SAVING SIGHT
An Alternative to Traditional Glaucoma Surgery

Glaucome is the leading cause of irreversible blindness worldwide. Encompassing a variety of conditions that increase pressure in the eye, glaucoma can lead to irreparable optic nerve damage and permanent blindness.

Effective surgical treatments for glaucoma have been continually refined and improved for decades. Minimally Invasive Glaucoma Surgery (MIGS) is a more recent addition to the arsenal, requiring less recovery time and follow-up.

"Because typical surgery can require so much of the patient, we've tended to wait until their glaucoma is more severe," said Daniel Bettis, MD, Clinical Assistant Professor, Ophthalmology and Visual Sciences. "The greater comfort and improved recovery time with MIGS means that we can offer it sooner in the disease course."

MIGS was the right choice for Anna Nelson, a 20-year-old from Omaha, Neb. Nelson was the first patient to undergo the new procedure offered by Dr. Bettis at UI Hospitals and Clinics.

The best candidates for MIGS have been diagnosed with glaucoma, and have accessible drainage structures (which can be affirmed by an ophthalmologist). Cataracts can present a unique opportunity for intervention: according to Medicare data, 15 to 20 percent of patients undergoing cataract surgery have glaucoma. Some MIGS procedures are designed to be performed concurrently with cataract surgery, others before and after.

MIGS is not ideal for advanced or severe glaucoma, where traditional trabeculectomy or tube shunt surgeries may be a better choice to get pressures low enough to protect the eye. It is also not intended as a prophylaxis to reduce the risk of developing glaucoma.

The surgery dramatically lowered the intraocular pressure in her eye and provided an opportunity to reduce and eventually eliminate the need for glaucoma medications.

Dr. Bettis accepts referrals for both cataract and glaucoma surgery, and sees patients at IRL and Pomerantz Family Pavilion. To refer a patient, contact scheduling at 356-1216, Kristy Welte at 356-3938, or email Dr. Bettis directly at daniel-bettis@uiowa.edu.
Promoting Your Practice: Presenting Your Reputation

National reputation is important to any health system, and UI Health Care is no exception. We know we have exceptional clinicians. We know we have extraordinary researchers. We know that our physicians regularly deliver outstanding presentations at important meetings and prestigious national conferences.

But there are many who don’t know these things. It is essential to our national reputation, and the rankings that lean heavily on it, to publicize those presentations. Our UI Hospitals and Clinics marketing and media relations teams need your help to maximize the effect of your national presentations. Here are some easy steps to help our staff create media interest and public buzz.

As soon as you know you’ll be presenting, please notify your department administrator, your marketing manager, and the media relations team at media-relations@uiowa.edu. Let them know the conference name, dates, and the subject of your presentation. Also tell them if you are willing to be contacted by the media before or at the conference.

Be assured that the media relations team is experienced with sensitive and embargoed information.

Media relations can pitch your story to medical and science reporters, as well as area media where there may be local interest. With sufficient time, and depending on the subject and budget, the marketing team may be able to promote your presentation both internally and at the event.

UNIVERSITY OF IOWA PHYSICIANS NEWSLETTER JANUARY 2016

Hear, Hear: Hybrid Technology Allows for Earlier Intervention, Improved Outcomes

Since the 1980s, cochlear implant technology has revolutionized treatment for profound hearing loss. Combining external components with an internally placed electrode array, these prostheses provide direct electrical stimulation to the auditory nerve.

More recent technology, approved by the FDA in 2014, combines acoustic and electric hearing, preserving and/or augmenting both low and high tones. This combination results in improved speech perception, especially with background noise, and even enhances enjoyment of music.

Within a Hybrid Cochlear Implant, an acoustic component amplifies low-frequency sounds, sending them through the normal hearing pathway. Meanwhile, high-frequency sounds are converted to digital signals and sent directly to the auditory nerve through the implant.

