

Radiology Administrator's

Compliance & Reimbursement Insider

DECEMBER 2006

Coding corner **2**

Learn how new CPT codes for 2007 affect radiology.

Imaging innovation **3**

Discover how to nominate someone for the Breast Imaging Innovation Award.

DRA timeline **5**

Examine actions which wrought the Deficit Reduction Act.

E-mail updates

Subscribe to our free electronic newsletter **Imaging Weekly**, which provides news and practical how-to advice on government and state regulations, Medicare updates, malpractice, mammography, billing and coding, safety, technology, and much more at www.hcmarketplace.com.

IN FUTURE ISSUES

- Working with ABNs
- Tracking claims denials to improve reimbursements



Get ready: DRA just weeks away

Ask a Magic 8-ball anything and generally, it replies, "Ask again later." "Unlikely." "Maybe so."

Now, ask imaging industry insiders to opine on the fiscal effect of the Deficit Reduction Act (DRA) and the proposed Access to Medicare Imaging Act (AMI) on the field of radiology.

Generally, they answer much the same way as the 8-ball.

"What's going to happen between now and January 1 is anybody's

guess," says **Bob Maier**, president of Regents Health Resources, Inc., in Brentwood, TN.

Recent history

President George W. Bush signed the DRA into law in February. The law essentially cuts federal spending across a variety of entitlement programs from school loans to community block grants, and from Medicaid to Medicare.

The Congressional Budget Office, in its January opinion, suggested that the cuts could save the federal government \$35 billion in less than four years. **> p. 4**

OIG picks radiology areas to examine

It's the \$64,000 question: What will regulators chose to scrutinize?

The answer comes every October from the U.S. Health and Human Services' (HHS) Office of the Inspector General (OIG) when it (usually) releases its *Work Plan*.

Although the report came a little earlier than usual this year—September 25—it continues to do what it always does—lay out plans for healthcare spending investigations in the coming year. "The *OIG Work Plan* represents a critical com-

ponent of any healthcare compliance road map," says **Lewis Morris**, chief counsel to the Inspector General. "Reviewing the *Work Plan* is a good first step to building an effective internal compliance program."

The *Work Plan* offers no guarantees on the limit or scope of *OIG* queries, any more than it promises to follow its suggested itinerary. Rather, the *Work Plan* establishes itself as a guide into the current thinking and investigative resources of the agency. **> p. 7**

Coding corner

CPT changes mark manual imaging moves

The 2007 American Medical Association (AMA) *CPT manual* contains 41 changes to codes that affect radiology and imaging services.

“Because these are codes that are used on an every-day basis, it’s going to be a tough transition,” says **Jackie Miller, RHIS, CPC**, of Coding Strategies, Inc., in Powder Springs, GA.

Many of the changes involve simply moving codes around to more accurately reflect respective modalities. Other coding alterations better align descriptor language to current procedure paths.

The code relocations represent the AMA’s organizational restructuring (CPT 5 Data Model Project), the American College of Radiology (ACR) says in an October release, “to facilitate computer processing and interoperability with various computer systems.”

The AMA previously placed many new imaging codes in the “other procedures” category, Miller explains.

“I think the 2007 changes represent an attempt to place these codes within the correct modality section of CPT,” she says.

Codes previously listed under the “other procedures” section include a host of well-established radiology

codes, says ACR. These include mammography codes—76082, 76083, 76086, 76088, 76090, 76091, 76092, 76093, 76094, 76095, 76096; many guidance codes—75998, 76003, 76005, 76006, 76355, 76360, 76362, 76370, 76393, 76394; bone studies—76020, 76040, 76061, 76062, 76065, 76066, 76070, 76071, 76075, 76076, 76077, 76078, 76400; and vertebroplasty codes—76012, 76013.

Changes for 2007 include alterations involving mammography, vascular access, and cardiac computed tomography angiography, among other items.

There’s a new code for uterine fibroid embolization—37210—which covers embolization of the uterine arteries to treat uterine fibroids, leiomyomata, with percutaneous approach inclusive of vascular access, vessel selection, and embolization. The code includes all of the radiological supervision and interpretation, intraprocedural road mapping, and imaging guidance necessary to complete the procedure.

“The new code is all-inclusive,” Miller says. “The catheter placements, embolization, supervision and interpretation, and follow-up angiograms are all covered by 37210.”

The AMA slightly altered three codes for radio frequency ablation, says Miller.

RACRI Subscriber Services Coupon

Start my subscription to **RACRI** immediately.

Options:	No. of issues	Cost	Shipping	Total
<input type="checkbox"/> Print & Electronic 1 yr	12 issues of each	\$239 (RACRIPE12)	\$24.00	
<input type="checkbox"/> Print & Electronic 2 yr	24 issues of each	\$430 (RACRIPE24)	\$48.00	
Order online at www.hcmarketplace.com . Be sure to enter source code N0001 at checkout!		Sales tax (see tax information below)*		
		Grand total		

For discount bulk rates, call toll-free at 888/206-6554.



*Tax Information

Please include applicable sales tax. Electronic subscriptions are exempt. States that tax products and shipping and handling: CA, CT, FL, GA, IL, IN, KY, MA, MD, MI, MN, NC, NJ, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI. State that taxes products only: AZ. Please include \$27.00 for shipping to AK, HI, or PR.

Your source code: **N0001**

Name _____

Title _____

Organization _____

Address _____

City _____

State _____

ZIP _____

Phone _____

Fax _____

E-mail address

(Required for electronic subscriptions)

Payment enclosed. Please bill me.

Please bill my organization using PO # _____

Charge my: AmEx MasterCard VISA

Signature _____

(Required for authorization)

Card # _____

Expires _____

(Your credit card bill will reflect a charge to HCPro, the publisher of RACRI.)

Mail to: HCPro, P.O. Box 1168, Marblehead, MA 01945 Tel: 800/650-6787 Fax: 800/639-8511 E-mail: customerservice@hcpro.com Web: www.hcmarketplace.com

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at www.copyright.com or 978/750-8400.

New codes for radio frequency ablation guidance include 77013 for computed tomography and 77022 for magnetic resonance. Code 76940 will still be used for ultrasound guidance.

