Driving Quality Improvement Initiatives in Radiology Practice Management

Exploratory Paper

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Abstract

Medical Practice Executives’ role in improving quality care is rapidly expanding as a result of the healthcare market move from volume of services to value of services. Establishing a State-sanctioned Continuous Quality Improvement Plan and following key principles for improvement activities will support the medical practice. New legislation, discussed in the paper, provides financial incentives to adopt improvement strategies. Eleven potential areas of focus are identified for the Radiology Medical Practice Executive to consider. These include patient satisfaction, peer review, technologist quality control, dose registry, result turnaround time, result audits, critical results, emergency department discrepancy reporting, clinical registries, biopsy trackers, and staff engagement.

*Keywords:* radiology quality, quality initiatives, continuous process improvement, quality control, quality improvement, peer review, critical results, discrepancy management, clinical registries, value metrics, technologist quality, cqip, radpeer, alara
Introduction

Healthcare management requires medical practice leadership to support and drive organization focus and commitment to continuous quality improvement. Quality is a broad term and encompasses a scope that extends from outcomes, to patient safety, to patient experience, and innumerable points in between. Accreditation organizations, professional associations, and of late, payer policy, also play a significant role in the quality movement. The goal of this paper is to explore the quality movement, continuous quality improvement strategies and quality initiatives in a radiology practice, and the role of the Medical Practice Executive in supporting and driving this process. This paper identifies the design, scope, and application of numerous quality initiatives in radiology.

Methodology

The research methodology incorporated an extensive literature review as well as interviews of various experts in quality improvement in healthcare. These interviews included academic radiology quality initiatives experts, vendor interviews for application of their tools in quality programs and interviews with quality management professionals working in the health
system environment or in radiology practice with roles in quality management and information technology.

**Background**

Quality improvement theories and strategies originated in industry in the early 1920’s. Healthcare links some of its early quality improvement efforts to the late 1800’s. Quality improvement and quality management methods have achieved profound impacts on both sectors. The evolution of Total Quality Management (TQM) which is a management approach utilizing an organizational wide model, theorizes that long-term success is achieved through customer satisfaction. TQM incorporates the vision of several quality pioneers who defined and created management approaches to achieve quality outcomes and manage improvement processes. These thought leaders and their focus on quality process are foundational to the current era in healthcare quality improvement.

Quality improvement management theories originated with several quality pioneers. Walter Shewhart’s work in the 1920’s focused on reducing variation in manufacturing processes. Shewhart created statistical process control tools and the well-known management approach of Plan, Do, Study,
Act cycle to support continuous process improvement. Joseph Juran, another quality pioneer, created the Quality Trilogy with a focus on the continuous quality improvement model and specific attention to quality as defined by the customer. He theorized that all members in an organization contribute to improvement processes, products and services. Juran’s work dates back to the 1950’s but his career spanned decades of contributions. Philip Crosby, another quality pioneer, made further contributions to the quality movement. His work focused on conformance to specification and the value of the zero-defect approach to quality management. This includes the theory that most costs of poor quality are hidden and cannot be measured. These hidden costs significantly impact the cost of operations and customer satisfaction. Crosby’s career began in 1952 and his contributions continued into the 1990’s. Finally, W. Edwards Deming, is often credited as the father of the quality evolution in industry. He believed management required transformation and advocated for management focus on quality noting that profits would follow. His book Out of the Chaos, first published in 1982, delineates fourteen points that aid management’s approach to organizational focus on quality.

The healthcare industry’s exploration of quality started in the late 1800’s with Louis Pasteur’s germ theory of disease. In the early 1900’s,
quality improvement in healthcare extended to improvements in anesthesia, and then proceeded to a focus on antisepsis and cleanliness. In 1910, Ernest Codman initiated the concept of tracking patients to discern whether treatment was effective. Codman’s work prompted the American College of Surgeons to define the concept of minimum standard of care. (Cantiello, 2016). The Joint Commission (TJC) was founded in 1952. TJC’s goal is to continuously improve the safety and quality of care. It is an organization with tremendous influence in today’s health systems.

