identification and treatment of CKD will be held April 25 in Kingsport, Tenn.

Attendees will be eligible for up to six CMEs upon completion of the symposium. Education opportunities include pre-dialysis care for CKD patients, Medicare billing protocols for CKD patients and the value of post-transplant care.

Visit www.kidneyetn.org for more details.

Coding Correctly { Know what codes to use for PQRI during 2009

Physicians across the country have been receiving extra Medicare dollars for their efforts as part of the Physician Quality Reporting Initiative (PQRI). Knowing what and how to code properly is the key to obtaining the maximum incentive payment during 2009 as many physicians have discovered during the previous reporting period.

Reporting PQRI in 2009

For 2009, physicians can earn a 2 percent PQRI bonus by successfully reporting on either 30 consecutive or 80 percent of Medicare Part B fee-for-service patients for which three or more quality measures (QMs) apply. The number of QMs for 2009 has increased from 119 to 153 and Medicare is offering an additional 2 percent bonus for e-prescribing.

PQRI measure groups for 2009 consist of specific conditions that are addressed by at least four measures that share a common denominator specification:

- ▶ Diabetes Mellitus
- ▶ Chronic Kidney Disease
- ▶ Preventive Care
- ▶ Rheumatoid Arthritis
- ▶ Perioperative Care
- ▶ Back Pain
- ▶ Coronary Artery Bypass Graft Surgery

Helpful Hints

During the previous reporting period in 2007, physicians noted complications when reporting. Medicare has reviewed comments and integrated suggestions into the new reporting capabilities.

“We urge participants to review the information received on the remittance advice along

with their own records (such as their own claims information) to ensure that PQRI quality information is being accurately submitted and captured on claims,” the agency said in the fee schedule posted online.

The bulk of the incentive and coding issues stem from not properly reporting quality measures. To deter this, here are three steps physicians may take to make reporting easier and more accurate:

Step 1: Ensure that your computerized practice management system can accept CPT Level II or G-codes. These codes are alpha-numeric and some systems will not accept them.

Step 2: If you are using a clearing house or scrubbing service to submit your bills, you must be sure that the service can accept CPT Level II or G-codes, as some cannot. Another potential computer problem is that some systems will not accept a 0 (zero) dollar amount in the field following a CPT code. If that is the case in your system, it is easily solved by inserting a small dollar amount, like \$1.

Step 3: Develop a systematic method to instruct your billing clerk to append the appropriate CPT Level II or G-codes to the CMS 1500 forms.

A complete guideline for proper coding and data submission for the 2009 reporting period, along with an executive summary reporting during 2007, is available online at <http://www.cms.hhs.gov/PQRI/>.

PQRI Background

The Tax Relief and Health Care Act of 2006 required that the Centers for Medicare & Medicaid Services (CMS) establish PQRI. The initiative does not reward adherence to established standards of care, but rather rewards *reporting* of a designated set of QMs.

Eligible professionals do not need to register to participate for PQRI; they can participate by reporting the appropriate QM data on submitted Medicare Part B fee-for-service claims. Data is collected by CMS using the National Provider Identifier (NPI).

The names of providers who successfully report in 2009 under PQRI and providers who are able to use electronic prescribing will be posted on the CMS Web site after the close of the reporting period.

Available online @ www.cms.hhs.gov/PQRI/:

- ▶ “The 2009 PQRI Quality Measures Specifications Manual & Release Notes”
- ▶ “The 2009 PQRI Implementation Guide”



Roughing It [Cannulation Camp focuses on technique and patient care]

When Deborah Brouwer says patients require more touchy-feely attention, she means it literally.

“It is important to look, listen and feel,” she told a group of dialysis clinicians during a Cannulation Camp. “Nephrologists aren’t trained to touch a patient. They look at charts. When a dialysis patient sits down, take a few moments to do a physical exam to determine if there is anything going on with that patient before dialysis starts. Look, listen and feel. It’s that important.”

Being patient-centered is one of the key messages Brouwer teaches as part of the training. She is a registered nurse, a nationally recognized expert in the area of vascular access, a published author of numerous articles and a chronic kidney disease (CKD) patient. She is currently the director of clinical business development for Renal Solutions located in Warrendale, Penn.

Her experience as both a clinician and patient allows her to shed light on how CKD is seen from both perspectives. It’s this insight that allows her to connect with peers and explain processes in both medical and layman terms.

