Bulletin... WINTER 2010

The Pennsylvania Radiological Society

A Chapter of the American College of Radiology

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PRESIDENT'S MESSAGE

Melvin Deutsch, MD, FACR
University of Pittsburgh
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I am honored to be the president of the Pennsylvania Radiology Society.

I first attended a PRS meeting over 15 years ago and was very impressed by the entire program. All of the speakers and attendees, except me, seemed so knowledgeable and articulate on the economic, political, legal, and practical issues facing medicine and, in particular, radiology. I have attended every PRS meeting since that time.

As in previous years, this past PRS meeting in Philadelphia had an excellent program, thanks to the efforts of Bob Pyatt. Even a non-diagnostic radiologist, such as I, found all the presentations to be interesting and informative. Because of Rich Duszak's presentation, I have been putting information on diagnoses and symptoms on all of my requests for diagnostic imaging and even laboratory studies. I now know why there is so much verbiage in a radiology report about the number of views, techniques, contrast administration, etc. It is for documentation and billing!

The medical profession is facing an extremely important election cycle in 2010 in which results of statewide and national elections will definitely impact upon the practice of medicine. I urge all radiologists to get involved with candidates for state and federal office to learn about their positions on health care issues. If all PRS physicians would meet personally with their elected representatives to make known our positions on various aspects of health care reform legislation, malpractice reform, problems with self-referral, etc., we would be a significant force. Also, do not forget to donate to individual candidates and, most importantly, to RADPAC.

Recently, with support of the PRS and other state medical organizations, Judge Joan Orie Melvin was elected to the Pennsylvania State Supreme Court. Her opponent reportedly received one million dollars from the PAC of Philadelphia trial lawyers. If physicians were as politically active and generous in political donations as trial lawyers, we could solve many of the problems facing the practice of medicine.

There are many problems and challenges facing us over the next twelve months and the PRS will play an important role in representing our interests. Therefore, it is important for us to remain active, recruit new members, and pay dues!

I look forward to a productive year and invite comments, thoughts, ideas, and advice from all members of the PRS.

EDITOR'S COLUMN

Anne P. Dunne, MD
Geisinger Medical Center
Danville PA

It is a delight and honor to be editor of The Pennsylvania Radiological Society Bulletin and I thank the officers of the PRS for offering me this great opportunity. I have been a member of the American College of Radiology since 1984. In recent years, I've been on the board of directors of the PRS and an alternate councilor and councilor. From these vantage points, I've seen first hand the valuable work done by the ACR

and PRS in representing radiologists and radiation oncologists throughout the nation and in Pennsylvania. The officers, staff and membership of the PRS are particularly impressive in their sincere dedication and hard work. They foster an atmosphere of camaraderie, genuinely welcoming new members and making it attractive and easy for people to become involved.

I had been feeling guilty that my only contribution was attending meetings. I was pondering how I might do more in the PRS when the advertisement appeared seeking applicants for editor of the PRS Bulletin. I thought this was something I could do! My qualifications include: 12 years of education in the 1950's and 1960's from nuns who emphasized attention to detail and proper sentence declension; the English award on graduation from grammar school; a staff position on my high school newspaper "The Mariel". More seriously, I love our field of radiology and, second to that, my favorite pastime is reading. I am in my 26th year on staff at Geisinger Medical Center in Danville, PA where I'm director of the radiology residency program and section head and academic chief of mammography.

Changes and Acknowledgements

The end of 2009 brought changes to the PRS leadership.
*****Dr. Irving Ehrlich ended his term as president of the PRS. His solid leadership is greatly appreciated by all.
*****Dr. Melvin Deutsch became the new president of the PRS. He is wished a most successful term.
*Dr. Thomas Chang stepped down as editor of the PRS Bulletin after dedicated service for 6 years. He did a fantastic job and set a high standard for this editor to follow. I am especially grateful for his kind instruction during this transition.

*Dr. Michael Love continues to earn the respect of the ACR for his fastidious compilation of ACR fellowship candidate submissions from Pennsylvania.

Annual Meeting

The 94th Annual Meeting of the PRS at the Ritz Carlton Hotel in Philadelphia on October 31, 2009 was a smashing success. Kudos once again are due to Dr. Robert Pyatt for an absorbing and topical program. The sobering statistics of Frank Lexa, MD served as a reality check. Future directions in radiology reporting were illustrated by Dr. Curt Langlotz. The factual presentations with real-life examples from Richard Duszak, MD help us to manage our practices. Dr. John Clarke's talk shed light on the workings of the Pennsylvania Patient Safety Authority. The lecture by Lillian Stern, MD gave us a perspective on how breast-specific gamma imaging fits in with other breast imaging modalities. Dr. Eric Faerber's innovative panel to discuss issues in radiology residency training was most valuable and timely.