Quality improvement focus in healthcare utilizes many variant definitions of quality. The Institute of Medicine (IOM) published its report on *To Err is Human* in 1999 and linked key concepts about patient safety to Dr. Deming’s model focusing on process to drive out variation and errors that compromise quality and safety. The IOM defines quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” (Institute of Medicine, 2001) The American Health Association (AHA) and Agency for Healthcare Research and Quality (AHRQ) define quality as “delivering care and doing the right things, at the right time and in the right place.” (AHRQ, 2009)
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Measuring quality in healthcare occurs through an array of organizations and quality initiatives. These span the Leapfrog Group, The Joint Commission, and the Centers for Medicare and Medicaid Services (CMS), and many others. The Medical Practice Executive should leverage these professional societies and accreditation organizations to obtain information about quality initiatives that would best serve their medical practice.

Medical Practice Executives are challenged to meet and comply with the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This legislation designed a new value-based reimbursement system named the Quality Payment Program (QPP). This CMS program provides a mechanism to reimburse providers for care using value metrics and measures as opposed to volume of services.

QPP has two pathways, one of which is the Merit-Based Incentive Payment Program (MIPS). The other pathway is the Advanced Alternative Payment Model (APMs). MIPS is a CMS quality program that provides for the collection and reporting of quality data in the medical practice. APMs is a CMS quality program that provides added incentives to medical practices aligned in a coordinated care delivery model such as Accountable Care
Organizations (ACO) for delivering high quality care in a cost-effective manner to certain patient populations. This paper will focus on quality initiatives defined through MIPS.

The CMS Innovation Center is another resource of active quality improvement initiatives that may yield value to Medical Practice Executives seeking ideas to launch their practice’s effort. The Medical Group Management Association (MGMA) and the American College of Radiology (ACR) provide numerous resources for meeting the MIPS quality metrics and thereby complying with the regulatory requirements.

The CMS focus on moving healthcare reimbursement from volume of service to value will promulgate further reimbursement strategies aimed at demonstrating value through quality. As with past CMS initiatives, these programs will spread to commercial payers and employer-based purchasers of healthcare. The current domains for Continuous Practice Improvement Activities (CPIA), as defined in MIPS, include clinical care, safety, care coordination, patient and caregiver experience, and population health and prevention. In addition, the Patient Protection and Affordable Care Act (ACA) signed into law in 2010, has spawned the creation of ACOs which serve to promote coordinated care among hospitals and providers. The
purchasers of care through ACOs often define health metrics and measures they hope to achieve via this care delivery model. These measures include points of focus ranging from potentially avoidable hospital readmissions, care coordination for high risk patients, total hip and knee surgery bundle, spinal fusion surgery bundle, low back pain improvement, end of life care improvement and addiction and dependence treatment improvement.

The Medical Practice Executive serves as a thought leader in the medical practice to support strategic and business goals focused on quality improvement. Clinical quality initiatives align with medical practice business objectives (such as sustaining revenue, properly allocating resources, monitoring operational and service metrics and other practice clinical and business objectives). Thus, it’s imperative that the Medical Practice Executive work closely with the physicians in the practice to support this focus and to define these quality, safety and operational goals. MIPS measures evolve yearly as CMS publishes the proposed and final rules. Radiology-practice specific MIPS measures may be found on the American College of Radiology’s website and is titled “2017 MIPS Improvement Activities Suggested for Radiologists.” The URL for these potential measures is:

https://www.acr.org/~/media/ACR/Documents/PDF/QualitySafety/Quality-
Medical Practice Executives are expected to support quality development in their practices. The MGMA *Body of Knowledge for Medical Practice Executives* defines core Medical Practice Executive skills as “Design and implement a quality management system that leads to the improvement of healthcare delivery and ensures patient safety. Engage clinical and nonclinical staff to apply quality management approaches to address and ensure safety for patients and staff as well as improve business and clinical operations.” Further, it defines the Medical Practice Executive’s role as: “Support physician leadership in the design and implementation of an effective peer review process.” This is at the heart of quality, patient safety, and patient outcomes in healthcare quality initiatives.

