

# The Testy Climate in Neurology and Radiology



By Terri Oskin, MD  
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Wow, can you believe it's already February? I hope 2012 is getting off to a smooth start for everyone.

This year will continue to bring many challenges to the medical community regarding reimbursement and

restrictions to our autonomy to practice medicine. In this month's The Message, we are focusing on the technical, clinical and payment issues facing Radiology and Neurology where: 1) significant reductions in payment are expected for many procedures, 2) State and other payers are expected to refuse to approve or pay for new, experimental or emerging techniques in treatment of our patients and 3) Medicaid and others indicate they will rely on evidence-based, outcome-oriented and expert opinion tools before approving new technology use.

No one will argue that making healthcare decisions based on the best evidence available is a bad idea. But is it really that simple? Consider these definitions by Dr. David Sackett, a pioneer in EBP:

"Evidence-based practice (EBP) is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research." (Sackett, D,1996)

"EBP is the integration of clinical expertise, patient values, and the best research evidence into the decision-making process for patient care. Clinical expertise refers to the clinician's cumulated experience, education and clinical skills. The patient brings to the encounter his or her own personal and unique concerns, expectations and values. The best evidence is usually found in clinically relevant research that has been conducted using sound methodology." (Sackett, D, 2002)

The concern of some physicians is that payers using an evidence-based model to determine benefits for their whole population may not be considering the individual patient's needs or the physician's individual clinical expertise and education to determine the value of a particular procedure. Some physicians worry that payers' decisions about care will be based on large cohort studies reflecting a population rather than the individual.

Now mind you, EBP has been very effective for treating populations. Hospitals and clinical groups have developed many protocols that decrease morbidity and mortality. Examples include the protocols used for sepsis, pneumonia and stroke in place at both hospital systems in Spokane (Providence Health Care and Community Health Systems) as well as mammogram screening and protocols for diabetes (used by medical groups such as Group Health and Rockwood Clinic). The protocols were developed by physicians and they can be individualized based on the clinician's expertise and the individual patient, and they aren't necessarily tied to reimbursement or payer approval.

One closing thought: Remember, we don't want to give up our autonomy by becoming complacent in the payer-physician process. Physicians need to play an active role and be part of the conversations with payers when determining standards of care and they need to be mindful of the ever rising costs of providing this care.

Also included in this issue is an update on the Washington State Emergency and Cardiac Stroke System. Similar to Washington's statewide trauma system, patients will be transported directly to hospitals that meet certain requirements. This assures that patients have the expertise and technologies available for prompt treatment. The intent of this law is to save more lives and reduce disability. As of November 2011, six counties in Washington had gone live, including Spokane with all four of our local hospitals participating. For more information visit the Washington Department of Health's Web site at [doh.wa.gov](http://doh.wa.gov).

February's publication is a meaty one. I welcome your feedback at [TOskin@columbiamedicalassociates.com](mailto:TOskin@columbiamedicalassociates.com).

## The Challenges of Delivering Quality Imaging and Interpretations in a Climate of Reform

By Jayson S. Brower, MD

As the lens of healthcare reform continues its unrelenting course of scrutiny, seemingly peering into every dark corner of healthcare delivery, I find myself alternating between optimism and anger. The anger is easy to understand: It is equal parts frustration that the career in which I am so heavily invested is being called out for being less than perfect, in combination with the dread of the unknown. So how could I possibly find hope in the swirling chaos that threatens to sweep away the current foundation of medicine? The simple answer is opportunity.

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