Congratulations to John W. Breckenridge, MD, FACR who was the PRS's honored radiologist for 2009. Dr. David Levin's lecture in honor of Dr. Breckenridge pointed out the necessity for radiology to look within itself as well as at outside forces to navigate its course.

Congratulations to Drs. Itri, Redfern and Scanlon from the Hospital of the University of Pennsylvania on winning 1st place for their poster exhibit at the PRS meeting. It was entitled "Improving Resident Performance on Call: The Value of Missed Case Conferences".

Thanks to Dr. Rickhesvar Mahraj for overseeing the scientific exhibits at the meeting once again.

Future Directions

As editor of the PRS Bulletin, I want to serve you and give back to the Society and radiology community. Please send me any suggestions and ideas that you have for the Bulletin. They will be gratefully received and introduced whenever feasible.
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Some things that will be debuted in coming issues are:

- **Guest Column:** In each issue, a chair or designate of a Pennsylvania radiology practice will be invited to submit a column on a concept or issue that she/he feels is important concerning radiological practice today. Over time, it is hoped that every radiology practice in the state will have this opportunity to be heard.
- **Profiles:** In each issue, a PRS board member or officer will be profiled. Over time, we will get to know more about some of our radiologists who are working every day for the betterment of our specialty.
- Reports on the activities of the Philadelphia and Pittsburgh Roentgen Ray Societies.

Goals for 2010:

- A robust membership roster of interested physicians is our best tool for accomplishing positive changes. Please continue your membership in the PRS and encourage your colleagues, who are not members, to join.
- The PRS needs an accurate membership directory. Please contact the PRS office with your current postal address, phone number and, most importantly, **e-mail address**.
- To continue integrating the residents and fellows in the state into ACR and PRS activities under the leadership of Dr. Eric Faerber.
- Increased number of scientific exhibits at the fall 2010 PRS meeting.
- Increase in Pennsylvania contributions to **RADPAC**.

Thanks to all the contributors to this issue of the PRS Bulletin.

Lastly, it is with great sadness that I inform the PRS membership of the passing of one of our Pennsylvania radiology residents. It is a major upset to the natural order of things that we lost someone so young and so full of promise and potential. Adam Daniel, MD was a wonderful person, a true friend, a great resident. He is sorely missed by all who knew him and the radiology profession has lost a stellar initiate to its ranks.

In Memoriam

Adam J. Daniel, M.D.
July 11, 1981-November 17, 2009

Adam Daniel, M.D. was a first year radiology resident at Geisinger Medical Center, Danville, PA. He grew up in Dover, Delaware. He earned a Bachelor of Science degree in cell biology and molecular genetics from the University of Maryland. He earned his medical degree from Thomas Jefferson University. He did internship at Christiana Medical Center in Delaware.

Dr. Daniel was a superb resident who had the promise and makings of an excellent radiologist. His passing is a profound loss to his colleagues and to the future of radiology.

Our heartfelt sympathy is extended to his wife, parents, brother and sister.

A Memorial Fund has been established in honor of Dr. Daniel.

Donations may be sent to the First National Bank, 354 Mill Street,
Danville, PA 17821.
Checks should be made to the Dr. Adam Daniel Memorial Fund.

Pennsylvania Resident Activities 2009

Eric N. Faerber, MD, FACR
St. Christopher's Hospital
Philadelphia PA

There has been considerable interest in meetings directed to Pennsylvania radiology residents following two extremely well attended previous annual resident dinner symposia held in Philadelphia and a very successful inaugural meeting held in Pittsburgh in February 2009. The two residents who assisted in the organization of the symposia for the period July 1, 2008 through June 30, 2009 were Marion Brody, MD in Philadelphia and Ceylan Cankurtaran, MD in Pittsburgh. Their enthusiasm and commitment were an integral part of the success of these meetings.

This year a panel discussion: "*Top Issues Facing Radiology Residents in Pennsylvania"* was included in the program for the PRS meeting held on October 31, 2009 and moderated by me. There were three teams of discussants, each team consisting of an attending radiologist and a radiology resident.

Philadelphia: Jason Itri, M.D., Ph.D and Mary Scanlon, M.D., FACR

Central Pennsylvania: Franco Verde, M.D. and Anne Dunne, M.D.

Pittsburgh: Melany Atkins, M.D. and Philip Orons, D.O.

The panel discussion was very well received and I hope there will be continued resident involvement and participation next year and beyond.

A summary of their presentations with references and suggested reading follows.

What's coming down the line with duty hours?

