

# PHILIPS

## 2011: The Quest for Quality

The Philips Healthcare “Reimbursement Simplified” Webinar Series



**NOVEMBER 2011**



# INTRODUCTION AND GUIDE

When you look closely at many of the complex changes underway in today's health care system—from global budgeting to value-based purchasing—a common theme becomes apparent: public and private payers are no longer content to purchase health care services blindly. They want assurance that those services are of the highest quality and offer clear clinical value. Most often that means quality that can be demonstrated through better patient outcomes, care that is appropriate for the patient, and greater patient safety.

In 2011, the Philips Healthcare “Reimbursement Simplified” Webinar Series explored some of the dimensions of quality and how to achieve it. The common message was that quality counts, that quality sells, and that quality is attainable in ways large and small.

Thus, as you look through this e-book of the 2011 webinars, you will learn about innovative approaches now being used by providers, payers, and other organizations. They include:

- Efforts by quality organizations and provider groups to examine some of the basic processes of care—from hand-washing to conducting imaging exams—to help caregivers better achieve the highest degree of quality and patient safety.
- Research and data-analysis by payers and providers to identify performance gaps and pinpoint improvement strategies, including a collaborative effort by Dartmouth-Hitchcock, Intermountain Healthcare, the Mayo Clinic, and other leading institutions to identify and share best practices in such conditions as knee surgery, diabetes and hip surgery.
- Greater focus in all levels of health delivery to better ensure the appropriateness of care for patients by setting standards for quality and performance, and basing accreditation, recognition, and payment on the ability to achieve those goals.

Running through all of these examples—and many more that you will hear when you listen to the individual webinars—is some of the most creative thinking about how to address some of the hard questions of the day. Such as: How do we achieve patient safety on the front lines of care? How can we reduce medical errors? And how can we put these to work in our own institutions such that they can fundamentally change the experience for patients?

This e-book is just an overview of our webinars in the 2011 “Reimbursement Simplified” webinar series. It is based on a selection of slides from webinar speakers, and it links electronically to the original webinars in case you want more details or a sense of the complete discussion. But this book is just a beginning. You will learn much more by taking the time to listen to the webinars themselves. The webinars are available on the Philips Healthcare reimbursement site: [www.philips.com/reimbursement](http://www.philips.com/reimbursement). We wish you good listening and great learning.

A silver binder clip is positioned at the top left of a white sheet of paper. Below it, a red pencil lies diagonally across the page. To the left of the pencil, there is a checklist with four red square boxes, each containing a black checkmark. The boxes are arranged in a descending staircase pattern. The word 'COMMENTS:' is partially visible in red at the bottom left of the page.

# Quality Check:

## Three Unique Approaches for Improving Value in Healthcare

March 23, 2011

### **Sarah Thomas**

*Vice President, Public Policy and Communications, National Committee for Quality Assurance*

### **Lisa Weiss**

*Managing Director, Health Collaborative Implementation, Dartmouth Institute for Health Policy & Clinical Practice*

### **Nancy Foster**

*Vice President of Quality, American Hospital Association*

### **Laurel Sweeney, Moderator**

*Senior Director, Health Economics & Reimbursement, Philips Healthcare*

To view the webinar visit: <http://vmx.na5.acrobat.com/p65547835>

# WEBINAR OVERVIEW

Public and private payers are no longer content just to purchase health care services. They want to purchase services that offer clear value and clear quality. For providers, that means achieving a variety of clinical or other quality standards that demonstrate improved health for patients. Of course, this trend of linking reimbursement and quality improvement is not new. This webinar explored three unique approaches to achieving quality performance. Each model takes its own pathway in establishing or adopting measures and using a variety of approaches in encouraging providers to achieve them.

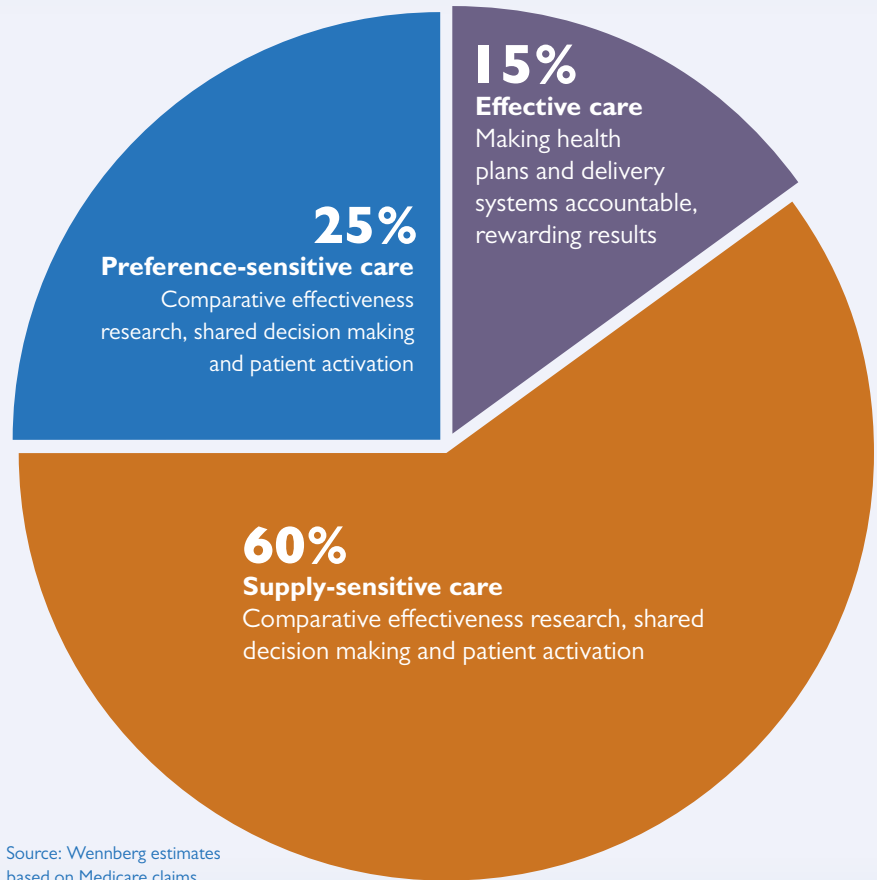
**Sarah Thomas** set the stage by defining an agenda for High-Value Health Care:

- Promoting effective care
- Measuring quality, getting results
- Advancing delivery system reform (Medical Homes, ACOs)
- Identifying value: high quality, efficient care (Relative resource use measures)
- Addressing preference sensitive care and
- Promoting high-value in exchanges