The Institute for Healthcare Improvement (IHI) stated:

“The era when quality aims could be delegated to ‘quality staff,’ while the executive team works on finances, facility plans, and growth, is over. System-level breakthrough aims are by their very nature strategic, and require the energy and attention of the entire
organization, led by the CEO and the entire executive team.”

(Reinertsen, 2008)

The Medical Practice Executive plays a supportive role and facilitates the decision-making process, but the key project definitions are best served by engaging the physicians. The IHI further states in its white paper, *Engaging Physicians*, “Physician engagement is imperative for activities such as physician credentialing, privileging, monitoring, and corrective action. It is also required for choosing and applying clinical practice guidelines, planning for physician recruitment, and many quality of care and patient safety initiatives.” (Reinertsen, 2007) In short, Medical Practice Executives are required to support this process but the true leaders are the clinicians in program and initiative design that will yield benefit to the patients, to the practice, to the health system partners, and to payers.

**Body**

To commence continuous process improvement (CPI), the Medical Practice Executive should consider 2015 IHI guidance titled *Model for Improvement*. It consists of three fundamental questions that help launch and frame the discussion within the medical practice:

- What are we trying to accomplish?
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- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

These questions are foundational to quality improvement efforts and provide the needed framework for guiding the discussion. Other key principles of improvement include:

- Document the aim of the improvement effort
- Create a feedback loop
- Develop a change that you believe will result in improvement
- Test the changes
- Plan the test
- Run the test
- Summarize the results of the test. What was learned?
- Act on the learning
- Implement. (Langley, 2009)

A key step in any CPI activity is to define the governance structure and team for assessing and implementing change. As stated earlier, the clinicians are the key leaders in this process, but the Medical Practice Executive will facilitate the effort by helping coordinate resources (human, data analytics, communication protocol, etc.) to ensure the projects are
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properly launched and followed. Once the initial assessment finishes, long-term adoption is often challenging. Knowledgeable quality professionals use the term “spread” to ensure the project withstands the test of time, aligns with the focus of the practice, and potentially spreads to other departments or sites within the practice.

The Medical Practice Executive should seek opportunities to incorporate the CPI methodology in the operational culture of the organization through value statements and by revisiting purpose with the teams. Personal involvement of the Medical Practice Executive sends a clear message about the import of the project and focus to all members of the organization. This time commitment helps garner further engagement and the likelihood of success.

Application of the CPI theories generally starts with goal formation or a known gap. Medical Practice Executives are expected to help facilitate this process and the adoption of best practices in their organizations. Radiology practices employ numerous tools to evaluate and improve quality and the following will identify several areas of focus that are commonly adopted to benefit patients.
Systems theory may help determine the best approach. Hard systems theory employs mechanical, mathematical, or scientific approaches to resolution. There is a well-defined objective and an end point. Soft systems theory supports an approach that has human factors. The problem may not be stated in objective terms, because there are multiple perspectives on the definition and the desired goals. This approach leads to a broad discussion and debate on the relevant contributing factors and, in the end, supports a direction that is continually moving. Soft systems theory upholds the belief that the end is to create learning organizations through an inquiry process that not only supports the initial situation but also leads the organization to appreciate more perspectives and to continually learn. Generally, the issues the healthcare system is challenged to address, are resolved through the soft systems management (SSM) approach.

Continuous process improvement initiatives useful by the Medical Practice Executive managing a radiology practice, are delineated as options below.