Franco Verde, MD, Geisinger Medical Center, Danville, PA

Residents rejoice! They soon won't be able to make us work those long hours like our predecessors. The ACGME's 80-hour workweek still holds but new recommendations have been published in the Institute of Medicine 2008 report titled: *Resident Duty Hours: Enhancing Sleep, Supervision, and Safety* further limiting the length of shifts. Forget about the grueling 24 hour shift. It will be replaced with a maximum 16 hour shift or 30 hour shift which somewhere must include a 5 hour nap! Why leave work? Time off between shifts will lengthen for night float from 10 to 12 hours and 10 to 14 hours for a 30 hour shift! Does it sound like the end of fatigue related work issues and associated medical errors?

Let's stop for a second and analyze these recommendations. Before 2003 and the 80 hour workweek, 37% of all residents were working greater than 80 hours. After 2003, all programs had to be compliant. Hospitals had to increase staff substitutes, create more shifts, and hire more residents, which is a heavy financial burden. In 2005, Nuckols and others published a study in the Journal of General Internal Medicine stating up to 2.2 billion dollars had to be spent to cover that 37% so programs would be compliant. To date, nearly 100% of programs are compliant or else face citations by the ACGME.

Have we reaped the benefits of less sleepy residents? By the IOM's own admission, "the impact of residents on patient safety is unknown", even after 6 years of enforced compliance to duty hour rules. There is insufficient data to determine the "extent to which errors in performance by fatigued residents affect patients and cause them harm." In 2007, Volpp and others in JAMA and Shetty and others in the Annals of Internal Medicine published studies yielding mixed results on any mortality benefit associated with duty hour restrictions.

But we do know what restrictions are causing- erosion of professionalism in creating shift work mentality, more patient handoffs which is a proven source of medical error, and more paperwork to produce for documentation of compliance. If the very steps to reduce patient harm are creating more opportunity for error, what good have we done? The hidden costs of sweeping regulation are never fully known prior to well-intended efforts to improve patient safety. European residents have seen even tighter regulation with 58 to 48 hour workweeks.

Academia already knows the burdens of further regulation which will ultimately manifest in private practice. After 4 years of working under tight regulation, how will private practices react to over one thousand graduating residents who are only comfortable with banker's hours? How will they incentivize and attract the best and brightest? Those institutions that utilize residents for external moonlighting will see less availability of residents since this moonlighting will also be calculated into the 80 hour workweek.

Therefore, before we jump on the IOM's bandwagon, we should all stop and critically analyze such proposals, demand convincing evidence, and have a deep understanding of the implications of benign appearing regulation.

References

Ulmer C, Wolman DM, Johns MME, eds. Resident duty hours: enhancing sleep, supervision and safety. Washington, DC: National Academies Press; 2009.

The European Working Time Directive and the effects on training of surgical specialists (doctors in training): a position paper of the surgical disciplines of the countries of the EU. Acta Neurochir (Wien). 2006 Nov; 148(11):1227-33.

Volpp KG, Rosen AK, Rosenbaum PR, et al. Mortality among hospitalized Medicare beneficiaries in the first 2 years following ACGME resident duty hour reform. JAMA 2007;298:975-83.

Volpp KG, Rosen AK, Rosenbaum PR, et al. Mortality among patients in VA hospitals in the first 2 years following ACGME resident duty hour reform. JAMA 2007; 298: 984-92.

Over-Regulation of Radiology Residency

Anne Dunne MD, Geisinger Medical Center, Danville, PA

The Accreditation Council for Graduate Medical Education (ACGME) accredits allopathic residency training programs in the United States much like the JCAHO accredits hospitals. It oversees training programs to maintain quality in education and protect residents from abuses. These are necessary and worthy objectives. However, many feel that the requirements have mushroomed. The current and proposed future requirements and the tracking and documentation needed are taking time and energy away from program directors and faculty to devote to resident teaching. Duty hour rules; restructuring of curricula with the core competencies; accounting for each moment of a resident's time-- I am worried that we may eventually have to track residents' I&O's daily and then per shift!

There is emphasis on metrics and outcome measurements. For example, to teach residents how to obtain informed consent one could give a pre-test to the residents; then instruction followed by a post-test. One would develop a 15-20 item checklist of the components of obtaining informed consent. Next, the resident would be observed obtaining informed consent-first by role playing with another resident and then with a real patient using the checklist as a grading system. Results would be reviewed with the resident and placed in the resident's learning portfolio. Subsequent encounters would be observed to determine improvement. Multiply this scenario by the number of residents in your program and the number of entities that must be mastered and you will understand the excess in documentation and tracking.

