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Understanding Population Health & Current Issues in Healthcare Administration

Ronald Bucci, MBA, Ph.D., FACHE

Philips Radiology Solutions

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Learning Objectives

- Understand population health
- Understand the US healthcare system and healthcare reform
- Review current reform challenges

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What are today's topics?

- Population health
- The Affordable Care Act/AHA/WHO
- Challenges for Radiology
- MACRA
- Metrics

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Population health

Population health has been one of the biggest buzz words in the United States healthcare system over the last few years. It is mentioned within healthcare organizations, State and Federal governments, and academia. What does population health really mean and how is it affecting the US?

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Job advertisements

VICE PRESIDENT, POPULATION HEA

Bon Secours Health System ★★★★☆ 315 review

Under the general direction of the Chief Medical Office
Management (VPPHM) is responsible for overall deve
population health and Clinically Integrated Network (C

The VPPHM is also responsible for providing the over
and support of a population health management progra

JOB REQUIREMENTS

1. Master's Degree in Healthcare, Nursing or Busines
education, training, and experience
2. Seven (7) years of experience working with internal
physicians, clinical staff, and administration.)
3. Experience leading quality and performance improv

Preferred:
4. Experience developing and executing joint ventures
5. Strong knowledge of healthcare operations in a mul
system.
6. Experience with health care population managemen
disease.

President, Population Health Services

Mercy Health - Cincinnati, OH

The President of Population Health Services (PHS) is responsible for the overall mission, stewardship of resources, strategic leadership of the PHS organization and the assurance of the delivery of quality, comprehensive healthcare services that are compliant with regulatoryagenciesandaccreditingbodies. The President will be expected to ensure sound fiscaloperationof thePHS organization.This executive, along with the Chief Clinical Officer will lead the delivery of the professional medical component of the Mercy Health PHSO and the clinically integrated network(CIN) with Mercy Health physicians at its core.

Mercy Health, the parent organization, is a Catholic Health Ministry serving 9 markets in Ohio and Kentucky.

This position will have an office in Cincinnati, OH and will be expected to travel throughout Mercy Heath's footprint as necessary.

To apply, please email your resume to: executivetalent@mercy.com .

Essential Functions & Responsibilities:

It is expected that all of the essential functions and responsibilities identified below will be performed in a manner that reflects the values of Mercy Health, which are: Excellence, Human Dignity, Justice, Compassion, Sacredness of Life and Service.

- Oversees and directs the development and implementation of strategic planning initiatives for care model innovation and the design and build of the optimal strategy and infrastructure needed to support the CIN/PHSO care management programs and initiatives
- Coordinates with the Clinical Analytics leadership and staff to develop, implement and monitor the care management processes for patient attribution, population risk identification and stratification, and outcomes measurement needed to support the care management programs and initiatives
- Coordinates with the Corporate CIO in selection and implementation of the IT infrastructure and technology tools needed to support care management programs and initiatives
- Coordinates with the leadership and staff responsible for the CIN/PHSO provider network to assure that the care management programs are aligned with network assets and care management capabilities
- Organizes the Accountable Care Solutions leadership and staff responsible for payor contracts and performance incentives and quality improvement initiatives across the Mercy Health System to assure that performance improvement activities are aligned with the Enterprise's care management strategies
- Responsible for the development, implementation and enforcement of the standards and quality initiatives/programs set forth by the CIN/PHSO program
- Oversees the CIN/PHSO physician education and remediation process
- Serves as liaison between the Clinical Integration (CI) program and health system/hospital executive team as a member of the Hospital Efficiency Program
- Acts as liaison between the CI physician participants and other clinical management key stakeholders to ensure success of the CI program.

Knowledge, Skills & Experience Required:

- Medical Degree or Doctor of Osteopathy; residency training; board certification; eligibility for licensure in Ohio; management/leadership training; MBA, MPH or MHA is a desired.
- Experience in health care leadership positions with at least five years in a senior-director level leadership position required.

Source: Indeed.com

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DIRECTOR, POPULATION HEALTH, RN

Temple University Health System

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Director of Population Health

ID	2014-1656	**Job Location**	US-CA-Sunnyvale
Category	Management	**Type**	Full-Time 40 hours per week
Company	Pathways Home Health and Hospice	**Shift**	Days

More information about this job:

Description:

OVERVIEW:
Come explore the exciting opportunity to contribute within a growing organization! Pathways Home Health & Hospice is celebrating over 35 years of service in the Greater Bay Area and has an immediate opening. We currently have an excellent opportunity for a Director of Population Health.

AREAS OF RESPONSIBILITY:
The Director of Population Health is an experienced health care leader with deep experience and knowledge in population health programs. Our ideal candidate will utilize knowledge of health care delivery across settings (acute, post-acute, including office-based) to manage care for targeted populations toward value-based quality and cost outcomes. The population health program will include management of home health services, community palliative care, and other new services for identified populations. This individual will utilize leadership skills to form meaningful partnerships with other providers, especially physician groups, hospitals, and SNFs. The Director will have deep knowledge of home-based services and can lead a team to transform those services for population health purposes. He or she is familiar with population health management approaches including care coordination, team-based care, tele-management, care transitions, guideline-driven care, and physician and patient engagement.

The Director will maintain a learning culture and sustainable operations and will ensure the day-to-day program operations are functioning at optimal level, utilizing data and systematic process review to monitor and drive performance of the team. This individual will strategically engage in activities to enhance the team's capabilities, such as improving care coordination processes with partnered organizations, develop and nurture clinician's skills, resolve process bottlenecks, develop team skills, create new tools and processes, and ensure compliance. They problem-solve at a program-level and has full view of the program's status on a daily basis and will utilize rapid cycle improvement processes to manage program's performance.
He or she also performs other duties as assigned consistent with skills and training for this position in alignment with the goals and mission of Pathways Home Health & Hospice.

QUALIFICATIONS:

- Registered Nurse licensed to practice in the State of California.
- Master's degree required.
- Master's degree in health or business related preferred.
- Minimum of ten (10) years of experience in clinical and managerial roles in a multi-faceted health care system and multi-service provider setting.
- Experienced in disease management programs or care management

Source: Indeed.com

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Director of Popul

All's Well ★★★★☆ 14

$180,000 a year

Population Health Directo
expanding in the bay area
recommendations. Impler
includes developing and i
program valuation framew
QI staff. Requirements ar
and seven+ years in Proje
equivalent education and
19 days ago

Director, Population Health Systems

epartment:	
Schedule:	Full-time
Shift:	Day shift
Hours:	
ob Details:	**Position Summary:** The Director, Population Health Systems is responsible for the systems which support population health Initiatives at Catholic Health Services of Long Island. Working closely with CHS IT, the Director, Population Health Systems: • Directs and/or participates in the selection of systems used for population health management, • Oversees implementation and support of population health systems • Works with healthcare partners of CHSLI to deploy and integrate systems as necessary to support population health initiatives. Population health systems support the patient over multiple settings of care. As such, the Director, Population Health Systems will work with healthcare partners within and outside of CHSLI. The systems will support the day-to-day clinical operations used in accountable care organizations, including care coordination, utilization management, disease management, population health, credentialing and other clinical operations optimizing clinical performance, driving quality outcomes and maximizing financial performance. **Education, Training and Experience:** • Bachelors' Degree in Information Systems/Computer Science, Health Care Administration or equivalent from an accredited university is required. Masters degree desired. • Excellent organizational, written and verbal communications skills. • A predisposition to collaborate with others in the attainment of common goals and objectives. • Effective human relations and personnel management skills. • Very strong clinical orientation and ability to develop solid working relationships with end users.

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Source: Indeed.com

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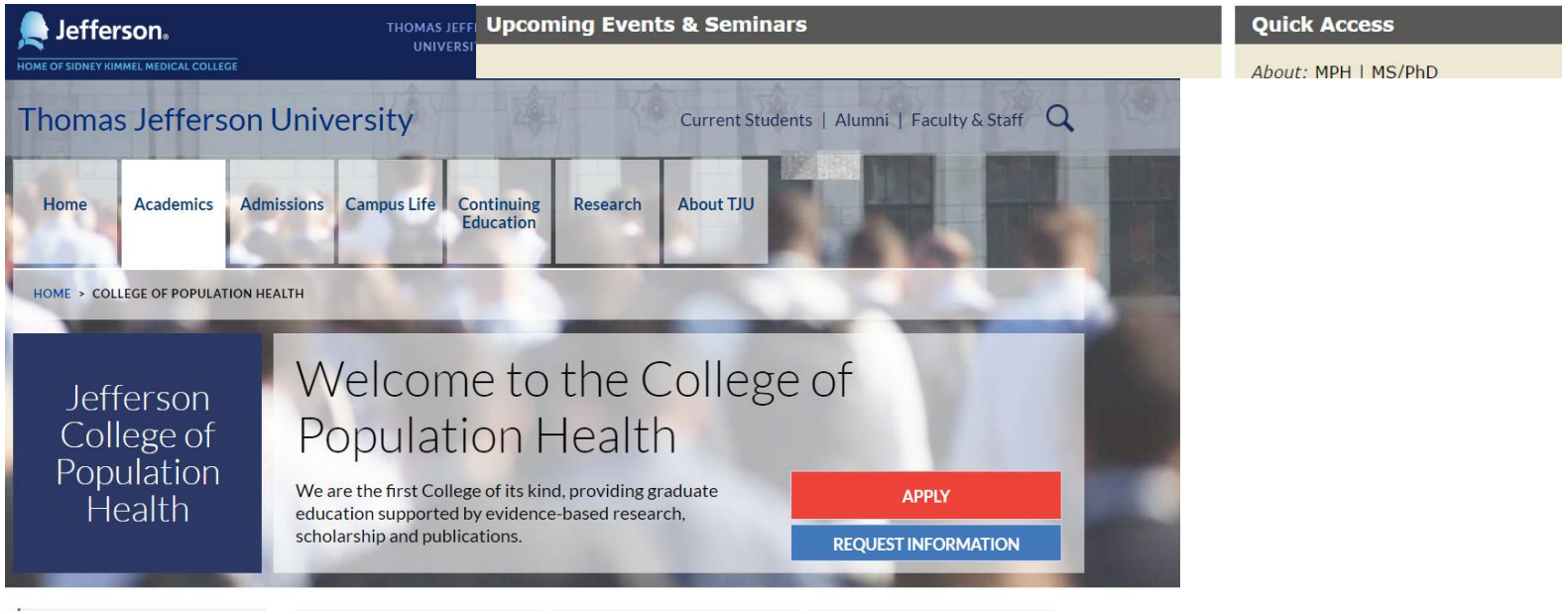
Schools: ?



Source: http://www.jefferson.edu/university/population-health.html

Source: https://pophealth.wisc.edu/

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What does population health mean?

Definitions?

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Definitions

"The health of a population as measured by status indicators and as influenced by social, economic, and physical environments, personal health practices, individual capacity in coping skills, human biology, early childhood development, and health services is another definition."

Dunn JR and Hayes MV. Toward a Lexicon of Population Health. Canadian Journal of Public Health. Supplement, November/December 1999: S7-10.

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Definitions

"The health outcomes of a group of individuals, including the distribution of such outcomes within the group."

Stoddart G and Kindig D. What Is Population Health? American Journal of Public Health. 2003;93(3):380. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447747/. Accessed August 26, 2014.

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Definitions

"Improving the health of populations is one element in the Institute for Healthcare Improvement's (IHI) Triple Aim for improving the US healthcare system (the other two elements call for improving the individual experience of care and reducing the per capita costs of care for populations)."

Stoto, D. Population Health in the Affordable Care Act Era. Academy Health. 2014. Available at: https://www.academyhealth.org/files/AH2013pophealth.pdf. Accessed August 25, 2014.

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Definitions

"Population health means improving the overall health status and lowering the cost of care for a specific population."

Numerof R. Improving the health of a group requires long-range planning. Modern Healthcare. 2014. Available at: http://www.modernhealthcare.com/article/20140426/MAGAZINE/304269978. Accessed August 27, 2014.

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Some claim that the term population health originated in Canada

"The overall goal of the population health approach is to maintain and improve the health of the entire population and to reduce inequalities in health between population groups"

Numerof R. Improving the health of a group requires long-range planning. Modern Healthcare. 2014. Available at: http://www.modernhealthcare.com/article/20140426/MAGAZINE/304269978. Accessed August 27, 2014.

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Good definitions?

- These definitions seem to get indistinct when discussed in healthcare organizations and governments.
- Some of the trending thoughts of these groups include improved patient health, reduced inpatient stays and procedures, holistic care of the entire population of a country, and a general approach to improve the quality of healthcare.
- Most of these ideas are included in the definitions of population health, except there seems to be no mention of payment for services and resources for reimbursement.

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Why?

Let’s try and figure out why and where the term population health originated…

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The US healthcare system

- Healthcare costs are dramatically higher in the U.S. compared to the rest of the world.
- The system is:
  - High In Costs
  - Unequal In Access
  - Quality Can Be Considered Questionable

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Characteristics of the US healthcare system

Exhibit 1.1 Main Characteristics of the U.S. Health Care System

- No central governing agency and little integration and coordination
- Technology-driven delivery system focusing on acute care
- High in cost, unequal in access, and average in outcome
- Delivery of health care under imperfect market conditions
- Government as subsidiary to the private sector
- Fusion of market justice and social justice
- Multiple players and balance of power
- Quest for integration and accountability
- Access to health care services selectively based on insurance coverage
- Legal risks influence practice behaviors

Source: Shi, Leiyu and Douglas A Singh. *Essentials Of The U.S. Health Care System*. 1st ed. Burlington, MA: N.p., 2017. Print.