**Patient Satisfaction**

Radiology practices are challenged to manage patient satisfaction in their privately held imaging centers, but also to support patient satisfaction
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initiatives in the radiology departments of the hospitals they serve. The Hospital Consumer Assessment of Providers and Systems (HCAHPS) is a survey tool used by CMS and it impacts the hospital’s annual payment update. Patient engagement and compliance is an important factor in driving patient comfort and thus patient safety (Studer, 2003). As a result, health systems invest in training their teams using the Studer Group AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank you) model to positively impact these scores. Radiology providers are part of the patient’s overall interaction with the system and therefore, contribute to the patient’s safety and satisfaction improvement effort with techniques such as acknowledging the patient, explaining the service, and managing the transition between those involved in the patient care. The Press Ganey survey tool uses a measure of the patient’s likeliness to recommend the facility as a benchmark of satisfaction. Hospital imaging departments typically use this tool to measure and help support initiatives to drive patient satisfaction. Most radiology practices use similar patient experience survey tools to help provide feedback on operational performance.

Trending patient satisfaction information over time supports management attention and focus to evolving gaps. Finally, the CMS MIPS measures utilize patient satisfaction as one of the five key domains for
quality. Radiology practices may opt to use ACR Measure IA_EPA_3 to evaluate the collection of patient experience and satisfaction data on access to care and development of an improvement plan, such as outlining steps for improving communications with patients to help understanding of urgent access needs. This is one of multiple measures within the CPIA program. The role of the Medical Practice Executive is to support the design, administration, and analytics for the patient satisfaction survey. The Medical Practice Executive then facilitates the development and administration of interventions to improve the results, and overall coach for performance.

**Peer Review**

This quality focus is educational in nature so providers may improve their diagnostic skills through blinded review of cases. It is critical that the medical practice consult their State guidelines for ensuring this activity is completed under a sanctioned Department of Health Continuous Quality Improvement Plan (CQIP). This provides protection from discovery and potential accidental exposure of errors while supporting provider education and practice improvement. The American College of Radiology has a tool for blinded case review, called RadPeer, that allows practices to benchmark their performance to more than 19,000 radiologists practicing in the United
States.  Best practice design is to provide for both blinded review of cases using statistical sampling techniques, as well as focused review when that data yields a suggestion that the provider or practice may have outliers. Finally, in imaging practices, patients may return for follow up imaging or will submit comparison images that reveal a missed diagnosis. The radiology practice would be best served to create a provision in their CQIP to track and report these detected cases for further practice improvement. Radiology practices may implement mechanisms for formal review and presentation of cases labeled “disagrees” through the peer review process. There is a scoring mechanism that indicates the severity of the “disagree” and if the “disagree” was significant enough to potentially alter the medical treatment plan. The review process supports education by distributing the “disagree” cases to the original reading provider with an opportunity to appeal the “disagree” score to the Chair of the practice quality assurance committee. If the “disagree” is upheld and still contested, then the chair may consider engaging other quality assurance committee member review. This gives the providers a fair and balanced assessment of the scoring process. Another best practice defined in the CQIP is to create a blinded review of the “disagree” cases at practice meetings to spread the education and hopefully improve the overall awareness of all providers. (Please see Appendix A for
sample result format for Peer Review analytic for a single provider.) The role of the Medical Practice Executive is to help ensure the practice establishes a CQIP, and then abides by the program defined in the CQIP. This will likely include meeting coordination, data gathering, and communications with risk management departments and carriers as appropriate.

**Technologist Quality Control (QC)**

Radiologists often read in excess of one hundred cases each day. Radiology Technologists (RT) are challenged to obtain the best images possible, recognizing inherent limitations due to patients in pain and motion compromised images, body habitus constraints such as patient weight or girth that require judgment about the optimal radiation dose to create the best images, and other similar constraints. Simple errors are not uncommon. These range from generating images with too large a field of view, mis-labeling the images for laterality, failure to follow protocol, and similar imaging quality concerns. A CQIP will provide tools for scoring these images and getting feedback, on a case-by-case basis, to the technologist and their leaders so additional training may occur. A best practice is for this feedback to be factual, timely, and specific to the case and the technologist.
Radiologists expect that the department leadership will use this feedback to manage pointed education and to monitor improvement. Radiologists further expect to receive a response on actions taken to ensure these QC records are responded to timely, as it may be necessary for the patient to return for additional imaging to properly diagnose the case. Quarterly trending reports by technologist, service site, imaging modality, exam type, and reporting radiologist may yield additional information that is valuable to improving the quality of care and patient safety. (Please see Appendix B for sample reporting format for technologist QC data for one exam type.) The role of the Medical Practice Executive is to identify vendors for this reporting tool, and to facilitate policy development to ensure the feedback produces action and improvements.

