RPA REPORT

ARPE, CBRPA & RPAS Newsletter

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CBRPA Website Changes Go Live September 1, 2014

CBRPA is proud to announce the integration of new secure software feature to our website! As our number of registrants continues to grow, the task of keeping updated records is getting more challenging. This is the main purpose of the new program; to acquire, store, and keep up-to-date records on our registrants, applicants, and seminar participants. For nearly six months, CBRPA staff and Board members have been working with a program development company to create a customized system.

All of the paper-type records (applications, etc.) have been changed to a digital format. The changes will result in a more efficient manner of handling records and processing of renewals. The system will also assist in providing our registrants with reminders such as renewal, re-certification reminders, and upcoming seminars. There is also an "AUTO RENEW" feature included in the system if you wish to have the system handle your renewal each year. It will serve our registrants as a resource to maintain records of transactions to print and use for reimbursement or tax purposes. You will also be able to order new replacement membership ID or donate to the educational scholarship.

As part of this upgrade, **ALL RPAs** will have to RENEW ONLINE beginning September 1, 2014. Simply login to the secure site, pay your renewal fee, and then fax, email or mail your ACLS card and ARRT card to CBRPA. Your certification status will be listed as "pending" in the credentialing search database until we have received all required documentation. Once received, the pending status will be changed to certified. A pending status may impact your credentialing status with your employer so it is important that you get your renewal AND documentation in on time.

Quote of the Month:

Continuity gives us roots; change gives us branches, letting us stretch and grow and reach new heights.

~Pauline R. Kezer

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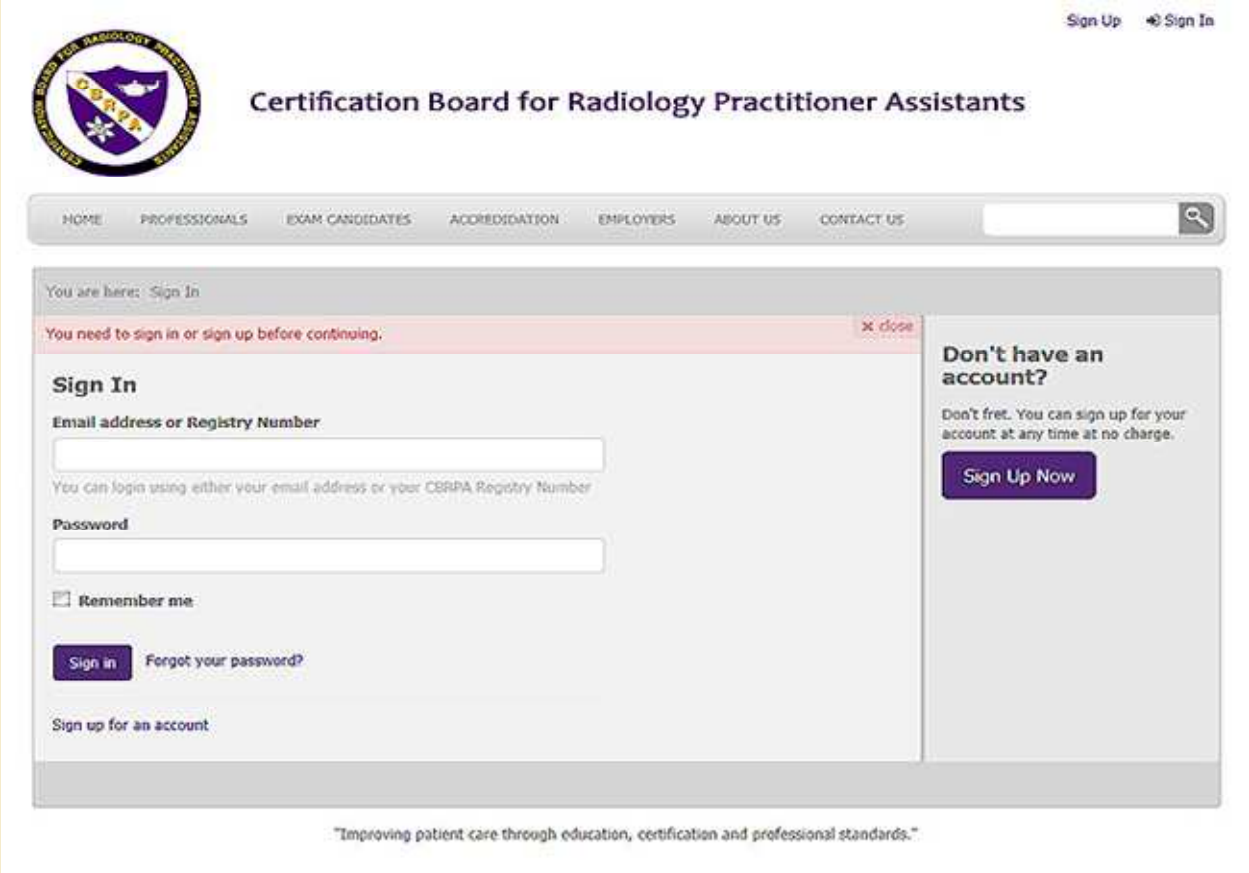

