

2009 PGIP Initiatives Radiology Management –Year 2

September 5, 2008



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Background: National and BCBSM Trends



National:

- Diagnostic imaging costs continue to be the fastest growing component in health spending
- Approaching \$100 billion a year
- Expected to double over the next 4 years¹

BCBSM:

- 2007 outpatient diagnostic radiology spend was \$938 million.
- Radiology PMPM trend has improved to 6%, as compared to 12% in 2006.
- High tech utilization rates were almost flat while PMPM still exhibited a 7% trend indicating that price drove high tech imaging costs.
- Hospital Outpatient still dominates as the primary place of service for diagnostic radiology.

¹ Ensuring Quality through Appropriate Use of Diagnostic Imaging, AHIP, July 2008.

Primary Drivers of Diagnostic Imaging Costs:



1. Redundant or unnecessary services²
2. Increased unit costs: high tech imaging services had the highest growth rates
3. Expanded capacity at physician offices^{2,3}
4. Volume and complexity of services³

² Ensuring Quality through Appropriate Use of Diagnostic Imaging, AHIP, July 2008.

³ Medicare Report to Congressional Requesters on the Rapid Spending Growth of Imaging Services, June 2008

- Improve both the quality and affordability of health care through:
 - Ensuring appropriate use of diagnostic imaging services
 - Improving patient safety through avoiding redundancy and unnecessary exposure to radiation

Moving Forward ...



- Sharing actionable radiology utilization data and dashboard reports with physicians
- “Profiling” physicians – providing feedback to physicians on their imaging ordering patterns
- Identifying physician outliers and determining reasons for variation
- Identifying clinical bundle of diagnostic imaging services (e.g. Cardiology and Spine) for focused intervention
- Sharing best practices in managing diagnostic imaging use
- Increase use of American Imaging Management (AIM) website to pre-authorize high-tech imaging services in the office and outpatient hospital locations



High Technology Radiology for Patients with Low Back Pain

- *Goals: moderate use rates and optimize patient outcomes and satisfaction*
- Design: CHRT partners with PGIP Physician Organizations to support optimal management of patients with low back pain
- Project components: physician education, practice pattern reporting, patient education and decision support, additional incentive payments
- Interventions: Participating Physician Organizations help design with support from low back pain experts and researchers at UMHS



- Benchmarking –
 - Establish performance benchmarks to identify best practices and areas for potential improvement
 - ABC Methodology
- Finalize 2009 Initiative Focus areas
- Fine-tune reports to be more actionable and user friendly
- Develop individual physician reports

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In Development Inpatient Use Management – Hospitalists

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“Official” Definition

“Hospitalists are physicians whose primary professional focus is the general medical care of hospitalized patients. Their activities include patient care, teaching, research, and leadership related to hospital care”

- *Society of Hospital Medicine*

Hospitalists in Michigan



- 2003 AHA Survey of 147 Hospitals
 - 30% had Hospitalists
- 2006 AHA Survey
 - 54% have hospitalists
- 2007 Keystone ICU Survey of 100 MI Hospitals with ICU's
 - 75% had open ICUs
 - 50% of these used hospitalists to staff their ICUs



- Hospitalists associated with improved efficiency and similar outcomes:
 - Shorter length of stay
 - By 12%, or nearly half a day¹
 - By nearly a day in some patient groups (reductions greatest among those with stroke, sepsis, asthma, COPD and urinary tract infection)²
 - Lower cost
 - \$268 less than internists¹
 - Similar mortality and readmission rates¹

¹ Lindenauer P., et al., Outcomes of Care by Hospitalists, General Internists, and Family Physicians, NEJM 2007; 357: 2589-2600

² Archives of Internal Medicine, Sept. 2007



- Transitions of Care: at admission and at discharge
 - Systematizing handoffs/communication between ambulatory care and inpatient care staff at admission and discharge
- During inpatient stay
 - Expediting initial assessment and implementation of diagnostic workup and treatment