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Trends in healthcare expenditures

US Prices

- Since 1980 medical care prices have grown far faster than other prices in the U.S. economy
- Since the 1990s price increases are usually almost double other sectors
- Largest growth rate was for hospitals
- The US Government pays for 46.5% of all healthcare costs
- Highest percentage of Gross National Product (GNP) spent on healthcare than any other country

Source, CMS.gov

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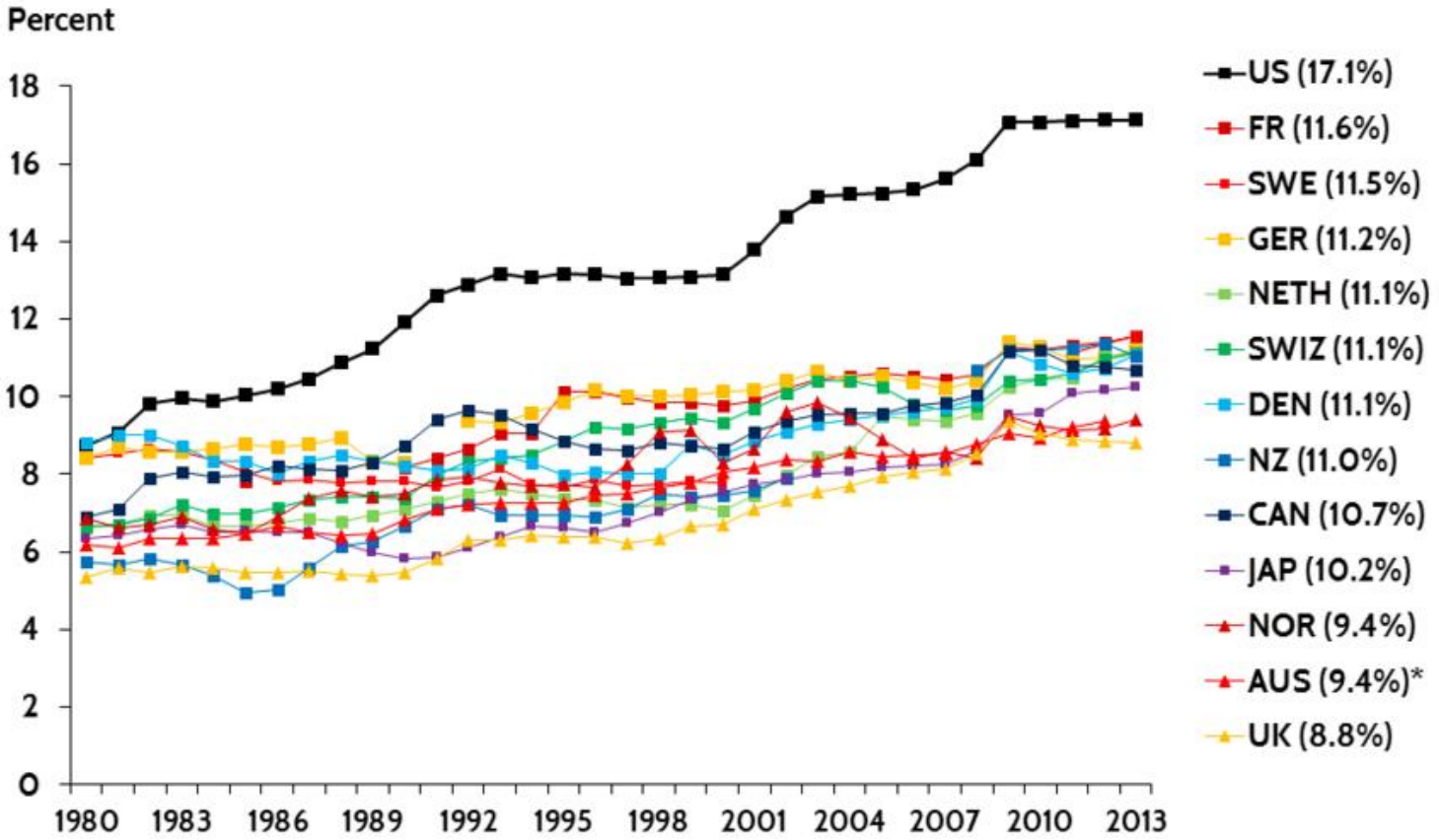
Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013



* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

Exhibit 5. Diagnostic Imaging Supply and Use, 2013

	Magnetic resonance imaging		Computed tomography		Positron emission tomography	
	MRI machines per million pop.	MRI exams per 1,000 pop.	CT scanners per million pop.	CT exams per 1,000 pop.	PET scanners per million pop.	PET exams per 1,000 pop.
Australia	13.4	27.6	53.7	110	2.0	2.0
Canada	8.8	52.8	14.7	132	1.2[a]	2.0
Denmark	–	60.3	37.8	142	6.1	6.3
France	9.4	90.9	14.5	193	1.4	–
Japan	46.9[b]	–	101.3[b]	–	3.7[b]	–
Netherlands	11.5	50.0[b]	11.5	71[b]	3.2	2.5[a]
New Zealand	11.2	–	16.6	–	1.1	–
Switzerland	–	–	36.6	–	3.5	–
United Kingdom	6.1	–	7.9	–	–	–
United States	35.5	106.9	43.5	240	5.0[a]	5.0
OECD median	11.4	50.6	17.6	136	1.5	–

[a] 2012. [b] 2011. [c] 2010.
Source: OECD Health Data 2015.

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Population health summary

- Cost control is important and in the forefront of health policy
- Health care market is imperfect
- Government now pays for almost half of U.S. healthcare spending
- Number of uninsured increases due to rising healthcare costs

Source, CMS.gov

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Where/why was population health created?

ACA

AHA

WHO

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ACA

- (PPACA)- Patient Protection and Affordable Care Act It is also commonly referred to as
- Affordable Care Act (ACA)

- The US government is concerned about population health as was reflected in the passing of the Patient Protection and Affordable Care Act (PPACA or ACA), which was signed into law by President Barack Obama on March 23, 2010.

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ACA

The intent of this law is to expand healthcare coverage to all citizens, reduce healthcare costs, increase patient protection, and eliminate or control many of the challenges in the current healthcare system.

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Major elements of ACA

- Expansion of Medicaid for those with the lowest income.
- Subsidies for low- to middle-income individuals and families to buy private health insurance in regulated markets.
- Mandates for employers to offer insurance and for individuals who are legal residents to acquire insurance.
- ACO's Accountable Care Organizations

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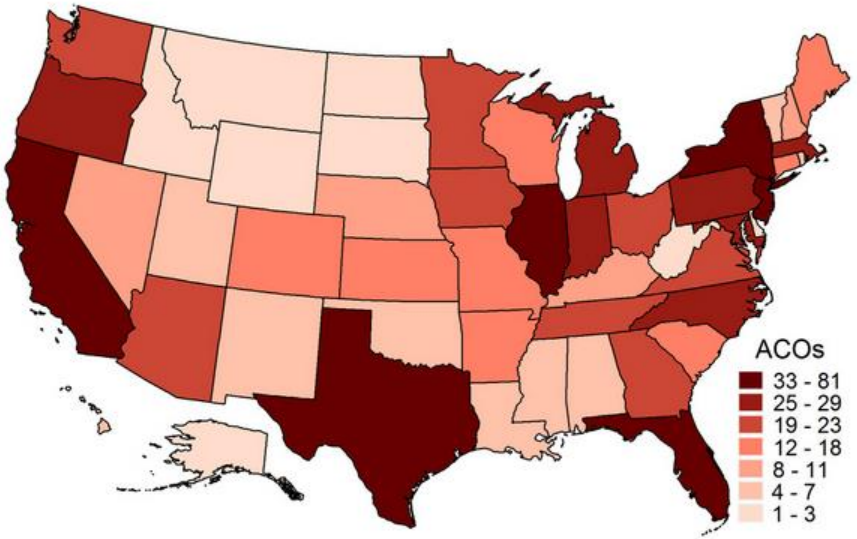
3 core principles of ACOs

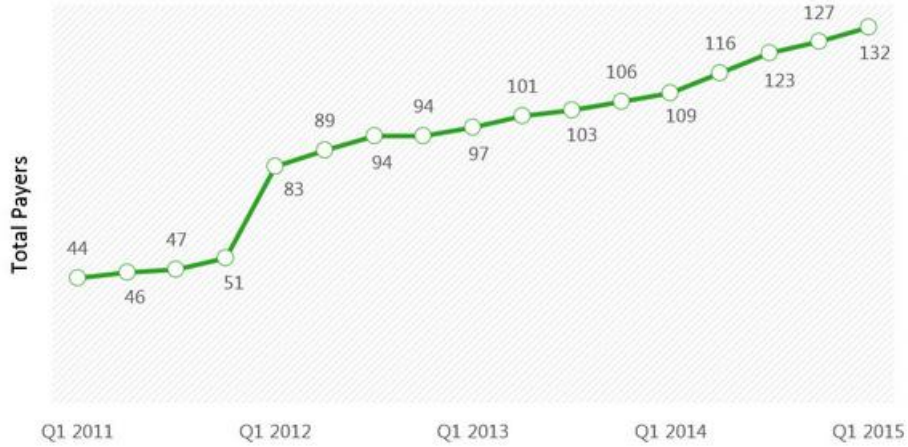
- Provider led organizations promoting primary and preventative care accountable for the cost and quality of care across a population
- Payment linked to quality
- Reward/penalty based on performance measurement system

Figure 3. Number of ACOs by State, January 2015



Source: Leavitt Partners Center for Accountable Care Intelligence

Figure 8. Number of Payers Participating in Accountable Care, 2011 to January 2015



Source: Leavitt Partners Center for Accountable Care Intelligence

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All Roads Lead to Population Health Management

ACOs give health systems a reason to target broad patient outcomes

June 13, 2016 *John Glaser* *3 Comments*

Approximately 750 accountable care organizations are in operation today, covering some 23.5 million lives covered under Medicare, Medicaid and private insurers. Although still in the learning stages, many ACOs have had notable success in improving quality while reducing cost. As promising results continue to emerge, more of these organizations — whose existence was once thought to be more fantasy than reality — are expected. In fact, Leavitt Partners predicts that 105 million people will be covered by ACOs by 2020.

Similarly, while the industry's move to value-based payment is also in its early stages, value-based contracts are expected to increase substantially in the next decade. For example, the Centers for Medicare & Medicaid Services has a goal of 50 percent of Medicare payments being tied to alternative payment models by the end of 2018. In addition, Aetna expects that 70 percent of its contracts will be value-based by 2020.

Source, American Hospital Association (AHA) -Hospitals and Health Networks, 2016

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Current state of ACO activity:

- Depending on the source and definition, there are between 850 (Leavitt Partners) and 1,300 (Definitive Healthcare) ACOs operating today. The majority of these participate in the Shared Savings Program.
- There are ACOs in every state, led by California with 74. Two Shared Savings ACOs (Advocate Health Care in Illinois and Physician Organization of Michigan) manage more than 100,000 Medicare lives, according to Leavitt.
- More than 28 million individuals are served by an ACO: 8.3 million Medicare, 2.9 million Medicaid and 17.2 million in commercial. Data about the performance of ACOs that contract with commercial and Medicaid payers is sparse, however.
- Among 477 ACOs contracting with Medicare in 2015, 31 percent performed well enough to share savings with Medicare, and quality scores improved for 91 percent of them. Both were increases from 2014. (Muhlestein et al. *Health Affairs* Sept. 9, 2016)

- Collectively, ACOs have generated approximately $1.29 billion in total Medicare savings since 2012.
- Breakdown: Between 2012 and 2013, the ACO model saved a total of $384 million ($279.7 million in 2012; $104.5 million in 2013); $411 million in total savings in 2014 (Year 3); and $466 million in 2015.
- It is highly unlikely that ACOs will diminish as an organizing framework through which physicians and hospitals become more effective in managing the total cost of care. In fact, as costs increase, they'll become more important. But the primary value created through ACOs likely will be quality improvement; cost reduction will be secondary, but nonetheless important.
- ACOs are here to stay. How they fit into a medical group or health system's contracting and population health strategies will change as regulations like MACRA kick in and as employers, insurers, Medicare and Medicaid assess their value.

Source: Hospitals & Health Networks, 2017

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AHA

The American Hospital Association (AHA) is the national organization that represents and serves all types of hospitals, health care networks, and their patients and communities. Nearly 5,000 hospitals, health care systems, networks, other providers of care and 43,000 individual members come together to form the AHA.

American Hospital Association®

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AHA initiative

- In 2010, the AHA formed a Committee on Performance Improvement (CPI) to provide guidance to the AHA with a vision of the future for hospitals based on the current and predicted economic, demographic, and regulatory changes occurring in the healthcare industry.
- Their goal was to motivate and energize hospital senior leadership teams to adapt and implement strategies to succeed in the future.

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Must do's

The CPI identified "must do" strategies for future success are as follows:

1. Aligning hospitals, physicians, and other providers across the continuum of care
2. Utilizing evidence-based practices to improve quality and patient safety
3. Improving efficiency through productivity and financial management
4. Developing integrated information systems
5. Joining and growing integrated provider networks and care systems
6. Educating and engaging employees and physicians to create leaders
7. Strengthening finances to facilitate investment and innovation
8. Partnering with payers
9. Advancing through scenario-based strategic, financial, and operational planning
10. Seeking population health improvement through pursuit of the "triple aim"

Source, American Hospital Association (AHA)

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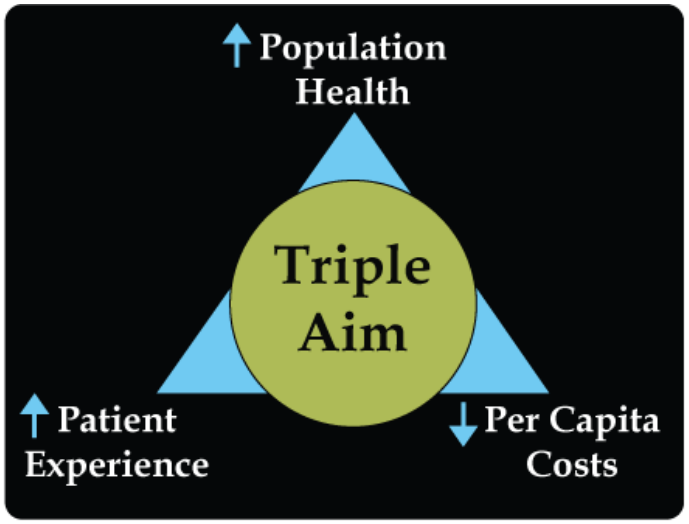
The Triple Aim

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care



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Strategies

To plan for and implement these must-do strategies, hospitals and health systems and providers will need to master these core competencies:

- Design and implementation of patient-centered, integrated care
- Creation of accountable governance and leadership
- Strategic planning in an unstable environment
- Internal and external collaboration
- Financial stewardship and enterprise risk management
- Engagement of full employee potential
- Collection and utilization of electronic data for performance improvement

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Who is WHO?

World Health Organization

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WHO

- WHO is the directing and coordinating authority for health within the United Nations system.
- It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.

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WHO

Public health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease.

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The 3 main public health functions are:

- The assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities.
- The formulation of public policies designed to solve identified local and national health problems and priorities.
- To assure that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services.