Any necessary changes in a registrant's name, address, email address or phone number is the responsibility of each individual. You can login to the secure website anytime and update your information.

Renewals will still be due during the birth month and must be submitted no later than 11:59 pm Mountain time on the last day of your birth month to avoid penalties that will be automatically applied on the 1st of the Month following your birth month. Mail-in renewals will no longer be accepted after a final notice of the implementation date is sent to all RPAs. The program will accept all credit cards and debit cards. The extra $10.00 credit card fee and the registration fee will no longer be charged.

CBRPA staff has started the process of building nearly 500 user profiles for our CBPRA registrants. Please DO NOT CREATE A NEW ACCOUNT if you are a registered CBRPA! Please watch your email for instructions on how to get into the user profile that we have started for you. You will need your CBRPA ID number. If you have not received an email with instructions by September 1, 2014, please email CBRPA staff with your most current and correct email address.

We are missing many email addresses and are in need of your updated information as soon as possible. Feel free to email your name, birthdate, email address now if you want to be sure we have your updated information. Email to staff@cbrpa.org

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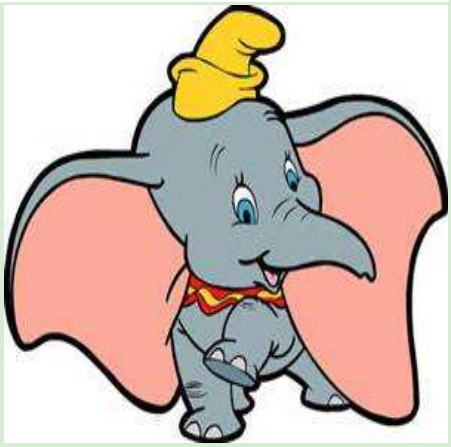
NOTICE OF NON-RENEWAL of REGISTRATION

Please be aware that the new database for CBRPA records has been updated and a number of former RPAs have been removed. Most have been removed for failure to pay and renew their registration. All RPAs will need to go to the CBRPA web site and check to be certain their name and information is correct. The task of updating of the roster was undertaken to prepare for the new computer program being implemented. The new program will send renewal notices to active RPAs and remind them when their certificate has lapsed. It is critical that the RPAs include their email address since all job notices, the newsletter and other information will be sent electronically. Please contact CBRPA staff if you are believe there is an error regarding your registration renewal by emailing: staff@cbrpa.org.

Note: CBRPA is aware of some former RPAs still using the RPA credential following their name. They must cease using a credential that they no longer possess since this is considered misrepresentation, unprofessional and unethical behavior. Notice will be sent to other credentialing organizations about this unethical conduct and their names will be given to the CBRPA legal counsel for action.