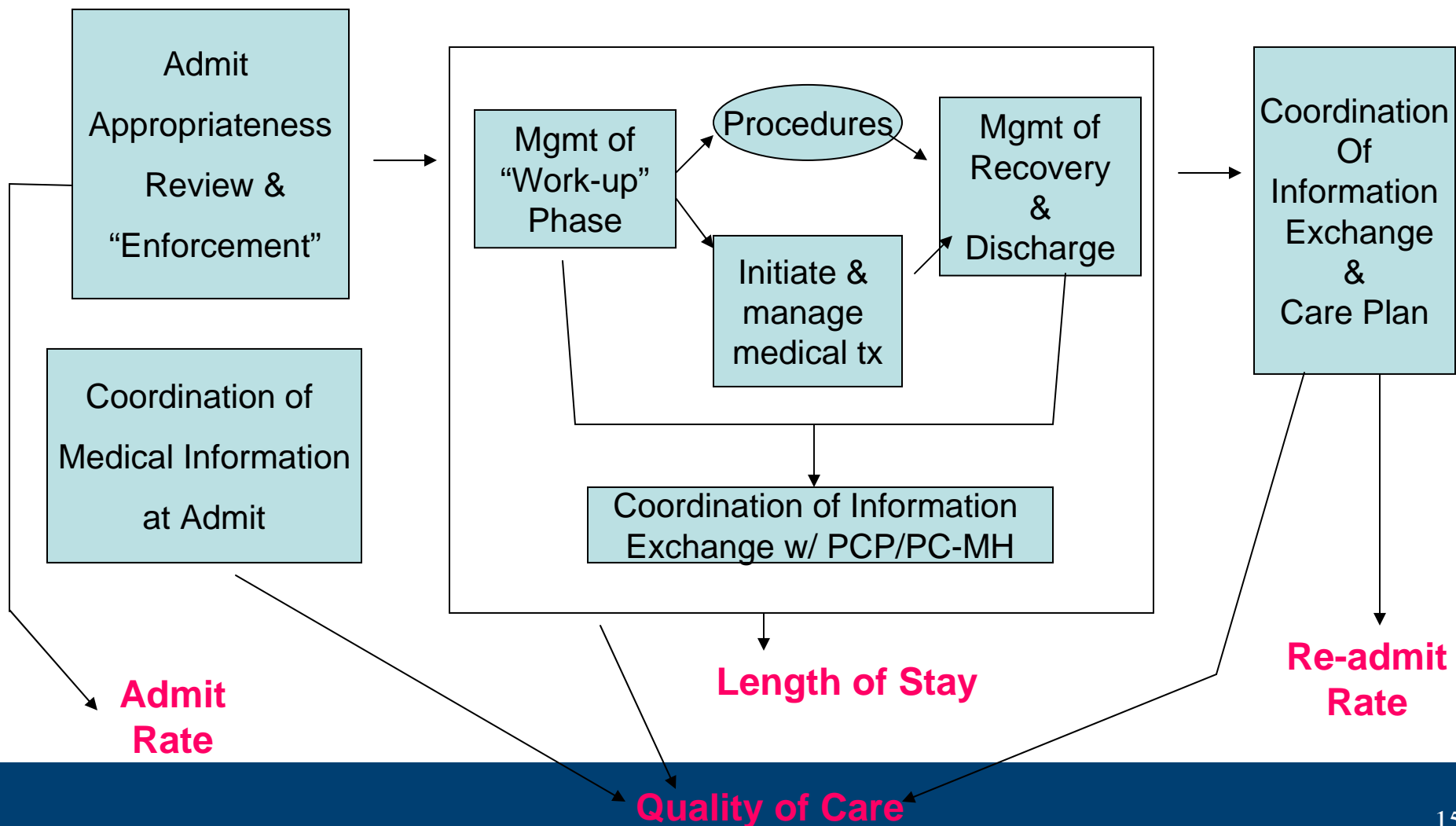
Core Clinical Processes of Hospital Medicine (Conceptual Model)



Before

During

After





- Improve communication and hand-offs between hospitalists and primary care physicians in pre-admission, inpatient stay and discharge planning for patients who are hospitalized
- Explore relationship between quality and cost of care
 - Assess potential cost savings realized from programs with:
 - Infrastructure and processes to support higher quality and
 - Demonstrated better outcomes
 - Evaluate utilization and total cost of care



- Expand PGIP to include hospitalists
- Promote enhanced care coordination at transition into and from inpatient care
- Promote collaboration among POs, with hospitals and with other hospitalist groups
- Promote in-hospital performance and patient experience
- Generate measurable savings and reward clinicians for their improvements in care



- PGIP expansion
 - All sub-specialty participation will need to be through primary care-based physician organizations
 - All physician members of a practice unit should be represented by a single physician organization
- Collaborative effort
 - Leadership committee/Initiative team
 - Promote collaboration among POs, with hospitals and with other hospitalist groups
- Data sharing and exchange
 - BCBSM – claims data and aggregate reports



- Develop Hospitalist physician list
- Data Analysis
 - Inpatient care
- Establish Leadership Committee/Initiative Team
- Develop Initiative Plan

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