**Dose Registry**

A safety and quality goal of imaging is to use the proper amount of radiation dose when performing CT scans. The proper radiation dose is defined in Title 10, Section 20.1003, of the *Code of Federal Regulations* (10 CFR 20.1003). ALARA is an acronym for "as low as (is) reasonably achievable,"
"which means making every reasonable effort to maintain exposures to ionizing radiation as far below the dose limits as practical, consistent with the purpose for which the licensed activity is undertaken, taking into account the state of technology, the economics of improvements in relation to state of technology, the economics of improvements in relation to benefits to the public health and safety, and other societal and socioeconomic considerations, and in relation to utilization of nuclear energy and licensed materials in the public interest."

To this end, radiologists take pledges for “Imaging Wisely” (ACR) and may also participate in a program that monitors the radiation dose administered. This can be achieved through compliance programs that track all scans performed and submits the cases via the CT scanning equipment, to a national registry. The quality and safety programs of the radiology practice will set up internal mechanisms for reviewing the results of these reports, as compared to national standards, and modifying protocols to optimize image quality and reduce dose. Imaging protocols are specific to clinical condition and the exam performed. The practice’s CQIP should speak to the monitoring process and how best to implement findings to optimize diagnostic accuracy following ALARA. The Medical Practice Executive
facilitates this process by helping with enrollment, ensuring registry report monitoring, and coordinating with the designated clinicians to review the results and then implement modifications within the various practice clinical sites. Educating technologists and documenting modifications, as well as communicating the results of these reviews, is an important support role for the Medical Practice Executive.

**Result Turnaround Time**

Quality and safety focus in the radiology practice also involves monitoring and reporting turnaround time on imaging exam orders. This requires utilizing the available reporting tools or hospital interfaces with the electronic medical records (EMR) or picture archive and communications System (PACs). This is a quality, safety, and provider and patient satisfaction metric used to ensure results of imaging tests meet standards defined by the practice and needed by the clinical staff that ordered the exam. There are numerous processes that impact this turnaround time, including patient preparation requirements (sometimes contrast is necessary as part of the imaging exam), other lab results, patient transport, technologist and scanner availability, and other points of coordination. The turnaround time is best analyzed by measuring the time of order to the time of result as
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the overarching value point, but radiology practices might choose to focus on measuring the time from when the study is available to read to the result time, and then assess variances among the practice members, shifts, service sites, modality and other relevant points of comparison. This is best accomplished through the use of run and control charts that measure not only the volume of studies, but also case mix and the workload intensity, using the work relative value unit (wRVU). The Medical Practice Executive supports this process by working with the hospital and practice information technology teams to collect these data points and generate the analytics needed to interpret the information. This leads to the identification of variances, and ultimately helps determine process improvement opportunities. The Medical Practice Executive often cannot influence these results directly, but can facilitate data collection, and the generation of control charts with standard deviation measurements. This information will arm the clinical leadership with the data it needs to assess performance. It is prudent to perform these assessments prior to an inquiry from a clinical partner or client site.

Result Audits
Unlike peer review, results audits may assess different components of the final result recorded in the medical record to evaluate compliance with the practice’s desired report structure and ultimately the value of the practice product. The audit parameters may assess different components of the report, including:

- the use of structured templates created in the voice recognition systems,
- assessing if the result answers the clinical question posed by the ordering physician,
- evaluating the use of “hedge” words, which encourages the use of clear and accurate communication and avoids vague and ambiguous terminology. “Vague and ambiguous terminology can be used against the radiologist in the court of law similar to absent communication.” (Bandla, 2017)
- assessing utilization of follow up algorithms defined by the practice for future imaging specific to modality and timing of follow-up. These are typically macros defined in the voice recognition system grounded in consensus statements from
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industry academic institutions. Follow-up imaging recommendations serve many purposes including monitoring the stability of a potentially malignant finding, or characterizing disease. The goal is to provide specific guidance on which imaging test to order and the appropriate timing.