The following mammography codes changed:

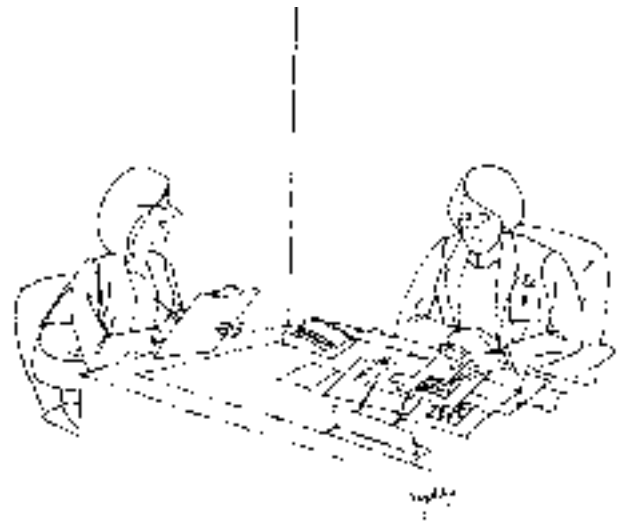
- Code 76090 became 77055—unilateral diagnostic mammography
- Code 76091 became 77056—bilateral diagnostic mammography
- Code 76092 became 77057—screening mammography, bilateral two-view film study of each breast
- Code 76093 became 77058—unilateral magnetic resonance imaging of the breast without and/or with contrast
- Code 76094 became 77059—bilateral magnetic resonance imaging of the breast without and/or with contrast

The following computer-aided detection (CAD) mammography screening codes have also changed slightly:

- Code 76082 became 77051—CAD for diagnostic mammography

- Code 76083 became 77052—CAD for screening mammography ■

Illustration by David Harbaugh



*“Tell me, how do you do the mammogram again?
I’m kind of a do-it-yourself person.”*

Breast Imaging Innovation Award nominees sought



HCPPro's Breast Imaging Innovation Award recognizes imaging professionals who work hard every day to fight breast cancer.

The award is given to a facility or individual who has developed an innovative breast-imaging program.

Facilities may nominate themselves or a colleague.

HCPPro looks for stories about facilities, or individuals, practicing innovative programs that

- improve patient care
- focus on community outreach
- increase breast cancer screening compliance
- otherwise help improve breast health

To submit a nomination, send us a one-page synopsis describing the program, including the following:

- Its purpose or goal
- When it began
- How it was carried out
- Its results

Our panel of experts will read through this year's entries to select a winner.

If you have a story to share or a nomination to submit for this year's contest, send it via e-mail to **Mammography Regulation and Reimbursement Report**, Managing Editor Kelly Bilodeau at kbilodeau@hcpro.com, subject line: Breast Imaging Innovation Award; or mail it to HCPPro's Breast Imaging Innovation Award, Attn: Kelly Bilodeau, P.O. Box 1168, 200 Hoods Lane, Marblehead, MA 01945.

The deadline for this year's contest is **December 31, 2006**.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at www.copyright.com or 978/750-8400.

Get ready < p. 1

The American College of Radiology (ACR), however, says \$1.2 billion annually comes from cuts to radiology reimbursement.

As required by the DRA, CMS would cap Medicare payment amounts for certain imaging services at the amount paid to hospitals under the Outpatient Prospective Payment System (OPPS).

In a release, the ACR says it views the policy “as ill-advised and inappropriate and believes it will lead to inequitable payment amounts and compromise Medicare beneficiaries’ access to high quality imaging services.”

For its part, CMS says it plans to exercise discretion in the case of imaging services potentially affected by both the multiple imaging procedure reduction and the cap by applying the multiple imaging procedure reduction *first* and then the OPPS cap, says the ACR.

Although it may help somewhat, the ACR says any technical component reduction for contiguous imaging is inappropriate and should be eliminated, because the Ambulatory Payment Classification (APC) payment rate already accounts for any cost efficiencies that are incurred when contiguous body parts are examined.

Road to remediation

Leaders of various radiology associations lobbied against the DRA as it moved swiftly across the Congressional landscape.

Despite the DRA’s passage, such efforts did produce results. Pennsylvania Representative Joseph Pitts presented mitigating legislation—AMI—just four months later.

Pitts’ proposal recommends a two-year moratorium on radiology reductions included in the DRA.

The temporary stopgap measure gives imaging time to analyze the effect both on the industry and on Medicaid and Medicare patients possibly disadvantaged by the DRA, says Maier.

Initial investigations show the DRA reimbursing some 87% of imaging scans at less than what it costs to perform them, says Maier.

At that rate, expect centers to start closing and facilities to stop performing expensive scans in order to keep bill collectors at bay.

“A two-year delay [as proposed in AMI] could be beneficial,” says Maier. “It may help us determine reasonable reductions in price. And, it offers providers two years to refinance loans, consolidate practices, and improve performance.”

Even with nearly 130 cosponsors of AMI, Maier holds little hope of the measure becoming law prior to the DRA’s January 1, 2007, implementation date.

“It’s a tall order for anything to happen before the December recess,” he says.

As **RACRI** hit the presses, Congress adjourned for its annual autumn recess. It returns after the November election.

Which political party wins the day will sway which legislation gets debated, says **Fred Gaschen, MBA, CHE**, executive vice president of Radiological Associates of Sacramento (CA) Medical Group.

“Let’s say the election goes to the Democrats, then a lame duck session through the new year is the best scenario. That’s what we hope for,” Gaschen says.

The best Magic 8-ball prognostication gives AMI a mid-February spot on the debate floor.

“If that’s the case, then good for us and bad for us,” says Gaschen.

Good, because radiology may indeed get the two-year moratorium it wants.

Bad, because the imaging industry must still deal with the DRA until Congress approves AMI.

DRA reimbursement countdown

October 27, 2005: New Hampshire Senator Judd Gregg introduces the Deficit Reduction Act (DRA) of 2005 (S. 1932, H.R. 4241) to provide for reconciliation for the fiscal year 2006 budget.

November 3, 2005: Senate passes the DRA with amendments by a 52 to 47 vote.

November 18, 2005: The DRA measure passes the House without objection.

December 19, 2005: The House files its conference report, which is approved 212 to 206.

December 21, 2005: Conference agreement amended and approved by the Senate, 51 to 50, with Vice President Dick Cheney casting the deciding vote.

January 27, 2006: Congressional Budget Office reports DRA would reduce direct spending by \$35 billion between the 2006–2010 period.

February 8, 2006: President George W. Bush signs

the DRA into law, No. 109–171.

June 28, 2006: Pennsylvania Representative Joseph Pitts introduces the Access to Medicare Imaging Act (H.R. 5704; S. 3795) to provide a budget-neutral, two-year moratorium on certain Medicare physician payment reductions for imaging services. The proposal garners 128 cosponsors.

July 18, 2006: The House Energy and Commerce Subcommittee on Health hears testimony from the American College of Radiology, among other organizations, regarding the fiscal effect of the DRA on imaging services and the importance of the Access to Medicaid Imaging Act.

September 30, 2006: Congress in recess until after November mid-term elections.

November 9, 2006: Congress returns to session.

January 1, 2007: Budget considerations included in the DRA take effect.

Worse, because even after an AMI study (assuming AMI passes), significant cuts to the imaging industry still loom on the horizon.

The Magic 8-ball says, “Likely so.”

Look to the future

Escalating imaging costs add to escalating healthcare costs. Look to any number of recent studies and investigations for proof.

“Imaging volume increases have been twice the average of all other physician services,” says Maier. “It’s a high-cost, high-tech service.”

So it makes sense for CMS to seek some remediation from increases in imaging costs, Maier and Gaschen both agree. It goes to the heart of why the DRA passed to begin with, says Gaschen. It’s about available government money and how to spend it.