Join us at the ARPE Educational Symposium for~~~Great education, Renewing friendships, Making new friends, Enjoying the major theme parks, Sampling a variety of cuisine, Partaking of the night life, Museums or walking on the famous Disney Boardwalk while shopping in the many stores, golfing is available, too. Come to Orlando and make lasting memories!!

Reputation and Perception of Radiology

Reputation with Patients

A small study presented at the 2012 RSNA meeting showed that only 53.5 percent of patients who underwent a CT scan knew that the radiologists reading their scans were physicians. Almost 28 percent thought they weren't. And lest you think that the population queried was uneducated, half of those polled had at least a college degree. Regardless of the radiologist's medical background, 64 percent of those polled had little to no idea what radiologists actually do.

There's no better lens through which to view radiologists' public image than how they're portrayed on television. When the television show House was broadcast, Lawrence Muroff, MD, CEO and president of Imaging Consultants Inc. in Tampa, Fla. said he'd ask people what the role of radiologists was and they'd say there was no role. "That's not true," he said. "Radiology played a central role. Every week someone got an MRI, CT scan or image-guided biopsy. But they were all done by House's fellows. There wasn't a radiologist around." It's important to make the public aware of what radiologists do.

Patients are unaware that radiologists are physicians.

Patients are often unaware who reads their imaging studies, let alone their qualifications, since the radiologist isn't typically visible to them. That's often a function of the workflow. The more challenging area is establishing a reputation for radiologists with patients and the public. Breast imagers have done this very nicely. They have an opportunity to be more interactive with the patient. Patients do choose a breast imager based on the radiologist and their reputation. One of the reasons is that they have contact, and the other is that they specialize."

For those in different imaging fields, the recommendation is raising their profile with patients by highlighting their expertise. The group can increase the level of specialization within how the cases are read. There are other ways to connect with patients, said Geraldine McGinty, MD, assistant professor of radiology, assistant director at Weill Cornell Medical College, and chair of the American College of Radiology's (ACR) Commission on Economics. "Introduce yourself during the imaging exam. Make reports, images and consultations available to patients, optimize your patient portal. Think about your patient experience and small ways you can connect," she said.

Reputation with Physicians

Referring physicians look to radiologists for their expertise, not just in reading studies, but in advising about the patient's treatment. Emory University School of Medicine surveyed referring physicians to find out what these doctors wanted from their radiology colleagues. The results were that they want greater interactions with the radiologists, including recommendations for next steps for treatment, in their reports. Half of respondents indicated that the limited contact between the radiologists and referring physicians hindered best patient care.

The radiologist's image has been changing over the years given the progress in technology. McGinty explained it as Imaging 1.0, 2.0 and 3.0. "Imaging 1.0 is essentially the discovery of X-ray and radiology as a subspecialty," she said. "They were retiring as I was starting my training. The reading room was a place where (all physicians would) gather to ask questions about patients."

The next generation, Imaging 2.0, was the explosion of technology with voice dictation and cases read remotely. "All these things greatly enhance our productivity," she said, however "we weren't seeing our colleagues in the reading room anymore." This technology, while valuable, made radiologists invisible. It led to commoditization. "Hospitals have looked at bringing in teleradiology groups to replace us." While everyone understands the value of imaging, the radiologist's value is less apparent.

And now Imaging 3.0, "we have a huge amount [of reports] to deliver, but we need to put ourselves out there," McGinty said. The solution is to try harder to communicate, to be engaged with the physicians. Communication opportunities present when ensuring that imaging exams are appropriate or when there's an unexpected finding. While many radiologists just call the referring physician if there's a life threatening finding, the suggestion is reaching out to the referring physician in a consultant manner which improves visibility and reputation with colleagues at the hospital.