Who can be a candidate for a Hybrid Cochlear Implant? A person age 18 or older, whose hearing aids are no longer performing satisfactorily, may be ideal. Patients with a high potential benefit typically have normal to mild low frequency hearing and steeply sloping high frequency hearing. Contraindications include brittle bone, diabetes and dementia.

“The most important thing for physicians to realize is that this is an option before profound hearing loss,” said Camille Dunn, Ph.D., Research Assistant Professor. “This device is closing the gap between when hearing aid amplifications stop helping and complete deafness.” Dunn is co-directing a study on speech and language outcomes in children receiving cochlear implants.

UI Health Care has a long and rich history of innovation in this field, and patients benefit from that extraordinary experience. The Iowa Cochlear Implant Clinical Research Center was established here in 1985 when the implants first became available and is directed by Bruce Gantz, MD, Professor and Head of Otolaryngology. While the FDA only approved the Hybrid Cochlear Implants in 2014, they have been studied at the University of Iowa since 1999.

Obtaining a Hybrid Cochlear Implant at UI Hospitals and Clinics is fairly quick. Depending on insurance issues, a patient could start the process in four to six weeks. First the internal portion is surgically implanted, and after healing for a month, the external parts are connected. The largest improvement is typically seen in the first six to eight months, though some patients experience an immediate effect.

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Endovascular Coiling: Minimally Invasive Aneurysm Surgery with Short Stay, Quick Recovery, Low Risk

In all of Iowa, there are only five physicians specializing in neurointerventional surgery, and all of them are here at UI Hospitals and Clinics. This expertise, combined with other specialties in multidisciplinary teams, means our patients receive comprehensive care for aneurysms – care they can get nowhere else in the state.

Neurology, neurosurgery and neuroradiology work together to develop the best plan of care. Years ago, aneurysm treatment required entering the skull and clipping the aneurysm – a highly invasive procedure with extensive post-operative recovery. Today’s technology provides a variety of solutions that are less invasive with minimal recovery times, allowing for earlier life-saving intervention.

Endovascular coiling is one of these technologies. Developed in the 1990s and continually refined, the procedure involves a catheter passed through the groin into the blood vessels of the brain. Once the aneurysm is located, miniscule coils of soft platinum are placed inside, sealing the opening and cutting off blood flow. In cases where the ‘neck’ of the aneurysm is wider or weaker than desired, a small temporary balloon or a fine mesh stent can be deployed to provide support. (On certain occasions, wide-neck aneurysms may be treated with an endovascular bypass stent or “flow-diverter.”)

“We can treat 80 to 90 percent of unruptured aneurysms with endovascular, with results equal to or better than open surgery,” said Santiago Ortega, MD, MSc, Clinical Assistant Professor of Neurology. “Only when the anatomy is cumbersome – like abnormality in the vessel’s or very specific locations of the aneurysm – would we consider open.”

Not all aneurysms need to be treated. “We make the decision based on the size, existing symptoms, location, age of patient and growth interval,” said Ortega. Sophisticated non-invasive brain imaging allows close monitoring of the aneurysm, tracking size and any additional risk factors that may lead to rupture.

If an unrecognized or untreated aneurysm ruptures, the prognosis dims. “Ruptured aneurysms cause remarkable brain injury,” said Ortega. “Up to 45% of patients die or do not recover because of the damage caused by the bleeding and intracranial pressure.”

The symptoms of an unruptured aneurysm can be as simple as headaches, dizziness, and blurred vision, although a large percentage may be asymptomatic and found incidentally. “The patient really needs to see a specialist,” Ortega said. “Experts need to follow up and treat them when appropriate.”

Integrating Business and Clinical Functions: GE-IDX to Epic Transition

In 2009, UI Hospitals and Clinics adopted the Epic electronic medical record system. Our use of Epic was expanded in 2014 to include a combined business office model, closely integrating patient records and billing. This integration of clinical and financial systems is essential to ensuring that revenue is flowing as efficiently as it can, satisfying all constituents.