“CMS wants this to happen,” says Maier. “It’s seen dramatic increases in costs over the last several years.

“The only way to mitigate cost, in theory, is by cutting reimbursement and driving people out of the market at the same time.”

“The DRA is only about the money that the government has to spend. It has nothing to do with what the market needs,” Gaschen says.

The real magic question, says Gaschen, isn’t *whether* DRA will be implemented, it’s *when* and *how much* it will cost the imaging industry. ■

Insider sources

Fred Gaschen, MBA, CHE, executive vice president, Radiological Associates of Sacramento Medical Group, Inc., 1500 Expo Parkway, Sacramento, CA 95815, 916/646-8400; ragaschen@radiological.com.

Bob Maier, president, Regents Health Resources, Inc., 783 Old Hickory Boulevard, Suite 260, Brentwood, TN 37027, 615/376-4424; bmaier@regentshealth.com.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at www.copyright.com or 978/750-8400.

Business plan, debt reduction: Proper responses to DRA

With mere weeks left until the Deficit Reduction Act (DRA) implementation, radiology administrators need to prepare. Some analysts say the DRA will cost the imaging industry more than \$1 billion annually.

Although many believe that something—divine intervention perhaps—will prevent the DRA implementation, “you have to behave as if this is really happening,” says **Bob Maier**, president of Regents Health Resources, Inc., in Brentwood, TN.

“Everyone should have done the math already,” to determine the effect of the DRA, says **Fred Gaschen, MBA, CHE**, executive vice president of Radiological Associates of Sacramento (CA) Medical Group.

Maier says to ask the following questions when conducting an analysis for your facility:

- How severe will the effect be?
- What will you do to make up costs?
 - Can you afford to cut costs internally?
 - Can you eliminate scheduling backlog?
 - Can you increase the volume of scans at your facility?
- Will you add a second shift or extend hours to increase your capacity?

Strategic plans plot business success

To diversify or specify your business line, look at your surrounding market, he says. “I am amazed at the number of facilities that never completed even a basic strategic plan,” says Gaschen.

A strategic plan helps your business find its focus and earn greater profits. It uses data to accurately describe the current pitfalls and powers of your business.

For example, everyone talks about the importance of imaging to an aging baby-boom population. Examine census data in your specific area, Gaschen says. Just because the general population of elderly has increased nationwide doesn't necessarily mean that the senior population near your facility grew as well, he says.

“The DRA makes imaging a much more competitive business,” says Maier.

Refinance debt

Centers that carry a large debt for previous facility, or equipment, improvements should look to refinance where possible, Maier says. DRA cuts could make debt repayment difficult. Should the proposed Access to Medicare Imaging Act's two-year delay come into play, it would provide a much-needed circuit breaker for centers to refinance or renegotiate their debts. Take advantage of this, Maier and Gaschen suggest.

Renegotiate payer contracts

Further, look at contracts with payers and keep an eye on new payer regulations, says Gaschen. Many private payers have already implemented measures similar to the DRA, he says. He points to insurers United and Aetna, both of which adopted payment policies mimicking CMS' payment reduction on same-day, contiguous body part scans. “Make sure that you're aware of what's going on around you in the industry so you can be prepared,” Gaschen says.

Examine commercial contracts and attempt to remove any ties to Medicare payments. Gaschen renegotiated contracts several years ago. “If you can, try to renegotiate with payers and aim for 2008. If not, you're looking down the barrel of a double blast,” he says.

Imaging shakedown

Consolidating the market may be part of CMS' overall design, says Maier. “Imaging centers will close [and] this can be a good thing or a bad thing,” he says.

If radiology services improve overall because of increased competition, everyone benefits. Conversely, if cuts to radiology stretch the industry too thin, then customer service suffers, he says.

“And with radiology,” adds Maier, “when we talk about customer service, we're talking about people's health and well-being.”

The federal government wants to reduce imaging costs, Gaschen says. “That's correct, that's fine. We're talking about taking a scalpel to remove a growth. They took a meat cleaver and hacked off a leg.” ■

Radiology areas

< p. 1

Generally, the OIG considers activities of the following governmental agencies:

- Centers for Disease Control and Prevention
- Food and Drug Administration
- National Institutes of Health
- CMS

The *Work Plan* also contains an expansive list of activities related to Medicare and healthcare professionals, including hospital capital payments and adjustments for graduate medical education payment, among other items.

Although not a comprehensive query into every avenue of concern, the *Work Plan* nevertheless provides a valuable tool for radiology administrators.

With it, imaging leaders can prioritize facility or department compliance activities.

The million-dollar question: implications for imaging

As the use of radiology rises, expect OIG scrutiny also to increase.

Although imaging has always caught investigators' eyes, high-priced procedures and complex coding and billing structures make it an ideal area to target, says **Stacey Gregory, RCC, CPC**, president of Gregory Medical Consulting Services in Tacoma, WA.

This year, the OIG's radiology concerns include diagnostic x-ray payments in the emergency department (ED); cardiography and echocardiography billing practices; and the use of advanced imaging procedures in physician offices.

Imaging in offices: 'Take it or leave it'

The latter *Work Plan* agenda item may cut to the heart of the imaging use or overuse issue being debated across the country by payers and providers alike.

From 1999 to 2005, the use of advanced imaging services (e.g., magnetic resonance imaging, PET, and CT scans) grew on average by 20% per year.

In 2005 alone, Medicare allowed charges of more than \$7 billion for these services, according to the *Work Plan*. This year's OIG review examines the appropriateness of imaging services provided in physician offices and considers the nature of the growth of these services.

To do this, the OIG plans to study billing patterns in certain geographic areas and practice settings over the previous years. The agency has already begun its review.

ED x-ray double-dipping: 'You'll be sorry'

Medicare-certified hospitals performed more than 2.5 million diagnostic x-rays in EDs, in 2004.

Is it any wonder that the 2007 OIG agenda includes inappropriate payments for interpretation of diagnostic x-rays in hospital EDs?

Imagine this situation: An elderly man enters the ED in the evening complaining of chest pain. Technologists take an x-ray.

The film and the patient return to the ED. The physician looks at the x-ray, sees a fracture on the man's ribs, and sends him home.

The next day, however, the radiologist looks at the film and also reports his findings.

On this level, according to the OIG *Work Plan*, the question is: 'Who gets to bill for the exam analysis?'

"This is a huge issue," says **Hugh E. Aaron, MHA, JD, CPC, CPC-H**, senior vice president, compliance and regulatory affairs/regulatory counsel, at HCPro, Inc., in Marblehead, MA. "This goes back to the rules for appropriate reporting and billing."

Contractors pay for only one interpretation of an x-ray procedure furnished to an ED patient, according to the *Medicare Claims Processing Manual*.

Second interpretations require modifier -77, but this should only occur under unusual > p. 8

Radiology areas

< p. 7

circumstances, such as if a specialist is needed, the *Work Plan* states.

Even then, documentation for this type of situation—including information regarding medical necessity—must be present to support the additional claim.