There is emphasis on using innovative teaching methods and modern educational theory and encouragement of faculty to obtain masters and PhD degrees in education. However, there is no proof that these endeavors are making better residents and better radiologists. Residents are adults and not children. Managing a residency with proper oversight and supervision is good and important. However, some of the new initiatives seem like busywork with numerous forms to complete and deadlines to meet during each academic year. With the increasing volume of work in almost all practices, there is not the time to comply with all of these endeavors and still have time to be with residents, teach, prepare conferences and lectures and do research.

In addition, practice-based learning projects, systems-based projects and restricted duty hours are taking residents away from day to day clinical work. Many faculty do not understand this new direction in education and do not participate. Faculty become disgruntled when the resident is absent from clinical service. They feel that residency is a transition period from student to trainee to independent physician and that the residency should prepare the resident for his/her career in the workplace. It is stated that the current generation of residents, Generation X, is the most coddled generation in our history. How are we preparing them for the real world and the expectations of employers? Will employers be able to accommodate the expectations of residents when they seek jobs?

We need enthusiastic and involved program directors of residency programs. The current state of residency requirements are regarded as very burdensome by many and a turn-off to otherwise interested faculty. The average tenure of a program director is less than 5 years. It has been stated that radiology has one of the highest turnovers of program directors—19-25% annual turnover. This is a waste since it takes several years to get up to speed in this role and some longevity and continuity is beneficial.

In summary, proper management and oversight of residencies is essential and proper supervision and education of residents is paramount for their future and the future of the profession. However, the pendulum has swung too far in this direction with the result of taking time and energy and focus away from teaching and perhaps not realistically preparing graduates for the workplace.

Reference:

"Over-Regulating Radiology Residencies: The Unforeseen Costs" by LN Nazarian; JACR, volume 6, number 6, June 2009, pages 393-396.

The effects of proposed health care reform on residents.

Jason Itri M.D., Ph.D, Hospital of the University of Philadelphia, PA

Reimbursement cuts will adversely affect the job market for radiology residents because imaging facilities will see significantly reduced reimbursement rates in an already challenging economic climate. The job market is already

strained and there will be additional uncertainty from the upcoming change in the board examinations.

Radiology departments and radiologists will be responsible for interpreting a greater volume of studies and be paid less to do it. There will also be more time spent on mandated and unfunded QA initiatives. This has a direct impact on residency training programs in that faculty will have less time for teaching, and there's the potential for shifting resident time towards more service-oriented activities.

Graduate medical education will be reducing the overall number of residents and fellows, forcing transition into non-ACGME accredited fellowships. This will be taking a step back in regards to the progress the ACGME has made in standardizing and improving graduate medical education.

There will be a mandated study of resident education (provision within proposed health care reform bills), allowing the government to redistribute unused residency positions to hospitals that agree to expand and maintain primary care training.

References

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Thrall JH. Drivers of health care costs: Technology vs. social, legal and behavioral factors. JACR 2009, 6:387-388.

Arl Van Moore. Radiology and the health care reform debate. JACR 2006, 3: 569-570.

Harris S. Overview: Graduate Medical Education and Health Care Reform. AAMC
Reporter, July 2009.

Flight of Physicians from Pennsylvania

Melany Atkins, MD. University of Pittsburgh Medical Center, Pittsburgh PA

According to an article in Diagnostic Imaging in March 2009, of the 2000 radiologists in the state of Pennsylvania, 85% are over the age of 50 and over 50% are over the age of 55. With the aging population of radiologists, recruiting current and incoming residents to stay in Pennsylvania becomes an even more important issue. However, the trend in recent years has shown increasing numbers of residents leaving the state. Postulated reasons for this trend include:

-Continued rising costs of medical malpractice

-Relatively low Medicare reimbursement in PA

-Relatively litigious nature of PA

-Job openings more common in rural or "non ideal" areas

-Medical schools and residency programs within the state have increasing numbers of out of state applicants and are matching more out of state residents.

-Out of state residents are much more likely to leave the state after training.

Recently, we created a short survey for current Pennsylvania residents which was sent to all programs. We received 72 responses. Six basic questions regarding future goals and qualities desired when job searching, were included in the survey. Of the respondents, 45 percent were in the 3rd and 4th years while 55% were in the 1st and 2nd years of training.

38% responded that they were very likely or somewhat likely to practice in Pennsylvania, while 40% said they were very unlikely or somewhat unlikely. The remaining 22% remain undecided. When these were further stratified based on year in residency, there was no significant difference between upper and lower levels except for approximately 30 percent of 1st years who returned the survey undecided on where they plan to practice in the future. Additionally, the residents where asked which state they would most like to practice in after graduation. Approximately 25% chose Pennsylvania.