## Strategies for Each Type of Care

*What gets measured gets improved*

- Promote effective care
  - » Use HEDIS to address underuse
  - » Can improve with public reporting, pay for performance, patient-centered medical homes
- Measure supply-sensitive care
  - » Payment and delivery system reform (ACOs)
  - » Measure whether providers use appropriately
- Engage patient in preference-sensitive care
  - » Use patient engagement, shared decision making to promote appropriate use



Source: Wennberg estimates  
based on Medicare claims



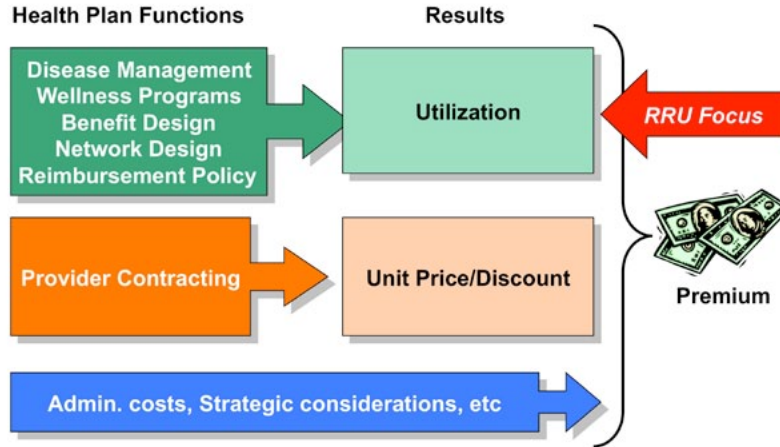
### NCQA's New Medical Home Standards

- Emphasis on **patient-centeredness**
- Reinforces incentives for **meaningful use (HIT)**
- NCQA's success in medical homes
- **Research** shows medical homes work

### NCQA's ACO Position

- We can define evidence-based **structure & process** measures to ID if ACOs have infrastructure to improve quality and costs
- Performance measures are also needed but it will take time to judge **outcomes**
- Draft criteria address:
  - Program structure operations
  - Access and availability
  - Primary care
  - Care management
  - Care coordination and transitions
  - Patient rights & responsibilities
  - Performance reporting

## Payers Can Have Impact



### Relative Resource Use (RRU) Measures

- Indicate how intensely physician, hospital, other resources are used vs similar plans
- With HEDIS quality measures, RRUs address both quality & cost functions together: VALUE
- Focus on 6 high-cost chronic conditions that total over 50% of costs: diabetes, asthma, COPD, cardiac care, hypertension, low back pain
- Can be used at plan and large group level

### What Can We Learn From RRU?

- Little correlation between quality and resource use
- Tremendous variation within regions among plans
- High quality care can be delivered at either high or low resource levels
- Moving to high-quality, low-resource use would yield significant savings

# PPACA Definition of Quality Improvement

PPACA	How NCQA Lines Up
<p>Improve health outcomes</p> <ul style="list-style-type: none"> <li>• Case management</li> <li>• Care coordination</li> <li>• Medical homes</li> <li>• Quality reporting and documentation of care</li> <li>• Disparities</li> </ul>	<ul style="list-style-type: none"> <li>• Many measures of process (case management, continuity and coordination of care)</li> <li>• Intermediate outcomes measures (HbA1C, blood pressure)</li> <li>• HOS and CAHPS measures</li> <li>• Patient-centered medical home</li> <li>• HEDIS used to measure disparities; Multicultural Health Care Distinction</li> </ul>
Reduce readmissions	<ul style="list-style-type: none"> <li>• New measure for use in Medicare to be collected in 2011</li> </ul>
Improve patient safety	<ul style="list-style-type: none"> <li>• Ambulatory measures such as:                         <ul style="list-style-type: none"> <li>— Antibiotic overuse</li> <li>— Medications to be avoided; monitoring</li> <li>— Falls prevention</li> </ul> </li> </ul>
Wellness and health promotion	<ul style="list-style-type: none"> <li>• Measures of process around identifying needs, engagement in activities</li> <li>• Immunization rates</li> <li>• Tobacco cessation</li> <li>• BMI measurement</li> </ul>





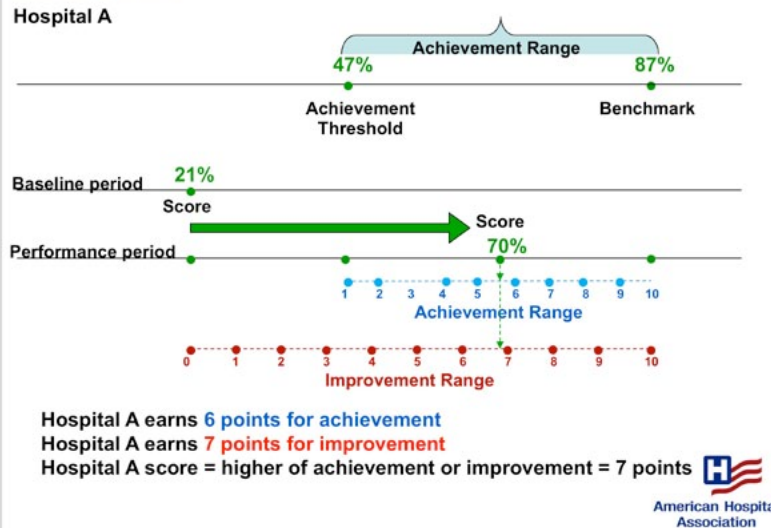
**Nancy Foster** highlighted the year's familiar rulemaking along with new rulemaking around health reform while explaining how the American Hospital Association (AHA) is helping hospitals adopt strategies to improve performance:

- Understand current performance gaps
- Identify and adopt improvement strategies and
- Ensure a supportive environment

**AHA provides advocacy, resources, and research to America's hospitals and health systems to support them in the achievement of these commitments:**

- Central line associated bloodstream infections (safety)
- Readmissions (efficiency)
- Mortality (quality)

## Sample VBP Score for Process Measure



### Value-Based Purchasing (VBP) Quality Measure

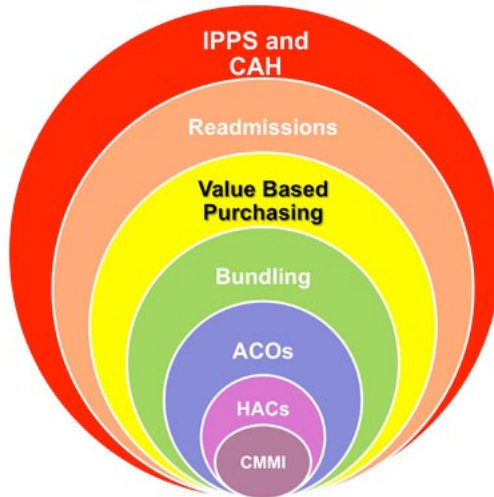
- For FY 2013, CMS proposes 18 total measures
  - » 17 process measures
  - » HCAHPS patient experiences with care
- For FY 2014, CMS proposes 20 additional measures
  - » 3 mortality measures
  - » 9 AHRQ patient safety measures
  - » 8 HACs
- For FY 2013, performance measured July 1, 2011—March 31, 2012