The OIG plans to examine whether the services were medically necessary and whether the tests were interpreted contemporaneously with the patient's treatment.

Cardiography and echocardiography services

As occurs with many physician services, cardiography and echocardiography include both technical and professional components, the OIG *Work Plan* states.

When a physician performs the interpretation separately, modifier -26 should be used to bill Medicare.

"Cardiology and radiology are often on the OIG's watch list," says Gregory. "They are high-priced

procedures, and there's a lot that goes along with them."

But when it comes to actually coding and billing for these procedures, physicians often confuse the issue.

"Essentially, the OIG is saying, 'We want to see if we're being properly billed.' That's very significant, particularly for freestanding facilities and physician practices," says Aaron.

"I think [the OIG] just wants to make sure that physician practices are using the appropriate modifiers and submitting appropriate bills for the appropriate levels of service," says Gregory. ■

Insider sources

Stacy Gregory, RCC, CPC, president, Gregory Medical Consulting Services, 2661 N. Pearl St. #364, Tacoma, WA 98407, 253/566-2494; stacy@gregorymedicalconsulting.com.

Hugh E. Aaron, MHA, JD, CPC, CPC-H, senior vice president, compliance and regulatory affairs/regulatory counsel, at HCPro, Inc., 200 Hoods Lane, P.O. Box 1168, Marblehead, MA 01945, 804/965-6387; haaron@hcpro.com.

Radiology Administrator's Compliance & Reimbursement Insider Editorial Advisory Board

Group Publisher: Lauren McLeod, lmcleod@hcpro.com

Executive Editor: Melissa Osborn, mosborn@hcpro.com

Managing Editor: Melissa Varnavas, mvarnavas@hcpro.com

Larry Balmer
Radiology Incorporated
Mishawaka, IN

Stacie L. Buck, RHIA, LHRM
Southeast Radiology Management Corp.
Stuart, FL

Alice G. Gosfield, Esq.
Alice G. Gosfield & Assocs., PC
Philadelphia, PA

Thomas W. Greeson, Esq.
Reed Smith, LLP
Falls Church, VA

Stacy Gregory, RCC, CPC
Gregory Medical Consulting Services
Tacoma, WA

Mark B. Langdon
Arent Fox, PLLC
Washington, DC

Jackie Miller, RHIS, CPC
Coding Strategies, Inc.
Powder Springs, GA

Diane S. Millman, Esq.
Powers Pyles Sutter & Verville
Washington, DC

Melody W. Mulaik, MSHS, CPC, CPC-H, RCC
Coding Strategies, Inc.
Powder Springs, GA

Claudia A. Murray
Provider Practice
Analysis, LLC
Baldwin, MD

Paula Richburg
QuadraMed
Columbia, MO

William A. Sarraille, Esq.
Sidley Austin Brown & Wood
Washington, DC

Michael F. Schaff, Esq.
Wilentz Goldman & Spitzer
Woodbridge, NJ

Jay Silverman, Esq.
Ruskin Moscou Faltischek, PC
Uniondale, NY

Edward Townley
Moncrief Cancer Center
Fort Worth, TX

Tobin N. Watt, Esq.
Smith Helms Murliss
& Moore, LLP
Atlanta, GA

Radiology Administrator's Compliance & Reimbursement Insider (ISSN: 1527-2338) is published monthly by HCPro, Inc., 200 Hoods Lane, Marblehead, MA 01945. Subscription rate: \$239/year; back issues are available at \$25 each. • Postmaster: Send address changes to **Radiology Administrator's Compliance & Reimbursement Insider**, P.O. Box 1168, Marblehead, MA 01945 • Copyright 2006 HCPro, Inc. All rights reserved. Printed in the USA. Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro, Inc., or the Copyright Clearance Center at 978/750-8400. Please notify us immediately if you have received an unauthorized copy. • For editorial comments or questions, call 781/639-1872 or fax 781/639-2982. For renewal or subscription information, call customer service at 800/650-6787, fax 800/639-8511, or e-mail customerservice@hcpro.com. Visit our Web site at www.hcpro.com. • Occasionally, we make our subscriber list available to selected companies/vendors. If you do not wish to be included on this mailing list, please write to the Marketing Department at the address above. • Opinions expressed are not necessarily those of **Radiology Administrator's Compliance & Reimbursement Insider**. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions. **Radiology Administrator's Compliance & Reimbursement Insider** is not affiliated in any way with the Joint Commission on Accreditation of Healthcare Organizations.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at www.copyright.com or 978/750-8400.



GOING DIGITAL

***Electronic information
revolutionizes radiology***

***A supplement to Radiology Administrator's
Compliance & Reimbursement Insider***

Dear Reader,

Technology changes fast. Facilities from coast to coast purchase magnetic resonance imaging (MRI) machines, PET scanners, and ever larger CT scanners. Scientists continue to push various modalities in the hope of someday viewing inside the body in the same, real-time, three-dimensional way we see it from the outside. But these high-powered images contain vast volumes of information. Managing that information requires tremendous technology. All this makes implementation and management of electronic health records vital to the success of your imaging facility.

That's why **Radiology Administrator's Compliance & Reimbursement Insider** brings you this special report regarding PACS implementation and support. From writing a request for proposals to securing protected health information, this special report will help you steer your facility and staff through the various stages of integrating electronic systems into your imaging practice.

Shifting from traditional film to a totally digital system brings a range of worries, efficiencies, and difficulties. If you're the radiology administrator, you have to manage not only the implementation of these technically tricky programs, but also your staff's reactions to their altered work environment.

Radiology administrators are well aware of the difficulty involved in running PACS systems and the importance of proper preparation. So, whether your facility is just beginning the digital transformation or whether its been a few years since you plugged in, we're sure that you'll find the tips, tricks, and tools included in this special report valuable to your continuing success.

Regards,



Melissa Varnavas,
Managing Editor

Radiology Administrator's Compliance Reimbursement Insider

781/639-1872, Ext. 3711

mvarnavas@hcpro.com

Table of contents

Securing electronic health records: Create protected systems to communicate across the Web	3
Four steps to secure remote access	4
Savvy shoppers prepare prior to PACS purchase: Create a request for proposals, vision for data needs	6
SIIM readies PACS admin certification program	8
PACS administration: Creating the support team	9
Establishing digital protocols in mammography	11

Securing electronic health records

Create protected systems to communicate across the Web

One of the biggest challenges that radiology facilities face under the impending movement toward electronic health records is the inherent risk that comes along with paperless systems. For example, for the first time, you may be opening up your internal computer system to physician users.

What once felt like secure information may now seem as though it resides for all to see on the Web.

By granting physician access, doctors and their staff can view their patients' hospital records and diagnostic imaging pictures online through a PACS system from any computer with an Internet connection.

Compare how others manage access

Nevertheless, some organizations still fear—regardless of the amount of security that they employ—that more access means more risk. This is not so. Learn how other facilities enforce consequences if a physician or member of a physician's staff inappropriately uses protected health information (PHI) to help eliminate such fears.