The Medical Practice Executive role is to support the clinicians’ practice improvement activities by helping the practice define its reporting goals and standards, thus lending definition to the types of audits to perform. This work effort will also define the management methods needed to score results, which includes potential engagement of a medical statistician in audit design. Finally, the role of the Medical Practice Executive is to help collect the audit results and tabulate the findings in a way that supports the clinicians tasked with the project design and assessments. Overall, the goal of the Medical Practice Executive is to assist the clinical staff in assessing the quality of the practice’s product, as defined by the quality committee. Often, these projects start by creating a definition of the desired standards, collecting data to derive a baseline and then measuring, over time, to track improvements or further opportunities to support the quality improvement process. These quality improvement efforts are iterative
as each cycle contributes to organization learning and has the potential to modify direction and future cycles of improvement.

**Critical Results**

The Joint Commission requires that health systems create and adhere to a policy for managing imaging test findings of a critical nature. The communication protocol is defined in the Joint Commission’s National Patient Safety Standards Goal 2 (NPSG-2). Radiology practices create policy in concert with the health systems they staff to meet this safety standard. Quality and patient safety standards benefit from a practice audit of compliance. The Medical Practice Executive should work with the practice and health systems to support education and re-education of providers on this standard. Report audits are also beneficial to confirm that the documentation complies with the ACR’s policy on communication standards. This standard recommends a verifiable record of communication. Natural language processing audits of results may help determine compliance with these communication standards although generally, the audit will identify those reports that comply versus those that should have included the record of communication and did not. Radiology vendors are increasingly adding audit capability to their tool set to allow radiology
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groups to identify non-compliance. The Medical Practice Executive’s role is to work with the practice CQIP leadership and determine audit processes and timing or seek out vendor relationships to facilitate this process.

Emergency Department Discrepancy Reporting

Another quality improvement initiative is to provide a defined reporting tool for managing results that are discrepant, as originally reviewed by the Emergency Department clinician. With the advent of voice recognition technology and turnaround time metrics, these circumstances are rare but still provide an opportunity to advance process and quality improvement in both the radiology practice and Emergency Department. The clinical personnel will establish processes for clinicians to review and analyze those cases that warranted the use of the discrepancy tool. EMRs support the use of in-basket communication tools that facilitate this communication. The role of the Medical Practice Executive is to be aware of this functionality, to help support radiologist adoption of the discrepancy reporting tool, and communicate the need for EMR development to support this function. A further role is to work with the information support teams to design analytics to drive down the occurrence of discrepancies and identify trends. Again, the Medical Practice Executive is best served to work with
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CQIP leadership to ensure the review is protected and appropriate for the practice and health system.

Clinical Registries

With the advent of MACRA, there are more clinical registries available to support radiology practices in monitoring and improving clinical quality. The ACR has registries that support practices performing imaging services such as CT Lung Screening services, CT Colonography, and the National Mammography database. The goal of these registries is to collect data on the indications for the testing, as well as outcomes across service sites and providers. The registries help advance clinical practice through comparative data. These databases augment other processes in the radiology practice to track patients needing follow up care, or to refine compliance with reporting standards, such as Lungrad (Lung Image Reporting and Data Systems) or Birads (Breast Imaging Reporting and Data Systems). The Medical Practice Executive works with the CQIP leadership to identify the registries that best fit their clinical process improvement goals. The next steps are to complete the necessary applications, design the data workflow solutions, facilitate the reporting process, and finally, disseminate analytics to the clinical leadership team. The Society of Interventional Radiology (SIR) also has a reporting registry for structured reports. SIR advocates the
adoption of standardized reporting format for interventional radiologists and offers a registry to help the radiology practice improve report standardization and meet MIPS quality initiatives. Again, the role of the Medical Practice Executive is to work with clinical leadership to determine the interest in the practice, support development or refinement of practice policy, work with the voice recognition vendor to adopt these templates, and work with the information systems technical support teams to report this data. SIR’s primary goal is ensuring high-quality outcomes and patient safety in vascular and interventional radiology. SIR hopes to leverage this tool to support quality improvement and create mechanisms to assess performance in interventional radiology.