We then asked residents to rank seven listed factors by degree of importance when choosing a future practice location. These included weather, malpractice climate, compensation, quality of life/ lifestyle options, quality of private practice options, quality of academic options, and proximity to family and friends. 45% of residents chose proximity to family and friends as their number one factor. Quality of life and lifestyle issues were a close second among all respondents and were actually number one among 4th year residents.

Another question was to rank Pennsylvania in relation to the above seven factors. 45% ranked PA as somewhat favorable in relation to lifestyle issues. When asked to rank PA in regards to malpractice issues, 83% of residents ranked PA as somewhat unfavorable or very unfavorable. Malpractice issues were ranked as the 4th most important issue when choosing a job.
Although this is just a simple survey with a small sample size, it again raises the concern that a large number of residents are leaving the state to practice. This is an important problem given the aging radiologist population in Pennsylvania and the persistent malpractice, litigious, and reimbursement issues we are faced with.

References

Moan, Rebekah. Pennsylvania Confronts Aging Radiologist Population and Recruiting Challenges. Diagnostic Imaging. 34:4, March, 2009

Twedt, Steve. Radiologists are in Great Demand. Pittsburgh Post-Gazette. November, 2008

Zeldis Research Associates. How Young Physicians Search for Jobs. NEJM Jobs. April 2004.

Effect of Medical Malpractice Issues on Residents

Philip Orons, DO, University of Pittsburgh Medical Center, Pittsburgh, PA

When I question my residents about future challenges to radiologists in Pennsylvania, one of the greatest areas of concern is medical malpractice. My residents are not alone in this regard. As part of the "Project on Medical Liability in Pennsylvania" funded by the Pew Charitable Trusts (www.pewtrusts.org), a survey was conducted in 2005 of residents in their last year of subspecialty training in 68 residency programs across the state including subspecialties in radiology, surgery, OBGYN, anesthesia, emergency medicine, and orthopedics. One-third of the over 350 surveyed residents were planning to leave the state of Pennsylvania secondary to lack of availability of affordable malpractice coverage. Those residents listed malpractice related issues 3 times more commonly than any other factor. Of the respondents of the survey, 15 percent were radiology residents.

Due to physician fears of malpractice claims, so called "defensive medicine" is often practiced. An additional part of the Pew Trusts survey found that of 800 surveyed Pennsylvania physicians, 83% admit to practicing defensive medicine at least part of the time. Although some may see this as an advantage for radiologists with more MRI's and CT scans, this "spiraling effect" ultimately raises health care costs. Plus, studies deemed unnecessary by insurance providers may not be reimbursed.

The medical malpractice discussion is not new to Pennsylvania. Lawmakers have hotly debated this issue for more than a decade. Then, in 2003, legislation was put into place in Pennsylvania which seems to have had the effect of sharply decreasing the numbers of suits filed (a decrease in 41% since 2002). These new rules included, among other things, a requirement of a "certificate of merit" from a medical professional establishing the merits of the case, and also the requirement that cases must be filed in the county in which the alleged malpractice occurred. Malpractice cases have decreased significantly, but Pennsylvania malpractice premiums remain the 7th highest in the country.

At about the same time, the Mcare (Medical Care and Availability for Reduction of Error) fund was begun. This is a state-run medical liability coverage fund started in the place of what was previously known as the CAT fund (Catastrophe Loss Fund). Pennsylvania Physicians are required to carry a minimum of $1,000,000 in liability coverage. The first $500,000 is primary private insurance followed by an additional $500,000 of insurance provided by Mcare. Physicians pay an assessment to the state for the additional coverage based on a percentage of prevailing primary premium. Mcare is a pay as you go system with no reserve for future claims. Initially Mcare abatements were put in place to help physicians practicing high risk specialties, but premiums have continued to increase and abatements have not been given for several years; none are planned for next year. Pennsylvania legislators plan to progressively decrease Mcare funding and eventually have 100% private insurance coverage. Although Mcare remains unchanged for the next 2 years, the program will eventually be phased out. However, Mcare insurance claims will continue for a period of time after the fund is abolished, and there is currently no plan in place to provide coverage during the transition between the phasing out of Mcare and total private coverage. This will cause a "lag" period, during which no funds will be available for potential claims. This is referred to as "unfunded liability" which is currently estimated at up to $1.7 billion. In addition, at the end of this past October, the state General Assembly voted to seize more than $800 million of Mcare and Health Care Provider Retention Account (HCPRA) funds and place them into the state's general funds to balance the state budget, increasing the risk to future physicians.