Kelly McLendon, RHIA, polled colleagues to shed light on how other facilities manage the access conundrum. He found the following:

- Some facilities don't grant physician access for fear of security breaches.
- Those that do grant physician access typically require a signed agreement. Penalties for breaches include dismissal or even prosecution. Dismissal may not be an option, but termination of access privileges and other physician privileges may deter inappropriate use.
- Facilities that grant physician access conduct routine audits of access. They do this by reviewing a random sampling of audit logs each month or quarter to determine whether there was any inappropriate access.

Mark Olson, manager of information systems security for Beth Israel Deaconess Medical Center in Boston, uses two types of audits to ensure security compliance.

The first type of audit performs a quarterly scan of the vulnerability of the server and applications that remote workers access. The second audit type analyzes patterns of PHI access.

For example, if the average employee examines 15 records per day, and a remote employee accesses 20, managers may want to investigate why.

"It's a very useful tool," Olson says. "It allows us to review abnormal access patterns to ensure [that] there is no violation of hospital policy."

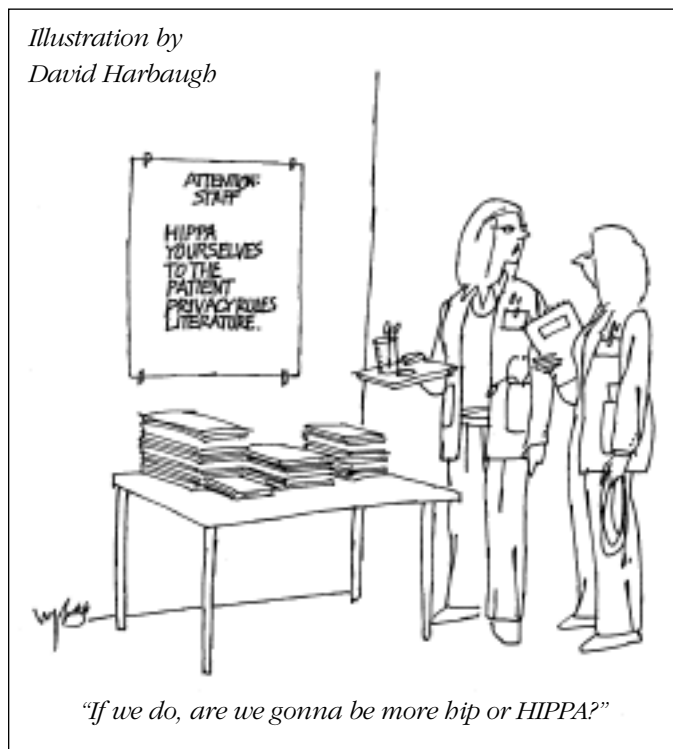
Provide a hotline for employees to report inappropriate access as an effective tool for managing access. But make sure that you market and promote the availability of this hotline to staff. If they don't know about it, they're certainly not going to use it.

Draft a policy

It's difficult to secure PHI on remote machines, says **Sybil Ingram-Campbell, MBA, PhD, CISM**, president of Enlightened, Inc., a consulting firm

> p. 5

Illustration by
David Harbaugh



Four steps to secure remote access

Take these four surefire steps to establish a remote-access program to minimize risk and ensure a smooth transition:

1. Conduct a risk assessment. “The more you open up your network, the less you can depend on perimeter defenses, naturally,” says **Søren Maigaard, MSc, CISSP**, a security consultant at NNIT, an information technology consulting firm in Denmark.

As with any adjustment to your security environment, conduct a risk assessment that determines the

- procedure (e.g., remote access through a secure sockets layer gateway)
- risk (e.g., whether the remote device will have up-to-date antivirus software)
- likelihood of the risk (e.g., somewhat likely)
- damage that the risk will cause (e.g., a network virus outbreak)

2. Analyze risk-assessment findings. Closely examine your risk-assessment findings and determine how you will lessen the risks or mitigate the damage.

For example, if you believe that your high-risk assets (e.g., servers that contain protected health information) may be vulnerable, consider conducting patterns analyses, as does **Mark Olson**, manager of information systems

security for Beth Israel Deaconess Medical Center in Boston.

3. Consider the operational effect. The risk assessment will guide you not only in selecting technologies and writing a security policy, but also in assessing remote employee access from an operational standpoint. For example, determine whether it is the responsibility of the user or the organization to upgrade security software on a remote device.

4. Train users. “Technology can only do so much,” Maigaard says. Regardless of how secure your remote access technologies are, remote employees sit on the front lines of your security.

This is especially true if the remote devices are user-owned. Conduct training that addresses remote employees’ roles and responsibilities and shows them how to conduct preventive maintenance of their machines.

Even after taking the most stringent measures to prevent security breaches, you still need to be prepared to take action if an incident occurs on a remote device.

If you discover a breach, quarantine the machine to a network segment where you can fix the machine without harming the rest of your network, says Maigaard.

RACRI Subscriber Services Coupon

Start my subscription to RACRI immediately.

Options:	No. of issues	Cost	Shipping	Total
<input type="checkbox"/> Print & Electronic 1 yr	12 issues of each	\$239 (RACRIPE12)	\$24.00	
<input type="checkbox"/> Print & Electronic 2 yr	24 issues of each	\$430 (RACRIPE24)	\$48.00	
Order online at www.hcmarketplace.com . Be sure to enter source code N0001 at checkout!		Sales tax <small>(see tax information below)*</small> Grand total		

For discount bulk rates, call toll-free at 888/206-6554.



***Tax Information**

Please include applicable sales tax. Electronic subscriptions are exempt. States that tax products and shipping and handling: CA, CT, FL, GA, IL, IN, KY, MA, MD, MI, MN, NC, NJ, NY, OH, OK, PA, RI, SC, TN, TX, VA, VT, WA, WI. State that taxes products only: AZ. Please include \$27.00 for shipping to AK, HI, or PR.

Your source code: N0001

Name _____
 Title _____
 Organization _____
 Address _____
 City _____ State _____ ZIP _____
 Phone _____ Fax _____

E-mail address

(Required for electronic subscriptions)

Payment enclosed. Please bill me.
 Please bill my organization using PO # _____
 Charge my: AmEx MasterCard VISA

Signature _____
(Required for authorization)

Card # _____ Expires _____
(Your credit card bill will reflect a charge to HCPro, the publisher of RACRI.)

Mail to: HCPro, P.O. Box 1168, Marblehead, MA 01945 Tel: 800/650-6787 Fax: 800/639-8511 E-mail: customerservice@hcpro.com Web: www.hcmarketplace.com

in Stone Mountain, GA. “Someone from home—a mother or father, say—accessing the network may be away for a minute or two and not use the proper logoff procedure. If a child or someone else in the house comes along and has access to the network, no one [will] ever know,” she says.

Olson estimates that there are 80–90 remote users accessing Beth Israel’s network at any time. Develop an appropriate policy and be sure to educate staff about it, he suggests.

Beth Israel’s policy works first on the behavioral level, instructing remote employees not to keep PHI on their home computers or allow others to view it.