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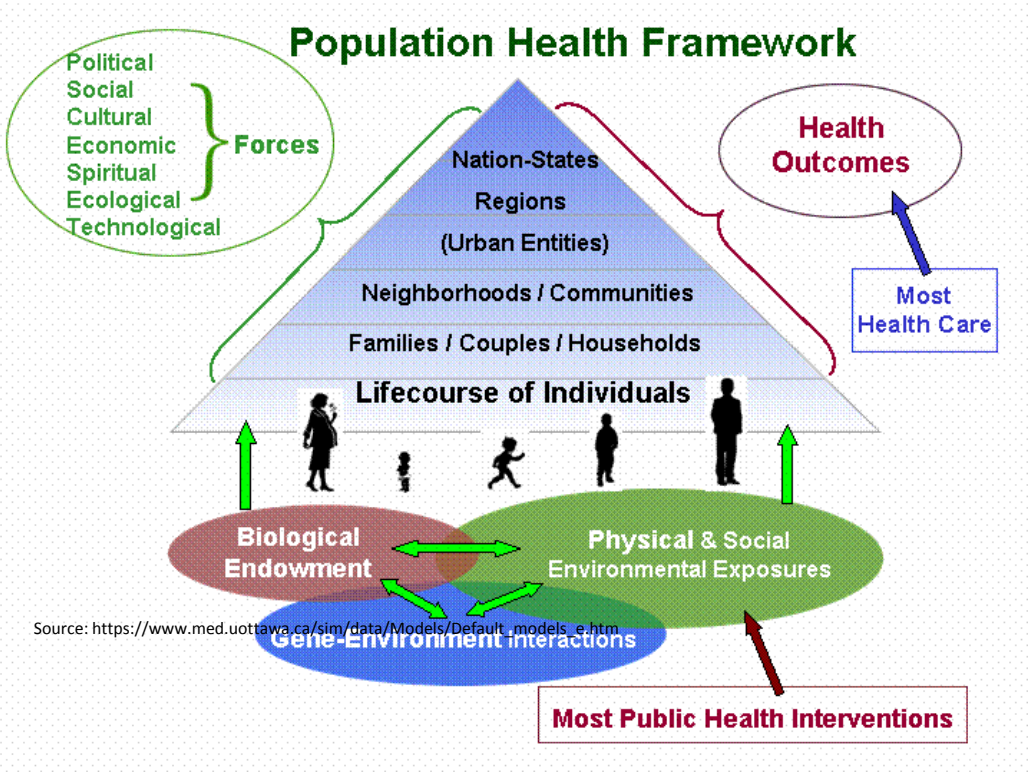
All together

- Combination of all forces together…



Source: https://www.med.uottawa.ca/sim/data/Models/Default_models_e.htm

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New model of care

- The combination of governmental and industry forces have created the model and future view of population health.
- The new healthcare model is forcing the industry to move from volume-based to value-based.
- In this new model, organizations will be rewarded for the quality of care and the oversight and scrutiny of procedures.
- The goals of population health are to keep citizens as healthy as possible and keep them out of physician offices and hospitals.
- Hospitals must realign themselves and change their measurements of success to be based on patient outcomes rather than volume of procedures and exams.

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New definition

A healthcare model managing a multitude of lives with a defined population in a holistic health manner;

employing quality and safety improvements, care coordination, and

expanded preventive services;

with a predetermined set of resources to manage the processes, organizations, providers, and other needed components in a shared risk environment with providers and payers.

Source: Bucci, R. Defining Population Health and Implications for Radiology. Radiology Management, Vol 36 No 6, 10-15, November/December 2014.

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What has happened?

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Workforce reductions

- Reductions in workforce through attrition and layoffs. There have been and continue to be layoffs in the healthcare market. "The Cleveland Clinic, which is ranked among the top four US hospitals, is making layoffs and cutting its budget more than $100 million as a direct result of the ACA. About half of their cuts for 2014 are related to the ACA.[13]"

Source: http://dailycaller.com/2013/11/25/top-4-u-s-hospital-laying-off-staff-due-to-obamacare/

14 healthcare layoffs in March

Leadership & Management

11 latest healthcare layoffs

Written by Kelly Gooch | March 23, 2017 | Print | Email

The following healthcare layoffs were reported by *Becker's Hospital Review* so far in March. They are listed below, beginning with the most recent.

1. **Gila Regional Medical Center lays off 12 employees to save $1M**
Silver City, N.M.-based Gila Regional Medical Center is laying off eight members of its "administrative and support" staff and four employees with the title of executive or director to save about $1 million.

2. **Stanford Health Care revises number of layoffs to 123**
Stanford (Calif.) Health Care cut 123 positions, down from the 168 it initially anticipated.

3. **Banner physicians affected in latest round of system layoffs**
Banner Health is laying off some physicians as the Phoenix-based system restructures operations.

4. **ZirMed lays off 60 employees**
Louisville, Ky.-based ZirMed, which provides cloud-based revenue cycle management solutions, is cutting 60 positions from its total workforce of about 670 people.

5. **St. John Health System lays off business office employees**
St. John Health System in Tulsa, Okla., part of St. Louis-based Ascension Health, is laying off employees in its business office.

6. **Shenandoah Medical Center cuts 14 positions**
Shenandoah (Iowa) Medical Center laid off employees amid restructuring efforts.

7. **Alabama hospital lays off 26 workers**
Highlands Medical Center in Scottsboro, Ala., laid off 26 employees.

8. **Banner Health issues another round of layoffs as it restructures operations**
Phoenix-based Banner Health is laying off more employees, including its top public relations executive, as it restructures operations.

9. **Partners' hospitals to lay off employees as part of cost-cutting plan**
North Shore Medical Center in Salem, Mass., which includes two campuses and is part of Boston-based Partners HealthCare, plans to lay off employees to help overcome financial losses.

10. **Humana to cut unspecified number of jobs, top positions in Kentucky, Wisconsin**
Louisville, Ky.-based Humana will lay off an undisclosed number of employees in Kentucky and Wisconsin as part of the insurer's growth strategy following its unsuccessful bid to merge with Aetna.

11. **MDwise to lay off 79 employees in departure from Indiana Medicaid program**
Indianapolis-based insurer MDwise will exit Indiana's Medicaid program at the end of March, affecting 79 workers.

To receive the latest hospital and health system business and legal news and analysis from *Becker's Hospital Review*, sign-up for the free *Becker's Hospital Review E-weekly* by clicking here.

Ky hospitals: Obamacare forcing cuts, layoffs

Laura Ungar, @laura_ungar 8:09 p.m. EDT June 9, 2015

(Photo: Jessica Ebelhar/The Courier-Journal)

LEXINGTON, Ky. – While Kentucky has gained national prominence as the only Southern state to fully embrace Obamacare, its hospitals say the law has left them facing billions of dollars in cuts and forced them to lay off staff, shut down services and worry for their financial health, and in some cases, survival.

The Kentucky Hospital Association outlined its concerns in a report released Friday called "Code Blue," saying payment cuts to hospitals are expected to reach nearly $7 billion through 2024. "Kentucky hospitals will lose more money under the Affordable Care Act than they gain in revenue from expanded coverage," it said, experiencing a net loss of $1 billion by 2020.

"This report provides the real picture of what our hospitals are facing," association President Mike Rust said during a news conference at the Lexington Convention Center, where the group was holding its annual convention. While the Medicaid expansion has given many residents health coverage that has brought new money into hospitals, "the rest of the story is the cuts."

THE COURIER-JOURNAL
Emergency room visits rise under Obamacare

Hospitals are suffering a net loss, officials said, partly because about three-quarters of newly insured Kentuckians signed up for Medicaid, which reimburses hospitals less than it costs to treat patients. Nationally, the Congressional Budget Office projected half of newly insured patients would have private insurance. But Kentucky is a poor state, so most people who signed up for Obamacare have qualified for expanded Medicaid, which covers those earning less than 138 percent of the federal poverty level, or about $33,000 for a family of four.

Source: http://www.courier-journal.com/story/news/2015/05/08/ky-hospitals-obamacare-forcing-cuts-layoffs/26990637/

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Partnerships/mergers

- Hospitals, physicians, providers, and payers have started and will continue to partner with each other in order to become population health providers.
- With new payment models aimed at rewarding value created over growth, physicians, hospitals, and payers have an unprecedented opportunity to align around the interests of patients.
- Mergers and acquisitions between health systems to become larger and gain increased amounts of patients.

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'Obamacare-Made-Me-Do-It' Defense to Hospital Mergers Gains Foothold

Roy Strom, The National Law Journal

May 17, 2016

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REPRINTS

Advocate Lutheran General Hospital (ALGH), a non-profit teaching hospital located in the Chicago suburb of Park Ridge, Illinois.

Credit: Wikipedia

In court battles against the Federal Trade Commission, the "Obamacare-made-me-do-it" defense to an antitrust challenge of a hospital merger goes something like this: With the Affordable Care Act moving health care payments away from a "fee-for-service" model, hospital mergers are necessary to control costs across a spectrum of services.

Plenty of hospitals have tried the argument. And judges have largely dismissed it, but a federal judge in Pennsylvania this month bucked that trend and allowed a contested merger to go through, in part because he said it was a needed response to changes in the health care business brought on by the 2010 law.

Source: http://www.law.com/sites/articles/2016/05/17/obamacare-made-me-do-it-defense-to-hospital-mergers-gains-foothold/?slreturn=20170114123954

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Topics: Operations & Business Management

Hospitals must consolidate, merge to manage population health

September 16, 2014 | By Zack Budryk

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TOOLS

In the modern healthcare era, providers must embrace mergers and acquisitions to manage population health, argues an opinion piece in the *Wall Street Journal*.

With hospitals' survival increasingly tied to how well they manage their population health, their futures depend on expanding that population, writes Kenneth L. Davis, M.D., CEO and president of Mount Sinai Health System in New York City. "Without that wide range, there is too great a risk that costs beyond hospital walls during post-acute care, patients who are high utilizers of medical services, will unbalance the scales," he writes. "Hospitals need a large pool to survive any increased medical needs and costly care." Moreover, with this larger population, Davis writes, hospitals can get a better idea of the kind of care different populations, such as elderly patients, need.

Stand-alone hospitals lack both the patients to manage population health and the resources to manage a broader population, which is where strategic mergers come in, Davis writes. They can improve care quality by giving more patients access to specialists, creating a setting where physicians in larger networks can draw better conclusions from the larger populations. They can also cut unneeded overlaps in regional healthcare, while retaining hospitals' support of community needs.

Source: http://www.fiercehealthcare.com/finance/hospitals-must-consolidate-merge-to-manage-population-health

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Employed physicians

- Continued transition of private practice physicians to hospital or health system employees.
- There has been a trend in the last few years of more doctors leaving private practice and becoming employees.
- Systems across the country have been rapidly buying physician groups to expand their referral networks and prepare for a not-too-distant future where they will have to manage the health of their patient populations and be held financially accountable for meeting costs and outcome goals.

Source: Bucci, R. Defining Population Health and Implications for Radiology. Radiology Management, Vol 36 No 6, 10-15, November/December 2014.

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The Death of Physician-Owned Private Practices

March 20, 2013

The days of doctor-owned medical practices are probably over now that the Affordable Care Act ("ObamaCare") increases the costs for doctors to practice individually. Physicians are now becoming hospital employees more frequently, which reduces quality of care and productivity, says Scott Gottlieb, a resident fellow at the American Enterprise Institute.

- ObamaCare shifts money to favor "accountable care organizations" that provide outpatient care and turns physicians into hourly employees.
- As hospital employees, doctors will no longer be reimbursed for how much care they deliver, which is theoretically supposed to limit unnecessary medical procedures.
- By next year, an estimated 50 percent of U.S. doctors will be working in hospitals. This represents a nearly 75 percent increase in the number of doctors employed by hospitals since 2000.
- Physicians who do remain independent will be mandated to install expensive information technology systems that will drive up costs.

In addition, for doctors who migrate to hospitals, productivity falls by more than 25 percent.

- Hospital physicians see fewer patients, perform fewer timely procedures and the continuity of care declines.
- Hospitals measure the value of physicians in Relative Value Units (RVU), which assigns a number to every service based on the time and physical effort a doctor exerts.
- The RVU model that hospitals use fails to account for the actual quality of care provided by doctors and instead focuses doctors on goals like filling out code chart correctly.

Hospitals use the RVU system because that is how the government and programs like Medicare reimburse for care provided. Because productivity generally decreases by 25 percent to 35 percent, ObamaCare will fall short on its goal of providing more health care while containing costs.

- Medicare pays more for services when they are delivered at a hospital than when they are delivered at an outpatient doctor's office.
- This payment system encourages hospitals to buyout doctors' practices in an attempt to build local market share and monopolies.
- Hospitals are favored by politicians in Washington because their mostly-unionized forces give them political power and because they are large employers in all congressional districts.

Source: Scott Gottlieb, "The Doctor Won't See You Now. He's Clocked Out," Wall Street Journal, March 14, 2013.

Source: http://www.ncpa.org/sub/dpd/index.php?Article_ID=22971

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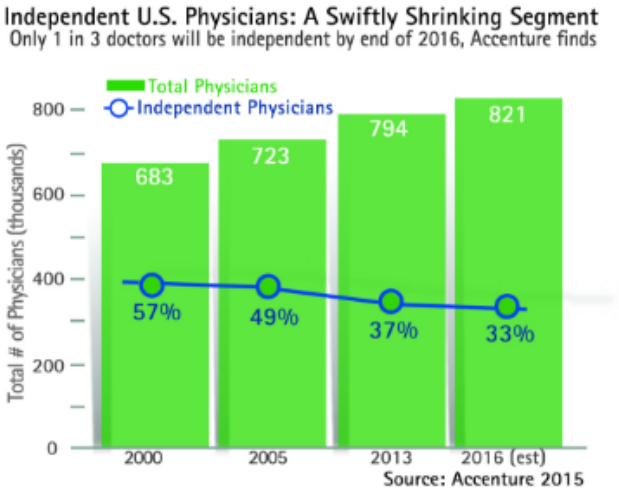
Many U.S. Doctors will Leave Private Practice for Hospital Employment, Accenture Reports

Many U.S. Doctors will Leave Private Practice for Hospital Employment, Accenture Reports

Only one-in-three doctors will remain independent by the end of 2016

CHICAGO; July 29, 2015 – A growing number of U.S. doctors are leaving private practice for hospital employment and only one-in-three will remain independent by the end of 2016, according to a new report from Accenture.

The number of independent physicians has declined over the last several years, from 57 percent in 2000 to 49 percent in 2005. Accenture predicts that next year this number will drop further, to 33 percent, and represents a 10 percent decline from Accenture's 2012 report.



Source: https://newsroom.accenture.com/news/many-us-doctors-will-leave-private-practice-for-hospital-employment-accenture-reports.htm

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Why Hospital Physician Employment Will Become the New Normal

By Bryan Barajas | Posted September 23, 2015

For years now, we've seen how physician employment has become increasingly more common in America. In 2013, PreCheck's Vice President of Compliance Vu Do *discussed the topic for the PreCheck Blog* after attending that year's American Health Lawyers Association Annual Meeting. The latest research indicates that physician employment is no longer simply a trend. It is quickly becoming the new normal. According to a *recent report by Accenture*, most U.S. doctors will leave private practice for hospital employment and only one-in-three will remain independent by the end of 2016.