Taking the mystery out of how the radiology department works is another way to improve reputation. Some of the radiologists who seem to enjoy the best relationships with members of the medical staff of a hospital are the radiologists that open up the reading room and invite others in to see what happens.

If a surgeon questions the accuracy of an image interpretation, the radiologist might react in two ways. The radiologist can get defensive which won't help build a strong relationship. This approach results in the radiologist not being collegial in their approach. An alternative approach is to ask the referring physician to stop by the reading room to review the images together.

Reputation and Perception of Radiology

When they look at the case together and the radiologist shows the surgeon the findings and rationale, it can become a conversation. Instead of it being a detente, it's an opportunity for learning for the physician and an opportunity to reinforce that positive relationship. Or if the radiologist did in fact make an error, their willingness to sit down and discuss the case can smooth over any hard feelings about the case. Learning how to master discussions about interpretation errors is an essential competency for a radiologist, she said.

Another way to teach referring physicians about radiology capabilities is to hold educational programs, said Muroff. "Many referring physicians, particularly in smaller towns, their education ended when their residency ended. They often don't know what we can do," given the rapid changes in radiology technology.

Reputation in Hospitals

When Radiology, Inc. of Indiana wanted to show their Elkhart General Hospital administration what value the radiologists provided, they started tracking all activities outside of study interpretation including committee work, teaching, research and conferences. They tracked 3,000 value-added hours in one year and presented this to the administration who could now more fully understand the value of the radiologists' services.

The radiologist's reputation in hospitals is critical because there's a lot at stake. "The more valued you are in your community, the harder it is to commoditize you," said McGinty. Commoditization leads to local groups getting replaced with other groups or with national teleradiology company contracts. "Groups that are intimately integrated into not only medical, but the social and political fabric of the hospital and community rarely get displaced," said Muroff.

In terms of getting involved at the hospital, McGinty said there should be a radiologist on every committee. This is difficult because radiology productivity is rewarded by the health care payment policy system and individual groups and is necessary for paying the bills. The big culture changes are in evaluating how you can do things differently, rather than just working harder.

The ACR Imaging 3.0 initiative aims to help radiologist's reputations by encouraging the notion that radiologists provide added value, and understanding that you have to be an active participant, said Muroff. "You have to get out of the mindset of just cranking out volume."

Reputation in Hospitals

Radiologists don't tend to be the first physicians volunteering because of the productivity focus; however those are ways to demonstrate engagement to the hospital and it puts them in a position of collaborating with customers and referring physicians.

Involvement directly helps the group's interests at the hospital, as well. An example is when serving on a committee would make a difference for a radiology group in a situation when the credentialing committee was putting a physician performance assessment system in place. The committee implemented a review instrument mandating evaluations for physicians having a small number of cases with adverse events within a certain time period that wasn't applicable to the radiologists. While this evaluation instrument might be appropriate for a surgeon with fewer cases, it didn't make sense with a high radiology volume. A hospital might use a one-size-fits-all approach because that's all they have to use and, without radiologist input, they don't realize how it would affect radiologists.

Radiologists can add value to a committee at a hospital because they have a unique perspective in that they interface with every other specialty across the health system, said McGinty. Radiologists have been using technology to move data around and for electronic health records for years and have a lot of wisdom to offer in technology use.

In addition to participation in hospital committees, it's vital to develop nonclinical skills as well, such as focusing on leadership, negotiation, human resources and basic finance. "These are all very important for being successful in times ahead," Muroff said. The health care field is changing and, whenever there are changes, there are opportunities. However, those who do well will do so at the expense of their less innovative and less progressive colleagues," he said.

"If you're just providing interpretations, you're no different than any other provider," said Muroff, and you're more vulnerable to replacement. Radiologists are facing increasingly aggressive competition from national entrepreneurial companies. If you're not readily available for consultations, going to conferences and serving on committees, you're seen as anonymous and replaceable. "Be significant to the patient and referring physician," he said. "If we don't make ourselves visible, we'll be fungible, replaced by other radiology practices, companies or even be replaced by non-radiologist-physicians," he said.