The new components of Epic went into service in August 2014. Some staff are still becoming accustomed to the new processes, but Phil Roudabush, Director of Patient Financial Services at UI Hospitals and Clinics, is confident of success. “Epic is an excellent product with great potential,” he said. “It’s a different paradigm, but will allow us to achieve so much.”

“Epic’s linear view of the revenue cycle allows staff to focus on a few tasks rather than many, encouraging specialization and enhancing accountability. ‘Epic will allow us to get to numbers we’ve never been able to approach before,’ Roudabush said. ‘We’ll be able to create the high-level metrics we ultimately want to achieve.’

Epic utilizes clinicians’ front-end data collection to create efficiencies in the background. Improved data collection enables robust reporting that far surpasses what was available in the GE-IDX system. Roudabush noted that Epic’s daily data is both interesting and accurate, and enhances the entire reporting aspect. “The ability to create dashboards is phenomenal,” he said.

It’s really all about the patient. Billing has to be efficient and effective, and the patient bears the burden if it’s not.” —PHIL ROUDABUSH

“Fully utilizing the new system enhances the bottom line: a more rapid shift of liability to the patient results in faster payment. And patients appreciate quicker billing turnaround and speedier statements.”
UI Health Alliance Announces Fifth Member

Great River Health Systems, with providers and facilities throughout Southeast Iowa, has joined the University of Iowa Health Alliance (UIHA). Great River has also become part of the UIHA Accountable Care Organization, committed to developing and implementing evidence-based care and best practices for keeping populations healthy – supporting the shift from fee-for-service to value-based care delivery.

The partnership coordinates and expands UIHA health care into Fairfield, Fort Madison, Keokuk, Mediapolis, Mount Pleasant, Wapello, Burlington, and West Burlington.

The Great River Medical Center in West Burlington is a 378-bed regional medical center that annually admits more than 6,500 patients and logs over 190,000 outpatient visits.

The UIHA now includes five of Iowa’s premier health care organizations, with 21 hospitals and over 2,000 physicians. Members work together to support increased quality, lower costs and a healthier Iowa.

Supporting What We Value:
UI Health Care Responds to CMS

As Medicare moves to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), especially the Merit-Based Incentive System (MIPS) and Alternative Payment Model (APM) portions, they requested comments from providers and the public. University of Iowa Health Care replied.

In a multi-page response, VPMA Robillard, CEO Kates, Dean Schwinn, and UIP Executive Director Van Daele, identified UI Health Care as a low-cost provider of complex medical services deeply engaged in value-based payment mechanisms.

They noted that the 2014 Commonwealth Fund Scorecard ranked Iowa 10th best in overall care, and Commonwealth’s Quality Spending Interactive scale rated Iowa’s quality 8 percent higher and spending 12 percent lower than the U.S. median.

In direct response to MIPS, which is replacing PQRS, EHR pay-for-performance incentives, and the Physician Value-Based Modifier, the UI Health Care group urged that CMS should:

• Recognize that quality of care relies on a team-based model, and not attribute patients of a physician group practice to a single physician in that group
• Make incremental changes and streamline program requirements for consistency, adherence to standards of care, and minimal reporting burden
• Ensure that “provision of quality care” programs have actually been proven to improve patient outcomes
• Refine risk adjustments for high-risk, high-cost patients, especially outside of primary care
• Recognize activities of teaching physicians as fulfilling the requirement for 15% clinical practice improvement activities
• Allow physicians to benefit from quality improvement efforts by reducing the two-year lag between the measured performance period and payment year.

You can review the call for comments, along with the many responses in their entirety from providers and interested parties across the nation, at www.regulations.gov, with a search for File Code CMS-3321-NC.

As the situation changes, and new programs evolve, we will continue to keep you informed of the progress and developments that will impact UI Physicians.