**Biopsy Trackers**

Radiology practices provide image-guided biopsy services spanning thyroid, lung, kidney and other organs. Biopsy samples, by definition, do not always yield a successful sample collection. Biopsy tracking technology facilitates radiologist practice improvement by logging these cases in a database to track sufficiency of sample, technique, pathology correlation and other similar metrics. The Medical Practice Executive can work with vendors to collect and tabulate this data and then present analytics to the clinical leadership to facilitate discussion of best practices. The role
of the Medical Practice Executive is to facilitate the vendor selection and
data collection, provide human resources for the analyst component, and
then generate the necessary reports for the clinical team to define best
practices. Radiology practices may also use this tool to support inferior vena
cava (IVC) filter placement tracking. Radiologists may be asked to place an
IVC filter, and despite receiving a referral for this purpose, they are
obligated to track the patients who received the filter and arrange for its
removal at the appropriate time after consultation with the patient’s
clinician. Quality databases support this reminder and tracking process for
these patients. The role of the Medical Practice Executive is, again, to ensure
there is defined policy, a tracking and communication protocol, and
personnel designated to provide care coordination processes.

Staff Engagement

Quint Studer’s writings in *Hardwiring Excellence* links staff and
provider engagement with patient comfort and thus, quality and safety.
Satisfaction surveys are not adequate to measure this desired state, and as a
result, it is incumbent on the Medical Practice Executive to support the
creation of an environment and a practice culture where patients feel
supported and safe. The Studer Group believes that patient satisfaction
metrics provide for measuring patients’ perceptions of specific aspects of
quality, yet it does not yield a result as rich as engagement. Engagement is a
more telling measurement that indicates whether a patient will choose to use
his discretionary effort to do something or not. Radiology practices
interested in quality improvement may employ strategies designed to support
employee engagement both in the health systems they staff, as well as in
their own imaging centers and practices. According to one of the 2016
Advisory Board engagement award winners, the Medical Practice
Executive’s role is “to lead, coach, set standards of behavior, communicate
expectations, and to provide the needed tools and support to meet
expectations, and demand personal accountability for results.” (Advisory
Board, 2016). They further counsel that engagement begins with employee
and leader selection, both of which are core responsibilities of the Medical
Practice Executive in both recruiting and retention for the medical practice.

Conclusion

Quality improvement initiatives in medical practice begin with an
understanding of the principles of continuous quality improvement, not the
least of which is properly framing the questions and projects to be
undertaken. The role of the Medical Practice Executive is to work in a
collaborative fashion with the clinical leadership, being especially mindful
of utilizing the CQIP format certified by the State where the practice is
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located. Creating a leadership team that focuses on quality improvement and a governance and communication process to support these efforts is foundational to the success of these quality initiatives. The Medical Practice Executive’s role is to provide support, arrange resources both human and data, and leverage outside expertise, to the extent warranted, to implement these initiatives. The Medical Practice Executive should develop and foster an environment focusing on continuous quality improvement process. The healthcare industry’s move from volume to value creates an environment where devoting these resources to CQIP is both prudent and necessary to support the practice and protect future revenue streams dependent on measurements such as clinical registries. CMS value initiatives are requiring deeper measurements and reporting of clinical value processes. These continue to evolve and require leadership to establish targets for the medical practice. The Medical Practice Executive should demonstrate strong communication skills, as well as organizational and leadership skills, to facilitate practice design and implementation of quality management systems that result in clinical improvements in their practice and service to its patients. The Medical Practice Executive may find additional information on these quality initiatives by networking with members of their professional associations such as the MGMA or Radiology