Walmart health and its implications for imaging

Walmart has opened five primary care offices across the country with plans to add more. These offices are in/near their stores and, the supply-chain-rich, nationally-networked behemoth, has decided to roll out this initiative by targeting underserved populations. It can be questioned whether the increasing number of Medicaid-covered patient influenced this decision

The implications of Walmart's entry into healthcare for this crowd doesn't need to be spelled out. The days of patient's visiting a private doctor's office for basic primary care needs may, in fact, be numbered. While primary care physicians will stridently argue that the care they provide is superior to that received/delivered at the local super-center, their sentiments fail to answer the more important question. Rather than asking which care is best, instead we must ask, "Is the care that Walmart provides good enough?" And if it is, then they will win and win big.

Visits to get a Z-pak for a cold, Lipitor for hypercholesterolemia and routine Hgb-A1C checks for diabetics will vanish from private doctor offices. And we have to ask, who is better suited to manage the health of our population than a nationally established, lean company like Walmart that can instantaneously implement standardization and common practices to optimize utilization of precious healthcare resources? Especially when the razor-thin margins that they're accustomed to render them willing and able to care for our poorest citizens.

This is a big deal.

Consequently, it is necessary to ask ourselves, "What is next?" I argue that imaging will be the next service offered at discount prices by our local stores. "Welcome to Walmart! Would you like to get a mammogram today?" Radiologists and hospital administrators must be prepared for this. Screening tests will be offered first. Mammograms, CT colonography and even our beloved CT lung-cancer screening tests likely will be available for purchase. They'll probably even offer specials, deals and coupons to influence consumer behavior. "Get a low-dose screening chest CT and get a free 2-liter of Diet Coke. Today only!"

How will we respond? Will we fervently declare that our images are better? That our radiation dose is marginally lower? That our yet-to-be-defined quality is superior? None of these questions matter if Walmart does good enough. Period. If we're honest with ourselves for a moment, who do you think would run a more efficient CT-scanning operation with the lowest overhead costs, a hospital or Walmart? It's a scary thought, and fortunately the current situation causes us to spend time reflecting on our performance. Scarier yet, do vendors realize the purchasing power Walmart has? I'm sure they've thought about it. How far do you think they can drive the price down for new CT scanners?

I certainly am not endorsing that we all should aim for "good enough" rather than "great." But this form of disruptive healthcare will eventually displace antiquated, traditional healthcare delivery and imaging-service models

Walmart health and its implications for imaging

Perhaps we should consider ourselves lucky. This move by Walmart to distribute and provide healthcare in an established, efficient and enormous business network forces us to look at what we do every day, to examine our strengths and analyze our weaknesses. It brings to light, with greater clarity, the fact that radiologists need to redefine what we do. Rather than being in the business of imaging (which can be mass-distributed and offered at discount prices), we need to be in the business of diagnosis. This charge is already being led by many smart radiologists such as Jim Brink of Massachusetts General Hospital and Bibb Allen, chairman of the American College of Radiology Board of Chancellors.

But in order for this transition to be successful, we all have to buy in. The commoditization of imaging has been under way for some time now. Walmart's entry into healthcare will only accelerate the race to bottom. Let's use this opportunity to focus our energy on redefining what we do and find ways to become the experts for diagnosing illnesses. Not just acquiring images. Let's find new partners (such as our pathology colleagues), new methodologies and new workflows to ensure that every patient is diagnosed quickly and correctly, every time.

Source: Matt Hawkins is a pediatric interventional radiologist and an assistant professor in the department of radiology and imaging sciences at Emory University in Atlanta. He also serves on FierceHealthIT's Editorial Advisory Board. www.fierceimging.com August 11, 2014

Remote robots cut imaging consult, procedure times

Researchers now are able to successfully perform imaging exams using robotic arms controlled remotely via the Internet, according to two papers published in the August issue of JACC: *Cardiovascular Imaging*.