With the latest findings and statistics indicating the growing prevalence of physician employment, what can healthcare organizations expect in this new era?

Source: https://www.precheck.com/blog/why-hospital-physician-employment-will-become-the-new-normal

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Expenses

- Cutting supply costs to reduce overall expenses. Health systems are concentrating either on increasing revenue or decreasing costs to meet tighter net revenues in this era of healthcare reform. Most are initiating cost reduction plans as a more effective and controllable measure than increasing revenue. “Many hospitals are moving aggressively to tighten spending on labor and supplies and to streamline care in response to recent and anticipated reductions in rates from public and private payers.”

Source: http://www.modernhealthcare.com/article/20131009/NEWS/310099963

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Why are hospitals cutting costs?

Written by Bobby Grajewski, President of Edison Nation Medical | May 12, 2015

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The healthcare industry is feeling pressure to cut costs. As the Affordable Care Act (ACA) continues to bring tighter federal regulations and uncertain insurance payout changes, more healthcare executives are bracing for the unknown by slashing their annual budgets now.

No hospital in the U.S. is immune to this pressure to scale back spending. In Premier Inc.'s fall 2014 Economic Outlook survey, 75 percent of hospital executives reported their hospitals are currently in the process of cutting expenses — especially when it comes to buying costly new medical devices. The survey's respondents were 127 C-suite executives at 112 hospitals across 32 states.

"Providers report a number of initiatives to better control spending and improve overall efficiency," according to the survey's analysis report. "More than three quarters of C-suite executives have resource utilization programs in place to better control the use of expensive supplies and purchases."

How exactly does the ACA impact a hospital's annual budget?

Overall, health care facilities are struggling to comply with the legislation's new insurance reimbursement procedures and coverage mandates, which continue to shift and change each year, according to Premier's survey. Twenty-three percent of respondents listed the legislation's mandates as the top driver of their costs in 2013, more so than in any other category.

"There's no question that reimbursement cuts put a severe strain on tight hospital budgets," Premier COO Michael Alkire said in a press release. "Shifting to new care delivery models designed to better manage population health involves a heavy up-front investment. As more hospitals make this transition, it's probable that we will see these cost centers grow in magnitude over the next few years."

In addition to budget cuts as a result of the ACA's reimbursement guidelines, the legislation's voluntary programs are also impacting a hospital's spending. According to the survey, 26 percent of respondents cited voluntary new care delivery and payment models, such as accountable care and bundling, as a major organizational expense. This figure is up from 14.3 percent just one year ago.

The Scope and Impact of the Mandate

The ACA, otherwise known as Obamacare, began rolling out on January 1, 2013, and the influx of new patients continues to send shockwaves throughout the medical industry. Last year, about 8 million Americans became insured, and even more are expected to do the same as open enrollment gears up, according to the U.S.

Source: Becker's Hospital Review

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The reality of cost containment in 2016

This year, Cardenas and other finance leaders say they are focused more than ever on driving down costs in order to match reimbursement losses. They are also looking to grow their margins to make important investments in technology and infrastructure, among other areas. "We are looking at how our reimbursement might change over the coming years and how we can keep people healthier while not overutilizing services," says Cardenas.

At MemorialCare Health System in Fountain Valley, California, CFO Karen Testman, RN, says she is most concerned about cost-reduction efforts keeping pace with reimbursement reduction, particularly given the tight nursing labor market. "Revenue reductions are coming so fast that it's a challenge to keep pace with that in terms of cost reductions," says Testman.

Other challenges include reducing costs to generate the margin required to invest in needed capital projects, IT and other physical and digital infrastructure, and diagnostic and treatment technologies. "IT and infrastructure investments required to stay competitive and succeed in a population health and wellness-focused environment have become very expensive," Testman says. "We need to make sure that we're well positioned for overall transformation in healthcare delivery."

Source, American Hospital Association (AHA) -Hospitals and Health Networks, 2016

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Cost cuts

Columbus, Ohio • Jan 06, 2015 • 18° Light Snow

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HEALTH CARE

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Keywords

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Columbus, OH

By Ben Sutherly

The Columbus Dispatch • Sunday December 28, 2014 6:12 AM

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Ohio State University's Wexner Medical Center has asked 300 of its largest vendors to discount their prices by 20 percent by June as part of an effort to shave $40 million from the medical center's annual cost of supplies and services.

The medical center has secured at least $20 million in savings so far, largely as a result of requesting the discounts, said Peter Geier, CEO of the university's health system.

Such a request is unprecedented for the medical center, which spent about $700 million on supplies in the fiscal year that ended on June 30. It has 3,400 suppliers.

"Nobody wants to overpay for anything," Geier told *The Dispatch*. "If we can save a buck in supplies and services, that frees up money to go out and recruit a top physician to come to Ohio State."

Source: The Columbus Dispatch, 2104

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Challenges in population health

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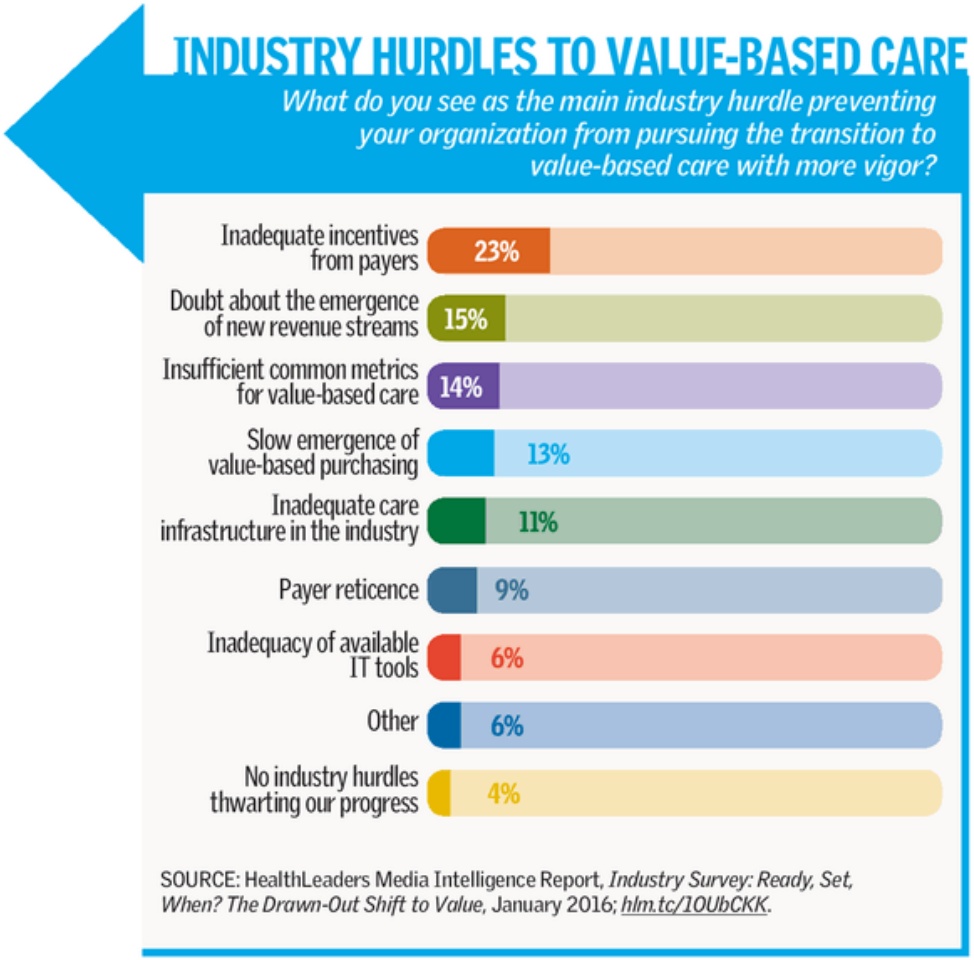
Doubt from healthcare leaders



Source, American Hospital Association (AHA) -Hospitals and Health Networks, 2016

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EMR

- There will be challenges gathering and sharing patient electronic medical records (EMRs). The EMR does not normally contain much information about patient history outside of that organization.
- The interconnection/sharing of EMRs between providers needs to occur in order for all providers to work in sync.

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Legislature

- Future governmental legislation will adopt further policy regarding population health models in either the positive or negative correction depending on how this new model affects the:
  - cash resources
  - gross national product
  - quality of care results
  - access and satisfaction of the citizens
  - overall results and approval of the new programs.

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Take care of ourselves?

- This new model requires motivating and working with patients to help them take care of themselves.
- The country currently exhibits challenges with patient compliance and healthy lifestyle habits.
- These challenges will likely continue into the future.

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Provider shortage

- Primary care physicians are the basis and the heart of the population health model.
- There is currently a shortage of primary care physicians in this country and the trend is predicted to continue into the future.
- Current strategies taking place to replace these resources are to empower nurse practitioners and physician assistants to help bridge this gap in order to have enough providers to care for US citizens.

Source:National Center for Biotechnology Information, U.S. National Library of Medicine

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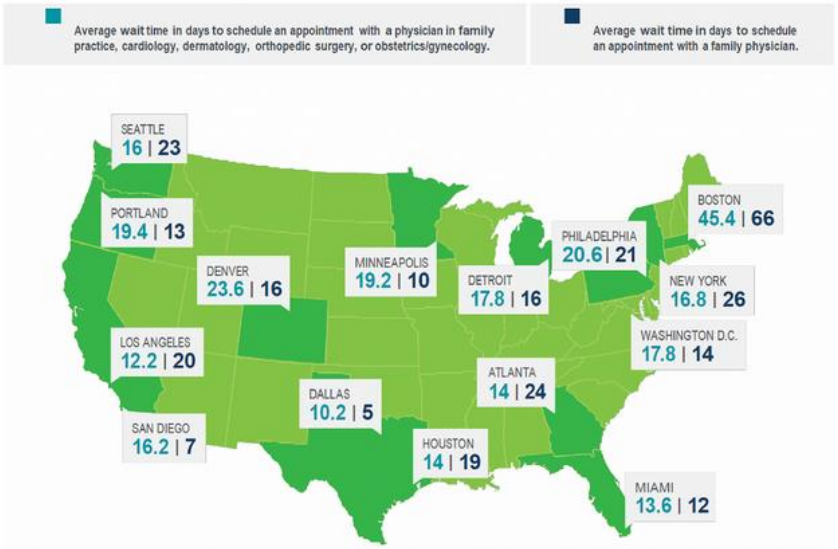
U.S. faces 90,000 doctor shortage by 2025, medical school association warns

A | 214

By Lenny Bernstein March 3 Follow @LennyMBernstein



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1 'Nicest people in the world': Minn. family of five found dead in apparent murder-suicide

2 Federal researchers urge older adults to aim for much

Source: https://www.washingtonpost.com/news/to-your-health/wp/2015/03/03/u-s-faces-90000-doctor-shortage-by-2025-medical-school-association-warns/?utm_term=.405a20a31984

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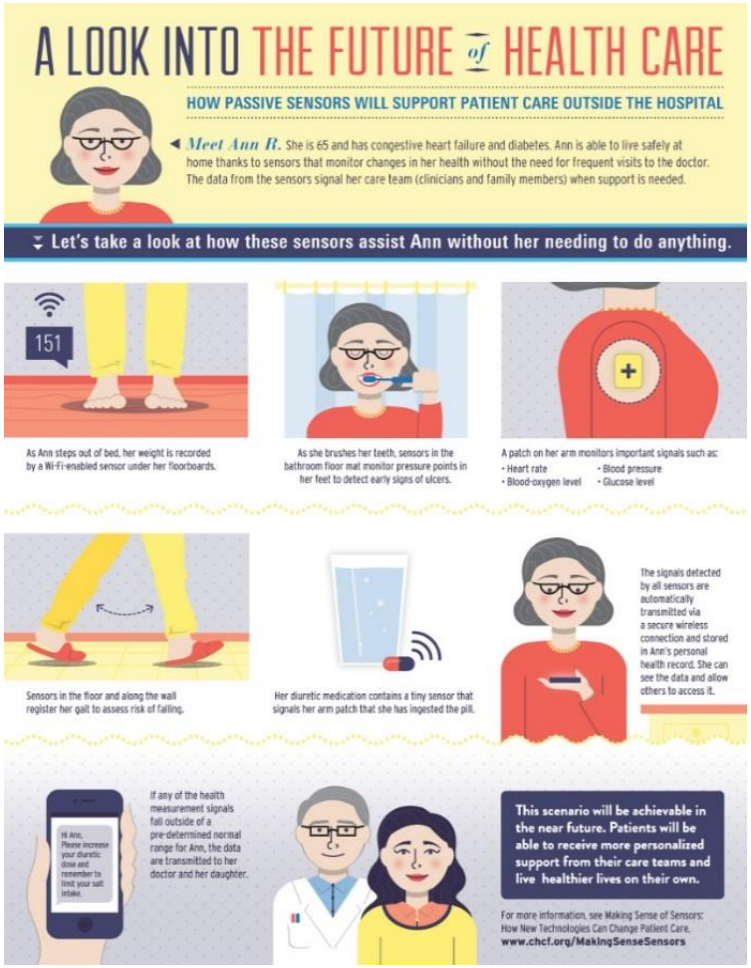
What me may see in the future



Source: http://visual.ly/look-future-health-care

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Lifestyle changes

- Prevention
- Health behavior change
  - Education
  - Motivation
    - Psychological rewards
    - Financial
  - Training
  - Marketing (e.g. smoking cessation)
  - Effectiveness of programs?

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Focus for disease management

- High volume of services used
- Preventable complications (inpatient, ED, etc.)
- Can be managed as an outpatient
- Complex referral patterns, multiple providers
- Well accepted care guidelines

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Prevention education

- Healthy Behaviors Education campaign (§4004)
- Restaurants with more than 20 locations required to post the nutritional content of their standard menu items. (§4205)
- School-based wellness—meal programs, vending machines, and physical education, at different levels of intensity, in preventing and treating overweight and obesity in children and adolescents

Source: Gov.org

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Wellness

- An active engagement in routine exercise
- A healthy diet
- Maintenance of a healthy weight
- Avoidance of risky behaviors (e.g., smoking, alcohol or drug abuse, driving without seatbelts)

Biometric-based wellness

- §2705 allows employers to reward employees who meet goals with a refund of up to 30 percent of their premium costs. This can be raised to 50 percent in the future.
- Medicaid financial incentives for wellness are available (§4108)
- Goals frequently used by employers
  - Body mass index
  - Cholesterol
  - Blood pressure
  - No smoking

Source: Gov.org

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The ACA – how is it going?