So how does this affect residents? The "unfunded liability" has to come from somewhere. While Mcare is being phased out, the additional costs will make it more difficult for new attendings to become insured. This is yet another reason for present and future residents to consider leaving the commonwealth.

References:

Guadagnino, C. Malpractice Liability in Western PA. Physician's News Digest. June 2001.

Darves, B. Coping with Medical Malpractice Insurance Rates. NEJM Career Center. April 2003.

Medical Malpractice in Pennsylvania: The Impact of Recent Reforms - Is It Too Soon to Tell? April, 2006

Jobbins, Cindy. New Survey Says Mounting Medical Malpractice Costs in PA affect Residents Decision to Stay in State. The Pew Charitable Trusts. 7/8/2005

2010 PRS Program Ideas

Robert S. Pyatt, Jr., MD, FACR
Chair, Committee on Continuing Education
Chambersburg Imaging Associates
Chambersburg, PA

Next year's Annual Meeting will be October 7 – 9, 2010, at the Omni Hotel, Pittsburgh, PA. The CME sessions will be on Saturday, Oct. 9th, from 8:00 am – 4:30 pm, plus the evening Annual Oration for the Honored Radiologist. Category 1 CME credit will again be awarded. This year's program was very successful, with high marks by attendees for the program's topics and discussions. Topic suggestions continue to roll in; Dr. Rajan Agarwal from Philadelphia has been especially helpful with ideas. Residents and Fellows are encouraged to submit ideas, as they will once again be an important part of our program. It is hoped to have more issues debated with panel discussions as well. Please send your topic/format ideas

to the Chair, Robert S. Pyatt, Jr., MD, FACR at: bob_pyatt@hotmail.com . Here are the latest suggestions for topics:

1. Radiation Terrorism Update, by Dr. Joel Greenburg, UPMC
2. Panel Discussion on Resident/Fellow "hot" issues
3. Utilization Management: Use of Appropriateness Criteria, CPOE, and other methods; Future of RBM's?
4. Update on the ABR; ongoing competencies; QI projects
5. HC Reform: New Economic Models; Accountable Care Organizations, bundled payments, etc.
6. PACS Integration with QA programs, RADPEER, meaningful radiology reporting; Paul Chang (Chicago, formerly at UPMC)
7. More from Rich Duszak, MD & Frank Lexa, MD, MBA
8. Teleradiology Future – Dayhawk? Declining use by some groups? Teleradiology networks, such as FRG, covering PA hospitals.
9. P4P Update/PQRI
10. Emerging trend: Radiologists as employees of the healthcare system
11. Structured reports; release of first 63 models at RSNA 2009
12. Patient Centered Care
13. RSNA ideas (this article is being written just before RSNA).
14. Molecular Imaging: Harnessing the power of this technology in community practice
15. Improving practice management and efficiency.
16. Patient Safety: Techniques to lower CT dose and optimize your CT protocols; Image Gently Campaign
17. Washington Politics Update from RADPAC
18. Informatics: Improving clinical and operational performance while improving quality of care utilizing automated business intelligence software tools/operational dashboards
19. CAD: Past, present and future – and not just mammography applications
20. Tracking radiation dose in your patients; national efforts with the ACR
21. Women's Imaging: How to make it a profit center.
22. Radiology group contracts/legal issues: Update on emerging issues & core information for Residents/Fellows
23. Radiation Oncology Program in afternoon.

QUALITY AND PATIENT SAFETY COMMITTEE REPORT

Robert S. Pyatt, Jr., MD, FACR, Chair
Chambersburg Imaging Associates
Chambersburg, PA

P4P/Quality Initiatives

With the escalation of health care costs no longer considered sustainable by a wide array of experts, including the greatly respected Institute of Medicine, there has been a growing call for a more sound health care reimbursement system, which "aligns payment policies with quality improvement." The goal is to make every health care dollar count to ensure each patient receives the highest quality of care possible.

This major shift to performance-based reimbursement is known as pay for performance (P4P). The ACR has made a deep commitment to P4P, to ensure we are at the vanguard of this rapidly growing movement, and that our P4P initiatives have the full input and support of our members.

With 130 public and private P4P programs already in existence, including Medicare's new bonus payments for reporting quality measures, the ACR believes P4P represents a golden opportunity for radiologists to receive full recognition—and long overdue value added compensation—for the superior services they provide.

We hope you will support the College's P4P activities and avail yourself of the opportunity to learn more about P4P and the ACR's related activities by visiting the links below. This includes information on the 2008 CMS Physician Quality Reporting Initiative (PQRI), and how to obtain the 2 percent reporting bonus for quality measures related to diagnostic and interventional radiology and radiation oncology.