### Scoring Hospitals' Performance

- Hospitals will receive the higher of its attainment or improvement score on each measure
- For FY 2013, process measures account for 70% of total performance score, HCAHPS 30%
- CMS proposes linear scale to translate total performance score into incentive payment
- Program budget neutral...some hospitals receive more than withheld, others less

# Layers of Regulatory Complexity

## CMS Challenged to Manage All Programs



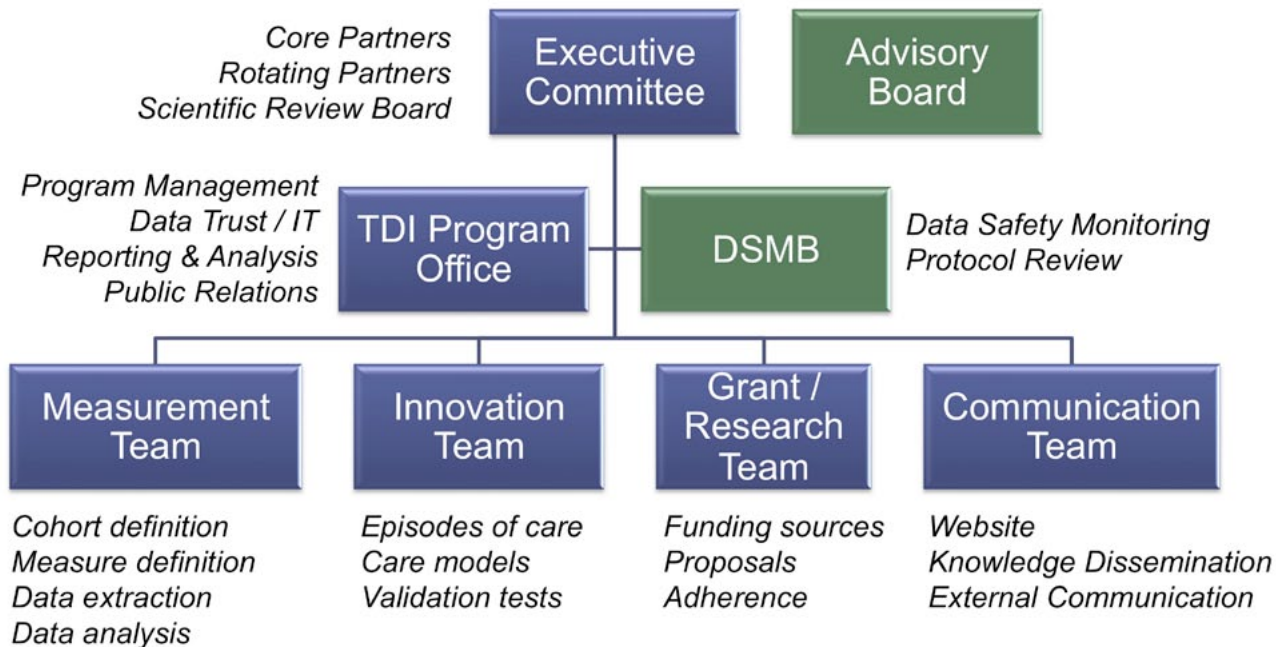
*Lisa Weiss provided a summary of the Collaborative's two goals:*

1. Demonstrate better care, better health, at lower cost, and
2. Accelerate widespread adoption of care models and payment models.

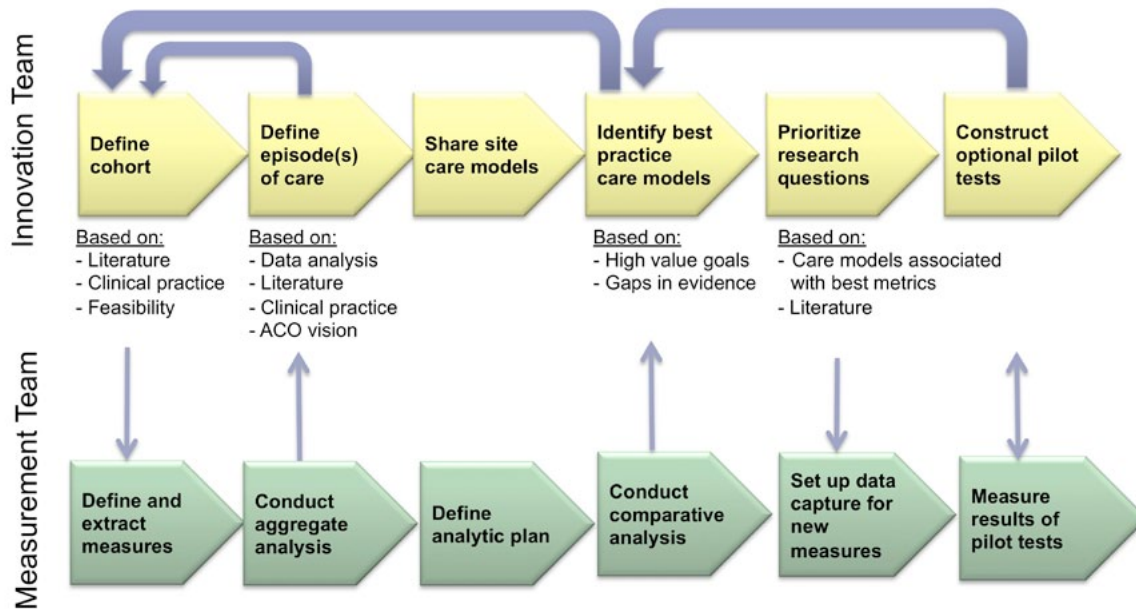
And six partners, which included:

- Cleveland Clinic
- Dartmouth-Hitchcock
- Denver Health
- Geisinger
- Intermountain Healthcare
- Mayo Clinic