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Access

ACCESS

Strong Enrollment in the Health Insurance Marketplace. On March 31, 2015 about **10.2 million** Americans had paid their premiums and had active coverage through the Health Insurance Marketplace.

Historic Reduction in the Uninsured. We have seen the largest reduction in the uninsured in four decades. Since the passage of the Affordable Care Act five years ago, about **16.4 million** uninsured people have gained health coverage. Those gains come primarily from the Marketplace, young adults who can stay on their parents' plans until they turn 26, and Medicaid expansions.

Progress in Fighting Health Inequity. Since 2013, the uninsured rate has declined 9.2 percentage points for African Americans, resulting in **2.3 million** adults gaining coverage and 12.3 percentage points for Latinos, resulting in **4.2 million** adults gaining coverage. Since 2013, the uninsured rate among women declined 7.7 percentage points, resulting in **7.7 million** women gaining coverage. An estimated **55 million** women are also benefiting from preventive services coverage with no out-of-pocket costs. And health insurers can no longer discriminate based on gender, so being a woman is no longer a preexisting condition.

Medicaid Expansion. Over **12.3 million** additional individuals are enrolled in Medicaid and CHIP as of April 2015, compared to before October 2013. To date, 28 states plus DC have expanded Medicaid under the Affordable Care Act. This is one of the areas where we know more can be done. We want to work with all the states that have yet to expand — to get as many people covered as possible.

Reducing Uncompensated Care in Hospitals. As a result of Marketplace coverage and Medicaid expansion, hospital uncompensated care costs were reduced by an estimated **$7.4 billion** in 2014, compared to what they would have been in the absence of the coverage expansion. Medicaid expansion states account for $5 billion, or 68 percent, of that reduction. If all States fully expanded Medicaid, uncompensated care costs would be about **$8.9 billion** lower in 2016 than they would be if no additional states expanded Medicaid.

From Coverage to Care. Now that millions of Americans have health coverage, we are working to **educate** consumers about their coverage and to reduce barriers so that they can get the care they need to live longer and healthier lives._

Reference: Hhs.gov,. 'The Affordable Care Act Is Working | HHS.Gov/Healthcare'. N.p.. Web. 11 Sept. 2015.

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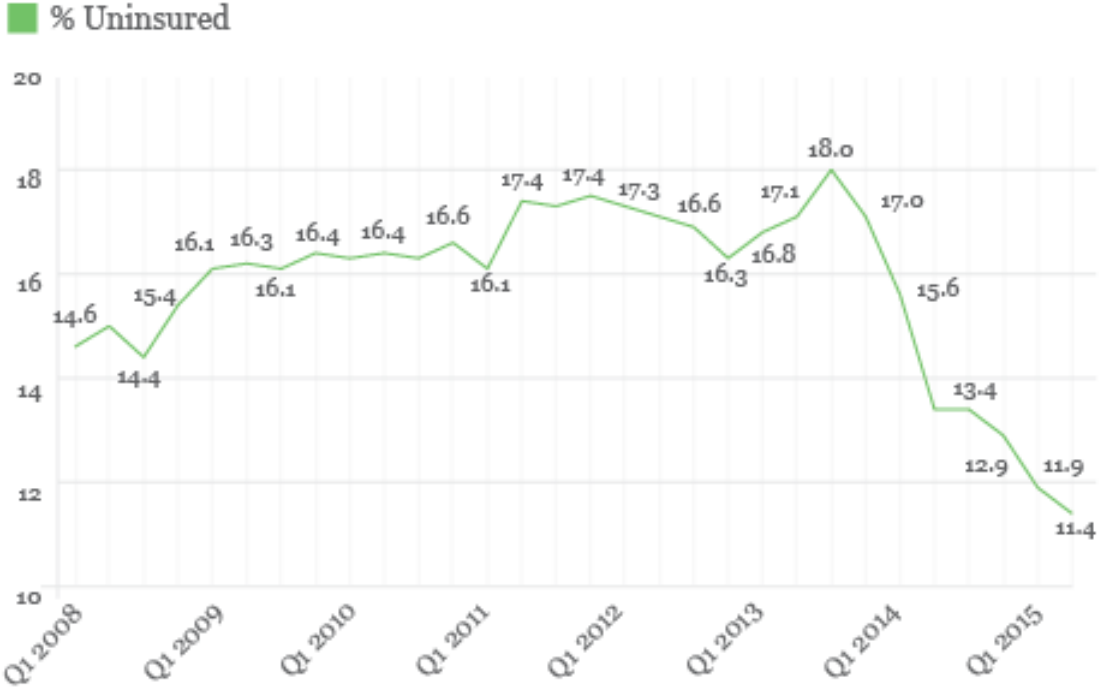
Percentage Uninsured in the U.S., by Quarter

Do you have health insurance coverage?
Among adults aged 18 and older



Quarter 1 2008-Quarter 2 2015
Gallup-Healthways Well-Being Index

GALLUP

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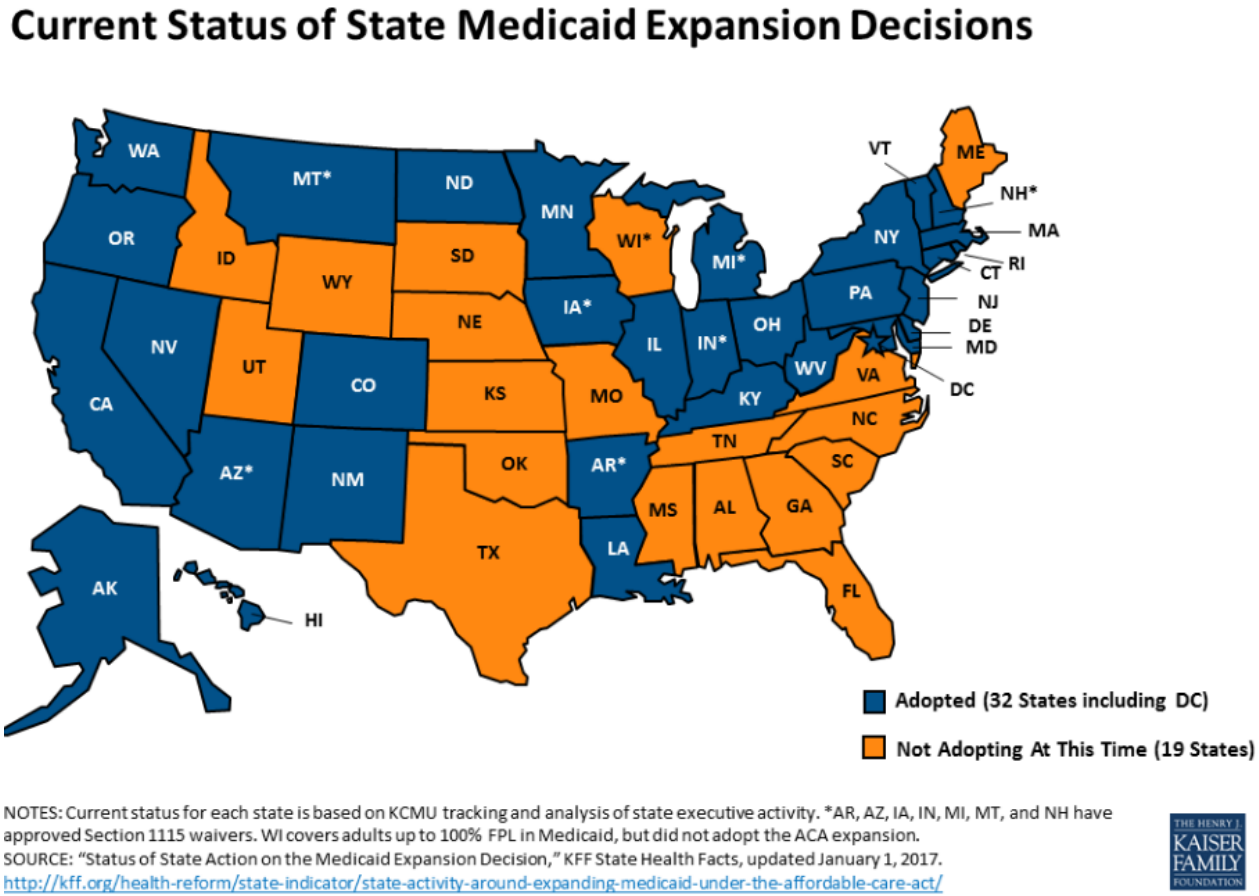
States that expanded Medicaid



NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 1, 2017.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

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Health coverage

- The ACA led to an estimated 8.7 million people gaining health coverage in 2014 through expanded Medicaid programs and from privately-sold health insurance plans, whose sale began through government-run marketplaces that year.
- Enrollment in private health plans increased by 2.2 million people to 189.9 million
- 7.7 million more people were covered by Medicaid, the U.S.-funded, state run program for the poor, bringing the total to 65.9 million.

Source: CMS.gov

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Quality

QUALITY

Improved Patient Safety. Since 2011, patient harms like hospital-acquired conditions, pressure ulcers, central line associated infections, falls and traumas have fallen by **17 percent**, saving an estimated **50,000 lives** and **$12 billion** dollars.

Fewer Avoidable Hospital Readmissions. The Medicare all-cause 30-day readmission rate fell to approximately 17.5 percent in 2013, translating to an estimated **150,000 fewer hospital readmissions** among Medicare beneficiaries between January 2012 and December 2013.

Alternative Care Models are Driving Value. Accountable Care Organizations (ACOs) are groups of providers and insurers who work together to put patients in the center of their care and create better health outcomes. Today, more than **one in every 14 Americans** gets their health care from one of more than 700 ACOs established by Medicare and other payers. ACOs have generated a combined **$417 million** in savings for Medicare. In addition, the Pioneer ACO model has been **certified** as the first patient care model to meet the stringent criteria for expansion to a larger population of Medicare beneficiaries.

Higher Quality Coverage. After years of dropped coverage, flimsy plans and barriers to care, everyone's coverage has improved because consumers have new protections, including those who get health insurance through their employers. They can't be turned away because of pre-existing conditions; they can't be dropped just because they get sick and insurance has to cover care that Americans count on like trips to the emergency room, prescriptions and preventive services.

We are transforming the way Americans get health care and they have sent a clear message that the Affordable Care Act's benefits are needed, wanted, and liked.

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Spending

National health expenditure data

- NHE grew 5.8% to $3.2 trillion in 2015, or $9,990 per person, and accounted for 17.8% of Gross Domestic Product (GDP).
- Medicare spending grew 4.5% to $646.2 billion in 2015, or 20 percent of total NHE.
- Medicaid spending grew 9.7% to $545.1 billion in 2015, or 17 percent of total NHE.
- Private health insurance spending grew 7.2% to $1,072.1 billion in 2015, or 33 percent of total NHE.
- Out of pocket spending grew 2.6% to $338.1 billion in 2015, or 11 percent of total NHE.
- Hospital expenditures grew 5.6% to $1,036.1 billion in 2015, faster than the 4.6% growth in 2014.
- Physician and clinical services expenditures grew 6.3% to $634.9 billion in 2015, a faster growth than the 4.8% in 2014.
- Prescription drug spending increased 9.0% to $324.6 billion in 2015, slower than the 12.4% growth in 2014.

Source: CMS.gov

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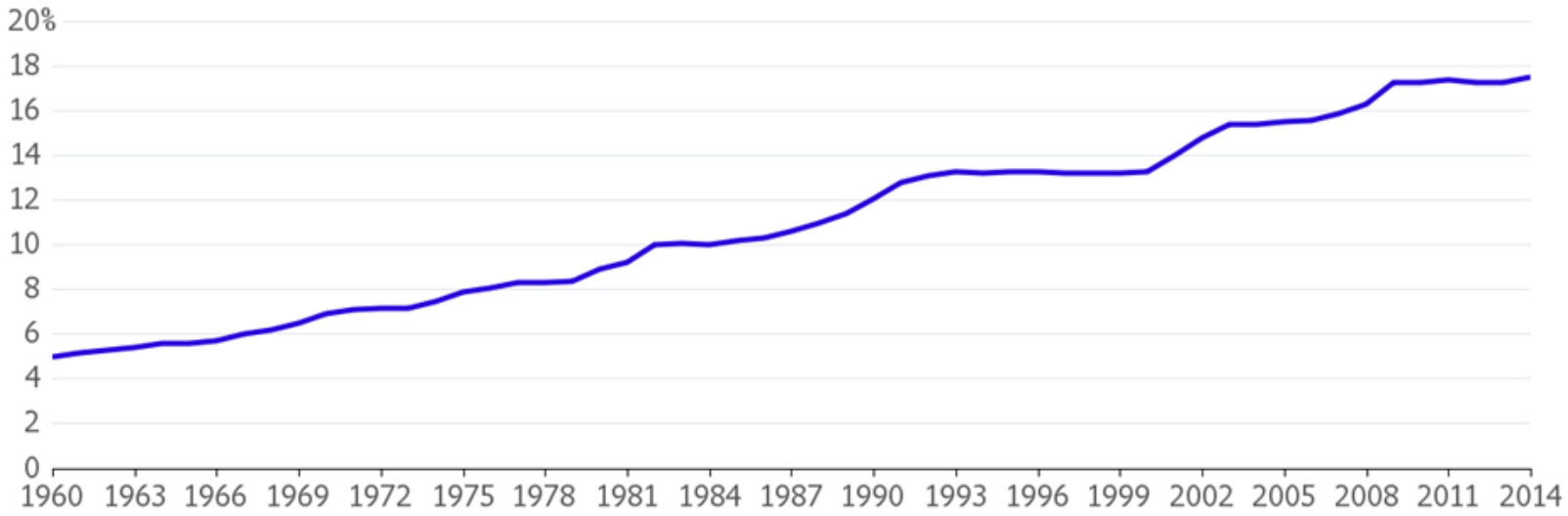
Health Care Grows as a Share of GDP

For decades, health care has been taking up an increasing piece of the U.S. economy, and totaled a record 17.5 percent of GDP in 2014, up from 17.3 percent the year before.