However, policies work only if you give staff the tools to comply. Training should directly address remote workers, Ingram-Campbell advises.

Take a tiered approach to network access training by dividing your work force into those using

- equipment owned by the organization on-site
- equipment owned by the organization off-site
- their own equipment off-site

Although Olson does not divide the work force in this manner, all of Beth Israel’s employees undergo yearly training online. Each year, Olson tweaks the program, adding new elements and taking out old ones.

Søren Maigaard, MSc, CISSP, a security consultant at NNIT, an information technology consulting firm in Denmark, agrees with this approach.

When he introduces employees to new technologies (e.g., remote access, PACS, etc.), Maigaard adds to the basics that they already know and teaches them information that outlines the new functionality. This method builds on the user’s overall security knowledge with each training session.

Take control of hardware

Beth Israel’s employees are diligent about keeping their remote devices secure by installing the latest patches and protection, Olson says.

However, risk-averse organizations should provide remote employees with organization-owned devices, which allow for a higher degree of control, Ingram-Campbell advises.

“If you’re going to allow them to work remotely, you need to make the investment and give them equipment that you want them to work on,” she says.

In lieu of this, Beth Israel employs strong technological protections. Most remote workers access the network through a secure sockets layer (SSL) gateway that compares the machine’s features with security requirements that Olson sets.

SSL is a protocol for encrypting information—in this case, PHI—to be sent to and from Web sites over the Internet.

For example, if the remote device does not have the latest patches installed, it’s connected to the network with reduced access.

Beth Israel also uses automatic logoffs at both the application and remote-access link levels to prevent unauthorized users (e.g., employees’ children) from accessing confidential information.

Facilities that want stronger protection should consider using radio frequency identification and other proximity sensors, Ingram-Campbell says.

Such sensors detect when remote workers leave their home workstations and sign them off quickly, without the delay time of automatic logoff. ■

Questions? Comments? Ideas?

Contact Managing Editor Melissa Varnavas



Telephone:

781/639-1872, Ext. 3711



E-mail:

mvarnavas@hcpro.com

Savvy shoppers prepare prior to PACS purchase

Create a request for proposals, vision for data needs

You wouldn't buy a new television without comparing prices at Best Buy and Wal-Mart, would you? Then why purchase a PACS system without first completing a request for proposals (RFP)?

RFPs provide a layer of protection for both radiology administrators and facilities. They focus the scope of your needs and eliminate unsuitable offers from multiple vendors. Using RFPs to guide purchasing or contracting decisions allows for more accurate comparisons between products and services.

Decide what you want and see whether they have it

Establishing selection criteria for your RFP gives you a concrete wish list to help you make objective comparisons. It shields you from the influence of a smooth-talking salesperson and provides protection against impulse purchases.

First, focus on your needs versus your wants. Ask yourself the following key questions:

- What features should the technology have?
- What type of service do we need?
- What problem does this purchase solve? Draw a work flow diagram and look for areas of process duplication.
- What improvements do we want to make to our organization?

Develop a list of "must-have" items. These may include items such as

- secured report delivery on a radiology information system
- hospital downloads on a practice management system
- experience in radiology
- guaranteed ratio of productive working time on a PACS system (i.e., "uptime")

With your wish list in hand, now develop a submission packet for vendors. Include a cover letter, along with the following information:

- A project overview
- Proposal due dates
- Estimates on decision dates

- The number of proposals to submit
- Requirements on electronic or paper submissions
- Price quote requirements
- Practice profile
- Vendor profile
- Specifications for the technology or service

Once the responses come in, compare them and eliminate the unqualified candidates. With your whittled-down list, schedule finalist demonstrations.

At this stage, include staff in the decision-making process. Those using the equipment on a daily basis should test it and have input into the final purchasing decision.

Offer staff an evaluation form when they test the new product and ask them for a final recommendation on what to buy. Ultimately, the facility may choose another option for cost reasons, but either way, staff input is important. Make sure to include several key pieces of information in your RFP to receive the best proposals possible.

Provide a profile of your practice

Despite imaging's traditional adversarial relationship with vendors, providing concrete information within the RFP helps lead to the purchase of a better product. If you provide vague information about your practice's needs, expect vague product and vendor information in return.

Details such as practice size, volume numbers, equipment, and resource information allow vendors to accurately assess your facility's needs and the cost required to meet those needs. Be sure to include the following information to provide an accurate picture of your practice:

1. Tell vendors about the size of your practice.

Vendors often base their price on the number of physicians in a practice.

2. Provide the number and types of sites. Let PACS vendors know whether you are a hospital-based or

freestanding radiology facility. Make sure that the vendors have experience with similar facilities.

A PACS vendor may present a lot of user-friendly functionality, but if the company hasn't dealt with a hospital's imaging needs and the volume issues associated with it, the PACS system may be overwhelmed when it's installed and put into use.

3. Plan future growth expectations. Explain plans for potential business developments. Remember, the system that you buy is the system that you keep. It needs to progress as your business progresses.

Examine previous years' growth trends to make predictions about the future. Get a grip on this information to negotiate solid deals that won't impede system growth.

4. Offer a managed care profile. Some systems verify payment amounts to ensure reimbursement. Help vendors determine your needs by providing accurate information regarding payers.

5. Provide information about employees/system users. Tell potential PACS vendors about your staffing demographics. Let them know how many staff work off-site versus on-site and what type of programming they require.

6. Describe other systems to integrate. For example, if you have a solid system for mammography reporting, find out whether it is compatible with vendor applicants' systems.

7. Outline data storage requirements. Sketch your current storage needs for possible vendors and anticipate what you might need in the future.

Examine issues related to data backup, recovery, and use. Establish a process for data recovery before you ever need it.

The vendor profile

In addition to providing information about your own facility, request information about the vendor. Knowing the following information gives you a good snapshot of a vendor or service provider's qualifications:

• **Is the vendor a publicly traded or private company?** If it is publicly traded, you can research the vendor's success—or lack thereof. You can find out whether the company is involved in any shareholder suits and also whether it is profitable. Such information gives you a better handle on the quality of the proposed vendors.

• **Where are the company's headquarters and customer service department based?** A west coast practice may not work well with an east coast service center with regular 9-a.m.-to-5-p.m. hours.

• **Can the vendor provide details about the PACS system itself?** Ask where and when the vendor developed the current software version. Determine how frequently it updates the system. Question whether it bases additions on the older or newer platform. Make sure that the system that the vendor offers comprises more than just a new façade on the same old wall.

• **Does it comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other regulations?** Make sure the vendor understands what PACS and other systems mean to your overall compliance program.

HIPAA violations can cost radiology programs big money, so a PACS that addresses these concerns could mean a big difference to your bottom line in the end.

• **Are audit systems included in the programming?** A PACS system that allows for easy retrospective reviews can offer additional value. Examine which audit features different vendors offer you.

• **Does the vendor offer disaster planning and assistance?** Consider the constant risk of terrorist attacks and natural disasters. Under such circumstances, the security of information and its rapid recovery can be an invaluable asset to your radiology program.