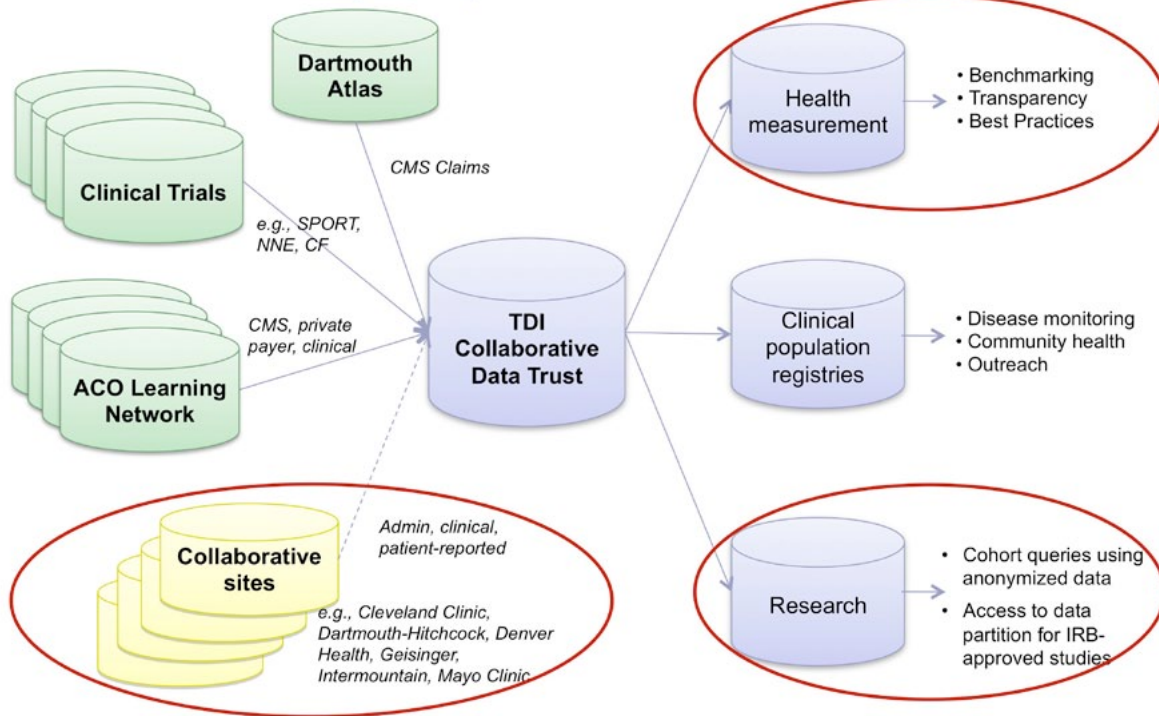
# Collaborative Governance Structure



## Collaborative rapid innovation process (6-month cycle)



## Collaborative to participate in measurement "Data Trust"



# **PRESENTER BIOS**

## **Sarah Thomas**

**Vice President, Public Policy and Communications**

**National Committee on Quality Assurance**

Sarah Thomas joined NCQA as Vice President for Public Policy and Communications in 2010. She is responsible for directing NCQA's relations with Congress, federal agencies and the states, as well as NCQA's work with the media and other aspects of NCQA's communications activities. Before joining NCQA, Sarah was Director of the Health Team at AARP's Public Policy Institute. She oversaw AARP's policy analysis and research in areas of cost, access, and quality relating to health care reform, Medicare, Medicaid, prescription drugs, private insurance and public health. Before AARP, Sarah was Deputy Director of the Medicare Payment Advisory Commission, an independent agency advising the Congress on Medicare payment policy. Sarah also held positions at the Centers for Medicare and Medicaid Services and at the Congressional Budget Office.

Sarah also has worked for America's Health Insurance Plans, the American Hospital Association and the Advisory Board Company. She worked for Virginia's Department of Medical Assistance Services, the state agency responsible for running the state Medicaid program. All told, Sarah has more than 20 years of experience in federal and state government and in nonprofit health care organizations. She holds a M.S. in Health Policy and Management from the Harvard School of Public Health and a B.A. from Williams College.

# PRESENTER BIOS

**Nancy Foster**

**Vice President, Quality and Patient Safety Policy**

**American Hospital Association**

Nancy Foster is the Vice President for Quality and Patient Safety Policy at the American Hospital Association. In this role, she is the AHA's point person for the Hospital Quality Alliance, which is a public-private effort to provide information to consumers on the quality of care in American hospitals. Nancy represents the AHA at the National Quality Forum, is the liaison to the Joint Commission's Board, co-chairs the National Priority Partners' care coordination work group, and represents hospital perspectives at many national meetings. She provides advice to hospitals and public policy makers on opportunities to improve patient safety and quality.

Prior to joining the AHA, Nancy was the Coordinator for Quality Activities at the Agency for Healthcare Research and Quality (AHRQ). In this role, she was the principal staff person for the Quality Interagency Coordination Task Force, which brought Federal agencies with health care responsibilities together to jointly engage in projects to improve quality and safety. She also led the development of patient safety research agenda for AHRQ and managed a portfolio of quality and safety research grants in excess of \$10 million. She is a graduate of Princeton University and has completed graduate work at Chapman University and Johns Hopkins University. In 2000, she was chosen as an Excellence in Government Leadership Fellow.



# PRESENTER BIOS

**Lisa Torrey Weiss**

**Managing Director, Health Collaborative Implementation  
Dartmouth Institute for Health Policy and Clinical Care**

Lisa Torrey Weiss is Managing Director, Health Collaborative Implementation, at The Dartmouth Institute for Health Policy and Clinical Care (TDI). In this role, Lisa is leading a collaboration of leading health care institutions to identify best practice care models and payment methods to improve care, health, and cost of high-cost conditions and treatments.

Prior to this role, Lisa co-founded Dynamic Clinical Systems, a healthcare software company providing Web-based solutions for collecting, managing, and analyzing patient-reported health information to improve care and research. Lisa spent ten years as a management consultant helping companies redesign business processes and information technology to improve operational efficiency and effectiveness. She began her career at GE working in various information technology roles.

Lisa earned a B.S. in Computer Science from the University of Michigan and an M.B.A. from Dartmouth's Tuck School of Business Administration.



# **On the Quality Front: New Approaches in Improving Patient Safety**

July 28, 2011

**Klaus Nether**

*Black Belt, Joint Commission Center for  
Transforming Healthcare*

**Carolyn Langer, MD, JD, MPH**

*Medical Director, Medical Management and  
Quality, Harvard Pilgrim Health Care*

**Becky Rufo, DNSc, RN, CCRN**

*Resurrection Health Care eICU Program  
Operations Director, Resurrection Health Care*

**Laurel Sweeney, Moderator**

*Senior Director, Health Economics &  
Reimbursement, Philips Healthcare*

To view the webinar visit: <http://vmx.adobeconnect.com/p66n6hnaz35/>

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# WEBINAR OVERVIEW

While the previous webinar examined initiatives to improve value and quality in health care, this webinar looked at what might be considered the bedrock of quality—that is, reducing medical errors and improving patient safety. These quality goals are inextricably linked to reimbursement and payment issues. Studies have estimated that measurable medical errors cost this country \$17 billion annually. Some see the evolution toward a performance-based payment system as the key to long-term cost-growth reduction and quality improvement, just as the Medicare prospective payment system was seen as a necessary innovation against continued hospital cost inflation in the 1980s. There are many efforts underway by hospitals, physicians, payers, private organizations, and Medicare to address the issue and fundamentally change the way health care is delivered and paid for in the US. This webinar was designed to highlight several of these—all of which are designed to get to the root cause of quality breakdowns through process improvements, standardized methods, and the use of innovative new technology.