Source: Office of the Actuary, Centers for Medicare and Medicaid Services

Bloomberg

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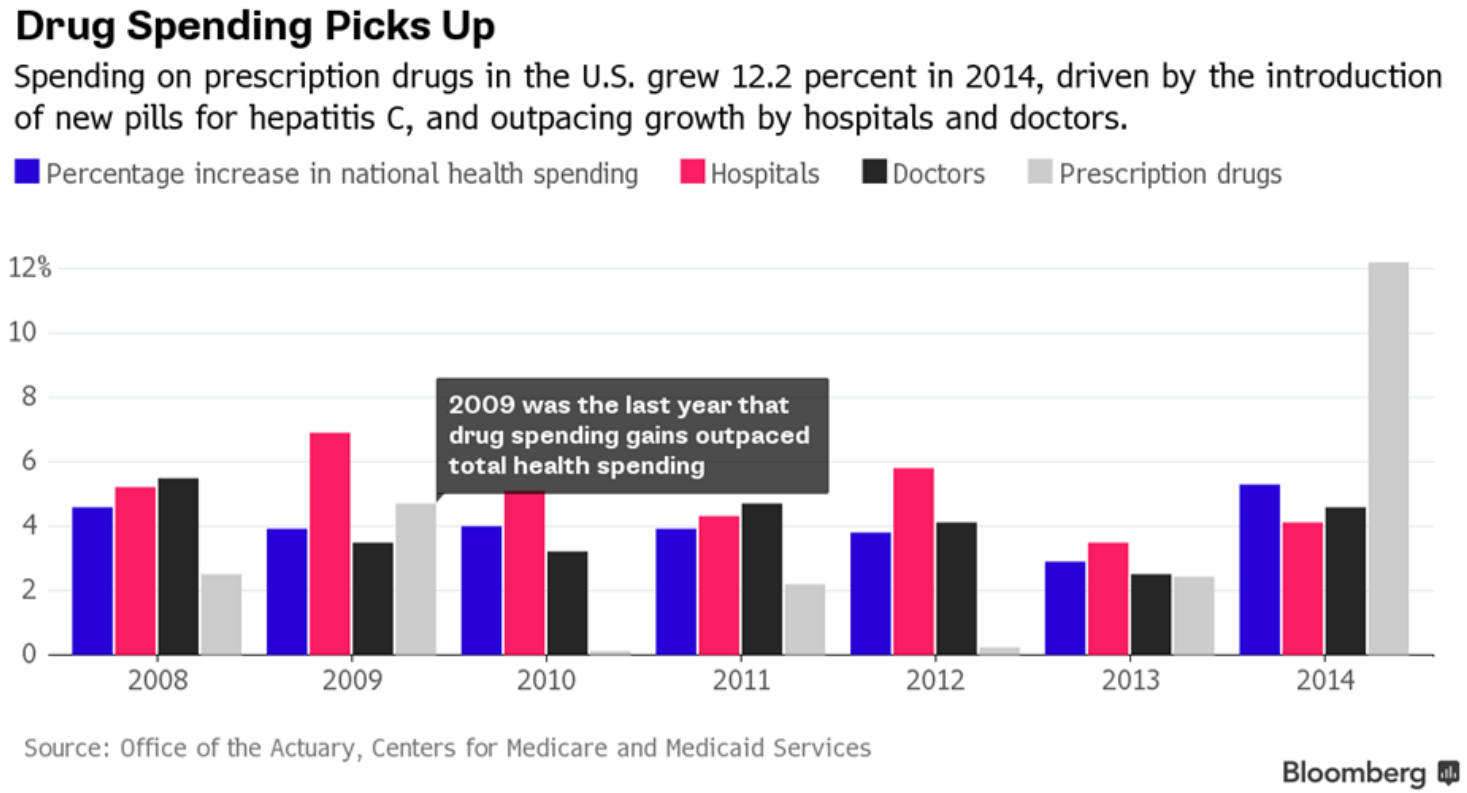
Total spending on prescription drugs increased by 12.2 percent last year



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POLITICS

The jury is still out on success of Obamacare

By The Denver Post Editorial Board

POSTED: 04/05/2014 05:01:00 PM MDT | UPDATED: 9 MONTHS AGO 57 COMMENTS

Enrollment numbers are in, and despite disastrous tech problems early on, the Affordable Care Act has cleared its first crucial hurdle.

Though many procrastinated, 7.1 million people signed up for private health plans by last week's initial deadline, slightly more than the administration originally projected.

And that's good news, since the nation as a whole will benefit if the health care law succeeds

However, President Obama's victory lap in a Rose Garden ceremony last week struck us as somewhat premature.

Speaking from the White House Rose Garden, President Barack Obama, with Vice President Joe Biden, announced Tuesday that 7.1 million Americans have signed up for insurance under the Affordable Care Act. (Jewel Samad, Getty Images)

There is a long way to go and many milestones before the administration can truly tout the health care overhaul as a success.

Source: http://www.denverpost.com/2014/04/04/the-jury-is-still-out-on-success-of-obamacare/

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Trump's Executive Order Could Dismantle Parts Of ACA Before Replacement Is Ready

January 21, 2017 · 1:13 AM ET

ALISON KODJAK

President Donald Trump, flanked by Vice President Mike Pence and Chief of Staff Reince Priebus, signs his first executive order on health care, on Friday.

Source: http://www.npr.org/sections/health-shots/2017/01/21/510901402/trumps-executive-order-could-dismantle-parts-of-aca-before-replacement-is-ready

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Radiology challenges

NEMA XR-29

MACRA

Metrics

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NEMA XR-29

- A provision in the same federal legislation signed into law in April 2014 to delay Medicare Sustainable Growth Rate cuts and mandate physician consultation of clinical decision support for advanced diagnostic imaging requires health care providers to comply with the NEMA Standard XR-29-2013 for improved computed tomography (CT) radiation safety.
- The NEMA Standard XR-29, also known as the MITA SmartDose Standard, includes DICOM-compliant radiation dose structured reporting, dose check features, automatic exposure control and reference adult and pediatric protocols.
- "Equipment not in compliance by Jan. 1, 2016, will be subject to a five percent /per scan technical component reduction on diagnostic CT procedures billed in physician office and hospital outpatient settings. The reduction will increase to 15 percent Jan. 1, 2017".

Source: American College of Radiology

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On December 18, 2015, President Obama signed into law the Consolidated Appropriations Act of 2015

Includes a wide range of government spending and tax provisions. As previously reported, the Act includes the following Medicare and Medicaid provisions:

- The Act "incentivizes" the transition from traditional x-ray imaging to digital radiography by reducing by 20% the Medicare hospital outpatient prospective payment system (OPPS) and physician fee schedule payment for the technical component (including the technical component portion of a global service) of film x-rays beginning in 2017.
- OPPS payment and physician fee schedule payment for the technical component of an x-ray taken using "computed radiography technology" will be reduced by 7% during 2018 through 2022, with a 10% reduction applicable beginning in 2023.
- The term "computed radiography technology" is defined to mean cassette-based imaging that utilizes an imaging plate to create the image.
- In addition, the Act reduces the discount in payment for the professional component of multiple imaging services furnished on or after January 1, 2017 from 25% to 5%.

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Reductions

Medicare Reimbursement Cuts to X-ray by Technology

X-ray Technology	Year Implemented	Reimbursement Reduction
Analog	2017	20%
Computed Radiography	2018	7%
Computed Radiography	2023	10%
Digital Radiography	None	None

Source: https://www.advisory.com/research/imaging-performance-partnership/the-reading-room/2016/02/x-ray-reimbursement-cuts

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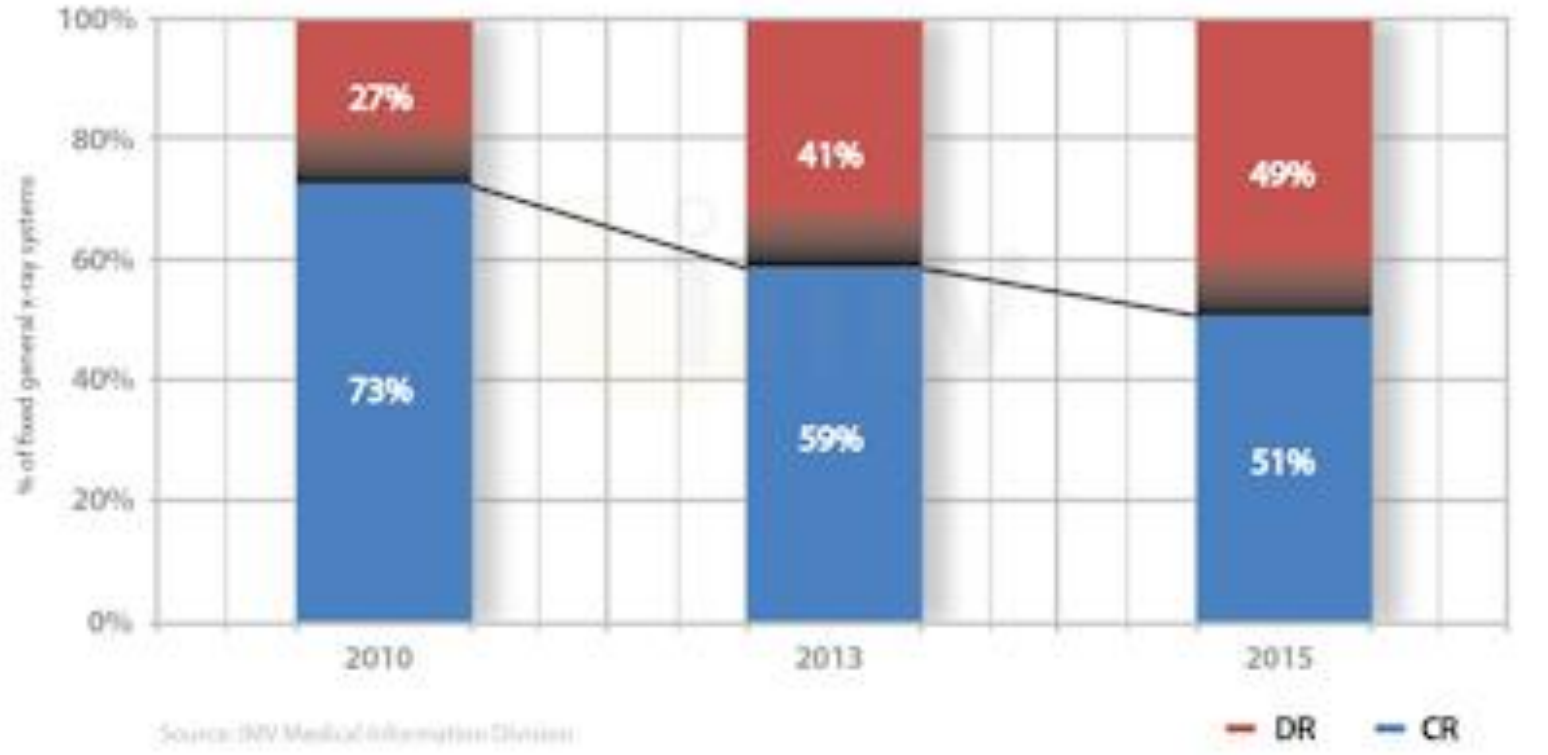
Mix of DR vs. CR fixed general x-ray systems installed in U.S. hospitals, 2010 to 2015



How many CR systems do you have?
How many diagnostic x-rays do you complete in a year?

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MACRA

- In April 2015 the Medicare Access and CHIP1 Re-Authorization Act (MACRA), was signed into law. MACRA mandates several critical updates to Medicare provider payment that take effect January 1, 2019.
- The MIPS track consolidates three existing CMS reporting programs–the EHR Incentive Programs (i.e., Meaningful Use [MU]); the Value-Based Payment Modifier (VBPM); and the Physician Quality Reporting Program (PQRS)–into a single program

Source: Advisory Board Company

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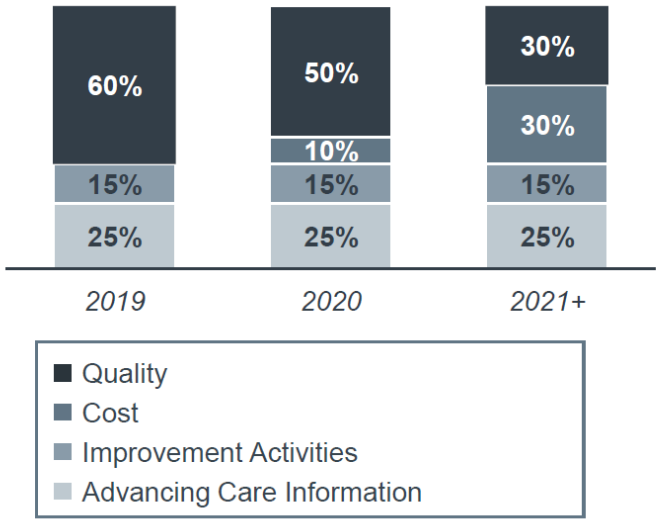
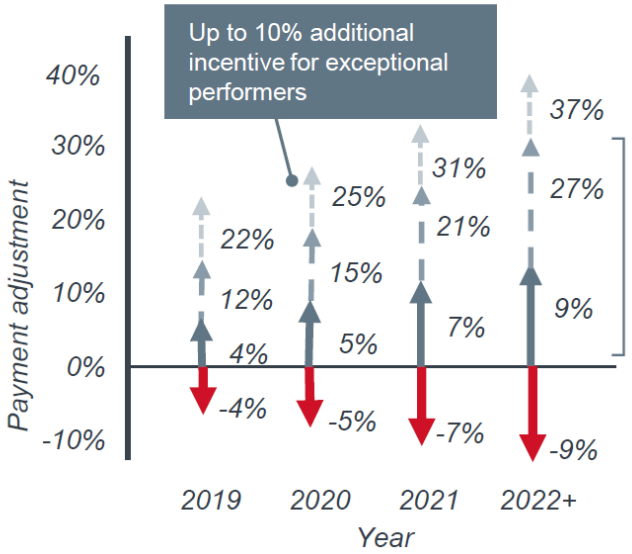
MACRA

The MIPS track will score providers (referred to as MIPS Eligible Clinicians [ECs]) on four categories: Quality, Cost, Advancing Care Information (ACI, i.e., EHR use), and Improvement Activities (IA). Providers' performance on these four categories will be used to calculate Medicare Part B bonuses or penalties.