Please feel free to direct any questions you may have to: P4Pquestions@acr.org.

Radiation Safety

This list offers access to a variety of informative and instructional resources designed to assist radiologists in providing effective imaging and therapy while minimizing risk during exposure to ionizing radiation.

ACR Reports and Statements

ACR White Paper on Radiation Dose in Medicine
ACR Statement on Whole Body CT Screening
ACR and American Society of Neuroradiology Statement on CT Protocols and Radiation Dose

ACR Practice Guidelines, Technical Standards and Appropriateness Criteria®

ACR Practice Guideline for Imaging Pregnant or Potentially Pregnant Adolescents and Women with Ionizing Radiation
ACR Practice Guideline for Diagnostic Reference Levels in Medical X-Ray Imaging
ACR Technical Standard for Management of the Use of Radiation in Fluoroscopic Procedures
ACR Technical Standard for Diagnostic Procedures Using Radiopharmaceuticals
ACR Appropriateness Criteria® Radiation Dose Assessment Introduction

Pediatric Radiation Safety

Image Gently™ - The Alliance for Radiation Safety
Radiation Risk to Children from Computed Tomography
National Cancer Institute – Radiation Risks and Pediatric Computed Tomography (CT): A Guide for Health Care Providers
National Quality Forum Safe Practices for Better Healthcare 2009 Update - A Consensus Report

Government Information

FDA Radiation Emitting Products
FDA Public Health Notification: Reducing Radiation Risk from Computed Tomography for Pediatric and Small Adult Patients
FDA: Whole Body Scanning, Using Computed Tomography
FDA: Radiation Injuries and Fluoroscopy

Patient Information

RadiologyInfo – The radiology information resource for patients – Radiation Exposure in X-ray Examinations
Image Gently™ - The Alliance for Radiation Safety

ACR Education Products

Case in Point – Radiation Dose Concerns
Self Assessment Module (SAM) Online: Patient Safety

RADPAC Report for 2009

Robert S. Pyatt, Jr., MD, FACR
Chambersburg Imaging Associates
Chambersburg, PA

The RADPAC (Radiology Political Action Committee) had a very good year in 2009:
-Raised $257,435 more in hard money compared to 2008.
-Had 535 more contributors in 2009 as compared to 2008.
-Had 137 more online contributors.
-Had a total of 69 group practice contributions in 2009 which is 22 more than in 2008.
-Attended 10 more fundraising events than in 2008.

SGR (SUSTAINABLE GROWTH RATE) "Fix"

The House recently passed a separate bill (from that of the health care reform package) providing for a permanent fix of the Medicare Physician Payment System, while the Senate was unable to invoke closure on legislation calling for a ten year update of a slightly modified SGR. The big obstacle to doing something more permanent is cost. The House bill is estimated to cost $245 billion over 10 years, with the Senate bill slightly over $200 billion over the same time period. It remains extremely hard to see where House and Senate leaders will find over $200 billion in revenue off-sets needed to pay for a more permanent SGR in the current health care reform legislation. In addition to the information regarding the decision by the Centers for Medicare and Medicaid Services (CMS) to eliminate consultation codes, on December 19, 2009, the President signed into law H.R. 3326, the Defense Omnibus Appropriations bill that included a short-term freeze on the physician sustainable growth rate, delaying a scheduled 21 percent cut to physician payments until March 1, 2010. During these next two months, the House, Senate, and the White House have committed to work on a permanent repeal of this formula and to replace it with a formula based on the Medicare Economic Index.

USPSTF Screening Recommendations

Confusion continues to grow over the recent U.S. Preventive Services Task Force's (USPSTF) recommendations that women under the age of 50 no longer be screened for breast cancer. The USPSTF recommends against routine screening mammography and clinical breast exam for women ages 40-49 who are not at increased risk for breast cancer, recommends biennial versus annual screening mammography in women ages 50-74, and no screening for women over the age of 75. The ACR would like to stress that the USPSTF recommendations were just that –recommendations. Kathleen Sebelius, Secretary of the Department of Health & Human Services, commented that the doctors and scientists on this task force "do not set federal policy, and they don't determine what services are covered by the federal government." She stressed that there will be no change in Medicare and Medicaid coverage for mammography. In addition, before any changes could be made to the Medicare payment policy for screening mammography, the change would need to be announced and a public comment period given. The House Energy & Commerce Committee held a hearing the first week of December to address the recommendations of the USPSTF. For more information, you can go to:
http://energycommerce.house.gov/index.php?option=com_content&view=article&id=1837:breast-cancer-screening-recommendations&catid=132:subcommittee-on-health&Itemid=72