*Klaus Nether began  
with the Health Care  
Quality Challenge:*

- More than 400,000 harmful, preventable bad outcomes occur in hospitals every year
- Costs associated with unsafe care and poor quality in hospitals are unacceptable
- Strong demand from health care organizations (HCOs) for specific guidance on how to solve these problems
- HCOs want highly effective, durable solutions and are ready to implement them

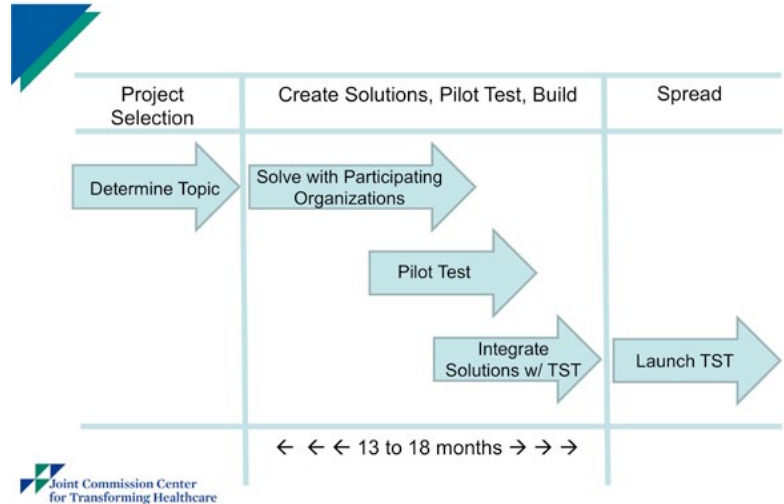
## Why the Joint Commission's Center for Transforming Healthcare (CTH) was created:

- Mission: transform healthcare into a high reliability industry and to ensure patients receive the safest, highest quality care they expect and deserve
- Presents a new approach to address critical safety and quality problems sought by The Joint Commission, healthcare organizations, patients and their families, physicians and other clinicians, and other public and private stakeholders

## Robust Process Improvement (RPI)

- Systematic approaches to problem solving proven in many other spheres of work
  - » Lean, six sigma, change acceleration, Toyota
  - » Different from what came before (CQI, TQM)
- Equally effective when applied to our toughest healthcare safety and quality problems
- Directly address critical failings of current QI
- Appealing to physicians and other clinicians

## Center Operating Model



## Center Projects

Project 1 Hand Hygiene Compliance

Project 2 Wrong Site Surgery

Project 3 Hand Off Communication

Project 4 Surgical Site Infection

Project 5 Preventing Avoidable Heart Failure Hospitalizations

## Causes Differ by Hospital

→ Each cause requires a very different strategy to eliminate

Main Causes of Failure to Clean Hands (across all participating hospitals)	A	B	C	D	E	F	G	H
Ineffective placement of dispensers or sinks		x		x	x		x	x
Hand hygiene compliance data are not collected or reported accurately or frequently	x	x		x	x			x
Lack of accountability and just-in-time coaching		x	x	x	x		x	x
Safety culture does not stress hand hygiene at all levels			x	x	x	x		x
Ineffective or insufficient education		x	x	x	x		x	
Hands full	x	x	x	x	x		x	
Wearing gloves interferes with process	x	x	x	x			x	
Perception that hand hygiene is not needed if wearing gloves	x		x	x	x		x	x
Health care workers forget	x	x		x			x	
Distractions	x	x				x	x	

Note that not all of the main causes of failure appear in every hospital. The chart above represents the validation of the root causes across hospitals. This underscores the importance of understanding hospital-specific root causes so that appropriate solutions can be targeted.

## How to Spread Improvement?

- To maximize impact, improvement knowledge must be able to reach healthcare organizations of varying sizes and capabilities
- Leverage reach of 19,000 accredited organizations
- CTH developed simple assessment and problem solving tools for organizations without RPI (Robust Process Improvement) capacity
  - » Measure process (e.g., hand hygiene)
  - » Assess specific causes of failures
  - » Match interventions to organization's causes
- Engaging industry in Center projects

## Targeted Solutions Tool (TST):

- Platform to connect to all Center solutions
  - » No cost barriers for access to TST
  - » Simplified, data-driven problem solving, based directly on RPI methods
  - » Confidential; instantaneous data analysis
- Guides users to customized solutions
- Educational, no jargon, no special training
- All solutions proven by testing in hospitals





*In explaining how information systems, data standards and a national infrastructure are key to improving safety, **Becky Rufo** outlined a paradigm shift:*

- Movement from paying more for quantity towards reimbursement for greater quality at the best cost
- Demonstrating value hit a crossroad
- Global integration of informatics and tele-health technology
- Innovative care delivery models

#### **Resurrection eICU Program Operations**

- Activated July 10, 2007
- 193 critical care beds monitored
- 15 ICUs, 5 acute care sites, 1 LTACH, 2 outreach
- eRN/DA: 24/7
- eMD: 14hr (M-F), 17 hrs (S-S)
- Operations Director
- Medical Director

## Multi-Professional Care Delivery Model... Safety/Quality

- A centralized, intensivist-led care team to continuously monitor, assess and intervene in support of the on-site caregivers
- Organizational infrastructure to promote standardized critical care and track results
- Information technology tools, decision support and business intelligence to incorporate best practice, standardization clinical resources, risk reduction, workflow redesign and enhanced bedside communication