Weights of MIPS Score Components



Maximum EC Penalties and Bonuses



Budget neutrality adjustment: Scaling factor up to 3x may be applied to upward adjustment to ensure payout pool equals penalty pool

Source: Advisory Board Company

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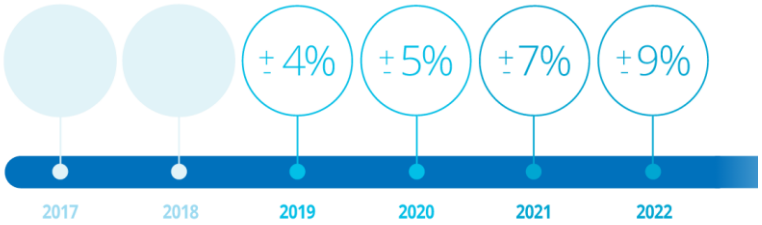
Radiology and MACRA



https://qpp.cms.gov/

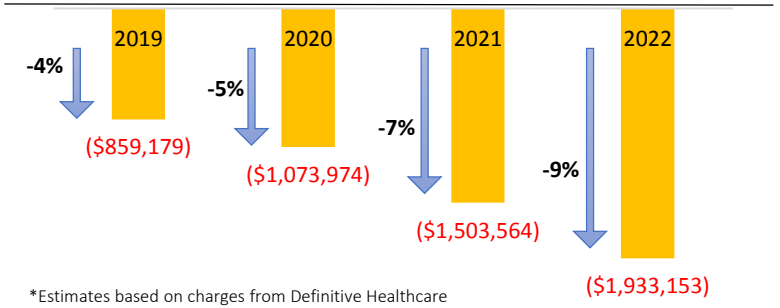
- 15% of all high priority MACRA metrics are imaging related
- 22 out of 24 radiology metrics are registry based data submission (not EHR)
- In terms of # MACRA metrics to report, ACR leads all professional societies

Three main focus areas for compliance in Radiology

- Radiation Dose Management and compliance
  - Tracking and reporting dose exposure and participation in dose registries
- Recommendation Follow-up compliance
  - Critical Findings follow-up and integrated patient scheduling
- External image sharing
  - DICOM image sharing and track record of patient exam history to avoid repeat exams

System-wide additional revenue at-risk due to MACRA penalties

Sample IDN (20+ hospitals)



*Estimates based on charges from Definitive Healthcare

Source: *5 MACRA takeaways for radiologists*, The Advisory Board Company, May 2016

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Metrics
DATA
Data Analysis

Why do we need them now more than ever?

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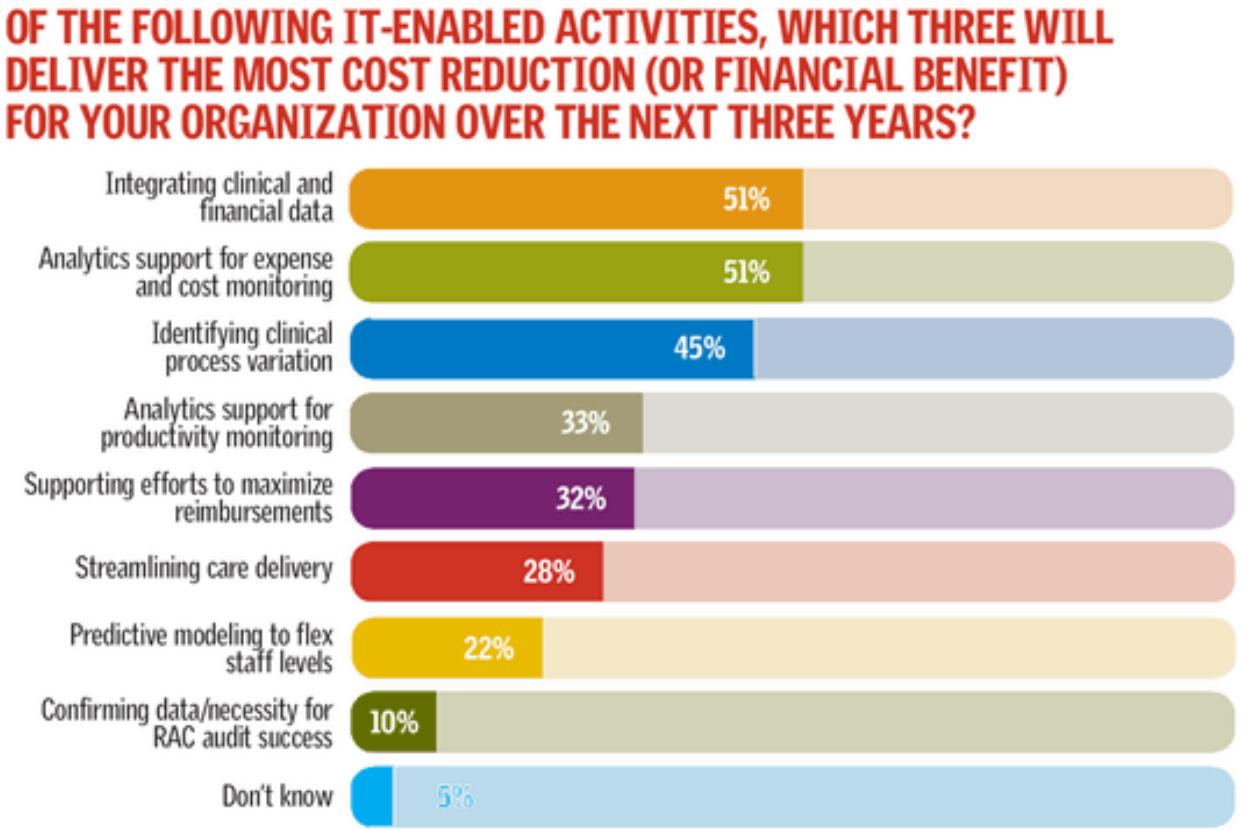
New metrics and analysis



Source, American Hospital Association (AHA) -Hospitals and Health Networks, 2016

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Value-based metrics?

Metrics for Radiologists in the Era of Value-based Health Care Delivery[1]

Ammar Sarwar, MD
Giles Boland, MD
Annamarie Monks, MS
Jonathan B. Kruskal, MD, PhD

Abbreviations: ACR = American College of Radiology, CMS = Centers for Medicare and Medicaid Services, PPACA = Patient Protection and Affordable Care Act, PQRS = Physician Quality Reporting System, RBM = radiology benefits manager

RadioGraphics 2015; 35:866–878

Published online 10.1148/rg.2015140221

Accelerated by the Patient Protection and Affordable Care Act of 2010, health care delivery in the United States is poised to move from a model that rewards the volume of services provided to one that rewards the value provided by such services. Radiology department operations are currently managed by an array of metrics that assess various departmental missions, but many of these metrics do not measure value. Regulators and other stakeholders also influence what metrics are used to assess medical imaging. Metrics such as the Physician Quality Reporting System are increasingly being linked to financial penalties. In addition, metrics assessing radiology's contribution to cost or outcomes are currently lacking. In fact, radiology is widely viewed as a contributor to health care

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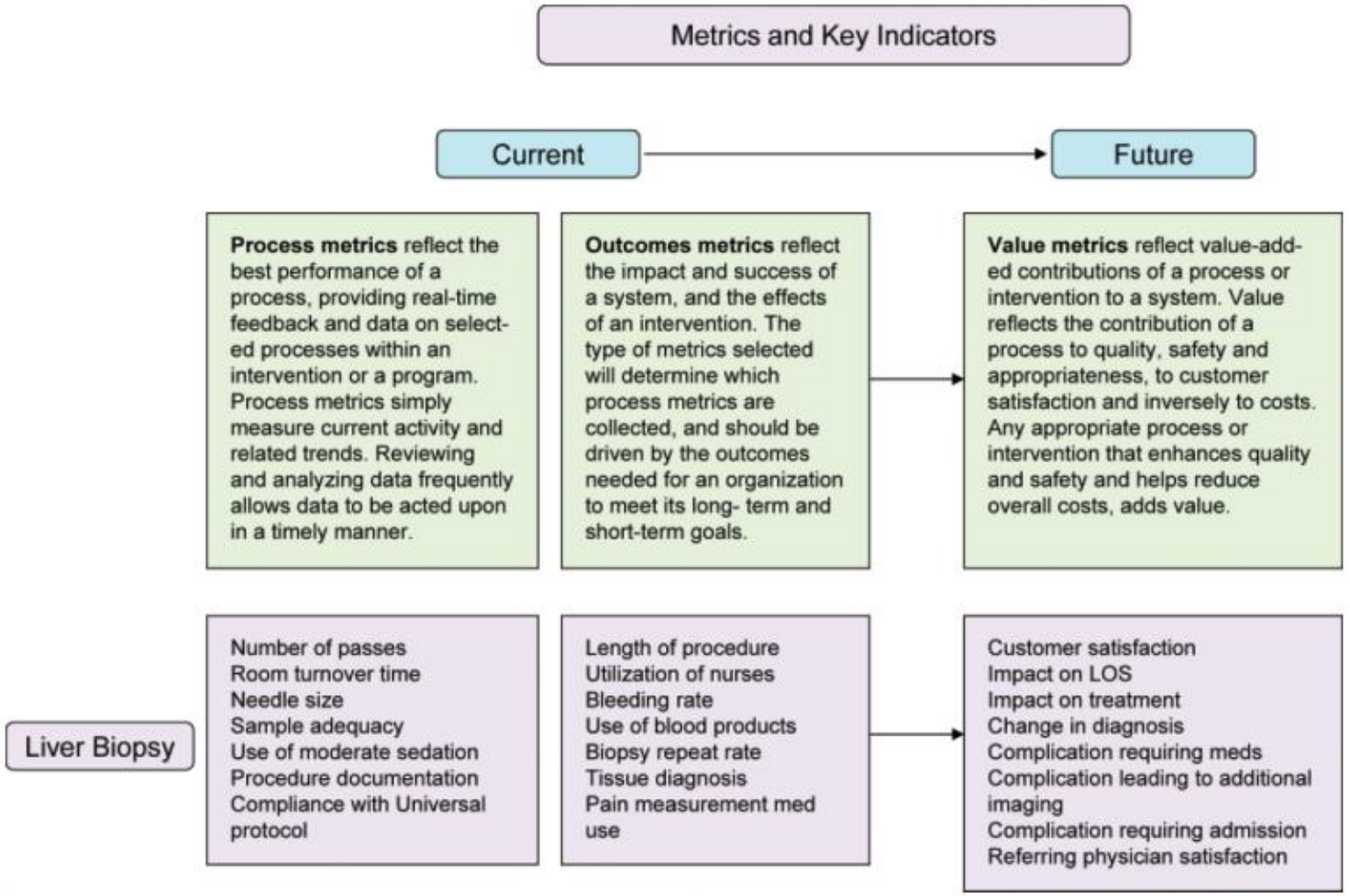

Figure 4. Current and future metrics and how they differ in principle and practice. *LOS* = length of stay, *med* = medication.

Source: Sarwar, Ammar et al. "Metrics For Radiologists In The Era Of Value-Based Health Care Delivery". *RadioGraphics* 35.3 (2015): 866-876. Web.

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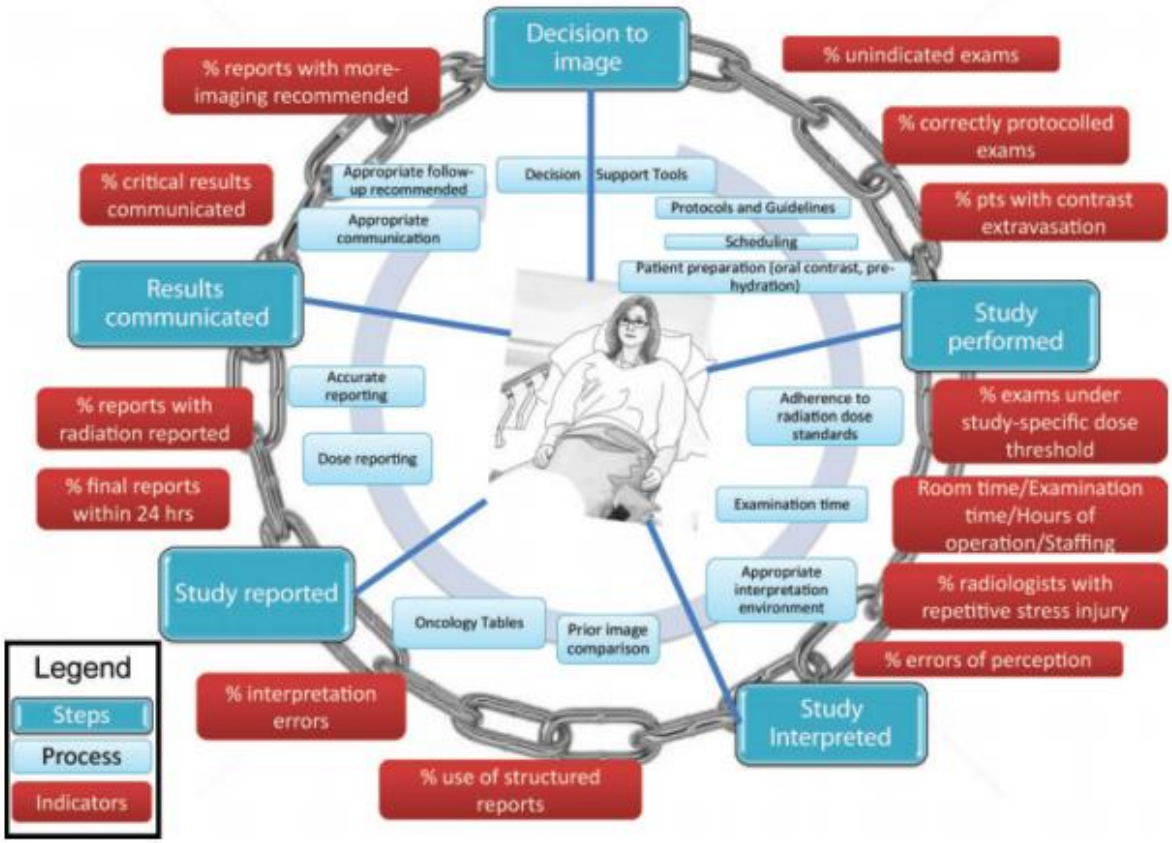

Figure 1. Drawing illustrates the steps in the imaging chain, the processes required for successful completion of an imaging request, and the indicators that measure these processes. *pts* = patients.

Source: Sarwar, Ammar et al. "Metrics For Radiologists In The Era Of Value-Based Health Care Delivery". *RadioGraphics* 35.3 (2015): 866-876. Web.

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Sample questions in an imaging department

"What are my monthly, weekly, daily and hourly study count?"

"How do we standardize our team's performance across imaging equipment? How can we target trainings only where needed?"

"What is my weekly average resource utilization?"

"How can we use data to better inform and direct the management of our department?"

"What are the contributors to our lagging turn around times for screening exams?"

"How am I doing in terms of meeting the budgeted volumes for this month, and year so far?"

"How do we identify and manage imbalances in imaging volumes and determine the root causes?"