“We need to stop thinking with the get them in, get them on, get them off, get them out mentality,” she said. “We need to start allowing patients to have control and ask questions. Don’t label patients who ask a

lot of questions as troublemakers. These are good patients. They’re the ones you should love. They’re making an effort to learn and understand. Encourage that.”

Terminology is also a big issue, stressing that choosing what words to use when describing a procedure can make the difference between a good and a bad experience for a patient.

“Words make a difference,” she said. “If you have a patient that is terrified of needles, you don’t want to use the word ‘stick’ to describe what you’re going to do. Instead say insert, put or place. Just remember how you would want to be treated.”

Brouwer’s techniques and lessons are a part of an 8-part online “Cannulation of the Arteriovenous Fistula (AVF)” series offered by the Fistula First initiative. Video, handouts and workbooks are available online for free at www.fistulafirst.org.

The End Stage Renal Disease (ESRD) Network 8 and the Vascular Access Centers of Memphis sponsored the event and offers cannulation camps free-of-charge throughout the year.

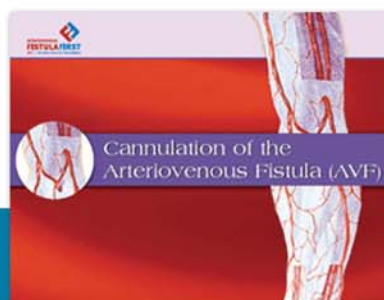
Network 8 is working to improve AFV rates in Tennessee, Mississippi and Alabama through educational workshops and online resources. Visit Network 8 online at www.esrdnetwork8.org.



Deborah Brouwer (center) talks with attendees at the Cannulation Camp.



www.fistulafirst.org
Visit online to watch the Cannulation Camp series.



View the 8-part series online. Topics include Assessment of a new AVF for maturity, protocol and cannulation techniques and complications.



PowerPoint handouts complementing the online series are available to use when viewing the series or for individual use as teaching tools for staff.

By the Numbers



75%
of new dialysis patients nationally have diabetes and/or hypertension as the underlying cause of irreversible kidney failure

Top 10 Counties in Tennessee

for total number of people (age 18 to 75) with Medicare that have diabetes

1	Shelby	9,985	6	Rutherford	1,957
2	Davidson	5,716	7	Madison	1,687
3	Hamilton	4,899	8	Putnam	1,589
4	Knox	4,651	9	Montgomery	1,582
5	Washington	2,166	10	Williamson	1,016

95,298

Tennessee Medicare population with diabetes

=

9.5%

Percent of people (18 to 75 years old) with Medicare in Tennessee with diabetes

Medicare diabetes population in Tennessee

National Facts about CKD

{ Source:

www.house.gov/mcdermott/kidneycaucus/numbers.html }

20 million

Adults in America with CKD

475,000+

Americans that have irreversible kidney failure

80,000+

People in the U.S. that die annually due to CKD

17,000+

Americans that received a kidney transplant in 2005



Resources online

Quick Reference on UACR and GFR (New) In Evaluating Patients with Diabetes for CKD

Presents key information about assessing kidney function, particularly estimated GFR and the urine albumin-to-creatinine ratio. For diabetes educators and other health care professionals.

First 50 copies free. Also available as a downloadable PDF.

CKD Quick Reference Card

Provides clinical targets for testing and treating patients at risk for kidney disease.

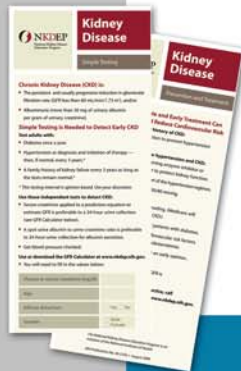
Two-sided card available only online in PDF format.

Explaining GFR (New) A Tear-off Pad for Clinical Use

Tear-off pad with 50 easy-to-read patient education sheets for use when explaining GFR results. Back of pad includes key concepts and talking points for providers on educating patients about chronic kidney disease.

Available in English and Spanish. First five pads free.

All resources available online at www.nkdep.nih.gov



Tools & Resources

Organization:

The National Kidney Disease Education Program

What They Do:

NKDEP is an initiative of the National Institutes of Health, designed to reduce the morbidity and mortality caused by kidney disease and its complications.

How They Help:

NKDEP aims to raise awareness of the seriousness of kidney disease, the importance of testing those at high risk (those with diabetes, high blood pressure, or a family history of kidney failure), and the availability of treatment to prevent or slow kidney failure.

Web site:

www.nkdep.nih.gov



Find more resources online at www.qsource.org

Address changes, subscription requests, contact to unsubscribe, corrections and other correspondence can be sent via email to:

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