### First Six Months

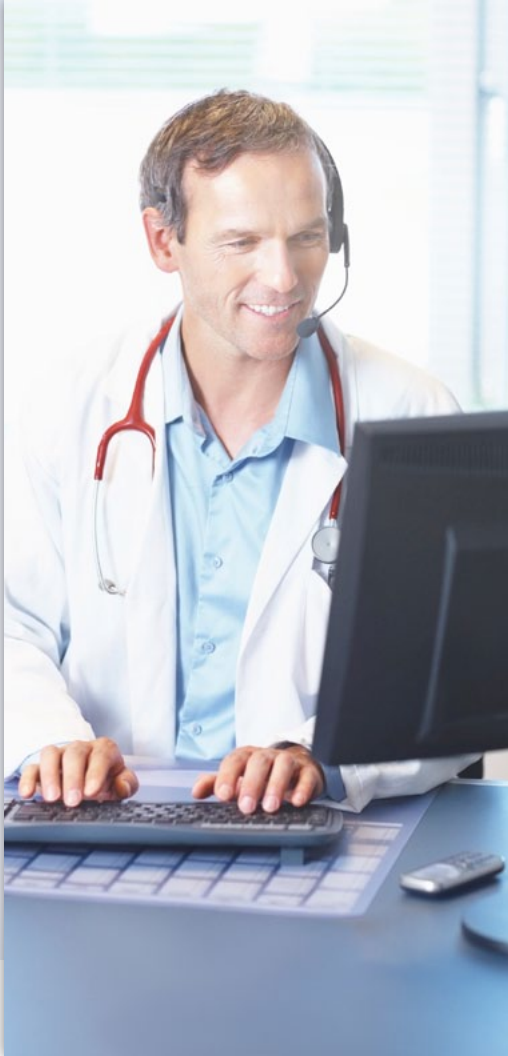
- 98 lives saved
- \$5-6M savings
- 41% decrease in mortality
- 3% decrease in DVTs
- 38% decrease in LOS (=\$3M savings)
- 7% decrease in blood transfusions (=\$11,200 savings)





# Fast Track to Integration and Performance





## **Tele-health Integration**

- Sharing of comparative data and integration of best practice drives outcomes and accountability
- Collaboration is multi-dimensional and cross-functional
- Accountability, transparency and collaboration with key stakeholders are critical to success
- Growth:
  - Outreach
  - ED Integration
  - Sepsis
  - Best practice compliance
  - Orientation/Mentoring

### Lessons Learned

- A quality framework is essential to executing change
- Framing change begins by a focused scope, goals, broad communication and helping the organization adapt to change
- Collaboration is multi-dimensional and cross-functional
- Sharing of comparative data and integration of best practice drives outcomes and accountability
- Regionalization initiatives promote a common purpose and stewardship
- Benchmark/APACHE reports are most effective to identifying areas of focused change
- Investment in human capital is empowering to growth
- Quality care directly impacts financial performance ( $V=Q/C$ )

**Carolyn Langer** began by defining and distinguishing Serious Reportable Events and Preventable Events:

**Serious Reportable Events (SRE, as defined by Massachusetts DPH):**

An event that occurs on premises covered by a hospital's license that:

- Results in an adverse patient outcome
- Is clearly identifiable and measurable
- Has been identified to be in a class of events that are usually or reasonably preventable, and
- Of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the hospital

**Preventable Events (PE, as defined by Massachusetts DPH):**

Events that could have been avoided by proper adherence to:

- Applicable patient safety guidelines
- Best practices, and
- Hospital policies and procedures



**Evaluation of the overall quality of care at an individual hospital should not be based solely on a raw number of SREs reported, because:**

- A higher number of SREs may indicate a strong reporting culture, rather than a quality concern
- SRE data are counts, not rates (i.e., SREs per 1,000 admits)
- NQF (National Quality Forum) acknowledges that not all SREs are preventable

### **Underreported Events**

*Serious Reportable Events identified via POA (Present on Admission) Claims Report or Clinical Occurrence that were not reported to DPH:*

- Deep Vein Thrombosis/Pulmonary Embolism
- Vascular catheter associated infection
- Acquired injury, dislocation, other injury, burn, other unspecified



## Challenges with SRE Process

- Lack of standardization and wide variability in definition (or interpretation of definition) and identification of SREs; lack of consistency in applying SRE categories and under-reporting to MA DPH
- Significant “lag period” between actual SRE and eventual review, delaying root cause analyses requests and corrective action plan reviews
- SRE identification through multiple channels (e.g., POA claims report, Clinical Concern/Occurrence report) is time consuming, requires additional resources, is confusing and causes delays in obtaining and reviewing clinical records
- Inconsistent responses to requests for root cause analyses (RCAs) and corrective action plans (CAPs)
  - » some organizations view RCA/CAPs as protected internal QA documents
  - » others refer RCA/CAPs to existing QA committees for review with no follow-up available
- Limited resources to monitor CAPs in order to gauge successful implementation and monitoring of improved patient safety efforts



# **PRESENTER BIOS**

**Klaus Nether**

**Black Belt, Robust Process Improvement**

**The Joint Commission**

Klaus Nether is a Black Belt in the Department of Robust Process Improvement at The Joint Commission. In this role, he supports the Joint Commission's activities associated with establishing and sustaining a robust process improvement (RPI) culture. This culture includes the use of Six Sigma, Lean, CAP, and other performance improvement methodologies to drive results. Mr. Nether is responsible for leading strategic projects, providing expert advice to process improvement teams, and helping develop and implement a quality improvement training program for all Joint Commission employees. Prior to his role as a Black Belt, Mr. Nether was the Associate Director of Operations in the Division of Standards and Survey Methods. In this role, he was responsible for drafting consensus-based standards, conducting research tasks associated with standards development, and oversight of all field surveys conducted related to proposed standards.

Before joining The Joint Commission in August 2004, Mr. Nether held a variety of clinical laboratory positions. Most recently he held the position of manager of the Olson Clinical Laboratories at Northwestern Memorial Hospital in Chicago, Illinois. He was responsible for six departments including Microbiology and Diagnostic Molecular Biology. Mr. Nether also received Six Sigma training from GE Healthcare. While at Northwestern Memorial Hospital, he also served as manager of the Microbiology department, supervisor of the Microbiology department, and supervisor of the Virology laboratory.

Mr. Nether received a Bachelor of Science degree in Biology and Medical Laboratory Sciences from the University of Illinois at Chicago. He also received his Six Sigma Black Belt Certification from Villanova University. Mr. Nether is certified by the American Society for Clinical Pathology (ASCP) Board of Registry as a Medical Technologist and as a Specialist in Virology. He is currently pursuing his Masters in Medical Informatics at Northwestern University in Chicago, IL.

# PRESENTER BIOS

**Becky Rufo DNSc RN CCRN**

**Resurrection Health Care eICU® Program Operations Director**

**Resurrection Health Care**

Dr. Rufo is a nationally recognized expert in Tele-Health leadership. Her 25 years of critical care experience includes clinical, educational, organizational development, administrative positions, and lead development of two different Tele-ICUs in the Chicago area.

Dr. Rufo is the Resurrection Health Care eICU® Program Director. Under her leadership the RHC eICU® Program is the national recipient of the Philips VISICU® Impact award, 2008, 2009 and finalist in 2010. Dr. Rufo presents at HIMSS, ATA, AONE, NTI; serves on the Regional Editorial Board for Advance for Nurses; and serves as content editor for the AACN's American Journal of Critical Care Nursing and Critical Care Nurse. She is on the Rush University's Nursing Alumni Board of Directors.