Finding a PACS vendor with the appropriate disaster-planning strategy in place may make all the difference to your decision-making process.

Find out whether the vendor offers replacement hardware, software, or disaster-support personnel. ■

SIIM readies PACS admin certification program

Everything is digital these days—x-rays, ultrasounds, and even your grandmother's recipes.

Managing the electronic information flow associated with Italian wedding soup may not require specialty knowledge, but moving billions of bytes of imaging data from radiologists to physicians and patients and back again requires a certain kind of intellectual fortitude.

That's why hiring a PACS administrator can be such a tricky business.

The term "PACS administrator" previously applied to someone with any radiology, medical, technical, or informational skills. Internally, professional battles were often waged. Should the information technology department take control of the PACS, or should the radiology professional take the lead?

The Society for Imaging Informatics in Medicine (SIIM) wants to quantify the skills of PACS by establishing a new set of certification criteria.

SIIM recently announced sponsorship of Certified Imaging Informatics Professionals, a new initiative to certify PACS administrators.

The PACS Administrators Registry and Certification Association (PARCA) established a certification program in early 2005, and other radiology groups have offered their own fee-based certifications.

But SIIM hopes to standardize its program through the National Commission for Certifying Agencies, which officially endorses certification bodies, says **J. Anthony Seibert, MD**, professor of radiology at the University of California Davis and chair of the SIIM certification committee.

Charles Socia, vice president of operations for Synergy Imaging in Little Rock, AR, and a member of the committee, says that other organizations are set up similar to schools—you pay to take their exams. SIIM certification resembles a medical professional exam.

SIIM hopes that certification creates an accurate measure of the knowledge and skills held by imaging informatics professionals, offering a means for employers to better evaluate their qualifications for PACS-related positions.

Seibert expects the first test to be available in September 2007. Exams initially will take place twice per year at multiple locations nationwide.

The increasingly technical nature of PACS and the complex range of its functions have produced PACS administrators with widely divergent aptitudes, backgrounds, and experiences.

The SIIM certification process reflects the changing nature of PACS managers, Seibert says.

The program plans to incorporate interpersonal, business, and technical skills, he says.

The committee wants to create a universal certification standard without unfairly disqualifying anyone from taking the exam, Socia says.

So far, exam eligibility requires two years of experience, continuing education, and a certain level of performance, Seibert says.

Someone with a radiology technologist background, but not an equally strong information technology background, should have basic knowledge about how PACS systems function.

The outcry from experienced PACS administrators over the hiring of less experienced workers became a driving force behind the program, Seibert says.

Facilities looking to hire PACS administrators prior to the certification exam rollout should look to the SIIM framework and go from there.

SIIM plans to periodically place sample exam questions on its Web site before the test's debut, which will give prospective employers an idea of whether their PACS administrators are eligible. ■

PACS administration: Creating the support team

In the spirit of keeping up with the Joneses, your hospital system decided to renovate the east wing, purchase two new magnetic resonance imaging machines and a PET/CT, upgrade the hospital's entire computer system, and implement a PACS system. And, by the way, because you're the imaging director, it's your job to make sure that all these systems work.

To keep PACS implementation moving along, it's critical to establish an appropriate and capable support team to guide the process, said **Wil Reddinger, MS, RT (R), (CT)**, quality systems specialist at Children's Hospital and Regional Medical Center in Seattle, during the 34th annual American Healthcare Radiology Administrators meeting in August in Las Vegas.

"PACS isn't simply a computer software program that runs by itself," he said. "You may be working away, and the next thing you know, your boss comes over and says, 'Hey, how'd you like to be a PACS administrator?' [Implementing a successful PACS transition is] only 15% magic. The rest is careful planning."

PACS support: Avoid common mistakes

Getting a PACS system up and running can be a difficult task, and getting people to change the way in which they do things is often an even bigger challenge, said Reddinger.

"We take the people managing our film libraries, and we tell them, 'Guess what, guys, now you can manage this PACS.' You cannot take a \$9-an-hour transporter and tell them they get to be a PACS operator now."

In radiology departments and mammography facilities alike, directors have a tendency to recruit PACS team members from their existing staff. Although there's nothing inherently wrong with that, you need to provide appropriate training within a reasonable time frame, he said.

Another common mistake is delegating PACS tasks to overburdened staff—based on the idea that existing staff can handle additional tasks without additional compensation, transition time, or training.

Successful training means fewer disconnects

To ease the process of transitioning to PACS, it's important to create specific job descriptions and offer current staff the necessary training to operate under those revised job descriptions, said Reddinger. Ongoing education is key. Make staff training a team-oriented experience, he said.

"Don't just educate your internal staff, the ones who are in your department right now. Educate everybody—internal staff and external staff," added Reddinger.

Train staff on the following topics:

- Network
- Software
- Computers
- Operations/workflow
- Applications
- Quality control
- Troubleshooting
- Security

The last issue, security, is particularly important. Include documentation of any and all security training in the handouts and paperwork provided to staff.

Further, retain sufficient copies of the documentation in a centralized location, so when federal officials or your hospital's compliance officer come looking, you can say assuredly that your staff understand all of the proper security protocols, Reddinger said.

Convince the staff of PACS pragmatism

The best-laid plans won't get you anywhere if your staff aren't onboard. Follow these tips to ensure appropriate PACS teamwork:

- **Communicate well to ensure buy-in.** Don't be a dictator. "Don't tell staff it's this way or the highway. You have to let them communicate their needs, and you need to listen to them," said Reddinger.

- **Increase urgency—inspire and electrify.** "Tell people, 'This is going to make our lives better,' " said Reddinger. "Not only that, but it's

> p. 10

going to make your patients' lives better. Then show them how."

Demonstrate how the new system works, he said. Walk staff through the process. Let them know that they are not alone. Tell them that they can do it and that you'll work together to see that it happens.

- **Build the right team.** "While many among your current team will be able to make the transition, others may be unwilling or unable to adjust to new skill sets," Reddinger said.

That means that some people may have to be let go. Reddinger advised gathering appropriate documentation of training attempts, as well as getting human resources involved early in the process.

- **Empower action, remove obstacles.** Cross train your staff and offer preceptor training. Make sure that everyone is able to do every job in that department so no one stands alone. "Don't let staff say they can't do something because they don't know how or because it's not their job," Reddinger said. "Offer training so everyone performs as active team members."

What not to do

Although planning and precision are key to PACS administration success, any number of the following common pitfalls may muddle your efforts:

- **You take on too much at once.** Change is difficult for even the most agile spirit. Staff often feel overwhelmed when asked to learn new tasks within a limited time frame.

Instead, when establishing capital and programmatic improvements, consider staff training and learning needs as well, Reddinger said.

- **The physical layout and functionality needs are not properly met.** "You can't place your PACS people in a closet and expect it to all work out," he said.

- **There is a lack of communication.** Poor communication can exist between people and between

machines. Your people must be able to talk to one another, and machines need to communicate with one another as well via a network. "What good is a new system going to be to you if it can't communicate with your old system?" asked Reddinger.