In one study, Partho Sengupta, director of cardiac ultrasound research at Icahn School of Medicine at Mount Sinai in New York, used a computer to perform a robot-assisted ultrasound examination from Germany on a patient in Boston. He and his colleagues were able to complete a robotic ultrasound exam of a patient's carotid artery in four minutes. "Our first-in-man experiment shows long-distance, telerobotic ultrasound examinations over standard Internet are possible," Sengupta said.

Source: Bassett, Max, www.fierceimaging.com August , 2014

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Recert Exam Cheat Sheet

Preparing for the recertification exam? In light of the recent RPA job openings, it is prudent to review the format of a preliminary report. What must be included legally, according to the ACR format and what information do the billing people need? While enrolled in the RPA program you had a module entitled, "Professional Communication". Find the module and review or go online and find articles providing the information.

Review the topics listed under Patient Education in the content specifications—things like cultural differences, socioeconomic differences, interacting with older patients and with children. Go to the www.cbrpa.org web site and click on Exam Candidates to find the content specifications. Interaction with patients is extremely important in the changing health care system; therefore expect such questions on the examination.

Four misconceptions about ICD-10

Myth 1: ICD-9 does not need to be replaced. There are costs and dangers associated with not replacing the old coding system.. ICD-9 is "obsolete" and not up-to-date with current clinical knowledge, medical terminology or the modern practice of medicine. It also lacks the flexibility needed to keep up with changes in health IT. Because the old system can't capture new technologies, there are problems when it comes to electronic health records and interoperability--which require a modern coding system for reporting data.

Myth 2: ICD-10 makes it harder to find the right coding. Far from being more difficult the transition will actually make it easier to find the needed code because it is a more comprehensive and detailed code set. ICD -9 is much more ambiguous, with codes that can be open to numerous interpretations. ICD-10 offers greater detail when it comes to certain surgical complications and types of devices.

Myth 3: SNOMED CT and ICD-10 are complementary. They both serve separate purposes. SNOMED deals with "input" and covers laboratory tests and some types of clinical measurements, while ICD deals with "output" and serves as an international standard diagnostic classification to organize content into standardized criteria. ICD is statistical; SNOMED is clinical.

Myth 4: The U.S. can wait for ICD-11. The World Health Organization's release. date of 2017 for ICD-11, two years later than was originally planned, is just the start of the process for the U.S. ICD-11 will need to be evaluated for national use and a national version will likely be created to allow for updating required by Congress and stakeholders, and those steps will take a least a decade. It would take too much valuable time to skip ICD-10 and go straight to ICD-11. Even the American Medical Association's board of trustees discourages moving on to ICD -11, saying it would be "fraught with its own pitfalls."

RPA REPORT

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RPAS-
RPASociety.org

This newsletter focuses on the changing health care industry and the perception of radiology within the system. It is often heard, "why can't we be more like the nurses." To become recognized, you first must be noticed. You will find nurses on all committees within the hospital and their presence denotes the amount of influence they have within the facility. Radiology is busy and the excuse is "I don't have time." Radiology personnel must make time and join the system. Meetings are scheduled ahead of time, so adjustments must be made to attend. RPAs can have an influence by creating an awareness of what they do and the contribution radiology makes to the facility. Committees ,such as the credentialing committee , are important . RTs can also serve on committees and be the eyes and ears for the department. If one does not participate, then one can despair about decisions made.

Changing Health Care Industry

During the past month, CBRPA has been contacted to advertise for 20 RPA positions . These openings are located throughout the country. Fortunately, they have all been filled. However, this is an indication of the growing need for the RPA. The RPA fills a very special niche in the health care industry. An awareness is growing of the increase of efficiency and cost effectiveness of hiring an RPA.

HOO-RAY!!