## **PRESENTER BIOS**

**Carolyn S. Langer, MD, JD, MPH**

**Medical Director, Medical Management and Quality**

**Harvard Pilgrim Health Care**

Dr. Carolyn Langer is Medical Director of Medical Management and Quality at Harvard Pilgrim Health Care (HPHC). She is responsible for the development and implementation of medical policy and clinical strategies in support of the overall medical management agenda at HPHC. In this role, she provides medical leadership for quality, medical policy, utilization management, pharmacy and other related functions.

She previously worked in medical management roles at Fallon Community Health Plan, Blue Cross Blue Shield of MA, and the Tufts Health Care Institute. She also served as VP and Chief Medical Officer at ManagedComp, a managed care workers' compensation company. Dr. Langer is an Instructor at the Harvard School of Public Health, where she teaches a graduate course in Occupational Health Law, Policy and Administration. She is also an Adjunct Instructor in Public Health and Family Medicine at the Tufts University School of Medicine.

Dr. Langer received her medical degree from Jefferson Medical College in Philadelphia and completed her residency at the Harvard School of Public Health. She is board certified in occupational medicine. Dr. Langer also holds a law degree and a Masters in Public Health from Harvard University.

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# Imaging Wars:

## Report from the Front Lines

October 20, 2011

**Former US Representative Earl Pomeroy, D-ND**

*Counsel, Alston & Bird LLP, Washington DC*

**Christoph Wald, MD PhD**

*Vice Chairman, Radiology Department, Lahey Clinic, Boston MA;*

*Member, American College of Radiology (ACR) and Radiological Society of North America (RSNA) Joint Task force on Adult Radiation Protection*

**Laurel Sweeney, Moderator**

*Senior Director, Health Economics & Reimbursement, Philips Healthcare*

To view the webinar visit:

<http://vmx.highroadsolution.com/se/Meetings/Playback.aspx?meeting.id=321468>

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# WEBINAR OVERVIEW

There is no doubt that medical imaging has profoundly changed the face of health care delivery. Not only does imaging dramatically reduce diagnostic time, but it plays a critical role in disease prevention, early detection and treatment. Over the years, imaging has reduced the need for exploratory surgery, rendering the term itself (almost) obsolete. All of these advances, however, have prompted a series of questions by public and private payers and policymakers. They have increasingly raised concerns about the rapid growth and utilization of imaging, questioning the appropriateness of the technology. In addition, questions have been raised around the issue of radiation safety. This webinar was designed to answer these questions and learn from the experts “in the field:”

- What new policies will affect medical imaging in the coming years?
- Can we expect additional reimbursement cuts?
- How do we respond to concerns about radiation safety?
- Is imaging on the table in the debt ceiling debates?
- Will Congress fix the SGR?

**Congressman Pomeroy** explained that the imaging “wars” largely began as a result of three trends:

- Growth in imaging services, spending
- Concerns about appropriate utilization
- Pressure on rising federal spending

## The main elements of battle consist of:

### Congress

- significant legislation since 2006 changed payments, policies
- Health reform introduced new incentives, new energy

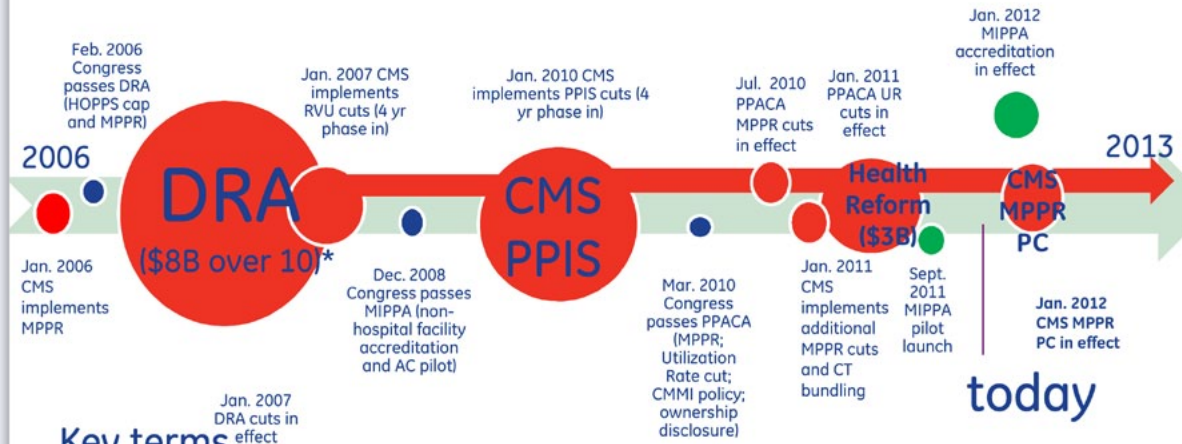
### CMS

- introduced new initiatives through rules, demonstrations
- now implementing health reform

### Federal Deficit

- budget battles since 2006 are unequalled

# Timeline of Federal Imaging Policy 2006 - 2013



## Key terms

MPPR = same day multiple procedure payment reduction of 25% in DRA and 50% in PPACA  
 HOPPS cap = limits non-hospital payment levels to no higher than hospital outpatient levels  
 RVU = relative value units, how physician services are valued on a revenue neutral scale  
 AC pilot = testing the use of imaging appropriateness criteria or clinical guidelines  
 PPIS = AMA's physician practice information survey, lacked representative data  
 Utilization rate (UR) = how often equipment is in use, part of the payment formula  
 CMMI policy = CMS Innovation Center test varied payments based on adherence to guidelines  
 MPPR PC = same day multiple procedure professional component (diagnosis) reduction of 25%

\* 2006 Moran Co. analysis concludes impact to be \$13B over ten years.

## Sample of Impact

procedure	2006	2013
MRI brain	\$1,118	\$439
MRA neck	\$968	\$662
CT abdomen	\$745	\$457
MRI lower extremity	\$1,089	\$446
X-ray artery	\$564	\$165
X-ray chest	\$36	\$27
Mammography	\$86	\$72
DXA	\$139	\$44

## What's Next?

- **Debt Ceiling, Super Committee**

- » \$1.2 trillion in deficit reduction over 10 years
- » to be accomplished in two stages: Stage 1, no Medicare cuts; Stage 2, if no agreement then \$140 billion in Medicare cuts, potentially including imaging

- **Deficit reduction bill does not fix the Medicare Sustainable Growth Rate (SGR)**

- » so Congress must pass legislation by January 1, 2012 to prevent a drastic, unpopular reduction in physician reimbursements