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Strategies for data-driven performance improvement management

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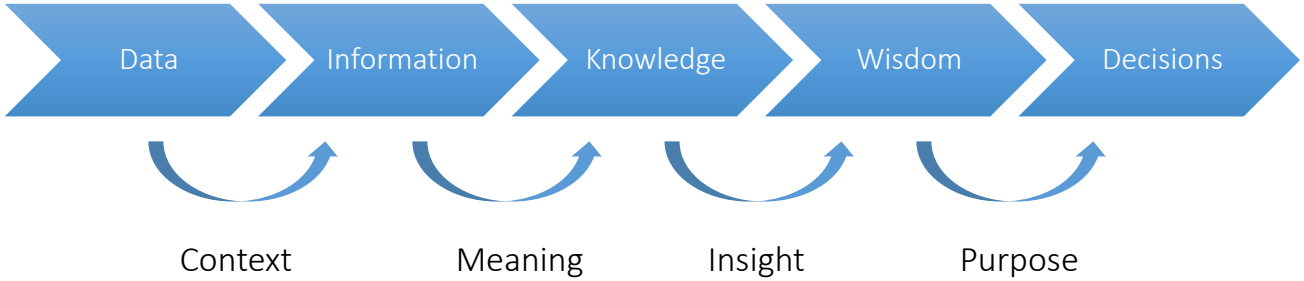
Stages of data sophistication



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Data-driven practice management

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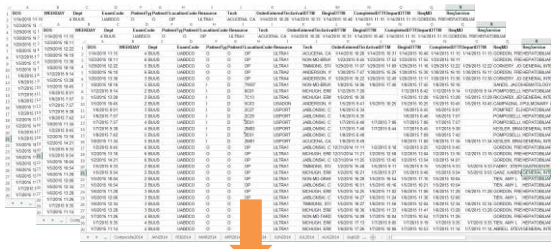
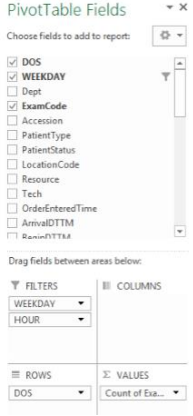
Initial approach to Performance Reporting

Centricity PACS (GE)

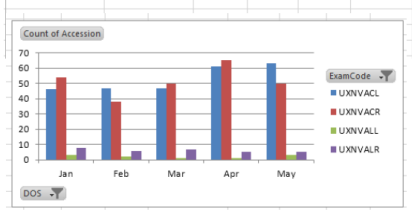
RIS

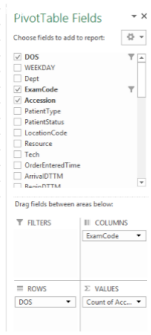


	A	B
1	WEEKDAY	(Multiple Items)
2	HOUR	(Multiple Items)
3		
4	Row Labels	Count of ExamCode
5	Jan	1543
6	Feb	1341
7	Mar	1506
8	Apr	1647
9	May	1470
10	Jun	1460
11	Jul	1561
12	Aug	1461
13	Grand Total	11989



Count of Accession	Column Labels				
Row Labels	UXNVACL	UXNVACR	UXNVALL	UXNVALR	Grand Total
Jan	46	54	3	8	111
Feb	47	38	2	6	93
Mar	47	50	1	7	105
Apr	61	65	1	5	132
May	63	50	3	5	121
Grand Total	264	257	10	31	562





Takes a *lot* of time
- Data extraction
- Data import
- Formatting
- Context switching

Error prone
- Lot of copy-pasting
- Manual calculations

Aesthetics
- Drill-down capabilities
- Trend identification

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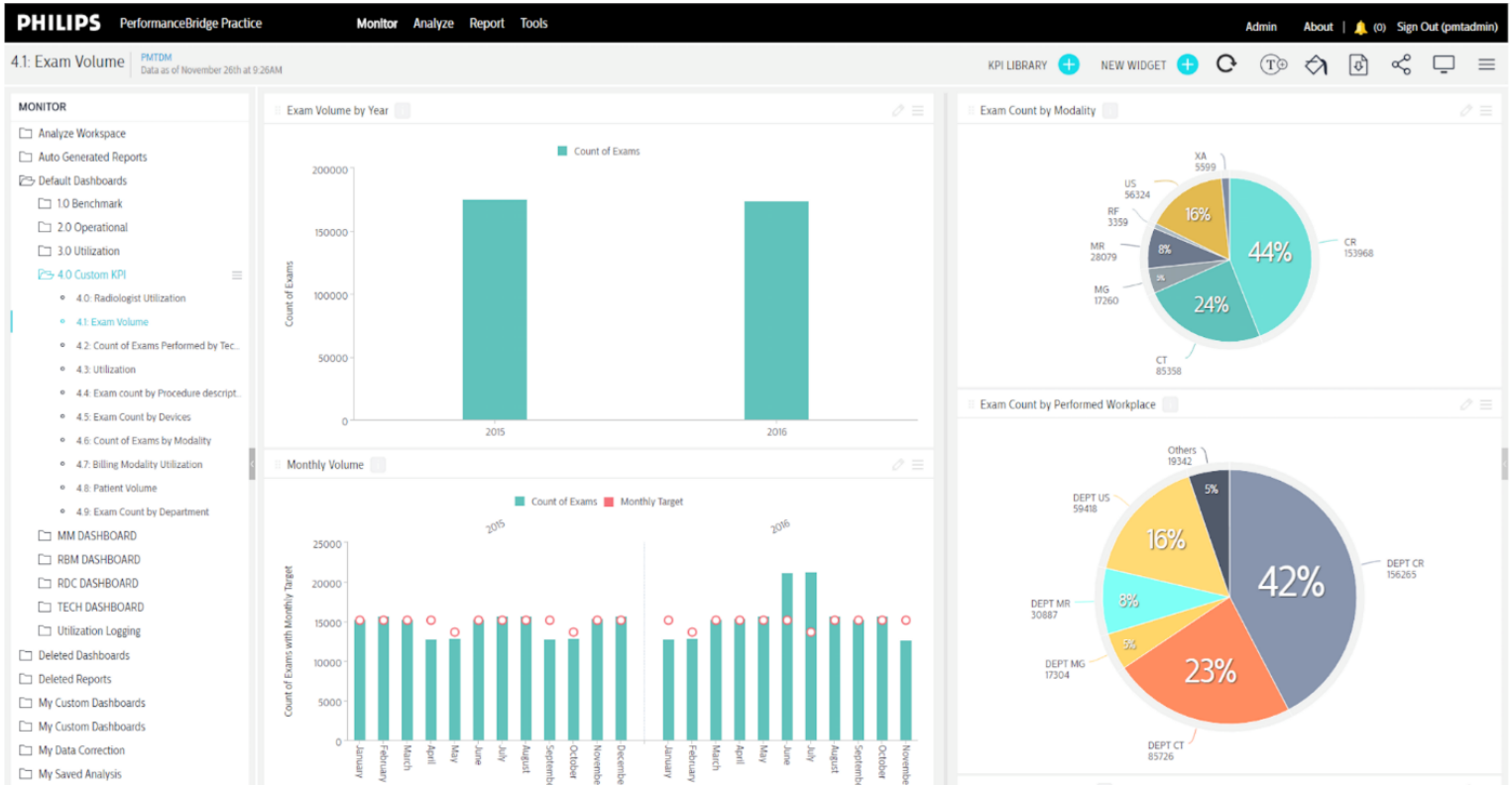
Interactive dashboards for exploration and reporting



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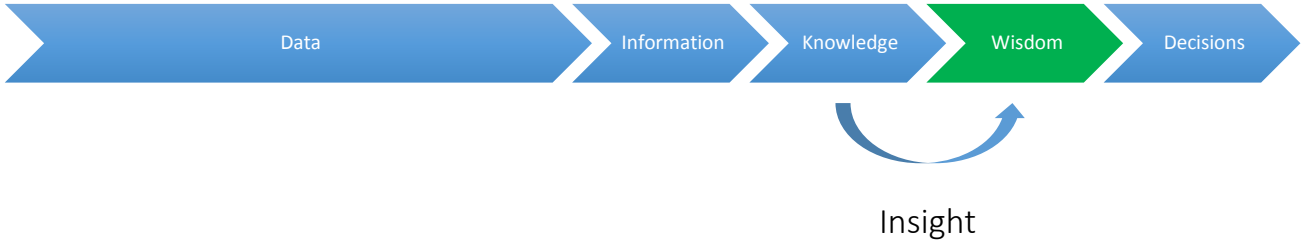
Data-driven practice management



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Variability in MR protocols

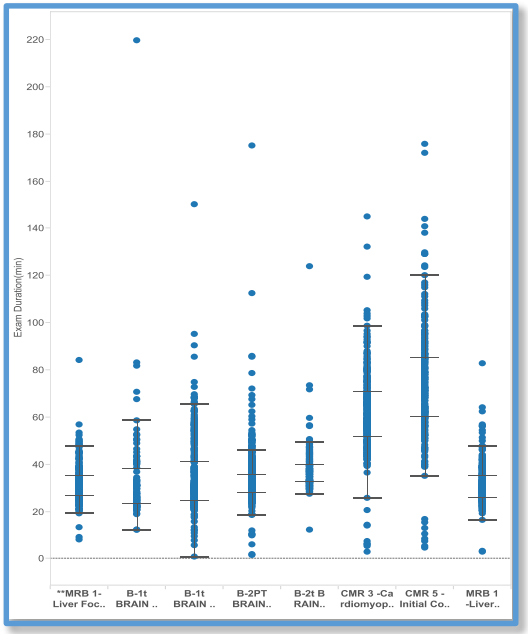
Case Example

Lean six sigma methodology can be applied to radiology to:

- Reduce variability,
- Enable more predictable and efficient patient scheduling,
- Improve patient satisfaction[1].

Patient satisfaction is improved if appointments begin on time, last their expected duration, and end on time.

Applying six-sigma in healthcare, and for radiology in particular, requires accurate data to measure variability and identify root-causes of variability.



MRI log-file data demonstrating variability in examination duration for the 7 most common MRIs performed at UW Medical Center.

1. Bucci RV and Musitano A; Radiology Management 2011 33, 3: 27-33

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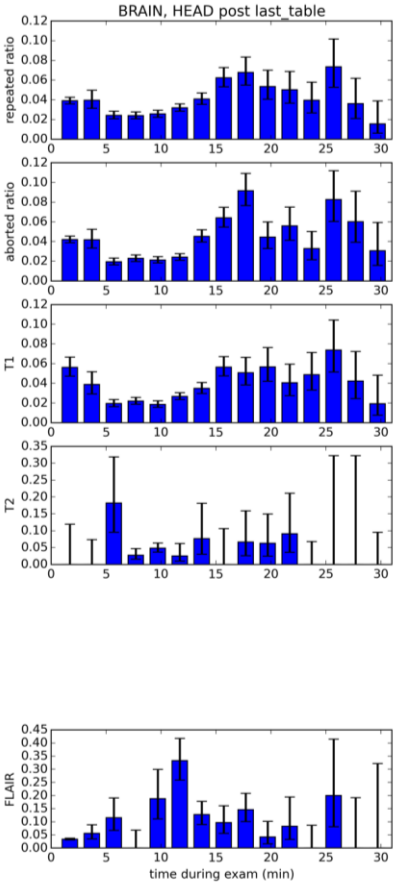
Case Example

Application: quality improvement measuring repeated MRI sequences

Motion artifact impairs a significant proportion of MRI scans.

- In one recent study, significant motion was found in 7.5% of outpatient and about 30% of inpatient/ED MRI scans[1]. Overall, 20% of MRI sequences were repeated.



Probability of Repeated Sequence as a Function of Scan Duration

1. Andre JB, et al. JACR 2015; 12 (7):689-695

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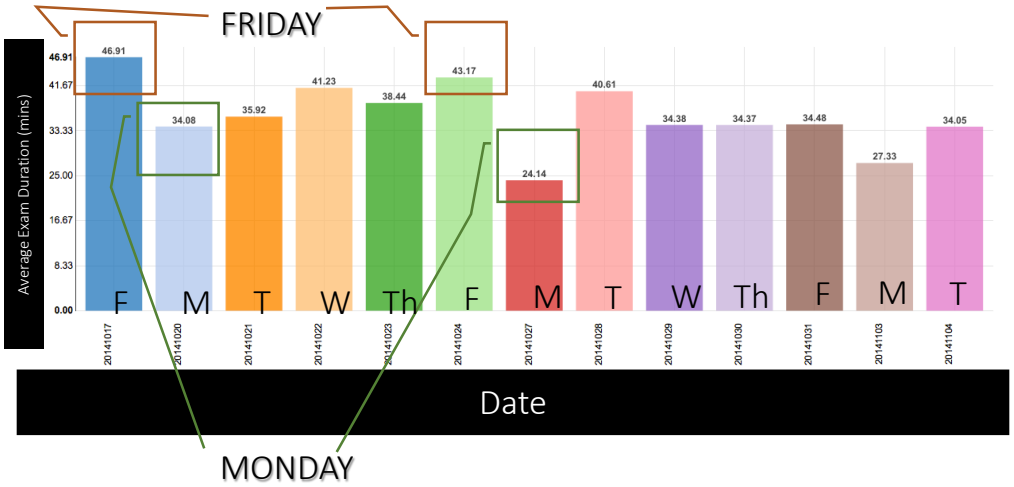
Planning slot-length and staffing

- Granular data about variation in utilization can assist with patient scheduling and optimization of staffing levels.
- Our data shows that at our hospital, MRIs take longer on Fridays! This is due to the types of clinics scheduling cases on Fridays and add-on acute cases being scanned before the weekend.



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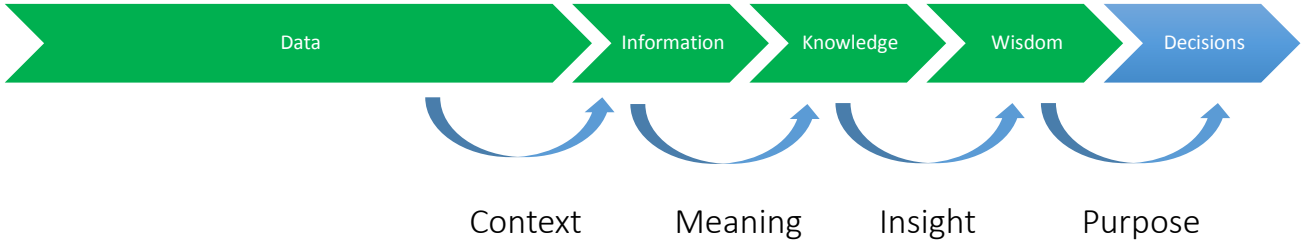
Data driven capital asset planning process



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Summary and conclusions

- Measurement tools enable continuous improvement -- but it is important to…
  - Ensure the decisions are made based on trusted data
  - Integrate metrics into the daily way of working
  - Explore novel solutions but always measure their impact
- In order to
  - Drive Value (Cost, Quality, Access) for the Patient
- Through
  - Adoption of a continuous improvement culture

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Thank you

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