- **You rely too heavily on vendor support.** Vendors can be a valuable source of support, but don't rely on them too heavily. Don't expect vendors to train the whole staff. Also, keep in mind that sometimes current staff understand more about your specific system needs than the vendor does.

- **There is too much finger-pointing.** "Too often, even those in administration forget it's a team effort. Some people will say, 'It's not my problem,' or blame others for problems. It's better to steer clear of laying blame and focus on fixing whatever problem has arisen," Reddinger said.

- **You fail to form a PACS committee.** "Once the PACS system gets implemented, management often forgets about it. They think everything will continue to flow smoothly, which is not always the case," said Reddinger.

Form a PACS committee that includes supervisors, radiologists, technologists, administration, and information technology (IT) staff. This group will be vital to heading off PACS problems, he said.

- **There are territory battles (e.g., IT versus PACS).** In the trenches, staff take their jobs very seriously. They may even see the implementation of PACS as a threat to their job security.

Turf wars might break out regarding who has the right background to do the work. Remind staff that PACS administration is about patient care, not about who has the proper credentials to do the job, said Reddinger.

"If the PACS is down and the patient has to wait, then we're not doing our job. So put the territory battles to bed. If you can help, great. If not, get out of the way, and let's find someone who can," he said. ■

Establishing digital protocols in mammography

You've gone digital—now what? You may need to create new positions, realign old staff to new job requirements, or phase out positions altogether.

Changes associated with digital mammography implementation add stress to a facility. Staff must learn new ways to accomplish the same tasks that they've done for years.

You may need to add a PACS administrator and one or more information technology positions. Depending on your facility's volume and workflow, you also may need technologist assistants or coordinators to help with digital image-hanging protocols and to smooth your processes.

The Elizabeth Wende Breast Clinic (EWBC) in Rochester, NY, added two temporary positions when its mammography facility moved from traditional film to digital imaging. One position digitizes film images and one sorts patient records each morning to determine which women would most benefit from a digital exam.

EWBC retained some film equipment in addition to its digital units. Facility leaders determined that it could not fully manage its population with digital systems alone. Making the leap to total digital all at once eliminates the need for those additional positions, because all patient exams take place on digital units.

Because connectivity and compatibility may be problematic during the early implementation stages of digital mammography, be sure to cover all of the personnel requirements. You may need additional staff to ensure that the correct scan appears on the correct workstations to eliminate radiologist downtime.

Despite the hiccups of switching to 100% digital mammography systems, breast scanning programs will eventually cut back on darkroom assistants, radiology aides (both physician and technologist aides) who help to hang films, chart room staff, and possibly transcription and billing personnel if such features become automated through your PACS/radiology information system.

When your system becomes fully electronic, it is likely that one digital unit can replace two film systems, which decreases the need for staffing and helps you increase your volume.

Establish a plan to fill the knowledge gap

Prepare for the unavoidable learning curve when implementing PACS or other digital systems. Build in additional time for staff to perform digital exams. Do not cut back on staff until your digital workflow runs smoothly—a process that can take months or longer.

Although manufacturers say you'll be able to complete 40 or more mammograms per day on a single full-field digital mammography unit, it takes time to reach that level of efficiency.

In the meantime, expect a slowdown in productivity. Anticipate the need to trim the patient load until you resolve staff and connectivity problems. EWBC converted to digital on a limited basis at first. This course of action allowed the facility to pick and choose the patients who were best suited for digital exams.

Be ready to make other practice adjustments as well. For example, EWBC offered same-day service to many of its patients. During the first few months of digital mammography implementation, it performed only screening mammograms for those who could wait an additional day or two for the results. This allowed physicians more time to gain experience on the equipment provide more complete image interpretation without interfering with the facility's overall workflow.

Physicians only recently began using units for diagnostic exams, as they take more time and require specialized positioning. Diagnostic procedures sometimes tie up the full-field digital mammography unit and add complications to the electronic hanging procedure. With more experience comes more confidence and increased throughput. As for fewer staff, well, that comes later.

The right person for the right position

For the most part, staff at EWBC eased into

> p. 12

new positions as the transition to digital transpired. Sometimes the best person for the job already works at your facility. For example, a former technologist now at EWBC focuses on troubleshooting digital equipment, working with service staff, and answering employee questions. The EWBC team coupled the transition with a new title—lead digital technologist—to solidify the new role. EWBC's new PACS administrator also came from within the facility's existing ranks.

A PACS administrator is one of the most important positions that you must fill. Look for the following qualifications to get started in your search:

- **Solid people skills.** The PACS administrator must work well with frustrated staff, physicians, and vendors. He or she must act as the liaison between clinical personnel and the PACS service representatives and help desk, working with both groups to fix any problems that arise.
- **Aptitude for computers.** Technical computer background is a boon but is not necessary. The new staffer can be brought up to speed on basic networking by attending educational seminars and learning on the job.

Nevertheless, the debate continues, in both the mammography world and radiography at large, regarding qualifications for PACS administrators (see the related story on p. 8).

EWBC decided to hire its own clinical staff person and then trained that person on PACS and other information technology tasks. When the facility joined the American College of Radiology's Imaging Network study as a clinical trial site, the new PACS administrator received training on soft-copy review

workstations. When EWBC installed its PACS, the new administrator received additional training—enough to become a so-called “super-user.” When associations or other organizations offered training, the new administrator attended. The rest of the training came on the job.

Because a smooth electronic environment relies on understanding clinical workflow, it made sense for EWBC to train an insider as a PACS administrator rather than hire from outside the organization. Although hiring a noncomputer type as a PACS administrator may seem daunting, EWBC wanted someone who understood the organization's workflow, physician preferences, and hanging protocols for the different exams and types of patients.

If your PACS administrator has a technical background, that's a bonus, but it's probably more important—at least in EWBC's experience—that he or she have a clinical background and know your current workflow. EWBC's pick for the new PACS position not only showed acumen for digital technology, but also a desire to learn and improve existing skills.

Complete a full assessment of your facility's needs and its current staffing to determine whether such a switch would work for you.

The practice retained all of its staff for the immediate future but kept its options open because, down the road, as processes solidify and additional digital units come onboard, fewer staff may be required. So far, EWBC has managed the changes within the natural flow of turnover. ■

12/06

SR 3406

This special report is published by HCPro, Inc., 200 Hoods Lane, Marblehead, MA 01945. • Copyright © 2006 HCPro, Inc. All rights reserved. Printed in the USA. Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro or the Copyright Clearance Center at 978/750-8400. Please notify us immediately if you have received an unauthorized copy. • For editorial comments or questions, call 781/639-1872 or fax 781/639-2982. If you have questions, contact customer service at 800/650-6787, fax 800/639-8511, or e-mail customerservice@hcpro.com • Opinions expressed are not necessarily those of the editors. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions. HCPro, Inc., is not affiliated in any way with the Joint Commission on Accreditation of Healthcare Organizations.