Races to Watch

RADPAC has added a new category to its website called 111th Congress Races to Watch, www.radpac.org for ACRA members to view the House and Senate Races in 2010, the dates for each state's primary and the listing of candidates that have received RADPAC contributions. RADPAC will update

this information periodically so that it remains current through the general elections in November, 2010.
To see this category: http://www.acr.org/SecondaryMainMenuCategories/GR_Econ/FeaturedCategories/RADPAC/RacestoWatch.aspx.
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Is your group helping to fund RADPAC? Many groups do a simple $10, $20, or more deduction from every paycheck. This is accumulated over a year and sent as a lump payment to RADPAC, collectively, for each group member, for a combined group contribution. Your group contributions are *very* needed, if you wish to have your interests represented in Washington. If you have any questions, please call me at 717-264-4169, or contact me by email: bob_pyatt@hotmail.com.

Pennsylvania Judgeship Election

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An election critical to the physicians of Pennsylvania took place on November 3, 2009. On that day, Republican candidate, Joan Orie Melvin was elected to the Pennsylvania Supreme Court for 10 years, defeating trial lawyer supported Democrat Jack Panella, 53.2% to 46.8%. An election of this importance to Pennsylvania medicine last occurred November 6, 2001, when Republican J. Michael Eakin won a 10 year term over Democratic challenger Kate Ford Elliott, 52.4% to 47.6%.

Why are elections for the Pennsylvania courts during interim election years more important to physicians than legislative elections during election cycle years? Because the Pennsylvania Supreme Court possesses extraordinary jurisdiction to rule in any case before a lower court involving an issue of immediate public importance. The Court can assume this jurisdiction on its own or upon petition from any party.

This power, known as King's bench power, was granted to the Court when it was established on May 22, 1722 by the General Assembly of Pennsylvania with the following definition of its function: "The justices shall exercise the jurisdictions and powers hereby granted concerning all and singular the premises according to law, as fully and amply, to all intents and purposes whatsoever, as the Justices of the Court of King's Bench, Common Pleas, and Exchequer, at Westminster, or any of them, may or can do." Other states which recognize the common law King's bench power or a modification for their highest courts include New Mexico, New York, Oklahoma, Wisconsin, Florida, and Virginia.

Factors that are important in the Supreme Court's exercise of extraordinary jurisdiction include: 1. need for a prompt final decision, 2. impact on the administration of justice, 3. presence of important constitutional issues, and 4. expeditious disposition of criminal matters. Between 1979 and 1994, 97 extraordinary jurisdiction cases proceeded from briefing to decision in the Pennsylvania Supreme Court. According to Judge Orie Melvin, "In the 1990's attempts at tort reform were made by the Pennsylvania Legislature, especially in the medical malpractice area, with the excessive verdicts in Philadelphia. The Supreme Court, which was Democratic at the time, declared such laws unconstitutional." When the Court changed sides in 2001, with the election of Justice Eakin, new statewide rules were instituted that helped mitigate the malpractice crisis. These included the elimination of venue shopping and a requirement that cases be certified up front by an expert as not frivolous (certificate of merit rule). After these rules were enacted, a study one year later showed that malpractice cases decreased by 50% in Philadelphia County and by 35% in Allegheny County.

Orie Melvin, a Republican, makes the Court balance 4-3 with Justices who favor stricter medical malpractice rules, ensuring that the progress made in the earlier part of this decade will not be overturned. Both Orie Melvin and Eakin were supported by Pennsylvania physicians through grass roots campaigns. While Pennsylvania is not considered a tort reform state, Pennsylvania physicians, through their State Medical Society, have favorably balanced the State Supreme Court, allowing for positive change restricting unnecessary medical malpractice lawsuits. Orie Melvin's election is especially important this year, as the Pennsylvania Medical Society has filed litigation over the use of over $100 million in excess physician Mcare premium payments by the Pennsylvania Legislature to balance the state budget.

ANNOUNCEMENTS

Saint Joseph's Medical Center is a progressive, brand new 220-bed hospital located in southeastern Pennsylvania in close proximity to Philadelphia, New York City, Baltimore and Washington D.C. Diagnostic imaging services are provided by our six member group. A position with the practice is opening in the near future. This position represents an excellent professional and financial opportunity. The group is a hospital based private practice. We provide a wide spectrum of radiology services including interpretation of plain films, mammography, ultrasound, computed tomography, MRI/MRA, nuclear medicine/PET, and interventional radiology. The group is composed of well trained, board certified radiologists, with several Fellowship trained members. Beginning salary and term to partnership are competitive. If you are interested in joining this practice, please contact Barry Tom M.D. at 610-378-2240 or 610-670-2360 (barrytom@cathoichealth.net).