Anytime, Anywhere™ Application for Mobile Devices

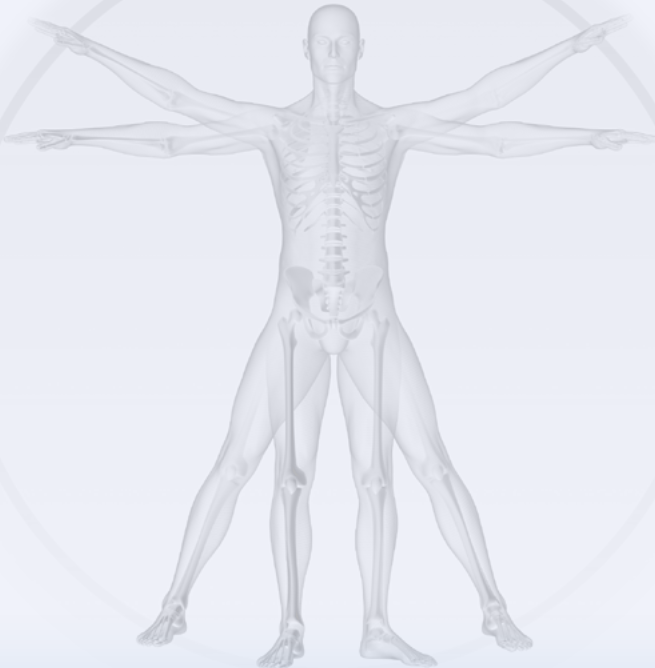


ACR  
Appropriateness Criteria®

*Dr. Cristoph Wald began his remarks with an overview of Appropriateness Criteria:*

- Appropriateness criteria helps ordering physicians make better informed choices and curb unnecessary testing
- Practice experience + medical literature + sets of recommendations
- Online search engine, mobile solution, web-interface (API)

Pilots underway at U Wisconsin and Henry Ford Hospital, in collaboration with CMS





## Keys to Dose Reduction

**Justification:** any medically indicated imaging test is justified, and benefits outweigh the risks – medical radiation exposure aids immediate diagnosis and subsequent therapy.

**Optimization:** ALARA → Optimization. Team effort, systems based effort, multipronged approach to dose control

**Diagnostic Reference Levels (DRLs):** Technique factors and scan parameters that are common and appropriate for a diagnostic image while maintaining lowest required dose

## National Radiology Dose Registry

- ACR initiative to trend CT dose parameters and protocols
- Effective May 2011
- Dose Index Registry permits automated, anonymized web-transfer of data via local, networked software client
- Facilities can compare their exposure data to regional and national level benchmarks
- Challenges: body habitus normalization, protocol complexity and lack of uniformity in protocol nomenclature
- Enrollment @ <https://nrdr.acr.org>



### **Strategies for Radiology Departments/Practices and Hospitals**

- Work with referring physicians on appropriate test ordering
- Educate ordering physicians about alternative imaging test without ionizing radiation
- Understand, encourage and enforce the use of the radiation dose reduction tools on your scanners
- Optimization of protocols (“right size” the scan)
- Monitor skin dose in interventional radiology, record monitor fluoro times
- Obtain ACR accreditation
- Participate in the ACR Dose Registry Index
- Staff credentialing in different modalities and across departments
- Monitor compliance with department protocols, feedback to techs
- Department wide comprehensive dose management database



### **Education and Leadership: New Roles for Radiologists**

- Radiologists, Radiation Oncologists, Medical Physicists have dedicated training in the effects of radiation exposure
- Tailored information is available for groups of imaging professionals
- Lead organizations to a state where ALARA is pervasive in the whole spectrum of care
- Guidance on equipment purchasing, education about radiation dose reduction, appropriate use, and ensuring proper credentialing
- Pledge to IMAGE WISELY at [www.imagewisely.org](http://www.imagewisely.org)

### **The High Reliability Organization**

- Communication
- Mistakes recognized and addressed without repercussion
- Constant process improvements



## PRESENTER BIOS

### **Earl Pomeroy**

**Former U.S. Representative, D-ND  
Counsel, Alston & Bird**

Earl Pomeroy is counsel in Alston & Bird's Washington, D.C., office, focusing his practice on healthcare regulatory and legislative matters. He brings special expertise on advising clients on health policy and legislative strategies for healthcare delivery. Mr. Pomeroy served as North Dakota's lone representative in the U.S. House of Representatives since 1992. During this term, he earned a reputation as an independent-minded leader that brought North Dakota common sense to the debate over issues that affected our nation.

Mr. Pomeroy was first elected to the North Dakota House of Representatives in 1980, and voters selected him as the state insurance commissioner in 1984. During his tenure as insurance commissioner, he served as president of the National Association of Insurance Commissioners.

Throughout his time in Congress, Mr. Pomeroy made the concerns of North Dakota his top priority. Called "articulate, cheerful and sincere" by the Almanac of American Politics and a "billboard for North Dakota values" by the Bismarck Tribune, Pomeroy's leadership and hard work earned him a spot on the powerful House Ways and Means Committee. This post gave him influence over key policy decisions on tax, trade, and Social Security and Medicare issues. In addition, Pomeroy was one of the few members of the Ways and Means Committee to secure a post on a second House committee. His leadership and advocacy on behalf of rural America earned him a special waiver allowing him to also hold a seat on the House Agriculture Committee.

With his dual roles in the House committees that oversee tax and agriculture policy, Pomeroy was in a unique position to shape the last farm bill to provide a stronger safety net for family farmers and ranchers in North Dakota. His ongoing work made him one of the nation's most respected advocates of producers and rural America. He earned undergraduate and law degrees from the University of North Dakota before returning to his hometown to practice law for five years.

# **PRESENTER BIOS**

**Christoph Wald, MD PhD**

**Vice Chairman, Radiology Department**

**Lahey Clinic**

**Boston, MA**

Dr. Christoph Wald is the Vice Chairman of the Department of Radiology in Boston's Lahey Clinic, a physician-led group practice with medical centers serving some 4,000 patients each day. Dr. Wald has served with the Lahey Clinic since 1998, specializing in body imaging and 3D/advanced image analysis.

He is a member of the American College of Radiology (ACR) and Radiological Society of North America (RSNA) joint task force focused on improving imaging appropriateness, reducing radiation, and educating patients on the risks and benefits of imaging.

Dr. Wald is an Associate Professor of Radiology at Tufts University School of Medicine and currently serves as President of the MA Radiological Society.

# Appendix: The Philips Healthcare “Reimbursement Simplified” Webinar Series

Imaging Wars: Report from the Front Lines

*October 20, 2011*

View the webcast: <http://vmx.highroadsolution.com/se/Meetings/Playback.aspx?meeting.id=321468>

On the Quality Front: New Approaches in Improving Patient Safety

*July 28, 2011*

View the webcast: <http://vmx.adobeconnect.com/p66n6hnaz35/>

Quality Check: Three Unique Approaches for Improving Value in Healthcare

*March 23, 2011*

View the webcast: <http://vmx.na5.acrobat.com/p65547835>